

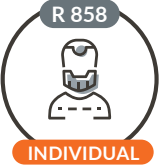
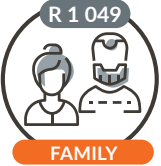


ELITE⁵⁰⁰

Our **top-of-the-range option** offers the widest range of **in- and out-of-hospital** benefits at the highest level of cover.

PREMIUMS FOR INDIVIDUALS AND FAMILIES

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

IF YOU'RE 64 OR YOUNGER	IF EVERYONE IN THE FAMILY IS 64 OR YOUNGER	IF YOU'RE 65 OR OLDER	IF YOU OR ANYONE IN THE FAMILY IS 65 OR OLDER
R 529  INDIVIDUAL	R 650  FAMILY	R 858  INDIVIDUAL	R 1 049  FAMILY

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

Child dependants registered on your or your spouse's medical aid plan may remain on your **Gap Cover** policy regardless of age. However, when a child dependant applies for their own medical aid membership, they must apply for their own policy. A full-time student **26 or younger** may remain on your policy even if they belong to a different medical aid plan, provided proof of full-time studies is submitted annually. Distance and online learning don't qualify.



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.

**GAP BENEFIT**
www.stratumbenefits.co.za/gap-benefit/
IN- AND OUT-OF-HOSPITAL COVER**HOW IT WORKS**

We cover the **shortfalls** when:

- the cost of your medical procedure performed in a day clinic, hospital, or your healthcare provider's room is more than your medical aid plan's rate,
- as long as your medical aid pays an amount from a **hospital benefit**, also known as a **risk, major medical, insured day-to-day or block benefit**.

WHAT WE COVER

We pay up to an **additional 500%** on top of your medical aid plan's rate to cover shortfalls on your doctors', specialists' and healthcare providers' accounts related to the following in- and out-of-hospital medical events:

- consumable items, such as catheters, medical gloves and syringes;
- medication administered during your medical event;
- medical procedures, surgeries and treatments;
- physiotherapy;
- pathology, such as blood, saliva and urine tests; and
- Prescribed Minimum Benefit (PMB) medical procedures.

Subject to the **OPL of R 219 845 per insured person per year**.

GOOD TO KNOW

- PMBs are specific benefits your medical aid must provide for a defined list of medical procedures. If your medical aid's qualifying criteria for PMBs aren't met, we'll assess the shortfalls when you incur out-of-pocket medical expenses.
- Look at **DENTAL, MATERNITY and RADIOLOGY COVER** to see what other shortfalls we cover.
- Allied healthcare providers aren't covered, except for clinical perfusionists, midwives, nurses, physiotherapists, and radiographers.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

**CO-PAYMENT BENEFITS**

There are **three benefit categories**.

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

HOW IT WORKS

We **refund** co-payments that your **medical aid imposes** as rand amounts or percentages for:

- admissions to network and non-network day clinics and hospitals and medical procedures, such as in- or out-of-hospital scopes and scans,
- as long as the co-payments are paid from your **medical savings account or pocket**.

WHAT WE COVER

Claim as many admission and procedure-related co-payments as needed. Subject to the OPL of R 219 845 per insured person per year . Benefit limits apply to our PENALTY and ROBOTIC SURGERY CO-PAYMENT BENEFITS .	If your medical aid has a preferred network of day clinics, hospitals and healthcare providers you must use for planned medical procedures, you can claim the penalty co-payments when using non-network providers. Limited to 2 co-payments up to R 16 000 per co-payment per policy per year .	When co-payments apply to robotic-assisted surgeries, such as prostatectomies, we'll refund the co-payments. Limited to R 10 000 per policy per year .
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GOOD TO KNOW

- If your healthcare provider asks you to pay an amount before your medical event, it's called split billing. The upfront amount makes up the provider's private fee that doesn't reflect on the account submitted to your medical aid for payment. Ask your provider to submit a detailed account reflecting their private fee to your medical aid so we can assess any shortfalls under our **GAP BENEFIT**.
- Some medical aids require members to use specific provider networks for planned procedures such as hip and knee replacements, spinal surgery, and cataract surgery. These networks may include hospitals, clinics, specialists, and anaesthetists. If you use a non-network provider, your medical aid may apply a co-payment across all related accounts. You can claim these co-payments from us, though depending on how your medical aid processes them, they may fall under our **PENALTY CO-PAYMENT BENEFIT**. Staying in-network is the best way to avoid unnecessary out-of-pocket expenses.
- Look at **DENTAL, MATERNITY and RADIOLOGY COVER** to see what co-payments we cover for dentistry, childbirth and specialised radiology.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.



DENTAL COVER

If you're booked into a day clinic or hospital for extractions, dental implants or oral surgery, our benefits can assist with the shortfalls and co-payments.

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

SPECIALIST SHORTFALLS IN-HOSPITAL COVER	CO-PAYMENTS IN-HOSPITAL COVER
HOW IT WORKS	
We cover the shortfalls when: - the cost of your dental-related procedure performed in a day clinic or hospital is more than your medical aid plan's rate, - as long as your medical aid pays an amount from a hospital benefit, also known as a risk or major medical benefit.	We refund co-payments that your medical aid imposes as rand amounts or percentages for: - admissions to day clinics and hospitals and in-hospital dental-related procedures, - as long as the co-payments are paid from your medical savings account or pocket.
WHAT WE COVER	
We pay up to an additional 500% on top of your medical aid plan's rate to cover shortfalls on your dentists' and specialists' accounts related to the following in-hospital medical events: - dental procedures, such as dental implants and wisdom teeth extractions. Limited to R 50 000 per policy per year. - dental procedures due to accidental events or cancer treatment. Subject to the OPL of R 219 845 per insured person per year. Subject to our GAP BENEFIT.	Claim as many admission and dental procedure-related co-payments as needed. Subject to our ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT. Claim the penalty co-payments when using day clinics or hospitals outside your medical aid's preferred network. Subject to our PENALTY CO-PAYMENT BENEFIT.

GOOD TO KNOW

- If your healthcare provider asks you to pay an amount before your medical event, it's called split billing. The upfront amount makes up the provider's private fee that doesn't reflect on the account submitted to your medical aid for payment. Ask your provider to submit a detailed account reflecting their private fee to your medical aid so we can assess any shortfalls under our **GAP BENEFIT**.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.

GAP MATCH

This guiding tool matches the best-suited **Gap Cover** option with your medical aid plan.

Go to www.stratumbenefits.co.za/gap-match/ or scan the QR code.

Chat with your financial advisor to sign up, or contact our **Client Support Centre** for general questions and information.



EXPLAINER VIDEOS

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



MATERNITY COVER

We offer cover from pre- to post-bump.

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

BEFORE THE DELIVERY	THE DELIVERY	AFTER THE DELIVERY
HOW IT WORKS AND WHAT WE COVER		
PRE-NATAL CONSULTATIONS OUT-OF-HOSPITAL COVER Claim the shortfalls between what: - healthcare professionals, such as your gynaecologist or obstetrician, charge for virtual or face-to-face consultations in their rooms and the rate your medical aid applies, - as long as your medical aid pays an amount from a maternity or risk benefit, or your medical savings account. Subject to our OUT-PATIENT SPECIALIST CONSULTATION BENEFIT. Ancillary tests or investigations typically done with consultations, such as urine tests and sonars, won't be covered.	CHILDBIRTH SHORTFALLS IN- AND OUT-OF-HOSPITAL COVER We cover the shortfalls when: - healthcare professionals, such as your gynaecologist, obstetrician or midwife, charge more than your medical aid plan's rate for delivering your baby in the hospital or at home, - as long as your medical aid pays an amount from a hospital benefit, also known as a risk or major medical benefit. Subject to our GAP BENEFIT.	POST-NATAL CONSULTATIONS OUT-OF-HOSPITAL COVER Claim the shortfalls between what: - healthcare professionals, such as your gynaecologist or the paediatrician, charge for virtual or face-to-face consultations in their rooms and the rate your medical aid applies, - as long as your medical aid pays an amount from a risk or insured day-to-day benefit, or your medical savings account. Subject to our OUT-PATIENT SPECIALIST CONSULTATION BENEFIT.
PREVENTATIVE PROCEDURES OUT-OF-HOSPITAL COVER Soon-to-be moms can get a flu vaccination in their second trimester if recommended by the healthcare professional. Claim the shortfalls of a flu vaccination and other preventative tests and procedures, such as a full blood count, when your medical aid pays part of the cost from a risk, insured day-to-day or block benefit, or the total cost when paid from your medical savings account or pocket, subject to our benefit limit. Subject to our PREVENTATIVE CARE BENEFIT.	CO-PAYMENTS IN-HOSPITAL COVER We refund co-payments that your medical aid imposes for elective caesareans as long as the co-payments are paid from your medical savings account or pocket. Subject to our ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT. Claim the penalty co-payments when using hospitals outside your medical aid's preferred network. Subject to our PENALTY CO-PAYMENT BENEFIT.	IMMUNISATIONS AND BIRTH CONTROL OUT-OF-HOSPITAL COVER We cover the shortfalls when your medical aid pays part of the cost of childhood immunisations and other preventative tests and procedures, such as your baby's flu vaccination from 7 months or older or a contraceptive device implant from a risk, insured day-to-day or block benefit, or the total cost when paid from your medical savings account or pocket, subject to our benefit limit. Subject to our PREVENTATIVE CARE BENEFIT. Our CASUALTY BENEFIT covers your little one for after-hours medical treatment due to illness.

PRIVATE ROOM IN-HOSPITAL COVER

Enjoy the comfort and privacy of a private room.

Claim the **shortfalls** when your medical aid pays part of the cost of a private hospital room from a **hospital** or **risk benefit**, or the **total cost** when your medical aid excludes it from cover, subject to our benefit limit.

We also cover the hospital's lodger fee if a loved one registered on your **Gap Cover** policy stays with you or the nursery fee if you're hospitalised after the delivery and need to nurse your baby.

Subject to our **PRIVATE ROOM BENEFIT**.

GOOD TO KNOW

- Send us a medical aid membership or birth certificate to add your newborn.
- Our **PRIVATE ROOM BENEFIT** isn't subject to the **Overall Policy Limit (OPL)** because we give this benefit to you over and above those that form part of the **OPL**.
- Unless we confirm otherwise, waiting periods apply and our **GAP** and **CO-PAYMENT BENEFITS** are subject to the **Limited Payout Benefit**. Refer to the **Waiting Periods** page.



SUB-LIMIT BENEFITS

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

There are **four benefit categories**.

COLONOSCOPIES, ENTEROSCOPIES AND GASTROSCOPIES	INTERNAL PROSTHETIC DEVICE SHORTFALLS	INTERNAL PROSTHETIC DEVICE TOP-UP	RENAL DIALYSIS TREATMENTS
IN- AND OUT-OF-HOSPITAL COVER	IN-HOSPITAL COVER	IN-HOSPITAL COVER	OUT-OF-HOSPITAL COVER

HOW IT WORKS

When your medical aid pays part of the cost of a colonoscopy, enteroscopy, gastroscopy, internal prosthetic device or renal dialysis treatment, we'll cover the **difference** or **top up** your cover when your medical aid plan's internal prosthetic device benefit limit has been reached.

WHAT WE COVER

If you go for an in- or out-of-hospital colonoscopy, enteroscopy or gastroscopy: - we'll cover the shortfall on the anaesthetist's account when your medical aid pays an amount from a sub-limit or annual limit, or - the difference if your medical aid pays part of the cost of the scope from a sub-limit or annual limit. Limited to R 7 000 per insured person per event.	We'll cover the difference in the cost of any internal prosthetic device that replaces a body part, such as a hip joint, or improves a lost or reduced bodily function, such as a cardiac pacemaker, cochlear implant, or intraocular lenses when your medical aid pays part of the cost from a sub-limit or annual limit. Limited to R 40 000 per insured person per event.	Does your medical aid plan cover internal prosthetic devices up to a benefit limit? When your medical aid plan's benefit limit has been reached, we'll top up your cover and pay the total cost of any internal prosthetic device, up to our benefit limit. Limited to R 10 000 per insured person per event.	Claim the difference in the cost of renal dialysis treatments when your medical aid pays part of the cost from a sub-limit or annual limit. Limited to R 30 000 per insured person per event.
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External medical items aren't covered.

GOOD TO KNOW

- Look at **RADIOLOGY COVER** to see what we cover for MRI, CT, and PET scans.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.



PHYSICAL REHABILITATION TOP-UP BENEFIT

OUT-OF-HOSPITAL COVER

HOW IT WORKS

If your medical aid plan covers physical rehabilitation due to an accident up to a benefit limit or limits the number of days you may stay at a sub-acute or step-down facility, we'll **top up** your cover and pay the **total cost** of ongoing rehabilitation, up to our benefit limit, when your medical aid plan's benefit limit has been reached.

WHAT WE COVER

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

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

GOOD TO KNOW

- A sub-acute or step-down facility is a registered facility focusing on rehabilitation after physical injury due to an accident, where appropriately qualified and registered therapists provide treatment.
- Physical rehabilitation related to illness or ongoing rehabilitation after discharge isn't covered.
- You're covered from day one because this benefit isn't subject to any waiting periods.



CANCER BENEFITS

There are **three benefit categories**.

BREAST RECONSTRUCTION

IN-HOSPITAL COVER

HOW IT WORKS

We'll cover the **total cost** of reconstructing an **unaffected** breast, up to our benefit limit, if the surgery meets specific qualifying criteria.

Our benefit applies if:

- your medical aid plan excludes the reconstruction from cover;
- the cancer diagnosis of the affected breast is **Stage 2** or higher;
- a mastectomy of the affected and unaffected breasts and reconstruction of both breasts are done simultaneously, except when clinically motivated to be performed in different stages; and if
- it's the first breast reconstruction in your lifetime.

Our benefit doesn't apply to the:

- mastectomy of an unaffected breast; or to a
- second reconstruction of an affected or unaffected breast or any subsequent reconstruction procedure.

If you undergo a lumpectomy and reconstruction of an affected breast or a mastectomy and reconstruction of an affected or unaffected breast not excluded by your medical aid, our **GAP BENEFIT** can assist with the shortfalls when the cost of the procedure is more than your medical aid plan's rate.

WHAT WE COVER

We'll cover a breast implant reconstruction procedure or flap breast reconstruction surgery.

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

CANCER TREATMENT SHORTFALLS
IN- AND OUT-OF-HOSPITAL COVERCANCER TREATMENT TOP-UP
IN- AND OUT-OF-HOSPITAL COVER

HOW IT WORKS

We cover the **shortfalls** when your healthcare providers charge more than your medical aid plan's rate for in- or out-of-hospital cancer treatment, as long as your medical aid pays an amount from an **oncology benefit**.

If your medical aid plan covers in- or out-of-hospital cancer treatment up to an oncology benefit limit, we'll **top up** your cover and pay the **total cost** of ongoing cancer treatment, up to the available **OPL**, when your medical aid plan's oncology benefit limit has been reached.

WHAT WE COVER

The shortfalls we'll cover are subject to the oncology treatment plan approved by your medical aid.

Our benefit typically covers:

- biological medication;
- chemotherapy and radiotherapy;
- consultations with your oncologist; and
- specialised radiology, such as bone density and PET scans.

We'll also **refund** the oncology-related co-payments that your **medical aid imposes** as rand amounts or percentages when your medical aid plan's oncology benefit limit has been reached.

Subject to the **OPL of R 219 845 per insured person per year**.

We'll cover the cost of your ongoing cancer treatment subject to the oncology treatment plan approved by your medical aid.

Subject to the **OPL of R 219 845 per insured person per year**.

GOOD TO KNOW

- Some medical aids impose co-payments from the start of treatment, often for precision or innovative oncology medication. These co-payments aren't covered, as our benefit only refunds co-payments that apply once your medical aid plan's oncology benefit limit has been reached.
- Look at our **FIRST-TIME CANCER DIAGNOSIS BENEFIT** to see what we cover for a cancer diagnosis.
- Unless we confirm otherwise, waiting periods apply. Refer to the **Waiting Periods** page.



RADIOLOGY COVER

What does your medical aid plan cover for basic and specialised radiology? Do upfront co-payments apply to in- or out-of-hospital MRI, CT, and PET scans, or a combined benefit limit for x-rays and scans? We've got the cover you need.

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

RADIOLOGY SHORTFALLS IN- AND OUT-OF-HOSPITAL COVER	MRI, CT AND PET SCAN CO-PAYMENTS IN- AND OUT-OF-HOSPITAL COVER	MRI, CT AND PET SCAN SUB-LIMITS IN- AND OUT-OF-HOSPITAL COVER	MRI, CT AND PET SCAN TOP-UP IN- AND OUT-OF-HOSPITAL COVER
HOW IT WORKS			
We cover the shortfalls when: - the radiologist or radiology facility charges more than your medical aid plan's rate for in- or out-of-hospital basic and specialised radiology, - as long as your medical aid pays an amount from a hospital or insured day-to-day benefit, also known as a risk, major medical or block benefit.	We refund co-payments that your medical aid imposes as rand amounts or percentages for in- or out-of-hospital MRI, CT, and PET scans, as long as the co-payments are paid from your medical savings account or pocket.	When your medical aid covers the cost of: - in- or out-of-hospital MRI, CT, or PET scans from a sub-limit or annual limit, - but the rand amount available under the sub-limit or annual limit doesn't cover the total cost, we'll cover the difference.	Does your medical aid plan cover in- or out-of-hospital MRI, CT, and PET scans up to a benefit limit? When your medical aid plan's radiology benefit has been reached, we'll top up your cover and pay the total cost of an in- or out-of-hospital MRI, CT, or PET scan up to our benefit limit.
WHAT WE COVER			
We pay up to an additional 500% on top of your medical aid plan's rate to cover shortfalls on basic and specialised radiology. Subject to our GAP BENEFIT.	Claim as many radiology-related co-payments as needed. Subject to our ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT.	Limited to R 6 000 per insured person per event.	Limited to R 6 000 per policy per year.

GOOD TO KNOW

- Unless we confirm otherwise, waiting periods apply and our **GAP, CO-PAYMENT** and **SUB-LIMIT BENEFITS** are subject to the **Limited Payout Benefit**. Refer to the **Waiting Periods** page.



OUT-PATIENT SPECIALIST CONSULTATION BENEFIT

OUT-OF-HOSPITAL COVER

HOW IT WORKS

Claim the **shortfalls** when:

- your specialists charge more than your medical aid plan's rate for virtual or face-to-face consultations in their rooms,
- as long as your medical aid pays part of the consultation fees from either a **risk benefit**, also known as an **insured day-to-day or block benefit**, or from your **medical savings account**.

There won't be shortfalls for us to cover if:

- your medical aid covers the consultation fees in full from a **risk benefit**, your **medical savings account**, or both, or
- you pay the consultation fees yourself without claiming from your medical aid. Remember, your medical aid must pay part of the fees from a **risk benefit** or your **medical savings account** for us to cover the shortfalls.

WHAT WE COVER

We'll cover the shortfalls between your medical aid plan's rate and the amounts your specialists charge.

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

GOOD TO KNOW

- This benefit doesn't refund consultation fees or any part of the fee paid by your medical aid from your medical savings account.
- Consultations with general practitioners or allied healthcare providers, such as biokineticists, chiropractors and physiotherapists, aren't covered.
- Ancillary tests or investigations typically done with consultations, such as urine tests and sonars, aren't covered.
- Routine, prophylactic (elective), or preventative procedures, such as annual check-ups and physical examinations, aren't covered.
- Unless we confirm otherwise, waiting periods apply. A **3 Month General Waiting Period** always applies, except when switching cover from another **Gap Cover** provider with a similar benefit. Refer to the **Waiting Periods** page.

**CASUALTY BENEFITS**

There are **three benefit categories**.

ACCIDENTAL EVENTS INDIVIDUALS OF ALL AGES OUT-OF-HOSPITAL COVER	ILLNESS EVENTS CHILDREN 10 YEARS OR YOUNGER OUT-OF-HOSPITAL COVER	ILLNESS EVENTS INDIVIDUALS 11 YEARS OR OLDER OUT-OF-HOSPITAL COVER
HOW IT WORKS		
Visit any registered medical facility within 24 hours of an accident, such as the doctor's room or emergency unit at the nearest hospital, when anyone in the family requires medical treatment for bodily injury. Limited to R 15 000 per policy per year .	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. Limited to R 2 000 per policy per year .	Individuals 11 years or older 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. Limited to R 2 000 per policy per year .
We'll cover the shortfalls when your medical aid pays part of the cost of a casualty event from a risk, insured day-to-day or block benefit , or refund the total cost when paid from your medical savings account or pocket , subject to our benefit limits.		

WHAT WE COVER

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

- basic and specialised radiology and pathology;
- co-payments;
- facility and doctors' consultation fees; and
- medication administered during an event;
- external medical items received at the medical facility, such as a neck brace or arm sling, limited to **R 2 000 per policy per year**, subject to the **R 15 000** benefit limit; and
- follow-up visits related to accidental events, such as having stitches or a cast removed, limited to **1 visit per insured person per event**, subject to the **R 15 000** benefit limit.
- basic and specialised radiology and pathology;
- co-payments;
- facility and doctors' consultation fees; and
- medication administered during an event.

GOOD TO KNOW

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

**TRAUMA COUNSELLING BENEFIT**

www.stratumbenefits.co.za/trauma-counselling-benefit/

When dealing with a traumatic event and wanting to see a counsellor, our benefit can assist with the costs.

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

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

WHAT WE COVER

You're covered when you:

- witness an accident or act of physical violence;
- are directly affected by an accident or act of physical violence, for example, suffering bodily injury resulting in total and permanent disability;
- receive news of a loved one's or your own diagnosis of a critical illness; or
- mourn the death of a loved one.

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

GOOD TO KNOW

- Trauma affects everyone at different times. We provide cover even if the traumatic event occurred before your cover start date.
- Our benefit applies even if your medical aid doesn't cover trauma counselling consultations.
- Read more about our **WELLNESS CARELINE** value-added product, which offers complimentary telephonic and virtual counselling to support better mental wellness.
- You're covered from day one because this benefit isn't subject to any waiting periods.



PREVENTATIVE CARE BENEFIT

OUT-OF-HOSPITAL COVER

HOW IT WORKS

You're covered for essential preventative and screening tests.

Claim the **shortfalls** when your medical aid pays part of your healthcare provider's consultation fee, preventative test or procedure from a **risk, insured day-to-day** or **block benefit**, or claim the **total cost**, up to our benefit limit, when paid from your **medical savings account** or **pocket**.

WHAT WE COVER

Our benefit covers the consultation fees and cost of the following immunisations, procedures, scans, screenings, tests and vaccinations:

- blood glucose tests;
- bone density scans;
- childhood immunisations;
- cholesterol tests;
- contraceptive device implants;
- flu vaccinations;
- full blood counts;
- Human Papillomavirus vaccinations (HPV vaccines);
- mammograms and breast sonars;
- pap smears;
- prostate-specific antigen screenings; and
- testicular screenings.

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

GOOD TO KNOW

- Our benefit applies even if your medical aid doesn't cover preventative tests, screenings or procedures.
- Unless we confirm otherwise, a **General Waiting Period** applies. Refer to the **Waiting Periods** page.

BENEFITS NOT SUBJECT TO THE OVERALL POLICY LIMIT (OPL)

Our **PRIVATE ROOM**, **ACCIDENTAL DEATH AND DISABILITY**, **FIRST-TIME CANCER DIAGNOSIS**, **MEDICAL AID CONTRIBUTION WAIVER** and **STRATUM POLICY PREMIUM WAIVER BENEFITS** aren't subject to the **OPL** because we give these benefits to you over and above those that form part of the **OPL**.



PRIVATE ROOM BENEFIT

IN-HOSPITAL COVER

HOW IT WORKS

Claim the **shortfalls** when your medical aid pays part of the cost of a private hospital room from a **hospital** or **risk benefit**, or the **total cost**, up to our benefit limit when your medical aid excludes it from cover.

WHAT WE COVER

Our benefit applies when:

- you choose to stay in a private hospital room;
- the hospital charges a lodger fee when you stay with a loved one or a loved one stays with you, as long as they're registered on your **Gap Cover** policy; or
- a fee is charged when you're in hospital and need to nurse your baby.

Limited to **R 3 500 per policy per year**.

GOOD TO KNOW

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

PAYOUT BENEFITS



ACCIDENTAL DEATH AND DISABILITY

HOW IT WORKS

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

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

The benefit amount that applies to:

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

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

WHAT WE COVER

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

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

ACCIDENT...

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

TOTAL AND PERMANENT DISABILITY...

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

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

GOOD TO KNOW

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



FIRST-TIME CANCER DIAGNOSIS

www.stratumbenefits.co.za/first-time-cancer-diagnosis-benefit/

HOW IT WORKS

A benefit amount is payable on the first diagnosis of cancer if the diagnosis meets specific qualifying criteria.

Our benefit applies if:

- cancer is diagnosed for the first time in your life;
- the diagnosis is made whilst on cover with us;
- cancerous cells have invaded the surrounding or underlying tissue; and
- cancer is diagnosed **before** age 65.

Our benefit doesn't apply if the diagnosis:

- was made before your cover start date;
- is made during a **General Waiting Period**;
- is a second diagnosis, regardless of the cancer type;
- is for a tumour histologically described as pre-malignant, non-invasive or cancer in situ;
- is for skin cancer, except for malignant melanoma;
- is for **Stage 1** breast or prostate cancer; or if
- cancerous cells haven't invaded the surrounding or underlying tissue, regardless of the cancer stage.

WHAT WE COVER

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

GOOD TO KNOW

- We look at the following cancer stages when assessing a claim:
 - **Stage 1** usually means the cancer is small and contained within the organ it started in.
 - **Stage 2** usually means the tumour is larger than **Stage 1**, but the cancer hasn't started to spread into surrounding tissues. Sometimes **Stage 2** means cancer cells have spread into lymph nodes close to the tumour. This depends on the type of cancer.
 - **Stage 3** usually means the cancer is larger than **Stage 2**. It may have started to spread into surrounding tissues, and cancer cells in the lymph nodes are nearby.
 - **Stage 4** means cancer has spread from where it started to another body organ, such as the liver or lung. This is also called secondary or metastatic cancer.
- If you're diagnosed with **Stage 2** cancer that hasn't spread when the first diagnosis is made, our benefit doesn't apply.
- Unless we confirm otherwise, a **General Waiting Period** applies. Refer to the **Waiting Periods** page.

WAIVER BENEFITS



MEDICAL AID CONTRIBUTION WAIVER

HOW IT WORKS

In the event of the medical aid contribution payer's accidental death or total and permanent disability due to an accident, we'll step in and pay the monthly contributions.

If your employer pays your medical aid contributions on your behalf, the contributions must form part of your total salary package, also known as cost to company.

WHAT WE COVER

We'll pay the contributions for the members registered on your membership at the time of the event for **6 months**, up to **R 4 500 per month per medical aid membership**.

GOOD TO KNOW

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



STRATUM POLICY PREMIUM WAIVER

HOW IT WORKS

In the event of the policy premium payer's accidental death or total and permanent disability due to an accident, we'll take over the premium payments.

If your employer pays your policy premiums on your behalf, the premiums must form part of your total salary package, also known as cost to company.

WHAT WE COVER

We'll pay the policy premiums for the insured persons registered on your **Gap Cover** policy at the time of the event, limited to **12 months**.

GOOD TO KNOW

- A premium payer is a person, registered company, or entity solely responsible for paying your premiums.
- You're covered from day one because this benefit isn't subject to any waiting periods.

LIFESTYLE BENEFITS

Our LIFESTYLE BENEFITS are complimentary value-added products.



INTERNATIONAL TRAVEL INSURANCE

www.stratumbenefits.co.za/international-travel-insurance/

The whole family is covered for acute illness and injury when travelling for leisure outside South African borders, limited to **1 trip per policy per year** for a maximum of **31 days** shared between all travellers.

If you travel alone, you'll be insured for up to **31 days**, but if you travel with a dependant, the **31 days** will be divided between the travellers.

Please let us know of your upcoming trip at least **7 days** before departure and send proof of travel.

Follow the link for more information on international travel insurance cover and how to register.



WELLNESS CARELINE

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

Coming In 2026.

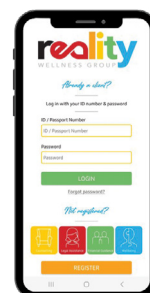
Even the strongest people need support sometimes, and that's where professional help can truly make an impact.

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 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:

GAP BENEFIT | CO-PAYMENT BENEFITS | SUB-LIMIT BENEFITS | CANCER BENEFITS | MRI, CT AND PET SCAN TOP-UP BENEFIT | OUT-PATIENT SPECIALIST CONSULTATION BENEFIT | PREVENTATIVE CARE BENEFIT | PRIVATE ROOM BENEFIT | FIRST-TIME CANCER DIAGNOSIS 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:

GAP BENEFIT | CO-PAYMENT BENEFITS | SUB-LIMIT BENEFITS | CANCER BENEFITS | MRI, CT AND PET SCAN TOP-UP BENEFIT | OUT-PATIENT SPECIALIST CONSULTATION BENEFIT | PRIVATE ROOM BENEFIT

EXCEPTION TO THE RULE

The following benefits aren't subject to waiting periods:

PHYSICAL REHABILITATION TOP-UP BENEFIT | CASUALTY BENEFITS | TRAUMA COUNSELLING BENEFIT | ACCIDENTAL DEATH AND DISABILITY BENEFIT | MEDICAL AID CONTRIBUTION WAIVER BENEFIT | STRATUM POLICY PREMIUM WAIVER BENEFIT

GOOD TO KNOW

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

Go to www.stratumbenefits.co.za/gap-cover-transfer-process-for-individuals/ or scan the QR code for our **Gap Cover Transfer Process for Individuals**.



LIMITED PAYOUT BENEFIT

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

HOW IT WORKS

If you claim from our **GAP BENEFIT**, **CO-PAYMENT BENEFITS** or **SUB-LIMIT BENEFITS** for any of the listed medical procedures or scans in the first **10 months** of cover, we'll pay **20%** of the **approved claim amount**, subject to applicable benefit limits.

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

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

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/elite500/ 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, except when claiming from our **TRAUMA COUNSELLING BENEFIT**.
(We cover consultation fees for trauma counselling received after your cover start date, even if the trauma event occurred before your cover start date.)
2. events during waiting periods, except for accidental events that occur after your cover start date.
3. line items that don't meet the South African medical coding standards, such as CPT, NHRPL, and ICD-10.
4. events your medical aid pays as concessions, exceptions, or ex-gratia payments.
5. medical events for which pre-authorisation hasn't been obtained from your medical aid or when your medical aid's rules haven't been followed, except if your policy offers a benefit.
(For example, 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.
7. shortfalls that exceed the **500% GAP BENEFIT** your policy provides.
8. events your policy doesn't cover or provides an appropriate benefit to claim from.
9. additional shortfalls when your healthcare or service provider increases their fees after we've finalised your claim.
10. additional shortfalls when your healthcare or service provider agrees to a discount but increases their fee after we've finalised your claim.
11. costs for medical documents, such as scripts and medical reports.
12. split billing charges.
(These are upfront payments your healthcare or service providers may ask you to pay before your medical event. These amounts make up the providers' private fees and don't reflect on the accounts submitted to medical aid for payment. We assess shortfalls under our **GAP BENEFIT** when all charges reflect on your providers' accounts and refund upfront co-payments your medical aid imposes under our **CO-PAYMENT BENEFITS**.)

SPECIFIC POLICY EXCLUSIONS

We don't pay claims related to:

13. allied healthcare professionals, except if your policy offers a benefit.
14. assisted reproductive therapy (ART), fertility treatments or contraceptives, except for contraceptive device implants, tubal ligations, and vasectomies if your policy offers a benefit.
15. a second breast reconstruction or any subsequent reconstruction procedure.
(We cover one event per insured person provided it's the first breast reconstruction in your lifetime and your policy offers a benefit.)
16. diagnosing or treating sleeping disorders.
17. elective, prophylactic (preventative), routine procedures or physical examinations, such as annual check-ups and medical tests for insurance purposes, risk-reducing mastectomies, and scopes based on family history, except if your policy offers a benefit.
18. external medical items, such as 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.
19. external prosthetic devices, such as artificial limbs.
20. home or private nursing or admission to a step-down or sub-acute facility, such as frail care centres, hospice centres, mental health facilities, and rehabilitation facilities, except if your policy offers a benefit.
21. hospital charges, such as ward fees.
22. treating mood disorders or emotional or psychological illnesses, except when claiming for counselling from our **TRAUMA COUNSELLING BENEFIT**.

SPECIFIC POLICY EXCLUSIONS CONTINUED

- 23. obesity or treatments required due to obesity.
 - 24. prescription or take-home medication, except when claiming prescription medication from our **CANCER BENEFITS**.
 - 25. reconstructive cosmetic surgery, except if your policy offers a benefit.
 - 26. robotic-assisted surgery co-payments, except when claiming from our **ROBOTIC SURGERY CO-PAYMENT BENEFIT**.
 - 27. specialised mechanical or computerised devices, such as CPAP machines, glucometers, insulin pumps, oxygen machines, and ventilators.
 - 28. stem cell harvesting or treatments.
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STANDARD NON-LIFE POLICY EXCLUSIONS

We don't pay claims related to:

- 29. attempted suicide, suicide, or intentional self-injury.
- 30. deliberate exposure to exceptional danger, except if trying to save a human life.
(*Exceptional danger includes but isn't limited to hazardous sports or activities, such as skydiving, mixed martial arts fighting (MMA), and speed racing.*)
- 31. events covered by legislation, such as contractual liability and consequential loss.
- 32. illegal behaviour or breaking the law of the Republic of South Africa.
- 33. events outside the borders of the Republic of South Africa.
- 34. 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.
- 35. illness or injury caused by using alcohol.
- 36. nuclear weapons, nuclear material or ionising radiation.
- 37. 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.
- 38. transport charges or healthcare services provided while being transported in an emergency vehicle, vessel, or aircraft.

FREQUENTLY ASKED QUESTIONS

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

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

GET COVER!

There's only one thing left to do.

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