Stratum Gap Cover

2019

ELITE

ENTRY AGES	MONTHLY PREMIUM
64 or younger	Single ..... R 326 Family ..... R 392
65+	Single ..... R 519 Family ..... R 635

Our 65+ premium applies to the policy where any person applying for cover is 65 or older.

WE COVER

- You and your spouse on one policy, even if you belong to different medical aids or medical aid options, including all dependants registered on your or your spouse's medical aid option.
- Each insured person to an Overall Policy Limit (OPL) of R 157 000 **per person** per year.

This is not a medical aid and the cover is not the same as that of a medical aid. This policy is not a substitute for medical aid membership.

When only the best in health insurance will do, we've got it.

From covering the gap that exists when your healthcare providers charge more than what your medical aid pays, to refunding you for upfront co-payments and everything in between, this Gap Cover option is the perfect match for most medical aid options and the **elite** choice for individuals who don't compromise on cover.

GAP BENEFIT

WE COVER

- The gap that exists between what your healthcare providers charge and the rate your medical aid pays for medical procedures performed in hospital, a day clinic or your doctor's or specialist's private room when a portion of your healthcare providers' accounts are paid from your **hospital** or **risk benefit**, and **not** from your **day-to-day benefit** or **medical savings account**.
- Our **GAP BENEFIT** provides 500% cover, **over and above** the rate your medical aid pays for:
  - Medical procedures performed by your doctors and specialists;
  - Dental related procedures limited to **R 5 000 per policy** per year;
  - Dental procedures related to accidental injury or cancer, limited to **R 10 000 per policy** per year;
  - Basic radiology;
  - Specialised radiology limited to MRI, CT, PET scans and ultrasounds to **R 2 000 per policy** per year;
  - Pathology;
  - Physiotherapy;
  - Consumable items such as surgical gloves and bandages;
  - Medication administered or provided during your medical event; and
  - Prescribed Minimum Benefit (PMB) medical procedures.

CO-PAYMENT BENEFIT

WE COVER

- Upfront co-payments, deductibles or hospital admission fees that your medical aid requires you to pay before undergoing certain medical procedures or specialised radiology scans. The amount that you must pay towards the cost of your medical event is determined by your medical aid as either a rand amount or a percentage.
- The co-payment that applies when you choose to use a hospital or day clinic that does not form part of your medical aid's preferred hospital network, limited to **1 co-payment** up to **R 8 500 per policy** per year.
- You will be refunded for the fee that you pay out of your own pocket, or that your medical aid deducts from your **medical savings account**.

ONCOLOGY CARE BENEFITS

CANCER DIAGNOSIS BENEFIT

(Not subject to the OPL)

WE COVER

- A once-off benefit amount of **R 30 000** when you are diagnosed with cancer for the very first time before you reach the age of **65**, subject to specific qualifying criteria as explained under our benefit exclusions.

ONCOLOGY SHORTFALL BENEFIT

WE COVER

- The difference between what your healthcare providers charge and the rate your medical aid pays from your **oncology benefit**, for healthcare services that form part of your oncology treatment plan, such as:
  - Specialists' consultations;
  - Radiotherapy and chemotherapy;
  - Basic and specialised radiology;
  - Pathology; and
  - Biological and specialised medication.
- We also cover you when you become liable to pay an oncology-related co-payment.

ONCOLOGY OPTIMISER BENEFIT

WE COVER

- The cost of your ongoing oncology treatment, when your medical aid provides an **oncology benefit** with a rand amount limit that has been reached.

SUB-LIMIT BENEFIT

WE COVER

- The difference in cost when your medical aid provides a benefit for internal prosthetic devices, renal dialysis treatment, colonoscopies, gastroscopies, MRI and CT scans and pays a portion of your healthcare providers' accounts from a **sub-limit** or **annual limit**, but the benefit limit does not cover the full cost of the device, treatment, scope or scan.
- The portion that you become liable for relating to:
  - an internal prosthetic device or renal dialysis treatment, up to **R 30 000 per person per event**; or
  - a colonoscopy or gastroscopy, up to **R 1 500 per person per event**.
- You are also covered when you become liable to pay a portion of your MRI or CT scan, or the full amount of your scan when the **sub-limit** or **annual limit** has been reached, limited to **2 scans** up to **R 3 000 per scan per policy** per year.

Stratum Benefits

086 111 3499 086 633 3761 info@stratumbenefits.co.za www.stratumbenefits.co.za

CASUALTY BENEFIT

WE COVER

- A casualty event at any registered medical facility when you require immediate medical treatment due to an accident.
- Your healthcare providers' accounts related to:
  - Doctors' and specialists' consultations;
  - Basic and specialised radiology;
  - Pathology;
  - Consumable items such as surgical gloves and bandages;
  - Medication administered or provided during your casualty event;
  - External medical items required as a result of your casualty event provided at the registered medical facility, such as a neck brace;
  - Return visits to the registered medical facility, when follow-up treatment is required as a result of your initial casualty event related to an accident; and
  - Upfront casualty co-payments or facility fees.
- Your child **under** the age of **5**, when they become ill and need after-hours medical treatment at a registered **casualty facility**.
- You will be refunded for the cost of your casualty event when you become liable to pay your healthcare providers' accounts out of your own pocket, or when your medical aid pays your healthcare providers' accounts from your **medical savings account**, limited to **R 12 000 per policy** per year.

TRAUMA COUNSELLING BENEFIT

WE COVER

- The cost of your trauma counselling consultation fees when you:
  - have witnessed, or are directly affected by an act of physical violence or an accident;
  - have received word of a loved one's, or your own diagnosis of a dread disease; or
  - mourn the death of a loved one.
- You will be refunded for the cost of your registered counsellor's, clinical psychologist's or psychiatrist's consultation fees when you become liable to pay your healthcare providers' accounts out of your own pocket, or when your medical aid pays your healthcare providers' accounts from your **medical savings account**, limited to **R 10 000 per policy** per year.

REHABILITATION OPTIMISER BENEFIT

WE COVER

- The cost of your ongoing rehabilitation treatment when your medical aid provides a **rehabilitation benefit** for the treatment of a physical injury due to an accident, and the rand amount limit or the limit to the number of days you may be admitted for treatment has been reached.
- Your admission to a registered sub-acute or step-down facility for physical rehabilitation required due to an accident, including the treatment and therapy provided by on-site therapists during your stay, limited to **R 10 000 per person** per year.

PREVENTATIVE CARE BENEFIT

WE COVER

- The cost of your healthcare provider's consultation fee and the cost of your medical procedure when you undergo specific preventative tests or procedures.
- We will refund the cost of your healthcare provider's consultation fee and the cost of your preventative test or procedure that you pay out of your own pocket, or that your medical aid pays from your **medical savings account** limited to **R 800 per policy** per year for a:
  - Contraceptive device implant;
  - Full blood count (FBC test);
  - Mammogram;
  - Pap smear; and
  - Prostate screening (PSA test).

OUT-PATIENT SPECIALIST CONSULTATION BENEFIT

(Launching **1 January 2019**)

Subject to a standard **3 MONTH GENERAL WAITING PERIOD**.

WE COVER

- The difference in cost between what your specialists charge and the rate your medical aid pays for specialists' consultation fees, when a portion of the consultation fees for visits to your specialists' private rooms are paid from your **hospital**, **risk**, **day-to-day benefit** or **medical savings account**.
- We will refund the portion of your out-patient specialist's consultation fee that your medical aid does not pay in full up to **R 1 000 per consultation**, with a maximum of **3 consultations per person** limited to **R 6 000 per policy** per year.

ADDITIONAL BENEFITS

(Not subject to the OPL)

GAP POLICY PREMIUM WAIVER BENEFIT

WE COVER

- Your Gap Cover policy premium for a period of **12 months** when the person paying your premium is forcibly retrenched, becomes totally and permanently disabled or passes away.

MEDICAL AID CONTRIBUTION WAIVER BENEFIT

WE COVER

- Your medical aid contribution for a period of **6 months** up to **R 4 500** per month, when the person paying your medical aid contribution becomes totally and permanently disabled or passes away.

ACCIDENTAL DISABILITY AND DEATH BENEFIT

WE COVER

- You and your spouse in the event of your total and permanent disability or death due to an accident, limited to **1 event per person** per year to a benefit amount of **R 25 000**.
- Your dependant in the event of their total and permanent disability or death due to an accident, limited to **1 event per person** per year to a benefit amount of **R 5 000**.

LIFESTYLE BENEFITS

STRATUM FUEL REWARDS (Launching **1 December 2018**)

Get more bang for your buck!

Fill up with diesel at any **SHELL** service station and get rewarded with **22 cents** cash back per litre.

A litre really goes a long way!

INTERNATIONAL TRAVEL INSURANCE (Launching **1 January 2019**)

Travelling abroad?

Whenever, wherever... from the moment you need medical assistance to the time your healthcare providers' accounts are paid, your international travel insurance provider will be with you all the way.

Limited to **1 event per policy per year**.

OUR 10 MONTH BENEFIT RULE

Should you claim from our **GAP**, **CO-PAYMENT** or **SUB-LIMIT BENEFITS** after the **General Waiting Period** but within the first **10 months** of cover for the below listed medical events, your related healthcare providers' accounts will be covered at **20%** of the approved medical expense shortfall amount:

Adenoidectomy, Tonsillectomy, Myringotomy/Grommets, Cardiovascular procedures, Cataract removal, Dentistry, Hernia repairs, Hysterectomy (if required due to cancer that is diagnosed after the **General Waiting Period** applicable to your policy, your claim will be covered in full), Joint replacements, MRI, CT and PET scans, Nasal and sinus surgery, Pregnancy and childbirth, Spinal procedures and Scopes.

If your medical event is due to a pre-existing medical condition, your claim will be subject to the **Pre-Existing Condition Waiting Period** applicable to your policy. If this waiting period does not apply your claim will be covered at **20%** as specified above.

Claims for accidental events that occur after your cover start date will be covered in full from the first day of cover.

WAITING PERIODS AND BENEFIT EXCLUSIONS

YOUR GAP COVER POLICY WAITING PERIODS

Waiting periods apply from each insured person's cover start date before specific policy benefits can be claimed from, unless otherwise specified in your policy documentation.

3 MONTH GENERAL WAITING PERIOD

During this period, cover does not apply unless you are claiming for an accidental event that occurs after your cover start date.

12 MONTH PRE-EXISTING CONDITION WAITING PERIOD

During this period, cover does not apply for an investigation, treatment, procedure or surgery relating to any illness or condition that you have been diagnosed with and/or received advice or treatment for **12 months** before your cover start date.

GAP COVER BENEFIT EXCLUSIONS

OUR GAP BENEFIT DOES NOT COVER

1. Line items on your healthcare providers' accounts;
   a. paid in full from your hospital or risk benefit, or as a concession or ex-gratia payment.
   b. not partially paid from your hospital or risk benefit.
   c. partially paid or paid in full from your day-to-day benefit or medical savings account.
   d. while you are in your medical aid self-payment gap.
   e. for a private upfront fee that you must pay and cannot claim back from your medical aid.
   f. for specialised radiology except for MRI, CT, PET scans and ultrasounds.
   g. for out-patient consultation fees, except where the fee forms part of a medical procedure partially paid from your hospital or risk benefit.
   h. for consumable items not partially paid from your hospital or risk benefit.
   i. for medication not partially paid from your hospital or risk benefit, as well as prescription and take-home medication.
   j. for allied healthcare providers such as occupational and speech therapists, unless our benefit specifically makes provision for cover.
   k. for treatment dates that differ from the date of your claimable medical event.
   l. related to Adenoidectomy, Tonsillectomy, Myringotomy/Grommets, Cardiovascular procedures, Cataract removal, Dentistry, Hysterectomy, Hernia repair, Joint replacement, MRI, CT and PET scans, Nasal and sinus surgery, Pregnancy and childbirth, Spinal procedures or Scopes at more than **20%** of the approved medical expense shortfall amount if claimed within the first **10 months** of cover.
2. Medical procedures subject to a rand amount limit, where you become liable to pay a portion of, or the full amount of your medical procedure because the benefit limit does not cover the full amount of your medical procedure, or where the benefit limit has been reached.
3. Hospital accounts including, but not limited to theatre and ward fees.

OUR CO-PAYMENT BENEFIT DOES NOT COVER

1. Co-payments or deductibles that apply;
   a. for not obtaining pre-authorisation, or an appropriate healthcare provider referral as required by your medical aid.
   b. for not following your medical aid's rules, or for using a facility or healthcare provider that does not form part of your medical aid's preferred provider network, unless our benefit specifically makes provision for cover.
   c. when your healthcare providers charge private upfront fees that you must pay and cannot claim back from your medical aid, or when higher fees than what your medical aid requires are charged.
   d. to out-patient consultation fees.
   e. to chronic, acute, formulary, non-formulary or over-the-counter medication.
   f. to robotic surgery, or for the use of other specialised mechanical or computerised items and equipment.
   g. to Adenoidectomy, Tonsillectomy, Myringotomy/Grommets, Cardiovascular procedures, Cataract removal, Dentistry, Hysterectomy, Hernia repair, Joint replacement, MRI, CT and PET scans, Nasal and sinus surgery, Pregnancy and childbirth, Spinal procedures or Scopes, at more than **20%** of the approved medical expense shortfall amount if claimed within the first **10 months** of cover.

ONCOLOGY CARE BENEFITS

OUR CANCER DIAGNOSIS BENEFIT DOES NOT COVER

1. A cancer diagnosis;
   a. that is not the first diagnosis made in your lifetime.
   b. made before the first day your cover starts or during a **GENERAL WAITING PERIOD**.
   c. for cancers of the skin, unless the cancer diagnosis is for cancerous moles that have invaded surrounding or underlying tissue.
   d. where cancerous cells have not invaded surrounding or underlying tissue.
   e. for **Stage 1** breast or prostate cancer.
   f. made after you have reached the age of **65**.

OUR ONCOLOGY SHORTFALL AND ONCOLOGY OPTIMISER BENEFITS DO NOT COVER

2. Healthcare providers' accounts;
   a. for oncology treatment not approved by your medical aid as part of your oncology treatment plan.
   b. paid in full from your medical aid oncology benefit.
   c. partially paid or paid in full as a concession or an ex-gratia payment.
   d. partially paid or paid in full from your day-to-day benefit or medical savings account, except when our **ONCOLOGY OPTIMISER BENEFIT** applies because your oncology benefit limit has been reached and your medical aid pays your ongoing oncology treatment from your day-to-day benefit, or from funds available in your medical savings account.
   e. where you have not followed your medical aid's rules, or where a facility or healthcare provider was used that does not form part of your medical aid's preferred provider network.
3. Co-payments or deductibles that apply to oncology medication, except for co-payments or deductibles that apply after a benefit limit has been reached.

OUR SUB-LIMIT BENEFIT DOES NOT COVER

1. Healthcare providers' accounts;
   a. for healthcare services subject to a sub-limit or annual limit, except for internal prosthetic devices, renal dialysis treatment, colonoscopies, gastroscopies, MRI and CT scans.
   b. not partially paid from your sub-limit or annual limit because the benefit limit has been reached, except where our benefit specifically makes provision for cover.
   c. for renal dialysis treatment not approved by your medical aid as part of your renal dialysis treatment plan.
   d. where you have not followed your medical aid's rules, or where a facility or healthcare provider was used that does not form part of your medical aid's preferred provider network.
   e. related to Adenoidectomy, Tonsillectomy, Myringotomy/Grommets, Cardiovascular procedures, Cataract removal, Dentistry, Hysterectomy, Hernia repair, Joint replacement, MRI, CT and PET scans, Nasal and sinus surgery, Pregnancy and childbirth, Spinal procedures or Scopes, at more than **20%** of the approved medical expense shortfall amount if claimed within the first **10 months** of cover.

OUR CASUALTY BENEFIT DOES NOT COVER

1. Healthcare providers' accounts;
   a. for a casualty event not due to an accident, or not due to illness of your child **under** the age of **5**.
   b. for a casualty event due to an accident, but medical treatment was not provided immediately.
   c. for medication not administered or provided during your casualty event or your related follow-up consultation, as well as prescription and take-home medication.
   d. for a return visit for follow-up treatment not related to an accident.
   e. for external medical items not received during your initial casualty event.
   f. for a casualty event where treatment due to illness was provided to your child **under** the age of **5** at a medical facility other than a registered casualty facility.
   g. for a casualty event where treatment due to illness was provided to your child **under** the age of **5** at a registered casualty facility, but medical treatment was not provided after-hours. After-hours is Mondays to Fridays between **18:00pm** and **07:00am** and Saturdays, Sundays and public holidays.
   h. for a casualty event where medical treatment due to illness was provided to your child aged **5** and **older**.
   i. paid in full from your risk benefit.

BENEFIT EXCLUSIONS CONTINUED AND GENERAL EXCLUSIONS

OUR TRAUMA COUNSELLING BENEFIT DOES NOT COVER

1. Healthcare providers' accounts;
   a. if you have not witnessed or are not directly affected by an act of physical violence or an accident.
   b. if you are not affected by a loved one's diagnosis of a dread disease or death, or by your own diagnosis of a dread disease.
   c. paid in full from your risk benefit.
   d. if your healthcare provider is not registered with a recognised South African regulatory body.

OUR REHABILITATION OPTIMISER BENEFIT DOES NOT COVER

1. Rehabilitation facility costs or healthcare providers' accounts;
   a. not approved by your medical aid as part of your physical rehabilitation treatment plan.
   b. partially paid or paid in full from your day-to-day benefit or medical savings account, except when our benefit applies because your rehabilitation benefit limit has been reached and your medical aid pays your facility and healthcare providers' accounts from a day-to-day benefit, or from funds available in your medical savings account.
   c. where you have not followed your medical aid's rules, or where a facility or healthcare provider was used that does not form part of your medical aid's preferred provider network.
   d. not related to an accident.
   e. provided by off-site therapists or after discharge from the rehabilitation facility.
   f. for healthcare services provided by counsellors, clinical psychologists and psychiatrists.
   g. if your healthcare provider is not registered with a recognised South African regulatory body.

OUR PREVENTATIVE CARE BENEFIT DOES NOT COVER

1. Healthcare providers' accounts;
   a. for preventative care except for consultation fees, preventative tests or procedures related to contraceptive device implants, full blood count tests (FBC tests), mammograms, pap smears or prostate screening tests (PSA tests).
   b. paid in full from your risk benefit.

OUR OUT-PATIENT SPECIALIST CONSULTATION BENEFIT DOES NOT COVER

1. Healthcare providers' accounts;
   a. where a referral letter has not been obtained from your general practitioner or where a referral letter is not dated for the current benefit year.
   b. not partially paid from your hospital, risk, day-to-day benefit or medical savings account.
   c. paid in full from your hospital, risk, day-to-day benefit or medical savings account.
   d. for healthcare services provided in your specialists' private rooms, except for out-patient consultation fees.
   e. for an in-hospital medical event.

ADDITIONAL BENEFITS

OUR GAP POLICY PREMIUM WAIVER BENEFIT DOES NOT COVER

1. Events;
   a. where the person paying your premium has not been forcibly retrenched, has not become totally and permanently disabled or has not passed away.
   b. for which a claim is received for forced retrenchment, total and permanent disability or death of a person not noted as the premium payer.
   c. where a new premium payer is appointed **3 months** before the claimable event, except where total and permanent disability or death is due to an accident.

OUR MEDICAL AID CONTRIBUTION WAIVER BENEFIT DOES NOT COVER

2. Events;
   a. where the person paying your medical aid contribution has not become totally and permanently disabled or has not passed away.
   b. for which a claim is received for total and permanent disability or death of a person not noted as the medical aid contribution payer.
   c. where a new contribution payer is appointed **3 months** before the claimable event, except where total and permanent disability or death is due to an accident.

OUR ACCIDENTAL DISABILITY AND DEATH BENEFIT DOES NOT COVER

3. Events;
   a. where total and permanent disability or death is not due to an accident.
   b. that exceed one claimable event per qualifying person in a benefit year.

GENERAL EXCLUSIONS APPLICABLE TO YOUR GAP COVER POLICY

We do not cover service or healthcare providers' accounts for related medical procedures and/or treatment, nor hospitalisation, illness, disease, loss, damage, death, bodily injury or liability for:

1. Events you want to claim for, but you are not an insured person at the time of the event.
2. Events that occur during your policy waiting period(s), unless you are claiming for an accidental event.
3. Events where a benefit limit or a policy limit has been reached.
4. Events where your policy does not provide the appropriate benefit for you to claim from.
5. Events where you did not obtain pre-authorisation from your medical aid, or where you did not follow your medical aid's rules.
6. Events where the hospital, day clinic, registered medical facility or healthcare provider used does not form part of your medical aid's preferred provider network, unless a benefit specifically makes provision for cover.
7. Medical aid exclusions where no underlying cover exists, unless a benefit specifically makes provision for cover.
8. Maxillo-facial surgery and related medical conditions and/or procedures, unless your claim is related to accidental injury or cancer.
9. External prostheses such as artificial limbs, or external medical items such as wheelchairs and crutches, unless a benefit specifically makes provision for cover.
10. Robotic surgery, unless your claim is related to a medical expense shortfall for which a benefit specifically makes provision for cover.
11. The use of specialised mechanical or computerised items.
12. Artificial insemination, infertility treatment, procedures or contraceptives, except for tubal ligation, vasectomies and contraceptive device implants where a benefit specifically makes provision for cover.
13. Obesity and bariatric surgery.
14. Non-medically necessary reconstructive cosmetic surgery.
15. Breast reconstruction performed as a second or subsequent medical procedure, and/or the insertion or removal of a breast implant performed as a second or subsequent medical procedure.
16. Home nursing, admission to a step-down or sub-acute facility such as a frail care centre or a rehabilitation facility, unless a benefit specifically makes provision for cover.
17. Depression, insanity, emotional or mental illness or any stress-related conditions.
18. Costs associated with supporting medical reports that assist in the finalisation of your claim.
19. Routine physical, diagnostic procedures or examinations where there is no objective indication of impairment in your health.
20. Expenses incurred for transport charges or for healthcare services that you receive during transportation in an emergency vehicle, vessel or aircraft.
21. Riots, wars, political acts, public disorder, terrorism, civil commotions, labour disturbances, strikes, lock-out, or any attempted such acts.
22. A deliberate criminal or fraudulent act, or any illegal activity conducted by you or a member of your household which directly or indirectly results in loss, damage or injury.
23. Attempted suicide, intentional self-injury and deliberate exposure to exceptional danger except when you attempt to save a human life.
24. Events where the use of drugs or alcohol is involved.
25. Active military, police and police reservist activities whilst on active duty.
26. Nuclear weapons material, ionising radiations or contamination by radioactivity from any nuclear fuel, nuclear waste or from the combustion of nuclear fuel that includes any self-sustaining process of nuclear fission.
27. Events where the actual damage is covered by legislation, such as contractual liability and consequential loss.
28. Discounts directly negotiated with your healthcare provider where full reimbursement of the claim will result in enrichment.
29. Non-disclosure of material information that is likely to affect the assessment or acceptance of risk.
30. Dual insurance where cover is provided by more than one gap cover policy through different insurers, or the same insurer.