AFFINITY HEALTH

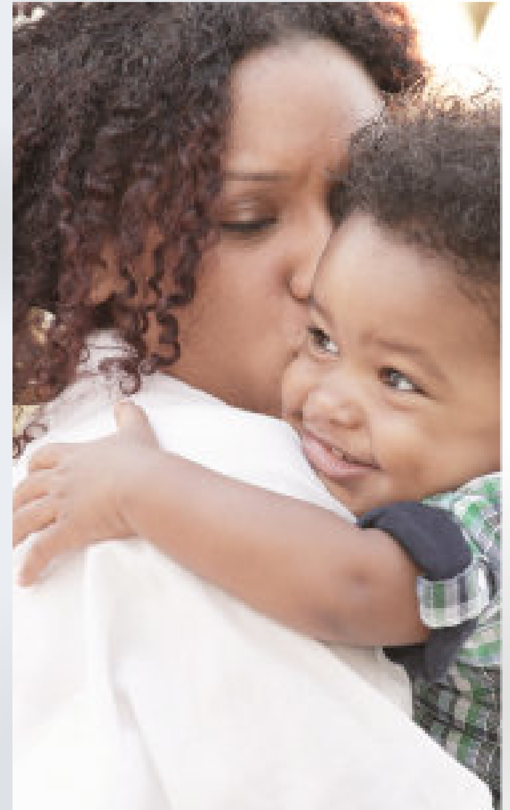
HOSPITALISATION
BENEFIT GUIDE

2021

INTRODUCTION

Affinity Health Members are covered for those events that result in hospitalisation as per the terms and conditions outlined in this document.

Affinity Health pays for the hospital illness benefit Per Diem, subject to Annual Hospital Benefit Limits and Pre-authorisation. This document details cover offered by Affinity Health to Members in the event of an admission to a treating facility for illness and injuries. Please refer to the Benefit Section below for information specific to the selected health plan.



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.

Affinity

Means the company named Affinity Health (Pty) Ltd.

Affinity Health/We/Us/Our

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

Annual Benefit Limit

The cap on the Member's benefits that Affinity will pay in a calendar 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. The number of Dependants on the Policy will determine the amount as well as the type of benefit. After the Annual Benefit Limit is reached, all additional associated healthcare expenses will be for the Members account.

The Assurer

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

Casualty/Emergency Room

Means the Casualty or Emergency Department of a Hospital (that is part of the Hospital or a seperate practice) providing immediate treatment for emergency cases.

Commence/Commencement Date

The date on which the Policy comes into force and effect for the first time as specified in the Policy Schedule. Prior to Commencement, the Policy and contractual relationship between Affinity/The Assurer and the Policyholder does not exist.

Co-payment

Co-payment is an amount that the Member needs to pay towards a healthcare service. The amount can vary by the type of diagnostic procedure, not making use of a network service provider or services that are not part of the formularies or if the amount the service provider charges more than what Affinity Health will cover. If the co-payment amount is higher than the amount charged for the healthcare service, Members will have to pay for the cost of the healthcare service.

Day Clinic

A facility that offers surgical procedures that do not require an overnight stay; and that is part of the Network Service Providers contracted with Affinity Health.

Designated Service Provider (DSP)

A Designated Service Provider is a service provider that is contracted to Affinity Health. DSPs offer preferential rates and are required to be used for most benefits and are Affinity's first choice when its Members need diagnosis, treatment or care. For certain benefits, State Hospitals are Designated Service Providers. Visit www.affinityhealth.co.za to view the full list of DSPs.

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.

An emergency does not necessarily require a hospital admission.

Family

For the purpose of this policy, family includes the main Member's spouse, adult dependants and child dependants added to the Policy.

Spouse means the named spouse of a policyholder, including any life partner.

Child Dependant means the named child of a Policyholder under the age of 21 (twenty-one) years, including:

- a natural child;
- a step child;
- a legally adopted child, including a child adopted in terms of a customary adoption under a tradition practiced by the people of South Africa, provided that the child's natural parents are both deceased;
- an adoption under the tenets of any religion practiced by the people of South Africa provided that the child's natural parents are both deceased; or
- a child of a Child Dependant and/or Adult Dependant.

Adult Dependant means a person other than a Spouse of the Policyholder who is wholly dependant on the Policyholder for financial support including:

- a Child of the Policyholder over the age of 21 (twenty-one) years;
- an immediate family Member (sibling or parent) over the age of 21 (twenty-one) years; or
- the second or any additional Spouse of a Member under a customary union recognised as a marriage under the tenets of any religion

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.

Guarantor

The Guarantor is a person who assumes financial responsibility for another, i.e. the person who promises to be financially responsible for any additional payments, shortfalls and/or co-payments for the Members on this Policy.

Illness

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.

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.

Non-emergency

Non-emergency conditions mean conditions that do not meet Affinity Health's Emergency Definition but that do require medical care within 4 to 24 hours based on international emergency triage protocols.

Out-of-Network Provider

Providers not on the Affinity Health Network or have no business relationship with Affinity Health. Costs incurred for most out-of-network providers are not reimbursed unless specifically Pre-authorised per event.

Per diem

Means the amount paid per day for certain benefits of the specific policy selected, where applicable.

Planned Surgery

Surgery that needs to be done in order to retain quality of life and can be planned in advance but does not need to be performed immediately because of a medical emergency condition.

Pre-Authorisation

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

Policyholder

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

Serious Illness

Specified health conditions that have a large cost and if not treated immediately carry a high risk of mortality and may either negatively impact a person's daily function or quality of life. (Heart Attack,3rd Degree Heart Block, Stroke, Cancer)

Shortfall

The shortfall is the difference between the benefit amount available that will be paid by Affinity and the amount that is charged by the Service Provider. The Member is responsible for the payment of the shortfall.

Sub-acute Facility

Means a Facility where comprehensive care is given to a patient who has had an Acute Illness, injury or exacerbation of a disease; either immediately after or instead of acute care hospitalisation to treat specific medical conditions or to administer any necessary medical treatments.

Waiting Period

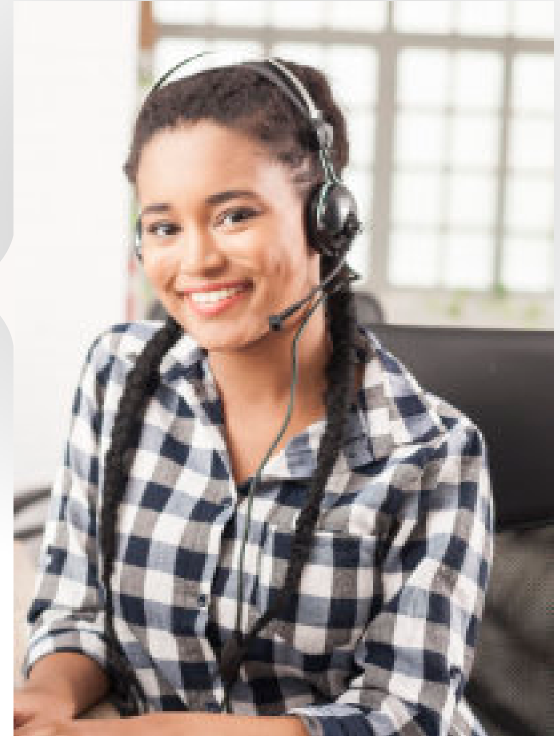
Means the number of months from Commencement Date before the Members and Dependant(s) can access benefits. No claims will be payable during this period.

UTILISING THIS BENEFIT

A hospital is a medical treating facility that holds a licence as a Private or Public Hospital, Day Clinic, or Sub-Acute Facility that operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients.

The Member or someone acting on behalf of the Member, will be required to **obtain Pre-authorisation** prior to receiving treatment in Hospital.

Obtaining Pre-authorisation will ensure that the Member's claim will be processed correctly. A Member's failure to obtain Pre-authorisation for a hospital admission may result in the full bill being charged to the Policyholder/Member/ Guarantor's account.



The Pre-authorisation Department can be contacted on

0861 11 00 33

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

Hospital admission is subject to obtaining Pre-authorisation, and the treatment meeting the Clinical Guidelines, and Managed Healthcare Protocols. The Affinity Health Pre-authorisation team may require additional information from Members to confirm the planned treatment and to ensure the illness or accident criteria are met.

A Member will be covered for hospital admission up to the annual maximum limit according to the Member's policy type, see the Benefits section below for more detail.

Should the treatment amount to more than the maximum benefit available, the Member will be liable for the shortfalls.

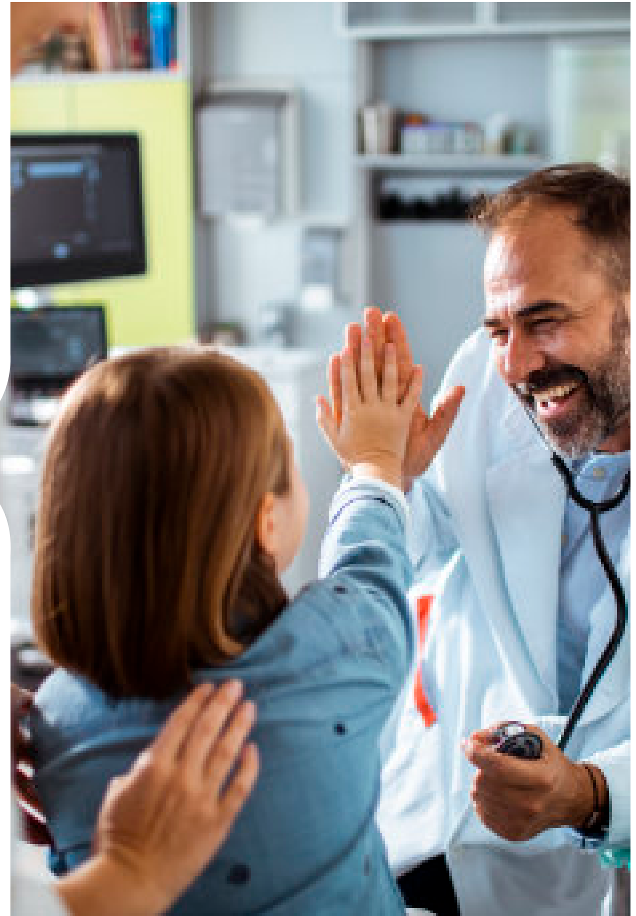
NETWORK HOSPITALS

A Member may make use of any hospital, but the Member is required to contact Affinity Health to **obtain Pre-authorisation** for benefits to be confirmed with the treating facility.

Affinity Health has a **defined network of treatment facilities** with preferential payment structures. The Member is encouraged and may be recommended to make use of this network to **save costs, and obtain the best service** as well as preserve the balance of the annual benefit for possible future visits.

For more information on the network hospitals for specific policy types, visit **www.affinityhealth.co.za** and search under the **"Find a healthcare provider"** tab for the list of Hospitals in the Network.

HOSPITAL ILLNESS BENEFIT SECTION



This benefit accumulates a daily amount according to the amount of days a Member spends in hospital for an illness, with a total of up to R125,000 over a 21 day period being the Annual Hospital Illness Limit.

This benefit is available for any planned procedures or illnesses other than emergencies and childbirth, which are covered under the Maternity and Emergency benefits.

For planned admissions, the Member is required to **contact Affinity Health at least 48 hours prior to the procedure/admission** to ensure authorisation is provided timeously so that the appropriate treatment facility can be arranged for the Member.

In-hospital admissions are subject to:

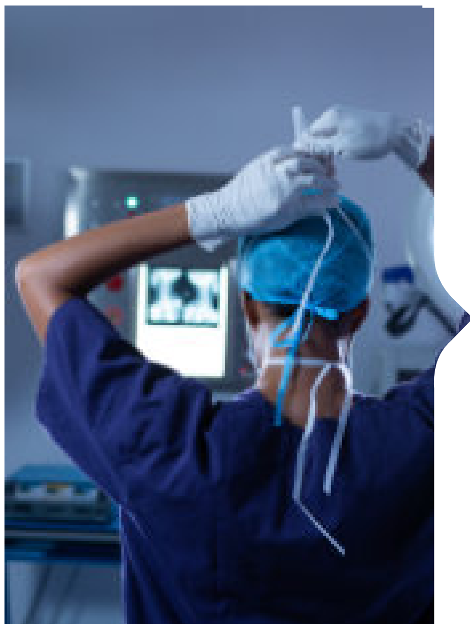
- A 3 Month Waiting Period upon taking out a policy (12 months for pre-existing conditions);
- the obtaining of Pre-authorisation and;
- the treatment meeting the clinical guidelines and managed care protocols.

See a full list of all policy exclusions on the latest policy document:

The daily limits for this benefit are as follows:

PLANS SOLD **FROM** 2019						PLANS SOLD **BEFORE** 2019 (Unless upgraded separately)					
DAY 1	**DAY 2**	**DAY 3**	**DAY 4**	**DAY 5**	**DAY 6 - 21**	**DAY 1**	**DAY 2**	**DAY 3**	**DAY 4**	**DAY 5**	**DAY 6 - 21**
R20,000	R20,000	R20,000	R8,500	R8,500	R3,000 per day up to Day 21	R10,000	R10,000	R10,000	R4,250	R4,250	R1,500 per day up to Day 21
R24,000*	**R24,000***	**R24,000***	**R12,500***	**R12,500***		**R12,500***	**R12,500***	**R12,500***	**R12,500***	**R12,500***	

*** Total cover applicable when admitted into ICU and combined with the ICU Booster.**



The ICU Booster is an optional benefit which accompanies the Daily Illness Hospitalisation Benefit and provides the Assured Person with additional cover for days spent in ICU, up to a maximum of 5 (five) days per event.

SURGICAL INTERVENTIONS

If a Member requires a surgical procedure for the treatment of an illness, coverage may be accessed from the Daily Illness Benefit, in a network Day Clinic or hospital subject to Pre-authorisation. Approval will be provided if the event meets the Affinity Health Clinical Guidelines and Managed Healthcare Protocols.

Any planned procedures that are authorised in the first 12 months of the Membership, will carry a 20% Co-Payment. Pre-existing conditions will be excluded for the first 12 months.

Admission of a Member to a Day Clinic

Affinity Health Members may access treatment in a Day Clinic up to a maximum of R25,000 per Member per year. Dental Treatment as the result of an illness is limited to R10,000 per Member per year. Admissions into Day Clinics are subject to Pre-authorisation to an Affinity Health DSPs only. Affinity Health covers the following admissions into a Day Clinic:

Achilles tendon release	Cervical cerclage	Turbinectomy
Haemorrhoidectomy	Tooth extractions	Endometrial ablation
Adenoidectomy	Cyst and soft tumour removal	Tympanoplasty
Inguinal hernia repair	Apicectomy	Ganglionectomy
Anal dilatation	Release of trigger finger	Umbilical hernia repair
Antrostomy	Cervical Lletz	Temporo-mandibular surgery
Laparoscopy and removal of cyst	Removal of pterygium	Frenectomy
Arthroscopy	Corneal surgery	**Accident Related Day Procedures**
Myringotomy	Renal calculus removal and stent insertion	• Closed reduction of fracture
Peripheral nerve neuroplasty	Cystoscopy and ureteral dilation	• Insertion or removal of K wires or other
Carpal tunnel release	Sinus surgery	internal fixatives
Posterior and anterior vitrectomy	Drainage of abscesses/haematoma	• Reduction of nose fracture
Cataract surgery	Tonsillectomy	• Removal of pins and plates
Probing and repair of tear ducts	Drainage of Bartholin cyst	

Admission of a Member into a Sub-Acute Facility

The Member also has access to the Affinity Health Network of Sub-Acute Facilities. Sub-Acute care is a comprehensive and cost-effective in-patient programme for Members that have suffered an acute event as a result of an illness, injury or disease; have a determined course of treatment; and do not require intensive diagnostic and/or invasive procedures. Sub-Acute benefits are limited to **R20,000** per Member per year.

Sub-Acute (Step Down) Facility care includes, but is not limited to the following services:

1. IV antibiotic therapy.
2. Post-surgical care.
3. Recovery from a cardiac incident such as a heart attack, orthopaedic care and pulmonary care.
4. Advanced wound care.
5. Pulmonary and respiratory care (including ventilator and tracheostomy care).
6. Rehabilitation and mobilising care after general, brain or spinal cord injury, stroke or trauma.
7. Any other care as Pre-authorised by Affinity Health deemed medically necessary.

Affinity Health covers Hospital Admissions according to the hospital illness benefit Per Diem.

The Member will be able to access any of the Affinity Health Network of Hospitals.

The specific benefits per policy type are outlined below. Visit www.affinityhealth.co.za to view the list of the Network Hospitals. Members will be liable for costs incurred that are more than the benefits available per policy type.

Members have an annual limit of two admissions for illness related events per year, up to the maximum amounts detailed on this page.

This benefit includes admissions of a Member into an Acute facility, Sub-Acute facility or Day Clinic.

Admissions defined as the same or similar or defined as continuation of treatment within a 6 month period will be considered the same event and therefore will be limited to the maximum expenditure for one event.

A Maximum Benefit payable is up to **R125,000** per event.

If a Member 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. Only 2 (two) Admission claims per Member per year will be payable.

Members may be required to make use of Day Clinics, as part of the treatment process. A Member must also make use of an affiliated day clinic. Treatment at a Day Clinic will be considered an Admission claim under the Daily Illness Hospitalisation Benefit.

A Member will also be required to make use of an affiliated Sub-Acute facility. Pre-authorisation is required and treatment at a Sub-Acute facility will be considered an admission under the Daily Illness Hospitalisation Benefit.

Serious Illness Hospital Benefit

Should a member be admitted for any of the Serious Illnesses, authorised under the Hospital Illness Benefit, the member will receive additional benefits based on the diagnosis and treatment required as per the tables in Schedule 4 of this Policy document.

Heart Attack, **Third Degree Heart Block**, **Stroke**, and **Cancer** will be covered under the Serious Illness Hospital Benefit.

Heart Attack

The Heart Attack must be confirmed, and the evidence needs to be submitted to qualify for this Benefit. The following evidence is required:

- A letter from the treating doctor to confirm the diagnosis and symptoms of a typical chest pain or other symptoms typically associated with a heart attack.
- Electrocardiographic (ECG) changes indicative of a heart attack.
- Elevation of the cardiac enzyme (CPK-MB) and Trop T blood test results above the generally accepted laboratory levels of normal.

Third Degree Heart Block

The Heart Block must be confirmed and the evidence needs to be submitted to qualify for this benefit. The following evidence is required:

- A letter from the treating doctor to confirm the diagnosis and symptoms of a third degree heart block.
- Electrocardiographic (ECG) changes indicative of a third degree heart block.

Stroke

The Stroke must be confirmed with changes seen in a CT scan or MRI and certified by a Physician or Neurologist and the evidence needs to be submitted to qualify for this benefit.

Cancer

The Cancer must be confirmed by histology and the evidence of malignancy needs to be submitted to qualify for this benefit.

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

The maximum Serious Illness Benefit available, will be R150,000 in the lifetime of the Policy.

Heart Attack & Heart Block

Confirmed Heart Attack or a 3rd Degree Heart Block, according to Clinical Guidelines and Protocols. (Excluding angina or unstable angina).	R37 500
Heart Attack or a 3rd Degree Heart Block requiring Thrombolytic Drug Treatment or Temporary Pacemaker.	R75 000
Heart Attack or a 3rd Degree Heart Block requiring an Angioplasty with stent placement or Permanent Pacemaker.	R112 500
Heart Attack requiring Bypass Surgery.	R150 000

Stroke

Confirmed Ischemic or Hemorrhagic Stroke, according to clinical guidelines and protocols. (Excluding Transient Ischemic Attack (TIA)).	R37 500
Stroke requiring Thrombolytic Drug Treatment.	R75 000
Stroke requiring an Endovascular Stenting or Endarterectomy or Thrombolysis or Thrombectomy.	R112 500
Stroke requiring a Craniotomy.	R150 000

Cancer:

Cancer that requires surgical removal of a tumor or growth.	R37 500
Cancer that requires major surgery to remove a tumor or growth (abdomen, chest or skull) OR Brachytherapy OR Chemotherapy.	R75 000
Cancer that requires surgical removal AND chemotherapy.	R112 500
Cancer that requires surgical removal AND chemotherapy and/or Radiation Therapy.	R150 000

ACCIDENT BENEFIT SECTION

LOCATE AN ASSOCIATED FACILITY IN YOUR AREA

For admissions related to accidents, Members have access of up to R 175,000 per single Member per event and up to R 275,000 per family per event.

Accident Benefits carry no waiting periods and are available from commencement date of the policy.

Members are required to contact Affinity Health to **obtain Pre-authorisation** and make use of an Affinity Health Network Provider. Accident events are covered within maximum expenditure and up to the treatment costs, whichever is the lesser.

Accident events exclude injuries as the result of micro-traumas and pathological fractures. Dental treatment required as the result of an accident is limited to **R20,000** per year, and treatment in a casualty room for accidents is limited to **R10,000** per event on the applicable plan types. For specific limits refer to the Benefits Table below.

USE A NETWORK PROVIDER

A Member is encouraged to make use of a Network Hospital, for planned procedures to **avoid a 20% Co-Payment or deductible**, or to avoid being liable for part of all of the account.

For more information on the network hospitals for specific policy types, visit www.affinityhealth.co.za and search under the Find a healthcare provider tab.

Obtaining Pre-authorisation will ensure that Members are directed to a network provider 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.

For **cover limitations**, please visit www.affinityhealth.co.za to view the list of general exclusions.

Benefits available by policy type

Combined //
Standard / Junior / Senior Plans

Hospital //
Standard / Junior / Senior Plans

- There is no Illness or Accident Hospitalisation cover on the **Day-to-Day Plan**
- 3 month general waiting period. 12 month waiting period for pre-existing conditions.

Hospital / Combined Plan > **Standard and Junior**

ILLNESS COVER

Up to **R125,000** per illness event, for related admissions within 6 months, up to 21 days based on per diem amounts per per day. The Benefit amount payable will recommence from the last day of the previous admission. This includes:

Up to **R20,000** per member per year for admissions into a Sub-Acute Facility.

Up to **R25,000** per member per year for Day Procedures at a DSP according to formulary and subject to co-payment.

Limited to 2 illness events per Member per year.

Should a member be admitted for any of the Serious Illnesses authorised under the Hospital Illness Benefit, the Member will receive additional benefits based on the diagnosis and treatment required.

For policies sold before September 2019, only up to **R70,000** is available per event.

ACCIDENT COVER

Up to **R175,000** per single Member per accident event including related admissions within 6 months.

Up to **R275,000** per family policy, per accident event including related admissions within 6 months.

Dental Treatment as the result of an accident is limited to **R20,000** per policy per year.

Treatment in a Casualty Room, as the result of an accident, is limited to **R10,000** per year.

Hospitalisation due to an accident between the application date and the commencement date is subject to one admission per policy up to **R100,000** per single Member policy and **R150,000** per Family policy. This is available for the first two months following the date of application.

DIAGNOSTIC COVER

Diagnostic Procedures from the Affinity Health Diagnostic Formulary up to **R20,000** for single members and up to **R25,000** per family per year or as per the accumulation of benefits in the first year.

Subject to Pre-authorisation after a 12-month waiting period for pre-existing conditions. Applicable co-payments and maximum annual policy limits apply in conjunction with Affinity Health Guidelines and Managed Healthcare Protocols.

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

ILLNESS COVER

Up to **R125,000** per illness event, for related admissions within 6 months, up to 21 days based on per diem amounts per day. The Benefit amount payable will recommence from the last day of the previous admission. This includes:

Up to **R20,000** per Member per year for admissions into a Sub-Acute Facility.

Up to **R25,000** per Member per year for Day Procedures at a DSP according to formulary and subject to co-payment.

Limited to 2 illness events per Member per year.

For policies sold before September 2019, only up to **R62,500** is available per event.

ACCIDENT COVER

Up to **R110,000** per single Member per accident event including related admissions within 6 months.

Up to **R150,000** per family policy, per accident event including related admissions within 6 months.

Dental Treatment as the result of an accident is limited to **R20,000** per policy per year.

Treatment in a Casualty Room, as the result of an accident, is limited to **R10,000** per year.

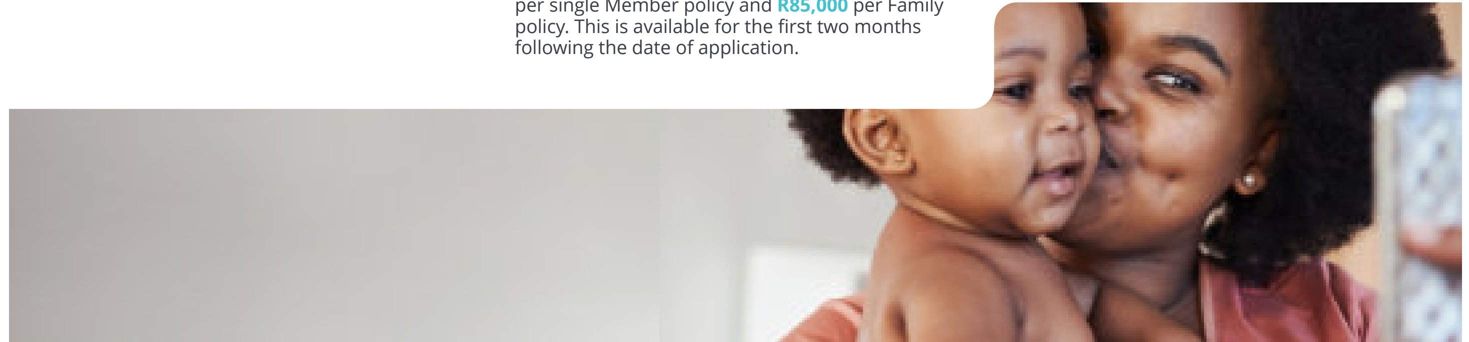
Hospitalisation due to an accident between the application date and the commencement date is subject to one admission per policy up to **R70,000** per single Member policy and **R85,000** per Family policy. This is available for the first two months following the date of application.

DIAGNOSTIC COVER

Diagnostic Procedures from the Affinity Health Diagnostic Formulary up to **R20,000** for single members and up to **R25,000** per family per year or as per the accumulation of benefits in the first year.

Subject to Pre-authorisation after a 12-month waiting period for pre-existing conditions. Applicable co-payments and maximum annual policy limits apply in conjunction with Affinity Health Guidelines and Managed Healthcare Protocols.

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



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 availalbe at any office or branch of the provider, as well as though 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 to hear from you. Kindly forward compliments or suggestions to email: compliments@affinityhealth.co.za.

f 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

g 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.
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.

h 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.