TRA

TOTALRISKADMINISTRATORS

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

2021

GAP COVER

In-Hospital Medical Shortfall Cover

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CONTACT US

Physical Address: 16 Jersey Drive, Longmeadow Business Estate East, Longmeadow, Edenvale, 1609

Postal Address: P.O. Box 8012, Greenstone, 1616

T: 011 372 1540 **F:** 011 372 1579
E: info@totalrisksa.co.za
W: www.totalrisksa.co.za

General Queries:
info@totalrisksa.co.za

Claims:
claims@totalrisksa.co.za

New Applications/Updates:
membership@totalrisksa.co.za

Brokers/Commissions:
brokerqueries@totalrisksa.co.za

GAP COVER

Like most people, you have a medical aid to give you peace of mind that if you need medical care for any reason – be it through accident or illness – your bills will be taken care of. After all, who needs to add financial worry to the stress of being hospitalised?

And... like most people, you probably assume that if you have a medical aid, then you're 100% covered. Unfortunately, this is not always true – which is why you need gap cover to ensure that you don't receive a huge bill if there's a shortfall between what the doctors charge and what your medical aid will pay for in-hospital procedures.

All of our 2021 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.**
- Are subject to the aggregate gap cover annual limit of R171 000 per insured person per annum. (This limit may change due to regulatory amendment).
- All of our 2021 product options offer the following TRA ASSIST (powered by ituASSIST) benefits:
  - Home Drive (including Uber services)
  - Panic Button
  - Medical Health and Trauma Counselling Line. Now includes a COVID-19 CARE LINE
- **NB: Refer to the policy document for the complete list of terms and conditions.**

CORPORATE / GROUP BUSINESS

We welcome the opportunity to quote on any corporate or group business and we are able to offer tailored and discounted products based on size and demographics. Intermediaries/brokers should contact us directly to discuss these opportunities.

Our Gap Cover product range is underwritten by Auto & General Insurance Company Limited

auto general

Auto & General Insurance Company Limited, an Authorised Insurer & Financial Services Provider - Reg No 1973/016880/06

DEFINITION OF BENEFITS

THE FOLLOWING BENEFITS ARE SUBJECT TO THE AGGREGATE ANNUAL LIMIT OF R171 000 PER INSURED PERSON

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

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.

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.

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.

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..

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.

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.

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.

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.

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.

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).

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).

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..

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.

ONCOLOGY EXTENDER BENEFIT:
Includes ANY approved costs above annual scheme oncology limit but subject to the medical aid scheme covering up to this limit.

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).

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.

COVID-19 ISOLATION HOTEL BENEFIT:
The **shortfall** that arises due to an admission into a Covid-19 Isolation Hotel, based on testing positive for Covid-19.

THE FOLLOWING BENEFITS ARE NOT SUBJECT TO THE AGGREGATE ANNUAL LIMIT OF R171 000 PER INSURED PERSON (This limit may be subject to regulatory amendment) (Sub-limits may apply)

ACCIDENTAL DEATH BENEFIT
This benefit will provide an amount in the event of death of the insured and/or spouse, and in the event of the death of the dependant, caused by violent, accidental, external, or visible means.

POLICY EXTENDER
The full gap cover premium is covered for 9 months in the case of the **accidental** death of the main policyholder.

TRA ASSIST (powered by ituASSIST)
Home Drive (includes Own Vehicle" OR "Uber" services), Panic Button, Medical Health and Trauma Counselling Line (now includes a COVID-19 CARE LINE), Submit Claim - Access via TRA mobile app.

BASICCOVER300 our entry level product

Please see **DESCRIPTION OF BENEFITS** on page 3

- **Gap Cover**
  300%
- **Policy Extender**
  9 months
- **Prescribed Minimum Benefits**
  Covered, subject to medical aid review
- **TRA Assist**
  (powered by ituASSIST)
- **Casualty**
  Up to R2 750 PER POLICY PER ANNUM
- **Oncology Gap**
  Up to an aggregate of R171 000
  PER INSURED PERSON PER ANNUM
- **Accidental Death**
  Insured / Spouse: R5 000
  Dependants: R2 500

Premium per policy per month

Individuals	Families	Over 65's*
R99 p/m	R165 p/m	R330 p/m

*age of oldest beneficiary - for individuals and/or families

GAP COVER EXAMPLE:
HIATUS HERNIA REPAIR

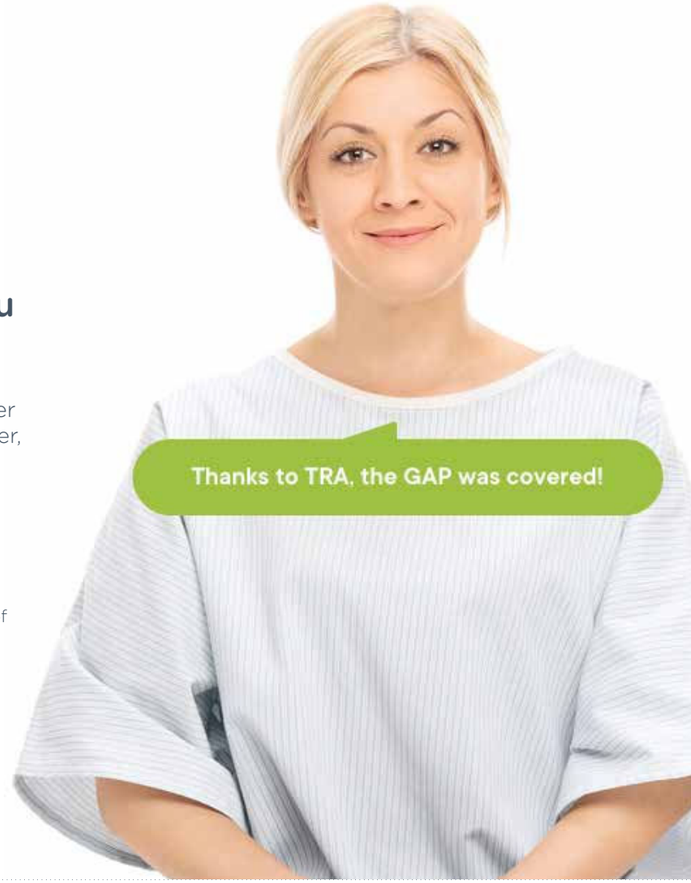
Michelle saved R 9631.54. By choosing Basic Cover 300, you can too.

Your medical aid, just like Michelle's, may not cover 100% of the private rate of the medical practitioner, resulting in a shortfall payment due from you.

Eliminate the financial worry from the stress of a hospital operation or stay.

***Annual Limit:** The Basic Gap, Casualty and Oncology Gap benefits are subject to the aggregate gap cover annual limit of R171 000 per insured person per annum.

(This limit may change due to regulatory amendment)



Attending Doctor	Private Rate	Medical Aid Tariff	Gap Cover	Your Share
Surgeon	R 12 289.47	R 8 293.02	R 3 996.45	R 0
Specialist Anesthesiologist	R 9 403.37	R 3 768.28	R 5 635.09	R 0
	R 21 692.84	**R 12 061.30**	**R 9 631.54**	**R 0**

VITALCOVERPLUS

our second entry level product

Please see **DESCRIPTION OF BENEFITS** on page 3

- **Gap Cover**
  700%
- **Accidental Death**
  Insured / Spouse: R7 500
  Dependants: R3 750
- **Prescribed Minimum Benefits:**
  Covered, subject to medical aid review
- **Policy Extender**
  9 months
- **Casualty**
  Up to R7 500 PER POLICY PER ANNUM
- **TRA Assist**
  (powered by ituASSIST)
- **Co-Payment**
  In Network only - up to R10 000
  PER POLICY PER ANNUM
- **Sub-Limit**
  Internal prosthesis only
  - up to R5 000 PER POLICY PER ANNUM
- **Oncology Gap**
  Up to an aggregate of R171 000
  PER INSURED PERSON PER ANNUM
- **Oncology Co-Payment**
  Up to R10 000 PER POLICY PER ANNUM
- **Covid-19 Isolation Hotel**
  Up to R300 per day for a maximum of 10 days

Premium per policy per month

Individuals	Families	Over 65's*
R235 p/m	R235 p/m	R350 p/m

*age of oldest beneficiary - for individuals and/or families

GAP COVER EXAMPLE:
SPINAL SURGERY

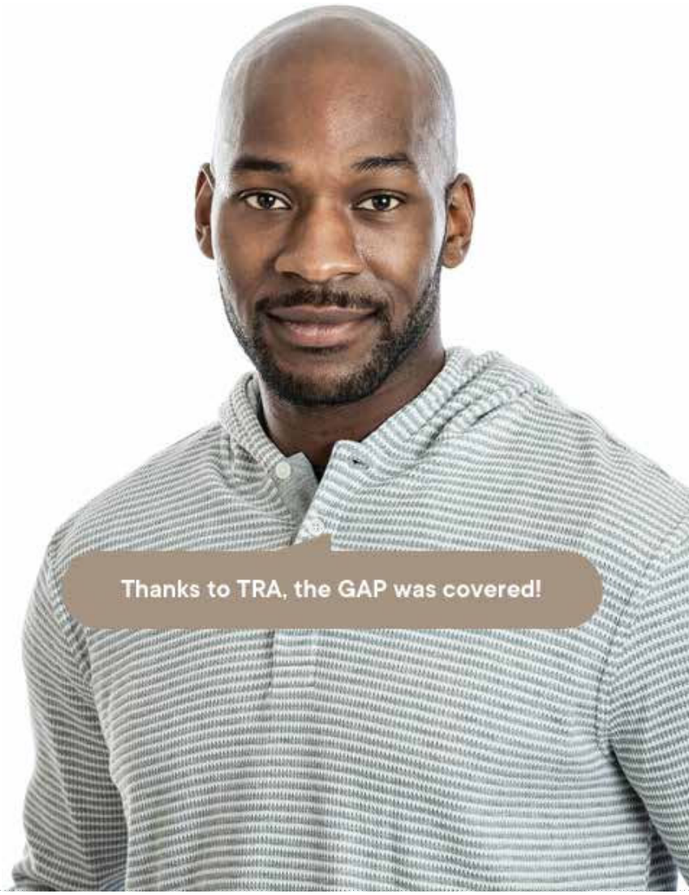
Ezra saved R 80 536.51. By choosing Vital Cover Plus, you can too.

Your medical aid, just like Ezra's, may not cover 100% of the private rate of the medical practitioner, resulting in a shortfall payment due from you.

Eliminate the financial worry from the stress of a hospital operation or stay.

***Annual Limit:** The Basic Gap, Casualty and Oncology Gap benefits are subject to the aggregate gap cover annual limit of R171 000 per insured person per annum.

(This limit may change due to regulatory amendment)



Attending Doctor	Private Rate	Medical Aid Tariff	Gap Cover	Your Share
Surgeon	R 143 385.17	R 92 712.79	R 50 672.38	R 0
Specialist Anesthesiologist	R45 067.77	R 15 203.64	R 29 864.13	R 0
	R 188 452.94	**R 107 916.43**	**R 80 536.51**	**R 0**

SUPERCOVER**PLUS** our mid-range gap cover product

Please see **DESCRIPTION OF BENEFITS** on page 3

Gap Cover
700%

Prescribed Minimum Benefits
Covered, subject to medical aid review

Casualty
Up to R10 000 PER POLICY PER ANNUM

Co-Payment
In Network: Up to R50 000 PER POLICY PER ANNUM
Out of Hospital MRI/CT/PET scans: 1 MRI / CT / PET scan PER POLICY PER ANNUM up to R10 000

Sub-Limit
Internal prosthesis: Up to R10 000 PER POLICY PER ANNUM
MRI / CT / PET Scans: 1 MRI / CT / PET scan PER POLICY PER ANNUM. Up to R3 000
Colonoscopies + Gastroscopies: Up to R12 000 PER POLICY PER ANNUM up to R3 000 per event

Global Fee Benefit
Up to R6 000 PER POLICY PER ANNUM

Oncology Gap
Up to an aggregate of R171 000
PER INSURED PERSON PER ANNUM

Oncology Co-Payment
Up to R50 000 PER POLICY PER ANNUM

Oncology Extender
Up to R30 000 PER POLICY PER ANNUM

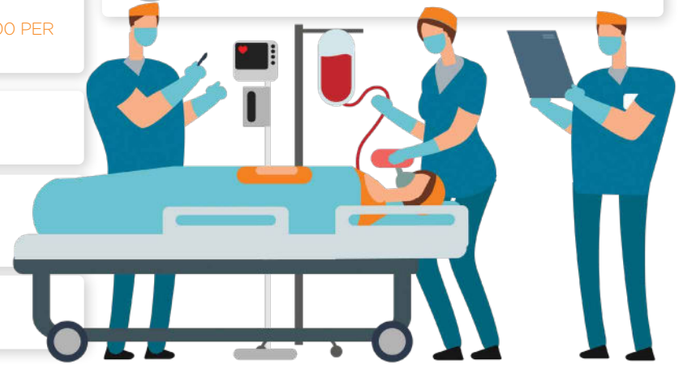
Oncology
Breast Reconstruction Surgery Up to R10 000 PER POLICY PER ANNUM

Covid-19 Isolation Hotel
Up to R600 per day for a maximum of 10 days

Accidental Death
Insured / Spouse: R10 000
Dependants: R5 000

Policy Extender
9 months

TRA Assist
(powered by ituASSIST)



Premium per policy per month

Individuals	Families	Over 65's*
R265 p/m	R265 p/m	R380 p/m

*age of oldest beneficiary - for individuals and/or families

GAP COVER EXAMPLE:
CERVICAL DISORDER

Sashnee saved R 94 757.28. By choosing Super Cover Plus, you can too.

Your medical aid, just like Sashnee's, may impose a co-payment on Endoscopic or Laporoscopic Procedures, Hysterectomies as well as Colonoscopies.

Eliminate the financial worry from the stress of a hospital operation or stay.

***Annual Limit:** The Basic Gap, Casualty, Co-Payment, Sub-Limit and Oncology Gap and Co-payment benefits are subject to the aggregate gap cover annual limit of R171 000 per insured person per annum.

(This limit may change due to regulatory amendment)

Attending Doctor	Private Rate	Medical Aid Tariff	Gap Cover	Your Share
Surgeon	R 125 525.56	R 41 841.40	R 83 684.16	R 0
Specialist Anesthesiologist	R 13 434.30	R 5 861.18	R 7 573.12	R 0
	R 138 959.86	**R 47 702.58**	**R 91 257.28**	**R 0**

Medical Aid imposed co-payment (R 3 500.00)	R 3 500.00	R 0
TOTAL	**R 94 757.28**	**R 0**

ABSOLUTECOVERPLUS

our flagship gap cover product

Please see DESCRIPTION OF BENEFITS on page 3

Gap Cover
700%

Prescribed Minimum Benefits
Covered, subject to medical aid review

Casualty
Up to R20 000 (PER POLICY PER ANNUM)

Co-Payment
In Network: Unlimited, subject to R171 000 (PER INSURED PERSON PER ANNUM)
Out of Network: 2 co-payments per policy per annum up to a combined maximum of R15 000
Out of Hospital MRI/CT/PET scans: 2 scans per policy per annum. Unlimited but subject to R171 000 (PER INSURED PERSON PER ANNUM)

Sub-Limit
Internal prosthesis: Unlimited, subject to R171 000 (PER INSURED PERSON PER ANNUM). Up to R30 000 per event
MRI / CT / PET Scans: 2 MRI / CT / PET scans (PER POLICY PER ANNUM) up to R4 000 per scan
Colonoscopies + Gastroscopies: Up to R20 000 (PER INSURED PERSON PER ANNUM). Up to R4 000 per event

Global Fee Benefit
Up to R12 000 (PER POLICY PER ANNUM)

Oncology Gap
Up to an aggregate of R171 000 (PER INSURED PERSON PER ANNUM)

Oncology Co-Payment
In Network: Unlimited but subject to R171 000 (PER INSURED PERSON PER ANNUM)
Out of Network: 2 Co-payments (PER POLICY PER ANNUM) up to a combined limit of R15 000

Oncology Extender
Unlimited, subject to R171 000 (PER INSURED PERSON PER ANNUM)

Oncology
Breast Reconstruction Surgery Up to R20 000 (PER POLICY PER ANNUM)

Maternity Private Ward
Limited to a maximum of R1 000 per day, for a total of 3 consecutive days

Covid-19 Isolation Hotel
Up to R900 per day for a maximum of 10 days

Accidental Death
Insured / Spouse: R15 000
Dependants: R7 500

Policy Extender
9 months

TRA Assist
(powered by ituASSIST)

Premium per policy per month

Individuals	Families	Over 65's*
R480 p/m	R480 p/m	R585 p/m

*age of oldest beneficiary - for individuals and/or families

GAP COVER & PROSTHESES SUB-LIMIT EXAMPLE:
PLACEMENT OF INTERNAL PROSTHESIS

Judy saved R118 735.08. By choosing Absolute Cover Plus, you can too.

Your medical aid, just like Judy's, may impose a sub-limit fee for Hip or Knee Replacements, as well as Pacemaker and Stent Operations.

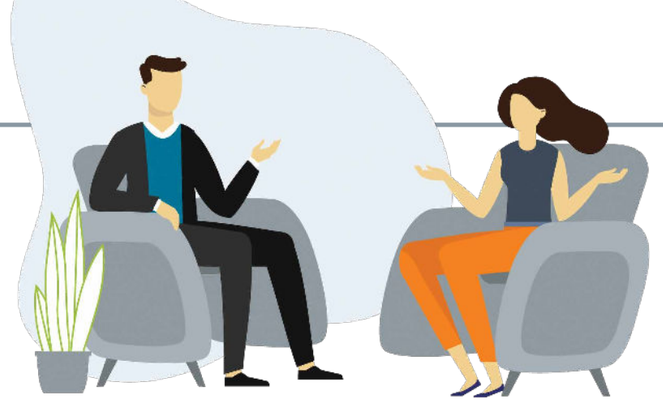
Eliminate the financial worry from the stress of a hospital operation or stay.

***Annual Limit:** The Basic Gap, Casualty, Co-Payment, Sub-Limit and Oncology Gap, Co-payment and Extender benefits are subject to the aggregate gap cover annual limit of R171 000 per insured person per annum.

(This limit may change due to regulatory amendment)

Attending Doctor	Private Rate	Medical Aid Tariff	Gap Cover	Your Share
Surgeon	R 128 554.38	R 41 492.05	R 87 062.33	R 0
Specialist Anesthesiologist	R 29 301.52	R 12 717.99	R 16 583.53	R 0
	R 157 855.90	**R 54 210.04**	**R 103 645.86**	**R 0**

Medical Aid Sub Limit for Internal Prosthesis	R 45 089.22	R 30 000.00	R 15 089.22	R 0
			R 118 735.08	**R 0**



When can you claim?

WAITING PERIODS

There is no general three (3) month waiting period.

If a membership certificate is provided to show proof of a previous membership on another legitimate Gap Cover provider (and this membership is for a period of at least 24 months with no break in cover to the benefit start date of this policy), the below waiting periods i.e. 10 months, 9 months and 6 months which run concurrently, may be waivered.

The following waiting periods are/were applicable from the 'Join Date' until such time as they are completed. The waiting periods all start on the same 'Join Date' as specified in the certificate. Where a claim relates to a condition that is described in more than one waiting period definition, the longer of the two definitions shall apply.

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.

WHEN ARE YOU NOT COVERED UNDER YOUR GAP POLICY?

- WHEN YOU HAVE REACHED THE ANNUAL AGGREGATE LIMIT OF R171 000 PER INSURED PERSON PER ANNUM. (EXCEPT FOR THE ACCIDENTAL DEATH AND POLICY EXTENDER BENEFITS - THIS LIMIT IS SUBJECT TO REGULATORY AMENDMENT).
- WHERE YOU AND YOUR DEPENDANTS DO NOT BELONG TO A MEDICAL AID WHICH IS REGISTERED WITH THE COUNCIL FOR MEDICAL SCHEMES.
- Where you have reached any of your benefit limits according to the maximum benefit insured i.e. the amount insured in respect of a Policyholder, Spouse, Child or Dependant as stated in the Schedule.
- Where your medical aid scheme does not pay their portion of an account first from the Risk or Major Medical benefit. No claims processed from your Scheme's day to day benefit will be covered - except for the Casualty benefit. (Please check your option benefits in the Schedule).
- Where you have not been admitted into hospital - except for the Casualty benefit OR where the treatment has been authorised and paid from your medical aid scheme's In-Hospital or Major Medical benefit.
- Where the dates of a claim are before or after the period you were admitted to hospital.
- Where your hospital charges theatre and ward fees over and above medical aid rates.
- MRI, CT and PET scans where your medical aid does not pay any portion of the account. Dependent on product choice.
- Where the hospital charges for medication that is not part of an authorised procedure or that is taken home when being discharged.
- Where you have been charged a co-payment or deductible by your medical aid because you did not adhere to your medical aid rules OR you chose to see a doctor or hospital that is not on your Scheme's network. This is dependent on product option choice.
- Where the claim is below R100.
- Where your claim is not related to Oncology, but you want to claim from the benefits which fall under the Oncology benefit e.g. Oncology Co- Payments - see the Schedule for your option benefits.
- Where your claim is related to Oncology, but you want to claim from benefits which do not fall under the Oncology Benefit - see the Schedule for your option benefits.
- Where you want to claim twice for one unique medical expense/item from two benefits e.g. claiming a co-payment expense from the co-payment benefit as well as from the gap cover/shortfall benefit.
- NB: WHERE YOU HAVE BEEN CHARGED ANY PENALTY BY YOUR MEDICAL AID E.G. BECAUSE YOU DID NOT ADHERE TO YOUR MEDICAL AID RULES or YOU CHOSE A DOCTOR OR HOSPITAL THAT IS NOT ON YOUR SCHEME'S NETWORK.

CO-PAYMENT COVER (Excludes Oncology Benefit)

- Where you have been charged a co-payment or deductible by your medical aid because you did not adhere to your medical aid rules OR you chose to see a doctor or hospital that is not on your Scheme's network. This is dependent on product choice.
- Where your provider charges a separate fee (split billing) which you need to pay upfront and which cannot be claimed back from your medical aid.
- Where your treatment is related to Oncology, this co-payment does not apply at all. See Oncology Benefit in the Schedule and/or Oncology Benefit hereafter.
- Where the treatment has NOT been authorised and paid from your medical aid scheme's In-Hospital or Major Medical benefit.

SUB-LIMIT COVER (Excludes Oncology Benefit)

- Where your medical aid sub-limit applies to any items besides MRI, CT or PET scans, internal prostheses and colonoscopies and gastroscopies. See the Schedule to see what your product option provides regarding this benefit.
- Where your medical aid sub-limit is used up and your medical aid does not contribute any amount towards this account.
- Where your treatment is related to Oncology, this sub-limit benefit does not apply at all. See Oncology Benefit in the Schedule or Oncology Benefit hereafter.
- Where the treatment has NOT been authorised and paid from your medical aid scheme's In-Hospital or Major Medical benefit.

GLOBAL FEE BENEFIT

- Where the fee is related to a tariff rate, co-payment or sub-limit.

ACCIDENTAL TRAUMA / CASUALTY UNIT BENEFIT (Excludes Oncology Benefit)

- Where the treatment was not caused by a sudden accident, and treated in a casualty unit immediately after this accident, unless the treatment provided was for a child under the age of 8 years old, and the treatment was provided at the times and days as specified in the Option Benefits.
- Where the Casualty Unit is not attached to a hospital.
- Where the hospital charges for medication that is not part of an authorised procedure or that is taken home when being discharged.
- Where your medical aid covers casualty costs as part of a hospital benefit.
- Where your treatment is related to Oncology, this casualty benefit does not apply at all.
- For children under 8 years, where the treatment is not received within the hours of 19h00 to 07h00 from Monday to Friday, from 19h00 on a Friday until 07h00 on a Monday, and all public holidays.

ONCOLOGY BENEFIT

- Where you want to claim for anything not related to Oncology under this benefit.
- Where your claim is related to Oncology treatment and you have reached any of your Oncology limits (see the Schedule), so you want to claim from the benefits which do not fall under the Oncology benefit e.g. Co-Payments.
- Where you have been charged a co-payment or deductible by your medical aid because you did not adhere to your medical aid rules OR you chose to see a doctor or hospital that is not on your Scheme's designated network. This is dependent on product choice.
- Where your provider charges a separate fee (split billing) which you need to pay upfront and which cannot be claimed back from your medical aid.
- Where your medical aid does not authorise treatment and/or biological medication as part of an approved oncology treatment plan.
- Where the Oncology costs are above scheme tariff (for the Oncology Gap Benefit applicable to all options) and the medical aid has not covered up to scheme tariff.
- Where the Oncology costs are above scheme tariff (for the Oncology Gap Benefit), or the Oncology costs are related to Oncology co-payments, and the treatment costs are not within the annual scheme oncology limit.
- Where the Oncology costs are above scheme limit (for the Oncology Extender Benefit) but the scheme has not covered up to this limit. (This is dependent on product choice).

ONCOLOGY GAP BENEFIT: BREAST RECONSTRUCTION SURGERY

- Where the procedure has not been approved by the medical aid (as part of an approved oncology related procedure).
- Where the scheme has not paid up to scheme tariff.
- Where the costs do not fall within the annual scheme limit.
- Where the medical aid has not paid their full portion first, as stipulated in the medical aid plan's annual benefits.
- Where the medical aid will not pay anything towards this surgery first.
- Where the Policyholder has not been diagnosed with medically defined breast cancer ((a MALIGNANT (not benign) growth)), in one or both breasts, by a qualified oncologist or pathologist, and submitted proof of such to TRA at the claims stage.
- Where the date of diagnosis is prior to membership (although this will be reviewed in line with the Cancer Diagnosis Waiting period - see: 'Cancer Diagnosis Waiting Period' in this policy document).
- Where the Policyholder fails to submit all medical and any other reports requested from TRA at the claims stage.
- Where the Policyholder withholds or fails to disclose any relevant information at any point.

- Where the Policyholder wants to do a partial or full mastectomy and then reconstruction on one or both breasts as a merely preventative measure i.e. no cancer is yet present.
- Where the reconstruction is for any cosmetic purposes.
- Where the claims involve or relate to any post-operative care, fixing or repairing anything from the initial first operation, or any follow-up treatments or operations.

MATERNITY PRIVATE WARD BENEFIT

- Where your medical aid has not paid their portion of the related General Ward Rate.
- Where the claim is not related to the shortfall between the General Ward Rate and the Private Ward Rate.
- Where the claim is not related to hospitalisation for childbirth.

COVID-19 ISOLATION HOTEL BENEFIT

- Where you have not been admitted into a designated Covid-19 isolation hotel.
- Where you have not tested positive for Covid-19.
- Where your medical aid has not paid their portion of the Covid-19 isolation hotel Daily Rate.
- Where no designated hotel rooms are available or the isolation hotel facilities are no longer in operation.

POLICY EXTENDER BENEFIT

- Where the benefit is not related to accidental death. All of the terms and conditions related to the Accidental Death Benefit below apply.
- Where the official documents i.e. the death certificate is not provided for.
- Where it is not related to the accidental death of the Principal Policyholder who was paying the premium contributions for the Gap Cover Policy.
- Where the premiums are to be provided for by TRA for a period of longer than 9 months..

ACCIDENTAL DEATH BENEFIT

- Where death does not occur within 12 months of the incident.
- When claims are submitted and received after a period equal to 3 (three) months after the date of death.
- Where death is caused, complicated or attributed to any of the following:
  - AIDS (Acquired Immune Deficiency Syndrome)
  - HIV (Human Immunodeficiency Virus) or any venereal diseases
  - Use or suspected use of drugs or intoxicating liquor
  - Any self-inflicted event, including suicide or attempted suicide
  - Any wrongful or illegal action by the Insured, including active participation in any riotous or such-like behaviour
- Death while:
  - engaged in any form of military or police duties including reservist duties
  - working in any mining or tunnelling operation
  - involved in any form of racing, other than by foot on solid ground
  - mountain climbing where the use of ropes is required, winter sport involving snow or ice, big game hunting, steeple chasing, potholing, surfing, bungee jumping, hang gliding, aerial suspension, sky-diving, parachuting or any other pastime involving similar and exceptional high risk
  - participating in any form of professional sport
  - motorcycling, either as a rider or passenger
  - driver or passenger in any open-top type vehicle (including convertibles, trailers, and open-back vehicles) or fibre glass constructed vehicles; flying, other than as an ordinary passenger in a commercial aircraft licensed to carry passengers
- Non-compliance with Policy terms and obligations or not responding to our request for:
  - Medical examination
  - Release of medical records and information
  - Post-mortem examination or documents relating thereto, including death certificates
  - Identification certificates

PRESCRIBED MINIMUM BENEFIT CONDITIONS (PMB'S)

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 the health plans they offer to their Policyholders. There are, however, certain requirements that a Policyholder must meet before he or she can benefit from the PMB's, as follows:

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

PMB'S are covered, but for non-emergency PMB conditions only. The Medical Schemes Act (131 of 1998) clearly states that a medical scheme must cover all emergency PMB conditions in full / at cost and all non-emergency PMB conditions subject to the medical scheme's approved rules. TRA processes non emergency PMB claims only once valid reasons for the scheme rejecting the above tariff portion of such claim is received by TRA, and the reason for the rejection is aligned to the definitions of PMB's per the Medical Schemes Act (131 of 1998). The PMB claims process, in certain circumstances, will require the Policyholder to liaise with their medical scheme to obtain the necessary information confirming the reasons as to why the scheme is not covering these types of claims in full / at cost. The required information must be submitted to TRA within 90 days from the date of the request or the claim will be rejected as late/stale in terms of the Policy and will not be paid. All other terms and conditions apply.

ELIGIBILITY

- Only the Policyholder, Spouse and dependants who are members on one policy of a registered medical aid scheme may be covered on one TRA Gap Cover policy. (Subject to proof of membership and the premium being based on the age of the oldest beneficiary.)
- Policyholders 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 at least 12 months of cohabitation.
- There is no entry age limit.
- Policyholder dependants may be added or removed from this Policy.
- If new and eligible Dependants are to be added to the Policy (for example: a newborn baby or a new spouse), TRA must be informed within 30 days and provided with written notice of such an addition to the Policy. If TRA is not notified within this time frame, for example, from the date of birth / adoption / adjustment / marriage, and then a claim is made for this 'Dependant' thereafter, this claim will under no circumstances be valid and will not be paid. If the dependant/s are registered after the 30-day period mentioned above, waiting periods and exclusions will apply.

CLAIMS - MANUAL AND AUTOMATIC PROCESSES

IT REMAINS THE POLICYHOLDER'S RESPONSIBILITY TO ENSURE THAT CLAIMS ARE SUBMITTED TO AND ARE RECEIVED BY TRA WITHIN SIX (6) MONTHS FROM THE DATE OF TREATMENT, AS WELL AS ENSURING THAT TRA HAS THE CORRECT BANKING DETAILS INTO WHICH THE CLAIM MUST BE PAID.

CLAIMS - MANUAL PROCESS

Policyholders need to submit the following:

- Claim from the Service Provider.
- First TWO (2) pages of the hospital account showing the admission and discharge dates of the hospital event.
- The Medical Aid statement showing the payment of the Service Provider claim and reason for short payment. Claim documents can be emailed to claims@totalrisksa.co.za, submitted online via our website www.totalrisksa.co.za or submitted via our mobile app, TRA Assist. Alternatively, TRA may be contacted directly on +27 (11) 372 1540. One of our highly qualified and friendly claims specialists will gladly assist.

CLAIMS - AUTOMATIC PROCESS

TRA receives claims submitted by selected medical aid schemes on behalf of the Policyholder. Should your medical aid scheme have such an agreement with TRA, it is not necessary for the Policyholder to submit their claim to TRA. TRA will receive an electronic version of the claim and will process said claim within seven (7) working days of receipt thereof.

CO-PAYMENT AND SUB-LIMIT CLAIMS MUST ALWAYS BE SUBMITTED MANUALLY BY THE POLICYHOLDER. (IN ADDITION TO ALL THE REQUIRED CLAIMS DOCUMENTATION PLEASE ALSO PROVIDE PROOF OF ANY DIRECT PAYMENT/S MADE TO THESE SERVICE PROVIDERS).

SHOULD A CLAIM BE REJECTED FOR ADDITIONAL INFORMATION (E.G. PRE-AUTHORISATION LETTER, MEDICAL AID STATEMENT, DOCTOR'S ACCOUNT OR FIRST 2 PAGES OF THE HOSPITAL ACCOUNT) NOT RECEIVED, ALL THE ADDITIONAL INFORMATION MUST BE SUBMITTED TO TRA WITHIN 30 DAYS FROM THE DATE OF REQUEST OR THE CLAIM WILL BE REJECTED AS LATE/STALE IN TERMS OF THIS POLICY AND WILL NOT BE PAID.

SHOULD A DISCOUNT BE RECEIVED BY A SERVICE PROVIDER AFTER THE GAP CLAIMS PAYMENT IS RECEIVED, PLEASE REFUND THE DISCOUNTED AMOUNT TO TRA. PLEASE CONTACT CLAIMS@TOTALRISKSA.CO.ZA OR CALL (011) 372 1540 TO RECEIVE OUR BANKING DETAILS.

THE CORRECTNESS OF STATEMENTS MADE TO THE INSURER

The Insurer relies on the truth, completeness and correctness of all statements submitted. If the benefits granted, or reinstatement thereof has been obtained through any misrepresentation or concealment, this Policy shall be void and monies paid in respect thereof shall be forfeited.

Should any benefits have been paid out on the basis of the information provided by the Scheme or Insured Person to the Insurer and such information subsequently proves to be incorrect in any material respect, the Insurer shall have the right to take such steps as may be required to put it in the position it would have been in if the correct information had been provided in the first instance.

PREMIUM PAYMENT

All premiums are payable monthly. The period of grace allowed for non-payment of premiums is 30 days after the month in which the premium was due. If the premiums are not paid within the period of grace, the Policy will lapse. If premiums in whole or in part are in arrears, then no claim shall be payable.

Should a backdated termination arise due to non-payment of premiums, any claims paid between the last date of receipt of a premium and the termination date will be reversed and the policyholder will be liable to pay these claims amounts to the Insurer. It is the policyholder's responsibility to monitor that monthly premiums are received by the insurer.

Where payment is to be made to or by the Insurer it shall be made in the currency of the Republic of South Africa.

Where payment is to be made to the Insurer, proof of such payment must be submitted to TRA and the Policy number must be used as a reference. (Phone (011) 372-1540 for details).

AMENDMENT TO BANKING DETAILS

Amendments to personal banking details which relate to debit orders or claim refunds must be received by TRA within 7 working days prior to the action date for such transaction.

LIABILITY OF THE INSURER

The liability of the Insurer, unless otherwise agreed with the Insured, shall be limited to the benefits actually purchased by the premiums received according to the rates in force in respect of benefits agreed on under this Policy at the time of purchase.

TERMINATION OR ALTERATION

Cover shall cease:

1. At 24h00 hours on the last day of cover on which the premium has been paid. If a premium is not paid when due or if a premium debit is dishonoured, unless the Insured can prove to the satisfaction of the Insurer that this was an error by his paying agent.
2. Once the Insured (or his legal representative) has given one (1) month's written notice to terminate this Policy, or once the Insurer has provided at least two (2) month's written notice to the Insured of any such alteration or termination. Upon receipt of this notice, all the benefits will be cancelled forthwith and all subsequent premiums paid will be refunded.
3. Upon the death of the Policyholder, the Policy may be terminated. A new Policyholder who will be responsible for payment of premiums can be nominated or the Policy can be terminated.

Alteration:

4. The Insurer must be advised of any new dependants to be added to the Policy. The Insurer must be supplied with a current medical aid certificate showing the new dependant. If new and eligible Dependants are to be added to the Policy (for example: a newborn or a Spouse), TRA must be informed, in writing, within 30 days of such an addition to the Policy.

   If TRA is not notified within this time frame, for example from the date of birth/adoption/adjustment/marriage, and a claim is submitted for this 'Dependant' thereafter, this claim will under no circumstances be valid and will not be paid.

   If the dependant/s are registered after the 30-day period mentioned above, waiting periods and exclusions will apply.
5. Failure to advise TRA of resignation from a medical aid does not constitute a valid claim for a refund of premiums collected.
6. Cover may be altered by the Insurer upon giving at least one month's written notice of any possible changes to the policy.

This Policy cannot be reinstated, under any circumstances, after Policy termination as described above.

OPTION CHANGES/NEW POLICIES

A Policyholder cannot change product option plans during the year. Policies are only renewable annually within a certain time frame which is stipulated in the year-end communication to the Policyholder. However,

if the Policyholder is for some reason permitted by TRA Management to change product option plans at another time apart from this time frame, and if any amount is claimed for thereafter, OR, if they resign from this current Policy and join under a new plan and Policy number, the first claim made under this Policy may be subject to an excess (the amount of this excess will be stipulated at the time of claiming and is at the discretion of the TRA Management Committee). Upon changing options or joining a new Policy after resigning from current Policy membership, Option Benefit limits as stipulated in the Schedule may be pro-rated.

CONSENT FOR COMMUNICATION

TRA has a duty to keep Policyholders updated about any offers and new products that are made available from time to time. TRA might communicate about these. As a Policyholder who has accepted this policy, you accept this possible communication channel.

TREATING CUSTOMERS FAIRLY

This product has been created to meet the requirements of our clients. We will at all times deliver on customer service and customer expectations by enforcing the principles of Treating Customers Fairly (TCF). The TCF principles ensure we apply fairness to all client experiences relating to new business, policy terms, service and claims processes. The TCF framework has six (6) outcomes which are:

1. You are confident that Your fair treatment is key to our culture.
2. Products and services are designed to meet Your needs.
3. We will communicate clearly, appropriately and on time during the lifespan of Your policy.
4. We provide advice that is suitable to Your needs and circumstances.
5. Our products and services meet Your standards and deliver to expectations.
6. There are no unreasonable barriers to access our services, or to lodge a claim or to lodge any complaints.

JURISDICTION

The Policy shall be subject to the laws of the Republic of South Africa whose courts shall have sole jurisdiction to the exclusion of the courts of any other country.

GENERAL GAP COVER POLICY LIMITATIONS

Notwithstanding all exclusions, including pre-existing conditions and waiting periods applicable to the Policyholder and/or his Medical Aid Scheme or Employer Scheme, TRA shall not be liable for hospitalisation, bodily injury, sickness or disease, directly or indirectly caused by, related to or in the consequence of:

1. War, invasion, act of foreign enemy, hostilities or warlike operations (whether war be declared or not) or civil war.
2. Nuclear weapons or nuclear material or by ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel. For the purpose of this exception combustion shall include any self-sustaining process of nuclear fission.
3. Mutiny, military or usurped power, martial law or state of siege or any other event or cause which determines the proclamation or maintenance of martial law or state of siege. Insurrection, rebellion or revolution.
4. Hospitalised psychiatric care is limited to 14 days per annum.
5. Costs of operations, treatments and procedures for cosmetic purposes.
6. Costs incurred for the treatment of obesity and health holidays.
7. The purchase of bandages, aids, patent foods (including baby foods), contraceptives, slimming preparations as advertised to the public, domestic and bio-chemical remedies.
8. Investigations, treatments, surgery for obesity or its sequelae or cosmetic surgery other than as a result of an insured event otherwise insured.
9. Participation in civil commotion, labour disturbances, riot, strike or the activities of locked out workers.
10. Participation in any form of race or speed test (other than on foot or in non-mechanically propelled watercraft on inland or coastal waters).
11. The cost of any treatment which is recoverable from another party.
12. Expenses incurred by a Policyholder or Dependant in the case of wilfully self-inflicted injuries, professional sport, speed contests and speed trials.
13. Travelling expenses.
14. Cost of infertility or hormone treatment.
15. Cost of artificial insemination.
16. Services rendered by persons not registered with the SA Medical and Dental Council, SA Nursing Council or the Health Professions Council of South Africa.
17. Benefits for the following shall be limited to R200.00 per annum - alcoholism, narcotism, venereal disease, AIDS, breast reduction, augmentation, otoplasty and surgery performed at the same time as cosmetic surgery - for each of the seven (7) prescribed services.
18. In illness of a protracted nature, the committee may nominate a specialist of its choice in consultation with the attending practitioner.
19. Bionic ear implants (cochlear implants).
20. **All** reconstructive surgeries, including but not limited to, breast, jaw, maxillofacial and nasal construction, are limited to R1000.00 per case ((Unless the surgery is the result of oncology treatment (also see Cancer Diagnosis Waiting Period)), or due to an accident which occurred after the 'Join Date' of this policy.
21. Expenses incurred by a Policyholder or Dependants charged by either hospital, nursing home, unattached operating theatres and day-clinics for:
    a. Accommodation (general / private ward); or
    b. Theatre Fees; or
    c. Drugs, medicines and materials; or
    d. Intensive care
    e. Surgical equipment, e.g. scopes.
22. All external appliances, e.g. wheelchairs, crutches, knee/ back braces.
23. Claims for external prosthesis/ses.
24. Benefits for spectacles, lenses and contact lenses.
25. Dental implants and any preparation for dental implants and ANY other related costs, including any aftercare treatment and any co-payments, irrespective of medical aid approval.
26. Any benefits and dental treatment in hospital (unless, it is for children under the age of 18, or was authorised by the medical scheme and is for the treatment of impacted wisdom teeth, extractions, apicectomies or loss of teeth due to oncology or trauma). No other treatments for adults over the age of 18 are covered.
27. Any ex-gratia payment approved by the medical aid scheme. (Including medical aid exceptions).
28. Biological medicine. (except on approved oncology treatment - see benefit).
29. Transportation and harvesting costs for/related to organ transplant/s.
30. Any general transportation costs, including ambulances.
31. Robotic Surgery (except for the shortfall covered if paid as a global fee by the medical aid - covered from the gap cover global fee benefit- see product option benefits on page 3 of this Policy document).

TRA Assist

Powered by ITUASSIST

ASSIST Number: 087 135 1241

TRA has partnered with **ituASSIST** to provide a mobile app which has exciting services available to all GAP COVER policyholders, irrespective of option choice. If a policyholder does not want to or cannot download the app, they can still utilise these services by using the **Assist Number** above.

The app is available to the main policyholder, who can also invite their dependants who are OVER THE AGE OF 18 YEARS OLD. Please note that only the main policyholder will be able to modify the profile details on the app. You should add as much information as possible under your profile, in order to make the most of the services provided to you.

NB: For the app to work to its full potential, leave your cell phone's GPS location service on. **For each of the benefits, once the request has been submitted, a TRA Assist agent will make contact to provide assistance for the service you require**.

Home Drive

OWN VEHICLE

A designated driver service that will ensure that members are safe after a night out, with them being taking home safely in their own vehicle. A pair of drivers will arrive and one will drive with the client as the other follows. Generally, if the client is a female, a female driver will drive with her.

Drivers are equipped with a cell phone application to determine the exact location, as well as the personal information and destination to where the client needs to be transported to. Home Drive will safely transport clients within a 50km radius of city centres in Durban, Johannesburg, Pretoria, Cape Town, Port Elizabeth, East London, George and Nelspruit.

Benefits

- Access to 6 free trips per policy per annum.
- Available to each member and up to a maximum of two of their guests that can be collected from a single pickup point and transported to a single drop-off point.
- In the event where you own a larger vehicle and can seat more than 2 guests, additional passengers will be accommodated for, provided there are seatbelts for all the passengers in your car.

Operating Hours

The service can only be utilised from 18h00 until 03h00. The last available booking time is 01h00 (peak periods) or 02h00 (off peak periods).

Peak Periods & Public Holidays

Please try to book 48 hours in advance where possible and up to no less than 2 hours in advance in case of last minute arrangements. **Peak period times are Thursday evenings to Sunday mornings as well as public holidays (the night before and on the day) and in some instances major public events that occur within the service area, for example sporting events and concerts.**

Additional Charges

If you exceed the number of total covered trips, you may continue to use the service at your own expense (±R450 cash per additional trip). If your trip exceeds 50km, payment for the additional distance will be ±R10 per KM. The user should agree that they will pay these amounts and they need to pay them to the driver on collection or they cannot utilise the service.

Cancellations

Bookings can be cancelled up until 60 minutes before the arranged collection time. Any booking cancelled within 60 minutes of the collection time will be deducted from your total covered trips or billed at the full rate.

UBER SERVICE

- If you do not have your own vehicle that you want driven, an Uber taxi can be dispatched to your location.
- The same GPS settings as with your own vehicle apply.
- NB: The total radius allowed for a single trip is 50kms.
- NB: Trip locations: Only in locations where Uber South Africa is currently available.
- The Uber service falls within the same Home Drive benefits, forming part of the 6 free trips per policy per annum.
- 3 Uber services are available:

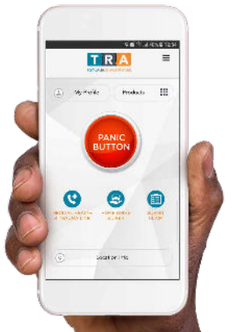
  Uber X - 1 trip deducted per one way request.

  Uber Black - 2 trips deducted per one way request.

  Uber Van - 3 trips deducted per one way request.

  NB: After 6 trips, the user may use the Own Vehicle service at their own expense (see above) or will need to make other arrangements themselves.
- Bookings - should be tried to be made in advance as last minute arrangements are not guaranteed, but you should be able to book a trip more spontaneously than with your **Own Vehicle**.
- The Uber Service can be utilised at any time, seven days a week.

NB: For both services (**Own Vehicle** and **Taxi Service**) which fall under the Home Drive service, the driver/s might leave after 10 - 15 minutes if you are not present for collection and have not communicated with them as to why you may not be ready for collection as arranged.



Panic Button

In any panic situation, you will never want to be alone! The TRA Assist Panic button provides clients with 24-hour access to our own experienced crisis manager – who will assist you through an emergency. TRA Assist is the most reputable emergency support for any client – you will never have to remember another emergency number again. TRA Assist has access to every emergency service you may need, as well as access to your own security company, medical information and other useful contacts. You will never be alone in an emergency!

Our TRA Assist service provides clients with a comprehensive and overall service, ensuring that the family is safe and secure. When you are in an emergency – we take charge! Your crisis manager will call you back on your cell phone and help you through your crisis – whatever that may be.

Medical Health and Trauma Counselling Line

MEDICAL ADVICE LINE

ituASSIST nurses will be available 24 hours a day to provide general medical assistance in confidence. This is an advisory and information service, as a telephonic conversation does not permit an accurate diagnosis. This service is inclusive of referrals to medical practitioners. We create a critical link between you and your medical queries, ensuring that professional guidance from a qualified nurse is just a phone call away.

Benefits

Medical Health Line is a healthcare service providing unlimited access to qualified nurses 24 hours a day. Members benefit from:

- Emergency medical advice.
- Assessment of symptoms and referral to the most appropriate healthcare professional.
- Knowledge on all aspects of healthcare including home care remedies with scheduled follow-up assessment calls, if required.
- Explained medical terms, results of tests and information relating to medication.
- Counselling for chronic ailments and diseases to minimise the impact of these conditions on daily life.

Service

- Supporting the individual after the traumatic experience and facilitating post-traumatic growth.
- Physical well-being, with a focus on diet, exercise and sleep, such as during pregnancy, caring for children and the elderly.
- Medical well-being, with a focus on medical symptoms (headaches, stomach pains, etc.) and their causes, and advice on home care treatment or when to contact a health professional or facility.
- Chronic condition support, helping individuals to understand their condition and the lifestyle changes required to live optimally with their illness.
- Chronic conditions may include, but are not limited to: diabetes, HIV and AIDS, chronic respiratory illness, cancer and coronary heart disease.
- All calls are responded to by a team of accredited, multi-disciplinary and multilingual health and well-being professionals (psychologists, social workers, registered nurses, biokineticists and dieticians).
- 24/7 access to telephonic health and well-being information, advice and self-help tools.

Trauma Counselling

- The promotion of emotional well-being and critical incident support services are an essential component of EMS. ituASSIST has a professional trauma counselling service.
- Our Counsellors are based in and around the Urban hubs of South Africa. The top 5 reasons for calling our team are death, armed robbery, threatened suicide, hijacking, and shooting incidents. The regions with the highest incidence rates include Johannesburg, Cape Town and Durban.

Services Include:

- Telephonic counselling with Nurse Case Management team or Trauma Counsellors.
- Face-to-face trauma counselling with our specialist Trauma Counselling team.
- Critical incident management and emotional support.
- Referral to specialist network of psychologists and psychiatrists if required.

COVID-19 Care Line

As part of the Medical Health and Trauma Counselling Line, you can have access to trained professionals and nurses, who are available to provide medical advice and support regarding COVID-19, as well as support to the individual after the traumatic experience of being tested positive for the novel Coronavirus. This may include psychological telephonic counselling, referral to medical care, hospital care, treatment and diagnostic regimes.

Submit Claim

- Now submitting a claim is easy on the mobile app (this service cannot be supported with just a phone call).
- Simply take pictures on your cell phone of the claims documents required (as stipulated on the app in the submit claim section); and once in 'submit claim' on the app, follow the instructions to upload these pictures from your gallery onto the app and submit. Your documents for your claim are sent directly to our claims department and completing the claim form itself is optional.
- Once submitted, our claims department will get back to you as soon as possible.
- Alternatively, please send claims and follow-up queries to claims@totalrisksa.co.za.

Updating Details

If a TRA main policyholder updates their details i.e. medical aid information, email address etc. on their app profile, these modified details will be sent to our membership department for them to action these relevant updates on our internal administration system, so that TRA has the latest available details for you. Alternatively, please send any updates or corrections to membership@totalrisksa.co.za.

NB: All TRA Assist benefits are subject to the standard ituASSIST terms and conditions. Please see www.totalrisksa.co.za for further information. These services are subject to change from the time of the distribution of this document/wording. Please double check when you utilise the service that you are getting what you may require at the time.
TRA Assist is not a medical aid scheme and the cover is not the same as that of a medical aid scheme. The benefits are not a substitute for medical scheme membership.
The use of this app does not imply or represent a commitment, in any way, to cover any costs associated with medical (or any other) claims arising from the use of this app/service.

THE **LEGAL & COMPLIANCE** SIDE

Protection of Personal Information Policy

TRA collects, stores and uses the personal information provided by an individual. Personal information is collected only when an individual knowingly and voluntarily submits information. Personal Information may be required to provide an individual with further services or to answer any requests or enquiries relating to this service.

It is TRA's intention that this policy will protect an individual's personal information from being prejudiced in any way and this policy is consistent with the privacy laws applicable in South Africa. TRA will not, without an individual's consent, share information with any other third parties, for any purposes whatsoever.

TRA will not reveal any personal information to anyone unless:

- It is compelled to comply with legal and regulatory requirements or when it is otherwise allowed by law.
- It is in the public interest.
- TRA needs to do so to protect their rights.

Any questions relating to TRA's privacy policy or the treatment of an individual's personal data may be addressed to **info@totalrisksa.co.za.**

Treating Customers Fairly (TCF) Policy

TRA's overriding business culture and ethos is that our "customers" – being our policyholders and intermediary network – come first.

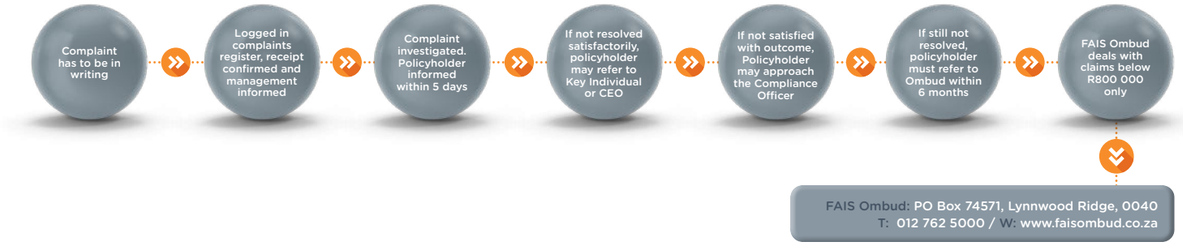
This product has been created to meet the requirements of our clients. We will at all times deliver on customer service and customer expectations by enforcing the principles of Treating Customers Fairly (TCF). The TCF principles ensure we apply fairness to all client experiences relating to new business, policy terms, service and claims processes.

The TCF framework has 6 outcomes which are:

1. You are confident that Your fair treatment is key to our culture.
2. Products and services are designed to meet Your needs.
3. We will communicate clearly, appropriately and on time during the lifespan of Your policy.
4. We provide advice that is suitable to Your needs and circumstances.
5. Our products and services meet Your standards and deliver to expectations.
6. There are no unreasonable barriers to access our services, or to lodge a claim or to lodge any complaints.

Complaints Policy

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. **The following procedure will be followed:**



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

16 Jersey Drive, Longmeadow Business Estate East, Longmeadow, Edenvale, 1609

PO Box 8012, Greenstone, 1616

T: 011 372 1540 I **F:** 011 372 1579

W: www.totalrisksa.co.za