Simple, cost-effective and reliable health cover.

AFFINITY HEALTH
2020

Policy v1.07
Document
This is not a medical scheme and the cover is not the same as that of a medical scheme. This policy is not a substitute for medical scheme membership.

Subject to Demarcation Regulations, the Insurer does not refuse membership on the basis of any means of discrimination.
Introduction

This Affinity Health Policy is underwritten by National Risk Managers (Pty) Ltd, a registered Financial Service Provider (FSP Number 47132), under contract from Lion of Africa Life Assurance Company Limited, the registered Insurer, registration number 1942/015587/06.

This is a long-term insurance policy as issued in terms of the Policy Administration Rules, which in turn is regulated by the Council for Medical Schemes.

Subject to Demarcation Regulations, the Insurer does not refuse membership on the basis of any means of discrimination.

This Policy Document should be read in conjunction with your Policy Schedule, and the Policy Administration Rules (“Rules”) which govern this Policy Document. Should these provisions be in conflict with the Rules, the Rules will enjoy preference.

Definitions

In this Policy, unless the circumstances indicate a different intention, the following words and expressions bear the meanings given to them and similar expressions bear corresponding meanings –

2.1 “Accident” means an unfortunate, sudden, unusual, specific incident which occurs unexpectedly and unintentionally at an identifiable time and place resulting in Bodily Injury during the period of the Policy;

2.2 “Acute Medication” means medication that meets the following requirements:

2.2.1 Is within the Formulary, as amended from time to time, and prescribed by a medical practitioner for disease or conditions that have a rapid onset and severe symptoms;

2.2.2 Is prescribed for less than 90 (ninety) days;

2.3 “Admission” means admission into a Hospital as an inpatient;

2.4 “Application Date” means the date on which the application for this insurance is completed in its entirety and submitted to the Insurer;

2.5 “Benefit” means the Benefit amount as set out in the Policy Schedule, provided by the Insurer in terms of this Policy;

2.6 “Benefit Start Date” means the date on which an Insured Person becomes entitled to Benefits upon completion of Waiting Periods;

2.7 “Bodily Injury” means Bodily Injury by violent, external and visible means caused by an Accident;

2.8 “Casualty/Emergency Room” means the department of a Hospital providing immediate treatment for emergency cases;

2.9 “Chronic Medication” means medication that meets all the following requirements:

2.9.1 Is within the Formulary, as amended from time to time, and prescribed by a network medical practitioner for an uninterrupted period of at least 3 (three) months;

2.9.2 Is for a condition appearing on the list of approved chronic conditions, as amended from time to time;

2.9.3 Has been applied for in the manner and at the frequency prescribed and which application has been approved and accepted;

2.10 “Commencement Date” means the date on which the application for this insurance becomes effective, as specified in the Policy Schedule;

2.11 “Contraception” means any of the activities, procedures and medications which are intended to prevent pregnancy;

2.12 “Day” means 24 (twenty-four) consecutive hours from time of Admission;

2.13 “Day Clinic” means a facility that offers surgical procedures that do not require an overnight stay;

2.14 “Defined Event” means the event which gives rise to the Insured Person having to seek medical treatment and which will be payable by the Insurer as set out in this document;

2.15 “Domicilium Citandi et Executandi” means the address nominated by the Policyholder in the application for the purpose of receiving legal notices, documents and processes. This shall include any electronic details;

2.16 “Emergency Treatment” means immediate medical treatment required as a matter of urgency to save a person’s life, or prevent serious damage to the person’s health;

2.17 “Exclusions” means the specific medications, treatments and procedures which Affinity will not cover in terms of the Policy;

2.18 “Fair Use” means the prohibition of unnecessary and wasteful misuse of Benefits;
2.19 “Family” means the Policyholder (being a natural person) in whose name this Policy is effected and all Insured Persons on the Policy;

2.20 “Formulary” means the complete list of procedures, prices, medication and service providers, as approved and amended from time to time by Affinity Health, which together constitutes the maximum limit of Benefits which the Insurer will be bound to pay in terms of this Policy;

2.21 “Grace Period” means the 15 (fifteen) day period of grace allowed for payment of missed premiums, prior to policy suspension/termination;

2.22 “Hospital” means an establishment which meets the following requirements:

2.22.1 holds a licence as a Private or Public Hospital, Day Clinic or Sub-Acute Facility;

2.22.2 operates primarily for the reception, care and treatment of sick, ailing or injured persons as inpatients;

2.22.3 provides organised facilities for diagnosis and surgical treatment;

2.22.4 is not primarily a rest or convalescent home or similar establishment and is not, other than incidentally, a place for rehabilitation of alcoholics or drug addicts;

2.23 “Illness” means the onset of any acute somatic, unforeseeable, unpredictable illness, including Microtrauma and Pathological Fractures (excluding mental Illness). A recurrence of any illness, or the occurrence of a related Illness, will only be considered a separate Illness if 6 (six) months have elapsed from the date of onset of the preceding Illness;

2.24 “Insured Persons” means the Dependents who have applied and been accepted by the Insurer and whose Premium is paid and up to date;

2.25 “Intensive Care Unit” means the special department of a Hospital or healthcare facility that provides intensive care to patients. Such care includes constant, close monitoring and support from specialised equipment and medications. Also known as Critical Care Unit (CCU). This will include high care;

2.26 “Major trauma” means a specified life-threatening injury, caused by external or violent means, that requires immediate treatment in ICU including ventilation and/or immediate surgery;

2.27 “Medicine” means a substance registered under the Medicines and Related Substances Control Act 1965, as amended from time to time, and within the Formulary;

2.28 “Member” means each individual insured under this Policy;

2.29 “Microtrauma” means injuries resulting from frequent, repeated use of a part of the body;

2.30 “Network Dentist” means a dentist that is part of Affinity Health’s appointed dentist network;

2.31 “Network Provider” means a registered medical practitioner registered in terms of HPCSA that is part of Affinity Health’s appointed networks;

2.32 “Network GP” means a general practitioner that is part of Affinity Health’s appointed GP network;

2.33 “Option” means a plan registered under Affinity Health, which offers a specific structure of Benefits;

2.34 “Pathological Fracture” means an injury caused by a disease;

2.35 “Policyholder” means the parent or person responsible for a minor that has applied for this Policy on behalf of said minor;

2.36 “Policy Schedule” means the membership certificate issued to the Policyholder in terms of section 48 of the Long-Term Insurance Act, which should be read in conjunction with this document;

2.37 “Pre-authorisation” means the act of contacting us to utilise certain Benefits;

2.38 “Pre-Existing Condition” means a condition for which medical/dental advice, diagnosis, care or treatment was recommended or received within the 12 (twelve) month period ending on the Commencement Date;

2.39 “Premium/Contribution” means the premium payable to the Insurer on a monthly basis in terms of this Policy in order to secure the Benefits;

2.40 “Professional Sport” means a sporting activity in which an Insured Person engages and from which such Insured Person derives the majority of their annual income;

2.41 “Service Provider” means registered healthcare providers and institutions for the provision of relevant healthcare services;

2.42 “Severe Illness” means any of the following:

2.42.1 Cancer as defined in clause 2 of schedule 4;

2.42.2 Heart Attack as defined in clause 3 of schedule 4;

2.42.3 Chronic Coronary Heart Disease, open-heart bypass surgery or surgical treatment of Coronary Disease. This excludes angioplasty and/or similar intra-arterial procedures;
2.42.4 Stroke as defined in clause 4 of schedule 4;

2.43 “Territorial Limits” means the Republic of South Africa;

2.44 “The/This Policy” means this insurance agreement concluded between the Insurer and the Policyholder in respect of the Benefits underwritten by the Insurer;

2.45 “The Medical Society” means the group of medical centres that provide basic healthcare;

2.46 “Waiting Period” means the number of months from Commencement Date before Insured Persons can access Benefits. No claims will be payable during this period;

2.47 “Year” means a calendar year;

2.48 Any reference to the singular includes the plural and vice versa;

2.49 Any reference to a gender includes other genders;

2.50 The clause headings in this Policy Document have been inserted for convenience only.

General Provisions

3.1 This Policy Document together with the Policy Schedule and application form constitute the entire agreement and any word or expression to which a specific meaning has been assigned shall bear specific meaning wherever it may appear. Please read clauses in their entirety to understand their full meaning.

3.2 Persons joining this Policy after the age of 18 (eighteen) will be subjected to increased Premiums.

3.3 Once any Insured Person has been insured under this Policy for a period of 12 (twelve) consecutive months, any Pre-Existing Condition shall no longer apply.

3.4 Insurance cover shall commence on the Commencement Date subject to receipt of the first Premium by the Insurer, unless otherwise stated.

3.5 Special Conditions under Section 5 should be read in conjunction with Section 8.

3.6 The Insurer may alter the terms and conditions, Premiums, or Benefits of the Policy by providing the Policyholder with at least 31 (thirty-one) days’ notice in writing.

3.7 It shall be the duty of the Policyholder/Insured Person to inform the Insurer of any material changes which may affect the terms and conditions of the Policy, such as a change in medical health or personal details.

3.8 This Policy shall be cancelled in the event of misrepresentation, misdescription or non-disclosure of any material fact by or on behalf of an Insured Person.

3.9 This Policy does not accumulate a cash or surrender value.

3.10 Only 1 (one) Policy may be issued to any one Insured Person.

3.11 Insured Persons shall only be covered within the borders of the Republic of South Africa.

3.12 This Policy shall be governed by, construed and interpreted in accordance with the laws of the Republic of South Africa.

Premium Payments

4.1 All Premiums are payable monthly in advance.

4.2 If the Premium is not paid on the payment date selected, a 15 (fifteen) day Grace Period will be applicable.

4.3 The Grace Period will commence from the second month following the Commencement Date provided that collection of the first Premium was successful.

4.4 The Insurer reserves the right to collect any failed or rejected Premium, which may include a double debit, from the nominated bank account.

4.5 Non-payment of Premiums for 2 (two) consecutive months will result in automatic termination of this Policy and no further Benefits will be payable.

Benefits

Day-to-Day Benefits

If this Option is selected, the following benefits are payable subject to the Formulary:

5.1 Primary Healthcare Referrals

5.1.1 Defined Event

Unlimited GP consultations when referred by a designated primary healthcare professional.
5.1.2 Waiting Period
This Benefit is subject to a 1 (one) month Waiting Period from the Commencement Date.

5.2 Doctor Consultations

5.2.1 Defined Event
Unlimited, managed, Network GP consultations subject to a maximum Rand value as per the Formulary.

5.2.2 Waiting Period
This Benefit is subject to a 1 (one) month Waiting Period from the Commencement Date.

5.2.3 Special Conditions
5.2.3.1 Pre-authorisation is required.
5.2.3.2 Insured Persons will be required to make use of a Network GP.

5.3 In-Room GP Procedures

5.3.1 Defined Event
Unlimited cover for minor procedures that can be performed in a GP’s rooms.

5.3.2 Waiting Period
This Benefit is subject to a 1 (one) month Waiting Period from the Commencement Date.

5.3.3 Special Conditions
5.3.3.1 Cover will be provided according to Formulary. A non-exhaustive list of procedures is detailed in schedule 1.
5.3.3.2 Insured Persons will be required to make use of a Network GP.
5.3.3.3 Pre-authorisation is required.

5.4 Out-of-Network GP Visits

5.4.1 Defined Event
Unlimited out-of-network visits. The Insured Person will be required to make an upfront payment and claim back from the Insurer up to the defined amount.

5.4.2 Waiting Period
This Benefit is subject to a 1 (one) month Waiting Period from the Commencement Date.

5.4.3 Special Conditions
5.4.3.1 The Insured Person will be entitled to a reimbursement amount of up to R250.
5.4.3.2 Pre-authorisation is required.

5.5 Primary Healthcare Consultations

5.5.1 Defined Event
Unlimited, managed, consultations with a primary healthcare professional at a conveniently located Medical Society Centre. Includes Acute Medication and treatment dispensed by the medical professional according to Formulary.

5.5.2 Waiting Period
This Benefit is subject to a 1 (one) month Waiting Period from the Commencement Date.

5.5.3 Special Conditions
5.5.3.1 Only medication up to schedule 4 can be dispensed by the primary healthcare professional at the centre.
5.5.3.2 The Insured Person will be liable for payment of any procedures or medication not on the Formulary.

5.6 Specialist Visit

5.6.1 Defined Event
Up to R1 200 per single Member Policy per Year or R3 000 per Family Policy per Year.

5.6.2 Waiting Period
This Benefit is subject to a 3 (three) month Waiting Period from the Commencement Date.

5.6.3 Special Conditions
5.6.3.1 Referral from a GP is required to claim this Benefit.
5.6.3.2 Pre-authorisation is required.

5.7 Telemedicine Consulting

5.7.1 Defined Event
Unlimited telephonic consultations with a designated primary healthcare professional. Includes acute medication recommended by the primary healthcare professional according to Formulary.
5.7.2 Waiting Period
5.7.2.1 This Benefit has no Waiting Period and is applicable from the Commencement Date.
5.7.2.2 Medication linked to this Benefit is subject to a 1 (one) month Waiting Period from the Commencement Date.

5.7.3 Special Conditions
5.7.3.1 Medication authorised or prescribed will be covered according to Formulary.

5.8 Casualty Room Treatment
5.8.1 Defined Event
Emergency Casualty Room treatment for an Accident or Illness up to R3 000 per Policy per Year.

5.8.2 Waiting Period
5.8.2.1 In the event of an Accident, this Benefit has no Waiting Period and is applicable from the Application Date.
5.8.2.2 In the event of Illness, this Benefit is subject to a 1 (one) month Waiting Period from the Commencement Date.

5.8.3 Special Conditions
5.8.3.1 Pre-authorisation is required.
5.8.3.2 Casualty Room Treatment as a result of an Accident between the Application Date and the Commencement Date is subject to 1 (one) event up to R1 000 per Policy. This is only available within the first 2 (two) months following the first date of application.
5.8.3.3 In the event of this benefit being claimed before the Commencement Date, the claim value will be deducted from the annual benefit amount.

5.9 Acute Medication
5.9.1 Defined Event
Acute Medication linked to a GP consultation and either prescribed or dispensed by the GP will be covered.

5.9.2 Waiting Period
This Benefit is subject to a 1 (one) month Waiting Period from the Commencement Date.

5.9.3 Special Conditions
5.9.3.1 Medication will be covered subject to the Formulary.
5.9.3.2 Insured Persons are responsible for payment of medication outside of the Formulary.
5.9.3.3 No cover for over-the-counter medication.
5.9.3.4 No cover for medication scripted by a dispensing provider.

5.10 Radiology
5.10.1 Defined Event
Unlimited cover for basic radiology.

5.10.2 Waiting Period
This Benefit is subject to a 1 (one) month Waiting Period from the Commencement Date.

5.10.3 Special Conditions
5.10.3.1 A referral from a medical practitioner is required to claim this Benefit.
5.10.3.2 Only basic x-rays will be covered subject to the Formulary.
5.10.3.3 Radiology related to an Accident will be covered under the Accident Benefit, if applicable to the chosen Option and subject to Benefit limits.

5.11 Pathology
5.11.1 Defined Event
Unlimited cover for basic pathology.

5.11.2 Waiting Period
This Benefit is subject to a 1 (one) month Waiting Period from the Commencement Date.

5.11.3 Special Conditions
5.11.3.1 A referral from a medical practitioner is required to claim this Benefit.
5.11.3.2 Basic pathology will be covered subject to the Formulary.
5.12 Dentistry

5.12.1 Defined Event
Basic dentistry cover including 1 (one) full mouth assessment or 1 (one) scale and polish, infection control, 2 (two) intraoral radiographs, 3 (three) extractions and 3 (three) fillings per Insured Person per Year.

5.12.2 Waiting Period
This Benefit is subject to a 3 (three) month Waiting Period from the Commencement Date.

5.12.3 Special Conditions
5.12.3.1 Insured Persons will be required to make use of a Network Dentist.
5.12.3.2 Cover will be provided in accordance with the Formulary and Benefit limits.
5.12.3.3 Pre-authorisation is required.

5.13 Optometry

5.13.1 Defined Event
1 (one) eye test and 1 (one) set of standard frames and lenses per Insured Person per 24 (twenty-four) months.

5.13.2 Waiting Period
This Benefit is subject to a 12 (twelve) month Waiting Period from the Commencement Date.

5.13.3 Special Conditions
5.13.3.1 Insured Persons will be required to make use of Spec-Savers.
5.13.3.2 Cover will be provided in accordance with the Formulary.
5.13.3.3 No cover is provided for contact lenses or cosmetic finishes.

5.14 Maternity Scans

5.14.1 Defined Event
2 (two) growth sonars referred by a network GP, subject to Formulary.

5.14.2 Waiting Period
5.14.2.1 This benefit is subject to a 3 (three) month Waiting Period from the Commencement Date.
5.14.2.2 Pre-existing Conditions are subject to a 12 (twelve) month Waiting Period from the Commencement Date.

5.14.3 Special Conditions
5.14.3.1 Scans are only available during the first and second trimester of pregnancy.

5.15 HIV Chronic Medication Management Programme

5.15.1 Defined Event
Access to an HIV/AIDS management programme that provides Insured Persons living with HIV/AIDS with suitable treatment and tools to live a healthy life.

5.15.2 Waiting Period
This Benefit is subject to a 3 (three) month Waiting Period from the Commencement Date.

5.15.3 Special Conditions
5.15.3.1 Members will be required to register for this Benefit.
5.15.3.2 Medication will be covered according to formulary, up to R350 per Member per month, subject to payment of a surcharge in accordance with the Chronic Essential Benefit.
5.15.3.3 Blood tests will be covered according to Formulary.

5.16 Post-Hospital Private Home Nursing

5.16.1 Defined Event
Up to R10 000 per Policy per Year for the assistance of a private nurse following a stay in a Hospital, subject to 5.16.3.

5.16.2 Waiting Period
This Benefit has no Waiting Period and is applicable from the Commencement Date.

5.16.3 Special Conditions
5.16.3.1 This Benefit is only available where the Insured Person is unable to perform 3 (three) or more activities of daily living, listed below, as a result of Illness or
accidental injury, without the help of another person, but with the use of appropriate assistive or corrective aids and appliances.

- **Washing:** The ability to wash in a bath or shower (including getting into and out of a bath or shower);

- **Dressing:** The ability to put on, take off, secure and unfasten all garments;

- **Feeding:** The ability to cut meat, butter bread and to get food and drink into the mouth using fingers or utensils;

- **Toileting:** The ability to use the lavatory and to recognize the need to clear the bladder or bowel;

- **Mobility:** The ability to move indoors from room to room on level surfaces;

- **Transferring:** The ability to move from a bed to a chair or wheelchair and vice versa;

- **Communicating:** The ability to answer the telephone and take a message.

5.16.3.2 This must be confirmed in a report from a medical practitioner and an examination by a medical professional appointed by the Insurer.

### Hospital Benefits

If this Option is selected, the following benefits are payable subject to the Formulary:

All of the below Benefits require Pre-authorisation.

#### 5.17 Accident Cover

- **5.17.1 Defined Event**
  Cover in the event of an Accident as defined in Section 2 above. Up to R175 000 per single Member per event or R275 000 per Family per event.

- **5.17.2 Waiting Period**
  This Benefit has no Waiting Period and is applicable from the Application Date.

- **5.17.3 Special Conditions**
  - **5.17.3.1** Hospitalisation as a result of an Accident between the Application Date and the Commencement Date is subject to 1 (one) Admission per Policy for Emergency Treatment, up to R100 000 per single Member policy and R150 000 per Family policy. This is only available within the first 2 (two) months following the first date of application.
  - **5.17.3.2** No cover will be provided for Microtrauma injuries and Pathological Fractures.
  - **5.17.3.3** Dental treatment as a result of an Accident is limited to R20 000 per Policy per Year.
  - **5.17.3.4** Up to R10 000 per event for treatment in a Casualty Room as a result of an Accident.

#### 5.18 Major Trauma

- **5.18.1 Defined Event**
  Up to R500 000 per Member per event.

- **5.18.2 Waiting Period**
  This Benefit has no Waiting Period and is applicable from the Commencement Date.

- **5.18.3 Special Conditions**
  - **5.18.3.1** The injury must meet the definition of Major Trauma in section 2 above, and is limited to treatment of the following:
    - Near drowning;
    - Internal and/or external head injuries;
    - Gunshot wounds;
    - Loss of a limb(s);
    - Polytrauma (severe injuries to at least 2 or more body systems endangering the life of the injured persons);
    - Severe burns (third and/or fourth degree across more than 10% of the body surface);
    - Paraplegia (loss of all motor and sensory function below the level of injury);
    - Quadriplegia (loss of all motor and sensory function below the level of injury).
  - **5.18.3.2** Treatment required after Hospital discharge is limited to R100 000 per Member per event, subject to the maximum Benefit amount.
5.18.3.3 This Benefit is subject to a limit of R1 100 000 per Policy.

5.18.3.4 Upon payment of 100% of the Benefit amount, this Benefit will be terminated and cannot be reinstated.

5.19 Casualty Room Treatment

5.19.1 Defined Event
Emergency Casualty Room treatment for an Accident or Illness up to R2 500 per Policy.

5.19.2 Waiting Period
This Benefit is subject to a 1 (one) month Waiting Period from the Commencement Date.

5.20 24-Hour Emergency

5.20.1 Defined Event
24/7 emergency medical advice, ambulance services, inter-hospital transfers, Hospital pre-authorisation & arranging for guarantee of payment to the treating facility.

5.20.2 Waiting Period

5.20.2.1 If claimed as a result of an Accident, this Benefit has no Waiting Period and is applicable from the Application Date.

5.20.2.2 If claimed as a result of Illness, this Benefit has no Waiting Period and is applicable from the Commencement Date.

5.21 Daily Illness Hospitalisation

5.21.1 Defined Event
When hospitalised due to Illness, the following amounts will be payable:

<table>
<thead>
<tr>
<th>Day</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>Up to R20 000 / R24 000*</td>
</tr>
<tr>
<td>2nd</td>
<td>Up to R20 000 / R24 000*</td>
</tr>
<tr>
<td>3rd</td>
<td>Up to R20 000 / R24 000*</td>
</tr>
<tr>
<td>4th</td>
<td>Up to R8 500</td>
</tr>
<tr>
<td>5th</td>
<td>Up to R8 500</td>
</tr>
</tbody>
</table>

thereafter up to R3 000 per day up to a maximum of 21 days per Member, per illness event.

* Cover applicable when admitted to ICU and combined with the ICU Booster.

5.21.2 Waiting Period
This Benefit has a 3 (three) month Waiting Period from the Commencement Date.

5.21.3 Special Conditions

5.21.3.1 Maximum Benefit payable is up to R125 000 per event.

5.21.3.2 If an Insured Person is admitted into Hospital within a 6 (six) month period for the same or a related Illness, the Benefit amount payable will recommence from the last day of the previous Admission.

5.21.3.3 Insured Persons may be required to make use of Day Clinics if instructed to do so by the Insurer.

5.21.3.4 Only 2 (two) Admission claims per Insured Person per Year will be payable.

5.22 Diagnostic Procedures

5.22.1 Defined Event
Up to R20 000 per Policy per Year.

5.22.2 Waiting Period
This Benefit is subject to a 3 (three) month Waiting Period from the Commencement Date.

5.22.3 Special Conditions

5.22.3.1 Insured Persons will be required to make an upfront co-payment as detailed in schedule 2.

5.22.3.2 This Benefit will be subject to sub-limits as detailed in schedule 2.

5.22.3.3 Upon completion of the Waiting Period, this Benefit will accumulate at R1 000 per month. The full Benefit amount will become available from the 13th (thirteenth) month of cover.

5.22.3.4 Pre-authorisation is required.

5.23 Day Clinic Procedures

5.23.1 Defined Event
Up to R25 000 per Member per Year for procedures conducted at a Day Clinic.
5.23.2 Waiting Period
This Benefit is subject to a 3 (three) month Waiting Period from the Commencement Date.

5.23.3 Special Conditions
5.23.3.1 Insured persons will be required to make use of an affiliated Day Clinic.
5.23.3.2 Cover will be provided for procedures detailed in schedule 3. This list is not exhaustive and is dependent on the scope of the Day Clinic.
5.23.3.3 Pre-authorisation is required.
5.23.3.4 Treatment at a Day Clinic will be considered an Admission claim under the Daily Illness Hospitalisation Benefit.
5.23.3.5 Dental treatment is limited to R10 000 per Member per Year.

5.24 Maternity
5.24.1 Defined Event
The following stated Benefits are payable regardless of the amount of Days spent in Hospital as an inpatient:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity (Natural)</td>
<td>R25 000</td>
</tr>
<tr>
<td>Maternity (C-Section)</td>
<td>R35 000</td>
</tr>
</tbody>
</table>

5.24.2 Waiting Period
5.24.2.1 This Benefit is subject to a 12 (twelve) month Waiting Period from the Commencement Date.

5.24.3 Special Conditions
5.24.3.1 Only 1 (one) claim per Insurer Person per 12 (twelve) month period will be payable.
5.24.3.2 Birth before 35 (thirty-five) weeks of gestation will only be covered in a public hospital.

5.25 Severe Illness Shortfall
5.25.1 Defined Event
Up to R150 000 is payable as a result of treatment of a Severe Illness as described in Section 2 above.

5.25.2 Waiting Period
5.25.2.1 This Benefit is subject to a 3 (three) month Waiting Period from the Commencement Date.
5.25.2.2 Pre-existing Conditions are subject to a 12 (twelve) month Waiting Period from the Commencement Date.

5.25.3 Special Conditions
Upon payment of 100% of the Benefit amount, this Benefit will be terminated and cannot be reinstated.

5.26 Sub-acute Hospitalisation
5.26.1 Defined Event
Up to R20 000 per Member per Year for treatment at a sub-acute facility.

5.26.2 Waiting Period
This Benefit is subject to a 3 (three) month Waiting Period from the Commencement Date.

5.26.3 Special Conditions
5.26.3.1 Insured Persons will be required to make use of an affiliated sub-acute facility.
5.26.3.2 Pre-authorisation is required.
5.26.3.3 Treatment at a sub-acute facility will be considered an Admission claim under the Daily Illness Hospitalisation Benefit.

5.27 Post-Hospital Private Home Nursing
5.27.1 Defined Event
Up to R10 000 per Policy per Year for the assistance of a private nurse following a stay in a Hospital, subject to 5.30.3.

5.27.2 Waiting Period
This Benefit has no Waiting Period and is applicable from the Commencement Date.

5.27.3 Special Conditions
5.27.3.1 This Benefit is only available where the Insured Person is unable to perform 3 (three) or more activities of daily living, listed below, as a result of Illness or accidental injury, without the help of another person, but with the use of appropriate assistive or corrective aids and appliances.
- **Washing**: The ability to wash in a bath or shower (including getting into and out of a bath or shower);

- **Dressing**: The ability to put on, take off, secure and unfasten all garments;

- **Feeding**: The ability to cut meat, butter bread and to get food and drink into the mouth using fingers or utensils;

- **Toileting**: The ability to use the lavatory and to recognize the need to clear the bladder or bowel;

- **Mobility**: The ability to move indoors from room to room on level surfaces;

- **Transferring**: The ability to move from a bed to a chair or wheelchair and vice versa;

- **Communicating**: The ability to answer the telephone and take a message.

5.27.3.2 This must be confirmed in a report from a medical practitioner and an examination by a medical professional appointed by the Insurer.

### Optional Benefits

If selected, Optional Benefits are payable as follows:

#### 5.28 Chronic Essential

5.28.1 **Defined Event**
Chronic Medication covered under the Chronic Essential Benefit and linked to the Formulary will be obtained via prescription from a pharmacy.

5.28.2 **Waiting Period**
This Benefit is subject to a 3 (three) month Waiting Period from the Commencement Date.

5.28.3 **Special Conditions**
- 5.28.3.1 Medication is endorsed upon application.
- 5.28.3.2 A surcharge of R79 per Insured Person per condition per month will be payable when this Benefit is claimed.
- 5.28.3.3 Chronic medication is subject to an approval process determined by Affinity Health.

#### 5.29 Chronic Booster

5.29.1 **Defined Event**
Chronic Medication covered under the Chronic Booster Benefit and linked to the Formulary will be obtained via prescription from a pharmacy.

5.29.2 **Waiting Period**
This Benefit is subject to a 1 (one) month Waiting Period from the Commencement Date.

5.29.3 **Special Conditions**
- 5.29.3.1 Medication is endorsed upon application for this Benefit.
- 5.29.3.2 A surcharge dependent on the medication required will be payable when this Benefit is claimed.
- 5.29.3.3 Chronic medication is subject to an approval process determined by Affinity Health.

#### 5.30 Accident Booster

5.30.1 **Defined Event**
The Accident Booster Benefit accompanies the Accident Cover Benefit. The amount payable for this Benefit will increase according to the level of booster selected by the Policyholder:

<table>
<thead>
<tr>
<th>Option</th>
<th>Single Cover</th>
<th>Option</th>
<th>Family Cover</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Up to R250 000</td>
<td>Level 1</td>
<td>Up to R400 000</td>
</tr>
<tr>
<td>Level 2</td>
<td>Up to R350 000</td>
<td>Level 2</td>
<td>Up to R550 000</td>
</tr>
<tr>
<td>Level 3</td>
<td>Up to R450 000</td>
<td>Level 3</td>
<td>Up to R700 000</td>
</tr>
<tr>
<td>Level 4</td>
<td>Up to R550 000</td>
<td>Level 4</td>
<td>Up to R850 000</td>
</tr>
<tr>
<td>Level 5</td>
<td>Up to R650 000</td>
<td>Level 5</td>
<td>Up to R1 050 000</td>
</tr>
<tr>
<td>Level 6</td>
<td>Up to R750 000</td>
<td>Level 6</td>
<td>Up to R1 000 000</td>
</tr>
</tbody>
</table>

5.30.2 **Waiting Period**
This Benefit has no Waiting Period and is applicable from the Commencement Date.

#### 5.31 IER Booster

5.31.1 **Defined Event**
The IER Booster provides Insured Persons with the following:
5.31.1.1 Emergency Casualty Room stabilisation up to R6 000 per event.

5.31.1.2 Hospital stabilisation Benefit up to R40 000 per event.

5.31.2 Waiting Period
This Benefit has no Waiting Period and is applicable from the Commencement Date.

5.31.3 Special Conditions
5.31.3.1 When taken in conjunction with the Day-to-Day Option, access to 24-hour emergency medical advice, ambulance services as well as access to a network of emergency services is included.

5.31.3.2 Single Member policies get cover for 1 (one) event per Year.

5.31.3.3 Family policies get cover for 2 (two) events per Year.

5.31.3.4 This Benefit provides cover for Emergency Treatment only.

5.32 ICU Booster

5.32.1 Defined Event
The ICU Booster accompanies the Daily Illness Hospitalisation Benefit and provides Insured Persons with up to R12 500 cover per Day spent in ICU, up to a maximum of 5 (five) Days per Illness event.

5.32.2 Waiting Period
This Benefit is subject to a 3 (three) month Waiting Period from the Commencement Date.

5.32.3 Special Conditions
5.32.3.1 If claimed, this Benefit amount will replace any amount payable by the Daily Illness Hospitalisation Benefit.

5.32.3.2 This Benefit is subject to the rules of the Daily Illness Hospitalisation Benefit.

If a Combined Option has been selected by the Policyholder, Day-to-Day and Hospital Benefits will be payable. The amounts for the following Benefit is increased as follows:

5.37 Casualty Room Treatment

5.37.1 Defined Event
Emergency Casualty Room Treatment for Illness only up to R4 000 per Policy per Year.

5.37.2 Waiting Period
This Benefit has a 1 (one) month Waiting Period from Commencement Date.

5.37.3 Special Conditions
Casualty Room Treatment related to an Accident will be covered under the Accident Benefit.

Claims

6.1 Insured Persons must obtain Pre-authorisation for all Benefits as contained in this document. Moreover, the Insured Person must determine the maximum Benefit payable for each and every Defined Event as the level of Benefit is determined by the actual procedure conducted by the service provider. To do this, the Insured must contact us via telephone on 0861 11 00 33 or via email info@affinityhealth.co.za.

6.2 Day-to-Day claims can be emailed to claims@affinityhealth.co.za.

6.3 Hospital claims can be emailed to hospitalclaims@affinityhealth.co.za.

6.4 The Insurer will not be liable for any bookings or appointments not kept by a Member.

6.5 All Benefits will be subject to Fair Use rules.

6.6 All claims under this Policy are covered when the Premium is paid. If the GP or Service Provider charges a rate above the Benefit payable under this Policy, then such difference is payable by the Insured Person.

6.7 It is the sole responsibility of the Insured Person to seek medical assistance immediately when the Insured Person becomes aware of a medical condition that requires treatment. The Insurer will not be liable to provide cover because of negligence in the treatment of medical requirements.

6.8 Written notice on the prescribed form must be given to the Insurer in writing as soon as practicable of any occurrence which may give rise to a claim under this insurance, but in any event within 3 (three) months of such occurrence, failing which the claim will not be entertained.

6.9 Costs associated with the claim need to be submitted to the Insurer within 120 (one hundred and twenty) days of the Defined Event. In the event of the costs being submitted after 120 (one hundred and twenty)
days, they will be deemed stale and the Insurer will not be liable to cover
the costs.

6.9.1 Any claims for the Accident Benefit need to be submitted within
30 (thirty) days of the event giving rise to such claim. Any claim
received thereafter will be deemed stale and the Insurer will not
be liable to cover the costs.

6.9.2 Any claims relating to an Accident will be payable for a maximum
period of 6 (six) months up to the Benefit amount, limited to
treatment in Hospital or a Casualty Room.

6.10 If the Insurer repudiates a claim:

6.10.1 The Insured Person has 90 (ninety) days to make representations
for repudiated claims;

6.10.2 Representations must be made in writing outlining the Insured
Person's reason for the dispute;

6.10.3 We will provide the Insured Person with a written response
within 30 (thirty) days;

6.10.4 Should the response be unsatisfactory, the Insured Person may
lodge a dispute in accordance with clause 17 of the Policy
Administrative Rules;

6.10.5 Should the Insured Person not exercise these rights within these
time frames the claim will be deemed abandoned.

6.11 All certificates, information and evidence required by the Insurer shall be
furnished in the form prescribed and without expense to the Insurer. The
Insured Person shall attend a medical examination on behalf of, and at
the expense of, the Insurer as often as shall be required in connection
with any claim. Should such documentation not be received the Insurer
shall not be liable to consider the claim.

6.12 The Insured Person must notify us at least 48 (forty-eight) hours prior to
being hospitalised by contacting us on 0861 11 00 33 and providing full
particulars of the hospitalisation. Failure to do so may result in non-
payment of claims. Where the Insured Person is physically unable to
notify us prior to hospitalisation, this condition will not apply, subject to
us being notified within 48 (forty-eight) hours after admission provided
that the Insured Person is physically able to do so.

6.13 If any claim under this Insurance be in any respect fraudulent or
intentionally exaggerated or if any fraudulent means or devices are used
by the Insured Person or anyone acting on their behalf to obtain any
Benefits under this Insurance, all Benefits herein shall be forfeited, and
no Premiums shall be refunded.

6.14 The Policyholder hereby gives the Insurer the right to claim from the
Insured Person any payment or compensation received by the Insured
Person from any third party due to an event that is covered by this Policy.

6.15 Should a Pre-Existing Condition exist that results in the injury or Illness
becoming more severe, the Insured Person shall only be due the amount
deemed to have been incurred because of the specific Accident or Illness.

6.16 Compensation under one Benefit pertaining to this Policy shall not be in
addition to another.

6.17 Any leniency offered in the processing/payment of claims or extension of
cover to an Insured Person is not deemed to be leniency on an ongoing
basis and the terms of this Policy remain in full force and effect.

6.18 Insured Persons shall take all reasonable precautions to prevent
Accidents and to comply with all statutory requirements and regulations.

7 Amendment/Upgrade/Cancellation Procedure

7.1 Should the Policyholder wish to change personal details, amend any
Option or add Dependants onto their existing plan they must contact us
directly on 0861 11 00 33, or email info@affinityhealth.co.za along with
their membership number.

7.2 The Policyholder may cancel membership by giving written notification.
Insured Persons will, however, still be covered for the remainder of the
month for which the last Premium was collected. No Premiums will be
refunded in instances where Benefits were not utilised by the Insured
Person. Should cancellation fall within the 31 (thirty-one) day cooling off
period, Premiums will be refunded provided no Benefits were utilised.

7.3 If the Policyholder cancels the Policy, no claim will be payable for any
event occurring after the effective date of termination.

7.4 The Insurer reserves the right to cancel or vary membership or that of
any Insured Person by giving written notification, where possible, if any
Insured Person:

7.4.1 Provides false information or fail to disclose information upon
application;

7.4.2 Provides false information upon submission of a claim;

7.4.3 Allows any other person to use your membership card;

7.4.4 Commits any other fraudulent act;

7.4.5 Fails to pay Premiums;
Generally act in a manner indicative of a premeditated selection against the Insurer.

Exclusions

8.1 The Insurer shall not be liable to pay Compensation in respect of any Insured Person:

8.1.1 if caused by a Pre-Existing Condition within the first 12 (twelve) months of cover;

8.1.2 if resulting from suicide of such person or attempt thereat, whether due to mental disorders or not, or any other self-injury or intentional exposure to obvious risk of Injury (unless in an attempt to save a human life);

8.1.3 if caused by, or as a result of, the influence of alcohol, drugs or narcotics upon such Insured Person, unless administered by or prescribed by and taken in accordance with the instructions of a Member of the medical profession (other than himself);

8.1.4 if caused by, or arising from, exposure to, or contamination by, atomic energy and/or nuclear fission or reaction;

8.1.5 whilst travelling by air other than as a passenger and not as a Member of the aeroplane crew, technical staff or for the purpose of any technical operation thereon or therein;

8.1.6 whilst participating in any riot, civil commotion or public disorder, including authorised and sanctioned union activity or active involvement in war, acts of terrorism, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or political risk of any kind;

8.1.7 whilst participating in a Professional Sport as defined in section 2 above;

8.1.8 for treatment relating to any mental and/or nervous disorders, other than those caused by an Accident as defined in this Insurance, and covered under this Policy;

8.1.9 who is in employment of or service in the permanent force of the South African National Defence Force, South African Police Service or any other service where the Insured Person is armed;

8.1.10 for any claims for mountaineering or rock climbing necessitating the use of ropes or guides, potholing, hang-gliding, skydiving, riding or driving in a race or rally, underwater activities involving the use of artificial breathing apparatus unless the Insured Person has an open water diving certificate and is diving within the depth limitations of such certification, but to a depth no greater than 30 (thirty) meters, and/or similar activities, unless agreed to by the Insurer;

8.1.11 for any claim arising whilst the Insured Person is perpetrating an intentional unlawful act in terms of South African Law;

8.1.12 if caused by any gradually operating cause of which the Insured Person is aware;

8.1.13 for the treatment of any congenital abnormalities, diseases or disorders;

8.1.14 for claims in respect of expenses arising out of regular medical treatments on an ongoing (chronic) basis;

8.1.15 for Contraception medication or fertility-related therapies;

8.1.16 for mental-related conditions, including the consultation and use of specialists;

8.1.17 for elective cosmetic surgery, corrective optical and laser surgery or treatment and costs resulting therefrom;

8.1.18 for treatment, directly or indirectly arising from, or connected with, male and female birth control, infertility and any form of assisted reproduction;

8.1.19 if the person is at the time of an Accident engaged in a race or speed test;

8.1.20 if injuries are sustained whilst any person driving a vehicle is under the age prescribed by law, or who is not authorised or qualified to drive the vehicle;

8.1.21 for the cost incurred for the treatment of obesity;

8.1.22 for the treatment of any sexually transmitted diseases, unless as a result of rape or a crime that has been reported to the South African Police Services;

8.1.23 for services rendered by a person not registered with the SA Medical and Dental Council and/or the South African Health Professions Council and/or the South African Nursing Council;

8.1.24 for any treatment or control of any superbug, any multi-drug resistant illness and/or MRSA;

8.1.25 where the Insured Person is covered in terms of a statutory body or their successors, in relation to a Defined Event, this Policy...
shall be obliged to pay only the amounts for which the Insured Person is liable, up to the maximum Benefit amount;

8.1.26 for costs incurred as a result of failure to carry out the instructions or advice of a medical doctor, including deferring treatment to have costs covered once Waiting Periods and endorsements are no longer applicable;

8.1.27 for costs incurred as a result of fertility treatment resulting in multiple births;

8.1.28 for a Pandemic;

8.1.29 In the case where the Insured Person is also covered by a Medical Aid as defined in the Medical Schemes Act, 131 of 1998, this Policy shall only be liable for the cost of hospitalisation not covered by the Medical Aid.

Dispute Resolution

9.1 Should any dispute arise between a Member and Affinity such a dispute shall be dealt with in accordance with provision 17 of the Policy Administration Rules.

Sharing of Insurance Information

10.1 The sharing of insurance information for underwriting and claims purposes (including credit information) between insurers is in the public interest as it enables insurers to underwrite policies and assess the risks fairly and to reduce the incidence of fraudulent claims.

10.2 Insured Persons hereby consent to the sharing of any insurance information provided by them, or on their behalf, in respect of any insurance policy or claims lodged. Insured Persons also consent to this information being disclosed to any other insurance company and/or verified against other legitimate sources or databases.

SCHEDULE 1 | In-room GP procedures

- Circumcision (clamp procedure)
- Excision of nailbed
- Cauterisation of warts, nevus, lipoma and skin lesion
- Resection of the big toenail
- Excision of nevus, lipoma and skin lesion
- Skin biopsy
- Drainage of an abscess
- Stitching of wounds
- Removal of foreign body

SCHEDULE 2 | Diagnostic Procedures

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Benefit Amount</th>
<th>Co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amniocentesis</td>
<td>Up to R6 000</td>
<td>R300</td>
</tr>
<tr>
<td>Barium x-ray studies</td>
<td>Up to R6 000</td>
<td>R300</td>
</tr>
<tr>
<td>Bone marrow aspiration</td>
<td>Up to R6 000</td>
<td>R300</td>
</tr>
<tr>
<td>Computed tomography (CT)</td>
<td>Up to R10 000</td>
<td>R500</td>
</tr>
<tr>
<td>Doppler</td>
<td>Up to R6 000</td>
<td>R300</td>
</tr>
<tr>
<td>Fluoroscopy</td>
<td>Up to R6 000</td>
<td>R300</td>
</tr>
<tr>
<td>Magnetic resonance imaging (MRI)</td>
<td>Up to R20 000</td>
<td>R1 500</td>
</tr>
<tr>
<td>Myelography</td>
<td>Up to R6 000</td>
<td>R300</td>
</tr>
<tr>
<td>Nuclear scan</td>
<td>Up to R10 000</td>
<td>R500</td>
</tr>
<tr>
<td>Positron emission tomography (PET)</td>
<td>Up to R20 000</td>
<td>R1 500</td>
</tr>
<tr>
<td>Retrograde Urography</td>
<td>Up to R6 000</td>
<td>R300</td>
</tr>
<tr>
<td>Venography</td>
<td>Up to R6 000</td>
<td>R300</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Up to R20 000</td>
<td>R1 000</td>
</tr>
<tr>
<td>Gastroscopy</td>
<td>Up to R5 000</td>
<td>R1 000</td>
</tr>
<tr>
<td>Biopsy</td>
<td>Up to R10 000</td>
<td>R0</td>
</tr>
<tr>
<td>Colposcopy, Cone biopsy, Dilation and curettage (D&amp;C), Hysteroscopy</td>
<td>Up to R15 000</td>
<td>R0</td>
</tr>
</tbody>
</table>

SCHEDULE 3 | Day Procedures

- Achilles tendon release
- Haemorrhoidectomy
- Adenoidectomy
- Inguinal hernia repair
- Anal dilatation
- Laparoscopic appendicectomy
- Anstrostomy
- Laporoscopy and removal of cyst
- Arthroscopy
- Myringotomy
- Bunionectomy
- Peripheral nerve neuroplasty
- Carpal tunnel release
- Posterior and anterior vitrectomy
- Cataract surgery
- Probing and repair of tear ducts
- Cervical cerclage
- Release of trigger finger
- Cervical Lletz
- Removal of pterygium
- Corneal surgery
- Renal calculus removal and stent insertion
• Cystoscopy and ureteral dilation
• Sinus surgery
• Drainage of abscesses/haemotoma
• Tonsillectomy
• Drainage of Bartholin cyst
• Turbinectomy
• Endometrial ablation
• Tymanoplasty
• Ganglionectomy
• Umbilical hernia repair

**Accident Related Day Procedures**

• Closed reduction of fracture
• Insertion or removal of K wires or other internal fixatives
• Reduction of nose fracture
• Removal of pins and plates

**SCHEDULE 4 | 1. SCIDEP Definitions**

1.1 For purposes of this Policy, the Severe Illnesses shall bear the meanings as assigned to them in this schedule 4, which definitions are prescribed in terms of the Standardised Critical Illness Definitions Project (SCIDEP) definitions.

1.2 For the sake of convenience, a layman’s definition is included herein due to the complexity of the medical definitions of Dread Diseases.

1.3 Affinity Health will cover Severe Illnesses according to Tiered Benefits as per SCIDEP Definitions and will be applicable to all Severe Illness Benefits (where severity D is the mildest and severity A the most severe).

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Severity A</th>
<th>Severity B</th>
<th>Severity C</th>
<th>Severity D</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>75%</td>
<td>50%</td>
<td>25%</td>
<td></td>
</tr>
</tbody>
</table>

2. Cancer

2.1 Cancer is an uncontrolled growth that spreads into the normal tissue surrounding the organ where the cancer originates. The diagnosis must be supported by evidence received from a radiologist, pathologist and/or histology laboratory. Some cancers have been specifically excluded because the long-term outcome is good and the effect on quality of life is minimal, and treatment is neither expensive nor extensive.

2.2 There are specific exclusions to this definition and as such also excluded from any Benefits. These include:

2.2.1 Cancerous cells that have not invaded the surrounding or underlying tissue;

2.2.2 Early cancer of the prostate gland and breast; and

2.2.3 All cancers of the skin except cancerous moles that have invaded underlying tissue.

2.3 Staging of cancer:

2.3.1 As a general rule there are four stages of cancer.

- **Stage 1** cancer is defined by an invasive cancer confined to the tissue or organ of origin.

- **Stage 2** cancer is defined by the involvement of adjacent structures or organs.

- **Stage 3** cancer involves spreading to regional lymph nodes.

- **Stage 4** cancer is characterised by distant metastasis.

2.3.2 However, each type of cancer is staged specifically by the American Joint Committee for Cancer (AJCC). This staging is based on the outcome of the specific cancer and does not always follow the general rule as stated above.

3. Heart Attack

Four levels of severity of heart attacks are defined:

3.1 Severity D is the mildest and Severity A is the most severe.

3.2 In Severity A and B, more permanent damage has resulted, which means the heart function is less than 100% after recovery.

3.3 The effect of the heart attack on heart function should be measured 6 weeks after the heart attack.

3.4 Severity A: Heart attack severe impairment in function.

3.4.1 These are heart attacks where a significant proportion of the heart muscle was damaged. The same tests are used to measure the damage as under Severity B but the results would show a more serious level of impaired function.

3.4.2 The patient will have difficulty coping with normal activities of daily living, and will most likely not be able to work.

3.5 Severity B: Heart attack with mild permanent impairment in function.
3.5.1 This is usually a heart attack in which the heart does not recover 100% of normal function. The degree of permanent damage can be measured by a heart sonar, an exercise tolerance test or a measurement of physical abilities.

3.6 Severity C: Moderate heart attack of specified severity.

3.6.1 In this case, damage to the heart muscle is more than in Severity D. In some cases a cardiologist will intervene early and reverse the potential damage. This intervention may include administration of drugs to dissolve the blood clot in the coronary artery(ies) or balloon stretching of the coronary artery, with or without a stent.

3.6.2 Due to clinical methods of diagnosing the severity of this heart attack being unambiguous, only 2 (two) of the 3 (three) below criteria are required to be met:

3.6.2.1 Typical chest pain or other symptoms typically associated with a heart attack;

3.6.2.2 Certain defined ECG changes. At this level the changes are more marked and more specific to a heart attack;

3.6.2.3 Elevated blood test results greater than required for Severity D.

3.7 Severity D: Mild heart attack with full recovery.

3.7.1 This is a heart attack where the ECG changes and blood test results are mildly abnormal. Therefore, all 3 (three) of the below criteria are required to be met:

3.7.1.1 Typical chest pain or other symptoms typically associated with a heart attack;

3.7.1.2 Certain defined ECG changes;

3.7.1.3 Elevated blood test results.

4. Stroke

4.1 A stroke occurs when the blood supply to a portion of the brain is obstructed and this part of the brain tissue dies. It can also happen when there is bleeding into the brain tissue due to a weakening or abnormality of the blood vessel wall. A common cause of the rupture of a brain blood vessel is longstanding, uncontrolled high blood pressure.

4.2 The result of a stroke is usually paralysis of an arm and leg, sometimes with one half of the face affected as well. In some cases people also lose their ability to speak. The paralysis can recover to varying degrees. Some recover fully, whereas others may retain permanent weakness of a limb(s).

4.3 A Transient Ischaemic Attack (TIA) occurs when the blood supply is momentarily interrupted, but restored before any permanent damage can occur. It usually results in 1 (one) or more of the following symptoms:

4.3.1 A loss of sensation;

4.3.2 Dizziness;

4.3.3 Lameness of a limb;

4.3.4 Loss of speech, which only occurs for a few minutes to hours.

Recovery is quick and spontaneous and is therefore excluded from any Benefits.

NOTES
24-Hour Emergency
084 124

Hospital pre-authorisation
0861 11 00 33

Call Centre
0861 11 00 33

Email Address
info@affinityhealth.co.za

Fax Number
086 607 9419

Physical Address
1 Dingler Street,
Rynfield,
Benoni 1501

Postal Address
Posnet Suite 124,
Private Bag x101,
Farramere,
Benoni 1518

www.affinityhealth.co.za

This is not a medical scheme and the cover is not the same as that of a medical scheme. This policy is not a substitute for medical scheme membership.

Subject to Demarcation Regulations, the Insurer does not refuse membership on the basis of any means of discrimination.

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