THE CLEAR PRINT | INDIVIDUAL & CORPORATE PRODUCT RANGES 2018

We believe in consistently communicating in a simple, clear and concise manner and have therefore removed the insurance jargon so that you don't have to read between the lines.

Waiting periods applicable to our Corporate Product Ranges are subject to the demographic profile of the employer group and the tailored Employer Group Scheme Proposal provided.

YOUR GAP COVER POLICY WAITING PERIODS

From the first day your cover starts, waiting periods will apply before you are able to claim from specific policy benefits.

3 MONTH GENERAL WAITING PERIOD

Within the first **3 months** of cover a general waiting period will apply, where no claims can be submitted unless you are claiming for an injury resulting from an accident caused by physical impact.

12 MONTH PRE-EXISTING CONDITION WAITING PERIOD

Within the first **12 months** of cover a waiting period for pre-existing medical conditions will apply, where no claims can be submitted for a procedure, surgery, treatment or an investigation relating to any illness or condition for which you received advice or treatment **12 months prior** to your cover start date.

YOUR HEALTH INSURE POLICY WAITING PERIODS

From the first day your cover starts, waiting periods will apply to the **DAY-TO-DAY BENEFITS** on your **ESSENTIAL PRIMARY PLUS** option.

2 MONTH GENERAL WAITING PERIOD

Within the first **2 months** of cover a general waiting period will apply to all benefits.

9 MONTH MATERNITY CARE WAITING PERIOD

Within the first **9 months** of cover a waiting period will apply to the **MATERNITY CARE BENEFIT**.

12 MONTH BASIC EYE CARE & CHRONIC MEDICATION WAITING PERIOD

Within the first **12 months** of cover a waiting period will apply to the **BASIC EYE CARE** and **CHRONIC MEDICATION BENEFITS**.

EXCEPTIONS TO THE RULE

- A **2 Month** General Waiting Period applies to the **ESSENTIAL WELLNESS BENEFITS** on your **ESSENTIAL PRIMARY PLUS** option.
- Waiting periods do not apply to the **EMERGENCY & ACCIDENTAL BENEFITS** on your **ESSENTIAL PRIMARY PLUS** option.

GAP COVER BENEFIT EXCLUSIONS

WHAT OUR BENEFITS DO NOT COVER

GAP BENEFIT DOES NOT COVER

1) Service providers' accounts;
   a) where the shortfall is more than what our gap benefit provides.
   b) that are covered in full or covered as a concession from your medical scheme hospital benefit, where no shortfalls exist.
   c) where your medical scheme did not pay a portion towards the account, or towards an individual line item on the account from your medical scheme hospital benefit.
   d) where your medical scheme paid a portion of, or the full amount of the account from your medical scheme savings account or day-to-day benefit, also known as a block or insured benefit.
   e) where your medical scheme benefit limit is exceeded.
   f) where the treatment dates differ from the date of your in- or out-of-hospital medical event.
2) Consultations in the rooms nor consultations prior to, or following an in- or out-of-hospital medical event.
3) A private upfront fee charged by your doctor or specialist which you are responsible to pay and cannot claim from your medical scheme.
4) Paid by you whilst you are in your medical scheme self-payment gap.
5) Hospital accounts including, but not limited to theatre and ward fees.
6) Specialised radiology except for MRI, CT and PET scans.
7) Consumable items and medication which your medical scheme did not pay during your in- or out-of-hospital medical event, prescription medication or medication provided to take home.
8) Allied service providers' accounts for diagnostic, technical, therapeutic, direct patient care and support services, such as occupational and speech therapy unless our benefit specifically makes provision for cover.

CO-PAYMENT BENEFIT DOES NOT COVER

1) Co-payments or deductibles applied;
   a) where you failed to obtain pre-authorisation or an appropriate service provider referral.
   b) where you had not followed your medical scheme rules.
   c) for the voluntary use of a hospital, day clinic or service provider that does not form part of your medical scheme's network, unless our benefit specifically makes provision for cover.
2) Split billing invoicing, where a private upfront fee is charged by your service provider which you are responsible to pay and cannot claim from your medical scheme.
3) Co-payments applied for chronic, acute, formulary or non-formulary medication.

ONCOLOGY BENEFITS DO NOT COVER

1) Cancer treatment costs and biological medication not approved by your medical scheme as part of your initial or ongoing oncology treatment plan.
2) Service providers' accounts where your medical scheme paid a portion of, or the full amount of the account from your medical scheme savings account or day-to-day benefit, also known as a block or insured benefit.
3) Service providers' accounts;
   a) where you had not followed your medical scheme rules.
   b) for the voluntary use of a service provider that does not form part of your medical scheme's network.
4) Our CANCER DIAGNOSIS BENEFIT does not cover a first-time diagnosis;
   a) when the cancerous cells have not invaded surrounding or underlying tissue.
   b) for cancers of the skin except cancerous moles that have invaded underlying tissue.
   c) for Stage 1 prostate or breast cancer described as T1a, N0, M0 or G1. (T) refers to the size of the tumour, (N) to the number of lymph nodes affected, (M) to metastasis and (G) to the grade or aggressiveness of cancer.
   d) if your diagnosis is made before the first day your cover starts or whilst your 3 Month General Waiting Period applies.
   e) of a second or subsequent diagnosis.
   f) after the benefit ceased at age 65.

SUB-LIMIT BENEFIT DOES NOT COVER

1) Service providers' accounts;
   a) where your medical scheme applied a sub-limit or annual limit to in- or out-of-hospital medical procedures, treatment or investigations except for internal prostheses, non-PMB day procedures, renal dialysis and MRI & CT scans, where applicable.
   b) where your medical scheme's sub-limit or annual limit is exhausted at the time of the event and your medical scheme did not pay a portion towards your service provider's account, unless our benefit specifically makes provision for cover.
2) Renal dialysis treatment costs not approved by your medical scheme as part of your initial or ongoing dialysis treatment plan, where applicable.
3) Renal dialysis treatment where you had not followed your medical scheme rules and / or for the voluntary use of a service provider that does not form part of your medical scheme's network, where applicable.

CASUALTY BENEFIT DOES NOT COVER

1) A casualty event that was not due to an accident and / or did not require immediate treatment for physical injury, which resulted from an external force outside of the body due to impact with someone or something.
2) Service providers' accounts where your medical scheme provided a casualty benefit and paid the accounts in full from your medical scheme hospital benefit.
3) Service providers' accounts where the treatment dates differ from the date of the casualty event, except for return visits to the registered medical facility where follow-up treatment is required as a result of the initial casualty event.
4) Medication prescribed or provided to take home.

TRAUMA COUNSELLING BENEFIT DOES NOT COVER

1) Registered counsellor's, clinical psychologist's or psychiatrist's accounts if you;
   a) did not witness, or were not directly affected by an act of physical violence or an accident resulting in serious bodily injury or death.
   b) were not diagnosed with a dread disease, or were not affected by a loved one's diagnosis of a dread disease or death.
2) Service providers' accounts where your medical scheme provided a trauma counselling benefit and paid the accounts in full from your medical scheme hospital benefit.
3) The fee charged by your counsellor, clinical psychologist or psychiatrist if they are not registered with a recognised South African regulatory body.

REHABILITATION OPTIMISER BENEFIT DOES NOT COVER

1) Rehabilitation admission or treatment costs not approved by your medical scheme as part of your initial or ongoing rehabilitation treatment plan.
2) Service providers' accounts;
   a) where your admission or treatment is not due to a physical injury resulting from an accident.
   b) where therapy or treatment is provided off-site or after discharge.
   c) for counsellors, clinical psychologists or psychiatrists.
3) Rehabilitation admission or treatment costs where you had not followed your medical scheme rules and / or for the voluntary use of a service provider that does not form part of your medical scheme's network.
4) Rehabilitation facilities providing services other than physical rehabilitation.
5) The fee charged by your service providers if they are not registered with a recognised South African regulatory body.

PREVENTATIVE CARE BENEFIT DOES NOT COVER

1) Service providers' accounts where your medical scheme provided a preventative screening benefit and paid the accounts in full from your medical scheme hospital benefit.
2) Preventative tests except for a pap smear, prostate screening (PSA test) or full blood count (FBC) to help diagnose certain cancers.

ADDITIONAL BENEFITS

GAP POLICY PREMIUM WAIVER, MEDICAL SCHEME CONTRIBUTION WAIVER & ACCIDENTAL DEATH BENEFITS DO NOT COVER

1) Events where disability is temporary or where retrenchment is voluntary.
2) Death, permanent disability or forced retrenchment of an insured person if that person is not noted as the gap policy premium payer or the medical scheme contribution payer, where applicable.
3) Forced retrenchment, permanent disability and death where the premium or contribution payer's details changed to another payer's details 3 months prior to the event, except for death or permanent disability due to an accident.
4) Death due to natural causes applicable to our ACCIDENTAL DEATH BENEFIT only.

ACCESS OPTIMISER BENEFIT DOES NOT COVER

1) Medical procedures listed as specific exclusions by your medical scheme that do not form part of our list of medical procedures covered.
2) Service providers' accounts;
   a) where your medical scheme provides a benefit and paid a portion towards the account.
   b) where your medical scheme provides a sub-limit or annual limit from which you can claim for in-hospital medical procedures, but is exhausted at the time of the event.
   c) where your chosen service providers charge a rate that exceeds the rand amount limit we provide.
   d) that are covered as a concession from your medical scheme hospital benefit, although the medical procedure forms part of the medical scheme's exclusions.

GENERAL EXCLUSIONS APPLICABLE TO YOUR GAP COVER POLICY

We do not cover service providers' accounts for related medical procedures and / or treatment, hospitalisation, illness, disease, loss, damage, death, bodily injury or liability that is caused by or results from:

1) An event where the claimant is not an insured person at the time of the event, unless a benefit specifically makes provision for cover.
2) Medical scheme exclusions where no underlying cover exists, unless a benefit specifically makes provision for cover.
3) An event where a benefit limit or an Overall Policy Limit (OPL) has been reached.
4) An event where the policy does not provide the relevant benefit to claim from.
5) An event where pre-authorisation was not obtained from the medical scheme or where medical scheme rules were not followed.
6) An event where the use of a hospital, day-clinic or service provider was voluntary and the service provider does not form part of the medical scheme's network, unless a benefit specifically makes provision for cover.
7) An event that occurs during a policy waiting period, unless otherwise specified.
8) Maxillo-facial surgery and related medical conditions and / or medical procedures unless due to accidental impact resulting in severe physical injury.
9) Dental implants, orthodontic, prosthodontic or cosmetic dentistry.
10) External prostheses or appliances such as artificial limbs, wheelchairs and crutches.
11) Robotic surgery, specialised mechanical or computerised appliances and equipment.
12) Artificial insemination, infertility treatment or contraceptives except for tubal ligation and vasectomies.
13) Obesity.
14) Non-medically necessary reconstructive cosmetic surgery.
15) Breast reconstruction performed as a second or subsequent reconstruction.
16) Home nursing or admission to a step-down facility such as a frail care centre, unless a benefit specifically makes provision for cover.
17) Depression, insanity, emotional or mental illness or any stress-related conditions.
18) Costs associated with supporting medical reports that assist in the finalisation of a claim.
19) Routine physical, diagnostic procedures or examination where there are no objective indications of impairment in normal health.
20) Expenses incurred for transport charges or for services rendered whilst being transported in an emergency vehicle, vessel or aircraft.
21) Riots, wars, political acts, public disorder, terrorism, civil commotions, labour disturbances, strikes, lock-out, or any attempted such acts.
22) A deliberate criminal or fraudulent act or any illegal activity conducted by you or a member of your household which directly or indirectly results in loss, damage or injury.
23) Attempted suicide, intentional self-injury and deliberate exposure to exceptional danger except in an attempt to save a human life.
24) An event where the use of drugs or alcohol is involved.
25) Active military, police and police reservist activities whilst on active duty.
26) Nuclear weapons material, ionising radiations or contamination by radioactivity from any nuclear fuel, nuclear waste or from the combustion of nuclear fuel that includes any self sustaining process of nuclear fission.
27) Events that occur for which the actual damage is provided for by legislation, including contractual liability and consequential loss.
28) Discounts negotiated by an insured person directly with a service provider where reimbursement of a claim will enrich the insured person.
29) Non-disclosure of material information that is likely to affect the assessment or acceptance of risk.

GENERAL EXCLUSIONS APPLICABLE TO YOUR HEALTH INSURE POLICY

We do not cover service providers' accounts for related medical procedures and / or treatment, hospitalisation, illness, disease, loss, damage, death, bodily injury or liability that is caused by or results from:

1) An event where the claimant is not an insured person at the time of the event.
2) An event where a benefit limit or an Overall Policy Limit (OPL) has been reached.
3) An event where the health insurance policy does not provide the relevant benefit to claim from.
4) An event where pre-authorisation or an appropriate service provider referral was not obtained and / or where the Unity Health guidelines or protocols were not adhered to.
5) An event where a service provider was utilised that does not form part of the Unity Health network, unless otherwise specified.
6) An event where healthcare services, such as consultations, basic medical procedures, acute and chronic medication and basic dentistry do not form part of Unity Health's list of approved services, tariff codes or benefits.
7) An event that occurs during a policy waiting period, unless otherwise specified.
8) A hospital event that was not due to an accident or an emergency.
9) A hospital event for a planned medical procedure.
10) Costs incurred for the voluntary stay at a private facility following stabilisation due to an emergency.
11) Reconstructive cosmetic surgery and / or maxillo-facial surgery, including related medical conditions and procedures, if not performed during an authorised hospital event resulting from an accident.
12) Investigations, treatment or surgery for obesity or its sequel, 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 a claimable event.
13) Contact lenses.
14) External prostheses or appliances, such as artificial limbs.
15) Artificial insemination, infertility treatment or contraceptives.
16) Robotic surgery, specialised mechanical or computerised appliances, equipment and all related service providers' accounts.
17) Routine physical, diagnostic procedures or examination where there are no objective indications of impairment in normal health.
18) Riots, wars, political acts, public disorder, terrorism, civil commotions, labour disturbances, strikes, lock-out, or any attempted such acts.
19) A deliberate criminal or fraudulent act or any illegal activity conducted by you or a member of your household which directly or indirectly results in loss, damage or injury.
20) Attempted suicide, intentional self-injury and deliberate exposure to exceptional danger except when attempting to save a human life.
21) An event where the use of drugs or alcohol is involved.
22) Participation in:
    a) Active military, police or police reservist duty.
    b) Aviation other than as a passenger.
    c) Hazardous, competitive or professional sports or activities.
    d) Any form of race or speed test, other than on foot or involving any non-mechanically propelled vehicle vessel craft or aircraft.
23) Nuclear weapons material, ionising radiations or contamination by radioactivity from any nuclear fuel, nuclear waste or from the combustion of nuclear fuel that includes any self-sustaining process of nuclear fission.
24) Events that occur for which the actual damage is provided for by legislation, including contractual liability and consequential loss.
25) Non-disclosure of material information that is likely to affect the assessment or acceptance of risk.