



SIRAGO
U.M.A.

**GAP PRODUCT
INFORMATION GUIDE
2020**

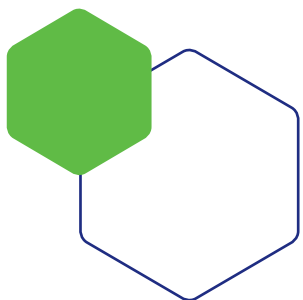
FOR A WORLD OF
POSSIBILITIES **#GOGETGAP**

Underwritten by



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*"A healthy outside starts from the inside."
- Robert Urich*



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

WHAT IS GAP COVER?

Gap Cover is the invaluable safety net that covers the shortfall between what medical schemes pay and what specialist doctors charge. Without this, policyholders may find themselves paying for unexpected costs from their own pockets.

INTRODUCTION

Sirago Underwriting Managers (Pty) Ltd is a registered Financial Services Provider (FSP4710), and underwritten by GENRIC Insurance Company Limited (FSP 43638). Sirago offers a variety of Gap Cover solutions tailored for the unique requirements of the South African healthcare market.

Our philosophy of continuous improvement means that you are always guaranteed individual attention and superior products, which will meet your needs and exceed your expectations.

Our competitive and affordable products are unparalleled in the market place and are the ideal complement to your overall healthcare portfolio. With a range of insurance solutions, Sirago provides comprehensive effective cover to suit every individual.

Disclaimer:

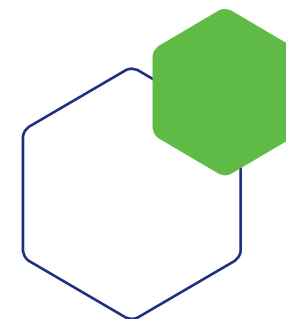
This is not a substitute for a medical scheme membership and the cover is not the same as that of a medical scheme. This is a Short-term Insurance Accident and Health policy in terms of the Short-term Insurance Act 53 of 1998. The policy wording supercedes any marketing documentation and all benefits will be payable against the policy wording terms and conditions only.

OUR PARTNERSHIP WITH YOU

At Sirago we provide a loyal partnership of care and understanding, opening up a new world of possibility which is focused on quality assurance, efficiency and the best customer service experience for you.

WHY CHOOSE SIRAGO?

- Personalised customer service
- Gap Cover solutions
- Cover for in-and out-of-hospital
- Shortfall cover for day-to-day specialists, GPs, dentists and alternative therapy
- Standard waiting periods
- Emergency room cover for accident, trauma and illness
- No maximum entry age and benefits do not cease at 65
- Cover for you and your family either on a single medical scheme or on multiple medical schemes
- We pride ourselves on effective turnaround times so as not to compromise policyholders
- A Stated Benefit is paid straight into your bank account, or arrangements can be made to settle directly with the providers
- Weekly claim runs



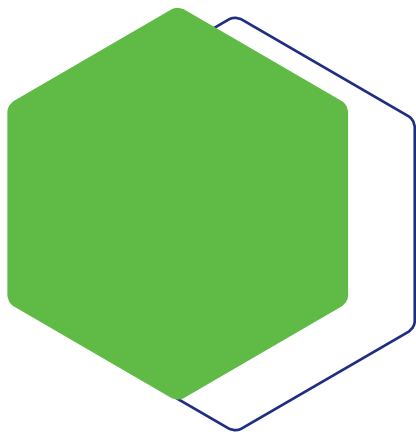
WHO IS COVERED BY THIS POLICY?

We cover policyholders and beneficiaries of all ages. 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 three age bands:

- 54 years and younger,
- 55 years to 64 years, and
- 65 years or older.

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 (ie the policyholder and on 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 dependant 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.



“Love yourself enough to live a healthy lifestyle.”

- Jules Robson

BENEFIT CATEGORY DESCRIPTIONS

GAP COVER

Covers the difference between the medical scheme rate and the rate that service providers charge.

CO-PAYMENT

The fixed amount excess imposed in terms of your medical scheme rules for undergoing a specific procedure whether in or out of hospital. This will include, for example MRI scans, CT scans, ultrasound scans, and scopes.

PENALTY FEE

The amount you have to pay in terms of your medical scheme rules when you are admitted to a hospital that is not a designated service provider as provided for in your medical scheme rules.

ADMISSION FEE

The fixed amount you have to pay in terms of your medical scheme rules when you are admitted to hospital as an in-patient.

PRIMARY CARE BENEFITS

The Gap portion claimable for the difference between the medical scheme rate and the charged amount for the listed set of primary care consultations applicable per option.

IN-ROOM SURGICAL PROCEDURES/DAY CLINICS

A procedure in a surgical suite that meets the requirements of a restricted area, and which is designated and equipped for performing surgical operations, or other invasive procedures that require an aseptic field which would/could ordinarily be undertaken in an acute facility.

SPECIALIST CONSULTATION

The Gap portion claimable for the difference between the medical scheme rate and the charged amount for the in-room consultation fee as charged by a specialist doctor, applicable per option.

EMERGENCY ROOM

A serious situation or occurrence that happens unexpectedly and demands immediate medical attention in an Emergency Room.

ACCIDENT

An event that occurs unintentionally and usually results in harm, injury, damage or loss. Policy cover only extends to accidents occurring after inception of the policy.

ILLNESS

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

EMERGENCY ILLNESS

A disease or period of sickness affecting the body, which warrants treatment at an emergency facility, however restricted to beneficiaries under the age of 8 years old.

PRESCRIBED MINIMUM BENEFITS (PMB)

A set of benefits as defined in the Medical Scheme Act and Regulations which ensures that all scheme members have access to certain minimum health benefits, regardless of your medical scheme option. This includes a requirement for medical schemes to pay the full cost of diagnosis and treatment for a list of medical conditions.

CANCER BENEFITS

Diseases in which abnormal cells divide without control and are able to invade other tissues. This definition includes leukaemia, lymphoma and Hodgkin's disease but specifically excludes benign, pre-cancerous/in-situ tumours or growths, as well as all stage zero cancer diagnoses. Any cancer that is diagnosed and treated through primary biopsy and not requiring additional intervention such as radiation therapy, or chemotherapy, shall not be deemed as cancer and will not have any benefit paid. Cover under cancer benefits will not be available for the first 12 months for any person diagnosed with cancer prior to the inception of this policy.

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

*Malignant Cancer: refers to cancer cells that can invade and kill nearby tissue and spread to other parts of the body. This definition excludes any diagnosis related to skin cancer.

HOSPITAL ACCOUNT SHORTFALL

The amount claimable on the medical statement, not covered by your medical scheme up to a specified limit.

PREVENTATIVE CARE

The Gap portion claimable for the difference between the medical scheme rate and the charged amount for preventive care treatment which is the care you receive to prevent illnesses or diseases.

SUB-LIMIT ENHANCER

This benefit covers the shortfall on a limitation applied in terms of your medical scheme benefits for internal prosthesis, MRI scans and CT scans on the amount of coverage available to cover a specific stated benefit within this insurance policy. It places a maximum on the amount available, rather than providing additional coverage.

APPLIANCES

An instrument or device designed for a particular medical use.

STEP-DOWN

Individuals who require on going treatment for rehabilitation purposes.

TRAUMA COUNSELLING

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

GAP COVER PREMIUM WAIVER

A premium waiver benefit is claimable for the surviving spouse/adult dependent of the current Sirago policy in the event of death or total permanent disability of the policyholder (irrespective of source of premium) on the Sirago policy.

MEDICAL SCHEME PREMIUM WAIVER

Only in event of death and/or total permanent disability of the policyholder, will we contribute towards your medical scheme payments, provided the medical scheme membership is active for a 6 month period. See benefit description.

WHAT ARE OUR WAITING PERIODS?



A "Waiting Period" is a defined period of time in which a policyholder may not claim any or may only claim certain policy benefits imposed by Sirago.

GENERAL WAITING PERIODS:

- A 3 month general waiting period is applicable on any newly inception policies and/or additional dependants to the current policy, except in the event of an accident.
- In the event that the policyholder has held a Sirago policy for 12 months without a break in cover and wants to upgrade to a higher option, all additional benefits will be subject to a 3 month waiting period.
- If the policyholder has held a Sirago policy for less than 12 months and intends to upgrade to a higher option, the balance of the relevant waiting periods in the higher option per benefit category are applicable.
- A 10 month waiting period on pre-existing conditions, diseases or illness.

SPECIFIC WAITING PERIODS APPLICABLE TO CERTAIN PROCEDURES: (ON GAP POLICIES ONLY)

POLICY SPECIFIC WAITING PERIODS:

The following conditions are excluded within the first 6 months of the policy cover inception.

- Myringotomy and grommets;
- Adenoidectomy;
- Tonsillectomy;
- Hysterectomy (except where malignancy can be proven);
- Spinal, back, neck and joint related procedures (repairs, scopes, joint replacement) except in the case of an accident. This includes treatments related to any and/or investigations including MRI scans, CT scans and scopes.

Thereafter, benefits will be payable at a rate of:

- 50% of benefits available from month 7 to 10.
- From month 11, the policy benefits will be fully available except where there are condition-specific exclusions and when a new beneficiary joins the policy, and is subject to underwriting terms.

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

- 10 month waiting period for pregnancy and confinement.
- Accidental Death, Total Permanent Disability and Premium Waivers are subject to a 6 month waiting period.
- Initial Cancer Diagnosis is subject to a 3 month waiting period.
- A 12 month waiting period on all pre-existing cancer related treatments.

GAP COVER COMPARISON

Abbreviation Description:

GP - General Practitioner OAL - Overall Annual Limit DSP - Designated Service Provider

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Your Sirago policy has an Overall Annual Limit (OAL) of R164 000 per beneficiary.

IN-HOSPITAL BENEFITS

Benefit Category	Ultimate Gap Cover		
Age	0 - 54	55 - 64	65+
Individual	R413	R491	R569
Family	R467	R556	R645
Age Limit	None		
OAL Per Beneficiary Per Annum	R164 000 OAL from 1 April 2020		
Gap Cover	Will cover an additional 500% of the medical scheme rate or at the stated benefit value. In the event of a claim for robotic surgery, appearing on the hospital account only, we will cover up to a sub-limit of R30 000 per policy per annum, limited to R12 000 per claim. A maximum of 2 claims per beneficiary per policy per annum.		
Co-payments	Are 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. Subject to OAL. Co-payments related to cancer are catered for in a separate benefit category.		
Co-payments Charged as a Percentage	If your medical scheme defines your co-payment as a percentage of the benefit, your co-payment benefit will be limited to a maximum payment of R16 000 per claim.		
Penalty Fee Cover	Subject to a sub-limit of R10 500 per claim, a maximum of 3 claims per policy per annum for the voluntary use of a non-designated service provider/network hospital. This includes the use of a partial-cover network hospital as determined by your medical scheme.		
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 OAL.		
Hospital Account Shortfalls	Subject to a sub-limit of R5 000 per policy per annum. Maximum of R1 250 per claim. Maximum 3 claims per beneficiary.		
Sub-limit Enhancer	Sub-limit of R100 000 per policy per annum subject to R25 000 per claim. Maximum of 2 claims per beneficiary, limited to 4 claims per policy per annum. The Sub-limit Enhancer benefits are limited to MRI scans, CT scans, intraocular lenses and internal prosthesis only.		
Step-down	A sub-limit of up to R9 000 per policy applies to this section of cover. In the event that your medical scheme provides benefits for rehabilitation as an in-patient in a step-down or sub-acute facility, resulting from an accident, cover will be provided for ongoing treatments by resident healthcare practitioners during your recovery once medical scheme benefits have been exhausted or limits have been reached.		
Primary Care Consultation Benefits	Subject to a sub-limit of R3 750 per policy per annum. GP claims x 3 with a R375 limit per consultation. Dental claims x 3 with a R375 limit per consultation. Alternative Therapy x 3 with a limit of R375 per claim per consultation. This applies to the Gap portion only.		
Emergency Room Cover	A sub-limit of R12 000 is applicable. This benefit covers an emergency at any registered emergency facility when you require immediate medical treatment due to an accident or illness. The following benefits collectively accumulate to the sub-limit: Accident 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: when you visit an emergency room in a medical emergency as a result of illness, we will cover the Gap portion only. Emergency illness benefit: this benefit is applicable to children under the age of 8 who require out 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.		

Plus Gap Cover		
0 - 54	55 - 64	65+
R324	R400	R475
R370	R457	R543
None		
R164 000 OAL from 1 April 2020		
Gap Cover will settle claims up to 500% above your medical scheme option rate, to a maximum of 600%, or at the scheme stated benefit value as determined within your scheme policy.		
Are 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. Subject to OAL. Co-payments related to cancer are catered for in a separate benefit category.		
If your medical scheme defines your co-payment as a percentage of the benefit, your co-payment benefit will be limited to a maximum payment of R13 000 per claim.		
Subject to a sub-limit of R6 500 per claim, a maximum of 2 claims per policy per annum for the voluntary use of a non-designated service provider/network hospital. This includes the use of a partial cover network hospital as determined by your medical scheme.		
Will settle the Gap portion of claims.		
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 OAL.		
Subject to a sub-limit of R3 000 per policy per annum. Maximum R800 per claim, 3 claims per beneficiary per annum.		
Subject to a sub-limit of R36 000 per policy per annum, and to R12 000 per claim. Maximum of 2 claims per beneficiary, limited to 3 claims per policy per annum. The sub-limit enhancer benefits are limited to MRI scans and CT scans only.		
No benefit		
No benefit		
A sub-limit of R7 000 is applicable. This benefit covers an emergency at any registered emergency facility when you require immediate medical treatment due to an accident or illness. The following benefits collectively accumulate to the sub-limit. Accident 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: when you visit an emergency room in a medical emergency as a result of illness, we will cover the Gap portion only.		

OUT-OF-HOSPITAL BENEFITS

OUT-OF-HOSPITAL BENEFITS

Day-to-day Specialist Consultation Fee

Preventative Care Cover

Appliance Benefit

Trauma Counselling

Cancer Co-payment Benefit

Cancer Boost Benefit

Cancer Breast Reconstruction Benefit

Cancer Benefit - PMB

Subject to a sub-limit of R6 500 per policy per annum. R1 350 per claim. 4 claims per beneficiary per annum for the Gap portion only.

R8 000 sub-limit per policy. R1 200 per claim. 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.

Maximum claim amount R6 600 per policy per annum for your Gap component as per the defined list: hearing aids, wheelchairs, CPAP machine, humidifiers, insulin pump, glucometer, nebuliser and the Mirena device.

A sub-limit of R5 000 per policy per annum with a registered medical professional. You will be covered within the first 6 months after a traumatic incident. Limited to a stated benefit of R750 per claim. This benefit covers you for, but is not limited to; dread disease, hijacking and/or violent crimes. (At the discretion of the insurer, on the provision of supporting documentation.)

The Cancer Co-payment benefit is applied once your medical scheme cancer benefit has been reached, and a percentage co-payment is imposed. This benefit incorporates co-payments for ongoing cancer treatment, and co-payments related to biological drugs. In order to access this benefit, you need to be on a registered treatment plan with your medical scheme. Subject to OAL.

The Cancer Boost benefit is limited to R100 000 per beneficiary per annum. This benefit is restricted to policyholders where their medical scheme option has a defined rand limit for cancer treatment. The Cancer Boost benefit can only be claimed once your rand limit on your medical scheme cancer benefit has been reached and you require ongoing treatment. This benefit is dependent upon the insured having already been registered on the medical scheme's cancer programme. The Cancer Boost benefit is limited to those that were determined within the approved medical scheme treatment plan which must be submitted to Sirago upon application for this benefit

In the event of the medical scheme approving reconstructive surgery on the affected breast, we will cover the Gap portion up to 300% of the claim. In addition to this, Sirago will make available up to R25 000 for the reconstruction of the non-affected breast. This benefit is available within the first 12 (twelve) months of the initial mastectomy. We require, subject to Sirago protocols, which include but are not limited to: medical scheme pre-authorisation and a motivation/letter from your treating provider.

Please note the above benefits are only available in the event that the treatments do not form part of the legislative PMB framework.

Subject to a sub-limit of R4 500 per policy per annum. Maximum of R825 per claim. 3 claims per beneficiary per annum for the Gap portion only.

R4 000 sub-limit per policy. R1 000 per claim, 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.

No benefit

A sub-limit of R3 000 per policy per annum. Limited to a stated benefit of R600 per claim. You will be covered within the first 6 months after a traumatic event with a registered medical professional. This benefit covers you for, but is not limited to; dread disease, hijacking and/or violent crimes. (At the discretion of the insurer, on the provision of supporting documentation.)

The Cancer Co-payment benefit is applied once your medical scheme cancer benefit has been reached, and a percentage co-payment is imposed. This benefit incorporates co-payments for ongoing cancer treatment, and co-payments related to biological drugs. In order to access this benefit, you need to be on a registered treatment plan with your medical scheme. Subject to OAL.

The Cancer Boost benefit is limited to R50 000 per beneficiary per annum. This benefit is restricted to policyholders where their medical scheme option has a defined rand limit for cancer treatment. The Cancer Boost benefit can only be claimed once your rand limit on your medical scheme cancer benefit has been reached and you require ongoing treatment. This benefit is dependent upon the insured having already been registered on the medical scheme's cancer programme. The Cancer Boost benefits are limited to those that were determined within the approved medical scheme treatment plan which must be submitted to Sirago upon application for this benefit.

In the event of the medical scheme approving reconstructive surgery on the affected breast, we will cover the Gap portion up to 200% of the claim. In addition to this, Sirago will make available up to 16 000 for the reconstruction of the non-affected breast. This benefit is available within the first 12 (twelve) months of the initial mastectomy. We require, subject to Sirago protocols, which include but not limited to: medical scheme pre-authorisation and a motivation/letter from your treating provider.

Please note the above benefits are only available in the event that the treatments do not form part of the legislative PMB framework.

CANCER BENEFITS

Gap Cover Premium Waiver

Medical Scheme Premium Waiver

Accidental Death

Cancer Cover (Initial Diagnosis)

Sira-Go' Baby

In event of death or total permanent disability of the policyholder of the Sirago policy. The premium waiver is directly linked to your policy premium per month as indicated in your Schedule of Insurance. This benefit is not paid in cash, but held as a credit against the policy for the applicable 12-month period. Should there be any premium adjustments within the 12-month period, the credit balance available for the rest of the waiver period, will be adjusted accordingly. This benefit cannot be transferred, ceded or converted to cash.

Payable in event of death or total permanent disability of the policyholder of the Sirago Gap Cover. In the event of dual medical scheme membership, this benefit is only payable in event of death or total permanent disability of the principal policyholder. Sirago will pay the medical scheme premium to the actual amount of the contribution, but not higher than the sub-limit of R4 500 per month for a 6-month period, which will be paid to the beneficiary for the upkeep of their medical scheme contributions. In order to receive the benefit, the Gap Cover policy and medical scheme membership must remain active during this period. A certificate of membership from your medical scheme must be presented monthly for authentication of current membership.

R15 000 principal, R10 000 adult dependent, R5 000 per child per policy per life.

This benefit will pay you a lump sum of R22 500 upon the initial diagnosis of malignant cancer per beneficiary per annum as defined. This excludes any incidence of cancer/pre-cancer prior to inception of the policy.

A branded Sirago welcome gift will be posted to your physical address, or delivered to your contracted broker, as per your application form upon receipt of the instruction to add the new-born child. The instruction to add the child to the policy must be submitted within 31 days of the birth of the child. (Subject to availability. Please allow 6 weeks for delivery).

In event of death and/or total permanent disability of the policyholder of the Sirago policy. The premium waiver is directly linked to your policy premium per month as indicated in your Schedule of Insurance. This benefit is not paid in cash, but held as a credit against the policy for a 12-month period. Should there be any premium adjustments within the 12-month period, the credit balance available for the rest of the waiver period will be adjusted accordingly. This benefit cannot be transferred, ceded or converted to cash

Payable in event of death or total permanent disability of the policyholder of the Sirago Gap Cover. In the event of dual medical scheme membership, this benefit is only payable in event of death or total permanent disability of the principal policyholder. Sirago will pay the medical scheme premium to the actual amount of the contribution, but not higher than the sub-limit of R3 250 per month for a 6-month period, which will be paid to the beneficiary for the upkeep of their medical scheme contributions. In order to receive the benefit, the Gap Cover policy and medical scheme membership must remain active during this period. A certificate of membership from your medical scheme must be presented monthly for authentication of current membership.

R8 000 principal, R5 000 adult dependent, R3 000 per child per policy per life.

R14 000 upon the initial diagnosis of cancer per beneficiary per annum as defined.

A branded Sirago welcome gift will be posted to your physical address, or delivered to your contracted broker, as per your application form upon receipt of the instruction to add the new-born child. The instruction to add the child to the policy must be submitted within 31 days of the birth of the child. (Subject to availability. Please allow 6 weeks for delivery).

WAITING PERIODS. Please refer to page 6 for more information.

VALUE ADDED BENEFITS

GAP COVER COMPARISON

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Your Sirago policy has an Overall Annual Limit (OAL) of R164 000 per beneficiary.

IN-HOSPITAL BENEFITS

Benefit Category
Age
Individual
Family
Age Limit
OAL Per Beneficiary Per Annum
Gap Cover
Co-payments
Penalty Fee Cover
Day Hospital/Clinic and/or In Room Surgical Procedures Cover
PMB Cover
Hospital Account Shortfalls

OUT-OF-HOSPITAL BENEFITS

Emergency Room Cover
Appliance Benefit
Cancer Co-payment Benefit
Cancer Boost Benefit

VALUE ADDED BENEFITS

Gap Cover Premium Waiver
Sira-Go' Baby

Gap Assist Cover		
0 - 54	55 - 64	65+
R278	R344	R409
R299	R371	R443
None		
R164 000 OAL from 1 April 2020		
Will settle claims up to 500% of the medical scheme rate. Limited to a maximum of 600% or at the stated benefit value.		
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 R42 000 per policy per annum, limited to R11 000 per claim. Co-payments related to cancer are catered for in a separate benefit category.		
No benefit		
Will settle the Gap portion of claims.		
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. Limited to R30 000 per claim. Subject to OAL.		
R2 000 sub-limit per policy per annum. Maximum of R500 per claim, maximum 3 claims per beneficiary per policy per annum.		
A sub-limit of R4 500 is applicable. This benefit covers an emergency at any registered emergency facility when you require immediate medical treatment due to an accident or illness. The following benefits collectively accumulate to the sub-limit. Accident 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: when you visit an emergency room in a medical emergency as a result of illness, we will cover the Gap portion only. We will cover a GP's emergency facility where no hospital emergency is available within a 30km radius within the above stated benefit limits.		
Subject to a sub-limit of R3 600 per policy per annum with a claim limit of R1 200 for your Gap component as per the defined list: hearing aids; wheelchairs; CPAP machine; humidifiers; insulin pump; glucometer; nebuliser and the Mirena device.		
A R100 000 limit per policy applies once your medical scheme oncology benefit has been reached and a percentage co-payment is applied. Subject to OAL with a limit of R15 000 per claim for cancer co-payments. Cancer cover incorporates co-payment cover and biological drugs. In order to access this benefit, you need to be on a registered treatment plan with your medical scheme.		
The Cancer Boost benefit is limited to R50 000 per beneficiary per annum. This benefit is restricted to policyholders where their medical scheme option has a defined rand limit for cancer treatment. The Cancer Boost benefit can only be claimed once your rand limit on your medical scheme cancer benefit has been reached and you require ongoing treatment. This benefit is dependent upon the insured having already been registered on the medical scheme's cancer programme. The Cancer Boost benefits are limited to those that were determined within the approved medical scheme treatment plan which must be submitted to Sirago upon application for this benefit. This benefit provides a subsidy towards the cost of ongoing treatments and drugs. This applies when the medical scheme's cancer benefit limit is reached and provides no further funding.		

In event of death and/or total permanent disability of the policyholder of the Sirago policy. The premium waiver is directly linked to your policy premium per month as indicated in your Schedule of Insurance. This benefit is not paid in cash, but held as a credit against the policy for a 6-month period. Should there be any premium adjustments within the 6-month period, the credit balance available for the rest of the waiver period will be adjusted accordingly. This benefit cannot be transferred, ceded or converted to cash.
A branded Sirago welcome gift will be posted to your physical address, or delivered to your contracted broker, as per your application form upon receipt of the instruction to add the new-born child. The instruction to add the child to the policy must be submitted within 31 days of the birth of the child. (Subject to availability. Please allow 6 weeks for delivery.)

Gap Lite Cover		
0 - 54	55 - 64	65+
R203	R244	R285
R218	R272	R325
None		
R164 000 OAL from 1 April 2020		
Will settle claims at an additional 200% above medical scheme rate or at the stated benefit value.		
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 R25 000 per policy per annum, limited to R5 500 per claim.		
Subject to a sub-limit of R3 000 per claim, a maximum of 2 claims per policy per annum for the voluntary use of a non-designated service provider/network hospital. This includes the use of a partial cover network hospital as determined by your medical scheme. Co-payments related to cancer are catered for in a separate benefit category		
Will settle the Gap portion of claims.		
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. R50 000 sub-limit per policy per annum. Paid to a maximum of R20 000 per claim. Subject to OAL.		
No benefit		
A sub-limit of R4 000 is applicable. This benefit covers an emergency at any registered emergency facility when you require immediate medical treatment due to an accident or illness. The following benefits collectively accumulate to the sub-limit. Accident 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: when you visit an emergency room in a medical emergency as a result of illness, we will cover the Gap portion only. We will cover a GP's emergency facility where no hospital emergency is available within a 30km radius, within the above stated benefit limits. Subject to OAL.		
No benefit		
No benefit		
No benefit		

No Benefit
A branded Sirago welcome gift will be posted to your physical address, or delivered to your contracted broker, as per your application form upon receipt of the instruction to add the new-born child. The instruction to add the child to the policy must be submitted within 31 days of the birth of the child. (Subject to availability. Please allow 6 weeks for delivery.)

SUMMARY OF POLICY TERMS AND CONDITIONS

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; and
- 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;
- 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 treatment 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; and
- 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.

The above is a summary of terms and conditions, for a concise list please refer to the policy wording which forms part of your Schedule of Insurance.

STANDARD SHORT-TERM POLICY EXCLUSIONS

No benefits will be paid for claims arising from:

- Participation in war, invasion, acts 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; and
- Consequential loss or damage.

The above is a summary of terms and conditions, for a concise list please refer to the policy wording which forms part of your Schedule of Insurance.



If you wish to cancel your insurance, please do so in writing by giving 31 days notice



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. Always consult your broker if in doubt.

STEP 1: REPORT YOUR CLAIM

You need to report your claim to us as soon as possible but not later than 30 days after any health event. This includes events for which you do not want to claim, but which may result in a claim in the future. Should you be incapacitated and not be able to make contact, you may get someone to contact us on your behalf.

STEP 2: SUBMIT YOUR DOCUMENTS

All required relevant documents must be submitted to us within 90 days after your medical scheme paid their portion of the claim.

STEP 3: SUPPORTING DOCUMENTS

- Fully completed and signed Sirago claim form for each event;
- All hospital and related accounts substantiating your claim;
- Your medical scheme statement showing all the payments made by you or your medical scheme for the health event;
- Completed medical reports substantiating the clinical information or any other documentation as requested if requested by our claims team;
- Pre-authorisation letter from your medical scheme for co-payment claims;
- In the event of a value added benefit claim; all supporting documentation and certification are required by the Insurer, which would include a death certificate and/or a report from a registered medical practitioner confirming total permanent disability; and
- In the event of a claim for Initial Cancer Diagnosis, we require a histology report.

GENERAL INFORMATION

Contact one of our customer service consultants to attend to any of your queries.

For new applications or to follow up on submitted applications, please contact your broker, or send an email to:

applications@sirago.co.za

Client queries or policy updates:

info@sirago.co.za

To make changes to existing policies:

changes@sirago.co.za

For new claims or follow ups on claims:

claims@sirago.co.za

For new groups or follow up on groups:

groups@sirago.co.za

For any payment related queries:

payments@sirago.co.za

Broker queries and statements:

info@sirago.co.za

Disclaimer:

This policy does not discriminate or refuse membership 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 may however charge a different premium dependent on your age at the time of inception, or apply waiting periods if applicable.





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BROKER DETAILS

CONTACT US

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