

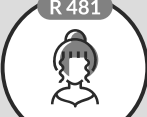

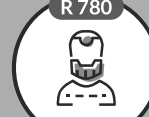



ELITE⁵⁰⁰

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 |
|--|--|---|--|
| <div>R 481</div>  <div>INDIVIDUAL</div> | <div>R 591</div>  <div>FAMILY</div> | <div>R 780</div>  <div>INDIVIDUAL</div> | <div>R 954</div>  <div>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 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 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 **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

| | | |
|--|---|--|
| <p>Claim as many admission and procedure-related co-payments as needed.</p> <p>Subject to the OPL of R 210 580 per insured person per year.</p> <p>Benefit limits apply to our PENALTY and ROBOTIC SURGERY CO-PAYMENT BENEFITS.</p> | <p>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.</p> <p>Limited to 2 co-payments up to R 15 000 per co-payment per policy per year.</p> | <p>When co-payments apply to robotic-assisted surgeries, such as prostatectomies, we'll refund the co-payments.</p> <p>Limited to R 10 000 per policy per year.</p> |
|--|---|--|

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 rand 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 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:</p> <ul style="list-style-type: none"> 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 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. 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.

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 | | |
| <p>PRE-NATAL CONSULTATIONS OUT-OF-HOSPITAL COVER</p> <p>Claim the shortfalls between what:</p> <ul style="list-style-type: none"> 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. <p>Subject to our OUT-PATIENT SPECIALIST CONSULTATION BENEFIT.</p> <p>Ancillary tests or investigations typically done with consultations, such as urine tests and sonars, won't be covered.</p> | <p>CHILDBIRTH SHORTFALLS IN- AND OUT-OF-HOSPITAL COVER</p> <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>POST-NATAL CONSULTATIONS OUT-OF-HOSPITAL COVER</p> <p>Claim the shortfalls between what:</p> <ul style="list-style-type: none"> 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. <p>Subject to our OUT-PATIENT SPECIALIST CONSULTATION BENEFIT.</p> |
| <p>PREVENTATIVE PROCEDURES OUT-OF-HOSPITAL COVER</p> <p>Soon-to-be moms can get a flu vaccination in their second trimester if recommended by the healthcare professional.</p> <p>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.</p> <p>Subject to our PREVENTATIVE CARE BENEFIT.</p> | <p>CO-PAYMENTS IN-HOSPITAL COVER</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> <p>Claim the penalty co-payments when using hospitals outside your medical aid's preferred network.</p> <p>Subject to our PENALTY CO-PAYMENT BENEFIT.</p> | <p>IMMUNISATIONS AND BIRTH CONTROL OUT-OF-HOSPITAL COVER</p> <p>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.</p> <p>Subject to our PREVENTATIVE CARE BENEFIT.</p> <p>Our CASUALTY BENEFIT covers your little one for after-hours medical treatment due to illness.</p> |

**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.
- 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 IN- AND OUT-OF-HOSPITAL COVER | INTERNAL PROSTHETIC DEVICE SHORTFALLS IN-HOSPITAL COVER | INTERNAL PROSTHETIC DEVICE TOP-UP IN-HOSPITAL COVER | RENAL DIALYSIS TREATMENTS 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

| | | | |
|---|--|---|---|
| <p>If you go for an in- or out-of-hospital colonoscopy, enteroscopy or gastroscopy:</p> <ul style="list-style-type: none"> 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. <p>Limited to R 6 500 per insured person per event.</p> | <p>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.</p> <p>Limited to R 40 000 per insured person per event.</p> | <p>Does your medical aid plan cover internal prosthetic devices up to a benefit limit?</p> <p>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.</p> <p>Limited to R 10 000 per insured person per event.</p> | <p>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.</p> <p>Limited to R 30 000 per insured person per event.</p> |
|---|--|---|---|

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 210 580 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 210 580 per insured person per year**.

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.



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 | MRI, CT AND PET SCAN TOP-UP IN- AND OUT-OF-HOSPITAL COVER |
|--|---|--|---|
| HOW IT WORKS | | | |
| We cover the shortfalls when: <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. | 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: <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. | Does your medical aid plan cover in- or out-of-hospital MRI, CT, and PET scans up to a benefit limit? <p>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.</p> |
| 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 5 000 per insured person per event . | Limited to R 5 000 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 the rooms,
- as long as your medical aid pays an amount from a **risk benefit**, also known as an **insured day-to-day** or **block benefit**, or your **medical savings account**.

If, for example, your medical aid pays an amount from a **risk benefit** and your **medical savings account**, the payments will be added together to see if there's a shortfall. If the two payments make up the total cost of the consultation fee, there won't be a shortfall for us to cover.

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

- Our benefit doesn't cover consultation fees of general practitioners or allied healthcare providers, such as biokineticists, chiropractors and physiotherapists.
- Ancillary tests or investigations typically done with consultations, such as urine tests and sonars, aren't covered.
- Unless we confirm otherwise, waiting periods apply. A **3 Month General Waiting Period** always applies. 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 18:00 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 18:00 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;
- 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.
- 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

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 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.
- 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 1 800 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)

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**.



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

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 BENEFIT

This Lifestyle Benefit is a complimentary value-add product.

Visit our website at www.stratumbenefits.co.za for more information about this benefit and how to register.



INTERNATIONAL TRAVEL INSURANCE

WHAT'S ON OFFER

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.

If your medical aid or any other insurance policy provides similar cover, our international travel insurance partner will only be liable to pay a pro-rata portion of the claim submitted in terms of the policy.