ONE PLAN™

Gap Cover

GAP COVER

Learner Guide

www.oneplan.co.za

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Contents

Purpose

This guide serves as a reference of knowledge as you travel the Oneplan journey to competency.

Learning outcomes

Once the training programme is concluded you will be able to:

- Demonstrate a firm understanding of:
    - All processes and procedures
    - Email etiquette to communicate in a professional manner whether internally or externally.
    - GAP plans and features
    - The legislation regulating the industry and Oneplan GAP
    - Operational terminology
- Follow and deliver the relevant scripts according to company's policies and procedures.
- Accurately capture customer information on OPA and Connex/Softphone.
- Understand the QA process and its impact on you and our clients.
- Be able to accurately resolve and give feedback to the customer with regards to policy changes and queries.
- Comply with operational processes and procedures.

1. Introduction to GAP Cover

In this introduction, we will look at the new Oneplan Accident and Health Plan, which is based on medical expense shortfall policies under the Short-Term Accident and Health categories, and is often known as GAP Cover.

The product is described below in the Short-Term Insurance Act.

CATEGORY	CONTRACT TYPE	CONTRACT DESCRIPTION	REQUIREMENTS RELATING TO POLICY BENEFITS
1	Medical expense shortfall	A Contract: a) In terms of which a person, in return for a premium, undertakes to provide policy benefits if a health event contemplated in the contract as a risk event occurs, and b) The purpose of which is to cover the difference or a part of the difference between the total costs or expenses of a relevant health service and the amount a person's medical scheme paid.	Policy Benefits: a) Are one or more sums of money; and b) In aggregate do not exceed R198 000.00 (One hundred and ninety eight thousand rands) per insured per annum.

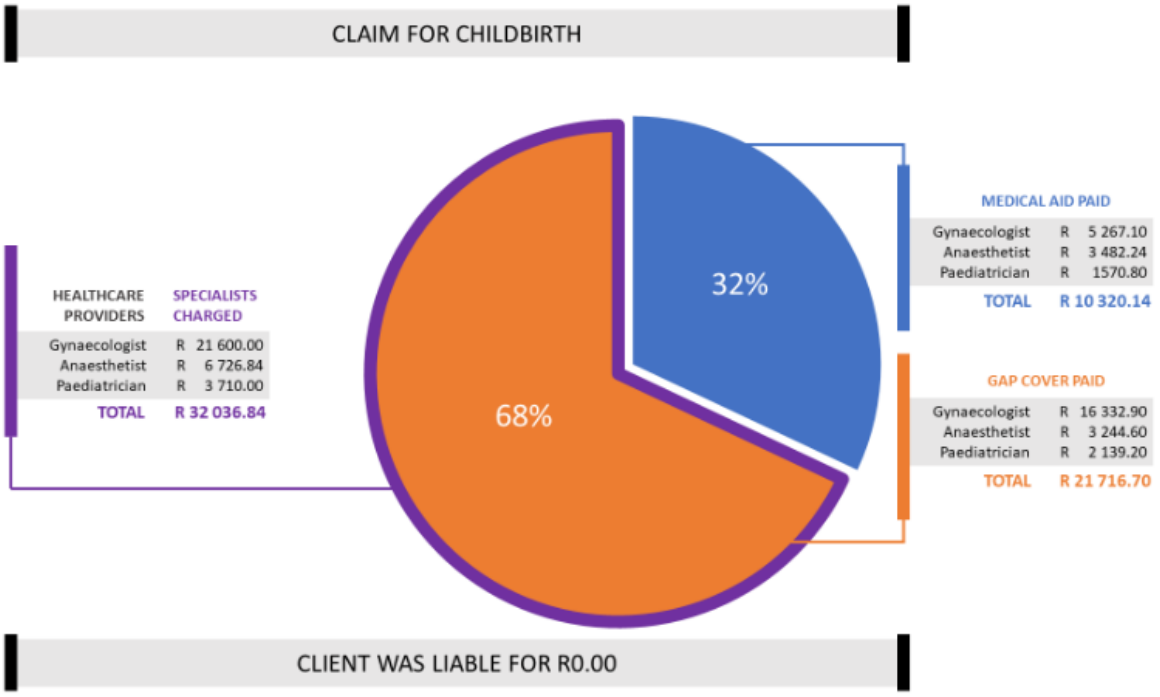
So, if we dig a little deeper, this means the shortfall that is created between what a registered medical aid in South Africa pays when a health event occurs and what the Hospital or Medical Provider charges. Medical scheme rates (MSR) are the amounts a medical aid scheme is prepared to pay for specific treatments and procedures.

What is the National Health Reference Price List NHRPL?

- This is a list of tariffs regarding health care professionals.
- The government releases the NHRPL annually.
- The Department of Health is responsible for the list
- It serves as a guideline for, not as an enforceable regulation of, rates.
- Medical aids use it to determine how much they pay out.

- Each year the Department of Health publishes the National Health Reference Price List (NHRPL). The Department draws up the list, which serves as a guideline for the cost of medical procedures and fees for medical practitioners.
- Entry-level medical aid options usually pay for in-hospital expenses at 100% of the scheme rate. More expensive, comprehensive plans pay up to 300% of the scheme rate, but therein lies the rub.
- Specialists can, and do, charge up to five times the scheme rate, and there's no prohibitive legislation stopping them from working with high profit margins.

Therefore, depending on what Medical Aid Plan a client has, a medical aid may, for example, only cover 100% of an event but the specialist or other providers may want 200%, 300% or 500% of the RPL published rates.



2. Legal Definitions

Learning outcome

By the end of this section, you will be able to explain the definitions in accordance with the policies and procedures of Oneplan Insurance.

Term	Explanation
Accident	A sudden, unexpected, unforeseen, unusual, unintended event which occurs at a specific time and place, excluding suicide or attempted suicide, the result of which incident requires immediate medical attention.
Acute Medication	This is medicine used for diseases or conditions that have a rapid onset, severe symptoms, and that require a short course of medicine treatment that is not considered to be chronic medication.
Admission	A prolonged stay (overnight as an in-patient) in a facility that meets the definition of a hospital; this does not include casualty wards.
Application form	The form that the Principal Insured completes and shall be the legal basis for the selection of cover. This may be paper, electronic or voice recorded applications.
Calendar month	A calendar month is the period from the 1st day in one month to the last day of that month; therefore, as an example, from April 1st to April 30th. A calendar month is not a fixed number of days but varies according to the actual month concerned.
Children	The Principal Insured's unmarried minor children who have not yet reached the age of twenty-one. This age may be extended to twenty-three in respect of an unmarried child who is a full-time student and who is dependent on the Principal Insured. There will be no age restriction for children who are either mentally or physically incapacitated from maintaining themselves, provided that the children are dependent on the Principal Insured for support and maintenance.
Chronic	Any illness or disease that requires medication or treatment for an uninterrupted period of more than 3 months.

Combined Annual limit	The maximum amount of coverage provided by this policy per insured, within a policy year (12 months from inception). The combined limit is the cumulative amount available for all claims made by the insured during the policy period, regardless of the number of individual claims or occurrences. Once the combined limit is reached, there will no longer be coverage for additional claims, even if the individual claim limits or sub-limits have not been exhausted.
Day	Where an Insured Person has been admitted before 24h00 as an inpatient in a medical facility and then follows to include a portion of the next consecutive 24-hour period.
Dependant	A spouse, partner, children under the age of twenty-one or children over the age of twenty-one dependent upon the Principal Insured due to mental or physical ability or still financially dependent on the Principal Insured.
Event	An occurrence that would cause the Insurer to pay a claim as per the cover provided in this policy. A health event refers to a specific occurrence or incident that affects an individual's physical, mental, or emotional well-being. It typically involves an illness, injury, or condition that requires medical attention, diagnosis, treatment, or management. <u>Examples of health events include but are not limited to:</u> **Illnesses:** Such as respiratory infections, gastrointestinal disorders, chronic conditions like diabetes or asthma, or infectious diseases like influenza or COVID-19. **Injuries:** Including fractures, sprains, burns, wounds, or any physical trauma resulting from accidents, falls, or other incidents. **Surgical Procedures:** Any planned or emergency surgical interventions, such as appendectomies, orthopaedic surgeries, or cardiac procedures. **Out of Hospital Medical Treatments:** Non-surgical treatments or interventions, including chemotherapy, radiation therapy, physical therapy, or rehabilitation programs. **Mental Health Events:** Instances involving mental health concerns, such as anxiety disorders, depression, post-traumatic stress disorder (PTSD), or any other condition affecting mental wellbeing.

Exclusions	Any conditions or illnesses that are excluded as determined by your Scheme and/or exclusions listed under this policy.
Fraud	If any claim under this policy be in any respect fraudulent, or if any fraudulent means or devises be used by you or anyone acting on your behalf, to obtain any benefit under this Policy - or if any accident, loss, destruction, damage or liability be made through a suspected collusion by you, all benefits under the claim shall be forfeited and the policy will be cancelled.
Grace Period	This is the period of grace allowed for non-payment of premium. The Grace Period is fifteen days after the month in which the premium was due and is applied from the second month of cover. If you select a date other than the first of each month, you must ensure we have received your premium before you may claim. During the Grace Period, the policy will be suspended, and no claims will be entertained. The Insurer reserves the right to cancel the policy after non-receipt of a premium within the Grace Period.
HIV	Human Immunodeficiency Virus that breaks down the human body's immune system and can cause acquired immunodeficiency syndrome (AIDS). AIDS is a condition where the immune system begins to fail, leading to life threatening opportunistic infections.
Hospital	An institution for health care providing patient treatment by specialised staff and equipment, for sick or injured persons where they are given surgical or medical treatment and providing for longer-term patient stays. This excludes places of recovery and or rehabilitation, drug or otherwise as well as mental institutions.
Inception date	The date on which the policy first became active. This will always fall on the first day of a calendar month.
In-hospital	This is admission to a hospital ward, limited to a general and high care ward and special care units for Treatment required.
Insurer	This refers to Bryte Insurance Company Limited, a licensed non-life insurer and authorised FSP (17703).
Illness	Any unforeseen sickness, illness or disease originating, contracted, commencing or first manifesting itself during the period of insurance.
Injury	Any physical injury, cut, abrasion, bruise, burn or disfigurement, bodily harm, sickness, or disease caused to a person by an unforeseen accident.

Leniency	A process that we will apply when assessing your claim and making changes to your policy. This application, which we deem to be in your interest, will be applied at our discretion and subject to all other terms and conditions of the policy.
Medical Expenses	Means expenses incurred as a result of receiving treatment for a disease or an accident. These expenses include the costs associated with medical services provided by a licensed medical doctor or other healthcare professionals, including medication, therapy, and various forms of treatment (these treatments must be medically justifiable).
Month	Means one full calendar month.
Out of Hospital	Refers to treatment by a Service Provider in their private rooms, day clinic or other registered medical facility.
Policy Period	The policy year begins on the policy's inception date, which is when the coverage becomes active for a period of twelve months. At the end of the policy year, the policy limits typically reset, unless the policy is terminated earlier. During the policy year, the insured is responsible for paying the premiums as agreed upon and adhering to the terms and conditions of the policy.
Pre-Existing condition	A medical condition that existed prior to the inception date of this policy. It also includes any medical condition that was diagnosed within the first three months from the policy's inception date, whether or not it was known or unknown to the insured individual. Additionally, any medical condition that arises during the first three months waiting period is also considered a pre-existing condition.
Premium	The fixed monthly amount as stipulated by the Insurer in order to indemnify the Insured for specific events as defined in the policy schedule.
Principal Insured	The natural person in whose name the agreement is entered and whose name is reflected on the Schedule.
Schedule	The document that lists the detail of the Insured amounts.
Scheme	The Policyholder's authorised registered Medical Aid Scheme.
Soth African Borders	The land within the registered and published national boundaries of the Republic of South Africa.
Specialist	A physician whose practice is limited to a particular branch of medicine or surgery.

Spouse	A partner in marriage, civil union, domestic partnership, common-law marriage or customary marriage.
Waiting period	The period during which no claims will be entertained.
We/us	Oneplan Underwriting Managers (Pty) Ltd, FSP43628 an authorised Financial Services Provider and the Insurer, Bryte Insurance Company Limited a licensed insurer and authorised Financial Services Provider (17703).
Year	The twelve-month period from the inception date of the policy.
You/Insured Person	A natural person who has applied and been accepted by us and whose Premium is paid and up to date.

Triage Categories

Triage Category	Cover
Green (4 hours)	Covered under applicable health cover, for example GP, medication, radiology, or pathology. Not covered under the emergency cover.
Yellow (1 hour)	Only covered under applicable health cover, for example GP, medication, radiology, or pathology. Emergency cover will be considered based on the final diagnosis and treatment required.
Orange (10 minutes)	Cover under emergency cover if not related to a pre-existing condition or exclusion.
Red (Immediate)	Cover under emergency cover if not related to a pre-existing condition or exclusion.

3. Introduction to plans and features

Learning outcome

By the end of this section, you will be able to demonstrate an understanding of the different plans and features we offer our clients.

Plans

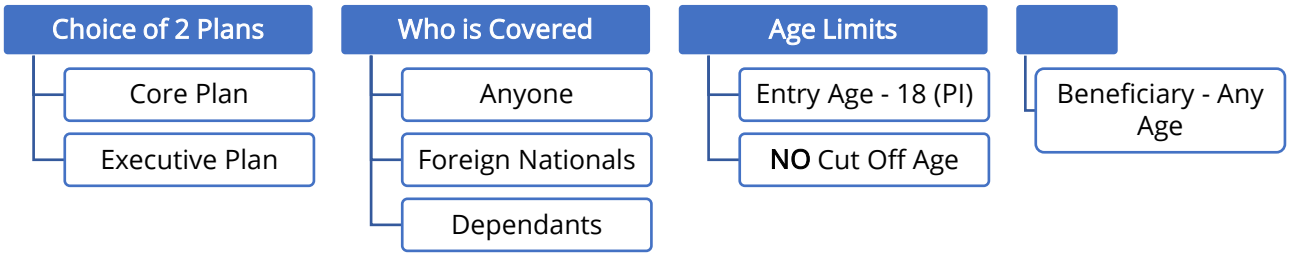
CORE PLAN FROM R220PM	EXECUTIVE PLAN FROM R285PM
OUTPATIENT COVER	
SAVINGS GAP COVER The Savings Benefit will not be covered if insured belongs to a scheme Hospital Plan Only 30 days waiting period **R2 000** per annum per policy (limited to **R500** per event)	SAVINGS GAP COVER The Savings Benefit will not be covered if insured belongs to a scheme Hospital Plan Only 30 days waiting period **R4 000** per annum per policy (limited to **R750** per event)
IN HOSPITAL & SPECIALISED COVER	
SHORTFALLS & CO-PAYMENTS FOR ALL IN-HOSPITAL TREATMENT AND PROCEDURES Excluding penalties imposed by your Scheme Immediately available for Accident 3-month waiting period for Illness **Up to 200% of Scheme Rate** (we double the Scheme Rate)	SHORTFALLS & CO-PAYMENTS FOR ALL IN-HOSPITAL TREATMENT AND PROCEDURES Excluding penalties imposed by your Scheme Immediately available for Accident 3-month waiting period for Illness **Up to 400% of Scheme Rate** (we quadruple the Scheme Rate)
CANCER CO-PAYMENT BENEFIT 6-month waiting period **Up to 200% of Scheme Rate** (we double the Scheme Rate)	CANCER CO-PAYMENT BENEFIT 6-month waiting period **Up to 400% of Scheme Rate** (we quadruple the Scheme Rate)
CASUALTY ACCIDENT/ILLNESS Immediately available for Accident 3-month waiting period for Illness **R5 000** per event per policy (limited to 2 events)	CASUALTY ACCIDENT/ILLNESS Immediately available for Accident 3-month waiting period for Illness **R7 000** per event per policy (limited to 2 events)

SCANS & SCOPES (SPECIALISED RADIOLOGY) 3-month waiting period for Illness **R5 000** per event per policy (limited to 2 events)	SCANS & SCOPES (SPECIALISED RADIOLOGY) 3-month waiting period for Illness **R7 000** per event per policy (limited to 2 events)
POST PREGNANCY COVER 12-month waiting period **R3 000** per annum per policy	POST PREGNANCY COVER 12-month waiting period **R5 000** per annum per policy
ACCIDENTAL HIV INFECTION & TREATMENT Testing Immediately available Treatment Immediately available HIV Testing - **R5 000** per policy Treatment after Positive diagnosis. Must be reported within 48 hours - **R10 000** per policy	ACCIDENTAL HIV INFECTION & TREATMENT Testing Immediately available Treatment Immediately available HIV Testing - **R5 000** per policy Treatment after Positive diagnosis. Must be reported within 48 hours - **R10 000** per policy
VALUE ADDED PRODUCTS	
Accidental Death Cover Principal: **R10 000** Spouse / Partner: **R10 000** Children 14 - 21 yrs: **R10 000** Children 6 - 13 yrs: **R7 500** Children 1 - 5 yrs: **R5 000**	Accidental Death Cover Principal: **R25 000** Spouse / Partner: **R25 000** Children 14 - 21 yrs: **R25 000** Children 6 - 13 yrs: **R15 500** Children 1 - 5 yrs: **R10 000**
TRAUMA, ASSAULT & COUNSELLING Immediately available **R5 000** per policy	TRAUMA, ASSAULT & COUNSELLING Immediately available **R5 000** per policy

3.1 Gap Cover

COMBINED ANNUAL LIMIT - **R198 000** Per Insured per policy period

It is IMPORTANT to note the following:



- Oneplan Gap Cover does not provide full payment (settlement). The coverage under the Executive Gap Cover Plan is designed to partially pay for eligible claims based on the terms and conditions of the policy.
- Your Scheme must pay some of the cost of a coded line from a hospital or risk benefit for us to consider the claim.
- The Executive Gap Cover Plan provides coverage that pays up to quadruple the Scheme approved amount. However, it is essential to note that the coverage is subject to the prescribed table limits under Regulation 7.2(1) (2022 up to R198 000 per insured). This means that the combined limit per policy is based on the prescribed limits set by regulations and may not cover the full claim amount for a particular medical service or procedure.
- The Core Gap Cover Plan only pays up to 200% of the Scheme approved amount.
- The Executive Gap Cover Plan only pays up to 400% of the Scheme approved amount.

3.2 Out-of-Hospital Feature:

Out of Hospital Savings Cover

- This benefit provides cover for the difference between the fees charged by a healthcare provider for services rendered and the amount reimbursed by the insured's Scheme for consultations and medical treatment received at the provider's practice. It is important to note that coverage will not be provided if the Scheme has not paid the first portion of the claim, either from the patient's savings account, threshold, or day-to-day risk benefits.
- The Out-of-Hospital Savings Cover includes shortfalls and co-payments for events (illness or injury) necessitating any one or a combination of the below health services, treatments or procedures:
    - General Practitioner visits.
    - Basic Dentistry.
    - Basic radiology or pathology that is deemed necessary by your medical specialist for treatment and diagnosis purposes.
    - Prescription Medication (Acute or Chronic) that covers the shortfall between what the dispensing practitioner charged and what the Scheme paid.
- Waiting period: 30 days from Inception

SPECIAL CONDITION:

- An Insured may claim several treatments or services under one event up to the claim limit. A claim event will remain open for 14 days before
- A similar or related event can be claimed for, subject to the event and combined limit.
- The cover limit and the combined limit are per policy and not per insured. The combined policy limit is per insured.

EXCLUSION:

- OTC Medication.

3.3 In hospital features: Gap cover

The following section pertains to coverage for in-hospital (inpatient) specialised treatment and casualty events. We pay up to double (Core Plan) or quadruple (four times – Executive Plan) the Scheme approved settlement for all IN-HOSPITAL and specialised treatment and procedures that are higher than what your Scheme pays, notwithstanding the Scheme Rate. All payments will further be subject to both the claim amount, the cover limit and the combined policy limit per insured person per policy period calculated according to the prescribed table under Regulation 7.2(1) of Regulation 7.2(2). This will include cover for all shortfalls on:

Shortfalls & Co-payments For all In-Hospital and Specialised Treatment and Procedures

- We provide coverage for shortfalls and co-payments for all in-hospital treatment and procedures that have been approved by the Scheme. This means that if the Scheme's reimbursement for a particular in-hospital treatment, specialised treatment or procedure is less than the actual cost incurred, we will cover the difference up to the cover limit subject to the combined limit per policy period and the number of events available per policy, as well as any co-payments required by the Scheme. Our goal is to ensure that you receive the necessary medical care without incurring additional financial burden.
- 3 month waiting period.

Cancer-related claims:

- Settlement for cancer-related claims will be provided once the Scheme's cancer threshold has been reached. This coverage extends to various expenses, including but not limited to out-of-hospital co-payments, internal prosthetic devices, and cancer treatment. Our aim is to support individuals in their journey with cancer by providing financial assistance for the necessary medical expenses associated with their treatment and recovery.
- 6 months waiting period applies.

SPECIAL CONDITIONS:

- The cover under cancer co-payment benefit is only applicable if the patient is registered on the Scheme's cancer program and for claims partially rejected under this program.

Casualty:

- This benefit provides coverage for the expenses related to a medical or surgical procedure that arises from an emergency situation in the casualty unit of a hospital.
- Waiting periods:
    - Accidents – Immediate
    - Illness (subject to pre-existing conditions) – 3 months
- This benefit is subject to triage categories. The triage categories prioritise patients based on the severity of their condition, ensuring that urgent and critical cases receive immediate attention and care.

Triage Category	Cover
Green (4 hours)	Covered under applicable health cover, for example GP, medication, radiology, or pathology. Not covered under the emergency cover.
Yellow (1 hour)	Only covered under applicable health cover, for example GP, medication, radiology, or pathology. Emergency cover will be considered based on the final diagnosis and treatment required.
Orange (10 minutes)	Cover under emergency cover if not related to a pre-existing condition or exclusion.
Red (Immediate)	Cover under emergency cover if not related to a pre-existing condition or exclusion.

SPECIAL CONDITIONS:

- All casualty claims are subject to triage rules, and only claims falling under the red and orange categories will be processed. The triage category may change based on changes in the condition of the insured or the actual diagnosis and treatment received. In cases where the final triage category is changed from green to Red or Orange, the Underwriters will require a motivation for assessment. This motivation is necessary to evaluate the change in triage category and determine the eligibility for coverage under the policy. The motivation provides additional information to support the assessment process and ensure that the claims are handled accurately and fairly.
- If the final triage category is Green or Yellow, the claim will be processed under the Savings Gap limits.
- Only two events will be covered per policy year, subject to the combined policy limit.

EXCLUSIONS:

- Scheme Exclusions
- Any claims within either general or pre-existing waiting periods

Scans & Scopes:

- We provide coverage for SPECIALISED RADIOLOGY services, including MRI, CT, and PET scans, as well as SCOPES such as colonoscopy, gastroscopy and bone density scans. In the event that your Scheme authorises these procedures under your risk benefit, whether as an inpatient or outpatient, and deems them necessary for treatment or diagnostic purposes. Our aim is to ensure that you have access to essential diagnostic and treatment services without experiencing excessive financial burden.
- 3 month waiting period.

SPECIAL CONDITIONS:

- Only two events will be covered per policy year, subject to the combined policy limit.
- This claim type cannot be used in conjunction with other claim types. Should these specialised diagnostics form part of an event that is covered under a different claim type, they will be covered under that claim type and be subject to that claim type terms and limits.
- Any claims paid from your Scheme's savings account will be covered under your out of hospital savings benefit.

EXCLUSIONS:

- Pregnancy sonars and 3D scans excluded.

Post Pregnancy:

- POST PREGNANCY COVER includes coverage for any shortfalls that your Scheme paid from your Medical Savings Account (MSA) for post-pregnancy related expenses.
- This coverage extends to various procedures such as pap smears, routine blood tests, immunisations, and intrauterine devices (IUDs).
- 12 months waiting period.

SPECIAL CONDITIONS:

- Event limit is only available up to 6 months after birth.
- Child dependants cannot claim under this cover.
- Claims related to the newborn will only be covered if the newborn is registered on both the medical scheme and Oneplan GAP cover within 30 days of birth.

EXCLUSIONS:

- As per Scheme Exclusions.

Accidental HIV Infection & Treatment:

"ACCIDENTAL HIV INFECTION TESTING" means the occurrence of HIV infection resulting from specific circumstances such as a violent assault, for example, rape, or accidental exposure to contaminated needles, such as a needle prick.

- In the event of such accidental HIV infection, you and your family will have access to comprehensive hospital care, treatment, and diagnostic regimes aimed at managing the consequences of the infection.
- Recognising the intense emotional impact of an HIV diagnosis, psychological counselling services will also be covered to support you during this challenging time. The goal is to ensure that you receive the necessary medical and psychological support to manage the effects of the accidental HIV infection.

In the event of accidental exposure to HIV as confirmed by a general practitioner and provided that you are:

a. **HIV NEGATIVE (as per a rapid test),** he or she will be provided with access to the following per event:

- Three HIV blood tests: one test immediately after the event, the second test at six (6) weeks and the third test at three (3) months
- 30-day starter pack of antiretroviral medication
- A 7-day course of STI (Sexually Transmitted Infections) medication
- A 'morning-after pill' to prevent pregnancy (for women who are raped)
- Registration for an HIV management treatment, where applicable
- Three counselling sessions with either a general practitioner, trauma trained nurse or trauma counsellor

b. Should the rapid test indicate that you are **HIV POSITIVE**, you will have access to the following:
    - One Counselling session with either a general practitioner, trauma trained nurse or trauma counsellor
    - A 7-day course of STI medication
    - A 'morning-after pill' to prevent pregnancy

"ACCIDENTAL HIV INFECTION TREATMENT" - Should the test at 3 months indicate that you are HIV positive then, provided the initial rapid test was negative, you will have access to the following additional cover:

- An additional amount of R10 000, per event, that can be used towards antiretroviral treatment that is required because of an accidental HIV exposure event.
- Any further GP/specialist consultations and pathology related to the accidental exposure will be covered as part of the original R5 000 authorised.
- Pre-Authorisation must be obtained within fourteen (14) days of the diagnosis and treatment will not be provided for pre-existing or related conditions - this means you need to call us so that we can authorise treatment.

SPECIAL CONDITIONS:

- The event must be reported within forty-eight (48) hours of occurrence by emailing your rapid results through to gapclaims@oneplan.co.za.

EXCLUSIONS:

Cover will not be payable in the event of:

- An HIV infection claim not reported within forty-eight (48) hours (up to a maximum of seventy-two (72) hours). We cannot accept the claim for the HIV protection medication, although you can still make use of our trauma counselling. This exclusion pertains to the fact that the antiretroviral medication (Starter Pack) will no longer be effective after expiry of seventy-two (72) hours.
- Any claim which is in any respect fraudulent. Loss, damage or bodily injury deliberately caused by you or any person acting in collusion with you, consequential loss or damage except as specifically provided.

Waiting Periods:

OUTPATIENT COVER	
BENEFITS	**WAITING PERIODS**
Savings Gap Cover	**30 days from Inception**
IN-HOSPITAL COVER	
SHORTFALLS & CO-PAYMENTS for all In-Hospital and Specialised Treatment And Procedures	**3 months**
CANCER CO-PAYMENT BENEFIT	**6 months**
CASUALTY	
Accident	**Immediately**
Illness (subject to pre-existing conditions)	**3 months**
SCANS & SCOPES	**3 months**
POST PREGNANCY	**12 months**

We apply Waiting Periods and general Exclusions to certain healthcare services from the start date of each Insured person's gap cover policy

- 3 MONTH GENERAL

  There is an automatic three-month general waiting period for all healthcare services and treatment, except accident-related events.

- CANCER WAITING PERIOD

  6 month waiting period, anything manifesting within this period will be excluded for 12 months.

- PRE-EXISTING CONDITIONS WAITING PERIODS

  12 month waiting period.

- 30 DAYS

  A Calendar Month waiting period.

- LIKE-FOR-LIKE WAITING PERIODS (THIS IS IMPORTANT TO NOTE)

  Benefits that are similar in benefit design when your previous Gap Cover policy and your new Oneplan policy are compared are subject to a Pre-Existing Condition Waiting Period if your previous Gap Cover policy has been active for less than 12 months.

  In the event that you previously had a similar Gap policy, but not longer than 90 days before the inception of the Oneplan policy, the 12-month Pre-Existing Conditions Waiting Period may be

reduced by the expired portion of the Pre-Existing Conditions Waiting Period served under your previous Gap Cover.

Oneplan benefits that were not covered under your previous Gap Cover are subject to a 12 Month Pre-Existing Condition Waiting Period.

Where a claim is received in the first 12 months of cover for a planned medical event that you are aware of at the time of applying for cover, your claim will be covered at a capped maximum shortfall payment of 20% of the approved claim amount subject to benefit limits where applicable.

Proof of Scheme membership certificate (showing the Join Date, length of cover/waiting period/s served and pre-existing conditions) on the previous legitimate Gap Cover provider needs to be provided in order for claims to be accurately assessed.

Where a claim relates to a condition that is described in more than one waiting period definition, the longer of the two definitions shall apply.

3.4 Value Added Products

Value added products, such as accidental death cover and trauma and assault counselling, are additional benefits provided separately from the combined annual limit of the policy. These value-added products offer specific coverage and assistance that are not included within the limits of the policy. The benefits provided by these value-added products are independent of the combined limits per policy period and serve to address specific needs, such as compensation for accidental death or access to counselling services for trauma and assault. Therefore, they are not subject to the same limitations or restrictions as the combined limits of the policy per policy period.

Accidental Death Cover

- This is a lump sum compensation in the unfortunate event an Insured Person dies due to an unforeseen accidental event.
- In such circumstances, the policy will pay the designated recipient, whether it be the Principal Insured, their Estate, or a nominated beneficiary, the death cover amount specified in the Schedule of the policy. This coverage aims to provide financial support and assistance to the beneficiaries during a difficult time, helping to alleviate some of the financial burdens that may arise due to the unexpected loss of the Insured Person.
- "BENEFICIARY" means the natural person/s entitled to be paid the benefits provided for in terms of this policy upon the accidental death of the Insured. For purposes of this policy, the beneficiary shall be either the nominated beneficiary stated in the policy schedule in the event of the accidental death of the Principal Insured, or the Principal Insured in the event of the accidental death of any of the Dependants.
- The following persons may be covered as members in terms of this policy:
  The Principal Insured, Spouse and Children of the Principal Insured. Only Spouses and up to four (4) Children may be covered in terms of this policy.
- There is no waiting period for this cover.

Claim Documentation – we know that death is difficult, but to make this process of claiming easier, we need the following documents from you:

1. A claim notification document duly completed and signed by you or your nominated beneficiary.
2. The duly certified final death certificate signed, stamped, and dated by a Commissioner of Oaths.

3. A fully completed Bl1663 Form – You can get this from Home Affairs and it is a notification of death.

4. Where the death is a result of an Accident Event, a copy of the completed "Accidental Death Claim Form" to be completed by the Investigating Police Officer.

5. A Certified copy of the Identity Document of the beneficiary.

6. A Certified copy of the deceased's Identity Document.

7. Proof of relationship and/or validity of cover where applicable.

8. Proof of banking details of the nominated beneficiary or estate late bank account, on a bank letterhead which has a bank stamp on it.

9. POPI Consent Form D002.

10. The Underwriter and or Claims Manager reserves the right to request further documentation from the claimant to properly assess a claim and such documentation must be submitted within six (6) months after the date of accidental death.

SPECIAL CONDITIONS:

- It is your responsibility to ensure that the beneficiary nominated on your policy is notified of the benefit and must submit the claim documentation timeously.
- We will not be able to entertain any claim after six (6) months after the event occurrence. We will also not be able to liaise with any third party who is not a nominated beneficiary regarding the payment of a benefit under this cover. In the event payment is not able to be made to a nominated beneficiary (for example, where the beneficiary has pre-deceased the PI), or where no beneficiary is nominated and/or contactable, payment of the benefit will be made into the applicable deceased estate.

Trauma & Assault Counselling:

Trauma and Assault Counselling:

"TRAUMA AND ASSAULT COUNSELLING" refers to the provision of assistance for the necessary treatments that an insured may require following a traumatic event such as assault, accidental exposure to HIV, or any other form of trauma. This coverage includes access to counselling services aimed at addressing the psychological and emotional impact of the traumatic experience. The goal is to provide

support to individuals in coping with the aftermath of the trauma, facilitating their healing and overall wellbeing.

1. Limited to three (3) counselling sessions per incident up to R3 000 per policy period at a public trauma centre or a private institution.

2. Should you be diagnosed with post-traumatic stress disorder, the full cover of an amount of R5 000 per Insured person per annum will be available.

- A 24-hour emergency authorisations line is available which will direct you for the necessary help you may require in a situation where assault, accidental exposure to HIV, or any other trauma occurs.
- Limited to three (3) counselling sessions per incident up to R 3 000.00 per annum at a public Trauma Centre or a private institution.
- Should you be diagnosed with post-traumatic stress disorder, the full cover of an amount of R 5 000 per Insured person per annum will be available.
- In the case of trauma, you will receive psychological counselling from a public trauma centre or a private institution in the event of the following:
    - Rape; Hijacking; Child abuse; Suicide of close family members; Fire; Motor Vehicle Accident; Death of next-of-kin; Domestic violence and/or abuse; Woman abuse; Kidnapping/abduction; and terminally ill persons.
- There is no waiting period applicable to this benefit.

4. Who do we cover?

Foreign nationals

Take learners through the foreign national checklist and print copies for them:

- A fully completed application form.
- Passport with a visa.
- ID of payer if different from PI.

The above are acceptable both non- or certified and is required for each insured (PI and dependants).

*Refer to examples of these documents attached.

Students

- Biological Child/Adopted Child over the age of 21 (or over 21 with approval from Compliance, but not older than 23)
- Proof of registration at a recognised tertiary institution. No need to have it approved by Compliance.

Stepchildren

In terms of stepchildren, please note: IF THE PI IS THE STEPMOTHER, the following is required:

- Written Consent from both stepmother and father that the stepmother may provide medical cover for the underaged child;
- The PI is required to provide consent that the biological parent may have access to the child's personal information;
- A birth certificate of the child;
- ID of both of the biological parents.
- A note on OPA to this effect:
- The client also is required to provide consent via nominated email address that the biological mother and father may act on behalf of the dependant "XXXX" on this policy.

Non-biological minor dependants

- ID copy of Policyholder.
- Birth Certificate of each minor dependant.
- Relevant current court order confirming that custody / guardianship / care of the child has been provided to the PI (not expired).

For Adoption/Caretaker

- New-born:
    - Certified copy of the birth certificate within 30 days from the birth of your child.
    - Final letter of adoption.
- Child under 18:
    - Court Order / Affidavit from Social worker
    - Birth Certificate of child.

New-born registration process

- The baby must be discharged with a clean bill of health.
- The baby must be registered with Oneplan within the first 30 days of birth.
- The baby must not be 3rd generation.
- If the new-born registration process is followed – no waiting periods will apply to the child.
- If the new-born is not discharged with a clean bill of health or registered late, all waiting periods will apply.

5. General Exclusions

Notwithstanding all exclusions, including pre-existing conditions applicable to the Insured, the Insurer shall not be liable for expenses, hospitalisation, injury, sickness or disease directly or indirectly caused by or related to the following if not specifically included elsewhere in this document:

1. When you have reached the annual combined limit of R198 000 per insured person per annum. (except for the accidental death and trauma, assault & accidental HIV). This amount is calculated annually according to the prescribed table under Regulation 7.2(1) of Regulation 7.2(2) – Policy benefits escalation, in terms of the Short-term Insurance Act, 1998 (Act No. 53 of 1998). This amount will be increased on 1 April every year by the official CPI as published by Statistics South Africa (as defined in the Statistics Act, 1999 (Act No. 6 of 1999)).
2. All claims excluded by your Scheme.
3. Any shortfalls on your Scheme's Overseas Treatment Benefit claims.
4. Where you or your dependants do not belong to a Scheme which is registered with the Council of Medical Aid.
5. Where your Scheme does not pay their portion of an account first from their relevant In-Hospital Risk Benefits.
6. Where you have not been admitted into hospital – except for the Savings Shortfall Gap Cover.
7. Where you have been charged a co-payment or deductible by your Scheme because you did not adhere to your Scheme rules OR you chose to see a doctor or hospital that is not on your Scheme's network.
8. Caused as a direct or indirect result of negligence to the Insured's medical needs or health.
9. All costs incurred during any waiting period and for conditions not disclosed.
10. All costs that exceed the stated and maximum allowed event and combined limits.
11. All costs incurred for permanently excluded conditions.
12. Costs incurred as a result of failure to carry out the instructions or advice of a medical doctor or dentist.
13. Any treatment relating to non-disclosure, whether intentionally or unintentionally, of a condition.
14. There is no surrender or maturity value for the policy.
15. No refund of premiums will be authorised in the event of cancellation of the policy with no claim history or due to unsuccessful claims.
16. Consequential loss or damage which is not directly caused by an Insured risk.
17. Declined or repudiated claims re-submitted after the waiting period has expired will not be covered.

18. Nuclear weapons or nuclear material or by ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel. For the purpose of this exception, combustion shall include any self-sustaining process of nuclear fission.
19. War, invasion, act of foreign enemy, hostilities or warlike operations (whether war be declared or not) or civil war.
20. Total grid failure.
21. Fraud.
22. Mutiny, military rising, military, martial law or state of siege, insurrection, rebellion or revolution.
23. Cost of operations, treatments and procedures for cosmetic or not medically justifiable and/or elective i.e. all other lines of conservative treatment must first be considered.
24. Participation in civil commotion, labour disturbances, riot, strike or the activities of locked out workers.
25. Expenses incurred by the Insured or dependants of the Insured in the case of wilfully self-inflicted injuries.
26. Any sexually transmitted diseases, unless as a direct result of rape or crime that has been officially reported to the South African Police Services.
27. Services rendered by persons not registered with the SA Medical and Dental Council the SA Nursing Council or the South African Health Service Professions Board.
28. As a result of the influence of alcohol, drugs or narcotics upon such Insured Person unless administered by or prescribed by and taken in accordance with the instructions of a member of the medical profession other than himself/herself.
29. A criminal act as defined by the laws governing the Republic of South Africa, this specifically includes driving under the influence of Alcohol or non-prescription drugs.
30. Claims paid as an exception by the Scheme included, but not limited to, *Ex Gratia* and leniency payments.
31. Infertility and/or any procedure related to infertility and/or complications thereof.
32. Bariatric surgery and/or any procedure related to obesity and/or complications thereof.

6. Standard Conditions

Premium Payments

1. All premiums are payable monthly in advance via debit order or Authenticated Collections to be deducted from your nominated bank account. Should your bank account details change, please inform us immediately to avoid suspension or cancellation of your policy due to the unsuccessful collection of your premium.
2. ***We make every effort to ensure your premium is collected; however, we do not have control over ensuring premiums are received due to conditions out of our control, such as no funds and/or no authorisation. If you are paying via EFT or other method, the onus is on You to ensure that the premium is received by Us.***
3. The period of grace allowed for non-payment of premiums is fifteen (15) days after the first day of the month in which the premium was due. Should premiums not be received or be returned for any reason, the cover of this policy will become suspended for a fifteen-day period within which period no cover will be payable to the Insured until receipt of the overdue premiums have been received. Should this premium not be paid within the fifteen-day Grace Period, all cover may be immediately cancelled or suspended, and this agreement may be terminated.
4. In the event that the Insured receives payment or service within this policy during the Grace Period and the premium remains unpaid after this fifteen-day period expires, the Insured undertakes to pay back to the Insurer all costs incurred as a result of this claim being authorised including any collection and/or legal fees.
5. Should premiums, in whole or in part, be in arrears, then no claim shall be payable.
6. The Grace Period will commence from the second month of the policy's inception after successful collection of the first premium.
7. It is the responsibility of the Insured to notify the Insurer or the Insurer's collection department should the premium fail to be deducted from the specified account.
8. A premium holiday may be granted at the Underwriter's discretion in the event of the premium payer being unable to pay the premium. Only one premium holiday will be granted, and no claims will be entertained during the period of the premium holiday. Application for a premium holiday must be done in writing. A premium holiday shall not constitute a waiver of Our rights.
9. We reserve the right to increase premiums, on a group basis, with thirty-one (31) days' (one month's calendar) notice in writing.
10. Non-payment of premiums for two consecutive months will result in automatic cancellation.

11. By entering this policy, you have agreed to Us submitting your details to ITC for credit ratings and credit records.
12. No premium refunds will be completed unless the requirements of the Underwriter have been met.
13. PLEASE NOTE THAT PREMIUMS for the Gap Cover Policy are subject to Late Joiner penalties and age loadings. The Late Joiner penalties are applied based on the MSA penalty bands, which determine the additional premium amounts for individuals who join a short-term insurance policy later in life. These penalties are designed to incentivise individuals to invest in a short-term policy early and maintain continuous coverage.
14. Additionally, age loadings may be applied to the premiums, which reflect the increased risk associated with age. As individuals grow older, the likelihood of experiencing certain health conditions or requiring medical care may increase, and age loading helps to account for this increased risk.
15. It is IMPORTANT to consider both Late Joiner penalties and age loadings when determining the premium amounts for the gap insurance policy. These factors ensure that the premiums accurately reflect the individual's risk profile and help to maintain a sustainable and fair insurance system.

HOW TO CLAIM

Submit your claim plus your Scheme authorisation and medical claim statement.

We will pay You into your bank account:

- following an Insured event, where We were provided with a payment statement from your Scheme, and
- when so requested, You supply in writing any such proof, medical evidence or other information as the Insurer may reasonably request.

PROCESS OF SUBMITTING IN-HOSPITAL CLAIMS

i. Claims must be submitted no later than one (1) calendar month after your Scheme approved and paid your claim. Should You not observe your Medical Aid submission dates and your Scheme declines payment due to submission cut off dates not being observed, we will not approve the claim for the reason that the claim has become stale. It is your responsibility to ensure that the claim documentation, as requested by Us, has been received within this period.

ii. If you do not send us these documents within a month after your Scheme's settlement date you will have to provide us with a reason for the delay and we may consider payment of the claim, however a claim will not be considered or paid if it is submitted later than four (4) months after the claim event.

iii. If we take a decision to apply Leniency in respect of a claim that you have lodged with us or a change that you have requested on your policy, we will only consider this Leniency at our discretion and in accordance with our internal processes and procedures.

iv. It is the duty of the Insured to declare / disclose all Scheme, medical and health information when applying for the policy. It is the responsibility of the Insured to supply and assist in obtaining any medical history reports from any medical practitioner or facility if requested to do so to enable the Underwriter to entertain any request or authorisation for any operation or procedure.

PROCESS OF SUBMITTING OUT OF HOSPITAL CLAIMS

i. Each coded line on your healthcare or service provider's account makes up the total amount that they charge.

ii. A coded line describes the medical procedure that was performed, like a gastroscopy, or the service that was provided, like an in-hospital consultation.

iii. We assess each coded line to see where shortfalls are and will pay up to double or double the approved amount, not the charged amount.

iv. Your Scheme must pay some of the cost of a coded line from a hospital or risk benefit for us to consider the claim.

v. When your medical aid pays some of the cost of a specialist's consultation from a hospital, risk, or day-to-day benefit or from your medical savings account, we can assist with covering the difference.

vi. We use your medical aid plan's rate (tariff) as a benchmark to assess shortfalls from.

vii. For the Savings Gap Cover refunds, there is a seven (7)-day turn-around time from the date of receipt of the valid proof of payment.

viii. When your Scheme's Savings account limit has been reached and you submit claims within the Threshold Gap which is approved by your Scheme, you may submit these for Gap Cover payment.

Example of payments on the Executive Gap Plan:

OUT-OF-HOSPITAL CLAIMS:

We will pay the shortfall between what your Scheme paid and the provider's statement up to the selected plan limit as it appears on your Oneplan Schedule. The statement must provide us with the amount the Scheme paid and the shortfall.

IN-HOSPITAL CLAIMS:

We pay up to quadruple the amount your Scheme has paid towards your claim. It is that simple. Whatever statement you submit, we will pay up to quadruple that amount paid by your Scheme subject to the limit as per the prescribed table under Regulation 7.2(1) of Regulation 7.2(2), as it appears on your Schedule and may be subject to annual reviews.

All claims are paid directly to You.

Oneplan Quadruples Whatever the Scheme Rate Was:

CLAIM AMOUNT (this is the amount the provider invoices you)	**SCHEME SETTLES:** (this is the amount the Scheme has approved and settled partially)	**SCHEME SHORTFALL**	Oneplan pays 400% of the Scheme approved Claim up to the **Oneplan Gap Cover Policy Overall Limit UP TO R198 000**	**CLAIM SHORTFALL**
R500 000	R250 000	R250 000	**R198 000 Combined Limit**	R52 000
R300 000	R290 000	R10 000	**R10 000**	
R300 000	R102 000	R198 000	**R198 000 Combined Limit**	
R200 000	R10 000	R190 000	**R40 000**	R150 000

7. System Training

Learning outcomes

By the end of this section, you will be able to:

- Competently navigate through email, Connex and OPA
- Capture the customer's and dependant's information on Connex and OPA
- Understand how leads work on Connex and how to submit your calls to Pending QA

Manual calls and inbound transfers

Responsibilities:

MicroSIP Users

It is the responsibility of the agent who is transferring or manually dialling another operational area to ensure that the correct procedure is followed by making use of the correct short codes for MicroSIP, to ensure that no customer is affected by the incorrect process, and SLAs are correctly interpreted across the business. MicroSIP will be used as a fallback system and during periods with no disaster communicated no one will answer these extensions. The list of Connex codes is listed below.

Connex Users

It is the responsibility of the agent who is transferring or manually dialling another operational area to ensure that the correct procedure is followed by making use of the correct short codes for Connex and that MicroSIP is not utilised to manually dial another operational. This ensures that no customer is affected by the incorrect process and SLAs are correctly interpreted across the business.

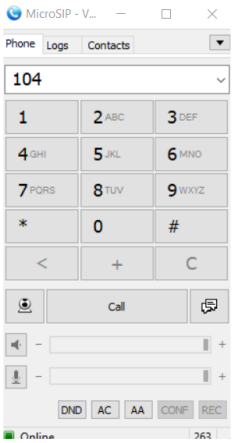
Contacting Departments Internally

MicroSIP User Short Codes to Dial Other Operational Areas:

The following short codes must be utilised by all MicroSIP users to manually dial another operational area or transfer a call to another operational area from MicroSIP to Connex.

Short Codes

Queue	MicroSIP To Connex Short Code
Health Care Inbound	104
Pet Care Inbound	103
Health Assessors	102
Health Auths	101
Pet Assessors	100



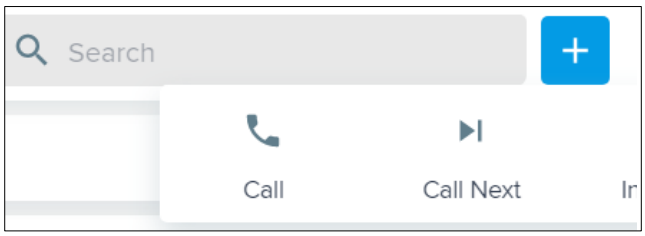
Connex User Short Codes to Dial Other Operational Areas Manually

The following short codes must be utilised by all Connex users to manually dial another operational area from Connex within Connex.

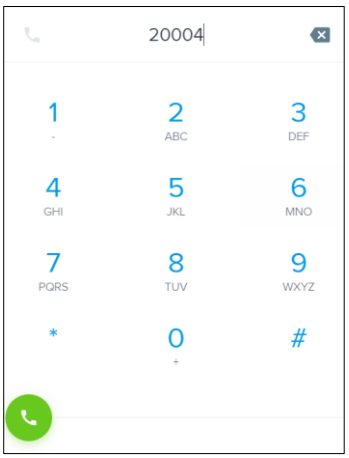
Short Codes

Queue	Connex to Connex Short Code
Health Care Inbound	20004
Pet Care Inbound	20003
Health Assessors	20002
Health Auths	20001
Pet Assessors	20005

Click on Plus Sign at the top of your Connex Screen and Press Call



Enter Connex Short Code for relevant Queue as per the above and press the call button.

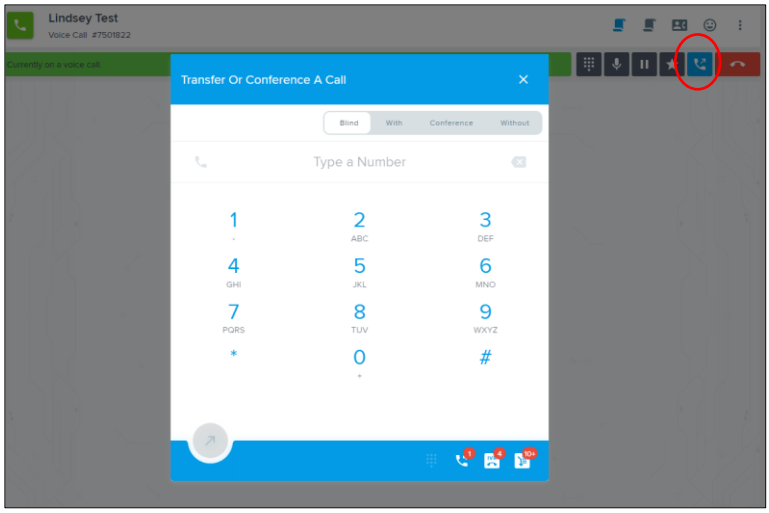


Transferring Customers to Another Department

Connex User Transfer of Client to Another Operational Area

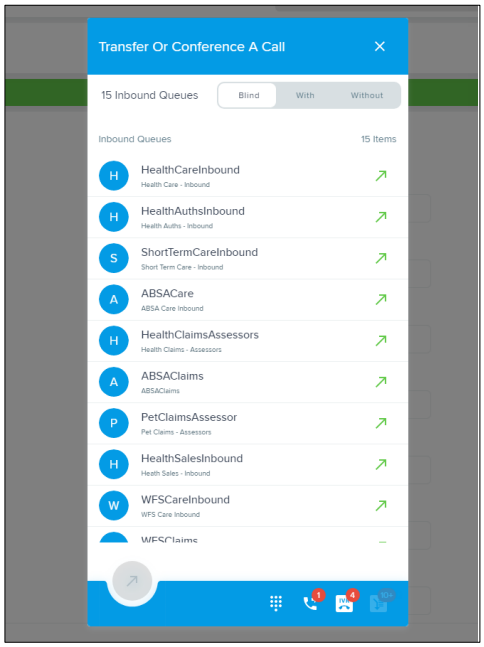
The following process must be utilised by all Connex users to transfer a customer from Connex to another operational area from Connex within Connex.

Whilst in a call, click the transfer button at the top right of your screen in blue circled below.



Make use of Transfer without option – allows the agent to transfer calls by placing the call on hold. The user will then be able to speak with the transfer user before transferring the original call over. The user can then complete or cancel the transfer.

Inbound Queues transfers a call to a premade inbound queue you can select this option by clicking the inbound queue icon at the bottom right and queues will be displayed.



Once you have chosen your option, hit the green Transfer ↗ button. You have now made your transfer.

Contacting Customers for Outbound Calls Via Different Platforms

Connex Users: Care, Claims, and Auths Departments

Users currently make use of MicroSIP to place outbound calls to customer. These are the only calls that should be placed via MicroSIP; all other manual internal calls and transfers must be done using the above transfer and manual dial methods.

Connex Users:

Sales

All sales users in the Pet and Health campaigns may only make outbound calls via Connex and MicroSIP must not be used at any time in this area for any purpose.

MicroSIP Users

MicroSIP users that do not have a Connex license must make use of MicroSIP to place outbound calls. Any internal manual dials or transfers by MicroSIP must be done using the codes and must utitlise the MicroSIP User Short Codes as outlined in Section 1.

Email

Email etiquette

1. Include a clear subject matter

- Short and snappy summary will likely be more effective than a full sentence. If it is for review, put that at the beginning of the subject line to make it more eye-catching.

2. Always use an appropriate greeting

- If you are writing to a close colleague, an informal 'Hi' will likely be sufficient, but if you are writing to someone you do not know so well, then always add a formal salutation and an introduction.

3. Only use shorthand if you know your recipients

- If you are writing to your own team about a project that you have been discussing, then you can write short emails with a list of bullet points.

4. Be wary of using humour or colloquialism across cultures

- Be aware of funny sayings or colloquialisms. Instead, keep your emails to the point and as clear as possible.

5. Consider the purpose of your email

- Always state if your email needs an action and by when. You could even bold this or italicise a due date or the action needed so it is clear.

6. Think before you use an emoji

- If you are sending them to people you know well, and you know will understand them, then that is fine. If not, then consider if they are really needed.

7. Don't hit "reply all" or CC everyone

- By replying to people who do not need to be copied, it will only clog up their inbox – and potentially yours if they reply to something you don't need them to.

8. Reply in a timely fashion

- Always reply within 24 hours, even if it is to acknowledge an email and explain that you will revert with an appropriate response within a defined timescale.

9. Think about where your email could end up

- Never use inappropriate language in a work email. The reality is that your email will remain on the server long after you have deleted it.

10. Always spell check

- Take the time to re-read your emails, make sure they make sense and have the right tone before you send them.

8. Compliance

Learning outcome

By the end of this section, you will be able to explain the FAIS Act and how it impacts the operations and compliance activities of Oneplan Insurance.

8.1 Introduction

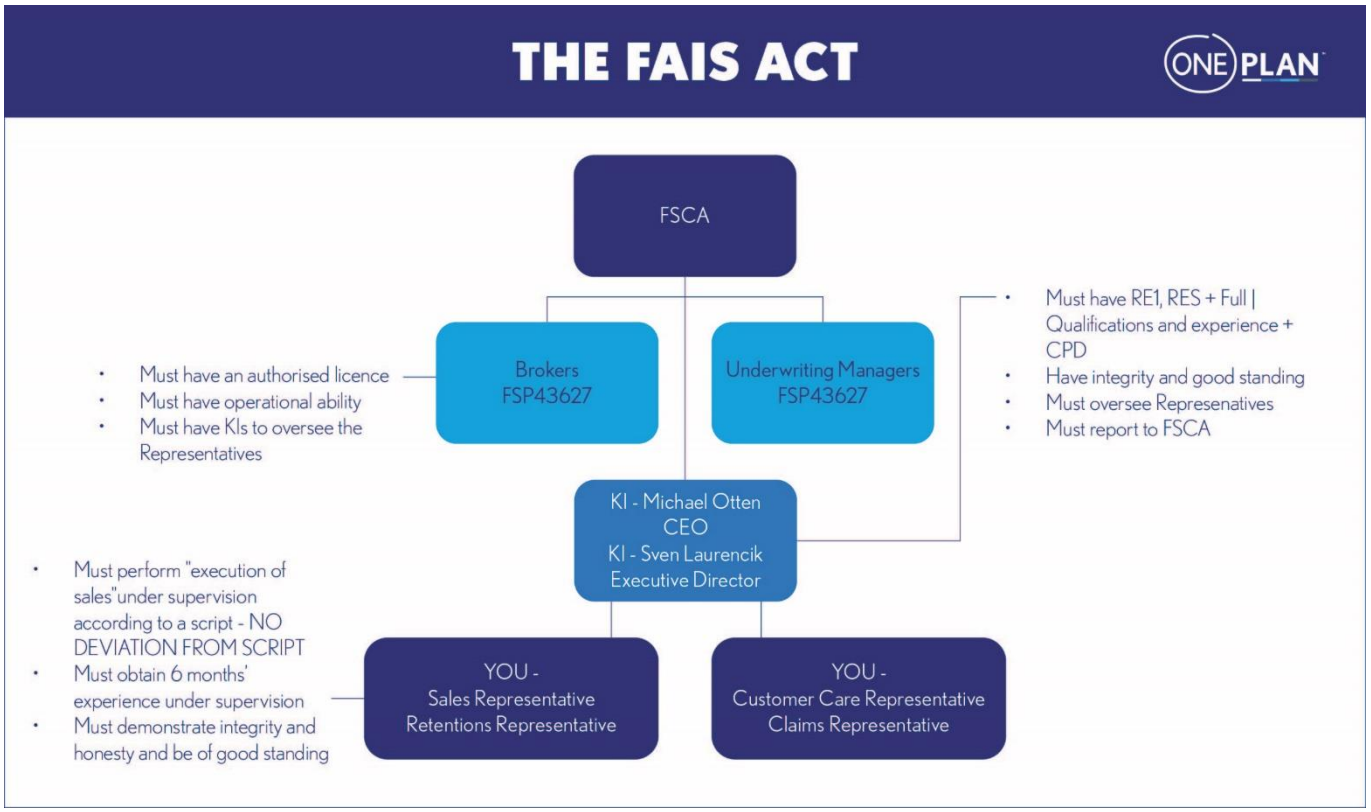
Having joined Oneplan, you have created your first footprint in an industry where your honesty and integrity is the most important aspect of your service.

Compliance at Oneplan is wanting to do what is right; it is treating the clients you are going to sell or provide a service to fairly, with respect, and within the law.

Act Regulation	Why is this important to me?
FAIS Act, 37 of 2002	Financial Advisory and Intermediary Services Act
BN194, 2017	Determination of Fit and Proper Regulations This BN sets out what qualification certain representatives must have, what regulatory exams must be obtained, and what CPD hours must be done in one (1) year
FAIS Notice 86, 2018	Exemption of Services under Supervision, 2018 This Notice exempts those who perform "execution of sales" from writing the RE exam and sets out how a representative under supervision must be supervised. It also exempts certain representatives from the minimum requirement of matric and made the entry level Grade 10 or equivalent for Category 1.2 representatives (that is you).

BN80, 2018	General Code of Conduct for FSPs and Representatives This regulation prescribes our ethical obligations when we sell a product to a client as well as how we must disclose all our products exclusions, limitations, and what the client will be paying, how they can complain, and how we service them after a sale.
FICA, 38 of 2001	Financial Intelligence Centre Act – Anti Money Laundering This act requires us to make sure we know who we are doing business with. When we are dealing with a Governmental VIP, we must tell the AML Officer – this is Irene Willis – immediately. Not so she can get an autograph, but because she needs to report it. This act also says that we cannot accept cash deposits more than R25,000.00 (because it is all about the cash) from a client or anybody without telling the FIC about it. We must also report suspicious transactions because money laundering is always a secondary offence to criminal activity.
POCA, POCDATARA	Terrorist Financing Control Regulations This act prohibits us to ensure a client that is on a Sanctions list, so therefore we must, again, know who we deal with!

8.2 The FAIS act



Fit and Proper

You

- Sales Representative
- Customer Care Representative
- Claims Representative

Honesty and Integrity

- You must be solvent and have a good credit record
- You must not have a criminal record or, if you have one, it must be expunged
- You must not have been removed from an office or trust, or declined membership to a professional body due to your lack of integrity
- No conflict of interest

Qualification

- You must have the minimum qualification of grade 10 or equivalent

Experience

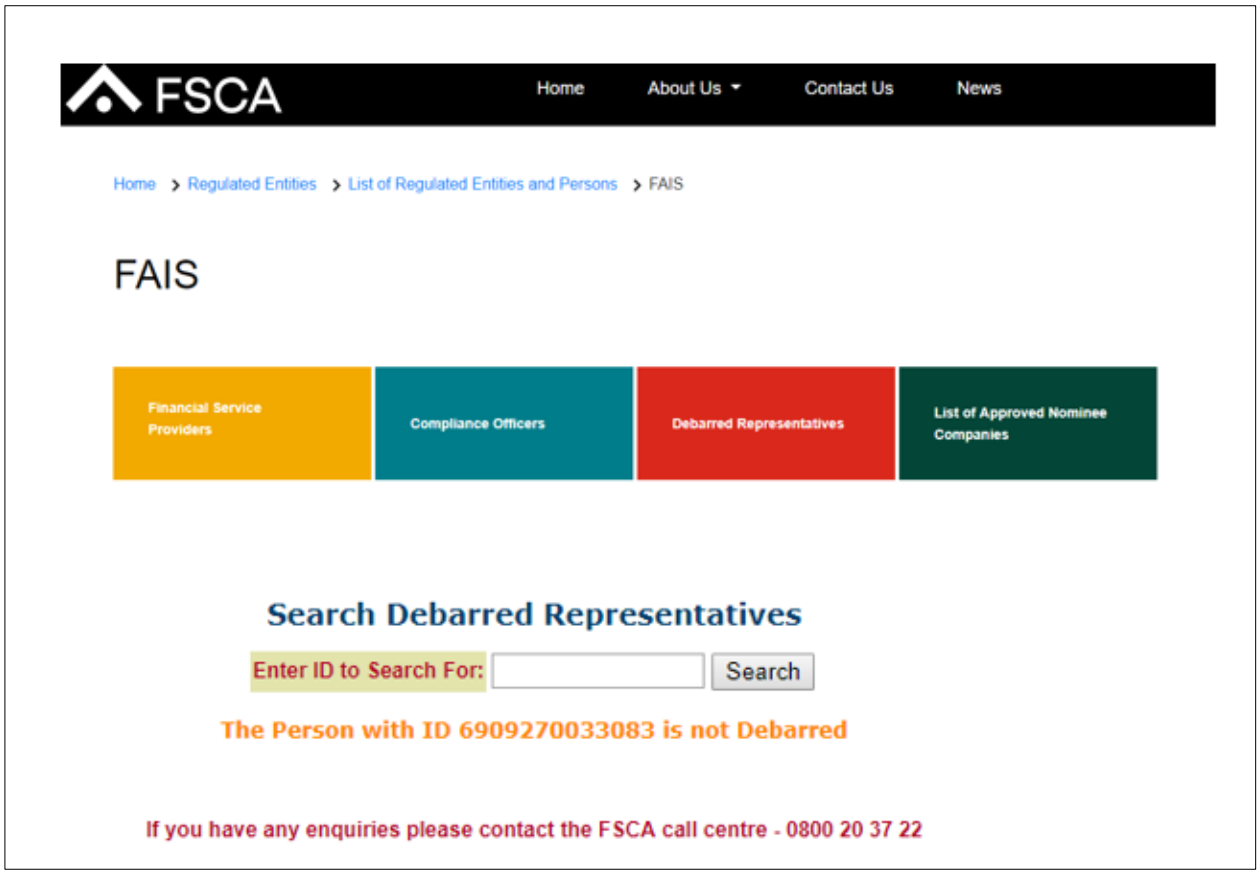
- You must have six (6) months' experience under supervision and have records to prove it

Section 13

- If you comply to all the above, you will be appointed a representative of Oneplan and you will have to change your email signature and disclosures as follows:
    - *"I am a representative authorised to render intermediary services limited to execution of sales on behalf of Oneplan Brokers Pty Ltd in terms of an employment contract and meet all the fit and proper requirements. Oneplan brokers is an authorised financial services provider FSP43627."*

8.3 Debarment

In the financial services industry, you must maintain a good name. If you act dishonest, if you commit fraud, or when your honesty and integrity are compromised, you may be debarred. This is recorded on the FSCA website, and this means you will not be able to find further work in this industry.



9. Phonetic alphabet

Your facilitator will take you through the phonetic alphabet in a practical setting. You will also understand why it is important to make use of phonetic alphabet.

10. Complaints Resolution Policy

- The purpose of the Complaints Resolution Policy is to ensure that we treat our clients fairly and with skill and care.
- We endeavour to apply the principles of TCF (Treating Customers Fairly) into the Oneplan culture and which principles form the foundation of our commitment in investigating and resolving complaints.
- Our Complaints Resolution Policy also provides us with valuable feedback on where we can improve in our service and our product.

Our commitment to you

A) Fair Treatment

- We will investigate your complaint fairly and independently based on facts.
- We will treat you with respect and professionalism.
- We will provide you with an opportunity to escalate your complaint.
- We will endeavour to provide you with an appropriate resolution and remedy to your complaint.
- We will keep your information private and only use it for the purposes it was provided to us in addressing your complaint.
- We will keep all records of complaints for five (5) years.
- We will always adhere to the requirements of the Short-Term Insurance PPRs and the FAIS GCoC.

B) Turn-Around Times

- We will acknowledge your complaint within 24 hours.
- We will endeavour to resolve your complaint within twenty-one (21) days on a first in, first out basis.

- We will attend to any complaint of non-compliance to the Complaints Resolution Policy within 3 working days.

Complaints must be in writing

- In order for a complaint to receive the attention that it deserves, we request that your complaint is submitted to us in writing. Please ensure, that where the complaint is delivered by hand or by any other means, that you retain proof of delivery.
- Please address your written complaints to:
    - The Complaints Officer
    - complaints@oneplan.co.za
- The following information must be provided in order for us to assist you:
    - The Complaint must be sent from the policy nominated email address. Should the address be different than the nominated email address, please provide us with authority to address the complaint with the third party.
    - Please provide us with a complete and detailed description of your complaint and include any relevant supporting documentation and let us know what your expected outcome / remedy or resolution is.

Procedure

Where any of the Oneplan services have failed to address your enquiries sufficiently, you may submit a formal complaint to be investigated as follows:

- Email your complaint to complaints@oneplan.co.za.
- Your complaint will be acknowledged within twenty (24) business hours.
- If a valid complaint, your complaint will be logged into our central complaints register.
- Your complaint will be allocated to a trained and skilled person who specialises in that type of complaint. This may not necessarily be the person to whom you addressed the complaint.
- Your complaint will be investigated, and we will revert to you with our findings within twenty-one (21) days. You may be requested to provide additional information before we provide you with a final resolution. If we require further time to investigate the complaint, this will be communicated to you in writing.
- You will receive a response in writing.
- If, after receiving the outcome of your complaint, you are still not satisfied, we will regard the complaint as being unsatisfactorily resolved. In such a case, you may:
    - INTERNALLY: Appeal any decision made. The appeal will be heard by an appropriate senior staff member if possible. We are prepared to consider any new information or argument that may arise in terms of the procedure where this is material to the matter at hand. Where the

matter has already been heard by the most senior staff member, an appeal is not possible, and you will be required to refer the matter externally.

  - EXTERNALLY: Approach the office of the FAIS or Short-Term Insurance Ombud (OSTI) or take such other steps as may be advised by your legal representatives.

- For rejected claims, representation must be made within ninety (90) days of the date of the letter of rejection or repudiation.
- If a dispute is not satisfactorily resolved after following the above steps, legal action may be instituted. Summons must be served within one hundred and eighty (180) days from the date of original letter of rejection.
- In the event of us not reverting to you within the time periods indicated above, kindly contact Irene Willis (irene.w@oneplan.co.za) for an explanation as to why we have not yet communicated with you. Please do not accept any communication from any person until it has been confirmed in writing.

Escalating your complaint

You must, if you wish to refer a matter to an Ombud or Ombudsman, do so within a period of six (6) months.

OSTI (Ombud for Short-Term Insurance)	FAIS OMBUD
Tel: (011 726 8900)	Tel: (012 762 5000)
Sharecall: (0860 726 890)	Email: info@faisombud.co.za
Email: info@osti.co.za	Website: www.faisombud.co.za
Website: www.osti.co.za	

Protection of personal information complaints

- Should your personal information have been compromised or breached; or
- Where your information has been processed without your consent; or
- Should you wish to opt-out of any marketing material,

You may submit your complaint to popi@oneplan.co.za.

If your complaint is not addressed satisfactory, you may escalate these complaints to the Information Regulator as follows:

INFORMATION REGULATOR
Tel: 010 023 5200
Email: enquiries@inforegulator.org.za
Website: inforegulator.org.za

Your feedback is important.

Should you wish to provide us with feedback on your experience in how your complaint was handled, please do so by submitting a COMPLIMENT to compliance@oneplan.co.za or partake in the below survey:

Click here for Complaints Handling Survey

This policy has been approved by the Board of Directors and shall be reviewed annually.

11. FAQs

Banking Details - Authority to Debit

When you close a sale where the insured and the policy payer are different people, the below script must be followed, and a confirmation note MUST be created on OPA including the principal insured's contact number. Authority to debit must be obtained from the accountholder even if the client has signing rights. If authority cannot be obtained from the accountholder over a recorded line, then the following documents are required from the accountholder:

- Accountholder's copy of ID.
- Bank statement
- Letter of authority from the accountholder.

***NOTE** Script to be read to policy payer:*

Dear (Insert Policy Payer), you are speaking to (Insert Agent Name and Surname) calling you from Oneplan Gap Cover. We have (Insert Policyholder Name) who has signed up a policy with us and nominated your bank account to collect the monthly premium of RXXX (Insert Policy Total Amount – plus the once off initiation fee) to be debited on (insert debit order date).

Are you authorising us to debit your account? (You need a yes or no to this answer)

Yes - Thank you. We require your ID number and bank account details in order to load the monthly debit order. Be assured that this information will only be used in line with the POPI regulation. The abbreviated name Oneplan will appear on your bank statement and your first debit will be on the (insert debit order date).

If the client wishes to pay via EFT, capture the client's banking details for refund purposes and select the debit order date as the date the client states he will make the EFT payment. Provide the client with the following banking details (available on the INFO folder). Change Payment Method on OPA.

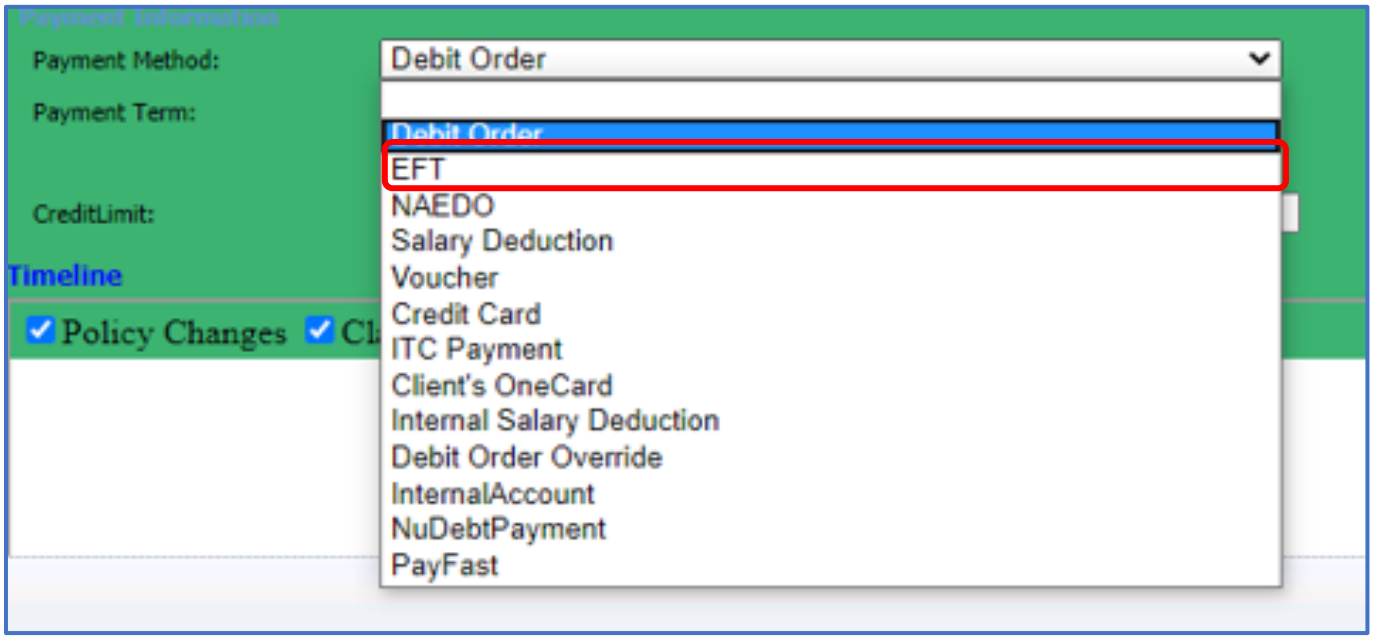
BANKING DETAILS

Banking Details for Premium Payments:

Banking Institution:	First National Bank
Bank Account Name:	BRYTE INSURANCE COMPANY LTD
Account Branch Code:	255 005
Account Number:	62817977533
Reference:	For premium payments please use your ***Policy Number only.***

Please e-mail your proof of payment to care@oneplan.co.za

Then change the Payment Method on OPA to EFT. Remember to save the change.



The following debit order dates are available:

- 1st
- 2nd
- 7th
- 20th
- From the 25th up to the last day of the month.

Please note, even though we debit premiums in advance, if the inception date falls on the 1st of this month, we will allow the nominated debit date up to the 7th of this month.

If there is a promotion tied to the inception dates, please confirm that the promotion is current and apply accordingly. Remember to explain that we collect our premiums in advance and confirm the first debit date and month in relevance to the inception date requested (if not done, this is a fail).
If captured in error, send to either your manager or Escalations to correct and remember to add a note on OPA or you will still be failed as you have not communicated the error and its correction so QA will be unaware that action was taken.

Physical/Residential Address

Under no circumstance are we allowed to sell a policy where we are unable to obtain the exact physical address of the client. During the correction, retention, validation, claims or service stage, the same rule will apply.

Correction of Inception Dates

If the inception date has been incorrectly captured, then we first need to inform the client that we will debit within the next 72 hours if inception date is earlier. Then depending on the debit date, he selects, we might debit him again this month for next month (because we collect in advance).
We then send an email to the escalations department at escalations@oneplan.co.za informing them of the details of correct inception date. A note must be made on OPA confirm that the email has been sent to escalations.

Waiting Periods

Waiting periods are calculated from inception date and not the debit order date. However, at claim stage if premiums are not up to date, claims can be denied.

Annual Increases

If the client asks whether we have annual increases. The correct answer is yes, we do have a policy review annually. Clients are notified 31 days prior to the change in writing.

Do I have to go for tests and fill out any paperwork?

No, you do not Mr Client. The amazing thing about our cover is that we can do everything for you now, over the phone. It is that simple, quick, and easy. It simply takes me a couple of minutes to collect a few of your details, quickly go through a few basic questions about your health, and just like that, we can get you covered. We aim to take the hassle out of how tricky healthcare can be and give you and your family added peace of mind within minutes.

When can a client upgrade or downgrade their plans?

- A calendar months' notice must be given for the upgrade of any plans.
- For upgrades, waiting periods as per cover type will apply for any new cover from the effective date of the upgrade.
- For existing benefits, the waiting periods will only apply to the difference between your old cover limits and the new higher cover limit.
- You can downgrade at any time.
- However, you cannot downgrade within six (6) months of an Illness or Natural Birth claim or within twelve (12) months of a Dread Disease claim.
- There are no waiting periods applicable in a downgrade.
- If you have downgraded, you must wait six (6) months before you can upgrade again.

Selling on Cancellation

When on a Sales Call, we are not allowed to sell a policy to you so that you can cancel at a later stage. The cooling off period in the telephonic disclosure is the only time this should be mentioned. Rather say that, if they have any concerns, they are welcome to contact Oneplan so that we can discuss/explain/alleviate their concerns.

Why do I need this if I already have a medical aid?

It is great that you already have a medical aid Mr. Client. That means that you are someone who makes provisions for yourself as well as your family and that is good. Where we come in is that we compliment your medical aid – sort of like tea and cake – we go well together, and we can cover any shortfalls or outstanding amounts that your Medical Aid unfortunately could not cover in full which was destined to be an expense out of your pocket. We then act as a GAP Cover to avoid such financially straining situations especially in these tough times, where every penny counts. We give you that peace of mind and added value.

Medical questions and exclusions and telephonic disclosure with PI only

When you are doing a telephonic sale, all medical questions, exclusions, and telephonic disclosures must be done with the PI only. If you explained the plan to the PP and they want to take it out for someone, the entire application MUST be explained as well and completed with the principal insured. In actuality,

the contract is between Oneplan and the PI, not the premium payer. Therefore, the PI needs to understand what they are covered for and how the policy works. If PI is not available, and PP wants to take out the plan, plan can be explained to PP and the application form to be sent to PI to be completed.

Email addresses and sale with no email address and smart phone and cell phone number

If the client has no email address, we can ask them for a 3rd party email from a trusted family member or friend.

Note: Making up an email address/telephone number or using one that the client did not give you so you can process the sale will be considered as FRAUD, you will be suspended immediately and will go into a possible DE.

Promise to call back not honoured

When an agent promises to call the client back or on any other number, honour the promise. Our reputation is at stake. If you cannot get hold of the client, put a note on OPA so that QA and other departments are aware that you are still trying to contact the client.

If previous or existing client and they do not have their banking details with them.

If nothing has changed, client can confirm first or last 4 digits of the account number that we have on our system.

Fails and disputing process

Fails are reported on and updated immediately once assessed, in WFO. It is your responsibility to check your fails and dispute the outcome, should you wish to, within 48 hours. There is a dispute form which needs to be filled out and sent to qadisputes@oneplan.co.za. Ensure that you check your fails and dispute the QA outcome within the 48-hours as the dispute will not be entertained after 48-hours. All managers will meet on a weekly basis to go through the fails that are disputed, and feedback will be given once a decision has been made.

Principle Decisions

When there are scenarios where the outcome is in question or there are grey areas of uncertainty, a Principal Decision request can be made. The request form can be found with your manger. This must be sent to your Sales Manager. All decisions already made can be found in the Health Principal Decisions document. It is your responsibility to continuously check this document to ensure that you always apply the correct processes.

Application forms must include a copy of PI's ID

When capturing a sale from an application form, the PI's ID copy must be included.

Manual application process:

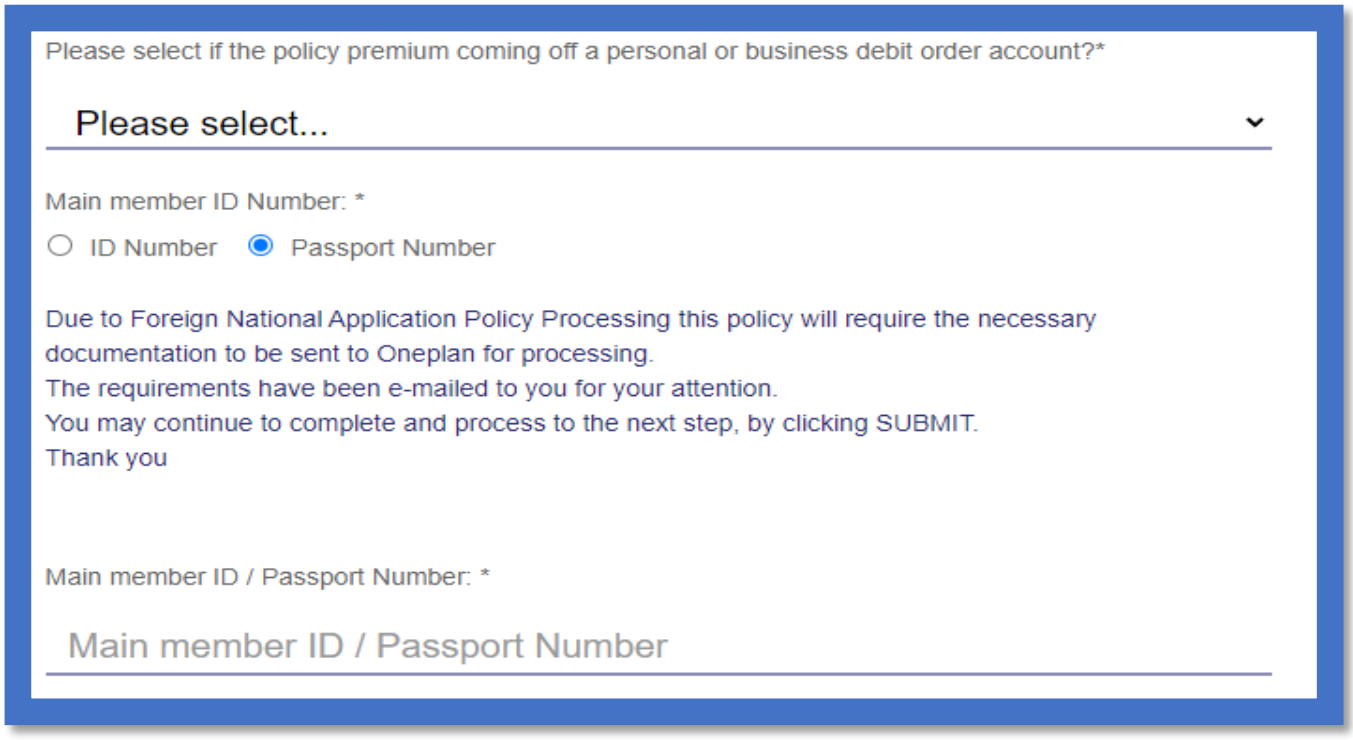
Once the application has been received, the team manager must sign off the application on each page and mail that the agent may proceed to capture the application. The agent must ensure that the application is attached on OPA within 24 hours. If there is any missing information on a manual application, the customer would have to complete the information and send it back to us before processing the application. After capturing a manual application, the sales agent must call the customer with the final premium and exclusions which the client accepts on the recorded line, or a signed written permission from the PI or PP (via nominated email address).

Duplicate policies

Please check for duplicate policies prior to calling the clients as they become very irate and then doubt our competency as a company as we do not even know they are an existing client.

Compliance process for Foreign National clients

- When completing the Sales journey with a foreign National client, select the Passport number tick box in the Banking details section.
- Type in the passport number and inform the client that he will receive an email from us requesting the relevant documents we require. He must email the required documents directly to Compliance as per the emails received. (documents@oneplan.co.za) Compliance will validate the documents within 48 hours.
- Complete the application. The policy will remain under *foreign national status* until Compliance has approved the Documents.
- They will then push the policy to "New" status.

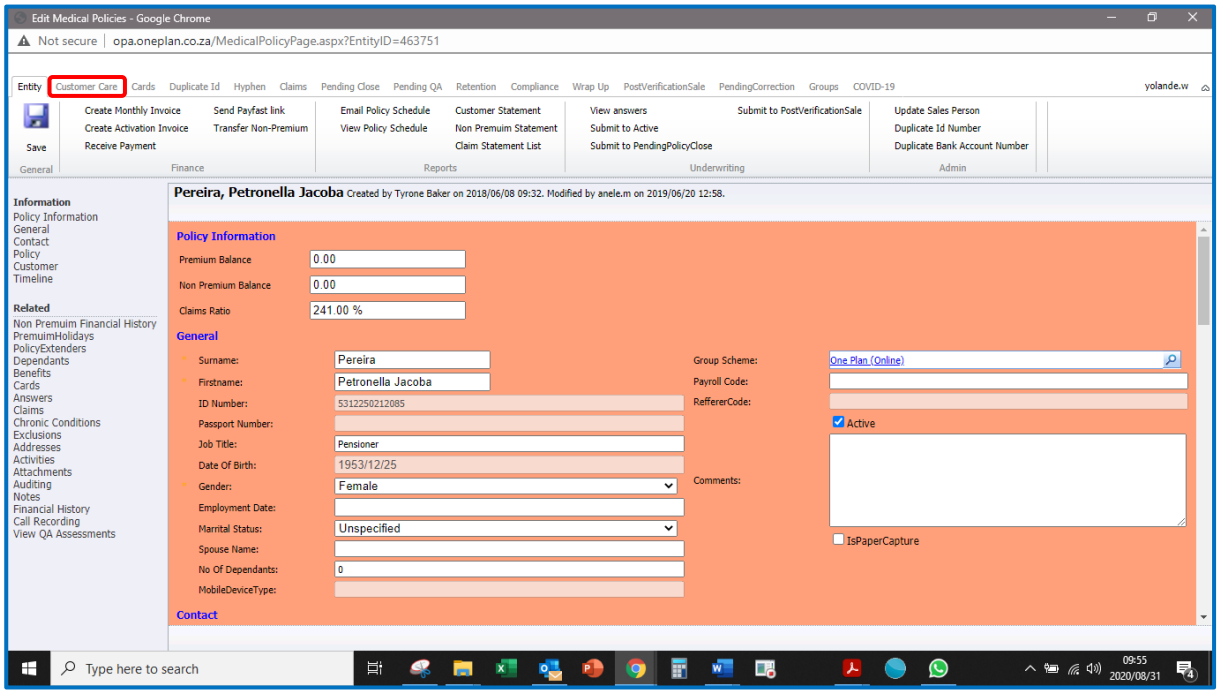


Compliance process for Business Accounts

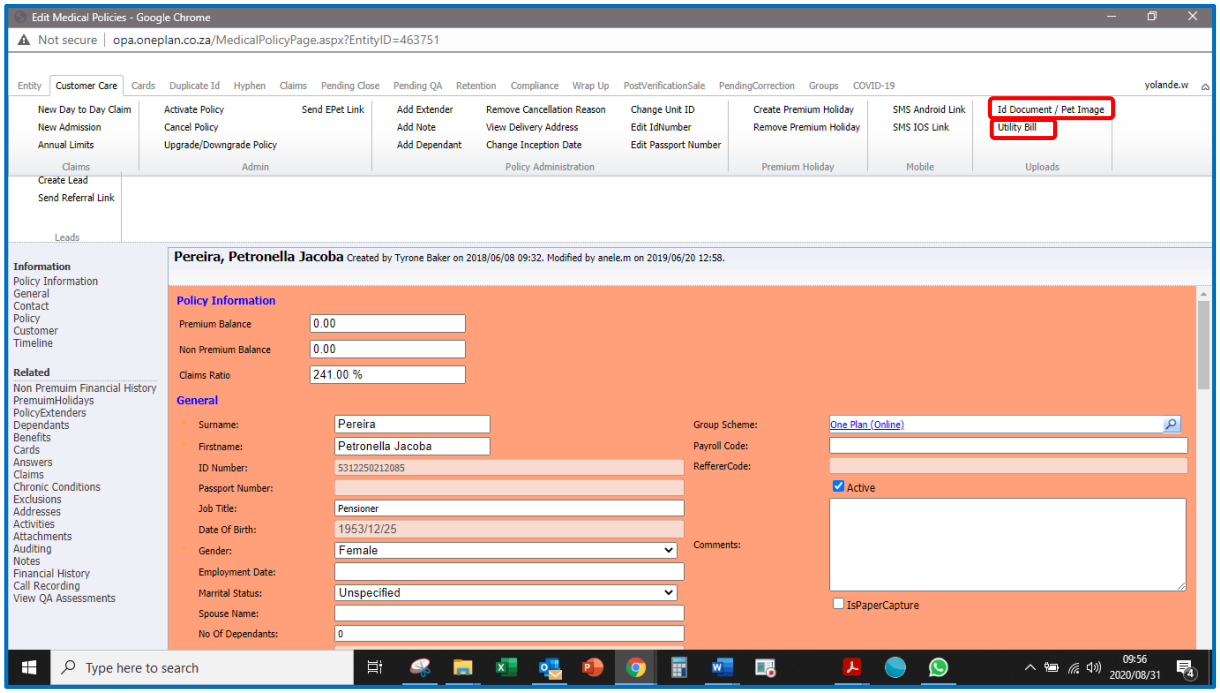
The sales agent must stop the sale and advise the customer that the following documents as per the checklist that applies will be required before the application can be submitted. The sales agent must then email the checklist along with the application form to the client. Remind the client that they should ensure that all documents required must be submitted before the process can be completed. Once received, these documents must then be sent to documents@oneplan.co.za (Compliance) for approval. This will take approximately 48 hours for approval. Once you receive the approval outcome, complete the sale. This will require a call to the customer to confirm exclusions and inception dates, etc. You must then upload the documents on OPA (including the approval email from Compliance) within 24 hours of completing the sale.

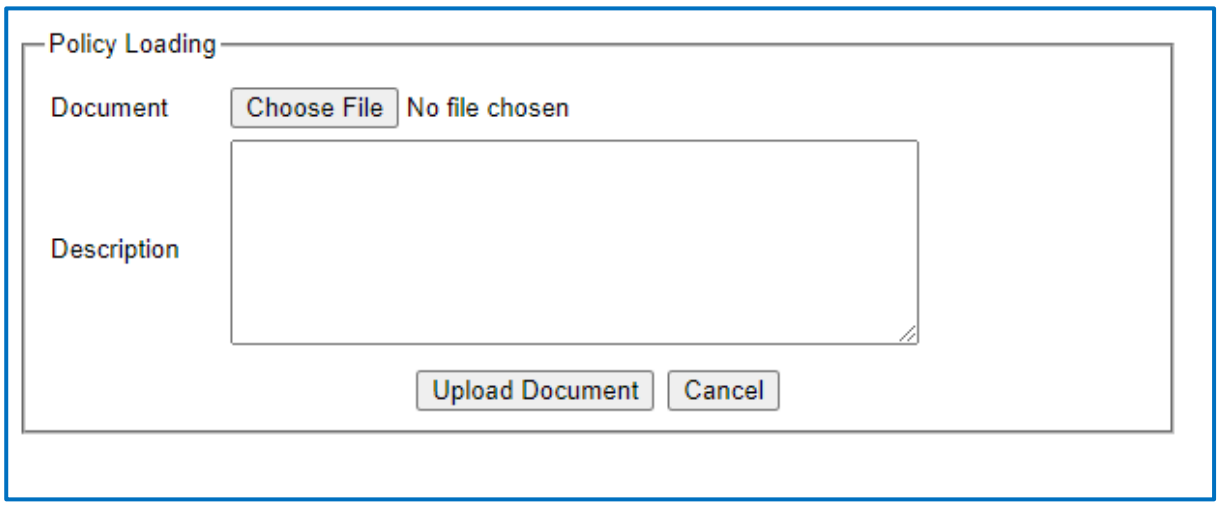
How to upload documents on OPA

- On OPA – Open the policy – Select the Customer Care tab



- In the Uploads section – you can select either Utility Bill or ID Document / Pet Image



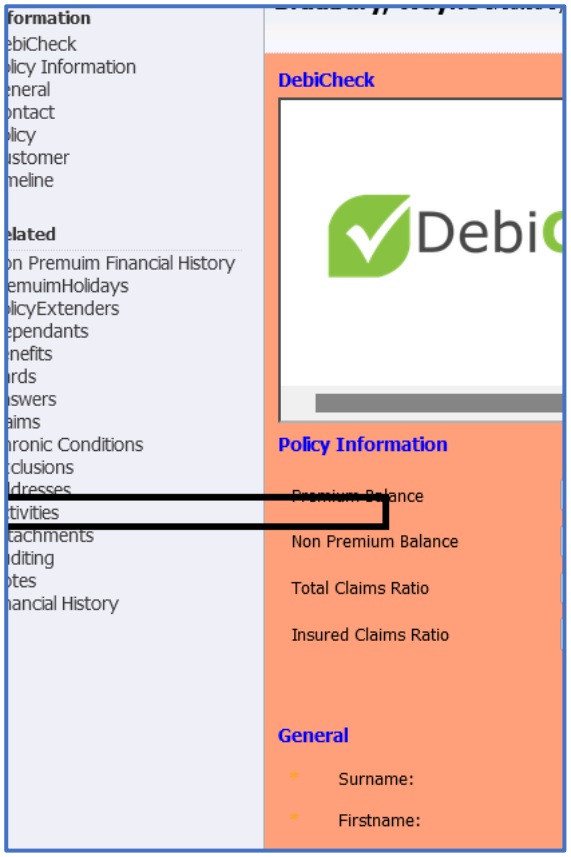


- The following screen will be displayed – choose the documents to be uploaded.
- Type in a description of the documents
- Then click on Upload Document

How to resend communication to clients via OPA

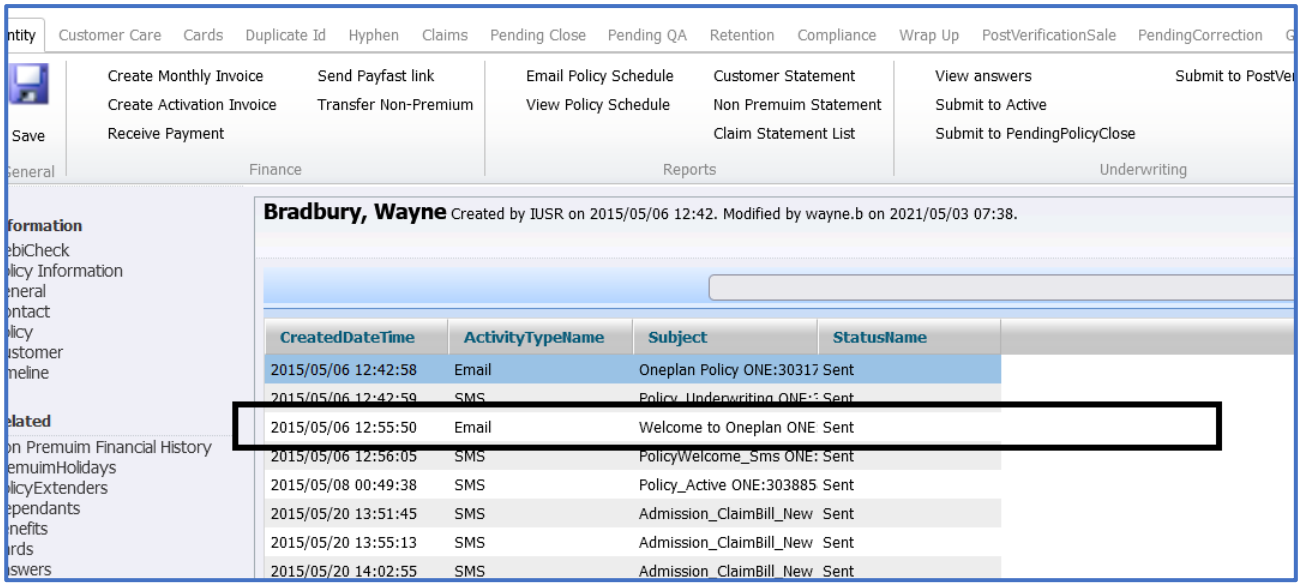
Step 1

- Open the customer policy in question and click on activities on the Entity screen



Step 2

- Select the activity that you would like to resend to a customer by double clicking on the entry. This could be any activity that has been sent in the past.

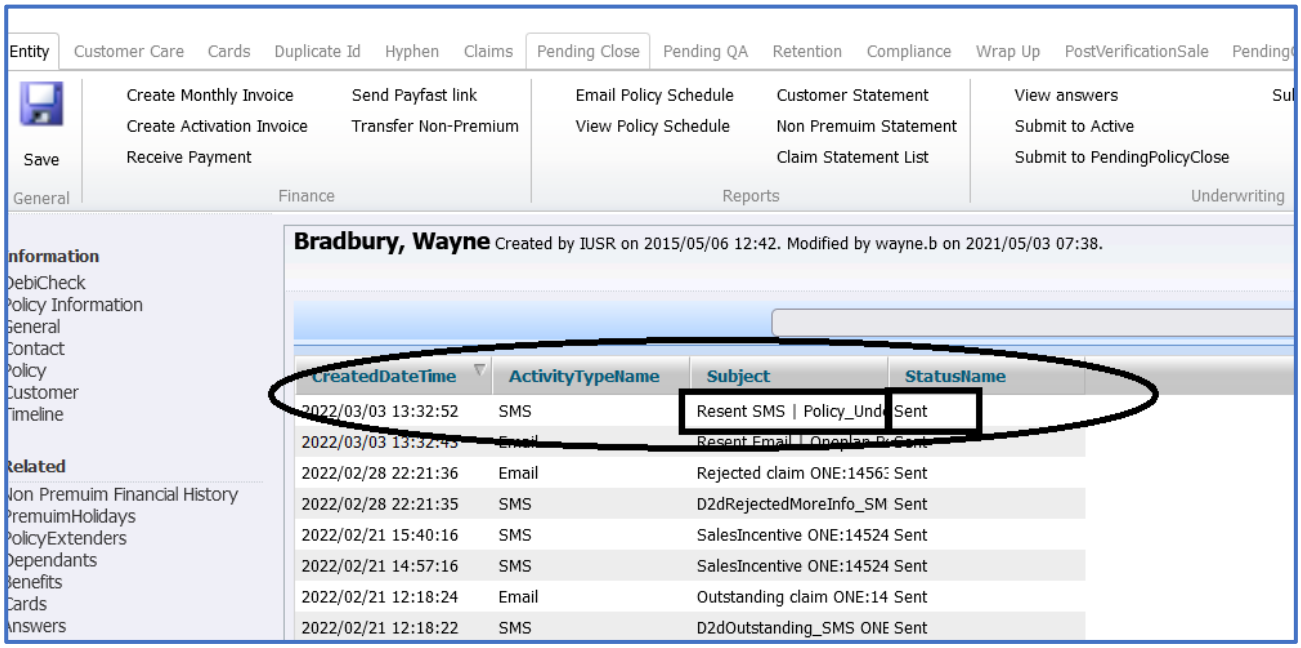


Step 3

- A new windows box will open and click on the “resend Email” or “Resend SMS” button depending on the activity you have selected

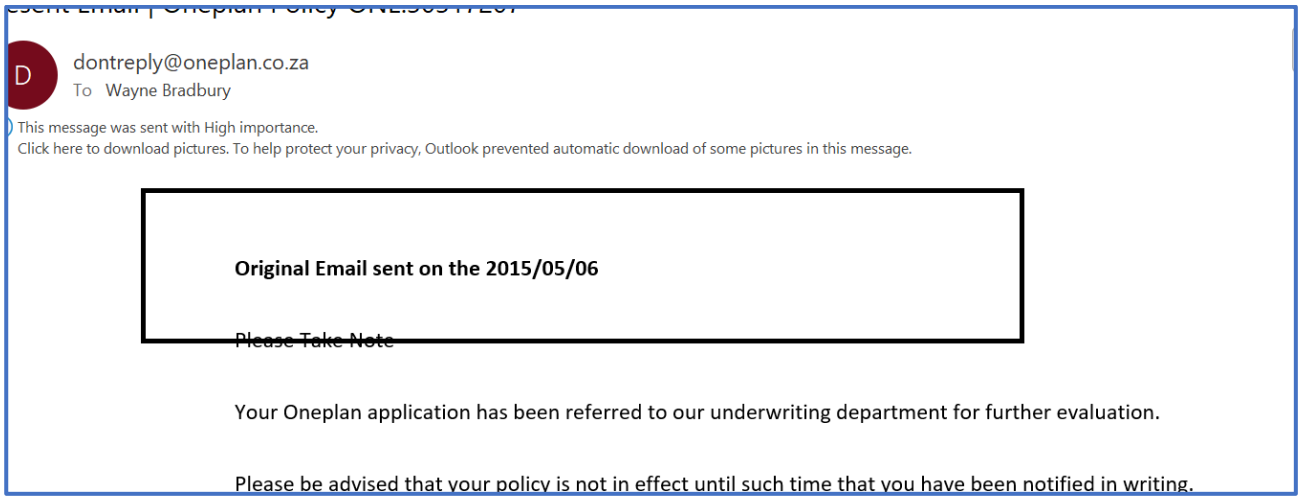
Step 4

The new communication will be saved under activities and refer to the resend and the successful delivery indicator.



Customer View

The customer will receive the SMS/mail that you have resend and the communication will make reference to the original date the communication was sent.



TIP – No charge

If the customer's cell number over the years changed, please ensure you update the cell number or mail address before you hit send. If not, the resend activity will be sent to the incorrect mail or email address. Also ensure that these new details are saved on OPA. Remember to ask for lead referral and, equally important complete, a health check on the policy and ask for a Hello Peter rating.