



NAPTOSA GAP SUPREME MASTER POLICY WORDING

Master Policy Wording No.: CICL/SUPREME/2016

In consideration of and conditional upon the prior payment of the premium by or on behalf of the Insured and the acceptance thereof by or on behalf of Constantia Insurance Company Limited (*the Company*) before the inception date or renewal date (as the case may be) and subject to the Definitions, Defined Events, General Exceptions, General Conditions, Table of Benefits, Limitations and any Endorsements to the policy the Company agrees to pay the Principal Insured Person for an insured incident occurring during the period of insurance up to the limit of indemnity stated for the Insured Person and the benefit as stated in the Policy. The application form and declaration completed by the Insured Person and/or Principal Insured Person are the basis and form part of this policy as well as the policy schedule and any endorsement to the policy.

DEFINITIONS

In this policy all words and expressions signifying the singular shall include the plural and vice versa. Words and expressions implying the masculine gender shall include the feminine. Where an age is mentioned in the policy, it will be the age attained. The following words and expressions shall have the following meanings:

1. **“Accident”** means bodily injury caused by violent accidental and external physical means.
2. **“Biological Cancer Drug”** means a substance that is made from a living organism or its products and is used in the prevention, diagnosis, or treatment of cancer. For the purpose of this Policy Biological Drugs include antibodies, interleukins, and vaccines.
3. **“Company”** means Constantia Insurance Company Limited, Reg No. 1952/001514/06, FSP No. 31111.
4. **“Eligible Child”** means a child who is by way of natural/ biological child born of or stepchild or legally adopted child placed under the foster care of the Principal Insured Person and is financially dependent on the Principal Insured Person and who has not attained the age of twenty one (21) and who is not already insured under this policy or any other insurance issued by a company providing similar cover.

This age may be extended to twenty five (25) in respect of an unmarried child who is a dependant on the Principal Insured Person’s Medical Scheme and is financially dependent on the Principal Insured Person.

There will be no age restriction for children who are either mentally or physically incapacitated from maintaining themselves, always provided that the children are wholly dependent on the Principal Insured Person for support and maintenance. A child shall only be accepted for cover if such child is covered by a registered medical aid scheme.

5. **“Eligible Spouse”** means the spouse of the Principal Insured Person who is not already insured under this section or any other policy issued by a company providing similar cover. A spouse shall only be accepted for cover in terms of this policy if such spouse is covered by a registered medical aid scheme.

For the purpose of the Policy “Eligible Spouse” shall include a party to any union acceptable according to South African Law.

Where a person shares an abode with a Principal Insured Person and has done so for at least six months and lives together in the manner of a legally married couple the person shall be regarded as a spouse.

Should a Principal Insured Person have more than one spouse who could qualify as an Eligible Spouse then that Principal Insured Person must make an irrevocable nomination of one Eligible Spouse to whom the benefits provided by this policy are to apply.

No benefits will be paid in respect of an Eligible Spouse if more than one person qualifies as such and no nomination has been made by the Principal Insured Person.

6. **“Emergency”** means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or an operation. If the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or death.
7. 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.
8. **“Family”** means the Principal Insured Person, Eligible Spouse and Eligible Children (as defined) provided that the Eligible Spouse and Eligible Child are Insured Persons.

9. **“Hospital”** means any institution in the territory of the Republic of South Africa which in the opinion of the Company meets each of the following criteria:
- Has diagnostic and therapeutic facilities for surgical and medical diagnosis treatment and care of insured 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 other than incidentally either a mental institution or a convalescent home.
 - 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 the blind, deaf, dumb or other handicapped persons.
10. **“Hospital Confinement”** means admission to a hospital ward.
11. **“Illness”** means any one somatic illness or disease which manifests itself during the period of insurance and includes premature senile degenerative changes, but not 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.
12. **“Insured Incident”** means any one accident or illness which causes an Insured Person to be confined to hospital and to undergo certain medical or surgical procedures and/or operations.
13. **“Insured Person”** means
- A Principal Insured Person or an Eligible Spouse of a Principal Insured Person or an Eligible Child of a Principal Insured Person. Such persons must be covered by a registered medical aid scheme and
 - Such other person as the Company may from time to time deem eligible.
14. **“Medical practitioner”** means a legally qualified medical practitioner registered by the Board of Health Care Funders (BHF).
15. **“Medical Aid Scheme Contribution”** means the amount paid by or in respect of a member or his registered dependants if any as membership fees of a Registered Medical Scheme
16. **“Medical Aid Scheme Option”** means the Medical Aid Scheme Option of the Principal Insured Person immediately prior to the Defined Event.
17. **“Medical Scheme Option Reimbursement Rate”** means the multiple of the Medical Scheme Tariff as indicated by the rules of the Medical Scheme.
18. **“Medical Scheme Tariff”** means the rate equal to the Insured Person’s Medical Scheme Rate.
19. **“Principal Insured Person”** means the Insured as detailed in the Schedule and accepted by the Company as eligible for participation in the insurance provided by this policy.
20. **“Schedule”** means the Schedule of Insurance attaching to and forming part of this Policy.
21. **“Treatment”** means any form of investigation or examination by or consultation with or treatment by a medical practitioner for the purpose of treating or monitoring an Insured Person’s medical condition arising out of an insured incident.
22. **“Total and Permanent Disability”** means the state of totally and permanently disabled for one’s own occupation, or similar occupation and/or any other occupation.
23. **“Underwriting Manager”** means Ambledown Financial Services (Pty) Ltd, Reg. No. 2004/006271/07, FSP No. 10287.

DEFINED EVENTS

In the event of an Insured Person suffering an insured incident (as defined) which necessitates the Insured Person:

- Being confined to hospital and
- Undergoing Medical and Surgical procedures and/or operations (as defined) or Treatment (as defined) whilst in hospital, including:
 - The necessity for chemotherapy or radiotherapy for the treatment of cancer on an out-patient basis,
 - The necessity for kidney dialysis on an out-patient basis,
- The necessity for outpatient treatment for the following procedures:
 - General Surgery
 - Surgical biopsy of breast lump
 - Hernia repairs
 - Inguinal hernia
 - Femoral hernia
 - Umbilical hernia
 - Epigastric hernia
 - Spigelian hernia
 - Ischio-rectal abscess drainage
 - Closure of colostomy
 - Surgical haemorrhoidectomy (excluding sclerotherapy or band ligation)
 - Lymph node biopsy
 - Endoscopy
 - Urology
 - Vasectomy
 - Cystoscopy
 - Orchidopexy
 - Prostate biopsy
 - Ophthalmology
 - Cataract removal
 - Pterygium removal
 - Trabeculectomy

- IV. ENT surgery
 - i. Direct laryngoscopy
 - ii. Tonsillectomy
 - iii. Laser ENT Surgery
 - iv. Conventional ENT Surgery
 - v. Nasal surgery (Turbinectomy and Septoplasty)
 - vi. Sinus surgery (FESS)
 - vii. Myringotomy
 - viii. Grommets

- V. Orthopaedic
 - i. Arthroscopy
 - ii. Carpal Tunnel Release
 - iii. Ganglion surgery
 - iv. Bunionectomy

- VI. Paediatric surgery
 - i. Orchidopexy

- VII. Hepatobiliary surgery
 - i. Needle biopsy of the liver

- VIII. Cardiothoracic surgery
 - i. Bronchoscopy

General medical cardiology

- i. Coronary angioplasty
- ii. Coronary angiogram

- IX. Neurology
 - i. 48-hour halter EEG

- X. Immunology
 - i. Plasmatheresis

- XI. Gastroenterology
 - i. Oesophagoscopy
 - ii. Gastroscopy
 - iii. Colonoscopy
 - iv. ERCP

- XII. Diagnostic radiology
 - i. Myelogram
 - ii. Bronchograhya
 - iii. Angiograms
 - Carotid
 - Cerebral
 - Coronary
 - Peripheral

- XIII. Obstetrics & gynaecology
 - i. Tubal ligation
 - ii. Childbirth in a non-hospital setting
 - iii. Incision and drainage of Bartholin's cyst
 - iv. Marsupialisation of Bartholin's cyst
 - v. Cervical laser ablation
 - vi. Hysteroscopy
 - vii. Phototherapy
 - viii. Dilatation and curettage

- XIV. Hyperbaric oxygen treatment for:
 - i. Radionecrosis
 - ii. Malunion of major fractures
 - iii. Avascular leg ulcers
 - iv. Decompression sickness
 - v. Chronic osteitis

- vi. Serious anaerobic infections

4. The necessity for outpatient diagnostic radiology limited to:
 - a. Magnetic Resonance Imaging (MRI)
 - b. Computed Tomography Scans (CT Scans)
5. The treatment received in a casualty unit of a Hospital provided that such treatment is not for routine physical treatment or any other medical examination or treatment other than emergency medical treatment.
6. The death of the Principal Member of the Registered Medical Aid Scheme or the event that an accident or illness resulted in the Total Permanent Disability of the Principal Member of the Registered Medical Aid Scheme.

The Company will pay to the Principal Insured Person an amount in accordance with the table of benefits subject to the limitations.

GENERAL EXCEPTIONS

The Company shall not be liable for hospitalisation, bodily injury, sickness or disease directly or indirectly caused by related to or in consequence of

1. Nuclear weapons or nuclear material or by ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel. For the purpose of this exception combustion shall include any self-sustaining process of nuclear fission.
2. Investigations, treatment, surgery for obesity, its sequelae or cosmetic surgery or surgery directly or indirectly caused by or related to or in consequence of cosmetic surgery other than as a result of an insured event otherwise insured.
3. Cosmetic surgery shall include surgery for breast reduction or reconstruction unless necessitated as a result of treatment for cancer.
4. Routine physical or any procedure of a purely diagnostic nature or any other examination where there is no objective indication of impairment in normal health and laboratory diagnostic or X-ray examinations except in the course of a disability established by prior call or attendance of a physician.
5. Suicide, attempted suicide or intentional self-injury.
6. The taking of any drug or narcotic unless prescribed by and taken in accordance with the instructions of a registered medical practitioner (other than the Insured Person) or any illness caused by the use of alcohol.
7. Drug addiction.
8. An event directly attributable to the Insured Person where the alcohol content in the blood exceeds the legal level permitted by law.
9. Participation in

- a. Active military duty, police duty, police reservist duty, civil commotion, labour disturbances, riot, strike or the activities of locked out workers.
 - b. Aviation other than as a passenger.
 - c. Any form of race or speed test (other than on foot or involving any non-mechanically propelled vehicle vessel craft or aircraft).
10. No benefits are payable which should be provided by the medical aid scheme such as Prescribed Minimum Benefits.
 11. No Benefits Shall be payable due to the Insured person's failure to comply with the Medical Scheme rules regarding the failure to make use of a Hospital that is a Designated Service Provider. This exclusion does not apply to traditional cancer treatment if such Designated Service Provider is Public Hospitals or Public Clinics.
 12. No benefits are payable for ward fees, theatre fees, medicines, material expenses / costs and other hospital expenses.
 13. Any procedure not covered or declined by the medical aid scheme.
 14. No benefits shall be payable for an insured incident for which the Insured Person received treatment or advice twelve (12) months prior to becoming an Insured Person. This exclusion only applies to the first twelve (12) months of an Insured Person's cover.
 15. Investigations, treatment or surgery for artificial insemination or hormone treatment for infertility.
 16. Depression, insanity or mental stress or psychotic/psychoneurotic disorders.
 17. No benefits shall be payable in the event of fraudulent submission by the claimant.
 18. No benefit shall be payable for the Private Care for Cancer or Biological Cancer Drug benefits for any pre-existing condition (meaning any form of cancer) occurring or manifesting prior to the Commencement Date of the Private Care for Cancer and Biological Cancer Drug Benefits.

GENERAL CONDITIONS

1. Cooling-Off Period

A Principal Insured Person may:

- a. in any case where no benefit has yet been paid or claimed or an insured incident has not yet occurred; and
- b. within a period of 30 days of receipt of the policy by the Principal Insured, or from a reasonable date on which it can be deemed that the policyholder received the policy referred to above, cancel the policy by written notice sent to the Underwriting Manager.
- c. All premiums or moneys paid by the policyholder to the insurer up to the date of receipt of the

cancellation notice or received at any date thereafter in respect of the cancelled or varied policy, shall be refunded to the policyholder.

2. Claims

- a. Following an insured event the Principal Insured Person shall at his own expense:
 - i. As soon as possible notify the Underwriting Manager of any claim in writing but not later than one hundred and eighty (180) days from the first day of treatment for such insured incident.
 - ii. Supply in writing any such proof or other information as the Company may reasonably request.
 - iii. As often as required, provide authority for the Company to inspect all current and/or past medical or other information including the results of any blood tests and submit to medical examination on behalf of and at the expense of the Company.
 - iv. Where the Insured Person is not a Principal Insured Person the Principal Insured Person shall provide or obtain the necessary permission or consent to comply with this condition failing which all benefits in respect of any claims subject to this condition shall be avoidable.
- b. Any claim in terms of this policy will prescribe after twelve (12) calendar months from the date of occurrence of the insured incident if the claim is outstanding and not a subject of a then pending court case.
- c. Where the Company rejects or disputes a claim or the quantum of a claim, or voids the policy, the Principal Insured has ninety (90) days (the "representation period") from receipt of the Company's written notification to dispute the decision of the Company. This must be done in writing to the Company:

The Operational Officer
 Constantia Insurance Company Limited
 PO Box 3518
 Cramerview
 2060

Tel: 011 686 4200 Fax: 011 789 8828
 Email: info@constantiaigroup.co.za

Alternatively, the Principal Insured may contact:

The Ombudsman for Short-Term Insurance
 PO Box 32334
 Braamfontein
 2017

Tel: 011 726 8900 Fax: 011 726 5501
Info@osti.co.za www.osti.co.za

If the dispute is not satisfactorily resolved in this manner, the Principal Insured has a further 180 (one hundred and eighty) days after the expiry of

the representation period for the service of summons on the Company.

- d. Any benefit payable in respect of hospital confinement shall only become due at the end of a period of such confinement. However payments on account can be made to the Principal Insured Person at the end of a thirty (30) day period of hospital confinement at the discretion of the Company.
- e. All benefits payable shall be paid to the Principal Insured Person or his legal representative whose receipt shall in every case be a full discharge to the Company.
- f. No benefit payable shall carry interest.

3. Premiums

- a. The premium is due by the first day (1st) of the month that the premium relates to. The premium must be paid by the premium payment date as set out in the policy schedule.
- b. If the premium is not paid by the premium payment date, the Company will allow a forty (40) day grace period from the premium payment date.
- c. If the outstanding premium is not paid within the forty (40) day grace period, then this policy shall be deemed to have been cancelled at midnight on the last day of the month for which the last premium was received.
- d. The Company may offer terms of reinstatement, but is not obliged to do so or to reinstate the Insured Person's policy.
- e. The Company is not obliged to accept premium tendered to it after the grace period or after the period of insurance detailed in the schedule.
- f. The Company will not consider any claim that arises during the grace period unless the Company receives the full outstanding premium before the end of the grace period.
- g. A full month's premium is due in respect of any Insured Person whose cover commences or ceases during a calendar month if such person enjoyed cover for fifteen (15) days or more in that particular month.

4. Termination of cover

- a. This policy may be cancelled by either party at any time by giving thirty (30) days' notice in writing.
- b. An insured incident will only qualify for benefits if the hospitalisation caused by such insured incident commences before the date of cancellation in which case all outstanding claims must be submitted to the Company within three months after the date of cancellation.
- c. Cover terminates on the death of the Principal Insured Person. However, on the death of the

Principal Insured Person the cover of the Eligible Spouse under this policy may be continued should such spouse elect to do so within sixty (60) days of the death of the Principal Insured Person.

- d. This policy shall be voidable in the event of misrepresentation, misdescription or non-disclosure by or on behalf of the Insured Person regarding any fact material to this insurance.
- e. No Premium refund shall be due in the case of cancellation by either party.

5. Medical examination

Payment of any benefit is conditional on

- a. The Insured Person supplying such medical evidence as is required; and
- b. If requested by the Company, an Insured Person undergoing any medical examination at the Company's expense.

6. Jurisdiction

The policy shall be subject to the laws of the Republic of South Africa whose courts shall have sole jurisdiction to the exclusion of the courts of any other country.

Where payment is to be made to or by the Company it shall be made in the currency of the Republic of South Africa at the Company's head office unless the Company allows otherwise.

7. Commencement of cover

Cover in terms of this policy commences on the first day (1st) of the calendar month for which the premium has been paid by or for the Insured Person.

8. Amendments

The company reserves the right to amend this policy wording by way of endorsement as well as to adjust the premiums by giving thirty (30) days written notice.

9. Cover

- a. Cover shall only be in force provided that the Insured Person is registered with a medical aid scheme.
- b. No benefit shall be payable in respect of any medical or surgical treatment unless such treatment occurred during the period of hospital confinement as an in-patient or during chemotherapy or radiotherapy as an out-patient for the treatment of cancer or during treatment as an out-patient for the necessity of kidney dialysis.
- c. The minimum entry age for the Principal Insured Person is age 18 (eighteen) and the maximum entry age is age 70 (seventy).

TABLE OF BENEFITS

- a. Gap Cover - A benefit equal to actual cost limited to five (5) times the Medical Scheme Tariff less the higher of the Medical Scheme Tariff or Medical Scheme Option

Reimbursement Rate for treatment received whilst as an in-patient and/or outpatient (as stated in the Defined Event).

- b. Co-payment Cover - A benefit equal to the charges in the form of a co-payment or deductible applied for treatment received whilst as an in-patient and/or outpatient (as stated in the Defined Event).
 - c. Sub-limitation Cover - A benefit equal to charges above any sub-limitation imposed by the Medical Scheme for treatment received whilst as an in-patient and/or outpatient (as stated in the Defined Event).
 - d. Private Care for Cancer Treatment Cover: The benefits provided over the sub-limitation and/or the co-payment imposed by the medical scheme for treatment in a private facility for cancer. Treatment includes in-hospital expenses, chemicals, medication and outpatient radiotherapy or chemotherapy.
- For the purpose of this Policy outpatient treatment excludes specialist's consultations.
- e. Biological Cancer Drug Treatment Cover - The sub-limitation imposed by the Medical Scheme for biological cancer drugs, limited to Herceptin, Mylotarg, Nexavar, Gleevec, Sprycel, Faslodex, Velcade, Tarceva, Alimta, Zevalin, Avastin, Erbitux, Sutent, Fludara, Mabthera with specific oncological condition and/or specific sub-groups of cancers limited to subgroups of the following categories.

- i. HER 2-positive Breast Cancer
- ii. Acute myeloid leukaemia
- iii. Advanced hepatocellular carcinoma
- iv. Acute lymphoblastic leukemia
- v. Chronic myeloid leukemia
- vi. Chronic lymphocytic leukemia
- vii. Hairy cell leukaemia
- viii. Myelodysplasia
- ix. HER 2-negative breast cancer
- x. Gastrointestinal stromal tumour
- xi. Multiple myeloma
- xii. Non small cell lung cancer
- xiii. Non-hodgkins lymphoma
- xiv. Metastatic colorectal cancer
- xv. Advanced renal cell carcinoma
- xvi. Head and neck cancer

- f. The cost of a medical or a surgical procedure following an Emergency incurred in a hospital casualty unit of a Hospital where such costs were not met by the Medical scheme.
- g. Following the death or the Total and Permanent Disability of the Principal Member of the Medical Scheme, a benefit equal to the total value of Medical Aid Scheme Contribution calculated for 6 months on the Medical Aid Scheme Option of the Registered Medical Aid Scheme within the stated limitations.

The company shall pay the Registered Medical Aid Scheme the Medical Aid Scheme Contribution for 6 months commencing on the 1st day of the following month from the date the incident occurred.

Where:

A Registered Medical Aid Scheme:

- i. discontinues the selected Medical Scheme Option or
- ii. is liquidated or
- iii. is amalgamated with another registered medical aid scheme or

The Principal Member discontinues participation with the Registered Medical Aid Scheme or the original Medical Aid Scheme Option

The Company will pay out a lump sum benefit equal to 6 months for Medical Aid Scheme Contributions on the selected Medical Aid Scheme Option less any benefit provided to the member or on behalf of the member.

Where the total value of one month's current Medical Aid Scheme Contribution is greater than the total value of previous monthly Medical Aid Scheme Contributions representing earlier benefits then the difference in the value of the Medical Aid Scheme Contributions will be deducted from the lump sum benefit.

The member may request that a lump sum benefit equal to the total Medical Aid Scheme Contributions for the selected Medical Aid Scheme Option for the 6 months be paid from the inception of the benefit subject to limitations as specified.

SPECIFIC LIMITATIONS

The maximum benefit payable in terms of this policy shall be as follows:

- a. Gap Cover is limited to R2,000,000 in the aggregate per annum per Family.
- b. Co-payment Cover is limited to the following maximum benefit payable:
 - I. R30,000 in the aggregate per annum per Insured Person.
 - II. R50,000 in the aggregate per annum per family.
- c. Sub-limitation Cover is limited to R30,000 in the aggregate per annum per Insured Person.
- d. Cancer treatment in a private hospital is subject to an excess of R200,000, provided such treatment was received in a private institution and limited to R100,000 per insured person per annum
- e. Biological Cancer Drug Treatment Cover is subject to an excess of R200,000 for the treatment of cancer in a private institution unless a R200,000 excess has been deducted as per paragraph (c) in the Specific Limitations for the private treatment of cancer. Biological Cancer Drug Treatment Cover is limited to R200,000 per insured person per annum.
- f. Treatment in a casualty unit of a Hospital shall be limited to R7,500 in the aggregate per annum per family.