TOTALRISKADMINISTRATORS

CENTRIQ INSURANCE INNOVATION

TOTAL RISK GAP COVER

THE POLICY

In consideration of and conditional upon the prior payment of the premium by or on behalf of the Insured and the receipt thereof by or on behalf of the Insurer before the inception date or renewal date (as the case may be) and subject to the terms, exceptions, conditions and provisions of the Policy, the Insurer agrees to pay the principal insured person for an insured incident occurring during the period of insurance up to the limit of indemnity stated for the insured person and the benefit as stated in the Policy.

The Policy, its schedules and annexures/endorsements shall be read together as one contract.

The Intermediary and Underwriting Manager / UMA have an agreement with the Insurer in terms of which remuneration is payable for the insurance business.

If the Policy was sold to you by the Intermediary's telemarketer, the same details as those of the Intermediary are applicable. Recordings of the telephone discussion with the telemarketer can be made available to you on request.

CONDITION PRECEDENT

Strict compliance by both the Member and TRA with all provisions, conditions and terms of the Policy shall be a condition precedent to liability on the part of TRA hereunder.

POLICY DEFINITIONS

In this Policy, all words and expressions signifying the singular shall include the plural and vice versa.

Words and expressions implying the masculine gender shall include the feminine.

The following words and expressions shall have the following meanings:

Commencement Date	Effective start date of Policy.
Insured Event	The admission of an Insured Person, stated in the Schedule, into hospital.
Application Form	The form that the Principal Member completes and shall be the basis for the selection of benefits.
Entry Date	The Commencement Date and/or the first day of any month thereafter.
Expiry / Resign Date	The notified date of cancellation of benefits by either the Insured or his legal representative. One Calendar month's notice is required.
Hospital	Hospital, unattached operating theatre or day clinic.
Principal Policyholder/ Member / Insured Person	The person who took out the policy, and who is to be insured under this Policy, and whose benefit(s) have not expired in terms of the Expiry Date.
Scheme	The Insured Person's authorised Scheme Medical Aid Scheme.
Maximum Benefit Principal Policyholder	The amount insured in respect of a Member, Spouse, Child or Dependant as stated in the Schedule.
Children (Child) / Dependant	The Principal Member's unmarried minor child who has not yet attained the age of 21. This age may be extended to 25 in respect of an unmarried child who is a full-time student. There will be no age restriction for children who are either mentally or physically incapacitated from maintaining themselves, provided that the children are wholly dependant on the Principal Member for support and maintenance. Once a child has become independant of the principal member for support and maintenance, dependancy definition of a child cannot be revived at a later date unless that child is still under the age of 21. Child/ren shall mean the Principal Member's natural, legally adopted or step child/ren.
Spouse	The legal or common law husband/wife of a Principal Member or such person residing with the member who is normally regarded by the community as the Principal Member's husband/ wife.

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WHEN CAN YOU CLAIM?

GENERAL WAITING PERIOD

There is no general three (3) month waiting period where a policy commences

from 1st January, 2017. There is a 3 month waiting period for policies

commencing prior to 1st January, 2017.

The following waiting periods are specific to policies commencing from 1st January, 2017: -

10 MONTH CONDITION SPECIFIC WAITING PERIOD

No claims may be submitted withing 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
- Recurrent hernia repair/s
- Endoscopic procedures e.g. Colonoscopy, Gastroscopy
- Pregnancy and childbirth
- 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
- Nasal and sinus
- Cardiac (relating to the heart)
- Dentistry (unless due to accidental trauma)
- Cataracts and / or eye laser surgery
- 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

These conditions may be reviewed for appeal at medical management discretion within the first 10 months of membership.

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 (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.

WHEN ARE YOU NOT COVERED UNDER YOUR GAP POLICY?

- WHEN YOU HAVE REACHED THE ANNUAL AGGREGATE LIMIT OF R150 000 PER INSURED PERSON PER ANNUM (Except for the Accidental Death and Policy Extender Benefits.)
- Where your medical aid does not pay their portion of an account - except for the Casualty benefit. (Please check your option benefits on Page 3.)
- Where your medical aid covers some or all of an account using funds from your savings account and/or you pay some or all of an account yourself because you are in a self-payment gap - except for the Casualty benefit. (Please check your option benefits on Page 3.)
- Where you have not been admitted into hospital. We only cover service providers that treat you whilst in hospital and where their related charges exceed medical aid tariff/s. The only exceptions are charges from casualty units and these will be covered under the casualty benefit. (Please check your option benefits on Page 3).
- 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.
- **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

- 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 Schemes 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.

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SUB-LIMIT COVER

- Where your medical aid sub-limit appllies to any items besides MRI and CT scans and internal prostheses.
- Where your medical aid sub-limit is used up and your medical aid does not contribute any amount towards this account.

CASUALTY COVER

- Where the treatment is not 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 your medical aid covers casualty costs as part of a hospital benefit.
- Where the hospital charges for medication that is not part of an authorised procedure or that is taken home when being discharged.

ONCOLOGY COVER

- Where your medical aid covers some or all of an account using funds from your savings account and/or you pay some or all of an account yourself because you are in a self-payment gap.
- Where your medical aid does not authorise treatment or biological medication as part of an approved oncology treatment plan.

ACCIDENTAL DEATH COVER

- Where death does not occur within twelve (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 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 the insured person is:
  - 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 does not respond to our request for:
  - medical examination for the insured
  - release of medical records and information
  - a 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 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 designaed healthcare service providers.

Please check your product options on Page 3 of this policy document to establish your cover.

ELIGIBILITY

A dependant in 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 (not common law or any other definition).

- There is no entry age limit.
- Policyholder dependants may be added or removed from this policy.

ALL 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.

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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** or submitted online via our website **www.totalrisksa.co.za** 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 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 of 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 thirty (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 submited to the Insurer 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 fulltime 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 one 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 an new dependants to be added to the policy. The Insurer must be supplied with a current medical aid certificate showing the new dependant.

Cover may be altered by the Insurer upon giving at least one month's written notice of any possible changes to the policy.

COMPLAINT RESOLUTION PROCESS

In order for a complaint to receive the attention that it deserves, we request that your complaint is submitted in writing to **complaints@totalrisksa.co.za**

Please retain proof of delivery where the complaint is delivered by hand or other means.

Complaints procedure is as follows:

Complaint submitted in writing, logged in complaints register, receipt confirmed, management informed, Complaint investigated.

- Policyholder informed within five (5) days.
- If not resolved satisfactorily, policyholder may refer to CEO.
- If still not resolved, policyholder must refer to Ombud within six (6) months.
- FAIS Ombud deals with claims below R800 000 only. See statutory notice for contact details.lifespan of your policy.

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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 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 biochemical 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, 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, 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).
    b. Theatre fees.
    c. Drugs medicines and materials.
    d. Intensive care.
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 12 years unless authorised by the Medical Aid Scheme.
24. Any ex-gratia payment approved by the medical aid scheme.
25. Any procedure performed without a policyholder being admitted to hospital unless specified in the policy document.
26. Claims for external prosthesis that are not approved by the Scheme unless specified in the policy document.