TOTALRISKADMINISTRATORS

www.totalrisksa.co.za

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

DON'T STRESS!

THE GAP IS COVERED.

GAP COVER

In-Hospital Medical Shortfall Cover

BASIC COVER 300

VITAL COVER PLUS

SUPER COVER PLUS

ABSOLUTE COVER PLUS

2019

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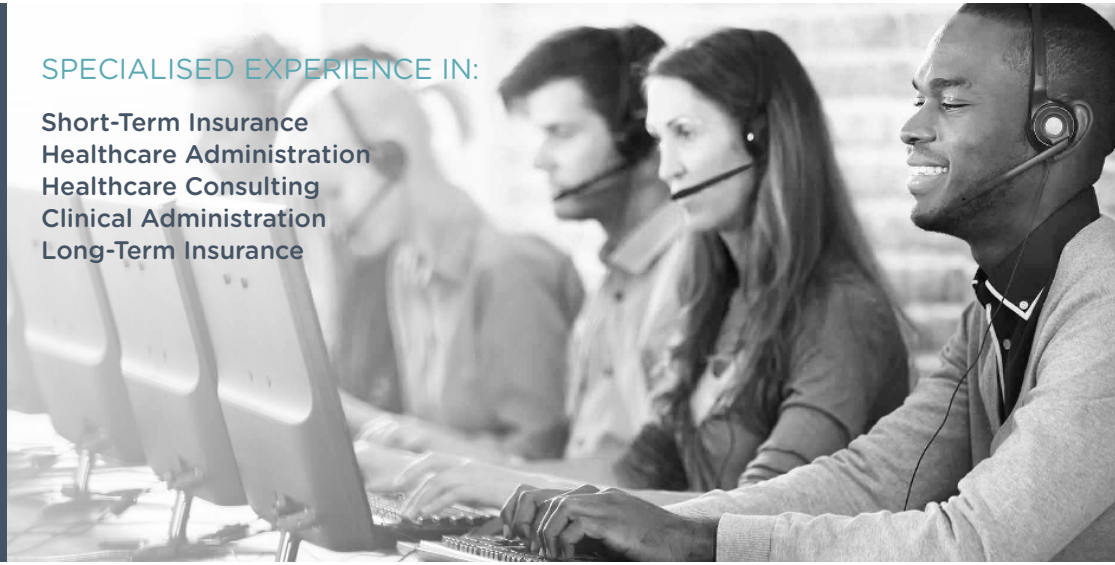
OUR WEBSITE

- Extensive content about each of our products
- Information about us and our clients
- An online application and claims process
- TRA Assist
- A broker contact process
- An admin query callback request form
- FAQ page
- TRA TV - product videos
- News articles
- A gallery
- Contact details
- Compliance forms
- Access to our social media pages:

OUR TEAM

TRA has specialist staff with years of insurance, clinical and healthcare administration experience, so there's really no need to stress! This GAP is indeed Covered.



SPECIALISED EXPERIENCE IN:

Short-Term Insurance
Healthcare Administration
Healthcare Consulting
Clinical Administration
Long-Term Insurance

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

auto general
car | home | business | life insurance

Auto & General Insurance Company Limited - Registration No 1973/016880/06 I FSP No 16354

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 hospital 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 2019 Gap Cover Policies:

- Provide benefits for members and their dependants (spouse and/or child/children) 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.
- 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
  - Panic Button
  - Medical Health Line

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.

*All products are subject to an aggregate annual limit of R158 000 per insured person per annum (This limit may be subject to regulatory amendment).

WHICH PRODUCT SHOULD I CHOOSE FOR HOSPITALISATION AND PMB'S ?

- I am on a registered medical aid and I want to be sure that if service providers charge above scheme tariff for authorised in-hospital procedures, including for Prescribed Minimum Benefits, then this shortfall will be covered up to the maximum percentage, regardless of the number of times per year this cover is needed. *SEE PRESCRIBED MINIMUM BENEFITSS AND GAP COVER CLAIM DEFINITIONS.

- I am on a registered medical aid and the option I'm on requires a member co-payment for certain procedures performed in-hospital. I want cover for this co-payment and WILL USE my medical aid's designated service provider network.*SEE CO-PAYMENT CLAIM & IN NETWORK DEFINITIONS.

- I am on a registered medical aid and the option I'm on requires a member co-payment for certain procedures performed in-hospital. I want cover for this co-payment and WILL NOT USE my medical aid's designated service provider network.*SEE CO-PAYMENT CLAIM & OUT OF NETWORK DEFINITIONS.

- I am on a registered medical aid and the option I'm on has sub-limits for internal prostheses costs as part of the hospitalisation benefit. I want additional cover should this specific limit be reached. *SEE SUB-LIMIT CLAIM DEFINITION.

- I am on a registered medical aid and the option I'm on has sub-limits for MRI/CT/PET scans as part of the hospitalisation benefit. I want additional cover should this specific limit be reached. *SEE SUB-LIMIT CLAIM DEFINITION.

WHICH PRODUCT SHOULD I CHOOSE FOR ONCOLOGY?

- I am on a registered medical aid and I want to be sure that if service providers charge above scheme tariff for approved oncology treatment, including for Prescribed Minimum Benefits, then this shortfall will be covered up to the maximum percentage, regardless of the number of times per year this cover is needed. *SEE ONCOLOGY GAP COVER BENEFIT DEFINITION.

- I am on a registered medical aid and the option I'm on requires a member co-payment for certain oncology procedures performed in-hospital. I want cover for this co-payment and will use my medical aid's designated service provider network.*SEE ONCOLOGY CO-PAYMENT BENEFIT DEFINITION.

- I am on a registered medical aid and I want to know that charges above an annual scheme limit on oncology treatment will be fully covered SUBJECT TO THE AGGREGATE LIMIT OF R158 000 PER INSURED PERSON PER ANNUM. *SEE ONCOLOGY EXTENDER BENEFIT DEFINITION.

DEFINITIONS

PRESCRIBED MINIMUM BENEFTS (PMB's):
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 (see below); a limited set of 270 medical conditions; and 27 chronic conditions.

EMERGENCY MEDICAL CONDITION:
An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or an operation. If the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death.

GAP COVER CLAIM:
A claim for 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.

CO-PAYMENT CLAIM:
- A claim for the co-payment or deductible charged by your medical aid 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

SUB-LIMIT CLAIM:
A claim for the shortfall on a service provider account that is not covered because you have reached a sub limit imposed by your medical aid and this is directly related to an authorised hospitalisation event.

IN NETWORK:
Use of your medical aid's designated provider network for hospitalisation. This normally results in the member not paying anything out of their own pocket..

OUT OF NETWORK:
The voluntary use of providers that are NOT part of your medical aid's designated provider network for hospitalisation. This may result in the member having to pay additional amounts out of their own pockets.

ONCOLOGY:

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
- 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 scheme covering up to this limit.

Premium per policy per month

- Individuals = R99
- Families = R150
- Over 65+ years (age of main insured - for individuals and/or families) = R300

BASICCOVER300

Basic Cover 300 is our entry level product which is sufficient in providing for Gap cover, Casualty cover and a separate Oncology Gap cover benefit.

Benefits:

*Annual Limit: The Basic Gap, Casualty and Oncology Gap benefits 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).

Basic Gap*

- The Basic Cover 300 option covers up to 300% above medical aid scheme tariff. This means that if your service provider charges anything up to 3 times what your medical aid will cover, TRA will provide for this gap, subject to the annual limit.*

Casualty*

Sometimes emergencies occur and you need to rush to casualty.

- Your medical aid does not always cover the total costs in full. Whether payment comes from your medical scheme savings account or day-to-day benefit, the gap will be covered.
- Sometimes the medical aid will not account for anything regarding this casualty visit, leaving you to cover the bill in full. This benefit will cover you for up to R2 750 per policy per annum (subject to the annual limit*) EVEN IF YOUR MEDICAL AID COVERS NOTHING.

ONCOLOGY*:

Oncology Gap Benefit: Up to an aggregate of R158 000 per insured person per annum. 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: None**
- **Oncology Extender Benefit: None**

Accidental Death

- Accidents happen! Unfortunately, some severe accidents may even result in death. The situation is made worse if that person was the main breadwinner. Costs can run into the thousands and often funds are tied up to an estate.
- This benefit will provide an amount of R3 000 in the event of death of the insured and / or spouse, and R1 500 in the event of the death of the dependant, caused by violent, accidental, external, or visible means.

Policy Extender

- We often hear of cases where one of our policyholders passes away, leaving their loved ones to pick up the pieces. They are left with the challenge to make sure that the gap cover they were used to is funded for a period of time.
- This benefit will provide for your gap cover premiums for a period of 6 months after the death of the original policyholder.

TRA ASSIST powered by ER24 ASSIST

Benefits: Home Drive, Panic Button, Medical Health Line (see more details on page 17).

***Subject to the aggregate gap cover annual limit of R158 000 per insured person per annum.**

Premium per policy per month

- Individuals and/or families = R180
- Over 65+ years (age of main insured - for individuals and/or families) = R270

VITALCOVERPLUS

Vital Cover Plus is our second entry level product, which is sufficient in providing for Gap cover, Casualty cover, Co-Payment cover, Sub-Limit cover and a separate Oncology benefit that provides Oncology Gap cover and Oncology Co-Payment cover.

Benefits:
*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 R158 000 per insured person per annum. (This limit may change due to regulatory amendment).

Basic Gap*
- The Vital Cover Plus option covers up to 700% above medical aid scheme tariff. This means that if your service provider charges anything up to 7 times what your medical aid will cover, TRA will provide for this gap, subject to the annual limit.*

Casualty*
- Sometimes emergencies occur and you need to rush to casualty.
- Your medical aid does not always cover the total costs in full. Whether payment comes from your medical scheme savings account or day-to-day benefit, the gap will be covered.
- Sometimes the medical aid will not account for anything regarding this casualty visit, leaving you to cover the bill in full. This benefit will cover you for up to R5 000 per policy per annum (subject to the annual limit*) EVEN IF YOUR MEDICAL AID COVERS NOTHING.

Co-Payment*
- These days most medical aid schemes insist that members pay an upfront amount for certain diagnostic and endoscopic procedures like gastroscopies and colonoscopies.
- This amount is known as a co-payment or deductible.
- This benefit will cover you for up to R10 000 per policy per annum (subject to the annual limit*) for co-payment or deductible costs imposed by your medical aid, provided you make use of your medical aid's designated service provider network.
- NO cover is provided where a policyholder voluntarily chooses to make use of a service provider that is not part of their medical aid's service provider network.

Sub-Limit*
- These days most medical aid schemes impose a sub-limit on in-hospital internal prostheses costs. Members may be out of pocket and will have to cover these costs themselves.
- Prosthesis sub-limit: This benefit provides an amount of up to R5 000 per policy per annum, subject to the annual limit*.
- **No other sub-limits are included in this benefit.**

ONCOLOGY*:
Oncology Gap Benefit: Up to an aggregate of R158 000 per insured person per annum. 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: Up to R10 000 per policy per annum
- 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 none 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.

Oncology Extender Benefit: None

Accidental Death
- Accidents happen! Unfortunately, some severe accidents may even result in death. The situation is made worse if that person was the main breadwinner. Costs can run into the thousands and often funds are tied up to an estate.
- This benefit will provide an amount of R4 000 in the event of death of the insured and / or spouse, and
- R2 000 in the event of the death of the dependent, caused by violent, accidental, external, or visible means.

Policy Extender
- We often hear of cases where one of our policyholders passes away, leaving their loved ones to pick up the pieces. They are left with the challenge to make sure that the gap cover they were used to is funded for a period of time.
- This benefit will provide for your gap cover premiums for a period of 6 months after the death of the original policyholder.

TRA ASSIST powered by ER24 ASSIST
Benefits: Home Drive, Panic Button, Medical Health Line (see more details on page 17).

***Subject to the aggregate gap cover annual limit of R158 000 per insured person per annum.**

Premium per policy per month

- Individuals and/or families = R227
- Over 65+ years (age of main insured - for individuals and/or families) = R340

SUPERCOVERPLUS

Super Cover Plus is our mid-range product which provides Gap cover, Casualty cover, Co-Payment cover, Sub-Limit cover and a separate Oncology benefit that provides Oncology Gap cover and Oncology Co-Payment cover.

Benefits:
*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 R158 000 per insured person per annum. (This limit may change due to regulatory amendment).

Basic Gap*
- The Super Cover Plus option covers up to **700%** above medical aid scheme tariff. This means that if your service provider charges anything up to 7 times what your medical aid will cover, TRA will provide for this gap, subject to the annual limit.*

Casualty*
- Sometimes emergencies occur and you need to rush to casualty.
- Your medical aid does not always cover the total costs in full. Whether payment comes from your medical scheme savings account or day-to-day benefit, the gap will be covered.
- Sometimes, your medical aid will not account for anything regarding this casualty visit, leaving you to cover the bill in full.
- This benefit will cover you for up to **R7 500** per policy per annum (subject to the annual limit*) EVEN IF YOUR MEDICAL AID COVERS NOTHING.

Co-Payment*
- These days most medical aid schemes insist that members pay an upfront amount for certain diagnostic and endoscopic procedures like gastroscopies and colonoscopies.
- This amount is known as a co-payment or deductible.
- This benefit will cover you for up to **R50 000** per policy per annum (subject to the annual limit*) for co-payment or deductible costs imposed by your medical aid, provided you make use of your medical aid's designated service provider network.
- NO cover is provided where a policyholder voluntarily chooses to make use of a service provider that is not part of their medical aid's service provider network.

Sub-Limit*
- These days most medical aid schemes impose a sub-limit on in-hospital internal prostheses costs. Members may be out of pocket and will have to cover these costs themselves.
- Prosthesis sub-limit: This benefit provides an amount of up to **R10 000** per policy per annum, subject to the annual limit*.
- **No other sub-limits are included in this benefit.**

ONCOLOGY*:
Oncology Gap Benefit: Up to an aggregate of **R158 000** per insured person per annum. 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: Up to **R50 000** per policy per annum
- 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 none 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.

Oncology Extender Benefit: None

Accidental Death
- Accidents happen! Unfortunately, some severe accidents may even result in death. The situation is made worse if that person was the main breadwinner. Costs can run into the thousands and often funds are tied up to an estate.
- This benefit will provide an amount of **R6 000** in the event of death of the insured and / or spouse, and **R3 000** in the event of the death of the dependant, caused by violent, accidental, external, or visible means.

Policy Extender
- We often hear of cases where one of our policyholders passes away leaving their loved ones to pick up the pieces. They are left with the challenge to make sure that the gap cover they were used to is funded for a period of time.
- This benefit will provide for your gap cover premiums for a period of 6 months after the death of the original policyholder.

TRA ASSIST powered by ER24 ASSIST
Benefits: Home Drive, Panic Button, Medical Health Line (see more details on page 17).

***Subject to the aggregate gap cover annual limit of R158 000 per insured person per annum.**

Premium per policy per month

- Individuals and/or families = R390
- Over 65+ years (age of main insured - for individuals and/ or families) = R470

ABSOLUTECOVERPLUS

Absolute Cover Plus is our flagship product which provides Gap cover, Casualty cover, Co-Payment cover and Sub-Limit cover, as well as a separate Oncology benefit that provides Oncology Gap cover, Oncology Co-Payment cover and Oncology Extender cover.

Benefits:

*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 **R158 000** per insured person per annum. (This limit may change due to regulatory amendment.)

Basic Gap*

- The Absolute Cover Plus option covers up to **700%** above medical aid scheme tariff. This means that if your service provider charges anything up to 7 times what your medical aid will cover, TRA will provide for this gap, subject to the annual limit.*

Casualty*

- Sometimes emergencies occur and you need to rush to casualty.
- Your medical aid does not always cover the total costs in full. Whether payment comes from your medical scheme savings account or day-to-day benefit, the gap will be covered.
- Sometimes, your medical aid will not account for anything regarding this casualty visit, leaving you to cover the bill in full.
- This benefit will cover you for up to **R15 000** per policy per annum (subject to the annual limit*), EVEN IF YOUR MEDICAL AID COVERS NOTHING.

Co-Payment*

- Unlimited per policy per annum but subject to **R158 000** per insured person per annum.
- These days most medical aid schemes insist that members pay an upfront amount for certain diagnostic and endoscopic procedures like gastroscopies and colonoscopies.
- This amount is known as a co-payment or deductible.
- The amount of times and total you can claim from this Co-Payment benefit is Unlimited (subject to the annual limit*), provided you make use of your medical aid's designated service provider network.
- Where a policyholder voluntarily chooses to make use of a service provider that is NOT part of their medical aid's designated service provider network, this benefit will be limited to 2 co-payment or deductible events per policy per annum, to a combined maximum of **R14 000**, subject to the annual limit*.

Sub-Limit*

- These days most medical aid schemes impose a sub-limit on in-hospital prostheses costs and some even limit the monetary amount that is available for MRI and CT and PET scans. In both cases, members may be out of pocket and will have to cover these costs themselves.
- Prosthesis sub-limit: Unlimited but subject to **R158 000** per insured person per annum. Up to **R30 000** per event.
- MRI / CT / PET scans sub-limit: This benefit provides for 2 MRI or CT or PET scans per policy per annum and up to **R4 000** per scan, subject to the annual limit*.
- **No other sub-limits are included in this benefit.**

ONCOLOGY*:

Oncology Gap Benefit: Up to an aggregate of **R158 000** per insured person per annum. 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: Unlimited per policy per annum but subject to **R158 000** per insured person per annum.

- 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 none 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.

Oncology Extender Benefit

Includes ANY approved costs above annual scheme oncology limit but subject to scheme covering up to this limit. **Unlimited per policy per annum but subject to R158 000 per insured person per annum.**

Accidental Death

- Accidents happen! Unfortunately, some severe accidents may even result in death. The situation is made worse if that person was the main breadwinner.
- Costs can run into the thousands and often funds are tied up to an estate.
- This benefit will provide an amount of **R8 000** in the event of death of the insured and / or spouse, and **R4 000** in the event of the death of the dependant, caused by violent, accidental, external, or visible means.

Policy Extender

- We often hear of cases where one of our policyholders passes away leaving their loved ones to pick up the pieces. They are left with the challenge to make sure that the gap cover they were used to is funded for a period of time.
- This benefit will provide for your gap cover premiums for a period of 6 months after the death of the original policyholder.

TRA ASSIST powered by ER24 ASSIST

- Benefits: Home Drive, Panic Button, Medical Health Line (see more details on page 17).

***Subject to the aggregate gap cover annual limit of R158 000 per insured person per annum.**

Gap Cover Examples

TONSILLECTOMY AND ADENOIDECTOMY				
Attending Doctor	Private Rate	Medical Aid Tariff	* Gap Cover	Your Share
Ear, Nose and Throat Surgeon	R 9 142.43	R 2 859.47	R 6 282.96	NIL
Specialist Anaesthesiologist	R 3 362.43	R 1 113.41	R 2 249.02	NIL
TOTAL	**R 12 504.86**	**R 3 972.88**	**R 8 531.98**	**NIL**

*** Cover provided by all 4 Gap products.**

PARTIAL KNEE REPLACEMENT				
Attending Doctor	Private Rate	Medical Aid Tariff	* Gap Cover	Your Share
Orthopaedic Surgeon	R 60 300.45	R 18 710.42	R 41 590.03	NIL
Specialist Anaesthesiologist	R 11 406.41	R 6 950.99	R 4 455.42	NIL
TOTAL	**R 71 706.86**	**R 25 661.41**	**R 46 045.45**	**NIL**

*** Cover provided by all 4 Gap products.**

OBSTETRIC CARE/CHILDBIRTH - C SECTION (PMB EXAMPLE)

Attending Doctor	Private Rate	Medical Aid Tariff	* Gap Cover	Your Share
Gynaecologist	R 24 763.01	R 7 167.65	R 17 595.36	NIL
Specialist Anaesthesiologist	R 18 553.05	R 5 767.14	R 12 785.92	NIL
TOTAL	**R 43 316.06**	**R 12 934.79**	**R 30 381.28**	**NIL**

*** Cover provided by all 4 Gap products.**

VASECTOMY

Attending Doctor	Private Rate	Medical Aid Tariff	* Gap Cover	Your Share
Uorologist	R 2 473.24	R 1 126.63	R 1 346.61	NIL
Specialist Anaesthesiologist	R 14 641.00	R 4 850.48	R 9 790.52	NIL
TOTAL	**R 17 114.24**	**R 5 977.11**	**R 11 137.13**	**NIL**

*** Cover provided by all 4 Gap products.**

PROSTHESES SUB-LIMIT EXAMPLES THAT MAY BE IMPOSED BY YOUR MEDICAL AID

Pacemaker	R49 610
Hip Replacement	R45 980
Stent	R27 830
Knee Replacement	R42 955

*** Cover provided by Absolute Cover Plus only.**

ONCOLOGY EXTENDER

Oncology Treatment	Medical aid Limit	Oncology Extender	Your Share
R264 000	R220 000	R44 000	NIL

*** Cover provided by Absolute Cover Plus only.**

HIATUS HERNIA REPAIR

Attending Doctor	Private Rate	Medical Aid Tariff	* Gap Cover	Your Share
Surgeon	R 11 593.84	R 7 823.60	R 3 770.24	NIL
Specialist Anaesthesiologist	R 8 871.10	R 3 554.98	R 5 316.12	NIL
TOTAL	**R 20 464.94**	**R 11 378.58**	**R 9 086.36**	**NIL**

*** Cover provided by all 4 Gap products.**

CO-PAYMENT EXAMPLES THAT MAY BE IMPOSED BY YOUR MEDICAL AID

Endoscopic Procedures	R 3 025
Hysterectomy	R 7 623
Colonoscopy	R 4 235
Laparoscopic Procedures	R 3 630

*** Cover provided by Super Cover Plus and Absolute Cover Plus only.**

ONCOLOGY GAP: BREAST CANCER TREATMENT

Attending Doctor	Private Rate	Medical Aid Tariff	* Gap Cover	Your Share
Plastic and Reconstructive Surgeon	R 39 993.75	R 13 239.59	R 26 754.16	NIL
Specialist Anaesthesiologist	R 24 629.55	R 13 731.81	R 10 987.74	NIL
TOTAL	**R 64 623.30**	**R 26 971.40**	**R 37 651.90**	**NIL**

*** Cover provided by all 4 Gap products.**

***Subject to Product Option Benefits and Imposed Waiting Periods.**

***Subject to the aggregate gap cover annual limit of R158 000 per insured person per annum. (This may change due to regulatory amendment).**

GAP COVER: THE IMPORTANT INFORMATION

WHEN CAN YOU CLAIM?

GENERAL WAITING PERIOD

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

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, Meta-tarsal Osteotomy) but excluding treatment due to accidental trauma
- Inability to walk / move without pain
- Renal Failure
- 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)
- Reconstructive surgery as a result of an incident or condition that occurred prior to membership (including skin grafts)
- Mental health or psychiatric conditions
- Varicose veins
- Oesophagitis, Gastroenteritis and Gastro-Intestinal Disorders
- Male genital system (including prostatectomy/ robotic prostatectomy)
- All robotic type surgery
- 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 R158 000 PER INSURED PERSON PER ANNUM. (EXCEPT FOR THE ACCIDENTAL DEATH AND POLICY EXTENDER BENEFITS). THIS LIMIT IS SUBJECT TO REGULATORY AMENDMENT.
- Where you have reached any of your benefit limits according to the maximum benefit insured i.e. the amount insured in respect of a Member, Spouse, Child or Dependant as stated in the Schedule.
- Where your medical aid 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.
- 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 medial aid does not pay any portion of the account.
- 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 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.

SUB-LIMIT COVER (Excludes Oncology Benefit)

- Where your medical aid sub-limit applies to any items besides MRI, CT or PET scans and internal prostheses. 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.

CASUALTY COVER (Excludes Oncology Benefit)

- Where the treatment is not an emergency / immediately required, is of an internal nature or did not come about due to an external force and/or impact with something or someone.
- 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.

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.
- 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).

POLICY EXTENDER BENEFIT

- Where it is not related to the death of the Principal Policyholder who was paying the premium contributions for the Gap Cover Policy.
- Where the official documents i.e. the death certificate is not provided for.
- Where the benefit is not related to death.
- Where the premiums are to be provided for by TRA for a period of longer than 6 months.

ACCIDENTAL DEATH BENEFIT

- Where death does not occur within 12 months of the incident.
- Where death is caused, complicated or attributed to any of the following:
  - AIDS (Acquired Immune Deficiency Syndrome)
  - HIV (Human Immunodeficiency Virus) or any venereal disease
  - Use or suspected use of drugs or intoxicating liquor
  - Any self-inflicted event, including suicide or attempted suicide
  - Any wrongful or illegal action, 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 and
  - 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, treatment 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 members. There are, however, certain requirements that a member 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.
- Members must use the scheme's designated healthcare service providers.

PMB'S, regardless of how they are classified by a medical scheme, are covered on certain product options only, and for non-emergencies only.

Please check your product options in the Schedule of this policy document to establish your cover.

ELIGIBILITY

- A dependant registered under this Policy must also be a dependant of the Policyholder and covered by a registered medical aid scheme that may or may not be the same 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.
- There is no entry age limit.
- Policyholder dependants may be added or removed from this Policy.
- Dependants (excluding 'Spouse') need to take out their own Gap Cover Policy if 21 years of age or older (25 in the case of an unmarried full-time student). A student needs to prove that they are a student by means of an official acceptance letter (the original or certified copy is to be provided for) into the registered tertiary institution for the current calendar year.
- Only the Principal Policyholder, Spouse and Child Dependants, 21 years old or younger (or 25 in the case of an unmarried, full-time student), may be on the same Policy as the Principal Policyholder. Even if the Principal Policyholder has other Dependants, for example, their parents who are on their Medical Aid Policy, these Dependants are not permitted to be on the same Gap Cover Policy as the Principal Policyholder and should take out their own Gap Cover Policy, separate to that of the Principal Policyholder.
- **If new and eligible Dependants are to be added to the Policy (for example: a new born 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 TRA RECEIVES CLAIMS WITHIN THREE (3) MONTHS FROM THE DATE THE CLAIM WAS PROCESSED AND PAID BY THE MEDICAL AID SCHEME. PLEASE ALSO ENSURE THAT WE HAVE THE CORRECT BANKING DETAILS INTO WHICH THE CLAIM MUST BE PAID.

CLAIMS - MANUAL PROCESS

- Policyholders need to submit the following:
- Claim/account from the Service Provider.
- First TWO (2) pages of the hospital account showing the admission and discharge dates of the hospital event or the medical scheme's hospital authorisation letter.
- 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 TRA's mobile app. Alternatively, TRA can be contacted directly on **+27 (11) 372 1540**, and 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 company 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.

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 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 in advance. 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.

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).

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. In respect of minor children at the end of the calendar month in which he/she gets married or attains the age of twenty-one years, twenty-five if full-time student.
3. 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 months 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.
4. Upon the death of the main member, the Policy may be terminated. A new main-member who will be responsible for payment of premiums can be nominated or the Policy can be terminated.
5. **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 new born or a 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 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.**
6. **Failure to advise TRA of resignation from a medical aid does not constitute a valid claim for a refund of premiums collected.**

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. a. 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.
   b. Insurrection, rebellion or revolution.
4. Hospitalised psychiatric care is limited to 14 days per annum.
5. Cost 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 treatment for infertility.
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), breast reconstruction and nasal reconstruction are limited to R1000.00 per case.
20. **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; or
    e. Equipment (scope, robotic surgery etc.)
21. Benefits for spectacles, lenses and contact lenses.
22. Dental implants.
23. Any benefits and dental treatment in hospital for individuals over the age of 18 years unless authorised by the medical aid scheme.
24. Any ex-gratia payment approved by the medical aid scheme (including medical aid exceptions).
25. Any procedure performed without a Policyholder being admitted to hospital unless specified in the policy document.
26. Claims for external prosthesis/ses that are not approved by the Scheme unless specified in the policy document.
27. Biological medicine (except on approved oncology treatment - see benefit).

TRA ASSIST powered by ER24 ASSIST

TRA has partnered with ER24 Assist 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.

The TRA Assist services available are as follows:

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 17h30 until 03h00. The last available booking time is 02h00 (seven days a week).

ASSIST Number: 087 135 1241

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.

TAXI SERVICE

- If you do not have your own vehicle that you want driven, a 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 taxi service falls within the same Home Drive benefits, forming part of the 6 free trips per policy per annum.

  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 Taxi 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 any 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 LINE

MEDICAL HEALTH LINE

ER24 Assist 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.

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.

All TRA Assist benefits are subject to the standard ER24 Assist terms and conditions. Please see www.totalrisksa.co.za for further information.

NB: 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.

Gap Cover and its product benefits (including TRA Assist) are not medical aid schemes 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 AND 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

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

Postal Address: PO Box 8012, Greenstone, 1616

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