



AFFINITY
HEALTH



WORKMEN'S COMPENSATION
BENEFIT GUIDE

INTRODUCTION

Workmen's Compensation is a government-run fund that pays for medical services related to injury and disease sustained or contracted within the workplace. Employers contribute to this national fund on a monthly basis and there is compensation available should a disability or death event occur while at work.

Affinity Health will cover a Member for medical expenses related to an injury on duty or occupational disease according to the Member's applicable benefits and Affinity Health Rates, Guidelines and Managed Care Protocols. Medical expenses may be paid in part or full according to available benefits, and Affinity Health will recover all or a portion of these costs from the Compensation Fund.

Some service providers will agree to claim directly from the Workmen's Compensation. Please make sure that the medical service provider is aware of the fact that the treatment is related to injury on duty or occupational disease if possible.



The list below defines some of the important **phrases** and corresponding **definitions and explanations** which will be referred to throughout this document.

Accident

An unforeseen, unfortunate, sudden, unusual, specific incident or event which could not reasonably have been expected to occur and was not planned or happened unintentionally at an identifiable time and place resulting in Bodily Injury due to violent, external and visible means during the period of the Policy, such as a motor vehicle accident.

Active/Active Cover

Means that the cover and benefits provided in terms of this policy are in force and available for claims, subject to the terms and conditions contained in the Policy Wording.

Affinity

Means the company named Affinity Health (Pty) Ltd.

Affinity Health/We/Us/Our

The Health Benefit Cover Product underwritten by National Risk Managers (Pty) Ltd, a registered Financial Services Provider (FSP Number 47132) under contract from the Assurer.

Affinity Health Rate

This is a rate Affinity Health pays for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant health services.

Annual Benefit Limit

The Annual Benefit Limit is the cap on the Member's benefits that Affinity will pay in a year. Annual Limits can be placed either on specific services as an annual amount for covered services or on the number of visits that will be covered for a particular service. After the Annual Benefit Limit is reached, all associated healthcare expenses will be for the Members account.

Assurer/The Assurer

Lion of Africa Life Assurance Company Limited, the registered Assurer with FSP Number 15283, as may be amended from time to time

Emergency Medical Condition

A sudden and at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment of bodily functions or serious dysfunction of a bodily organ or part thereof, or would place the person's life in serious jeopardy.

The Affinity Health Pre-authorisation team may ask Members for additional information to confirm the emergency.

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 limits of Benefits which Affinity will be bound to pay.

General Practitioner (GP)

A network General Practitioner who has contracted with Affinity Health to provide the Member with coordinated care for primary care, treats acute illnesses and provides preventive care, health education and defined chronic conditions.

Injury on duty or occupational disease (IOD/OD)

An unexpected occurrence, at a specific date, time and place and arising out of and in the course of the employee's employment, resulting in personal injury or death, or when an occupational disease is contracted due to exposure at the workplace.



Member

The Member or Policyholder as named on the policy schedule and their Dependants who have applied and been accepted by the Assurer and whose Premium is paid and up to date and thus includes each individual assured under this Policy.

Network Provider

The service providers contracted or who have an ongoing business relationship with Affinity Health. These providers offer preferential rates and are required to be used for most benefits. A Network Provider is also called a Designated Service Provider or DSP.

Policyholder

The Policyholder is the person who applied for the Assurance Cover under this Policy and is included in the definition of Member.

Pre-Authorisation

Means the act of contacting and obtaining authorisation from Affinity Health before utilising certain Benefits.

Waiting Period

Means the number of months from Commencement Date before the Members and Dependant(s) can access benefits. No claims will be payable during this period.





**UTILISING
THIS BENEFIT**





INFORM THE EMPLOYER AND AFFINITY HEALTH ABOUT THE INJURY ON DUTY

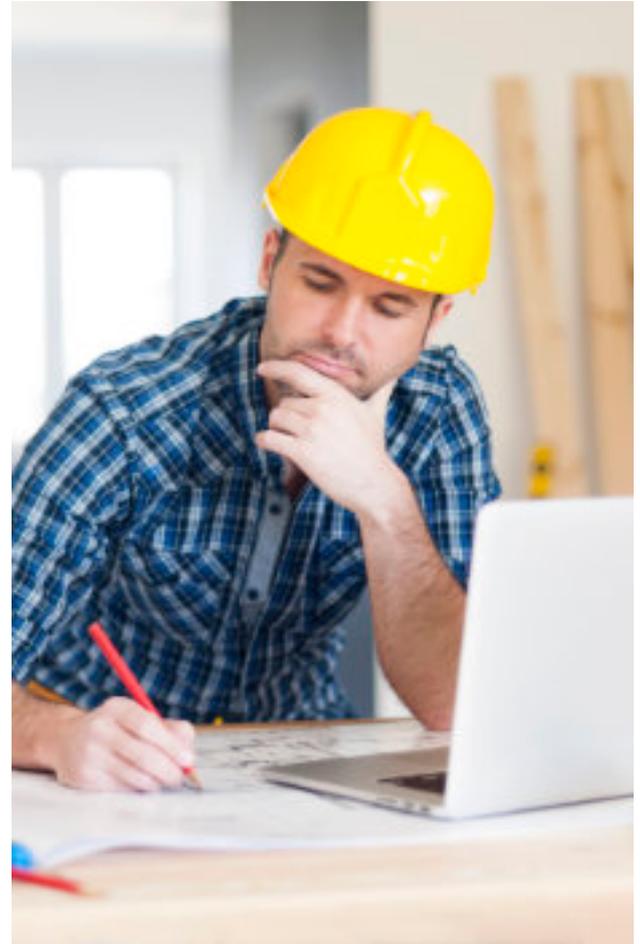
Members are required to report any injury sustained while on duty to their employer as soon as possible. The Employer will report such injuries including occupational diseases to the Compensation Commissioner within 7 days of being informed. The Relevant Employer Insurer (Compensation Commissioner/or insurers licensed thereby) may provide cover for the medical expenses related to the injury on duty.

Please remember to inform Affinity Health of the injury sustained or occupational disease contracted due to exposure while on duty. If a claim against the Compensation Fund is duly lodged, all supporting documents must be submitted, whether by Members or on Members behalf. Members must obtain Pre-Authorisation for injury on duty or occupational disease claims if possible. Obtaining Pre-Authorisation will ensure that Members get directed to a network provider that treats injury on duty cases, and that the Member's claim will be paid correctly.

The Pre-Authorisation Department can be contacted on

0861 11 00 33

and is open **24** hours a day **7** days a week.





BENEFITS WILL INCLUDE THE FOLLOWING

Day-to-Day cover for **GP consultations, basic radiology and pathology** as well as **acute medication** according to Affinity Health Formulary and rate, as part of the Day-to-Day benefit package (if applicable to the plan type selected).

Casualty benefit for assistance should emergency care be required, if casualty benefits are available on the plan type chosen.

Daily Illness benefit for the treatment of occupational disease, if hospitalisation cover is available on the plan type chosen.

Accident benefit for the treatment of an injury on duty, if hospitalisation cover is available on the plan type chosen.

* All benefits are subject to the policy being active (active cover), waiting periods, exclusions, annual limits, Affinity Rates as well as Affinity Guidelines and Managed Healthcare Protocols. Claiming from the Compensation Commissioner is not possible if Members are self employed (unless registered with the Compensation Commissioner).



The Process when claiming from the Compensation Commissioner

Once Affinity Health has been informed of the Injury of Duty, or once Affinity Health becomes aware of the injury sustained whilst on duty or occupational disease, Affinity Third Party Recovery Services will:

- Provide Members and their employer with advice and administrative assistance with regard to the claim against the Compensation Commissioner (or insurers licensed thereby).
- Keep all parties updated on the progress of the claim.
- Communicate with medical service providers pertaining to medical expenses related to the injury on duty or occupational disease on Members behalf.
- Recover all medical expenses from the injury on duty or occupational disease, which was claimed and paid for by Affinity Health from the Compensation Commissioner.
- Should the Compensation Commissioner approve the claim, all medical expenses will be paid for up to 2 years, from the date of the accident or the diagnosis of the disease.

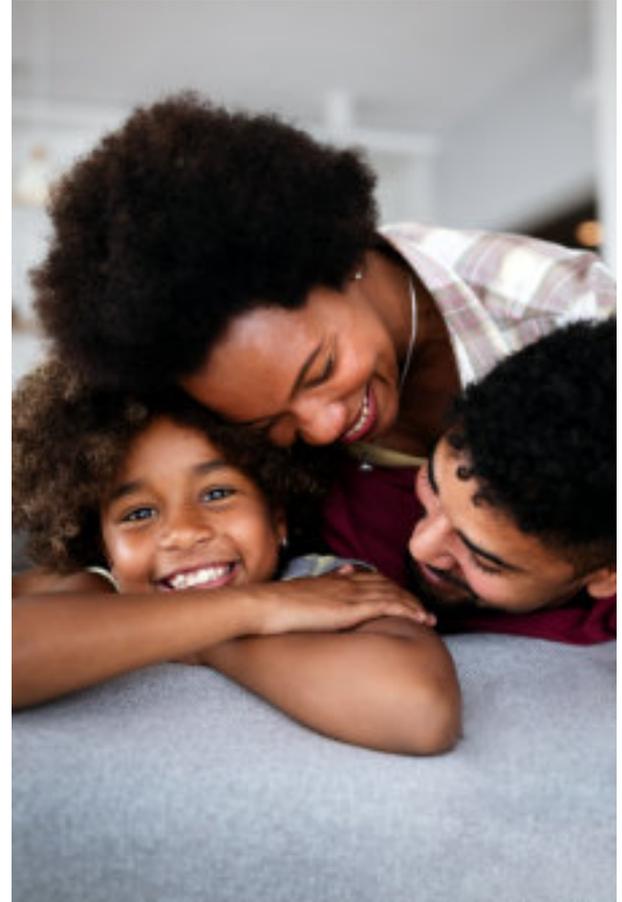
Claims will only be paid if they are submitted in the correct way and on time. Claims will not be paid if:

- The claim is made more than 12 months after the accident or death, or after the disease is diagnosed.
- Members (or their Dependant(s) claiming) are off work for three days or more.
- The accident resulted from your own wrongdoing (unless the Member or Dependant are seriously disabled or die in the accident, the fund will still pay compensation).
- Members or Dependants unreasonably refuse to have medical treatment.



Claims Process

1. The employer completes a WCL2 form (employer's report), of which part B is submitted to the treating service provider.
2. The treating service provider completes a WCL4 form (first medical report) and/or WCL5 form (progress/final report).
3. The service provider (Doctor, Hospital or other medical service provider) is required to attach a copy of each of the WCL2 and WCL4 and/or WCL5 forms together with each account submitted (it is recommended that the Member keeps copies of both the WCL2 and WCL4 as well as WCL5 forms, including any medical reports for future reference).
4. Submit all claims to claims@affinityhealth.co.za.
5. If Members have paid cash, please complete the refund form, and send the invoices and proof of payment to refunds@affinityhealth.co.za in order to process the reimbursement.
6. All requested documentation must be submitted within 120 days of the date of the claim event.
7. Affinity Health will submit these claims on the Member's behalf to the Compensation Commissioner.
8. Kindly remember that the Compensation Commissioner approves benefits subject to the Compensation for Occupational Injuries and Diseases Act rules.





**GET IN
TOUCH**



MEMBERS

Please call **0861 11 00 33** for customer care.



HEALTH PRACTITIONERS

Please call **0861 11 00 33** > **Option 5**.



Write to us at Postnet Suite
124, Private Bag X101,
Farrarmere, Benoni 1518.



Use the website www.affinityhealth.co.za or
the **customer care walk-in centre** at 1 Dingler
Street, Rynfield, Benoni.



FAX

086 607 9419



EMAIL

info@affinityhealth.co.za



COMPLAINTS PROCESS

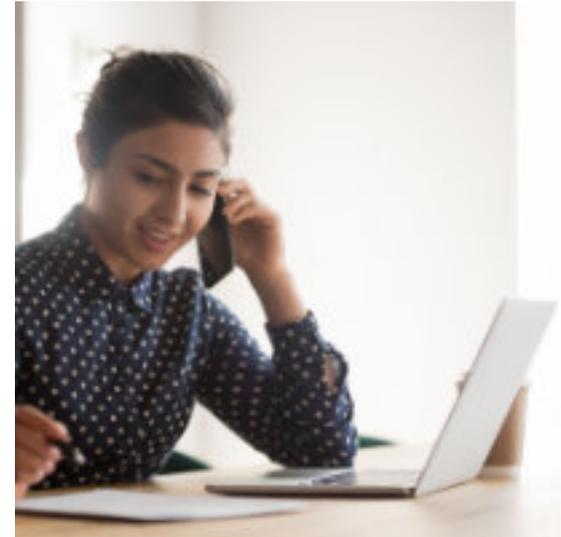
The Internal Complaints Resolution Policy is available on the Affinity Health Website.

www.affinityhealth.co.za



Affinity Health is committed to maintaining an internal complaints resolution system, ensuring procedures are based on the following:

- a** — **Maintenance of a comprehensive complaints policy that outlines the company's commitment to, and system and procedures for, internal resolution of complaints.**
- b** — **Transparency and visibility:** ensuring that Members have full knowledge of the procedures for resolution of their complaints.
- c** — **Accessibility of facilities:** ensuring that members have easy access to such procedures made available at any office or branch of the provider, as well as through electronic means such as email or via the Affinity Health website.
- d** — **Fairness:** ensuring that a resolution of a complaint falls in line with the resolution process which is fair to both the Member and the Company.
- e** — **Compliments and Suggestions:** Affinity Health is committed to ensuring that the products and services provided meet the Member's fullest expectations, Affinity Health values Members' honest feedback. Should a Member wish to compliment Affinity, or they have any suggestions on how the products or service delivery can be improved, the Affinity Team would love to hear from you. Kindly forward compliments or suggestions to email: compliments@affinityhealth.co.za.



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How to submit a complaint?

Affinity is committed to investigating and resolving all complaints in a fair, honest and professional manner. If the Member is not satisfied with the service received, he or she can lodge a formal complaint with Affinity Health's Complaints Department at:

Complaints Department

Physical Address

1 Dingler Street, Rynfield, Benoni, 1501

Postal Address

Postnet Suite 124, Private Bag X101, Farrarmere, Benoni, 1516

Telephone

086 110 6040

Email

complaints@affinityhealth.co.za

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Feedback from the Complaints Department

Treating customers fairly and keeping them informed is a crucial aspect of Affinity's customer relationship management. During the course of the complaint investigation and resolution process, the Member can expect the following:

1. Affinity will acknowledge the Member's complaint in writing within 48 hours of receipt.
2. The Member will be notified of the name and contact details of the person that will oversee the complaint resolution process.
3. The Member will be informed of the expected timeframe required for an investigation to be conducted.
4. Affinity will provide the Member with regular updates on the progress of their complaint.

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5. When a decision has been reached, the Member will be provided with the outcome of such decision in writing with reasons for the decision reached.
6. Affinity aims to resolve complaints as soon as possible, but within a maximum of 21 working days.
7. Where a complaint is resolved in the Member's favour, Affinity will ensure that full and appropriate corrective action is taken without delay.

Appeal of rejected claims:

1. Affinity Health will acknowledge receipt of the appeal in writing within 48 hours of receipt from the Assurer.
2. If the Member's claim was rejected by Affinity Health, policyholders have 90 days from the receipt of the rejection letter to make representation.
3. Subject to the above, Affinity Health will make a final decision and will notify the Member in writing within 45 days after receipt of the rejection appeal.

Further steps

If a Member is unhappy with the outcome of their complaint or Affinity's complaint resolution process, please direct the complaint, in writing, to the Assurer at:

LION OF AFRICA LIFE ASSURANCE COMPANY LTD

Physical Address

Office 16/02, 16th Floor the Golden Acre, Adderley Street, Cape Town CBD, 8001

Telephone

021 461 8233

Email

info@lionlife.co.za

External complaint resolution measures

If the Member is not satisfied with the outcome of the internal complaint resolution processes, or the resolutions have not been in the Member's favour, they can have the decision reviewed by an authorised external party. These include the following:

THE COUNCIL FOR MEDICAL SCHEMES

Complaints Unit

Physical Address

Block A, Eco Glades 1 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157

Telephone

0861 123 267

Email

complaints@medicalschemes.co.za

Website

www.medicalschemes.co.za

Affinity Health is regulated by the Council for Medical Schemes.

Members can approach the Council for Medical Schemes for rejected claims or during any stage of the complaints process. Affinity, however, encourages the Member to follow the above steps to resolve the complaints first, before contacting the Council.

THE FAIS OMBUDSMAN

Telephone

012 762 5000

Fax

012 348 3447

Fax

info@faisombud.co.za

Website

www.faisombud.co.za

The FAIS Ombud deals with the complaints against the conduct, service or advice provided by a financial services provider. If you are unhappy with the quality of information or explanation provided to you, then this is the correct ombudsman to approach.

