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HOW TO CHOOSE A HEALTH INSURANCE

- ✓ Accident Cover
- ✓ Illness Cover
- ✓ Primary Care
- ✓ All the providers

Please note that the information in this publication is meant as an **introduction to the topic**, and should not be considered as accurate until confirmed by the insurer or your broker. Benefits, policies and regulations change regularly. **Always** speak to a broker before starting or changing an insurance or medical aid product.

OCTOBER 2025

Welcome!

You're reading *the* resource to help you make informed decisions about your health insurance.

I'm *thrilled* this guide found its way to you.

Choosing the right health cover is *ridiculously* complicated, so I hope our Guides at least help you have **informed conversations** with your broker, partner or friends.

When you are ready to do more research, please use our award-winning site, **rehealth.co.za**. There, you can view *all* the open medical aid plans, compare them for *every* benefit, get pricing, match to a gap cover and more. The site is **free**, does not require registration, gives you instant information and I *promise* nobody from my team will ever call to sell you an extended warranty :-).

Also: **join our newsletter, *Boost!*** We share medical aid hacks, wellness-info specific to us South Africans and lots of exclusive deals to help you keep your family healthy, for less. (rehealth.co.za/join)

Lastly, **please send me** your medical aid experiences - good and bad. I always learn something new from our community, and I can pass the info onto others. eved@rehealth.co.za

Wishing you good health, always

Eve D

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HEALTH INSURANCE 101

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How it works

Broadly speaking, health insurance can help you in three scenarios:

- with your **day to day** expenses (primary care)
- in case of an injury due to an **accident** (falling off a ladder, car accident)
- in case of **illness** (heart attack, kidney stones). Childbirth falls under this category too.

Health insurance plans come in all sorts of configurations, and you can choose to be covered for any combination of the above three scenarios. Often, an insurer will allow you to **custom-make** your own plan by stacking a number of optional benefits together. *Episodic* is a good example of this.

What is Primary Care?

This is cover for **day to day** benefits, like seeing your GP or getting an X-ray. Depending on your plan, you will either pay these costs upfront and be reimbursed later, or your insurer will have an arrangement with the service provider. See *page* 6 for more detail.

Tip: *Oneplan tops up a dedicated debit card that you can then use to pay for the services*

What is Accident Cover?

This is for all unplanned events that occur due to an external source, and that require medical attention. (See sidebar for more detailed definition). Accident cover is usually separated into three levels:

- Casualty only ie no admission to hospital is covered
- Stabilisation only. You can be admitted to hospital until you are stabilised. You can then be discharged or moved to a State facility.
- Treatment. You are treated in private hospital until discharged, or until cover runs out.

See page 8 for more detail on available benefits.

What is Illness Cover?

"Illnesses" are medical events that are not caused by an external source. Examples include a stroke, hernia or cancer. Illness cover is broadly separated into three levels:

- **Casualty** only
- Hospital Treatment, for conditions that require you to be admitted to hospital
- Extra cover for **dread diseases** (cancer, heart attack, stroke)

Every plan will have their own spin on these, with specific limits and conditions, and different combinations of benefits. See *page 14* for more detail on available benefits.

Pre-Existing Conditions

Just like with any other healthcare cover products, you will likely have a waiting period for any pre-existing condition, usually 12 months.

Some plans also have general waiting periods when you first join, although those can sometimes be waived for claims arising due to an accident.

There are also condition-specific waiting periods. For example, there is usually a 12 month waiting period before maternity benefits are available.

WHAT IS AN ACCIDENT?

It's a sudden and **unexpected** event, that occurs at an **identifiable time** and place, and that requires **immediate medical treatment** due to physical **injury** caused by **physical impact**, and that is **independent of** illness, disease or other bodily malfunction.

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How it works (2)

How much does it cost?

Plans start at about R200 per person, and go up to R1,500+.

Policies are usually quoted **per person**, and there are different rates for main members, adult dependants and children.

Children over the age of 21 are usually considered to be adult dependents, although some insurers like *Episodic* charge child rates up to the age of 26 if child is a full time student.

Note that unlike medical aid, health insurance providers can limit cover to a certain **maximum age**, or charge a higher premium for seniors. Some insurers (*Example: Unity Health*) will waive the senior penalty if you can prove continuous membership of medical aid for the past 15 years.

SOME PROVIDERS

- ☐ Affinity Health (*affinityhealth.co.za*)
- ☐ Day1health (*day1health.co.za*)
- ☐ Dischem Health (*dischemhealth.co.za*)
- ☐ Elixi (*elixi.co.za*)
- ☐ Episodic (*episodic.co.za*)
- ☐ EssentialMed (*essentialmed.co.za*)
- ☐ Flexicare (*discovery.co.za*)
- ☐ GetSavvi (*getsavvi.co.za*)
- ☐ Health4me (*bloom.insure*)
- ☐ Kaelo Health (*kaelo.co.za*)
- ☐ NetcarePlus (*netcare.co.za*)
- ☐ OnePlan (*oneplan.co.za*)
- ☐ Stratum (*stratumbenefits.co.za*)
- ☐ Unity Health (*unityhealth.co.za*)

Can you have medical aid and insurance?

Yes. This makes most sense for primary care cover, where you can **complement your "hospital" medical aid** with day-to-day cover for GPs, x-rays and medications as well as cover for all ER events.

Note: *Some plans do not allow you to be on the plan and medical aid. (Example: Discovery's Flexicare).*

How do claims get paid?
For day-to-day costs, you can either pay out of pocket and be reimbursed later, or you can use a network provider with a payment arrangement with your insurer.

For hospital admissions, you need pre-authorisation which will give you a GOP (**guarantee of payment**) which most hospitals honour. Alternatively, any cash lump sums will be paid directly to you.

What are group Policies?

Group policies can be taken out by companies to provide their employees with healthcare cover as an added benefit to their pay package. They work out cheaper than individual policies, and can often be negotiated on the finer details. See page 13 for other benefits of a group policy. (Example: Kaelo)

You can also take out cover for your domestic staff or other third parties.

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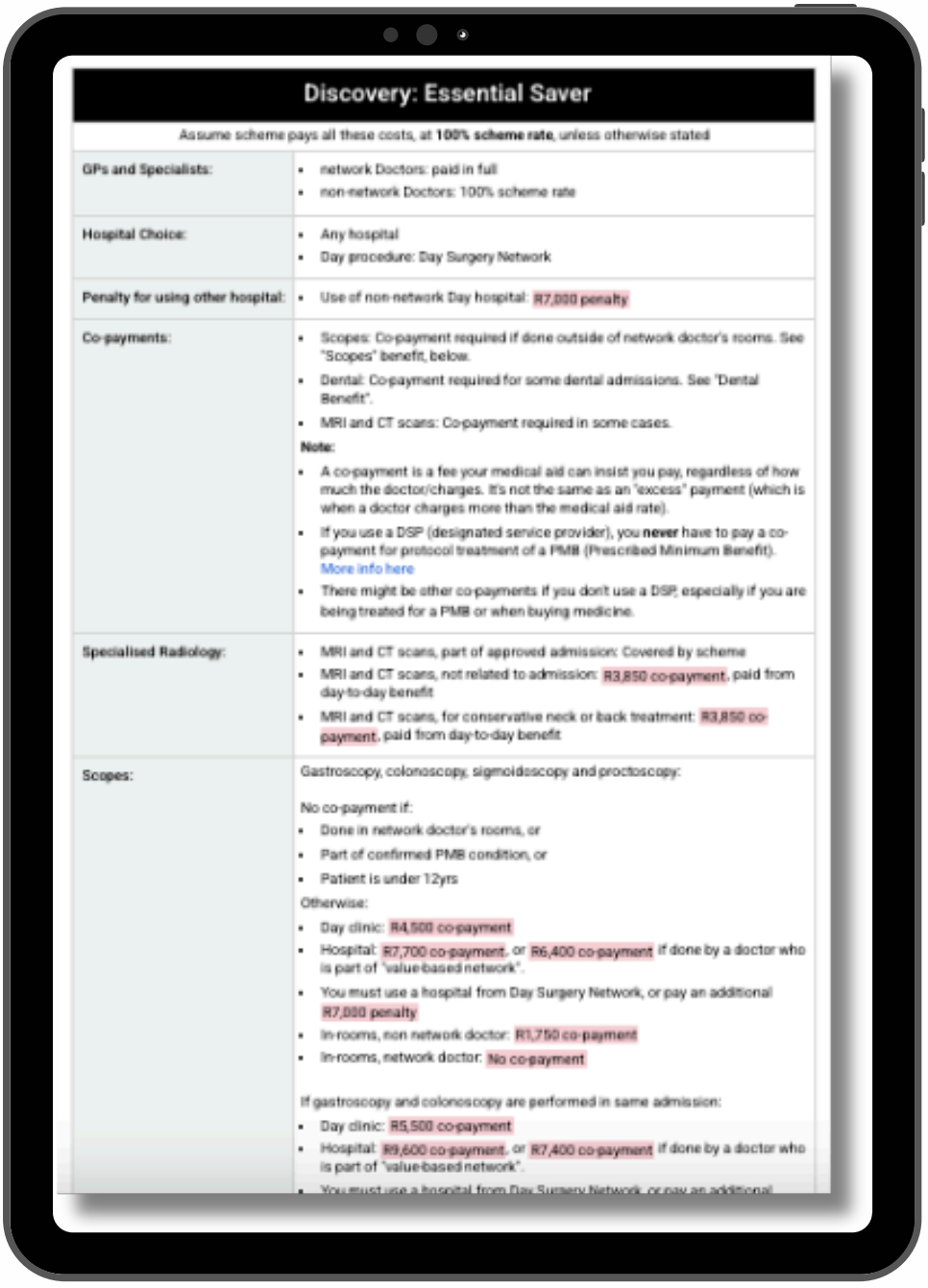
HOW REHEALTH CAN HELP YOU:

View all the plan benefits!

We list *all* the benefits, for *all* the open plans so you can quickly see what cover you have. (**Tip:** Find your plan code at the end of this guide, and use it on rehealth.co.za/code for quick access)



Discovery: Essential Saver

Assume scheme pays all these costs, at **100% scheme rate**, unless otherwise stated

GPs and Specialists:	• network Doctors: paid in full • non-network Doctors: 100% scheme rate
Hospital Choice:	• Any hospital • Day procedure: Day Surgery Network
Penalty for using other hospital:	• Use of non-network Day hospital: R7,000 penalty
Co-payments:	• Scopes: Co-payment required if done outside of network doctor's rooms. See "Scopes" benefit, below. • Dental: Co-payment required for some dental admissions. See "Dental Benefit". • MRI and CT scans: Co-payment required in some cases. **Note:** • A co-payment is a fee your medical aid can insist you pay, regardless of how much the doctor charges. It's not the same as an "excess" payment (which is when a doctor charges more than the medical aid rate). • If you use a DSP (designated service provider), you **never** have to pay a co-payment for protocol treatment of a PMB (Prescribed Minimum Benefit). More info here • There might be other co-payments if you don't use a DSP, especially if you are being treated for a PMB or when buying medicine.
Specialised Radiology:	• MRI and CT scans, part of approved admission: Covered by scheme • MRI and CT scans, not related to admission: R3,850 co-payment, paid from day-to-day benefit • MRI and CT scans, for conservative neck or back treatment: R3,850 co-payment, paid from day-to-day benefit
Scopes:	Gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy: No co-payment if: • Done in network doctor's rooms, or • Part of confirmed PMB condition, or • Patient is under 12yrs Otherwise: • Day clinic: R4,500 co-payment • Hospital: R7,700 co-payment, or R6,400 co-payment if done by a doctor who is part of "value-based network". • You must use a hospital from Day Surgery Network, or pay an additional R7,000 penalty • In-rooms, non network doctor: R1,750 co-payment • In-rooms, network doctor: No co-payment If gastroscopy and colonoscopy are performed in same admission: • Day clinic: R5,500 co-payment • Hospital: R9,600 co-payment, or R7,400 co-payment if done by a doctor who is part of "value-based network". • You must use a hospital from Day Surgery Network, or pay an additional

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Insurance vs Medical Schemes

Medical aid and medical insurance are **two very different products**, and it's important you understand the differences, so you can make informed choices.

Generally speaking, medical aid gives you **better cover for claims**, but it is also considerably more **expensive**.

With health insurance, if you choose your plan wisely (speak to your broker!) you should get access to private care when you need it most, but with the possibility - for serious cases - that you will finish treatment in a state facility.

Cost vs Benefits

All medical aids have a **generous benefit** for hospital events - in fact, for most serious conditions the benefit is almost literally unlimited. If you need to spend 60 days in the ICU due to an illness, your medical aid will most likely pay. If you need extensive oncology treatment, dialysis or critical mental health help, medical aid will cover at least part of the claim.

It's ***not* reasonable** to have such expectations from an insurance product. Afterall, the goal is to provide **cheaper options** than medical aid, and to do that, it follows that benefits have to be contained.

This does put patients at risk of no cover should their insurance benefit run out. And because it is impossible to foresee what emergency you might have in the future, or how much it will cost to treat, it is difficult to choose an appropriate insurance plan.

PMB Cover

This is the most significant difference between medical schemes and insurance products.

Medical schemes *have to* cover the cost of managed care for 270 PMB conditions, in and out of hospital, regardless of the member's plan (see our Medical Aid Guide for an explanation on this). The plus side of that is that you know you always have **full cover for any life threatening or serious conditions**. On the downside, since it costs on average over R850+ per patient per month to provide this level of cover, medical aids are expensive and you are forced to pay for benefits you might not want or need.

Insurance plans have no such PMB requirements, and insurers can be very specific and selective about what they do and do not cover. On the minus side, it means **you aren't guaranteed the cover you might need** in an emergency, but on the plus side you do have many options of **more affordable premiums**.

Unlimited Enrollment

Medical schemes cannot deny enrollment to anyone, regardless of their age or how sick they are. They also cannot exclude cover for any pre-existing condition for more than 12 months.

Insurers on the other hand, can deny cover of pre-existing conditions. Some insurers even define a pre-existing condition as one that is diagnosed in the first 6 months of their cover, and reserve the right to not provide cover for that condition going forward. Insurers can also charge higher premiums for senior age groups.

Waiting Periods

With medical aids, the maximum waiting period is 12 months, and that's only for pre-existing conditions under certain circumstances.

Insurers can impose any waiting periods they want, and many impose 12-24 month waiting periods on regular procedures like tonsillectomy or hernia repair, even if they are not pre-existing conditions.

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Insurance vs Medical Schemes (2)

Cover for newborns

With medical aid, newborn babies born to a mother with medical aid receive **full cover immediately on birth**, irrespective of any waiting periods or restrictions on either of the parents. That means the baby is guaranteed some level of private care if it is born with complications, or for a premature birth (see our *Medical Aid Guide* for more on this).

With health insurance, newborns usually **share benefit limits with the mom**, and have more onerous criteria for receiving full cover. For example, many insurers will not cover a baby if it is not discharged with a clean bill of health post-birth. That means that insurance won't pay for further hospital admissions.

Family Composition

Many medical aids consider children who are full time students as child dependants up to the age of 25 or 26.

Insurers tend to limit age of child dependant to 21, after which the child is treated as an adult. Also, medical aids often only charge for 2 or 3 children, whereas insurers tend to charge for all children.

Late Joiner Penalty

Medical schemes charge a potential late joiner penalty if you are over a 35 yrs old, and haven't had continuous medical aid cover.

There is no late joiner penalty for insurance products.

Medical Schemes Act

Only medical aids are governed by the Medical Schemes Act, which has very **strict restrictions** on what medical aid schemes can and cannot do. This piece of legislation has proved extremely useful for members when they **challenge how claims** are paid.

Insurers don't have such strict limitations, and can impose "small print" conditions unique to their product, and often you will only realise the impact when you claim.

Customizable Plans

Medical aid members don't have the option of a non-hospital plan: they have to pay for a plan that covers hospital admissions. And they don't have a choice to opt out of non-accident events.

With insurance, you can choose to only be covered for day to day expenses, or only accidents etc. You can customize your cover to your needs and wants.

Gap Cover Option

Medical Aid members have the option of supplementing their plan with gap cover.

There is no such option for insurance plans, although members can have multiple insurance products to extend cover.

Preventative Benefits

Because medical aids are responsible for so many claims, it is in their best interest to keep members as healthy as possible. Almost every medical aid plan comes with a lot of **"extra" benefits**, all focussed on wellness and preventative care. These can include mammograms, pap smears, PSA checks, flu shots, immunisation and more. There will also be managed programmes that help with oncology, spinal problems, maternity and more.

Few insurance plans offer more than an annual **wellness check**.

Non-Profits

Medical aid schemes are non profit organisations (although, as a loophole, the *administrators* that manage them can do so for a profit).

Insurers, on the other hand, are always a **for-profit business**. That means their incentives are somewhat differently aligned.

HOW REHEALTH CAN HELP YOU:

Compare any 2 plans

Instantly compare any 2 plans side by side for every benefit, as well as costs and savings accounts. Make informed decisions about yor plan. (No registration, no forms, and no calls!)

In Hospital Procedures

	Essential Saver	BonSave
	Discovery Health	Bonitas
non-Network Specialists:	• 100% scheme rate	• 100% scheme rate
Network Specialists:	• Covered in full	• Covered in full
non-Network GPs:	• 100% scheme rate	• 100% scheme rate
Network GPs:	• Covered in full	• Covered in full
Hospital Choice:	• Any hospital • Day procedure: Day Surgery Network	• Network hospital • Day procedure: Day network hospital
Penalty for using other hospital:	• Use of non-network Day hospital: R7,000 penalty	• Use of non-network long stay hospital: 30% penalty • Use of non-network Day Hospital: R5,170 penalty
Specialised Radiology:	• MRI and CT scans, part of approved admission: Covered by scheme • MRI and CT scans, not related to admission: R3,850 co-payment, paid from day-to-day benefit • MRI and CT scans, for conservative neck or back treatment: R3,850 co-payment, paid from day-to-day benefit	• MRI and CT Scans: R30,430 per family, in and out of hospital • R1,860 co-payment, unless PMB

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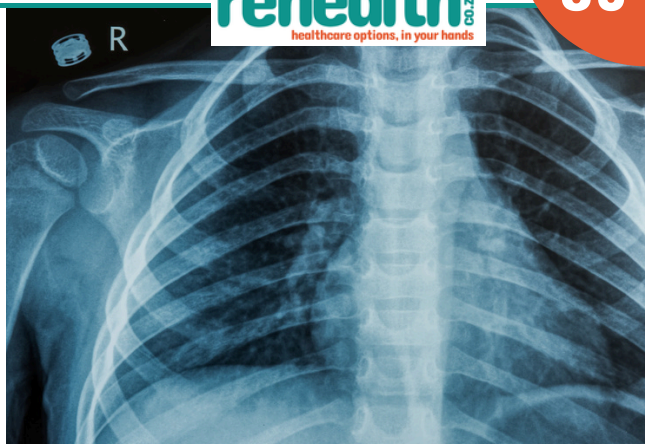
Primary Care



The first pillar of health insurance is the benefit that pays for various **day to day expenses**, also known as primary care.

You can use this benefit as a standalone plan (no hospital cover), or as an addition to your "hospital" medical aid plan.

Note: not all these benefits are available on all the plans.

Doctor (GP) Visits

There are usually two types of benefits for GP consults:

- You have **unlimited** consults available, from a network of doctors or (*Example: Discovery Flexicare, Episodic, Stratum, Healh4Me*)
- You have a **Rand limit per consult**, and can choose any GP (*Example: Affinity, Oneplan*)

Some plans will give you both of these options (*Example: Unity Health*).

There might be implied limits, even in "unlimited" benefits. For example: OnePlan Core plan pays up to R400 for a GP consult, but has an *overall* R13,465 per family limit for *all* primary healthcare services.

Other things to consider:

Q: *When will the claim be paid?* If you are seeing a network doctor, chances are they will claim from the insurer directly. But if you are seeing a non-network GP, you would need to pay out of pocket first and be reimbursed later.

Tip: *Oneplan gives you a debit card which they top up with funds prior to you seeing the doctor, so you are not out of pocket.*

Q: *Is prescribed medicine covered by the insurer?* See next section.

Q: Are minor procedures covered? Some plans include minor in-room treatments like stitches, and casts. *(Example: Affinity Health, Flexicare)*.

Tip: *Some insurers offer unlimited nurse consults at clinics like Clicks (Example: Elixi).*

Medication

Your plan can cover prescribed medication, over-the-counter medication and even chronic medication (*Example: Dischem MyHealth Plus Plan, EssentialMed, Health4me*).

Even with this benefit, the insurer will have a list of medicine it is obliged to pay for (this is known as the formulary), and any medicine not on the list needs to be paid out of pocket.

Tip: *Watch out for waiting periods and exclusion of pre-existing conditions, especially if claiming for chronic medicine.*

Specialist Consults

Not all plans offer this benefit.

If this is a benefit on your plan, you are usually able to choose your own specialist, but must be referred by a GP.

There are always strict limits on the maximum claim allocated to specialists. In addition, check if the limits are per person or per family. (Example: Kaelo Health, Unity Health).

Blood Tests and X-rays

Insurers often cover basic blood tests and black and white x-rays under the Primary Cover benefit, although these will most likely need to be requested by your GP first and be obtained from specific providers.

Primary care plans rarely cover specialised radiology, such as MRI or CT scans but accident and illness policies might do so.

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Primary Care

continued...

Vaccines

This can include the first immunizations for children and flu shots for adults *(Example: Flexicare)*.

Some plans offer more extensive vaccine cover, including a combination of pneumococcal vaccination, hepatitis A and B vaccination, and tetanus vaccination. There are usually limits to the frequency of f these. *(Example: Stratum, GetSavvi)*

Preventative Benefits

Some plans pay for a pap smear and prostate screening (*Example: Stratum, Elixi, Unity Health*).

Wellness

Your plan might include an annual wellness check. This can consist of checks of blood pressure, blood glucose (blood sugar), cholesterol and body mass index (BMI). (Example: *GetSavvi, Flexicare, Kaelo Health*).

Dentistry

Premium primary plans often cover standard dentistry, with a “per consult” limit, as well as an overall limit per year. Standard dentistry most often includes consults, fillings and extractions. *(Example: Stratum, Health4Me).*

Specialized dentistry like crowns, implants and dentures are rarely covered on a standard plan, although you can sometimes upgrade your cover at an additional cost. *(Example: EssentialMed)*

If you need hospitalization for your dental issues (due to trauma or cancer, for example) this would only be potentially covered under an Illness or Accident insurance plans .

Tip: *Stratum offers cover for root canal as part of a primary care plan. Kaelo MyHealth Plus pays for dentures.*

HIV Treatment

This benefit includes a regular HIV test, and can include treatment, antiretroviral drugs as well as counselling. *(Example: Kaelo Health, Affinity Health)*

Optometry

With this benefit, you can get cover for annual standard eye tests and a set of glasses, once every 24 months.

There is often a 12 month waiting period for this benefit, and you will need to use network providers. (*Example: Unity Health, Elixi*)

Maternity

This does not include paying for the delivery of the baby. But you can get extra benefits such as 2D or 3D scans, blood tests, prescribed medication and consults with gynaecologists. (*Example: Affinity Health, Unity Health, One Plan*)

How to use primary care with your medical aid

Health insurance can help you save money on your medical costs. It can also help you **choose a cheaper medical aid plan** (similar to how a gap cover does, see our *Gap Cover Guide*).

You can choose a plan **without a medical savings account**. Instead, you can rely on a health insurance plan to cover your GP costs, medication and x-rays. You will still receive cover from your medical scheme for any PMB related claims, and - depending on your health insurance plan - can enjoy unlimited GP consults.

Of course, not all your claims are guaranteed to be covered: for example, you will still possibly have to pay out of pocket for specialist consults. You can still opt to use a medical savings account to cover these claims.

But if you can only afford a “hospital only” medical aid, health insurance might be a clever way to bridge the gap of unpaid claims, especially for GP and medication costs.

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Shhhhh!

We tell you things the medical schemes don't want you to know

Our weekly newsletter is **full of secrets and hacks** to get the most out of your medical aid.
PLUS: Wellness news, tips, deals, stories and more...

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Accident Cover

Hospitalisation is usually required because you have had an unexpected accident (fallen off a ladder, attacked by a dog, involved in a car collision), or because something has gone wrong "healthwise" (kidney stones, stroke, cysts). You need different cover for each cause. Here we deal with Accident Cover.

Note that plans that cover treatment needed as a result of an accident are usually much cheaper than those for illness (see *page 12*).

Note: not all these benefits are available on all the plans.

Casualty Benefit

Two types of cover for casualty as a result of an accident:

- Requires **admission** to hospital
- Does **not require** admission

If there is no admission required, then you will be using a simple "ER accident" benefit. These usually have a per event and per year limits and will apply to "per person" or "per family".

If your injury *does* require admission to hospital, then things get more tricky. In order to be covered for this portion, you need some sort of hospital benefit.

Tip: *Be careful. Some ER benefits only apply to "after hour" visits.*

Hospitalisation

There are three main types of hospital cover for accidents:

- has a flat limit, per event or per year. (*Example: Flexicare has R1 million limit, Affinity Health has R275,000 per event limit*)
- and/or has a cash payout per day spent in hospital (*Example: Stratum pays additional R2,000/day*)
- pays for stabilisation only

Cash payouts are paid to you directly, and can be used at your discretion.

If you have a stabilisation only benefit, once you are stabilised you will need to provide alternative cover to continue to stay in a private hospital.

[illegible]tcare has no limit if you are treated in one of their hospitals for less than 90 days

Heart Attacks and Stroke

Some plans are including heart attacks and strokes under their "accident-only" plans, and are providing an explicit sublimit to treat these. Normally, this would be an "illness benefit". See page 12 for more on that. *(Example: Dischem Health)*

MRI and CT Scans

With this benefit, you will be covered for specialised radiology if you are admitted to hospital due to accident. Without this explicit benefit, all such costs will likely need to be paid out of your cash payout or other sublimit, unless otherwise stated.

There will be a limit to this benefit, and hospital admission is a requirement. (*Example: Elixi, Stratum*)

Disability Payout

This is a **lump sum cashout** should you be disabled as a result of an accident. *(Example: OnePlan)*

In a similar vein, some plans have a benefit to pay for out of hospital **rehabilitation and physiotherapy**, if you were hospitalised due to an accident. *(Example: Stratum)*

Funeral and Death Cover

On a more sombre note, should you die as a result of your accident, this benefit would pay out a lump sum to your family, either to help with funeral expenses or to alleviate other financial pressures. (Example: OnePlan and Elixi)

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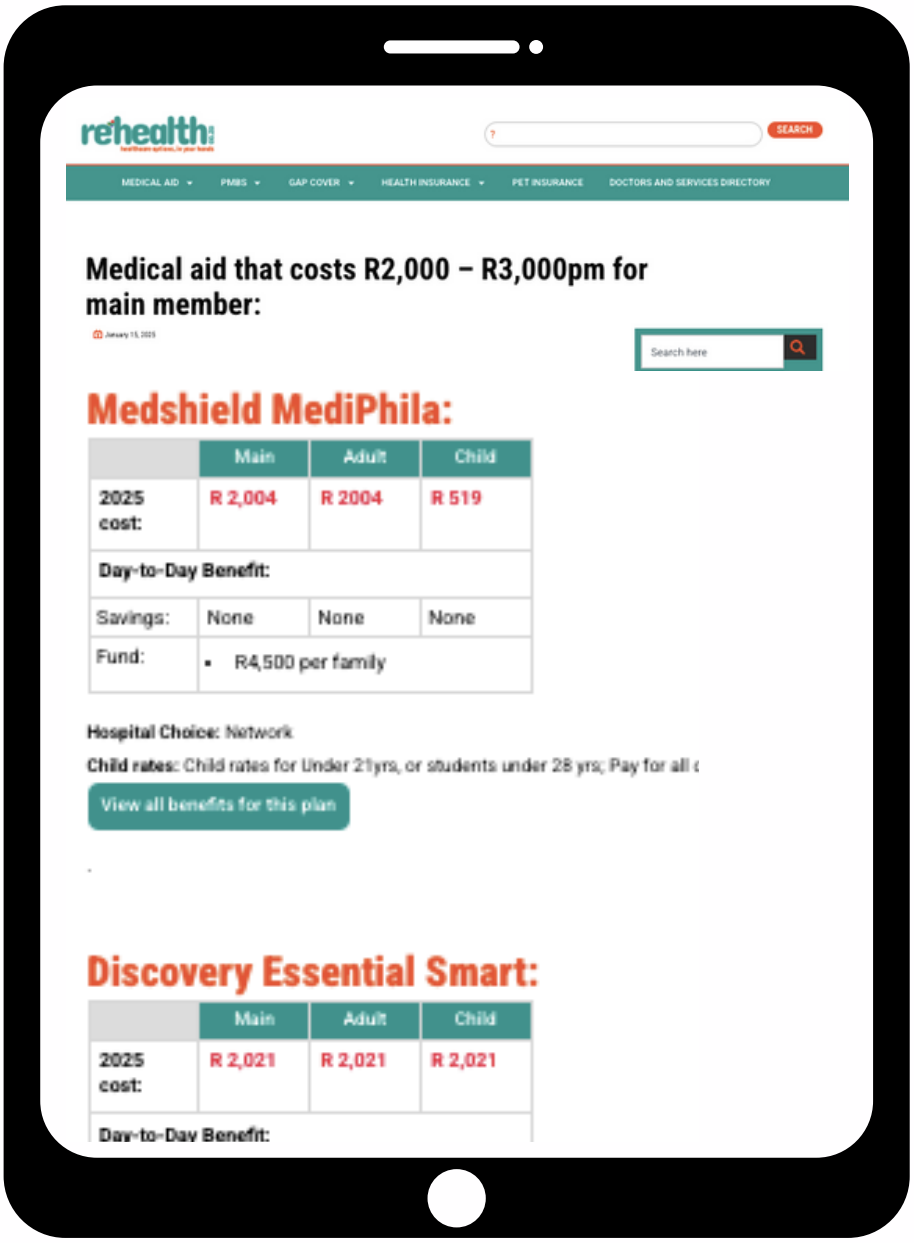
Find a new plan by price!

There are over 200 plans!
On rehealth.co.za you can find a new one by price,
to match your wallet and save time.



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View and compare the benefits of *any* open medical aid plan

HEALTH INSURANCE 101

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Illness Cover

Illness Hospital Benefit can help pay for costs associated with hospital stays and treatment, but because such procedures are often unpredictable in costs, you should not expect to have comprehensive cover in the event of an illness.

Nevertheless, insurers have come up with some very clever and helpful plans that will alleviate some of the stress around hospital admissions.

Remember that this benefit is separate to "Accident" benefits, as described on *page 11*.

Note: not all these benefits are available on all the plans.

Casualty

Illnesses that require a visit to ER might be sudden shortness of breath, food poisoning, high fever. There are two types of cover for casualty as a result of an illness:

- **Requires admission** to hospital
- Does **not require** admission

If there is no admission required, then you will be using a simple "ER accident" benefit. These usually have a per event and per year limits and will apply to "per person" or "per family". But make sure your ER benefit covers you for illness!

Hospitalisation

Your plan will at least partially cover stays and treatment in private hospitals, and possibly procedures in day hospitals too (*Example: Affinity Health Hospital Plan*).

Cover for illness hospitalisation can range from unlimited to a set limit per day, (*Example: Affinity Health*) or set limit per year or event.

Some plans also pay out a fixed, lump sum for specific procedures, sometimes in addition to a per-day payout. Example, EssentialMed pays R21,200 for a hernia repair.

Size of benefits is of course related to the premium cost. It is difficult to predict just how expensive surgery or hospital stays can get, so it's important to make sure your plan matches your risk and your pocket. Speak to your broker about your options.

Sub Acute Treatment

If your illness requires a **step down facility** post treatment, some insurers will include this benefit. *(Example: Affinity Health)*

ICU Stays

An optional benefit that pays out per day spent in ICU. Limits daily payout and days paid. *(Example: EssentialMed)*

Dread Disease

Some plans will include additional cover for dread diseases like cancer, heart attack and stroke. (*Example: Affinity Health*).

Birth

Plans will often include a pre-set amount for natural and/or C-section delivery. Many hospitals also charge a set fee for private patients, so you will have a good idea of your financial exposure.

Expect a 12 month waiting period from for this benefit.

Newborns are rarely automatically covered (like they are with medical aid). Some insurers provide specific cover for newborns in the first weeks post-birth. (*Example: Oneplan*).

Also Available:

- Post hospital private nursing
- Ambulance transport, repatriation and trauma support.
- Funeral policies and death cover

YOUR UNFAIR ADVANTAGE?

Employee Benefits

HOW TO EASILY BOOST PRODUCTIVITY, JOB SATISFACTION AND PROFITABILITY

Employers who prioritise the health and well-being of their employees gain competitive advantages in the market, leading to considerable increases in productivity and hence, profitability.

It's not difficult to see the logic. The public sector is unable to bear the burden of providing healthcare to the 52 million people who are unable to access private care. Public hospitals often have 7-hour waiting times just to see a doctor and collect medication. And even those with private care are looking for more affordable solutions.

Not convinced? Here are **5 good reasons** to include health insurance as an employee benefit:

1. REDUCTION IN ABSENTEEISM

Unplanned absenteeism is disruptive to processes and operations, places strain on the at-work employees and leads to a negative culture. Current absenteeism rates are around 12 days per employee per year!

The Fix: *With a well-designed health insurance product that includes good day-to-day benefits, a comprehensive network of providers and astute mental well-being care, absenteeism can be reduced by up to 84%.*

2. INCREASE IN PRODUCTIVITY

Employee benefits that promote health and well-being, for employees and their families, increase job satisfaction and boost morale. When employees recognise that their employer is meeting their external needs they are motivated to work harder and perform better.

Bonus: *There is also a reduction in stress levels when employees are covered for potential unforeseen medical events.*

3. REDUCTION OF BURDEN

South Africa has an epidemic of chronic and non-communicable diseases, and has one of the highest disease burdens of all countries in the world. This has been aggravated by largely undiagnosed conditions.

Wellness screenings offered by health insurance products are a key mechanism used to detect, diagnose and treat employees and reduce mortality and disability rates for those with chronic diseases or severe illnesses.

4. COST-EFFICIENT SOLUTION

Individual cover is surprisingly affordable, but when purchased on a group basis (especially on a compulsory level), further savings of up to 50% can be achieved due to the pooling of risk and diminishing admin fees. Employers can potentially also claim a tax relief for the contributions to the products.

5. TOP EMPLOYER EFFECT

Health insurance is widely becoming a "must-have" in employment packages in South Africa. By offering it to their employees, companies are seen as a "top employer". They can more easily attract and retain premium talent, while also benefiting from the other built-in advantages of productivity and job satisfaction.

HOW TO GET STARTED:

At Kaelo our mission is to provide more South Africans with access to affordable, quality healthcare. As a leading provider in healthcare, we offer innovative, essential solutions enabling the physical and psychological well-being of all South Africans.

Contact your health intermediary to explore what options would be suitable for your employees or contact salesadmin@kaelo.co.za.

Kaelo Risk (Pty) Ltd, is an authorised Financial Services Provider (FSP 36931).
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Medical Insurance is not a Medical Scheme and the cover is not the same as that of a Medical Scheme. Medical Insurance is not a substitute for Medical Scheme membership.


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