






COMPACT³⁰⁰

Our **well-rounded option** is packed with benefits that cover the **most often experienced in- and out-of-hospital** medical expense shortfalls.

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 OR ANYONE IN THE FAMILY IS 65 OR OLDER
<div>R 330</div>  <div>INDIVIDUAL</div>	<div>R 399</div>  <div>FAMILY</div>	<div>R 629</div>  <div>INDIVIDUAL or FAMILY</div>

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.





KEY BENEFITS SUBJECT TO AN OVERALL POLICY LIMIT (OPL)

An **OPL of R 210 580 per 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

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 300%** 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 210 580 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.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.



CO-PAYMENT BENEFITS

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

There are **two benefit categories**.

ADMISSION AND PROCEDURE CO-PAYMENTS IN- AND OUT-OF-HOSPITAL COVER

PENALTY CO-PAYMENTS 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.

Limited to **R 20 000 per policy per year**.

If your medical aid has a preferred network of day clinics and hospitals you must use for planned medical procedures, you can claim the penalty co-payments when using non-network providers.

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

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**.
- 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	
<p>We cover the shortfalls when:</p> <ul style="list-style-type: none"> 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. 	<p>We refund co-payments that your medical aid imposes as and amounts or percentages for:</p> <ul style="list-style-type: none"> 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	
<p>We pay up to an additional 300% 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:</p> <ul style="list-style-type: none"> dental procedures, such as dental implants and wisdom teeth extractions. Limited to R 30 000 per policy per year. dental procedures due to accidental events or cancer treatment. Subject to the OPL of R 210 580 per insured person per year. <p>Subject to our GAP BENEFIT.</p>	<p>Claim as many admission and dental procedure-related co-payments as needed.</p> <p>Subject to our ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT.</p> <div style="border: 1px dashed black; padding: 5px;"> <p>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.</p> </div>

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.



MATERNITY COVER

We cover the bump.

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

THE DELIVERY	
CHILDBIRTH SHORTFALLS IN- AND OUT-OF-HOSPITAL COVER	CO-PAYMENTS IN-HOSPITAL COVER
HOW IT WORKS AND WHAT WE COVER	
<p>We cover the shortfalls when:</p> <ul style="list-style-type: none"> 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. <p>Subject to our GAP BENEFIT.</p>	<p>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.</p> <p>Subject to our ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT.</p> <div style="border: 1px dashed black; padding: 5px;"> <p>Claim the penalty co-payments when using hospitals outside your medical aid's preferred network. Subject to our PENALTY CO-PAYMENT BENEFIT.</p> </div>

GOOD TO KNOW

- Send us a medical aid membership or birth certificate to add your newborn.
- Unless we confirm otherwise, waiting periods and the **Limited Payout Benefit** apply. Refer to the **Waiting Periods** page.



SUB-LIMIT BENEFIT

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

INTERNAL PROSTHETIC DEVICES

IN-HOSPITAL COVER

HOW IT WORKS

When your medical aid pays part of the cost of an internal prosthetic device, we'll cover the **difference**.

WHAT WE COVER

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 30 000 per insured person per event**.

GOOD TO KNOW

- External medical items aren't covered.
- 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.



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-LIMIT IN- AND OUT-OF-HOSPITAL COVER
HOW IT WORKS		
<p>We cover the shortfalls when:</p> <ul style="list-style-type: none"> • 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. 	<p>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.</p>	<p>When your medical aid covers the cost of:</p> <ul style="list-style-type: none"> • 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.
WHAT WE COVER		
<p>We pay up to an additional 300% on top of your medical aid plan's rate to cover shortfalls on basic and specialised radiology.</p> <p>Subject to our GAP BENEFIT.</p>	<p>Claim as many radiology-related co-payments as needed.</p> <p>Subject to our ADMISSION AND PROCEDURE CO-PAYMENT BENEFIT.</p>	<p>Limited to R 3 500 per insured person per event.</p>

GOOD TO KNOW

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



CANCER BENEFITS

There are **two benefit categories**.

CANCER TREATMENT SHORTFALLS IN- AND OUT-OF-HOSPITAL COVER	CANCER 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 our benefit limit, when your medical aid plan's oncology benefit limit has been reached.
WHAT WE COVER	
<p>The shortfalls we'll cover are subject to the oncology treatment plan approved by your medical aid.</p> <p>Our benefit typically covers:</p> <ul style="list-style-type: none"> • biological medication; • chemotherapy and radiotherapy; • consultations with your oncologist; and • specialised radiology, such as bone density and PET scans. <p>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.</p> <p>Subject to the OPL of R 210 580 per insured person per year.</p>	<p>We'll cover the cost of your ongoing cancer treatment subject to the oncology treatment plan approved by your medical aid.</p> <p>Limited to R 60 000 per insured person per year.</p>

GOOD TO KNOW

- Your medical aid may impose co-payments for precision and innovative oncology medication that apply from the onset of cover. Our benefit refunds co-payments that apply after an 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.



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	
<p>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.</p> <p>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.</p>	<p>Children 10 years or younger are covered for after-hours illness-related events at any registered casualty facility between 18:00 and 7:00 Monday through Friday and all day Saturday, Sunday, and public holidays.</p>
WHAT WE COVER	
<p>We cover all the healthcare and service providers' accounts related to a casualty event, typically including:</p> <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. 	
<p>Limited to R 6 000 per policy per year.</p>	

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.



TRAUMA COUNSELLING BENEFIT

OUT-OF-HOSPITAL COVER

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

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 5 000 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.
- You're covered from day one because this benefit isn't subject to any waiting periods.

BENEFITS NOT SUBJECT TO THE OVERALL POLICY LIMIT (OPL)

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

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 15 000 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

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 15 000 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.

🔗 FIRST-TIME CANCER DIAGNOSIS BENEFIT GUIDE

For more information about this benefit, go to www.stratumbenefits.co.za/first-time-cancer-diagnosis-benefit/ or scan the **QR code**.

**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.





GAP BENEFIT CLAIM EXAMPLES

If you're unsure if **Gap Cover** is for you, look at the claim examples of how our **GAP BENEFIT** covers medical expense shortfalls.



GAP BENEFIT

Having a 100% medical aid plan doesn't mean your medical aid will cover all healthcare expenses. Even a more comprehensive 300% plan only pays a portion of what private healthcare providers charge.

The Department of Health published the **Reference Price List (RPL)**, a list of recommended tariffs for medical procedures and treatments, as a departure point for medical aids to determine their rate structures.

The real impact of what your healthcare providers charge and the medical aid rate is on your pocket, as healthcare providers aren't obligated to charge these recommended fees.

Our **GAP BENEFIT** covers shortfalls up to an **additional 300%, 400% or 500%** of your medical aid plan's rate when your healthcare providers charge private fees not fully covered by your medical aid.

The below represents a childbirth claim. If your medical aid pays 100% of the medical aid rate, and the specialists charge 400%, you'll be left with a 300% shortfall.

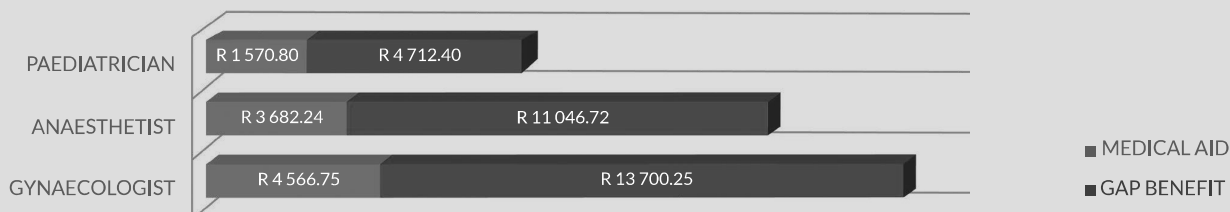
When submitting a claim for the shortfalls, the **Medical Aid Rate** column on the medical aid statement is our reference point for assessing them.

Service Provider	Amount Claimed	Medical Aid Rate (100%)	Claims paid from		Claims paid to		Claims not paid	RC**
			Hospital / Risk Benefit	MSA*	Member	Service Provider	Your Portion	
Anaesthetist	R 14 728.96	R 3 682.24	R 3 682.24	R 0.00	R 3 682.24	R 0.00	R 11 046.72	45
Gynaecologist	R 18 267.00	R 4 566.75	R 4 566.75	R 0.00	R 4 566.75	R 0.00	R 13 700.25	45
Paediatrician	R 6 283.20	R 1 570.80	R 1 570.80	R 0.00	R 1 570.80	R 0.00	R 4 712.40	45
Totals	R 39 279.16	R 9 819.79	R 9 819.79	R 0.00	R 9 819.79	R 0.00	R 29 459.37	

MSA* = Medical Savings Account RC** = Reason Code 45: This claim exceeds the maximum amount payable

100% MEDICAL AID PLAN RATE + COMPACT³⁰⁰

If you're on a **100% medical aid plan** and have **300% cover** with us, you'll have **400% cover** in total, meaning the shortfalls on your specialists' accounts would be covered in full.



200% MEDICAL AID PLAN RATE + MERIDIAN⁴⁰⁰

In the same way, if you're on a **200% medical aid plan** and have **400% cover** with us, you'll have **600% cover** in total.



300% MEDICAL AID PLAN RATE + ELITE⁵⁰⁰

And if you're on a **300% medical aid plan** and have **500% cover** with us, you'll have **800% cover** in total.

