| 2025 |

Stratum Benefits

COMPACT^{300}

Our **well-rounded option** is packed with benefits that cover the **most often experienced in-** and **out-of-hospital** medical expense shortfalls.

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** OR ANYONE IN THE **FAMILY** IS **65** OR **OLDER**
R 330 INDIVIDUAL	R 399 FAMILY	R 629 INDIVIDUAL or 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.

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.

Stratum Benefits

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KEY BENEFITS SUBJECT TO AN OVERALL POLICY LIMIT (OPL)

*An **OPL** of **R 210 580 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 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 210 580 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 the hospital or undergo a medical procedure, such as a laparoscopy or joint replacement surgery, it's called a co-payment or deductible.

There are **two benefit categories**.

ADMISSION AND PROCEDURE CO-PAYMENTS IN- AND OUT-OF-HOSPITAL COVER	PENALTY 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- 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 20 000 per policy per year**.	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 **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 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 210 580 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 30 000 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-LIMIT 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**.
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 3 500 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	CANCER TREATMENT TOP-UP 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**.	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	
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 210 580 per insured person per year**.	We'll cover the cost of your ongoing cancer treatment subject to the oncology treatment plan approved by your medical aid. Limited to **R 60 000 per insured person per year**.

GOOD TO KNOW

- Your medical aid may impose co-payments for precision and innovative oncology medication that apply from the onset of cover. Our benefit refunds co-payments 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.

CASUALTY BENEFITS

There are **two benefit categories**.

ACCIDENTAL EVENTS INDIVIDUALS OF ALL AGES OUT-OF-HOSPITAL COVER	ILLNESS EVENTS CHILDREN 10 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 **10 years** or **younger** are covered for after-hours illness-related events at any registered casualty facility between **18:00** 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 6 000 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

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 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 5 000 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.

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**.*

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 15 000 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 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.

FIRST-TIME CANCER DIAGNOSIS BENEFIT GUIDE

For more information about this benefit, go to www.stratumbenefits.co.za/first-time-cancer-diagnosis-benefit/ or scan the **QR code**.

GAP MATCH

This guiding tool matches the best-suited **Gap Cover** option with your medical aid plan.

Go to www.stratumbenefits.co.za/gap-match/ or scan the **QR code**.

Chat with your financial advisor to sign up, or contact our **Client Support Centre** for general questions and information.

EXPLAINER VIDEOS

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

WAITING PERIODS

UNDERWRITING APPLICABLE TO FIRST-TIME JOINERS

Waiting periods 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:

GAP BENEFIT
CO-PAYMENT BENEFITS
SUB-LIMIT BENEFIT
CANCER BENEFITS
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
CANCER BENEFITS

EXCEPTION TO THE RULE

The following benefits aren't subject to waiting periods:

CASUALTY BENEFITS
ACCIDENTAL DEATH AND DISABILITY BENEFIT
TRAUMA COUNSELLING 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 for any of the listed medical procedures or scans in the first **10 months** of cover, we'll pay **20%** of the **approved claim amount**, subject to applicable benefit limits.

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 will 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.

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.

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 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, 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 **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 for medical reports.
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 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 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. mood disorders or emotional or psychological illnesses, except when claiming 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.
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. 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.
34. illness or injury caused by using alcohol.
35. nuclear weapons, nuclear material or ionising radiation.
36. 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.
37. 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.

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