Stratum Benefits

2027



CORPORATE

GAP COVER

PRODUCT RANGE

GUARDRISK TAILORED RISK SOLUTIONS

Stratum Benefits (Pty) Ltd, an authorised FSP 2111 (Reg No. 2003/018155/07) is underwritten by Guardrisk Insurance Company Limited, a licensed non-life insurer and authorised FSP 75. This brochure is a summary and does not replace any information provided in your Policy Schedule. If there are any differences, please refer to your Policy Schedule. Terms and conditions apply.

Gap Cover is not a medical aid, does not provide similar cover as medical aid and cannot be substituted for a medical aid membership.



Gap Cover is a non-life medical expense shortfall policy that complements your medical aid.

It is not a medical aid, does not provide the same cover as a medical aid, and cannot replace a medical aid membership.

Depending on your policy's benefits, **Gap Cover** may help cover certain medical expense shortfalls, co-payments, selected medical aid exclusions, and a range of healthcare-related expenses that can arise before, during, or after a medical event, subject to policy terms, conditions, and benefit limits.

OUR WILDLIFE. OUR INSPIRATION

South Africa's wildlife has long been part of the **Stratum Benefits** brand. The qualities reflected in these remarkable animals inspire how we do business every day.

Strength. **Resilience**. **Adaptability**. **Intelligence**. **Leadership**.

These qualities guide how we support our clients, work with financial advisors, and collaborate with our healthcare partners.

EXPLORE MORE ONLINE

Our website gives you access to a wide range of resources, including:

- Product brochures and benefit overviews
- **Gap Cover** information for employer groups and employees
- Application forms and claim forms
- Helpful guides and downloadable resources
- Policy documents and supporting resources

LOOKING FOR COVER FOR YOUR FAMILY?

Your family members can also apply for **Gap Cover** in their **private capacity**. Our **Individual Gap Cover** range offers options designed for individuals and families.

Visit **www.stratumbenefits.co.za** to learn more about our products, download documents, and access support tools.

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APPLY FOR GAP COVER

Chat with your HR representative or financial advisor.

Apply online or download the application form: **www.stratumbenefits.co.za/get-cover/**

Send your completed form to your HR representative, financial advisor or to us at: **yourapplication@stratumbenefits.co.za**

QUERIES AND POLICY CHANGES

Chat with your HR representative or financial advisor to change your option or update dependants.

For general updates, like debit order details or benefit queries, email us at: **yoursupport@stratumbenefits.co.za**

GAP COVER CLAIMS

Submit or follow up on a claim: **yourclaim@stratumbenefits.co.za**

Submit a claim online: **www.stratumbenefits.co.za**

QUICK REPLIES

For an **online chat**, click the chat icon on our website.

For **WhatsApp**, save our number, 010 448 0861, or scan the **QR code** to start a conversation.

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CONFIDENCE. PROTECTION. CARE.

Life's journey doesn't always unfold as expected. The right **Gap Cover** helps protect you against unexpected medical expense shortfalls, providing the financial confidence and support you need to focus on what matters most.

THIS IS US

Like the eagle, we see the bigger picture.

For two decades, we've helped South Africans protect themselves and their loved ones against unexpected medical expense shortfalls through solutions designed for every stage of life.

Because to us, exceptional service is about supporting people through life's uncertainties, not simply selling policies.



WHY GAP COVER?

Unexpected medical expense shortfalls can happen when you least expect them, leaving you with costs that may not be fully covered by your medical aid.

Gap Cover provides an additional layer of financial protection, helping to cover medical expense shortfalls, co-payments and other healthcare costs, so you can face life's uncertainties with greater confidence.

Whatever stage of life you're in, there's a **Gap Cover** option designed to support your healthcare journey.

WHY CHOOSE US?

Flexible cover

Designed to adapt to your family, your medical aid and your changing needs.

- No maximum entry age.
- One policy covers you and your spouse, even if you belong to different medical aid plans, including the dependants registered on either plan.
- Child dependants may remain on your policy regardless of age while they remain registered as dependants on your or your spouse's medical aid plan.
- Full-time students aged **26** or **younger** may remain on your policy with annual proof of full-time studies, even if they belong to a different medical aid plan.

Trusted support

- Cover for both in- and out-of-hospital procedures.
- Some benefits aren't subject to the **Overall Policy Limit**.
- Several benefits don't require your medical aid to pay a portion first.

Extended protection

Depending on your option, cover may include:

- Cancer treatment
- Internal prosthetic devices
- MRI, CT and PET scans
- Dental procedures
- Physical rehabilitation
- Trauma counselling
- Private room accommodation
- Preventative care
- Medical aid and policy premium waivers

SUPPORT BEYOND YOUR POLICY

Depending on your option, you'll have access to one or more complimentary LIFESTYLE BENEFITS designed to support your wellbeing at home, at work, and while travelling.

INTERNATIONAL TRAVEL INSURANCE

Cover for emergency hospital treatment for acute illness and accidental injury while travelling for leisure outside South Africa.

WELLNESS CARELINE

Confidential telephonic and virtual counselling for you and your dependants through registered counsellors and social workers.

CORPORATE GAP COVER PRODUCT RANGE OVERVIEW

	CORPORATE ELITE[500]		CORPORATE NOVA[500]		CORPORATE MERIDIAN[400]		CORPORATE COMPACT[300]	
OVERALL POLICY LIMIT (OPL)	**R 226 880** per insured person per year							
IN- OR OUT-OF-HOSPITAL COVER	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
BENEFITS SUBJECT TO THE OPL								
GAP BENEFIT	✓ 500%	✓	✓ 500%		✓ 400%		✓ 300%	✓
CO-PAYMENT BENEFITS								
ADMISSION AND PROCEDURE CO-PAYMENTS	✓ Subject to OPL of **R 226 880** per person	✓	✓ **R 55 000** per policy		✓ Subject to OPL of **R 226 880** per person		✓ **R 22 000** per policy	✓
PENALTY CO-PAYMENTS	✓ **2 Co-Payments** up to **R 17 000** per co-payment per policy		✓ **1 Co-Payment** up to **R 6 500** per policy		✓ **1 Co-payment** up to **R 11 500** per policy		✓ **R 13 000** per policy	
ROBOTIC SURGERY CO-PAYMENTS	✓ **R 11 000** per policy		⊗		⊗		⊗	
SCOPE CO-PAYMENTS	✓ Subject to **Admission and Procedure Co-Payment Benefit**	✓	Subject to **MRI, CT, PET Scan** and **Scope Co-Payment Benefit**	✓	✓ **2 Co-payments** up to **R 4 000** per co-payment per policy		✓ Subject to **Admission and Procedure Co-Payment Benefit**	✓
DENTAL COVER								
SPECIALIST SHORTFALLS	✓ Subject to **Gap Benefit**		✓ Subject to **Gap Benefit**		✓ Subject to **Gap Benefit**		✓ Subject to **Gap Benefit**	
Dental procedures such as wisdom teeth extractions	✓ **R 50 000** per policy		✓ **R 8 000** per policy		✓ **R 10 000** per policy		✓ **R 30 000** per policy	
Dental procedures due to accidental events or cancer treatment	✓ Subject to OPL of **R 226 880** per person		✓ **R 15 000** per policy		✓ **R 28 000** per policy		✓ Subject to OPL of **R 226 880** per person	
ADMISSION AND PROCEDURE CO-PAYMENTS	✓ Subject to **Admission and Procedure Co-Payment Benefit**		✓ Subject to **Admission and Procedure Co-Payment Benefit**		✓ Subject to **Admission and Procedure Co-Payment Benefit**		✓ Subject to **Admission and Procedure Co-Payment Benefit**	
PENALTY CO-PAYMENTS	✓ Subject to **Penalty Co-Payment Benefit**		✓ Subject to **Penalty Co-Payment Benefit**		✓ Subject to **Penalty Co-Payment Benefit**		✓ Subject to **Penalty Co-Payment Benefit**	
MATERNITY COVER								
CHILDBIRTH SHORTFALLS	✓ Subject to **Gap Benefit**	✓	✓ Subject to **Gap Benefit**	✓	✓ Subject to **Gap Benefit**		✓ Subject to **Gap Benefit**	✓
ADMISSION AND PROCEDURE CO-PAYMENTS	✓ Subject to **Admission and Procedure Co-Payment Benefit**		✓ Subject to **Admission and Procedure Co-Payment Benefit**		✓ Subject to **Admission and Procedure Co-Payment Benefit**		✓ Subject to **Admission and Procedure Co-Payment Benefit**	
PENALTY CO-PAYMENTS	✓ Subject to **Penalty Co-Payment Benefit**		✓ Subject to **Penalty Co-Payment Benefit**		✓ Subject to **Penalty Co-Payment Benefit**		✓ Subject to **Penalty Co-Payment Benefit**	
PRE- AND POST-NATAL CONSULTATIONS	✓ Subject to **Out-Patient Specialist Consultation Benefit**		⊗		⊗		⊗	
PREVENTATIVE PROCEDURES	✓ Subject to **Preventative Care Benefit**		⊗	✓	Subject to **Preventative Care Benefit**		⊗	
PRIVATE ROOM	✓ Subject to **Private Room Benefit**		⊗		⊗		⊗	
RADIOLOGY COVER								
RADIOLOGY SHORTFALLS	✓ Subject to **Gap Benefit**	✓	✓ Subject to **Gap Benefit**		✓ Subject to **Gap Benefit**		✓ Subject to **Gap Benefit**	✓
ADMISSION AND PROCEDURE CO-PAYMENTS	✓ Subject to **Admission and Procedure Co-Payment Benefit**	✓	✓ Subject to **Admission and Procedure Co-Payment Benefit**		✓ Subject to **Admission and Procedure Co-Payment Benefit**	✓	✓ Subject to **Admission and Procedure Co-Payment Benefit**	✓
MRI, CT AND PET SCAN CO-PAYMENTS	✓ Subject to **Admission and Procedure Co-Payment Benefit**	✓	Subject to **MRI, CT, PET Scan and Scope Co-Payment Benefit**	✓	✓ **2 Co-Payments** up to **R 4 000** per co-payment per policy	✓	✓ Subject to **Admission and Procedure Co-Payment Benefit**	✓
MRI, CT AND PET SCAN AND SCOPE CO-PAYMENTS	✓ Subject to **Admission and Procedure Co-Payment Benefit**	✓	**2 Co-payments** up to **R 4 000** per co-payment per policy	✓	Subject to **MRI, CT and PET Scan Co-Payment Benefit**	✓	✓ Subject to **Admission and Procedure Co-Payment Benefit**	✓
MRI, CT AND PET SCAN SUB-LIMITS	✓ **R 6 000** per person per event	✓	⊗	✓	**R 5 000** per person per event	✓	✓ **R 4 400** per person per event	✓
MRI, CT AND PET SCAN TOP-UP	✓ **R 6 500** per policy	✓	⊗		⊗		✓ **R 4 000** per policy	✓
SUB-LIMIT BENEFITS								
COLONOSCOPIES, ENTEROSCOPIES AND GASTROSCOPIES	✓ **R 7 000** per person per event	✓	⊗		⊗		⊗	
INTERNAL PROSTHETIC DEVICE SHORTFALLS	✓ **R 40 000** per person per event		✓ **2 Events** up to **R 22 000** per event per policy		✓ **2 Events** up to **R 20 000** per event per policy		✓ **R 32 000** per person per event	
INTERNAL PROSTHETIC DEVICE TOP-UP	✓ **R 10 000** per person per event		⊗		⊗		⊗	
RENAL DIALYSIS TREATMENTS	✓ **R 30 000** per person per event		⊗		⊗		⊗	
CANCER BENEFITS								
BREAST RECONSTRUCTION	✓ **1 Event** up to **R 35 000** per person per lifetime		⊗		⊗		⊗	
CANCER TREATMENT SHORTFALLS	✓ Subject to OPL of **R 226 880** per person	✓	✓ Subject to OPL of **R 226 880** per person	✓	**R 55 000** per person	✓	✓ Subject to OPL of **R 226 880** per person	✓
CANCER TREATMENT TOP-UP	✓ Subject to OPL of **R 226 880** per person	✓	⊗	✓	**R 55 000** per person	✓	**R 65 000** per person	✓
PHYSICAL REHABILITATION TOP-UP BENEFIT	✓ **R 10 000** per person		⊗		⊗		⊗	
OUT-PATIENT SPECIALIST CONSULTATION BENEFIT	✓ **4 Consultations** up to **R 1 300** per consultation per policy		⊗		⊗		⊗	
CASUALTY BENEFITS								
ACCIDENTAL EVENTS Individuals of all ages	✓ **R 16 000** per policy		✓ **2 Events** up to **R 5 500** per policy		✓ **R 10 000** per person per event		✓ **R 6 500** per policy	
ACCIDENTAL EVENTS External medical items	✓ **R 2 200** per policy Subject to **R 16 000** benefit limit		✓ Subject to **Casualty Benefit**		✓ **2 Events** up to **R 1 100** per person per event Subject to **R 10 000** benefit limit		✓ **R 1 100** per policy Subject to **R 6 500** benefit limit	
ACCIDENTAL EVENTS Follow-up visits	✓ **1 Visit** per person per event Subject to **R 16 000** benefit limit		⊗		⊗		✓ **1 Visit** per person per event Subject to **R 6 500** benefit limit	
ILLNESS EVENTS Children 12 years or younger	✓ Subject to **R 16 000** benefit limit		⊗	✓	**2 Events** up to **R 3 300** per event per policy		✓ Subject to **R 6 500** benefit limit	
ILLNESS EVENTS Individuals 13 years or older	✓ **R 2 200** per policy			✓			⊗	
TRAUMA COUNSELLING BENEFIT	✓ **R 11 000** per policy		⊗	✓	**3 Consultations** up to **R 2 200** per consultation per policy	✓	**R 5 500** per policy	
PREVENTATIVE CARE BENEFIT	✓ **R 2 200** per policy		⊗	✓	**2 Events** up to **R 550** per event per policy		⊗	
BENEFITS NOT SUBJECT TO THE OPL								
PRIVATE ROOM BENEFIT	✓ **R 3 800** per policy		⊗		⊗		⊗	
PAYOUT AND WAIVER BENEFITS								
ACCIDENTAL DEATH AND DISABILITY	**1 Event** per person **R 25 500** Principal Insured **R 25 500** Spouse **R 5 500** Other Dependants		⊗		⊗		**1 Event** per person **R 15 500** Principal Insured **R 15 500** Spouse **R 5 500** Other Dependants	
FIRST-TIME CANCER DIAGNOSIS	**1 Event** of **R 30 000** per person per lifetime		⊗		⊗		**1 Event** of **R 15 000** per person per lifetime	
MEDICAL AID CONTRIBUTION WAIVER	**6 Months** up to **R 4 500** per month		⊗		⊗		⊗	
STRATUM POLICY PREMIUM WAIVER	**12 Months**		⊗		⊗		⊗	
LIFESTYLE BENEFITS								
INTERNATIONAL TRAVEL INSURANCE	**1 Trip** per policy up to **30 days** per person		⊗		⊗		⊗	
WELLNESS CARELINE	Telephonic and virtual counselling		Telephonic and virtual counselling		Telephonic and virtual counselling		Telephonic and virtual counselling	
MONTHLY PREMIUMS *Premiums increase annually on 1 January*	Determined by factors like the employer group's size, average age and if cover is compulsory or voluntary.							

CORPORATE OPTIMISER PRODUCT RANGE OVERVIEW

		CORPORATE ACCESS PLUS[500]			CORPORATE ACCESS CO-PAY PLUS[300]			CORPORATE ACCESS	
	OVERALL POLICY LIMIT (OPL)	**R 226 880** per insured person per year							
	IN- OR OUT-OF-HOSPITAL COVER	**IN**	**OUT**		**IN**	**OUT**		**IN**	**OUT**
	BENEFITS SUBJECT TO THE OPL								
	GAP BENEFIT	✓	✓	500%	✓	✓	300%		✗
	CO-PAYMENT BENEFIT								
	ADMISSION AND PROCEDURE CO-PAYMENTS	✓	✓	✗	✓	✓	**R 7 500** per policy		✗
	DENTAL COVER								
	SPECIALIST SHORTFALLS	✓		Subject to **Gap Benefit**	✓		Subject to **Gap Benefit**		✗
	Dental procedures such as wisdom teeth extractions	✓		**R 30 000** per policy	✓		**R 30 000** per policy		✗
	Dental procedures due to accidental events or cancer treatment	✓		Subject to OPL of **R 226 880** per person	✓		Subject to OPL of **R 226 880** per person		✗
	ADMISSION AND PROCEDURE CO-PAYMENTS			✗	✓		Subject to **Admission and Procedure Co-Payment Benefit**		✗
	MATERNITY COVER								
	CHILDBIRTH SHORTFALLS	✓	✓	Subject to **Gap Benefit**	✓	✓	Subject to **Gap Benefit**		✗
	ADMISSION AND PROCEDURE CO-PAYMENTS			✗	✓		Subject to **Admission and Procedure Co-Payment Benefit**		✗
	RADIOLOGY COVER								
	RADIOLOGY SHORTFALLS	✓	✓	Subject to **Gap Benefit**	✓	✓	Subject to **Gap Benefit**		✗
	ADMISSION AND PROCEDURE CO-PAYMENTS			✗	✓	✓	Subject to **Admission and Procedure Co-Payment Benefit**		✗
	MRI AND CT SCAN SUB-LIMITS		✓	**R 2 200** per policy		✓	**R 2 200** per policy	✓	**R 2 200** per policy
	ACCESS BENEFIT	✓	✓	Covers the costs and expenses incurred for the medical procedures and treatments listed below when these aren't covered by your medical aid plan, subject to our benefit limits **per procedure**, **per person**.					
				R15 500 Adenoidectomy, myringotomy (grommets) or tonsillectomy					
				R72 500 Arthroscopic surgery					
				R72 500 Back or neck surgery					
				R20 500 Bunion surgery					
				R85 500 Cochlear implant, auditory brain implant and internal nerve stimulator surgery (incl. procedure, device, processor and hearing aids if part of a bimodal solution)					
				R20 500 Dental procedures for impacted teeth (children **younger** than **18**)					
				R85 500 Dental procedures for reconstructive surgery (due to an accident)					
				R10 500 Endoscopic procedures					
				R30 500 Functional nasal surgery					
				R60 500 Joint replacement surgery (incl. non-PMB joint replacements and internal prosthetic devices)					
				R30 500 Knee or shoulder surgery					
				R15 500 MRI or CT scan (due to an accident)					
				R25 500 Non-cancerous breast conditions (incl. breast reconstruction of an unaffected breast)					
				R60 500 Oesophageal reflux and hiatus hernia surgery					
				R25 500 Removal of varicose veins					
				R25 500 Skin disorders (incl. benign growths and lipomas)					
	CASUALTY BENEFITS								
	ACCIDENTAL EVENTS Individuals of all ages		✓	**R 4 400** per policy		✓	**R 4 400** per policy	✓	**R 4 400** per policy
	ACCIDENTAL EVENTS External medical items		✓	Subject to **Casualty Benefit**		✓	Subject to **Casualty Benefit**	✓	Subject to **Casualty Benefit**
	ACCIDENTAL EVENTS Follow-up visits		✓			✓		✓	
	ILLNESS EVENTS Children 12 years or younger		✓			✓		✓	
	BENEFITS NOT SUBJECT TO THE OPL								
	PAYOUT BENEFIT								
	ACCIDENTAL DEATH AND DISABILITY			**1 Event** per person **R 5 500** Principal Insured **R 5 500** Spouse			**1 Event** per person **R 5 500** Principal Insured **R 5 500** Spouse		**1 Event** per person **R 5 500** Principal Insured **R 5 500** Spouse
	LIFESTYLE BENEFIT								
	WELLNESS CARELINE			Telephonic and virtual counselling			Telephonic and virtual counselling		Telephonic and virtual counselling
	MONTHLY PREMIUMS *Premiums increase annually on 1 January*	Determined by factors like the employer group's size, average age and if cover is compulsory or voluntary.							



CORPORATE ELITE^{500}

Our **premier option**, available exclusively for **employer groups**, offers the widest range of **in-** and **out-of-hospital benefits** at our highest level of cover.

One **Gap Cover** policy covers you and your spouse, even if you belong to different medical aid plans, including the dependants registered on either medical aid plan.

Child dependants registered on your or your spouse's medical aid plan may remain on your **Gap Cover** policy regardless of age. However, when a child dependant applies for their own medical aid membership, they must apply for their own policy.

A full-time student **26** or **younger** may remain on your policy even if they belong to a different medical aid plan, provided proof of full-time studies is submitted annually. Distance and online learning don't qualify.

We cover **5** or **more employees** as an employer group if you join through your employer.

Ask your employer if your spouse and dependants may join. If your employer agrees, add them to your policy.

Premiums are determined by factors such as the size of the employer group, the average age, and whether cover is compulsory or voluntary.

ASK US FOR A CORPORATE QUOTE

BENEFITS SUBJECT TO AN OVERALL POLICY LIMIT (OPL)

*An **OPL** of **R 226 880 per insured person per year**, or any higher amount published by the Regulator during the year, applies to the following benefits. All approved claim amounts will be deducted from the available **OPL**.*

GAP BENEFIT

www.stratumbenefits.co.za/gap-benefit/

IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS

We cover the **shortfalls** when:

- the cost of your medical procedure performed in a day clinic, hospital, or your healthcare provider's room is more than your medical aid plan's rate,
- as long as your medical aid pays an amount from a **hospital benefit**, also known as a **risk**, **major medical**, **insured day-to-day** or **block benefit**.

WHAT WE COVER

We pay up to an **additional** 500% on top of your medical aid plan's rate to cover shortfalls on your doctors', specialists' and healthcare providers' accounts related to the following in- and out-of-hospital medical events:

- consumable items, such as catheters, medical gloves and syringes;
- medication administered during your medical event;
- medical procedures, surgeries and treatments;
- physiotherapy;
- pathology, such as blood, saliva and urine tests; and
- Prescribed Minimum Benefit (PMB) medical procedures.

Subject to the **OPL** of **R 226 880 per insured person per year**.

GOOD TO KNOW

- PMBs are specific benefits your medical aid must provide for a defined list of medical procedures. If your medical aid's qualifying criteria for PMBs aren't met, we'll assess the shortfalls when you incur out-of-pocket medical expenses.
- Look at **DENTAL**, **MATERNITY** and **RADIOLOGY COVER** to see what other shortfalls we cover.
- Allied healthcare providers aren't covered, except for clinical perfusionists, midwives, nurses, physiotherapists, and radiographers.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

CO-PAYMENT BENEFITS

There are **three benefit categories**.

ADMISSION AND PROCEDURE CO-PAYMENTS	PENALTY CO-PAYMENTS	ROBOTIC SURGERY CO-PAYMENTS
IN- AND OUT-OF-HOSPITAL COVER	IN-HOSPITAL COVER	IN-HOSPITAL COVER

HOW IT WORKS

We **refund** co-payments that your **medical aid imposes** as rand amounts or percentages for:

- admissions to network and non-network day clinics and hospitals and medical procedures, such as in- or out-of-hospital scopes and scans,
- as long as the co-payments are paid from your **medical savings account** or **pocket**.

WHAT WE COVER

ADMISSION AND PROCEDURE CO-PAYMENTS	PENALTY CO-PAYMENTS	ROBOTIC SURGERY CO-PAYMENTS
Claim as many admission and procedure-related co-payments as needed. Subject to the **OPL** of **R 226 880 per insured person per year**. Benefit limits apply to our PENALTY and ROBOTIC SURGERY CO-PAYMENT BENEFITS.	If your medical aid has a preferred network of day clinics, hospitals and healthcare providers you must use for planned medical procedures, you can claim the penalty co-payments when using non-network providers. Limited to **2 co-payments** up to **R 17 000 per co-payment per policy per year**.	When co-payments apply to robotic-assisted surgeries, such as prostatectomies, we'll refund the co-payments. Limited to **R 11 000 per policy per year**.

GOOD TO KNOW

- If your healthcare provider asks you to pay an amount before your medical event, it's called split billing. The upfront amount makes up the provider's private fee that doesn't reflect on the account submitted to your medical aid for payment. Ask your provider to submit a detailed account reflecting their private fee to your medical aid so we can assess any shortfalls under our **GAP BENEFIT**.
- Some medical aids require members to use specific provider networks for planned procedures such as hip and knee replacements, spinal surgery, and cataract surgery. These networks may include hospitals, clinics, specialists, and anaesthetists. If you use a non-network provider, your medical aid may apply a co-payment across all related accounts. You can claim these co-payments from us, though depending on how your medical aid processes them, they may fall under our **PENALTY CO-PAYMENT BENEFIT**. Staying in-network is the best way to avoid unnecessary out-of-pocket expenses.
- Look at **DENTAL**, **MATERNITY** and **RADIOLOGY COVER** to see what co-payments we cover for dentistry, childbirth and specialised radiology.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

DENTAL COVER

If you're booked into a day clinic or hospital for extractions, dental implants or oral surgery, our benefits can assist with the shortfalls and co-payments.

DENTAL COVER is made up of **various benefits** you can claim from.

SPECIALIST SHORTFALLS IN-HOSPITAL COVER	CO-PAYMENTS IN-HOSPITAL COVER
HOW IT WORKS	
We cover the **shortfalls** when: • the cost of your dental-related procedure performed in a day clinic or hospital is more than your medical aid plan's rate, • as long as your medical aid pays an amount from a **hospital benefit,** also known as a **risk** or **major medical benefit**.	We **refund** co-payments that your **medical aid imposes** as rand amounts or percentages for: • admissions to day clinics and hospitals and in-hospital dental-related procedures, • as long as the co-payments are paid from your **medical savings account** or **pocket**.
WHAT WE COVER	
We pay up to an **additional** 500% on top of your medical aid plan's rate to cover shortfalls on your dentists' and specialists' accounts related to the following in-hospital medical events: • dental procedures, such as dental implants and wisdom teeth extractions. Limited to **R 50 000 per policy per year**. • dental procedures due to accidental events or cancer treatment. Subject to the **OPL** of **R 226 880 per insured person per year**. Subject to our GAP BENEFIT.	Claim as many admission and dental procedure-related co-payments as needed. Subject to our ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT. Claim the penalty co-payments when using day clinics or hospitals outside your medical aid's preferred network. Subject to our PENALTY CO-PAYMENT BENEFIT.

GOOD TO KNOW

- If your healthcare provider asks you to pay an amount before your medical event, it's called split billing. The upfront amount makes up the provider's private fee that doesn't reflect on the account submitted to your medical aid for payment. Ask your provider to submit a detailed account reflecting their private fee to your medical aid so we can assess any shortfalls under our **GAP BENEFIT**.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

MATERNITY COVER

We offer cover from pre- to post-bump.

MATERNITY COVER is made up of **various benefits** you can claim from.

BEFORE THE DELIVERY	THE DELIVERY	AFTER THE DELIVERY
HOW IT WORKS AND WHAT WE COVER		
PRE-NATAL CONSULTATIONS OUT-OF-HOSPITAL COVER Claim the **shortfalls** between what: • healthcare professionals, such as your gynaecologist or obstetrician, charge for virtual or face-to-face consultations in their rooms and the rate your medical aid applies, • as long as your medical aid pays an amount from a **maternity** or **risk benefit**, or your **medical savings account**. Subject to our **OUT-PATIENT SPECIALIST CONSULTATION BENEFIT**. Ancillary tests or investigations typically done with consultations, such as urine tests and sonars, won't be covered.	**CHILDBIRTH SHORTFALLS** IN- AND OUT-OF-HOSPITAL COVER We cover the **shortfalls** when: • healthcare professionals, such as your gynaecologist, obstetrician or midwife, charge more than your medical aid plan's rate for delivering your baby in the hospital or at home, • as long as your medical aid pays an amount from a **hospital benefit**, also known as a **risk** or **major medical benefit**. Subject to our **GAP BENEFIT**.	**POST-NATAL CONSULTATIONS** OUT-OF-HOSPITAL COVER Claim the **shortfalls** between what: • healthcare professionals, such as your gynaecologist or the paediatrician, charge for virtual or face-to-face consultations in their rooms and the rate your medical aid applies, • as long as your medical aid pays an amount from a **risk** or **insured day-to-day benefit**, or your **medical savings account**. Subject to our **OUT-PATIENT SPECIALIST CONSULTATION BENEFIT**.
PREVENTATIVE PROCEDURES OUT-OF-HOSPITAL COVER Soon-to-be moms can get a flu vaccination in their second trimester if recommended by the healthcare professional. Claim the **shortfalls** of a flu vaccination and other preventative tests and procedures, such as a full blood count, when your medical aid pays part of the cost from a **risk**, **insured day-to-day** or **block benefit**, or the **total cost** when paid from your **medical savings account** or **pocket**, subject to our benefit limit. Subject to our **PREVENTATIVE CARE BENEFIT**.	**CO-PAYMENTS** IN-HOSPITAL COVER We **refund** co-payments that your **medical aid imposes** for elective caesareans as long as the co-payments are paid from your **medical savings account** or **pocket**. Subject to our **ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT**. Claim the penalty co-payments when using hospitals outside your medical aid's preferred network. Subject to our **PENALTY CO-PAYMENT BENEFIT**.	**IMMUNISATIONS AND BIRTH CONTROL** OUT-OF-HOSPITAL COVER We cover the **shortfalls** when your medical aid pays part of the cost of childhood immunisations and other preventative tests and procedures, such as your baby's flu vaccination from **7 months** or **older** or a contraceptive device implant from a **risk**, **insured day-to-day** or **block benefit**, or the **total cost** when paid from your **medical savings account** or **pocket**, subject to our benefit limit. Subject to our **PREVENTATIVE CARE BENEFIT**. Our **CASUALTY BENEFIT** covers your little one for after-hours medical treatment due to illness.

PRIVATE ROOM

IN-HOSPITAL COVER

Enjoy the comfort and privacy of a private room.

Claim the **shortfalls** when your medical aid pays part of the cost of a private hospital room from a **hospital** or **risk benefit**, or the **total cost** when your medical aid excludes it from cover, subject to our benefit limit.

We also cover the hospital's lodger fee if a loved one registered on your **Gap Cover** policy stays with you or the nursery fee if you're hospitalised after the delivery and need to nurse your baby.

Subject to our **PRIVATE ROOM BENEFIT**.

GOOD TO KNOW

- Send us a medical aid membership or birth certificate to add your newborn.
- Our **PRIVATE ROOM BENEFIT** isn't subject to the **Overall Policy Limit (OPL)** and is available over and above benefits that fall within the **OPL**.
- Unless we confirm otherwise, waiting periods apply and our **GAP** and **CO-PAYMENT BENEFITS** are subject to the **Limited Payout Benefit**. Refer to the **Waiting Periods** page.

SUB-LIMIT BENEFITS

Your medical aid plan might provide unlimited hospital cover, but if certain medical services or items are limited to a rand amount, it's called a sub-limit or annual limit.

There are **four benefit categories**.

COLONOSCOPIES, ENTEROSCOPIES AND GASTROSCOPIES	INTERNAL PROSTHETIC DEVICE SHORTFALLS	INTERNAL PROSTHETIC DEVICE TOP-UP	RENAL DIALYSIS TREATMENTS
IN- AND OUT-OF-HOSPITAL COVER	IN-HOSPITAL COVER	IN-HOSPITAL COVER	OUT-OF-HOSPITAL COVER
HOW IT WORKS			
When your medical aid pays part of the cost of a colonoscopy, enteroscopy, gastroscopy, internal prosthetic device or renal dialysis treatment, we'll cover the **difference** or **top up** your cover when your medical aid plan's internal prosthetic device benefit limit has been reached.			
WHAT WE COVER			
If you go for an in- or out-of-hospital colonoscopy, enteroscopy or gastroscopy: • we'll cover the **shortfall** on the anaesthetist's account when your medical aid pays an amount from a **sub-limit** or **annual limit**, or • the **difference** if your medical aid pays part of the cost of the scope from a **sub-limit** or **annual limit**. Limited to **R 7 000 per insured person per event**.	We'll cover the **difference** in the cost of any internal prosthetic device that replaces a body part, such as a hip joint, or improves a lost or reduced bodily function, such as a cardiac pacemaker, cochlear implant, or intraocular lenses when your medical aid pays part of the cost from a **sub-limit** or **annual limit**. Limited to **R 40 000 per insured person per event**.	Does your medical aid plan cover internal prosthetic devices up to a benefit limit? When your medical aid plan's benefit limit has been reached, we'll **top up** your cover and pay the **total cost** of any internal prosthetic device, up to our benefit limit. Limited to **R 10 000 per insured person per event**.	Claim the **difference** in the cost of renal dialysis treatments when your medical aid pays part of the cost from a **sub-limit** or **annual limit**. Limited to **R 30 000 per insured person per event**.
	External medical items aren't covered.		

GOOD TO KNOW
- Look at **RADIOLOGY COVER** to see what we cover for MRI, CT, and PET scans.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

PHYSICAL REHABILITATION TOP-UP BENEFIT

OUT-OF-HOSPITAL COVER

HOW IT WORKS

If your medical aid plan covers physical rehabilitation due to an accident up to a benefit limit or limits the number of days you may stay at a sub-acute or step-down facility, we'll **top up** your cover and pay the **total cost** of ongoing rehabilitation, up to our benefit limit, when your medical aid plan's benefit limit has been reached.

WHAT WE COVER

Claim the admission cost to a sub-acute or step-down facility and all the related healthcare providers' accounts for on-site treatment, subject to the physical rehabilitation treatment plan approved by your medical aid.

Limited to **R 10 000 per insured person per year**.

GOOD TO KNOW
- A sub-acute or step-down facility is a registered facility focusing on rehabilitation after physical injury due to an accident, where appropriately qualified and registered therapists provide treatment.
- Physical rehabilitation related to illness or ongoing rehabilitation after discharge isn't covered.
- You're covered from day one because this benefit isn't subject to any waiting periods.

CANCER BENEFITS

There are **three benefit categories**.

BREAST RECONSTRUCTION

IN-HOSPITAL COVER

HOW IT WORKS

We'll cover the costs and expenses incurred in reconstructing an **unaffected** breast, up to our benefit limit, if the surgery meets specific qualifying criteria.

Our benefit applies if:

- your medical aid plan excludes the reconstruction from cover;
- the cancer diagnosis of the affected breast is **Stage 2** or higher;
- a mastectomy of the affected and unaffected breasts and reconstruction of both breasts are done simultaneously, except when clinically motivated to be performed in different stages; and if
- it's the first breast reconstruction in your lifetime.

Our benefit doesn't apply to the:

- mastectomy of an unaffected breast; or to a
- second reconstruction of an affected or unaffected breast or any subsequent reconstruction procedure.

If you undergo a lumpectomy and reconstruction of an affected breast or a mastectomy and reconstruction of an affected or unaffected breast not excluded by your medical aid, our GAP BENEFIT can assist with the shortfalls when the cost of the procedure is more than your medical aid plan's rate.

WHAT WE COVER

We'll cover the costs and expenses incurred for breast implant reconstruction or flap breast reconstruction surgery that's not covered by your medical aid plan.

Limited to **1 event** up to **R 35 000 per insured person per lifetime**.

CANCER TREATMENT SHORTFALLS

IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS

We cover the **shortfalls** when your healthcare providers charge more than your medical aid plan's rate for in- or out-of-hospital cancer treatment, as long as your medical aid pays an amount from an **oncology benefit**.

WHAT WE COVER

The shortfalls we'll cover are subject to the oncology treatment plan approved by your medical aid.

Our benefit typically covers:

- biological medication;
- chemotherapy and radiotherapy;
- consultations with your oncologist; and
- specialised radiology, such as bone density and PET scans.

We'll also **refund** the oncology-related co-payments that your **medical aid imposes** as rand amounts or percentages when your medical aid plan's oncology benefit limit has been reached.

Subject to the **OPL** of **R 226 880 per insured person per year**.

CANCER TREATMENT TOP-UP

IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS

If your medical aid plan covers in- or out-of-hospital cancer treatment up to an oncology benefit limit, we'll **top up** your cover and pay the **total cost** of ongoing cancer treatment, up to the available **OPL**, when your medical aid plan's oncology benefit limit has been reached.

WHAT WE COVER

We'll cover the cost of your ongoing cancer treatment subject to the oncology treatment plan approved by your medical aid.

Subject to the **OPL** of **R 226 880 per insured person per year**.

GOOD TO KNOW

- Some medical aids impose co-payments from the start of treatment, often for precision or innovative oncology medication. These co-payments aren't covered, as our benefit only refunds co-payments that apply once your medical aid plan's oncology benefit limit has been reached.
- Look at our **FIRST-TIME CANCER DIAGNOSIS BENEFIT** to see what we cover for a cancer diagnosis.
- Unless we confirm otherwise, waiting periods apply. Refer to the **Waiting Periods** page.

RADIOLOGY COVER

What does your medical aid plan cover for basic and specialised radiology? Do upfront co-payments apply to in- or out-of-hospital MRI, CT, and PET scans, or a combined benefit limit for x-rays and scans? We've got the cover you need.

RADIOLOGY COVER is made up of **various benefits** you can claim from.

RADIOLOGY SHORTFALLS IN- AND OUT-OF-HOSPITAL COVER	MRI, CT AND PET SCAN CO-PAYMENTS IN- AND OUT-OF-HOSPITAL COVER	MRI, CT AND PET SCAN SUB-LIMITS IN- AND OUT-OF-HOSPITAL COVER	MRI, CT AND PET SCAN TOP-UP IN- AND OUT-OF-HOSPITAL COVER
HOW IT WORKS			
We cover the **shortfalls** when: • the radiologist or radiology facility charges more than your medical aid plan's rate for in- or out-of-hospital basic and specialised radiology, • as long as your medical aid pays an amount from a **hospital** or **insured day-to-day benefit,** also known as a **risk**, **major medical** or **block benefit**.	We **refund** co-payments that your **medical aid imposes** as rand amounts or percentages for in- or out-of-hospital MRI, CT, and PET scans, as long as the co-payments are paid from your **medical savings account** or **pocket**.	When your medical aid covers the cost of: • in- or out-of-hospital MRI, CT, or PET scans from a **sub-limit** or **annual limit**, • but the rand amount available under the **sub-limit** or **annual limit** doesn't cover the total cost, we'll cover the **difference**.	Does your medical aid plan cover in- or out-of-hospital MRI, CT, and PET scans up to a benefit limit? When your medical aid plan's radiology benefit has been reached, we'll **top up** your cover and pay the **total cost** of an in- or out-of-hospital MRI, CT, or PET scan up to our benefit limit.
WHAT WE COVER			
We pay up to an **additional** 500% on top of your medical aid plan's rate to cover shortfalls on basic and specialised radiology. Subject to our GAP BENEFIT.	Claim as many radiology-related co-payments as needed. Subject to our ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT.	Limited to **R 6 000 per insured person per event**.	Limited to **R 6 500 per policy per year**.

GOOD TO KNOW

- Unless we confirm otherwise, waiting periods apply and our **GAP**, **CO-PAYMENT** and **SUB-LIMIT BENEFITS** are subject to the **Limited Payout Benefit**. Refer to the **Waiting Periods** page.

OUT-PATIENT SPECIALIST CONSULTATION BENEFIT

www.stratumbenefits.co.za/out-patient-specialist-consultation-benefit/

OUT-OF-HOSPITAL COVER

HOW IT WORKS

Claim the **shortfalls** when:

- your specialists charge more than your medical aid plan's rate for virtual or face-to-face consultations in their rooms,
- as long as your medical aid pays part of the consultation fees from either a **risk benefit**, also known as an **insured day-to-day** or **block benefit**, or from your **medical savings account**.

There won't be shortfalls for us to cover if:

- your medical aid covers the consultation fees in full from a **risk benefit**, your **medical savings account**, or both, or
- you pay the consultation fees yourself without claiming from your medical aid. Remember, your medical aid must pay part of the fees from a **risk benefit** or your **medical savings account** for us to cover the shortfalls.

WHAT WE COVER

We'll cover the shortfalls between your medical aid plan's rate and the amounts your specialists charge.

Limited to **4 consultations** up to **R 1 300 per consultation per policy per year**.

GOOD TO KNOW

- This benefit doesn't refund consultation fees or any part of the fee paid by your medical aid from your medical savings account.
- Consultations with general practitioners or allied healthcare providers, such as biokineticists, chiropractors and physiotherapists, aren't covered.
- Ancillary tests or investigations typically done with consultations, such as urine tests and sonars, aren't covered.
- Routine, prophylactic (elective), or preventative procedures, such as annual check-ups and physical examinations, aren't covered.
- Unless we confirm otherwise, waiting periods apply. A **3 Month General Waiting Period** always applies, except when switching cover from another **Gap Cover** provider with a similar benefit. Refer to the **Waiting Periods** page.

CASUALTY BENEFITS

There are **three benefit categories**.

ACCIDENTAL EVENTS INDIVIDUALS OF ALL AGES OUT-OF-HOSPITAL COVER	ILLNESS EVENTS CHILDREN 12 YEARS OR YOUNGER OUT-OF-HOSPITAL COVER	ILLNESS EVENTS INDIVIDUALS 13 YEARS OR OLDER OUT-OF-HOSPITAL COVER
HOW IT WORKS		
Visit any registered medical facility **within 24 hours** of an accident, such as the doctor's room or emergency unit at the nearest hospital, when anyone in the family requires medical treatment for bodily injury.	Children **12 years** or **younger** are covered for after-hours illness-related events at any registered casualty facility between **19:00** and **7:00** Monday through Friday and all day Saturday, Sunday, and public holidays.	Individuals **13 years** or **older** are covered for after-hours illness-related events at any registered casualty facility between **19:00** and **7:00** Monday through Friday and all day Saturday, Sunday, and public holidays.
Limited to **R 16 000 per policy per year**.		Limited to **R 2 200 per policy per year**.

We'll cover the **shortfalls** when your medical aid pays part of the cost of a casualty event from a **risk**, **insured day-to-day** or **block benefit**, or **refund** the **total cost** when paid from your **medical savings account** or **pocket**, subject to our benefit limits.

WHAT WE COVER

We cover all the healthcare and service providers' accounts related to a casualty event, typically including:

- basic and specialised radiology and pathology;
- co-payments;
- facility and doctors' consultation fees;
- medication administered during an event;
- external medical items received at the medical facility, such as a neck brace or arm sling, limited to **R 2 200 per policy per year**, subject to the **R 16 000** benefit limit; and
- follow-up visits related to accidental events, such as having stitches or a cast removed, limited to **1 visit per insured person per event**, subject to the **R 16 000** benefit limit.

- basic and specialised radiology and pathology;
- co-payments;
- facility and doctors' consultation fees; and
- medication administered during an event.

GOOD TO KNOW

- If you're admitted to the hospital after being treated in the casualty or medical facility for an accidental-related event or in the casualty facility for an after-hours illness-related event, the admission becomes a new medical event, and claims will be assessed based on the hospital admission.
- Our benefit applies even if your medical aid doesn't cover casualty events.
- You're covered from day one because this benefit isn't subject to any waiting periods.

TRAUMA COUNSELLING BENEFIT

www.stratumbenefits.co.za/trauma-counselling-benefit/

When dealing with a traumatic event and wanting to see a counsellor, our benefit can assist with the costs.

OUT-OF-HOSPITAL COVER

HOW IT WORKS

We'll cover the **shortfalls** when your medical aid pays part of your registered counsellor's consultation fees from a **risk**, **insured day-to-day** or **block benefit**, or **refund** the **total cost** when paid from your **medical savings account** or **pocket**, subject to our benefit limit.

WHAT WE COVER

You're covered when you:

- witness an accident or act of physical violence;
- are directly affected by an accident or act of physical violence, for example, suffering bodily injury resulting in total and permanent disability;
- receive news of a loved one's or your own diagnosis of a critical illness; or
- mourn the death of a loved one.

Limited to **R 11 000 per policy per year**.

GOOD TO KNOW

- Trauma affects everyone at different times. We provide cover even if the traumatic event occurred before your cover start date.
- Our benefit applies even if your medical aid doesn't cover trauma counselling consultations.
- Read more about our **WELLNESS CARELINE** value-added product, which offers complimentary telephonic and virtual counselling to support better mental wellness.
- You're covered from day one because this benefit isn't subject to any waiting periods.

PREVENTATIVE CARE BENEFIT

OUT-OF-HOSPITAL COVER

HOW IT WORKS

You're covered for essential preventative and screening tests.

Claim the **shortfalls** when your medical aid pays part of your healthcare provider's consultation fee, preventative test or procedure from a **risk**, **insured day-to-day** or **block benefit**, or claim the **total cost**, up to our benefit limit, when paid from your **medical savings account** or **pocket**.

WHAT WE COVER

Our benefit covers the consultation fees and cost of the following immunisations, procedures, scans, screenings, tests and vaccinations:

- blood glucose tests;
- bone density scans;
- childhood immunisations;
- cholesterol tests;
- contraceptive device implants;
- flu vaccinations;
- full blood counts;
- Human Papillomavirus vaccinations (HPV vaccines);
- mammograms and breast sonars;
- pap smears;
- prostate-specific antigen screenings; and
- testicular screenings.

Limited to **R 2 200 per policy per year**.

GOOD TO KNOW

- Our benefit applies even if your medical aid doesn't cover preventative tests, screenings or procedures.
- Unless we confirm otherwise, a **General Waiting Period** applies. Refer to the **Waiting Periods** page.

BENEFITS NOT SUBJECT TO THE OVERALL POLICY LIMIT (OPL)

*Our PRIVATE ROOM, ACCIDENTAL DEATH AND DISABILITY, FIRST-TIME CANCER DIAGNOSIS, MEDICAL AID CONTRIBUTION WAIVER and STRATUM POLICY PREMIUM WAIVER BENEFITS aren't subject to the **OPL** and are available over and above benefits that fall within the **OPL**.*

PRIVATE ROOM BENEFIT

IN-HOSPITAL COVER

HOW IT WORKS

Claim the **shortfalls** when your medical aid pays part of the cost of a private hospital room from a **hospital** or **risk benefit,** or the **total cost**, up to our benefit limit when your medical aid excludes it from cover.

WHAT WE COVER

Our benefit applies when:

- you choose to stay in a private hospital room;
- the hospital charges a lodger fee when you stay with a loved one or a loved one stays with you, as long as they're registered on your **Gap Cover** policy; or
- a fee is charged when you're in hospital and need to nurse your baby.

Limited to **R 3 800 per policy per year**.

GOOD TO KNOW

- Unless we confirm otherwise, waiting periods apply. Refer to the **Waiting Periods** page.

PAYOUT BENEFITS

ACCIDENTAL DEATH AND DISABILITY

HOW IT WORKS

In the event of accidental death or total and permanent disability due to an accident, a benefit amount is payable on each insured person's life.

Our benefit compensates you for any current or future costs and expenses, including any potential loss of earnings.

The benefit amount that applies to:

- the principal insured is payable to the surviving spouse or the principal insured's estate if there's no surviving spouse.
- the spouse is payable to the principal insured or the spouse's estate if there's no surviving principal insured.
- any other dependant is payable to the principal insured or the principal insured's estate if there's no surviving principal insured.

In the event of the simultaneous death of the principal insured and spouse, the benefit amounts are payable to the principal insured's estate.

WHAT WE COVER

You and your spouse are covered for **R 25 500 per insured person**, and your dependants for **R 5 500 per insured person** if either one of you passes away or becomes totally and permanently disabled due to an accident.

Limited to **1 event per insured person per year**.

ACCIDENT...
means a sudden, unplanned and unexpected accidental event resulting in bodily injury caused by physical impact.

TOTAL AND PERMANENT DISABILITY...
means bodily injury resulting in complete and absolute disablement beyond hope of improvement, preventing an employed insured person from following their usual occupation or similar work for which they're suited by education or training.
If the insured person is an individual or pensioner who's not gainfully employed, total and permanent disability will mean the loss of both hands or feet, one hand and one foot, or the sight of both eyes.

GOOD TO KNOW

- You're covered from day one because this benefit isn't subject to any waiting periods.

FIRST-TIME CANCER DIAGNOSIS

www.stratumbenefits.co.za/first-time-cancer-diagnosis-benefit/

HOW IT WORKS

A benefit amount is payable on the first diagnosis of cancer if the diagnosis meets specific qualifying criteria.

Our benefit applies if:

- cancer is diagnosed for the first time in your life;
- the diagnosis is made whilst on cover with us;
- cancerous cells have invaded the surrounding or underlying tissue; and
- cancer is diagnosed **before** age **65**.

Our benefit doesn't apply if the diagnosis:

- was made before your cover start date;
- is made during a **General Waiting Period**;
- is a second diagnosis, regardless of the cancer type;
- is for a tumour histologically described as pre-malignant, non-invasive or cancer in situ;
- is for skin cancer, except for malignant melanoma;
- is for **Stage 1** breast or prostate cancer; or if
- cancerous cells haven't invaded the surrounding or underlying tissue, regardless of the cancer stage.

WHAT WE COVER

The benefit amount payable for a first-time cancer diagnosis is **R 30 000 per insured person per lifetime**.

GOOD TO KNOW

- We look at the following cancer stages when assessing a claim:
  - **Stage 1** usually means the cancer is small and contained within the organ it started in.
  - **Stage 2** usually means the tumour is larger than **Stage 1**, but the cancer hasn't started to spread into surrounding tissues. Sometimes **Stage 2** means cancer cells have spread into lymph nodes close to the tumour. This depends on the type of cancer.
  - **Stage 3** usually means the cancer is larger than **Stage 2**. It may have started to spread into surrounding tissues, and cancer cells in the lymph nodes are nearby.
  - **Stage 4** means cancer has spread from where it started to another body organ, such as the liver or lung. This is also called secondary or metastatic cancer.
- If you're diagnosed with **Stage 2** cancer that hasn't spread when the first diagnosis is made, our benefit doesn't apply.
- Unless we confirm otherwise, a **General Waiting Period** applies. Refer to the **Waiting Periods** page.

WAIVER BENEFITS

MEDICAL AID CONTRIBUTION WAIVER

HOW IT WORKS

In the event of the medical aid contribution payer's accidental death or total and permanent disability due to an accident, we'll step in and pay the monthly contributions.

If your employer pays your medical aid contributions on your behalf, the contributions must form part of your total salary package (cost to company).

WHAT WE COVER

We'll pay the contributions for the members registered on your membership at the time of the event for **6 months**, up to **R 4 500 per month per medical aid membership**.

GOOD TO KNOW

- A contribution payer is a person, registered company, or entity solely responsible for paying your contributions.
- If you change your medical aid plan when our benefit applies, we'll pay the medical aid contribution amount that applied before an upgrade.
- You're covered from day one because this benefit isn't subject to any waiting periods.

STRATUM POLICY PREMIUM WAIVER

HOW IT WORKS

In the event of the policy premium payer's accidental death or total and permanent disability due to an accident, we'll take over the premium payments.

If your employer pays your policy premiums on your behalf, the premiums must form part of your total salary package (cost to company).

WHAT WE COVER

We'll pay the policy premiums for the insured persons registered on your **Gap Cover** policy at the time of the event, limited to **12 months**.

GOOD TO KNOW

- A premium payer is a person, registered company, or entity solely responsible for paying your premiums.
- You're covered from day one because this benefit isn't subject to any waiting periods.

LIFESTYLE BENEFITS

Our LIFESTYLE BENEFITS are complimentary value-added products.

INTERNATIONAL TRAVEL INSURANCE

www.stratumbenefits.co.za/international-travel-insurance/

Cover is provided for emergency hospital treatment following an acute illness or accidental injury while travelling for leisure **outside South Africa.**

Limited to **1 trip per policy per year**, for up to **30 days per insured traveller**.

Please let us know of your upcoming trip at least **7 working days** before departure and send proof of travel.

Follow the link for more information on international travel insurance cover and how to register.

WELLNESS CARELINE

www.stratumbenefits.co.za/wellness-careline/

Through our partnership with **Reality Wellness Group**, you and your dependants have access to confidential counselling with registered counsellors and social workers, telephonically or virtually.

Support is available **24/7**, **365 days** a year, in all **11 official languages**.

Download the **Reality Wellness Group** Mobile App for expert resources, inspiring talks and practical wellbeing tools.

Visit our website for your **access code** to create your user profile.



BENEFIT AND GENERAL EXCLUSIONS

Each benefit has specific qualifying criteria and exclusions. Refer to the **Benefit & General Exclusions** page.



CORPORATE NOVA 500

Our **well-balanced in-hospital option**, available exclusively for **employer groups**, provides comprehensive protection against medical expense shortfalls **during hospital treatment**.

One **Gap Cover** policy covers you and your spouse, even if you belong to different medical aid plans, including the dependants registered on either medical aid plan.

Child dependants registered on your or your spouse's medical aid plan may remain on your **Gap Cover** policy regardless of age. However, when a child dependant applies for their own medical aid membership, they must apply for their own policy.

A full-time student **26** or **younger** may remain on your policy even if they belong to a different medical aid plan, provided proof of full-time studies is submitted annually. Distance and online learning don't qualify.

We cover **10** or **more employees** as an employer group if you join through your employer.

Ask your employer if your spouse and dependants may join. If your employer agrees, add them to your policy.

Premiums are determined by factors such as the size of the employer group, the average age, and whether cover is compulsory or voluntary.

ASK US FOR A CORPORATE QUOTE

BENEFITS SUBJECT TO AN OVERALL POLICY LIMIT (OPL)

*An **OPL** of **R 226 880 per insured person per year**, or any higher amount published by the Regulator during the year, applies to the following benefits. All approved claim amounts will be deducted from the available **OPL**.*

GAP BENEFIT

www.stratumbenefits.co.za/gap-benefit/

IN-HOSPITAL COVER

HOW IT WORKS

We cover the **shortfalls** when:
- the cost of your medical procedure performed in a day clinic or hospital is more than your medical aid plan's rate,
- as long as your medical aid pays an amount from a **hospital benefit**, also known as a **risk** or **major medical benefit**.

WHAT WE COVER

We pay up to an **additional** 500% on top of your medical aid plan's rate to cover shortfalls on your doctors', specialists' and healthcare providers' accounts related to the following in-hospital medical events:
- consumable items, such as catheters, medical gloves and syringes;
- medication administered during your medical event;
- medical procedures, surgeries and treatments;
- physiotherapy;
- pathology, such as blood, saliva and urine tests; and
- Prescribed Minimum Benefit (PMB) medical procedures.

Subject to the **OPL** of **R 226 880 per insured person per year**.

GOOD TO KNOW
- PMBs are specific benefits your medical aid must provide for a defined list of medical procedures. If your medical aid's qualifying criteria for PMBs aren't met, we'll assess the shortfalls when you incur out-of-pocket medical expenses.
- Look at **DENTAL**, **MATERNITY** and **RADIOLOGY COVER** to see what other shortfalls we cover.
- Allied healthcare providers aren't covered, except for clinical perfusionists, midwives, nurses, physiotherapists, and radiographers.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

CO-PAYMENT BENEFITS

There are **two benefit categories**.

ADMISSION AND PROCEDURE CO-PAYMENTS
IN-HOSPITAL COVER

HOW IT WORKS

We **refund** co-payments that your **medical aid imposes** as rand amounts or percentages for:
- admissions to network and non-network day clinics and hospitals and medical procedures, such as in-hospital scopes,
- as long as the co-payments are paid from your **medical savings account** or **pocket**.

WHAT WE COVER

Claim as many admission and procedure-related co-payments as needed.

Limited to **R 55 000 per policy per year**.

PENALTY CO-PAYMENTS
IN-HOSPITAL COVER

WHAT WE COVER

If your medical aid has a preferred network of day clinics, hospitals and healthcare providers you must use for planned medical procedures, you can claim the penalty co-payment when using a non-network provider.

Limited to **1 co-payment** up to **R 6 500 per policy per year**.

GOOD TO KNOW
- If your healthcare provider asks you to pay an amount before your medical event, it's called split billing. The upfront amount makes up the provider's private fee that doesn't reflect on the account submitted to your medical aid for payment. Ask your provider to submit a detailed account reflecting their private fee to your medical aid so we can assess any shortfalls under our **GAP BENEFIT**.
- Some medical aids require members to use specific provider networks for planned procedures such as hip and knee replacements, spinal surgery, and cataract surgery. These networks may include hospitals, clinics, specialists, and anaesthetists. If you use a non-network provider, your medical aid may apply a co-payment across all related accounts. You can claim these co-payments from us, though depending on how your medical aid processes them, they may fall under our **PENALTY CO-PAYMENT BENEFIT**. Staying in-network is the best way to avoid unnecessary out-of-pocket expenses.
- Look at **DENTAL**, **MATERNITY** and **RADIOLOGY COVER** to see what co-payments we cover for dentistry, childbirth, specialised radiology and scopes.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

DENTAL COVER

If you're booked into a day clinic or hospital for extractions, dental implants or oral surgery, our benefits can assist with the shortfalls and co-payments.

DENTAL COVER is made up of **various benefits** you can claim from.

SPECIALIST SHORTFALLS IN-HOSPITAL COVER	CO-PAYMENTS IN-HOSPITAL COVER
HOW IT WORKS	
We cover the **shortfalls** when: • the cost of your dental-related procedure performed in a day clinic or hospital is more than your medical aid plan's rate, • as long as your medical aid pays an amount from a **hospital benefit**, also known as a **risk** or **major medical benefit**.	We **refund** co-payments that your **medical aid imposes** as rand amounts or percentages for: • admissions to day clinics and hospitals and in-hospital dental-related procedures, • as long as the co-payments are paid from your **medical savings account** or **pocket**.
WHAT WE COVER	
We pay up to an **additional** 500% on top of your medical aid plan's rate to cover shortfalls on your dentists' and specialists' accounts related to the following in-hospital medical events: • dental procedures, such as dental implants and wisdom teeth extractions. Limited to **R 8 000 per policy per year**. • dental procedures due to accidental events or cancer treatment. Limited to **R 15 000 per policy per year**. Subject to our GAP BENEFIT.	Claim as many admission and dental procedure-related co-payments as needed. Subject to our ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT. Claim the penalty co-payment when using a day clinic or hospital outside your medical aid's preferred network. Subject to our PENALTY CO-PAYMENT BENEFIT.

GOOD TO KNOW

- If your healthcare provider asks you to pay an amount before your medical event, it's called split billing. The upfront amount makes up the provider's private fee that doesn't reflect on the account submitted to your medical aid for payment. Ask your provider to submit a detailed account reflecting their private fee to your medical aid so we can assess any shortfalls under our **GAP BENEFIT**.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

MATERNITY COVER

We cover the bump.

MATERNITY COVER is made up of **various benefits** you can claim from.

THE DELIVERY

CHILDBIRTH SHORTFALLS IN- AND OUT-OF-HOSPITAL COVER	CO-PAYMENTS IN-HOSPITAL COVER
HOW IT WORKS AND WHAT WE COVER	
We cover the **shortfalls** when: • healthcare professionals, such as your gynaecologist, obstetrician or midwife, charge more than your medical aid plan's rate for delivering your baby in the hospital or at home, • as long as your medical aid pays an amount from a **hospital benefit**, also known as a **risk** or **major medical benefit**. Subject to our GAP BENEFIT.	We **refund** co-payments that your **medical aid imposes** for elective caesareans as long as the co-payments are paid from your **medical savings account** or **pocket**. Subject to our ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT. Claim the penalty co-payment when using a hospital outside your medical aid's preferred network. Subject to our PENALTY CO-PAYMENT BENEFIT.

GOOD TO KNOW

- Send us a medical aid membership or birth certificate to add your newborn.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

SUB-LIMIT BENEFIT

Your medical aid plan might provide unlimited hospital cover, but if certain medical services or items are limited to a rand amount, it's called a sub-limit or annual limit.

INTERNAL PROSTHETIC DEVICES

IN-HOSPITAL COVER

HOW IT WORKS

When your medical aid pays part of the cost of an internal prosthetic device, we'll cover the **difference**.

WHAT WE COVER

We'll cover the **difference** in the cost of any internal prosthetic device that replaces a body part, such as a hip joint, or improves a lost or reduced bodily function, such as a cardiac pacemaker, cochlear implant, or intraocular lenses when your medical aid pays part of the cost from a **sub-limit** or **annual limit**.

Limited to **2 events** up to **R 22 000 per event per policy per year**.

GOOD TO KNOW

- External medical items aren't covered.
- Look at **RADIOLOGY COVER** to see what we cover for MRI, CT, and PET scans.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

RADIOLOGY COVER

What does your medical aid plan cover for basic and specialised radiology? Do upfront co-payments apply to in- or out-of-hospital MRI, CT, PET scans and scopes? We've got the cover you need.

RADIOLOGY COVER is made up of **various benefits** you can claim from.

RADIOLOGY SHORTFALLS IN-HOSPITAL COVER	MRI, CT, PET SCAN AND SCOPE CO-PAYMENTS IN-HOSPITAL COVER	MRI, CT, PET SCAN AND SCOPE CO-PAYMENTS OUT-OF-HOSPITAL COVER
HOW IT WORKS		
We cover the **shortfalls** when: • the radiologist or radiology facility charges more than your medical aid plan's rate for in-hospital basic and specialised radiology, • as long as your medical aid pays an amount from a **hospital benefit**, also known as a **risk** or **major medical benefit**.	We **refund** co-payments that your **medical aid imposes** as rand amounts or percentages for in-hospital MRI, CT, PET scans and scopes, as long as the co-payments are paid from your **medical savings account** or **pocket**.	We **refund** co-payments that your **medical aid imposes** as rand amounts or percentages for out-of-hospital MRI, CT, PET scans and scopes, as long as the co-payments are paid from your **medical savings account** or **pocket**.
WHAT WE COVER		
We pay up to an **additional** 500% on top of your medical aid plan's rate to cover shortfalls on basic and specialised radiology. Subject to our GAP BENEFIT.	Claim as many radiology- and scope-related co-payments as needed. Subject to our ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT.	Limited to **2 co-payments** up to **R 4 000 per co-payment per policy**.

GOOD TO KNOW

- Although scopes aren't classified as radiology, CORPORATE NOVA[500] offers a unique combined benefit for **in-** and **out-of-hospital scopes** and **scans**.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

CANCER BENEFIT

CANCER TREATMENT SHORTFALLS

IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS

We cover the **shortfalls** when your healthcare providers charge more than your medical aid plan's rate for in- or out-of-hospital cancer treatment, as long as your medical aid pays an amount from an **oncology benefit**.

WHAT WE COVER

The shortfalls we'll cover are subject to the oncology treatment plan approved by your medical aid.

Our benefit typically covers:

- biological medication;
- chemotherapy and radiotherapy;
- consultations with your oncologist; and
- specialised radiology, such as bone density and PET scans.

We'll also **refund** the oncology-related co-payments that your **medical aid imposes** as rand amounts or percentages when your medical aid plan's oncology benefit limit has been reached.

Subject to the **OPL** of **R 226 880 per insured person per year**.

GOOD TO KNOW

- Some medical aids impose co-payments from the start of treatment, often for precision or innovative oncology medication. These co-payments aren't covered, as our benefit only refunds co-payments that apply once your medical aid plan's oncology benefit limit has been reached.
- Unless we confirm otherwise, waiting periods apply. Refer to the **Waiting Periods** page.

CASUALTY BENEFIT

ACCIDENTAL EVENTS

OUT-OF-HOSPITAL COVER

HOW IT WORKS

Visit any registered medical facility **within 24 hours** of an accident, such as the doctor's room or emergency unit at the nearest hospital, when anyone in the family requires medical treatment for bodily injury.

We'll cover the **shortfalls** when your medical aid pays part of the cost of a casualty event from a **risk**, **insured day-to-day** or **block benefit**, or **refund** the **total cost** when paid from your **medical savings account** or **pocket**, subject to our benefit limit.

WHAT WE COVER

We cover all the healthcare and service providers' accounts related to a casualty event, typically including:

- basic and specialised radiology and pathology;
- co-payments;
- facility and doctors' consultation fees;
- medication administered during an event; and
- external medical items received at the medical facility, such as a neck brace or arm sling.

Limited to **2 events** up to **R 5 500 per policy per year**.

GOOD TO KNOW

- If you're admitted to the hospital after being treated in the casualty or medical facility for an accidental-related event, the admission becomes a new medical event, and claims will be assessed based on the hospital admission.
- Our benefit applies even if your medical aid doesn't cover casualty events.
- You're covered from day one because this benefit isn't subject to any waiting periods.

LIFESTYLE BENEFIT

Our LIFESTYLE BENEFIT is a complimentary value-added product.

WELLNESS CARELINE

www.stratumbenefits.co.za/wellness-careline/

Through our partnership with **Reality Wellness Group**, you and your dependants have access to confidential counselling with registered counsellors and social workers, telephonically or virtually.

Support is available **24/7**, **365 days** a year, in all **11 official languages**.

Download the **Reality Wellness Group** Mobile App for expert resources, inspiring talks and practical wellbeing tools.

Visit our website for your **access code** to create your user profile.



BENEFIT AND GENERAL EXCLUSIONS

Each benefit has specific qualifying criteria and exclusions. Refer to the **Benefit & General Exclusions** page.



CORPORATE MERIDIAN400

Our **core in-hospital option**, available exclusively for **employer groups**, focuses on the medical expense shortfalls most commonly experienced **during hospital treatment**.

One **Gap Cover** policy covers you and your spouse, even if you belong to different medical aid plans, including the dependants registered on either medical aid plan.

Child dependants registered on your or your spouse's medical aid plan may remain on your **Gap Cover** policy regardless of age. However, when a child dependant applies for their own medical aid membership, they must apply for their own policy.

A full-time student **26** or **younger** may remain on your policy even if they belong to a different medical aid plan, provided proof of full-time studies is submitted annually. Distance and online learning don't qualify.

We cover **5** or **more employees** as an employer group if you join through your employer.

Ask your employer if your spouse and dependants may join. If your employer agrees, add them to your policy.

Premiums are determined by factors such as the size of the employer group, the average age, and whether cover is compulsory or voluntary.

ASK US FOR A CORPORATE QUOTE

BENEFITS SUBJECT TO AN OVERALL POLICY LIMIT (OPL)

*An **OPL** of **R 226 880 per insured person per year**, or any higher amount published by the Regulator during the year, applies to the following benefits. All approved claim amounts will be deducted from the available **OPL**.*

GAP BENEFIT

www.stratumbenefits.co.za/gap-benefit/

IN-HOSPITAL COVER

HOW IT WORKS

We cover the **shortfalls** when:
- the cost of your medical procedure performed in a day clinic or hospital is more than your medical aid plan's rate,
- as long as your medical aid pays an amount from a **hospital benefit**, also known as a **risk** or **major medical benefit**.

WHAT WE COVER

We pay up to an **additional** 400% on top of your medical aid plan's rate to cover shortfalls on your doctors', specialists', and healthcare providers' accounts related to the following in-hospital medical events:
- consumable items, such as catheters, medical gloves and syringes;
- medication administered during your medical event;
- medical procedures, surgeries and treatments;
- physiotherapy;
- pathology, such as blood, saliva and urine tests; and
- Prescribed Minimum Benefit (PMB) medical procedures.

Subject to the **OPL** of **R 226 880 per insured person per year**.

GOOD TO KNOW
- PMBs are specific benefits your medical aid must provide for a defined list of medical procedures. If your medical aid's qualifying criteria for PMBs aren't met, we'll assess the shortfalls when you incur out-of-pocket medical expenses.
- Look at **DENTAL**, **MATERNITY** and **RADIOLOGY COVER** to see what other shortfalls we cover.
- Allied healthcare providers aren't covered, except for clinical perfusionists, midwives, nurses, physiotherapists, and radiographers.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

CO-PAYMENT BENEFITS

There are **three benefit categories**.

ADMISSION AND PROCEDURE CO-PAYMENTS	PENALTY CO-PAYMENT	SCOPE CO-PAYMENTS
IN-HOSPITAL COVER	IN-HOSPITAL COVER	OUT-OF-HOSPITAL COVER

HOW IT WORKS

We **refund** co-payments that your **medical aid imposes** as rand amounts or percentages for:
- admissions to network and non-network day clinics and hospitals and medical procedures, such as in- or out-of-hospital scopes,
- as long as the co-payments are paid from your **medical savings account** or **pocket**.

WHAT WE COVER

ADMISSION AND PROCEDURE CO-PAYMENTS	PENALTY CO-PAYMENT	SCOPE CO-PAYMENTS
Claim as many admission and procedure-related co-payments as needed. Subject to the **OPL** of **R 226 880 per insured person per year**. Benefit limits apply to our PENALTY and SCOPE CO-PAYMENT BENEFITS.	If your medical aid has a preferred network of day clinics, hospitals and healthcare providers you must use for planned medical procedures, you can claim the penalty co-payment when using a non-network provider. Limited to **1 co-payment** up to **R 11 500 per policy per year**.	Claim the co-payments that apply to out-of-hospital scopes, such as cystoscopies and gastroscopies. Limited to **2 co-payments** up to **R 4 000 per co-payment per policy per year.**

GOOD TO KNOW
- If your healthcare provider asks you to pay an amount before your medical event, it's called split billing. The upfront amount makes up the provider's private fee that doesn't reflect on the account submitted to your medical aid for payment. Ask your provider to submit a detailed account reflecting their private fee to your medical aid so we can assess any shortfalls under our **GAP BENEFIT**.
- Some medical aids require members to use specific provider networks for planned procedures such as hip and knee replacements, spinal surgery, and cataract surgery. These networks may include hospitals, clinics, specialists, and anaesthetists. If you use a non-network provider, your medical aid may apply a co-payment across all related accounts. You can claim these co-payments from us, though depending on how your medical aid processes them, they may fall under our **PENALTY CO-PAYMENT BENEFIT**. Staying in-network is the best way to avoid unnecessary out-of-pocket expenses.
- Look at **DENTAL**, **MATERNITY** and **RADIOLOGY COVER** to see what co-payments we cover for dentistry, childbirth and specialised radiology.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

DENTAL COVER

If you're booked into a day clinic or hospital for extractions, dental implants or oral surgery, our benefits can assist with the shortfalls and co-payments.

DENTAL COVER is made up of **various benefits** you can claim from.

SPECIALIST SHORTFALLS
IN-HOSPITAL COVER

HOW IT WORKS

We cover the **shortfalls** when:
- the cost of your dental-related procedure performed in a day clinic or hospital is more than your medical aid plan's rate,
- as long as your medical aid pays an amount from a **hospital benefit,** also known as a **risk** or **major medical benefit**.

WHAT WE COVER

We pay up to an **additional** 400% on top of your medical aid plan's rate to cover shortfalls on your dentists' and specialists' accounts related to the following in-hospital medical events:
- dental procedures, such as dental implants and wisdom teeth extractions.

  Limited to **R 10 000 per policy per year**.
- dental procedures due to accidental events or cancer treatment.

  Limited to **R 28 000 per policy per year**.

Subject to our GAP BENEFIT.

CO-PAYMENTS
IN-HOSPITAL COVER

HOW IT WORKS

We **refund** co-payments that your **medical aid imposes** as rand amounts or percentages for:
- admissions to day clinics and hospitals and in-hospital dental-related procedures,
- as long as the co-payments are paid from your **medical savings account** or **pocket**.

WHAT WE COVER

Claim as many admission and dental procedure-related co-payments as needed.

Subject to our ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT.

Claim the penalty co-payment when using a day clinic or hospital outside your medical aid's preferred network.

Subject to our PENALTY CO-PAYMENT BENEFIT.

GOOD TO KNOW
- If your healthcare provider asks you to pay an amount before your medical event, it's called split billing. The upfront amount makes up the provider's private fee that doesn't reflect on the account submitted to your medical aid for payment. Ask your provider to submit a detailed account reflecting their private fee to your medical aid so we can assess any shortfalls under our **GAP BENEFIT**.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

SUB-LIMIT BENEFIT

Your medical aid plan might provide unlimited hospital cover, but if certain medical services or items are limited to a rand amount, it's called a sub-limit or annual limit.

INTERNAL PROSTHETIC DEVICES
IN-HOSPITAL COVER

HOW IT WORKS

When your medical aid pays part of the cost of an internal prosthetic device, we'll cover the **difference**.

WHAT WE COVER

We'll cover the **difference** in the cost of any internal prosthetic device that replaces a body part, such as a hip joint, or improves a lost or reduced bodily function, such as a cardiac pacemaker, cochlear implant, or intraocular lenses when your medical aid pays part of the cost from a **sub-limit** or **annual limit**.

Limited to **2 events** up to **R 20 000 per event per policy per year**.

GOOD TO KNOW
- External medical items aren't covered.
- Look at **RADIOLOGY COVER** to see what we cover for MRI, CT, and PET scans.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

MATERNITY COVER

We offer cover from pre- to post-bump.

MATERNITY COVER is made up of **various benefits** you can claim from.

THE DELIVERY

CHILDBIRTH SHORTFALLS IN- AND OUT-OF-HOSPITAL COVER	CO-PAYMENTS IN-HOSPITAL COVER
HOW IT WORKS AND WHAT WE COVER	
We cover the **shortfalls** when: • healthcare professionals, such as your gynaecologist, obstetrician or midwife, charge more than your medical aid plan's rate for delivering your baby in the hospital or at home, • as long as your medical aid pays an amount from a **hospital benefit**, also known as a **risk** or **major medical benefit**. Subject to our GAP BENEFIT..	We **refund** co-payments that your **medical aid imposes** for elective caesareans as long as the co-payments are paid from your **medical savings account** or **pocket.** Subject to our ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT. Claim the penalty co-payment when using a hospital outside your medical aid's preferred network. Subject to our PENALTY CO-PAYMENT BENEFIT.

BEFORE AND AFTER THE DELIVERY | PREVENTATIVE PROCEDURES, IMMUNISATIONS AND BIRTH CONTROL

Claim the **shortfalls** of the cost of a recommended flu vaccination in your second trimester, as well as other preventative tests and procedures such as a full blood count, childhood immunisations, your baby's flu vaccination from **7 months**, or a contraceptive device implant when your medical aid pays part of the cost from a **risk**, **insured day-to-day** or **block benefit**, or the **total cost** when paid from your **medical savings account** or **pocket**, subject to our benefit limit.

Subject to our PREVENTATIVE CARE BENEFIT.

GOOD TO KNOW
- Send us a medical aid membership or birth certificate to add your newborn.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

RADIOLOGY COVER

What does your medical aid plan cover for basic and specialised radiology? Do upfront co-payments apply to in- and out-of-hospital MRI, CT, and PET scans, or a combined benefit limit for x-rays and scans? We've got the cover you need.

RADIOLOGY COVER is made up of **various benefits** you can claim from.

RADIOLOGY SHORTFALLS IN-HOSPITAL COVER	MRI, CT AND PET SCAN CO-PAYMENTS IN-HOSPITAL COVER	MRI, CT AND PET SCAN CO-PAYMENTS OUT-OF-HOSPITAL COVER	MRI, CT AND PET SCAN SUB-LIMITS IN- AND OUT-OF-HOSPITAL COVER
HOW IT WORKS			
We cover the **shortfalls** when: • the radiologist or radiology facility charges more than your medical aid plan's rate for in-hospital basic and specialised radiology, • as long as your medical aid pays an amount from a **hospital benefit,** also known as a **risk** or **major medical benefit**.	We **refund** co-payments that your **medical aid imposes** as rand amounts or percentages for in-hospital MRI, CT, and PET scans, as long as the co-payments are paid from your **medical savings account** or **pocket**.	We **refund** co-payments that your **medical aid imposes** as rand amounts or percentages for out-of-hospital MRI, CT, and PET scans, as long as the co-payments are paid from your **medical savings account** or **pocket**.	When your medical aid covers the cost of: • in- or out-of-hospital MRI, CT, or PET scans from a **sub-limit** or **annual limit**, • but the rand amount available under the **sub-limit** or **annual limit** doesn't cover the total cost, we'll cover the **difference**.
WHAT WE COVER			
We pay up to an **additional** 400% on top of your medical aid plan's rate to cover shortfalls on basic and specialised radiology. Subject to our GAP BENEFIT.	Claim as many radiology-related co-payments as needed. Subject to our ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT.	Limited to **2 co-payments** up to **R 4 000 per co-payment per policy per year**.	Limited to **R 5 000 per insured person per event**.

GOOD TO KNOW
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

CANCER BENEFITS

There are **two benefit categories**.

CANCER TREATMENT SHORTFALLS
IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS

We cover the **shortfalls** when your healthcare providers charge more than your medical aid plan's rate for in- or out-of-hospital cancer treatment, as long as your medical aid pays an amount from an **oncology benefit**.

WHAT WE COVER

The shortfalls we'll cover are subject to the oncology treatment plan approved by your medical aid.

Our benefit typically covers:

- biological medication;
- chemotherapy and radiotherapy;
- consultations with your oncologist; and
- specialised radiology, such as bone density and PET scans.

We'll also **refund** the oncology-related co-payments that your **medical aid imposes** as rand amounts or percentages when your medical aid plan's oncology benefit limit has been reached.

Limited to **R 55 000 per insured person per year**.

CANCER TREATMENT TOP-UP
IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS

If your medical aid plan covers in- or out-of-hospital cancer treatment up to an oncology benefit limit, we'll **top up** your cover and pay the **total cost** of ongoing cancer treatment, up to our benefit limit, when your medical aid plan's oncology benefit limit has been reached.

WHAT WE COVER

We'll cover the cost of your ongoing cancer treatment subject to the oncology treatment plan approved by your medical aid.

Limited to **R 55 000 per insured person per year**.

GOOD TO KNOW

- Some medical aids impose co-payments from the start of treatment, often for precision or innovative oncology medication. These co-payments aren't covered, as our benefit only refunds co-payments that apply once your medical aid plan's oncology benefit limit has been reached.
- Unless we confirm otherwise, waiting periods apply. Refer to the **Waiting Periods** page.

CASUALTY BENEFITS

There are **two benefit categories**.

ACCIDENTAL EVENTS
INDIVIDUALS OF ALL AGES
OUT-OF-HOSPITAL COVER

HOW IT WORKS

Visit any registered medical facility **within 24 hours** of an accident, such as the doctor's room or emergency unit at the nearest hospital, when anyone in the family requires medical treatment for bodily injury.

WHAT WE COVER

We cover all the healthcare and service providers' accounts related to a casualty event, typically including:

- basic and specialised radiology and pathology;
- co-payments;
- facility and doctors' consultation fees;
- medication administered during an event; and
- external medical items received at the medical facility, such as a neck brace or arm sling, limited to **2 events** up to **R 1 100 per insured person per event**, subject to the **R 10 000** benefit limit.

Limited to **R 10 000 per insured person per event**.

ILLNESS EVENTS
INDIVIDUALS OF ALL AGES
OUT-OF-HOSPITAL COVER

HOW IT WORKS

We cover the whole family for after-hours illness-related events at any registered casualty facility between **19:00** and **7:00** Monday through Friday and all day Saturday, Sunday, and public holidays.

We'll cover the **shortfalls** when your medical aid pays part of the cost of a casualty event from a **risk**, **insured day-to-day** or **block benefit**, or **refund** the **total cost** when paid from your **medical savings account** or **pocket**, subject to our benefit limits.

WHAT WE COVER

- basic and specialised radiology and pathology;
- co-payments;
- facility and doctors' consultation fees; and
- medication administered during an event.

Limited to **2 events** up to **R 3 300 per event per policy per year**.

GOOD TO KNOW

- If you're admitted to the hospital after being treated in the casualty or medical facility for an accidental-related event or in the casualty facility for an after-hours illness-related event, the admission becomes a new medical event, and claims will be assessed based on the hospital admission.
- Our benefit applies even if your medical aid doesn't cover casualty events.
- You're covered from day one because this benefit isn't subject to any waiting periods.

TRAUMA COUNSELLING BENEFIT

www.stratumbenefits.co.za/trauma-counselling-benefit/

When dealing with a traumatic event and wanting to see a counsellor, our benefit can assist with the costs.

OUT-OF-HOSPITAL COVER

HOW IT WORKS

We'll cover the **shortfalls** when your medical aid pays part of your registered counsellor's consultation fees from a **risk**, **insured day-to-day** or **block benefit**, or **refund** the **total cost** when paid from your **medical savings account** or **pocket**, subject to our benefit limit.

WHAT WE COVER

You're covered when you:

- witness an accident or act of physical violence;
- are directly affected by an accident or act of physical violence, for example, suffering bodily injury resulting in total and permanent disability;
- receive news of a loved one's or your own diagnosis of a critical illness; or
- mourn the death of a loved one.

Limited to **3 consultations** up to **R 2 200 per consultation per policy per year**.

GOOD TO KNOW

- Trauma affects everyone at different times. We provide cover even if the traumatic event occurred before your cover start date.
- Our benefit applies even if your medical aid doesn't cover trauma counselling consultations.
- Read more about our **WELLNESS CARELINE** value-added product, which offers complimentary telephonic and virtual counselling to support better mental wellness.
- You're covered from day one because this benefit isn't subject to any waiting periods.

PREVENTATIVE CARE BENEFIT

OUT-OF-HOSPITAL COVER

HOW IT WORKS

You're covered for essential preventative and screening tests.

Claim the **shortfalls** when your medical aid pays part of your healthcare provider's consultation fee, preventative test or procedure from a **risk**, **insured day-to-day** or **block benefit**, or claim the **total cost**, up to our benefit limit, when paid from your **medical savings account** or **pocket**.

WHAT WE COVER

Our benefit covers the consultation fees and cost of the following immunisations, procedures, scans, screenings, tests and vaccinations:

- blood glucose tests;
- bone density scans;
- childhood immunisations;
- cholesterol tests;
- contraceptive device implants;
- flu vaccinations;
- full blood counts;
- Human Papillomavirus vaccinations (HPV vaccines);
- mammograms and breast sonars;
- pap smears;
- prostate-specific antigen screenings; and
- testicular screenings.

Limited to **2 events** up to **R 550 per event per policy per year**.

GOOD TO KNOW

- Our benefit applies even if your medical aid doesn't cover preventative tests, screenings or procedures.
- Unless we confirm otherwise, a **General Waiting Period** applies. Refer to the **Waiting Periods** page.

LIFESTYLE BENEFIT

Our LIFESTYLE BENEFIT is a complimentary value-added product.

WELLNESS CARELINE

www.stratumbenefits.co.za/wellness-careline/

Through our partnership with **Reality Wellness Group**, you and your dependants have access to confidential counselling with registered counsellors and social workers, telephonically or virtually.

Support is available **24/7**, **365 days** a year, in all **11 official languages**.

Download the **Reality Wellness Group** Mobile App for expert resources, inspiring talks and practical wellbeing tools.

Visit our website for your **access code** to create your user profile.



BENEFIT AND GENERAL EXCLUSIONS

Each benefit has specific qualifying criteria and exclusions. Refer to the **Benefit & General Exclusions** page.



CORPORATE COMPACT300

Our **well-rounded option**, available exclusively for **employer groups**, covers many of the most common **in-** and **out-of-hospital** medical expense shortfalls.

One **Gap Cover** policy covers you and your spouse, even if you belong to different medical aid plans, including the dependants registered on either medical aid plan.

Child dependants registered on your or your spouse's medical aid plan may remain on your **Gap Cover** policy regardless of age. However, when a child dependant applies for their own medical aid membership, they must apply for their own policy.

A full-time student **26** or **younger** may remain on your policy even if they belong to a different medical aid plan, provided proof of full-time studies is submitted annually. Distance and online learning don't qualify.

We cover **5** or **more employees** as an employer group if you join through your employer.

Ask your employer if your spouse and dependants may join. If your employer agrees, add them to your policy.

Premiums are determined by factors such as the size of the employer group, the average age, and whether cover is compulsory or voluntary.

ASK US FOR A CORPORATE QUOTE

BENEFITS SUBJECT TO AN OVERALL POLICY LIMIT (OPL)

*An **OPL** of **R 226 880 per insured person per year**, or any higher amount published by the Regulator during the year, applies to the following benefits. All approved claim amounts will be deducted from the available **OPL**.*

GAP BENEFIT

www.stratumbenefits.co.za/gap-benefit/

IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS

We cover the **shortfalls** when:

- the cost of your medical procedure performed in a day clinic, hospital, or your healthcare provider's room is more than your medical aid plan's rate,
- as long as your medical aid pays an amount from a **hospital benefit**, also known as a **risk**, **major medical**, **insured day-to-day** or **block benefit**.

WHAT WE COVER

We pay up to an **additional 300%** on top of your medical aid plan's rate to cover shortfalls on your doctors', specialists' and healthcare providers' accounts related to the following in- and out-of-hospital medical events:

- consumable items, such as catheters, medical gloves and syringes;
- medication administered during your medical event;
- medical procedures, surgeries and treatments;
- physiotherapy;
- pathology, such as blood, saliva and urine tests; and
- Prescribed Minimum Benefit (PMB) medical procedures.

Subject to the **OPL** of **R 226 880 per insured person per year**.

GOOD TO KNOW

- PMBs are specific benefits your medical aid must provide for a defined list of medical procedures. If your medical aid's qualifying criteria for PMBs aren't met, we'll assess the shortfalls when you incur out-of-pocket medical expenses.
- Look at **DENTAL**, **MATERNITY** and **RADIOLOGY COVER** to see what other shortfalls we cover.
- Allied healthcare providers aren't covered, except for clinical perfusionists, midwives, nurses, physiotherapists, and radiographers.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

CO-PAYMENT BENEFITS

There are **two benefit categories**.

ADMISSION AND PROCEDURE CO-PAYMENTS

IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS

We **refund** co-payments that your **medical aid imposes** as rand amounts or percentages for:

- admissions to network and non-network day clinics and hospitals and medical procedures, such as in- or out-of-hospital scopes and scans,
- as long as the co-payments are paid from your **medical savings account** or **pocket**.

WHAT WE COVER

Claim as many admission and procedure-related co-payments as needed.

Limited to **R 22 000 per policy per year**.

PENALTY CO-PAYMENTS

IN-HOSPITAL COVER

WHAT WE COVER

If your medical aid has a preferred network of day clinics, hospitals and healthcare providers you must use for planned medical procedures, you can claim the penalty co-payments when using non-network providers.

Limited to **R 13 000 per policy per year**.

GOOD TO KNOW

- If your healthcare provider asks you to pay an amount before your medical event, it's called split billing. The upfront amount makes up the provider's private fee that doesn't reflect on the account submitted to your medical aid for payment. Ask your provider to submit a detailed account reflecting their private fee to your medical aid so we can assess any shortfalls under our **GAP BENEFIT**.
- Some medical aids require members to use specific provider networks for planned procedures such as hip and knee replacements, spinal surgery, and cataract surgery. These networks may include hospitals, clinics, specialists, and anaesthetists. If you use a non-network provider, your medical aid may apply a co-payment across all related accounts. You can claim these co-payments from us, though depending on how your medical aid processes them, they may fall under our **PENALTY CO-PAYMENT BENEFIT**. Staying in-network is the best way to avoid unnecessary out-of-pocket expenses.
- Look at **DENTAL**, **MATERNITY** and **RADIOLOGY COVER** to see what co-payments we cover for dentistry, childbirth and specialised radiology.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

DENTAL COVER

If you're booked into a day clinic or hospital for extractions, dental implants or oral surgery, our benefits can assist with the shortfalls and co-payments.

DENTAL COVER is made up of **various benefits** you can claim from.

SPECIALIST SHORTFALLS IN-HOSPITAL COVER	CO-PAYMENTS IN-HOSPITAL COVER
HOW IT WORKS	
We cover the **shortfalls** when: • the cost of your dental-related procedure performed in a day clinic or hospital is more than your medical aid plan's rate, • as long as your medical aid pays an amount from a **hospital benefit,** also known as a **risk** or **major medical benefit**.	We **refund** co-payments that your **medical aid imposes** as rand amounts or percentages for: • admissions to day clinics and hospitals and in-hospital dental-related procedures, • as long as the co-payments are paid from your **medical savings account** or **pocket**.
WHAT WE COVER	
We pay up to an **additional 300%** on top of your medical aid plan's rate to cover shortfalls on your dentists' and specialists' accounts related to the following in-hospital medical events: • dental procedures, such as dental implants and wisdom teeth extractions. Limited to **R 30 000 per policy per year**. • dental procedures due to accidental events or cancer treatment. Subject to the **OPL** of **R 226 880 per insured person per year**. Subject to our **GAP BENEFIT**.	Claim as many admission and dental procedure-related co-payments as needed. Subject to our **ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT**. Claim the penalty co-payments when using day clinics or hospitals outside your medical aid's preferred network. Subject to our **PENALTY CO-PAYMENT BENEFIT**.

GOOD TO KNOW

- If your healthcare provider asks you to pay an amount before your medical event, it's called split billing. The upfront amount makes up the provider's private fee that doesn't reflect on the account submitted to your medical aid for payment. Ask your provider to submit a detailed account reflecting their private fee to your medical aid so we can assess any shortfalls under our **GAP BENEFIT**.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

MATERNITY COVER

We cover the bump.

MATERNITY COVER is made up of **various benefits** you can claim from.

THE DELIVERY

CHILDBIRTH SHORTFALLS IN- AND OUT-OF-HOSPITAL COVER	CO-PAYMENTS IN-HOSPITAL COVER
HOW IT WORKS AND WHAT WE COVER	
We cover the **shortfalls** when: • healthcare professionals, such as your gynaecologist, obstetrician or midwife, charge more than your medical aid plan's rate for delivering your baby in the hospital or at home, • as long as your medical aid pays an amount from a **hospital benefit**, also known as a **risk** or **major medical benefit**. Subject to our **GAP BENEFIT**.	We **refund** co-payments that your **medical aid imposes** for elective caesareans as long as the co-payments are paid from your **medical savings account** or **pocket**. Subject to our **ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT**. Claim the penalty co-payments when using hospitals outside your medical aid's preferred network. Subject to our **PENALTY CO-PAYMENT BENEFIT**.

GOOD TO KNOW

- Send us a medical aid membership or birth certificate to add your newborn.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

SUB-LIMIT BENEFIT

Your medical aid plan might provide unlimited hospital cover, but if certain medical services or items are limited to a rand amount, it's called a sub-limit or annual limit.

INTERNAL PROSTHETIC DEVICES

IN-HOSPITAL COVER

HOW IT WORKS

When your medical aid pays part of the cost of an internal prosthetic device, we'll cover the **difference**.

WHAT WE COVER

We'll cover the **difference** in the cost of any internal prosthetic device that replaces a body part, such as a hip joint, or improves a lost or reduced bodily function, such as a cardiac pacemaker, cochlear implant, or intraocular lenses when your medical aid pays part of the cost from a **sub-limit** or **annual limit**.

Limited to **R 32 000 per insured person per event**.

GOOD TO KNOW
- External medical items aren't covered.
- Look at **RADIOLOGY COVER** to see what we cover for MRI, CT, and PET scans.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

RADIOLOGY COVER

What does your medical aid plan cover for basic and specialised radiology? Do upfront co-payments apply to in- or out-of-hospital MRI, CT, and PET scans, or a combined benefit limit for x-rays and scans? We've got the cover you need.

RADIOLOGY COVER is made up of **various benefits** you can claim from.

RADIOLOGY SHORTFALLS IN- AND OUT-OF-HOSPITAL COVER	MRI, CT AND PET SCAN CO-PAYMENTS IN- AND OUT-OF-HOSPITAL COVER	MRI, CT AND PET SCAN SUB-LIMITS IN- AND OUT-OF-HOSPITAL COVER	MRI, CT AND PET SCAN TOP-UP IN- AND OUT-OF-HOSPITAL COVER
HOW IT WORKS			
We cover the **shortfalls** when: • the radiologist or radiology facility charges more than your medical aid plan's rate for in- or out-of-hospital basic and specialised radiology, • as long as your medical aid pays an amount from a **hospital** or **insured day-to-day benefit**, also known as a **risk**, **major medical** or **block benefit**.	We **refund** co-payments that your **medical aid imposes** as rand amounts or percentages for in- or out-of-hospital MRI, CT, and PET scans, as long as the co-payments are paid from your **medical savings account** or **pocket**.	When your medical aid covers the cost of: • in- or out-of-hospital MRI, CT, or PET scans from a **sub-limit** or **annual limit**, • but the rand amount available under the **sub-limit** or **annual limit** doesn't cover the total cost, we'll cover the **difference**.	Does your medical aid plan cover in- or out-of-hospital MRI, CT, and PET scans up to a benefit limit? When your medical aid plan's radiology benefit has been reached, we'll **top up** your cover and pay the **total cost** of an in- or out-of-hospital MRI, CT, or PET scan up to our benefit limit.
WHAT WE COVER			
We pay up to an **additional 300%** on top of your medical aid plan's rate to cover shortfalls on basic and specialised radiology. Subject to our **GAP BENEFIT**.	Claim as many radiology-related co-payments as needed. Subject to our **ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT**.	Limited to **R 4 400 per insured person per event**.	Limited to **R 4 000 per policy per year**.

GOOD TO KNOW
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

CANCER BENEFITS

There are **two benefit categories**.

CANCER TREATMENT SHORTFALLS
IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS

We cover the **shortfalls** when your healthcare providers charge more than your medical aid plan's rate for in- or out-of-hospital cancer treatment, as long as your medical aid pays an amount from an **oncology benefit**.

WHAT WE COVER

The shortfalls we'll cover are subject to the oncology treatment plan approved by your medical aid.

Our benefit typically covers:

- biological medication;
- chemotherapy and radiotherapy;
- consultations with your oncologist; and
- specialised radiology, such as bone density and PET scans

We'll also **refund** the oncology-related co-payments that your **medical aid imposes** as rand amounts or percentages when your medical aid plan's oncology benefit limit has been reached.

Subject to the **OPL** of **R 226 880 per insured person per year**.

CANCER TREATMENT TOP-UP
IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS

If your medical aid plan covers in- or out-of-hospital cancer treatment up to an oncology benefit limit, we'll **top up** your cover and pay the **total cost** of ongoing cancer treatment, up to our benefit limit, when your medical aid plan's oncology benefit limit has been reached.

WHAT WE COVER

We'll cover the cost of your ongoing cancer treatment subject to the oncology treatment plan approved by your medical aid.

Limited to **R 65 000 per insured person per year**.

GOOD TO KNOW

- Some medical aids impose co-payments from the start of treatment, often for precision or innovative oncology medication. These co-payments aren't covered, as our benefit only refunds co-payments that apply once your medical aid plan's oncology benefit limit has been reached.
- Unless we confirm otherwise, waiting periods apply. Refer to the **Waiting Periods** page.

CASUALTY BENEFITS

There are **two benefit categories**.

ACCIDENTAL EVENTS
INDIVIDUALS OF ALL AGES
OUT-OF-HOSPITAL COVER

HOW IT WORKS

Visit any registered medical facility **within 24 hours** of an accident, such as the doctor's room or emergency unit at the nearest hospital, when anyone in the family requires medical treatment for bodily injury.

WHAT WE COVER

We cover all the healthcare and service providers' accounts related to a casualty event, typically including:

- basic and specialised radiology and pathology;
- co-payments;
- facility and doctors' consultation fees;
- medication administered during an event;
- external medical items received at the medical facility, such as a neck brace or arm sling, limited to **R 1 100 per policy per year**, subject to the **R 6 500** benefit limit; and
- follow-up visits related to accidental events, such as having stitches or a cast removed, limited to **1 visit per insured person per event**, subject to the **R 6 500** benefit limit.

ILLNESS EVENTS
CHILDREN 12 YEARS OR YOUNGER
OUT-OF-HOSPITAL COVER

HOW IT WORKS

Children **12 years** or **younger** are covered for after-hours illness-related events at any registered casualty facility between **19:00** and **7:00** Monday through Friday and all day Saturday, Sunday, and public holidays.

We'll cover the **shortfalls** when your medical aid pays part of the cost of a casualty event from a **risk**, **insured day-to-day** or **block benefit**, or **refund** the **total cost** when paid from your **medical savings account** or **pocket**, subject to our benefit limit.

WHAT WE COVER

- basic and specialised radiology and pathology;
- co-payments;
- facility and doctors' consultation fees; and
- medication administered during an event.

Limited to **R 6 500 per policy per year**.

GOOD TO KNOW

- If you're admitted to the hospital after being treated in the casualty or medical facility for an accidental-related event, or your child is admitted after being treated in the casualty facility for an after-hours illness-related event, the admission becomes a new medical event, and claims will be assessed based on the hospital admission.
- Our benefit applies even if your medical aid doesn't cover casualty events.
- You're covered from day one because this benefit isn't subject to any waiting periods.

TRAUMA COUNSELLING BENEFIT

www.stratumbenefits.co.za/trauma-counselling-benefit/

When dealing with a traumatic event and wanting to see a counsellor, our benefit can assist with the costs.

OUT-OF-HOSPITAL COVER

HOW IT WORKS

We'll cover the **shortfalls** when your medical aid pays part of your registered counsellor's consultation fees from a **risk**, **insured day-to-day** or **block benefit**, or **refund** the **total cost** when paid from your **medical savings account** or **pocket**, subject to our benefit limit.

WHAT WE COVER

You're covered when you:

- witness an accident or act of physical violence;
- are directly affected by an accident or act of physical violence, for example, suffering bodily injury resulting in total and permanent disability;
- receive news of a loved one's or your own diagnosis of a critical illness; or
- mourn the death of a loved one.

Limited to **R 5 500 per policy per year**.

GOOD TO KNOW

- Trauma affects everyone at different times. We provide cover even if the traumatic event occurred before your cover start date.
- Our benefit applies even if your medical aid doesn't cover trauma counselling consultations.
- Read more about our **WELLNESS CARELINE** value-added product, which offers complimentary telephonic and virtual counselling to support better mental wellness.
- You're covered from day one because this benefit isn't subject to any waiting periods.

BENEFITS NOT SUBJECT TO THE OVERALL POLICY LIMIT (OPL)

*Our **ACCIDENTAL DEATH AND DISABILITY** and **FIRST-TIME CANCER DIAGNOSIS PAYOUT BENEFITS** aren't subject to the **OPL** and are available over and above benefits that fall within the **OPL**.*

PAYOUT BENEFITS

ACCIDENTAL DEATH AND DISABILITY

HOW IT WORKS

In the event of accidental death or total and permanent disability due to an accident, a benefit amount is payable on each insured person's life.

Our benefit compensates you for any current or future costs and expenses, including any potential loss of earnings.

The benefit amount that applies to:

- the principal insured is payable to the surviving spouse or the principal insured's estate if there's no surviving spouse.
- the spouse is payable to the principal insured or the spouse's estate if there's no surviving principal insured.
- any other dependant is payable to the principal insured or the principal insured's estate if there's no surviving principal insured.

In the event of the simultaneous death of the principal insured and spouse, the benefit amounts are payable to the principal insured's estate.

WHAT WE COVER

You and your spouse are covered for **R 15 500 per insured person**, and your dependants for **R 5 500 per insured person** if either one of you passes away or becomes totally and permanently disabled due to an accident.

Limited to **1 event per insured person per year**.

ACCIDENT...
means a sudden, unplanned and unexpected accidental event resulting in bodily injury caused by physical impact.

TOTAL AND PERMANENT DISABILITY...
means bodily injury resulting in complete and absolute disablement beyond hope of improvement, preventing an employed insured person from following their usual occupation or similar work for which they're suited by education or training.
If the insured person is an individual or pensioner who's not gainfully employed, total and permanent disability will mean the loss of both hands or feet, one hand and one foot, or the sight of both eyes.

GOOD TO KNOW

- You're covered from day one because this benefit isn't subject to any waiting periods.

FIRST-TIME CANCER DIAGNOSIS

www.stratumbenefits.co.za/first-time-cancer-diagnosis-benefit/

HOW IT WORKS

A benefit amount is payable on the first diagnosis of cancer if the diagnosis meets specific qualifying criteria.

Our benefit applies if:

- cancer is diagnosed for the first time in your life;
- the diagnosis is made whilst on cover with us;
- cancerous cells have invaded the surrounding or underlying tissue; and
- cancer is diagnosed **before** age **65**.

Our benefit doesn't apply if the diagnosis:

- was made before your cover start date;
- is made during a **General Waiting Period**;
- is a second diagnosis, regardless of the cancer type;
- is for a tumour histologically described as pre-malignant, non-invasive or cancer in situ;
- is for skin cancer, except for malignant melanoma;
- is for **Stage 1** breast or prostate cancer; or if
- cancerous cells haven't invaded the surrounding or underlying tissue, regardless of the cancer stage.

WHAT WE COVER

The benefit amount payable for a first-time cancer diagnosis is **R 15 000 per insured person per lifetime**.

GOOD TO KNOW

- We look at the following cancer stages when assessing a claim:
  - **Stage 1** usually means the cancer is small and contained within the organ it started in.
  - **Stage 2** usually means the tumour is larger than **Stage 1**, but the cancer hasn't started to spread into surrounding tissues. Sometimes **Stage 2** means cancer cells have spread into lymph nodes close to the tumour. This depends on the type of cancer.
  - **Stage 3** usually means the cancer is larger than **Stage 2**. It may have started to spread into surrounding tissues, and cancer cells in the lymph nodes are nearby.
  - **Stage 4** means cancer has spread from where it started to another body organ, such as the liver or lung. This is also called secondary or metastatic cancer.
- If you're diagnosed with **Stage 2** cancer that hasn't spread when the first diagnosis is made, our benefit doesn't apply.
- Unless we confirm otherwise, a **General Waiting Period** applies. Refer to the **Waiting Periods** page.

LIFESTYLE BENEFIT

Our LIFESTYLE BENEFIT is a complimentary value-added product.

WELLNESS CARELINE

www.stratumbenefits.co.za/wellness-careline/



Through our partnership with **Reality Wellness Group**, you and your dependants have access to confidential counselling with registered counsellors and social workers, telephonically or virtually.

Support is available **24**/**7**, **365 days** a year, in all **11 official languages**.

Download the **Reality Wellness Group** Mobile App for expert resources, inspiring talks and practical wellbeing tools.

Visit our website for your **access code** to create your user profile.

BENEFIT AND GENERAL EXCLUSIONS

Each benefit has specific qualifying criteria and exclusions. Refer to the **Benefit & General Exclusions** page.



CORPORATE
ACCESS PLUS^{500}

Our **enhanced booster option**, available exclusively for **employer groups**, covers selected procedures, treatments, scans and surgeries that certain medical aid plans exclude, while also protecting against common **in-** and **out-of-hospital** medical expense shortfalls on procedures they do cover.

One **Gap Cover** policy covers you and your spouse, even if you belong to different medical aid plans, including the dependants registered on either medical aid plan.

Child dependants registered on your or your spouse's medical aid plan may remain on your **Gap Cover** policy regardless of age. However, when a child dependant applies for their own medical aid membership, they must apply for their own policy.

A full-time student **26** or **younger** may remain on your policy even if they belong to a different medical aid plan, provided proof of full-time studies is submitted annually. Distance and online learning don't qualify.

We cover **5** or **more employees** as an employer group if you join through your employer.

Ask your employer if your spouse and dependants may join. If your employer agrees, add them to your policy.

Premiums are determined by factors such as the size of the employer group, the average age, and whether cover is compulsory or voluntary.

ASK US FOR A CORPORATE QUOTE

BENEFITS SUBJECT TO AN OVERALL POLICY LIMIT (OPL)

*An **OPL** of **R 226 880 per insured person per year**, or any higher amount published by the Regulator during the year, applies to the following benefits. All approved claim amounts will be deducted from the available **OPL**.*



ACCESS BENEFIT

IN- AND OUT-OF-HOSPITAL COVER

Claim the cost of any medical procedure, treatment, scan or surgery listed below if your medical aid plan excludes it.

HOW IT WORKS

Our benefit helps with the cost of a planned medical procedure if:

- your medical aid plan excludes it from cover, or
- your plan only covers Prescribed Minimum Benefit (PMB) medical procedures, and your procedure isn't listed as a PMB.

PMBs are specific benefits your medical aid must provide for a defined list of medical procedures.

To claim, send us cost estimates from all your chosen providers, such as the hospital or day clinic, surgeon, and anaesthetist, along with a completed claim form.

We'll review the quotes. If approved, we'll issue a guarantee of payment to your providers as an undertaking to pay them directly after your procedure.

After your procedure, submit the final invoices. We'll settle them in the order received, up to the procedure benefit limit. Any costs above the limit will be for your pocket.

WHAT WE COVER

We'll cover the costs and expenses incurred for the medical procedures and treatments listed below when these aren't covered by your medical aid plan, subject to our benefit limits **per procedure**, **per insured person per year**.

LISTED MEDICAL PROCEDURES AND TREATMENTS	ACCESS BENEFIT
Adenoidectomy, myringotomy (grommets) or tonsillectomy	**R 15 500**
Arthroscopic surgery	**R 72 500**
Back or neck surgery	**R 72 500**
Bunion surgery	**R 20 500**
Cochlear implant, auditory brain implant and internal nerve stimulator surgery (including the procedure, device, processor and hearing aids if part of a bimodal solution)	**R 85 500**
Dental procedures for impacted teeth for children **younger** than **18**	**R 20 500**
Dental procedures for reconstructive surgery required due to an accident	**R 85 500**
Endoscopic procedures	**R 10 500**
Functional nasal surgery	**R 30 500**
Joint replacement surgery (including non-PMB joint replacements and internal prosthetic devices)	**R 60 500**
Knee or shoulder surgery	**R 30 500**
MRI or CT scan required due to an accident	**R 15 500**
Non-cancerous breast conditions (including breast reconstruction of an unaffected breast)	**R 25 500**
Oesophageal reflux and hiatus hernia surgery	**R 60 500**
Removal of varicose veins	**R 25 500**
Skin disorders (including benign growths and lipomas)	**R 25 500**

GOOD TO KNOW

- Unless we confirm otherwise, waiting periods apply. Refer to the **Waiting Periods** page.

CORPORATE ACCESS PLUS[500] is ideal if your medical aid plan excludes any of the medical procedures or treatments listed above and covers doctors' and specialists' private fees at 100%, 200%, or 300% of the medical aid rate.

GAP BENEFIT

www.stratumbenefits.co.za/gap-benefit/

IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS

Our **ACCESS BENEFIT** helps pay for the costs and expenses incurred for specific medical procedures, treatments, scans and surgeries that aren't covered by your medical aid plan or are only covered as Prescribed Minimum Benefit (PMB) medical procedures.

Our **GAP BENEFIT** covers the shortfalls on medical procedures, treatments, scans, and surgeries not excluded by your medical aid plan.

We cover the **shortfalls** when:

- the cost of your medical procedure performed in a day clinic, hospital, or your healthcare provider's room is more than your medical aid plan's rate,
- as long as your medical aid pays an amount from a **hospital benefit,** also known as a **risk**, **major medical**, **insured day-to-day** or **block benefit**.

WHAT WE COVER

We pay up to an **additional 500%** on top of your medical aid plan's rate to cover shortfalls on your doctors', specialists' and healthcare providers' accounts related to the following in- and out-of-hospital medical events:

- consumable items, such as catheters, medical gloves and syringes;
- medication administered during your medical event;
- medical procedures, surgeries and treatments;
- physiotherapy;
- pathology, such as blood, saliva and urine tests; and
- Prescribed Minimum Benefit (PMB) medical procedures.

Subject to the **OPL** of **R 226 880 per insured person per year**.

GOOD TO KNOW

- PMBs are specific benefits your medical aid must provide for a defined list of medical procedures. If your medical aid's qualifying criteria for PMBs aren't met, we'll assess the shortfalls when you incur out-of-pocket medical expenses.
- Look at **DENTAL**, **MATERNITY** and **RADIOLOGY COVER** to see what other shortfalls we cover.
- Allied healthcare providers aren't covered, except for clinical perfusionists, midwives, nurses, physiotherapists, and radiographers.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

DENTAL COVER

If you're booked into a day clinic or hospital for extractions, dental implants or oral surgery, our benefit can assist with the shortfalls.

SPECIALIST SHORTFALLS

IN-HOSPITAL COVER

HOW IT WORKS

We cover the **shortfalls** when:

- the cost of your dental-related procedure performed in a day clinic or hospital is more than your medical aid plan's rate,
- as long as your medical aid pays an amount from a **hospital benefit**, also known as a **risk** or **major medical benefit**.

WHAT WE COVER

We pay up to an **additional 500%** on top of your medical aid plan's rate to cover shortfalls on your dentists' and specialists' accounts related to the following in-hospital medical events:

- dental procedures, such as dental implants and wisdom teeth extractions.

  Limited to **R 30 000 per policy per year**.
- dental procedures due to accidental events or cancer treatment.

  Subject to the **OPL** of **R 226 880 per insured person per year**.

Subject to our **GAP BENEFIT**.

GOOD TO KNOW

- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

MATERNITY COVER

We cover the bump.

THE DELIVERY

CHILDBIRTH SHORTFALLS

IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS AND WHAT WE COVER

We cover the **shortfalls** when:

- healthcare professionals, such as your gynaecologist, obstetrician or midwife, charge more than your medical aid plan's rate for delivering your baby in the hospital or at home,
- as long as your medical aid pays an amount from a **hospital benefit**, also known as a **risk** or **major medical benefit**.

Subject to our GAP BENEFIT.

GOOD TO KNOW

- Send us a medical aid membership certificate or birth certificate to add your newborn.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

RADIOLOGY COVER

What does your medical aid plan cover for specialised radiology? Does a combined benefit limit apply to MRI and CT scans? We've got the cover you need.

RADIOLOGY COVER is made up of **various benefits** you can claim from.

RADIOLOGY SHORTFALLS

IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS

We cover the **shortfalls** when:

- the radiologist or radiology facility charges more than your medical aid plan's rate for in- or out-of-hospital basic and specialised radiology,
- as long as your medical aid pays an amount from a **hospital** or **insured day-to-day benefit**, also known as a **risk**, **major medical** or **block benefit**.

WHAT WE COVER

We pay up to an **additional** 500% on top of your medical aid plan's rate to cover shortfalls on basic and specialised radiology.

Subject to our GAP BENEFIT.

MRI AND CT SCAN SUB-LIMITS

OUT-OF-HOSPITAL COVER

HOW IT WORKS

When your medical aid covers the cost of:

- out-of-hospital MRI or CT scans from a **sub-limit** or **annual limit**,
- but the rand amount available under the **sub-limit** or **annual limit** doesn't cover the total cost, we'll cover the **difference**.

WHAT WE COVER

Limited to **R 2 200 per policy per year**.

GOOD TO KNOW

- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

LIFESTYLE BENEFIT

Our LIFESTYLE BENEFIT is a complimentary value-added product.

WELLNESS CARELINE www.stratumbenefits.co.za/wellness-careline/

Through our partnership with **Reality Wellness Group**, you and your dependants have access to confidential counselling with registered counsellors and social workers, telephonically or virtually.

Support is available **24/7**, **365 days** a year, in all **11 official languages**.

Download the **Reality Wellness Group** Mobile App for expert resources, inspiring talks and practical wellbeing tools.

Visit our website for your **access code** to create your user profile.



BENEFIT AND GENERAL EXCLUSIONS

Each benefit has specific qualifying criteria and exclusions. Refer to the **Benefit & General Exclusions** page.

CASUALTY BENEFITS

There are **two benefit categories**.

ACCIDENTAL EVENTS INDIVIDUALS OF ALL AGES OUT-OF-HOSPITAL COVER	ILLNESS EVENTS CHILDREN 12 YEARS OR YOUNGER OUT-OF-HOSPITAL COVER

HOW IT WORKS

Visit any registered medical facility **within 24 hours** of an accident, such as the doctor's room or emergency unit at the nearest hospital, when anyone in the family requires medical treatment for bodily injury.	Children **12 years** or **younger** are covered for after-hours illness-related events at any registered casualty facility between **19:00** and **7:00** Monday through Friday and all day Saturday, Sunday, and public holidays.

We'll cover the **shortfalls** when your medical aid pays part of the cost of a casualty event from a **risk**, **insured day-to-day** or **block benefit**, or **refund** the **total cost** when paid from your **medical savings account** or **pocket**, subject to our benefit limit.

WHAT WE COVER

We cover all the healthcare and service providers' accounts related to a casualty event, typically including:

- basic and specialised radiology and pathology;
- co-payments;
- facility and doctors' consultation fees;
- medication administered during an event;
- external medical items received at the medical facility, such as a neck brace or arm sling; and
- follow-up visits related to accidental events, such as having stitches or a cast removed.

- basic and specialised radiology and pathology;
- co-payments;
- facility and doctors' consultation fees; and
- medication administered during an event.

Limited to **R 4 400 per policy per year**.

GOOD TO KNOW

- If you're admitted to the hospital after being treated in the casualty or medical facility for an accidental-related event, or your child is admitted after being treated in the casualty facility for an after-hours illness-related event, the admission becomes a new medical event, and claims will be assessed based on the hospital admission.
- Our benefit applies even if your medical aid doesn't cover casualty events.
- You're covered from day one because this benefit isn't subject to any waiting periods.

BENEFIT NOT SUBJECT TO THE OVERALL POLICY LIMIT (OPL)

*The following benefit isn't subject to the **OPL** and is available over and above benefits that fall within the **OPL**.*

PAYOUT BENEFIT

ACCIDENTAL DEATH AND DISABILITY

HOW IT WORKS

In the event of accidental death or total and permanent disability due to an accident, a benefit amount is payable on each insured person's life.

Our benefit compensates you for any current or future costs and expenses, including any potential loss of earnings.

The benefit amount that applies to:

- the principal insured is payable to the surviving spouse or the principal insured's estate if there's no surviving spouse.
- the spouse is payable to the principal insured or the spouse's estate if there's no surviving principal insured.

In the event of the simultaneous death of the principal insured and spouse, the benefit amounts are payable to the principal insured's estate.

WHAT WE COVER

You and your spouse are covered for **R 5 500 per insured person** if either one of you passes away or becomes totally and permanently disabled due to an accident.

Limited to **1 event per insured person per year**.

ACCIDENT...
means a sudden, unplanned and unexpected accidental event resulting in bodily injury caused by physical impact.

TOTAL AND PERMANENT DISABILITY...
means bodily injury resulting in complete and absolute disablement beyond hope of improvement, preventing an employed insured person from following their usual occupation or similar work for which they're suited by education or training.
If the insured person is an individual or pensioner who's not gainfully employed, total and permanent disability will mean the loss of both hands or feet, one hand and one foot, or the sight of both eyes.

GOOD TO KNOW

- You're covered from day one because this benefit isn't subject to any waiting periods.



CORPORATE ACCESS CO-PAY PLUS^{300}

Our **comprehensive booster option**, available exclusively for **employer groups**, covers selected procedures, treatments, scans and surgeries that some medical aid plans exclude. It also covers common **in-** and **out-of-hospital** medical expense shortfalls for medical procedures that aren't excluded, and refunds co-payments.

One **Gap Cover** policy covers you and your spouse, even if you belong to different medical aid plans, including the dependants registered on either medical aid plan.

Child dependants registered on your or your spouse's medical aid plan may remain on your **Gap Cover** policy regardless of age. However, when a child dependant applies for their own medical aid membership, they must apply for their own policy.

A full-time student **26** or **younger** may remain on your policy even if they belong to a different medical aid plan, provided proof of full-time studies is submitted annually. Distance and online learning don't qualify.

We cover **5** or **more employees** as an employer group if you join through your employer.

Ask your employer if your spouse and dependants may join. If your employer agrees, add them to your policy.

Premiums are determined by factors such as the size of the employer group, the average age, and whether cover is compulsory or voluntary.

ASK US FOR A CORPORATE QUOTE

BENEFITS SUBJECT TO AN OVERALL POLICY LIMIT (OPL)

*An **OPL** of **R 226 880 per insured person per year**, or any higher amount published by the Regulator during the year, applies to the following benefits. All approved claim amounts will be deducted from the available **OPL**.*

ACCESS BENEFIT

Claim the cost of any medical procedure, treatment, scan or surgery listed below if your medical aid plan excludes it.

IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS

Our benefit helps with the cost of a planned medical procedure if:

- your medical aid plan excludes it from cover, or
- your plan only covers Prescribed Minimum Benefit (PMB) medical procedures, and your procedure isn't listed as a PMB.

PMBs are specific benefits your medical aid must provide for a defined list of medical procedures.

To claim, send us cost estimates from all your chosen providers, such as the hospital or day clinic, surgeon, and anaesthetist, along with a completed claim form.

We'll review the quotes. If approved, we'll issue a guarantee of payment to your providers as an undertaking to pay them directly after your procedure.

After your procedure, submit the final invoices. We'll settle them in the order received, up to the procedure benefit limit. Any costs above the limit will be for your pocket.

WHAT WE COVER

We'll cover the costs and expenses incurred for the medical procedures and treatments listed below when these aren't covered by your medical aid plan, subject to our benefit limits **per procedure**, **per insured person per year**.

LISTED MEDICAL PROCEDURES AND TREATMENTS	ACCESS BENEFIT
Adenoidectomy, myringotomy (grommets) or tonsillectomy	**R 15 500**
Arthroscopic surgery	**R 72 500**
Back or neck surgery	**R 72 500**
Bunion surgery	**R 20 500**
Cochlear implant, auditory brain implant and internal nerve stimulator surgery (including the procedure, device, processor and hearing aids if part of a bimodal solution)	**R 85 500**
Dental procedures for impacted teeth for children **younger** than **18**	**R 20 500**
Dental procedures for reconstructive surgery required due to an accident	**R 85 500**
Endoscopic procedures	**R 10 500**
Functional nasal surgery	**R 30 500**
Joint replacement surgery (including non-PMB joint replacements and internal prosthetic devices)	**R 60 500**
Knee or shoulder surgery	**R 30 500**
MRI or CT scan required due to an accident	**R 15 500**
Non-cancerous breast conditions (including breast reconstruction of an unaffected breast)	**R 25 500**
Oesophageal reflux and hiatus hernia surgery	**R 60 500**
Removal of varicose veins	**R 25 500**
Skin disorders (including benign growths and lipomas)	**R 25 500**

GOOD TO KNOW

- Unless we confirm otherwise, waiting periods apply. Refer to the **Waiting Periods** page.

CORPORATE ACCESS CO-PAY PLUS300 is ideal if your medical aid plan excludes any of the medical procedures or treatments listed above, covers doctors' and specialists' private fees at 100%, 200%, or 300% of the medical aid rate, and imposes procedure-related co-payments.

GAP BENEFIT

www.stratumbenefits.co.za/gap-benefit/

IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS

Our **ACCESS BENEFIT** helps pay for the costs and expenses incurred for specific medical procedures, treatments, scans and surgeries that aren't covered by your medical aid plan or are only covered as Prescribed Minimum Benefit (PMB) medical procedures.

Our **GAP BENEFIT** covers the shortfalls on medical procedures, treatments, scans, and surgeries not excluded by your medical aid plan.

We cover the **shortfalls** when:

- the cost of your medical procedure performed in a day clinic, hospital, or your healthcare provider's room is more than your medical aid plan's rate,
- as long as your medical aid pays an amount from a **hospital benefit,** also known as a **risk**, **major medical**, **insured day-to-day** or **block benefit**.

WHAT WE COVER

We pay up to an **additional 300%** on top of your medical aid plan's rate to cover shortfalls on your doctors', specialists' and healthcare providers' accounts related to the following in- and out-of-hospital medical events:

- consumable items, such as catheters, medical gloves and syringes;
- medication administered during your medical event;
- medical procedures, surgeries and treatments;
- physiotherapy;
- pathology, such as blood, saliva and urine tests; and
- Prescribed Minimum Benefit (PMB) medical procedures.

Subject to the **OPL** of **R 226 880 per insured person per year**.

GOOD TO KNOW

- PMBs are specific benefits your medical aid must provide for a defined list of medical procedures. If your medical aid's qualifying criteria for PMBs aren't met, we'll assess the shortfalls when you incur out-of-pocket medical expenses.
- Look at **DENTAL**, **MATERNITY** and **RADIOLOGY COVER** to see what other shortfalls we cover.
- Allied healthcare providers aren't covered, except for clinical perfusionists, midwives, nurses, physiotherapists, and radiographers.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

CO-PAYMENT BENEFIT

ADMISSION AND PROCEDURE CO-PAYMENTS

IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS

We **refund** co-payments that your **medical aid imposes** as rand amounts or percentages for:

- admissions to day clinics and hospitals and medical procedures, such as in- or out-of-hospital scopes and scans,
- as long as the co-payments are paid from your **medical savings account** or **pocket**.

WHAT WE COVER

Claim admission and procedure-related co-payments.

Limited to **R 7 500 per policy per year**.

GOOD TO KNOW

- If your healthcare provider asks you to pay an amount before your medical event, it's called split billing. The upfront amount makes up the provider's private fee that doesn't reflect on the account submitted to your medical aid for payment. Ask your provider to submit a detailed account reflecting their private fee to your medical aid so we can assess any shortfalls under our **GAP BENEFIT**.
- Look at **DENTAL**, **MATERNITY** and **RADIOLOGY COVER** to see what co-payments we cover for dentistry, childbirth and specialised radiology.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

DENTAL COVER

If you're booked into a day clinic or hospital for extractions, dental implants or oral surgery, our benefits can assist with the shortfalls and co-payments.

DENTAL COVER is made up of **various benefits** you can claim from.

SPECIALIST SHORTFALLS IN-HOSPITAL COVER	CO-PAYMENTS IN-HOSPITAL COVER
HOW IT WORKS	
We cover the **shortfalls** when: • the cost of your dental-related procedure performed in a day clinic or hospital is more than your medical aid plan's rate, • as long as your medical aid pays an amount from a **hospital benefit**, also known as a **risk** or **major medical benefit**.	We **refund** co-payments that your **medical aid imposes** as rand amounts or percentages for: • admissions to day clinics and hospitals and in-hospital dental-related procedures, • as long as the co-payments are paid from your **medical savings account** or **pocket**.
WHAT WE COVER	
We pay up to an **additional** 300% on top of your medical aid plan's rate to cover shortfalls on your dentists' and specialists' accounts related to the following in-hospital medical events: • dental procedures, such as dental implants and wisdom teeth extractions. Limited to **R 30 000 per policy per year**. • dental procedures due to accidental events or cancer treatment. Subject to the **OPL** of **R 226 880 per insured person per year**. Subject to our GAP BENEFIT.	Claim admission and dental procedure-related co-payments. Subject to our ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT.

GOOD TO KNOW

- If your healthcare provider asks you to pay an amount before your medical event, it's called split billing. The upfront amount makes up the provider's private fee that doesn't reflect on the account submitted to your medical aid for payment. Ask your provider to submit a detailed account reflecting their private fee to your medical aid so we can assess any shortfalls under our **GAP BENEFIT**.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

MATERNITY COVER

We cover the bump.

MATERNITY COVER is made up of **various benefits** you can claim from.

THE DELIVERY

CHILDBIRTH SHORTFALLS IN- AND OUT-OF-HOSPITAL COVER	CO-PAYMENTS IN-HOSPITAL COVER
HOW IT WORKS AND WHAT WE COVER	
We cover the **shortfalls** when: • healthcare professionals, such as your gynaecologist, obstetrician or midwife, charge more than your medical aid plan's rate for delivering your baby in the hospital or at home, • as long as your medical aid pays an amount from a **hospital benefit**, also known as a **risk** or **major medical benefit**. Subject to our GAP BENEFIT.	We **refund** co-payments that your **medical aid imposes** for elective caesareans as long as the co-payments are paid from your **medical savings account** or **pocket**. Subject to our ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT.

GOOD TO KNOW

- Send us a medical aid membership certificate or birth certificate to add your newborn.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

RADIOLOGY COVER

What does your medical aid plan cover for basic and specialised radiology? Do upfront co-payments apply to in- or out-of-hospital MRI, CT, and PET scans, or a combined benefit limit for x-rays and scans? We've got the cover you need.

RADIOLOGY COVER is made up of **various benefits** you can claim from.

RADIOLOGY SHORTFALLS IN- AND OUT-OF-HOSPITAL COVER	MRI, CT AND PET SCAN CO-PAYMENTS IN- AND OUT-OF-HOSPITAL COVER	MRI AND CT SCAN SUB-LIMITS OUT-OF-HOSPITAL COVER
HOW IT WORKS		
We cover the **shortfalls** when: • the radiologist or radiology facility charges more than your medical aid plan's rate for in- or out-of-hospital basic and specialised radiology, • as long as your medical aid pays an amount from a **hospital** or **insured day-to-day benefit**, also known as a **risk**, **major medical** or **block benefit**.	We **refund** co-payments that your **medical aid imposes** as rand amounts or percentages for in- or out-of-hospital MRI, CT, and PET scans, as long as the co-payments are paid from your **medical savings account** or **pocket**.	When your medical aid covers the cost of: • out-of-hospital MRI or CT scans from a **sub-limit** or **annual limit**, • but the rand amount available under the **sub-limit** or **annual limit** doesn't cover the total cost, we'll cover the **difference**.
WHAT WE COVER		
We pay up to an **additional 300%** on top of your medical aid plan's rate to cover shortfalls on basic and specialised radiology. Subject to our **GAP BENEFIT**.	Claim as many radiology-related co-payments as needed. Subject to our **ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT**.	Limited to **R 2 200 per policy per year**.

GOOD TO KNOW
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

CASUALTY BENEFITS

There are **two benefit categories**.

ACCIDENTAL EVENTS INDIVIDUALS OF ALL AGES OUT-OF-HOSPITAL COVER	ILLNESS EVENTS CHILDREN 12 YEARS OR YOUNGER OUT-OF-HOSPITAL COVER
HOW IT WORKS	
Visit any registered medical facility **within 24 hours** of an accident, such as the doctor's room or emergency unit at the nearest hospital, when anyone in the family requires medical treatment for bodily injury.	Children **12 years** or **younger** are covered for after-hours illness-related events at any registered casualty facility between **19:00** and **7:00** Monday through Friday and all day Saturday, Sunday, and public holidays.

We'll cover the **shortfalls** when your medical aid pays part of the cost of a casualty event from a **risk**, **insured day-to-day** or **block benefit**, or **refund** the **total cost** when paid from your **medical savings account** or **pocket**, subject to our benefit limit.

WHAT WE COVER

We cover all the healthcare and service providers' accounts related to a casualty event, typically including:

• basic and specialised radiology and pathology; • co-payments; • facility and doctors' consultation fees; • medication administered during an event; • external medical items received at the medical facility, such as a neck brace or arm sling; and • follow-up visits related to accidental events, such as having stitches or a cast removed.	• basic and specialised radiology and pathology; • co-payments; • facility and doctors' consultation fees; and • medication administered during an event.

Limited to **R 4 400 per policy per year**.

GOOD TO KNOW
- If you're admitted to the hospital after being treated in the casualty or medical facility for an accidental-related event, or your child is admitted after being treated in the casualty facility for an after-hours illness-related event, the admission becomes a new medical event, and claims will be assessed based on the hospital admission.
- Our benefit applies even if your medical aid doesn't cover casualty events.
- You're covered from day one because this benefit isn't subject to any waiting periods.

BENEFIT NOT SUBJECT TO THE OVERALL POLICY LIMIT (OPL)

*The following benefit isn't subject to the **OPL** and is available over and above benefits that fall within the **OPL**.*

PAYOUT BENEFIT

ACCIDENTAL DEATH AND DISABILITY

HOW IT WORKS

In the event of accidental death or total and permanent disability due to an accident, a benefit amount is payable on each insured person's life.

Our benefit compensates you for any current or future costs and expenses, including any potential loss of earnings.

The benefit amount that applies to:

- the principal insured is payable to the surviving spouse or the principal insured's estate if there's no surviving spouse.
- the spouse is payable to the principal insured or the spouse's estate if there's no surviving principal insured.

In the event of the simultaneous death of the principal insured and spouse, the benefit amounts are payable to the principal insured's estate.

WHAT WE COVER

You and your spouse are covered for **R 5 500 per insured person** if either one of you passes away or becomes totally and permanently disabled due to an accident.

Limited to **1 event per insured person per year**.

ACCIDENT...
means a sudden, unplanned and unexpected accidental event resulting in bodily injury caused by physical impact.

TOTAL AND PERMANENT DISABILITY...
means bodily injury resulting in complete and absolute disablement beyond hope of improvement, preventing an employed insured person from following their usual occupation or similar work for which they're suited by education or training.
If the insured person is an individual or pensioner who's not gainfully employed, total and permanent disability will mean the loss of both hands or feet, one hand and one foot, or the sight of both eyes.

GOOD TO KNOW

- You're covered from day one because this benefit isn't subject to any waiting periods.

LIFESTYLE BENEFIT

Our LIFESTYLE BENEFIT is a complimentary value-added product.

WELLNESS CARELINE www.stratumbenefits.co.za/wellness-careline/

Through our partnership with **Reality Wellness Group**, you and your dependants have access to confidential counselling with registered counsellors and social workers, telephonically or virtually.

Support is available **24/7**, **365 days** a year, in all **11 official languages**.

Download the **Reality Wellness Group** Mobile App for expert resources, inspiring talks and practical wellbeing tools.

Visit our website for your **access code** to create your user profile.



BENEFIT AND GENERAL EXCLUSIONS

Each benefit has specific qualifying criteria and exclusions. Refer to the **Benefit & General Exclusions** page.



CORPORATE ACCESS

Our **booster option**, available exclusively for **employer groups**, covers selected procedures, treatments, scans and surgeries that certain medical aid plans exclude.

One **Gap Cover** policy covers you and your spouse, even if you belong to different medical aid plans, including the dependants registered on either medical aid plan.

Child dependants registered on your or your spouse's medical aid plan may remain on your **Gap Cover** policy regardless of age. However, when a child dependant applies for their own medical aid membership, they must apply for their own policy.

A full-time student **26** or **younger** may remain on your policy even if they belong to a different medical aid plan, provided proof of full-time studies is submitted annually. Distance and online learning don't qualify.

We cover **5** or **more employees** as an employer group if you join through your employer.

Ask your employer if your spouse and dependants may join. If your employer agrees, add them to your policy.

Premiums are determined by factors such as the size of the employer group, the average age, and whether cover is compulsory or voluntary.

ASK US FOR A CORPORATE QUOTE

BENEFITS SUBJECT TO AN OVERALL POLICY LIMIT (OPL)

*An **OPL** of **R 226 880 per insured person per year**, or any higher amount published by the Regulator during the year, applies to the following benefits. All approved claim amounts will be deducted from the available **OPL**.*

ACCESS BENEFIT

Claim the cost of any medical procedure, treatment, scan or surgery listed below if your medical aid plan excludes it.

IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS

Our benefit helps with the cost of a planned medical procedure if:

- your medical aid plan excludes it from cover, or
- your plan only covers Prescribed Minimum Benefit (PMB) medical procedures, and your procedure isn't listed as a PMB.

PMBs are specific benefits your medical aid must provide for a defined list of medical procedures.

To claim, send us cost estimates from all your chosen providers, such as the hospital or day clinic, surgeon, and anaesthetist, along with a completed claim form.

We'll review the quotes. If approved, we'll issue a guarantee of payment to your providers as an undertaking to pay them directly after your procedure.

After your procedure, submit the final invoices. We'll settle them in the order received, up to the procedure benefit limit. Any costs above the limit will be for your pocket.

WHAT WE COVER

We'll cover the costs and expenses incurred for the medical procedures and treatments listed below when these aren't covered by your medical aid plan, subject to our benefit limits **per procedure**, **per insured person per year**.

LISTED MEDICAL PROCEDURES AND TREATMENTS	ACCESS BENEFIT
Adenoidectomy, myringotomy (grommets) or tonsillectomy	**R 15 500**
Arthroscopic surgery	**R 72 500**
Back or neck surgery	**R 72 500**
Bunion surgery	**R 20 500**
Cochlear implant, auditory brain implant and internal nerve stimulator surgery (including the procedure, device, processor and hearing aids if part of a bimodal solution)	**R 85 500**
Dental procedures for impacted teeth for children **younger** than **18**	**R 20 500**
Dental procedures for reconstructive surgery required due to an accident	**R 85 500**
Endoscopic procedures	**R 10 500**
Functional nasal surgery	**R 30 500**
Joint replacement surgery (including non-PMB joint replacements and internal prosthetic devices)	**R 60 500**
Knee or shoulder surgery	**R 30 500**
MRI or CT scan required due to an accident	**R 15 500**
Non-cancerous breast conditions (including breast reconstruction of an unaffected breast)	**R 25 500**
Oesophageal reflux and hiatus hernia surgery	**R 60 500**
Removal of varicose veins	**R 25 500**
Skin disorders (including benign growths and lipomas)	**R 25 500**

GOOD TO KNOW

- Unless we confirm otherwise, waiting periods apply. Refer to the **Waiting Periods** page.

Sometimes, two **Gap Cover** policies are better than one.

CORPORATE ACCESS is ideal if your medical aid plan excludes any of the medical procedures or treatments listed above.

However, if you're on a 100%, 200%, or 300% medical aid plan and want cover for shortfalls on doctors' and specialists' private fees and additional cover for cancer treatment, co-payments, and internal prosthetic devices, CORPORATE ACCESS with CORPORATE MERIDIAN[400] or CORPORATE COMPACT[300] is an ideal combination.

Consider a combination of CORPORATE ACCESS and CORPORATE ELITE[500] for the highest level of cover and additional benefits for out-patient specialist consultations, private room fees, scopes, and specialised scans.

RADIOLOGY COVER

What does your medical aid plan cover for specialised radiology? Does a combined benefit limit apply to MRI and CT scans? We've got the cover you need.

MRI AND CT SCAN SUB-LIMITS

OUT-OF-HOSPITAL COVER

HOW IT WORKS AND WHAT WE COVER

When your medical aid covers the cost of out-of-hospital MRI or CT scans from a **sub-limit** or **annual limit**, but the rand amount available under the **sub-limit** or **annual limit** doesn't cover the total cost, we'll cover the **difference**.

Limited to **R 2 200 per policy per year**.

GOOD TO KNOW

- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

CASUALTY BENEFITS

There are **two benefit categories**.

ACCIDENTAL EVENTS	ILLNESS EVENTS
INDIVIDUALS OF ALL AGES	CHILDREN 12 YEARS OR YOUNGER
OUT-OF-HOSPITAL COVER	OUT-OF-HOSPITAL COVER

HOW IT WORKS

Visit any registered medical facility **within 24 hours** of an accident, such as the doctor's room or emergency unit at the nearest hospital, when anyone in the family requires medical treatment for bodily injury.	Children **12 years** or **younger** are covered for after-hours illness-related events at any registered casualty facility between **19:00** and **7:00** Monday through Friday and all day Saturday, Sunday, and public holidays.

We'll cover the **shortfalls** when your medical aid pays part of the cost of a casualty event from a **risk**, **insured day-to-day** or **block benefit**, or **refund** the **total cost** when paid from your **medical savings account** or **pocket**, subject to our benefit limit.

WHAT WE COVER

We cover all the healthcare and service providers' accounts related to a casualty event, typically including:

• basic and specialised radiology and pathology; • co-payments; • facility and doctors' consultation fees; • medication administered during an event; • external medical items received at the medical facility, such as a neck brace or arm sling; and • follow-up visits related to accidental events, such as having stitches or a cast removed.	• basic and specialised radiology and pathology; • co-payments; • facility and doctors' consultation fees; and • medication administered during an event.

Limited to **R 4 400 per policy per year**.

GOOD TO KNOW

- If you're admitted to the hospital after being treated in the casualty or medical facility for an accidental-related event, or your child is admitted after being treated in the casualty facility for an after-hours illness-related event, the admission becomes a new medical event, and claims will be assessed based on the hospital admission.
- Our benefit applies even if your medical aid doesn't cover casualty events.
- You're covered from day one because this benefit isn't subject to any waiting periods.

BENEFIT NOT SUBJECT TO THE OVERALL POLICY LIMIT (OPL)

*The following benefit isn't subject to the **OPL** and is available over and above benefits that fall within the **OPL**.*

PAYOUT BENEFIT

ACCIDENTAL DEATH AND DISABILITY

HOW IT WORKS

In the event of accidental death or total and permanent disability due to an accident, a benefit amount is payable on each insured person's life.

Our benefit compensates you for any current or future costs and expenses, including any potential loss of earnings.

The benefit amount that applies to:

- the principal insured is payable to the surviving spouse or the principal insured's estate if there's no surviving spouse.
- the spouse is payable to the principal insured or the spouse's estate if there's no surviving principal insured.

In the event of the simultaneous death of the principal insured and spouse, the benefit amounts are payable to the principal insured's estate.

WHAT WE COVER

You and your spouse are covered for **R 5 500 per insured person** if either one of you passes away or becomes totally and permanently disabled due to an accident.

Limited to **1 event per insured person per year**.

ACCIDENT...
means a sudden, unplanned and unexpected accidental event resulting in bodily injury caused by physical impact.

TOTAL AND PERMANENT DISABILITY...
means bodily injury resulting in complete and absolute disablement beyond hope of improvement, preventing an employed insured person from following their usual occupation or similar work for which they're suited by education or training.
If the insured person is an individual or pensioner who's not gainfully employed, total and permanent disability will mean the loss of both hands or feet, one hand and one foot, or the sight of both eyes.

GOOD TO KNOW

- You're covered from day one because this benefit isn't subject to any waiting periods.

LIFESTYLE BENEFIT

Our LIFESTYLE BENEFIT is a complimentary value-added product.

WELLNESS CARELINE www.stratumbenefits.co.za/wellness-careline/

Through our partnership with **Reality Wellness Group**, you and your dependants have access to confidential counselling with registered counsellors and social workers, telephonically or virtually.

Support is available **24/7**, **365 days** a year, in all **11 official languages**.

Download the **Reality Wellness Group** Mobile App for expert resources, inspiring talks and practical wellbeing tools.

Visit our website for your **access code** to create your user profile.



BENEFIT AND GENERAL EXCLUSIONS

Each benefit has specific qualifying criteria and exclusions. Refer to the **Benefit & General Exclusions** page.

GAP BENEFIT CLAIM EXAMPLES

If you're unsure if **Gap Cover** is for you, look at the claim examples of how our **GAP BENEFIT** covers medical expense shortfalls.

GAP BENEFIT

Having a 100% medical aid plan doesn't mean your medical aid will cover all healthcare expenses. Even a more comprehensive 300% plan only pays a portion of what private healthcare providers charge.

The Department of Health published the **Reference Price List (RPL)**, a list of recommended tariffs for medical procedures and treatments, as a departure point for medical aids to determine their rate structures.

The real impact of what your healthcare providers charge and the medical aid rate is on your pocket, as healthcare providers aren't obligated to charge these recommended fees.

Our **GAP BENEFIT** covers shortfalls up to an **additional** 500%, 400% or 300% of your medical aid plan's rate when your healthcare providers charge private fees not fully covered by your medical aid.

The below represents a childbirth claim. If your medical aid pays 100% of the medical aid rate, and the specialists charge 400%, you'll be left with a 300% shortfall.

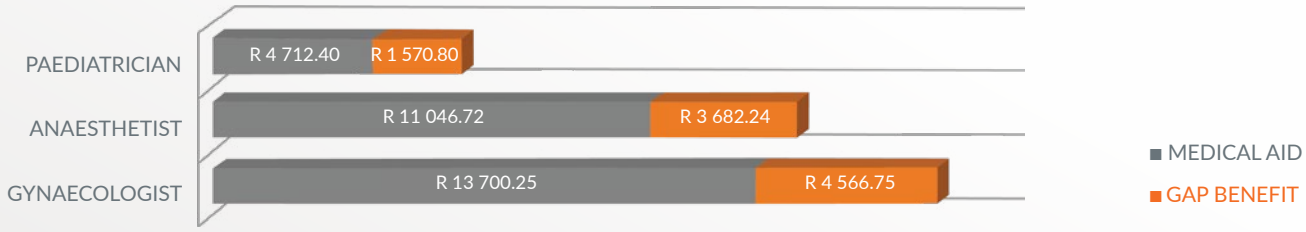
When submitting a claim for the shortfalls, the **Medical Aid Rate** column on the medical aid statement is our reference point for assessing them.

Service Provider	Amount Claimed	Medical Aid Rate (100%)	Claims paid from		Claims paid to		Claims not paid	RC**
			Hospital / Risk Benefit	MSA*	Member	Service Provider	Your Portion	
Anaesthetist	R 14 728.96	R 3 682.24	R 3 682.24	R 0.00	R 3 682.24	R 0.00	R 11 046.72	45
Gynaecologist	R 18 267.00	R 4 566.75	R 4 566.75	R 0.00	R 4 566.75	R 0.00	R 13 700.25	45
Paediatrician	R 6 283.20	R 1 570.80	R 1 570.80	R 0.00	R 1 570.80	R 0.00	R 4 712.40	45
Totals	**R 39 279.16**	**R 9 819.79**	**R 9 819.79**	**R 0.00**	**R 9 819.79**	**R 0.00**	**R 29 459.37**	

MSA* = Medical Savings Account **RC**** = Reason Code 45: This claim exceeds the maximum amount payable

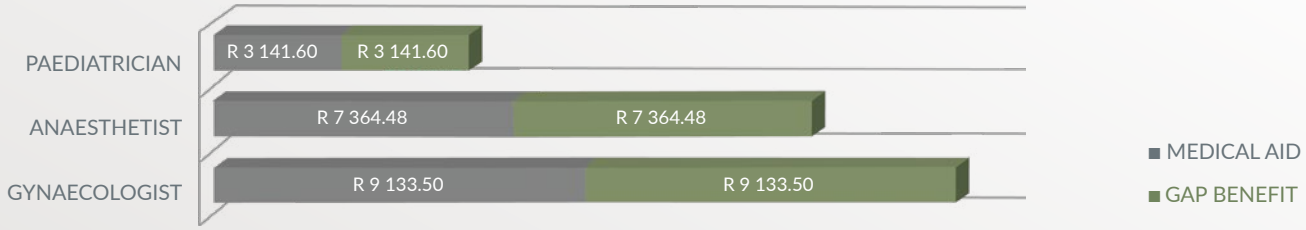
300% MEDICAL AID PLAN RATE + CORPORATE ELITE[500] OR CORPORATE NOVA[500]

And if you're on a **300% medical aid plan** and have 500% cover with us, you'll have **800% cover** in total.



200% MEDICAL AID PLAN RATE + CORPORATE MERIDIAN[400]

In the same way, if you're on a **200% medical aid plan** and have 400% cover with us, you'll have **600% cover** in total.



100% MEDICAL AID PLAN RATE + CORPORATE COMPACT[300]

If you're on a **100% medical aid plan** and have 300% cover with us, you'll have **400% cover** in total, meaning the shortfalls on your specialists' accounts would be covered in full.



CLAIM SUBMISSION GUIDE

Our **Claim Submission Guide** explains how to submit a claim, the supporting documents you'll need, and how we assess your claim.

Visit www.stratumbenefits.co.za/gap-cover-downloads/ to view the guide.

WAITING PERIODS

Waiting periods may apply from your and your dependants' cover start dates, but never to accidental events that occur after your cover start dates.

3 MONTH GENERAL WAITING PERIOD

There's no cover during this period except for accidental events that occur after your and your dependants' cover start dates.

Unless we confirm otherwise, the following benefits are subject to this waiting period:

- ACCESS BENEFIT
- GAP BENEFIT
- CO-PAYMENT BENEFITS
- SUB-LIMIT BENEFITS
- CANCER BENEFITS
- PRIVATE ROOM BENEFIT
- PREVENTATIVE CARE BENEFIT
- FIRST-TIME CANCER DIAGNOSIS BENEFIT
- MRI, CT AND PET SCAN TOP-UP BENEFIT
- OUT-PATIENT SPECIALIST CONSULTATION BENEFIT

12 MONTH PRE-EXISTING MEDICAL CONDITION WAITING PERIOD

There's no cover during this period for investigations, medical procedures, surgeries or treatments related to any illness or medical condition diagnosed or for which advice or treatment was received **12 months** before your or your dependants' cover start dates.

Unless we confirm otherwise, the following benefits are subject to this waiting period:

- ACCESS BENEFIT
- GAP BENEFIT
- CO-PAYMENT BENEFITS
- SUB-LIMIT BENEFITS
- CANCER BENEFITS
- PRIVATE ROOM BENEFIT
- MRI, CT AND PET SCAN TOP-UP BENEFIT
- OUT-PATIENT SPECIALIST CONSULTATION BENEFIT

EXCEPTION TO THE RULE

The following benefits aren't subject to waiting periods:

- CASUALTY BENEFITS
- TRAUMA COUNSELLING BENEFIT
- PHYSICAL REHABILITATION TOP-UP BENEFIT
- ACCIDENTAL DEATH AND DISABILITY BENEFIT
- MEDICAL AID CONTRIBUTION WAIVER BENEFIT
- STRATUM POLICY PREMIUM WAIVER BENEFIT

SWITCHING COVER FROM ANOTHER GAP COVER PROVIDER

Transfer underwriting may apply to applicants who switch cover from another **Gap Cover** provider.

LIMITED PAYOUT BENEFIT

Unless we confirm otherwise, the **Limited Payout Benefit** applies from your and your dependants' cover start dates.

HOW IT WORKS

If you claim from our GAP BENEFIT, CO-PAYMENT BENEFITS or SUB-LIMIT BENEFITS for any of the listed medical procedures or scans in the first **10 months** of cover, we'll pay between **20%** and **100%** of the **approved claim amount**, subject to applicable benefit limits.

The percentage is determined by the quote your employer accepted.

If your medical event is related to a pre-existing medical condition for which you received advice or treatment **12 months** before your cover start date, the claim may be subject to a **Pre-Existing Medical Condition Waiting Period**.

- adenoidectomy;
- cardiovascular procedures;
- cataract removal;
- dentistry;
- hernia repair;
- hysterectomy (full cover if due to cancer diagnosed after the **General Waiting Period**);
- joint replacements;
- MRI, CT, and PET scans;
- myringotomy (grommets);
- nasal and sinus surgery;
- pregnancy and childbirth;
- scopes (including medical events where a scope is used);
- spinal procedures; or
- tonsillectomy.

BENEFIT & GENERAL EXCLUSIONS

Gap Cover works with your medical aid cover.

Gap Cover includes various benefits covering medical expense shortfalls for just about every medical eventuality.

Depending on the benefit's qualifying criteria, your medical aid must first pay a portion of the cost of a medical event before we step in and take care of the rest. However, not every medical event will qualify for benefits as policies are subject to benefit and general exclusions.

BENEFIT EXCLUSIONS

Gap Cover offers many benefits, each with specific qualifying criteria.

Benefit exclusions apply only to specific benefits, not the entire policy. They limit or exclude cover for certain medical procedures, treatments, and events within a particular benefit category.

For more information about what you can and can't claim, go to www.stratumbenefits.co.za/benefit-exclusions/ or scan the **QR code** to view or download our **Benefit Exclusions**.

GENERAL EXCLUSIONS

General exclusions are standard conditions and events that aren't covered, regardless of the specific claim or benefit. These exclusions apply to the entire policy, not only a specific benefit.

Read the general exclusions below, or visit www.stratumbenefits.co.za/general-exclusions/ or scan the **QR code** to download our **General Exclusions**.

GENERAL POLICY EXCLUSIONS

We don't pay claims related to:

1. events that occurred before your cover start date, except when claiming from our TRAUMA COUNSELLING BENEFIT.
   (We cover consultation fees for trauma counselling received after your cover start date, even if the trauma event occurred before your cover start date.)
2. events during waiting periods, except for accidental events that occur after your cover start date.
3. line items that don't meet the South African medical coding standards, such as CPT, NHRPL, and ICD-10.
4. events your medical aid pays as concessions, exceptions, or ex-gratia payments.
5. medical events for which pre-authorisation hasn't been obtained from your medical aid or when your medical aid's rules haven't been followed, except if your policy offers a benefit.
   (For example, late pre-authorisation requests or using non-network hospitals on a network-based medical aid plan.)
6. events when benefit limits or your policy's overall limit has been reached.
7. shortfalls that exceed the 500%, 400% or 300% GAP BENEFIT your policy provides.
8. events your policy doesn't cover or provides an appropriate benefit to claim from.
9. additional shortfalls when your healthcare or service provider increases their fees after we've finalised your claim.
10. additional shortfalls when your healthcare or service provider agrees to a discount but increases their fee after we've finalised your claim.
11. costs related to medical documents, such as prescriptions, medical reports and the completion of chronic medicine registration forms.
12. split billing charges.
    (These are upfront payments your healthcare or service providers may ask you to pay before your medical event. These amounts make up the providers' private fees and don't reflect on the accounts submitted to medical aid for payment. We assess shortfalls under our GAP BENEFIT when all charges reflect on your providers' accounts and refund upfront co-payments your medical aid imposes under our CO-PAYMENT BENEFITS.)

SPECIFIC POLICY EXCLUSIONS

We don't pay claims related to:

13. allied healthcare professionals, except if your policy offers a benefit.
14. assisted reproductive therapy (ART), fertility treatments or contraceptives, except for contraceptive device implants, tubal ligations, and vasectomies if your policy offers a benefit.
15. a second breast reconstruction or any subsequent reconstruction procedure.
    (We cover one event per insured person provided it's the first breast reconstruction in your lifetime and your policy offers a benefit.)
16. diagnosing or treating sleeping disorders.
17. elective, prophylactic (preventative), routine procedures or physical examinations, such as annual check-ups and medical tests for insurance purposes, risk-reducing mastectomies, and scopes based on family history, except if your policy offers a benefit.
18. external medical items, such as spectacles, arm slings, compression socks, crutches, moon boots and neck braces, except when claiming from our CASUALTY BENEFIT for items received at the medical facility.
19. external prosthetic devices, such as artificial limbs.
20. home or private nursing or admission to a step-down or sub-acute facility, such as frail care centres, hospice centres, mental health facilities, and rehabilitation facilities, except if your policy offers a benefit.
21. hospital charges, such as ward fees.
22. treating mood disorders or emotional or psychological illnesses, except when claiming for counselling from our TRAUMA COUNSELLING BENEFIT.

23. obesity or treatments required due to obesity.
24. prescription or take-home medication, except when claiming prescription medication from our CANCER BENEFITS.
25. reconstructive cosmetic surgery, except if your policy offers a benefit.
26. robotic-assisted surgery co-payments, except when claiming from our ROBOTIC SURGERY CO-PAYMENT BENEFIT.
27. specialised mechanical or computerised devices, such as CPAP machines, glucometers, insulin pumps, oxygen machines, and ventilators.
28. stem cell harvesting or treatments.

STANDARD NON-LIFE POLICY EXCLUSIONS

We don't pay claims related to:

29. attempted suicide, suicide, or intentional self-injury.
30. deliberate exposure to exceptional danger, except if trying to save a human life.
    (Exceptional danger includes but isn't limited to hazardous sports or activities, such as skydiving, mixed martial arts fighting (MMA), and speed racing.)
31. events covered by legislation, such as contractual liability and consequential loss.
32. illegal behaviour or breaking the law of the Republic of South Africa.
33. events outside the borders of the Republic of South Africa.
34. illness or injury caused by using drugs or narcotics, except if prescribed by a healthcare provider, provided the healthcare provider isn't an insured person.
35. illness or injury caused by using alcohol.
36. nuclear weapons, nuclear material or ionising radiation.
37. participation in active military, police or police reservist duty, civil commotion, invasion, labour disturbance, political act, rebellion, riot, strike, terrorist activity, war, or the activity of locked-out workers.
38. transport charges or healthcare services provided while being transported in an emergency vehicle, vessel, or aircraft.

FREQUENTLY ASKED QUESTIONS

Reading through frequently asked questions is one way of understanding **Gap Cover** better.

Go to our **Frequently Asked Questions** page, www.stratumbenefits.co.za/gap-cover-faqs/, or scan the **QR code**.

GET COVER!

There's only one thing left to do.

Speak with your HR representative, call your financial advisor, visit www.stratumbenefits.co.za/get-cover/ to apply online, or download and email the application form.

