Stratum Gap Cover

COMPACT²⁰⁰ 2018

ENTRY AGES	MONTHLY PREMIUM
64 and younger	Single ..... R 180 Family ..... R 210
65+*	Single or Family .... R 350

** Limited to two insured individuals per policy*

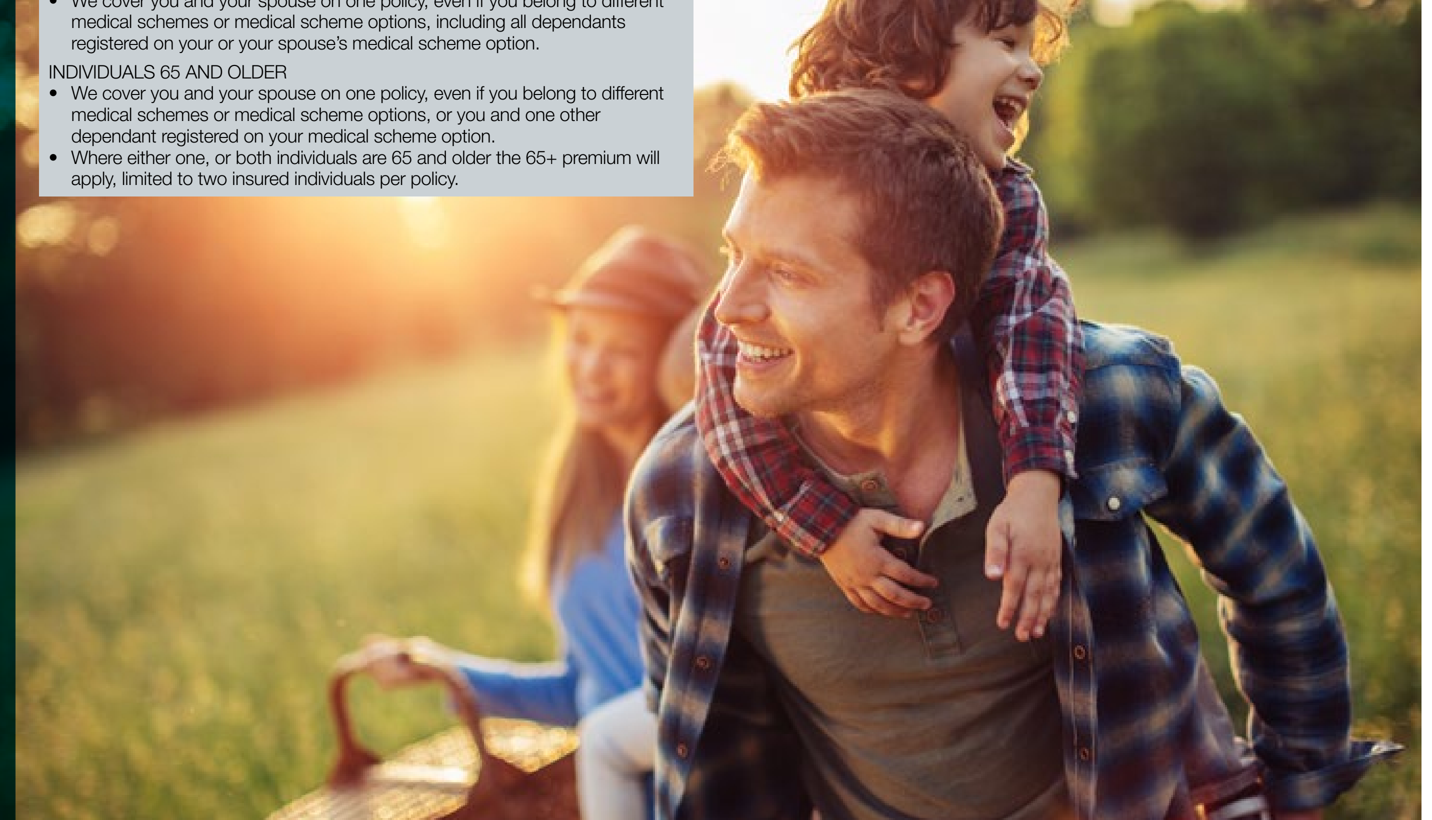
WE COVER

INDIVIDUALS 64 AND YOUNGER

- We cover you and your spouse on one policy, even if you belong to different medical schemes or medical scheme options, including all dependants registered on your or your spouse's medical scheme option.

INDIVIDUALS 65 AND OLDER

- We cover you and your spouse on one policy, even if you belong to different medical schemes or medical scheme options, or you and one other dependant registered on your medical scheme option.
- Where either one, or both individuals are 65 and older the 65+ premium will apply, limited to two insured individuals per policy.



Our **COMPACT²⁰⁰** option has been conceptualised with medical scheme members in mind because when account shortfalls affect your financial wellbeing, we'll absorb the impact. Complete peace of mind is offered by our comprehensive benefits that fill the gaps in your medical scheme cover. We cover you when your medical scheme does not pay your private healthcare fees in full, refund upfront co-payment costs and lend a helping hand when you need oncology treatment.

GAP BENEFIT

WHY WE COVER YOU

Our **GAP BENEFIT** leaves you feeling assured that when an in- or out-of-hospital medical procedure is necessary and your service provider, such as your doctor or specialist, charges a rate more than what your medical scheme pays, the unexpected difference you are liable for won't leave you out of pocket.

WHEN WE COVER YOU

- You are covered when your service providers charge a rate more than what your medical scheme pays for medical procedures performed in hospital, doctors' and specialists' private rooms, day clinics and other registered facilities, provided your service providers' accounts are paid from your **medical scheme hospital benefit**, also known as a **risk** or **major medical benefit**, and **not** from your **medical scheme savings account or day-to-day benefit**.
- You are covered for Prescribed Minimum Benefit (PMB) medical procedures.

WHAT WE COVER YOU FOR

Our **GAP BENEFIT** provides an **additional** 200% cover, when you become liable for the difference between what your service providers charge, and what your medical scheme pays from your **medical scheme hospital benefit** for account shortfalls related to the following:

- Doctors and specialists
- Dentistry and related procedures limited to **R 3 000 per policy** per year
- Basic radiology
- Specialised radiology limited to MRI, CT and PET scans up to **R 2 000 per policy** per year
- Pathology
- Physiotherapy
- Consumable items such as surgical gloves, bandages and gauze
- Medication provided as part of your in- or out-of-hospital event

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CO-PAYMENT BENEFIT

WHY WE COVER YOU

Our **CO-PAYMENT BENEFIT** provides you with the peace of mind that when your medical scheme requires you to pay upfront costs, we have you covered.

WHEN WE COVER YOU

- You are covered when your medical scheme requires you to settle a fee, known as a co-payment, deductible or hospital admission fee, prior to undergoing certain in- and out-of-hospital medical procedures or specialised radiology scans.
- We will refund the co-payment, deductible or hospital admission fee which is either settled by you or deducted from your **medical scheme savings account**.

WHAT WE COVER YOU FOR

- Our **CO-PAYMENT BENEFIT** covers in- and out-of-hospital medical procedure related and specialised radiology scan co-payments, deductibles or hospital admission fees, represented as either a rand amount or a percentage and is limited to **R 15 000 per policy** per year.

ONCOLOGY BENEFITS

WHY WE COVER YOU

Our **ONCOLOGY BENEFITS** alleviate the financial pressure that is not conducive to an environment of healing, by offering you superior and unique benefits for your necessary oncology treatment.

WHEN AND WHAT WE COVER YOU FOR

ONCOLOGY BENEFIT

- You are covered when your medical scheme only pays a portion towards your approved oncology treatment such as radiotherapy, chemotherapy, basic and specialised radiology, pathology, specialist consultations, registered oncology facility fees, biological or specialised medication etc. The difference you are liable for may be referred to as a co-payment by certain medical schemes, or may reflect as a rand amount where your service provider charges a rate more than what your medical scheme pays.
- Our **ONCOLOGY BENEFIT** covers you when your medical scheme only pays a portion towards your service providers' accounts.

ONCOLOGY OPTIMISER BENEFIT

- You are covered when your medical scheme provides you with an oncology benefit but applies a rand amount limit from which you can claim per year. Once this rand amount limit is reached, you will be liable to pay all treatment costs thereafter.
- Our **ONCOLOGY OPTIMISER BENEFIT** covers your oncology treatment costs when your medical scheme no longer does and is limited to **R 50 000 per person** per year.

CANCER DIAGNOSIS BENEFIT

- Our **CANCER DIAGNOSIS BENEFIT** provides a once-off payment of **R 15 000** when you are diagnosed with cancer for the first time and the diagnosis aligns to specific qualifying criteria.
- This benefit is **not** subject to the Overall Policy Limit (OPL).

SUB-LIMIT BENEFIT

WHY WE COVER YOU

Our **SUB-LIMIT BENEFIT** affords you the opportunity to ensure that your health and recovery remain a priority, when your medical scheme applies a rand amount limit to your internal prostheses benefit, leaving you liable to pay a portion of the cost.

WHEN WE COVER YOU

- You are covered when your medical scheme provides you with a rand amount limit, known as a sub-limit or annual limit, from which you can claim for an internal prosthesis but the device costs more than the amount your medical scheme pays.

WHAT WE COVER YOU FOR

- Our **SUB-LIMIT BENEFIT** provides cover when you become liable to settle a portion of your internal prosthesis provider's account, up to **R 15 000 per event** with a maximum of **R 30 000 per person** per year.

CASUALTY BENEFIT

WHY WE COVER YOU

Our **CASUALTY BENEFIT** offers rich benefits to ensure that you not only receive the very best medical care, but also not having to worry about an unforeseen out of pocket expense for a casualty event.

WHEN WE COVER YOU

- You are covered at a registered medical facility in the event of an accident, when immediate treatment is required for physical injury resulting from an external force outside your body due to impact with someone or something.
- We will refund the cost of the casualty event to you when you become liable to pay out of your own pocket, or when your medical scheme pays the event from your **medical scheme savings account**.

WHAT WE COVER YOU FOR

Our **CASUALTY BENEFIT** covers the cost of your casualty event up to **R 5 000 per policy** per year, for accounts related to the following:

- Doctors and specialists
- Basic and specialised radiology
- Pathology
- Consumable items such as surgical gloves, bandages and gauze
- Medication provided as part of your casualty event at the registered medical facility
- Upfront casualty co-payments or facility fees

TRAUMA COUNSELLING BENEFIT

WHY WE COVER YOU

Our **TRAUMA COUNSELLING BENEFIT** ensures you receive the support you need, when circumstances outside of your control alter the course of your life.

WHEN WE COVER YOU

- You are covered when you have witnessed, or are directly affected by an act of physical violence or an accident resulting in serious bodily injury or death.
- You are also covered when you are diagnosed with a dread disease, or are affected by a loved one's diagnosis of a dread disease or death.
- We will refund the cost of the registered counsellor's, clinical psychologist's or psychiatrist's consultation fee when you become liable to pay out of your own pocket, or when your medical scheme pays the fees from your **medical scheme savings account**.

WHAT WE COVER YOU FOR

- Our **TRAUMA COUNSELLING BENEFIT** covers your consultation fees up to **R 5 000 per policy** per year.

ADDITIONAL BENEFIT

ACCIDENTAL DEATH BENEFIT

WHY WE COVER YOU

Our **ACCIDENTAL DEATH BENEFIT** offers you and your loved ones the security of knowing that when you are faced with unexpected change resulting in financial difficulty, we have you covered.

WHEN AND WHAT WE COVER YOU FOR

- Our **ACCIDENTAL DEATH BENEFIT** provides a payment of **R 15 000** in the event of the accidental death of the principal insured or spouse and **R 5 000** for the accidental death of a dependant.
- This benefit is **not** subject to the Overall Policy Limit (OPL).

Where a claim under our GAP BENEFIT, CO-PAYMENT BENEFIT or SUB-LIMIT BENEFIT is received for a condition, procedure, surgery, treatment or an investigation and any related accounts in respect of Adenoidectomy, Tonsillectomy, Myringotomy/Grommets, Cardiovascular procedures, Cataract removal, Dentistry, Hysterectomy (unless due to cancer diagnosis), Hernia repair, Joint replacement, MRI, CT and PET scans, Nasal and sinus surgery, Pregnancy and childbirth, Spinal procedures and Scopes within the first 10 months of cover, and is not deemed as pre-existing or accidental, 20% of the total claim amount will be payable.

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We believe in consistently communicating in a simple, clear and concise manner and have therefore removed the insurance jargon so that you don't have to read between the lines.

YOUR GAP COVER POLICY WAITING PERIODS

From the first day your cover starts, waiting periods will apply before you are able to claim from specific policy benefits.

3 MONTH GENERAL WAITING PERIOD

Within the first **3 months** of cover a general waiting period will apply, where no claims can be submitted unless you are claiming for an injury resulting from an accident caused by physical impact.

12 MONTH PRE-EXISTING CONDITION WAITING PERIOD

Within the first **12 months** of cover a waiting period for pre-existing medical conditions will apply, where no claims can be submitted for a procedure, surgery, treatment or an investigation relating to any illness or condition for which you received advice or treatment **12 months prior** to your cover start date.

GAP COVER BENEFIT EXCLUSIONS

WHAT OUR BENEFITS DO NOT COVER

GAP BENEFIT DOES NOT COVER

1) Service providers' accounts;
   a) where the shortfall is more than what our gap benefit provides.
   b) that are covered in full or covered as a concession from your medical scheme hospital benefit, where no shortfalls exist.
   c) where your medical scheme did not pay a portion towards the account, or towards an individual line item on the account from your medical scheme hospital benefit.
   d) where your medical scheme paid a portion of, or the full amount of the account from your medical scheme savings account or day-to-day benefit, also known as a block or insured benefit.
   e) where your medical scheme benefit limit is exceeded.
   f) where the treatment dates differ from the date of your in- or out-of-hospital medical event.
2) Consultations in the rooms nor consultations prior to, or following an in- or out-of-hospital medical event.
3) A private upfront fee charged by your doctor or specialist which you are responsible to pay and cannot claim from your medical scheme.
4) Paid by you whilst you are in your medical scheme self-payment gap.
5) Hospital accounts including, but not limited to theatre and ward fees.
6) Specialised radiology except for MRI, CT and PET scans.
7) Consumable items and medication which your medical scheme did not pay during your in- or out-of-hospital medical event, prescription medication or medication provided to take home.
8) Allied service providers' accounts for diagnostic, technical, therapeutic, direct patient care and support services, such as occupational and speech therapy unless our benefit specifically makes provision for cover.

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THE CLEAR PRINT CONTINUED

CO-PAYMENT BENEFIT DOES NOT COVER

1) Co-payments or deductibles applied;
   a) where you failed to obtain pre-authorisation or an appropriate service provider referral.
   b) where you had not followed your medical scheme rules.
   c) for the voluntary use of a hospital, day clinic or service provider that does not form part of your medical scheme's network, unless our benefit specifically makes provision for cover.
2) Split billing invoicing, where a private upfront fee is charged by your service provider which you are responsible to pay and cannot claim from your medical scheme.
3) Co-payments applied for chronic, acute, formulary or non-formulary medication.

ONCOLOGY BENEFITS DO NOT COVER

1) Cancer treatment costs and biological medication not approved by your medical scheme as part of your initial or ongoing oncology treatment plan.
2) Service providers' accounts where your medical scheme paid a portion of, or the full amount of the account from your medical scheme savings account or day-to-day benefit, also known as a block or insured benefit.
3) Service providers' accounts;
   a) where you had not followed your medical scheme rules.
   b) for the voluntary use of a service provider that does not form part of your medical scheme's network.
4) Our CANCER DIAGNOSIS BENEFIT does not cover a first-time diagnosis;
   a) when the cancerous cells have not invaded surrounding or underlying tissue.
   b) for cancers of the skin except cancerous moles that have invaded underlying tissue.
   c) for Stage 1 prostate or breast cancer described as T1a, N0, M0 or G1. (T) refers to the size of the tumour, (N) to the number of lymph nodes affected, (M) to metastasis and (G) to the grade or aggressiveness of cancer.
   d) if your diagnosis is made before the first day your cover starts or whilst your 3 Month General Waiting Period applies.
   e) of a second or subsequent diagnosis.
   f) after the benefit ceased at age 65.

SUB-LIMIT BENEFIT DOES NOT COVER

1) Service providers' accounts;
   a) where your medical scheme applied a sub-limit or annual limit to in- or out-of-hospital medical procedures, treatment or investigations except for internal prostheses, non-PMB day procedures, renal dialysis and MRI & CT scans, where applicable.
   b) where your medical scheme's sub-limit or annual limit is exhausted at the time of the event and your medical scheme did not pay a portion towards your service provider's account, unless our benefit specifically makes provision for cover.
2) Renal dialysis treatment costs not approved by your medical scheme as part of your initial or ongoing dialysis treatment plan, where applicable.
3) Renal dialysis treatment where you had not followed your medical scheme rules and / or for the voluntary use of a service provider that does not form part of your medical scheme's network, where applicable.

CASUALTY BENEFIT DOES NOT COVER

1) A casualty event that was not due to an accident and / or did not require immediate treatment for physical injury, which resulted from an external force outside of the body due to impact with someone or something.
2) Service providers' accounts where your medical scheme provided a casualty benefit and paid the accounts in full from your medical scheme hospital benefit.
3) Service providers' accounts where the treatment dates differ from the date of the casualty event, except for return visits to the registered medical facility where follow-up treatment is required as a result of the initial casualty event.
4) Medication prescribed or provided to take home.

TRAUMA COUNSELLING BENEFIT DOES NOT COVER

1) Registered counsellor's, clinical psychologist's or psychiatrist's accounts if you;
   a) did not witness, or were not directly affected by an act of physical violence or an accident resulting in serious bodily injury or death.
   b) were not diagnosed with a dread disease, or were not affected by a loved one's diagnosis of a dread disease or death.
2) Service providers' accounts where your medical scheme provided a trauma counselling benefit and paid the accounts in full from your medical scheme hospital benefit.
3) The fee charged by your counsellor, clinical psychologist or psychiatrist if they are not registered with a recognised South African regulatory body.

ADDITIONAL BENEFIT

ACCIDENTAL DEATH BENEFIT DOES NOT COVER

1) Death due to natural causes.

GENERAL EXCLUSIONS APPLICABLE TO YOUR GAP COVER POLICY

We do not cover service providers' accounts for related medical procedures and / or treatment, hospitalisation, illness, disease, loss, damage, death, bodily injury or liability that is caused by or results from:

1) An event where the claimant is not an insured person at the time of the event, unless a benefit specifically makes provision for cover.
2) Medical scheme exclusions where no underlying cover exists, unless a benefit specifically makes provision for cover.
3) An event where a benefit limit or an Overall Policy Limit (OPL) has been reached.
4) An event where the policy does not provide the relevant benefit to claim from.
5) An event where pre-authorisation was not obtained from the medical scheme or where medical scheme rules were not followed.
6) An event where the use of a hospital, day-clinic or service provider was voluntary and the service provider does not form part of the medical scheme's network, unless a benefit specifically makes provision for cover.
7) An event that occurs during a policy waiting period, unless otherwise specified.
8) Maxillo-facial surgery and related medical conditions and / or medical procedures unless due to accidental impact resulting in severe physical injury.
9) Dental implants, orthodontic, prosthodontic or cosmetic dentistry.
10) External prostheses or appliances such as artificial limbs, wheelchairs and crutches.
11) Robotic surgery, specialised mechanical or computerised appliances and equipment.
12) Artificial insemination, infertility treatment or contraceptives except for tubal ligation and vasectomies.
13) Obesity.
14) Non-medically necessary reconstructive cosmetic surgery.
15) Breast reconstruction performed as a second or subsequent reconstruction.
16) Home nursing or admission to a step-down facility such as a frail care centre, unless a benefit specifically makes provision for cover.
17) Depression, insanity, emotional or mental illness or any stress-related conditions.
18) Costs associated with supporting medical reports that assist in the finalisation of a claim.
19) Routine physical, diagnostic procedures or examination where there are no objective indications of impairment in normal health.
20) Expenses incurred for transport charges or for services rendered whilst being transported in an emergency vehicle, vessel or aircraft.
21) Riots, wars, political acts, public disorder, terrorism, civil commotions, labour disturbances, strikes, lock-out, or any attempted such acts.
22) A deliberate criminal or fraudulent act or any illegal activity conducted by you or a member of your household which directly or indirectly results in loss, damage or injury.
23) Attempted suicide, intentional self-injury and deliberate exposure to exceptional danger except in an attempt to save a human life.
24) An event where the use of drugs or alcohol is involved.
25) Active military, police and police reservist activities whilst on active duty.
26) 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.
27) Events that occur for which the actual damage is provided for by legislation, including contractual liability and consequential loss.
28) Discounts negotiated by an insured person directly with a service provider where reimbursement of a claim will enrich the insured person.
29) Non-disclosure of material information that is likely to affect the assessment or acceptance of risk.