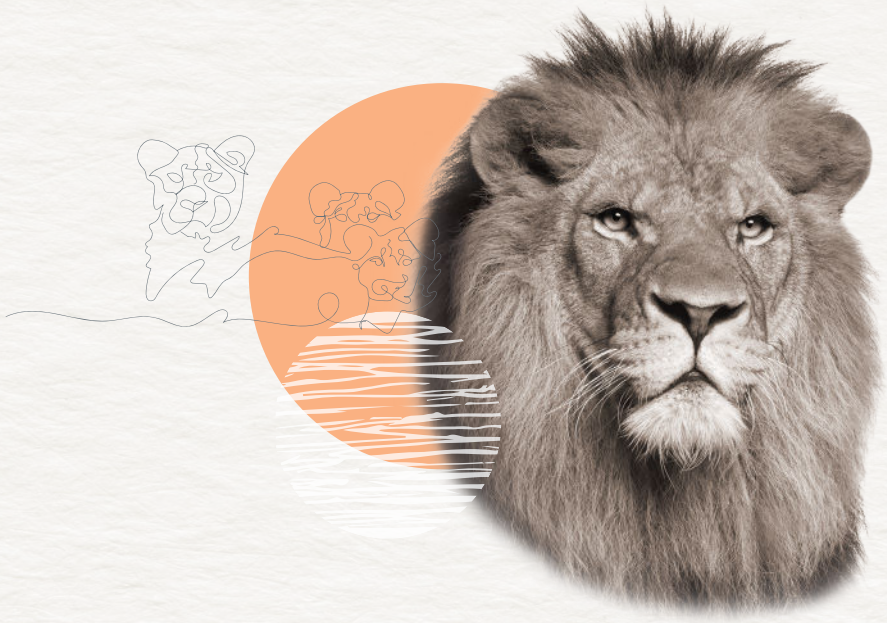
| 2024 |

Stratum Benefits



ELITE^{500}

Our **top-of-the-range option** offers the widest range of **in-** and **out-of-hospital** benefits at the highest level of cover.

PREMIUMS FOR INDIVIDUALS AND FAMILIES

Premiums are determined by age at entry, and there's no maximum entry age.

IF YOU'RE **64** OR **YOUNGER**	IF EVERYONE IN THE **FAMILY** IS **64** OR **YOUNGER**	IF YOU'RE **65** OR **OLDER**	IF **YOU** OR ANYONE IN THE FAMILY IS **65** OR **OLDER**
R 438 INDIVIDUAL	R 538 FAMILY	R 712 INDIVIDUAL	R 869 FAMILY

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. When a child dependant moves to their own medical aid plan, they must apply for cover on their own policy.

ELITE^{500}

GUARDRISK TAILORED RISK SOLUTIONS

Stratum Benefits (Pty) Ltd, an authorised FSP 2111, is underwritten by Guardrisk Insurance Company Limited, a licensed non-life insurer and authorised FSP 75. This document 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.

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KEY BENEFITS SUBJECT TO AN OVERALL POLICY LIMIT (OPL)

*An **OPL** of **R 198 660 per person per year** applies to the following benefits or any higher amount published by the Regulator during the year. All approved claim amounts will be deducted from the available **OPL**.*

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 198 660 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.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

CO-PAYMENT BENEFITS

If your medical aid requires upfront payment before you're admitted to hospital or before you go for a medical procedure, such as a laparoscopy or joint replacement surgery, it's called a co-payment or deductible.

Our benefit has **three 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 and deductibles 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 or deductibles are paid from your **medical savings account** or **pocket**.

WHAT WE COVER

Claim as many admission and procedure-related co-payments and deductibles as needed. Subject to the **OPL** of **R 198 660 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 and hospitals 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 15 000 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 10 000 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.
- Look at DENTAL, MATERNITY and RADIOLOGY **COVER** to see what co-payments and deductibles 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

Whether you have extractions or fillings done in the dentist's chair or booked into a day clinic or hospital for 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- AND OUT-OF-HOSPITAL COVER	CO-PAYMENTS AND DEDUCTIBLES IN- AND OUT-OF-HOSPITAL COVER
HOW IT WORKS	
We cover the **shortfalls** when: • the cost of your dental-related procedure performed in a day clinic, hospital, or your healthcare professional's room is more than your medical aid plan's rate, • 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 and deductibles that your **medical aid imposes** as rand amounts or percentages for: • admissions to day clinics and hospitals and in- or out-of-hospital dental-related procedures, • as long as the co-payments or deductibles 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- and out-of-hospital medical events: • dental procedures, such as dental implants, orthodontic treatment and wisdom teeth extractions. Limited to **R 8 000 per policy per year**. • dental procedures due to accidents or cancer treatments. Limited to **R 48 000 per policy per year**. Subject to our GAP BENEFIT.	Claim as many admission and dental procedure-related co-payments and deductibles 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.

NOTES

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 and 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 and 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. Always consult your healthcare professional first. Claim the **shortfall** or **total cost** of the flu vaccination and other preventative tests and procedures, such as a full blood count, when paid from your **medical savings account** or **pocket**. Subject to our **PREVENTATIVE CARE BENEFIT**.	**CO-PAYMENTS AND DEDUCTIBLES** IN-HOSPITAL COVER We **refund** co-payments and deductibles that your **medical aid imposes** for elective caesareans as long as the co-payments or deductibles 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** or **total cost** of your baby's flu vaccination from **7 months** or **older** when paid from your **medical savings account** or **pocket**. Always consult the healthcare professional first. We also cover childhood immunisations and other preventative tests and procedures, such as a contraceptive device implant. 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

Spend time with your newborn. Claim the **shortfalls** or **total cost** when your medical aid pays part of the cost of a private hospital room or when your medical aid plan excludes it from cover.

We also cover the hospital's lodger fee if your spouse 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.
- 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 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.

Our benefit has **three categories**.

COLONOSCOPIES, ENTEROSCOPIES AND GASTROSCOPIES	INTERNAL PROSTHETIC DEVICES	RENAL DIALYSIS TREATMENTS
IN- AND OUT-OF-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 from a **sub-limit** or **annual limit**, we'll cover the **difference**.

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 5 000 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**.

External medical items aren't covered.

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**.

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 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 BENEFIT

Our benefit has **three categories**.

BREAST RECONSTRUCTION

IN-HOSPITAL COVER

HOW IT WORKS

We'll cover the **total cost** of reconstructing an **unaffected** breast 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 on an affected or unaffected breast or any reconstruction after that.

If you undergo a mastectomy or 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 a breast implant reconstruction procedure or flap breast reconstruction surgery.

Limited to **1 event** up to **R 30 000 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 and deductibles 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 198 660 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 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 198 660 per insured person per year**.

GOOD TO KNOW

- Your medical aid may impose co-payments or deductibles for precision and innovative oncology medication that apply from the onset of cover. Our benefit refunds co-payments and deductibles that apply after an 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 AND DEDUCTIBLES IN- AND OUT-OF-HOSPITAL COVER	MRI, CT AND PET SCAN SUB-LIMIT 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 and deductibles 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 or deductibles 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? We'll **top up** your cover and pay the **total cost** of in- or out-of-hospital MRI, CT, and PET scans when your medical aid plan's radiology benefit has been reached.
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 and deductibles as needed. Subject to our ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT.	Limited to **R 5 000 per insured person per event**.	Limited to **R 5 000 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

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 the rooms,
- as long as your medical aid pays an amount from a **risk benefit**, also known as an **insured day-to-day** or **block benefit**, or your **medical savings account**.

If, for example, your medical aid pays an amount from a **risk benefit** and your **medical savings account**, the payments will be added together to see if there's a shortfall. If the two payments make up the total cost of the consultation fee, there won't be a shortfall for us to cover.

WHAT WE COVER

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

Limited to **3 consultations** up to **R 1 300 per consultation per policy per year**.

GOOD TO KNOW
- Our benefit doesn't cover general practitioners' or allied healthcare providers' consultation fees, such as biokineticists, chiropractors and physiotherapists.
- Ancillary tests or investigations typically done with consultations, such as urine tests and sonars, aren't covered.
- Unless we confirm otherwise, waiting periods apply. A **3 Month General Waiting Period** always applies. Refer to the **Waiting Periods** page.

CASUALTY BENEFIT

Our benefit has **two categories**.

ACCIDENTAL EVENTS OUT-OF-HOSPITAL COVER	ILLNESS EVENTS CHILDREN 10 YEARS OR YOUNGER OUT-OF-HOSPITAL COVER	ILLNESS EVENTS INDIVIDUALS 11 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 aged **10 years** or **younger** are covered after hours for illness at any registered casualty facility between **18:00** and **7:00** on Mondays to Fridays and all day on Saturdays, Sundays, and public holidays.	Any insured person aged **11 years** or **older** is covered after hours for illness at any registered casualty facility between **18:00** and **7:00** on Mondays to Fridays and all day on Saturday, Sundays, and public holidays.
Limited to **R 12 000 per policy per year**.		Limited to **R 1 500 per policy per year**.

We'll **refund** the **shortfalls** or **total cost** of a casualty event when your medical aid pays it from your **medical savings account** or when you pay it from **your pocket**.

WHAT WE COVER

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

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

GOOD TO KNOW

- If you're admitted to the hospital after being treated for bodily injury due to an accident, 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

OUT-OF-HOSPITAL COVER

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

HOW IT WORKS

We'll **refund** the **shortfalls** or **total cost** of your registered counsellor's consultation fees when your medical aid pays it from your **medical savings account** or when you pay it from **your pocket**.

WHAT WE COVER

You're covered when you:

- witness an act of physical violence or an accident or when you're directly affected by it;
- receive news of a loved one's diagnosis of a critical illness or when you're diagnosed;
- mourn the death of a loved one; or when
- an accident leaves you totally and permanently disabled.

Limited to **R 10 000 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.
- 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** or **total cost** when your medical aid pays your healthcare providers' consultation fees or the cost of preventative tests or procedures from your **medical savings account** or when you pay it from **your 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 vaccine);
- mammograms and breast sonars;
- pap smears;
- prostate-specific antigen screenings; and
- testicular screenings.

Limited to **R 1 600 per policy per year**.

GOOD TO KNOW
- Our benefit applies even if your medical aid doesn't cover preventative tests, screenings and 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)

*The following benefits aren't subject to the **OPL** because we give these benefits to you over and above those that form part of the **OPL**.*

PRIVATE ROOM BENEFIT

IN-HOSPITAL COVER

HOW IT WORKS

Whether your medical aid pays part of the cost of a private hospital room from your **medical savings account** or excludes it and the cost is paid from **your pocket**, we've got you covered.

WHAT WE COVER

Claim from us 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 covered on your **Gap Cover** policy, or when
- a fee is charged when you're in hospital and need to nurse your baby.

Limited to **R 3 000 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 25 000 per insured person**, and your dependants for **R 5 000 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

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, also known as 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.
- You can change your medical aid plan when our benefit applies, but 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, also known as 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 BENEFIT

This Lifestyle Benefit is a complimentary value-add product.

Visit our website at **www.stratumbenefits.co.za** for more information about this benefit and how to register.

INTERNATIONAL TRAVEL INSURANCE

WHAT'S ON OFFER

The whole family is covered for acute illness and injury when travelling for leisure outside South African borders, limited to **1 trip per policy per year** for a maximum of **31 days** shared between all travellers.

If you travel alone, you'll be insured for up to **31 days**, but if you travel with a dependant, the **31 days** will be divided between the travellers.

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

If your medical aid or any other insurance policy provides similar cover, our international travel insurance partner's benefit doesn't apply.

WAITING PERIODS

UNDERWRITING APPLICABLE TO FIRST-TIME JOINERS

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

3 MONTH GENERAL WAITING PERIOD

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

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

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

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

EXCEPTION TO THE RULE

The following benefits aren't subject to waiting periods:

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

GOOD TO KNOW

- Transfer underwriting applies to applicants who switch cover from another **Gap Cover** provider. Go to www.stratumbenefits.co.za/gap-cover-transfer-process-for-individuals/ or scan the **QR code** for our **Gap Cover Transfer Process for Individuals**.

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 BENEFIT in the first **10 months** of cover for any of the medical procedures or scans listed below and the medical event isn't related to a pre-existing medical condition, we'll pay **20%** of the **approved claim amount**, subject to the benefit's rand amount limits, where applicable:

- 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.

GOOD TO KNOW

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

Gap Cover works with your medical aid cover.

Your **Gap Cover** policy 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 your medical event before we step in and take care of the rest. However, not every medical event will qualify for benefits as your policy is subject to benefit and general exclusions.

BENEFIT EXCLUSIONS

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

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

The following exclusions apply to your policy and not only to specific benefits.

Go to 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 trauma consultation fees for 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 accidents that occur after your cover start date.
3. events your medical aid pays as concessions, exceptions, or ex-gratia payments.
4. 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, using non-network hospitals when you're on a network-based medical aid plan.*)
5. events when benefit limits or your policy's overall limit has been reached.
6. shortfalls that exceed the **500% GAP BENEFIT** your policy provides.
7. events your policy doesn't cover or doesn't provide an appropriate benefit to claim from.
8. additional shortfalls when your healthcare or service provider increases their fees after we've finalised your claim.
9. additional shortfalls when your healthcare or service provider agrees to a discount but increases their fee after we've finalised your claim.
10. costs for medical reports.
11. 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 and deductibles your medical aid imposes under our **CO-PAYMENT BENEFITS**.)*

SPECIFIC POLICY EXCLUSIONS

We don't pay claims related to:

12. allied healthcare professionals, except if your policy offers a benefit.
13. assisted reproduction therapy (ART), contraception-related or fertility treatments, except for contraceptive device implants, tubal ligations, and vasectomies if your policy offers a benefit.
14. a second breast reconstruction or any reconstructions after that.
    (*We cover one event per insured person per lifetime if it's the first reconstruction and if your policy offers a benefit.*)
15. diagnosing and treating sleeping disorders.
16. elective and routine procedures or physical examinations, such as annual check-ups and consultations for chronic conditions registered as Prescribed Minimum Benefit (PMB) medical conditions.
17. external medical items, such as crutches and moon boots, except when claiming from our **CASUALTY BENEFIT**.
18. external prosthetic devices, such as artificial limbs.
19. home and private nursing or admissions to step-down and sub-acute facilities, such as frail care, hospice centres, and rehabilitation facilities, except if your policy offers a benefit.
20. hospital charges, such as ward fees.
21. maxillofacial surgeries and related medical conditions and procedures, except if required for specialised dental surgeries or due to accidents or cancer treatment.
22. mood disorders and emotional and psychological illnesses, except when claiming from our **TRAUMA COUNSELLING BENEFIT**.
23. obesity or treatments required due to obesity.
24. prescription and take-home medication, except when claiming prescription medication from our **CANCER BENEFIT**.
25. reconstructive cosmetic surgery, except if your policy offers a benefit.
26. robotic-assisted surgery co-payments and deductibles, except when claiming from our **ROBOTIC SURGERY CO-PAYMENT BENEFIT**.
27. specialised mechanical and computerised devices, such as ventilators, oxygen and CPAP machines.
28. stem cell harvesting and treatments.

STANDARD NON-LIFE POLICY EXCLUSIONS

We don't pay claims related to:

29. attempted suicide, suicide, and 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 and 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. illnesses or injuries caused by using drugs or narcotics, except if prescribed by registered medical practitioners other than the insured person.
34. illnesses or injuries caused by using alcohol.
35. nuclear weapons and nuclear or ionising radiation.
36. participation in active military, police or police reservist duties, civil commotions, invasions, labour disturbances, political acts, rebellions, riots, strikes, terrorist activities, wars, or the activities of locked-out workers.
37. transport charges and healthcare services provided while being transported in emergency vehicles, vessels, or aircraft.

EXPLAINER VIDEOS

Go to our **YouTube** channel, www.youtube.com/@stratumbenefits8206, or scan the **QR code** for short, animated videos that explain how our benefits work.

GET COVER!

There's only one thing left to do.

Call your financial advisor, visit www.stratumbenefits.co.za/apply-today/ to apply online, or download and email the application form.