Stratum Benefits

INDIVIDUAL PRODUCT RANGE

2025 GAP COVER

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.

OUR WILDLIFE REFLECTS OUR BRAND

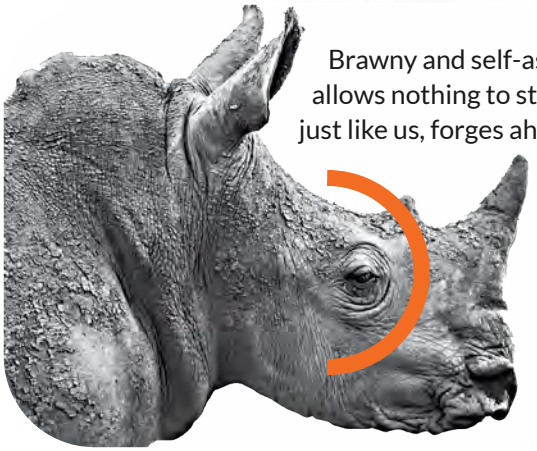
Wildlife must be resourceful to survive in their respective environments, similar to how we overcome challenges in the industry.

To thrive, animals co-exist in symbiotic relationships just like the interconnected relationships we have with our valued clients, financial advisors and medical aids.

Like our brand, the **buffalo** possesses immense strength, determination, and endurance.

The **elephant** is highly intelligent and projects a forceful, imposing presence comparable to how we lead from the front.

The **lion** is a fierce leader, commanding respect and dominance, reflecting our industry position.



Brawny and self-assured, the **rhino** allows nothing to stand in its way and, just like us, forges ahead with resilience.

The **leopard** is agile and strategic, seizing opportunities swiftly and precisely… the Stratum way.

Safeguarding our wildlife for its majestic beauty and balance to many of nature's processes is a collective duty.
Protecting those we cover, is our duty because every client we serve is as unique and precious as our wildlife.

CONTENTS

APPLY FOR GAP COVER

Chat with your financial advisor.
Download the application form: www.stratumbenefits.co.za
Send your completed form to your financial advisor or to us at:
e yourapplication@stratumbenefits.co.za

POLICY CHANGES AND QUERIES

Chat with your financial advisor about changing your option or adding and removing dependants, or email us about general changes like new debit order details and benefit queries:
e yoursupport@stratumbenefits.co.za

GAP COVER CLAIMS

Submit or follow up on a claim:
e yourclaim@stratumbenefits.co.za
Submit a claim online:
w www.stratumbenefits.co.za

WhatsApp

Contact us for general questions and information. Scan the **QR code** or save our number:
010 448 0861

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REG NO.: 2003/018155/07

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BUSINESS HOURS: Monday - Thursday 8:00 - 16:30 Friday 8:00 - 16:00

THIS IS US

Leaders are like eagles. Masters of their territory, bold and powerful, with sights set firmly on their goals.

Our dedicated team has created **Gap Cover** solutions for individuals and families for nearly two decades that suit every pocket, healthcare need, and lifestyle.

We strive to make every interaction memorable because we believe that excellent service gains a client, not a sale.

GAP COVER IN A NUTSHELL

It's a non-life insurance policy designed to cover medical expense shortfalls when your healthcare and service providers, such as your doctor and specialist, charge more than your medical aid plan's rate for in- and out-of-hospital medical procedures.

Our **Gap Cover** options complement all registered South African medical aid plans regulated by the Council for Medical Schemes.

EXPLAINER VIDEO

Go to www.stratumbenefits.co.za/what-is-gap-cover/ for a short animated video that explains what **Gap Cover** is.

WHAT'S ON OFFER

We cover you for just about every medical eventuality.

From providing up to an **additional** 300%, 400%, or 500% on top of your medical aid plan's rate to cover the most often experienced shortfalls to benefits for co-payments, cancer treatment, internal prosthetic devices, scopes, scans, casualty events, and more.

Whether you're an individual who needs basic cover or a growing family needing more comprehensive cover, we've got the perfect fit.

10 REASONS TO JOIN US

1. All are welcome! No maximum entry ages.
2. 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.
3. 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 **Gap Cover** 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.
4. In- and out-of-hospital medical procedures are covered. Out-of-hospital procedures aren't subject to a defined list.
5. Not all benefits are subject to an **Overall Policy Limit**.
6. The following benefits don't require part payment from your medical aid:
   - ACCESS
   - ACCIDENTAL DEATH AND DISABILITY
   - BREAST RECONSTRUCTION
   - CASUALTY
   - FIRST-TIME CANCER DIAGNOSIS
   - MEDICAL AID CONTRIBUTION WAIVER
   - PREVENTATIVE CARE
   - PRIVATE ROOM
   - STRATUM POLICY PREMIUM WAIVER
   - TRAUMA COUNSELLING
7. Unique cover for cancer treatment, internal prosthetic devices, MRI, CT, PET scans, and physical rehabilitation when your medical aid plan's benefit limits have been reached.
8. In-hospital basic and specialised dental-related procedures, such as dental implants and wisdom teeth extractions, are covered.
9. Our TRAUMA COUNSELLING BENEFIT covers trauma counselling consultation fees even if the traumatic event occurred before your cover start date.
10. Our ACCESS OPTIMISER and ACCESS CO-PAY PLUS[300] options cover specific medical procedures excluded by some medical aids.

GAP MATCH

Every medical aid plan has a **Gap Cover** option to match — the perfect pair. Like the buffalo and oxpecker.

The level of medical expense shortfall cover you need depends on your medical aid plan.

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, either option would be ideal for you.	COMPACT[300] OR MERIDIAN[400]
• 100%, 200%, or 300% medical aid plan and want the highest level of cover for shortfalls on doctors' and specialists' private fees and additional cover for cancer treatment, co-payments, internal prosthetic devices, out-patient specialist consultations, private room fees, scopes, and specialised scans, this option is ideal for you.	ELITE[500]
• medical aid plan that excludes specific medical procedures, such as arthroscopic surgery and dental procedures for impacted teeth, this option is for you.	ACCESS OPTIMISER
• 100%, 200%, or 300% medical aid plan that excludes specific procedures, such as bunion surgery and endoscopic procedures, and want cover for shortfalls on doctors' and specialists' private fees and additional cover for co-payments, this option is ideal for you.	ACCESS CO-PAY PLUS[300]
• 100%, 200%, or 300% medical aid plan that excludes specific procedures, such as functional nasal and joint replacement surgeries, and want cover for shortfalls on doctors' and specialists' private fees and additional cover for cancer treatment, co-payments, and internal prosthetic devices, the 300% or 400% combination would be ideal for you.	ACCESS OPTIMISER AND COMPACT[300] OR MERIDIAN[400]
• 100%, 200%, or 300% medical aid plan that excludes specific procedures, such as oesophageal reflux and hiatus hernia surgery, and want the highest level of cover for shortfalls on doctors' and specialists' private fees and additional cover for cancer treatment, co-payments, internal prosthetic devices, out-patient specialist consultations, private room fees, scopes, and specialised scans, this combination is ideal for you.	ACCESS OPTIMISER AND ELITE[500]

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.

INDIVIDUAL GAP COVER PRODUCT RANGE & PREMIUM OVERVIEW

		MERIDIAN[400]			COMPACT[300]		
OVERALL POLICY LIMIT (OPL)		**R 210 580** per insured person per year					
IN- OR OUT-OF-HOSPITAL COVER		**IN**	**OUT**		**IN**	**OUT**	
KEY BENEFITS SUBJECT TO THE OPL							
	GAP BENEFIT	✓		400%	✓	✓	300%
	CO-PAYMENT BENEFITS						
ADMISSION AND PROCEDURE CO-PAYMENTS		✓		Subject to OPL of **R 210 580** per person	✓	✓	**R 20 000** per policy
PENALTY CO-PAYMENTS		✓		**1 Co-payment** up to **R 9 000** per policy	✓		**R 10 000** per policy
ROBOTIC SURGERY CO-PAYMENTS		✓		✗	✓		✗
SCOPE CO-PAYMENTS			✓	**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**
Dental procedures such as wisdom teeth extractions		✓		**R 10 000** per policy	✓		**R 30 000** per policy
Dental procedures due to accidental events or cancer treatment		✓		**R 28 000** per policy	✓		Subject to OPL of **R 210 580** per person
ADMISSION AND PROCEDURE CO-PAYMENTS		✓		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**
	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**	✓		Subject to **Admission and Procedure Co-Payment Benefit**
PENALTY CO-PAYMENTS		✓		Subject to **Penalty Co-Payment Benefit**	✓		Subject to **Penalty Co-Payment Benefit**
PRE- AND POST-NATAL CONSULTATIONS			✓	✗		✓	✗
PREVENTATIVE PROCEDURES			✓	✗		✓	✗
PRIVATE ROOM		✓		✗	✓		✗
	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**	✓	✓	Subject to **Admission and Procedure Co-Payment Benefit**
MRI, CT AND PET SCAN CO-PAYMENTS			✓	**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 SUB-LIMITS		✓	✓	**R 5 000** per person per event	✓	✓	**R 3 500** per person per event
MRI, CT AND PET SCAN TOP-UP		✓	✓	✗	✓	✓	✗

GOOD TO KNOW

We offer an extensive **Corporate Gap Cover Product Range** to employer groups. Premiums for employer groups are determined by factors such as the group's size, average age, and compulsory vs. voluntary cover.

Visit www.stratumbenefits.co.za/gap-cover-downloads/ or scan the **QR code** to view or download our **Corporate Gap Cover Product Range Overview**.

ELITE[500]	ACCESS OPTIMISER			ACCESS CO-PAY PLUS[300]
R 210 580 per insured person per year	**R 210 580** per insured person per year			
	IN	OUT		
	KEY BENEFITS SUBJECT TO THE OPL			
500%	✓	✓	✗	300%
Subject to OPL of **R 210 580** per person	✓	✓	✗	**R 6 500** per policy
2 Co-payments up to **R 15 000** per co-payment per policy	✓		✗	✗
R 10 000 per policy	✓		✗	✗
Subject to **Admission and Procedure Co-Payment Benefit**	✓	✓	✗	Subject to **Admission and Procedure Co-Payment Benefit**
Subject to **Gap Benefit**	✓		✗	Subject to **Gap Benefit**
R 50 000 per policy	✓		✗	**R 30 000** per policy
Subject to OPL of **R 210 580** per person	✓		✗	Subject to OPL of **R 210 580** per person
Subject to **Admission and Procedure Co-Payment Benefit**	✓		✗	Subject to **Admission and Procedure Co-Payment Benefit**
Subject to **Penalty Co-Payment Benefit**	✓		✗	✗
Subject to **Gap Benefit**	✓	✓	✗	Subject to **Gap Benefit**
Subject to **Admission and Procedure Co-Payment Benefit**	✓		✗	Subject to **Admission and Procedure Co-Payment Benefit**
Subject to **Penalty Co-Payment Benefit**	✓		✗	✗
Subject to **Out-Patient Specialist Consultation Benefit**		✓	✗	✗
Subject to **Preventative Care Benefit**		✓	✗	✗
Subject to **Private Room Benefit**	✓		✗	✗
Subject to **Gap Benefit**	✓	✓	✗	Subject to **Gap 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**	✓	✓	✗	Subject to **Admission and Procedure Co-Payment Benefit**
R 5 000 per person per event	✓	✓	✗	✗
R 5 000 per policy	✓	✓	✗	✗

IN- OR OUT-OF-HOSPITAL COVER	MERIDIAN[400] IN	MERIDIAN[400] OUT	MERIDIAN[400]	COMPACT[300] IN	COMPACT[300] OUT	COMPACT[300]
KEY BENEFITS SUBJECT TO THE OPL						
ACCESS BENEFIT	✓	✓	✗	✓	✓	✗
SUB-LIMIT BENEFITS						
COLONOSCOPIES, ENTEROSCOPIES AND GASTROSCOPIES	✓	✓	✗	✓	✓	✗
INTERNAL PROSTHETIC DEVICE SHORTFALLS	✓		**2 Events** up to **R 20 000** per event per policy	✓		**R 30 000** per person per event
INTERNAL PROSTHETIC DEVICE TOP-UP	✓		✗	✓		✗
RENAL DIALYSIS TREATMENTS		✓	✗		✓	✗
CANCER BENEFITS						
BREAST RECONSTRUCTION	✓		✗	✓		✗
CANCER TREATMENT SHORTFALLS	✓	✓	**R 50 000** per person	✓	✓	Subject to OPL of **R 210 580** per person
CANCER TREATMENT TOP-UP	✓	✓	✗	✓	✓	**R 60 000** per person
PHYSICAL REHABILITATION TOP-UP BENEFIT		✓	✗		✓	✗
OUT-PATIENT SPECIALIST CONSULTATION BENEFIT		✓	✗		✓	✗
CASUALTY BENEFITS						
ACCIDENTAL EVENTS Individuals of all ages		✓	**R 9 500** per person per event		✓	**R 6 000** per policy
ILLNESS EVENTS Children 10 years or younger		✓	**2 Events** up to **R 3 000** per event per policy		✓	
ILLNESS EVENTS Individuals 11 years or older		✓			✓	✗
TRAUMA COUNSELLING BENEFIT		✓	**3 Consultations** up to **R 2 000** per consultation per policy		✓	**R 5 000** per policy
PREVENTATIVE CARE BENEFIT		✓	✗		✓	✗
BENEFITS NOT SUBJECT TO THE OPL						
PRIVATE ROOM BENEFIT	✓		✗	✓		✗
PAYOUT BENEFITS						
ACCIDENTAL DEATH AND DISABILITY			✗			**1 Event** per person **R 15 000** Principal Insured **R 15 000** Spouse **R 5 000** Other Dependants
FIRST-TIME CANCER DIAGNOSIS			✗			**1 Event** of **R 15 000** per person per lifetime
WAIVER BENEFITS						
MEDICAL AID CONTRIBUTION WAIVER			✗			✗
STRATUM POLICY PREMIUM WAIVER			✗			✗
LIFESTYLE BENEFIT						
INTERNATIONAL TRAVEL INSURANCE			✗			✗

MONTHLY PREMIUMS

Premiums increase annually on 1 January

MERIDIAN[400]		
INDIVIDUAL 35 or YOUNGER		R 250
INDIVIDUAL BETWEEN 36 and 64		R 320
FAMILY 64 or YOUNGER		R 320
INDIVIDUAL OR FAMILY 65 or OLDER		R 698

COMPACT[300]		
INDIVIDUAL 64 or YOUNGER		R 330
FAMILY 64 or YOUNGER		R 399
INDIVIDUAL OR FAMILY 65 or OLDER		R 629

ELITE[500]	IN	OUT	ACCESS OPTIMISER	ACCESS CO-PAY PLUS[300]
			KEY BENEFITS SUBJECT TO THE OPL	
⊗	✓	✓	Covers specific medical procedures and treatments that some medical aid plans exclude, subject to our benefit limits per person:	
			R 10 000 • Endoscopic procedures	
R 6 500 per person per event			**R 15 000** • Adenoidectomy, myringotomy (grommets) or tonsillectomy	
R 40 000 per person per event			**R 15 000** • MRI or CT scan (due to an accident)	
R 10 000 per person per event			**R 20 000** • Bunion surgery	
R 30 000 per person per event			**R 20 000** • Dental procedures for impacted teeth (children **younger** than **18**)	
			R 25 000 • Non-cancerous breast conditions (incl. breast reconstruction of an unaffected breast)	
1 Event up to **R 30 000** per person per lifetime			**R 25 000** • Removal of varicose veins	
Subject to OPL of **R 210 580** per person			**R 25 000** • Skin disorders (incl. benign growths and lipomas)	
Subject to OPL of **R 210 580** per person			**R 30 000** • Functional nasal surgery	
R 10 000 per person			**R 30 000** • Knee or shoulder surgery	
4 Consultations up to **R 1 300** per consultation per policy			**R 60 000** • Joint replacement surgery (incl. non-PMB joint replacements and internal prosthetic devices)	
			R 60 000 • Oesophageal reflux and hiatus hernia surgery	
			R 72 000 • Arthroscopic surgery	
			R 72 000 • Back or neck surgery	
			R 85 000 • Cochlear implant, auditory brain implant and internal nerve stimulator surgery (incl. procedure, device, processor and hearing aids if part of a bimodal solution)	
			R 85 000 • Dental procedures for reconstructive surgery (due to an accident)	
R 15 000 per policy		✓	**R 3 000** per policy	**R 3 000** per policy
		✓		
R 2 000 per policy		✓	⊗	⊗
R 10 000 per policy		✓	⊗	⊗
R 1 800 per policy		✓	⊗	⊗
			BENEFITS NOT SUBJECT TO THE OPL	
R 3 500 per policy	✓		⊗	⊗
1 Event per person **R 25 000** Principal Insured **R 25 000** Spouse **R 5 000** Other Dependants			**1 Event** per person **R 5 000** Principal Insured **R 5 000** Spouse	**1 Event** per person **R 5 000** Principal Insured **R 5 000** Spouse
1 Event of **R 30 000** per person per lifetime			⊗	⊗
6 Months up to **R 4 500** per month			⊗	⊗
12 Months			⊗	⊗
1 Trip up to **31 days** per policy			⊗	⊗

ELITE[500]		ACCESS OPTIMISER		ACCESS CO-PAY PLUS[300]	
INDIVIDUAL 64 or YOUNGER	R 481	INDIVIDUAL OR FAMILY 64 or YOUNGER	R 197	INDIVIDUAL OR FAMILY 64 or YOUNGER	R 404
FAMILY 64 or YOUNGER	R 591	INDIVIDUAL OR FAMILY 65 or OLDER	R 262	INDIVIDUAL OR FAMILY 65 or OLDER	R 537
INDIVIDUAL 65 or OLDER	R 780				
FAMILY 65 or OLDER	R 954				

COMPACT300

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.

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.

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 300%**, **400%** or **500%** 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.

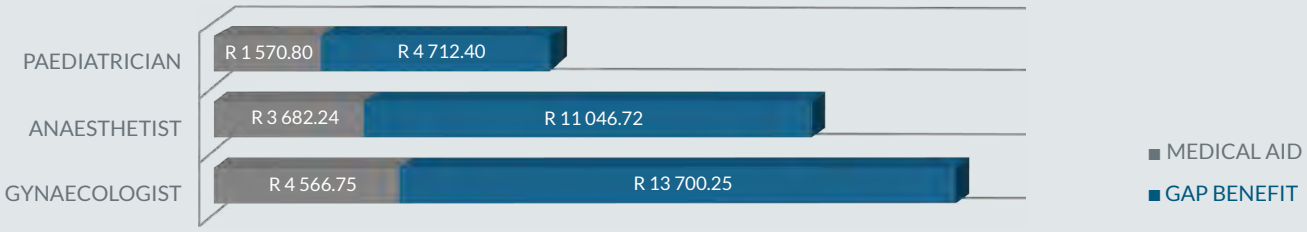
When submitting a claim for the shortfalls, the **Medical Aid Rate** column on the medical aid statement is our reference point for assessing them.

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

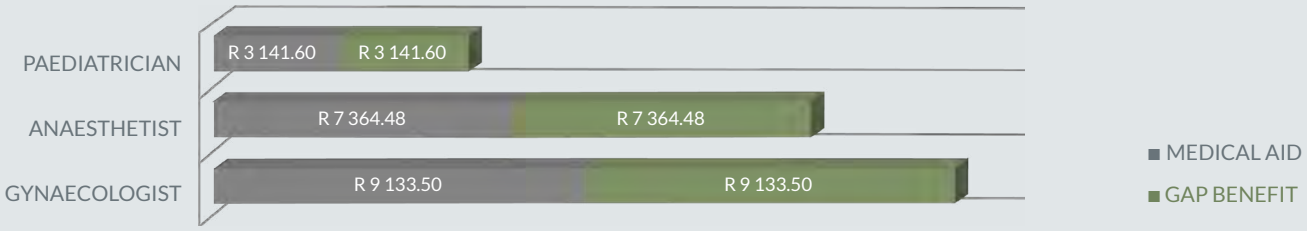
100% MEDICAL AID PLAN RATE + COMPACT[300]

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.



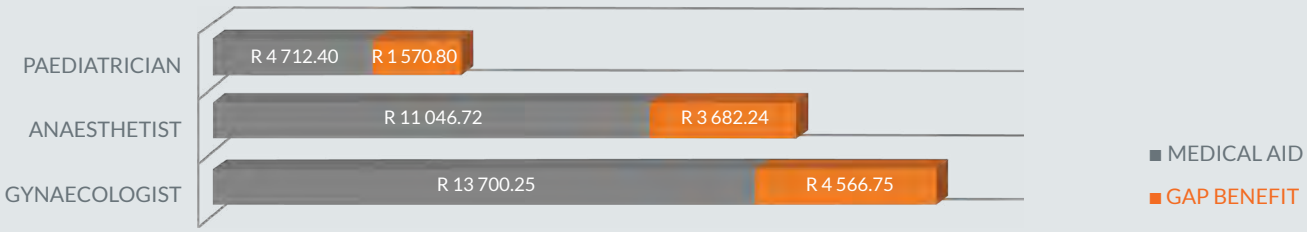
200% MEDICAL AID PLAN RATE + MERIDIAN[400]

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.



300% MEDICAL AID PLAN RATE + ELITE[500]

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



MERIDIAN400

Our **middle-of-the-range option** covers the most often experienced **in-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 **35** OR **YOUNGER**	IF YOU'RE BETWEEN **36** AND **64**	IF EVERYONE IN THE FAMILY IS **64** OR **YOUNGER**	IF **YOU** OR ANYONE IN THE **FAMILY** IS **65** OR **OLDER**
R 250 INDIVIDUAL	R 320 INDIVIDUAL	R 320 FAMILY	R 698 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.

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-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 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 **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 210 580 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 and hospitals 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 9 000 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**.
- 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** 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.	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 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.

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 sub-limit or annual limit to in- and out-of-hospital MRI, CT, or PET 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-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-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 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.

Limited to **R 50 000 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.
- 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 **R 9 500 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 **18:00** and **7:00** Monday through Friday and all day Saturday, Sunday, and public holidays.

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; and
- medication administered during an event.

Limited to **2 events** up to **R 3 000 per event 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.

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

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 **3 consultations** up to **R 2 000 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.
- You're covered from day one because this benefit isn't subject to any waiting periods.

TRAUMA COUNSELLING BENEFIT GUIDE

For more information about this benefit, go to www.stratumbenefits.co.za/trauma-counselling-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.

ELITE500

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 481 INDIVIDUAL	R 591 FAMILY	R 780 INDIVIDUAL	R 954 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.

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** 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 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 **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

Claim as many admission and procedure-related co-payments as needed. Subject to the **OPL** of **R 210 580 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 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 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.

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.

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.
- 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

IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS

When your medical aid pays part of the cost of a colonoscopy, enteroscopy or gastroscopy, we'll cover the **difference** or **top up** your cover when your medical aid plan's sub-limit or annual 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 6 500 per insured person per event**.

INTERNAL PROSTHETIC DEVICE SHORTFALLS

IN-HOSPITAL 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 40 000 per insured person per event**.

External medical items aren't covered.

INTERNAL PROSTHETIC DEVICE TOP-UP

IN-HOSPITAL COVER

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 person per event**.

RENAL DIALYSIS TREATMENTS

OUT-OF-HOSPITAL COVER

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, 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 **total cost** of 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 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 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**.

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 210 580 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.

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

GOOD TO KNOW

- Our benefit doesn't cover consultation fees of general practitioners or allied healthcare providers, 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 BENEFITS

There are **three benefit categories**.

ACCIDENTAL EVENTS INDIVIDUALS OF ALL AGES 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 **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.	Individuals **11 years** or **older** 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.
Limited to **R 15 000 per policy per year**.		Limited to **R 2 000 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; 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.

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

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 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** 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 1 800 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)

*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

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 3 500 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.
- 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, 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

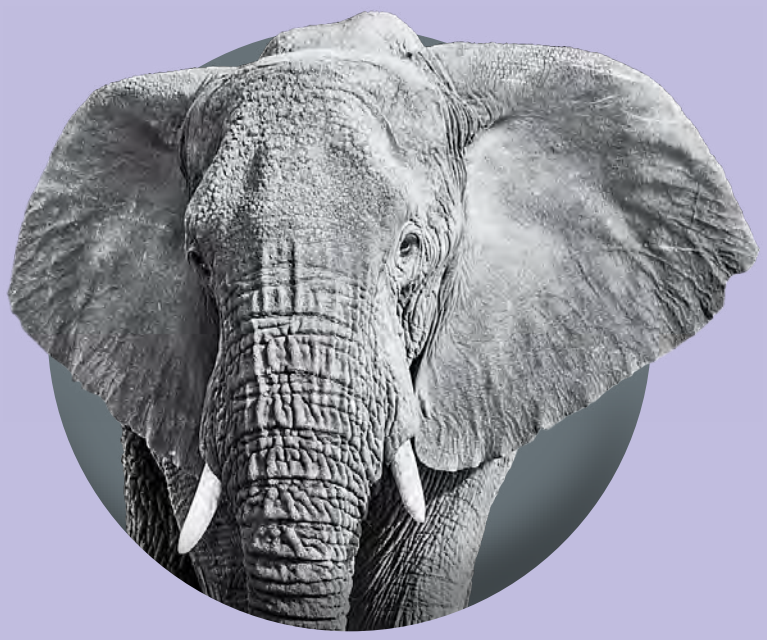
WHAT'S ON OFFER

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 will only be liable to pay a pro-rata portion of the claim submitted in terms of the policy.



ACCESS OPTIMISER

Our **booster option** covers specific medical procedures, treatments, scans, and surgeries that some medical aid plans exclude.

PREMIUMS FOR INDIVIDUALS AND FAMILIES

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

IF **YOU** AND EVERYONE IN THE **FAMILY** ARE **64** OR **YOUNGER**	IF **YOU** OR ANYONE IN THE **FAMILY** IS **65** OR **OLDER**
R 197 INDIVIDUAL or FAMILY	R 262 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.

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**.*

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 cover the cost of an upcoming medical event if:

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

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

Please send us the cost estimates from all the service providers you choose as your preferred providers, such as the day clinic or hospital, surgeon, and anaesthetist and a claim form. If your claim is approved, we'll issue a guarantee of payment to all the providers as an undertaking to pay them directly after your medical event.

WHAT WE COVER

We'll cover the cost of your admission to a day clinic or hospital and the related service and healthcare providers' fees up to the benefit limit specific to your upcoming medical event.

Limited **per insured person per year**.

MEDICAL PROCEDURES AND TREATMENTS NOT COVERED BY YOUR MEDICAL AID	ACCESS BENEFIT
Adenoidectomy, myringotomy (grommets) or tonsillectomy	**R 15 000**
Arthroscopic surgery	**R 72 000**
Back or neck surgery	**R 72 000**
Bunion surgery	**R 20 000**
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 85 000**
Dental procedures for impacted teeth for children **younger** than **18**	**R 20 000**
Dental procedures for reconstructive surgery required due to an accident	**R 85 000**
Endoscopic procedures	**R 10 000**
Functional nasal surgery	**R 30 000**
Joint replacement surgery (including non-PMB joint replacements and internal prosthetic devices)	**R 60 000**
Knee or shoulder surgery	**R 30 000**
MRI or CT scan required due to an accident	**R 15 000**
Non-cancerous breast conditions (including breast reconstruction of an unaffected breast)	**R 25 000**
Oesophageal reflux and hiatus hernia surgery	**R 60 000**
Removal of varicose veins	**R 25 000**
Skin disorders (including benign growths and lipomas)	**R 25 000**

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.

ACCESS OPTIMISER is ideal if your medical aid plan excludes any of the medical procedures and 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, ACCESS OPTIMISER with COMPACT[300] or MERIDIAN[400] is an ideal combination.

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

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 3 000 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.

BENEFIT NOT SUBJECT TO THE OVERALL POLICY LIMIT (OPL)

*The following benefit isn't subject to the **OPL** because we give this benefit to you over and above those that form part of 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 5 000 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.

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.

ACCESS CO-PAY PLUS[300]

Our **booster option** covers specific medical procedures, treatments, scans, and surgeries that some medical aid plans exclude. It also covers the **most often experienced in-** and **out-of-hospital** medical expense shortfalls for medical procedures that aren't excluded.

PREMIUMS FOR INDIVIDUALS AND FAMILIES

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

IF **YOU** AND EVERYONE IN THE **FAMILY** ARE **64** OR **YOUNGER**	IF **YOU** OR ANYONE IN THE **FAMILY** IS **65** OR **OLDER**
R 404 INDIVIDUAL or FAMILY	R 537 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.

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**.*

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 cover the cost of an upcoming medical event if:

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

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

Please send us the cost estimates from all the service providers you choose as your preferred providers, such as the day clinic or hospital, surgeon, and anaesthetist and a claim form. If your claim is approved, we'll issue a guarantee of payment to all the providers as an undertaking to pay them directly after your medical event.

WHAT WE COVER

We'll cover the cost of your admission to a day clinic or hospital and the related service and healthcare providers' fees up to the benefit limit specific to your upcoming medical event.

Limited **per insured person per year**.

MEDICAL PROCEDURES AND TREATMENTS NOT COVERED BY YOUR MEDICAL AID	ACCESS BENEFIT
Adenoidectomy, myringotomy (grommets) or tonsillectomy	**R 15 000**
Arthroscopic surgery	**R 72 000**
Back or neck surgery	**R 72 000**
Bunion surgery	**R 20 000**
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 85 000**
Dental procedures for impacted teeth for children **younger** than **18**	**R 20 000**
Dental procedures for reconstructive surgery required due to an accident	**R 85 000**
Endoscopic procedures	**R 10 000**
Functional nasal surgery	**R 30 000**
Joint replacement surgery (including non-PMB joint replacements and internal prosthetic devices)	**R 60 000**
Knee or shoulder surgery	**R 30 000**
MRI or CT scan required due to an accident	**R 15 000**
Non-cancerous breast conditions (including breast reconstruction of an unaffected breast)	**R 25 000**
Oesophageal reflux and hiatus hernia surgery	**R 60 000**
Removal of varicose veins	**R 25 000**
Skin disorders (including benign growths and lipomas)	**R 25 000**

GOOD TO KNOW

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

ACCESS CO-PAY PLUS[300] is ideal if your medical aid plan excludes any of the medical procedures and 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

IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS

Our **ACCESS BENEFIT** helps cover the cost of specific medical procedures, treatments, scans, and surgeries if your medical aid plan excludes it or only covers 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 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 BENEFIT

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.

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 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**.
- 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 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?

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
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**.
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 radiology-related co-payments. Subject to our **ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT**.

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 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 3 000 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.

BENEFIT NOT SUBJECT TO THE OVERALL POLICY LIMIT (OPL)

*The following benefit isn't subject to the **OPL** because we give this benefit to you over and above those that form part of 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 5 000 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.

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:

- 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 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 BENEFITS 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%, 400% or 500% 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, 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. 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.