



COMPACT³⁰⁰

It's our **well-rounded option** that's packed with just the right benefits to cover the **most often experienced** medical expense shortfalls.

COMPACT 300 PREMIUMS FOR INDIVIDUALS

If you're an individual who's **65 or older**, or if you apply for cover as a family and either you or one of your dependants is **65 or older**, you'll pay the **65 or older individual or family premium**.

R 257

INDIVIDUAL
64 or YOUNGER

R 311

FAMILY
64 or YOUNGER

R 490

INDIVIDUAL or FAMILY
65 or OLDER

Joining as a family? One Gap Cover policy covers you, your spouse and all the dependants registered on both your and your spouse's medical aid plans.

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 for a knee replacement, or having a scope done in the specialist's rooms?

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 300% 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 6 000 per policy per year;
- dental procedures due to accidents or cancer treatment, limited to R 8 000 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 wisdom teeth extractions or an elective caesarean, 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 benefit limit of R 15 000 per policy per year.

If you claim for the below co-payment, a benefit limit will apply:

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 1 co-payment of up to R 5 000 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 20 000 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.

MRI & CT SCANS

Limited to R 3 000 per person per event.

CANCER COVER

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 limit is reached and you're responsible to pay the cost from your own pocket, we'll cover:

CANCER TREATMENT TOP-UP

The cost of your treatment according to the cancer treatment plan that your medical aid approved, limited to R 60 000 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.

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 6 000 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 5 000 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.

PAYOUT BENEFITS



ACCIDENTAL DISABILITY AND DEATH

You and your spouse are covered for a benefit amount of **R 15 000 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 15 000 per person per lifetime** if cancer is diagnosed before the age of 65.

10 MONTH LIMITED PAYOUT BENEFIT

If you claim from our **GAP COVER**, **CO-PAYMENT COVER**, **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;
- 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**),
- tonsillectomy;
- cardiovascular procedures;
- dentistry;
- joint replacements;
- nasal and sinus surgery;
- spinal procedures;

we'll cover only **20%** of the **approved claim amount** subject to benefit limits where applicable.

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

Waiting periods apply from the start date of your policy, from the effective option change date when you upgrade your policy, and from each person's cover start date when they're added after the policy's start date.

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 BENEFIT

Our **Lifestyle Benefit** is complimentary and doesn'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.

*Visit our website at www.stratumbenefits.co.za to read more about this **LIFESTYLE BENEFIT** 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 **300%** 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 more than 20% of the approved claim amount 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. *(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.)*
- 2.5 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.)*
- 2.6 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.
- 2.7 if it's for cancer treatment.
- 2.8 if it's for out-patient consultation fees.
- 2.9 if it's for chronic, acute, formulary, non-formulary, or over-the-counter medication.
- 2.10 if it's for robotic surgery, or for the use of other specialised mechanical or computerised items or equipment.
- 2.11 at more than 20% of the approved claim amount 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 more than 20% of the approved claim amount 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

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:

- 5.1 if your medical aid paid it as an exception to the rule.
- 5.2 if it's for cancer treatment that your medical aid didn't approve as part of a cancer treatment plan.
- 5.3 if your medical aid fully paid it from an oncology benefit, as there'll be no claimable event.
- 5.4 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.
- 5.5 if you've used healthcare or service providers that don't form part of your medical aid's preferred network.

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.

BENEFITS NOT SUBJECT TO THE OVERALL POLICY LIMIT (OPL)

8. PAYOUT BENEFITS

8.1 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:

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

8.2 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:

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

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 300% 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 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.
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.
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.