auto & general

GAP COVER RANGE 2022

THE FOLLOWING BENEFITS ARE SUBJECT TO AN AGGREGATE ANNUAL LIMIT OF R177 800 PER INSURED PERSON.

This amount is calculated annually according to the prescribed table under Regulation 7.2(1) of Regulation 7.2(2) - Policy benefits escalation, in terms of the Short-term Insurance Act, 1998 (Act No. 53 of 1998). This amount will be increased on 1 April 2022 by the official CPI as published by Statistics South Africa (as defined in the Statistics Act, 1999 (Act No. 6 of 1999)).

PRODUCT	AUTO & GENERAL ESSENTIAL GAP	AUTO & GENERAL COMPREHENSIVE GAP	AUTO & GENERAL ABSOLUTE GAP
STANDARD BENEFITS			
GAP COVER: The **shortfall** that arises after your medical aid has processed your account and is due to service providers charging above scheme tariff for authorised in-hospital procedures. The cover is limited to a percentage of the original scheme tariff.	300%	500%	700%
PRESCRIBED MINIMUM BENEFITS: A set of defined benefits, as per the Medical Schemes Act, in terms of which all medical schemes have to cover the costs related to the diagnosis, treatment and care of: any emergency medical condition; a limited set of 270 medical conditions; and 27 chronic conditions.	Covered, subject to medical aid review	Covered, subject to medical aid review	Covered, subject to medical aid review
CASUALTY UNIT BENEFIT: • Accidents only. • Children under the age of 8 ONLY - May be admitted for any treatment at a casualty unit linked to a hospital between the hours of 7pm to 7am from Monday to Friday, from 7pm on a Friday until 7am on a Monday, and all day on a public holiday.	Up to R7 500 per policy per annum	Up to R15 000 per policy per annum	Up to R20 000 per policy per annum
CO-PAYMENT BENEFIT: (In Network) • The co-payment or deductible that your medical aid charges you for certain in-hospital procedures, **e.g. a gastroscopy, colonoscopy, sigmoidoscopy or proctoscopy**. • The co-payment or deductible that your medical aid charges you for certain procedures performed in the doctor's rooms **e.g. a gastroscopy, colonoscopy, sigmoidoscopy or proctoscopy** BUT which have been authorised and paid from the In-Hospital or Major Medical benefit. • This co-payment or deductible is NOT related to the scheme tariff and service provider charge shortfall or designated service provider arrangements.	No Benefit	Up to R50 000 per policy per annum	Unlimited but subject to the aggregate annual limit per insured person per annum
CO-PAYMENT BENEFIT: (Out of Network i.e. Voluntary use of a non-designated service provider) • The co-payment or deductible that your medical aid charges you for certain in-hospital procedures. • This co-payment or deductible is NOT related to the scheme tariff and service provider charge shortfall or designated service provider arrangements.	No Benefit	No Benefit	2 Co-payments / deductibles per policy per annum to a combined maximum of R15 000
SUB-LIMIT BENEFIT: Internal Prostheses The **shortfall** on a service provider account that is not covered because you have reached the sub-limit for Internal Prostheses imposed by your medical aid AND which has been authorised and paid from the In-Hospital or Major Medical benefit.	No Benefit	Up to R20 000 per policy per annum	Unlimited but subject to the aggregate annual limit per insured person per annum. Up to R40 000 per event
SUB-LIMIT BENEFIT: MRI / CT / PET Scans The **shortfall** on a service provider account that is not covered because you have reached the sub-limit for MRI / CT / PET scans imposed by your medical aid AND which has been authorised and paid from the In-Hospital or Major Medical benefit.	No Benefit	No Benefit	2 MRI / CT / PET scans per policy per annum up to R4 000 per scan
DENTAL BENEFIT: The **shortfall** that arises after your medical aid has processed your account and is due to service providers charging above scheme tariff for authorised dental procedures performed in hospital or in doctor's rooms and paid from the in-hospital or major medical benefit only. The cover is limited to a percentage of the original scheme tariff, as follows: **Adults and dependants over 18 years of age:** Treatment of impacted wisdom teeth, extractions, apicectomies or loss of teeth due to oncology or trauma ONLY. **Dependants up to 18 years of age:** Any procedure or treatment.	Unlimited but subject to the aggregate annual limit per insured person per annum	Unlimited but subject to the aggregate annual limit per insured person per annum	Unlimited but subject to the aggregate annual limit per insured person per annum
GLOBAL FEE BENEFIT: Where a global fee has been negotiated between a medical aid and service providers for a specific procedure e.g. robotic surgery (which includes ALL costs related to that procedure) and service providers charge amounts in excess of this global fee (not related to a tariff rate, co-payment or sub-limit).	No Benefit	Up to R10 000 per policy per annum	Up to R20 000 per policy per annum
ONCOLOGY BENEFITS			
ONCOLOGY GAP BENEFIT: The **shortfall** that arises after your medical aid has processed your account and is due to service providers charging above scheme tariff for medical aid approved oncology treatment plans. (**NB:** Subject to: the gap cover percentage; and medical aid approved treatment plan being covered up to scheme tariff and within annual scheme oncology limit).	Unlimited but subject to the aggregate annual limit per insured person per annum	Unlimited but subject to the aggregate annual limit per insured person per annum	Unlimited but subject to the aggregate annual limit per insured person per annum
ONCOLOGY CO-PAYMENT BENEFIT: (In Network) • The co-payment or deductible that your medical aid charges you for certain in-hospital procedures. This co-payment is NOT related to the scheme tariff and service provider charge **shortfall** or designated service provider arrangements. • For claims where the medical aid will only pay a percentage for the approved treatment and the policyholder needs to pay the remaining percentage of the account. • All costs to be within the annual scheme oncology limit.	No Benefit	No Benefit	Unlimited but subject to the aggregate annual limit per insured person per annum. Up to R40 000 per event
ONCOLOGY CO-PAYMENT BENEFIT: (Out of Network i.e. voluntary use of a non-designated service provider) • The co-payment or deductible that your medical aid charges you for certain in-hospital procedures. This co-payment is NOT related to the scheme tariff and service provider charge **shortfall** or designated service provider arrangements. • For claims where the medical aid will only pay a percentage for the approved treatment and the policyholder needs to pay the remaining percentage of the account. • All costs to be within the annual scheme oncology limit.	No Benefit	No Benefit	2 Co-payments per policy per annum up to a combined limit of R15 000
ONCOLOGY EXTENDER BENEFIT: Includes ANY approved costs above annual scheme oncology limit but subject to the medical aid scheme covering up to this limit.	No Benefit	No Benefit	Unlimited but subject to the aggregate annual limit per insured person per annum
ONCOLOGY "NEW-TECH" BENEFIT: We cover the shortfall / co-payment on new technology oncology treatment (specifically Keytruda®, Xalkori®, Tagrisso®, Yervoy®, Zelboraf®, Imbruvica®). Subject to a medical aid authorised treatment plan and designated service providers being utilised.	No Benefit	Up to R7 500 per policy per annum	Up to R15 000 per policy per annum
ENHANCED CANCER COVER: LUMP SUM PAYOUT This cancer must be defined as cancer which is confirmed by the oncologist or pathologist as at least the medical equivalent of 'Stage 2' or higher cancer. This benefit is however limited to ONE claim per individual per cancer type for the life of the policy (a unique, new, primary source of cancer), and excludes any claim which in any way relates to a cancer type previously identified and for which cover was granted.	No Benefit	Lump Sum payout of R20 000 based on first diagnosis of cancer (as defined- check the full policy document for full definition and exclusions).	No Benefit

THE FOLLOWING BENEFITS ARE NOT SUBJECT TO THE AGGREGATE ANNUAL LIMIT.

PRODUCT	AUTO & GENERAL ESSENTIAL GAP	AUTO & GENERAL COMPREHENSIVE GAP	AUTO & GENERAL ABSOLUTE GAP
POLICY EXTENDER The full gap cover premium is covered in the case of the **accidental** death of the main policyholder.	12 months	12 months	12 months
MEDICAL AID CONTRIBUTION WAIVER Provides cover towards a policyholder's medical aid contribution in the case of the accidental death of the main policyholder. Cover is limited to the lower of the actual medical aid contribution or the maximum amount allowed.	No Benefit	6 months. Up to a max. of R4 000 per month	6 months. Up to a max. of R5 000 per month

MONTHLY PREMIUMS

PRODUCT	AUTO & GENERAL ESSENTIAL GAP	AUTO & GENERAL COMPREHENSIVE GAP	AUTO & GENERAL ABSOLUTE GAP
Under 65's (Based on the age of the oldest Beneficiary) premium per policy per month		R265	R410
Premium per Individual per policy per month	R 99		
Premium per Family per policy per month	R165		
Over 65's (Based on the age of the oldest Beneficiary) premium per policy per month	R330	R445	R575

GAP COVER: The Important Information

All of our 2022 Gap Cover Policies:

- Provide benefits for a policyholder and their spouse and those financially dependent on them (child/children and/or aged parents) who are covered on one policy of a registered medical aid scheme. **Subject to proof of membership and the premium being based on the age of the oldest beneficiary.** Members and their dependants can also be on two different medical aids and one Gap Cover Policy but only if they are legally married, or common law partners verified by submission of an affidavit confirming 12 months of cohabitation.
- Have no entry age limit.
- May allow for immediate benefits for all policyholders except for a limited list of specific conditions and/or procedures **(there is no general 3 month waiting period).**
- Cover Prescribed Minimum Benefits (PMB's) where a medical aid scheme has failed to meet its obligations in this regard (Subject to medical aid scheme review and for non-emergencies only).
- **Are not medical aid schemes. The cover is not the same as that of a medical aid scheme. The cover is not a substitute for a medical aid scheme membership.**
- **NB:** Refer to the policy document for the complete list of terms and conditions.

WHEN CAN YOU CLAIM?

We have payment runs twice a week, making us well known for our great claims turnaround time!

GENERAL WAITING PERIOD

There is no general three (3) month waiting period. The following waiting periods commence from the join date of the Gap Cover Policy:

10 MONTH CONDITION SPECIFIC WAITING PERIOD

No claims may be submitted within the first 10 months of membership for any Gap Cover policy if they relate to any of the following conditions:

- Head, neck and spinal procedures (including stimulators) e.g. Laminectomy
- All types of hernia procedures
- Endoscopic procedures e.g. Colonoscopy, Gastroscopy
- Pregnancy and childbirth (including caesarean delivery)
- Gynaecological conditions e.g. Hysterectomy
- Joint replacement (including Arthroplasty, Arthroscopy, Metatarsal Osteotomy) but excluding treatment due to accidental trauma
- Inability to walk / move without pain
- Any renal, kidney and bladder conditions
- Cardiac (relating to the heart)
- Dentistry (unless due to accidental trauma or oncology)
- Cataracts and / or eye laser surgery (including all eye and lens procedures)
- Neurological conditions and procedures (including stimulators)
- Organ transplants (including cochlear implants)
- Reconstructive surgery as a result of an incident or condition that occurred prior to membership (including skin grafts)
- Mental health or psychiatric conditions (including depression)
- Varicose veins
- Oesophagitis, Gastroenteritis and Gastro-Intestinal Disorders
- Male genital system (including prostatectomy)
- Carpal Tunnel Syndrome
- Any Ear, Nose and Throat procedures (including nasal, sinus, tonsil and adenoid procedures)
- Diabetes and related complications

All claims for these conditions received within the waiting period will be reviewed by medical management to identify pre-existing conditions.

CANCER DIAGNOSIS WAITING PERIOD

If a Policyholder is diagnosed with any form of cancer prior to membership, all related claims will be subject to a nine (9) month waiting period. If a Policyholder has previously been diagnosed with cancer and is currently in remission, the Policyholder needs to advise the insurer by way of medical evidence that the remission period has been for two (2) or more consecutive years.

PRE-EXISTING MEDICAL CONDITION/S WAITING PERIOD

NO claims relating to any pre-existing condition/s that may lead to hospitalisation (excluding cancer: see above) will be covered within the first six (6) months of membership. The insurer reserves the right to request any clinical information from a Policyholder's doctor should a claim in this period indicate, and/or relate to, a pre-existing condition. **All claims for these conditions received within the waiting period will be reviewed by medical management to identify pre-existing conditions.**

Auto & General Insurance Company Limited, an Authorised Insurer & Financial Services Provider
Reg No 1973/016880/06

Administered by:
Total Risk Administrators (Pty) Ltd (TRA) authorised financial services provider - FSP No 40815