
Gap cover
you can count on
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Auto&General

Rely on Auto&General
Gap Cover

Have you been admitted to hospital for a procedure or due to an illness and been left with a hefty bill that your medical aid won't cover? These unplanned costs can be detrimental to your finances. To assist in bridging the gap between what your medical aid pays and what doctors are charging, you can rely on Auto&General Gap Cover. It will assist in covering this shortfall and provide financial relief for you and your loved ones.

The following shortfalls are covered:

- In-hospital procedure shortfalls
- Prescribed minimum benefits
- Treatment for accidents in a casualty unit
- In network hospital co-payments
- Out of network hospital co-payments
- Charges above sub-limits
- Dental treatment shortfalls
- Oncology
- Global fees

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.

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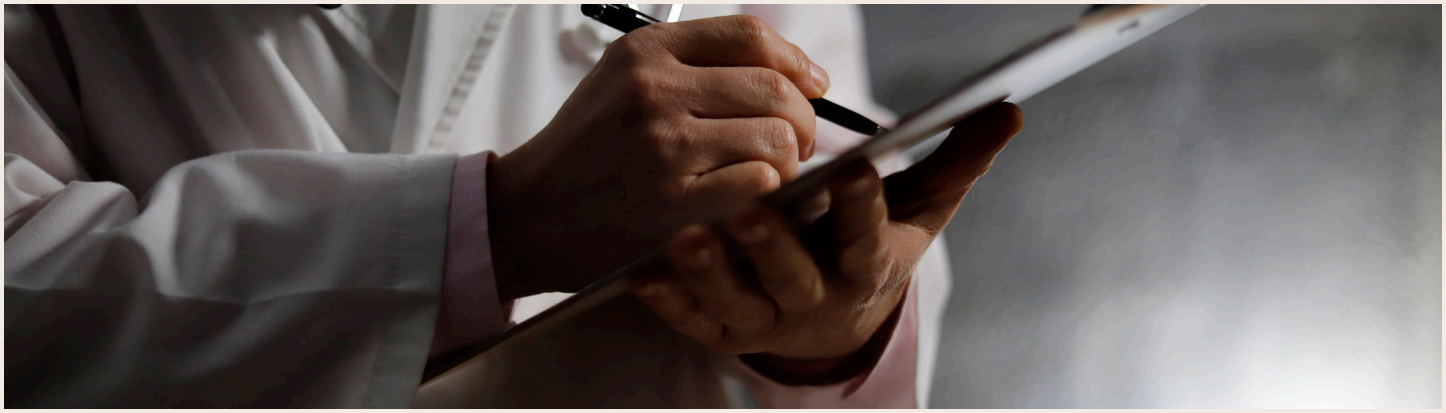
Standard benefits

	Gap Cover options		
Benefits	**Essential Gap**	**Comprehensive Gap**	**Absolute Gap**
In-hospital procedure shortfalls	Covers the shortfalls on procedure claims up to an additional 300% of the medical scheme tariff.	Covers the shortfalls on procedure claims up to an additional 500% of the medical scheme tariff.	Covers the shortfalls on procedure claims up to an additional 700% of the medical scheme tariff.
Prescribed minimum benefits This is a list of all conditions which all medical schemes need to cover including: any emergency medical condition, a limited set of 270 medical conditions and 27 chronic conditions.	Covered, subject to medical aid review		
Treatment for accidents in a casualty unit Should you be involved in an accident and need to go to an emergency room or casualty unit at a hospital, we will pay for the treatment required, up to the stipulated amount for accidents only. Children under the age of 8 ONLY - May be admitted for any treatment at a casualty unit linked to a hospital between the hours of 7pm to 7am from Monday to Friday, from 7pm on a Friday until 7am on a Monday, and all day on a public holiday.	Up to R8 200 per policy per annum	Up to R16 500 per policy per annum	Up to R22 000 per policy per annum
In network hospital co-payments We will cover the co-payment/deductible that your medical aid charges you for certain in-hospital procedures as well as when these authorised procedures are performed in the doctor's rooms. (BUT only when they have been authorised and paid from the In-Hospital or Major Medical benefit.) This co-payment or deductible is NOT related to the scheme tariff and service provider charge shortfall or designated service provider arrangements.	No benefit	Up to R60 000 per policy per annum	Unlimited but subject to the aggregate annual limit per insured person per annum
Out of network hospital co-payments We will cover the co-payment/deductible that your medical aid charges you for certain in-hospital procedures. This co-payment or deductible is NOT related to the scheme tariff and service provider charge shortfall or designated service provider arrangements.	No benefit	1 co-payment per policy per annum. Up to R4 000.	2 co-payments/deductibles per policy per annum to a combined maximum of R16 000
Co-payment benefit: Out of hospital MRI/CT/PET scans The co-payment or deductible that your medical aid charges you for MRI / CT / PET scans BUT which have been authorised and paid from the in-hospital or Major Medical benefit.	No benefit	1 MRI / CT / PET scan per policy per annum up to R12 000	2 scans per policy per annum. Unlimited but subject to the aggregate annual limit per insured person per annum

Standard benefits

	Gap Cover options		
Benefits	**Essential Gap**	**Comprehensive Gap**	**Absolute Gap**
Sub-limit benefit: Internal Prostheses Should you reach the sub-limit imposed by your medical aid for Internal Prostheses that has been authorised and paid for from your In-Hospital or Major Medical benefit, we will cover the shortfall.	No benefit	Up to R20 000 per policy per annum	Unlimited but subject to the aggregate annual limit per insured person per annum. Up to R40 000 per event
Sub-limit benefit: MRI/CT/PET Scans Should you reach the sub-limit imposed by your medical aid for MRI / CT / PET scans that have been authorised and paid from your In-Hospital or Major Medical benefit, we will cover the shortfall.	No benefit	No benefit	2 MRI/CT/PET scans per policy per annum up to R5 000 per scan
Dental treatment benefit We will cover the shortfall (once your medical aid has processed your account) for authorised in-hospital or in doctor's rooms dental procedures that have been paid from the in-hospital or major medical benefit only. This cover is limited to a percentage of the original scheme tariff, as follows: Adults and dependents over 18 years of age: Treatment of impacted wisdom teeth, extractions, apicectomies or loss of teeth due to oncology or trauma ONLY. Dependants up to 18 years of age: Any procedure or treatment.	Unlimited but subject to the aggregate annual limit per insured person per annum		
Global fee benefit Should service providers charge over the global fee that's been negotiated between your medical aid and service providers for a specific procedure like robotic surgery, we will cover the shortfall.	No benefit	Up to R12 000 per policy per annum	Up to R24 000 per policy per annum



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Oncology benefits

	Gap Cover options		
Oncology benefits	**Essential Gap**	**Comprehensive Gap**	**Absolute Gap**
Oncology Gap Benefit We will cover the shortfall between the service provider and what your medical scheme pays. NB: This is subject to the gap cover percentage; and medical aid approved treatment plan being covered up to scheme tariff and within annual scheme oncology limit.	Unlimited but subject to the aggregate annual limit per insured person per annum		
In-network oncology co-payment We will cover: • the co-payment/deductible that your medical aid charges for certain in-hospital procedures • claims where the medical aid will only pay a percentage of the approved treatment All costs must be within the annual scheme oncology limit. This co-payment is NOT related to the scheme tariff and service provider charge shortfall or designated service provider arrangements.	No benefit	No benefit	Unlimited but subject to the aggregate annual limit per insured person per annum. Up to R40 000 per event
Out of network oncology co-payment We will cover: • the co-payment/deductible that your medical aid charges for certain in-hospital procedures • claims where the medical aid will only pay a percentage of the approved treatment All costs must be within the annual scheme oncology limit. This co-payment is NOT related to the scheme tariff and service provider charge shortfall or designated service provider arrangements.	No benefit	1 co-payment per policy per annum. Up to R4 000.	2 Co-payments per policy per annum up to a combined limit of R16 000
Oncology extender benefit Should your annual medical aid scheme oncology limit be reached, we will cover any approved costs above this limit.	No benefit	No benefit	Unlimited but subject to the aggregate annual limit per insured person per annum
Oncology "New tech" benefit We cover the shortfall/co-payment on new technology oncology treatment (specifically Keytruda®, Xalkori®, Tagrisso®, Yervoy®, Zelboraf®, Imbruvica®). This is subject to a medical aid authorised treatment plan and the use of designated service providers.	No benefit	Up to R8 200 per policy per annum	Up to R16 500 per policy per annum

Oncology benefits

	Gap Cover options		
Benefits	**Essential Gap**	**Comprehensive Gap**	**Absolute Gap**
Enhanced cancer cover: Lump sum payout Should your oncologist or pathologist confirm that the cancer is the medical equivalent of 'Stage 2' or higher cancer, we will pay out a lump sum. Note: This benefit is limited to ONE claim per individual per cancer type for the life of the policy and excludes any claim related (in any way) to a cancer type previously identified and paid for.	No benefit	Lump sum payout of R20 000 based on first diagnosis of cancer (as defined- check the full policy document for full definition and exclusions).	No benefit

THE ABOVE BENEFITS ARE SUBJECT TO AN AGGREGATE ANNUAL LIMIT OF R198 660 PER INSURED PERSON.

This amount is calculated annually according to the prescribed table under Regulation 7.2(1) of Regulation 7.2(2) - Policy benefits escalation, in terms of the Short-term Insurance Act, 1998 (Act No. 53 of 1998). This amount will be increased on 1 April 2024 by the official CPI as published by Statistics South Africa (as defined in the Statistics Act, 1999 (Act No. 6 of 1999)).

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The following benefits are not subject to the aggregated annual limit			
Benefits	**Essential Gap**	**Comprehensive Gap**	**Absolute Gap**
Policy extender We will pay the full gap cover premium in the case of the accidental death of the main policyholder.	12 months		
Medical aid contribution waiver We will pay towards a policyholder's medical aid contribution in the case of the accidental death of the main policyholder. Cover is limited to the lower of the actual medical aid contribution or the maximum amount allowed	No benefit	6 months. Up to a max of R5 500 per month	6 months. Up to a max of R6 600 per month
Monthly premiums			
Monthly premiums	**Essential Gap**	**Comprehensive Gap**	**Absolute Gap**
Under 65's (Based on the age of the oldest beneficiary) premium per policy per month		R295	R510
Premium per individual per policy per month	R99		
Premium per family per policy per month	R180		
Over 65's (Based on the age of the oldest beneficiary) premium per policy per month	R360	R495	R710

Important information

All of our Gap Cover policies:

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

NB: Refer to the policy document for the complete list of terms and conditions.

What you need to **know about claiming**

General waiting period

When you take out a Gap Cover policy with us, there is no general three (3) month waiting period. However, the following waiting periods begin from the date of joining:

10-month condition specific waiting period

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

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

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

Cancer diagnosis waiting period

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

Pre-existing medical condition/s waiting period

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

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