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1. WELCOME TO ESSENTIAL MED

There is nothing more important than your health and the health of your Loved ones. Good health equips us to make the most of life, in work and play. Thank you for choosing Essential Med as your partner in good health.

With the benefits we offer, your healthcare needs are provided for and managed enabling you to live a life uninterrupted.

We look forward to a long and healthy relationship with you.

I. PRODUCT OFFERINGS

Essential Med offers a choice of two product offerings:

1. A day-to-day option providing access to essential every day services such as consultations with doctors and dentists, as well as medication at no additional cost through a national network of affiliated medical practitioners.
2. A comprehensive hospital plan providing generous in-hospital benefits.

Both product options also provides all our clients a range of value-add services with around-the-clock access to a dedicated helpline offering a vast array of useful services to cater for most emergency situations.

In light of this:

- Please check your policy schedule to confirm which policy option you have chosen and benefits you have cover for.
 - Out-of-hospital (day-to-day) benefits are provided by network service providers.
 - In hospital benefits service provider – most hospitals (private and state) Contact hospital pre-authorization.
 - The hospital plan is powered by Day1 Health.
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- Always quote your policy number.
- Always confirm that the practitioner is still contracted as a network provider.

II. GENERAL INFORMATION

When am I entitled to benefits?

You are entitled to benefits from the inception date of your policy, provided that no general waiting period or condition-specific waiting periods are applicable.

What is the inception date?

Inception date is the date of registration of policy for both you and your dependants.

The inception date is always the 1st of a month.

Premiums paid before the 1st inception date is the 1st of the following month.

The inception date for policy premiums collected on the 1st is the 1st of the current month.

If the application is received within 30 days of the new dependant becoming eligible for registration (e.g. through marriage, birth or adoption), the inception date will be the date on which the dependant became eligible.

If the application is received after 30 days of the new dependant becoming eligible for registration, the inception date will be the 1st of the month following the one in which the application was received, or the 1st of the month following the one in which we receive all the information we may need in respect of such application.

When do my dependants become entitled to benefits?

Your dependants are entitled to benefits from the inception date, unless a waiting period is applicable.

What happens in the event of the death of the insured client?

The eldest dependent has the right to continue with the policy, with the status of the other dependants remaining unchanged, provided that

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Essential Med receives a copy of the death certificate. Unless such person informs Essential Med of his/her intention not to become a client he/she will be admitted as a client to the Scheme. Bank details should be furnished to the Scheme to avoid any interruption in the payment of contributions.

III. WAITING PERIODS

Day-to-day benefits

A 30-day waiting period applies for the Day-to-Day benefits from policy inception date.

Optical benefits have a 12-month waiting period from policy inception date.

Hospital Plan

A 90-day waiting period apply in respect of the Illness and the

Dread Disease benefits apply from inception date.

The Accident, Permanent Disability and Death Benefits (Accident only) are available immediately upon policy inception.

No waiting periods will be imposed on a child dependant born during the period (On condition that the mother was on the plan for 12 consecutive months) and on condition that the child is added to the policy within 48 hours of delivery.

Pre-Existing Conditions

A condition-specific exclusion from the inception date of your policy applies in respect of any pre-existing condition. Note that all claims arising from a known pre-existing condition are excluded for a minimum period of 24 months.

IV. CHANGING OPTIONS / ADDING DEPENDANTS

How do I add a new dependant to my existing policy?

Complete and submit an Amendment Form (available on www.essentialmed.co.za).

When may I change my option?

You may change your option on the first day of the month, after giving at least 30 days' written notice.

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How do I change my Option, add or take off dependants?

Complete and submit an Amendment Form (available on www.essentialmed.co.za).

V. HOSPITAL PRE-AUTHORISATION

Pre-Authorisation (PAR) is the prior approval of any planned admission to a hospital. Note that a PAR is NOT a guarantee of payment of a claim.

Payment is at all times subject to available benefits and co-payments may apply.

Application for a PAR should be made as soon as possible, preferably upon confirmation of admission by your network doctor. It is recommended that application be made at least three working days ahead of a planned procedure, in case more information is required from your doctor.

In the event of an emergency admission to hospital over a weekend or at night, you may apply for a PAR from Hospital Pre-Authorisation within two working days of the admission. In the case of pregnancy, it is recommended that pre-authorisation be obtained by the 28th week.

The following information is required when applying for a PAR:

- Policy number and dependant code,
- Patient's full name and date of birth,
- Date of admission and the date of procedure,
- Surname and initials of attending doctor or service provider and practice number,
- Name of hospital and practice number to which the patient will be admitted,
- The reason for the admission to hospital.

To assist with PAR-application, ask your doctor for a full description of the diagnosis, the planned procedure as well as the procedural codes he/she intends to use.

If you do not apply for a PAR in advance or within two working days (in the case of an emergency) of receiving treatment, no benefits will be payable.

Please note that visits to the doctor as a result of illness at a hospital's outpatient or casualty department will not be funded from your hospital benefit. For this reason, some hospitals may require that you pay cash for these visits. In this event, you may send the account to Essential Med and you will be refunded according to your day-to-day, out-of-hospital benefits.

IMPORTANT:

Whilst every effort is made to establish client eligibility and availability of funds any authorisation given may be excluded in terms of the Policy Rules and payment is therefore not guaranteed.

VI. POLICY PREMIUMS

Policy premiums are payable monthly in advance.

If the policy premium is not received in time (latest being the first of each month) payment of all benefits in terms of your policy is suspended.

When premiums cannot be collected, waiting periods are reinstated. If your contributions fall in arrears for more than three months, your policy will be terminated immediately without further notice.

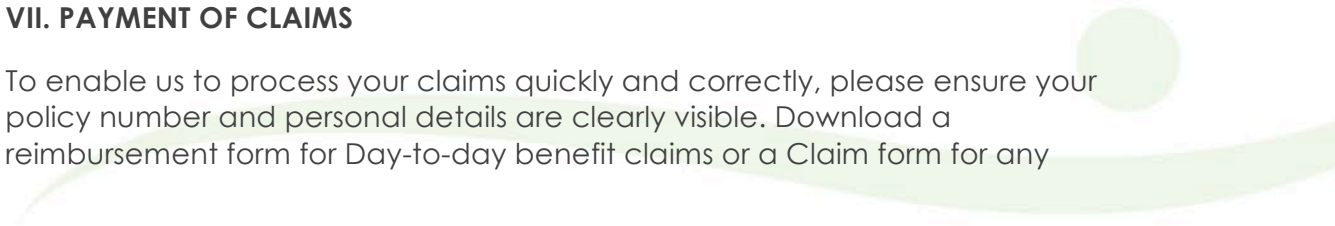
Increased premiums become due in respect of a new dependant:

- On the applicants inception date, if the dependant's addition was
- Indicated on the applicants application form; or
- From the first day of the month following the admission date of dependants registered within 30 days of marriage or date of birth; or
- When a minor dependant becomes an adult dependant on the first day of the month following the month in which the dependant turns.

A new application must then be submitted for the applicant. A dependant, who is registered as a full-time student will qualify as a minor dependant up to the age of 25 on receipt of annual proof of studies.

VII. PAYMENT OF CLAIMS

To enable us to process your claims quickly and correctly, please ensure your policy number and personal details are clearly visible. Download a reimbursement form for Day-to-day benefit claims or a Claim form for any

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Hospital claims, complete and return it to us with a detailed account and proof of payment.

The following information should be contained in a claim in order for it to be processed:

- Surname and initials of the member,
- Policy number,
- Identity number or date of birth of the patient,
- Doctor's practice number and
- The nature of service, relevant code, including ICD-10 code, service date and cost of each service rendered or item supplied.


For medicine claims:

- Also supply the name, quantity, dosage and net amount payable by the policyholder in respect of the medicine dispensed, as well as the relevant national pharmaceutical product interface (NAPPI) code and ICD-10 code.
- Non-electronic accounts payable by the client must also be accompanied by a copy of the original prescription made out by a person legally authorised to prescribe the medicine (if applicable).
- Proof of payment must be attached.
- A claim must be submitted within 30 days from the end of the month in which the service was rendered. If not submitted within 90 days of the service date the claim will not be paid.

VIII. POLICY CANCELLATIONS

You may terminate your policy by giving 30 days' written notice. In this case, you will enjoy cover for the remainder of the month for which the last premium was collected. No premiums will be refunded.

Essential Med reserves the right to cancel your policy or that of any of your dependants if you or any of your dependants:

- Provide false information, or fail to disclose material information when applying for registration.
- 
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- Provide false information upon submission of a claim, submit a fraudulent claim, or intentionally allow a service provider to do so on your behalf.
- Allow any other person to use your policy card.
- Without a good explanation, neglect to inform Essential Med that it has paid for services or supplies that were not delivered or received.
- Commit any other fraudulent act.
- Fail to pay premiums.

GENERAL DEFINITIONS AND ABBREVIATIONS

Acute medicine means medicine used for diseases or conditions that have a rapid onset, severe symptoms, and that require a short course of medicine treatment, as well as medicines that qualify for benefits but have not been classified as chronic medicine.

Adult means a dependant who is 21 years or older, excluding full-time students who are younger than 25.

Beneficiary means each individual policyholder and dependant.

Benefit start date means the date on which a beneficiary becomes entitled to benefits.

Chronic medicine means medicine that meets all the following requirements:

- Is prescribed by a network medical practitioner for an uninterrupted period of at least three months; and
- Is for a condition appearing on the list of approved chronic conditions, as amended from time to time; and
- Which has been applied for in the manner and at the frequency prescribed and which application has been approved and accepted.

Dependant means the following persons for whom the principal applicant is liable for care and support who are duly registered as dependants:

1. A spouse; and/or partner (NOT an ex-spouse),
2. A child – including an adopted child, stepchild or foster child, sisters and brothers; and/or any other person approved by the Scheme.

Excess means the first amount of medical expenses payable by the insured person.

Family means a policyholder and his/her dependants.

Hospital means registered unattached theatre and day clinic, but excludes an institution for rehabilitation for substance abuse.

Inception date means the date on which the registration of the policy becomes effective.

Medicine means a substance registered under the Medicines and

Related Substances Control Act, 1965, as amended or replaced from time to time.

Option means a product registered under the policy, which offers a specific structure of benefits.

Policyholder means a person who has been registered as the principal applicant.

Minor means a dependant who is not yet 21 years old, and, a dependant who is over the age of 21 but not over the age of 25 years, who is studying full time at a recognised institution.

Pre-authorisation (PAR) reference number means a number allocated by a managed healthcare agent, which is required before certain services qualify for benefits.

Pre-Existing Condition means Any Dread Disease/Illness for which the

Insured Person received medical advice and or treatment in the 12 (twelve) months in respect of an Illness or 24 (twenty four) months in respect of a Dread Disease prior to the Inception Date stated in the

Insurance Certificate (unless otherwise provided for herein). This also includes any operation up to 5 years prior to the Inception date for which the dependent still receives treatment or medication.

Service date means in the event of:

- Hospitalisation – the date of each discharge from a hospital; or

- Any other service or supplies – the date on which the service was rendered or the supplies obtained, whether for the same illness or not.

Service Provider means a medical practitioner, dentist, pharmacist, medical auxiliary or hospital duly registered or licensed as such with a statutory council or relevant state department.

Spouse means a person to whom a client is married under a system recognised by South African law.

Year means a period of 12 months beginning on 1 January and ending on 31 December.



2. DAY-TO-DAY BENEFITS

Colds and flu, tummy bugs, allergies, routine health checks and more, these out-of-hospital medical needs are taken care of with unlimited access to a network of more than 3000 health practitioners nationwide. All that is needed for free consultation and medication from any of these Care Cross healthcare professionals is your Essential Med card and policy number.

I. GP Visits

Please click to download a list of network-affiliated general practitioners in your area. Be sure to check whether the practitioner is a dispensing or scripting GP and still an active contracted network service provider. Medication is available immediately from dispensing GPs, whereas scripting GPs issue a script that can be fulfilled at a network pharmacy.

Please note:

1. Doctors are only available on weekdays and usually until midday on Saturdays. They are not available on Sundays.
2. Visits to GPs during normal working hours are unlimited.
3. Small procedures done in the doctor's surgery may be included:

Procedure Code	Description
0300	Stitching of wound
0301	Stitching additional wound
0307	Excision and repair
0255	Drainage of subcutaneous abscess & Avulsion of nail
0259	Removal of foreign body superficial to deep fascia
2133	Circumcision - clamp
0887	Limb cast (Inclusive of cost of P.O.P. and other material)

4. The cost of emergency consultations (after hours, casualty or out of network visits) may be partially recovered. The plan makes provision for three such visits per year and includes medication, tests and procedures. The total available for the year per family is R1 000.

II. Chronic Medication

1. No over-the-counter medication benefit is available.
2. Chronic medication is subject to registration and approval.

Click to download our [Chronic Medication Application Form](#), ask your network doctor to complete it and return it to Essential Med.

3. Medication will be couriered to the nominated address. If no nomination address is given, the medication will be delivered to your doctor's rooms.
4. Contact the Chronic department for any inquiries regarding the processing and approval for chronic medication.
5. Depending on the service provider medication available from the pharmacy

III. Acute Medication

1. No over-the-counter medication benefit is available.
2. A dispensing GP will provide medication from the Acute Medication formulary or an alternative if the medication is not immediately available from the surgery.
3. A dispensing GP's prescription cannot be taken off at a network pharmacy.
4. If the GP is listed as a scripting GP, the prescription may be taken off at any pharmacy linked to the Medi-Kredit system.
5. Visit our website to view [affiliated pharmacies](#).

IV. Dentistry

1. Services are limited to basic dentistry. This includes cleaning, pain control, fillings and extractions.
2. Emergency root canals and wisdom teeth extractions are covered if the procedure is done in the dentist chair in the surgery under local anesthetic.

3. Full and semi-sedations by an anesthetist are not covered.

V. Optometry

1. A 12-month waiting period applies for this benefit and is limited to one visit for eye tests per year per beneficiary.

2. One pair of white standard mono- or bi- focal lenses in a standard frame or contact lenses per beneficiary every 24 months.

3. Visit our website to view Care Cross-affiliated optometrists.

4. Visit our website to view dental benefits and procedure codes

VI. Radiology

1. Only a network contracted GP may request x-rays. The GP will complete an X-ray request form and refer you to a radiologist.

2. X-rays as per the Care Cross formulary only will be covered.

3. X-rays will be sent to your GP's rooms or you may collect them yourself.

VII. Growth Sonars

1. Your network GP will refer you to a radiologist (GP to provide a referral note).

2. The benefit covers two growth sonars: one each for the second and third trimester at a radiologist.


3. The radiologist usually forwards the account to the Care Cross, but some practitioners may require an initial payment, which you may then claim back.

VIII. Pathology

1. Only network contracted GP's may request pathology tests.

2. Practitioners are to complete a pathology request form according to the pathology formulary.

3. Clients may go to any Path Care provider, or a GP will take samples and send them to the pathology provider.



Please note: this is not a Medical Scheme; it is a pre-paid Preventative Health Care Service.

Benefits are effective 30 days after inception of your policy; the optometry benefits are available after 12 months.

You and or your spouse partner have to 55 or younger when joining.

EXCLUSIONS - 2011

The following shall not be included in the Services provided in terms of this policy:

- Any services obtained from a non-CareCross Supplier other than those covered under 'Out of Network' benefit,
- Travel expenses;
- Cosmetic treatment, operations, procedures and applicators, toilet preparations, etc;
- Reports, examinations and tests for insurance policies, legal reasons;
- Injuries arising from or appliances for professional sport, bungee or parachute jumps;
- Accommodation in an old age home, general care institutions, spa's, health or holiday resorts,
- Treatment for obesity, alcohol or drug abuse;
- Treatment and operations of choice and non-essential medical items;
- Acupuncture, biokinetics, chiropractors, herbalists, nature and homeopaths;
- Any other chronic conditions
- Treatment and medication in respect of Tuberculosis other than general health management at general practitioner level;
- Injuries sustained during participation in strikes, illegal picketing, riots or physical struggle;
- Nutritional supplements, tonics, stimulants, vitamins, and minerals;

- Contraceptives and devices to prevent pregnancy;
- Stimulant laxatives;
- Treatment for infertility and sexual dysfunction;
- Root canal treatment, and other advanced dentistry; and
- Services in respect of the treatment of any sickness condition or injury sustained by a Beneficiary for which any other party may be liable.



3. HOSPITAL INSURANCE PLAN

You want peace of mind and guarantees that you will be able to take care of the unexpected. Essential Med's Hospital Plan gives you all this and more – our involved and caring assistance, when you and your loved ones need it most.

Accidents happen and even the healthiest can become victim to disease and illness. These and other eventualities are taken care of with Essential Med's hospital cover. All that is needed for hospital pre-authorisation and the payment of a stated benefit to cover in-hospital expenses irrespective of procedure, consultation or service is your Essential Med card and policy number.

Hospital Plan Options

Please refer to your ID card or welcome letter to see your option

Description	Waiting period	Basic Plan benefits	Subsidiary Plan benefits	Social Plan benefits
GDP (Guarantee of payment) To Network Tiered-Provider™ services include pre-authorisation & GDP arrangement to facilitate admission.	Pre-approval		\$10 000 admission guarantee	\$10 000 admission guarantee
Illness Hospitalisation Per 24 hours spent in hospital irrespective of procedure, medication, consultation fees. Max of 21 days per illness per beneficiary.	90 days		Day 1: R4 500	Day 1: R4 500
			Day 2: R4 500	Day 2: R4 500
			Day 3: R4 500	Day 3: R4 500
			Day 4 onwards: R1 500	Day 4 onwards: R1 500
Maternity Hospitalisation Per 24 hours spent in hospital irrespective of procedure, medication, consultation fees. Max of 21 days.	72 months		Day 1: R4 500	Day 1: R4 500
			Day 2: R4 500	Day 2: R4 500
			Day 3: R4 500	Day 3: R4 500
			Day 4 onwards: R1 500	Day 4 onwards: R1 500
Direct disease In-hospital expenses for treatment covering heart attack, coronary heart disease, stroke, brain tumour, cancer, kidney failure, major organ transplant, stroke-related and equivalent.	90 days		R9 000 is payable per day upon diagnosis with annual limit of R180 000	R9 000 is payable per day upon diagnosis with annual limit of R200 000
Accident In-hospital expenses paid in increments of R200 per event. R150 of expenses. Provision for multiple claims subject to charges of R200 per claim.	Pre-approval	Up to R75 000 per beneficiary (max 2 events per annum)	Up to R125 000 per beneficiary / R250 000 per family	Up to R200 000 per beneficiary / R400 000 per family
Permanent disability Accident permanent disability	Pre-approval	R200 000 principal policy holder only	R200 000 principal policy holder only	R200 000 principal policy holder & spouse / partner only
Emergency rooms or casualty visits Due to accidents, visits and procedures subject to R200 excess per claim.	Pre-approval	R2 000 per family per incident	R4 000 per family per incident	R4 000 per family per incident
Death	Pre-approval	R3 000 principal policy holder only	R10 000 principal policy holder only	R18 000 principal policy holder only

I. After-hours Illness Events Hospital / Casualty Visits

Any emergency visits to hospital/casualty to see a doctor as a result of an illness will fall under "Out of town or Emergency visit".

1. Authorisation for hospital admission will only be given for hospitalisation for a period of 24 hours or more and on condition that premiums are paid up and that the respective waiting periods is over.

2. If any of the above is not in order and the patient is admitted then the account is for the client's own account.

3. Any hospitalisation for less than 24 hours will be for your own account but may be reimbursed.
4. Download a Reimbursement Form from the website, complete it and forward it to Essential Med with proof of payment and a detailed account.
5. The plan makes provision for three such visits per year and includes medication, tests and procedures. The total available for the year per family is R1 000.

Illness Event / Maternity Hospitalisation

The Illness Benefit ensures that you aren't left with huge bills after a visit to hospital. The Policy pays a daily contribution per illness, per person per overnight stay in hospital, up to 21 days per illness event.

The Maternity Benefit will pay a daily contribution based on the number of days spent in hospital for the delivery – irrespective of the procedures performed. A 12-month exclusion period is applicable in respect of pregnancy i.e. a person has to be on the plan for 12 consecutive months before benefits become applicable in respect of childbirth.

II. Illness Events

An insured client may have many illness events in a year; however, benefits are only payable if the insured client is hospitalised. If an insured client is admitted to hospital for 5 days, and then a few weeks later is readmitted for the same illness, the insured would only have benefits for a further 16 hospital days. However, if the insured client was readmitted for a different illness, they would have 21 days of cover available for the new illness. Should an insured client be admitted to hospital for the full insured period (i.e. 21 days), they may not be readmitted for the same illness, unless 6 months have elapsed between the first and second diagnosis.

Please note that if the hospital/procedure costs exceed these limits, the insured client is responsible for paying the difference. No benefit is payable should a person be hospitalised for less than 24 hours.

A client who is admitted to hospital for 5 days will not receive the same 1st and 2nd day benefit if they are readmitted for the same illness within a 6-month period. The benefit will only be payable if they are admitted to hospital for a different illness.

Illness Top-up

The additional illness protection benefit payable per annum will increase to R25 000 for a Single member and up to R40 000 for a Family, payable if the daily cash benefits are insufficient to cover hospital costs. This benefit is subject to a 3-month waiting period from 1 June 2011 and an excess of R2 000 applies for each and every occurrence.

Admission procedures:

1. You first need to see a network GP, who will provide a letter of motivation stating the reason for hospitalisation and the respective codes.
2. If you are covered under the hospital plan only, you will be liable for the account from the doctor who issues the referral letter for hospital admission.
3. You are to contact Hospital Pre-Authorisation and provide the necessary details and nominated hospital. Essential Med makes the necessary arrangements on your behalf and provides an authorisation number, which you take to hospital to facilitate admittance.
4. On discharge you will receive an account. This must be sent to us within 30 days.

Please note that the policy does not provide cover for specific procedures or consultation fees. Instead, Essential Med pays out the benefits as stated on the policy schedule for each day spent in hospital.

Accident Event Hospitalisation

1. The benefit covers any accidental/unintentional or unforeseen bodily injuries and is available immediately on inception of policy and successful collection of first policy premium.
2. If you need an ambulance, call 0861 911 011 or go to the casualty ward at a hospital.
3. You or the hospitals are to contact Hospital Pre-Authorisation for an authorisation number.



4. It pays the stated benefit as per the option benefits. The benefit pays out in increments of R200 for every R190 in hospital expense incurred. An excess of R500 is payable per claim, and you may have multiple claims in any year

5. Any costs of treatment as a result of the accident i.e. physio, further operations, X-rays or scans up to 12 months after the incident will be covered with the balance of the money available for the specific claim.

III. Dread Disease Event Hospitalisation

The Dread Disease Benefit pays a lump sum in daily installments (upon diagnosis), once per single person or family per year. It covers heart attacks, coronary heart disease, cancer, strokes, brain tumours, kidney failure, organ transplants, paraplegia and blindness. This covers is available after 90 days of inception.

Explanations:

The Dread Disease Benefit is payable once per year. For example: in the unlikely event of two (2) family members being diagnosed with a Dread

Disease in the same year, only one (1) benefit is payable.

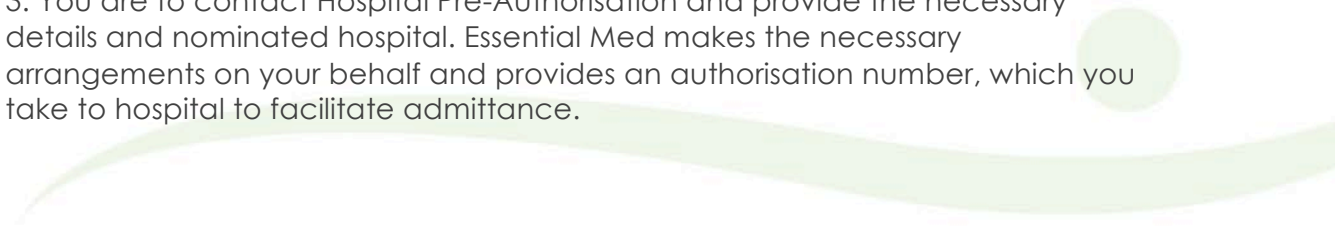
Once an insured client is diagnosed and has been paid out for a specific dread disease, the insured will not be eligible for another payout for the same dread disease should it recur in any subsequent year.

If admission to hospital is for a period of less than 20 days, once the insured person has been discharged from hospital then a requirement for a survival period of 30 days from the date of first diagnosis is in force, before the balance of the benefit is payable.

1. You first need to see a network GP, who will provide a letter of motivation, reason for hospitalisation and respective codes.

2. If you are covered under the Hospital Plan, you will be liable for the account from the doctor who issues the referral letter for hospital admission.

3. You are to contact Hospital Pre-Authorisation and provide the necessary details and nominated hospital. Essential Med makes the necessary arrangements on your behalf and provides an authorisation number, which you take to hospital to facilitate admittance.



4. If you are positively diagnosed with a dread disease, the benefit provides cover per day for treatment whilst in hospital.
5. On discharge you will receive an account, which is to be forwarded to Essential Med.
6. There is a 30-day survival period where after the balance of the stated benefit will be paid over to your banking account within 30 days.

IV. HIV/Aids Protection Benefit

Each client covered under the plan will receive assistance in the event of accidental exposure to HIV/Aids. The incident resulting in possible exposure to HIV must be reported to our helpline within 72 hours. An insured client can use this benefit twice (2 times) per year, subject to a maximum of two (2) visits per family, per year.

V. Death Benefit

A Stated Death Benefit is payable to the named beneficiary/s following the death of the principal insured client.

VI. Important Facts

Please note that this is not a Medical Scheme; this is a Stated Benefit Insurance Hospital Plan.

You and your spouse / partner have to be younger than 55 years of age when you join.

If you have a medical insurance policy and/or medical aid with another financial service provider, and that policy/scheme covers you and your family (i.e. the insured person/s) for the defined events that give rise to a medical expense claim under the policy, that company shall be liable to make good only the ratable portion of the amount payable by you/to you/on your behalf in respect of such an insured event.

The daily in-hospital benefit will be limited to actual medical expenses up to the maximum of the daily in-hospital benefit. The actual medical expenses to be applied will be those not paid by any other insurer and or medical aid scheme.

You may choose to use most private or state-run hospitals.

The Accident Benefits are subject to an excess of R500 for each claim.

The Illness and Dread Disease Benefits are subject to a 90-day waiting period.

You will enjoy cover while you pay your monthly premium, or until you reach 65 years of age.

All stated benefits are paid to the insured member.

For further details please refer to your policy wording.

A 12-month exclusion period is applicable in respect of pregnancy i.e. a person has to be on the plan for 12 consecutive months before benefits become applicable in respect of childbirth.

Exclusions and waiting periods may apply for known pre-existing conditions.

This product is powered by Day1Health Pty Ltd and the benefits are underwritten by Sanlam Developing Markets.



4. ESSENTIAL PLUS (These services on variable degrees are available to all policy holders)

Essential Med offers essential medical healthcare insurance with no frills, no clever gimmicks and no empty promises. Our policies include real benefits and as one of our valued clients, you have around-the-clock access to the vast array of useful services listed below:

For assistance, simply dial 0861 911 011 – and we will gladly do the rest.

Benefits are available 30 days after inception of policy.

If you require any sort of assistance (see the list below), simply dial

0861 911 011 – and we will be glad do the rest.

I. Emergency Medical Evacuation

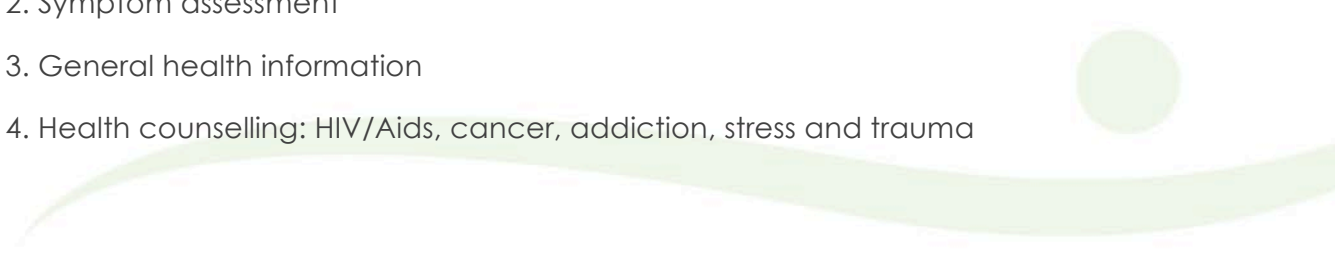
A single call from you (or a 3rd party) to our emergency number –

0861 911 011 – results in immediate action:

1. Emergency vehicles dispatched immediately (cost covered)
2. Telephonic advice to assist in stabilising the patient
3. Informing your next-of-kin about your accident

II. Personal Health Advisor

Experienced professionals are available on the emergency number, to identify the situation and assist you with:

1. Emergency medical advice
 2. Symptom assessment
 3. General health information
 4. Health counselling: HIV/Aids, cancer, addiction, stress and trauma
- 

III. Emergency Identification and Information Service

Emergency response personnel have instant access to vital information about your medical status prior to commencement of any medical treatment.

Medical Data Bureau (MDB) allows them access to your:

1. Personal information
2. Life-threatening allergies
3. Medical history
4. Major medical conditions
5. Blood type
6. Chronic medication
7. Medical aid details
8. Religious or special request

Essential Med clients are easily identified through a range of multicoloured MDB identification items. Each item has a unique reference number that cross-references to each particular client's database information. Clients may choose from a variety of ID items (cost of items is not included).



- License Disc Holder
- Car Window Sticker
- Wrist Band
- Wallet ID Card



* ID items cost R10 per item not included in membership fee.

If you are unable to communicate, your Medical Data Bureau identification items will ensure:

1. Instant identification by means of your PIN
2. Personal information available from MDB database
3. Medical history and background
4. Fast, accurate decisions are made possible – delays could cost lives

IV. Legal Assistance / Law Call

The Legal Assistance line, offering members access to any type of legal advice, from trained and highly qualified lawyers is available 24-hours a day. The service includes:

- General Advisory Line
- General legal advice
- Criminal procedures
- Family disputes
- Advice on breach of contracts
- Divorce
- Maintenance etc.
- Labour Law Advice
 - Labour Relations Act
 - Basic Conditions of Employment Act
 - Employment Equity
 - Skills Development
 - Unfair labour practices
 - Basic wages etc.

Motor Accident Advice

- The process to follow after an accident
- What details to supply and obtain
- How to contact the Road Accident Fund
- Your rights after an accident
- Third Party claims

Standard Legal Documentation

- Small Claims Court Kit
- Child Maintenance Kit
- Domestic Employment Agreement
- Lease Agreement
- Purchase Agreement
- Last Will and Testament

Attorney Referral Service

In addition to the above telephonic assistance services, members can also be referred to a national panel of Attorneys for matters that require legal intervention or representation in a court of law. The service involves a free 30-minute consultation with the attorney and/or the drafting of one letter, or one call to a third party. If the member wishes to engage the services of the attorney, he or she can do so at the cost of the practicing attorney's fees.

Legal Assistance is a telephonic legal advice help-line that provides free guidance and information on all legal matters concerning:

V. Emergency Home Response


This 24-hour help-line, offers assistance with household emergency repairs that could result in consequential loss or damage. The service is rendered in cases of electrical or plumbing failures, if the services of a locksmith or glazier are needed and if domestic appliances such as fridges, freezers, stoves, ovens and washing machines need to be repaired. The service includes:

- The repair cost of 3 incidents per annum, limited to R500 per incident (R1 500 per annum)
- The repair cost includes a call out fee and kilometre cost, but is not limited to parts and labour.
- The member is put in touch with the appropriate service provider – all complying with specific requirements and maintaining a high level of professional service.
- Should the incident amount exceed R500, the outstanding amount is payable by the member to the service provider. The service guarantee varies from one service provider to another and will be stated on the service provider's invoice.

VI. Roadside Assistance

Provides essential services when you have a breakdown, and covers you within the borders of South Africa (Covers one vehicle, R15 per additional vehicle)

This is a 24-hour assistance service that renders essential services in the event of a breakdown, from changing a flat tyre to assistance with mechanical or electrical breakdowns. The service includes:

- Mechanical or electrical failure – a case manager will dispatch a service provider who will, either repair the vehicle at the scene, or tow it to the most appropriate place of repair.
 - Flat battery – a service provider will be dispatched to restart the vehicle.
 - Flat tyre – a service provider will be dispatched to assist.
 - Running out of fuel – 10 litres of fuel will be supplied.
 - Keys locked in vehicle or broken in either the lock or ignition – a locksmith will be dispatched to assist. If the vehicle operates with a smart key, the case manager will arrange for the vehicle to be towed to the nearest service provider. Costs for new keys are covered up to R500.
 - Regular monitoring of any long distance trip made.
 - Messages relay service.
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- A decorative graphic at the bottom of the page consists of a light green wavy line that spans across the width of the page, and a solid light green circle positioned on the right side of the wave.

In addition to the above benefits, the following benefits apply in the event of a breakdown 100km or more from home:

- Accommodation for one night (maximum R500 per night) or rental of a class B vehicle (maximum R500 per day) for one day.
- Cost of recovery of vehicle following repair (maximum R500 per recovery)
- Cost of transport back to holiday or permanent residence in the event of the theft or hi-jacking, provided you submit the police case number within 24 hours of the incident (maximum R500 per incident)

Assistance will be arranged, but the costs are for the member's account or that of their insurer in the event of:

- A locksmith's service being needed if there is an attempted theft of the vehicle, loss of car keys and if they are not locked in the vehicle.
- A tyre being needed in case of a flat tyre and spare.

VII. Travel Map and Direction Service

24-hour access to a help line, offering information on availability and costs with regards to national and international accommodation and includes:

- A list of hotels, guesthouses and lodges, transport and special packages.
- A direct link to www.travel.co.za, SA's leading Internet Travel company, which provides the latest and most competitively priced airfares, packages, insurance, car rental, accommodation, on-line booking engine and package builder.
- For all the information you need on accommodation (hotels, guest houses and lodges), transport and special packages, please visit **www.travel.co.za**.
- The Direction Service is a 24-hour directions service for guidance when travelling within the borders of South Africa and offers assistance when the member is lost, left the directions behind or need confirmation that they are on the correct route. The service includes:

- Clear and concise directions given telephonically whilst on-route, or faxed or e-mailed to the member before the journey
- Detailed map information of major metropolitan areas such as Johannesburg CBD, West Rand, East Rand, southern and northern suburbs of Johannesburg, Pretoria suburbs, Port Elizabeth, Cape Town, etc.
- Basic route information in rural areas.
- Directions are provided telephonically, or faxed/emailed to you before you commence your journey.

