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essential cover with everyday benefits



WELCOME...

Your health is a priority and Essential Med is pleased to be your partner of choice to help you take care of yourself and your loved ones.

Please read this Policy Guide carefully to familiarise yourself with the benefits that you as a policyholder enjoy. It is also important to read the Terms and Conditions to ensure you are able to maximise your use of the policy benefits.

We trust that you have peace of mind knowing that you can access private medical care whenever you need it. If you have any questions or queries, please feel free to contact us.

Kind regards

Client Services

PRODUCT OFFERINGS

Essential Med provides a choice of two product offerings:

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.

A comprehensive Hospital Insurance Plan providing generous in-hospital benefits.

All Essential Med clients also enjoy our range of value-add services. By providing around-the-clock access to a dedicated helpline offering a vast array of useful services, we aim to meet clients' needs most emergency situations.

Please note the following:

- *Please check your policy schedule to confirm which offering you have selected.*
- *Out-of-hospital (Day to Day) benefits are provided by either CareCross or OneDoctor. Please check your policy schedule to see with which network provider you are registered.*
- *In hospital service provider – most hospitals (Private and State). Please check our website for a list of preferred hospital service providers.*
- *The product is powered by Day1 Health.*
- *The option is Platinum Direct Plus.*
- *Always quote your full policy number i.e. Day10807097Pol.*
- *Always confirm that the medical practitioner or hospital is still contracted as a network provider when making an appointment.*

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?

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

- *The inception date for policy premiums collected on the 15th or 25th is the 1st day 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 Essential Med receives all the information required in respect of such application.*

When do my dependants become entitled to benefits?

Your dependants are entitled to benefits from inception date, unless a waiting period applies.

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

The eldest dependant has the right to continue with the policy, with the status of the other dependants remaining unchanged, provided that 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 Insuring Health Plan. Bank details should be furnished to the Insuring Health Plan to avoid any interruption in the payment of contributions.

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 in respect of the Day1, Day2 Illness and the Dread Disease benefits applies from inception date. Should a client be hospitalised for a period of eight days before the 90 days are over, then the plan will only start paying out benefits from the third day.

The Accident, Permanent Disability and Death Benefits are available immediately on policy inception.

No waiting periods will be imposed on a child dependant born during the period of policy on condition that the child is added to the policy within 48 hours of delivery.

Pre-existing conditions

A condition-specific exclusion from policy inception date 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.

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 Essential Med at least 30 days' written notice.

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

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

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 to which the patient will be admitted.*
- *The reason for the admission to hospital or the planned diagnostic procedure.*

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 at a hospital's out-patient or casualty department will not always 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 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 Insuring Health Plan Rules and payment is therefore not guaranteed.

POLICY PREMIUMS

Policy premiums are payable monthly in advance. Debit order dates are the 25th or 1st of the month.

If the policy premium is not received 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 applicant's inception date, if the dependant's addition was indicated on the applicant's 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 1st day of the month following the month in which the dependant turns 21. 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.

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 from our website, 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 policy holder 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 three months from the end of the month in which the service was rendered. If not submitted within this period, the account will not be paid.*

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.*
- *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:

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

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).

PREFERRED PROVIDER MEANS a Service Provider with whom preferential rates were negotiated or who is part of a preferred provider network contracted.

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.



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DAY TO DAY BENEFITS

GP VISITS

Please visit our website to access a list of network-affiliated general practitioners in your area. Be sure to check whether the practitioner is a dispensing or scripting GP and is 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. Medication is free.

Please note:

- *Doctors are only available on weekdays and usually until midday on Saturdays. They are not available on Sundays.*
- *Visits to GPs during normal working hours are unlimited.*
- *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.*

CHRONIC MEDICATION

No over-the-counter medication benefit is available.

Chronic medication is subject to registration and approval. Visit our website to download our Chronic Medication Application Form, ask your network doctor to complete it and return it to Essential Med.

Depending on the service provider medication will be couriered to the nominated address or collected from a network pharmacy.

Please contact the Chronic Medicine Contact Centre for any inquiries regarding the processing and approval for chronic medication.

ACUTE MEDICATION

No over-the-counter medication benefit is available.

A dispensing GP will provide medication from the Acute medication formulary from the surgery.

A dispensing GP's prescription cannot be taken off at a network pharmacy.

If the GP is listed as a scripting GP, the prescription may be taken off at a network pharmacy.

Please visit our website to view the affiliated pharmacies.

DENTISTRY

Services are limited to basic dentistry through our network providers. This includes cleaning, pain control, fillings and extractions.

Emergency root canals and wisdom teeth extractions are covered if the procedure is done in the dentist chair in the surgery under local anaesthetic.

Full and semi-sedations by an anaesthetist are not covered.

OPTOMETRY

A 12-month waiting period applies for this benefit and is limited to one visit for eye tests per year per member, and contact lenses, frames or spectacles once every 24 months per member.

The amounts allocated for this benefit cover items for up to 65% discount on the item's normal listed price.

Visit our website for a list of network optometrists.

RADIOLOGY

Your network GP will complete an X-ray request form and refer you to a radiologist.

X-rays as per the Service Provider formulary only will be covered.

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

GROWTH SONARS

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

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

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

PATHOLOGY

Only network practitioners may request pathology tests.

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

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



VALUE-ADD BENEFITS

Essential Med provides all policyholders with 24/7 access to a dedicated helpline offering a vast array of useful services. Help when you need it most, and where speed is of the essence, is a mere call away.

For assistance, dial 0861 911 011 and we will gladly do the rest. Benefits are available 30 days after policy inception.

EMERGENCY MEDICAL RESPONSE

A single call from you (or a 3rd party) to our emergency number - 0861 911 011 - results in immediate action:

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

EMERGENCY IDENTIFICATION & 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:

- *Personal information*
- *Life-threatening allergies*
- *Medical history*
- *Major medical conditions*
- *Blood type*
- *Chronic medication*
- *Medical aid details*
- *Religious or special request*

Essential Med clients are easily identified through a range of multi-coloured 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).

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

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

PERSONAL HEALTH ADVISOR

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

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

LEGAL ASSISTANCE

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

- Criminal offences
- Fines
- Debt
- Contracts
- Divorce and maintenance

HOME ASSISTANCE

Covers the cost of the call-out fee, plus one hour of labour (up to R500) for:

- Electrical faults
- Plumbing
- Locksmith
- Glass window repair
- Appliances

ROADSIDE ASSISTANCE

Provides essential services if you have a mechanical or electrical breakdown and covers:

- *Cost of towing (to an approved dealer)*
- *Flat tyre (tyre change)*
- *Flat battery (jump start)*
- *Running out of fuel (10 litres of fuel supplied)*
- *Keys locked in car (locksmith)*

In addition 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 transport back to holiday or permanent residence in the event of theft or hi-jacking (maximum R500 per incident).*

TRAVEL MAP AND DIRECTION SERVICE

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 offers assistance should you become lost while travelling – directions are provided telephonically, or faxed/emailed to you before you commence your journey.



HOSPITAL INSURANCE PLAN

Essential Med's Hospital Insurance Plan ensures you can take care of the unexpected. Enjoy peace of mind knowing that your policy covers hospital visits, whether it be a planned procedure or emergency treatment. Our involved and caring assistance is always given when you and your loved ones need it most.

AFTER-HOURS ILLNESS EVENTS: HOSPITAL / CASUALTY VISITS

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

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.

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

Any hospitalisation for less than 24 hours will be for your own account. This may be reimbursed if you are a Day to Day benefits policyholder.

Download a Reimbursement Form from our website, complete it and forward it to us with proof of payment and a detailed account.

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 plan will pay 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.

An illness / maternity benefit of R15 500 is payable after the first three days in hospital, and is made up as follows:

- R6 500 payable after the first day in hospital
- R4 500 payable after the second day in hospital
- R4 500 payable after the third day in hospital
- Thereafter a further benefit of R1 500 is payable per day, up to a further 18 days per illness, per person, while in hospital

ILLNESS EVENT / MATERNITY HOSPITALISATION

An insured person may have many illness events in a year, however, benefits are only payable if the insured person is hospitalised. If an insured person is admitted to hospital for 5 days, and then a few weeks later is readmitted for the same illness, the insured person would only have benefits for a further 16 hospital days. However, if the insured person was readmitted for a different illness, they would have 21 days of cover available for the new illness. Should an insured person 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.

How it works:

Should an insured person be admitted for an illness for 5 days in hospital, the payment will be as follows:

- 1st 24-hour day: R6 500
- 2nd 24-hour day: R4 500
- 3rd 24-hour day: R4 500
- 4th 24-hour day: R1 500
- 5th 24-hour day: R1 500
- Total payout: R18 500

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

The 1st and 2nd day benefits are subject to a 90 day waiting period from inception of the policy and payable once per each 21-day illness period insured. For example, an insured person who is admitted to hospital for 5 days will not receive the same 1st and 2nd day benefit if they are re-admitted 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.

- *You first need to see a network GP, who will provide a letter of motivation stating the reason for hospitalisation and the respective codes.*
- *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.*
- *You are to contact Hospital Pre-Authorisation and provide the necessary details and nominated hospital. We make the necessary arrangements on your behalf and provide an authorisation number which you take to hospital to facilitate admittance.*
- *On discharge you will receive an account. This must be sent to us within three months from the end of the month in which the service was rendered. If not submitted within this period, the account will not be paid.*

Important:

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

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.

If you need an ambulance, call 0861 911 011 or go to the casualty ward at a hospital.

You or the hospital are to contact Hospital Pre-Authorisation for an authorisation number.

The stated benefit as per the schedule is up to R125 000 for a single person and up to R250 000 for a family per incident.

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.

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.

DREAD DISEASE EVENT HOSPITALISATION

The Dread Disease Benefit pays a lump sum of R1 85 000 in daily instalments of R9 000 (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 cover is available after 90 days of inception of policy.

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 up to R1 85 000 is payable.

Once an insured person is diagnosed and has been paid out for a specific dread disease, the insured person 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.

- *You first need to see a network GP, who will provide a letter of motivation, reason for hospitalisation and respective codes.*
- *If you are covered under the Hospital Insurance Plan, you will be liable for the account from the doctor who issues the referral letter for hospital admission.*
- *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.*

- *If you are positively diagnosed with a dread disease, the benefit provides cover of up to R9 000 per day for treatment whilst in hospital.*
- *On discharge you will receive an account, which has to be forwarded within three months from the end of the month in which the service was rendered. If not submitted within this period, the account will not be paid.*
- *There is a 30-day survival period whereafter the balance of the stated benefit will be paid over to your banking account.*

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.

DEATH BENEFIT

A Death Benefit of R10 000 is payable to the named beneficiary/s following the death of the principal insured client.

OTHER IMPORTANT FACTS

- *Please note that this is not a Medical Scheme; this is a Stated Benefit Insurance Hospital Plan.*
- *You may choose to use most private or state-run hospitals. Visit our website for a list of the preferred service providers in your area.*
- *All stated benefits are paid to the insured member.*

TERMS AND CONDITIONS

PLEASE DOWNLOAD THE HOSPITAL PLAN TERMS AND CONDITIONS DOCUMENT FROM OUR WEBSITE