ONE PLAN™
Health Insurance

HEALTH PRODUCT
Study Guide

www.oneplan.co.za

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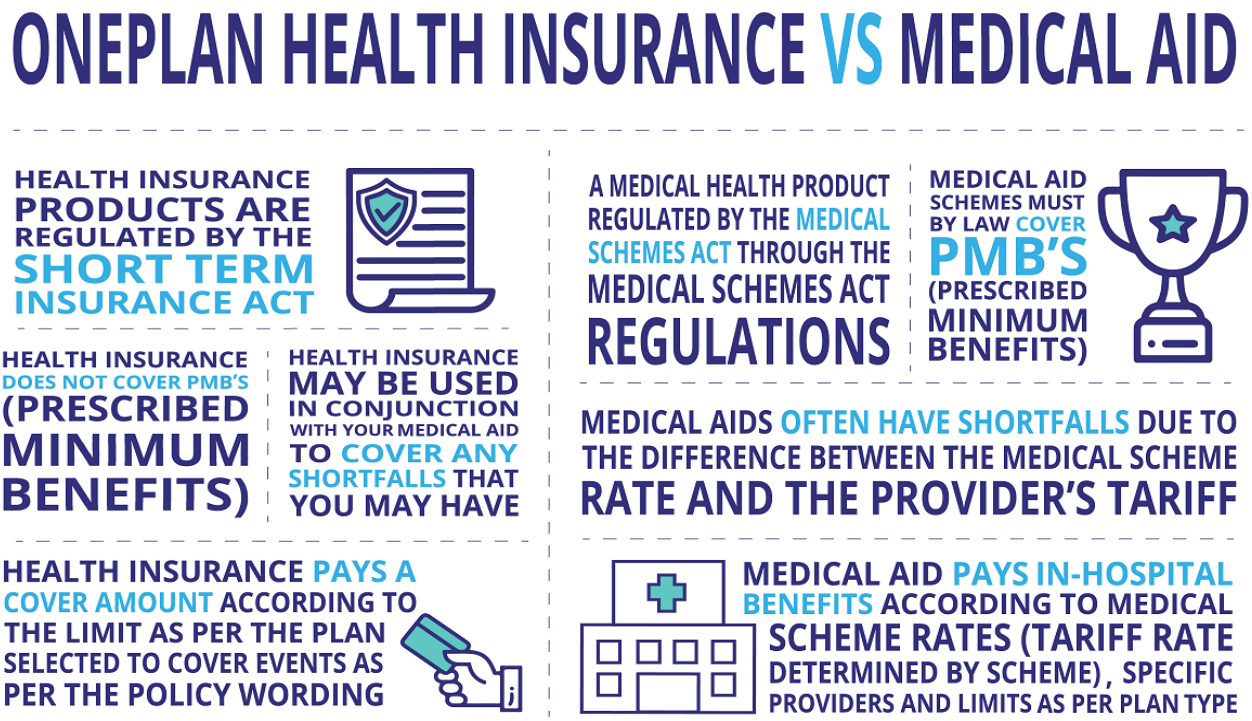
1. Health Insurance vs Medical Aid



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 R500PM	CORE PLUS PLAN FROM R685PM	BLUE PLAN FROM R1 000PM	PROFESSIONAL PLAN FROM R1 465PM	EXECUTIVE PLAN FROM R1 975PM
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 800** 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 **R5 800** for life threatening emergency illness in casualty units.	Casualty Illness Up to **R6 000** for life threatening emergency illness in casualty units.	Casualty Illness Up to **R6 200** for life threatening emergency illness in casualty units.
Casualty Accident Up to **R5 800** 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 **R5 800** for life threatening emergency accidents in casualty units.	Casualty Accident Up to **R6 000** for life threatening emergency accidents in casualty units.	Casualty Accident Up to **R6 200** for life threatening emergency accidents in casualty units.

Accident Cover Up to **R190 000** per insured event. Up to **R380 000** per family per event. Excess: R600 Contact sport - 15% of claim amount	Accident Cover Up to **R190 000** per insured event. Up to **R380 000** per family per event. Excess: R600 Contact sport - 15% of claim amount	Accident Cover Up to **R245 000** per insured event. Up to **R490 000** per family per event. Excess: R600 Contact sport - 15% of claim amount	Accident Cover Up to **R265 000** per insured event. Up to **R530 000** per family per event. Excess: R600 Contact sport - 15% of claim amount	Accident Cover Up to **R350 000** per insured event. Up to **R700 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 **R45 000** per insured event p/p. Up to **R112 500** per insured per year. Excess: 4-6 Months - 15% 7 Months + - 5%	Illness In Hospital Up to **R70 000** per insured event p/p. Up to **R175 000** per insured per year. Excess: 4-6 Months - 15% 7 Months + - 5%	Illness In Hospital Up to **R75 000** per insured event p/p. Up to **R187 500** per insured per year. Excess: 4-6 Months - 15% 7 Months + - 5%	Illness In Hospital Up to **R85 000** per insured event p/p. Up to **R212 500** 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 **R340 000** per defined disease per year.	Dread Disease Up to **R350 000** per defined disease per year	Dread Disease Up to **R395 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	Neonatal Up to **R65 000** per insured event p/p. Cover forms part of illness and operations	Neonatal Up to **R75 000** per insured event p/p. Cover forms part of illness and operations

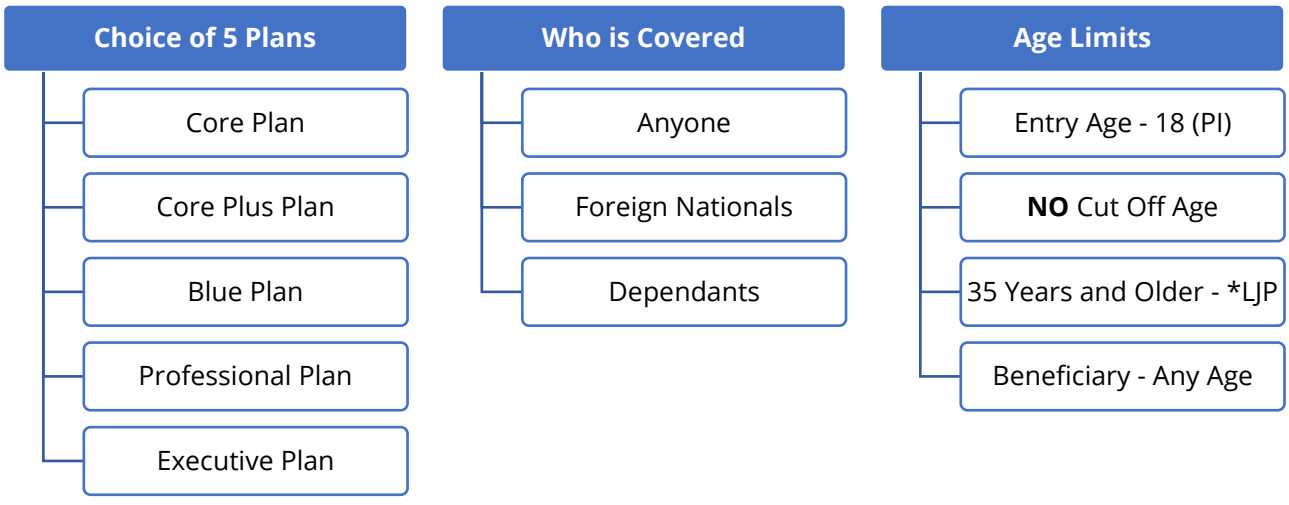
		annual limits. Excess: 10% of claim amount.	annual limits. Excess: 10% of claim amount.	annual limits. Excess: 10% of claim amount.
Repatriation Up to **R15 000** per insured person. Repatriation of mortal remains to funeral home.	Repatriation Up to **R15 000** per insured person. Repatriation of mortal 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**	Accidental Death Cover Principal Insured: **R13 000** Spouse/Partner: **R13 000**	Accidental Death Cover Principal Insured: **R15 000** Spouse/Partner: **R15 000**	Accidental Death Cover Principal Insured: **R20 000** Spouse/Partner: **R20 000**	Accidental Death Cover Principal Insured: **R25 000** Spouse/Partner: **R25 000**

Children 14-21 yrs: **R13 000** Children 6-13 yrs: **R9 000** Children 1-5 yrs: **R7 000**	Children 14-21 yrs: **R13 000** Children 6-13 yrs: **R9 000** Children 1-5 yrs: **R7 000**	Children 14-21 yrs: **R15 000** Children 6-13 yrs: **R10 000** Children 1-5 yrs: **R7 500**	Children 14-21 yrs: **R20 000** Children 6-13 yrs: **R12 500** Children 1-5 yrs: **R8 750**	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.

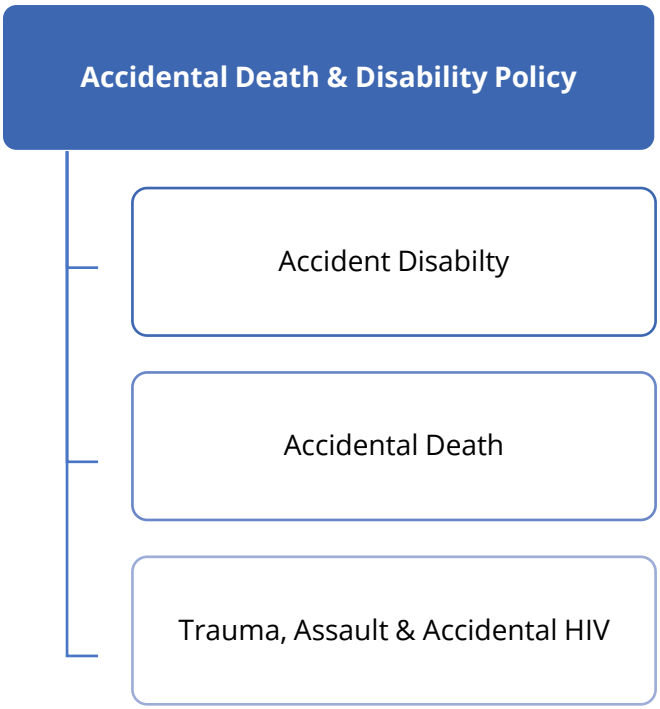
1st Policy – Health	2nd Policy – Accidental Death & Disability
Personal information	Personal information
Plan information	Accidental permanent disability cover
Legal definitions	Accidental death assistance cover
Oneplan Health cover	Trauma, assault, and accidental HIV
General conditions	General conditions
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	No Excess
Accident Cover	R600
Casualty Illness	No Excess
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
Neo-Natal Hospital Care	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.

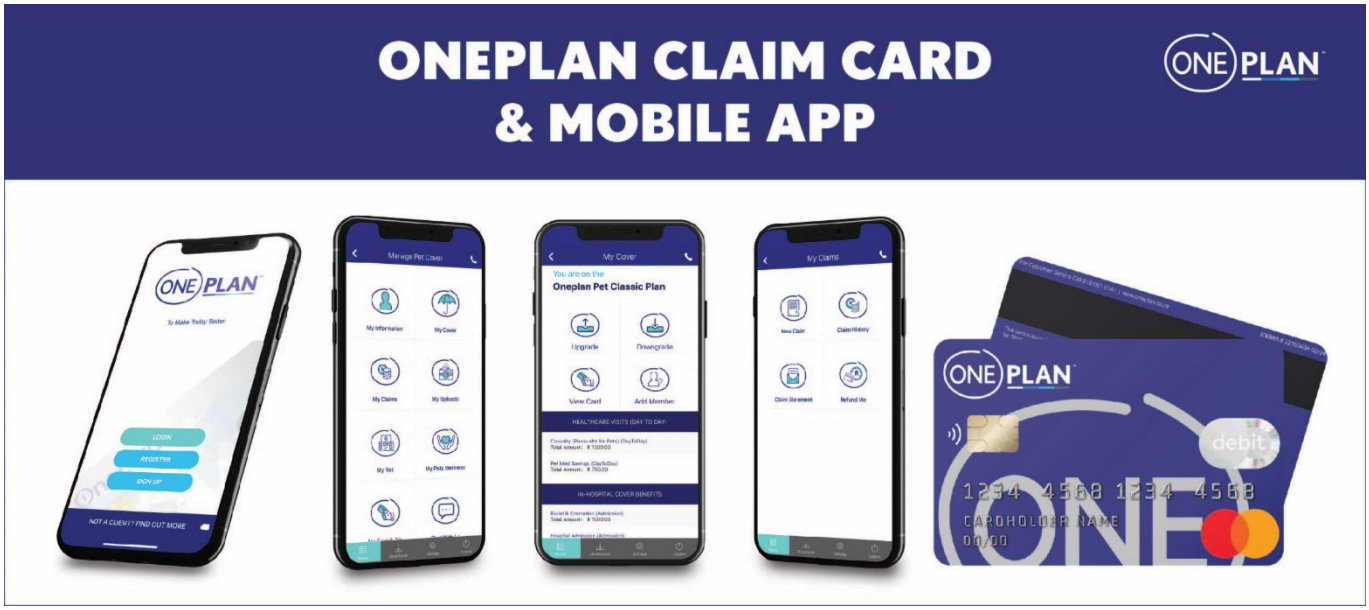
- Claims submitted after four (4) months.
- No claim will be payable if we have not been notified of the event within three (3) months of the event.
- Admission to a medical facility/hospital for investigative purposes /diagnostic procedures and/or pain control.
- Costs incurred for the treatment of 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. FAQs

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.

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.