CMAC
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Stratum Benefits
Gap Cover

2020 GAP COVER PRODUCT RANGE BENEFIT AND GENERAL EXCLUSIONS

ASSESSING CLAIMS

We assess claims per line item, which means that each line item on your healthcare and/or service providers' accounts are assessed to identify shortfalls. Line items describe the medical procedures and/or services that were performed and/or provided.

Your medical aid must pay an amount towards each line item from a **hospital** or **risk benefit** in order for us to pay a shortfall on that line item, unless otherwise specified.

BENEFIT EXCLUSIONS

1. GAP COVER

Our benefit provides **additional** cover above your medical aid plan's rate to cover the difference between what your healthcare providers charge and the rate your medical aid pays from a **hospital** or **risk benefit**.

WHAT OUR BENEFIT DOES NOT COVER

We do not cover line items on your healthcare providers' and/or service providers' accounts:

1.1 that your medical aid paid in full from a **hospital** or **risk benefit**, paid as a concession or an ex-gratia payment.
(Concessions and ex-gratia payments are payments made by your medical aid outside of their normal rules and regulations.)

1.2 that your medical aid has not paid a portion of from a **hospital** or **risk benefit**.

1.3 that your medical aid paid a portion of or paid in full from a **day-to-day benefit** or your **medical savings account**.

1.4 that your medical aid processed against your self-payment gap.

1.5 for upfront fees that you are required to pay in your private capacity and cannot claim back from your medical aid as the fees are not imposed by your medical aid.

1.6 for out-patient consultation fees, unless a consultation fee was charged as part of a medical procedure that your medical aid paid a portion of from a **hospital** or **risk benefit**.

1.7 relating to hospital account fees, unless you claim for consumable items and/or medication that your medical aid has paid a portion of from a **hospital** or **risk benefit**.

1.8 if the healthcare providers are allied healthcare providers, unless your Gap Cover policy makes provision for cover.
(Allied healthcare providers are healthcare professional associated with your medical event who are not doctors or specialists. We only cover the following allied healthcare providers:

- 1.8.1 *clinical perfusionists;*
- 1.8.2 *dental hygienists;*
- 1.8.3 *midwives;*
- 1.8.4 *nurses; and/or*
- 1.8.5 *physiotherapists.)*

1.9 that you are responsible to pay when the benefit limits provided by your medical aid plan have been reached.

1.10 at more than **20%** of the approved claim amount if you claim within the first **10 months** of cover against a benefit limit provided by your Gap Cover policy for medical events related to:

- 1.10.1 adenoidectomy;
- 1.10.2 tonsillectomy;
- 1.10.3 myringotomy/grommets;
- 1.10.4 cardiovascular procedures;
- 1.10.5 cataract removal;
- 1.10.6 dentistry;
- 1.10.7 hernia repairs;
- 1.10.8 hysterectomy (unless due to cancer that is diagnosed after the **General Waiting Period**);
- 1.10.9 joint replacements;
- 1.10.10 MRI, CT and PET scans;
- 1.10.11 nasal and sinus surgery;
- 1.10.12 pregnancy and childbirth;
- 1.10.13 spinal procedures; and/or
- 1.10.14 scopes (including medical events where a scope is used).

2. CO-PAYMENT COVER

Our benefit refunds the co-payments or deductibles that your medical aid requires you to pay before undergoing certain medical procedures and/or diagnostic services.

WHAT OUR BENEFIT DOES NOT COVER

We do not cover co-payments or deductibles that apply to your healthcare providers' and/or service providers' accounts:

2.1 when you do not obtain pre-authorisation, or a referral required by your medical aid.

2.2 when you do not follow your medical aid's rules, or when you choose to use healthcare providers and/or service providers that do not form part of your medical aid plan's preferred provider network, unless your Gap Cover policy makes provision for cover.

2.3 when you are required to pay upfront co-payments to your healthcare providers that you cannot claim back from your medical aid (also referred to as split billing).

2.4 when you are responsible to pay upfront co-payments to your healthcare providers and/or service providers that are more than the co-payment amounts your medical aid plan imposes.

2.5 for cancer treatment, unless your Gap Cover policy makes provision for cover.

2.6 for out-patient consultation fees.

2.7 for chronic, acute, formulary, non-formulary and/or over-the-counter medication.

2.8 for robotic surgery, or for the use of other specialised mechanical or computerised items and/or equipment, unless your Gap Cover policy makes provision for cover.

2.9 at more than **20%** of the approved claim amount if you claim within the first **10 months** of cover against a benefit limit provided by your Gap Cover policy for medical events related to:

- 2.9.1 adenoidectomy;
- 2.9.2 tonsillectomy;
- 2.9.3 myringotomy/grommets;
- 2.9.4 cardiovascular procedures;
- 2.9.5 cataract removal;
- 2.9.6 dentistry;
- 2.9.7 hernia repairs;
- 2.9.8 hysterectomy (unless due to cancer that is diagnosed after the **General Waiting Period**);
- 2.9.9 joint replacements;
- 2.9.10 MRI, CT and PET scans;
- 2.9.11 nasal and sinus surgery;
- 2.9.12 pregnancy and childbirth;
- 2.9.13 spinal procedures; and/or
- 2.9.14 scopes (including medical events where a scope is used).

3. SUB-LIMIT COVER

Our benefit covers the difference in cost that you are responsible to pay when your medical aid pays a portion of specific medical events from a **sub-limit** or **annual limit**.

WHAT OUR BENEFIT DOES NOT COVER

We do not cover line items on your healthcare providers' and/or service providers' accounts:

3.1 for healthcare services that your medical aid plan applies a **sub-limit** or **annual limit** to, unless you claim for the healthcare services your Gap Cover policy provides cover for.

3.2 that your medical aid has not paid a portion of from a **sub-limit** or **annual limit**, unless your Gap Cover policy makes provision for cover.

3.3 when you do not follow your medical aid's rules, or when you choose to use healthcare providers and/or service providers that do not form part of your medical aid's preferred provider network.

3.4 at more than **20%** of the approved claim amount if you claim within the first **10 months** of cover against a benefit limit provided by your Gap Cover policy for medical events related to:

- 3.4.1 adenoidectomy;
- 3.4.2 tonsillectomy;
- 3.4.3 myringotomy/grommets;
- 3.4.4 cardiovascular procedures;
- 3.4.5 cataract removal;
- 3.4.6 dentistry;
- 3.4.7 hernia repairs;
- 3.4.8 hysterectomy (unless due to cancer that is diagnosed after the **General Waiting Period**);
- 3.4.9 joint replacements;
- 3.4.10 MRI, CT and PET scans;
- 3.4.11 nasal and sinus surgery;
- 3.4.12 pregnancy and childbirth;
- 3.4.13 spinal procedures; and/or
- 3.4.14 scopes (including medical events where a scope is used).

4. PRIVATE WARD COVER

Our benefit covers the hospital fees that you are responsible to pay when your medical aid plan does not provide cover for private ward, lodger and/or nursery fees.

WHAT OUR BENEFIT DOES NOT COVER

We do not cover line items on your service providers' accounts:

4.1 that your medical aid paid in full from a **hospital** or **risk benefit**, paid as a concession or an ex-gratia payment.
(Concessions and ex-gratia payments are payments made by your medical aid outside of their normal rules and regulations.)

4.2 for the portion of the fee that your medical aid paid from a **hospital** or **risk benefit**, except for the portion of the fee that you pay from your own pocket or that your medical aid pays from your **medical savings account**.

4.3 if your medical aid and/or the hospital requires you to be admitted to a private ward due to clinical reasons.

4.4 if the lodger and/or nursery fee is for a person not covered on your Gap Cover policy.

5. CANCER COVER

5.1 BREAST RECONSTRUCTION

Our benefit covers the cost of a breast reconstruction done on an unaffected breast that your medical aid plan excludes from cover, subject to the below qualifying criteria.

WHAT OUR BENEFIT DOES NOT COVER

We do not cover line items on your healthcare providers' accounts:

5.1.1 for a mastectomy of an unaffected breast.

5.1.2 for a breast reconstruction of an unaffected breast that is not due to **Stage 2** or a **higher** breast cancer diagnosis of the affected breast.

5.1.3 for a breast reconstruction of the unaffected breast that is not done at the same time as a bilateral mastectomy and reconstruction of the affected breast.

5.1.4 for a breast reconstruction of the unaffected breast that is covered by your medical aid plan.

5.2 CANCER TREATMENT SHORTFALL AND CANCER TREATMENT TOP-UP

Our **Cancer Treatment Shortfall** benefit covers the difference in cost between what your healthcare providers charge and the rate your medical aid pays from an oncology benefit for healthcare services related to your cancer treatment, including co-payments related to your cancer treatment when the oncology benefit limit your medical aid plan provides is reached.

Our **Cancer Treatment Top-Up** benefit covers the cost of your ongoing cancer treatment when the **oncology benefit** limit your medical aid plan provides is reached.

WHAT OUR BENEFITS DO NOT COVER

We do not cover line items on your healthcare providers' and/or service providers' accounts:

5.2.1 for cancer treatment that your medical aid did not approve as part of a cancer treatment plan.

5.2.2 for cancer treatment that your medical aid paid in full from your medical aid plan's **oncology benefit**.

5.2.3 for cancer treatment that your medical aid paid a portion of or paid in full as a concession or an ex-gratia payment.
(Concessions and ex-gratia payments are payments made by your medical aid outside of their normal rules and regulations.)

5.2.4 for cancer treatment that your medical aid paid a portion of or paid in full from a **day-to-day benefit** or your **medical savings account**. If, however, you claim from our **Cancer Treatment Top-Up Cover** because your medical aid agrees to pay your ongoing cancer treatment from a **day-to-day benefit** or from your **medical savings account**, even though your medical aid plan's **oncology benefit** limit has been reached, our benefit will apply if all qualifying criteria are met.

5.2.5 when you do not follow your medical aid's rules, or when you choose to use healthcare providers and/or service providers that do not form part of your medical aid's preferred provider network.

5.2.6 for co-payments or deductibles that your medical aid requires you to pay before your medical aid plan's **oncology benefit** limit is reached.

6. PHYSICAL REHABILITATION TOP-UP COVER

Our benefit covers the cost of admission and therapy provided in a sub-acute or step-down facility when the **rehabilitation benefit** your medical aid plan provides is reached and you require ongoing physical rehabilitation treatment due to an accident.

WHAT OUR BENEFIT DOES NOT COVER

We do not cover line items on your healthcare providers' and/or service providers' accounts:

6.1 that are not related to an accident.

6.2 that your medical aid did not approve as part of your physical rehabilitation treatment plan.

6.3 that your medical aid paid in full or paid a portion of from a **day-to-day benefit** or your **medical savings account**. If, however, you claim from our benefit because your medical aid agrees to pay your ongoing physical rehabilitation treatment from a **day-to-day benefit** or from your **medical savings account**, even though your medical aid plan's **physical rehabilitation benefit** limit has been reached, our benefit will apply if all qualifying criteria are met.

6.4 when you do not follow your medical aid's rules, or when you choose to use healthcare providers and/or service providers that do not form part of your medical aid's preferred provider network.

6.5 if your treatment was provided by healthcare providers outside of the sub-acute or step-down facility or after you have been discharged.

6.6 for healthcare services that are provided by counsellors, clinical psychologists and/or psychiatrists.

6.7 if your healthcare providers and/or service providers are not registered with a South African regulatory body.

7. OUT-PATIENT SPECIALIST CONSULTATION COVER

Our benefit covers the difference in cost between what your specialist charges for a consultation in their private rooms and the rate your medical aid plan applies to out-patient specialist consultation fees. Our benefit applies to **only** specialists' consultation fees of which your medical aid must pay a portion from a **hospital**, **risk**, or **day-to-day benefit** or from your **medical savings account**.

WHAT OUR BENEFIT DOES NOT COVER

We do not cover line items on your specialists' accounts:

7.1 for out-patient consultations that occur during a **General Waiting Period.**
7.2 that your medical aid paid in full from a **hospital**, **risk**, or **day-to-day benefit** or from your **medical savings account**.
7.3 that your medical aid has not paid a portion of from a **hospital**, **risk**, or **day-to-day benefit** or from your **medical savings account**.
7.4 that your medical aid processed against your self-payment gap.
7.5 where the difference in cost between what your specialists charge and the amount your medical aid paid is more than your medical aid plan's rate. In this case, we will cover the difference between the amount charged by your specialist and the amount paid by your medical aid.
7.6 for healthcare services provided in your specialists' private rooms, except for out-patient consultation fees.
7.7 for an in-hospital medical event.
7.8 Our benefit does not cover any allied healthcare providers accounts.

8. CASUALTY COVER

Our benefit covers the cost of a casualty event, including all related healthcare services provided at a registered **medical facility**, when you need **immediate treatment** due to an **accident**. We also cover your child dependant **younger** than **6** at a registered **casualty facility** when they are **ill** and need **after-hours** medical treatment.

WHAT OUR BENEFIT DOES NOT COVER

We do not cover line items on your healthcare providers' and/or service providers' accounts:

8.1 that are not related to an accident or not related to illness of your child dependant **younger** than **6**.
8.2 that are related to an accident, but medical treatment was provided either **48-hours** or **later** following an accident.
8.3 for medication that you did not receive during a casualty event or during a follow-up consultation that was required due to your initial casualty event. We also do not cover medication given to you to take home and/or prescription medication that you collect at a pharmacy.
8.4 for external medical items that you did not receive at the registered medical facility during your initial casualty event.
8.5 for return visits to a registered medical facility for follow-up treatment that is not related to an accident.
8.6 for return visits to a registered medical facility when follow-up treatment is required due to an accident, but follow-up treatment follows a hospital admission.
*(When you are admitted to hospital for an accident for which you have been treated at a registered medical facility, the hospital admission becomes a new medical event and return visits for follow-up treatment will not be considered under our **Casualty Cover.**)*
8.7 for medical treatment due to illness for your child dependant **younger** than **6** but medical treatment was not provided at a registered casualty facility.
8.8 for treatment due to illness provided to your child dependant younger than **6** at a registered casualty facility, but medical treatment was not provided after-hours. *(After-hours is **Mondays** to **Fridays** between **18:00pm** and **07:00am** and all-day* **Saturdays**, **Sundays** *and* **public holidays**.*)*
8.9 for medical treatment due to illness that was provided to an insured person aged **6** or **older**.
8.10 that your medical aid paid in full from a **risk benefit**.

9. TRAUMA COUNSELLING COVER

Our benefit covers the cost of your registered counsellor's consultation fees when you need counselling due to specific traumatic events.

WHAT OUR BENEFIT DOES NOT COVER

We do not cover registered counsellor's accounts:

9.1 if you have not witnessed or are not directly affected by an act of physical violence or an accident.
9.2 if you are not affected by a loved one's diagnosis of a critical illness or death, or by your own diagnosis of a critical illness.
9.3 that your medical aid paid in full from a **risk benefit**.
9.4 if your counsellor is not registered with a recognised South African regulatory body.

10. PREVENTATIVE CARE COVER

Our benefit covers the cost of your healthcare provider's consultation fee and the cost of specific preventative tests and/or procedures.

WHAT OUR BENEFIT DOES NOT COVER

We do not cover line items on your healthcare providers' accounts:

10.1 for preventative care, except for consultation fees, preventative tests and/or procedures related to contraceptive device implants, full blood count tests, mammograms, pap smears and/or prostate screening tests.
10.2 that your medical aid paid in full from a **risk benefit**.

11. PAYOUT AND WAIVER BENEFITS

11.1 ACCIDENTAL DISABILITY AND DEATH

Our benefit covers you, your spouse and your dependants (option specific) in the event of your and/or their total and permanent disability or death due to an accident.

WHAT OUR BENEFIT DOES NOT COVER

We do not cover instances:

11.1.1 where total and permanent disability and/or death is not due to an accident.
11.1.2 that exceed one claimable event per qualifying person in a benefit year.

11.2 FIRST-TIME CANCER DIAGNOSIS

Our benefit covers you when cancer is diagnosed for the first time in your life, subject to the below qualifying criteria.

WHAT OUR BENEFIT DOES NOT COVER

We do not cover you:

11.2.1 if your cancer diagnosis is not the first cancer diagnosed in your life.
11.2.2 when cancer is diagnosed before the first day your cover starts or during a **General Waiting Period**.
11.2.3 for cancer of the skin, unless cancerous moles have invaded surrounding or underlying tissue.
11.2.4 if cancerous cells have not invaded surrounding or underlying tissue.
11.2.5 for **Stage 1** breast or prostate cancer.
11.2.6 if cancer is diagnosed at age **65** or **older**.

11.3 MEDICAL AID CONTRIBUTION WAIVER

Our benefit covers you when the person responsible for paying your monthly medical aid plan contributions becomes totally and permanently disabled or passes away.

WHAT OUR BENEFIT DOES NOT COVER

We do not cover instances:

11.3.1 where the person paying your medical aid contributions has not become totally and permanently disabled and/or has not passed away.
11.3.2 of total and permanent disability and/or death of a person that is not noted as the medical aid contribution payer.
11.3.3 where a new contribution payer is appointed within **3 months** before the claimable event, unless the new contribution payer's total and permanent disability and/or death is due to an accident.

11.4 STRATUM POLICY PREMIUM WAIVER

Our benefit covers you when the person responsible for paying your monthly policy premium is forcibly retrenched, becomes totally and permanently disabled or passes away.

WHAT OUR BENEFIT DOES NOT COVER

We do not cover instances:

11.4.1 where the person paying your premiums has not been forcibly retrenched, has not become totally and permanently disabled and/or has not passed away.
11.4.2 of forced retrenchment, total and permanent disability and/or death of a person that is not noted as the premium payer.
11.4.3 where a new premium payer is appointed within **3 months** before the claimable event, unless the new premium payer's total and permanent disability and/or death is due to an accident.

ACCESS COVER

Our benefit covers the cost of the hospital or day clinic, and all your related healthcare providers' accounts, when you need specific medical procedures and/or treatments that your medical aid plan excludes from cover.

WHAT OUR BENEFIT DOES NOT COVER

We do not cover your healthcare providers' and/or service providers' accounts:

12.1 that your medical aid paid a portion of, paid in full or paid as a concession or an ex-gratia payment.
(Concessions and ex-gratia payments are payments made by your medical aid outside of their normal rules and regulations.)
12.2 that your medical aid processed against your self-payment gap.
12.3 for medical procedures and/or treatments that are not excluded by your medical aid plan.
12.4 for medical procedures and/or treatments that your medical aid plan excludes from cover but that do not form part of the list of medical procedures and/or treatments that we cover.
12.5 at more than **20%** of the approved claim amount if you claim within the first **10 months** of cover against a benefit limit provided by your Gap Cover policy for a medical event related to:
12.5.1 arthroscopic surgery;
12.5.2 back and/or neck surgery;
12.5.3 bunion surgery;
12.5.4 cochlear implant, auditory brain implant and internal nerve stimulator surgery (including the procedure, device, processor and hearing aids);
12.5.5 dental procedures for impacted teeth for children **younger** than **18**;
12.5.6 functional nasal surgery;
12.5.7 joint replacement surgery;
12.5.8 knee and/or shoulder surgery;
12.5.9 non-cancerous breast conditions;
12.5.10 removal of varicose veins; and/or
12.5.11 skin disorders (including benign growths and/or lipomas).

GENERAL EXCLUSIONS

We do not cover healthcare providers' and/or service providers' accounts related to any medical procedure and/or treatment, nor hospitalisation, illness, disease, loss, damage, death, bodily injury and/or liability for:

1. events that you want to claim for, but you were not an insured person at the time of the event.
2. events that occur during your Gap Cover policy's waiting period(s), unless you claim for an accidental event.
3. events where your Gap Cover policy's benefit limit(s) and/or policy limit(s) have been reached.
4. events where your Gap Cover policy does not provide an appropriate benefit for you to claim from.
5. events where you did not obtain pre-authorisation from your medical aid, or where you did not follow your medical aid's rules.
6. maxillofacial surgery and related medical conditions and/or procedures, unless your claim is related to accidental injury or cancer.
7. for prescription medication that you collect at a pharmacy and/or medication given to you to take home, unless your Gap Cover policy makes provision for cover.
8. external prostheses, such as artificial limbs,
9. external medical items, such as crutches, unless your Gap Cover policy makes provision for cover.
10. mechanical/computerised devices, such as ventilators, unless your Gap Cover policy makes provision for cover.
11. co-payments related to robotic surgery, unless your Gap Cover policy makes provision for cover.
12. artificial insemination, infertility treatment, procedures and/or contraceptives, unless you claim for tubal ligation, a vasectomy and/or a contraceptive device implant for which your Gap Cover policy makes provision for cover.
13. obesity and bariatric surgery.
14. reconstructive cosmetic surgery that is not medically necessary.
15. breast reconstruction, including the insertion and/or removal of a breast implant, performed as a second or subsequent medical procedure, regardless of whether the procedure is for cosmetic or medically necessary reasons.
16. home nursing, admission to a step-down and/or sub-acute facility, such as a frail care centre, rehabilitation facility and hospice, unless your Gap Cover policy makes provision for cover.
17. depression, emotional and/or mental illnesses.
18. sleeping disorders.
19. stem cell harvesting and/or treatment.
20. costs related to medical reports.
21. full reimbursement of a claim where we negotiated a discount with your healthcare providers and/or service providers as this will result in enrichment.
22. resubmission of a claim due to service fees being increased.
23. non-disclosure of information that is likely to affect the assessment and/or acceptance of risk.
24. dual insurance where you are covered by more than one Gap Cover policy through different insurers, or the same insurer.
25. routine physical, diagnostic procedures and/or examinations where there is no objective indication of impairment in your health.
26. transport charges and/or healthcare services that you receive when being transported in an emergency vehicle, vessel and/or aircraft.
27. deliberate criminal and/or fraudulent acts, or any illegal activity conducted by you or a member of your household which directly or indirectly results in loss, damage and/or injury.
28. attempted suicide, intentional self-injury and/or deliberate exposure to exceptional danger unless you attempt to save a human life.
29. events where the use of drugs and/or alcohol is involved.
30. riots, wars, political acts, public disorder, terrorism, civil commotions, labour disturbances, strikes, lock-out or any attempt to such acts.
31. active military, police and/or police reservist activities while you are on active duty.
32. nuclear weapons material, ionising radiations and/or contamination by radioactivity from any nuclear fuel, nuclear waste and/or from the combustion of nuclear fuel that includes any self-sustaining process of nuclear fission.
33. events where the actual damage is covered by legislation, such as contractual liability and consequential loss.