

OMNIGAP STANDARD OPTION 2026

1. INTRODUCTION

Sirago Underwriting Managers (Pty) Ltd is an Authorised Financial Services Provider (FSP 4710), underwritten by GENRIC Insurance Company Limited (FSP 43638). GENRIC is an Authorised Financial Services Provider and licensed non-life Insurer and a member of the Old Mutual Group, as indicated on your Schedule of Insurance.

The Overall Annual Limit (OAL) for claims is aggregated to a maximum of **R223 000** (two hundred and twenty-three thousand rand) from **1 April 2026 to 31 March 2027**, unless specified, per beneficiary per annum. The number of claims that can be submitted against this policy are unlimited, except if the benefit category defines otherwise or until the maximum overall annual limit is reached.

This is a Short-term insurance accident and health policy regulated by the Financial Sector Conduct Authority (FSCA) and Prudential Authority (PA) under the auspices of the Short-term Insurance Act 53 of 1998 and the Insurance Act 18 of 2017.

All fees, commissions, benefits, and premium values quoted are inclusive of Value Added Tax (VAT).

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, however, to activate this policy, a copy of your current Certificate of Membership from your medical scheme is required. Your medical scheme must be registered in terms of the Medical Schemes Act 131 of 1998. This policy will only be activated and valid if purchased as a complementary product to an approved and registered medical scheme in South Africa.

- **Open Enrolment:** This policy is subject to open enrolment which allows all eligible members to join a health insurance solution of their choice without facing any form of unfair discrimination.
- **Community Rating:** This policy is subject to community rating which requires health insurance providers to offer health insurance policies within a given territory at the same price to all persons regardless of their health status.
- **Cross Subsidisation:** This policy is subject to cross-subsidisation which is applied on the premium rating basis where the risk pool of policyholders is big enough to cater for a cross-subsidisation element.
- **Discrimination:** This policy does not discriminate based on race, age, gender, marital status, ethical or social origin, sexual orientation, pregnancy, disability, state of health, geographical location, or any other means. We may however charge a different premium depending on your age at the time of inception or apply waiting periods, if applicable.
- **Treating Customers Fairly (TCF):** Sirago applies the principle of TCF in all our business functions. To this end the policy schedule attached to this document demonstrates all the required information required on benefits, premiums payable, and any limitations applicable within the terms of the policy.
- **Policyholder Protection Rules:** The Policyholder Protection Rules published under the Short-term Insurance Act is a fundamental business practice within Sirago and GENRIC. This is evident in all information, advertising, and interactions — both directly and indirectly — with policyholders and intermediaries always.

Effective – **01 January 2026**, please note that this policy wording replaces any previous policy wording regarding this product. As such, claim events occurring as of **01 January 2026** will be assessed strictly as per these terms. Benefits cannot be transferred, extended, or carried over to another benefit year, unless otherwise stated in the benefit entitlement. The increased OAL of **R 223 000** is effective from **1 April 2026**.

The increased OAL is effective from 1st April 2026. For ease of reference, the OAL is applied as follows:

- Policies that are incepted between 1st January 2026 and 31st December 2026 will have access to the applicable OAL at the time of claims.
 - The policy benefit year is from 1st January to 31st December. You will have access to the increased applicable OAL from 1st April 2026 to 31 March 2027.
 - Effective 1st April 2026, the difference in the change in the OAL benefit from 2025 to 2026 will become available to all policy holders until 31 December 2026.

- o There will be no pro-rating of the OAL limits and benefits.

2. WAITING PERIODS

2.1. [General Waiting Periods:](#)

- 2.1.1. **3** (three)-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, refer to clause **27.1**.
- 2.1.2. **10** (ten)-month waiting period on pre-existing conditions, diseases, or illness.

2.2. [Policy Specific Waiting Periods Applicable to Certain Procedures:](#)

The following conditions are excluded within the first **6** (six) months of the inception of the policy.

- 2.2.1. Myringotomy and grommets
- 2.2.2. Adenoidectomy
- 2.2.3. Tonsillectomy
- 2.2.4. Hysterectomy (except where malignancy is proven)
- 2.2.5. 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:

- 2.2.6. **50%** (fifty percent) of benefits available from month **7** (seven) to **10** (ten).
- 2.2.7. From month **11** (eleven), 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.

2.3. [Specific Waiting Periods Applicable to Certain Benefit Categories, and Certain Conditions, and/or Relevant Options:](#)

- 2.3.1. **3** (three)-month waiting period on Initial Diagnosis and Accidental Death.
- 2.3.2. **6** (six)-month waiting period on Premium Waivers,
- 2.3.3. **10** (ten)-month waiting period for pregnancy, confinement, and all related treatment.
- 2.3.4. **12** (twelve)-month waiting period on all pre-existing cancer-related treatments.

2.4. [Transfer of Cover](#)

- 2.4.1. When transferring your cover to OmniGap and you've been on cover with a previous Gap Cover provider for **12** (twelve) consecutive months or more, we will only impose a **3** (three)-month waiting period on Additional Benefits for which you did not have cover at the previous Gap Cover provider.
- 2.4.2. When transferring your cover to OmniGap and you've been on cover with a previous Gap Cover provider for less than **12** (twelve)-months, the balance of the relevant waiting periods per benefit category will still apply, and there will only be a **3** (three)-month waiting period on the Additional Benefits available within the policy.
- 2.4.3. General policy terms, conditions & exclusions will apply as per the policy schedules and wording.

2.5. [OmniGap Cover Upgrades](#)

- 2.5.1. If the policyholder has held an OmniGap policy for **12** (twelve) consecutive months and wants to upgrade to a higher option, all the Additional Benefits will be subject to a **3** (three)-month waiting period, from the effective date of transfer.
- 2.5.2. If the policyholder has held an OmniGap policy for less than **12** (twelve) consecutive months and intends to upgrade to a higher option, the balance of the relevant waiting periods per benefit category will still apply, and there will be an additional **3** (three) month waiting period on the Additional Benefits.

3. PRODUCT DESCRIPTION

This is a Short-term Insurance Accident and Health policy regulated by the FSCA and PA under auspices of the Short-term Insurance Act 53 of 1998 and the Insurance Act 18 of 2017 that consists of the following benefit categories, provided that all costs for both planned and emergency treatments incurred against this policy are:

- obtained within the borders of South Africa.
- by a registered medical professional with a valid practice number issued by the HPCSA (Health Professions Council of South Africa).

This policy consists of the following benefit categories, namely In-Hospital Benefits, Out-of-Hospital Benefits, Cancer Benefits and Value-Added Benefits.

3.1. IN-HOSPITAL BENEFITS

3.1.1. **GAP COVER (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL OF R223 000** PER DEPENDANT PER YEAR)**

- The Gap Cover benefit covers the difference between the medical scheme rate and the rate that service providers charge.
- We cover up to **500%** (five hundred percent) above the medical scheme rate, to a maximum of **600%** (six hundred percent) or at the amount above the medical scheme stated benefit value as determined by your medical scheme.
- Claims related to robotic surgery shortfalls on the hospital account are covered and limited to **R19 000** (nineteen thousand rand) per policy per annum.
- The shortfall on BMI codes are covered.
- Benefit category is subject to OAL.

3.1.2. **CO-PAYMENTS (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL OF R223 000** PER DEPENDANT PER YEAR)**

- **Co-payments:** Co-payment cover is for the co-payments (including co-payments expressed as a percentage), excesses, or deductibles imposed by a medical scheme for specified procedures, cover for hospital admission fees, scans, or surgical procedures. Refer to the Cancer Co-payment benefit for claims related to cancer.
- **Penalty Fee Co-payments:** This benefit covers the penalty fee co-payment or deductible charged by your medical scheme for the voluntary use of a non-designated service provider/network hospital, or the use of a partial cover network hospital. We cover up to **R16 000** (sixteen thousand five hundred rand) per claim, **1** (one) claim per policy per annum, irrespective of whether a rand amount or percentage penalty fee is charged by the medical scheme. Co-payments for administration charges are specifically excluded from cover on this policy.
- Benefit category is subject to OAL.

3.1.3. **DAY HOSPITAL/CLINIC AND/OR IN-ROOM SURGICAL PROCEDURES COVER (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL OF R223 000** PER DEPENDANT PER YEAR)**

- This benefit will cover the Gap Cover portion for any day hospital/clinic and/or in-room procedures including acute hospitals if a policyholder elects to have the treatment that would normally be performed on an in-patient basis, performed as an out-patient, by a registered medical professional.
- This includes, but is not limited to, for example, gastroscopies, colonoscopies, wisdom teeth extractions, homebirth, stent insertions, and renal dialysis.
- Admissions where no clinical/medical reason for admission can be provided, will not be covered.
- Benefit category is subject to OAL.

3.1.4. **PRESCRIBED MINIMUM BENEFIT (PMB) COVER (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL OF R223 000** PER DEPENDANT PER YEAR)**

- Prescribed Minimum Benefits (PMB) as defined in the Medical Schemes Act and Regulations determines 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 of a list of medical conditions.
- This benefit covers the shortfall resulting from the voluntary use of a non-designated service provider for planned procedures, except in the event of an emergency.
- PMB claims will be processed once the medical scheme rate has been defrayed.
- Benefit category is subject to OAL.

3.1.5. **HOSPITAL ACCOUNT SHORTFALLS (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL OF R223 000** PER DEPENDANT PER YEAR)**

- The Hospital Account Shortfall benefit will cover any charges on the hospital account that the medical scheme has not paid for items like consumables, or take-home medication.

- Should your treating hospital (for the same admission) require you to obtain medication from the hospital's dispensing pharmacy, this will be considered under this benefit provided that the script was issued by the hospital on the same day as you or your dependants were discharged. Medication needs to be obtained from the hospital's pharmacy on the same day, if a claim is submitted for a different pharmacy, you will have no cover for medication under this benefit.
- We pay up to **R5 000** (five thousand rand) per policy with a maximum of **R1 000** (one thousand rand) per claim. A **R1 200** (one thousand two hundred rand) sub-limit is applicable for private room upgrades.
- Benefit category is subject to OAL.

3.1.6. SUB-LIMIT ENHANCER BENEFIT (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL OF R223 000** PER DEPENDANT PER YEAR)

- Claims Sub-limit of **R40 000** (forty thousand rand) per policy per annum and subject to **R15 000** (fifteen thousand rand) per claim.
- The sub-limit enhancer benefit applies to all sub-limits when you have Medical Scheme benefit available at the time of incident but exceed your medical scheme benefit limit during the time of incident.
- Cover is not available when the sub-limit or annual limit is reached at the time of the event, and your medical scheme does not contribute towards this benefit.
- Benefit category is subject to OAL.

3.2. OUT-OF-HOSPITAL BENEFITS

3.2.1. SPECIALIST CONSULTATION FEE BENEFIT (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL OF R223 000** PER DEPENDANT PER YEAR)

- The Specialist Consultation Fee benefit covers the difference between the medical scheme rate and the rate which the specialist charges for the cost of the consultation **ONLY**, up to the available sub-limits. Payment is dependent upon the medical scheme paying a portion towards the consultation fee – (please refer to section 7).
- We cover **R5 000** (five thousand rand) per policy at **R1 100** (one thousand one hundred rand) per claim for the cost above medical scheme rate only.
- This includes consultations charged for ICD-10 (Diagnosis) Code F83.

ICD10-Code:	ICD-10 Description
F83	Mixed specific developmental disorders

- Benefit category is subject to OAL.

3.2.2. CASUALTY BENEFIT (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL OF R223 000** PER DEPENDANT PER YEAR)

- A sub-limit of **R15 000** (fifteen thousand rand) per policy per annum is applicable to accident, trauma, and illness categories. This benefit covers the costs directly related to the initial emergency event at any registered emergency/hospital/casualty facility when you require immediate medical treatment due to an accident or trauma. The following benefits collectively accumulate to the sub-limit:
 - **Accident/Trauma Benefit:** This benefit covers all costs directly related to the initial accidental event and paid to a maximum value of the sub-limit available, irrespective whether you are liable to pay the costs related to the emergency event out of your own pocket or your medical scheme pays.
 - **Illness Benefit:** All costs related directly to the initial emergency illness event will be covered and paid up to **R1 500** (one thousand five hundred rand) per claim up to the casualty benefits sub-limit, irrespective whether you are liable to pay the costs related to the emergency event out of your own pocket or your medical scheme pays. This is applicable to any dependant **13** (thirteen) years and older who require emergency treatment outside of normal consulting hours. After hours/outside of normal consultation hours means between **18:00 to 07:00** on a Monday to Friday as well as the whole of Saturday, Sunday, and South African recognised public holidays.
 - **Child Casualty Illness Benefit:** This benefit is subject to **R3 000** (three thousand rand) per claim of the Casualty benefit sub-limit and is applicable to children **12** (twelve) years and younger who require emergency treatment outside of normal consultation hours. After hours/outside of normal consultation hours means between **18:00 to 07:00** on a Monday to Friday as well as the whole of Saturday, Sunday, and South African recognised public holidays. All costs directly related to the initial event will be covered, irrespective whether you are liable to pay the costs related to the emergency event out of your own pocket or paid by your medical scheme.

- Accident/Trauma Benefit; Illness Benefit and Child Casualty Illness Benefit is covered as a stated benefit on this option. A medical scheme statement is not a requirement.
- Date and time stamp on the facility account as provided by the casualty facility, this will be the trigger to the eligibility of the claim.
- All treating providers seen whilst in the casualty facility for the initial event will be reviewed under this benefit entitlement.
- The accident and trauma benefit will not provide cover for any conditions considered as illness.
- Ambulance costs are not covered by this benefit.
- Any follow up visits to casualty/treating providers will not be covered.
- We will cover a GP's emergency facility where no hospital emergency is available within a 30km radius within the above stated benefit limits.
- Benefit category is subject to the OAL.

3.2.3. PREVENTATIVE CARE COVER (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL OF R223 000** PER DEPENDANT PER YEAR)

- A sub-limit of **R5 000** (five thousand rand) per policy applies to this section and provides cover if your medical scheme option makes provision for these benefits.
- Should your medical scheme make a payment towards this benefit either through risk or savings, we will cover the difference between charged and paid amount (gap portion only).
- This benefit will cover the difference between that rate that the service provider charges and the benefit amount on your medical scheme option for any of the listed procedures/diagnoses or treatments ONLY. Claims will be paid up to a maximum of **R1 000** (one thousand rand) per claim.
- The following procedures/diagnoses or treatments are covered as part of this benefit:
 - Pap smear.
 - Cholesterol test.
 - Blood glucose test.
 - Flu vaccination.
 - Childhood immunisation (Department of Health Formulary) – up to the age of 12 years.
 - Bone density scans.
 - Prostate specific antigen tests.
 - Mammogram.
 - Contraceptive implantation only, this excludes costs related to the device.
- Alternatively, if there is no benefit available at the time of claim, Sirago will pay, as a stated benefit up to **R1 000** (one thousand rand) per policy per annum towards the cost of the consultation and for all tests/procedures listed above.
- Benefit category is subject to the OAL.

3.2.4. APPLIANCES (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL OF R223 000** PER DEPENDANT PER YEAR)

- The Appliance benefit will cover the shortfall of claims for any of the following appliances, if there is a **defined** rand limit for benefits on the medical scheme:
 - Hearing Aids.
 - Wheelchairs.
 - CPAP Machine.
 - Humidifiers.
 - Insulin Pump.
 - Glucometer.
 - Nebulisers.
 - Mirena Device.
- We will pay up to **R6 500** (six thousand five hundred rand) per policy per annum.
- Benefit category is subject to OAL.

3.2.5. TRAUMA COUNSELLING (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL OF R223 000** PER DEPENDANT PER YEAR)

- A sub-limit of **R6 000** (six thousand rand) per policy per annum applies to this benefit.
- This benefit covers you for trauma counselling with a registered medical professional, **within the first 6 months after a traumatic incident**, not limited to: dread disease, hijacking, and/or violent crimes, at the discretion of the insurer, on the provision of supporting documentation and paid as a stated benefit.
- Benefit category is subject to OAL.

3.2.6. CO-PAYMENTS (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL OF R223 000** PER DEPENDANT PER YEAR)

- **Co-payments:** Co-payment cover is for the co-payments (including co-payments expressed as a percentage), excesses, or deductibles imposed by a medical scheme for specified procedures, cover for scans, or surgical procedures. Refer to the Cancer Co-payment benefit for claims related to cancer.

3.3. CANCER BENEFITS

Cancer benefits are paid to the maximum available sub-limits within your OAL of **R223 000**** per dependant and are only available if the treatments do not form part of the legislative PMB framework.

3.3.1. CANCER CO-PAYMENTS BENEFIT:

- The Cancer Co-payment benefit incorporates co-payments for ongoing cancer related treatments, biological drugs as approved by your Medical Scheme. The benefit is applied once your medical scheme cancer benefit has been exhausted, and a percentage co-payment is imposed for further treatment on the medical scheme's registered treatment plan.
- This benefit extends cover for ongoing cancer-related treatment for Innovation drugs to a maximum sub-limit of **R15 000** (fifteen thousand rand) per claim, as approved by your medical scheme.
- Benefit category is subject to OAL.

3.3.2. CANCER BOOST BENEFIT:

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

3.3.3. CANCER BREAST RECONSTRUCTION BENEFIT:

- The Cancer Breast Reconstruction Benefit covers up to **500%** (five hundred percent) of the medical scheme rate for breast reconstruction of the affected breast post-mastectomy if the medical scheme approves/authorises the procedure related to the reconstructive surgery.
- We will also cover up to **R25 000** (twenty-five thousand rand) sub-limit per dependant for all procedures related to the reconstruction of the unaffected breast, should the medical scheme not cover this at all. This benefit is only available, provided the dependant was a member of Sirago at the time of the event (mastectomy) and has retained their cover with Sirago since that event OR if they have transferred cover from another Gap Provider to Sirago and have been a Sirago dependant for a period of **12** (twelve) months or longer without a break in cover.
- There is no cover for subsequent breast reconstruction.
- Benefit category is subject to OAL.
- Payment of this benefit is specifically subject to initial payment by the Medical Scheme. To access this benefit, you will be required to present the following documents upon claim submission:
 - An invoice from the provider reflecting the procedure codes along with the amounts charged, and/or an invoice from the retailer reflecting the description of what was purchased along with the price.
 - Your current treatment plan from your Medical Scheme.

3.4. VALUE ADDED BENEFITS

(THESE DO NOT FORM PART OF THE AGGREGATED OAL OF R223 000 **)

3.4.1. PREMIUM WAIVERS:

The Premium waiver benefit consists of two sub-benefit categories and is only applicable to the dependants that are active on the OmniGap policy at the time of **accidental** death only or total permanent disability of the policyholder:

- **Gap Cover Premium Waiver:** A Premium Waiver benefit may be claimed by the surviving spouse/adult dependant on the current OmniGap policy, in the event of the **accidental** death or total permanent disability of the policyholder of the Sirago policy, irrespective of source of payment of the gap premium. We hold the premium of the policy as a credit against the policy for **6** (six) months if the medical scheme membership is maintained. Should there be any premium

adjustments within the **6** (six)-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. Certificate of Medical scheme membership is required monthly.
- **Medical Scheme Premium Waiver:** Payable in event of **accidental** death or total permanent disability of the policyholder of the OmniGap policy and where all dependants are linked to a single medical scheme. This includes payment for dual medical scheme membership, Sirago will pay a claim for the medical scheme premium of the actual rand amount of the contribution, but not higher than the sub-limit of **R4 500** (four thousand five hundred rand) per month for a **6** (six) month period. This will be paid to the beneficiary nominated on the policy for the upkeep of their medical scheme contributions. The medical scheme membership must remain active during this period and the Certificate of Membership from the medical scheme must be presented monthly for authentication. Payable from the month AFTER the event.
- Accidental death certificate and SAPS accident report are required for validation of the premium waiver claims.

3.4.2. ACCIDENTAL DEATH:

- The Accidental Death benefit will pay the nominated beneficiary for the accidental death of insured persons on the OmniGap policy at **R9 000** (nine thousand rand) per dependant upon the receipt of the death certificate and SAPS accident report.
- It is specifically noted that this benefit is provided to cover the costs not directly associated with medical expenses.

3.4.3. INITIAL CANCER DIAGNOSIS (FIRST DIAGNOSIS):

- This benefit will pay out a lump sum of **up to R24 000** (twenty-four thousand rand) depending on the stage of cancer the policyholder or dependant has been diagnosed with, upon the receipt of the histology report confirming initial diagnosis of malignant cancer, the policyholder or dependant will qualify for the following benefits:
 - Stage 2: R20 000 (twenty thousand rand) per dependant.
 - Stage 3: R22 000 (twenty-two thousand rand) per dependant.
 - Stage 4: R24 000 (twenty-four thousand rand) per dependant.
- This benefit is payable per dependant per lifetime as defined. Any incidence of cancer prior to the inception of the policy or pre-cancer is excluded from this benefit.
- This benefit specifically excludes any diagnosis related to skin cancer.
- It is specifically noted that this benefit is provided to cover costs not directly associated with medical expenses.

3.4.4. OMNI BABY:

- The Omni Baby benefit provides **R2 000** (two thousand rand) per newborn child payable as a stated benefit upon registration of the newborn on your policy, within **90** (ninety) days and available upon receipt of the following:
 - The birth certificate of the newborn.
- A newborn whose details are provided to the Insurer within **90** (ninety) days of birth will not be subject to underwriting and waiting periods.
- Newborn dependants added after **90** (ninety) days will be subject to full underwriting and waiting periods and an additional dependant form is required.
- This benefit will apply if the father, mother, or legal guardian is a dependant on the Sirago policy.

3.4.5. MEDCARE (FREE MEDICAL SCHEME ALTERNATIVE DISPUTE RESOLUTION SERVICE (ADR))

- After assessment of a PMB claim and not meeting the requirements of OmniGap for payment the policyholder will have access to a free ADR service via MedCare for all claims **exceeding R9 000** (nine thousand rand).
- Policy holders will also be able to **access the MedCare service** for all claims less than **R9 000** (nine thousand rand) **limit**, including all aspects that they want to dispute with their medical scheme. The policy

holder will be able to access this service in the following manner:

- Obtain **free advice, templates, and guidance** on the MedCare website.
- Obtain **access to a MedCare personalised ADR practitioner at a 60% discounted rate**. This means as an OmniGap policyholder you will **only pay R300** (three hundred rand) **per hour**, payable in advance, if you use this service despite the outcome. In this event you will have to enter into an agreement with MedCare when you want to access this service.
- Obtain **access to a MedCare personalised ADR practitioner at a 20% discounted rate**. This means as an OmniGap policyholder you will **only pay R600** (six hundred rand) **per hour** if you use this service. The fee is only payable if the claim is successfully resolved.
- You can also use the MedCare service to dispute waiting periods and late Joiner Penalties or any other matter such as limitation on benefits due to protocols or formularies etc. You will have **access to a MedCare personalised ADR practitioner at a 15% discounted rate**. This means as an OmniGap policyholder you will **only pay R635** (six hundred and thirty-five rand) **per hour**, payable in advance, if you use this service despite the outcome.
- **You can also utilise your broker to render this service on your behalf to avoid paying the fee to MedCare. Your Broker will also have access to the MedCare website.**

4. HOW THE POLICY WORKS

The headers in this document are for ease of reference only. Please read the entire clause to understand its full meaning. Check your Schedule of Insurance which, along with any relevant endorsements, explains the cover you have purchased. The benefit amount is not related to the specific cost of any medical treatment, or expense shortfall, or non-medical expense cover because of hospitalisation.

Claims will be assessed in accordance with best practice clinical and insurance guidelines and protocols as determined by OmniGap from time to time and does not require notification to policyholders.

[4.1. Option eligibility:](#)

Premiums are determined by age bands upon the policyholder's original entry age and the following age bands are applicable:

- 0-64
- 65+

5. WHAT MAKES UP YOUR POLICY OF INSURANCE?

Your policy consists of:

- The Schedule of Insurance.
- Policy Wording (Terms and Conditions).
- Correspondence and amendments that were sent to your last known email address, which remains your responsibility to keep OmniGap updated of.

Please ensure that you are familiar with the contents of all the documents and that all the detail noted on the Schedule of Insurance is correct in every respect. Please note it is the policyholder's specific responsibility to keep OmniGap informed of all their personal details and maintain accurately at all times.

6. WHO IS COVERED BY THIS POLICY?

• Individual membership

The premium for an individual will apply if there is only 1 (one) policyholder and no dependants on the policy.

• Family membership

This policy will cover the policyholder and the dependants who are listed on the Schedule of Insurance. The base rate includes the policyholder and **4** (four) dependants. [A total of **5** (five) insured people]

- **Single Medical Scheme Membership**
 - We cover all members listed on the Medical Scheme Certificate of Membership (COM).
- **Dual (two) Medical Scheme Membership**
 - Dual medical scheme membership is when the policyholder and dependants belong to more than **1** (one) medical scheme membership.
 - The cover is limited to a maximum of **2** (two) adults and all the child dependants on **1** (one) policy if you belong to a dual medical scheme,
 - We cover all members listed on the Certificate of Membership (COM)

All additional dependants added onto the policy as listed on the Certificate of Membership (COM) will be charged an additional rate per dependant based on their age as indicated below:

- For the 6th (sixth) insured person:
 - 64 and younger – R55.00 (fifty-five rand)
 - 65 and older – R110.00 (one hundred and ten rand)
- For the 7th (seventh) insured person:
 - 64 and younger – R30.00 (thirty rand)
 - 65 and older – R55.00 (fifty-five rand)
- For the 8th insured person onwards:
 - 64 and younger – R 25.00 (twenty-five rand)
 - 65 and older – R55.00 (fifty-five rand)

7. WHEN WILL A CLAIM (BENEFIT) BE AUTHORISED FOR PAYMENT?

- Once we have confirmed the validity of your policy and dependants.
- Once we confirm your premium payments are up to date.
- Once we have validated your claim using sub-contracted administrators if required.
- Once we have confirmed benefits for the claim ICD-10 Coding.
- Upon all policy conditions having been met.
- Upon confirmation of a valid HPCSA practice number.
- Once all required documents have been received.
- Depending on the benefit design of your chosen medical scheme option:
 - **Hospital Plan:** Benefits will be paid if your option pays a portion of the claim.
 - **Savings Plan:** Benefits will be paid if your option pays a portion of the claim. However, the value settled by the Insurer will be limited to the Gap portion after the scheme has defrayed the scheme rate of the claim if there was an accumulated or allocated savings balance at the time of claim.
 - **Traditional medical scheme option:** Benefits will be paid if your option pays a portion of the claim.

8. TO WHOM WILL THE POLICY BENEFITS BE PAID?

Only you or the persons indicated on the Schedule of Insurance will be entitled to claim and receive non-bereavement related benefits under this policy. The applicable benefits will be paid directly into the policyholder's account.

OmniGap reserves the right to initiate direct claims settlement with providers on behalf of policyholders to negotiate quicker and discounted claims settlement with providers.

In the event of a death-related claim the Insurer will pay the benefit into the policyholder or nominated beneficiary's account.

The beneficiary must be noted on the policy before any loss. We will require the full name, surname, and ID to note the beneficiary. At the time of a claim, we will require the beneficiary's ID and proof of banking details.

Should there be no beneficiary noted on the policy before the loss, or should we be unable to confirm the identity of the beneficiary, payment will always be made into the policyholder's account, or to the estate of the policyholder.

All payments are subject to the limits and benefits available as stated in the policy documents.

9. WHEN DOES THE POLICY BECOME ACTIVE?

The policy inception date is reflected on your Schedule of Insurance and is ratified once we have received your first monthly premium. All policy terms will apply from the actual date of inception of the policy.

No policy will be activated if the premium is not received, and such a policy is viewed as not taken up (NTU).

Any change of policy option benefits will have a **3** (three) month waiting period applied to the additional benefits.

Additional dependants added after policy inception will be subject to individual underwriting and waiting periods, unless it is a newborn whose details are provided to the Insurer within **90** (ninety) days of birth.

10. PREMIUMS

- Premiums payable for benefit cover are determined by age and family size (refer to clause **27.33**) and is based on the following **2** (two) age group categories: Prospective policyholders who are **64** (sixty-four) years and younger and **65** (sixty-five) years or older, will be charged different premiums when applying for cover as either individuals or families.
- The age of the policyholder is linked directly to the Certificate of Membership (COM) as issued by your registered medical scheme. The benchmark for premium determination is based on the prospective policyholder's age at the inception of the policy.
- Premiums are applicable for the duration of the relevant period of cover. Benefits do not change during this period and nor does any underwriting criteria.
- The premiums applicable to this policy are payable in advance.
- Sirago collects premiums via debit orders, alternatively, via the Pay@ service.
- Debit orders are collected on the following dates: 1st, 5th, 7th, 10th, 15th, and the 20th which is applicable to the current month.
- Debit orders that are collected on the 25th or the 31st/last day of the month is applicable to the following month.
- Any policyholder electing the 25th and/or the last day of the month, will automatically have the inception date of their policy defaulted to the 1st of the following/next month.

11. HOW LONG DOES THIS POLICY LAST?

The policy is in force for as long as your premiums are paid up to date or until your policy is cancelled by you, or by the Insurer giving **31** (thirty-one) days' notice.

12. YOUR RESPONSIBILITIES TOWARDS THE POLICY

To enjoy cover you need to:

- Pay your premiums.
- Provide us with true and complete information when you apply for cover, submit a claim or make changes to your policy. This also applies when anyone else acts on your behalf.
- Advise us of any changes to your health status between the point of application and actual activation of your policy.
- Not admit any fault, nor make any offer or settlement on our behalf without our written agreement.
- Agree to comply with all our reasonable requests.
- Use all reasonable care and take all reasonable precautions to prevent or minimize loss, damage, liability, injury, or death.
- Inform us immediately of any changes to your circumstances that may influence whether we provide cover, the conditions of cover or the premium we charge. This includes any changes to any information on the Schedule of Insurance or in regard to convictions for offences by any person covered under this facility relating to dishonesty, reckless and negligent driving or driving under the influence.

13. INSURANCE POLICY CHANGES

You must advise us when your contact details change. If you wish to cancel your insurance, you must do so in writing by giving **31** (thirty- one) days' calendar notice for cancellation. Should you wish to cancel the policy with "immediate effect," we may, at our discretion, accept the immediate cancellation and refund the premium related to the month in which the cancellation was requested, less all administrative expenses liable, to you.

You may make changes to your insurance policy at any time.

Confirmation of the change will be sent to you in writing. We may amend your policy by giving you **31** (thirty-one) days' notice. Notice can be given by fax, e-mail, or post/mail to the last known contact details we have on record as provided by the policyholder.

If for any reason the Insurer decides to discontinue and / or cancel this product line, all policyholders will be given the benefit of a **31** (thirty-one) day notice period of this decision before termination.

14. YOUR RESPONSIBILITY TOWARDS PREMIUM PAYMENTS

Your policy is an annual policy, payable in **12** (twelve) equal payments. Your policy will only be activated once we receive your first monthly premium. Thereafter you must pay the full monthly premium, in advance, on the agreed payment dates as stated on your Schedule of Insurance.

If we do not receive the premium for your policy on the agreed payment date, we will allow a **15** (fifteen) days' period of grace. During this grace period, you may pay your premium either by requesting a forced debit from OmniGap or utilizing the Pay@ service which can be sent to you via a link.

Cooling Off Period: A policyholder may, where a policy has a term longer than a month, and no benefit has yet been paid or claimed, or an event insured against under the policy has not yet occurred, within **14** (fourteen) days after the date of receipt of the Schedule of Insurance, cancel the policy entered into with the insurer by way of a written cancellation notice to the insurer. All premiums or moneys paid by the policyholder to the Insurer, up to the date of receipt of the notice received at any date thereafter, in respect of the cancelled or varied policy, must be refunded to the policyholder, subject to a 20% (twenty percent) handling fee for administration services.

Should your premium not be paid, a double debit is due on the next debit date. For debit order payments a double debit will be submitted to your bank. If this debit is also unpaid, the policy will be cancelled with effect from 24h00 on the last day of the month for which premium was received.

If the policy owner requests a reinstatement of a cancelled policy, this will only be considered at the Insurer's discretion and requires a signed health declaration document in support of the request. Considerations for reinstatement will be limited to a maximum of **90** (ninety) days after the cancellation date of the policy. Any requests that exceed the 90 (ninety) day period are subject to a new application and all relevant terms and conditions will apply.

Please note that you will not have any cover unless all premiums are paid up to date. Any revocation of premium debit authority will result in the immediate cancellation of your policy.

It remains the sole responsibility of the policyholder to ensure that full premiums are paid on the due date.

15. REFUNDS

Premiums will only be refunded for a maximum period of **3** (three) months if approved by the Insurer. No refunds

of the premium will be made in respect of:

- Any claim that, for whatever valid reason, is repudiated.
- Any policy that, for whatever valid reason, is cancelled by the Underwriter.
- Any policy that you cancel of your own accord (cancellation instruction must be in writing).
- Any cost difference resulting from changes to your policy option.

16. CLAIMS

For you to prove a claim, all required relevant documents must be submitted to us within **180** (one hundred and eighty) days from date of admission. We shall not be liable for claims where the documentation is received outside of this period.

We reserve the right to recover funds for claims that were paid in error or have since been fully reprocessed and paid by the medical scheme.

Claims can only be assessed for payment once your completed claim information is received. This information consists of the following:

- A claim form for each event that is fully completed and signed by the policyholder.
- It is important to note that all approved claims will be paid into the bank account details registered with Sirago, unless alternative bank details are provided on the claim form.
- If the claim is related to a hospital admission, a detailed hospital account is always required.
- All related service provider accounts are required to substantiate 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 by the Underwriter.
- Pre-authorisation letter from your medical scheme for co-payment claims as well as the proof of payment, or receipt of payment.
- The Cancer Breast Reconstruction Benefit is subject to Sirago protocols, and the following documentation will be required.
 - Medical scheme pre-authorisation.
 - Motivation/letter from your treating provider.
- As part of our claim validation process, we use the services of a contracted third party to authenticate medical scheme membership, plan option type, relevant dependants and agreed medical scheme option tariffs amongst other relevant information to validate the claim.
- Supporting documentation is required by the Insurer, includes a death certificate, SAPS accident report and/or a total permanent disablement certificate, or reports from a registered medical practitioner for Accidental Death or the Premium Waiver benefits.
- We reserve the right to call for additional information of a clinical nature. If Sirago requests a PMA (Post Medical Assessment) from your doctor as part of the claims assessing and authentication process, Sirago will cover the cost of the PMA (Post Medical Assessment) to a maximum cost of **R250** (two hundred and fifty rand) per event.
- If Sirago deems your claim or certain claim lines to be clinically inappropriate or falls outside of the policy terms, the whole claim or certain claim lines will be repudiated.
- Confirmation from the treating provider is required confirming the **stage** of cancer, and that this is a first-time diagnosis of any cancer, with the histology report for us to process claims for Initial Diagnosis of Cancer benefit.

17. DISPUTED CLAIMS

After we inform you of our decision on a claim, we will allow you **90** (ninety) days to make representations to us about our decision. If we do not compensate you for a claim or a part of it, and you want to contest our decision, you must do so in writing and outline your reasons for the dispute. We will provide you with a written response within **31** (thirty-one) days. If you do not agree with the outcome of the appeal, you may refer the dispute to the National Financial Ombud Scheme. You are afforded an additional **6** (six) months in addition to the **90** (ninety) days to take legal action. Should you not enforce these rights, your claim will be deemed prescribed/abandoned.

18. COMPLAINT PROCEDURE

Any complaint should be directed in writing to the office of Sirago Underwriting Managers (Pty) Ltd at:

- PO Box 1115, Bromhof, 2154, or
- Emailed to complaints@sirago.co.za

Any complaint received will be acknowledged, and responded to in writing, within **31** (thirty-one) days.

If you are not satisfied with the feedback and decisions taken by Sirago in terms of your complaint, you may lodge a further complaint with the Insurer, GENRIC.

- Emailed to complaints@genric.co.za

If the Insurer was not able to resolve the complaint in a satisfactory manner, you may lodge your complaint to the National Financial Ombud Scheme, details of which are contained within your schedule of insurance.

19. FRAUD, MISREPRESENTATION, NON-DISCLOSURE & DELIBERATE ACTS

Your fully completed application form with the relevant disclosures (including changes to your health status after your application, but before policy inception) provided by you or on your behalf forms the basis of our contract.

This policy can be re-underwritten, declared null and void, or terminated if any misrepresentation or non-disclosure is made regarding any detail that is material to this insurance. Any incorrect information may affect

the validity of this contract, or claims submitted.

We will not compensate you for a claim where you, or anybody who acts on your behalf, deliberately causes a loss, damage, or injury. All cover under this policy will be forfeited if you submit a fraudulent claim, or if anyone acts fraudulently on your behalf to obtain compensation.

20. JURISDICTION

This agreement shall be governed, interpreted, and construed in accordance with the laws of the Republic of South Africa. Any legal action or proceedings arising out of, or in connection with this policy, which is to be instituted in a court of law, shall be brought in the Court of South Africa and irrevocably submitted to the exclusive jurisdiction of such court.

21. TERRITORIAL LIMITS

Benefits payable for this policy is only valid for events incurred within the borders of the Republic of South Africa.

22. GUARANTEE CLAUSE

This is a Short-term Insurance Accident and Health policy regulated by the Financial Sector Conduct Authority under auspices of the Short-term Insurance Act 53 of 1998 and the Insurance Act 18 of 2017.

The stated benefit amount payable is not related to the specific cost of any medical expense shortfall or non-medical expense cover because of hospitalisation.

Only a medical scheme product can guarantee payment of full medical expense shortfall costs associated with a health event.

23. CONSENT CLAUSE

The sharing of claims information and underwriting information (including credit information) by Insurers is essential to:

- Enable the insurance industry to underwrite policies.
- Assess risks fairly.
- Reduce the incidence of fraudulent claims.
- Protect the public interest in terms of limiting excessive premium increases.
- To use your personal information to communicate with you to offer you additional services and solutions provided by the Insurer.

You hereby consent to this information being disclosed to any other insurance company and/or verified against other legitimate sources or databases. This will include contacting your medical scheme to validate applications and claims processes if necessary.

Any personal income or health information obtained shall not be used or sold commercially. Data security measures are in place to ensure the confidentiality of data management, and contractual agreements. OmniGap shall ensure that its staff also abides by the provisions of this clause and to do all things necessary to enforce such compliance. We collate age band, income band, demographics and race statistics, and all information will be for statistical and reporting purposes only.

24. POLICY SPECIFIC EXCLUSIONS

You will have no benefit, and we will not compensate you for any illness, condition, disease or injury, or the consequences of treatment of, or resulting from, or associated with:

- 24.1. Medical scheme exclusions stated benefit limits, and any claims or claim portions rejected or not authorised by your medical scheme, unless the benefits fall within the stated benefit entitlement as per this policy wording.
- 24.2. Where a medical scheme does not make provision for organ donation, and it is specifically stated as an exclusion in the scheme rules, there will be no benefit.
- 24.3. If a OmniGap policyholder is a donor no benefit is applicable. Refer to 27.51.
- 24.4. The first 100% (one hundred percent) of the medical scheme tariff/rate (this should be covered by your medical scheme).

- 24.5. Claims that exceed the utilisation or benefit limit per annum applicable to this policy.
- 24.6. Out-patient treatment other than defined as covered under this policy.
- 24.7. Any experimental treatments and medication, both in and out of hospital. (Including innovation drugs, unless approved by your medical scheme and forms part of your benefit entitlement on your Gap cover option.)
- 24.8. Any claim less than a minimum amount of **R100** (one hundred rand) due to the client per provider.
- 24.9. In the event that there were no benefits available from the scheme at the time of the procedure, Sirago will not provide any benefits unless defined.
- 24.10. There will be no benefit for the initial diagnosis of cancer from stage 0-1. There is only benefit for initial diagnosis of malignant cancer from stage **2** (two), where benefit is applicable on your chosen Gap option.
- 24.11. There will be no benefit for the initial diagnosis for skin cancer.
- 24.12. There will be no benefit in the event of natural death of the policyholder under the Gap and Medical scheme premium waiver benefits, where benefit is applicable on your chosen option.

25. GENERAL POLICY EXCLUSIONS

- 25.1. An event not covered by this policy and/or falling outside of the policy's intention.
- 25.2. An event where pre-authorisation was not obtained from the medical scheme or where medical scheme rules were not adhered to.
- 25.3. Any claim that must be paid in terms of alternate proclaimed legislation, such as the Compensation for Occupational Injuries Act 90 of 1993, and the Road Accident Fund Act 56 of 1996.
- 25.4. Any dependant not registered on the policy at the time of the event.
- 25.5. Any pre-existing condition, disease, disorder, or illness, for 10 (ten) months. This will include any condition which existed before inception, whether diagnosed or not, or for which an insured person has sought/received medical advice, received treatment by a registered medical professional, or exhibited symptoms, before the actual inception of the policy.
- 25.6. Any pre-existing cancer condition, disease, disorder, or illness, for 12 (twelve) months. This will include any condition which existed before inception, whether diagnosed or not, or for which an insured person has sought or received medical advice, received treatment by a registered medical professional, or exhibited symptoms, before the actual inception of the policy.
- 25.7. Breast reconstruction, as well as breast reconstruction performed as a secondary or subsequent reconstruction, unless defined as part of the benefits of this policy.
- 25.8. Intraocular lenses, unless defined as part of the benefits of this policy.
- 25.9. Claims for regular or routine medical treatment and advice on an on-going basis, and routine physical examinations or procedures of a purely diagnostic nature, unless defined as part of the benefits of this policy.
- 25.10. Any illness, injury or consequence from alcohol, drug or substance intoxication, use, abuse, or addiction, directly or indirectly traceable to the insured being affected, permanently or temporarily.
- 25.11. Any psychiatric or psychological condition or emotional or nervous conditions including, but not limited to, depression, insanity, psychosis, stress-related and affective disorders, unless specified as part of the benefit entitlement to this policy.
- 25.12. Suicide, attempted suicide or any intentional or deliberate self-injury and/or self-exposure to danger or risk except to save a human life.
- 25.13. Medication, drugs, prescriptions, consumables, and equipment used, unless it forms part of the benefits of this policy.
- 25.14. Devices, such as artificial joints, braces, crutches, dental implants, crowns, orthodontic, prosthodontic and all cosmetic dentistry including all forms of internal and external prosthesis as defined, unless specified as part of the benefit entitlement of this policy.
- 25.15. Cosmetic surgery where no clinical indication for treatment is present, including any treatment and costs resulting from these procedures unless specified as part of the benefit entitlement to this policy.
- 25.16. Discounts negotiated by the insured person directly with a service provider where re-imburement of a claim will/could enrich the insured person.
- 25.17. Elective procedures with no clinical/medical indication, including any treatment and costs resulting from these procedures, unless specified as part of the benefit entitlement to this policy.
- 25.18. Investigations, treatment, or surgery for eating disorders, obesity, or weight management, including any consequence of such treatment.
- 25.19. Investigations, treatment, medication, or surgery related to any condition where the policyholder seeks advice, diagnosis, and/or treatments outside the border of South Africa.
- 25.20. Investigations, treatment, or surgery related to infertility, artificial insemination, hormone treatment for infertility, or any other form of assisted reproduction, other than those procedures defined.
- 25.21. Any claim related to contraceptive device implantation, unless specified.
- 25.22. Robotic surgery which includes specialised mechanical or computerised appliances and equipment. Unless your claim is related to a benefit which specifically makes provision for this type of cover.
- 25.23. Any claim submitted where you and/or your dependant has previously been diagnosed with cancer in your lifetime will not qualify for the initial cancer diagnosis benefit.
- 25.24. An event approved by the scheme outside of the normal scheme rules by Ex-Gratia will not be covered on this policy.
- 25.25. An event resulting in or related to gender reassignment or gender reassignment reversal procedures, treatment or admission does not fall within the benefit entitlement.

- 25.26. Any other related charges and costs incurred during the specialist and primary care consultation fee benefit performed during the visit will not be covered, unless defined as part of the benefits of this policy.
- 25.27. Any costs related to out-of-hospital radiology and pathology are excluded from cover, unless defined as part of the benefits of this policy.
- 25.28. Any costs related to emergency Prescribed Minimum Benefit (PMB) costs / medical interventions, unless defined as part of the benefits of this policy.
- 25.29. Any follow-up visits to casualty/treating providers will not be covered, unless specifically covered under the benefit entitlement.
- 25.30. Any claim related to nuclear medicine.
- 25.31. SPORT RELATED EXCLUSIONS:
Any illness, injury or condition resulting from, or directly associated with, professional sport as a paid profession:
- Participation in any form of race or speed test, other than on foot.
 - Involving any mechanically propelled vehicles or crafts.
 - Participation in a sport that is defined by Underwriters as hazardous (as defined) or dangerous except for scholars taking part in school activities.

26. STANDARD SHORT-TERM POLICY EXCLUSIONS

You will have no benefit, and we will not compensate you for any illness, condition, disease or injury, or the consequences of treatment of, or resulting from, or associated with:

- 26.1. Any claim arising directly or indirectly from active involvement in war, invasion, an act of a foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or political risk of any kind, or any act of any person acting on behalf of or in connection with any organisation, group or activity aimed at overthrowing any government by force or any deliberate act of terrorism or violence.
- 26.2. Any riot, strike, or public disorder (including civil commotion, labour disturbances, or lock-out) or any act or activity resulting in, or calculated to bring about a riot, strike, or such disorder.
- 26.3. Active military duty, police duty, police reservist duty, civil commotion, labour disturbances, riot, strike, or the activities of locked-outworkers.
- 26.4. The act of any lawfully established authority, police force, security force or any other local, provincial, or national body, in controlling, preventing, suppressing or in any other way dealing with any event referred to in the clauses above.
- 26.5. Compensation in terms of the War Damage Insurance Act 85 of 1976.
- 26.6. Nuclear weapons or nuclear material, ionizing radiation, or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel. For this exception combustion shall include any self-sustaining process of nuclear fission.
- 26.7. Any loss arising from any contractual liability.
- 26.8. Any consequential loss or damage whatsoever.
- 26.9. Any attempt by you to commit an unlawful act.

27. DEFINITIONS AND EXPLANATIONS - terms frequently used but not necessarily part of the benefits available

- 27.1. **Accident:** A sudden, unexpected, and unusual event that happens at a specific time and place, which the Insured Person could not foresee, anticipate, or envisage. This event must result in visible, violent, external, and traumatic physical Injury to the body during the period of the Policy.
- 27.2. **Accidental Death:** Death caused by an external, violent, unexpected, and visible event. The accidental death benefit does not provide cover for suicide or death by natural causes.
- 27.3. **Accidental dental:** Is defined as being the loss of **50%** or more of the visible portion of a tooth and where the dental nerve is permanently damaged. The benefit covers accidental tooth fracture to permanent teeth (crowns and implants are excluded) due to an external injury to the mouth.
- 27.4. **Acute:** Conditions or symptoms that start suddenly and are severe or intense. These conditions usually come on quickly and do not last as long, unlike chronic conditions, which develop slowly and persist over time.
- 27.5. **Acute Hospital:** A hospital that treats all major and minor conditions.
- 27.6. **Admission Fee:** The fixed amount you must pay in terms of your medical scheme rules when you are admitted to hospital as an **in-patient**.
- 27.7. **Adult:** An eligible dependant that is aged **21** (twenty-one) years and above that is registered on the Medical Scheme
- 27.8. **Alternative Care:** Any alternative therapists recognised and paid for by the medical scheme option you are on.
- 27.9. **Alternative Dispute Resolution Service:** This is a semi legal process to resolve complaints and disputes with medical schemes as provided for in terms of Section 29, 47, 48, 49 and 50 of the Medical Schemes Act.

- 27.10. **Appliances:** An instrument or device designed for a medical use.
- 27.11. **Beneficiary:** A person(s) other than the policyholder of an insurance policy who is entitled to receive benefits.
- 27.12. **Body Mass Index (BMI):** A measurement tool to establish the ideal weight of a person based on weight and height. Additional fees are charged for the management of patients who fall outside the prescribed **BMI**.
- 27.13. **Biological Drugs:** A substance that is made from a living organism or its products and is used in the prevention, diagnosis, or Treatment of Cancer and Rheumatoid Arthritis. For this Policy, Biological Drugs include antibodies, interleukins, and vaccines.
- 27.14. **Cancer:** Diseases in which abnormal cells divide without control and can 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 and one **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** before 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 is limited to **1** (one) claim per dependant per lifetime provided there is benefit on your chosen option. This benefit excludes any incidence of cancer/pre-cancer before the 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; however Metastatic melanoma occurs when the cancer spreads from the tumour to other parts of your body. This is also known as stage 4 melanoma. Melanoma is the most likely of all skin cancers to become metastatic if not caught early.
- 27.15. **Certificate of Membership (COM).** An official document issued by your medical scheme or Gap Cover Provider indicating all relevant dependants, waiting periods and/or contributions/premiums applicable to the medical scheme/policy.
- 27.16. **Child:** A child is a natural/adopted/stepchild of a Sirago member who is younger than the age of **21** (twenty-one) years old, however can be extended to the age of **27** (twenty-seven) for full-time students. Documented proof of full-time studies is required to verify dependants over the age of **21** (twenty-one). Any benefits payable per benefit applicable will depend on the dependant status.
- 27.17. **Claimable health event:** An event relating to the health of the body of the insured person, adversely affected by illness or injury and necessitating bona-fide **in-patient** or treatment resulting in **hospitalisation** and out-patient procedures or other **treatment** approved by the **Underwriter**.
- 27.18. **Consumable Medical Supplies:** Non-durable medical supplies that:
- Are usually disposable in nature.
 - Cannot withstand repeated use by more than one individual.
 - Are primarily and customarily used to serve a medical purpose.
- 27.19. **Contraceptive Devices:** Devices used to prevent pregnancy, including the diaphragm, condom, and intrauterine devices.
- 27.20. **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.
- 27.21. **Council of Medical Schemes (CMS):** A statutory body established by the Medical Schemes Act (131 of 1998) to provide regulatory supervision of private health financing through medical schemes.
- 27.22. **Corrective Procedures:** In relation to cosmetic procedures that aim to correct function or structural defect.
- 27.23. **Cosmetic Surgery:** Procedures that focus on altering a person's appearance through procedures that alter and reshape structures of the body to improve or alter their form and function. These procedures are typically elective, meaning it is not medically necessary but rather chosen for personal reasons. This definition includes dental alterations and implants for cosmetic purposes.
- 27.24. **Dependant:** An Adult or Child who is dependent upon the Insured Person for access to the benefits available within this Policy may also be referred to as a Beneficiary or Insured Person.
- 27.25. **Designated Service Provider (DSP):** The hospital/specialists/network providers prescribed by your medical scheme rules where you can obtain diagnosis and **treatment** benefits without **co-payments** or penalties.
- 27.26. **Diagnostic:** A procedure or test which is performed to find out what is wrong with a patient. Diagnostic procedures do not aim to treat or cure a condition but are informative and exploratory in nature. This includes, for example, any examination, such as laboratory diagnostic or x-ray examination that does not result in a bona fide non-medical expense cover because of **hospitalisation** for **treatment** purposes.
- 27.27. **Elective Procedures:** A surgical procedure or medical treatment that is planned in advance and is not urgent or emergency related. These procedures are typically performed to improve quality of life and treat non-life-threatening conditions.
- 27.28. **Emergency Illness:** Means a sudden, and at the time, unexpected onset of a health condition that requires immediate medical treatment.
- 27.29. **Emergency Treatment:** Medical Care is given immediately to a Patient experiencing severe or life-threatening conditions to stabilise the Patient's condition, alleviate symptoms and prevent further harm. Emergency Treatment is provided without delay and involves urgent procedures, medications, or Surgical Procedures. The determination of an Emergency will be done through diagnosis (through classification by the attending Medical Practitioner and/or the Casualty Unit) and not on symptoms presented. This definition specifically excludes any investigative/Diagnostic Procedures such as basic pathology and

- radiology used in diagnosing a health condition, except under the Casualty benefit.
- 27.30. **Endoscopic Procedures:** An endoscopic procedure is performed to allow your medical professional to examine the body's internal organs by inserting a medical apparatus that has a tiny camera attached through a natural/minimally invasive incision.
- 27.31. **Excess:** The first portion of any claim payable by the insured person.
- 27.32. **Ex-gratia by medical scheme:** An event approved by the scheme which falls outside the normal approved scheme rules. In these instances, Sirago does not make any payment towards shortfalls as a result of Ex-gratia payments.
- 27.33. **Family Size:** Is defined as either:
- A policyholder and **4** (four) dependants.
 - All dependants listed on the COM (Certificate of Membership) or, **2** (two) adults on separate medical schemes and all their child dependants. This is defined as a group consisting of related adults and child dependants listed on your medical scheme option or dual membership.
- 27.34. **Gap Cover Premium Waiver:** A premium waiver benefit is claimable by the surviving spouse/adult dependant of the current Sirago policy in the event of accidental death or total permanent disability of the policyholder.
- 27.35. **General Waiting Period:** A period in which there is no claimable event.
- 27.36. **Hazardous/Dangerous (Sport):** Participation in extreme sports*:
- Abseiling.
 - Mountaineering.
 - Rock climbing.
 - Hang gliding.
 - Micro-lighting.
 - Base jumping.
 - Parachuting.
 - Skiing.
 - Hunting.
 - Kite surfing.
 - Underwater activity involving the use of artificial breathing apparatus.
 - All other forms of racing or speed trial or contest.
- *The **Underwriter** reserves the right to add to this list from time to time.
- 27.37. **Hospital:**
- Any institution in the territory of the Republic of South Africa that, in the opinion of the Insurer meets each of the following criteria:
 - Has diagnostic and therapeutic facilities for surgical and medical diagnosis, Treatment, and care of injured and sick persons by or under the supervision of a staff of Medical Practitioners.
 - Provides nursing service supervised by registered nurses or nurses with equivalent qualifications.
 - Is not, except incidentally, convalescent home, lodging facility, rehabilitation center, ward, or Step-Down facility.
 - Is not a place of rest for the aged, or a place for drug addicts or alcoholics or a health hydro or natural cure clinic or similar establishment.
 - Is not an institution providing long-term care for blind, deaf, deaf-mute, or other handicapped persons.
 - Must be registered by the Department of National Health.
 - Is not a place to recuperate after hospitalisation, such as a Step-Down facility.
- This definition includes day hospitals and clinics.**
- 27.38. **Hospitalisation:** Admission of an Insured Person as an in-patient to a hospital for medical or surgical care and Treatment.
- 27.39. **ICD-10 Coding:** The International Classification of Diseases is a diagnostic coding standard that was adopted by the South African National Department of Health in 1996.
- 27.40. **Illness:** Illness refers to a state of poor health, typically caused by disease, infection, or a medical condition that affects the body. Illness may be acute, lasting for a short period, or chronic, persisting for a longer time or recurring over time. This definition excludes an Illness which is of such a nature as to be incapable of diagnosis by objective evidence or which, though capable of diagnosis by such evidence, has not been so diagnosed.
- 27.41. **Individual:** A policyholder without dependants.
- 27.42. **Injury:** Damage to a body part sustained in an unforeseen event, caused solely and directly by any, but not limited to violent, accidental, external, and visible means independent of, and untraceable to, any other cause.
- 27.43. **In-patient:** A policyholder/dependant who is admitted into a hospital/day clinic.
- 27.44. **In-room Procedures:** A procedure in a surgical suite that meets the requirements of a restricted area and is designated and equipped for performing Surgical Procedures, which would/could ordinarily be undertaken in an acute facility.
- 27.45. **Insurer:** The Insurance Company, indicated on your Schedule of Insurance, which offers insurance policies in return for premiums. GENRIC Insurance Company Limited, Reg No. 2005/037828/06, FSP No. 43638 an Authorised Financial Services Provider and licensed non-life Insurer. Also referred to as "We," "Us," "Our," or "Ourselves."
- 27.46. **Insured Person:** is defined as an eligible person who qualifies for cover under this policy and whose interests are protected by the policy. This means a policyholder or dependant on your schedule of

Insurance, also referred to as “You,” “Your”, “Policyholder” or “Insured Person”.

- 27.47. **Medical Scheme:** A non-profit organisation that pools contributions (premiums) from its members to pay for their medical expenses, such as hospital visits, doctor consultations, medications, and other health-related services and is registered with the Council of Medical Schemes.
- 27.48. **Medical Scheme Premium Waiver: A waiver of premium** is a provision that assists the insured to pay medical scheme premiums. The Medical scheme premium membership must remain in force for the waiver benefit to apply.
- 27.49. **Medical Scheme Rate:** It means the set fee that your scheme pays the service provider (doctor, hospital) for specific treatments and procedures.
- 27.50. **Oncology Co-payment:** The percentage excess/co-payment your medical scheme imposes on claims paid after you reach your annual Oncology Limits.
- 27.51. **Organ Donation:** When a person allows an organ of their own to be removed and transplanted to another person, legally, either by consent while alive or dead with the consent of the next of kin.
- 27.52. **Out-patient:** A patient who receives medical and/or surgical Treatment, diagnostic services, or procedures at a hospital, clinic, or healthcare facility without being admitted for an overnight stay. Out-patient care is designed for conditions or procedures that do not require extended recovery in a hospital setting.
- 27.53. **Overall Annual Limit (OAL):** The total value of the compensation allowed for all aggregated claims as defined within this schedule, per beneficiary registered on the policy per annum.
- 27.54. **Penalty Fee:** The amounts for all costs per event, including the non-designated service provider / network hospital, you are required to pay in terms of your medical scheme protocols when you are admitted to hospital that is not a DSP on your medical scheme.
- 27.55. **Policy:** The formal contract issued by the Insurer, which contains terms and conditions of the short-term insurance cover and serves as its legal evidence.
- 27.56. **Policyholder:** A policyholder is an individual or entity whose name appears in the records of the insurance company. They are the owner or controller of an insurance policy and have the right to exercise the privileges outlined in the contract.
- 27.57. **Pre-existing Conditions:** Any illness, injury, condition, or disorder which existed prior to the inception of the policy.
- 27.58. **Prescribed Minimum Benefits (PMB):** A set of benefits as defined in the Medical Schemes 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 of a list of medical conditions.
- 27.59. **Primary Care:** The day-to-day healthcare given by a health care provider, specifically, GP, Dental and Alternative therapist consultations only, specified in the benefit entitlement.
- 27.60. **Professional Sport:** This is a sport where an individual derives their livelihood (income) from full-time participation in said sport.
- 27.61. **Prostheses (Internal or External):** Replacement or repair of tissues by prosthetic devices, permanent or temporary, weight-bearing, or non-weight bearing, free or fixed, and the removable replacement of a missing body part, specifically through trauma, disease and or congenital conditions. The benefit applies to devices replacing essential body functions, and therefore excluding breast implants, unless defined as covered.
- 27.62. **Psychiatric or Psychological Condition: Any kind** of mental illness and disability. This 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 & Neurodevelopmental disorders**.
- 27.63. **Registered Medical Professional:** A person legally licensed and duly qualified to practice medicine and surgery and is registered with the Health Professional Board of the Republic of South Africa (HPCSA).
- 27.64. **Robotic Surgery:** A technology to use robotic devices based on engineering principles to enhance the capabilities of surgeons performing open surgery.
- 27.65. **Specialist:** A specialist doctor is a medical professional who has completed advanced education and training in a specific area of medicine, allowing them to diagnose and treat a particular disease, condition, or group of patients. They are experts in their chosen field, providing more specialized care than a general practitioner.
- 27.66. **Stated benefit:** Means a fixed amount specified in the Policy wording under benefits, which is payable upon the occurrence of a defined event, subject to the terms and conditions of this Policy.
- 27.67. **Step-down:** A registered facility focused on rehabilitation to normal or near-normal functioning after a physical injury or medical procedure, where physical rehabilitation is provided by appropriately qualified and registered therapists.
- 27.68. **Student:** A child dependant that is registered at a tertiary institution (full time) who is a dependant on a Sirago policy.
- 27.69. **Sub-limit:** A sub-limit is a predetermined restriction on the amount an insurer will pay for a specific type of claim or Benefit. It functions as an internal limit that applies to particular categories of loss, Treatment, or service, and may limit reimbursement even when the Overall Annual Limit has not been reached.
- 27.70. **Sub-limit Enhancer:** A benefit that pays for the shortfall where the Medical Scheme does not pay the full cost of sub-limit benefits within the scheme rules.
- 27.71. **Surgical Procedure:** A medical and/or surgical intervention performed to diagnose, treat, or prevent a disease or medical condition which involves the use of surgical instruments, tools, and techniques and specifically excludes rehabilitation and other Policy exclusions unless specifically defined as covered.
- 27.72. **TAVI Procedure:** A TAVI procedure is a Transcatheter Aortic replacement procedure done to replace the ailing aortic valve.

- 27.73. **Tooth fracture** is defined under the Accidental Dental Cover benefit as being the loss of 50% or more of the visible portion of a tooth and where the dental nerve is permanently damaged. The benefit covers accidental tooth fracture to permanent teeth (crowns and implants are excluded) due to an external injury to the mouth).
- 27.74. **Total Permanent Disability:** This means that because of a sickness or injury, a person is unable to continue work in their own or any occupation for which they are suited by training, education, or experience, as evidenced by a registered and authorised clinical practitioner/board.
- 27.75. **Trauma:** is defined as an experience triggered by a sudden, external overwhelming event or persistent overwhelming conditions in which one's ability to cope is compromised, as one experiences a real or perceived threat to his/her life, bodily integrity, or that of a significant other. Examples of a traumatic event for the casualty benefit includes but is not limited to a bee sting/dog bite. Illness related conditions will be assessed against the appropriate benefit, where applicable.
- 27.76. **Trauma Counselling:** is the structured and problem-oriented treatment and/or intervention the affected (directly or indirectly – or as a witness provided you are an insured person on this policy) individual receives from a registered medical professional to address these internal processes. 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.
- 27.77. **Treatment:** The management and care of a patient to combat disease or disorder. It encompasses all procedures aimed at diagnosing, alleviating symptoms, or curing an illness or injury. Treatments can involve various interventions, including medication, therapy, surgery, or other approaches, depending on the specific condition.
- 27.78. **Treatment plan:** A plan developed and approved by your medical scheme in consultation with the relevant medical practitioner.

Please note: Effective 01 January 2026. This Policy Wording replaces any previous Policy Wording regarding this product. As such, claim events occurring as of 01 January 2026 will be assessed strictly in as per these terms.

The Overall Annual Limit (OAL) for claims is aggregated to a maximum of **R223 000 (two hundred and twenty-three thousand rand) from **01 April 2026**, unless otherwise specified, per beneficiary per annum.

PROCESSING OF INSURANCE INFORMATION

Your privacy is of utmost importance to Us. We will take the necessary measures to ensure that any and all information, including Personal Information (as defined in the Protection of Personal Information Act 4 of 2013) provided by You or which is collected from You is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and further, is stored in a safe and secure manner.

You hereby agree to give honest, accurate and up-to-date Personal Information and to maintain and update such information when necessary.

You accept that Your Personal Information collected by Us may be used for the following reasons:

- to establish and verify Your identity in terms of the Applicable Laws.
- to enable Us to fulfil Our obligations in terms of this Policy.
- to enable Us to take the necessary measures to prevent any suspicious or fraudulent activity in terms of the Applicable Laws; and
- reporting to the relevant Regulatory Authority/Body, in terms of the Applicable Laws.

We may share Your information for further processing, with the following third parties, which third parties have an obligation to keep Your Personal Information secure and confidential:

- Payment processing service providers, merchants, banks, and other persons that assist with the processing of Your payment instructions.
- Law enforcement and fraud prevention agencies and other persons tasked with the prevention and prosecution of crime.
- Regulatory authorities, industry ombuds, governmental departments, local and international tax authorities, and other persons that We, in accordance with the Applicable Laws, are required to share Your Personal Information with.
 - Credit Bureaus.
 - Our service providers, agents, and sub-contractors that We have contracted with, to offer and provide products and services to any Policyholder in respect of this Policy; and
 - Persons to whom We cede Our rights or delegate Our authority to, in terms of this Policy.

You acknowledge that any Personal Information supplied to Us in terms of this Policy is provided according to the Applicable Laws. Unless consented to by Yourself, we will not sell, exchange, transfer, rent or otherwise make available Your Personal Information (such as Your name, address, email address, telephone or fax number) to any other parties and You indemnify Us from any claims resulting from disclosures made with Your consent.

You understand that if We have utilised Your Personal Information contrary to the Applicable Laws, you have the right to lodge a complaint with GENRIC and Sirago, should GENRIC and Sirago not resolve the complaint to Your satisfaction you have the right to escalate the complaint to the Information Regulator.

You also similarly give consent to the sharing of information in regard to past insurance policies and claims that you have made. You also acknowledge that information provided by yourself, or your representative may be verified against any legally recognised sources or databases.

By insuring or renewing your insurance you not only consent to such information sharing but also relinquish any rights of confidentiality with regards to underwriting or claims information that you have provided or that has been provided by another person on your behalf.

In the event of a claim, the information you have supplied with your application together with the information you supply in relation to the claim, will be included on the system and made available to other insurers participating in the prevention of fraudulent and any criminal behaviour or activity.

COMMISSIONS

The table below demonstrates the standard commission calculations based on premiums that your appointed intermediary is entitled to earn. However, the table does not cater for any additional section 8(5) fees that might have been negotiated between you and your intermediary, before policy inception. This intermediary fee is optional and is paid to the intermediary in addition to the statutory commission on your behalf.

PREMIUM		% COMMISSION
FROM R1.00 to R300	Is	20%
THEN R301 to R600	Is	15%
THEN R601 to R1200	Is	10%
THEREAFTER R1201 +	Is	5%