



CORPORATE ACCESS

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

One **Gap Cover** policy covers you and your spouse, even if you belong to different medical aid plans, including the dependants registered on either medical aid plan.

Child dependants registered on your or your spouse's medical aid plan may remain on your **Gap Cover** policy regardless of age. However, when a child dependant applies for their own medical aid membership, they must apply for their own policy.

A full-time student **26 or younger** may remain on your policy even if they belong to a different medical aid plan, provided proof of full-time studies is submitted annually. Distance and online learning don't qualify.

We cover **5 or more employees** as an employer group if you join through your employer.

Ask your employer if your spouse and dependants may join. If your employer agrees, add them to your policy.

Premiums are determined by factors such as the size of the employer group, the average age, and whether cover is compulsory or voluntary.

ASK US FOR A CORPORATE QUOTE



BENEFITS SUBJECT TO AN OVERALL POLICY LIMIT (OPL)

An OPL of R 219 845 per insured person per year applies to the following benefits or any higher amount published by the Regulator during the year. All approved claim amounts will be deducted from the available OPL.

**ACCESS BENEFIT**

Claim the cost of any medical procedure, treatment, scan or surgery listed below if your medical aid plan excludes it.

IN- AND OUT-OF-HOSPITAL COVER**HOW IT WORKS**

Our benefit helps with the cost of a planned medical procedure if:

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

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

To claim, send us cost estimates from all your chosen providers, such as the hospital or day clinic, surgeon, and anaesthetist, along with a completed claim form.

We'll review the quotes. If approved, we'll issue a guarantee of payment to your providers as an undertaking to pay them directly after your procedure.

After your procedure, submit the final invoices. We'll settle them in the order received, up to the procedure benefit limit. Any costs above the limit will be for your pocket.

WHAT WE COVER

We'll cover the cost of your hospital admission and related provider fees, up to the procedure benefit limit.

Each benefit limit applies **per insured person per year**.

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

GOOD TO KNOW

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

Sometimes, two **Gap Cover** policies are better than one.

CORPORATE ACCESS is ideal if your medical aid plan excludes any of the medical procedures and treatments listed above.

However, if you're on a 100%, 200%, or 300% medical aid plan and want cover for shortfalls on doctors' and specialists' private fees and additional cover for cancer treatment, co-payments, and internal prosthetic devices, **CORPORATE ACCESS** with **CORPORATE COMPACT³⁰⁰** or **CORPORATE MERIDIAN⁴⁰⁰** is an ideal combination.

Consider a combination of **CORPORATE ACCESS** and **CORPORATE ELITE⁵⁰⁰** for the highest level of cover and additional benefits for out-patient specialist consultations, private room fees, scopes, and specialised scans.



RADIOLOGY COVER

What does your medical aid plan cover for specialised radiology? Does a combined benefit limit apply to MRI and CT scans? We've got the cover you need.

MRI AND CT SCAN SUB-LIMITS

OUT-OF-HOSPITAL COVER

HOW IT WORKS AND WHAT WE COVER

When your medical aid covers the cost of out-of-hospital MRI or CT scans from a **sub-limit** or **annual limit**, but the rand amount available under the **sub-limit** or **annual limit** doesn't cover the total cost, we'll cover the **difference**.

Limited to **R 2 000 per policy per year**.

GOOD TO KNOW

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



CASUALTY BENEFITS

There are **two benefit categories**.

ACCIDENTAL EVENTS

INDIVIDUALS OF ALL AGES
OUT-OF-HOSPITAL COVER

ILLNESS EVENTS

CHILDREN 10 YEARS OR YOUNGER
OUT-OF-HOSPITAL COVER

HOW IT WORKS

Visit any registered medical facility **within 24 hours** of an accident, such as the doctor's room or emergency unit at the nearest hospital, when anyone in the family requires medical treatment for bodily injury.

Children **10 years or younger** are covered for after-hours illness-related events at any registered casualty facility between **19:00** and **7:00** Monday through Friday and all day Saturday, Sunday, and public holidays.

We'll cover the **shortfalls** when your medical aid pays part of the cost of a casualty event from a **risk, insured day-to-day or block benefit**, or **refund** the **total cost** when paid from your **medical savings account** or **pocket**, subject to our benefit limit.

WHAT WE COVER

We cover all the healthcare and service providers' accounts related to a casualty event, typically including:

- | | |
|--|--|
| <ul style="list-style-type: none"> • basic and specialised radiology and pathology; • co-payments; • facility and doctors' consultation fees; • medication administered during an event; • external medical items received at the medical facility, such as a neck brace or arm sling; and • follow-up visits related to accidental events, such as having stitches or a cast removed. | <ul style="list-style-type: none"> • basic and specialised radiology and pathology; • co-payments; • facility and doctors' consultation fees; and • medication administered during an event. |
|--|--|

Limited to **R 4 000 per policy per year**.

GOOD TO KNOW

- If you're admitted to the hospital after being treated in the casualty or medical facility for an accidental-related event, or your child is admitted after being treated in the casualty facility for an after-hours illness-related event, the admission becomes a new medical event, and claims will be assessed based on the hospital admission.
- Our benefit applies even if your medical aid doesn't cover casualty events.
- You're covered from day one because this benefit isn't subject to any waiting periods.

BENEFIT NOT SUBJECT TO THE OVERALL POLICY LIMIT (OPL)

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

PAYOUT BENEFIT**ACCIDENTAL DEATH AND DISABILITY****HOW IT WORKS**

In the event of accidental death or total and permanent disability due to an accident, a benefit amount is payable on each insured person's life.

Our benefit compensates you for any current or future costs and expenses, including any potential loss of earnings.

The benefit amount that applies to:

- the principal insured is payable to the surviving spouse or the principal insured's estate if there's no surviving spouse.
- the spouse is payable to the principal insured or the spouse's estate if there's no surviving principal insured.

In the event of the simultaneous death of the principal insured and spouse, the benefit amounts are payable to the principal insured's estate.

WHAT WE COVER

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

Limited to **1 event per insured person per year**.

ACCIDENT...

means a sudden, unplanned and unexpected accidental event resulting in bodily injury caused by physical impact.

TOTAL AND PERMANENT DISABILITY...

means bodily injury resulting in complete and absolute disablement beyond hope of improvement, preventing an employed insured person from following their usual occupation or similar work for which they're suited by education or training.

If the insured person is an individual or pensioner who's not gainfully employed, total and permanent disability will mean the loss of both hands or feet, one hand and one foot, or the sight of both eyes.

GOOD TO KNOW

- You're covered from day one because this benefit isn't subject to any waiting periods.

**EXPLAINER VIDEOS**

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

LIFESTYLE BENEFIT

Our **LIFESTYLE BENEFIT** is a complimentary value-added product.

**WELLNESS CARELINE**

www.stratumbenefits.co.za/wellness-careline/

Coming In **2026**.

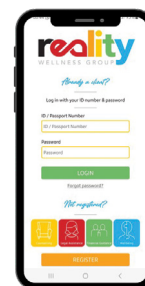
Even the strongest people need support sometimes, and that's where professional help can truly make an impact.

Through our partnership with **Reality Wellness Group**, you and your dependants can access a **WELLNESS CARELINE** – a confidential support service that connects you with qualified registered counsellors and social workers for one-on-one counselling, offered **telephonically** or **virtually**.

Support is available 24/7, 365 days a year, in all 11 official languages.

Download the **Reality Wellness Group** Mobile App for expert resources, inspiring talks, and practical tools to support your overall well-being.

Follow the link to our website to get your **access code** to create your Mobile App user profile.



WAITING PERIODS

Waiting periods may apply from your and your dependants' cover start dates, but never to accidental events that occur after your start dates.

3 MONTH GENERAL WAITING PERIOD

There's no cover during this period except for accidental events that occur after your and your dependants' cover start dates. Unless we confirm otherwise, the following benefits are subject to this waiting period:

ACCESS BENEFIT | SUB-LIMIT BENEFIT

12 MONTH PRE-EXISTING MEDICAL CONDITION WAITING PERIOD

There's no cover during this period for investigations, medical procedures, surgeries or treatments related to any illness or medical condition diagnosed or for which advice or treatment was received **12 months** before your or your dependants' cover start dates. Unless we confirm otherwise, the following benefits are subject to this waiting period:

ACCESS BENEFIT | SUB-LIMIT BENEFIT

EXCEPTION TO THE RULE

The following benefits aren't subject to waiting periods:

CASUALTY BENEFITS | ACCIDENTAL DEATH AND DISABILITY BENEFIT

SWITCHING COVER FROM ANOTHER GAP COVER PROVIDER

Transfer underwriting may apply to applicants who switch cover from another **Gap Cover** provider.

LIMITED PAYOUT BENEFIT

Unless we confirm otherwise, the **Limited Payout Benefit** applies from your and your dependants' cover start dates.

HOW IT WORKS

If you claim from our **SUB-LIMIT BENEFIT** in the first **10 months** of cover, we'll pay between **20%** and **100%** of the **approved claim amount**, subject to applicable benefit limits.

The percentage is determined by the quote your employer accepted.

If your medical event is related to a pre-existing medical condition for which you received advice or treatment **12 months** before your cover start date, the claim may be subject to a **Pre-Existing Medical Condition Waiting Period**.

BENEFIT & GENERAL EXCLUSIONS

Gap Cover works with your medical aid cover.

Gap Cover includes various benefits covering medical expense shortfalls for just about every medical eventuality.

Depending on the benefit's qualifying criteria, your medical aid must first pay a portion of the cost of a medical event before we step in and take care of the rest. However, not every medical event will qualify for benefits as policies are subject to benefit and general exclusions.

BENEFIT AND GENERAL EXCLUSIONS

Your **Gap Cover** policy offers many benefits, each with specific qualifying criteria. General exclusions apply to your policy and not only to specific benefits.

For more information about what you can and can't claim, refer to the **Benefit and General Exclusions** in the **Policy Schedule** or view the **General Exclusions** below.

Go to www.stratumbenefits.co.za/corporateaccess/ or scan the **QR code** to view or download the **Policy Schedule**.



GENERAL POLICY EXCLUSIONS

We don't pay claims related to:

1. events that occurred before your cover start date.
2. events during waiting periods, except for accidental events that occur after your cover start date.
3. line items that don't meet the South African medical coding standards, such as CPT, NHRPL, and ICD-10.
4. events your medical aid pays as concessions, exceptions, or ex-gratia payments.
5. medical events for which pre-authorisation hasn't been obtained from your medical aid or when your medical aid's rules haven't been followed.
(For example, late pre-authorisation requests or using non-network hospitals on a network-based medical aid plan.)
6. events when benefit limits or your policy's overall limit has been reached.

GENERAL POLICY EXCLUSIONS CONTINUED

7. events your policy doesn't cover or provides an appropriate benefit to claim from.
8. additional shortfalls when your healthcare or service provider increases their fees after we've finalised your claim.
9. additional shortfalls when your healthcare or service provider agrees to a discount but increases their fee after we've finalised your claim.
10. costs for medical documents, such as scripts and medical reports.
11. split billing charges.
(These are upfront payments your healthcare or service providers may ask you to pay before your medical event. These amounts make up the providers' private fees and don't reflect on the accounts submitted to medical aid for payment. We only refund co-payments imposed by your medical aid if your policy offers a benefit.)

SPECIFIC POLICY EXCLUSIONS

We don't pay claims related to:

12. allied healthcare professionals, except if your policy offers a benefit.
13. assisted reproductive therapy (ART), fertility treatments or contraceptives.
14. a second breast reconstruction or any subsequent reconstruction procedure.
(We cover one event per insured person provided it's the first breast reconstruction in your lifetime and your policy offers a benefit.)
15. diagnosing or treating sleeping disorders.
16. elective, prophylactic (preventative), routine procedures or physical examinations, such as annual check-ups and medical tests for insurance purposes, risk-reducing mastectomies, and scopes based on family history.
17. external medical items, such as spectacles, arm slings, compression socks, crutches, moon boots and neck braces, except when claiming from our **CASUALTY BENEFIT** for items received at the medical facility.
18. external prosthetic devices, such as artificial limbs.
19. home or private nursing or admission to a step-down or sub-acute facility, such as frail care centres, hospice centres, mental health facilities, and rehabilitation facilities.
20. hospital charges, such as ward fees, except if your policy offers a benefit.
21. treating mood disorders or emotional or psychological illnesses.
22. obesity or treatments required due to obesity.
23. prescription or take-home medication.
24. reconstructive cosmetic surgery, except if your policy offers a benefit.
25. robotic-assisted surgery co-payments.
26. specialised mechanical or computerised devices, such as CPAP machines, glucometers, insulin pumps, oxygen machines, and ventilators.
27. stem cell harvesting or treatments.

STANDARD NON-LIFE POLICY EXCLUSIONS

We don't pay claims related to:

28. attempted suicide, suicide, or intentional self-injury.
29. deliberate exposure to exceptional danger, except if trying to save a human life.
(Exceptional danger includes but isn't limited to hazardous sports or activities, such as skydiving, mixed martial arts fighting (MMA), and speed racing.)
30. events covered by legislation, such as contractual liability and consequential loss.
31. illegal behaviour or breaking the law of the Republic of South Africa.
32. events outside the borders of the Republic of South Africa.
33. illness or injury caused by using drugs or narcotics, except if prescribed by a healthcare provider, provided the healthcare provider isn't an insured person.
34. illness or injury caused by using alcohol.
35. nuclear weapons, nuclear material or ionising radiation.
36. participation in active military, police or police reservist duty, civil commotion, invasion, labour disturbance, political act, rebellion, riot, strike, terrorist activity, war, or the activity of locked-out workers.
37. transport charges or healthcare services provided while being transported in an emergency vehicle, vessel, or aircraft.

FREQUENTLY ASKED QUESTIONS

Reading through frequently asked questions is one way of understanding **Gap Cover** better.

Go to our **Frequently Asked Questions** page, www.stratumbenefits.co.za/gap-cover-faqs/, or scan the **QR code**.

GET COVER!

There's only one thing left to do.

Speak with your HR, call your financial advisor, visit www.stratumbenefits.co.za/get-cover/ to apply online, or download and email the application form.