TRA GAP COVER PRODUCT RANGE 2019

THE FOLLOWING BENEFITS ARE SUBJECT TO AN AGGREGATE ANNUAL LIMIT OF R158 000 PER INSURED PERSON

(This limit may be subject to regulatory amendment) (Sub-limits may apply)

NB: Please note that if you are still on a 'Non-Plus' product option which is closed to new business i.e. Super Cover or Absolute Cover (different to Super Cover Plus and Absolute Cover Plus as per the table below), you will not be covered for PMB's i.e. Prescribed Minimum Benefits as explained in the table below.

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	Covered	Covered	Covered
CASUALTY UNIT BENEFIT: • Costs related to the treatment received while in a hospital casualty unit. • The treatment is immediately required, is of an external nature or came about due to an external force and / or impact with something or someone. • Your medical aid has processed this account and paid their share of the claim, even if this amount is zero.	Up to R2 750 per policy per annum	Up to R5 000 per policy per annum	Up to R7 500 per policy per annum	Up to R15 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. • 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 R158 000 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 maximum of R14 000
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 this is directly related to an authorised hospitalisation event.	No Benefit	Up to R5 000 per policy per annum	Up to R10 000 per policy per annum	Unlimited but subject to R158 000 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 and/or PET scans imposed by your medical aid and this is directly related to an authorised hospitalisation event.	No Benefit	No Benefit	No Benefit	2 MRI / CT / PET scans per policy per annum up to R4 000 per scan

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).	Up to an aggregate of R158 000 per insured person per annum	Up to an aggregate of R158 000 per insured person per annum	Up to an aggregate of R158 000 per insured person per annum	Up to an aggregate of R158 000 per insured person per annum
ONCOLOGY CO-PAYMENT BENEFIT • 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, OR • 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.	None	Up to R10 000 per policy per annum	Up to R50 000 per policy per annum	Unlimited but subject to R158 000 per insured person per annum
ONCOLOGY EXTENDER BENEFIT (Includes ANY approved costs above annual scheme oncology limit but subject to scheme covering up to this limit)	None	None	None	Unlimited but subject to R158 000 per insured person per annum

THE FOLLOWING BENEFITS ARE NOT SUBJECT TO AN AGGREGATE ANNUAL LIMIT OF R158 000 PER INSURED PERSON (Sub-limits may apply)

PRODUCT	BASIC COVER 300	VITAL COVER PLUS	SUPER COVER PLUS	ABSOLUTE COVER PLUS
ACCIDENTAL DEATH COVER Insured / Spouse Dependant	R3 000 R1 500	R4 000 R2 000	R6 000 R3 000	R8 000 R4 000
POLICY EXTENDER The full gap cover premium is covered in the case of the death of the main policyholder.	6 months	6 months	6 months	6 months
TRA ASSIST (powered by ER24 Assist)				
Home Drive designated driver service (now includes a Taxi Service).	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 Line – Unlimited access to qualified nurses 24 hours a day for telephonic emergency medical advice, assessment of symptoms, explanation of medical terms, etc.	Included	Included	Included	Included
Submit Claim - Submit your claims documents via the mobile app.	Included	Included	Included	Included

MONTHLY PREMIUMS PAYABLE IN ADVANCE

PRODUCT	BASIC COVER 300	VITAL COVER PLUS	SUPER COVER PLUS	ABSOLUTE COVER PLUS
Under 65's (Age of main insured) premium per policy per month		R180	R227	R390
Over 65's (Age of main insured) premium per policy per month	R300	R270	R340	R470
Premium per Individual per policy per month	R 99			
Premium per Family per policy per month	R150			

GAP COVER: The Important Information

All of our 2019 Gap Cover Policies:

- Provide benefits for members and their dependants (spouse and/ or child/children **ONLY**) who are covered on one policy of a registered medical aid scheme. Members and their dependants can only be on two different medical aids and one Gap Cover Policy 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 (PMBs) where a medical aid has failed to meet its obligations in this regard (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 scheme membership.**
- Are subject to the aggregate gap cover annual limit of R158 000 per insured person per annum. (This limit may change due to regulatory amendment).
- All of our 2019 product options offer the following TRA ASSIST (powered by ER24 ASSIST) benefits:
  - Home Drive (now includes a taxi service)
  - Panic Button
  - Medical Health Line
- **NB:** Refer to the policy document for the complete list of terms and conditions.

WHEN CAN YOU CLAIM?

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
- Oesophagitis, Gastroenteritis and Gastro-Intestinal Disorders
- Pregnancy and childbirth (including caesarean delivery)
- Gynaecological conditions e.g. Hysterectomy
- Male genital system (including prostatectomy / robotic prostatectomy)
- All robotic type surgery
- Joint replacement (including Arthroplasty, Arthroscopy, Metatarsal Osteotomy) but excluding treatment due to accidental trauma.
- Inability to walk / move without pain
- Any Ear, Nose and Throat procedures (including nasal, sinus, tonsil and adenoid procedures)
- Cardiac (relating to the heart)
- Dentistry (unless due to accidental trauma)
- Cataracts and / or eye laser surgery (including all eye and lens procedures)
- Neurological conditions and procedures (including stimulators)
- Organ transplants (including cochlear implants)
- Renal Failure
- 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
- 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
car | home | business | life insurance

Underwritten by:
Auto & General Insurance Company Limited
Registration No 1973/016880/06 - FSP No 16354