LIFESTYLE GAP

COMPREHENSIVE COVER WHEN YOU NEED IT MOST

Covers the excess not paid by your medical scheme to ensure the best healthcare for your family.

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The Lifestyle Gap product range is designed to complement your Umvuzo Health Medical Scheme option and your pocket, offering complete peace of mind for a relatively small monthly charge.

WHAT IS GAP COVER AND WHY DO I NEED IT?

As a responsible adult you will have signed yourself and your family up with the best medical scheme option you can afford. Depending on your option, most medical schemes will pay out between 100% and 200% of the approved scheme rate. You would be forgiven for thinking that you and your family are fully covered in the event of a medical calamity. The reality is different. Medical practitioners are not regulated in terms of what they can charge and most charge in excess of the approved scheme rate.

Lifestyle Gap is a short-term insurance policy that pays you the difference between what medical practitioners charge in-hospital and what the medical scheme actually pays. There may be times when a significant portion of your bill is not covered by your medical scheme!

Medical scheme shortfall costs are your personal responsibility. **Lifestyle Gap** should therefore be considered an essential addition to your medical cover.

GAP PLAN OPTIONS

*** Combined gap benefits may, by law, not exceed R198 000 per person per annum**

LIFESTYLE GAP

Lifestyle Gap provides the following benefits:

- Gap tariff cover from Scheme tariff (100%) to a maximum of 600%;
- Sub-limitation benefit limited to R30 000 per beneficiary per annum; and
- Casualty ward benefit limited to R3 000 per beneficiary per annum.

WHAT IS NOT COVERED?

Does not cover hospital charges which are higher than the medical scheme tariff or additional hospital charges not covered by your medical scheme.

LIFESTYLE GAP PLUS

Lifestyle Gap Plus includes all the benefits of GapCore plus the following additional benefit:

- Gap tariff cover from Scheme tariff (100%) to a maximum of 600%;
- Sub-limitation benefit limited to R50 000 per beneficiary per annum;
- Cancer benefit (in excess of Scheme totals for private care) limited to R100 000 per beneficiary per 12-month treatment cycle;
- Casualty ward benefit limited to R3 000 per beneficiary per annum;
- A dread disease benefit of R30 000 on the first diagnosis of cancer; and
- A six-month premium waiver for the revised Medical Scheme contributions plus the gap cover premium, in the event of the accidental death;
- Out of hospital specialist co-payment benefit limit to R750 per event and R3 000 per family per annum

WHY DO I NEED IT?

Medical schemes place sub-limits on certain types of procedures in order to manage their exposure. This means they place a maximum on the amount available to pay for that type of procedure or treatment. Lifestyle Gap Plus increases the total levels of cover (as defined) for pathology, internal prosthesis, physiotherapy and radiology, amongst others.

SUMMARY OF BENEFITS

		LIFESTYLE GAP	LIFESTYLE GAP PLUS
Tariff/Medical scheme shortfall cover (up to six times the medical scheme tariff)		✓	✓
Chemotherapy, radiotherapy kidney dialysis outpatient treatment		✓	✓
Certain medical procedures performed in doctors' rooms		✓	✓
Consumables allowance for hospital disposables	R3 000* per family per annum	✓	✓
Casualty cover	R3 000* per insured person per annum		
Sub-limit cover	Lifestyle Gap: R30 000* per person per annum Lifestyle Gap Plus: R50 000* per person per annum	✓	✓
Cancer treatment sub-limit cover *After medical sub-limit reached	R100 000* per family per annum		✓
Appliance benefit	R3 000* per family per annum		✓
Private treatment cover for cancer - sub-limit cover on defined biologicaldrug benefit	R100 000* per person per treatment cycle		
Premium waiver	R20 000 maximum		
Out of hospital specialist co-payment benefit	R750 per event R3 000 per family per annum		✓

* Combined gap benefits may, by law, not exceed R198 000 per person per annum for medical expenses shortfalls.

For the first three years following inception of a contract, there is a limit of R30 000 in respect of the combined shortfall claims for hip and knee replacements or procedures.

SOME USEFUL DEFINITIONS

ICD 10 CODES International diagnostic codes used by doctors and hospitals which reflect on their accounts describing the diagnosis, symptoms and procedures recorded in conjunction with hospital care.	**PMB (PRESCRIBED MINIMUM BENEFITS)** All medical schemes must provide benefit cover to their members for approximately 250 clinical conditions listed in the medical schemes Act. The PMB conditions have been extended to include a chronic disease list of conditions. Cover relates to the diagnosis, medication, treatment and care of these conditions.
MEDICAL SCHEME STATEMENT A statement that is generated by your medical scheme showing which service providers accounts they have paid (or rejected) and showing how much was paid.	**MEDICAL SCHEME TARIFF** The rate set by a specific medical scheme at which claims and services for healthcare providers are paid.
OUT-PATIENT Any medical treatment, which would otherwise be treated in-hospital, but is rendered to you by a medical practitioner outside of a hospital admission, i.e. in a registered day clinic.	**MEDICAL SCHEME OPTION REIMBURSEMENT RATE** This refers to the multiple of the medical scheme tariff, as indicated by the rules of the medical scheme, at which claims and services for healthcare providers are paid.
IN-PATIENT Any medical treatment rendered to you by a medical practitioner whilst you are admitted to hospital.	**SUB-LIMIT** This refers to the maximum amount your medical scheme makes available from your plan for certain types of procedures or treatments. If you hit this limit, you may face the prospect of having to forgo further treatment.

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.

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