- 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.
- THE MASTER POLICY ISSUED IS THE SOURCE OF ALL BENEFITS, RIGHTS, AND OBLIGATIONS AND EXCLUSIONS. TO DETERMINE YOUR INDIVIDUAL NEEDS, WE SUGGEST THAT YOU CONTACT YOUR BROKER AND REQUEST ADVICE FROM HIM / HER.

AMBLEDOWN GAP SUPREME 2019

Version 4

Underwritten by Constantia Insurance Company Limited (CICL), Reg. No. 1952/001514/06, FSP No: 31111 (The Insurer)

ambledown
FINANCIAL SERVICES (PTY) LTD

Ambledown is an Authorised Financial Services Provider, No. 10287

CONSTANTIA
Insurance made personal

Constantia Insurance Company Limited, an authorised FSP 31111

2019 Product Range

As a member of a Private Medical Scheme, you would expect that an event in-hospital would be covered in full, this is not so. Most Medical Schemes will cover in-hospital expenses defined as services rendered by a Medical Practitioner at the Medical Scheme rate. However, most Specialists today are charging rates that are substantially higher than the Medical Scheme rates and you, as the member are liable for the difference, this is known as the tariff gap.

Ambledown Gap Supreme is an Insurance Product that provides cover for you and your immediate family for the shortfall (Gap) resulting from any Medical Practitioner charging above the Medical Aid Tariff for in-hospital surgical procedures and certain out of hospital procedures. The insured will receive a benefit equivalent to the costs incurred as a result of the Gap for any hospital admission as an in-patient. The Gap is defined as services rendered by a Medical Practitioner who charges above the Medical Scheme tariff.

Ambledown Gap Supreme is an offering that combines all of the following benefits, ie:

- **Gap Cover 100** provides for charges levied by the Medical Services Professionals above the Medical Scheme Tariff for associated services in-hospital and/or the necessity for chemotherapy or radiotherapy for the treatment of Cancer on an out-patient basis, and/or the necessity for kidney dialysis on an out-patient basis;
  - **Limited to 5 times the Medical Scheme Tariff less the higher of the Medical Scheme Tariff or the Medical Scheme Option Reimbursement Rate.**

We remind you that the Gap Cover 100 does not provide for charges above the tariff for the hospital costs or for additional costs of prosthesis, materials and medication. Cover is for the services provided by Specialists, General Practitioners and Medical Professionals such as Physiotherapists during the period of hospitalisation.

- **Major Medical Co-payment / Deductible Cover** provides for charges in the form of a co-payment or deductible applied for in-hospital admissions and charges in the form of a co-payment or deductible for major medical outpatient treatment limited to specialised diagnostic radiology limited to MRI and CT Scans.

Co-Payment is a procedure specific upfront payment charged by the Medical Aid Scheme payable to the Medical Services Provider prior to undergoing the procedure. The co-payment or deductible amounts applied are as per the rules of the patient's registered Medical Scheme.

As per the rules of the co-payment we will not pay a benefit if the co-payment was due to a penalty such as the failure to apply for pre-authorisation or where the member did not use a network hospital, then we will not consider such to be a co-payment, but a penalty and we will not pay the benefit. This will include the co-payment or sub-limitation imposed by the Medical Scheme through agreement with the policyholder where the co-payments or sub-limitations are not indicated in the rules of the Medical Scheme such as the use of robotic equipment for certain surgical procedures.

- **Sub-limitation Cover** covers the charges above any sub-limitation imposed by the Medical Scheme for in-hospital admissions.

Sub-limits are limits set by the Medical Aid Scheme on Medical Aid benefits. In certain instances these limits can be set per procedure type in an effort to manage exposure.

- **Cancer Cover** provides for charges related to Cancer treatment in a private institution subject to the Medical Scheme rules in the form of a co-payment or deductible applied after the sub-limitation imposed by the Medical Scheme for Cancer treatment and;

  provides for charges after the sub-limitation imposed by the Medical Scheme for defined biological Cancer drugs for defined oncological conditions and/or specific sub-groups of Cancer.

This benefit provides for Cancer treatment in a private facility where a cost incurred exceeds the R200,000 threshold in respect of biological and/or traditional Cancer treatment. Treatment includes in-hospital expenses, chemicals, medication and outpatient radiotherapy or chemotherapy however treatment excludes the cost of specialist's consultations.

- **Casualty Ward Benefit** covers you for 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.

  You are covered when immediate treatment is required and your Medical Scheme does not provide you with cover and you become liable to pay the cost of the casualty event. This benefit will cover the facility fee, consultations, medications, radiology and pathology associated with admission to a registered hospital's casualty facility.
  - **Treatment in a casualty unit of a hospital is subject to a specific limitation of R10,000 per insured person per annum**

"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. 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. The Medical Practitioner that treated you and / or the Casualty Unit that you have been treated in should use the correct codes and classification on the invoices they send to you and /or your Medical Aid.

All Gap Cover Benefits above are limited to R157,000 per insured person per annum

Dread Disease (Severe Illness) Benefit

Provides a once off dread disease benefit, limited to diagnosis of Cancer.

- **Limited to R50,000 per insured person on diagnosis.**
- **All tumours, which are histologically described as pre-malignant, as non-invasive or as cancer in situ.**
- **All forms of lymphoma in the presence of any Human Immunodeficiency Virus.**
- **Kaposi's sarcoma in the presence of any Human Immunodeficiency Virus.**
- **Any skin cancer other than malignant melanoma.**
- **Cancerous cells that have not invaded the surrounding or underlying tissue.**
- **Early cancer of the prostate gland or breast. (Stage1described as T1a, N0, M0, G1)**
- **Seniors excluded.**

The lump sum benefit will apply on first diagnosis of Cancer. The benefit will be excluded for any current member who has been diagnosed prior to inception or during the period of cover and is payable once in a lifetime per insured person.

Premium Waiver Benefit

This benefit covers the actual Medical Scheme contributions following the death or the total and permanent disability of the Principal Member of the Medical Scheme.

- **Limited to a benefit equal to the total value of Medical Aid Scheme Contribution calculated for 6 months.**
- **Seniors excluded.**

In the event of the death of the principal member of the Medical Aid Scheme or in the event that an accident or illness resulted in the total permanent disability of the principal member, 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.

AMBLEDOWN**GAP**SUPREME2019

Underwritten by Constantia Insurance Company Limited (CICL), Reg. No. 1952/001514/06, FSP No: 31111 (The Insurer)

BENEFITS	LIMITATIONS PER INSURED PERSON PER ANNUM	
GAP COVER 100	R157,000	⊙
CO-PAYMENT COVER		⊙
SUB-LIMIT COVER		⊙
CANCER COVER		⊙
CASUALTY WARD BENEFIT **(R10,000 LIMITATION)**		⊙
DREAD DISEASE (SEVERE ILLNESS) BENEFIT	ONCE OFF R50,000 ON DIAGNOSIS ** SEE DREAD DISEASE EXCLUSIONS * SEE SPECIFIC CONDITION	⊙
PREMIUM WAIVER BENEFIT	LUMP SUM OF 6 MONTHS MEDICAL AID CONTRIBUTIONS * SEE SPECIFIC CONDITION	⊙
PREMIUM	**PER FAMILY PER MONTH (incl.VAT) 18 TO 65 YEARS OLD**	**R465.00**

** DREAD DISEASE EXCLUSIONS

1. All tumours, which are histologically described as pre-malignant, as non-invasive or as cancer in situ.
2. All forms of lymphoma in the presence of any Human Immunodeficiency Virus.
3. Kaposi's sarcoma in the presence of any Human Immunodeficiency Virus.
4. Any skin cancer other than malignant melanoma.
5. Cancerous cells that have not invaded the surrounding or underlying tissue.
6. Early cancer of the prostate gland or breast. (Stage1 described as T1a, N0, M0, G1)

* SPECIFIC CONDITION

1. The Dread Disease & Premium Waiver Benefits terminate at the member reaching the benefit expiry age, or age 65. This means that claims submitted before the benefit expiry age will be assessed and paid, but claims after the benefit expiry age will not be accepted.

SPECIFIC EXCESS

1. Cancer treatment in a private hospital is subject to an excess of R200,000 per Treatment Cycle, provided such treatment was received in a private institution.
2. Biological Cancer Drug Treatment Cover is subject to an excess of R200,000 for the treatment of Cancer in a private institution per Treatment Cycle unless a R200,000 excess has been deducted as per point 1.

SPECIFIC LIMITATIONS

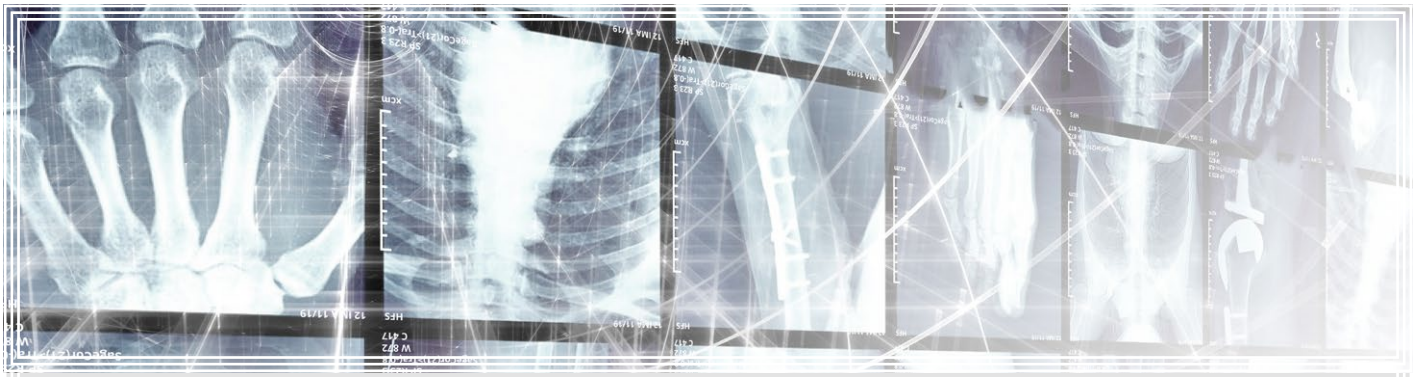
1. Treatment in a casualty unit of a hospital shall be limited to R10,000 in the aggregate per Insured Person per annum.
2. Severe Illness Benefit is limited to R50,000 payable once in a lifetime per Insured Person.

OVERALL LIMITATIONS

1. The Policy Benefits are subject to an overall benefit limitation of R157,000 in the aggregate per Insured Person per annum.

Underwriting matters which are of importance

- Please note that this product will assist with the shortfalls for in-hospital expenses and does not provide cover for day-to-day expenses once your Medical Savings Account has been depleted, nor will it cover your expense if you are in the self-payment gap.
- The minimum entry age for the Principal insured person is 18 and the maximum entry age is 65. Applicants 66 and older have the option of selecting products for seniors.
- Extended Family Dependants: A family is defined as the principal insured and immediate family which includes the spouse and children. Extended family dependants are not considered as part of the family.
- Eligible child is a person who has not attained the age of 21 and this age may be extended to 25 (under 26) in respect of a child who is unmarried and a dependant on the Principal Insured Persons' Medical Aid Scheme.
  - Adopted and fostered children are eligible dependants if they are under 21 years of age, or they are under 26 years of age and who is unmarried and a dependant on the Principal Insured Persons' Medical Aid Scheme.
  - There is no age limit for mentally or physically handicapped children who are wholly dependent on the principal insured and a dependant on the Principal Insured Persons' Medical Aid Scheme. There is no limit to the amount of children covered by the policy.
- Continuation: Any individual may apply to continue cover if that individual was a member of group policy and terminates his employment. Ambledown has the right to alter the premium rates to individual rates or adjust the premium for the additional costs of the debit order and other administrative tasks.
- Benefit upgrades: A 3 month general waiting period and 12 month pre-existing clause will apply to the additional benefits obtained when a member upgrades cover. The existing benefits enjoyed prior to the upgrade will not be subjected to the waiting periods mentioned.
- A 12 month pre-existing clause applies. The clause excludes claims for any treatment received for a condition for which treatment or advice has been received in the 12 months prior to the inception of the policy. The intention is to exclude any benefit where treatment or advice was received 12 months prior to inception. Once membership is greater than 12 months, then benefits are payable regardless of the date in which the illness manifested itself or the injury occurred.
- No benefits will be payable during a general 3 month waiting period for all treatment received unless the treatment was required as a result of an accident (external violent physical means).
- No benefit shall be payable for the severe illness benefit if the Insured Person was diagnosed with Cancer (as defined) prior to the inception of this Policy.
- This is not a Medical Scheme and the cover is not the same as that of a Medical Scheme.



Claiming Procedures

Claims should be submitted in writing (i.e. complete the claim form as soon as possible) by no later than one hundred and eighty (180) days / six (6) months from the first day of treatment. Claim forms are obtainable from www.ambledown.co.za and should be returned to:

Ambledown Financial Services (Pty) Ltd
PO Box 1862, Cramerview, 2060
Fax: 011 463 1665
Email: claims@ambledown.co.za

Your completed claim form, copies of your Medical Aid statement and all related accounts, i.e. for the hospital, surgeon, anaesthetist, etc., must be forwarded to us as soon as possible.

Enquiries

Enquiries should be addressed to Ambledown:

Tel: **086 126 2533**
Fax: **011 463 1600**

Individual debit order business:
admin@ambledown.co.za

Group business:
premium@ambledown.co.za

Broker Details:
[Brokerage Company Name]
[Emailaddress@emailaddress.com]
[Telephone number]
[Mobile number]

[Address description line1]
[Address description line2]
[Brokerage FSP Number]
[www.brokerwebsite.com]