



# westerngap

## Select Policy 2024

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. Kaelo Risk (Pty) Ltd is an authorised financial services provider (FSP 3693). This product is underwritten by Western National Insurance Company Limited (FAIS: Juristic Representative under FSP 9465).

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## DISCLAIMER

- This Policy replaces all previous versions of your Western Gap Policy. All terms and conditions in this Policy apply to all Insured Parties on the Policy.
- All definitions start with a capital letter throughout the Policy. Important points are written in bold.
- Processing of insurance information is done in line 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](http://www.kaelo.co.za)

## SECTION A: YOUR INSURER

The insurance Policy is underwritten by Insurer: Western National Insurance Company Limited, registration number 2005/017349/06, FAIS Juristic representative under FSP 9465. The cover provided is subject to all the terms and conditions explained throughout your Policy.

## SECTION B: YOUR UNDERWRITING MANAGER

- Kaelo Risk (Pty) Ltd, registration number 2008/019335/07, an authorised Financial Services Provider (FSP 36931), is your Underwriting Manager.
- The Underwriting Manager is responsible for administering your Policy which includes:
  - Issuing your Policy
  - Processing your claims
  - Collection of your Premium.
- You can reach Kaelo on 0861 008 258 or email [western@kaelo.co.za](mailto:western@kaelo.co.za)

## SECTION C: DEFINITIONS

- The words and expressions used are defined as follows:

| Number | Definition                 | Meaning  |
|--------|----------------------------|--|
| C1     | <b>Accidental Harm</b>     | Refers to bodily injury caused by violent, unintentional, external and physical means.   |
| C2     | <b>Administrator</b>       | Kaelo Risk (Pty) Ltd (registration no: 2008/019335/07), hereafter 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.  |
| C3     | <b>Balance Billing</b>     | This is 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. |
| C4     | <b>Basic Dentistry</b>     | Any of the following dental Treatments: cleaning, extractions (including wisdom teeth), fillings, inlays, bonding, root canal Treatment and Treatment for pain and abscesses.  |
| C5     | <b>Benefit or Benefits</b> | It is the Benefit amount payable to the Insured Party in relation to an Insured Event, as calculated in terms of the Benefit Schedule.   |
| C6     | <b>Benefit Date</b>        | The first day of the month on which Benefits begin, following waiting periods.   |
| C7     | <b>Benefit Schedule</b>    | The cover and Benefits detailed in this Policy in Addendum A: Detailed Benefits.   |

| Number | Definition  | Meaning   |
|--------|---|---|
| C8     | <b>Benefit Year</b>                               | The period from 1 January to 31 December of any year.   |
| C9     | <b>Biological Cancer Drug</b>                     | A substance that is made from a living organism or its products and is used in the prevention, diagnosis, or treatment of cancer. For the purpose of this Policy, biological drugs include antibodies, interleukins, and vaccines.  |
| C10    | <b>Condition-Specific Waiting Period</b>          | A period in which an Insured Party may not claim Policy Benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within 12 months before the cover start date.   |
| C11    | <b>Cover Type</b>                                 | <ul style="list-style-type: none"> <li>• “Single Policy Premium”: A chosen Premium type that only covers a Policyholder and excludes Eligible Special Dependants; Eligible Spouse; and Eligible Children.</li> <li>• “Family Policy Premium”: A chosen Premium type which covers a Policyholder as well as an Eligible Special Dependant; Eligible Spouse; and/or Eligible Children.</li> </ul>   |
| C12    | <b>Deductible or Co-payment</b>                   | This is a fixed, rand amount that the Medical Scheme applies to certain procedures according to your Medical Scheme plan option for hospital admissions.  |
| C13    | <b>Dependant</b>                                  | Either the Eligible Spouse, Eligible Child or Special Needs Child.  |
| C14    | <b>Designated Service Provider or DSP</b>         | A healthcare service provider chosen by a Medical Scheme as one of their preferred suppliers.   |
| C15    | <b>Eligible Child</b>                             | <ul style="list-style-type: none"> <li>• A child born to either the Policyholder or Eligible Spouse of this Policy.</li> <li>• An Eligible Child includes a legally adopted child or stepchild of a Policyholder.</li> </ul>  |
| C16    | <b>Eligible Special Dependant</b>                 | <ul style="list-style-type: none"> <li>• A dependant who is neither the Eligible Spouse nor an Eligible Child nor a Special Needs Child of the Policyholder but who is a dependant on the Policyholder’s Medical Scheme and has been accepted by the Insurer to be covered under this Policy.</li> <li>• If no such acceptance is provided by the Insurer, such dependants are not covered even though they are dependants on the Policyholder’s Medical Scheme.</li> </ul> |
| C17    | <b>Eligible Spouse</b>                            | <ul style="list-style-type: none"> <li>• The partner of the Policyholder, whether by means of South African law or religious belief.</li> <li>• The partner by common law who shares a home with the Policyholder and has done so for at least six months.</li> </ul>   |
| C18    | <b>Emergency</b>                                  | Admission to a Hospital Emergency Unit immediately following an accident.   |
| C19    | <b>Emergency – As it relates to Child Illness</b> | A serious, unexpected, and often dangerous situation requiring immediate action.  |
| C20    | <b>Exclusions</b>                                 | A list of services, conditions and events not covered on this Policy. This list can be found in the “Exclusions” section of this Policy.  |

| Number | Definition                                 | Meaning  |
|--------|--|--|
| C21    | <b>External Appliances</b>                 | Any external appliance including but not limited to wheelchairs, crutches, boots, braces, beds, hearing aids, C-PAP machines and any type of equipment used during the recovery of an illness or procedure.  |
| C22    | <b>Family</b>                              | Collectively it refers to the Policyholder, Eligible Spouse, Eligible Children, Special Needs Child and/or Eligible Special Dependants as defined in the Policy.   |
| C23    | <b>General Practitioner (GP) or Doctor</b> | It is a Medical Practitioner who provides primary healthcare services.   |
| C24    | <b>General Waiting Period</b>              | The period in which an Insured Party may not claim any Policy Benefits, except for Benefits directly arising from Accidental Harm.   |
| C25    | <b>Hospital</b>                            | Any institution in South Africa which meets all of the following criteria: <ul style="list-style-type: none"> <li>• Provides surgical and medical diagnostic and therapeutic facilities for the Treatment and care of sick or injured persons under the supervision of Medical Practitioners.</li> <li>• Provides 24-hour nursing services to sick or injured persons within the facilities.</li> <li>• Is not an institution that primarily cares for persons who are mentally disabled, blind, deaf, or in any other way physically disabled.</li> <li>• Is not a nursing home or home for the elderly.</li> <li>• Is not a place of rest or recuperation.</li> <li>• Is not an institution that primarily treats people for drug addiction, alcoholism, eating disorders or any other form of addictive behaviour.</li> <li>• Is not a health hydro or alternative therapy clinic or other similar establishments.</li> <li>• Is not a Step-Down Facility.</li> </ul> |
| C26    | <b>Hospital Confinement</b>                | Admission to a hospital ward.  |
| C27    | <b>Hospital Episode</b>                    | The period of time between admission to Hospital for an Insured Party until the time of discharge from Hospital of the same Insured Party for the same Insured Event.  |
| C28    | <b>Hospital Network</b>                    | 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.  |
| C29    | <b>Illness</b>                             | Any physical disease or sickness which presents itself in an Insured Party which can be diagnosed by a Medical Practitioner using factual evidence and has been diagnosed.   |
| C30    | <b>Inception Date</b>                      | The first day of the month on which cover begins for the relevant Insured Party as shown in the Policy Schedule.   |
| C31    | <b>Innovative Oncology Medicines</b>       | As described by the Insured Party's Medical Scheme in the Oncology Innovative benefit.   |



| Number | Definition                              | Meaning  |
|--------|---|--|
| C32    | <b>Insured Event</b>                    | <p>Any one or more of the following:</p> <ul style="list-style-type: none"> <li>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.</li> <li>Chemotherapy, radiotherapy or other drug regimens, approved by an Insured Party's Medical Scheme, that is administered to an Insured Party for treating a tumour, growth or other body tissue that has cancer (malignant neoplasm).</li> <li>An Insured Party receives kidney dialysis for the Treatment of acute or chronic renal failure.</li> <li>Accidental Harm that directly causes an Insured Party to receive Emergency medical Treatment at the outpatient casualty or Trauma ward of a Hospital.</li> </ul> |
| C33    | <b>Insurer</b>                          | Western National Insurance Company Limited, registration number 2005/017349/06, Juristic representative under FSP 9465.  |
| C34    | <b>Insured or Insured Party</b>         | It refers to the Policyholder, Eligible Spouse, Eligible Child or Eligible Special Dependant, as defined in this Policy.   |
| C35    | <b>Internal Prosthesis</b>              | <ul style="list-style-type: none"> <li>A device that is placed inside a body during a procedure with the specific purpose of permanently replacing a body part.</li> <li>In other words, a body part is removed and permanently replaced with a prosthesis during surgery. Examples include joint replacements and spinal fusions.</li> </ul>  |
| C36    | <b>Medical Expense Shortfall Policy</b> | 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.   |
| C37    | <b>Medical Practitioner</b>             | A person who is suitably qualified and registered with the Health Professions Council of South Africa to practice medicine.  |
| C38    | <b>Medical Procedure</b>                | Any procedure defined under the Medical Scheme rate. If the procedure is not defined, the Insurer will calculate, at their sole discretion, an appropriate Benefit to be paid to the Policyholder.   |
| C39    | <b>Medical Scheme</b>                   | A Medical Scheme registered under the Medical Schemes Act.   |
| C40    | <b>Medical Schemes Act</b>              | The Medical Schemes Act No. 131 of 1998.   |
| C41    | <b>Medical Scheme Main Member</b>       | The main member registered on the Medical Scheme.  |
| C42    | <b>Medical Scheme Tariff</b>            | The rate equal to the Insured Party's Medical Scheme rate.   |
| C43    | <b>Penalty</b>                          | Any Co-Payment, Deductible, exclusion or reduction, applied against the benefits of an Insured Party's Medical Scheme, that would not have been applied had the authorisation rules of that Medical Scheme been adhered to or had the benefits been attained from the Designated Service Provider or Hospital Network of that Medical Scheme plan type.  |
| C44    | <b>Per Annum</b>                        | The period from 1 January to 31 December of any year.  |
| C45    | <b>Permanent Disability</b>             | 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.  |

| Number | Definition                                    | Meaning  |
|--------|---|--|
| C46    | <b>Policy</b>                                 | This Policy, which includes Addendum A: Detailed Benefits and the Policy Schedule  |
| C47    | <b>Policy Schedule</b>                        | The schedule attached to and forming part of this Policy that defines the product option, cover type, Inception Date, monthly Premium, waiting periods and other information that pertains to the cover provided under this Policy.  |
| C48    | <b>Policyholder</b>                           | The person who applied and was accepted for cover under this Policy and who is responsible for the payment of Premiums.  |
| C49    | <b>Premium or Premiums</b>                    | The monthly amount due to the Insurer payable by, or on behalf of, the Policyholder.   |
| C50    | <b>Psychiatric or Psychological Condition</b> | Any kind of mental illness and disability, which includes all forms of major affective disorders, anxiety disorders, psychiatric conditions and all other mental disorders outlined under ICD-10 Coding F01: F99 - mental, behavioural and neurodevelopmental disorders.   |
| C51    | <b>Prescribed Minimum Benefits / PMBs</b>     | A set of defined benefits to ensure that all Medical Scheme members have access to certain minimum health services, regardless of the benefit option they have selected.   |
| C52    | <b>Renewal Date</b>                           | 1 January of each year or other date determined by the Insurer or its Underwriting Manager when Benefits will be amended.  |
| C53    | <b>SADC</b>                                   | <ul style="list-style-type: none"> <li>Any of the countries that form part of the Southern African Development Community (SADC).</li> <li>Currently, SADC has a membership of fifteen member states, namely, Angola, Botswana, Democratic Republic of Congo (DRC), Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, United Republic of Tanzania, Zambia and Zimbabwe.</li> </ul>  |
| C54    | <b>Special Needs Child</b>                    | Any child, including a legally adopted child or stepchild, of the Policyholder, who on account of either a physical or mental disability, is unable to financially support him/herself and remains reliant on the Policyholder for support and care.   |
| C55    | <b>Specialist</b>                             | A Medical Practitioner who has been registered in terms of regulations relating to the Specialties and Subspecialties in Medicine and Dentistry, published under Government Notice Number R.590 of 29 June 2001, as amended/replaced from time to time.  |
| C56    | <b>Split Billing</b>                          | A practice where a Medical Practitioner or other healthcare 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.  |
| C57    | <b>Start Date</b>                             | The first day of the month on which cover begins under this Policy.  |
| C58    | <b>Step-Down or Sub-Acute Facility</b>        | <p>Any institution in the territory of the Republic of South Africa or SADC which meets each of the following criteria:</p> <ul style="list-style-type: none"> <li>Provides nursing service supervised by registered nurses or nurses with equivalent qualifications.</li> <li>Is not other than incidentally either a mental institution or a nursing home.</li> <li>Is not a place of rest for the aged or a place for persons dependent on drugs or alcohol or a health hydro or natural cure clinic or similar establishment.</li> <li>Is not an institution providing long-term care for the blind, deaf, or other disabled persons.</li> </ul> |

| Number | Definition                            | Meaning  |
|--------|---------------------------------------|--|
| C60    | <b>Surgical Procedure</b>             | Refers to all invasive therapies performed as a surgical operation or procedure performed in a Hospital.   |
| C61    | <b>Tariff</b>                         | The scheme rate registered by a Medical Scheme to determine the rate at which its Benefits are payable.  |
| C62    | <b>Termination Date</b>               | The date of expiry of cover under this Policy.   |
| C63    | <b>Total and Permanent Disability</b> | Total and permanent loss of or use of: Speech 100%, hearing in both ears 100%, any limb 100%, sight in one or both eyes 100%, disfigurement of face and neck 100%, disfigurement of any other part of body 100%. |
| C64    | <b>Trauma</b>                         | Accidental Harm to an Insured Party that gives rise to an Insured Event.   |
| C65    | <b>Travelling</b>                     | Travelling in any country other than the Republic of South Africa.   |
| C66    | <b>Treatment</b>                      | 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.                                 |
| C67    | <b>Underwriting Manager</b>           | Kaelo Risk (Pty) Ltd (Registration No: 2008/019335/07), also trading as part of the Kaelo Group of Companies (FSP: 36931).   |

## SECTION D: DEFINED EVENTS

- In the event of an Insured Party suffering an Insured Event, which results in the Insured Party:
  1. Being confined to Hospital.
  2. Undergoing medical or Surgical Procedures or Treatment whilst in Hospital including:
    - a) Chemotherapy or radiotherapy for the Treatment of cancer on an outpatient basis
    - b) Kidney dialysis on an outpatient basis.
- Outpatient diagnostic radiology is limited to:
  1. Magnetic Resonance Imaging (MRI)
  2. Computed Tomography Scans (CT Scans)
- Outpatient Treatment where the Insured Party's Medical Scheme has paid their portion from the hospital/risk benefit.
- The Insurer will pay the Policyholder an amount in accordance with the table of Benefits in the Benefit Schedule subject to the limitations.

## SECTION E: CLAIMS

- Following an Insured Event, you or an Insured Party, as the case may be, shall at your own expense:
  1. 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 Insured Event will not be covered.
  2. 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, and Claims Transaction History Report. There may be additional information requested, such as medical reports as required and determined on a case-by-case basis.



3. Allow 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.
  4. Where the Insured Party is not the Policyholder, the Policyholder will provide or get permission or consent from the Insured Party to comply with the above condition, failing which the processing of the relevant claim will be suspended until Kaelo gets the required permissions or consent.
- 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 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 Benefits (PMBs), 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 regards to 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 you after a 31-day period during an Insured Event.
  - All Benefits payable will be paid to you or your legal representative whose receipt of the Benefits will be a full discharge of liability in every case.
  - If you die, 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 your estate.
  - All claim payments will be made into the same bank account from which the Policy Premium is deducted and should different account details be provided, we will need your signature on the Claim form. We reserve the right to negotiate a discounted rate with the relevant service providers on your behalf, to ensure you maintain a favourable risk profile. If granted, payment will be made directly into the respective service provider's bank account.
  - No Benefit payable will carry interest.
  - Any discount received by an Insured Party against the amount owing to any healthcare provider will be included in 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 send a written statement to the Insurer, challenging this decision. If the Insurer persists in rejecting the claim or disputing the quantum, the Insured Party can take legal action and have a summons issued and served on the Insurer, within **6 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 depends on the Insured Party supplying such medical evidence as is required by the Insurer to 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 F: PREMIUMS

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Your insurance Policy will remain in force for as long as your Premium is received.

### Individuals

- All Premiums are payable monthly in advance or arrears on either the **7th, 20th or the last working day of the month**. 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 arrears 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 Premium 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**.
- Should the double deduction of Premiums on the second month be unpaid, your membership will be terminated.
- 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**. If 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.
- 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** to the Policyholder.

### Corporates (On Behalf of The Policyholder)

- All Premiums are payable monthly in arrears by the last working day of each month.
- 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.
- Your **cover starts on the first calendar day of a particular month** and cannot be backdated.
- Your Premium will be reviewed annually.

## SECTION G: GENERAL TERMS AND CONDITIONS

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- These general terms and conditions apply to every section of your Policy. Some terms and conditions apply to specific sections of your Policy. You must ensure you understand all sections of your Policy and if you have any questions, please contact your broker.
- You accept the sharing of your insurance information between Insurers, including credit information, for underwriting and claims purposes. It enables Insurers to underwrite policies, assess risks fairly and reduce potential fraudulent claims.
- Your right to privacy, and that of any person who you represent, is waived in terms of the information that you (or another authorised person on your behalf) provide. The information that you provide may be stored in a shared database and used as set out above. It may also be used for any decision about your Policy, or for processing a claim.
- You consent to your information being provided to another insurance company or its agents and acknowledge that any information about you may be verified against legally recognised sources or databases.
- This Policy is based on, and includes, any information or communication, verbal or written, made by you or on your behalf.
- Examples are given where necessary to explain certain concepts within the Policy. These examples are for clarification purposes only and do not form part of the Policy.

- In this Policy, all words and expressions signifying the singular will include the plural and vice versa and all words and expressions signifying any one gender will include the other gender.
- Compensation limits and all Premiums are inclusive of VAT at the standard rate of 15%. With the direction of the Commissioner in terms of S20(7) of the VAT Act, this Policy together with proof of payment of the insurance Premium constitutes a valid tax invoice. All amounts are in South African rand, including Premiums and any amounts we may pay to you.
- Where age is mentioned in the Policy, it will be the age as on the last birthday.
- The table of Benefits found in the brochure applies in the territory of the Republic of South Africa or any of the SADC countries.
- The Insurer reserves the right to change how the Benefit is calculated by giving **31 days** written notice of any change to the participating employer group or Insured Party.
- If we found that you have not revealed important information that may affect the acceptance of your application or submitted a fraudulent or false claim, we may refuse to pay a valid claim or we may cancel your Policy from the date that we make the finding and you will not be entitled to a refund of Premiums. If a claim was paid and then found to be fraudulent, the amount paid must be refunded immediately. The Insurer reserves the right to institute legal action against the relevant party or report the fraudulent matter.
- Under no circumstances will we confirm the Benefit amount payable for a procedure before the Treatment occurs. Considering that the value of a Benefit can only be calculated after the procedure.
- There is no cash value to this Policy if it is cancelled.
- No payments/claims or refunds will bear any interest. This cover does not replace or act as a substitute for your Medical Scheme cover, nor does it cover you for every shortfall that arises from your Medical Scheme paying less than what the healthcare provider charges. It remains your responsibility to ensure you are familiar with the Benefits, limits and exclusions set out in this Policy.

## Jurisdiction

- This Policy is under the authority of the courts of the Republic of South Africa and South African law will apply. The payment of all Premiums and Benefits will be made in the currency of the Republic of South Africa.

## Commencement of Cover

- Cover in terms of this Policy begins after a waiting period, as specified in the schedule.
- A full month's Premium is due in respect of any Insured Party whose cover begins or ceases during a calendar month if such person enjoyed cover for 15 days or more in that particular month.

## Renewal Premium Payment

- The Insurer is not obliged to accept Premiums after the Renewal Date but may do so at its sole discretion.

## Cooling Off Period

- You may cancel the Policy within **31 days** of receipt of the Policy by giving Kaelo written notice, where no Benefit has yet been paid or claimed or an Insured Event has not yet occurred.
- All Premiums or money paid by you to the Insurer up to the date of the cancellation notice or received at any date thereafter regarding the cancelled or varied Policy, will be refunded to you.

## Cover

- Cover will only be in force or effect if the Family are also current and paid-up beneficiaries of a registered Medical Scheme.
- No Benefit will be payable in respect of any medical or surgical Treatment unless such Treatment occurred during the period of Hospital Confinement as an in-patient or during chemotherapy or radiotherapy as an outpatient for the Treatment of cancer or during Treatment as an outpatient for kidney dialysis.
- Unless in the event of an accident, no Benefit will be payable in respect of any medical or surgical Treatment unless pre-authorisation by the Medical Scheme was provided as prescribed by the Medical Scheme.
- Benefits for charges above the Medical Scheme Tariff only apply to services by a Medical Practitioner.
- Benefits for consumable charges above the Medical Scheme Tariff only apply to consumables used during a medical or Surgical Procedure by the Medical Practitioner.
- Kaelo may change the Benefits or how the Benefits are calculated under this Policy by giving 31 days written notice.

## Conditions of Policy

- Each Insured Party will be deemed to have accepted the terms and conditions of this Policy and so agree to be bound by them.
- It is a condition of membership that each Insured Party is a member of a South African Medical Scheme registered with the Medical Schemes Act.
- The minimum entry age for the Policyholder is **18 years**.
- If and when there is a change to the Family rate, the age-band will be adjusted accordingly.
- In order for parents to be considered as Dependants they must be dependants on the Policyholder's Medical Scheme at the inception of the Policy.
- Medical Scheme certificate of membership must be provided with the application form.

## SECTION H: TERMINATION OF COVER

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- **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 of cancellation, the cover end date will be the last day of the month.**
- If any fraudulent act is committed by any Insured Party or service provider, the Insurer reserves the right to immediately cancel this cover and/or institute legal action against the relevant party to recover any losses.
- If 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 can reject any claim under this Policy and/or void this Policy from its Start Date.

## SECTION I: WAITING PERIODS

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The Insurer will apply waiting periods to the cover of an Insured Party as set out below:

- Three-month General Waiting Period from the date of inception (unless due to an accident) and a ten-month waiting period for maternity and/or any procedures related to childbirth.
- Six-month procedure-specific waiting period for any event related to joint surgery, nasal and sinus surgery, tonsillectomy, adenoidectomy, grommets, endoscopic and arthroscopic procedures, hernia repairs, hysterectomy, cardiac surgery, spinal surgery, dentistry and cataract procedures (unless due to an accident). This specific waiting period applies where medical advice, diagnosis, care or treatment was recommended or received for the condition within 12 months before the Policy started.
- Previously diagnosed cancer, will be regarded as a pre-existing condition and Oncology Cover will be excluded for 12 months. The Oncology Diagnosis Benefit is for an Insured Party that has not previously been diagnosed with any form of cancer that required Treatment.
- Waiting Periods will be applied to the cover of the relevant Insured Party from their Inception Date.
- If an Insured Party previously had a similar Medical Expense Shortfall Policy, not longer than **90 days** before the inception of this Policy, 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 apply 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 apply to the Dependant.
- Kaelo reserves the right to waive or amend the waiting periods for the Policyholder and Insured Parties of participating employers based upon pre-determined criteria. Waiting periods applied may differ as per the plan selected.
- Any waiting periods waived or amended will be shown on the Policy Schedule.

## SECTION J: GENERAL EXCLUSIONS

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The Insurer will not be liable for any cost related to or in consequence of hospitalisation, bodily injury, sickness or disease directly or indirectly caused by:

- Any Co-Payment or upfront Deductible charged by the Medical Scheme before a medical or surgical event.
- Shortfalls or Co-payments as a result of not following your Medical Scheme's pre-authorisation and/or referral procedures.
- Any costs related to consultations or services provided on an outpatient basis, or outside of the hospitalisation dates except where provision for outpatient Treatment has been made as per the defined events.
- Nuclear weapons or nuclear material or by ionising radiation or contamination by radioactivity from any nuclear fuel or any nuclear waste from the combustion of nuclear fuel. For this exception, combustion includes any self-sustaining process of nuclear fission.
- An event caused by an Insured Party having an alcohol content of more than 80 milligrams per 100 millilitres of blood.
- Participation in active military duty, police duty, police reservist duty, civil commotion, labour disturbances, riots, strikes, and the activities of locked-out workers or war.



- Investigations, Treatment, or surgery for obesity, its consequence or cosmetic surgery or surgery directly or indirectly caused by or related to or in consequence of cosmetic surgery other than as a result of an Insured Event.
- Investigations, Treatment or surgery for artificial insemination or hormone Treatment for infertility.
- Suicide, attempted suicide or intentional self-injury.
- The taking of any drug or narcotic unless prescribed by and taken following the instructions of a registered Medical Practitioner.
- Outpatient dentistry, orthodontic, prosthodontic, cosmetic dentistry or dental implants, other than dental implants relating to an accident, Trauma or cancer related reconstructive surgery.
- Emergency casualty admissions that are not an Emergency or not done in a registered Hospital Emergency Unit or where the cost of such admission has been paid from the in-hospital risk portion of the Medical Scheme.
- Any procedure codes not covered or declined by the Medical Scheme unless specific cover has been provided for in the Policy.
- Any claim paid as an exception or ex gratia basis by the Medical Scheme unless specific cover has been provided for in the Policy.
- All costs related to ward fees, theatre fees and other Hospital expenses including materials and medication on the Hospital account.
- No Benefits are payable forward fees, theatre fees or other Hospital expenses unless specific cover has been provided in the Policy.
- Admin fees, levies or doctor's co-payments paid directly to the doctor or Specialist and not related to the Medical Scheme.
- Any cost or shortfall due to you exceeding your Benefit limit on your Medical Scheme unless specific cover has been provided in the Policy.
- Any costs related to to-take-home medication (TTO) dispensed for aftercare and External Appliances.
- Interest on overdue accounts and discounts negotiated with a service provider where payment of a claim will enrich the Insured Party.
- Cancer Treatment costs and biological medication not approved by your Medical Scheme as part of your initial or ongoing oncology Treatment plan.



## BENEFIT SCHEDULE

### Addendum A: Detailed Benefits

| Benefit Name                         | Benefit Description  | Western Gap - Select Limit  |
|--------------------------------------|--|---|
| <b>Medical Related Benefits</b>      |  |   |
| Overall Annual Limit                 | Over and above the specific limits on Benefits as indicated below, the Medical Related Benefits will be limited to R210 579, subject to the annual legislative limit.  |   |
| Tariff Shortfalls                    | <p>Benefits will be paid in respect of Treatment received as an in-patient and/or outpatient and charged for by an individual Medical Practitioner.</p> <p>Tariff Shortfalls Example</p> <ul style="list-style-type: none"> <li>Mr S is on a Medical Scheme – plan A which covers him to a maximum of 100% of the Medical Scheme Tariff.</li> <li>This means that the Medical Scheme will pay all expenses at the defined Medical Scheme Tariff towards Mr S' Treatment costs.</li> <li>The Medical Scheme Tariff for a total colonoscopy is R2 000 (100%).</li> <li>This means that the maximum that the Medical Scheme will pay is R2 000 (100%).</li> <li>The Specialist performing the procedure charged R12 000 which is six times the Medical Scheme Tariff (600%) The maximum Benefit payable for this procedure is therefore: <ul style="list-style-type: none"> <li>R12 000 – Fee charged by the Specialist</li> <li>LESS R2 000 – Benefit paid by the Medical Scheme</li> <li>= R10 000 – Your gap cover Benefit.</li> </ul> </li> </ul> | The Benefit provided is for charges above the Medical Scheme Tariff limited to an additional six times (600%) that of the Medical Scheme Tariff.                          |
| Standard Co-Payments and Deductibles | The requirement in the rules of the Medical Scheme is that the Policyholder contributes a standard Co-payment or an upfront Deductible amount for the cost of a Medical or Surgical Procedure, regardless of the cost of such procedure for Treatment received whilst as an in-patient and/or outpatient, and not related to the use of a non-Designated Service Provider (DSP) or not following the rules of the Medical Scheme relating to pre-authorisations.   | Subject to the Overall Annual Limit.  |
| Penalty Co-payments and Deductibles  | The requirement in the rules of the Medical Scheme is that the Policyholder contributes a Penalty Co-payment, related to the use of a non-Designated Service Provider (DSP).   | Charges in the form of Penalty Co-payments for the use of a non-Designated Service Provider (DSP) is limited to two events and a maximum of R12 830 per Policy Per Annum. |
| Sub-Limit                            | The cost for Surgical Procedures or the cost of Internal Prosthesis above a sub-limitation in terms of the Medical Scheme rules.   | The Benefit is limited to R70 800 per Policy Per Annum.   |
| Consumables                          | <ul style="list-style-type: none"> <li>Charges above the Medical Scheme Tariff related to shortfalls on medicine, materials and internal appliances on the doctor's account during an in-Hospital procedure where the cost is greater than the Scheme payment rate.</li> <li>This excludes external prostheses and appliances, for example, crutches, blankets, boots and braces.</li> <li>Shortfalls must be on the doctor's account and not the Hospital account.</li> </ul>   | The cost for medicine, materials and appliances used during an in-Hospital procedure above the Medical Scheme Tariff is limited to R7 120 per Insured Party Per Annum.    |

| Benefit Name   | Benefit Description  | Western Gap - Select Limit  |
|--|--|---|
| Oncology Co-Payments and Sub-Limits                    | A Benefit equal to charges above a sub-limitation, a Co-payment or a Deductible imposed by the Medical Scheme on chemotherapy or radiotherapy, basic and specialised radiology, pathology, Specialist consultations and Biological Cancer Drugs for Treatment received whilst as an in-patient and/or outpatient after you have reached your Scheme's oncology benefit limit, provided that such medical Treatment is for the Treatment of cancer. | Included.   |
| Step-Down Facility                                     | A stated Benefit for admission as an in-patient to a Step-Down or Sub-Acute Recovery Facility provided that such admission results in a minimum stay of three consecutive days.  | The stated Benefit for admission in a Step-Down or Sub-Acute Recovery Facility is limited to R11 660 and one event per Insured Party Per Annum.   |
| Dental Reconstruction Benefit                          | This Benefit is for charges above the Medical Scheme Tariff for Treatment received as an in-patient, related to dental reconstructive surgery due to an accident, Trauma or cancer.  | Charges related to dental reconstructive surgery due to an accident, Trauma or cancer are limited to R23 500 per Insured Party Per Annum.   |
| Accidental Casualty                                    | Following an Emergency due to an accident, all costs incurred for any investigations, Treatment, and/or surgery in a registered Hospital Emergency unit.   | Any Benefits provided for Accidental Emergency Treatment provided in a registered Hospital Emergency Unit is limited to R19 180 per Policy Per Annum.   |
| Casualty - Child Illness                               | <ul style="list-style-type: none"> <li>• Paid in respect of emergency outpatient services that are provided within a casualty ward of a Hospital.</li> <li>• The Benefit is only payable in the event of after-hours Treatment in an Emergency.</li> <li>• After-hours is Mondays to Fridays between 18:00 and 08:00 and all-day Saturdays, Sundays and South African public holidays.</li> </ul>  | <ul style="list-style-type: none"> <li>• Subject to two events and limited to R3 000 per event Per Annum</li> <li>• The Benefit is only for children under age 12.</li> </ul>   |
| Maternity Booster                                      | A stated Benefit for childbirth where additional medical expenses are incurred as a result of the childbirth.  | Subject to one maternity event Per Annum and limited to R3 700.   |
| Innovative Oncology Medicines                          | Approval for any innovative drugs will be required by your Medical Scheme.   | A value equal to the lesser of 25% of the total drug cost or R13 800.   |
| <b>Other Benefits</b>                                  |  |   |
| Accidental Death and Disability Benefit - Policyholder | If the Policyholder dies or suffers Total and Permanent Disability due to an accident, a stated Benefit will be payable to the Insured Party.  | The Benefit payable is limited to R15 600 per Policy Per Annum.   |
| Accidental Death and Disability Benefit - Dependants   | If a Dependant dies or suffers Total and Permanent Disability due to an accident, a stated Benefit will be payable.  | The Benefit payable is limited to R10 550 for any Dependant per Policy Per Annum.   |
| Oncology-First Time Diagnosis                          | <ul style="list-style-type: none"> <li>• A stated Benefit for the first-time diagnosis of cancer to the medical equivalent of stage 2 or higher form of cancer.</li> <li>• It excludes any form of cancer that was previously identified or required Treatment.</li> </ul>   | <ul style="list-style-type: none"> <li>• The Benefit payable is limited to R39 400 per Insured Party, provided that the Insured Party is younger than 66 years (at the time of diagnosis).</li> <li>• Subject to one claim per Insured Party for the lifetime of the Policy.</li> </ul> |

| Benefit Name        | Benefit Description  | Western Gap - Select Limit   |
|---------------------|--|--|
| Contribution Waiver | <ul style="list-style-type: none"> <li>In the event of the death or Total and Permanent Disability of the Medical Scheme Main Member, a Benefit equal to the monthly Premium of the Medical Scheme contribution is payable, provided that the Policyholder is younger than 66 years at the time of claim.</li> <li>The Benefit will be paid for a period of six months and takes into account the members registered on the Medical Scheme at the time of the qualifying event.</li> </ul> | The Benefit payable is equivalent to the monthly Medical Scheme contribution but is limited to R4 940 per month. |
| Gap Premium Waiver  | In the event of the death or Total and Permanent Disability or forced retrenchment of the Policyholder, Policy Premiums will be waived provided that the Policyholder is younger than 66 years at the time of the claim.   | The Policy Premiums will be waived for a period of six months from the date of the event.                        |

Kaelo Lifestyle Digital gives you and your dependants access to Counselling, Coaching, Support and Care through our AskNelson programme. You can contact AskNelson on 0861 635 766 or visit [www.kaelo.co.za](http://www.kaelo.co.za). If you have opted in for Lifestyle benefits, you also get access to the extra by Dis-Chem rewards programme. For detailed information please refer to the Kaelo Lifestyle Digital and Lifestyle Benefits Brochures. These benefits are exclusive Kaelo service offerings and are not underwritten by Western National Insurance Company. Any stated Benefit listed in this content is considered to be a contribution to pre-estimated costs and expenses.