Gap Cover Q & A

TOTALRISKADMINISTRATORS

HOW DO I SUBMIT CLAIMS MANUALLY?

- Policy holders need to forward their **medical aid statement** showing proof of processing of the hospital account, account/s from the service provider/s as well as copies of the related accounts. These claim documents can be emailed to **claims@totalrisksa.co.za** or you can submit these online via our website **www.totalrisksa.co.za**. Alternatively you can contact TRA on **011 372 1540** and ask for assistance from one of our highly qualified and friendly claims specialists.
- Certain Medical Aid Schemes may assist by providing this data electronically, and the process then becomes seamless for the policyholder.

DOES GAP COVER PAY FOR MEDICAL SHORTFALLS WHEN POLICYHOLDERS ARE TREATED OUT OF HOSPITAL?

- No. You have to be admitted into hospital for TRA to cover any medical shortfalls. We only cover service providers that treat you whilst hospitalised and where their related charges exceed medical aid tariff/s. The only exceptions are casualty and MRI/CT scan charges above tariff on the ABSOLUTEcover PLUS option.

PRESCRIBED MINIMUM BENEFIT ("PMB") CONDITIONS?

In terms of the Medical Aid Schemes Act of 1998 (Act number 131 of 1998) and its regulations, all medical schemes have to cover the costs related to diagnosis, treatments and care of:

- any life-threatening emergency medical condition
- a defined set of 270 diagnoses and
- 27 chronic conditions

These conditions and their treatments are known as the Prescribed Minimum Benefits (PMB's). All medical schemes in South Africa have to include PMB's in their health plans they offer to their members. There are, however, certain requirements that a member must meet before he or she can benefit from the PMB's, as follows:

1. The condition must be part of the list of defined PMB conditions
2. The treatment needed must match the treatments in the defined benefits on the PMB list
3. Members must use the scheme's designated healthcare service providers.

WHAT IS A CO-PAYMENT?

- A medical aid co-payment is a fee that the member is liable for when making use of certain medical services. The medical aid would not cover 100% of the costs and the member would have to pay for a certain percentage of the medical service before the medical aid pays their portion. These co-payments usually apply to a specialist or elective medical procedures.

WHAT IS A SUB LIMIT?

- Most medical aid schemes impose "sub limits" on certain in hospital procedures. There may be a sub limit imposed on internal prosthesis e.g. pins and plates as part of a back operation or heart stents.

IS THERE A TIME LIMIT AS TO WHEN CLAIMS CAN BE SUBMITTED?

- Valid claims must be submitted and received by TRA within 3 months from the date of processing of such claim/s by the policyholder's medical aid scheme.

HOW LONG DO YOU TAKE TO REFUND THE GAP COVER PORTION?

- Valid and approved claims are processed and paid every Saturday.

DOES TRA PAY THE DOCTOR'S DIRECTLY?

- With the proposed amended legislation, TRA will be able to pay the doctors directly. This will only be implemented once the new regulations become law. In the interim, claims will be refunded into the policyholder's nominated bank account for them to then settle the outstanding amount directly with the doctor.

DESIGNATED SERVICE PROVIDERS (DSP'S)

- Designated Service Providers (DSP's) and Network Providers are specified groups of providers contracted to the scheme to render specified services at an agreed rate.

WHERE CAN I UPDATE MY PERSONAL DETAILS?

- You can e-mail us at **membership@totalrisksa.co.za**

Complaints Policy

TOTALRISKADMINISTRATORS

COMPLAINT HAS TO BE IN WRITING

In order for a complaint to receive the attention that it deserves, we request that your complaint is submitted to us in writing to **complaints@totalrisksa.co.za**. Alternatively, please ensure that where the complaint is delivered by hand or by any other means, that you retain proof of delivery.

COMPLAINT HAS TO BE RELEVANT

The financial services environment is complex. We will endeavour to address all reasonable requests from our clients, but may also refer you to a more appropriate facility. Where the complaint pertains to any aspect of our service, or any disclosures that ought to be made by us, we will endeavour to address those complaints in writing, within 5 working days.

In instances where the complaint pertains to something not within our control, such as product information or investment performance, we will forward the complaint to the product provider concerned.

PROCEDURES

The following is a step-by-step guideline of how a complaint will be dealt with, once received by us:

1. The complaint will be lodged in our central complaints register on the same day that it is made and confirmation of receipt forwarded to you.
2. The complaint is immediately brought to the attention of the Key Individual of this provider for allocation to a trained and skilled person who specialises in that type of complaint.
3. The complaint will be investigated and we will revert to you with our findings within 5 working days.
4. In the event that you are not satisfied with our solution, you may refer the complaint to the Chief Executive Officer (CEO) of our business. The CEO may amend the solution or confirm it. Please be informed that certain decisions may have to be approved by the Board or Management Committee of the organisation. In such a case, we will communicate that fact to you, as well as the date on which a decision will be taken.
5. If, after having referred the complaint to the CEO, you are still not satisfied with the outcome, we will regard the complaint as being unsatisfactorily resolved. In such a case, you may approach the Office of the Ombud for Financial Services Providers or take such other steps as may be advised by your legal representatives. The referral to the Office of the Ombud must be done in accordance with the provisions of section 21 of the FAIS Act and the rules promulgated in terms of that section. In instances where we have not been able to arrive at a resolution within six weeks after you have lodged your complaint, the matter may automatically be referred to the Ombud.
6. You must, if you wish to refer a matter to the Ombud, do so within a period of six months. The Ombud will not adjudicate in matters exceeding a value of R800 000.00.
7. The Ombud may be contacted at his offices in Pretoria, at the following address:

FAIS Ombud
PO BOX 74571
Lynwood Ridge
0040

Tel: 012 470 9080
Fax: 012 348 3447

www.faisombud.co.za