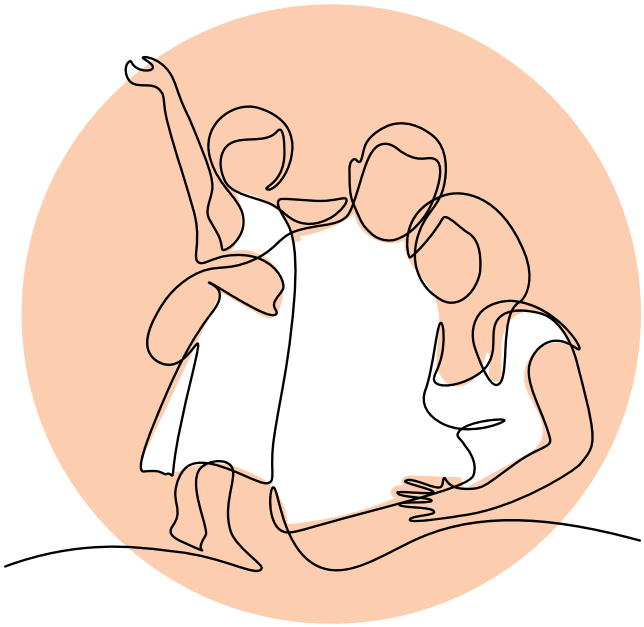
| 2023 |

Stratum Benefits



ELITE

It's our **premium option** that offers the **widest range** of benefits.

ELITE 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 ANY **DEPENDANT** IS **65** OR **OLDER**
R 404 INDIVIDUAL	R 496 FAMILY	R 656 INDIVIDUAL	R 801 FAMILY

One **Gap Cover** policy covers you, your spouse and all the dependants registered on your and your spouse's medical aid plans.

ELITE

Stratum Benefits

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KEY BENEFITS SUBJECT TO AN OVERALL POLICY LIMIT (OPL)

*An **OPL** of **R 185 837 per insured person per year** applies to the following benefits. 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**.

WHAT WE COVER

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

Subject to the **OPL** of **R 185 837 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 are met, you shouldn't incur any out-of-pocket medical expenses related to PMBs.
- Your medical aid could refer to a **hospital benefit** as a **risk**, **major medical**, **insured day-to-day** or **block benefit**.
- Our benefit is subject to waiting periods and the **10 Month Limited Payout Benefit** unless we confirm otherwise. Refer to the **Waiting Periods** page.

Have a look at **DENTAL**, **MATERNITY** and **RADIOLOGY COVER** to see what other shortfalls we cover.

CO-PAYMENT BENEFIT

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

Our benefit has **three categories**.

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

HOW IT WORKS

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

WHAT WE COVER

Claim as many admission and procedure-related co-payments and deductibles as needed. Subject to the **OPL** of **R 185 837 per insured person per year**. Benefit limits apply to **PENALTY CO-PAYMENTS** and **ROBOTIC SURGERY CO-PAYMENTS**.	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 from us when you choose to use non-network providers. Limited to **R 13 000 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

- We don't refund payments that your healthcare providers may ask you to pay to them before your medical event. This is known as split billing. We only refund co-payments and deductibles that your medical aid imposes. Ask your healthcare provider to submit a detailed account to your medical aid for payment that reflects their private fee. That way, your medical aid can pay their portion up to your medical aid plan's rate, and we can assess the shortfalls under our **GAP BENEFIT**.
- Our benefit is subject to waiting periods and the **10 Month Limited Payout Benefit** unless we confirm otherwise. Refer to the **Waiting Periods** page.

Our **CO-PAYMENT BENEFIT** also covers co-payments and deductibles specific to dentistry, childbirth and specialised radiology. Have a look at **DENTAL**, **MATERNITY** and **RADIOLOGY COVER**.

DENTAL COVER

Whether you have extractions or fillings done in the dentist's chair or booked into a day clinic or hospital for dental implants or oral surgery, our benefits can assist with the shortfalls and co-payments.

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

GAP BENEFIT IN- AND OUT-OF-HOSPITAL COVER	CO-PAYMENT BENEFIT ADMISSION AND PROCEDURE CO-PAYMENTS IN- AND OUT-OF-HOSPITAL COVER
HOW IT WORKS	
We cover the **shortfalls** when: • the cost of your dental-related procedure performed in a day clinic, hospital, or your healthcare professional's room is more than your medical aid plan's rate, • as long as your medical aid pays an amount from a **hospital** or **insured day-to-day benefit**.	We **refund** co-payments and deductibles that your **medical aid imposes** as rand amounts or percentages on: • day clinic and hospital admissions and dental-related procedures done in- or out-of-hospital, • as long as the co-payment or deductible is paid from your **medical savings account** or **your pocket**.
WHAT WE COVER	
We pay up to an **additional** 500% cover on top of what your medical aid provides to cover shortfalls on your dentists' and specialists' accounts related to the following in- and out-of-hospital medical events: • dental procedures, such as dental implants, orthodontic treatment and wisdom teeth extractions. Limited to **R 8 000 per policy per year**. • dental procedures related to accidental injury and cancer treatment. Limited to **R 24 000 per policy per year**.	Claim as many admission and dental procedure-related co-payments and deductibles as needed. Subject to the **OPL** of **R 185 837 per insured person per year**.

GOOD TO KNOW

- Your medical aid could refer to a **hospital** or **insured day-to-day benefit** as a **risk**, **major medical** or **block benefit**.
- We don't refund payments that your healthcare providers may ask you to pay to them before your medical event. This is known as split billing. We only refund co-payments and deductibles that your medical aid imposes. Ask your healthcare provider to submit a detailed account to your medical aid for payment that reflects their private fee. That way, your medical aid can pay their portion up to your medical aid plan's rate and we can assess the shortfalls under our **GAP BENEFIT**.
- Our benefits are subject to waiting periods and the **10 Month Limited Payout Benefit** unless we confirm otherwise. Refer to the **Waiting Periods** page.

Claim the penalty co-payments from us when your medical aid imposes co-payments or deductibles for the use of day clinics and hospitals outside their preferred network. Subject to our **PENALTY CO-PAYMENT BENEFIT**.

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** from us between what: • healthcare professionals, such as your gynaecologist or obstetrician, charge for virtual and face-to-face consultations in the 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**. This is a consultation benefit, meaning ancillary tests or investigations typically done with consultations, such as urine tests and sonars, won't be covered.	**CHILDBIRTH** 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 the delivery of your baby in hospital or at home, • as long as your medical aid pays an amount from a **hospital benefit**. Subject to our **GAP BENEFIT**.	**POST-NATAL CONSULTATIONS** OUT-OF-HOSPITAL COVER Claim the **shortfalls** from us between what: • healthcare professionals, such as your gynaecologist or the paediatrician, charge for virtual and face-to-face consultations in the rooms and the rate your medical aid plan 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 mommies can get a flu vaccination in their second trimester. Always consult your healthcare professional first. Claim the **shortfall** or **total cost** of the flu vaccination and other preventative tests and procedures, such as a full blood count, from us when paid from your **medical savings account** or **your pocket**. Subject to our **PREVENTATIVE CARE BENEFIT**.	**CO-PAYMENTS AND DEDUCTIBLES** IN-HOSPITAL COVER We **refund** co-payments and deductibles that your **medical aid imposes** on elective caesareans as long as the co-payment or deductible is paid from your **medical savings account** or **your pocket**. Subject to our **CO-PAYMENT BENEFIT**. Claim the penalty co-payments from us when your medical aid imposes co-payments or deductibles for the use of day clinics and hospitals outside their preferred network. Subject to our **PENALTY CO-PAYMENT BENEFIT**.	**CHILDHOOD IMMUNISATIONS AND BIRTH CONTROL** OUT-OF-HOSPITAL COVER We cover the **shortfalls** or **total cost** of a flu vaccination for your baby from **7 months** or **older**. Always consult your healthcare professional first. We also cover the **shortfalls** or **total cost** of childhood immunisations according to the Department of Health Formulary for children aged **12 years** or **younger**. Other preventative tests and procedures, such as a contraceptive device implant, are also covered when paid from your **medical savings account** or **your pocket**. Subject to our **PREVENTATIVE CARE BENEFIT**. Take your little one to the nearest registered casualty facility when they fall ill after-hours. Our **CASUALTY BENEFIT** provides cover for children aged **10 years** or **younger**.

PRIVATE ROOM BENEFIT
IN-HOSPITAL COVER

Spend time with your newborn. Claim the **shortfalls** or **total cost** from us when your medical aid pays part of the cost of a private hospital room or when they don't provide cover.

Or claim the hospital's lodger fee when your spouse stays with you and your newborn or the hospital's nursery fee if you're hospitalised after the delivery and need to nurse your little one.

Subject to our **PRIVATE ROOM BENEFIT**.

GOOD TO KNOW

- Send us a medical aid membership certificate or birth certificate to add your newborn.
- Your medical aid could refer to a **maternity benefit** as a **hospital**, **risk**, **major medical**, **insured day-to-day** or **block benefit**.
- Our benefits are subject to waiting periods and our **GAP** and **CO-PAYMENT BENEFITS** are also subject to the **10 Month Limited Payout Benefit** unless we confirm otherwise. Refer to the **Waiting Periods** page.

SUB-LIMIT BENEFIT

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

Our benefit has **three categories**.

COLONOSCOPIES, ENTEROSCOPIES AND GASTROSCOPIES	INTERNAL PROSTHETIC DEVICES	RENAL DIALYSIS TREATMENTS
IN- AND OUT-OF-HOSPITAL COVER	IN-HOSPITAL COVER	OUT-OF-HOSPITAL COVER

HOW IT WORKS

When your medical aid covers the cost of a:

- colonoscopy, enteroscopy, gastroscopy, internal prosthetic device or renal dialysis treatment 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 of the scope, device or treatment, we'll cover the **difference**.

WHAT WE COVER

Our benefit works in two ways. • If you go for an in- or out-of-hospital colonoscopy, enteroscopy or gastroscopy and there's a shortfall on the anaesthetist's account, we'll cover the shortfall. • We'll also cover the difference in cost of the scope itself if your medical aid pays part of the cost from a **sub-limit** or **annual limit**. Limited to **R 5 000 per insured person per event**.	We'll cover the difference in cost of any internal prosthetic device implanted into your body when your medical aid pays part of the cost from a **sub-limit** or **annual limit**. An internal prosthetic device can replace a body part, such as a hip joint, or improve a lost or reduced bodily function, such as a cardiac pacemaker, cochlear implant or an intraocular lens. Limited to **R 30 000 per insured person per event**. External medical items aren't covered.	We'll cover the difference in cost of renal dialysis treatment 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

- Our benefit is subject to waiting periods and the **10 Month Limited Payout Benefit** unless we confirm otherwise. Refer to the **Waiting Periods** page.

Have a look at our **SUB-LIMIT BENEFIT** and **TOP-UP BENEFIT** under **RADIOLOGY COVER** to see what we cover for MRI, CT and PET scans.

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 is there a combined benefit limit on x-rays and scans? We've got the cover you need.

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

GAP BENEFIT	CO-PAYMENT BENEFIT ADMISSION AND PROCEDURE CO-PAYMENTS	SUB-LIMIT BENEFIT MRI, CT AND PET SCANS	TOP-UP BENEFIT MRI, CT AND PET SCANS
IN- AND OUT-OF-HOSPITAL COVER	IN- AND OUT-OF-HOSPITAL COVER	IN- AND OUT-OF-HOSPITAL COVER	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**.	We **refund** co-payments and deductibles that your **medical aid imposes** as rand amounts or percentages on in- or out-of-hospital basic and specialised radiology, as long as the co-payment or deductible is paid from your **medical savings account** or **your 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 of the scans, we'll cover the **difference**.	Does your medical aid plan cover in- or out-of-hospital MRI, CT and PET scans up to a benefit limit? We'll **top up** your cover and pay the **total cost** of in- or out-of-hospital MRI, CT and PET scans when your medical aid plan's radiology benefit is reached.

WHAT WE COVER			
We pay up to an **additional** 500% cover on top of what your medical aid provides to cover shortfalls on basic and specialised radiology. Subject to the **OPL** of **R 185 837 per insured person per year**.	Claim as many radiology-related co-payments and deductibles as needed. Subject to the **OPL** of **R 185 837 per insured person per year**.	Limited to **R 5 000 per insured person per event**.	Limited to **R 5 000 per policy per year**.

GOOD TO KNOW

- Your medical aid could also refer to a **hospital** or **insured day-to-day benefit** as a **risk**, **major medical** or **block benefit**.
- Our benefits are subject to waiting periods and our **GAP**, **CO-PAYMENT** and **SUB-LIMIT BENEFITS** are also subject to the **10 Month Limited Payout Benefit** unless we confirm otherwise. Refer to the **Waiting Periods** page.

CANCER BENEFIT

Our benefit has **three categories**.

BREAST RECONSTRUCTION IN-HOSPITAL COVER	CANCER TREATMENT SHORTFALLS IN- AND OUT-OF-HOSPITAL COVER	CANCER TREATMENT TOP-UP IN- AND OUT-OF-HOSPITAL COVER
HOW IT WORKS		
Our benefit covers the **total cost** of the reconstruction of an **unaffected** breast when your medical aid plan excludes it from cover.	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 your ongoing cancer treatment when your medical aid plan's benefit limit is reached.
WHAT WE COVER		
We'll cover the cost of either the flap reconstruction, insertion or removal of the breast implant. Limited to **1 event** up to **R 30 000 per insured person per lifetime**. Our benefit doesn't cover the cost to have the unaffected breast removed, but the reconstruction thereof when your medical aid plan's doesn't provide cover. We'll cover the cost of the reconstruction of the unaffected breast limited to one event per insured person per lifetime. This means our benefit won't apply if you've had a breast reconstruction on an affected or unaffected breast before your policy's start date. Shortfalls that exist when breast cancer is diagnosed and the affected breast is removed and reconstructed can be claimed from our **GAP BENEFIT**.	The shortfalls we'll cover are subject to the oncology treatment plan your medical aid approved. Our benefit typically covers: • biological medication; • chemotherapy and radiotherapy; • consultations with your oncologist; and • specialised radiology, such as bone density and PET scans. We'll also **refund** the oncology-related co-payments and deductibles that your **medical aid imposes** as rand amounts or percentages when your medical aid plan's oncology benefit limit is reached. Subject to the **OPL** of **R 185 837 per insured person per year**. Your medical aid may impose co-payments or deductibles on precision and innovative oncology medication. These co-payments or deductibles typically apply from the onset of cover. Our benefit covers the co-payments and deductibles that apply after an oncology benefit limit is reached and not before.	We'll cover the cost of your ongoing cancer treatment subject to the oncology treatment plan your medical aid approved. Subject to the **OPL** of **R 185 837 per insured person per year**.

GOOD TO KNOW

- Our benefit is subject to waiting periods. Refer to the **Waiting Periods** page.

Have a look at our **FIRST-TIME CANCER DIAGNOSIS BENEFIT** under the **PAYOUT BENEFIT** to see what we cover for a cancer diagnosis.

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 the number of days you may stay at a sub-acute or step-down facility is limited, we'll **top up** your cover and pay the **total cost** of your ongoing rehabilitation when your medical aid plan's benefit limit is reached.

WHAT WE COVER

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

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

GOOD TO KNOW

- We define a sub-acute or step-down facility as a registered facility that focuses on rehabilitation after physical injury due to an accident, where rehabilitation is provided by appropriately qualified and registered therapists.
- You're covered from the first day your policy starts because this benefit isn't subject to any waiting periods.

We don't cover physical rehabilitation related to an illness or ongoing physical rehabilitation that you may need after you've been discharged.

OUT-PATIENT SPECIALIST CONSULTATION BENEFIT

OUT-OF-HOSPITAL COVER

HOW IT WORKS

Claim the **shortfalls** from us 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** 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 amount your specialists charge.

Limited to **R 1 300 per consultation** with a maximum of **3 consultations per policy per year**.

GOOD TO KNOW

- Your medical aid could also refer to a **risk benefit** as a **hospital**, **major medical**, **insured day-to-day** or **block benefit**.
- Our benefit doesn't cover consultation fees of general practitioners or allied healthcare providers, such as biokineticists, chiropractors and physiotherapists.
- Our benefit is subject to waiting periods and will always receive a **3 Month General Waiting Period** unless we confirm otherwise. Refer to the **Waiting Periods** page.

This is a consultation benefit, meaning ancillary tests or investigations typically done with consultations, such as urine tests and sonars, won't be covered.

CASUALTY BENEFIT

Our benefit has **two categories**.

ACCIDENTAL EVENTS OUT-OF-HOSPITAL COVER	ILLNESS OUT-OF-HOSPITAL COVER
HOW IT WORKS	
We cover the whole family at any registered medical facility, such as your doctor's room or the emergency unit at your nearest hospital, when: • an accident caused by physical impact results in bodily injury, • and medical treatment is required **within 24 hours** of the event. We'll **refund** the **shortfalls** or **total cost** of your casualty event when your medical aid pays it from your **medical savings account** or when you pay it from **your pocket**.	Children aged **10 years** or **younger** are covered at any registered casualty facility when: • they fall ill and require medical treatment after-hours, • between **18:00** and **7:00** on Mondays to Fridays or any time on Saturdays, Sundays and public holidays. We'll **refund** the **shortfalls** or **total cost** of the casualty event when your medical aid pays it from your **medical savings account** or when you pay it from **your pocket**.
WHAT WE COVER	
All the healthcare and service providers' accounts related to your event are covered, which typically include: • basic and specialised radiology; • co-payments and deductibles; • facility and consultation fees; • medication administered; • pathology; and • external medical items given to you at the facility on the day, such as a neck brace or arm sling. Go to any registered medical or casualty facility for a follow-up visit related to your accident to have, for example, stitches or a cast removed. You don't have to go back to the same facility.	All the healthcare and service providers' accounts related to the event are covered, which typically include: • basic and specialised radiology; • co-payments and deductibles; • facility and consultation fees; • medication administered; and • pathology.

Limited to **R 12 000 per policy per year**.

GOOD TO KNOW

- Our benefit applies even if your medical aid doesn't provide cover for casualty visits.
- You're covered from the first day your policy starts because this benefit isn't subject to any waiting periods.

If you go to a registered medical facility for treatment due to an accident and get admitted to hospital directly afterwards, the hospital admission becomes a new medical event, and any further claims submitted will be assessed based on the hospital admission and not the initial casualty event.

TRAUMA COUNSELLING BENEFIT

OUT-OF-HOSPITAL COVER

When you're dealing with a traumatic event and want to see a counsellor about it, our benefit can assist with the costs.

HOW IT WORKS

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

WHAT WE COVER

You're covered when you:

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

Limited to **R 10 000 per policy per year**.

GOOD TO KNOW

- Our benefit applies even if your medical aid plan doesn't provide cover for trauma counselling consultations.
- You're covered from the first day your policy starts because this benefit isn't subject to any waiting periods.

Trauma affects everyone at different times. We provide cover even if the traumatic event occurred before the start date of your policy.

PREVENTATIVE CARE BENEFIT

OUT-OF-HOSPITAL COVER

HOW IT WORKS

You're covered for essential preventative and screening tests.

Claim the **shortfalls** or **total cost** from us when your medical aid pays your healthcare providers' consultation fees or the cost of preventative tests or procedures from your **medical savings account** or when you pay it from **your pocket**.

WHAT WE COVER

Our benefit covers the following tests, scans, immunisations, procedures, vaccinations and screenings:

- blood glucose tests;
- bone density scans;
- childhood immunisations based on the Department of Health Formulary for children aged **12 years** or **younger**;
- cholesterol tests;
- contraceptive device implants;
- flu vaccinations;
- full blood counts;
- Human Papillomavirus vaccinations (HPV vaccine);
- mammograms and breast sonars;
- pap smears;
- prostate-specific antigen screenings; and
- testicular screenings.

Limited to **R 1 300 per policy per year**.

GOOD TO KNOW

- Our benefit applies even if your medical aid doesn't provide cover for preventative tests, screenings and procedures.
- This benefit is subject to only a **General Waiting Period**, meaning you can't claim during this period unless we confirm otherwise. Refer to the **Waiting Periods** page.

BENEFITS NOT SUBJECT TO THE OVERALL POLICY LIMIT (OPL)

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

PRIVATE ROOM BENEFIT

IN-HOSPITAL COVER

HOW IT WORKS

Whether your medical aid pays part of the cost of a private hospital room from your **medical savings account** or your medical aid plan doesn't provide cover, and the cost is paid from **your pocket**, we've got you covered.

WHAT WE COVER

Claim from us when:

- you choose to stay in a private hospital room;
- a hospital lodger fee is charged when you stay with your spouse or a family member when they're in hospital;
- a hospital lodger fee is charged when your spouse stays with you when you're in hospital; or when
- a hospital nursery fee is charged when you're in hospital and need to nurse your baby.

Limited to **R 3 000 per policy per year**.

GOOD TO KNOW

- The person the hospital lodger fee applies to must be a registered dependant on your **Gap Cover** policy.

PAYOUT BENEFITS

ACCIDENTAL DEATH AND DISABILITY

HOW IT WORKS

In the event of 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 that results in bodily injury caused by physical impact.

TOTAL AND PERMANENT DISABILITY...
means bodily injury resulting in total and absolute disablement that is beyond hope of improvement, which prevents the insured person from following their usual occupation or any other similar occupation for which they're suited by education or training. If the insured person is an individual or pensioner who's no longer gainfully employed, the 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 the first day your policy starts because this benefit isn't subject to any waiting periods.

FIRST-TIME CANCER DIAGNOSIS

HOW IT WORKS

When cancer is diagnosed for the first time in your life, a benefit amount is payable if the diagnosis meets specific qualifying criteria.

Our benefit applies when:

- you're diagnosed with cancer for the first time in your life after the start date of your policy;
- cancerous cells have invaded surrounding or underlying tissue; and
- cancer is diagnosed **before** age **65**.

Our benefit doesn't apply when the diagnosis is for:

- a tumour, that is histologically described as pre-malignant, non-invasive or as cancer in-situ;
- skin cancer, other than malignant melanoma;
- Stage 1 breast or prostate cancer; or when
- cancerous cells haven't invaded surrounding or underlying tissue, regardless of the stage of cancer.

WHAT WE COVER

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

GOOD TO KNOW

- This benefit is subject to a **General Waiting Period**, which means you can't claim for a cancer diagnosis made during this waiting period.
- 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 won't apply.

WAIVER BENEFITS

MEDICAL AID CONTRIBUTION WAIVER

HOW IT WORKS

If the contribution payer of your medical aid membership passes away or becomes totally and permanently disabled due to an accident, we'll step in and pay your 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 medical aid contributions for the members registered on your membership at the time of the event for **6 months**, limited to **R 4 500 per month per medical aid membership**.

GOOD TO KNOW

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

STRATUM POLICY PREMIUM WAIVER

HOW IT WORKS

If the premium payer of your **Gap Cover** policy passes away or becomes totally and permanently disabled due to an accident, we'll take over the payment of your premiums.

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 for **12 months**.

GOOD TO KNOW

- You can change your **Gap Cover** option when our benefit applies, but we'll pay the premium amount that applied before an upgrade.
- A premium payer is a person, registered company or entity who is solely responsible for paying your monthly policy premiums.
- You're covered from the first day your policy starts because this benefit isn't subject to any waiting periods.

LIFESTYLE BENEFITS

These Lifestyle Benefits are complimentary value-add products.

Visit our website at **www.stratumbenefits.co.za** for more information about the **LIFESTYLE BENEFITS** and how to register.

EXTRA HIGH SCHOOL LEARNING SUPPORT

WHAT'S ON OFFER

Gr.8 to **Gr.12** high school learners can access various e-learning solutions through Boston Online Home Education.

These solutions offer mind-stimulating offerings such as online CAPS and Cambridge International Curriculum content, educational webinars, career guidance for learners looking to enter the tertiary world, a wide variety of short learning programs and more.

After registering online, a coupon with a unique voucher number will be issued to access the Boston Online Home Education platform.

Your child has access to this platform during their high school years for as long as they remain covered on your policy.

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**. Inform us of your upcoming trip at least **7 days** before departure and submit proof of travel.

If your medical aid or any other insurance policy provides similar cover, our international travel insurance partner won't offer this cover.

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

WAITING PERIODS

UNDERWRITING APPLICABLE TO FIRST-TIME JOINERS

Waiting periods apply:

- from your policy's start date;
- to enhanced benefits when you upgrade to an option that provides more comprehensive cover; and
- each dependant's cover start date when they're added to your policy.

Accidental events that occur after your policy's start date are never subject to any waiting periods.

The below waiting periods will apply unless we confirm otherwise:

3 MONTH GENERAL WAITING PERIOD

- You don't have cover during this period except for accidental events that occur after your policy's start date.
- A standard **3 Month General Waiting Period** applies to our **OUT-PATIENT SPECIALIST CONSULTATION BENEFIT**.

12 MONTH PRE-EXISTING CONDITION WAITING PERIOD

You don't have cover during this period for investigations, medical procedures, surgeries or treatments related to any illness or medical condition diagnosed or that you received advice or treatment for **12 months** before your policy's start date.

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** to read more about our **Gap Cover Transfer Process for Individuals**.

10 MONTH LIMITED PAYOUT BENEFIT

The **10 Month Limited Payout Benefit** applies from your policy's start date and each dependant's cover start date when they're added to your policy, unless we confirm otherwise.

HOW IT WORKS

If you claim from our **GAP BENEFIT**, **CO-PAYMENT BENEFIT**, **PENALTY** or **ROBOTIC SURGERY CO-PAYMENT BENEFITS**, or **SUB-LIMIT BENEFIT** in the first **10 months** of cover for any of the medical events listed below, we'll cover **20%** of the **approved claim amount** subject to benefit limits where applicable:

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

GOOD TO KNOW

- The **10 Month Limited Payout Benefit** applies to medical events unrelated to pre-existing medical conditions. If the medical event is related to a medical condition for which you or your dependants received advice or treatment **12 months** before your policy's start date or their cover start date, the claim will be subject to a **Pre-Existing Condition Waiting Period**.

GENERAL EXCLUSIONS

Your **Gap Cover** policy consists of various benefits that cover medical expense shortfalls for just about every medical eventuality. Depending on the benefit you're claiming from, your medical aid must first pay a portion of the cost of your medical event before we step in and take care of the rest, subject to the benefit's qualifying criteria.

Go to www.stratumbenefits.co.za/general-exclusions/ or scan the **QR code** to view or download our **General Exclusions**.

BENEFIT EXCLUSIONS

Your **Gap Cover** policy offers a wide range of benefits, but each benefit has specific qualifying criteria.

For a detailed description of what you can and can't claim for, find the benefit exclusions applicable to your option in your Policy Schedule, go to www.stratumbenefits.co.za/benefit-exclusions/ or scan the **QR code** to view or download our **Benefit Exclusions**.