Total Risk Administrators (Pty) Ltd (TRA)
an authorised financial services provider -
FSP No 40815

TOTALRISKADMINISTRATORS

www.totalrisksa.co.za

BASIC COVER 300 | ABSOLUTE COVER PLUS | VITAL COVER PLUS | SUPER COVER PLUS

GAP COVER
In-Hospital Medical Shortfall Cover

DON'T STRESS!
THE GAP IS COVERED.

GAP COVER FROM R99 PER MONTH

2022

THE FOLLOWING BENEFITS ARE SUBJECT TO AN AGGREGATE ANNUAL LIMIT OF R177 800 PER INSURED PERSON.

This amount is calculated annually according to the prescribed table under Regulation 7.2(1) of Regulation 7.2(2) - Policy benefits escalation, in terms of the Short-term Insurance Act, 1998 (Act No. 53 of 1998). This amount will be increased on 1 April 2022 by the official CPI as published by Statistics South Africa (as defined in the Statistics Act, 1999 (Act No. 6 of 1999)).
Click **HERE** to see a table showing the latest limit amount.

PRODUCT	BASIC COVER 300	VITAL COVER PLUS	SUPER COVER PLUS	ABSOLUTE COVER PLUS
GAP COVER: The **shortfall** that arises after your medical aid has processed your account and is due to service providers charging above scheme tariff for authorised in-hospital procedures. The cover is limited to a percentage of the original scheme tariff.	300%	700%	700%	700%
PRESCRIBED MINIMUM BENEFITS: A set of defined benefits, as per the Medical Schemes Act, in terms of which all medical schemes have to cover the costs related to the diagnosis, treatment and care of: any emergency medical condition; a limited set of 270 medical conditions; and 27 chronic conditions.	Covered, subject to medical aid review	Covered, subject to medical aid review	Covered, subject to medical aid review	Covered, subject to medical aid review
CASUALTY UNIT BENEFIT: • Accidents only. • Children under the age of 8 ONLY - May be admitted for any treatment at a casualty unit linked to a hospital between the hours of 7pm to 7am from Monday to Friday, from 7pm on a Friday until 7am on a Monday, and all day on a public holiday.	Up to R3 000 per policy per annum	Up to R8 000 per policy per annum	Up to R12 000 per policy per annum	Up to R20 000 per policy per annum
CO-PAYMENT BENEFIT: (In Network) • The co-payment or deductible that your medical aid charges you for certain in-hospital procedures, **e.g. a gastroscopy, colonoscopy, sigmoidoscopy or proctoscopy**. • The co-payment or deductible that your medical aid charges you for certain procedures performed in the doctor's rooms **e.g. a gastroscopy, colonoscopy, sigmoidoscopy or proctoscopy** BUT which have been authorised and paid from the In-Hospital or Major Medical benefit. • This co-payment or deductible is NOT related to the scheme tariff and service provider charge **shortfall** or designated service provider arrangements.	No Benefit	Up to R10 000 per policy per annum	Up to R50 000 per policy per annum	Unlimited but subject to the aggregate annual limit per insured person per annum
CO-PAYMENT BENEFIT: (Out of Network i.e. Voluntary use of a non-designated service provider) • The co-payment or deductible that your medical aid charges you for certain in-hospital procedures. • This co-payment or deductible is NOT related to the scheme tariff and service provider charge **shortfall** or designated service provider arrangements.	No Benefit	No Benefit	No Benefit	2 co-payments per policy per annum up to a combined limit of R15 000
CO-PAYMENT BENEFIT: Out of Hospital MRI/CT/PET scans The co-payment or deductible that your medical aid charges you for MRI / CT / PET scans BUT which have been authorised and paid from the In-Hospital or Major Medical benefit.	No Benefit	No Benefit	1 MRI / CT / PET scan per policy per annum up to R10 000	2 scans per policy per annum. Unlimited but subject to the aggregate annual limit per insured person per annum
SUB-LIMIT BENEFIT: Internal Prostheses The **shortfall** on a service provider account that is not covered because you have reached the sub-limit for Internal Prostheses imposed by your medical aid AND which has been authorised and paid from the In-Hospital or Major Medical benefit.	No Benefit	Up to R5 000 per policy per annum	Up to R10 000 per policy per annum	Unlimited but subject to the aggregate annual limit per insured person per annum. Up to R30 000 per event
SUB-LIMIT BENEFIT: MRI / CT / PET Scans The **shortfall** on a service provider account that is not covered because you have reached the sub-limit for MRI / CT / PET scans imposed by your medical aid AND which has been authorised and paid from the In-Hospital or Major Medical benefit.	No Benefit	No Benefit	1 MRI / CT / PET scan per policy per annum up to R3 000	2 MRI / CT / PET scans per policy per annum up to R5 000 per scan
SUB-LIMIT: COLONOSCOPIES AND GASTROSCOPIES The **shortfall** on a service provider account that is not covered because you have reached the sub-limit for Colonoscopies and Gastroscopies imposed by your medical aid AND which has been authorised and paid from the In-Hospital or Major Medical benefit.	No Benefit	No Benefit	Up to R12 000 per policy per annum. Up to R3 000 per event	Up to R20 000 per insured person per annum. Up to R5 000 per event
DENTAL BENEFIT: The **shortfall** that arises after your medical aid has processed your account and is due to service providers charging above scheme tariff for authorised dental procedures performed in hospital or in doctor's rooms and paid from the in-hospital or major medical benefit only. The cover is limited to a percentage of the original scheme tariff, as follows: **Adults and dependants over 18 years of age:** Treatment of impacted wisdom teeth, extractions, apicectomies or loss of teeth due to oncology or trauma ONLY. **Dependants up to 18 years of age:** Any procedure or treatment.	Unlimited but subject to the aggregate annual limit per insured person per annum	Unlimited but subject to the aggregate annual limit per insured person per annum	Unlimited but subject to the aggregate annual limit per insured person per annum	Unlimited but subject to the aggregate annual limit per insured person per annum
GLOBAL FEE BENEFIT: Where a global fee has been negotiated between a medical aid and service providers for a specific procedure e.g. robotic surgery (which includes ALL costs related to that procedure) and service providers charge amounts in excess of this global fee (not related to a tariff rate, co-payment or sub-limit).	No Benefit	No Benefit	Up to R10 000 per policy per annum	Up to R20 000 per policy per annum

ONCOLOGY:	BASIC COVER 300	VITAL COVER PLUS	SUPER COVER PLUS	ABSOLUTE COVER PLUS
ONCOLOGY GAP BENEFIT: The **shortfall** that arises after your medical aid has processed your account and is due to service providers charging above scheme tariff for medical aid approved oncology treatment plans. (**NB:** Subject to: the gap cover percentage; and medical aid approved treatment plan being covered up to scheme tariff and within annual scheme oncology limit).	Unlimited but subject to the aggregate annual limit per insured person per annum	Unlimited but subject to the aggregate annual limit per insured person per annum	Unlimited but subject to the aggregate annual limit per insured person per annum	Unlimited but subject to the aggregate annual limit per insured person per annum
ONCOLOGY CO-PAYMENT BENEFIT: (In Network) • The co-payment or deductible that your medical aid charges you for certain in-hospital procedures. This co-payment is NOT related to the scheme tariff and service provider charge **shortfall** or designated service provider arrangements. • For claims where the medical aid will only pay a percentage for the approved treatment and the policyholder needs to pay the remaining percentage of the account. • All costs to be within the annual scheme oncology limit.	No Benefit	Up to R10 000 per policy per annum	Up to R50 000 per policy per annum	Unlimited but subject to the aggregate annual limit per insured person per annum
ONCOLOGY CO-PAYMENT BENEFIT: (Out of Network i.e. voluntary use of a non-designated service provider) • The co-payment or deductible that your medical aid charges you for certain in-hospital procedures. This co-payment is NOT related to the scheme tariff and service provider charge **shortfall** or designated service provider arrangements. • For claims where the medical aid will only pay a percentage for the approved treatment and the policyholder needs to pay the remaining percentage of the account. • All costs to be within the annual scheme oncology limit.	No Benefit	No Benefit	No Benefit	2 co-payments per policy per annum up to a combined limit of R15 000
ONCOLOGY EXTENDER BENEFIT: Includes ANY approved costs above annual scheme oncology limit but subject to the medical aid scheme covering up to this limit.	No Benefit	No Benefit	Up to R30 000 per policy per annum	Unlimited but subject to the aggregate annual limit per insured person per annum
ONCOLOGY "NEW-TECH" BENEFIT We cover the shortfall / co-payment on new technology oncology treatment (specifically Keytruda®,Xalkori®, Tagrisso®, Yervoy®, Zelboraf®, Imbruvica®). Subject to a medical aid authorised treatment plan and designated service providers being utilised.	No Benefit	No Benefit	Up to R7 500 per policy per annum	Up to R15 000 per policy per annum
ONCOLOGY GAP BENEFIT: BREAST RECONSTRUCTION SURGERY The **shortfall** that arises after your medical aid has processed your account and is due to service providers charging above scheme tariff for medical aid approved oncology related breast reconstruction surgery, including the unaffected breast. (**NB:** Subject to: the gap cover percentage; and medical aid approved treatment plan being covered up to scheme tariff and within the annual scheme oncology limit).	No Benefit	No Benefit	Up to R15 000 per beneficiary per life of the policy	Up to R30 000 per beneficiary per life of the policy

MATERNITY PRIVATE WARD BENEFIT: The **shortfall** between the General Ward Rate and the Private Ward Rate, for hospitalisation for childbirth, where an admission to a Private Ward occurred.	No Benefit	No Benefit	No Benefit	Limited to a maximum of R1 000 per day, for a total of 3 consecutive days

THE FOLLOWING BENEFITS ARE NOT SUBJECT TO THE AGGREGATE ANNUAL LIMIT.

PRODUCT	BASIC COVER 300	VITAL COVER PLUS	SUPER COVER PLUS	ABSOLUTE COVER PLUS
ACCIDENTAL DEATH COVER Insured / Spouse Dependant	R5 000 R2 500	R7 500 R3 750	R15 000 R5 000	R25 000 R7 500
POLICY EXTENDER The full gap cover premium is covered in the case of the **accidental** death of the main policyholder.	12 months	12 months	12 months	12 months
MEDICAL AID CONTRIBUTION WAIVER Provides cover towards a policyholder's medical aid contribution in the case of the accidental death of the main policyholder. Cover is limited to the lower of the actual medical aid contribution or the maximum amount allowed.	No Benefit	6 months. Up to a max. of R3 000 per month	6 months. Up to a max. of R4 000 per month	6 months. Up to a max. of R5 000 per month

TRA ASSIST (powered by ituASSIST)				
HOME DRIVE A designated driver service including "Own Vehicle" OR "Uber" services.	6 free trips per policy per annum. Limited to a 50km radius.	6 free trips per policy per annum. Limited to a 50km radius.	6 free trips per policy per annum. Limited to a 50km radius.	6 free trips per policy per annum. Limited to a 50km radius.
PANIC BUTTON 24-hour access to a crisis manager who will guide you through an emergency.	Included	Included	Included	Included
MEDICAL HEALTH AND TRAUMA COUNSELLING LINE Unlimited access to qualified nurses 24 hours a day for telephonic emergency medical advice, assessment of symptoms, explanation of medical terms, etc. Now includes a COVID-19 CARE LINE.	Included	Included	Included	Included
SUBMIT CLAIM Submit your claims documents via the mobile app.	Included	Included	Included	Included

PRODUCT	BASIC COVER 300	VITAL COVER PLUS	SUPER COVER PLUS	ABSOLUTE COVER PLUS
TRAVEL BENEFIT All TRA Gap Cover policyholders have access to comprehensive travel insurance provided by Hepstar Financial Services (Pty) Ltd and underwritten by Guardrisk Insurance Company Limited, a Licensed Financial Service Provider, the cost of which is covered by TRA provided that you remain a TRA Gap Cover policyholder and ensure that premium payments thereunder are up to date. Should you plan to travel and have any enquiries about the cover or wish to request the documentation confirming cover, please contact Hepstar Financial Services (Pty) Ltd on +27 (0)11 929 3185 or email info@hepstar.com	Benefits include but are not limited to: Emergency Medical and Related expenses: R600 000. Excess R500. COVID-19 Extension: Emergency inpatient or outpatient treatment due to COVID-19 R600 000. Medical evacuation, repatriation or transportation to a medical centre - FULL COST covered when arranged by Hepstar. Hospital Cash benefit R500 per day (max R3 000). Inconvenience Cover: Baggage Cover: R5 000 for theft, damage or loss by travel supplier.			

MONTHLY PREMIUMS

PRODUCT	BASIC COVER 300	VITAL COVER PLUS	SUPER COVER PLUS	ABSOLUTE COVER PLUS
Under 65's (Based on the age of the oldest Beneficiary) premium per policy per month		R250	R280	R495
Premium per Individual per policy per month	R 99			
Premium per Family per policy per month	R165			
Over 65's (Based on the age of the oldest Beneficiary) premium per policy per month	R330	R370	R405	R610

GAP COVER: The Important Information

All of our 2022 Gap Cover Policies:

- Provide benefits for a policyholder and their spouse and those financially dependent on them (child/children and/or aged parents) who are covered on one policy of a registered medical aid scheme. **Subject to proof of membership and the premium being based on the age of the oldest beneficiary**. Members and their dependants can also be on two different medical aids and one Gap Cover Policy but only if they are legally married, or common law partners verified by submission of an affidavit confirming 12 months of cohabitation.
- Have no entry age limit.
- May allow for immediate benefits for all policyholders except for a limited list of specific conditions and/or procedures **(there is no general 3 month waiting period)**.
- Cover Prescribed Minimum Benefits (PMB's) where a medical aid scheme has failed to meet its obligations in this regard (Subject to medical aid scheme review and for non-emergencies only).
- **Are not medical aid schemes. The cover is not the same as that of a medical aid scheme. The cover is not a substitute for a medical aid scheme membership.**
- **NB:** Refer to the policy document for the complete list of terms and conditions.

WHEN CAN YOU CLAIM?

We have payment runs twice a week, making us well known for our great claims turnaround time!

GENERAL WAITING PERIOD

There is no general three (3) month waiting period. The following waiting periods commence from the Join Date of the Gap Cover Policy:

10 MONTH CONDITION SPECIFIC WAITING PERIOD

No claims may be submitted within the first 10 months of membership for any Gap Cover policy if they relate to any of the following conditions:

- Head, neck and spinal procedures (including stimulators) e.g. Laminectomy
- All types of hernia procedures
- Endoscopic procedures e.g. Colonoscopy, Gastroscopy
- Pregnancy and childbirth (including caesarean delivery)
- Gynaecological conditions e.g. Hysterectomy
- Joint replacement (including Arthroplasty, Arthroscopy, Metatarsal Osteotomy) but excluding treatment due to accidental trauma
- Inability to walk / move without pain
- Any renal, kidney and bladder conditions
- Cardiac (relating to the heart)
- Dentistry (unless due to accidental trauma or oncology)
- Cataracts and / or eye laser surgery (including all eye and lens procedures)
- Neurological conditions and procedures (including stimulators)
- Organ transplants (including cochlear implants)
- Reconstructive surgery as a result of an incident or condition that occurred prior to membership (including skin grafts)
- Mental health or psychiatric conditions (including depression)
- Varicose veins
- Oesophagitis, Gastroenteritis and Gastro-Intestinal Disorders
- Male genital system (including prostatectomy)
- Carpal Tunnel Syndrome
- Any Ear, Nose and Throat procedures (including nasal, sinus, tonsil and adenoid procedures)
- Diabetes and related complications

All claims for these conditions received within the waiting period will be reviewed by medical management to identify pre-existing conditions.

CANCER DIAGNOSIS WAITING PERIOD

If a Policyholder is diagnosed with any form of cancer prior to membership, all related claims will be subject to a nine (9) month waiting period. If a Policyholder has previously been diagnosed with cancer and is currently in remission, the Policyholder needs to advise the insurer by way of medical evidence that the remission period has been for two (2) or more consecutive years.

PRE-EXISTING MEDICAL CONDITION/S WAITING PERIOD

NO claims relating to any pre-existing condition/s that may lead to hospitalisation (excluding cancer: see above) will be covered within the first six (6) months of membership. The insurer reserves the right to request any clinical information from a Policyholder's doctor should a claim in this period indicate, and/or relate to, a pre-existing condition. **All claims for these conditions received within the waiting period will be reviewed by medical management to identify pre-existing conditions.**

auto general

Underwritten by:
Auto & General Insurance Company Limited, an Authorised Insurer & Financial Services Provider. Reg No 1973/016880/06