



Clientèle Ultimate Health Event Life Plan

POLICY TERMS AND CONDITIONS

SECTION A: BENEFITS

The benefits start when you have paid your first premium. It is important to keep paying your premiums to ensure that you are covered. In the event of unpaid premiums, cover will cease until such time as premiums are paid. Please note that waiting periods will re-start if your policy has lapsed, so please read the Policy Rules carefully. All benefits will be paid less any outstanding premiums.

HOSPITALISATION BENEFIT

Lump Sum Benefit: We will pay you, the Policy Owner, the Lump Sum Benefit amount for every hospital stay in excess of 3 days, subject to the limits and conditions outlined below.

Daily Benefit: We will pay you, the Policy Owner, the Daily Benefit amount for every day spent in hospital from day 11, subject to the limits and conditions outlined below.

What you are covered for:

Event	Benefit	Waiting Period*
Hospitalisation due to an Accident for more than 3 but less than 11 days	Lump Sum Benefit	No waiting period
Hospitalisation due to an Accident for more than 10 days	Lump Sum Benefit PLUS Daily Benefit	No waiting period
Hospitalisation due to a Specific Pre-Existing Medical Condition for more than 3 but less than 11 days	Lump Sum Benefit	12 months (minimum 12 paid Premiums)
Hospitalisation due to a Specific Pre-Existing Medical Condition for more than 10 days	Lump Sum Benefit PLUS Daily Benefit	12 months (minimum 12 paid Premiums)
Hospitalisation due to an Illness for more than 3 but less than 11 days	Lump Sum Benefit	3 months (minimum 3 paid Premiums)
Hospitalisation due to an Illness for more than 10 days	Lump Sum Benefit PLUS Daily Benefit	3 months (minimum 3 paid Premiums)
Hospitalisation due to Maternity related conditions for more than 1 day	Daily Benefit limited to 4 days or 7 days if there are complications.	12 months (minimum 12 paid Premiums)

*The waiting period is calculated from the date of commencement or resale of this policy (whichever occurred last). If you had another active policy with similar benefits in the past 90 days, the waiting period for specific pre-existing conditions will be determined from the commencement of that policy. During the waiting period you receive limited or no cover. In other words, you are not allowed to claim for hospitalisation due to Illness even though the Policy has commenced. The main reason for imposing a waiting period is to prevent clients from purposefully taking out a policy only to immediately submit a claim. Due to the fact that waiting periods reduce this risk, they also reduce the insurance premium or potential impact of further increases.

Limits of Cover:

- Total claims in terms of Hospitalisation Benefit Cover (Lump Sum and Daily Benefits) per calendar year are limited to the Total Annual Hospital Cover amount as it appears on your Insurance Personal Policy Schedule. This limitation applies to the Policy and not to each individual Insured Person.
- The Lump Sum Benefit is limited to R20 000 per Insured Person per calendar year. Once this limit has been reached, the Daily Benefit will be paid for each day of hospitalisation for subsequent hospital stays of longer than 3 days in the same calendar year.
- The Lump Sum benefit is not payable for the following conditions – instead 50% of the Daily Hospital Benefit will be payable subject to a limit of 3 days per calendar year:
 - The treatment or control of chronic or acute pain.
 - The treatment of any Gastro Intestinal Tract infections or diseases.



- The treatment of any Pelvic Inflammatory disease.
- Hospitalisation related to any Chronic Illness not listed above will be limited to a maximum of 15 days per policy per calendar year.
- For maternity related conditions the claim amount will be determined by the number of days that the Main Insured or Spouse stays in hospital, limited to 4 days or 7 days for complications. This is payable once per calendar year.
- The claim event date will determine the level of benefit for that claim.
- Benefits covered under this policy are subject to regulatory maximum limits.
- An Insured Person can be covered on a maximum of 1 Clientèle Health Event Life Plan.

When will you not be covered:

- Hospitalisation that is not authorised by us or where we have not received reasonable notification.
- Hospitalisation or treatment received for an Excluded Condition (refer to the table in EXCLUSIONS Section).
- Hospitalisation not recommended by a Medical Specialist.
- Hospitalisation in a month where the Premium is not received.
- Hospitalisation for 3 days or less (other than for maternity claims).
- Hospitalisation due to Illness during a waiting period.
- Where the claim is fraudulent or exaggerated in any way.
- Hospitalisation in a facility that does not meet our definition of a Hospital.
- Hospitalisation related to any Illness where the length of stay exceeds the maximum recommended number of days for such conditions (refer to limits of cover and definitions).

Conditions:

- You are required to notify us of all hospitalisation prior to admission, or no later than the next business day following admission, regardless of the duration of stay.
- Authorisation is required for certain conditions and for hospital stays exceeding 10 days.
- We reserve the right to refuse payment for claims where reasonable notification is not obtained.
- We reserve the right to refuse payment for claims resulting from hospitalisation at certain hospitals. A list of approved hospitals is available at www.clientele.co.za and can change from time-to-time.
- An Insured Person must be in hospital for at least 3 consecutive days (including the day of admission, not the day of discharge), and for at least 1 day for hospitalisation due to a maternity related condition.
- An Insured Person must be admitted to Hospital within 30 days of the Illness or Accident.
- If you are discharged from Hospital and have to be re-admitted within 10 days due to the same cause, it will be considered as the same claim event and the total number of days spent in Hospital due to this event will be used in determining the Benefit to be paid.
- This Policy is free from all restrictions on occupation or travel of an Insured Person.
- You must be a South African resident admitted into a registered South African Hospital.
- Hospitalisation for maternity related conditions is restricted to the Main Insured Person or Spouse only and does not apply to children covered on the policy.
- Benefits in respect of children covered under this policy may be subject to restrictions posed by present and future legislation and are defined as per your Insurance Personal Policy Schedule.

ACCIDENTAL DEATH BENEFIT

What you are covered for:

We will pay your Beneficiary the Accidental Death Benefit amount if you die in an Accident after the date the policy application was received and accepted by us and before the age of 70.

When will you not be covered:

- Death due to an Excluded Condition (refer to the table in the EXCLUSIONS Section).
- Death in a month where the premium is not received.
- Death after the age of 70.
- Where the claim is fraudulent or exaggerated in any way.
- Death due to an Accident where such Accident occurred before policy commencement or resale (whichever occurred last).

Conditions:

- The Accidental Death Benefit covers the Main Insured Person and their Spouse only.
- The Accidental Death Benefit and Premiums will cease on the earlier of the Main Insured Person or Spouse's



70th birthday.

- In order to claim on this benefit, death must be as a direct result of and occur within 12 months of the date of the Accident.

ACCIDENTAL DISABILITY BENEFIT

What you are covered for:

We will pay you the Accidental Disability Benefit amount if you are disabled (Total and Permanent Disability) due to an Accident before the age of 70.

When will you not be covered:

- Disability resulting from an Excluded Condition (refer to the table in EXCLUSIONS Section below).
- If the Accident occurs in a month where the premium is not received.
- If the Accident occurs after the age of 70.
- Where the claim is fraudulent or exaggerated in any way.
- If the Accident occurs before policy commencement or resale (whichever occurred last).

Conditions:

- The Accidental Disability Benefit covers the Main Insured Person and their Spouse only.
- The Accidental Disability Benefit and Premiums will cease on the earlier of the Main Insured Person or Spouse's 70th birthday.
- In order to claim on this Benefit, Disability must occur within 12 months of the Accident.
- Permanency of the Disability will be established 6 months after the claim.
- Payment of the Accidental Disability Benefit will result in the Benefit ceasing for that Insured Person. This means that each Insured Person can only claim once on this Benefit.

DREAD DISEASE BENEFIT

What you are covered for:

We will pay you 100% of the Dread Disease Benefit amount if you are diagnosed with a Dread Disease before the age of 60 and 50% of the Dread Disease Benefit amount if you are diagnosed with a Dread Disease after the age of 60 but before the age of 70.

Event	A Most severe	B Moderate impairment	C Mild impairment	D Almost full recovery	Waiting Period
Stroke	100%	100%	100%	100%	6 months (minimum 6 paid Premiums)
Cancer	100%	100%	100%	100%	6 months (minimum 6 paid Premiums)
Renal Failure	100%	100%	100%	100%	6 months (minimum 6 paid Premiums)
Major Organ Transplant	100%	100%	100%	100%	6 months (minimum 6 paid Premiums)
Heart Attack	100%	100%	100%	0%	6 months (minimum 6 paid Premiums)
Coronary Artery Bypass Graft	0%	0%	0%	0%	N/A

This disclosure grid is based on ASISA's master Critical Illness Definition Document which is available on www.clientele.co.za.

This means that if you are diagnosed with any of these conditions, with the exception of Coronary Artery Bypass Graft, and the Illness meets the definition below, we will pay 100% of the Dread Disease Benefit Amount. Please refer to the Dread Disease Definitions section below to understand exactly what you are covered for.

When will you not be covered:



- Dread Disease resulting from an Excluded Condition (refer to the table in EXCLUSIONS Section below).
- If the Dread Disease is diagnosed in a month where the Premium is not received.
- If the Dread Disease is diagnosed after the age of 70.
- If the Dread Disease results in death within the Survival Period of 14 days following diagnosis.

Conditions:

- The Dread Disease Benefit covers the Main Insured Person only.
- The Dread Disease Benefit and Premiums will cease on the Main Insured Person's 70th birthday.
- Please read the Dread Disease Definitions in order to understand exactly what you are covered for.
- Payment of the Dread Disease Benefits will result in the Benefit ceasing. This means that you can only claim once on this Benefit.

PREMIUM PAY BACK BENEFIT

What you are covered for:

After 6 months and 6 paid premiums, on the death of an Insured Person and approval of a valid death claim, we will pay back all premiums received for the specific Insured Person (see Insurance Personal Policy Schedule for relevant premium split). This benefit only applies to the Main Insured Person and Spouse, in other words this benefit does not apply to any Children covered on the policy. After the death of the Main Insured Person or Spouse (where applicable) the premium going forward will be halved.

A Main Insured Person that was younger than 50 years of age on the date of commencement can elect for us to pay back 50% of all premiums paid to age 65, on or after the Main Insured Person's 65th birthday. On the subsequent death of the Main Insured Person we will pay back all premiums paid for the Main Insured Person less the amount already paid back.

If your Spouse is covered on the policy, for purposes of determining the Premium Pay Back Benefit amount, the Main Policy Premium is considered to be 50% in respect of the Main Insured Person and 50% in respect of the Spouse. In other words, if a valid Premium Pay Back Benefit claim is received for your Spouse, 50% of the received Main Policy Premium and Other Benefit Premium will be paid.

When will you not be covered:

- Death before we have received 6 premiums in at least 6 months.
- Death due to riot, terrorism, war or similar event.
- Death due to a violation of an act of law.
- Where the claim is fraudulent in any way.

Conditions:

- Should a premium not be received in the month preceding the death of the Insured Person, only the premiums received from the Date of Commencement or resale (whichever occurred last) up to that point will be paid after the completion of the applicable waiting period.
- Premiums paid back will exclude additional benefit premiums.
- Premiums paid prior to resale are forfeited from the Premium Pay Back Benefit.
- Where a Spouse is covered, the premiums paid back will be 50% of the total premium in the event of the death of either the Main Insured Person or Spouse.

AIRTIME BENEFIT

On notification of a claim for any Insured Person we will load the airtime benefit to a non-contract cell phone number of the Main Insured Person's choosing. This benefit is payable once per valid claim event.

SECTION B: HOW TO CLAIM

Notification no later than the next business day following Hospitalisation

- Contact our National Contact Centre on 011 320 3000; or,
- SMS your Name, Policy Number and ICD 10 Code to 47081 (Standard rates apply).
- We must be notified no later than the next working day after admission.
- For the certain conditions that require Authorisation we will SMS you an Authorisation number after we have confirmed the details with your admitting doctor. (Details of the conditions requiring Authorisation can be found



at www.clientele.co.za).

- Further Authorisation will be required if you are in hospital for more than 10 days.

Upon discharge from Hospital and for Accidental Death, Accidental Disability and Dread Disease Claims

Tell us about the Claim:

- Contact our National Contact Centre on 011 320 3000; or,
- SMS the Policy number to 47081 (Standard rates apply)

We must be notified within 90 days of the claim event.

The Claimant must have the following information available when they contact us:

- The Insured Person's Policy number;
- A fax or e-mail address; and
- The date and cause of the claim event.

We will then provide a unique claim number, send a claim form and advise what other documents we need in order to process the claim.

Return completed claim form and other required documents in one of the following ways:

- Fax the required documents to 011 320 3170
- E-mail the required documents to claims@clientele.co.za
- Or visit the Clientèle Head Office: Clientèle Office Park, Cnr. Alon & Rivonia Roads, Morningside.

Important points to know regarding the claims process:

- We require a certified copy of the Insured Person's Identity Document, a copy of the hospital account, a full medical history and reports by the regular and attending doctors and Medical Specialists in order to assess the claim.
- We may request the opinion of an independent medical practitioner, or any additional documentation to validate the claim. The claimant is responsible for providing this information to us.
- All information provided is at the Claimant's own cost.
- All payments in terms of this Policy shall be made in South African Rands.
- If the Beneficiary cannot be traced after a period of 2 months from the date the claim was approved, payment will be made into the estate of the deceased Insured Person.

SECTION C: POLICY RULES

- You have a 31-day cooling off period to cancel the policy. This means, from the time we send your policy documents, as long as there has been no claim or you have not received any benefit under the policy, if the policy is cancelled within these 31 days, we will refund the premiums you have paid.
- We reserve the right to submit a debit instruction to your bank at any time during the month and to debit your account using any reasonable collection methods. To do this, we may also track and debit your account up to 10 working days earlier than the debit date. Should the total premium be adjusted by us or yourself as a general increase / decrease, the adjusted premium will be deducted from your bank in the same manner. This instruction will remain in force unless otherwise notified by us or cancelled by you, the Policy Owner.
- You must make sure that there are sufficient funds in your bank account to pay your premium on the agreed date. If any debit order is not paid, you will be responsible for the related bank charges.
- If we do not receive your premium on the agreed date, you have a grace period of 15 days to pay it.
- If you are on a monthly premium frequency your policy will lapse if we do not receive your premium for three consecutive months. If you are on an annual premium frequency your policy will lapse if we do not receive your annual premium when due.
- If you are on a monthly premium frequency, we reserve the right to lapse your policy after two consecutive disputes.
- You have the right to cancel this policy by giving us 31 days' notice. Premiums paid during this notice period will not be refunded.
- We reserve the right to change the terms and conditions of this policy at any time. Written notice of changes will be sent to the Policy Owner's latest contact details we have on record one month in advance and will be binding on you, the Policy Owner and us.
- If a policy is resold, the waiting periods will start again from the date of resale. We may choose to apply special

terms and conditions when reselling your lapsed or cancelled policy.

- We reserve the right to cancel your policy with immediate effect if a claim is found to be fraudulent in any respect. This means that you will no longer be covered and all premiums paid will be forfeited.
- If a date of birth of an Insured Person has been recorded incorrectly, we may amend the benefits at the date of a claim, taking into account the correct age of the Insured Person. It is important to notify us if this information is incorrect on your Insurance Personal Policy Schedule.
- The annual premiums and benefits will be reviewed by 1 December each year. We will let you know each year what the new benefits and premiums are for the next calendar year. If you do not receive this communication, please contact us to confirm the updated premiums and benefits applicable.
- Clientèle reserves the right to cancel all policies in this product line on 31 December each year, by giving one month's notice.
- Additional Insured Dependents may only be added within six months of a life event, i.e. marriage, birth or legal adoption. Cover will start from the 1st premium (whether varied or not) paid after the Additional Insured Dependents have been added. A maximum of 4 children may be covered on your Family Plan.
- You may increase or decrease your cover level at any time, subject to the minimum and maximum limits of the policy, with a consequent change in the policy premium. Waiting periods will be applied to any additional cover and will start from the first revised premium paid after the cover increase.
- The Policy Owner may change the Beneficiary(ies) nominated at any time prior to a claim event, by notifying us. Please ensure that you are always in possession of a Insurance Personal Policy Schedule that reflects your latest nomination. Where a minor Child is a Beneficiary, payment will be made into a trust fund and will only be paid out when the minor Child attains the age of majority.
- Any question of law arising shall be decided according to the laws of the Republic of South Africa.
- This policy has been issued on the basis that the information provided during the application process was true and correct.
- **IMPORTANT NOTE:** This Policy is classified as a Health Insurance Product. 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. This document is issued in accordance with the Policyholder Protection Rules as set out in the Rules published in terms of Sections 48 and 62 of the Long Term Insurance Act of 1998.
- The Accidental Disability, Accidental Death and Dread Disease Benefits are only payable once if claims arise out of the same event. In order to claim on more than 1 Benefit, the claim event must be different.

SECTION D: DEFINITIONS

Words used in this document have a specific meaning, as stipulated below, which may differ from the standard dictionary definition.

GENERAL DEFINITIONS

Accident	Means a sudden and unexpected event, which is caused solely and directly by violent, physical means and resulting in an external, visible injury confirmed by clinical examination and appropriate testing. Please note that the following is specifically excluded: • Any event occurring before policy commencement or resale date (whichever occurred last) and, • Suicide or Self-Inflicted Injury.
Authorisation	Is permission from us to claim for hospitalisation resulting from certain conditions and for hospitalisation exceeding 10 days.
Beneficiary	Is the person(s) entitled to the proceeds of the death benefits.
Child	Is an unmarried dependent who is under 18 years of age unless dependent due to mental or physical incapacity. We reserve the right to request proof of dependency at claims stage. Cover will be extended to 21 years if a Child is enrolled as a full time student at a registered tertiary institution.
Chronic illness	A disease that persists for a long time (3 months or more) and generally cannot be prevented by vaccines or cured by medication, nor do they simply disappear. This includes any condition where medication is, or should be, taken for a period exceeding three months. For example Hypertension, Diabetes, Epilepsy, Asthma, Tuberculosis, etc.
Claimant	Is the person that notifies us of a claim and may or may not be the Beneficiary.



Dangerous Activities	Engaging in or training for underwater activities for which artificial breathing apparatus is required, climbing or mountaineering, potholing, parachuting, hang-gliding, winter sports, professional sports and racing other than on foot; Flying, other than as a fare-paying passenger in a fixed-wing aircraft or helicopter, provided and operated by an airline or air charter company which is duly licensed for the regular transportation of fare-paying passengers, and only between established commercial airports and/or licenced commercial heliports.
Date of Commencement Day	Is the first day of the month during which the first premium is due. Means a period of 24 consecutive hours of hospitalisation, including the day of admission but excluding the day of discharge.
Hospital	An institution which: • is licensed in accordance with the applicable laws of the Republic of South Africa; • is primarily engaged in providing, for compensation from its patients, diagnostic, medical and surgical facilities for the care and treatment of injured or sick persons; • has staff of 1 or more qualified Medical Specialists available at all times; • has 24 hour day nursing services by registered graduate nurses under the permanent supervision of the Medical Specialists in charge; • excludes any sub-acute facility whether registered as a hospital or not; • maintains in-patient facilities; • maintains a daily medical record for each of its patients; • does not include any institution which is primarily a rest or recovery facility, rehabilitation wards or centres or a step-down facility, a place for custodial care, hospices, a facility for the aged or alcoholics or drug addicts or for the treatment of psychiatric or mental disorders, or a nursing home, even if it is registered as a Hospital or clinic. • We reserve the right to refuse payment for claims resulting from hospitalisation at certain hospitals. A list of approved hospitals is available at www.clientele.co.za and can change from time-to-time.
Illness	Means a sickness or disease contracted and commencing during the Currency of the policy.
Insured Dependents	Includes Spouse and Children who must be indicated on your Insurance Personal Policy Schedule in order to be covered.
Insured Person	The person(s) named in your Insurance Personal Policy Schedule and includes Insured Dependents. All Insured Persons must reside in South Africa and be in possession of a valid RSA Identity Document. 'Resident/Residing in the RSA' means the Insured Person must have spent at least 9 of the preceding 12 months before the claim event inside the borders of South Africa.
Main Policy Premium	Is the amount due by the Policy Owner for the benefits specified in the Policy Documents. This excludes the premium covering any Additional Benefits.
Medical Specialist	A Medical Specialist means a medical practitioner who, in addition to his/her basic medical degree, has specialised in a particular field and has graduated with an additional degree to that effect. For example a Cardiologist, who specialises in dealing with disorders of the heart, or a Paediatrician, who specialises in the medical care of children, will recommend a hospital stay. Medical Specialist shall not include the Insured Person whose hospitalisation is the basis of a claim hereunder, or a relative by blood or marriage of such Insured Person unless approved by The Company.
Policy Owner	Is the person who applied for the policy and who is also responsible for payment of the premium.

Specific Pre-Existing Medical Condition	Means any of the following conditions or a condition related to any of the following conditions, for which medical advice, diagnosis, care or treatment was recommended or received within a period of 12 months preceding the date of commencement or resale (whichever occurred last). • Chronic conditions – Diabetes, Hypertension, Epilepsy, Anaemia, Autoimmune conditions, Tuberculosis, and any other condition where medication is (or reasonably should be taken) for a period exceeding three months • Digestive Disorders – Gastro Intestinal Tract infections, Gastric ulcers, Gastroesophageal Reflux Disease/GORD, Hernia, Irritable Bowel Syndrome, Hepatitis • Heart Conditions – Heart Attack/ Myocardial Infarction, Heart Failure, Cardiomyopathy, Heart valve disorders, arrhythmias, Ischaemic Heart disease • Back Problems – Back Pain and Neck Pain, Spondylosis, Spinal Stenosis, Intervertebral Disc Disorders/Diseases • Bone And Joint Disorders – Arthritis, Fractures, Joint replacements, Joint Dislocations • Lung Conditions – Asthma, Pneumonia, Tuberculosis, Chronic Obstructive Pulmonary Disease/COPD • Cancer – Malignant neoplasms, Benign Neoplasms, Leukaemia, Lymphoma • Kidney or Bladder Diseases – Chronic Kidney Disease, Kidney Failure, Urinary Tract Infections, Kidney Stones, Nephritis.
Spouse	Means the person married to the main insured person and named in your Insurance Personal Policy Schedule. Cover is limited to one nominated spouse. Proof of such union will be requested at claims stage.
Total and Permanent Disability	Is where an Insured Person is totally and permanently unable to carry out the functions of his/her own or any reasonably suited occupation or where an Insured Person suffers total and permanent loss of one of the following: • Sight in both eyes • Ability to speak • Loss of use of a combination of any 2 limbs (hand, foot, leg, arm) provided that they are not part of the same limb; • Loss of use of both feet (ankle or below) or both legs (above the knee, including the knee and below); • Loss of the use of both hands (below the wrist) or both arms (above the elbow, including the elbow and below).

DREAD DISEASE DEFINITIONS

Words used in this document have a specific meaning and are in line with the ASISA Critical Illness definitions according to the severity levels indicated in the disclosure grid under the Dread Disease Benefit.

Cancer

A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma. The classifications are based on the latest edition of the AJCC Cancer Staging Manual. Pathological staging overrides the clinical staging.

The following conditions are excluded from this definition:

- Tumours which are histologically described as benign, pre-malignant, low malignant potential. Any tumour classified as carcinoma in-situ (Tis) or (Ta) by the latest edition of the AJCC Cancer Staging Manual.
- All tumours of the prostate unless histologically classified as having a Gleason score of 7 or more or having progressed to at least clinical TNM classification T2N0M0.
- All non-melanoma skin cancers are excluded. A malignant melanoma that has been histologically classified as T1N0M0 or higher is covered under this definition.
- All myelodysplastic syndromes and myeloproliferative neoplasms including but not limited to, essential thrombocythemia, primary myelofibrosis, polycythemia vera.
- Primary cutaneous lymphoma and dermatofibrosarcoma which are confined to the skin and which have not spread to the lymph nodes or distant sites.
- All cancers only identified from tumour cells, pieces of DNA, or any other biomarkers, any of which may be present in the blood, saliva, urine, or other bodily fluids, including, but not limited to, tests known as “liquid biopsies”.
- Any Pre-Existing cancers prior to the date of commencement or resale date (whichever occurred last) of this Benefit.

Heart Attack

A Heart Attack or Acute Myocardial Infarction (MI) is defined as acute myocardial injury confirmed by a certified physician as having occurred as a direct consequence of acute myocardial ischemia resulting from inadequate blood supply to the heart, as evidenced by any of the following combinations of criteria:

1. Compatible clinical symptoms AND raised cardiac biomarkers
OR
2. Compatible clinical symptoms AND new pathological Q-waves on ECG as defined in Annexure A (b)
OR
3. New pathological Q-waves on ECG as defined in Annexure A (b) AND raised cardiac biomarkers
OR
4. ST-segment and T-wave changes on ECG indicative of myocardial injury as defined in Annexure A (a) AND raised cardiac biomarkers. Where raised cardiac biomarkers are referenced above, they are defined as any one of the following Troponin Markers:

Marker		Value**	
*Assay (test)	Troponin Type	Unit: ng/L	Unit: ng/ml
Roche hsTnT	TnT	> 1000	> 1,0
Abbott ARCHITECT	TnI	> 3000	> 3,0
Beckman AccuTnI	TnI	> 5000	> 5,0
Siemens Centaur Ultra	TnI	> 6000	> 6,0
Siemens Dimension RxL	TnI	> 6000	> 6,0
Siemens Stratus CS	TnI	> 6000	> 6,0

Use the relevant manufacturer's assay (test) or equivalent as it appears on the laboratory report. **Values represent multiples of the World Health Organisation (WHO) MI rule in levels and not the 99th percentile values (upper limit of normal) as quoted on the laboratory result.

Conventional Troponin Markers:

Marker		Value	
*Assay (test)	Troponin Type	Unit: ng/L	Unit: ng/ml
Conventional TnT	TnT	> 1000	> 1,0
Conventional AccuTnI***	TnI	> 500	> 0,5

The evidence must show a definite acute myocardial infarction due to obstructive coronary heart disease. Other acute coronary syndromes, including but not limited to angina, are not covered by this definition.

Major Organ Transplant

The human-to-human organ transplant from a donor to the Insured Person of one or more of the following organs: heart, lung, liver, pancreas, small bowel, kidney or bone marrow.

Renal Failure

End stage renal failure presenting as chronic irreversible failure of both kidneys to function as a result of which regular renal dialysis is instituted.

Stroke

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit, confirmed by neuro-imaging investigation and appropriate clinical findings by a specialist neurologist. Symptoms and signs as well as imaging must confirm a new stroke with minor residual symptoms or signs, as measured by:

- a permanent objective neurological deficit that is evident on physical examination that has persisted for a continuous period of at least three months after the onset of the stroke, or
- a WPI of 1% to 10%

WPI figures are calculated as per the latest American Medical Association Guides to the Evaluation of Permanent Impairment.

For the above definition, the following are not covered:

- Transient ischaemic attack; this is defined as a transient episode of neurologic dysfunction (irrespective of duration) caused by focal brain, spinal cord, or retinal ischemia, without acute infarction (on neuroimaging investigations)
- Vascular disease affecting the eye or optic nerve;
- Migraine and vestibular disorders;
- Traumatic injury to brain tissue or blood vessels.

Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months.

Survival Period

A period of 14 days which the Insured Person survives without the use of life support after being diagnosed with a Dread Disease.

SECTION E: EXCLUSIONS

The Insurer will not be liable in respect of any claim for Hospitalisation, Accidental Death, Accidental Disability or Dread Disease which is directly or indirectly caused by, arising from, contributed to by, aggravated by, connected with or resulting from any of the following:

	Specific
Activities contrary to the law	Includes any act contrary to the laws of the Republic of South Africa, including driving a motor vehicle while the blood alcohol level is higher than that permitted by law, irrespective of whether such act is a cause of the claim event.
Addiction	Including treatment or where, in our opinion, the cause of admission arose from any underlying drug or alcohol dependence syndrome.
Cosmetic	Cosmetic or plastic surgery, except in the case of bodily reconstruction due to an accident will not be covered.
Cystic Fibrosis	Including treatment for any of its manifestations.
Dangerous Activity	See definition of 'Dangerous Activities'.
Dental	Including dental conditions or treatment that is related to any other illnesses.
Elective or treatments for Obesity	Operations, treatments and examinations for obesity or of the Insured Person's own choosing which has no connection with any illness.
Infertility	Including Artificial Insemination as defined in the Human Tissues Act No 65 of 1983 (as amended).
Intentional or Self-inflicted	Including attempted suicide independent of the Insured Person's state of mind.

Psychological or Psychiatric Disease

Any event traceable to psychiatric trauma, or your state of mental or physical health, prior to or after the event that gives rise to a claim. Including, but not limited to, diseases or disorders such as Depression and Post Traumatic Stress Disorder or any psychiatric trauma.

Quarantine

Includes where quarantine occurs in a registered Hospital.

Soft-tissue Injuries

Including all visible and non-visible soft-tissue injuries, except where ligament or tendon damage is confirmed and requires surgical intervention.

War

Including, but not limited to, riot, terrorism, war or similar events.

General

No objective impairment in health

Where, in our opinion, based on the medical information provided, the cause of admission did not require admission into hospital or equivalent treatment could have been provided as an out-patient.

Rehabilitation

Includes admissions into a registered Hospital, where the primary treatment is rehabilitative. Including admissions into rehabilitation centres, nature, cure clinics, or hydros.

Not recommended by a Medical Specialist

Including taking any drug, unless it is proved that the drug was taken in accordance with proper medical prescription (unrelated to any addiction). Only claims from patients referred to Hospital by a qualified Medical Specialist will be accepted.

Non-compliance to treatment

Where, in our opinion, based on the medical information provided, the cause of admission resulted from or is exaggerated by the non-compliance of prescribed treatment.

Investigations, Routine physical or any other examinations

Includes investigation of pain or pain-related conditions where a diagnosis cannot be confirmed by supporting test results, regardless of treatment received.

Additional Exclusions applicable to the Death, Accidental Disability and Dread Disease Benefits

Pre-Existing Medical Conditions

Any medical condition for which medical advice, diagnosis, care or treatment was recommended or received prior to the date of commencement or resale (whichever occurred last).

Contamination

The use of nuclear, biological or chemical weapons or any radioactive contamination.



NON-INSURANCE SUMMARY

As a valued **Clientèle Ultimate Health Event Life Plan** member, you have access to the below offerings through CBC Rewards (Pty) Ltd.

Basic Emergency Assistance Services including 24 Hour emergency helpline, with personal H.E.L.P advisors (nurses) to assist with health queries, provided in partnership with Direct Rewards. Access this service by calling 0860 320 333.

For more information, please email us at services@clientele.co.za or call our National Contact Centre on 011 320 3000. Our friendly consultants are standing by to assist you.

NON-INSURANCE TERMS AND CONDITIONS - BASIC EMERGENCY ASSISTANCE SERVICES

1. 24-HOUR HELPLINE

Call 0860 320 333 when an emergency arises.

1.1. BENEFITS

Emergency Medical Services:

This is a 24-hour emergency assistance helpline, which will arrange for necessary help you may require during a Medical Emergency.

Personal Health Advisor:

This advice service deals with any health query 24-hours a day, 365 days a year.

Trauma, Assault and HIV Counselling:

In the event of a traumatic experience you may call the helpline where dedicated and trained counsellors are available to listen and talk you through your recovery.

1.2. DEFINITIONS

Acute Illness shall mean the sudden unforeseeable onset of any acute, potentially life-threatening illness, which in Direct Rewards' discretion qualifies for the Assistance as defined herein;

Assistance shall mean the service Direct Rewards will provide to a member and which in summary, depending on the circumstances, may include any one or more of the following;

- Emergency medical advice (first aid advice);
- Dispatch of a response vehicle or ambulance in an emergency;
- Co-ordination of Air Ambulance transfers;
- Medically assisted repatriation to the member's place of residence;
- Guaranteed hospital admission (R5,000 maximum) – refundable by you and your medical aid; and
- Liaison with next-of-kin.

Bodily Injury shall mean any unforeseeable potentially life threatening bodily injury arising accidentally, which in Direct Rewards' discretion, qualifies for assistance as defined herein.

Clinical Assessment and Education Guidelines means a proprietary symptom based assessment, triage and education guidelines used by the nurses to provide the Personal Health Advisor service and to direct members to appropriate sources of care.

Main Policy means the original Policy that the Emergency Assistance Service is added on to. All the terms and conditions of The Main Policy are still in force in addition to the specifics regarding this Addendum. Please refer to the enclosed terms and conditions for the Emergency Assistance Service.

Medical Emergency shall mean any fortuitous incident resulting in bodily injury or acute illness, as defined herein.

Medically Justified shall mean Medical Emergency, as defined herein that justified the use of medical transportation.

Member means the main insured life, spouse and children as specified in the policy schedule.

Personal Health Advisor means an advisory service provided to members through inbound and outbound telephone calls to, and from the contact centre.

Premium means the regular monthly contractual payment made by a member in return for an undertaking by Direct Rewards to provide a service as specified in the Service Agreement.

Service

Direct Rewards shall provide assistance to a member in the event of a medical emergency.

1.3 SERVICES PROVIDED

Emergency pre-arrival instructions:

Direct Rewards will provide a member (or caller on his behalf) with pre-arrival instructions/ Emergency Medical Advice and Information regarding any emergency medical condition by telephone so that emergency assistance can immediately be provided to a person suffering illness or injury until a medical team arrives at the scene. Pre-arrival instructions will be regarded as such and not as an accurate or definite treatment of any condition any person might suffer.

1.3.1 ASSISTANCE

Emergency Medical Assistance Involving Evacuations or Relocation:

- In the event of a medical emergency, Direct Rewards will arrange and pay for the transfer of the member, with or without medical supervision by any means considered by Direct Rewards to be suitable (including road ambulance, chartered or commercial flight, or any road transport) to the nearest hospital;
- Direct Rewards will arrange further transportation as above, to the nearest hospital most appropriately equipped for the particular emergency should the treating doctors recommend that and if considered necessary by Direct Rewards' medical directors;
- Direct Rewards will, in its discretion, repatriate the member by road or air with medical supervision to a hospital close to the permanent residence of the member if his medical condition permits and should the treating doctor advise that the member would require prolonged hospitalisation.

The provision of assistance in terms of these standard conditions is further governed by the following:

- Immediate contact - In the case of a medical emergency the member or his representative shall immediately telephone the Direct Rewards Service Centre, unless the urgency of the situation, being a real threat to life, is such as to require prior action to be taken, in which event he shall telephone as soon as possible and in any event within twenty four (24) hours, and shall furnish Direct Rewards with:
 - his/her name, address and member number relating to this agreement;
 - the name, place and telephone number where Direct Rewards can reach



him/her;

- a brief description of the medical emergency and the nature of the assistance required.

Exclusions

Direct Rewards will provide assistance but will be under no obligation to pay for the services rendered in circumstances where the medical emergency is:

- of such a nature as can adequately be treated at or near the place where the medical emergency occurred (not medically justified);
- of such a nature that the member is nonetheless able to travel as a seated passenger in any form of transport, without requiring medical escort (not medically justified);
- the result of the intentional and/or deliberate act of the member, committing suicide or any such attempt and/or the participation by the member in any criminal activity.

Compliance

Compliance by the member with these standard terms and conditions shall be a condition precedent to any entitlement to assistance hereunder.

1.3.2. PERSONAL HEALTH ADVISOR

Providing the service:

Emergency Assistance via Access Health's nurses will provide Personal Health Advisor.

1.3.2.1 THE SERVICES

The Audio Health Library

There are many conditions that are not sufficiently urgent to take to a doctor or that may cause embarrassment (piles, pregnancy etc.) but a member would nevertheless like to learn about them. Normally, a member thinks twice about calling the doctor or visiting the medical library to obtain this information. Now all they have to do is call the Personal Health Advisor and listen to hundreds of practical and easy-to-understand topics. Managing health has never been easier.

Emergency Medical Advice

In the event of a medical emergency, Direct Rewards will provide appropriate first aid advice to enable a caller to provide assistance to the member until medical help arrives.

Assessing day-to-day symptoms

Every day we are faced with decisions regarding our health or that of a loved one. At any hour of the day or night a registered nurse will help the caller decide what to do.

Important health knowledge

Health issues are complicated and can be unsettling if they are not properly understood. For example, you get your blood test results back and you're not entirely sure what they mean. Direct Rewards carries a complete database on investigative procedures and can assist the caller with information. Basic health information such as dietary assistance and inoculations are also available.

Drug database

Direct Rewards has access to a complete drug database. The nurse assists the caller with information on the specific drug, the contra-indications, when it should be taken and whether there is any dietary specification linked to the usage of the drug.

Poisoning

Direct Rewards also comprises of a database with poisoning protocols for the nurses to assist the caller in his/her need. The immediate and long-term needs are addressed with the caller. Directions to a medical facility, or even an ambulance will be arranged where the patient is critical and in need of immediate medical care.

Health Counselling

Chronic ailments and diseases such as cancer, AIDS, diabetes and asthma require both a better understanding and specific treatment to help the patient, and those around them, cope with the problem.

AIDS and Cancer

AIDS and cancer are particularly difficult to come to terms with and our registered nurses are amongst the leading counsellors in this field. They will assist the caller in managing and living with his/her condition to the best of their ability.

Addiction

All the nurses are trained counsellors. This expertise linked to the knowledgebase assists them to counsel callers suffering from an addiction. The caller will be assisted with coping skills or referrals to appropriate medical care clinics.

Stress management

Currently we assist patients suffering from stress on a daily basis. Counselling, advice and relaxation techniques are shared with the callers.

No definite risk evaluation takes place, but in the case where a nurse suspects further assistance, the caller will be referred to their house doctor for initial assessment and further treatment.

Trauma debrief

Direct Rewards handles debriefing of any sort of trauma on a daily basis. Such a session is handled by any of the experienced nurses. A debrief takes place with an invitation to phone back if the need arises to discuss the situation further. In the case where assessment took place and the nurse feels that professional assistance will be required, they suggest to the patient to visit a professional for a one-on-one session.

Assistance for rape victims

Initial counselling is immediately available to the victim. After the assessment and counselling, the victims of rape are directed to the closest medical centre, where accredited protocols ensure that the victim and their families receive the most appropriate treatment in a caring environment. A complete rape care product is also available where the provision of medication and tests are also provided.

1.3.3 DR TOUCH: TRAUMA, ASSAULT & HIV PROTECTION

TERRITORY:

Cover will only be provided within the borders of South Africa.

PRODUCT DESCRIPTION:

This is a 24-hour emergency assistance helpline, which will arrange for the necessary help a member may require in a situation where Trauma and/or HIV infection as a result of an Assault occurs.

Assault is defined as a bodily injury sustained by violent external and visible means. Members will have access to medical treatment for bodily injury. In the case of trauma, the member will have access to psychological counselling from a public trauma centre or a private institution. A member may call the helpline in the event of:

- Rape
- Hi-jacking
- Child abuse
- Suicide of close family members
- Fire
- Death of next-of-kin
- Domestic violence and/or abuse
- Kidnapping / Abduction
- Woman abuse

The HIV protection service provides members with peace of mind because in the event of a violent assault such as rape or accidental exposure such as a needle prick with a contaminated needle, the member or his/her family has access to hospital care, treatment and diagnostic regimes for the management of the consequences. The imminence of HIV/Aids will often cause the trauma to be of a more intense nature; therefore the member will also have access to psychological counselling.

1.3.3.1 PRODUCT BENEFITS:

1.3.3.1.1 Trauma & Assault:

- A helpline that arranges the nearest local emergency assistance service for the member, as well as providing emergency transport to the nearest, most appropriate medical facility as a result of a bodily injury - Where necessary the member will be stabilised before transportation is provided (Note: Inter-hospital transfers are not included).
- The helpline is manned by professional resource nurses, maintaining a high level of service.
- Cover for Assault is R5,000 per member with a maximum of R10,000 per

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family per occurrence in respect of medical indicated treatment for bodily injury.

- The resource nurses also assist with referrals for psychiatric consultations.
- Cover for Trauma is R5,000 per member with a maximum of R10,000 per family per occurrence in respect of Psychiatric Consultations.

1.3.3.1.2 HIV Protection Treatment:

The HIV Protection Treatment Service enables the member to make use of, at his/her own discretion, of the following services, which can be paid out of the defined benefit of the policy:

- 24-hour access to trauma counsellors, providing telephonic trauma counselling as well as counselling for post-traumatic stress disorder.
- 3 Psychiatric consultations (per incident) with a specialist, which can be either a general practitioner, trauma trained registered nurse or trauma counsellor.
- 3 HIV blood tests (per incident): one immediately after the event and the second and third at 6 weeks and 3 months respectively. Should the member be HIV positive at the time of the initial blood test, further testing will not be covered.

Provided that exposure has been established, and strictly on the treating doctor's orders, if the person is HIV negative (following a rapid test) he/she will also be provided access to:

- A 30-day starter pack of antiretroviral medication ;
- A 7-day course of STI (Sexually Transmitted Infections) medication ;
- Registration for an HIV management programme, where applicable ;
- 24-hours-a-day, 365-days-a-year telephonic access to Direct Rewards HIV counselling centre for information, advice and support. Should the person be HIV positive at the time of the event, he/she will be provided access to:

Should the person be HIV positive at the time of the event, he/she will be provided access to:

- 24-hours-a-day, 365-days-a-year telephonic trauma counselling ;
- 24-hours-a-day, 365-days-a-year telephonic HIV counselling ;
- 3 consultations (per incident) with a specialist, either a general practitioner, trauma trained registered nurse or trauma counsellor ;
- A 7-day course of STI medication.

PROCEDURE FOR SERVICE UTILIZATION:

- The Direct Rewards call centre is a 24/7 facilitation centre that has the infra-structure for members suffering from trauma to have access to immediate assistance. The call centre nurses take control of situations and manage the process of communication with individuals and service providers and refer the members to an appropriate service provider. In the event of Trauma / Assault / HIV infection a member must:

In the event of Trauma / Assault / HIV infection a member must:

- Call the helpline and give details of their circumstances, any immediate dangers and their condition,
- The nurses will arrange for the necessary assistance, be it the police, or the nearest local emergency assistance services, etc,
- The nurses will monitor the medical condition of the member,
- Should the situation develop into a medical emergency, the nurses will:
 - Arrange for emergency medical evacuation either by road or air ambulance ;
 - Arrange for the member to be transported to a hospital (with emergency facilities) closest to the scene of the incident ;
 - Monitor the member's transportation and condition.

REQUIREMENTS:

- The member must notify the Direct Rewards call centre immediately following the incident.
- If Direct Rewards repudiates any claim, Direct Rewards will be relieved of liability unless summons is served within 90 days of repudiation.

EXCLUSIONS:

Compensation will not be payable as a result of the member's:

- Participation in any riot, civil commotion, labour disturbance, strike or lockout or public disorder or any act or activity which is calculated or directed to bring these about;
- Wilful misconduct;
- Performance or attempt to perform;

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- Any act on behalf of any organization, body or group of persons calculated or directed to overthrow or influence any state or government, or any provincial, local or tribal authority with force, or by means of fear, terrorism or violence.
- Any act which is calculated or directed to bring about destruction or damage or bodily injury in order to further any political aim, objective or cause, or to bring about any social or economic change or in protest against any state or government or any provincial, local or tribal authority for the purpose of inspiring fear in the public or any section thereof.
- Should a HIV infection claim not be reported within 48 hours (up to a maximum of 72 hours), Direct Rewards cannot accept the claim for the HIV protection medication, although members can still make use of our telephonic advice and trauma counselling. This exclusion pertains to the fact that the antiretroviral medication (Starter pack) will no longer be effective after expiry of 72 hours.

Direct Rewards will not be liable for:

- Any claim which is in any respect fraudulent;
- Loss, damage or bodily injury deliberately caused by the member or any person acting in collusion with the member, consequential loss or damage except as specifically provided.

