1. Why do I require Gap cover?
Medical Schemes are unable to cover the full cost of in-hospital Medical Practitioner services resulting in financial shortfalls for your own account.

2. What is Gap cover?
This product is designed to complement your Medical Scheme to assist with Medical Practitioner costs resulting from in-hospital treatment that have not been paid to their full extent by the Medical Scheme (subject to the parameters and terms and conditions of the elected Gap option).

3. What is Co-Payment cover?
Means the stated co-payment/upfront payment/deductible value required for a defined procedure for which hospitalisation is required and pre-authorised by your medical scheme. If you have elected to have Co-payment cover included in your Gap cover policy, the hospital co-payment/upfront payment/deductible value payable by you for specific in-hospital procedures as defined by your Medical Scheme Option, will be reimbursed to you (subject to the parameters and terms and conditions of the elected Gap and Co-Payment combination option). Penalty Co-Payments do not qualify for cover.

4. Does Gap cover form part of my Medical Scheme?
Your Gap cover policy is a separate contract between yourself and the short term insurance Gap provider, provided you are a member of a registered South African Medical Scheme. As such, should you wish to cancel your Gap cover, you have to give notice in terms of your policy terms and conditions as your Gap policy does not form part of your Medical Scheme.

5. Who will send the policy documents to me?
You should receive your policy documents from your broker within 30 days of the inception date of your policy.

6. Who should I contact if I do not receive the policy documents?
You should contact your broker for their assistance.

7. Does the product cover all the family members that are registered on the Medical Scheme?
Gap cover will cover a family comprising of a principal member, a spouse and child dependants. Adult dependants that might be registered on the Medical Scheme, will have to take out their own Gap policy.

8. My child dependant has reached the age of 21 and my Medical Scheme has changed his/her status to that of an adult. How does H&A deal with this change?
Should your child turn 21 and they are still registered as a dependant on your Medical Scheme, they will be covered on the Gap policy until age 23. Once they become 24 years of age they will be viewed as an overage dependant and an additional monthly premium is payable for each overage child dependant. If however your child is required to be on their own Medical Scheme, they will be required to take out their own Gap policy. You are required to notify us of this in writing in order for us to make the required changes and ensuring that you are paying the correct premium for the correct cover.

9. May a principal member and his/her spouse belong to separate Medical Schemes but have one gap policy?
Clients who do not belong to the same Medical Scheme are required to have separate Gap cover policies.

10. Will new waiting periods be imposed when changing from one Medical Scheme to another?
Although the Gap cover policy runs in conjunction with Medical Scheme cover, you will have continuity in you Gap cover when you change Medical Schemes provided that there is no break in Medical Scheme cover.

11. What are the policy exclusions and waiting periods?
Please refer to the product policy wording for a list of the exclusions. The standard waiting periods include a 12 month waiting period for both pre-existing conditions and maternity benefits and 1 month waiting period for all other benefits.

12. What is the time frame in which a claim can be submitted?
Within 180 days from the date of hospitalisation. If any additional information is required you will be notified in writing of these.

13. Are my out of hospital visits to GP's, Dentists and other practitioners covered?
No, out of hospital visits are not covered. Only claims where the attending medical practitioner has charged above the Medical Scheme rate for pre-authorised in-hospital procedures will be assessed for payment. The Medical Scheme must have paid up to the applicable Medical Scheme option rate with the balance rejected and reflected as a shortfall on their Medical Scheme statement.

14. **Do I need to first pay the co-payment to the hospital and then claim from my policy?**
Yes, should you have elected to include Co-Payment cover in your Gap cover policy, the stated co-payment benefit as defined by your Medical Scheme option in the event treatment is required in hospital may be reimbursed.

15. Are claims covered for medical services rendered outside the borders of South Africa?
No, cover is only provided within the borders of South Africa.

16. Will a guarantee of payment be provided to ensure claim payments?
Guarantees of payment may not be provided as we are not in a position to assess whether you have a valid claim until receipt of a fully completed claim form and supporting documents.

17. Are dental/oral surgeryprocedures performed in hospital covered?
Dental / oral surgery procedures are not covered by the Gap cover policy, however hospital co-payments relating to dental treatment will be covered, subject to restrictions as contained in your policy document.

18. Does Gap cover replace my MSA once it is used up or if annual sub-limits have been reached?
Your Gap cover policy only covers the difference, subject to a stated maximum, between doctors' and Medical Practioners' fees for pre-authorised in-hospital events and the rate at which Medical Schemes reimburse them and does not replace your MSA nor does it cover values in excess of your sub-limits on your Medical Scheme.

19. Can service providers be paid directly by the insurance company?
No, all claim benefit payments are paid to the Insured person.

20. What is the maximum entry age for Gap cover?
There is no maximum age of entry however the premiums differ for those maximum age 65 years and those >65 years. Please see your application form for details.

21. What is the turnaround time for claims?
All valid claims are settled within 3 working days from receipt of all supporting documents.

22. What happens if my debit order fails?
Your broker will be notified of the debit order failure and the reasons for the failure and in turn will advise you. In general policies are cancelled immediately if the failure reason is one of the following:

- Account closed
- Payment stopped by account holder
- No authority to debit
- Account frozen
- Double debit rejection

The policy will be double debited in the following month in the event it is the first debit order failure as a result of insufficient funds in your bank account.

23. **Where can I find information on how to claim?**
You can contact your broker for assistance on how to lodge a claim.

24. What can I do if my broker cannot assist me?
You may contact our office for assistance. The contact details are at the top of the application form and also contained in the Statutory Disclosures of the policy wording.

25. Does the policy pay for body repatriation?
Yes, in the event you die due to an accident more than 100km away from your usual place of residence and within the borders of South Africa, the policy covers the costs for transporting your body back to your usual place of residence up to a maximum of R20 000.

26. What is a pre-existing condition?
A pre-existing condition is a condition/illness/injury for which you have received treatment, sought treatment, reasonably known of or suspected which existed prior to the inception date of cover on the Gap cover policy. These conditions/illness/injuries are excluded for 12 months from inception of cover.

27. **Will the cover pay out if injuries were sustained in an accident caused by the driver while driving under the influence of alcohol or other drugs?**No, any claims arising out of alcohol or drug abuse are not covered.

28. Does the policy cover professional sports people?
No, any claims arising from playing sport and training for a sport for which remuneration is received, will not be covered.

29. Does this policy cover injuries sustained during attempted suicide?
No, claims arising out of attempted suicide of self-inflicted injuries are not covered.

30. Does this policy provide cover to permanent members of SAPS or South African Defence Force?
Yes, however only if the insured person is not on active duty.

31. Will the policy cover expenses related to elective, elective cosmetic or elective corrective optical treatment?
No, elective, elective cosmetic or elective corrective optical treatment is not covered.

32. If I make a visit to the Casualty facility but am not admitted to Hospital, do I have any cover?
Yes, some Medical Schemes cover such visits from the Hospital Insured Benefit, some from the Day to Day Benefit, and if you have a Hospital only Medical Scheme option you may have no cover. This cover offers a fixed benefit of R1 450 should you, due to injury, require medically necessary and immediate medical treatment at a Casualty Facility.

33. **Is there a maximum annual limit to benefits?**
Yes. Policy benefits (including all benefits) are limited to R164,000 per insured person per annum.