ONE PLAN™
Health Insurance

HEALTH SALES
Learner Guide

www.oneplan.co.za

010 0010 141

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Purpose

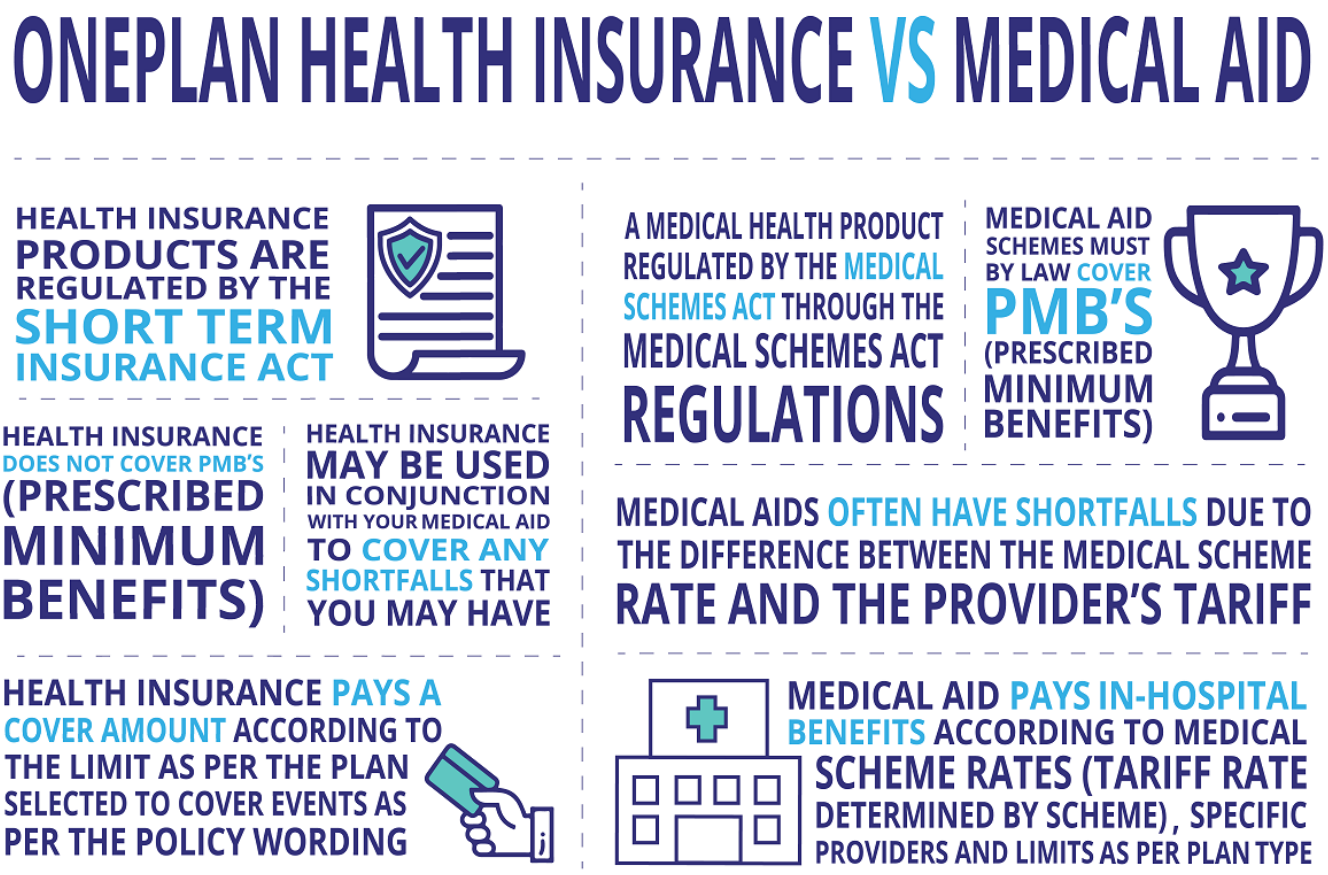
This guide serves as a reference of knowledge as you travel the Oneplan journey to competency.

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.
  - Health plans and features
  - The legislation regulating the industry and Oneplan Health Insurance
  - Operational terminology
- Follow and deliver the sales script according to company's policies and procedures
- Accurately capture customer information on Softphone and OPA
- Understand the QA process, its impact on you and our clients
- Be able to adapt sales techniques and handle objections to generate successful sales
- Comply with operational processes and procedures

1. Health Insurance vs Medical Aid



1.1 Differences between Health Insurance and Medical Aid

Health Insurance	Medical Aid
Health Insurance is regulated by the Short-Term Insurance Act	Medical Aids are regulated by the Medical Schemes Act
Health Insurance products are governed by the Council for Medical Schemes	Medical Aid schemes are governed by the Council for Medical Schemes
Health Insurance is risk cover for unforeseen events according to cover limits	Medical Aid schemes have got specified and yearly limits and health events do not need to be specifically identifiable
Health Insurance does not cover PMBs (Prescribed Minimum Benefits)	Medical Aid schemes must, by law, cover PMBs (Prescribed Minimum Benefits)
Health Insurance covers health events at fixed or specific amounts which is defined per specific identifiable events as per policy schedules	Day-to-day benefits are paid from the Medical Savings Account (members own contribution) or as per agreement with specific contracted providers
Health Insurance includes non-indemnity cover such as disability and death cover	Medical Aid schemes are not allowed to include any Personal Accident disability and loss of limbs cover or death and / or funeral cover as part of the Medical Aid Scheme

Health Insurance pays a cover amount according to the limit as per the plan selected to cover events as per the policy wording	Medical Aid pays in-hospital benefits according to Medical Scheme Rates (tariff rate determined by scheme), specific providers and limits as per plan type
Health Insurance may be used in conjunction with your medical aid to cover any shortfalls that you may have	Medical Aids often have shortfalls due to the difference between the Medical Scheme Rate and the provider's tariff
Health Insurance may exclude medical conditions on a group basis	Medical Aid schemes cover medical conditions according to scheme rules and managed health care protocols

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
Annual limit	The maximum amount of cover that would be paid for twelve (12) consecutive months from the date of inception, under each cover type. Once the Annual Limit is exhausted, no further event limits may be claimed. The annual limit is renewed every twelve (12) months on the inception day of the policy.
Accident	A sudden, unexpected, unforeseen, unintended injury that happens by chance or that is without apparent (for instance underlying degenerative) or deliberate cause, which occurs at a specific time and place, the result of which incident requires immediate (no more than seventy-two (72) hours) medical attention.
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	A form completed by the principal insured for the cover selected. (Telephonically or online)
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 child, who has not been emancipated (legally become an adult) and under the age of twenty-one (21). There is no age restriction for children who are either mentally or physically incapacitated from maintaining themselves, provided that these children are dependent on the Principal Insured for support and maintenance.
Clinical signs	Any changes to insured's normal healthy state, behaviour, or bodily functions.
Congenital	A condition existing at birth and often before birth or identified later in life.
Cover limit	Means the maximum amount you may claim for per event. You must submit actual and valid invoices for each event. Should the invoice amount be less than the event limit (the max amount we pay per claim), we will only pay the claim up to the invoice amount.
Professional Sport	Any professional sport from which an income is derived. All treatment, procedures and related conditions are excluded for 12 months from in hospital cover (pain control / diagnostic procedures / investigations are TOTALLY excluded from hospital cover).
Credible cover	Any period during which a late joiner was: 1. a member or a dependant of a medical scheme. 2. a member or a dependant of an entity doing the business of a medical scheme which, at the time of his/her membership of such entity, was exempt from the provisions of the Act. 3. a uniformed employee of the South African National Defence Force, or a dependant of such employee, who received medical benefits from the South African National Defence Force; or 4. a member or dependant of the Permanent Force Continuation Fund but excluding any period of coverage as a dependant under the age of twenty-one (21) years. (Membership of an overseas medical aid does not count for creditable coverage nor any period of cover as a dependant under the age of twenty-one (21).
Chronic	Any illness or disease that requires medication or treatment for an uninterrupted period of more than 3 months.

Chronic medication	Chronic medication is medication required for 3 months or more and is covered after 30 days from scripted medication up to the cover limit.
Dependant	A spouse, partner, children under the age of twenty-one (21) or children over the age of twenty-one (21), dependent upon the Principal Insured due to mental or physical ability and has been selected as such by the Principal Insured in the Application Form.
Debit order date	The date the client chooses as the date we debit the monthly premium. The following debit order dates are available: The 1st, the 2nd, the 7th, the 20th, from the 25th up to the last day of the month.
Dread disease	Specifically defined critical conditions listed below, subject to the minimum requirements which require detailed confirmation with results including but not limited to sonars, histological confirmations, CT scan and MRIs, ECGs, Cardiologist's Reports, Neuro-Imaging, investigative reports, etc.
Event	An occurrence that may or may not become a claim dependent on the type of cover according to the clients chosen plan.
Effective cover date	The date the cover will be available to you – effectively the date your waiting periods expire.
Exclusions	Any conditions or illnesses that you cannot claim for during a specific period of time.
Excess	This is an amount you will need to pay to Oneplan as specified in your Policy Schedule at claim stage for in hospital features.
Excess Buster	The additional amount that is added to the monthly premium that will waive all in hospital excess fees at claim stage.
Grace Period	1. Should your premium not be successfully received by the Insurer, there is a Grace Period in which you can pay the outstanding premium. The Grace Period is until the fifteenth (15th) day of the month in which the premium was due. If the premium is not paid during this time, the policy may lapse or be cancelled / terminated. 2. During the Grace Period, the policy will be suspended, and no claims will be entertained until the outstanding premium has been received. 3. The Grace Period will commence from the second (2nd) month of the policy inception after successful collection of the first (1st) premium. 4. If we have paid any claims during the Grace Period and the premium remains unpaid after the grace period expires, we will recover the claims

	paid as well as any costs incurred as a result of a claim being paid. This will include any collection or legal fees. 5. Should we receive your premium after the grace period has expired, no claim will be paid even though the event occurred after payment of premium.
Hereditary	A condition that has been passed down from your parents which may present during any stage of your life.
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.
Inception date	The date on which the policy first became active.
Insured event	An event that would cause the Insurer to pay a claim as per the cover provided in this policy. In applying the above, you are required to understand that an Insured Event may be, for instance, an Accident Event or an Illness Event, and any treatment related to these events will be paid as one event, notwithstanding the recurrence thereof within a six-month period.
Illness	Is a disease or sickness that started after your cover began.
Immediate treatment	Medical treatment sought or obtained within seventy-two (72) hours of an insured event.
Injury	Physical injury, cut, abrasion, burn caused to a person by an unforeseen accident. Specific to Accidental Disability: an unforeseen bodily injury that has an accidental cause occurring solely, directly, and independently of any other cause or any other physical defect or infirmity existing prior to the Accident within twelve (12) months of the date of the Accident.
Late Joiner Penalty	An additional contribution, imposed on persons joining Oneplan at the age of thirty-five (35) and older and who have not been a member of one or more medical aid schemes since April 2001, without a break in membership exceeding three (3) consecutive months. The penalty is calculated according to a prescribed formula in the Regulations that determines a maximum

	penalty according to the applicant's penalty band. The formula takes previous creditable coverage with other medical schemes into.
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.
Life threatening	An event in which failure to treat the injury or illness immediately (within one hour of onset) will result in permanent damage to the insured. Triaged as red and orange. Ambulance or emergency services only available to life threatening.
Mediscor	Electronic claims system that is used by pharmacies to process claims for scripted medication.
Month	1st to last day of any month.
Neo-natal	A newborn in the first 28 days after birth; the term applies to premature, full term, and postmature infants.
Old School	You opt not to utilise the Oneplan Mobile App and Oneplan Claim Card Transactional facility to process claims and instead opt for all claims to be submitted for processing and refunding to your bank account.
Oneplan Claim Card	The transactional cheque card onto which health cover claims are loaded via our easy-to-use Oneplan mobile app.
Permanent disability	The Principal Insured who has sustained an injury whereby they cannot perform ordinary tasks or occupations with the same ability as a person without such disability.
Policy schedule	The document that lists the detail of the insured amounts, exclusions, and cover limits.
Principal Insured	The natural person in whose name the agreement is entered and whose name is reflected on the Schedule.
Pre-Existing condition	A medical condition, or condition that presented Clinical Signs, that were in existence prior to this policy's Inception Date, or in existence during the first three (3) months during the waiting period or that was newly diagnosed within the first three (3) months from the Inception Date of the policy, whether it was known or unknown. Heads up - this kind of condition existed before your policy began and it does not mean that the insured was

	diagnosed with it, he or she could even have been showing the symptoms for it to be classified as pre-existing.
Professional sport	The insured's participation in a sporting activity, from which more than 50% of their income is earned (not covered)
Regulations	The Regulations in terms of the Medical Schemes Act, No 131 of 1998.
Specialist	A doctor who has completed advanced education and clinical training in a specific field of medicine, for example a physician such as, but not limited to a neurologist, pulmonologist, or surgeon such as a general surgeon, orthopaedic surgeon etc.
Spouse	A partner in marriage, civil union, domestic partnership, common-law marriage or customary marriage.
Symptom	Any sensation or change in bodily function experienced by an individual that could be associated with a disease and is regarded as evidence of the existence of a disease or illness. This includes, but is not limited to, pain, nausea, recurrent infections, or weakness and so on.
Triage	Assessing of emergency patients by medical professionals at the emergency unit into categories of priority based on the urgency of treatment required founded on national / international scales which includes time frames. The triage category may change based on change in the condition of the insured or the actual diagnosis and treatment received.
Waiting period	The time the insured must wait before making a claim.
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.
You/Principal Insured	The natural person over the age of eighteen (18) in whose name the agreement is entered and whose name is reflected on the Schedule. This is pretty much the main holder of this policy.
3rd Generation	The grandchild of the Principle Insured that will not be covered on the plan.
Regulations	The Regulations in terms of the Medical Schemes Act, No 131 of 1998.

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 R480PM	CORE PLUS PLAN FROM R635PM	BLUE PLAN FROM R955PM	PROFESSIONAL PLAN FROM R1 330PM	EXECUTIVE PLAN FROM R1 765PM
General Practitioner (Doctor/registered nurse) Up to **R 400** per visit	General Practitioner (Doctor/registered nurse) Up to **R 400** per visit	General Practitioner (Doctor/registered nurse) Up to **R420** per visit	General Practitioner (Doctor/registered nurse) Up to **R475** per visit	General Practitioner (Doctor/registered nurse) Up to **R550** per visit
Scripted Medication Up to **R170** per script. Paid through Mediscor electronic claim system.	Scripted Medication Up to **R170** per script. Paid through Mediscor electronic claim system.	Scripted Medication Up to **R190** per script. Paid through Mediscor electronic claim system.	Scripted Medication Up to **R275** per script. Paid through Mediscor electronic claim system.	Scripted Medication Up to **R315** per script. Paid through Mediscor electronic claim system.
Over-the-Counter Medication Up to **R170** per script. Paid through Mediscor electronic claim system.	Over-the-Counter Medication Up to **R170** per script. Paid through Mediscor electronic claim system.	Over-the-Counter Medication Up to **R190** per script. Paid through Mediscor electronic claim system.	Over-the-Counter Medication Up to **R275** per script. Paid through Mediscor electronic claim system.	Over-the-Counter Medication Up to **R315** per script. Paid through Mediscor electronic claim system.
Pathology Up to **R485** per event.	Pathology Up to **R485** per event.	Pathology Up to **R505** per event.	Pathology Up to **R555** per event.	Pathology Up to **R695** per event
Radiology Up to **R485** per event.	Radiology Up to **R485** per event.	Radiology Up to **R505** per event.	Radiology Up to **R555** per event.	Radiology Up to **R695** per event
Dentistry Up to **R650** per visit. Max of 3 visits a year.	Dentistry Up to **R650** per visit. Max of 3 visits a year.	Dentistry Up to **R685** per visit. Max of 3 visits a year.	Dentistry Up to **R810** per visit. Max of 3 visits a year.	Dentistry Up to **R905** per visit. Max of 3 visits a year.

Specialist Cover **NOT COVERED ON THIS PLAN.**	Specialist Cover **NOT COVERED ON THIS PLAN.**	Specialist Cover **NOT COVERED ON THIS PLAN.**	Specialist Cover **NOT COVERED ON THIS PLAN.**	Specialist Cover Up to **R2 215** per visit. 3 visits per family per year. Referral from GP required and subject to authorisation.
Maternity Pre-Birth Up to **R650** per visit. 3 Visits per Pregnancy. **Annual limit of R 1 955.**	Maternity Pre-Birth Up to **R650** per visit. 3 Visits per Pregnancy. **Annual limit of R 1 955.**	Maternity Pre-Birth Up to **R660** per visit. 3 Visits per Pregnancy. **Annual limit of R1 985.**	Maternity Pre-Birth Up to **R665** per visit. 3 Visits per Pregnancy. **Annual limit of R2 000.**	Maternity Pre-Birth Up to **R705** per visit. 4 Visits per Pregnancy. **Annual limit of R2 810.**
Optometry Up to **R 1 130** - Limited to claim this every 24 months per dependant.	Optometry Up to **R 1 130** - Limited to claim this every 24 months per dependant.	Optometry Up to **R1 215** - Limited to claim this every 24 months per dependant.	Optometry Up to **R1 595** - Limited to claim this every 24 months per dependant.	Optometry Up to **R1 760** - Limited to claim this every 24 months per dependant.
Day-to-Day Overall Limit Single: **R8 060** 2 or 3: **R13 465** 4 plus: **R16 765**	Day-to-Day Overall Limit Single: **R8 060** 2 or 3: **R13 465** 4 plus: **R16 765**	Day-to-Day Overall Limit Single: **R8 650** 2 or 3: **R13 520** 4 plus: **R17 845**	Day-to-Day Overall Limit Single: **R12 490** 2 or 3: **R19 415** 4 plus: **R24 065**	Day-to-Day Overall Limit Single: **R18 165** 2 or 3: **R26 770** 4 plus: **R32 175**
Casualty Illness Up to **R5 600** for life threatening emergency illness in casualty units.	Casualty Illness Up to **R5 600** for life threatening emergency illness in casualty units.	Casualty Illness Up to **R5 600** for life threatening emergency illness in casualty units.	Casualty Illness Up to **R5 800** for life threatening emergency illness in casualty units.	Casualty Illness Up to **R6 100** for life threatening emergency illness in casualty units.
Casualty Accident Up to **R5 600** for life threatening emergency accidents in casualty units.	Casualty Accident Up to **R5 600** for life threatening emergency accidents in casualty units.	Casualty Accident Up to **R5 600** for life threatening emergency accidents in casualty units.	Casualty Accident Up to **R5 800** for life threatening emergency accidents in casualty units.	Casualty Accident Up to **R6 100** for life threatening emergency accidents in casualty units.

Excess: 0-3 Months - 15 % 4 Months + - R200	Excess: 0-3 Months - 15 % 4 Months + -R200	Excess: 0-3 Months - 15 % 4 Months + -R200	Excess: 0-3 Months - 15 % 4 Months + -R200	Excess: 0-3 Months - 15 % 4 Months + -R200
Accident Cover Up to **R175 000** per insured event. Up to **R350 000** per family per event. Excess: R600 Contact sport - 15% of claim amount	Accident Cover Up to **R175 000** per insured event. Up to **R350 000** per family per event. Excess: R600 Contact sport - 15% of claim amount	Accident Cover Up to **R230 000** per insured event. Up to **R460 000** per family per event. Excess: R600 Contact sport - 15% of claim amount	Accident Cover Up to **R260 000** per insured event. Up to **R520 000** per family per event. Excess: R600 Contact sport - 15% of claim amount	Accident Cover Up to **R340 000** per insured event. Up to **R680 000** per family per event. Excess: R600 Contact sport - 15% of claim amount
Illness In Hospital **Not Covered on this plan**	Illness In Hospital Up to **R35 000** per insured event p/p. Up to **R87 500** per insured per year. Excess: 4-6 Months - 15% 7 Months + - 5%	Illness In Hospital Up to **R60 000** per insured event p/p. Up to **R150 000** per insured per year. Excess: 4-6 Months - 15% 7 Months + - 5%	Illness In Hospital Up to **R68 000** per insured event p/p. Up to **R170 000** per insured per year. Excess: 4-6 Months - 15% 7 Months + - 5%	Illness In Hospital Up to **R80 000** per insured event p/p. Up to **R200 000** per insured per year. Excess: 4-6 Months - 15% 7 Months + - 5%
Dread Disease **Not Covered on this plan**	Dread Disease **Not Covered on this plan**	Dread Disease Up to **R315 000** per defined disease per year.	Dread Disease Up to **R335 000** per defined disease per year	Dread Disease Up to **R390 000** per defined disease per year.
Natural Birth and Emergency Caesareans **Not Covered on this plan**	Natural Birth and Emergency Caesareans **Not Covered on this plan**	Natural Birth and Emergency Caesareans Up to **R55 000** per insured event p/p. Cover forms part of illness and operations annual limits. Excess: 10% of claim amount.	Natural Birth and Emergency Caesareans Up to **R65 000** per insured event p/p. Cover forms part of illness and operations annual limits. Excess: 10% of claim amount.	Natural Birth and Emergency Caesareans Up to **R75 000** per insured event p/p. Cover forms part of illness and operations annual limits. Excess: 10% of claim amount.

Neonatal **Not Covered on this plan**	Neonatal **Not Covered on this plan**	Neonatal Up to **R55 000** per insured event p/p. Cover forms part of illness and operations annual limits. Excess: 10% of claim amount.	Neonatal Up to **R65 000** per insured event p/p. Cover forms part of illness and operations annual limits. Excess: 10% of claim amount.	Neonatal Up to **R75 000** per insured event p/p. Cover forms part of illness and operations annual limits. Excess: 10% of claim amount.
Repatriation Up to **R15 000** per insured person. Repatriation of mortal remains to funeral home.	Repatriation Up to **R15 000** per insured person. Repatriation of mortal remains to funeral home.	Repatriation Up to **R15 000** per insured person. Repatriation of mortal remains to funeral home.	Repatriation Up to **R15 000** per insured person. Repatriation of mortal remains to funeral home.	Repatriation Up to **R15 000** per insured person. Repatriation of mortal remains to funeral home.
Ambulance and Emergency Services 24 hr medical assistance with an emergency dedicated line. In the event of a justifiable, life-threatening medical emergency, the insured will be transported by ambulance to the nearest appropriate medical facility.	Ambulance and Emergency Services 24 hr medical assistance with an emergency dedicated line. In the event of a justifiable, life-threatening medical emergency, the insured will be transported by ambulance to the nearest appropriate medical facility.	Ambulance and Emergency Services 24 hr medical assistance with an emergency dedicated line. In the event of a justifiable, life-threatening medical emergency, the insured will be transported by ambulance to the nearest appropriate medical facility.	Ambulance and Emergency Services 24 hr medical assistance with an emergency dedicated line. In the event of a justifiable, life-threatening medical emergency, the insured will be transported by ambulance to the nearest appropriate medical facility.	Ambulance and Emergency Services 24 hr medical assistance with an emergency dedicated line. In the event of a justifiable, life-threatening medical emergency, the insured will be transported by ambulance to the nearest appropriate medical facility.
Accident Disability Up to **R210 000** for the duration of the policy. only principal insured is covered.	Accident Disability Up to **R210 000** for the duration of the policy. only principal insured is covered.	Accident Disability Up to **R220 000** for the duration of the policy. Only principal insured is covered.	Accident Disability Up to **R230 000** for the duration of the policy. only principal insured is covered.	Accident Disability Up to **R230 000** for the duration of the policy. only principal insured is covered.

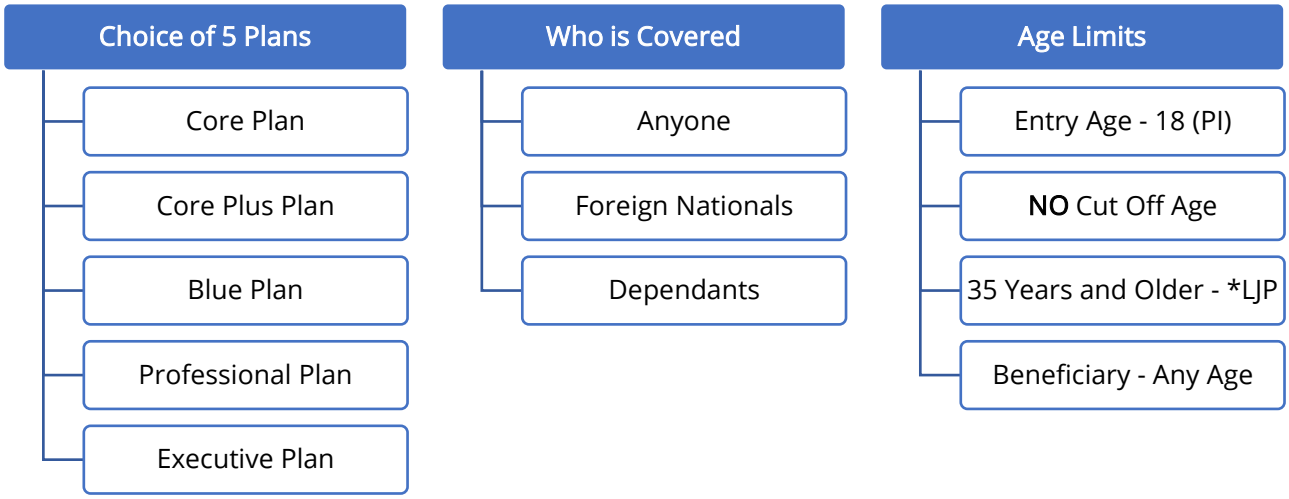
Accidental Death Cover Principal Insured: **R13 000** Spouse/Partner: **R13 000** Children 14-21 yrs: **R13 000** Children 6-13 yrs: **R9 000** Children 1-5 yrs: **R7 000**	Accidental Death Cover Principal Insured: **R13 000** Spouse/Partner: **R13 000** Children 14-21 yrs: **R13 000** Children 6-13 yrs: **R9 000** Children 1-5 yrs: **R7 000**	Accidental Death Cover Principal Insured: **R15 000** Spouse/Partner: **R15 000** Children 14-21 yrs: **R15 000** Children 6-13 yrs: **R10 000** Children 1-5 yrs: **R7 500**	Accidental Death Cover Principal Insured: **R20 000** Spouse/Partner: **R20 000** Children 14-21 yrs: **R20 000** Children 6-13 yrs: **R12 500** Children 1-5 yrs: **R8 750**	Accidental Death Cover Principal Insured: **R25 000** Spouse/Partner: **R25 000** Children 14-21 yrs: **R25 000** Children 6-13 yrs: **R15 000** Children 1-5 yrs: **R10 000**
Trauma, Assault and Accidental HIV Trauma and assault counselling, Accidental HIV protection services. Accidental HIV infection treatment.	Trauma, Assault and Accidental HIV Trauma and assault counselling, Accidental HIV protection services. Accidental HIV infection treatment.	Trauma, Assault and Accidental HIV Trauma and assault counselling, Accidental HIV protection services. Accidental HIV infection treatment.	Trauma, Assault and Accidental HIV Trauma and assault counselling, Accidental HIV protection services. Accidental HIV infection treatment.	Trauma, Assault and Accidental HIV Trauma and assault counselling, Accidental HIV protection services. Accidental HIV infection treatment.
ADD-ON PRODUCTS	ADD-ON PRODUCTS	ADD-ON PRODUCTS	ADD-ON PRODUCTS	ADD-ON PRODUCTS
Excess Buster to waive Excesses **R15 per person**	Excess Buster to waive Excesses **R15 per person**	Excess Buster to waive Excesses **R25 per person**	Excess Buster to waive Excesses **R40 per person**	Excess Buster to waive Excesses **R40 per person**

Our clients receive two policies as determined by regulations.

1st Policy – Health	2nd Policy – Accidental Death & Disability
Personal information	Personal information
Plan information	Accidental permanent disability cover
Legal definitions	Accidental death assistance cover
Oneplan Health cover	Trauma, assault, and accidental HIV
General conditions	General conditions

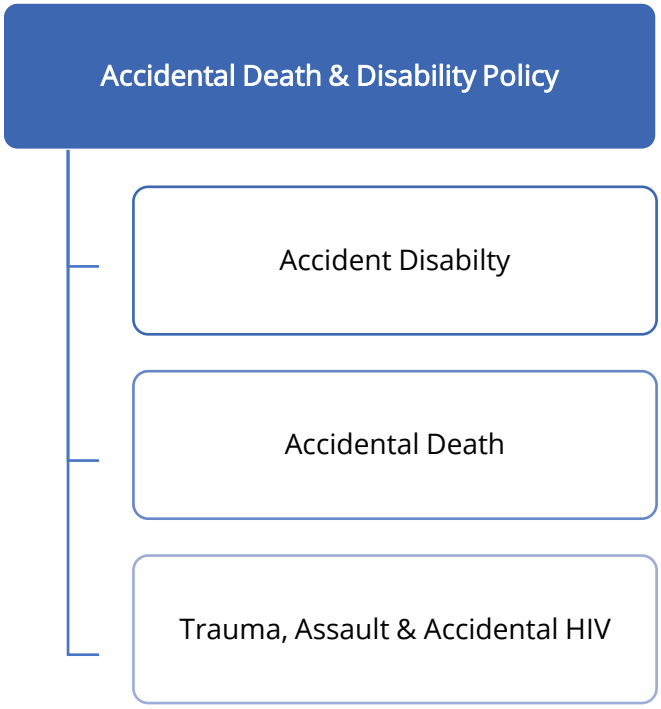
General exclusions	General exclusions
Standard conditions	Standard conditions
Appendix	
Complaints resolution policy	
Statutory disclosures	
Contact details	

3.1 First Policy - Health Cover



*Late Joiner Penalty

3.2 Second Policy – Additional Cover



3.3 Out-of-Hospital Features: Health Cover

General Practitioner

- A medical doctor who does not specialise in any particular field of medicine but deals with all illnesses and patients of all ages (also known as a family doctor) and who has obtained a qualification as a Medical Doctor and is a practicing member of the Health Professions Council of South Africa. This cover type includes Nurse Practitioners with a valid BHF practice number.
- Oneplan will indemnify the Insured up to the maximum cover amount as per the schedule, should the insured visit a general or nurse practitioner, due to the occurrence of an unforeseen health event that requires treatment or consultation
- 30 day waiting period.

Scripted Medication

- You require a prescription from your doctor. Claim directly from your pharmacy or via your mobile app. Chronic Medication is covered after 30 days from scripted medication up to cover limits. ARVs are covered under scripted medication up to the cover limit.
- 30 day waiting period.

What you are NOT covered for:

- Vaccinations for all local or international business or leisure travel purposes, including but not limited to, for example, yellow fever vaccinations.
- Stimulants, tonics, supplements.
- Over-the-counter medications.
- Preventative treatment such as contraceptives / birth control medication.
- Medication for conditions subject to a general exclusion such as medication for stress / insomnia /anxiety.

OTC Medication

- This is over-the-counter medication which is scheduled medication that can be bought at a pharmacy without a prescription. This is limited to schedule 1 and schedule 2 medication. This cover type has an annual limit and forms part of your health annual limit.
- Managed as a stated benefit. This means that you will be provided with the cover limit of this benefit in full of your first claim, which will be refunded to your Oneplan Claim Card. If the full

amount of this limit is not used for your claim, the difference will remain available until it has been used in full.

- 30 day waiting period.

Pathology

- The analysis of blood, urine, faeces, and diseased tissue. This includes, but is not limited to, the analysis performed on a blood sample extracted from a vein or fingerprint, throat and nasal swabs, and the analysis of tissue samples requested by a registered medical practitioner.
- 30 day waiting period.

What You are NOT Covered for:

- Sperm count, fertility tests, and / or DNA tests

Special Condition(s):

- Pathology tests done over a period of six (6) days will be seen as one (1) claim.

Radiology

- This is all image screening to diagnose a condition. This includes, but is not limited to, X-rays, sonars, ultrasounds, CT and MRI scans, mammograms, bone density tests, real-time imaging of the digestive tract or blood flow (fluoroscopy and angiography), and nuclear imaging / scans.
- 30 day waiting period.

Dentistry

- The prevention and treatment of diseases and other conditions that affect the teeth and gums, especially the repair and extraction of teeth including such operations as the filling and crowning of teeth performed by a registered dental practitioner. Specialised dentistry is covered under this benefit up to the cover limit per visit. We want to keep your teeth shining and your face smiling!
- 90 day waiting period.
- You are covered for:
    - Fillings, extractions, fluoride treatment, root canal, dentures (false teeth), crowns & bridges.

What You are NOT Covered for:

- Gum guards / gold inlays

Special Condition(s):

- Maximum visits per year (from date of inception) per member is limited to three (3). Annual and Event limits apply.
- This benefit is limited to procedures done in the dentist's rooms.

Specialist

- You can consult a specialist, for example, a physician such as, but not limited to a neurologist, pulmonologist, or surgeon such as a general surgeon, orthopaedic surgeon, etc. Keep in mind, you require a referral letter from your GP to obtain pre-authorisation. ONLY available on the EXECUTIVE plan.
- 90 day waiting period.

What You are NOT Covered for:

- Maternity related visits.
- Sleep studies are specifically excluded.
- Follow-up visits and routine check-up will be covered under GP Visits.
- Follow up visits within six weeks after a hospital admission will not require a referral letter. These visits will be covered under this section or GP visits.
- Any claims that have not been authorised will be covered GP visits. This includes claims that exceed the maximum number of visits allowed or once the annual limit has been reached.

Maternity Pre-birth

- Any gynaecologist and/or foetal specialist consultation. Once you have confirmation of pregnancy from your General Practitioner (letter from doctor). Pre-authorisation is based on proof of conception and is required to claim. Maximum visits per pregnancy is four (4). Cover extends to you, your spouse, or partner only.
- Waiting periods apply:
  - 7 months from date of inception.
  - If you are 4 or more months pregnant, you can claim from month 8 of pregnancy.

What You are NOT Covered for:

- 3D and 4D scans

Special Condition(s):

- You may claim from month four (4) or week sixteen (16) of a confirmed pregnancy - meaning you have been pregnant for four (4) months.
- Maximum visits per pregnancy is three (3).
- A general practitioner needs to refer you after diagnosis to a registered gynaecologist but only aft er the first four (4) months of the pregnancy.
- An authorisation code needs to be requested and received from us.
- Cover extends to you, your spouse, or partner only.

Optometry

- You can visit an optometrist for an eye test, glasses (frames and lenses), contact lenses, and/or tinting of lenses (cover limits apply). The maximum cover limit covers the cost of the eye test and glasses/lenses.
- Waiting periods apply:
    - 12 month waiting period from date of inception.
    - This cover can only be used once during every 24-month cycle.

What You are NOT Covered for:

- Low prescription lenses and sunglasses.

Special Condition(s):

Lenses will be covered if the following norms are met:

- An unaided visual acuity of at least 6/12 or worse on the Snellen Scale for distance and near vision.
- A refraction requirement of at least 0.75 dioptre sphere and/or 0.75 dioptre cylinder on distance vision for both eyes, or
- A refraction requirement of at least 1.25 dioptre sphere on near vision for both eyes.
- **PLEASE NOTE:** Low prescription lenses and sunglasses are not covered.
- The maximum cover limit covers the cost of the eye test and glasses / lenses.

3.4 In hospital features: Health cover

Casualty Illness Cover

- Emergency treatments for illnesses that do NOT require overnight hospital stays. Casualty refers to the emergency department in the hospital. Excess: 4 months + - R200.
- 90 day waiting period.

Casualty accident cover

- Emergency treatments and procedures in casualty for injuries that require immediate treatment. Must be triaged as red or orange. Excess: 0-3 Months - 15%. 4 months and longer - R200.
- Accidents are covered immediately from date of inception; no waiting period applies.

Special Condition(s):

- With reference to the Hospital Casualty Risk Cover (both Casualty Accident and Casualty Illness), we have included a "Special Condition" which states that re-admission for the same or related Insured Event will be covered under the same limit for a period of fourteen (14) days.

Illness in hospital cover

- Any unforeseen disease or sickness that started after your cover began (that is not pre-existing). It includes treatment and procedures that need a hospital admission. Excess: 4-6 months: 15% of the claim amount. 7 months and longer: 5% of the claim amount.
- 90 day waiting period.

The following conditions and related conditions are excluded for the first 12 months:

- Tonsillectomies, adenoidectomy, tonsillitis, adenoiditis.
- Grommets, ear surgery, adenoidectomies, and sinus and nasal surgery.
- Hernias.
- Pregnancy, complications of pregnancy, and deliveries.
- Gynaecological conditions and procedures including hysterectomies, CIN lesions, LLETZ, colposcopies, endometriosis treatment, ovarian cysts, polycystic ovaries, ablation of uterus, fibroids, hysteroscopies, myomectomies, enterocele and rectocele repairs.
- Genitourinary system treatment and procedures, including, but not limited to, prostate/urethra surgery, including cystoscopies and circumcisions.

- Ulcers, gastritis, GERD, diverticulitis, irritable bowel syndrome, rectal bleeding or gastrointestinal bleeding and associated gastroscopies, colonoscopies, and sigmoidoscopies.
- Gallstones and removal of gallbladder (cholecystectomy), cholecystitis.
- Spinal procedures and joint surgery, including carpal tunnel syndrome and ganglions.

What You are NOT Covered for:

- Admissions for arthroscopies (keyhole surgery) and related procedures.
- Specialised dentistry, dental conditions and dental operations including, but not limited to, wisdom teeth removal, jaw surgery, and treatment of dental abscesses.
- Pregnancy related complications.

Accident cover

- Unexpected, unforeseen injury that happens by chance and requires admission into a hospital. Excess: R600 per claim. An excess amount of 15% of the claim is payable for claims related to any professional sport from which an income is derived and a twelve (12) month waiting period applies.
- Re-admission within six (6) months for the same accident is seen as one event and covered under the same cover.
- Accidents are covered immediately from date of inception; no waiting period applies.

Dread Disease

- This is a critical condition and requires medical treatment. Can claim up to three (3) times for the same dread disease during the lifetime of the policy. If the dread disease is pre-existing a waiting period of 12 months will apply. No excess fee is applicable to dread disease.
- 6 months waiting period.
- 6 month waiting period between claims for same disease.

We cover 9 dreaded diseases which are listed below:

- Heart attack
- Coronary artery disease requiring surgery
- Heart valve replacement
- Aorta surgery / aneurysm
- Stroke
- Cancer

- Acute kidney failure
- Brain tumors
- Major organ transplant

Special Condition(s):

- Oneplan will consider cover for a Pacemaker under this cover type, subject to a specialist motivation, stress ECG, and/or an Echocardiogram. A "pacemaker" for this purpose means a small device that sends electrical impulses to the heart muscle to maintain a suitable heart rate and rhythm.

Natural Birth & Emergency Caesareans

- A natural birth event in a medical facility or at home, performed by a midwife or a waterbirth. The definition includes emergency or clinically indicated caesarean sections. It is important to note that mother and newborn (baby and/or babies) are covered under the same cover (one limit). Pregnancy related conditions / complications of pregnancy are covered under this benefit and will form part of the cover limit available for the delivery.
- 12-month waiting period from inception.
- All claims related to this cover will be subject to a 10% excess amount.

Special Condition(s):

- To book a bed for delivery, a letter of confirmation of cover needs to be requested from the Authorisations Department. Upgrades to private wards are not covered under this policy and all costs for private wards will be for your account. If you want a room with a view and fancy decorations, then this one's on you!
- Authorisation for the delivery will be provided two weeks prior to the delivery date or once payment of the premium for the month in which the delivery will occur is received.
- Caesarean sections must be clinically indicated, and a motivation letter must be sent to us for approval. This means your c-section is for a medical reason and not because you wanted one out of choice.
- The cover may only be utilised once during the lifetime of the policy for dependants other than a spouse or partner.
- Follow-up visits will be covered under Section 3.1 or 3.7, should your policy have specialist cover.
- Special Conditions for Newborn Babies:

- After the birth, the newborn baby will only be covered once he or she has been discharged from the hospital with a clean bill of health, subject to the baby being registered and accepted as an Insured child within thirty (30) days of the date of birth. This excludes any conditions related to a delivery that was not covered by the policy for a period of six (6) months from the date of birth. Yes, you need to register your baby for insurance with us. We want to know all about our new addition to the Oneplan Family.
- If next month's debit order is returned, we will have the right to claim back any cover paid towards the newborn baby.

Neonatal Cover

In the unfortunate event that your newborn baby needs to be admitted to the neonatal specialist care unit at a hospital after birth, your baby will be admitted as a dependant in his or her own right, provided your baby has been registered with Oneplan within 30 days of the birth.

Special Condition(s):

- This cover is only available provided authorisation for the birth event has been granted and will be available only up to the annual limit under the Illness cover.
- All claims related to this cover will be subject to a 10% excess amount.

Repatriation

- The return of the mortal remains of an Insured Person to the funeral home selected by the family closest to the place of burial within the borders of South Africa. Death events and burials outside the borders will not be covered. Cover will be paid directly to the third party transporting the mortal remains. There is no waiting period; cover will be immediate.

Ambulance and Emergency Services

- 24-hour medical assistance with an emergency dedicated line. In the event of a justifiable, life-threatening medical emergency, the insured will be transported by ambulance to the nearest appropriate medical facility. We do not cover for voluntary transfers. There is no waiting period; cover will be immediate.

3.5 Additional features

Accident Disability

- If the Principal Insured sustains a bodily Injury due to an accident within the borders of South Africa, which results, within twelve (12) calendar months from the date of the accident, in permanent disability or loss of the use of limbs, we will compensate the insured person the compensation in the percentage of the permanent disablement table of cover as stated on the policy schedule.
- Should compensation become due under multiple covers in that you lost limbs, hands, and an elbow, we will only cover up to 100% of the cover limit and not a percentage of the limit under each disablement. This cover will only be applicable to the Principal Insured.
- There is no waiting period applicable to this benefit.

Accidental Death Cover

- This is a lump sum compensation in the unfortunate event an Insured Person dies due to an unforeseen accidental event. The policy will pay the Principal Insured, his or her Estate, or nominated beneficiary as stated in the policy schedule.
- "Beneficiary": means the natural person/s entitled to be paid the benefits upon the accidental death of the Insured. 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.
- There is no waiting period applicable to this benefit.

Trauma, Assault and Accidental HIV

Trauma and Assault Counselling:

- A 24-hour emergency authorisations line 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 center 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.

Accidental HIV Infection:

- A violent assault such as rape or any other accidental exposure such as a needle prick with a contaminated needle. This cover provides access to hospital care, treatment, and diagnostic regimes for the management of the consequences. Due to the traumatic nature of this exposure, you will also receive psychological counselling.
- In the event of accidental exposure to HIV as confirmed by a general practitioner and providing you are HIV negative (as per a rapid test), he or she will be provided with access to the following per event:
    - Event must be reported within forty-eight (48) hours of occurrence.
    - 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-a 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. Should the rapid test indicate that you are HIV positive, you will have access to the following:
        - One counselling sessions with either a general practitioner, trauma trained nurse or trauma counsellor.
        - A 7-day course of STI medication.

Special Condition(s):

Event must be reported within forty-eight (48) hours of occurrence by calling 010 001 0141 and reporting the incident to the Hospital authorisations team.

Specific Exclusion:

Cover will not be payable in the event of:

- Should a HIV infection claim not be reported within fourty-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 telephonic advice and 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.

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:

- 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 the biological parent.

A note on OPA to this effect.

- Client to provide letter from biological mother and father giving consent that the stepmother may provide medical cover for the underage child, child's birth certificate, and ID of both biological parents.

- The client also is required to provide consent via nominated email address that 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.

Please note:

- 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, all waiting periods will apply.

5. Excess & Excess buster

5.1 Excess

An amount you will need to pay to Oneplan as specified in your policy schedule at claim stage for in hospital features.

COVER TYPE	EXCESS AMOUNT
Casualty Accident	First 3 months is 15%, month 4 onwards R200
Accident Cover	R600
Casualty Illness	Month 4 onwards R200
Illness in Hospital	Month 4 to 6 is 15%, month 7 onwards is 5%
Professional Sport	15% of the claim is payable for claims related to any professional sport from which an income is derived and a twelve (12) month waiting period applies.
Natural birth and emergency caesareans	10% of the claim amount

At claim stage, the client has four months to pay the excess once they have been discharged from hospital. This applies if there is no excess buster on policy.

5.2 Excess buster

An added amount to your monthly premium that will waive the excess fees payable by the client for an In-Hospital claim. The excess buster can be added to the policy at any time. There is no waiting period if the premium for the excess buster has been collected at claim stage.

- Core Plan: R15 per person.
- Blue Plan: R25 per person.
- Professional and Executive Plans: R40 per person.

6. General Exclusions

We will not be liable for expenses, hospitalisation, injury, sickness, or disease directly or indirectly caused by or related to the following:

- Nuclear weapons, nuclear material, or acts of war including military rising, rebellion, or revolution.
- Cost of operations, treatments, and procedures that are not medically justifiable i.e., all other lines of conservative treatment must first be considered.
- Cosmetic procedures – we think you are beautiful just the way you are!
- Costs, tests, and examinations and tests requested for immigration, emigration, visas, insurance policies, employment, admission to schools and universities, court medical reports, muscle-function tests, fitness examinations and tests, adoption of children, COVID tests for travel, and retirement because of ill health.

- Cost of treatment for infertility.
- Any sexually transmitted diseases, unless as a direct result of rape or crime that has been officially reported to the South African Police Services.
- 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.
- Any criminal act as defined by the laws governing the Republic of South Africa committed by the insured person.
- Caused as a direct or indirect result of negligence to your medical needs or health.
- Because 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.
- Mental illness, psychiatric disorders, symptoms and related treatment and hospitalisation.
- Self-inflicted injuries.
- Corrective procedures for optometry related conditions, including laser treatment, and the treatment of eye conditions.
- Any treatment relating to non-disclosure, whether intentionally or unintentionally, of a condition.
- Consequential loss or damage which is not directly caused by an Insured risk.
- Declined or repudiated claims re-submitted after the waiting period has expired will not be covered, unless proof of medically justifiable treatment is provided and/or doctor's motivation stating that the client may wait for the procedure, and this will not worsen the condition.
- Congenital disorders, diseases, or abnormalities or development disorders - these are issues that existed at birth.
- Claims submitted after four (4) months.
- No claim will be payable if we have not been notified of the event within three (3) months of the event.
- Admission to a medical facility/hospital for investigative purposes /diagnostic procedures and/or pain control.
- Costs incurred for the treatment of obesity and health holidays.

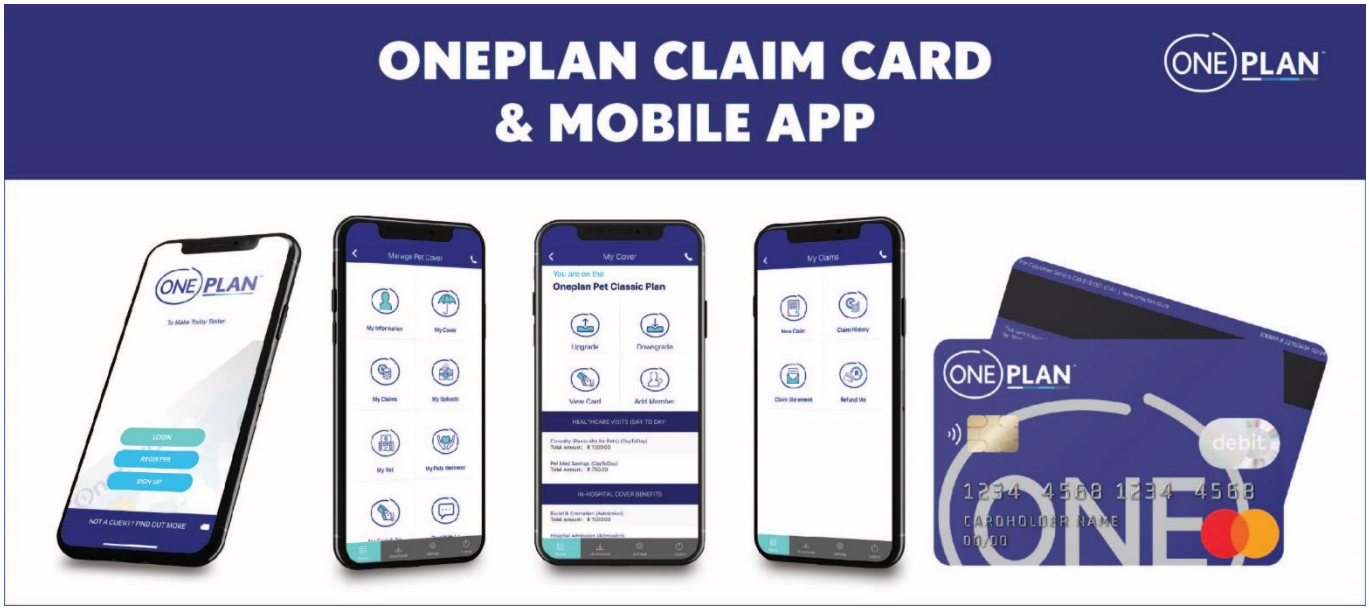
7. General Conditions

1. After premiums have been paid, for a twelve-month (12) period, the restrictions applicable to "pre-existing conditions" shall no longer apply in accordance with specific underwriting conditions but does not include the months where premium holidays were offered and accepted.

2. Where the Schedule refers to specified cover types which are subject to an exclusionary period or waiting period, this period is calculated from inception of the policy but does not include the months in which premium holidays were offered and accepted. So, if your policy began 1st May, a cover type which is subject to a twelve (12) month exclusion or waiting period will not be covered up until the 30th April of the next year; but if you accepted a premium holiday in this period, the twelve (12) month excluded conditions will only be covered from 1st June of the next year.
3. Third generation dependants will not be covered.
4. If you or your dependant(s) had twenty-four (24) months uninterrupted previous medical cover, the three (3) month general waiting period for Illness in Hospital and Casualty Illness will not apply.
5. Only one policy may be issued to any one Insured Person.
6. You agree to submit to medical examinations at our expense, as often as shall be required, about any claim after a claim has been accepted. Further, you agree to present on request from us, any documents or other information necessary to enrol the said Insured on the policy and to facilitate ongoing cover or claims processing.
7. It is your responsibility to seek medical assistance immediately from when you become aware of a medical condition that requires treatment. We will not be liable to indemnify you because of misconduct / negligence in the treatment of medical requirements.
8. Should a "pre-existing condition" exist that results in the injury or illness becoming more severe, you will only be due the amount deemed to have been incurred specifically because of the specific accident or illness.
9. This policy is intended as a risk cover. Therefore, if it becomes evident that you entered into this policy with prior knowledge of a foreseeable or predicted medical event that would ordinarily be covered under this policy, then we will not be liable to indemnify you in terms of this schedule. This means that if you only took out this policy to make sure you were covered for something you KNEW would happen, then we do not have to cover your health issues. Honesty really is our best policy.
10. You hereby give us the right to claim from you any payment or compensation received by you from any third party, due to an event that is covered by this policy and that we have paid to you or on your behalf.
11. If you receive payment or service within this policy during the Grace Period (means the period of grace allowed for non-payment of Premium) and the Premium remains unpaid after the fifteen (15) day period expires, you undertake to pay back to us all costs incurred because of this claim being authorised including any collection and/or legal fees. Pay on time and save yourself (and us) the hassle.
12. Any leniency offered in the processing of claims or extension of cover are not deemed to be leniency on an ongoing basis and the terms of this policy remain in full force and effect.

13. It is your duty to declare / disclose all medical and health information when applying for the policy. It is your responsibility to supply and assist in obtaining any medical history reports from any medical practitioner or facility if requested to do so to enable us to entertain any request or Authorisation for any operation or procedure.
14. No Certificate of Insurance will be issued if Premiums are unpaid.
15. Proof of insurance will be issued on written request from you to us. The policy must be active and a period of one (1) calendar month from the receipt of the first Premium must have passed.
16. It remains your duty to inform us of any material changes which may affect the terms and conditions of the policy, including but not limited to change in medical condition or personal details.
17. Only Insured Events that occur within the South African Borders will be covered.
18. Where the Schedule refers to specified cover types or exclusion per year (twelve (12) calendar months), the year is calculated as a twelve (12) month period from inception of the policy. However, should you utilise the premium holiday, the twelve (12) months will be extended.
19. It remains your duty to provide proof of previous uninterrupted, "creditable membership". Should the proof not be provided within thirty-one (31) days of application, the penalty band (as per Regulations in terms of the Medical Schemes Act, No 131 of 1998) will be applied, until such time as proof is submitted. (Please see definition on page 25).
20. No claim shall be payable if we are not notified of an Insured Event within three (3) months of its occurrence or within three (3) months of the termination of this policy, whichever occurs first.
21. Claims submitted after four (4) months from the Insured Event will not be accepted. It is your responsibility to ensure that the claim invoices have been received by us - claim as soon as you can!
22. Cover may not be used in conjunction with any other cover, for example, Illness in Hospital Cover cannot be used in conjunction with a Dread Disease or Natural Birth Cover. It's like this - you can't treat the flu the same way you would a broken bone, it's why each of our cover options is unique.

8. Oneplan Claim Card and Oneplan Mobile Application



Our easy-to-use Oneplan Claim Card allows the customer to pre-load funds for out of hospital claims via our Oneplan App or via our call centre. It is basically a smart and simple cheque card! Funds can be pre-loaded before the customer even visits the doctor.

8.1 Card delivery process

- For newly incepted policies, a card is only ordered once the first premium has been successfully collected which means that, if the debit date is set after the inception date, the 30-day period for delivery is calculated from the date we collected the premium and not the inception date.
- The card will be delivered by a courier service and not the postal service.
- The card will only be delivered Monday to Friday during working hours (8am to 5pm).
- Somebody must be present to sign and collect the card.
- The courier company will require the client's ID book to scan. If the person receiving the card is not the client, then both ID books must also be made available for scanning.
- FNF does not call the client before delivery! As SMS is sent out to the client informing them that the card is out on delivery.
- If the client wishes to change the delivery address, and email needs to be sent to card@oneplan.co.za with the new delivery address.
- If the client wishes to collect their card from our offices, once they receive the SMS, they must call in to the Card Department to inform them. The Card Department will then set the card aside for collection.

8.2 Registration process for mobile application

- Download the mobile app,
- SMS received with policy number,
- Open the app on your mobile device,
- Select register,
- Type in policy number, ID number, and create password,
- Click on register,
- Login with policy number and password.

9. Claim Process – Medication from a Pharmacy

No paperwork or administration required from client. No swipe or tap required of your Oneplan Claim Card.

10. Claim Process – Out-of-Hospital Claims

- Download the mobile application,
- Register your policy number and ID number, create password
- Login with policy number and password,
- Select the health plan,
- Select “My Claims”,
- Select “Load Claim”,
- Select applicable claim feature,
- Select the date (must be within 48 hours),
- Select the insured that is claiming,
- Select the process claim button,
- Funds are loaded on card within 60 seconds,

- Withdraw/swipe/tap Oneplan Claim Card to make payment,
- Upload photo of valid invoice within 48 hours.

OR

If you have opted for the "Old School" refund method, you will not receive a Oneplan Claim Card, and your claims will not be prefunded before you see the health provider. You will be required to pay at the practice and submit a valid invoice to the Oneplan Claims Department for processing via email on claims@oneplan.co.za or WhatsApp to 083 794 5452.

Should you wish to change your option, you will be required to contact Oneplan Customer Care and will be charged an administration fee of R160 per card.

11. Claim process – In-Hospital Claims

- Client must call us for pre-authorisation for admission.
- Supporting documentation needs to be sent to Oneplan:
    - Letter of motivation,
    - Treatment plan,
    - ICD-10 codes,
    - Procedure codes,
    - Date of procedure,
    - Estimated costs.
- Upon receipt of documentation, query will be escalated to our Clinical Underwriters pending a decision.
- Minimum turnaround time of 48 hours.
- If approved, Oneplan will issue a Guarantee of Payment.
- Case Managers will send updates to Oneplan.
- Payment will be made as invoices are sent to Oneplan for processing. Claims will be covered up to applicable cover limits.

Note: For health claims, we are open 24/7, 365 days a year. All decisions are subject to underwriting, waiting periods and exclusions.

12. QA metric & sales script

Learning outcome

By the end of this section, you will be able to demonstrate an understanding of the PASS requirements of the QA process according to the required policies and procedures.

Let us go through the Health QA Assessment form as well as the Sales Script to determine the following:

- What is a pass, fail, and fail with capturing?
- Am I meeting the criteria as set out in the process?
- What would be the impact if I do not follow the process:
    - On me?
    - On the customer?
    - On Oneplan as a business?

Debit order Dates

- The following debit order dates are available:
    - **1st, 2nd, 7th, 20th, from 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.

Inception Dates

This always falls on the first of the month. We will allow back-dating of the policy, subject to the policy being taken out from the 1st to the 5th of the month. Any later and the inception date will be the 1st of the following month. If we do back-date, an email must be sent to the escalations team at escalations@oneplan.co.za. The email should inform them of the details of the backdating and the debit order that must be manually collected.

Things to remember when capturing a policy

- Stick to the script do not leave anything out.
- Always check the addresses on the policy to ensure that they are in the right format i.e.:
    - Company Name / Building Name / Person's Name / Flat Number and Name / etc.
    - Street Address (street names need to be correct as by the time it gets to the card file, we cannot confirm if it is right or not)

    - Area (needs to be asked as there are same street names in different areas in South Africa)
    - Postal code (most important – postal codes are used to get the correct area)
- Always use Google Maps to check the address provided; if it is different to what is provided, then advise the client, confirm what you have picked up, and ask them if it is correct / incorrect. Always capture what the client has agreed / confirmed.
- If you are unsure about whether a question should be checked, rather check it so that the exclusions populate and put a note on OPA explaining why you checked the question.
- If an extra card is requested, this must be sent to card@oneplan.co.za and a note must be made on OPA that the request was sent. You can use the ticket number that you are sent back from the card department in the note on OPA.
- If the client discloses something, always add a note on OPA unless there is another place that you can capture this information under.
- Always ensure that correct casings are used during capturing; words should start with an uppercase on all fields on OPA.
- If you receive an email / application from a client and you need to confirm / disclose something, you must try contacting them at least three times before resorting to emailing the client with details.
- If you receive an email application from a client, and there is an area that has been left blank or you are not able to make out the client's handwriting, you must call and confirm this information.
- A copy of the client's ID must be requested when application is completed without calling the customer.
- If you amend the client's surname during capturing, it must also be amended under the Dependants Tab.
- If you incorrectly capture bank details, you must send email to escalations@oneplan.co.za and note it on OPA. Alternatively, you can amend it on OPA once you have confirmed the correct information with the customer and note it on OPA.

Things to check after processing:

- Casings on all fields
- ID number
- Name and surname
- Spelling on all fields
- Physical address including the format
- Delivery address including the format
- Phone numbers

- Bank account details
- View answers
- Check Dependants tab
- Check Policy Extenders tab
- Add all notes necessary

13. Sales

Learning outcome

By the end of this section, you will be able to demonstrate the ability to sell, close and handle sales objections effectively.

13.1 Closing techniques

Make sure you understand the contents in this section and create your own techniques as these are guidelines.

Understanding leads

Firstly, understand the lead you are dialling to handle client correctly.

- “Call Me” is from our website where client requested to be called and entered their details.
- “Quote Me” is also from our website with more info; client enters number of people, and which plan of interest. Use this to engage with client at first contact.
- “FDN” and “FDN-PRO” are Facebook leads where client saw an advert or video and responded.
- “Moneyshop” and “Afrilead” are generally SMSes sent to client with brief description and pricing of plans; client proceeded to reply with yes to be contacted.

Introduction of call

Start with your full name, where you are calling from, and the purpose of your call.

- Good day, you speaking to Zainub Wahed. I am calling from Oneplan regarding the inquiry you made for affordable medical cover.
- Let the client respond, e.g., "oh yes" or "OK".
- I am calling to assist you further with that.
- Let the client respond, e.g., " ok" or "I'm busy, call me back".
- If response is "ok," proceed with "thank you, please note all calls are recorded.”

Introduction questions

Now that you have the client's attention, you need to get straight to the point. The following should be the type of questions you ask to create rapport and get to know your client:

- Who are you looking to cover?
- How old is each person? (This will let you know if a formal quotation applies or standard pricing.)
- Have you or your family been on a medical aid before? If yes, for how many years altogether?
- When was the last time you were on a medical aid? (This builds rapport at questionnaire stage. When you repeat the information client gave you at the start of call, it also gives you an indication as to which plan to quote on considering a late joiner penalty may apply or not.)
- If client is below 35, ask: “Have you been on a medical aid in the last 2 years uninterrupted and until when?” (If there has been more than 2 months’ break in cover, it will not benefit the client regarding waiting periods.)
- What are you looking for in Health Cover for you or your family? (This also assists in directing the client to the most suitable plan. E.g., If the client mentions finances or medical aid is too expensive, you will start with blue.)
- How much are you looking to spend on Health cover for you or your family? (This does not always produce constructive conversation.)
    - The client could give you the amount of R100 – at this point you have already lost the sale, or

- The client could tell you that they are not going to give that information and you must offer what plans are available. The trust and rapport are on rocky ground, or
- The client could tell you that they are not sure as they are looking into having Health Cover.

- Do not open the floor for objection or animosity at the beginning of the call.
- Once the client has answered, you will use info to direct the client to a suitable plan. The most attractive and affordable plan is the Blue Plan, unless analysed otherwise while asking questions.
  - Create a brief explanation of what is offered on the plan. E.g., You will be covered for doctor, dentist, optometrist visits out of hospital, as well as hospitalisation, whether it is due to an illness or accident.
  - Throw in a benefit. E.g., We at Oneplan do not limit clients to use a specific network of doctors or facilities. This allows you to visit any healthcare provider and private hospital of your choice.

Handling the two outcomes

Under 35	Over 35
Give standard pricing and ask if the client is comfortable. **If yes – Great, so what I am going to do is a risk analysis so that I will be able to give you further information based on pre-existing conditions. Wait for client to respond e.g., "ok".** **If No – Offer Core Plan/lower plan as a starting point and offer an upgrade at a later stage when more information becomes available.**	I need to do a risk analysis which is where I am going to take down your information and do a medical questionnaire to give you final pricing. Proceed to do the quote.

The goal of each call is to get the client to do the quote. The more quotes you do, the more sales you will make.

- Follow script as per the system.
- Screen 3 – You do not need to go through the entire cover at this point, the brief description will do for QA Purposes.
- Capture on system instead of writing as the call can be provided and it will reduce time spent with client except on medical questions.
- Screen 5 – Read/ask verbatim, capture everything the client gives you.
- Anything that has not been diagnosed by a medical professional (self-diagnoses), tick the "Recurrent Symptom" question, and capture notes under "Other".

- If the client has not been on a medical aid until recently (cancelled at least 3 months ago) do not capture as it will not influence the premium or waiting period for illness in hospital.
- Use height and weight estimates for kids. You already have their ages so inform the client what the averages are and ask if you can use that.
- Screen 6 – Read Verbatim. When you have gone through the script and complete the Natural Birth cover limit, ask the client if they are happy with everything that they have heard thus far. This is a way to keep your clients' thoughts in mind and engage with client. This is a "buying signal" enquiry. Then add the "cherry on top" which is the additional benefits.
- When you get to the end of the product, initiate closing, e.g. "As you can hear, Oneplan offers very extensive cover at an affordable premium, so can we proceed to finalise the policy for you?" This shows your confidence in the product, which could be the exact spice a client needs to say yes.

13.2 Objection handling

- Common responses & objections given and points to remember when you are responding.
    - *"I am looking for a medical aid, not an insurance," or "What's the difference between medical aid and Health Insurance?"*
- We all know theoretically what the differences are, however, most clients do not understand when given the answer straight from the list of differences. You must understand the differences and be able to simplify it to give the client a simple explanation that they can digest.
    - E.g., Even though we cover you for both in- and out-of-hospital medical treatment, we are still governed by the Financial Sector Conduct Authority (FSCA). Medical aids are governed by the Council for Medical Schemes (CMS). This means we are not allowed to call ourselves a medical aid. If your question is, "are my medical needs going to be covered", the short answer is yes. Health insurance is much more affordable way to make sure you and your family are covered. Are you with me, Mr/Mrs client?

Using the claims process of hospitalisation to handle objections regarding to cover limits.

- When you need to be admitted into hospital, either you will call our pre-authorisation team, or, when you arrive at the hospital, you can hand over your Oneplan Claim Card. The hospital will then contact our pre-authorisation team on your behalf. If your hospital admission is approved, we will send a guarantee of payment (GOP) document which states we will fund your hospital admission up to the applicable cover limit. This is normally done within 30 days from discharge. You will be classified as a cash patient and thus be charged a reduced rate.

- E.g., The removal of an appendix through a medical aid can cost anywhere between R50 000 – R70 000 whereas a cash patient can look at having the same surgery for anything between R20 000 – R30 000. Please note this is an estimate and not exact values.

A client says that they want a medical aid as chronic medication is covered fully and work will be subsidising the Medical Aid.

- A Medical Aid does cover chronic medication in full; however, there is criteria that needs to be met first such as using a specific type of medication as well as a network pharmacy. You must also apply to have the condition covered according to the rules of Prescribed Minimum Benefits.
- As Health Insurance, we are not regulated by the same legislation and thus offering our clients a much simpler and possibly cheaper alternative. At Oneplan, you do not need to apply to have a chronic condition covered. The condition does not need to be part of a list as Prescribed Minimum Benefits only covers 271 conditions of which only 27 are deemed chronic. We also do not limit the type of medication covered.
- Now, as you can see, we offer a much simpler and possibly more affordable alternative. The difference in premiums would also have an impact as the cost of a Medical Aid is much higher than Health Insurance.

14. Operational procedures

Terminology and processes

Word or Phrase	Definition and Process
Contact Strategy	The procedure that must be followed when contacting a lead (client). *A lead must be dialled a MINIMUM of 3 times per day over 4 days at alternating times.*
Conversion	The percentage of leads that must be converted to sales. *Minimum conversion percentage in order to reach and maintain target is 23%.*
Callback Status	The status the lead must be put in if you have contacted the client and scheduled a callback or sent them an email. This lead must still be contacted a minimum of 9 times.

	Reason 1: This serves as a reminder for you to call the client back as promised. *Reason 2: For reporting statistics this differentiates the open leads (not contacted) with callbacks (contacted).*
Lead Wrap Up Reasons	The reason that you are closing the lead as a LOST lead. *It is important that the correct wrap up reason is used so that business can use this information to amend product and marketing strategies accordingly to provide a better product and service.* *The only time you wrap up a lead as lost is:* • *If you have followed the minimum contact strategy and been unsuccessful in contacting the client.* • *If the client has advised that they will not be taking up the cover.* *In this case, you must probe for an accurate reason as to why the client is not taking the cover. Then use the most appropriate wrap up reason.* *Only use the wrap up reason "Not Interested" if the client refuses to give you a reason. You will be required to confirm if this reason is applicable with your manager. Confirm the outcome of this discussion in an email to your manager.*
NTU	Not taken up. This is when the policy has been cancelled during the cooling off period or has been suspended due to non-payment of the first premium.
Open Lead	A lead where you have NOT been able to contact the client; that is, they did not answer, the phone was engaged, or you just reached voicemail.
Pipeline	The list of open leads on Softphone. *This should not exceed 120 at any given time.*
Pending QA	The sales that are awaiting Quality Assurance.

Sale	A lead that has been won and has resulted in the sale of a policy.
Quote	An email is sent to customer with the description of the cover required and the correct premium.

List of Wrap Up Reasons

The following is a list of wrap up reasons. Only these reasons must be used when wrapping up a lead.

Health: 3 Calls DONE over 4 Days
Health: Existing Client
Health: Affordability (NOT LATE JOINER)
Health: Cannot make contact – call blocked
Health: Client did not make an enquiry (Objection Handling)
Health: Client insists on a Medical Aid
Health: Client is underage (asked for parents' number)
Health: Cover is not sufficient – Health Cover
Health: Cover is not sufficient – Hospital Risk Cover
Health: Do not contact (POPI)
Health: Exclusions/Pre-existing
Health: Existing client
Health: Faulty number
Health: Foreign national – declined
Health: Language barrier – passed on to another agent
Health: Late joiner too high
Health: Lost to competitor
Health: Waiting periods (Time limits)

Processes and Procedures

- Official starting time is 8 am; however, the team meetings occur at 7:45 am.
- Lunch breaks are 45 minutes long and can be arranged in agreement with your manager.
- Breaks, including smoke breaks, are at 10 am and 3 pm; however, this is at the discretion of your manager and dependent on whether the team is on target.
- Sales cycles for QA conversion calculations will be calculated from the 25th of each month to the 26th of the next month, or the next business day.

- Your current NTU rate will be calculated for the past inception period.
- Duplicate ID cancelation has now become the second highest cancelation reason. By continuously processing duplicate sales, we are:
    - Inflating our sales numbers and conversions, and this will impact future targets and comms models
    - Increasing the support time to process and handle these unnecessary sales
    - Creating customer impacts and bad experience
- If a sales agent processes a sale while the customer has a policy in any active state (active, suspended, hyphen, post call verification, pending QA, advanced underwriting, underwriting, pre welcome, new, basic underwriting, pending correction), we will cancel the duplicate sale (This will be a NTU cancelation) and we will deduct another sale from the sales number achieved during comms calculation. This will continue for each "fake" sale that agents process.

15. 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.

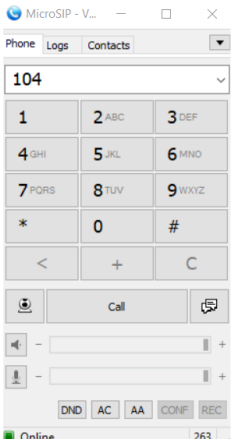
Contacting Departments Internally

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



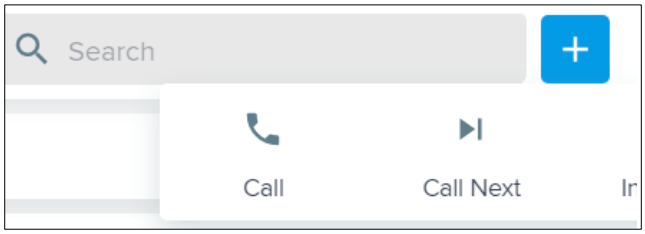
Connex User Short Codes to Dial Other Operational Areas Manually

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

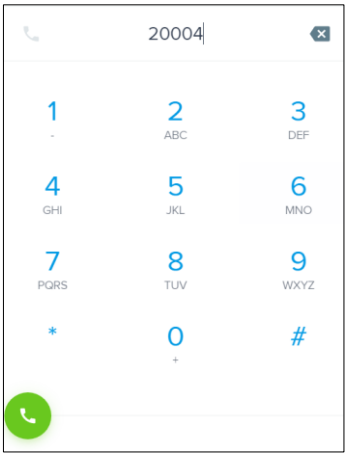
Short Codes

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.

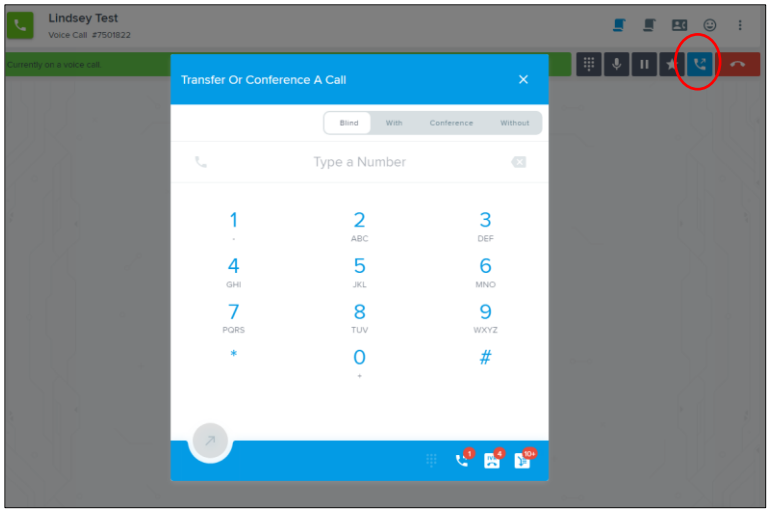


Transferring Customers to Another Department

Connex User Transfer of Client to Another Operational Area

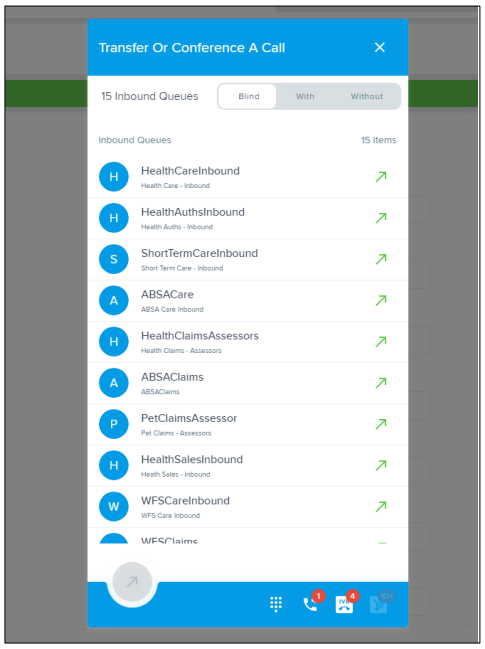
The following process must be utilised by all Connex users to transfer a customer from Connex to another operational area from Connex within Connex.

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.

16. 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.

16.1 Introduction

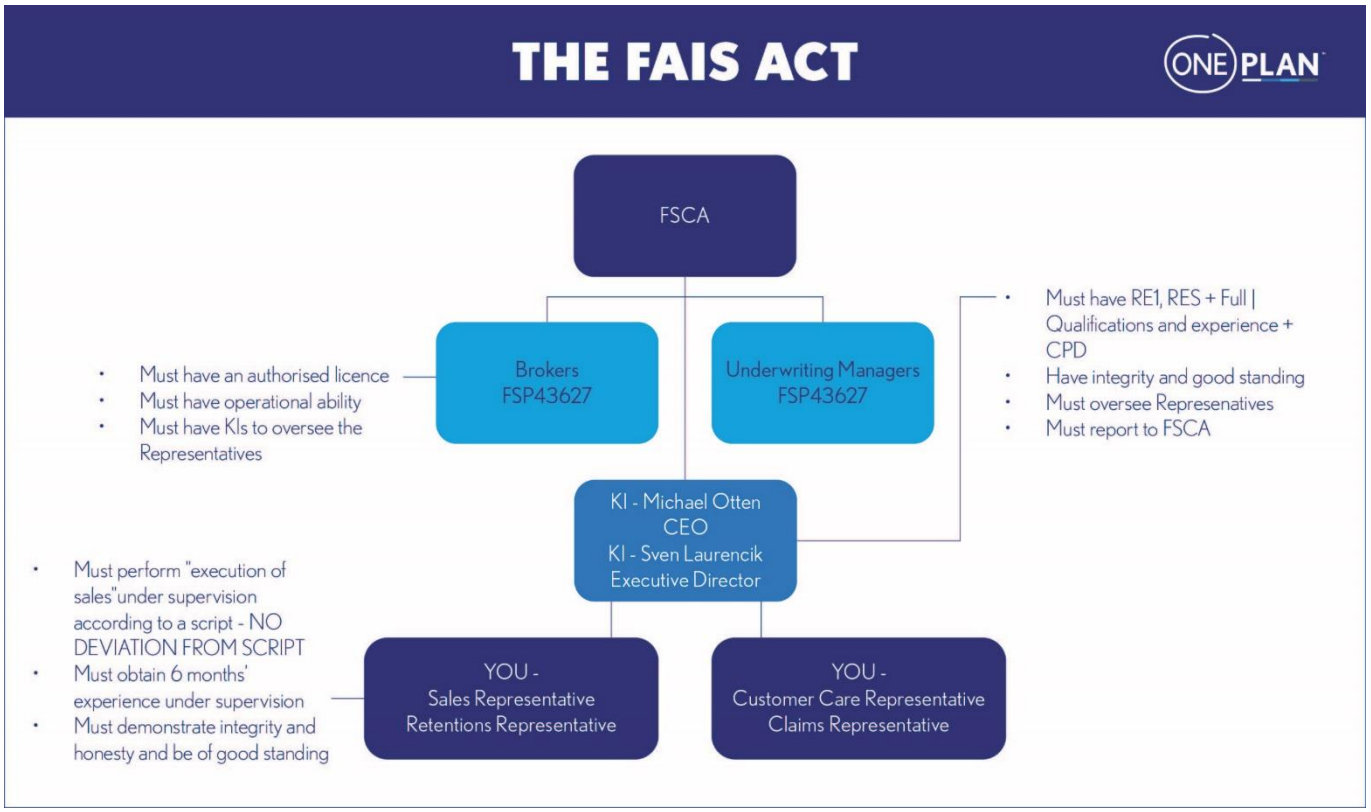
Having joined Oneplan, you have created your first footprint in an industry where your honesty and integrity is the most important aspect of your service.

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 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!

16.2 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, 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

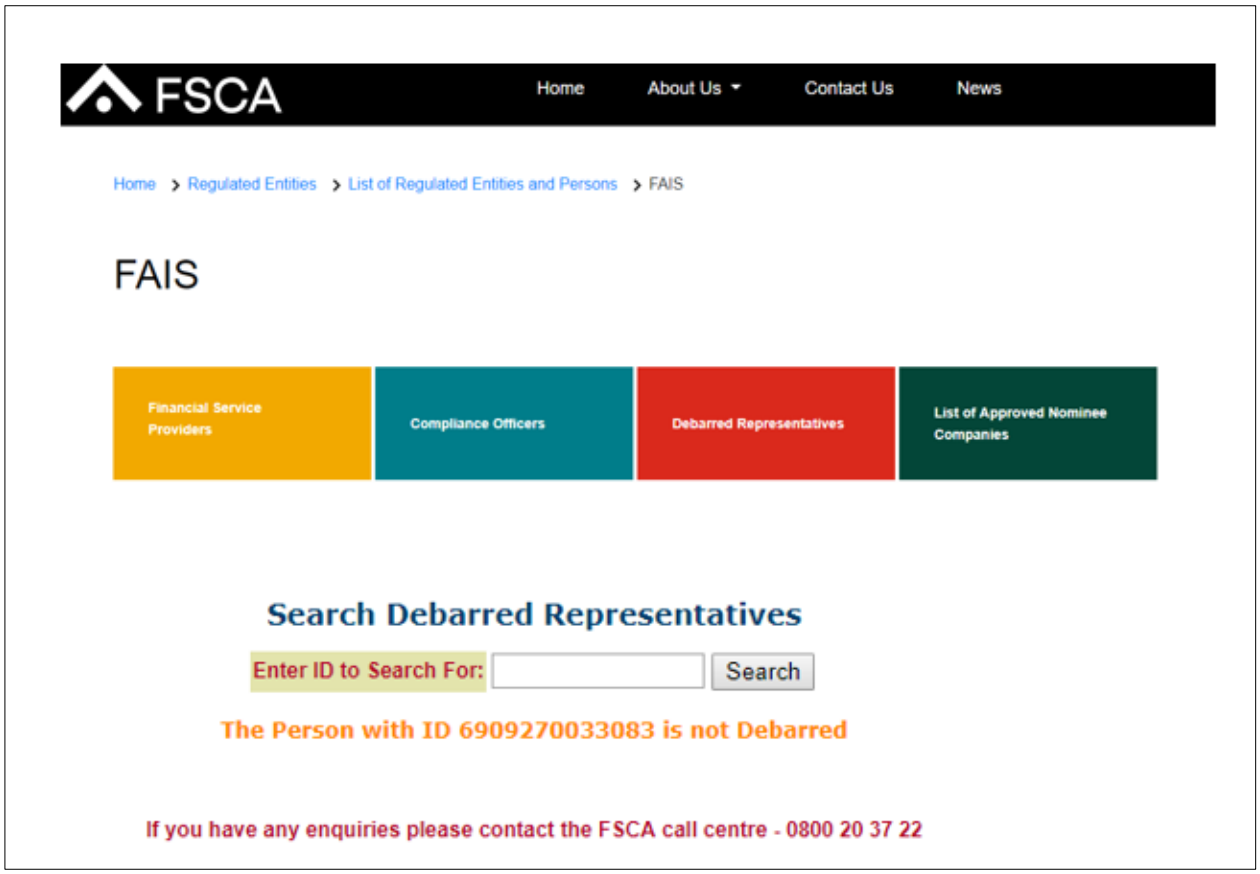
- You must have 6 months' experience under supervision and have records to prove it

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."*

16.3 Debarment

In the financial services industry, you must maintain a good name. If you act dishonest, if you commit fraud, 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.



17. 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.

18. Healthcare providers

The following practitioners are NOT covered:

- Acupuncturist
- Audiologist and Acousticians
- Bio-kineticist
- Chiropractor
- Clinical / Medical Technologist
- Counsellors including Genetic and Psychologist, Psychiatric Nurses and Social Workers
- Dietician
- Homeopaths, Herbalists, Naturopaths, and Osteopaths
- Occupational Therapists
- Orthodontist
- Physiotherapist
- Podiatrist
- Speech Therapists
- Traditional Healers

19. 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: Apeal 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.

20. 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 account holder even if the client has signing rights. If authority cannot be obtained from the account holder over a recorded line, then the following documents are required from the account holder:

- Account holder's copy of ID.
- Bank statement
- Letter of authority from the account holder.

***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 Health Insurance. We have (Insert Policy Holder Name) who has signed up a policy with us and nominated your bank account to collect the monthly premium of R(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.

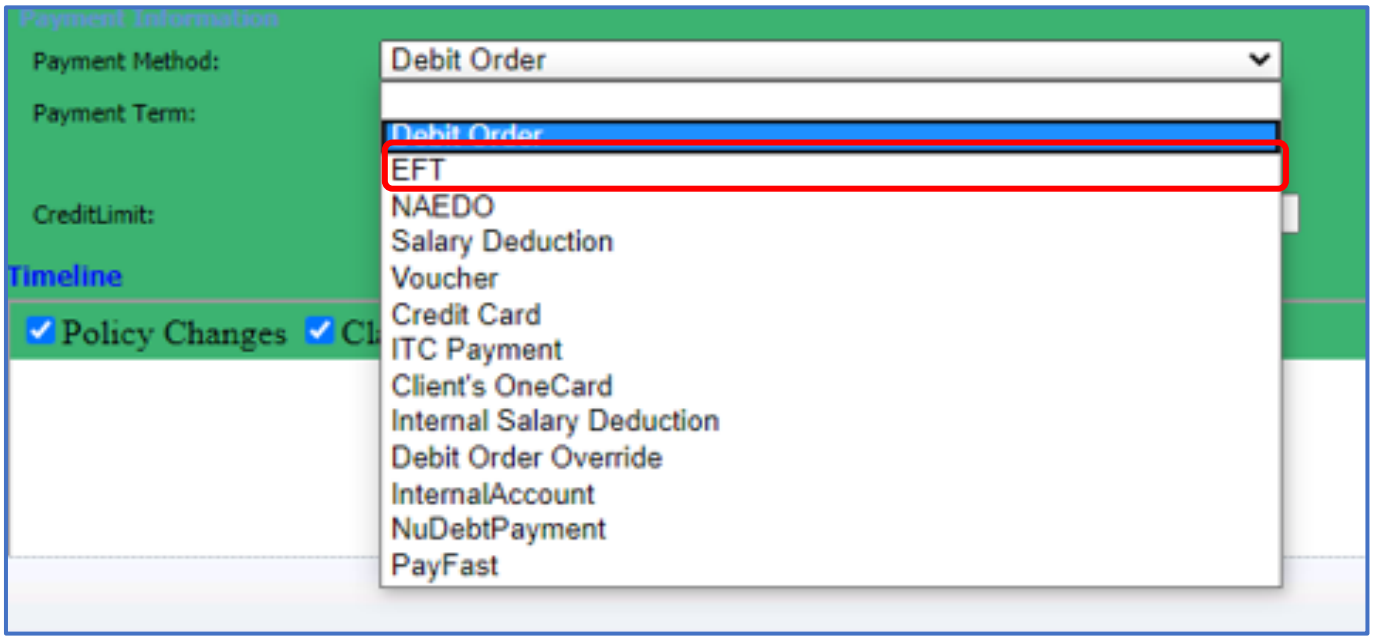
BANKING DETAILS

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.

Can the client order an additional Oneplan Claim Card?

Yes, the client can order additional cards at sale stage. If the customer requests an additional card, the request must be sent to card@oneplan.co.za and the principal insured and policy payer must be informed of the additional amount. A note must be added onto OPA confirming that the email was sent.

Can the Customer collect the Oneplan Claim Card from Oneplan?

Yes, the customer can collect. Once the card has been ordered and printed, the customer is notified via SMS that the card is ready. The customer must call us to inform us that he will be collecting, and the Card Department will ensure that the card is set aside for the customer. Regardless of this, a delivery address must still be captured at sales stage.

How can I load claims for out-of-hospital, like GP visits?

You can load claims via our Oneplan App.

What if I do not have the mobile app?

You are welcome to call our Customer Care team and they will load the claim for you, or you can use our self-service portal on our website.

Backdating of Inception Dates

This always falls on the first of the month. In Health, we will allow backdating of the policy, subject to the policy being taken out from the 1st to the 5th of the month. Any later and the following month will be the inception date. We first need to inform the client that we will debit within the next 72 hours. Then, depending on the debit date he selects, we might debit him again this month for next month (because

we collect in advance) If we do backdate, an email must be sent to the escalations department at escalations@oneplan.co.za informing them of the details of the backdating as well as the debit order that must now be manually collected. A note must be made on OPA confirm that the email has been sent to escalations.

Note

We do not encourage backdating unless the customer insists on starting his cover immediately.

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.

Dentistry

We do not cover dental procedures (in hospital) except for dental extractions performed in Dentist's rooms.

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 30 days prior to the change in writing.

What kind of specialists are covered?

Refer to the summary of health cover.

Can I see a specialist?

Out-of-hospital specialists are only covered on the Executive Plan. On the Core, Core Plus, Blue, and Professional Plans, only if you are admitted and treatment requires specialisation, can you see a specialist. For example, a cardiologist, in the event of a heart attack.

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.

Does Oneplan have yearly limits?

Yes, all features have a cover limit, which is an annual (yearly) limit. This limit will renew at policy anniversary.

How do I claim if the doctor is a self-dispensing doctor?

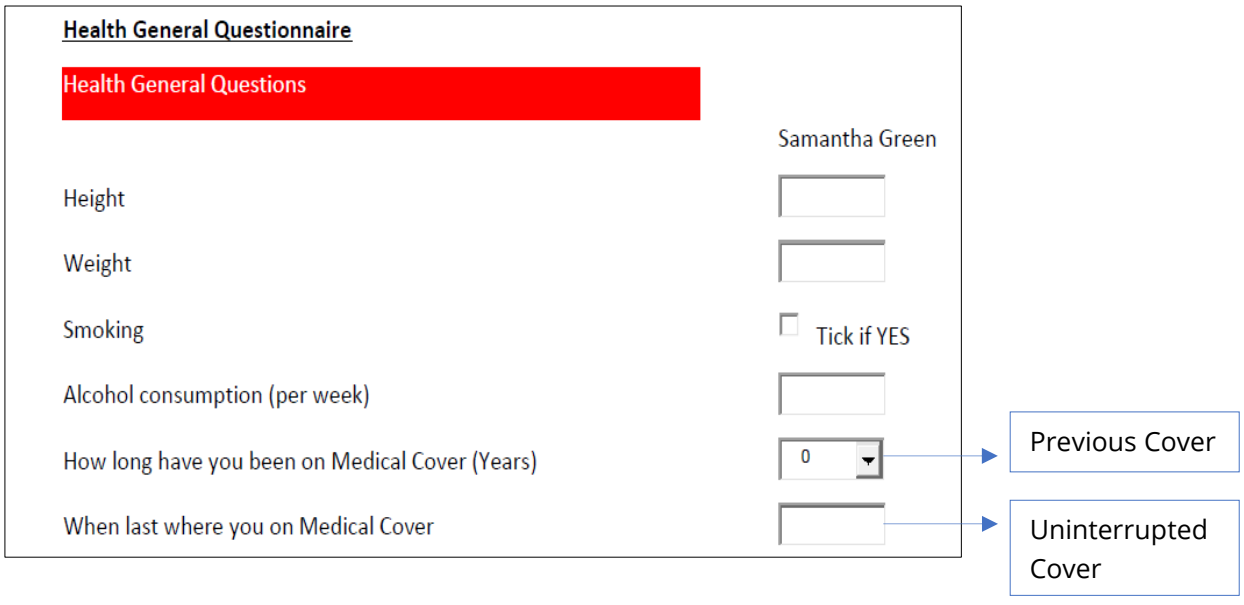
Two out-of-hospital claims need to be loaded via the mobile application (A GP Visit and Scripted Medication).

When can a client upgrade or downgrade their plans?

- A calendar months' notice must be given for the upgrade/downgrade of any plans.
- For upgrades, waiting periods as per cover type will apply for any additional cover from the effective date of the upgrade. 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.
- There are no waiting periods applicable in a downgrade.
- If you have downgraded, you must wait 6 months before you can upgrade again.

Previous creditable cover

Previous creditable cover is any cover the client might have previously had with a Medical Aid (not Health Insurance). If the client is over 35, this previous cover might reduce his late joiner penalty, and this is at the underwriter's discretion as well as the number of years of previous cover.



Uninterrupted creditable cover

This cover refers to when last the client has creditable cover with a Medical Aid (not Health Insurance). If the client has had uninterrupted cover (i.e., is still covered at time of sale) then we will waiver the waiting period of 90 days for Illness in hospital.

Pregnancy and how it is covered

Prior to Birth

- Covered under Maternity Pre-Birth (Out-of-Hospital)
- Waiting period is 7 months from inception of the policy.
- If you are 4 or more months pregnant, you can claim from month 8 of pregnancy.
- Client must produce confirmation of pregnancy at this stage. If a client is pregnant at sale stage, it is highly unlikely that she will be able to utilise this cover.

For Birth

- This is covered Under Natural birth and Emergency Caesarean (In-Hospital)
- There is a 12-month waiting period from the Inception of the policy.
- If the client is pregnant at the sale stage, she will not be able to use this cover.
- If the client goes into labour and needs an ambulance to take her to the hospital, we will not cover the ambulance claim. If the client goes into early labour (during the 12-month waiting period) that results in an emergency (Casualty In-Hospital) claim, we will not cover it.
-

Note

Seeing the Gynaecologist for any other reason aside from pregnancy will only be covered under the Executive Plan under Specialist.

Pre-existing conditions and chronic medication

If the client has any pre-existing conditions for which they receive chronic medication, we do not cover the pre-existing condition; however, the chronic medication is covered after 30 days from scripted medication up to the cover limit.

I have diabetes, when can I go to the doctor?

You can go to the doctor after 30 days (waiting period for GP Visits), where he can check your condition. Your diabetes is a pre-existing condition and receiving treatment for the condition in hospital will only be covered after the 12-month waiting period for pre-existing conditions. The chronic medication will be covered after 30 days from Scripted Medication up to the cover limit.

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.

Difference between medical aids and health insurance

Legally we are not allowed to say that we are "like" or "similar" to a medical aid. Always use positive language so rather approach this as follows:

"Good question Mr./Mrs. Client. So Oneplan is a smart insurance that covers you for your unexpected healthcare needs and medical emergencies which allows you to seek the best medical healthcare at affordable rates. We offer cover for day- to-day, for example, GP visits, optometry, and dentistry. We offer cover for in-hospital like accident, illness cover, and dread disease. We also offer additional insurance benefits like family death cover and accidental disability at no extra cost. We are governed by the Short-term Insurance act. Health Insurance cannot be used for a tax rebate. Therefore, we are not a medical aid."

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.

Covid-19

This is covered under illness in hospital.

Capturing medical conditions versus under other

When capturing, if the condition selection is obvious, for example, anaemia or skin disorder, you must tick the relevant box and do not capture under other as you will be failed at QA. If the condition selection is vague or not as obvious, for example meningitis or low blood pressure, these can be captured under other.

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.

Note: If the client has no smart phone, we can still sell as they can still call Customer Care for claims or use the Self-Service Portal.

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.

Selling the Core Plan

When selling the Core Plan, client must be notified that the following benefits are not covered:

- Specialist – day-to-day
- Illness in hospital

- Dread disease
- Natural Birth and Emergency Caesareans

***Failure to do so will result in not treating the client fairly.

Selling the Core Plus Plan

When selling the Core Plus Plan, client must be notified that the following benefits are not covered:

- Specialist – day-to-day
- Dread disease
- Natural Birth and Emergency Caesareans

The key difference between the Core Plan and the Core Plus Plan is that the later covers Illness In Hospital. Clients must be made aware of this difference and the fact that the two plans are identical in every other aspect.

***Failure to do so will result in not treating the client fairly.

Fails and disputing process

Fails are reported on and updated immediately once assessed, in the QA Reports Folder which all Sales staff will have access to. 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 in the QA Folder. 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.

Club Rugby

This is any registered social or professional league that the client plays for. The client must be 18 years or older.

Psychological Conditions

These conditions are totally excluded.

The following are examples of psychological conditions:

- Anxiety disorders, including panic disorder, obsessive-compulsive disorder, and phobias.
- Depression, bipolar disorder, and other mood disorders.
- Eating disorders.
- Personality disorders.
- Post-traumatic stress disorder.
- Psychotic disorders, including schizophrenia.

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).

The correct explanation of excess fees and Excess Buster and how they work

- The excess fees are only applicable to in-hospital claims and are payable to Oneplan.
- These fees are payable within 4 months from the date of discharge.
- The Excess Buster waives only the excess fees.
- Any hospital administration fees are at the client's expense.
- If the claim exceeds the cover limit, the client is liable for the balance.

3rd Generation

To capture 3rd generation on a policy, we require foster care or adoption documentation.

Duplicate policies

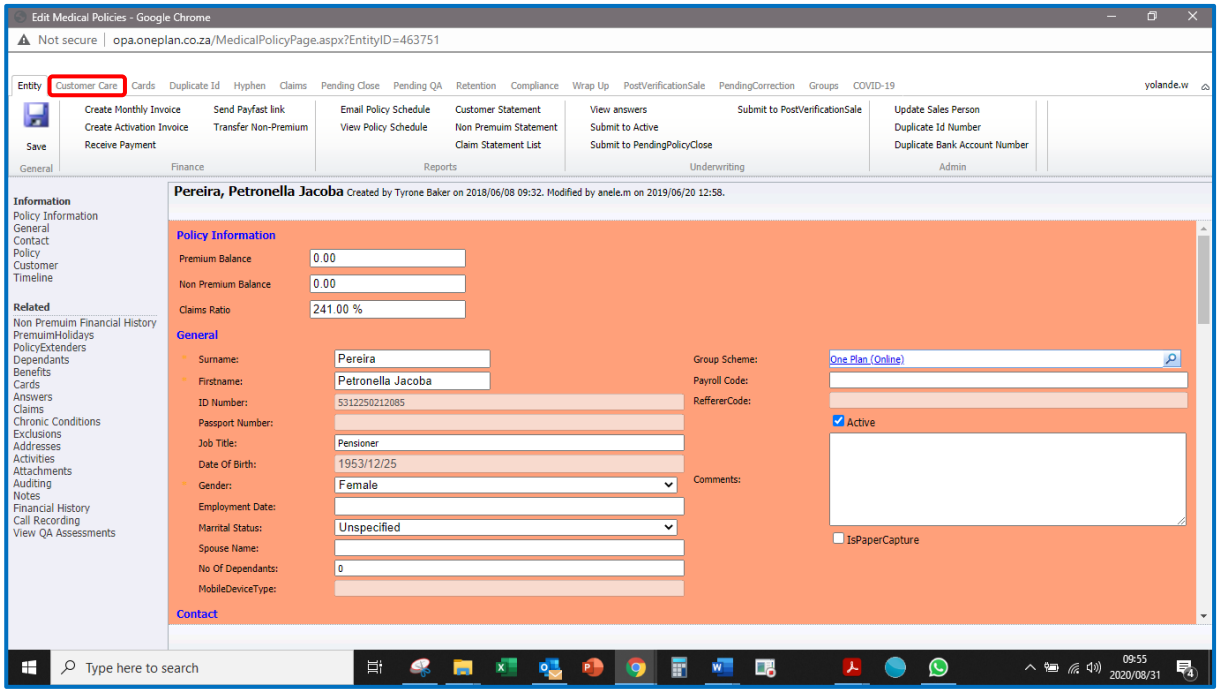
Please check for duplicate policies prior to calling the clients as they become very irate and then doubt our competency as a company as we do not even know they are an existing client.

Compliance process for Business Accounts and Foreign National clients

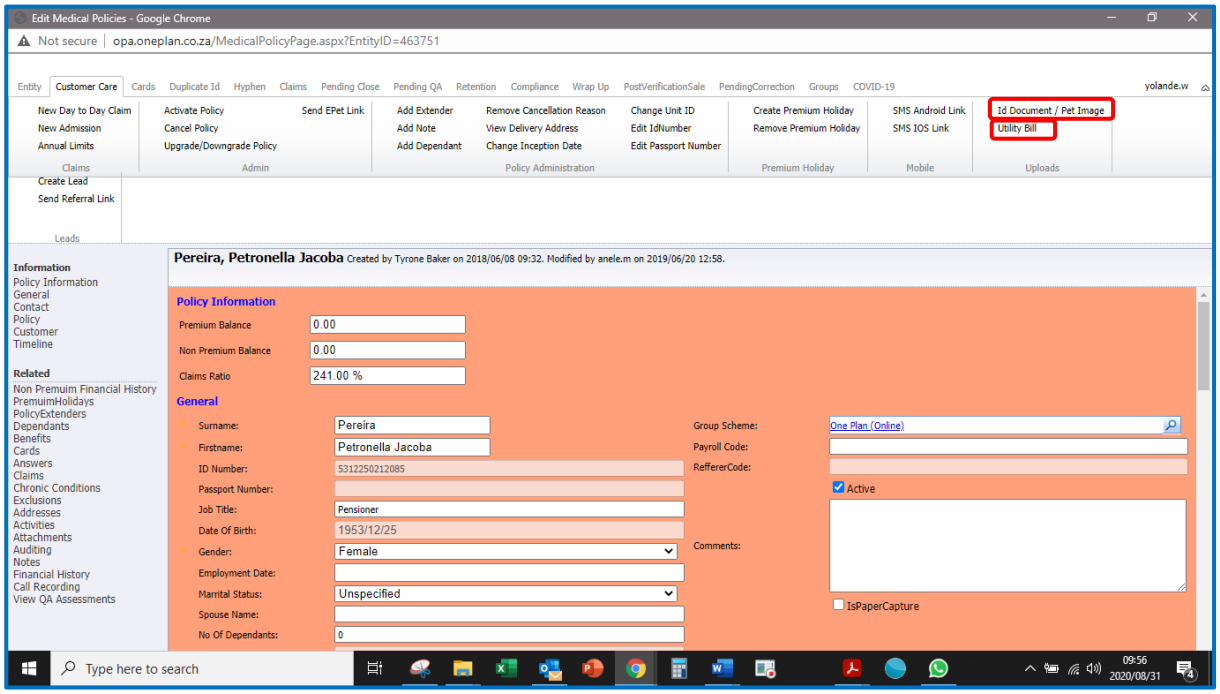
The sales agent must stop the sale and advise the customer that the following documents as per the checklist that applies will be required before the application can be submitted. The sales agent must then email the checklist along with the application form to the client. Remind the client that they 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.

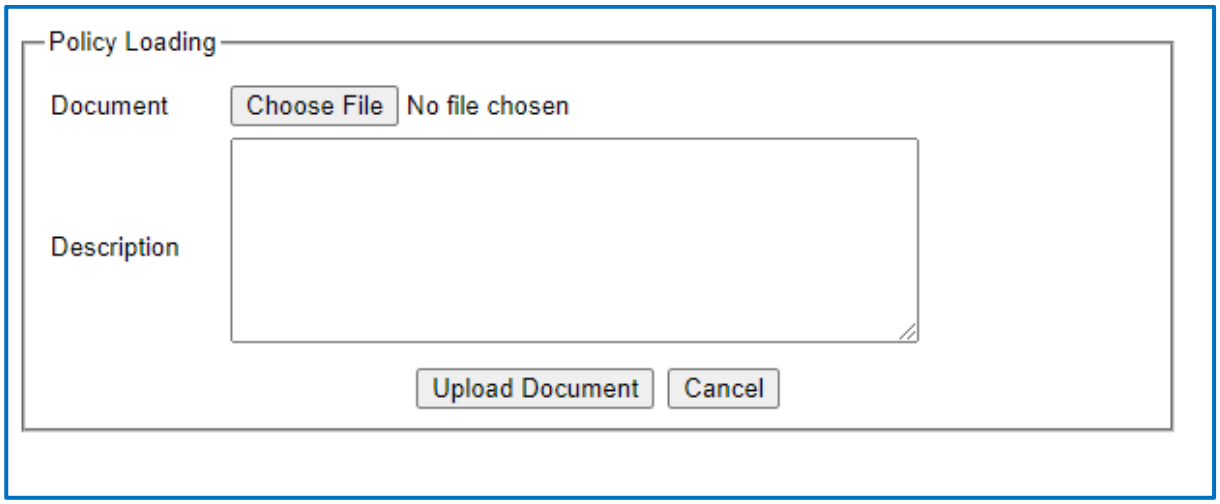
How to upload documents on OPA

- 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



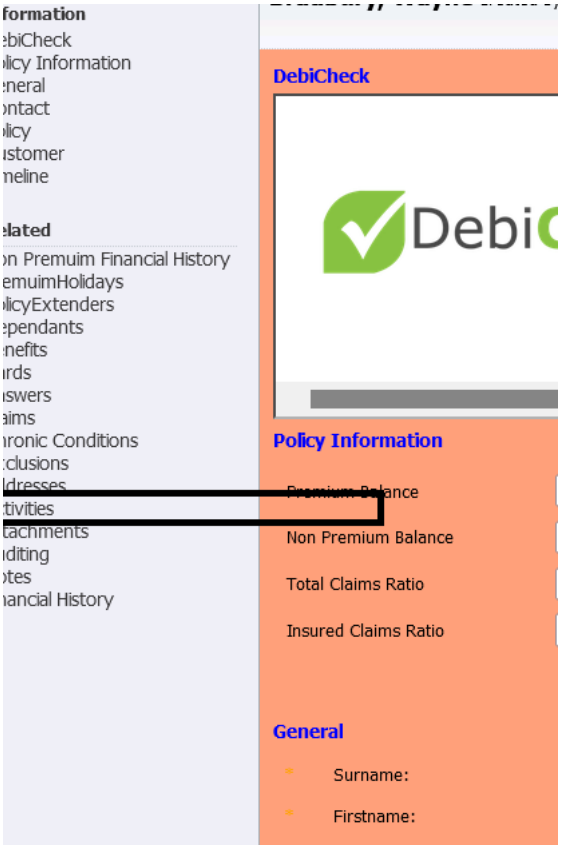


- The following screen will be displayed – choose the documents to be uploaded.
- Type in a description of the documents
- Then click on Upload Document

How to resend communication to clients via OPA

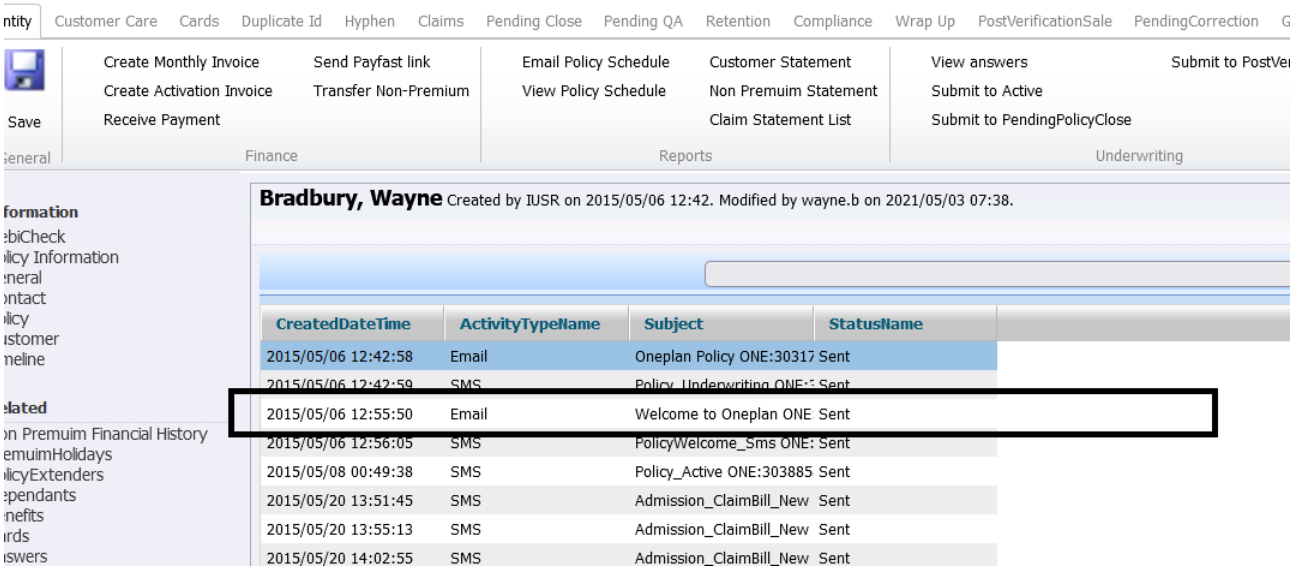
Step 1

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



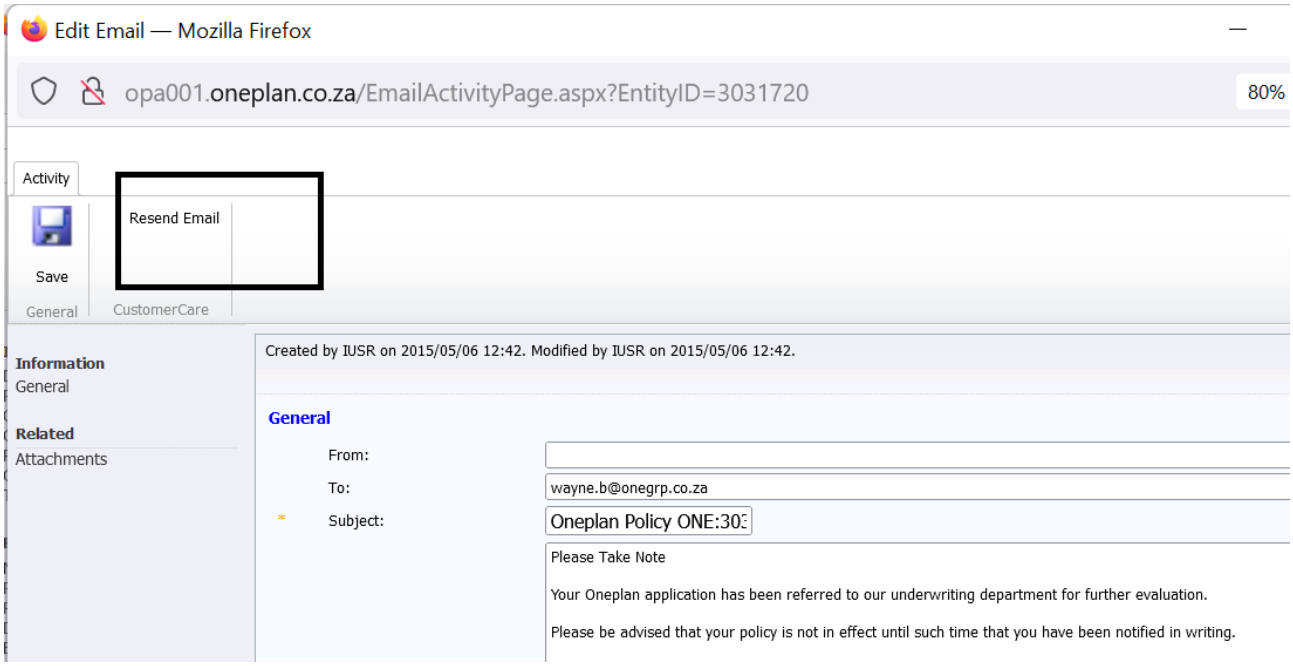
Step 2

- 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.



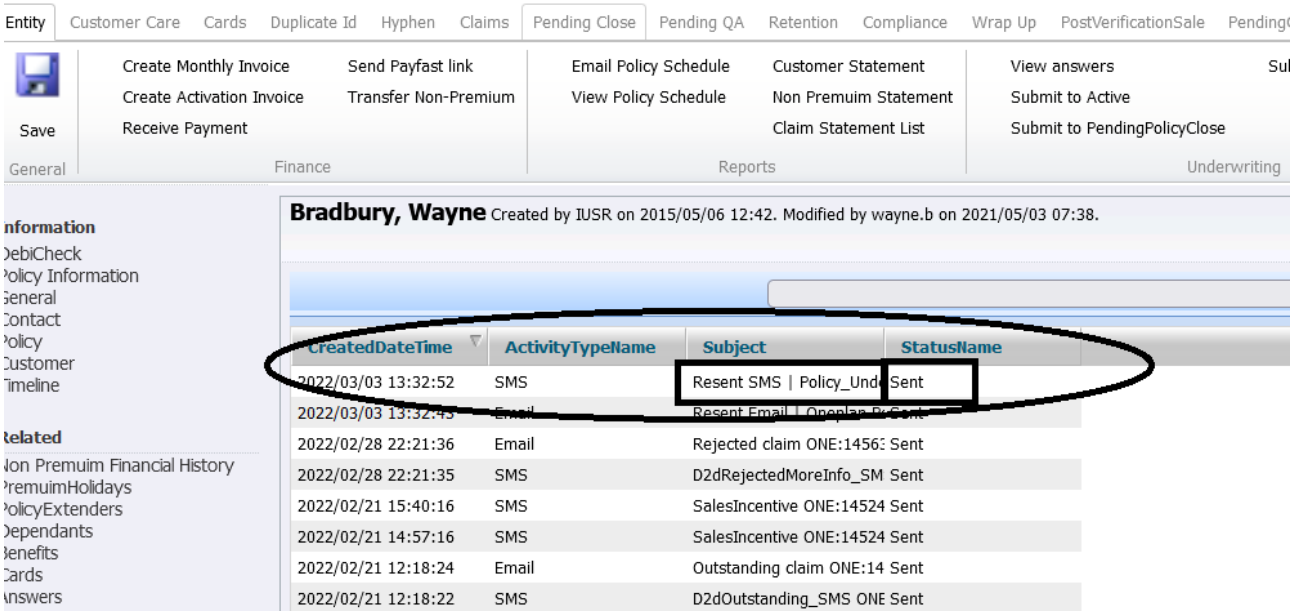
Step 3

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



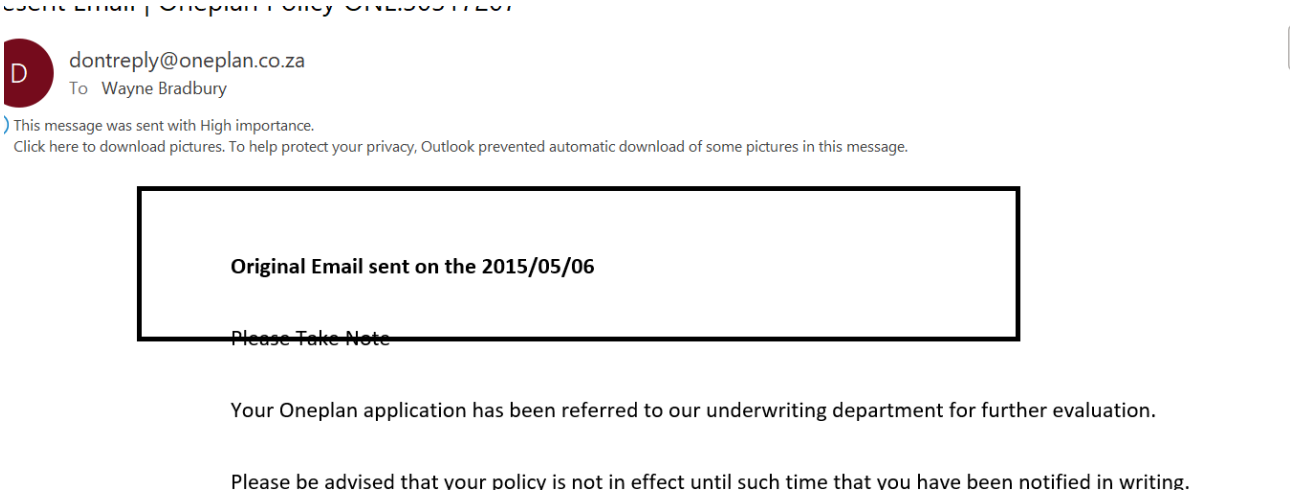
Step 4

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.



dontreply@oneplan.co.za
To Wayne Bradbury

This message was sent with High importance.
Click here to download pictures. To help protect your privacy, Outlook prevented automatic download of some pictures in this message.

Original Email sent on the 2015/05/06

~~Please Take Note~~

Your Oneplan application has been referred to our underwriting department for further evaluation.

Please be advised that your policy is not in effect until such time that you have been notified in writing.

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 Hellopeter rating.