

Stratum Benefits⁺

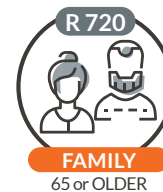
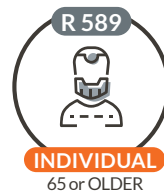


ELITE

Our individual and corporate Elite options offer the widest range of benefits.

ELITE PREMIUMS FOR INDIVIDUALS

If you're an individual aged **65 or older**, we'll cover you under the **65+ individual option**.
If you apply for cover as a family, and either you or one of your dependants is **65 years or older**, you and your family will be covered under the **65+ family option**.



Joining as a family? One Gap Cover policy covers you, your spouse and all the dependants registered on both your and your spouse's medical aid plans.



CORPORATE ELITE & CORPORATE ELITE PLUS

We cover employer groups if **10 or more** employees join through their employer. Ask your employer if your spouse and/or dependants may also join.

Premiums for employer groups are determined by factors like the employer group's average age and if cover for employees is compulsory or voluntary.

ASK FOR A CORPORATE QUOTE!

KEY BENEFITS SUBJECT TO AN OVERALL POLICY LIMIT (OPL)

An OPL of R 173 000 per person per year applies to the following benefits. This means that all approved claim amounts will get deducted off the OPL.

GAP COVER

Going into hospital to have your baby, or having wisdom teeth extracted in the dentist's chair?

Gap Cover kicks in when your doctor or specialist charges more than the amount your medical aid pays for in- and out-of-hospital medical procedures, as long as it's paid from a hospital or risk benefit.

We add an additional 500% cover on top of what your medical aid plan gives to cover shortfalls for:

- medical procedures performed by your doctor and specialist;
- basic radiology, like black and white x-rays;
- specialised radiology, like MRI and CT scans;
- consumable items, like surgical gloves;
- dental procedures, like wisdom teeth extractions, limited to R 8 000 per policy per year;
- dental procedures due to accidents or cancer treatment, limited to R 12 000 per policy per year;
- medication administered during your medical event;
- pathology;
- physiotherapy; and
- Prescribed Minimum Benefit (PMB) medical procedures.

Don't forget... your medical aid must make payment from a hospital or risk benefit, and not from a day-to-day benefit or your medical savings account.

CO-PAYMENT COVER

Have you ever had to go for a medical procedure, like a scope, scan or joint replacement surgery, and were asked by your medical aid to pay some money upfront? This is called a co-payment or deductible.

We refund in- and out-of-hospital co-payments or deductibles of any amount or percentage.

ADMISSION AND PROCEDURE CO-PAYMENTS

Claim as many times as you need for admission and procedure related co-payments, as long as it doesn't exceed the OPL.

If you claim for the below co-payments, benefit limits will apply:

ROBOTIC SURGERY CO-PAYMENT

When a co-payment applies to surgery that's done using computer-controlled robots, we'll refund the co-payment limited to R 10 000 per policy per year.

PENALTY CO-PAYMENT

Sometimes, medical aids have a preferred network of hospitals or day clinics that they want their members to use for planned medical procedures.

If you prefer a certain specialist for your procedure who doesn't operate at the network hospital or day clinic, you can choose to go elsewhere.

Limited to R 10 000 per policy per year.

We don't refund any payments that your doctor or specialist asks you to pay to them directly.



SUB-LIMIT COVER

Your medical aid plan might give unlimited benefits for procedures done in hospital but certain medical services or items might be limited, like internal prosthetic devices. This is called a sub-limit or annual limit.

We'll cover the shortfalls as long as your medical aid pays some of the cost from a sub-limit or annual limit:

INTERNAL PROSTHETIC DEVICES

Limited to R 30 000 per person per event.

We cover any internal prosthetic device that's implanted into your body to replace a body part, like a hip joint, or improve a lost or reduced bodily function, like a cardiac pacemaker.

We don't cover external devices. If it's not in your body, it's not covered.

RENAL DIALYSIS TREATMENTS

Limited to R 30 000 per person per event.

COLONOSCOPIES, GASTROSCOPIES & ENTEROSCOPIES

Limited to R 5 000 per person per event.

MRI & CT SCANS

Limited to R 5 000 per person per event.

Have a look at our TOP-UP COVER to see what else we cover for MRI & CT scans.



CANCER COVER

BREAST RECONSTRUCTION

Our Breast Reconstruction benefit provides cover when a breast reconstruction is done on an unaffected breast that your medical aid plan excludes from cover.

Limited to 1 event of up to R 30 000 per person per lifetime.



This benefit is exclusive to Elite and Corporate Elite Plus. It's not available on Corporate Elite.

Our Breast Reconstruction benefit does not cover the cost to have an unaffected breast removed, but it does cover the reconstruction thereof.

Good to know: If breast cancer is diagnosed and a mastectomy and/or reconstruction is done on an affected breast, our Gap Cover benefit will cover the shortfalls when your doctor or specialist charges more than the amount your medical aid pays from a hospital or risk benefit.

CANCER TREATMENT SHORTFALLS

We cover the difference between what your healthcare providers charge and the amount your medical aid pays from an oncology benefit for healthcare services related to cancer treatment.

The shortfalls that we'll cover will typically be for the healthcare and service providers that your medical aid approved as part of an oncology treatment plan, like:

- specialists' consultations;
- specialised radiology, like MRI, CT and PET scans;
- biological medication; and
- chemotherapy.

If your medical aid plan gives a benefit limit for cancer treatment, and you're charged co-payments when the benefit limit is reached, we'll refund those co-payments too.



TOP-UP COVER

When your medical aid plan's benefit limits are reached and you're responsible to pay the cost from your own pocket, we'll cover:

MRI & CT SCANS TOP-UP



Limited to R 5 000 per policy per year.

CANCER TREATMENT TOP-UP



The cost of your treatment according to the cancer treatment plan that your medical aid approved.

We'll cover everything that your medical aid covered... from the treatment you received to the facility you went to for treatment. This means you can't claim for something that wasn't initially approved by your medical aid.

PHYSICAL REHABILITATION TOP-UP



If your medical aid covers you in a sub-acute or step-down facility for physical rehabilitation due to an accident, but during your stay your medical aid benefit is reached, we'll cover the cost to continue your stay and receive the ongoing therapy you need.

We don't cover physical rehabilitation that's due to illness or physical rehabilitation after you've been discharged.

Limited to R 10 000 per person per year.



OUT-PATIENT SPECIALIST CONSULTATION COVER

This benefit always receives a 3 Month General Waiting Period.

When you get a specialist's bill that says, "Balance due in 30 days", we can help.

We'll cover the difference between what your specialist charges for a consultation in their private rooms and the rate your medical aid applies, as long as some of the cost is paid from a **hospital, risk, or day-to-day benefit** or from your **medical savings account**.

If an amount **↑above** your medical aid plan's rate is paid, we'll cover the difference between what was paid and what your specialist charged.

If an amount **↓below** your medical aid plan's rate is paid, we'll cover the difference between the rate and what your specialist charged.

Limited to R 1 000 per consultation with a maximum of 3 consultations per policy per year.



This benefit is exclusive to Elite and Corporate Elite Plus. It's not available on Corporate Elite.

- If your medical aid pays some of the cost from a hospital, risk, or day-to-day benefit and some from your medical savings account, we'll add the payments together to see what's still outstanding for us to cover.
- If the consultation fee is paid in full, no matter where payment is made from, there'll be no shortfall for us to cover.
- We don't refund what your medical aid pays from a day-to-day benefit or your medical savings account.



CASUALTY COVER

ACCIDENT COVER

For the whole family

For **immediate** medical treatment due to an **accident** you can go to your nearest **medical facility**.

ACCIDENTS are unexpected incidents that cause physical injury due to physical impact with someone or something.

IMMEDIATE means within 24-hours from the time of the incident.

What do we cover? Everything related to your casualty event, like:

- co-payments and facility fees;
- doctors' consultation fees;
- basic radiology, specialised radiology and pathology;
- medication administered during your casualty event; and
- external medical items that's given to you at the medical facility, like a neck brace.

Need a follow-up visit to a medical facility after an accidental event to have stitches or a cast removed? We'll refund that too.

ILLNESS COVER

Only for children younger than 8 years of age

If your child who's **younger than 8** gets sick **after-hours**, we'll cover the cost of a visit to a **casualty facility** and all the healthcare providers' accounts related to the visit.

WHEN IS AFTER-HOURS? Mondays to Fridays between 18:00pm and 07:00am and all-day Saturdays, Sundays and public holidays.

We'll refund the amount that you pay from your **own pocket** or that your medical aid pays from a **day-to-day benefit** or your **medical savings account**.

Casualty Cover is limited to R 12 000 per policy per year.



TRAUMA COUNSELLING COVER

Sometimes you just need to talk to someone about it.

If you've:

- witnessed, or are directly affected by an act of physical violence or an accident;
- received news of a loved one's, or of your own diagnosis of a critical illness; or
- mourn the death of a loved one,

we'll refund the registered counsellor's consultation fees that you pay from your **own pocket**, or that your medical aid pays from a **day-to-day benefit** or your **medical savings account**, limited to R 10 000 per policy per year.



PREVENTATIVE CARE COVER

Take care of yourself with the following preventative tests or procedures:

- contraceptive device implant;
- full blood count;
- mammogram;
- pap smear; or
- prostate screening.

The consultation fee and the cost of the test or procedure that you pay from your **own pocket**, or that your medical aid pays from a **day-to-day benefit** or your **medical savings account**, will be refunded limited to R 1 300 per policy per year.

BENEFITS NOT SUBJECT TO AN OVERALL POLICY LIMIT (OPL)

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



PRIVATE WARD COVER

Enjoy some alone time with your new-born or spend the night with your spouse or child when they're in hospital.

Use our benefit when your medical aid plan doesn't cover:

- a private ward that you choose to use;
- a lodger fee when you want your spouse or a family member to stay with you; or
- a nursery fee when you need to take care of your baby.

The person you're staying with, or who stays with you during hospitalisation must be registered on your Gap Cover policy.

Limited to R 3 000 per policy per year.

PAYOUT AND WAIVER BENEFITS



ACCIDENTAL DISABILITY AND DEATH

You and your spouse are covered for a benefit amount of R 25 000 per person and your dependants for R 5 000 per person if either one of you becomes totally and permanently disabled or passes away due to an accident.

Limited to 1 event per person per year.



FIRST-TIME CANCER DIAGNOSIS

When cancer is diagnosed for the very first time in your life after you've joined us, you'll receive a payout benefit.

Some cancer diagnoses, like Stage 1 breast or prostate cancer, aren't covered.

Our Benefit Exclusions explain the terms and conditions in more detail.

Limited to R 30 000 per person per lifetime if cancer is diagnosed before the age of 65.



MEDICAL AID CONTRIBUTION WAIVER

When the medical aid contribution payer, who we define as a premium payer, becomes totally and permanently disabled or passes away we'll continue to pay the medical aid contributions for 6 months limited to R 4 500 per month.

During the time our benefit applies you have the option to downgrade, but if you upgrade we'll only pay the contribution amount that applied before the upgrade.



STRATUM POLICY PREMIUM WAIVER

Your policy premiums will be paid by us for 12 months when the premium payer of your Gap Cover policy becomes forcibly retrenched, totally and permanently disabled, or passes away.



Our Corporate Elite option provides cover for 6 months only.

10 MONTH LIMITED PAYOUT BENEFIT

If you claim from our GAP COVER, CO-PAYMENT COVER or SUB-LIMIT COVER in the first 10 months of cover for a medical event related to:

- adenoidectomy;
- tonsillectomy;
- myringotomy/grommets;
- cardiovascular procedures;
- cataract removal;
- dentistry;
- hernia repairs;
- joint replacements;

- MRI, CT and PET scans;
- nasal and sinus surgery;
- pregnancy and childbirth;
- spinal procedures;
- scopes (including medical events where a scope is used); or
- hysterectomy (full cover applies if required due to cancer when diagnosed after the General Waiting Period),

we'll cover only 20% of the approved claim amount subject to benefit limits where applicable.

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

Accidental events don't form part of the 10 Month Limited Payout Benefit and aren't subject to any waiting periods.



EMPLOYER GROUPS: The percentage that applies to employer groups under the 10 Month Limited Payout Benefit is subject to the quote accepted by your employer.

WAITING PERIODS

Waiting periods apply from the start date of your policy, from the effective option change date when you upgrade your policy, and from each person's cover start date when they're added after the policy's start date.

3 MONTH GENERAL WAITING PERIOD

We don't cover you during this period unless you claim for accidental events that occur after your cover start date.

12 MONTH PRE-EXISTING CONDITION WAITING PERIOD

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



EMPLOYER GROUPS: Waiting periods that apply to employer groups are subject to the quote accepted by your employer.

LIFESTYLE BENEFITS

Our Lifestyle Benefits are complimentary and don't cost you a cent.



EXTRA HIGH SCHOOL LEARNING SUPPORT

Based on the CAPS curriculum, your Gr.8 to Gr.12 high school child gets instant access to content that'll help them study, improve their knowledge and boost their marks.



FUEL REWARDS

Fill up at any SHELL service station and get rewarded with 22 cents per litre of diesel and 15 cents per litre of petrol. Subject to change without prior notice.



INTERNATIONAL TRAVEL INSURANCE

Planning on travelling? Happy days.

We cover you for acute illness and injury when you travel outside of South African borders.

Whether you travel alone or with family members, cover is limited to 1 trip per policy per year to a maximum of 31 days.

Visit our website at www.stratumbenefits.co.za to read more about our LIFESTYLE BENEFITS and how to register.

Our Gap Cover policy isn't a medical aid, doesn't provide similar cover as that of a medical aid and can't be substituted for medical aid membership.

BENEFIT EXCLUSIONS

KEY BENEFITS SUBJECT TO THE OVERALL POLICY LIMIT (OPL)

1. GAP COVER



WHAT OUR BENEFIT DOESN'T COVER

We don't cover coded lines on your healthcare or service providers' accounts:

- 1.1 if your medical aid paid it as an exception to the rule.
- 1.2 if your medical aid didn't partly pay it from a hospital or risk benefit.
- 1.3 if your medical aid fully paid it from a hospital or risk benefit, as there'll be no claimable shortfall.
- 1.4 if your medical aid partly or fully paid it from a day-to-day benefit or your medical savings account.
- 1.5 if your medical aid processed it against your self-payment gap. *(A self-payment gap applies when you've used the funds in your medical savings account, after which you have to pay your day-to-day medical expenses from your own pocket up to a specific amount.)*
- 1.6 if it's for upfront fees or deposits that your healthcare providers ask you to pay to them directly.
- 1.7 if it's for out-patient consultation fees, unless a medical procedure was performed at the same time.
- 1.8 if it's for hospital accounts, unless you're claiming for consumable items or medication that your medical aid partly paid from a hospital or risk benefit.
- 1.9 if it's for allied healthcare providers, unless your policy provides a benefit that covers it. *(Allied healthcare providers are healthcare professionals associated with your medical event who aren't doctors or specialists. We only cover the following allied healthcare providers:*
 - 1.9.1 clinical perfusionists;
 - 1.9.2 dental hygienists;
 - 1.9.3 midwives;
 - 1.9.4 nurses; and
 - 1.9.5 physiotherapists.)
- 1.10 if your medical aid didn't partly pay it because a benefit limit provided by your medical aid plan's been reached.
- 1.11 at more than 20% of the approved claim amount if you claim in the first 10 months of cover from a benefit limit provided by your policy, for medical events related to:
 - 1.11.1 adenoidectomy;
 - 1.11.2 tonsillectomy;
 - 1.11.3 myringotomy/grommets;
 - 1.11.4 cardiovascular procedures;
 - 1.11.5 cataract removal;
 - 1.11.6 dentistry;
 - 1.11.7 hernia repairs;
 - 1.11.8 hysterectomy (unless it's for cancer that's diagnosed after a General Waiting Period);
 - 1.11.9 joint replacements;
 - 1.11.10 MRI, CT and PET scans;
 - 1.11.11 nasal and sinus surgery;
 - 1.11.12 pregnancy and childbirth;
 - 1.11.13 spinal procedures; or
 - 1.11.14 scopes (including medical events where a scope is used). *(Employer groups will receive a payout of between 20% and 100% under the 10 Month Limited Payout Benefit subject to a quote.)*

2. CO-PAYMENT COVER



WHAT OUR BENEFIT DOESN'T COVER

We don't refund co-payments or deductibles:

- 2.1 if your medical aid paid it as an exception to the rule.
- 2.2 if you didn't obtain pre-authorisation before your medical event.
- 2.3 if you don't follow your medical aid's rules.
- 2.4 if you used healthcare or service providers that don't form part of your medical aid plan's preferred provider network (*non-designated provider*), unless your policy provides a benefit that covers it.
- 2.5 that your healthcare providers ask you to pay to them directly. *(This is referred to as split-billing. We only refund co-payments or deductibles that your medical aid asks for.)*
- 2.6 if it's for co-payments or deductibles that you're responsible to pay to your healthcare or service provider because your medical aid imposes it, but what you paid is more than the amount your medical aid imposes. *(Any excess amounts that you pay to a provider will be for your own pocket.)*
- 2.7 if it's for cancer treatment.
- 2.8 if it's for out-patient consultation fees.
- 2.9 if it's for chronic, acute, formulary, non-formulary, or over-the-counter medication.
- 2.10 if it's for robotic surgery, or for the use of other specialised mechanical or computerised items or equipment, unless your policy provides a benefit that covers it.
- 2.11 at more than 20% of the approved claim amount if you claim in the first 10 months of cover from a benefit limit provided by your policy, for medical events related to:
 - 2.11.1 adenoidectomy;
 - 2.11.2 tonsillectomy;
 - 2.11.3 myringotomy/grommets;
 - 2.11.4 cardiovascular procedures;
 - 2.11.5 cataract removal;
 - 2.11.6 dentistry;
 - 2.11.7 hernia repairs;
 - 2.11.8 hysterectomy (unless it's for cancer that's diagnosed after a General Waiting Period);
 - 2.11.9 joint replacements;
 - 2.11.10 MRI, CT and PET scans;
 - 2.11.11 nasal and sinus surgery;
 - 2.11.12 pregnancy and childbirth;
 - 2.11.13 spinal procedures; or
 - 2.11.14 scopes (including medical events where a scope is used). *(Employer groups will receive a payout of between 20% and 100% under the 10 Month Limited Payout Benefit subject to a quote.)*

3. SUB-LIMIT COVER



WHAT OUR BENEFIT DOESN'T COVER

We don't cover coded lines on your healthcare or service providers' accounts:

- 3.1 if your medical aid paid it as an exception to the rule.
- 3.2 if it's for healthcare services that your medical aid plan applies a sub-limit or annual limit to, unless it's for internal prosthetic devices, renal dialysis treatments, colonoscopies, gastroscopies, enteroscopies, MRI or CT scans.
- 3.3 if your medical aid didn't partly pay it from a sub-limit or annual limit.
- 3.4 if you don't follow your medical aid's rules.
- 3.5 if you used healthcare or service providers that don't form part of your medical aid's preferred provider network.
- 3.6 at more than 20% of the approved claim amount if you claim in the first 10 months of cover from a benefit limit provided by your policy, for medical events related to:
 - 3.6.1 adenoidectomy;
 - 3.6.2 tonsillectomy;
 - 3.6.3 myringotomy/grommets;
 - 3.6.4 cardiovascular procedures;
 - 3.6.5 cataract removal;
 - 3.6.6 dentistry;
 - 3.6.7 hernia repairs;
 - 3.6.8 hysterectomy (unless it's for cancer that's diagnosed after a General Waiting Period);
 - 3.6.9 joint replacements;
 - 3.6.10 MRI, CT and PET scans;
 - 3.6.11 nasal and sinus surgery;
 - 3.6.12 pregnancy and childbirth;
 - 3.6.13 spinal procedures; or
 - 3.6.14 scopes (including medical events where a scope is used). *(Employer groups will receive a payout of between 20% and 100% under the 10 Month Limited Payout Benefit subject to a quote.)*

4. CANCER COVER



4.1 BREAST RECONSTRUCTION

WHAT OUR BENEFIT DOESN'T COVER

We don't cover coded lines on your healthcare or service providers' accounts:

- 4.1.1 if your medical aid paid it as an exception to the rule.
- 4.1.2 if it's for a mastectomy (removal) of an unaffected breast.
- 4.1.3 if it's for a breast reconstruction of an unaffected breast, but the cancer diagnosis of the affected breast isn't Stage 2 or a higher breast cancer diagnosis.
- 4.1.4 if it's for a breast reconstruction of an unaffected breast, but the breast reconstruction isn't done at the same time as a bilateral mastectomy (removal of both breasts) and the breast reconstruction of the affected breast.
- 4.1.5 if it's for a breast reconstruction of an unaffected breast that your medical aid plan covers, as there'll be no claimable event.

4.2 CANCER TREATMENT SHORTFALLS

WHAT OUR BENEFIT DOESN'T COVER

We don't cover coded lines on your healthcare or service providers' accounts:

- 4.2.1 if your medical aid paid it as an exception to the rule.
- 4.2.2 if it's for cancer treatment that your medical aid didn't approve as part of a cancer treatment plan.
- 4.2.3 if your medical aid fully paid it from an oncology benefit, as there'll be no claimable shortfall.
- 4.2.4 if your medical aid partly or fully paid it from a day-to-day benefit or your medical savings account.
- 4.2.5 if you don't follow your medical aid's rules.
- 4.2.6 if you used healthcare or service providers that don't form part of your medical aid's preferred network.
- 4.2.7 if it's for co-payments or deductibles that your medical aid asks you to pay before your medical aid plan's oncology benefit limit is reached. *(We only cover co-payments or deductibles that apply after your medical aid plan's benefit limit is reached.)*
- 4.2.8 if it's for secondary co-payments that apply to cancer treatment or cancer medication.

5. TOP-UP COVER



5.1 MRI AND CT SCANS TOP-UP



WHAT OUR BENEFIT DOESN'T COVER

We don't cover coded lines on your service providers' accounts:

- 5.1.1 if your medical aid paid it as an exception to the rule.
- 5.1.2 if your medical aid fully paid it from a hospital, risk, or specialised radiology benefit as there'll be no claimable event.
- 5.1.3 if your medical aid partly or fully paid it from a day-to-day benefit or your medical savings account.
- 5.1.4 if your medical aid processed it against your self-payment gap. *(A self-payment gap applies when you've used the funds in your medical savings account, after which you have to pay your day-to-day medical expenses from your own pocket up to a specific amount.)*
- 5.1.5 if your medical aid plan doesn't provide an MRI or CT scan benefit that you can claim from.
- 5.1.6 if your medical aid plan's benefit limit hasn't been reached.

5.2 CANCER TREATMENT TOP-UP



WHAT OUR BENEFIT DOESN'T COVER

We don't cover coded lines on your healthcare or service providers' accounts:

- 5.2.1 if your medical aid paid it as an exception to the rule.
- 5.2.2 if it's for cancer treatment that your medical aid didn't approve as part of a cancer treatment plan.
- 5.2.3 if your medical aid fully paid it from an oncology benefit, as there'll be no claimable event.
- 5.2.4 if it's for cancer treatment that your medical aid partly or fully paid from a day-to-day benefit or your medical savings account. If, however, your medical aid agrees to pay your ongoing cancer treatment from funds that's available in your medical savings account after the benefit limit is reached, we'll assess your claim.
- 5.2.5 if you've used healthcare or service providers that don't form part of your medical aid's preferred network.

5.3 PHYSICAL REHABILITATION TOP-UP



WHAT OUR BENEFIT DOESN'T COVER

We don't cover coded lines on your healthcare or service providers' accounts:

- 5.3.1 if your medical aid paid it as an exception to the rule.
- 5.3.2 if it's not related to an accident.
- 5.3.3 if it's for an admission or therapy that your medical aid didn't approve as part of your physical rehabilitation treatment plan.
- 5.3.4 if it's for physical therapy that your medical aid partly or fully paid from a day-to-day benefit or your medical savings account. If, however, your medical aid agrees to pay your ongoing physical therapy from available funds in your medical savings account after the benefit limit is reached, we'll assess your claim.
- 5.3.5 if you've used a healthcare or service provider that doesn't form part of your medical aid's preferred network.
- 5.3.6 if it's for physical therapy provided by healthcare providers outside of the sub-acute or step-down facility, or after you've been discharged.
- 5.3.7 if it's for healthcare services provided by counsellors, clinical psychologists or psychiatrists.
- 5.3.8 if your healthcare or service providers aren't registered with a South African regulatory body.

6. OUT-PATIENT SPECIALIST CONSULTATION COVER

WHAT OUR BENEFIT DOESN'T COVER

We don't cover coded lines on your specialists' accounts:

- 6.1 if it's for out-patient consultations that occur during a General Waiting Period.
- 6.2 if your medical aid fully paid it, regardless of whether payment is made from a hospital, risk, or day-to-day benefit or from your medical savings account, as there'll be no claimable shortfall.
- 6.3 if your medical aid didn't partly pay it from a hospital, risk, or day-to-day benefit or from your medical savings account.
- 6.4 if your medical aid processed it against your self-payment gap. *(A self-payment gap applies when you've used the funds in your medical savings account and pay your day-to-day medical expenses from your own pocket, up to a specific amount.)*
- 6.5 if the difference between what your specialist charged and the amount your medical aid paid is more than your medical aid plan's rate. *(We'll cover the difference between what your specialist charged and the amount your medical aid paid.)*
- 6.6 if there's no difference in cost between what your specialists charged and the rate your medical aid applied to the consultation, as there'll be no claimable shortfall.
- 6.7 if it's not for out-patient consultation fees.
- 6.8 if it's for in-hospital consultations.
- 6.9 We don't refund what your medical aid pays from a day-to-day benefit or from your medical savings account.
- 6.10 Our benefit doesn't cover any allied healthcare providers accounts.

7. CASUALTY COVER

WHAT OUR BENEFIT DOESN'T COVER

We don't cover coded lines on your healthcare or service providers' accounts:

- 7.1 if it's not related to an accident.
- 7.2 if it's not related to illness of your child dependant younger than 8.
- 7.3 that are related to an accident, but medical treatment wasn't provided within 24-hours from the time of the incident.
- 7.4 if it's for medication that wasn't administered during your casualty event, during follow-up visits to a registered medical facility after an accidental event, medication that you take home or that's prescribed to collect at a pharmacy.
- 7.5 if it's for external medical items that you didn't receive at the registered medical facility during your initial casualty visit.
- 7.6 if it's for follow-up visits that aren't related to accidental events.
- 7.7 if it's for follow-up visits to a registered medical facility that are related to an accident, but follow-up visits occurs after a hospital admission. *(When you're admitted to hospital after being treated at a registered medical facility, the hospital admission will be a new event and return visits for follow-up treatment won't be assessed under Casualty Cover.)*
- 7.8 if it's for medical treatment due to illness provided to your child younger than 8, but medical treatment wasn't provided at a registered casualty facility.
- 7.9 if it's for treatment due to illness provided to your child younger than 8 at a registered casualty facility, but your child didn't receive after-hours medical treatment. *(After-hours is Mondays to Fridays between 18:00pm and 07:00am and all-day Saturdays, Sundays and public holidays.)*
- 7.10 if it's for medical treatment due to illness provided to your child aged 8 or older.
- 7.11 that your medical aid fully paid from a risk benefit, as there'll be no claimable event.

8. TRAUMA COUNSELLING COVER

WHAT OUR BENEFIT DOESN'T COVER

We don't cover coded lines on your healthcare providers' accounts:

- 8.1 if you haven't witnessed or aren't directly affected by an act of physical violence or an accident.
- 8.2 if you aren't affected by a loved one's diagnosis of a critical illness or death, or by your own diagnosis of a critical illness.
- 8.3 if your medical aid fully paid it from a risk benefit, as there'll be no claimable event.
- 8.4 if your counsellors aren't registered with a recognised South African regulatory body.

9. PREVENTATIVE CARE COVER

WHAT OUR BENEFIT DOESN'T COVER

We don't cover coded lines on your healthcare or service providers' accounts:

- 9.1 if it's not for consultation fees, preventative tests or procedures that our benefit covers.
- 9.2 that your medical aid fully paid from a risk benefit, as there'll be no claimable event.

BENEFITS NOT SUBJECT TO THE OVERALL POLICY LIMIT (OPL)

10. PRIVATE WARD COVER

WHAT OUR BENEFIT DOESN'T COVER

We don't cover coded lines on your service providers' accounts:

- 10.1 if your medical aid paid it as an exception to the rule.
- 10.2 if your medical aid partly or fully paid it from a hospital or risk benefit.
- 10.3 if your medical aid partly or fully paid it from a day-to-day benefit.
- 10.4 if your medical aid, the hospital or day clinic requires you to be admitted to a private ward due to clinical reasons.
- 10.5 if the lodger or nursery fees are for someone who's not covered on your policy.

11. PAYOUT AND WAIVER BENEFITS

11.1 ACCIDENTAL DISABILITY AND DEATH

WHAT OUR BENEFIT DOESN'T COVER

We don't cover instances:

- 11.1.1 if total and permanent disability or death isn't due to an accident.
- 11.1.2 if it exceeds one claimable event per qualifying person in a benefit year.
- 11.1.3 if a death certificate or proof of disability isn't provided, where applicable.

11.2 FIRST-TIME CANCER DIAGNOSIS

WHAT OUR BENEFIT DOESN'T COVER

We don't cover:

- 11.2.1 a cancer diagnosis if it's not the first cancer diagnosed in your life.
- 11.2.2 a cancer diagnosis if it's diagnosed before the first day your cover starts with us or during a General Waiting Period.
- 11.2.3 you if pre-cancer cells have been found but a cancer diagnosis hasn't been confirmed.
- 11.2.4 cancer of the skin, unless cancerous moles have invaded surrounding or underlying tissue.
- 11.2.5 a cancer diagnosis if cancerous cells haven't invaded surrounding or underlying tissue.
- 11.2.6 Stage 1 breast or prostate cancer.
- 11.2.7 a cancer diagnosis if it's diagnosed at age 65 or older.

11.3 MEDICAL AID CONTRIBUTION WAIVER

WHAT OUR BENEFIT DOESN'T COVER

We don't cover instances:

- 11.3.1 if the medical aid contribution payer hasn't become totally and permanently disabled or hasn't passed away.
- 11.3.2 of total and permanent disability or death of a person who isn't noted as the medical aid contribution payer.
- 11.3.3 if a new contribution payer is appointed within 3 months before the claimable event, unless the new contribution payer's total and permanent disability or death is due to an accident.

11.4 STRATUM POLICY PREMIUM WAIVER

WHAT OUR BENEFIT DOESN'T COVER

We don't cover instances:

- 11.4.1 if the premium payer hasn't been forcibly retrenched, hasn't become totally and permanently disabled or hasn't passed away.
- 11.4.2 of forced retrenchment, total and permanent disability or death of a person who isn't noted as the premium payer.
- 11.4.3 if a new premium payer is appointed within 3 months before the claimable event, unless the new premium payer's total and permanent disability or death is due to an accident.

GENERAL EXCLUSIONS

We don't cover healthcare or service providers' accounts related to any medical procedure, treatment, hospitalisation, illness, disease, loss, damage, death, bodily injury or liability for:

1. events that occurred when you weren't an insured person.
2. events that occur during a policy waiting period unless it's for accidental events.
3. events where your policy's overall policy limit or a benefit limit has been reached.
4. amounts that exceed the additional 500% cover that your policy provides.
5. events where your policy doesn't provide the right benefit to claim from.
6. events that could be covered under more than one benefit provided by your policy, but because your initial medical event's been assessed and registered under a specific key benefit, continuation of treatment as a result of your initial medical event or events that follow your initial medical event, won't be assessed under another benefit.
7. claims that we've assessed as Prescribed Minimum Benefit (PMB) medical procedures that your medical aid reviews afterwards, and partly or fully pays according to the agreed payment arrangement your medical aid has with your healthcare or service provider.
8. events where you didn't obtain pre-authorisation from your medical aid, or where you didn't follow your medical aid's rules.
9. maxillofacial surgery and related medical conditions or procedures, unless it's related to accidental injury or cancer.
10. prescription medication that you collect at a pharmacy or medication that's given to you to take home, unless your policy has a benefit that covers it.
11. external prostheses, like artificial limbs.
12. external medical items, like crutches and birthing pools.
13. mechanical or computerised devices, like ventilators, unless your policy has a benefit that covers it.
14. co-payments related to robotic surgery, unless your policy has a benefit that covers it.
15. artificial insemination, infertility treatment, procedures or contraceptives, unless you're claiming for tubal ligation, a vasectomy or a contraceptive device implant if your policy has a benefit that covers it.
16. obesity and bariatric surgery.
17. reconstructive cosmetic surgery.
18. a breast reconstruction if it's not the first breast reconstruction in your lifetime.
(A breast reconstruction can be an implant or removal of a breast implant.)
19. home nursing, admission to a step-down or sub-acute facility, like a frail care centre, rehabilitation facility and hospice, unless your policy has a benefit that covers it.
20. mood disorders, emotional or mental illnesses, unless you're claiming for counselling under our Trauma Counselling Cover benefit.
21. sleeping disorders.
22. stem cell harvesting or treatment.
23. costs related to medical reports.
24. claims where we've negotiated discounts with your healthcare or service providers and paid them in full.
25. claims that are resubmitted due to your healthcare or service provider increasing their fees resulting in additional shortfalls, but your claim's already been finalised by us.
26. information that you didn't tell us about that can affect the assessment or acceptance of risk.
27. events that are covered by more than one Gap Cover insurer.
28. routine physical, diagnostic procedures or examinations that you go for as a standard and not because you require medical attention, unless your policy has a benefit that covers it.
29. transport charges and healthcare services that's provided to you while being transported in an emergency vehicle, vessel or aircraft.
30. deliberate criminal or fraudulent acts, or any illegal activity conducted by you or a member of your household which directly or indirectly results in loss, damage or injury.
31. attempted suicide or intentional self-injury.
32. deliberate exposure to exceptional danger unless you attempt to save a human life.
33. events where the use of drugs or alcohol is involved.
34. riots, wars, political acts, public disorder, terrorism, civil commotions, labour disturbances, strikes, lock-out or any attempt to such acts.
35. active military, police or police reservist activities while you are on active duty.
36. 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.
37. events that are covered by legislation, like contractual liability and consequential loss.