PPS GAP COVER 2023

FREQUENTLY ASKED QUESTIONS

1. WHO IS COVERED?

Cover is only available to members of Profmed medical scheme. Cover applies to the main medical aid member and all their family members registered as medical aid dependants. The policyholder's legally married spouse and child dependants will also qualify for cover even if they are registered on the spouse's separate membership with Profmed medical aid.

Single medical aid members under the age of 55, as the only life insured on the policy, qualify for a lower monthly premium. These members on the lower rate need to notify Zestlife (the product administrator) if their circumstances change, and that they require other dependants to also be covered by their gap policy. Additional dependants will not be covered until Zestlife has been notified.

An over-65 premium applies if the main medical aid member or any of the dependants are 65 years or older.

There is no maximum entry age and cover continues without a maximum expiry age.

This is not a medical aid scheme, nor is the cover the same as a medical aid scheme. This policy is not a substitute for a medical scheme membership.

Underwritten by Guardrisk Insurance Company Limited, an authorised financial services provider (FSP no. 75) and licensed non-life insurer.

Product administered by Zestlife. Zestlife is an authorised financial services provider, FSP no. 37485.

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2. WHAT DOES THE PPS GAP POLICY COVER?

A. MEDICAL EXPENSE SHORTFALL COVER

The policy covers doctor and specialist treatment charge shortfalls that are not covered in full by your medical aid. Cover is also provided for medical aid non-network co-payments that are levied. Together these are known as the Medical Expense Shortfall Cover.

In the 2023 calendar year all individuals insured have Medical Expense Shortfall Cover of R192 000 per insured person. This is the current maximum permitted Medical Expense Shortfall Cover under the South African Health Insurance regulations. This limit will be increased in line with the regulations each year.

1. In-hospital Cover: Shortfalls are covered on doctor and specialist charges of up to 500% of the Medical Scheme Tariff (MST). The shortfall cover amount provided is calculated as: doctor and specialist charges (limited to 5 times MST) less the greater of either the medical scheme's payment towards these costs or the MST amount.

2. Out-of-hospital Cover: Cover is provided for ±50 out-patient procedures including CT, PET and MRI scans. The shortfall cover amount provided is calculated as: doctor and specialist charges (limited to 5 times MST) less the greater of either the medical scheme's payment towards these costs or the MST amount.

3. Internal Prosthesis and Artificial Joint Cover: Cover for up to R38 500 per policy per calendar year is provided for medical expense shortfalls and on the cost of internal prostheses. This benefit is available to policyholders who are on medical aid options that provide internal prosthesis cover under the major medical benefit. This benefit will cover the shortfall if the medical aid does not cover the cost of internal prostheses in full because the medical aid annual limit has been exceeded.

An internal prostheses is a device that is placed inside a person's body during a procedure to permanently replace a body part or to improve a loss or reduction in bodily function. Examples of internal prostheses include joint replacements and spinal fusions.

Stents are covered but limited to a maximum shortfall amount of R3 200 for each individual insured under the policy, per calendar year.

Intraocular lenses, breast implants and pacemakers are, however, specifically excluded.

4. Medical Aid Co-payment Cover: Co-payments imposed by medical aids for hospital admissions, scans and medical procedures are covered. Cover is not available for penalty co-payments, e.g. not obtaining pre-authorisation or not following other protocol requirements.

5. Non-DSP Co-payment Cover: Up to R11 600 each year for each policy (one claim per year) is provided to cover the co-payment when using a hospital or medical practitioner outside of the medical aid's approved Designated Service Provider (DSP) network.

6. Enhanced Cancer Cover: In addition to the gap and co-payment benefits that cover the shortfalls on cancer treatment, additional cancer-specific cover is also provided.

Up to R24 000 cover is provided for cosmetic breast reconstruction for surgical costs that are not covered by the medical aid for breast reconstruction of a non-affected breast in the event of a single mastectomy resulting from cancer. This cover applies to cancer diagnosed after the commencement of cover and after completion of the 12-month waiting period. Any subsequent reconstructions or replacements required after the first one are not covered.

7. Oncology Treatment in Excess of Cancer Limit: Co-payment Cover
Cover for co-payments levied by medical aid when the annual cancer treatment limit is exceeded. This benefit is to cover general and specialised treatment and biological drugs. Cover is subject to a maximum co-payment of 25% of the costs of treatment.

8. Oncology Treatment in Excess of Cancer Limit: Contribution to Costs Cover
Cover for continued treatment costs of cancer when a medical aid treatment cost limit is imposed and no further funding is provided by medical aid. Cover is provided for 20% of the insured's continued treatment costs. This benefit is to cover general and specialised treatment and biological drugs.

9. In-hospital Dentistry Expense Shortfall Cover: This benefit covers in-hospital dental treatment as covered by the policyholder's medical aid and is calculated as follows: combined dentist, doctor and specialist charges, limited to 5 times Medical Scheme Tariff (MST) less the greater of either the medical scheme's payment towards these costs or the MST amount.

10. Casualty Facility Treatment for Accidental Injury: R22 100 cover per calendar year for treatment in a hospital casualty ward within 48 hours following accidental injury. This benefit will include the facility fee, consultations, medications, ward stock, radiology and pathology. This benefit does not cover prescribed medication for use after casualty facility treatment, follow-up treatment, fees charged for the fitment and cost of prosthesis and devices such as crutches, limb guards, splints and braces.

11. Casualty Facility Emergency Treatment: Cover for after-hours emergency treatment for children (younger than 11) in a casualty facility. Cover is for the facility fee, medical practitioner consultation, on sight medication, ward stock, radiology and pathology, as not covered by medical aid, after-hours Monday to Friday between 18h00 and 07h00 and all-day on Saturdays, Sundays and public holidays. Cover is provided up to a maximum amount of R2 500 per policy per calendar year. This benefit does not cover prescribed medicines for use after leaving the casualty facility, follow-up treatment, fees charged for the fitment and cost of prosthesis and devices such as crutches, limb guards, splints and braces.

12. Robotic Medical Procedure Cover: Cover of up to R33 000 per policy, per calendar year for medical expense shortfalls that arise directly from the use of robotic machinery in the course of in-hospital operative treatment.

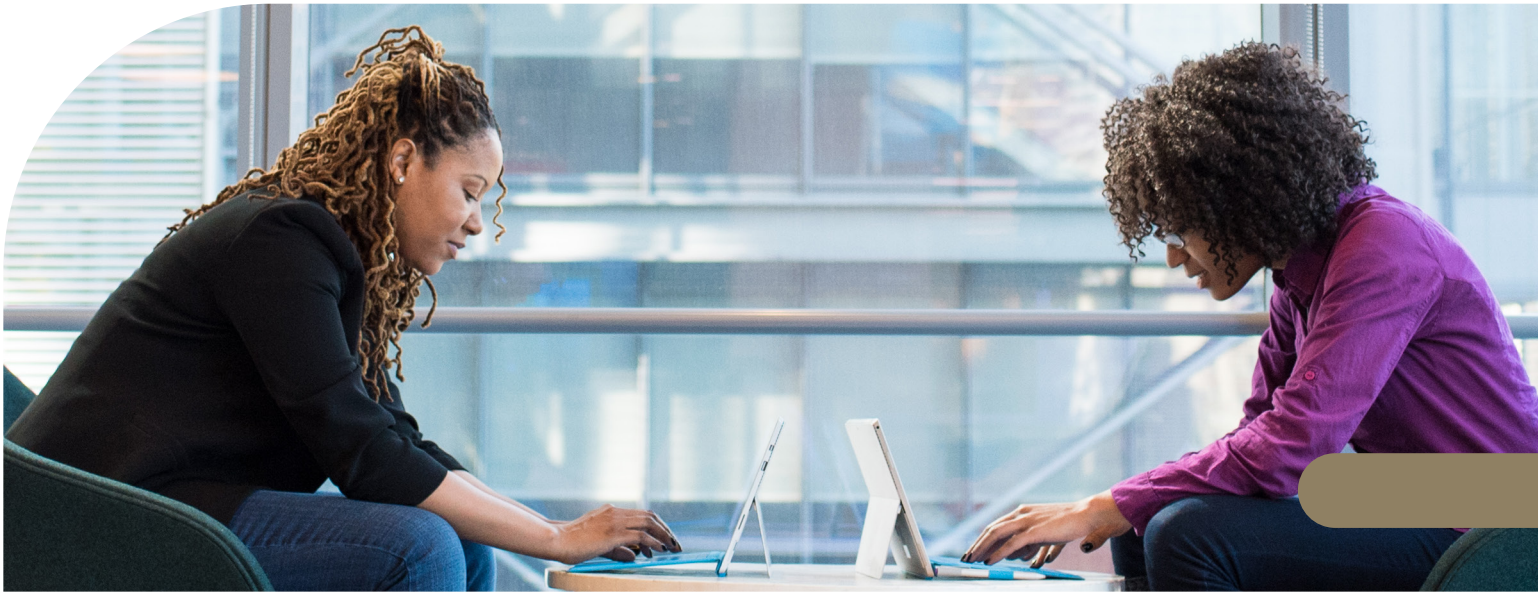
B. HEALTH INSURANCE COVER

The item listed below is covered under the PPS Gap Cover policy but is not subject to the over-all regulated Medical Expense Shortfall limit per individual per calendar year.

13. Enhanced Cancer Cover: The Enhanced Cancer Cover benefit of R30 000 is to cover the unexpected costs which may arise in the event of first-time diagnosis of cancer. This benefit applies to first-time diagnosis of stage II regional cancer and stage I prostate cancer where the Gleason score is 8 or higher. Payment of this benefit is subject to confirmed cancer diagnosis with an ICD-10 C code (International Classification of Diseases code), and the person insured under the policy registering on their medical aid oncology treatment program. This cover excludes skin cancer and only applies to the first-time diagnosis of cancer after the commencement of cover and after completion of a 12-month waiting period.

3. ARE DAY-TO-DAY GENERAL PRACTITIONER (GP) CONSULTATIONS COVERED BY THE PPS GAP COVER POLICY?

No. Day-to-day services such as GP, specialist, optometry and dentist visits, are not covered. These include specialist consultations not billed as part of the hospital or out-of-hospital procedures such as pre- and post-procedure consultations.



4. WHAT OUT-OF-HOSPITAL PROCEDURES ARE COVERED UNDER THE PPS GAP COVER POLICY?

Although gap cover has been primarily designed to cover shortfalls and co-payments arising from in-hospital treatment and procedures, benefits are also payable in the event of shortfalls and/or co-payments arising from certain out-patient treatment and procedures.

- Arthroscopy
- Bronchoscopy
- Bunionectomy
- Carpal tunnel release
- Cataract removal
- Cervical laser ablation
- Chemotherapy or radiotherapy for the treatment of cancer
- Childbirth in a non-hospital setting
- Closure of colostomy
- Colonoscopy or sigmoidoscopy
- Coronary angiogram
- Coronary angioplasty
- CT scan (Computer Axial Tomography)
- Cystoscopy
- Dilatation and curettage
- Direct laryngoscopy
- Endoscopy
- Female surgical and non-surgical permanent sterilisation
- Ganglion surgery
- Gastroscopy and gastrointestinal imaging
- Grommets
- Hernia repairs, limited to:
  - Inguinal Hernia
  - Femoral Hernia
  - Umbilical Hernia
  - Epigastric Hernia
  - Spigelian Hernia
- Hysteroscopy
- Incision and drainage of Bartholin's cyst
- Ischio-rectal abscess drainage
- Kidney dialysis
- Marsupialisation of Bartholin's cyst
- MRI scan (Magnetic Resonance Imaging)
- Myringotomy
- Needle biopsy of the liver
- Oesophagoscopy
- Orchidopexy
- Surgical biopsy of breast lump
- Surgical haemorrhoidectomy (excluding sclerotherapy or band ligation)
- Lymph node biopsy
- PET scan (Positron Emission Tomography)
- Prostate biopsy
- Pterygium removal
- Sinus surgery, limited to:
  - Frontal sinus
  - Functional endoscopic sinus
  - Bilateral function endoscopic sinus
- Tonsillectomy
- Trabeculectomy and trabeculoplasty
- Varicose veins
- Vasectomy

5. WHAT IS AN ADULT DEPENDANT?

An adult dependant is either a parent, child or sibling of the policyholder that is registered on their medical aid as an adult dependant. Adult dependants are covered under the policy.

6. MUST THE POLICYHOLDER NOTIFY THE INSURER OF ANY DEPENDANTS THAT SHOULD BE REMOVED OR ADDED TO THE LIST OF DEPENDANTS INSURED UNDER THE POLICY?

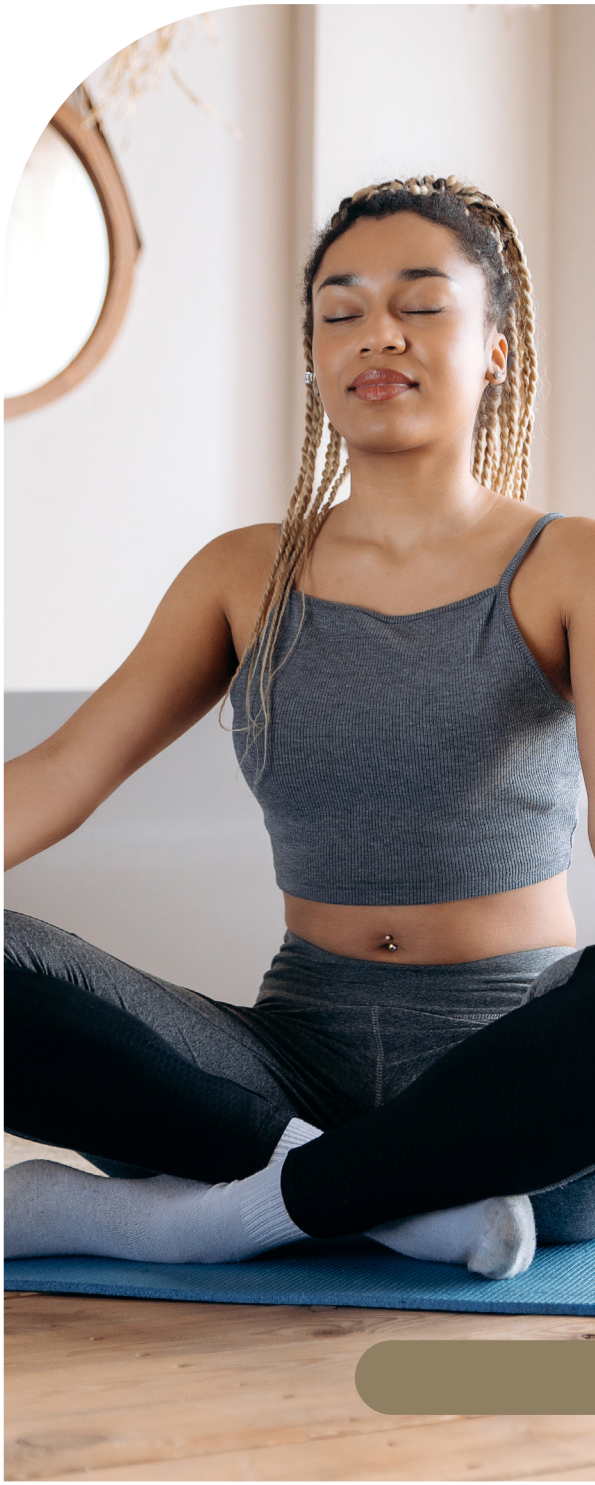
Yes or No, depending on your policy option.

Family cover option policyholders don't need to inform the insurer of medical aid dependants that are added or removed from their medical aid.

Individual cover option policyholders do need to notify Zestlife to extend the cover to additional medical aid dependents. This will require the policyholder to move to a family cover option.

7. DOES THE POLICY COVER MORE THAN ONE SPOUSE?

The family cover options only provide cover for one spouse. Policyholders with more than one spouse as medical aid dependants, are required to notify Zestlife of their nominated spouse for cover under the policy.



8. DOES COVER CONTINUE FOR THE SURVIVING SPOUSE AND DEPENDANTS IF THE POLICYHOLDER PASSES AWAY?

The surviving spouse and family members can continue the cover should they elect to do so, provided they inform Zestlife in writing within 90 days and remain a member of Profmed medical scheme.

9. WHAT COVER EXCLUSIONS EXIST FOR PPS GAP COVER?

The list of exclusions includes the standard insurance exclusions, such as sickness or injury that is caused from nuclear weapons or material, injury from an accident while over the legal alcohol limit, active participation in war, police duty and civil commotion. There are also a number of specific exclusions, such as cosmetic surgery, treatment for obesity, cancer treatment or planned procedures received outside of South Africa and any event not covered by your medical aid. It is worth studying the full list of exclusions, which appears in the policy document.

10. WHAT WAITING PERIODS ARE APPLIED BY PPS GAP COVER?

There is no 3-month general waiting period or condition-specific waiting periods. However, no benefits can be claimed for a period of 12 months from the start date of cover in respect of medical conditions for which, in the 12 months before the start date of the cover, medical advice, diagnosis, care or treatment was received or would reasonably have been recommended.

Pregnancy before the start date of cover will be regarded as a pre-existing condition and any pregnancy and birth-related claims will be excluded for 12 months from the start date of the cover.

If, prior to the start date of PPS Gap Cover, a policyholder had cover under another Medical Expense Shortfall Policy, then the pre-existing condition waiting period will only be applied to the unexpired period of the pre-existing condition waiting period from the previous policy. The pre-existing condition waiting period will, however, apply for the full period of 12 months for any benefit not provided under the previous Medical Expense Shortfall Policy.

11. WHICH INTERNAL PROSTHESES WILL BE COVERED BY THE POLICY?

An internal prostheses is a device that is placed inside a person's body during a procedure to permanently replace a body part or to improve a loss or reduction in bodily function. Examples of internal prostheses include joint replacements and spinal fusions. Stents are covered but limited to a maximum shortfall amount of R3 200 for each individual insured under the policy, per calendar year. Intraocular lenses, breast implants and pacemakers are, however specifically excluded.

12. WHICH INSURER UNDERWRITES THIS POLICY?

Your PPS Gap Cover policy is underwritten by Guardrisk Insurance Company Limited, a licensed non-life insurer and authorised (FSP no. 75).

13. WHO ADMINISTERS THIS POLICY?

Your PPS Gap Cover policy is administered by Zestlife (FSP no. 37485) and can be contacted on 021 180 4220 at info@zestlife.co.za.

14. WILL I BE REQUIRED TO GO FOR A MEDICAL EXAMINATION TO QUALIFY FOR THE POLICY?

There are no medicals required when applying for this policy and cover is effective from the 1st day of the month following application or from a future date.

15. DOES THIS POLICY HAVE A SURRENDER VALUE?

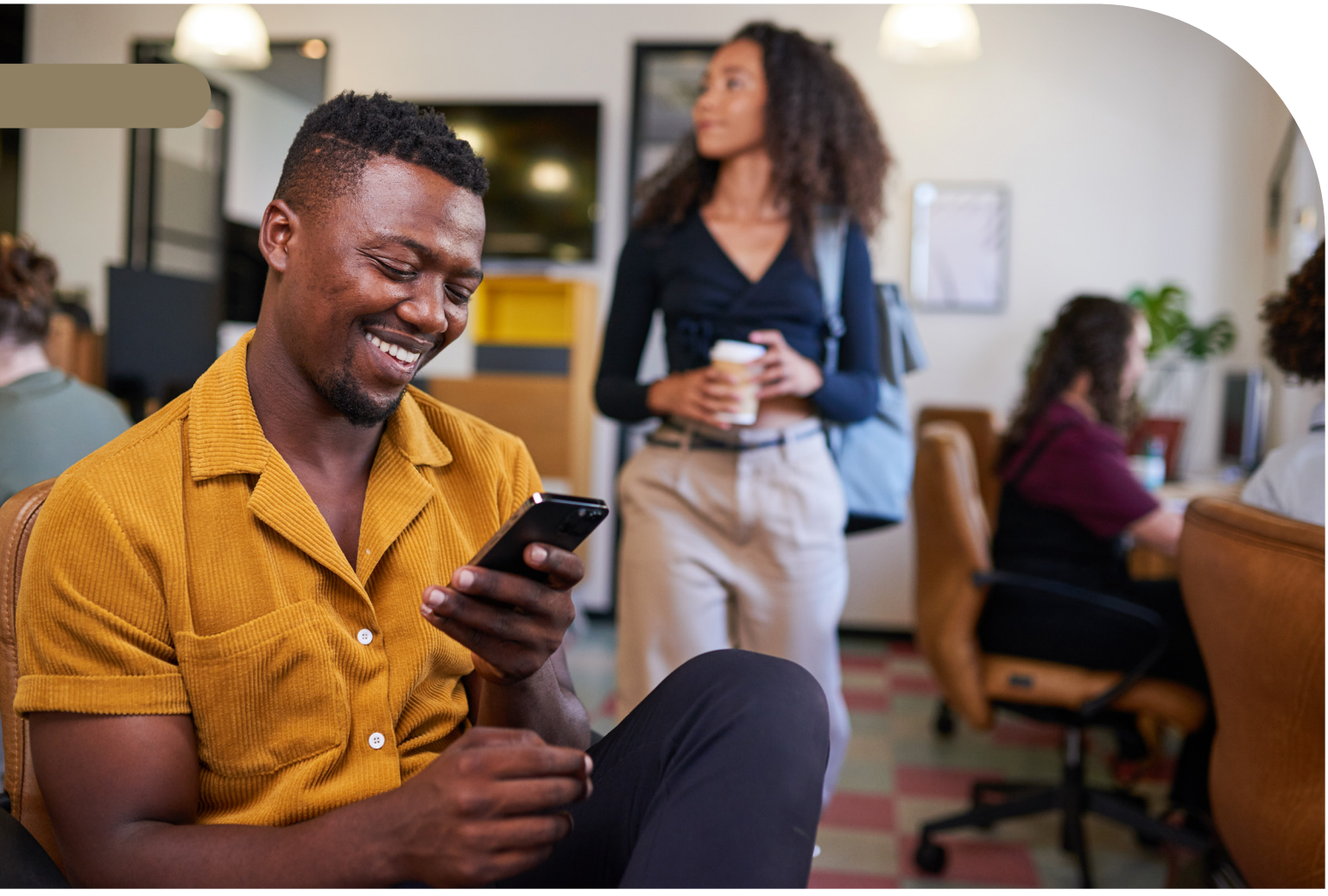
There is no savings or endowment portion and there is therefore no surrender value on the policy.

16. HOW CAN I CANCEL THE POLICY?

The policy may be cancelled at any time with one calendar month's written notice by informing Zestlife accordingly.

17. WILL MY PREMIUM INCREASE EACH YEAR?

Yes, it is likely to increase every year. The premium amount will be reviewed every year and policyholders will be notified in advance of any increases which will be made effective on 1 January. The policy terms and conditions are also reviewed annually and changes are effective from 1 January every year.



18. IS THERE A POLICY FEE ATTACHED TO THIS POLICY?

There is absolutely no additional policy fee. The costs incurred for administration is covered in your premium.

19. WHEN WILL PREMIUM PAYMENTS COMMENCE?

Your first premium will be debited in the first month of the activation of your policy. You can choose the day of the month that your debit order will be deducted.

20. WHEN WILL I RECEIVE MY POLICY DOCUMENTS?

Your policy documents will be sent to you within 1 week of taking out this cover.

21. WHEN DOES THE POLICY TERMINATE?

There is no specific age limit that gives rise to this policy terminating. However, if the policyholder allows the policy to lapse, due to non-payment of premiums or when the policyholder cancels the policy, it will terminate.

22. WHAT IS THE OLDEST AGE THAT AN INDIVIDUAL CAN APPLY FOR THE COVER?

There is no maximum entry age.

23. TO WHOM IS THE BENEFIT PAID?

Benefits will either be paid to you as the policyholder (in which case you are responsible for settling the accounts with the medical practitioner or service provider) or directly to the medical practitioner or service provider, at the discretion of the insurer. Note that benefits payable directly to the policyholder cannot be paid into a business bank account or into a third party's bank account. The benefit paid is net of any discount received/negotiated.

24. SHOULD I NOTIFY SOMEONE IF I NEED TO LODGE A GAP CLAIM

Please notify Zestlife when you want to lodge a gap claim. Email info@zestlife.co.za and provide the patient name, incident date and service provider names. PPSHA, Profmed's Administrator, will provide medical scheme claim payment transactions to Zestlife on your behalf to make your claims experience more efficient. You will not need to provide supporting documentation, such as medical aid statements and provider invoices. Zestlife will contact you if more information and/or documents are required.

25. HOW LONG DOES IT TAKE TO PAY A CLAIM?

Claims are paid in approximately 10 days from receipt of all documentation.

26. WHEN CHANGING TO PPS GAP COVER FROM ANOTHER GAP COVER POLICY HOW ARE WAITING PERIODS APPLIED TO PRE-EXISTING HEALTH CONDITIONS?

Where a policyholder is moving from an existing gap cover policy to PPS Gap Cover, waiting periods will only be applied to the unexpired part of a 12-month pre-existing condition waiting period. This is as determined from the commencement date of the existing gap policy and applies to shortfalls and co-payments covered under the existing gap cover policy and PPS Gap Cover.

A 12-month pre-existing condition waiting period will however apply to any Gap Cover benefit not provided under the existing policy.

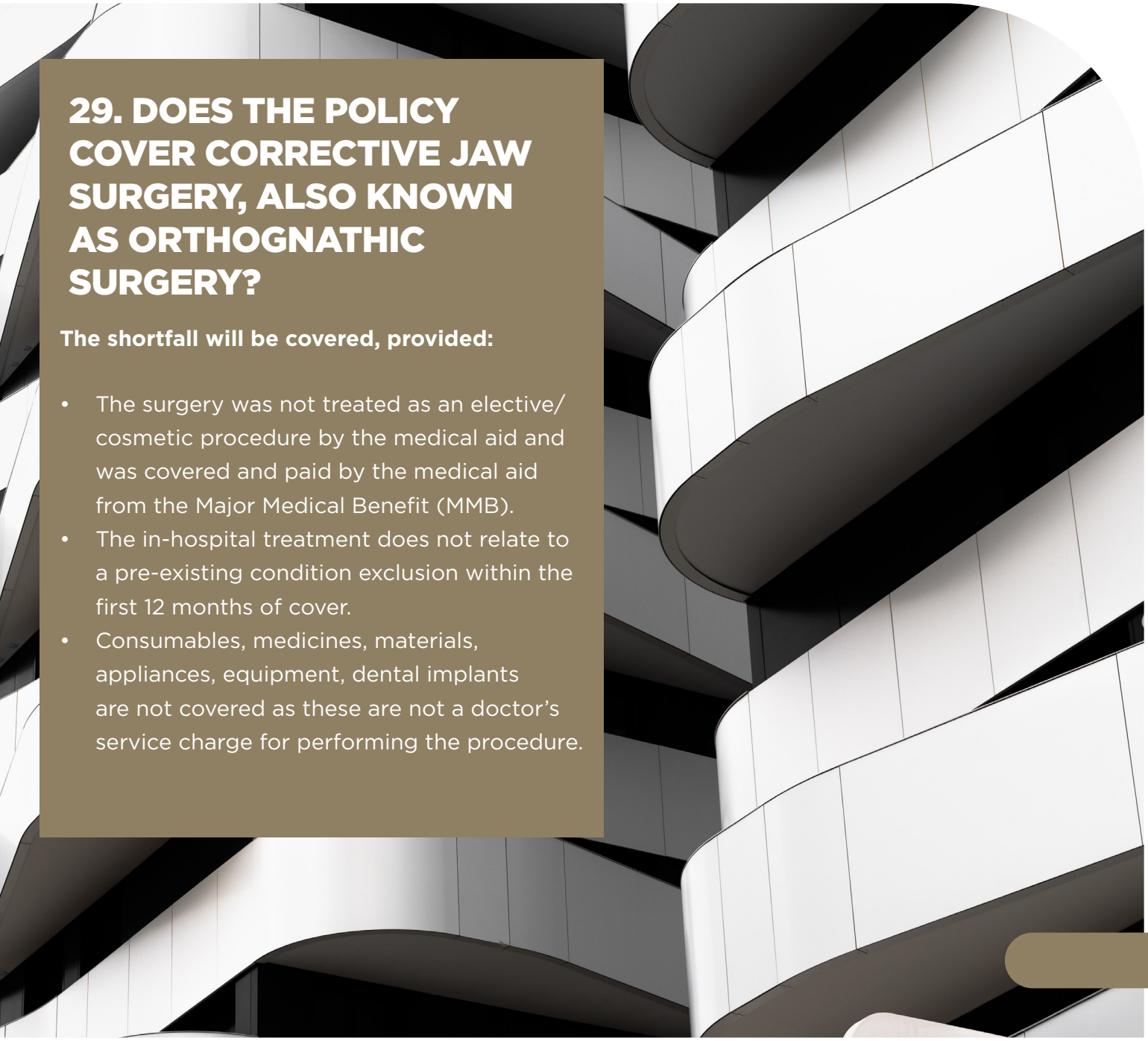
27. WHAT DOCUMENTATION IS REQUIRED TO REPLACE AN EXISTING GAP POLICY?

We require the following documents to be provided together with the completed PPS Gap Cover application form:

- Copy of client's current gap policy contract and schedule confirming the policy commencement date and current benefits provided by the policy.
- Confirmation of the client's effective date of cancellation of current policy.
- Confirmation of medical aid membership and list of medical aid dependants.
- Completion of Replacement Policy Advice Record.

28. CAN THE PPS GAP COVER COMMENCEMENT DATE BE BACKDATED TO THE MEDICAL AID COVER START DATE?

No, cover under the policy can only commence on a date after the PPS Gap Cover application is completed and submitted. This can be any date from the 1st day of the month, following the month of the PPS Gap Cover application.



29. DOES THE POLICY COVER CORRECTIVE JAW SURGERY, ALSO KNOWN AS ORTHOGNATHIC SURGERY?

The shortfall will be covered, provided:

- The surgery was not treated as an elective/ cosmetic procedure by the medical aid and was covered and paid by the medical aid from the Major Medical Benefit (MMB).
- The in-hospital treatment does not relate to a pre-existing condition exclusion within the first 12 months of cover.
- Consumables, medicines, materials, appliances, equipment, dental implants are not covered as these are not a doctor's service charge for performing the procedure.

30. ARE MEDICAL EXPENSE SHORTFALLS AND CO-PAYMENTS FOR CIRCUMCISION COVERED?

Yes, PPS Gap Cover will cover medical expense shortfall charges and co-payments levied by the medical aid if the circumcision is medically required due to an underlying health condition. However, routine and ritual circumcision is deemed an elective procedure and is therefore not covered.

31. IS MY PARTNER COVERED UNDER MY PPS GAP COVER POLICY?

Yes, but only if your partner is covered on your medical aid and you are on a family cover (not individual) option. If your partner to whom you are not legally married has their own medical aid, then your partner will have to take out their own gap policy.

32. DOES PPS GAP PAY FOR HOME BIRTHS?

This out-of-hospital procedure is covered, so the shortfall on the charges in excess of the medical aid tariff for the midwife/nurse will be covered by PPS Gap Cover. This is provided that the claim is not subject to the 12-month pre-existing condition exclusion applicable to the first 12 months of cover.

33. DOES THE GAP POLICY COVER SHORTFALLS IN RESPECT OF FEES CHARGED BY ALLIED HEALTH

No. Cover for fees charged by allied health professionals are excluded. Examples of allied health professionals are:

- Acupuncturists
- Audiologists
- Biokineticists
- Chiropractors
- Clinical technologists
- Diagnostic medical sonographers
- Dieticians
- Nurses
- Occupational therapists
- Physical therapists
- Physiotherapists
- Podiatrists
- Radiographers
- Respiratory therapists
- Scientists
- Sleep studies
- Speech therapists
- Technologists

34. WILL PPS GAP PAY FOR CO-PAYMENTS CHARGED WHEN USING A NON-NETWORK HOSPITAL?

Yes. PPS Gap Cover will cover the non-network hospital co-payment, subject to a maximum of R11 600 and limited to one claim per policy each year.

35. DOES PPS GAP COVER APPLY WHILE OUTSIDE THE BORDERS OF SOUTH AFRICA?

Yes, cover applies for the first 90 consecutive days while outside the borders of South Africa. PPS Gap Cover does not cover planned procedures and cancer treatment outside the borders of South Africa.

36. WILL I RECEIVE AN IT3 TAX CERTIFICATE FOR MY PPS GAP COVER CONTRIBUTIONS?

Gap cover policy premiums are not tax deductible in the same way that your medical aid premiums are. No IT3 tax certificates can therefore be issued for this purpose.

37. WHAT WOULD HAPPEN IF I MISS A PREMIUM PAYMENT?

If you miss a premium you have 31 days to pay the outstanding premium. If you pay by debit order and we are unable to collect your premium by the due date, we will try to deduct 1.5 times your monthly premium during the next monthly debit order run. If the outstanding premium is not paid within 31 days or we are again unable to collect your outstanding premium, we will cancel your policy and your cover will end at midnight on the day before your outstanding premium was due.

38. HOW DO I SIGN UP FOR PPS GAP COVER?

Contact Profmed New Business at **degree@profmed.co.za** or on 0800 334 733.

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