Cinagi

Medical Expense Shortfall Insurance Policy

Cinagi (Pty) Ltd is an authorised financial services provider (FSP No 50104)

infiniti insurance

Underwritten by Infiniti Insurance Limited a licensed non-life insurer and an authorised financial services provider (FSP No.35914).

CONTENTS

Effective Date: 01 January 2023

STATUTORY NOTICE

The statutory notice below is provided in accordance with regulation 7.5(1)(c) of the Demarcation Regulations – please note the following regarding this policy:

"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."

IMPORTANT NOTICE

Although this policy is not a Medical Scheme, it is a material condition of this policy that all persons insured under this policy are at all times active and paid up members of a registered Medical Scheme.

COVER SUMMARY

Please note that this is a summary of the cover given and the exclusions in this policy. It must be read in conjunction with the policy wording which starts on page 8 of this document. If there is any discrepancy between this summary and the policy wording, then the policy wording overrides this summary.

Medical Expense Shortfall Benefits

The medical expense shortfall benefits are commonly known as gap cover benefits and are collectively limited to the statutory maximum allowable benefit per annum per person insured under the policy. Two product options are available, namely Gap^{MAX} and Gap^{CORE} - see **Section F**.

MEDICAL SPECIALISTS – additional cover for tariff shortfalls for medical specialists and surgeons while receiving care in Hospital or approved oncology treatment

ONCOLOGY CO-PAYMENTS - covers co-payments applied by your Medical Scheme to cancer treatment costs

UPFRONT PAYMENTS - when you must pay an upfront payment applied by your Medical Scheme on certain procedures we will cover you for these upfront payments

BENEFIT LIMITS - benefits to enhance your cover if your Medical Scheme imposes rand limits on internal prosthetic devices, MRI/CT/PET scans, scopes and ocular lenses.

What we do not cover you for

These are some of the most common treatments for which we do not cover you:

- Cosmetic Surgery, unless it is a reconstruction following non-elective surgery
- Specialised dentistry or elective maxillofacial surgery, such as implants, bridges, frenectomy, orthognathic surgery
- Claims within your policy's waiting periods
- Claims older than 4 months
- Out-Patient Treatment (i.e. day-to-day care) regardless of whether paid from your Medical Scheme's risk benefits, savings account or out-of-pocket (unless specified)
- If your Medical Scheme excludes a service, gap cover doesn't cover that service (gap cover is only allowed to cover shortfalls on services covered by your Medical Scheme)

(PLEASE SEE SECTION D FOR A FULL LIST OF THE POLICY EXCLUSIONS)

IMPORTANT INFORMATION

It is important that you fully understand the cover you have purchased and that you comply with the terms, conditions, exclusions, exceptions and any endorsements of this policy.

Please read this policy document carefully as it explains your cover and forms the legal agreement between us.

We may update this policy document from time to time and we will inform you of any such changes. It is your responsibility to keep up to date with these changes as they may affect your cover.

YOU MUST BE HONEST

When applying for cover it is very important that the information you provide in your application is made honestly and completely.

We will not accept any responsibility under this policy if you or any person acting for you is dishonest or misrepresents any information. You will lose your right to claim if we are prejudiced or suffer a loss because of:

- dishonest behaviour, or
- misrepresentation, or
- criminal activity

If you do not disclose material information to us or if you misrepresent any facts, we may cancel this policy, or we may void it from inception. If we void your policy, we will refund your premiums less any claims already paid.

PREMIUM PAYMENT

For the policy to start, the first premium needs to be successfully paid. For the policy to renew each month, the premium will be collected on the first day of the month via debit order. If the first day of the month falls on a public holiday or over a weekend, your bank may only process the debit order on the first working day thereafter.

If your employer is deducting your premiums via payroll and paying them across to us it is important to ensure that this is successfully done every month. It is your responsibility to make sure your premium is paid.

HOW TO MAKE A CLAIM

If you wish to make a claim, you can submit the necessary details to us on www.cinagi.co.za/submit-a-claim.

In the event that we do not receive all the necessary documents to process your claim, then we will contact you with a request that you submit the requisite details directly to us.

You must submit claims within four months of the date of treatment for which you are claiming.

COMPLAINTS

We hope that you will not have a reason to complain but if you do, we will do our best to work through the complaint with you to find a suitable resolution.

You can lodge a complaint on our website www.cinagi.co.za/contact or with one of our customer consultants via Whatsapp on 060 070 2310.

If required, please ask to speak to a manager to further discuss your complaint.

If one of our managers is not able to fully resolve your complaint, you can take the matter further by writing to our internal dispute resolution committee at www.cinagi.co.za/contact.

Your concerns will be investigated by a person with full authority to deal with the complaint and we will inform you of the outcome within 15 working days of receiving your written complaint.

REJECTED CLAIMS AND CANCELLED POLICIES

Should we:

- reject a claim made in terms of this policy, or
- dispute the amount of a claim, or
- cancel this policy,

you may request us to review our decision.

We will only review our decision on receipt of a written request to do so within 90 days (the "representation period") of the date that we rejected your claim, disputed the claim amount or cancelled your policy. This can be done on our website at www.cinagi.co.za/contact

If you wish to lodge a complaint directly with the insurer, you may do so by sending an email to compliance@infinitiafrica.com.

COMPLAINING TO THE OMBUD

In the unlikely event that your concerns are not resolved to your satisfaction by the internal dispute resolution committee, you may contact the Insurance Ombud – this is for complaints relating to claim matters.

The relevant contact details are shown below:

- www.insuranceombudsman.co.za
- Fax: 086 589 0696
- info@insuranceombudsman.co.za
- Tel: 0860 103 236
  0860 726 890

COMPLAINTS ABOUT HOW THIS POLICY WAS SOLD

If you are not happy about this policy, how it was sold or the advice you were given, please write to The Compliance Officer at Infiniti Insurance Ltd on compliance@infinitiafrica.com - alternatively you may submit a formal written complaint to the FAIS Ombud.

The relevant contact details for the FAIS Ombud are:

Postal address:	PO Box 7457 1, Lynwood Ridge, 0040	Tel:	012 762 5000 / 012 470 9080
E-mail:	info@faisombud.co.za	Fax :	012 348 3447 / 012 470 9097
Website:	www.faisombud.co.za		

TAKING LEGAL ACTION

If you are not satisfied with the outcome of your complaint, you may also take legal action against us.

You have 90 (ninety) days to revert to the Insurer and a further 6 (six) months to take legal action against the Insurer. If you do not take legal action within this period then the right to do so is deemed to be waived.

COOLING OFF

If you want to cancel cover in the first 31 days, and you want it backdated to when you started, we will gladly refund you the full premium.

YOUR SERVICE PROVIDERS

Your Administrator

Cinagi

WhatsApp

Cinagi (Pty) Ltd
060 070 2310
010 312 6855

info@cinagi.co.za
www.cinagi.co.za

Cinagi (Pty) Ltd is an authorised financial services provider (FSP 50104) with professional indemnity insurance in place. We are appointed by Infiniti Insurance Ltd to manage this policy – we have a written mandate governing this.

Cinagi has complaints policy and conflict of interest policy in place, which can be found at www.cinagi.co.za

Your Insurer

infiniti insurance

Infiniti Insurance Ltd
011 718 1200
info@infinitiafrica.com
www.infinitiafrica.com

Infiniti Insurance Ltd is a licensed insurance company and an authorised financial services provider (FSP 35914). Infiniti Insurance Ltd has professional indemnity insurance and fidelity guarantee insurance in place.

THE POLICY DETAIL

Upon the payment of the Premium by or on behalf of the Insured, in accordance with this Policy Document and any schedules attached thereto and the receipt of such Premium by or on behalf of the Underwriter before the Inception Date (or renewal date, as the case may be) and subject to the terms, conditions, exclusions and provisions of this Policy Document and any schedules attached thereto, the Underwriter agrees to pay Benefits to the Eligible Member for an Insured Event in accordance with the sum insured, limits of indemnity and other criteria as stated in this Policy and the schedules attached thereto.

A. DEFINITIONS

In this Policy all words and expressions signifying the singular shall include the plural and vice versa and all words and expressions signifying any one gender shall include the other gender.

The following words and expressions shall have the following meanings:

1. "Accidental Harm" means bodily injury caused by violent, unintentional, external and physical means.

2. "Balance Billing" is a practice where a medical practitioner or service provider charges a separately identifiable fee that is over and above the Tariff fee that relates to a medical procedure, and is billed together on one statement or invoice and is not considered as a refundable benefit by a Medical Scheme.

3. "Basic Dentistry" is defined exclusively as the following dental treatment: cleaning, extractions (including impacted wisdom teeth), fillings, inlays, bonding, root canal treatment or treatment for pain and abscess.

4. "Benefit" or "Benefits" means the benefit amount payable to the Eligible Member in relation to a claim for an Insured Event, as calculated in terms of the Benefit Schedule herein.

5. "Benefit Schedule" means the Benefit Schedule outlined in Section F of this policy that defines the Benefits provided herein and which may be changed from time to time in accordance with Section B.2 of this policy.

6. "Casualty Ward" means the department within a Hospital, that may be owned or operated separately from the Hospital, that provides immediate medical treatment for emergency events.

7. "Cinagi" or "Underwriting Manager" means Cinagi (Pty) Ltd (Registration No: 2019/046543/07), who is appointed to manage this Policy on behalf of the Insurer and is also an authorised financial services provider (FSP No: 50104).

8. "Condition-Specific Waiting Period" means a period in which a policyholder is not entitled to claim policy benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within a period of 12 months preceding the day on which cover commenced.

9. "Cover Pay Level" or "CPL" is set on this policy at inception in accordance with the percentage of the Tariff, as defined, for cover for in-Hospital treatment by individual medical specialists. The CPL is determined as follows, where the percentage of the Tariff is:
    - 200% or greater, then CPL-200 applies
      or
    - less than 200%, then CPL-100 applies.

    The policy premium is set in accordance with the correct CPL, which also constitutes a key component of the benefit calculation as defined in Section F.

    The CPL can be amended if the Medical Scheme Membership, as defined, changes.

10. "Demarcation Regulations" means the amendment to the regulations under Section 70(2A) of the Short-Term Insurance Act in Government Notice 1582 of 23 December 2016.

11. "Designated Service Provider" or "DSP" means a medical service provider that has been contracted by a Medical Scheme as one of their preferred suppliers, and where members of the Medical Scheme are required to obtain medical services from the DSP in order to avoid the application of a Penalty (as defined in this policy document).

12. "Eligible Member" means the person who applied for the cover under this Policy and such cover was accepted by the Underwriter under the terms and conditions outlined in this Policy.

13. "Eligible Dependent" means either the spouse, child, stepchild, adopted child or foster child of the Eligible Member and on whose behalf the Eligible Member applied for cover under this policy and was accepted by the Insurer under the terms and conditions outlined in this Policy. An Eligible Dependent who is a child is only eligible for cover under this policy up until the age of 24 (twenty four) years.

14. "Excess" means a defined amount deducted from a Benefit amount owing to a member under this policy.

15. "General Waiting Period" means a period in which a policyholder is not entitled to claim any policy benefits, except for benefits directly arising from Accidental Harm, as defined herein.

16. "Hazardous Activity" is any activity or sport considered to be dangerous, thus increasing the likelihood of injury or death and includes, but is not limited to, the following:
    a. All forms of motorised or jet racing, whether by land, sea or air;
    b. All forms of motorised or jet aerobatics;
    c. Mountaineering, trekking or hiking above an altitude of 4,000m (four thousand metres);
    d. Hunting, shooting or deploying of firearms in any manner other than for self-defence purposes;
    e. Diving or jumping or gliding or specialised flying of any form, including paragliding, bungee jumping and wingsuit flying;
    f. SCUBA diving.

    This definition applies regardless of whether the activities above are performed privately, socially, during practice sessions, as an amateur or a professional or while participating in organised events.

17. "Hospital" or "Day Clinic" means means any institution in South Africa which is appropriately registered and meets all the criteria below:
    a. Provides diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of sick or injured persons by or under the supervision of Medical Practitioners.
    b. Provides nursing services to sick or injured persons within the Hospital or Day Clinic.
    c. Is not an institution that primarily cares for persons who are mentally retarded, blind, deaf, mute or in any other way physically handicapped.
    d. Is not a home for convalescing or for the elderly.
    e. Is not a place of rest or recuperation.
    f. Is not an institution that primarily treats people for drug addiction, alcoholism, eating disorders or any other form of addictive behaviour.
    g. Is not a health hydro or alternative therapy clinic or other similar establishment.
    h. Is not a step-down facility.
    i. Is not an institution that primarily treats people for mental health or addiction disorders.

18. "Hospital Network" means a list of Hospitals or day clinics specified under the defined Medical Scheme Membership as Designated Service Providers.

19. "Illness" means any physical disease or sickness which manifests in an Insured person.

20. "Inception Date" means the first day of the month on which cover commences as defined in the Policy schedule of the Eligible Member. Where the Eligible Member adds new Eligible dependents to his/her existing policy, the Inception Date for such Eligible Dependents will differ from the policy's original Inception Date

21. "In-Patient Treatment" or "In-Hospital Treatment" means any diagnosis, treatment or care that is provided during an admission into a Hospital or Day Clinic.

22. "Insured" or "Insured Person" means the Eligible Member and the Eligible Dependents, as the case may be, who must at all times be active and paid up members of a registered Medical Scheme.

23. "Insured Event" means any one or more, as the case may be, of the following: –
    a. Accidental Harm, Illness or other health incident that causes an Insured to be admitted to a Hospital or Day Clinic and to undergo Treatment or Medical Procedures during the admission.
    b. Chemotherapy, radiotherapy or other drug regimen, approved by an Insured's Medical Scheme, that is administered to an Insured for the purposes of treating a tumour, growth or other body tissue that has cancer (malignant neoplasm).
    c. Kidney dialysis for the treatment of acute or chronic renal failure.
    d. Accidental Harm that directly causes an Insured to receive emergency medical treatment at the outpatient casualty ward of a Hospital.
    e. Undergo a specialised radiological scan (MRI/CT/PET).

24. "Insurer" means Infiniti Insurance Ltd (FSP 35914) that underwrites the cover under this policy and is a licensed insurance company.

25. "Length of Stay" means the period of time elapsed between admission to and discharge from either a Hospital or day clinic of the same Insured person for the same admission.

26. "Medical Expense Shortfall Benefits" mean the benefit types defined in the contract description of a Medical Expense Shortfall Policy".

27. "Medical Expense Shortfall Policy" means an accident and health policy, as defined in Category 1 of section 7.2(1) of the Demarcation Regulations.

28. "Medical Practitioner" means a qualified medical practitioner, who is registered with the Health Professions Council of South Africa and is authorised to practice in the Republic of South Africa.

29. "Medical Procedure" means any procedure defined under the National Health Reference Price List (NHRPL). If any procedure or operation is not listed under the NHRPL, Cinagi and the Insurer will calculate, at its sole discretion, an appropriate benefit to be paid to the Eligible Member.

30. "Medical Scheme" means a Medical Scheme as registered under the Medical Schemes Act.

31. "Medical Scheme Membership" means the membership of a benefit option of a Medical Scheme, of which either the Eligible Member or his/her spouse are the principal member, and on which all the Insured Persons under this policy are covered.

32. "Medical Schemes Act" means the Medical Schemes Act No. 131 of 1998 as amended and includes the regulations thereto.

33. "National Health Reference Price List" or "NHRPL" means the benefit tariff set annually by the Department of Health as a guideline for charges by medical service providers or any replacement of the NHRPL effected by a change in law or statute or the generally accepted industry equivalent thereof.

34. "Out-Patient Treatment" or "Day-to-Day Treatment" means any diagnosis, treatment or care that is provided outside of an admission into a Hospital or Day Clinic.

35. "Participating Employer" means an employer who pays Premiums to the Insurer on behalf of employees or who collects premiums on behalf of employees, and the employees are Eligible Members under this Policy.

36. "Penalty" means where the standard benefits payable by an Insured's Medical Scheme to the Insured have a Co-payment, Deductible, Upfront Payment, exclusion or reduction, applied to such benefits because an Insured did not adhere to the rules of the Medical Scheme or the Insured did not obtain medical services from the Medical Scheme's Designated Service Provider (as defined in this policy document).

37. "Permanent Disability" means any accidental harm or physical illness that renders a person permanently unable to work in their own or other occupation for which they are suited by training, education or experience.

38. "Policy" or "Policy Document" means collectively this Policy and any relevant Schedules thereto.

39. "Policy Exclusions" means the list of services, conditions or events in Section D of this Policy which are excluded at all times from cover.

40. "Policy Schedule" means the Schedule attaching to and forming part of this Policy that defines the monthly Premium, Waiting Periods, inception date, Insured Persons and other details that pertain to the cover provided under this Policy.

41. "Premature Birth" is defined as the natural or surgically assisted birth of one or more infants by an Insured that occurs at less than 34 weeks of pregnancy.

42. "Premium" or "Premiums" means the monthly amount payable by or on behalf of the Eligible Member to the Insurer as defined in the Policy Schedule applicable to this Policy Document.

43. "Principal Member" also means the Eligible Member.

44. "Short-Term Insurance Act" means the Short-Term Insurance Act, 1998 and includes the rules and regulations thereto.

45. "Split Billing" is a practice where a medical practitioner or other medical service provider charges a separately identifiable fee that is over and above the Tariff fee that relates to a medical procedure, and is billed separately from the Tariff fees on two or more statements or invoices, and is not considered as a refundable benefit by a Medical Scheme.

46. "Tariff" means either the NHRPL tariff or a Medical Scheme's own tariff used to determine the reimbursement rate of its various benefit categories. A Medical Scheme may use different percentages of its tariff levels for its various benefit categories.

47. "Transferability" is the transfer of cover of an Eligible Dependent to a new policy in the name of the Eligible Dependent in any of the following events:

    a. Death of the Eligible Member; or
    b. Divorce or permanent separation from the Eligible Member; or
    c. An Eligible Dependent is no longer covered on the Medical Scheme Membership.

    The relevant Eligible Dependent may apply to transfer cover to a new policy in their own capacity within ninety (90) days of any one of the above events occurring.

48. "Treatment" means any form of diagnosis, treatment or care provided by a medical practitioner during an Insured Event for the purpose of treating or monitoring the physical condition of an Insured.

49. "Underwritten on a Group Basis" has the meaning assigned to it in clause 7.1 of the Demarcation Regulations.

50. "Upfront Payment" or "Co-payment" or "Deductible" means a fixed amount or a percentage of medical costs, defined by the Insured's Medical Scheme that is subtracted from the Medical Scheme benefit entitlement when undergoing defined Medical Procedures or Insured Events.

51. "WHO" means the World Health Organisation, constituted and implemented by the International Health Conference on 7 April 1948.

B. GENERAL

1. The Benefits apply only for services rendered within the territory of the Republic of South Africa. Any services provided outside of the borders of South Africa are excluded from cover.

2. Cinagi and the Insurer reserve the right to alter the Premiums, the basis on which the Benefits are calculated or any of the terms and conditions of this Policy on 31 (thirty one) days written notice and in accordance with clause 7.3(9) of the Demarcation Regulations.

3. It is a material condition of this policy that all Insured Persons under this policy must at all times be active and paid up members of a registered Medical Scheme.

C. WAITING PERIODS

1. Cinagi and the Insurer shall apply waiting periods to the cover of an Insured as outlined below:

2. During the first 3 (three) months of cover, a General Waiting Period, as defined herein, shall apply.

3. During the first 12 (twelve) months of cover, a Condition-Specific Waiting Period, as defined herein, shall apply.

4. In the event that any new Eligible Dependent is added to the policy after the original inception date, then waiting periods shall be applied to the cover of the new Eligible Dependent from the time that their cover commences under this policy.

5. In the event that an Insured Member under this policy previously had a Medical Expense Shortfall Policy with materially similar benefits to this policy, and the break in cover between the two policies is 90 (ninety) days or less, the period of the Condition-Specific Waiting Period above shall be reduced by the portion of the Condition-Specific Waiting Period served under such previous policy.

6. Cinagi and the Insurer reserve the right to waive or reduce the length of waiting periods depending on the participation criteria for group schemes or previous gap cover membership of individual applicants.

D. POLICY EXCLUSIONS

Cinagi or the Underwriter shall not be liable for any claim caused by or related to, regardless of whether such cause or related cause is as a direct or indirect consequence of any of the following:

1. Any Treatment or Medical Procedure related to weight-loss or obesity.

2. Cosmetic surgery except in the case where reconstructive cosmetic surgery is necessitated, in the sole opinion of Cinagi and the Insurer, as a direct result of Trauma or other non-elective Treatment or Medical Procedure.

3. Suicide, attempted suicide or intentional injury to oneself.

4. Abortion, attempted abortion or any complications related thereto unless treatment is, in the sole opinion of Cinagi, of a non-elective nature.

5. Any treatment or procedure for any form of mental health disorder.

6. Any procedure or examination where there is no objective indication of impairment in normal health.

7. The consumption of any drug or narcotic, whether legal or illegal, unless legally prescribed by and taken in accordance with the instructions of a Medical Practitioner.

8. The failure of an Insured to follow any medical advice given by a Medical Practitioner.

9. Any incident, Illness, Accidental Harm or event directly or indirectly caused by the consumption of alcohol or where the Insured suffers from alcoholism.

10. Any incident, Illness, Accidental Harm or event directly or indirectly attributable to the Insured having a blood alcohol content exceeding the legal limit applicable to driving on South African roads.

11. Nuclear weapons, nuclear material, ionising radiations or contamination by radioactivity from any nuclear fuel, or from any nuclear waste, or from the combustion of nuclear fuel which includes any self-sustaining process of nuclear fission.

12. Participation or attempted participation by any Insured Person in any of the following:

    12.1. Activities of the national defence force, police force, community policing, armed response, medical rescue service, firefighting service, correctional services facility or the disarming of explosives;
    12.2. Aviation activities where any medical expense incurred in relation to such activities are insured by any other party. This exclusion does not apply to fare-paying passengers in a licensed passenger carrying aircraft;
    12.3. Hazardous Activity, as defined in this policy;
    12.4. Any form of race or speed test (other than on foot or involving any non-mechanically propelled vehicle, vessel, craft or aircraft).

13. Riots, wars, political acts, public disorder or any acts or attempted acts, or laws of any of the following:

13.1. Civil commotion, labour disturbances, riot, strike, lock-out or public disorder or any act or activity which is calculated or directed to bring about any of the above;
13.2. War, invasion, act of foreign enemy, hostilities, civil war or warlike operations (regardless of whether war is declared or not);
13.3. Mutiny, military rising or usurped power, martial law or state of siege, or any other event or cause which determines the proclamation or maintenance of martial law or state of siege, insurrection, rebellion or revolution;
13.4. Any act (whether on behalf of an organisation, body, person or group of persons) calculated or directed to overthrow or influence any state or government or any provincial, local or tribal authority with force or by means of fear, terrorism or violence;
13.5. Any act calculated or directed to bring about loss or damage to further any political aim, objective or cause, or to bring about any social or economic change, or in protest against any state or government, or any provincial, local or tribal authority, or for the purpose of inspiring fear in the public, or any section thereof;
13.6. Any act of terrorism. An act of terrorism includes, without limitation, the use of violence or force or the threat thereof whether as an act harmful to human life or not, by any person or group of persons, whether acting alone or on behalf of or in connection with any organisation or government or any other person or body of persons, committed for political, religious, personal, ethnic or ideological reasons or purposes including any act committed with the intention to influence any government or for the purpose of inspiring fear in the public or any section thereof.
13.7. The act of any lawfully established authority in controlling, preventing, suppressing or in any other way dealing with any event referred to in any of clauses 13.1 to 13.6 above.
13.8. The War Damage Insurance and Compensation Act, 1976 (No 85 of 1976) or any similar Act.

14. Any injury, illness or claim directly or indirectly caused by, arising out of, resulting from, in consequence of, in any way involving or to any extent contributed to by, the hazardous nature of asbestos in whatever form or quantity. If the Insurer alleges that by reason of this exclusion, any loss is not covered by this policy, the burden of proving the contrary rests upon the insured.

15. This policy excludes any loss, damage, cost or expense directly or indirectly arising out of, contributed to by, or resulting from any epidemic or pandemic (if classified either way by the appropriate national or international body / agency) which leads to:

15.1. the imposition of quarantine or restriction in movement of people or animals by any national or international body or agency
15.2. any travel advisory or warning being issued by any national or international body or agency,

and in respect of 15.1 or 15.2 any fear or threat thereof (whether actual or perceived). If the Insurer alleges that by reason of this exclusion, any loss is not covered by this policy, the burden of proving the contrary rests upon the insured.

16. Any health service that is excluded or rejected by the Insured's Medical Scheme.

17. Any claim that does not form part of the registered benefits of the Insured's Medical Scheme but has been paid as an ex-gratia, goodwill or concessionary payment.

18. Any claim for treatment outside of the borders of South Africa (excludes the Travel Cover benefit as per Section F of this policy).

19. The following procedures, items, services, service providers or events, regardless of whether these are Out-Patient Treatment or In-Patient Treatment:

19.1. External prosthesis or any appliance including, but not limited to, wheelchairs, crutches, beds or convalescing equipment;
19.2. All dental procedures including, but not limited to, crowns, bridges, dental implant related procedures, orthognathic surgery, temporo-mandibular joint surgery, labial frenectomy, bone augmentations, bone or tissue regeneration. (The above definition does not include Basic Dentistry, as defined in this Policy);
19.3. Harvesting and/or preserving of human tissues, including but not limited to stem cell regeneration;
19.4. Breast augmentation, gastroplasty, lipectomy, otoplasty, gender change procedures, therapeutic massage therapists, rehabilitation/ frail care/ hospice services, step-down facilities , pathology or radiology services or TTO (to-take-out) medicines.

20. Any expenses incurred as a result of an injury in a motor vehicle accident that are subsequently recoverable by the relevant Insured Person from the Road Accident Fund or its succedent.

21. Any expenses incurred as a result of an injury on duty that are subsequently recoverable by the relevant Insured Person from the workers Compensation Fund or its succedent.

22. Any Co-payment, Deductible, Upfront payment or limitation applied by the Insured's Medical Scheme against the benefits to be received or paid out from their Medical Scheme, other than those specifically listed in the Benefit Schedule outlined in Section F.

23. Any Penalty, as defined in this policy document, applied by the Insured's Medical Scheme.

24. Any fee charged by a Medical Practitioner, Hospital or service provider that constitutes Split Billing as defined in this policy.

25. Any criminal act or attempted criminal act by an Insured which, which shall include the submission of any fraudulent information or the use of any fraudulent or attempted fraudulent means to obtain any benefit under this policy.

26. Any treatment or Medical Procedure for infertility.

27. Expenses incurred for transport charges or for services rendered whilst being transported in any vehicle, vessel or craft whether or not such vehicle, vessel or craft is specifically designed for the purposes of medical emergency transport.

28. Any act by an Insured that intentionally exposed the Insured to danger, except where such act was necessitated in order to save human life.

29. Any Treatment or Medical Procedure that, in the sole opinion of Cinagi and the Insurer, is of such a nature that it is not considered to be medically necessary, or where alternative conservative treatment would provide a similar outcome, or is of such a nature that an improvement in the medical condition is unlikely.

Cinagi and the Insurer reserves the right to add to, to amend or remove Exclusions in this section on 31 (thirty one) days' notice and in accordance with clause 7.3(9) of the Demarcation Regulations.

E. TERMS AND CONDITIONS

1. Claims Procedure

Following an Insured Event, the Insured or the Eligible Member shall at his own expense:

a. Notify Cinagi of any claim in writing, via email or online as soon as possible but in any event not later than 4 (four) months after the end of the Insured Event. Claims submitted more than 4 (four) months after the end of the Insured Event are excluded from cover.

b. Supply copies of medical accounts, Medical Scheme statements or other information as may reasonably be required for Cinagi to process the claim or to ensure the validity of the claim.

c. Provide authority for Cinagi to inspect all current or past medical information, clinical records or diagnostic tests.

d. Where the Insured Person is not the Eligible Member, the Eligible Member shall provide or obtain the necessary permission or consent from the Insured Person to comply with the above condition failing which the processing of the relevant claims shall be suspended until such time as the requisite permissions or consents are obtained.

e. Any Benefit payable in respect of an Insured Event shall only become payable after the end of the Treatment relating to the Insured Event.

f. All Benefits payable shall be paid to either the Eligible Member or his legal representative or the medical service provider/s against who the Eligible Member is claiming for, whose receipt of the Benefits shall be a full discharge of liability.

g. In the event of the death of the Eligible Member, any Benefit due shall be payable to the surviving Eligible Spouse, failing which the Benefit will be paid to the Eligible Children (or their legal guardians in the event of them being minors) or failing any of the above, the Benefit shall be paid to the Eligible Member's estate.

h. No Benefit payable shall carry interest.

i. Any discount accrued by an Insured, against the amount owing by the Insured to any medical provider, shall be factored into the calculation of the Benefits of this Policy.

j. If any of the information required above is not received by Cinagi within 1 (one) year of the event giving rise to the claim, then the claim will be deemed to have prescribed.

2. Premiums and Premium payment

a. Premiums are due monthly in advance payable on the first (1st) day of the month with a 15 (fifteen) day grace period.

b. If the Premium remains outstanding by the fifteenth (15th) day of the month, then any Benefit payable shall be suspended until all the outstanding Premiums are received by the Insurer.

c. If the Premium remains outstanding by the end of the month in which the premium is due, this Policy shall be deemed to have been cancelled at midnight on the last day of the preceding month of cover.

d. Inception of cover may only commence on the first (1st) day of a particular month and may not be backdated. The Insurer shall not be obliged to accept Premium tendered to it after the inception date or renewal date as the case may be but may do so upon such terms as Cinagi and the Insurer may determine at their sole discretion.

e. At the sole discretion of the Insurer, premiums may be accepted in arrears under the same terms and conditions as outlined above in this section.

3. Termination of cover

   a. The Eligible Member or Participating Employer may cancel this Policy at any time by giving 31 (thirty one) days written notice thereof.

   b. An Insured Event will only qualify as a valid claim if the Hospital Episode, Treatment or Medical Procedure relating to the Insured Event commences before the date of cancellation of this Policy.

   c. In the event that an Insured Person submits any fraudulent claim or commits any fraudulent act, or attempts to submit a fraudulent claim or commit a fraudulent act, Cinagi and the Insurer reserve the right to immediately cancel this policy or void this policy from its original inception date and/or to institute legal proceedings against the Insured Person to recover any losses.

4. Medical examination

   Payment of any Benefit is conditional on the Insured supplying such medical evidence as is required for Cinagi and the Insurer to adequately assess the validity of the claims or for an Insured to undergo any medical examination if requested and paid for by Cinagi.

5. Jurisdiction

   This Policy shall be subject to the laws and statutes applicable in the Republic of South Africa and the Insurer shall only abide by judgements first delivered by or obtained from a court of competent jurisdiction within the Republic of South Africa.

6. Commencement of cover

   Cover shall commence on the first day of the calendar month for which the Premium has been paid by or on behalf of the Eligible Member, subject to all the terms and conditions of this Policy.

7. Premiums

   The payment of all Premiums and Benefits shall be made in the currency of the Republic of South Africa.

8. Premium Amendments

   In accordance with Section B.2 of this policy, Cinagi may adjust the Premiums by giving at least 31 (thirty one) days written notice thereof to the Eligible Member, or the Participating Employer, as the case may be.

9. Cover and Benefits

   a. Cover shall only be of any force or effect if the Family, as defined, are also active and paid up beneficiaries of a registered Medical Scheme.

   b. No benefit shall be payable in respect of any Treatment or Medical Procedure unless such treatment occurred during the period of an Insured Event.

   c. No benefits shall be payable in respect of any additional costs incurred as a result of admission into a private ward of a Hospital or Day Clinic

   d. Any correspondence between Cinagi, the Underwriter, the Eligible Member or any Insured Person, the recorded application for insurance, including answers to medical questions or declarations of health status, regardless of whether on behalf of an Insured Person or the Eligible Member them self, forms the contract between the Eligible Member and the Insurer.

   e. In accordance with Section B.2 of this policy, Cinagi and the Insurer may alter the Benefits or the basis upon which Benefits are calculated under this policy by giving 31 (thirty one) days written notice thereof.

10. Non-Disclosure

    If any Insured Person, or any person acting on behalf of any Insured Person, has misrepresented, inaccurately described or not disclosed all the details that affect the risk insured under this Policy, Cinagi and the Insurer will be entitled to any one or more of the following actions:
    a. Declare that the whole or any part of this Policy is invalid; and/or
    b. Reject any claim under this Policy; and/or
    c. Immediately cancel this policy; and/or
    d. Void this Policy from its original inception date.

F. BENEFIT SCHEDULE

1. The events listed in the clauses below are deemed as separate events for the purposes of benefit calculations although some events may coincide.

2. The overall maximum benefit payable for the medical expense shortfall benefits of this policy shall be limited to the statutory maximum of R185,800 (one hundred and eighty five thousand and eight hundred rand) per Insured Person per annum, as prescribed by clauses 7.2(1) and 7.2(2) of the Demarcation Regulations. In accordance with these same regulations, the above statutory limit will automatically increase as from 1 April 2023 as determined and published by National Treasury.

3. Benefits that are classified as medical expense shortfall benefits are outlined in clauses 6 to 16 below and are collectively subject to the statutory limit in the above clause.

4. The policy benefits outlined in clauses 17 to 24 do not form part of the statutory benefit limitation. Each of these clauses outlines the benefits and limits applicable to that benefit clause.

5. The headings below are for reference purposes only and will not form part of any benefit definition.

GAP COVER BENEFITS

TARIFF SHORTFALLS

6. Benefits relating to this clause will only be paid in respect of services occurring during a Hospital Episode that are rendered and charged for by an individual medical practitioner.

   The Benefit payable is equal to 'A' minus 'B', each defined and limited as follows:

   'A' is equal to the actual cost of treatment, limited as follows:

   Gap^{CORE} = 5 (five) times the Tariff
   Gap^{MAX} = 6 (six) times the Tariff,

   plus the Cover Pay Level.

   'B' is equal to the greater of:
   - The Cover Pay Level, or
   - The benefit paid by the Medical Scheme.

UPFRONT PAYMENTS, CO-PAYMENTS & DEDUCTIBLES

7. Benefits relating to this clause will only be paid in respect of the Defined Diagnostic Procedures listed in Table 1 below and which occur during an Insured Event.

TABLE 1 – DEFINED DIAGNOSTIC PROCEDURES
Scopes –
• Cystourethroscopy
• Colonoscopy
• Proctoscopy
• Sigmoidoscopy
• Gastroscopy
• Cystoscopy
• Hysteroscopy
Scans –
• Computerised Axial Tomography (CT scans)
• Magnetic Resonance Imaging (MRI scans)
• Positron Emission Tomography (PET scans)

   The Benefit payable is equal to the fixed value Upfront Payment, as defined in the rules of the Insured member's Medical Scheme and relating to the defined diagnostic procedures listed in Table 1 above.

8. Benefits relating to this clause will only be paid in respect of medical procedures, defined by the Insured's Medical Scheme that attract a fixed value Upfront Payment when performed during an admission into a Hospital or Day Clinic.

   The Benefit payable is equal to the fixed value Upfront Payment, as defined in the rules of the Insured member's Medical Scheme.

9. If a Medical Scheme has applied an Upfront Payment where such Upfront Payment is calculated as a percentage of the claim value, rather than being a defined fixed rand value, then the policy benefit will be limited to a maximum of the following:

   Gap^{CORE} = R14,000 per event
   Gap^{MAX} = R22,000 per event

   The above limitations will also apply to any benefit payment relating to robotic surgery.

10. If a Medical Scheme applied an Upfront Payment because an Insured did not use a Hospital Network in accordance with the Medical Scheme benefit rules, then the policy benefit will be limited to a maximum of the following:

    Gap^{CORE} = R12,000 per event, subject also to a maximum of 1 (one) claim per policy per annum

    Gap^{MAX} = R18,000 per event, subject also to a maximum of 2 (two) claims per policy per annum

SHORTFALLS FROM SUB-LIMITS

11. Benefits relating to this clause will only be paid in respect of the actual cost of an internal prosthetic device and where the cost thereof has exceeded a relevant benefit sub-limit of the member's Medical Scheme benefit option.

    The Benefit payable is equal to the actual cost, less the benefit amount paid by the Eligible member's Medical Scheme, subject to a maximum of the following:

    Gap^{CORE} = R44,000 per event
    Gap^{MAX} = R64,000 per event

12. Benefits relating to this clause will only be paid in respect of the actual cost of one or more of the following:
    - MRI/CT/PET scan
    - Endoscope
    - Intraocular lens implant

    and where the cost thereof has exceeded a relevant benefit sub-limit of the member's Medical Scheme benefit option.

    The Benefit payable is equal to the actual cost, less the benefit amount paid by the Eligible member's Medical Scheme, subject to a maximum of the following:

    Gap^{CORE} = R5,800 per event
    Gap^{MAX} = R7,000 per event

ONCOLOGY TARIFF SHORTFALLS

13. Benefits relating to this clause will only be paid in respect of Oncology and related treatment, that has been approved by the Insured's Medical Scheme, for the purposes of treating cancer (malignant neoplasm) and which occurs during an Insured Event.

    For any oncology services that are rendered and charged for by an individual medical practitioner, the Benefit payable is equal to 'A' minus 'B', each defined and limited as follows:

    'A' is equal to the actual cost of treatment, limited as follows:

    Gap^{CORE} = 5 (five) times the Tariff
    Gap^{MAX} = 6 (six) times the Tariff,

    plus the Tariff.

    'B' is equal to the greater of:
    - The Cover Pay Level, or
    - The benefit paid by the Medical Scheme.

ONCOLOGY CO-PAYMENTS

14. Benefits relating to this clause will only be paid in respect of Oncology and related treatment, that has been approved by the Insured's Medical Scheme, for the purposes of treating cancer (malignant neoplasm) and which occurs during an Insured Event.

    Threshold Co-Payment

    The Benefit payable is equal to the 20% (twenty percent) Co-Payment applied by the Medical Scheme once the costs for the approved oncology treatment have exceeded the specific threshold defined on the member's benefit option of their Medical Scheme.

    Innovative Medicines Co-Payment

    The Benefit payable is equal to the Co-Payment applied on Innovative Medicines by the Medical Scheme for the approved oncology treatment, subject to a maximum of the following:

    Gap^{CORE} = R12,500 per claim
    Gap^{MAX} = R15,000 per claim.

    Ex-Gratia Medicines Co-Payment

    The Benefit payable is equal to the Co-Payment applied on cancer medicines, where the Medical Scheme has approved such benefit on an ex-gratia basis, subject to a maximum of the following:

    Gap^{CORE} = R12,500 per claim or R25,000 per treatment cycle, whichever is applicable

    Gap^{MAX} = R15,000 per claim or R30,000 per treatment cycle, whichever is applicable.

MATERNITY COVER

15. Benefits relating to this clause will be paid for consultations to a gynaecologist or general practitioner for an Insured who is in her 2nd or 3rd trimester of pregnancy, subject to the following maximum benefit amounts:

    Gap^{CORE} = R1,600 per pregnancy, subject to a maximum of R400 per consultation

    Gap^{MAX} = R2,400 per pregnancy, subject to a maximum of R600 per consultation

    The Benefit payable is equal to 'A' minus 'B', each defined and limited as follows:

    'A' is equal to the actual cost of treatment, limited as follows:

    Gap^{CORE} = 5 (five) times the Tariff
    Gap^{MAX} = 6 (six) times the Tariff,

    plus the Cover Pay Level.

    'B' is equal to the greater of:
    - The Cover Pay Level, or
    - The benefit paid by the Medical Scheme.

OUT-OF-HOSPITAL TARIFF SHORTFALLS

16. Benefits relating to this clause will only be paid in respect of out-patient procedures or treatment, that are rendered and charged for by an individual medical practitioner, that would have attracted an upfront payment or co-payment from the Insured's Medical Scheme had the procedure been performed in a Hospital or day clinic.

    The Benefit payable is equal to 'A' minus 'B', each defined and limited as follows:

    'A' is equal to the actual cost of treatment, limited as follows:

    Gap^{CORE} = 5 (five) times the Tariff
    Gap^{MAX} = 6 (six) times the Tariff,

    plus the Cover Pay Level.

    'B' is equal to the greater of:
    - The Cover Pay Level, or
    - The benefit paid by the Medical Scheme.

EXTENDER COVER

CASUALTY COVER

17. Benefits relating to this clause will only be paid in respect of emergency outpatient services that are a direct result of Accidental Harm and are provided within a Casualty Ward within 12 (twelve) hours of the event that gave rise to the Accidental Harm.

    The services covered under this benefit specifically exclude appliances, prosthetics, specialised radiology or any follow up consultations after the initial emergency consultation.

    The Benefit payable is equal to the actual cost of the emergency outpatient services, less any amount paid by the member's Medical Scheme, subject to a maximum of the following:

    Gap^{CORE} = R14,000 per event
    Gap^{MAX} = R18,000 per event

    A maximum of two events are covered per policy per annum.

    If the accident that gave rise to a claim under this section was while participating in sport, we will cover the shortfall on a maximum of 6 (six) follow up consultations at a physiotherapist or chiropractor, subject to a maximum of the following:

    Gap^{CORE} = R460 per consultation
    Gap^{MAX} = R680 per consultation

    The Benefit payable is equal to 'A' minus 'B', each defined and limited as follows:

    'A' is equal to the actual cost of treatment, limited as follows:

    Gap^{CORE} = 5 (five) times the Tariff
    Gap^{MAX} = 6 (six) times the Tariff,

    plus the Tariff.

    'B' is equal to the greater of:
    • The Cover Pay Level, or
    • The benefit paid by the Medical Scheme.

    The consultations are only covered if they occur within 6 (six) weeks of the accident.

TRAVEL COVER

18. In the event of a member having a claim paid against their international travel insurance resulting from any medical emergency event whilst travelling outside of South Africa, a benefit equal to the excess (or deductible) payable by the member against such travel insurance claim will be covered.

    This benefit is subject to the following limitations:

    Gap^{CORE} = R2,400 per policy per outbound international trip
    Gap^{MAX} = R3,400 per policy per outbound international trip

CANCER DIAGNOSIS

19. A once-off lump sum benefit is payable when an insured receives a first-time diagnosis of cancer that is classified as stage 2 (two) or higher. The benefits are as follows:

    Gap^{CORE} = R30,000 per person once-off benefit
    Gap^{MAX} = R40,000 per person once-off benefit

    This benefit only applies to a first-time diagnosis that occurred after inception of the policy and the 3-month general waiting period and can only be paid once per lifetime.

    This benefit excludes all skin cancers (except malignant melanomas) and the benefit ceases after an Insured reaches age 65 (sixty five).

20. If an Insured is diagnosed with cancer and thereafter the Insured upgrades their Medical Scheme benefit option to the highest benefit option of their Medical Scheme, a monthly benefit of up to R4,000 per month will be paid for a maximum period of 12 (twelve) months from the time of the upgrade.

    The following conditions apply to this benefit clause:
    - If no benefit option upgrade is undertaken, no benefit is payable.
    - If the benefit option upgrade is taken after the Insured has ceased oncology Treatment (i.e. the Insured is in remission), no benefit is payable.
    - The upgrade must be to the richest benefit option of the Insured's Medical Scheme or other benefit option as specifically agreed to in writing with Cinagi.
    - If the member downgrades their benefit option within 12 months of performing the upgrade, this benefit will cease at the time of the downgrade.
    - The benefit option upgrade remains subject to the specific rules of the Insured's Medical Scheme. The provision of this benefit by Cinagi does not affect the rules of the Insured's Medical Scheme and does not guarantee that the Insured's Medical Scheme will permit the Insured to upgrade their benefit option.

HOSPITAL COVER

21. The following daily lump sum benefits are payable:

    a. Where an Insured is admitted to a Hospital as a direct result of Accidental Harm, as defined in this policy and where the Length of Stay of such admission is 3 (three) days or more, then the following benefits are payable per day spent in Hospital by the insured of the same Hospital admission:

    Gap^{CORE} = R110 per day
    Gap^{MAX} = R160 per day

    is paid from the 1st to the 7th day (inclusive); and

    Gap^{CORE} = R1,100 per day
    Gap^{MAX} = R1,600 per day

    is paid from the 8th to the 28th day (inclusive).

The following conditions apply to this benefit clause:

- For the purposes of the above benefit calculation, the first day is defined as commencing at the time of admission to Hospital and ending 24 (twenty-four) hours later.
- All subsequent days spent in Hospital are defined as commencing and ending on the same start and end times respectively as the first day.
- Any portion of a day spent in Hospital will attract a pro-rata portion of the relevant benefit.

The following benefit limitations apply to this clause:

- If more than one Insured Person under the same Policy is Hospitalised as a result of the same event, only the Insured Person with the longest Hospital admission will attract a benefit under this clause.
- A maximum number of days that will attract a benefit is 28 (twenty-eight) per admission or event, whichever is applicable.

ACCIDENT COVER

22. The lump sum benefits listed below are payable upon the death or permanent disability of an Insured as a direct result of Accidental Harm:

    Gap^{CORE} = R28,000 per person once-off benefit
    Gap^{MAX} = R32,000 per person once-off benefit

    If the death or disability is caused by a criminal act the above benefit payable doubles.

    This benefit is limited to a maximum of 2 (two) Insured persons per event.

WAIVER COVER

23. In the event of death or permanent disability of the Eligible Member or their spouse as a direct result of Accidental Harm, we will cover the cost of the Medical Scheme contributions and the premiums under this policy for a maximum period of 6 (six) months. The policy premium will be covered in full each month and the Medical Scheme contributions will be covered up to the following monthly maximum amounts:

    Gap^{CORE} = R5,400 per month
    Gap^{MAX} = R7,800 per month

    The claim will be paid monthly over the 6 month period, subject to receipt of a monthly Medical Scheme membership certificate confirming the membership.

PREMATURE BIRTH

24. In the event of one or more premature births occurring, as defined in this policy, the following lump sum benefits will be paid:

    Gap^{CORE} = R15,000 per birth event
    Gap^{MAX} = R20,000 per birth event

Cinagi

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