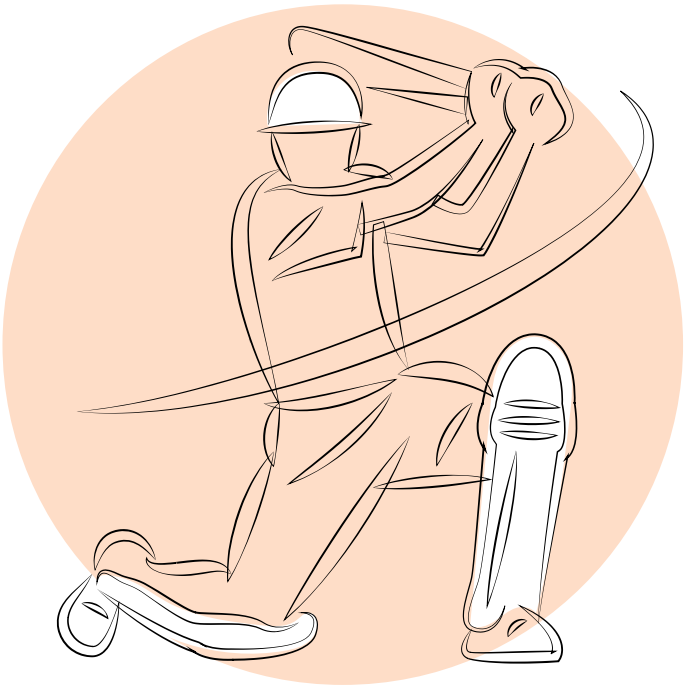
| 2022 |

Stratum Benefits

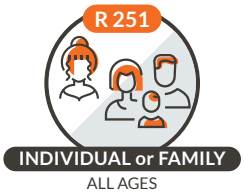


SACA CORPORATE ELITE

It's one of our **premium options** that offer the **widest range** of benefits exclusively tailored for the **SACA Member**.

SACA CORPORATE ELITE PREMIUM

We cover you, as a SACA Member, as well as your spouse and all the dependants registered on both your and your spouse's medical aid plans.



Stratum Benefits
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KEY BENEFITS SUBJECT TO AN OVERALL POLICY LIMIT (OPL)

*An **OPL** of **R 177 835 per person per year** applies to the following benefits. This means that all approved claim amounts will get deducted off the **OPL**.*

GAP COVER

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

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

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

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

*Remember... if your medical aid makes payment from your **medical savings account**, our **Gap Cover Benefit** won't apply.*

CO-PAYMENT COVER

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

We refund **in-** and **out-of-hospital co-payments** and **deductibles** that you pay from your **own pocket**, or that your medical aid pays from your **medical savings account**.

ADMISSION AND PROCEDURE CO-PAYMENTS

Claim as many times as you need for admission and procedure related co-payments, as long as it doesn't exceed the **OPL** of **R 177 835 per person per year**.

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

ROBOTIC SURGERY CO-PAYMENT

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

PENALTY CO-PAYMENT

Your medical aid might have a preferred network of hospitals or day clinics that they want you to use for planned medical procedures.

With our **Penalty Co-Payment**, you can choose to go elsewhere.

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

We don't refund any payments that your doctor or specialist asks you to pay to them directly. This is known as split-billing. We'll only refund co-payments and deductibles that your medical aid imposes.

SUB-LIMIT COVER

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

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

INTERNAL PROSTHETIC DEVICES

Limited to **R 30 000 per person per event**.

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

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

RENAL DIALYSIS TREATMENTS

Limited to **R 30 000 per person per event**.

COLONOSCOPIES, GASTROSCOPIES & ENTEROSCOPIES

Limited to **R 5 000 per person per event**.

MRI & CT SCANS

Limited to **R 5 000 per person per event**.

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

CANCER COVER

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

CANCER TREATMENT SHORTFALLS

We cover the difference between what your healthcare providers charge, and the amount your medical aid pays from an **oncology benefit** for healthcare services related to cancer treatment, subject to the **OPL** of **R 177 835 per person per year**.

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

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

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

*Have a look at **FIRST-TIME CANCER DIAGNOSIS** under our **PAYOUT BENEFIT** to see what else we cover for a cancer diagnosis.*

TOP-UP COVER

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

MRI & CT SCANS TOP-UP

Limited to **R 5 000 per policy per year**.

CANCER TREATMENT TOP-UP

The cost of your treatment according to the cancer treatment plan that your medical aid approved, subject to the **OPL** of **R 177 835 per person per year**.

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

PHYSICAL REHABILITATION TOP-UP

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

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

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

CASUALTY COVER

ACCIDENT COVER

*For the **whole family***

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

ACCIDENTS are unexpected incidents that cause physical injury due to physical impact with someone or something.
IMMEDIATE means within 24-hours from the time of the incident.

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

- facility and doctors' consultation fees;
- co-payments and deductibles related to your casualty event that you pay from your **own pocket**, or that your medical aid pays from your **medical savings account**;
- basic radiology, specialised radiology and pathology;
- medication administered during your casualty event; and
- external medical items that's given to you at the medical facility, like a neck brace.

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

ILLNESS COVER

Only for children who are 10 years or younger

If your child who's **10 years** or **younger** gets sick after-hours, we'll cover the cost of a visit to a **casualty facility** and all the healthcare providers' accounts related to the visit.

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

We'll refund the amount that you pay from your **own pocket**, or that your medical aid pays from your **medical savings account**.
Casualty Cover is limited to **R 12 000 per policy per year**.

TRAUMA COUNSELLING COVER

Sometimes you just need to talk to someone about it.

If you've:

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

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

PREVENTATIVE CARE COVER

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

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

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

BENEFITS NOT SUBJECT TO AN OVERALL POLICY LIMIT (OPL)

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

PRIVATE WARD COVER

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

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

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

The person you're staying with, or who stays with you during hospitalisation, must be registered on your **Gap Cover** policy.
Limited to **R 3 000 per policy per year**.

PAYOUT AND WAIVER BENEFITS

ACCIDENTAL DISABILITY AND DEATH

You and your spouse are covered for a benefit amount of **R 25 000 per person**, and your dependants for **R 5 000 per person** if either one of you becomes totally and permanently disabled, or passes away due to an accident.
Limited to **1 event per person per year**.

FIRST-TIME CANCER DIAGNOSIS

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

*Some cancer diagnoses, like **Stage 1 breast and prostate cancer**, and **skin cancer** where cancerous moles haven't invaded surrounding or underlying tissue, aren't covered.*
*Our **Benefit Exclusions** explain the criteria in more detail.*

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

MEDICAL AID CONTRIBUTION WAIVER

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

During the time our benefit applies, you can downgrade your medical aid plan, but if you upgrade we'll only pay the contribution amount that applied before the upgrade.
We'll pay the medical aid contributions for the registered members that the contribution payer was responsible for at the time of the claimable event.

STRATUM POLICY PREMIUM WAIVER

Your policy premiums will be paid by us for **6 months** when the premium payer of your **Gap Cover** policy is forcibly retrenched, becomes totally and permanently disabled, or passes away.

10 MONTH LIMITED PAYOUT BENEFIT

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

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

we'll cover 100% of the **approved claim amount** if you're a **SACA Member** already on cover, or a new member taking up cover **within 90 days** of joining the Association or from your permanent employment date.

We'll cover 20% of the **approved claim amount** if you're an **existing SACA Member** taking up cover **after 90 days** of joining the Association or from your permanent employment date.

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

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

WAITING PERIODS

From the first day your cover starts, waiting periods may apply before you're able to claim from specific policy benefits. If you join **within 90 days** from your permanent employment date no waiting periods will apply. If you join **after 90 days** from your permanent employment date, waiting periods as specified below will apply:

3 MONTH GENERAL WAITING PERIOD

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

12 MONTH PRE-EXISTING CONDITION WAITING PERIOD

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

LIFESTYLE BENEFITS

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

EXTRA HIGH SCHOOL LEARNING SUPPORT

Based on the **CAPS curriculum**, your **Gr.8** to **Gr.12** high school child gets instant access to content that'll help them study, improve their knowledge and boost their marks. Check out our website to see what else this **Lifestyle Benefit** offers.

INTERNATIONAL TRAVEL INSURANCE

Planning on travelling? Happy days.

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

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

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

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

BENEFIT EXCLUSIONS

KEY BENEFITS SUBJECT TO THE OVERALL POLICY LIMIT (OPL)

1. GAP COVER

Our benefit kicks in when your doctor or specialist charges more than the amount your medical aid pays for in- and out-of-hospital medical procedures, as long as the payment your medical aid makes isn't from your medical savings account.

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

WHAT OUR BENEFIT DOESN'T COVER

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

1.1 if your medical aid paid it as an exception to the rule.
1.2 if your medical aid didn't partly pay it from a hospital benefit.
1.3 if your medical aid fully paid it from a hospital benefit, as there'll be no claimable shortfall.
1.4 if your medical aid partly or fully paid it from your medical savings account.
1.5 if your medical aid processed it against your self-payment gap.
(A self-payment gap applies when you've used the funds in your medical savings account, after which you have to pay your day-to-day medical expenses from your own pocket up to a specific amount.)
1.6 if it's for upfront fees or deposits that your healthcare providers ask you to pay to them directly.
1.7 if it's for out-patient consultation fees, unless a medical procedure was performed at the same time.
1.8 if it's for pre-natal (pre-birth) consultations, including all ancillary procedures or investigations performed during, or following your consultation.
1.9 if it's for hospital accounts, unless you're claiming for consumable items or medication that your medical aid partly paid from a hospital benefit.
1.10 if it's for allied healthcare providers, unless your policy provides a benefit that covers it.
(Allied healthcare providers are healthcare professionals associated with your medical event who aren't doctors or specialists. We only cover the following allied healthcare providers:
1.10.1 clinical perfusionists;
1.10.2 dental hygienists;
1.10.3 midwives;
1.10.4 nurses; and
1.10.5 physiotherapists.)
1.11 if your medical aid didn't partly pay it because a benefit limit provided by your medical aid plan's been reached.
1.12 at a higher benefit percentage than the percentage applicable to the group if you claim in the first 10 months of cover from a benefit limit provided by your policy, for medical events related to:
1.12.1 adenoidectomy;
1.12.2 tonsillectomy;
1.12.3 myringotomy/grommets;
1.12.4 cardiovascular procedures;
1.12.5 cataract removal;
1.12.6 dentistry;
1.12.7 hernia repairs;
1.12.8 hysterectomy (unless it's for cancer that's diagnosed after a General Waiting Period);
1.12.9 joint replacements;
1.12.10 MRI, CT and PET scans;
1.12.11 nasal and sinus surgery;
1.12.12 pregnancy and childbirth;
1.12.13 spinal procedures; or
1.12.14 scopes (including medical events where a scope is used).

2. CO-PAYMENT COVER

When your medical aid asks you to pay upfront co-payments or deductibles for in- and out-of-hospital medical procedures, we'll refund you if you paid the co-payment or deductible from your own pocket, or if your medical aid paid it from your medical savings account.

WHAT OUR BENEFIT DOESN'T COVER

We don't refund co-payments or deductibles:

2.1 if your medical aid paid it as an exception to the rule.
2.2 if you didn't obtain pre-authorisation before your medical event.
2.3 if you didn't follow your medical aid's rules.
2.4 if you used healthcare or service providers that don't form part of your medical aid plan's preferred provider network (*non-designated provider*), unless your policy provides a benefit that covers it.
2.5 that your healthcare providers ask you to pay to them directly.
(This is referred to as split-billing. We only refund co-payments or deductibles that your medical aid asks for.)
2.6 if it's for co-payments or deductibles that you're responsible to pay to your healthcare or service provider because your medical aid imposes it, but what you paid is more than the amount your medical aid imposes.
(Any excess amounts that you pay to a provider will be for your own pocket.)
2.7 if it's for co-payments or deductibles that you didn't pay from your own pocket, or that your medical aid didn't pay from your medical savings account.
2.8 if it's for cancer treatment.
2.9 if it's for out-patient consultation fees.
2.10 if it's for chronic, acute, formulary, non-formulary, or over-the-counter medication.
2.11 if it's for robotic surgery, or for the use of other specialised mechanical or computerised items or equipment, unless your policy provides a benefit that covers it.
2.12 at a higher benefit percentage than the percentage applicable to the group if you claim in the first 10 months of cover from a benefit limit provided by your policy, for medical events related to:
2.12.1 adenoidectomy;
2.12.2 tonsillectomy;
2.12.3 myringotomy/grommets;
2.12.4 cardiovascular procedures;
2.12.5 cataract removal;
2.12.6 dentistry;
2.12.7 hernia repairs;
2.12.8 hysterectomy (unless it's for cancer that's diagnosed after a General Waiting Period);
2.12.9 joint replacements;
2.12.10 MRI, CT and PET scans;
2.12.11 nasal and sinus surgery;
2.12.12 pregnancy and childbirth;
2.12.13 spinal procedures; or
2.12.14 scopes (including medical events where a scope is used).

3. SUB-LIMIT COVER

This benefit covers the shortfalls on specific medical procedures or treatments when your medical aid pays some of the cost from a sub-limit or annual limit, but doesn't cover the full cost.

WHAT OUR BENEFIT DOESN'T COVER

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

3.1 if your medical aid paid it as an exception to the rule.
3.2 if it's for healthcare services that your medical aid plan applies a sub-limit or annual limit to, but it's not for the healthcare services that our benefit covers.
3.3 if your medical aid didn't partly pay it from a sub-limit or annual limit.
3.4 if you didn't follow your medical aid's rules.
3.5 if you used healthcare or service providers that don't form part of your medical aid's preferred provider network.
3.6 at a higher benefit percentage than the percentage applicable to the group if you claim in the first 10 months of cover from a benefit limit provided by your policy, for medical events related to:
- 3.6.1 adenoidectomy;
- 3.6.2 tonsillectomy;
- 3.6.3 myringotomy/grommets;
- 3.6.4 cardiovascular procedures;
- 3.6.5 cataract removal;
- 3.6.6 dentistry;
- 3.6.7 hernia repairs;
- 3.6.8 hysterectomy (unless it's for cancer that's diagnosed after a General Waiting Period);
- 3.6.9 joint replacements;
- 3.6.10 MRI, CT and PET scans;
- 3.6.11 nasal and sinus surgery;
- 3.6.12 pregnancy and childbirth;
- 3.6.13 spinal procedures; or
- 3.6.14 scopes (including medical events where a scope is used).

4. CANCER COVER

CANCER TREATMENT SHORTFALLS

When your healthcare providers charge more than the amount your medical aid pays from an oncology benefit, we'll cover the difference. We'll also refund the co-payments that your medical aid asks you to pay when your medical aid plan's oncology benefit limit is reached.

WHAT OUR BENEFIT DOESN'T COVER

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

4.1 if your medical aid paid it as an exception to the rule.
4.2 if it's for cancer treatment that your medical aid didn't approve as part of a cancer treatment plan.
4.3 if your medical aid fully paid it from an oncology benefit, as there'll be no claimable shortfall.
4.4 if your medical aid partly or fully paid it from your medical savings account.
4.5 if you didn't follow your medical aid's rules.
4.6 if you used healthcare or service providers that don't form part of your medical aid's preferred network.
4.7 if it's for co-payments or deductibles that your medical aid asks you to pay before your medical aid plan's oncology benefit limit is reached.
(We only cover co-payments or deductibles that apply after your medical aid plan's benefit limit is reached.)
4.8 if it's for secondary co-payments that apply to cancer treatment or cancer medication.

5. TOP-UP COVER

5.1 MRI AND CT SCANS TOP-UP

This top-up benefit covers the full cost of an MRI or CT scan when your medical aid plan's benefit limit is reached.

WHAT OUR BENEFIT DOESN'T COVER

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

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

5.2 CANCER TREATMENT TOP-UP

Need ongoing cancer treatment after your medical aid plan's oncology benefit is reached?

This benefit covers the cost of ongoing cancer treatment according to the cancer treatment plan that your medical aid approved.

WHAT OUR BENEFIT DOESN'T COVER

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

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

5.3 PHYSICAL REHABILITATION TOP-UP

If you've been in an accident and need ongoing physical rehabilitation treatment, we'll cover the cost when your medical aid plan's physical rehabilitation benefit is reached.

WHAT OUR BENEFIT DOESN'T COVER

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

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

6. CASUALTY COVER

You're covered at the nearest registered medical facility when you need immediate medical treatment due to an accident.

Children who are 10 years or younger are also covered for after-hours treatment due to illness at a registered casualty facility.

WHAT OUR BENEFIT DOESN'T COVER

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

6.1 if it's not related to an accident.
6.2 if it's not related to illness of your child dependant who's 10 years or younger.
6.3 that are related to an accident, but medical treatment wasn't provided within 24-hours from the time of the incident.
6.4 if it's for medication that wasn't administered during your casualty event, during a follow-up visit to a registered medical facility after an accidental event, medication that you take home, or that's prescribed to collect at a pharmacy.
6.5 if it's for external medical items that you didn't receive at the registered medical facility during your initial casualty visit.
6.6 if it's for follow-up visits that aren't related to accidental events.
6.7 if it's for follow-up visits at a registered medical facility that are related to an accident, but follow-up visits occurred after a hospital admission. *(When you're admitted to hospital after being treated at a registered medical facility, the hospital admission will be a new event, and return visits for follow-up treatment won't be assessed under Casualty Cover.)*
6.8 if it's for medical treatment due to illness provided to your child who's 10 years or younger, but treatment wasn't provided at a registered casualty facility.
6.9 if it's for medical treatment due to illness at a registered casualty facility for your child who's 10 years or younger, but your child didn't receive after-hours treatment. *(After-hours is Mondays to Fridays between 18:00pm and 07:00am and all-day Saturdays, Sundays and public holidays.)*
6.10 if it's for medical treatment due to illness provided to your child who's older than 10 years.
6.11 that you didn't pay from your own pocket, or that your medical aid didn't pay from your medical savings account.

7. TRAUMA COUNSELLING COVER

When you need to talk to a registered counsellor about specific traumatic events that are affecting you, we'll cover the consultation fees.

WHAT OUR BENEFIT DOESN'T COVER

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

7.1 if you haven't witnessed, or aren't directly affected by an act of physical violence or an accident.
7.2 if you aren't affected by a loved one's diagnosis of a critical illness or death, or by your own diagnosis of a critical illness.
7.3 that you didn't pay from your own pocket, or that your medical aid didn't pay from your medical savings account.
7.4 if your counsellors aren't registered with a recognised South African regulatory body.

8. PREVENTATIVE CARE COVER

We cover the cost of your healthcare providers' consultation fees and the cost of specific preventative tests and procedures.

WHAT OUR BENEFIT DOESN'T COVER

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

8.1 if it's not for consultation fees, preventative tests or procedures that our benefit covers.
8.2 that you didn't pay from your own pocket, or that your medical aid didn't pay from your medical savings account.

BENEFITS NOT SUBJECT TO THE OVERALL POLICY LIMIT (OPL)

9. PRIVATE WARD COVER

Don't want to share a ward next time you're hospitalised? Use our benefit when your medical aid plan doesn't provide cover for private ward, lodger, or nursery fees.

WHAT OUR BENEFIT DOESN'T COVER

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

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

10. PAYOUT AND WAIVER BENEFITS

10.1 ACCIDENTAL DISABILITY AND DEATH

We pay a benefit amount in the event of total and permanent disability or death due to an accident.

WHAT OUR BENEFIT DOESN'T COVER

We don't cover instances:

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

10.2 FIRST-TIME CANCER DIAGNOSIS

When cancer is diagnosed for the first time in your life after you've joined us, you'll receive a payout benefit if the diagnosis meets specific qualifying criteria.

WHAT OUR BENEFIT DOESN'T COVER

We don't cover:

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

10.3 MEDICAL AID CONTRIBUTION WAIVER

We'll pay your monthly medical aid contribution when the contribution payer becomes totally and permanently disabled, or passes away.

WHAT OUR BENEFIT DOESN'T COVER

We don't cover instances:

10.3.1 if the medical aid contribution payer hasn't become totally and permanently disabled, or hasn't passed away.
10.3.2 of total and permanent disability, or death of a person who isn't noted as the medical aid contribution payer.
10.3.3 if a new contribution payer is appointed within 3 months before the claimable event, unless the new contribution payer's total and permanent disability or death is due to an accident.
10.3.4 if the medical aid contribution payer is a person, registered company, or entity that doesn't solely fund your medical aid contributions.
10.3.5 where the company or entity is co-owned by two or more Insured Persons registered on your policy, as neither one of you will be regarded a medical aid contribution payer in your individual capacity.
10.3.6 if you're a member, and the company or entity pays your medical aid contributions on your behalf which doesn't form part of your cost to company, as you won't be regarded a medical aid contribution payer.
10.3.7 if medical aid contributions are paid by a trust of which you're a trust member, but not a trust beneficiary.

10.4 STRATUM POLICY PREMIUM WAIVER

We'll cover your monthly policy premium when the premium payer is forcibly retrenched, becomes totally and permanently disabled, or passes away.

WHAT OUR BENEFIT DOESN'T COVER

We don't cover instances:

10.4.1 if the Gap Cover policy premium payer hasn't been forcibly retrenched, hasn't become totally and permanently disabled, or hasn't passed away.

10.4.2 of forced retrenchment, total and permanent disability, or death of a person who isn't noted as the Gap Cover policy premium payer.

10.4.3 if a new Gap Cover policy premium payer is appointed within 3 months before the claimable event, unless the new premium payer's total and permanent disability or death is due to an accident.

10.4.4 if the Gap Cover policy premium payer is a person, registered company, or entity that doesn't solely fund your policy premiums.

10.4.5 where the company or entity is co-owned by two or more Insured Persons registered on your policy, as neither one of you will be regarded a Gap Cover policy premium payer in your individual capacity.

10.4.6 if you're a member, and the company or entity pays your Gap Cover policy premiums on your behalf which doesn't form part of your cost to company, as you won't be regarded a premium payer.

10.4.7 if Gap Cover policy premiums are paid by a trust of which you're a trust member, but not a trust beneficiary.

GENERAL EXCLUSIONS

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

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