LIBERTY
In it with you

Liberty Health Cover Membership guide 2022

Welcome to Liberty Health Cover.

We are passionate about providing access to reliable, comprehensive, quality healthcare. By joining us you and your family:

Enjoy **comprehensive benefits** that ensure access to quality healthcare when you need it

Receive **treatment on credit** (without having to pay cash upfront), with 96% of claims paid directly to our network of contracted healthcare providers

Have peace of mind with dedicated in-country **customer care support** and access to **24-hour assistance** for medical emergencies

Have access to secure and **proactive online health tools** and **self-service facilities**, 24 hours a day

Contents.

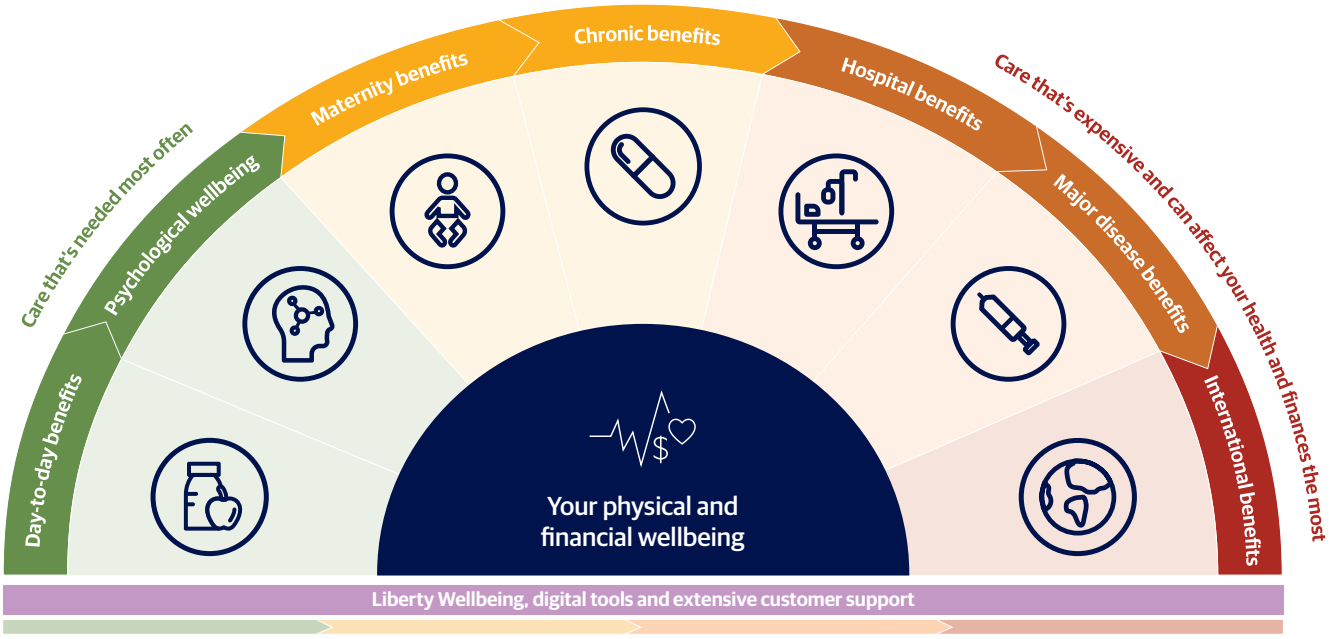
Access the care you need.

With access to comprehensive benefits you can have peace of mind about both your physical and financial wellbeing.

You have benefits for all these categories of cover:

To view the benefits for a specific category, click on the relevant icon.

To navigate back to this page, click the at the bottom of this page, or the to get back to the contents page.



Benefits are paid up to the relevant benefit limit shown in your Liberty Health Cover Benefit Table.

To view information on the benefits for your plan or to find a list of Network providers in your area, please:

- register or log in to your online profile on our website (www.libertyhealth.net) or via the Liberty Health App (see page 21 for details on how to register),
- contact your Human Resources (HR) department, or
- call your local Liberty Health Cover office – see the last page of this brochure for their details.

Using a Network versus a non-Network provider.

- If you use a Network provider, Liberty Health will pay the healthcare provider directly.
- If you use a provider outside the Network, you may have to pay for treatment upfront. If your benefit plan covers treatment from non-Network providers, you can submit a claim for a refund. (See page 16 for instructions on how to submit a claim.)

Day-to-day benefits.

Take care of your everyday medical needs such as GP consultations, medication, dental and optical care.

What we cover.

Consultations and procedures.

Consultations.

- General practitioner (GP) consultations
- Specialist consultations
- Annual medical examinations

Minor procedures.

- Pathology, for example blood tests requested by a doctor
- Basic radiology, for example out-of-hospital basic X-rays
- Out-of-hospital non-surgical procedures, such as applying plaster of Paris or stitching an injury

Prescribed acute medicines.

These are medicines that you require for a medical condition and that can legally only be prescribed by a doctor.

How we make your day-to-day benefits go further.

We provide cover for **psychological treatment, maternity and chronic conditions as separate benefits** for a reason – so you have more cover freed up for other day-to-day care.

By separating out these benefits from your day-to-day cover, it means that if, for example, you have a chronic condition that requires ongoing treatment, it won't reduce your day-to-day limits for other healthcare treatment you may need, like going to the dentist or having your eyes tested.

Vaccinations.

We cover several vaccinations for both children and adults that have been clinically proven to work, are cost-effective, and are recommended by local and international health guidelines.

Vaccinations for children.

For children up to and including age 6:

- Tetanus
- Hepatitis A and B
- Diphtheria
- Haemophilus influenza type B
- Tuberculosis (BCG)
- Measles
- Mumps
- German measles (Rubella)
- Polio
- Pneumococcal infections
- Typhoid
- Meningitis
- Rotavirus

We also cover the cost of **Vitamin A supplements** from the same benefit, as Vitamin A is known to reduce complications related to measles and diarrhoea.

Other vaccinations.

For members age 7 and older:

- Influenza
- Hepatitis B
- Meningitis
- Tetanus
- Pneumococcal infections
- Typhoid
- HPV (subject to pre-authorisation and clinical criteria)

Additional vaccinations covered for all ages.

- Yellow fever
- Rabies*
- Whooping cough (Pertussis)

* In an emergency you can have the first dose dispensed, then call us to inform us of the claim.

Dental benefits.

Basic dentistry.

- Dental consultations
- Basic dental procedures, such as:
  - Removal of teeth and roots
  - Fillings
  - Preventative treatment
  - Scaling and polishing
  - X-rays

Specialised dentistry.

- Root canal treatment
- Dentures
- Inlays
- Crowns
- Bridges
- Periodontal treatment
- Orthodontic treatment (under the age of 21 years old) and dental surgery
- Maxillofacial and oral surgery and removal of impacted wisdom teeth

Pre-authorisation required

How your in-hospital dental benefits are paid.

The costs for in-hospital dental treatment such as ward and theatre fees will be paid from the hospital benefit, subject to pre-authorisation.

Auxiliary services.

- Physiotherapy
- Biokinetic and chiropractic services
- Occupational therapy
- Speech therapy/audiology
- Hearing aid acoustician
- Podiatry
- Dietician services
- Orthotist and prosthetist services

Optical benefits.

- Eye examinations
- Frames and spectacle lenses, including contact lenses

Psychological wellbeing benefits.

Pre-authorisation required

Get the necessary treatment to manage your mental health and to live life optimally.

What we cover.

Please note: Some of these services require that you get pre-authorisation from us.

- Consultations with psychologists, psychiatrists and social workers
- Prescribed medication
- Hospitalisation

Maternity benefits.

Access all the care you and your baby need during and after your pregnancy.

What we cover.

Our maternity benefits include end-to-end day-to-day and hospital care for mothers and their babies, including benefits for high-risk pregnancies.

During pregnancy.

Out-of-hospital maternity care.

- Consultations
- Ultrasound scans
- Pathology tests:
  - IVDRL
  - Rhesus blood group
  - Haemoglobin
  - HIV test
- Dipstick protein and glucose
- Down syndrome screening
- 1st and 2nd trimester serum biochemical markers
- Chorionic villus sampling
- Amniocentesis (subject to pre-authorisation)

Out-of-hospital maternity care for high-risk pregnancies.

A high-risk pregnancy is one that **threatens the health or life** of the mother or unborn baby.

Your doctor will let us know if you have a high-risk pregnancy. We will then appoint a case manager who will help you to access additional benefits based on your doctor's recommendations. These can include additional consultations and ultrasound scans.

Childbirth and neonatal care.

In-hospital maternity care.

- Confinement (if you need to be separated from other patients)
- Childbirth (natural delivery)
- Midwives
- Cover of 15 days from the birth of the newborn baby under the mother's policy, subject to maternity hospital limits

Cover for a caesarean section.

Please note that we **do not cover** childbirth by caesarean section **unless:**

- it is deemed clinically necessary, and
- pre-authorisation has been obtained from us.

Neonatal care.

- Neonatal ward (incubator)
- Phototherapy
- Congenital abnormalities
- Prematurity

This benefit will apply from birth until the baby is discharged.

Postnatal depression.

- Medication
- Consultations
- Pathology

Maternity benefits for members in Nigeria.

How to access your benefits.

If you are a member in Nigeria, please contact our in-country office to register on the Maternity Programme to access your maternity benefits.

Members in Nigeria can also access:

- **Infertility treatment**
  (On specified benefit plans only)
  Covers the costs of consultations and diagnostic tests related to infertility, including radiology, semen tests, hormonal profile, chlamydia, VDRL, and histology
- **Maternity care outside the region of cover/Nigeria provider network**
  (On specified benefit plans only and subject to certain limits and payment upfront, for which you can submit a claim for reimbursement)
  Includes out-of-hospital and in-hospital maternity care, including for high-risk pregnancies

Chronic conditions benefits.

Pre-authorisation required

Get the necessary care to manage over 100 chronic conditions, such as diabetes, hypertension, HIV and asthma.

What we cover.

Please note: Some of these services require that you get pre-authorisation from us.

GP and specialist consultations	Prescribed medication (see below)	Pathology	Radiology

Chronic Medicine Benefits Programme.

This programme helps you access the appropriate treatment for your condition, based on international clinical protocols and guidelines.

You qualify for the Chronic Medicine Benefits Programme if you have a chronic condition that:

- requires medication and treatment for more than three continuous months,
- is included in the chronic disease list on the next page, and
- is included in the clinical funding protocols.

- See page 8 for the full list of chronic conditions we cover.
- See page 15 for more detail on how to register for the benefit and get pre-authorisation.

Chronic disease list

- Acne
- Addison's disease
- Allergic rhinitis
- Alzheimer's disease
- Anaemia
- Ankylosing spondylitis
- Anorexia nervosa
- Arrythmias and conduction disorders
- Asthma
- Attention deficit hyperactivity disorder (ADHD)
- Barrett's oesophagitis
- Benign prostatic hypertrophy
- Bipolar mood disorder
- Bronchiectasis
- Bulimia nervosa
- Cardiac failure
- Cardiomyopathy
- Chronic obstructive pulmonary disorder (COPD)
- Chronic renal disease
- Connective and soft tissue disorders
- Conn's syndrome
- Cor pulmonale
- Coronary artery disease/Ischemic heart disease
- Crohn's disease
- Cushing's disease
- Cystic fibrosis
- Deep vein thrombosis
- Dementia
- Depression
- Dermatitis/eczema
- Dermatomyositis
- Diabetes insipidus
- Diabetes mellitus type 1
- Diabetes mellitus type 2
- Diverticular disease
- Dysrhythmias
- Dystonia
- Endometriosis
- Enuresis
- Epilepsy
- Generalised anxiety disorder (GAD)
- Glaucoma
- Gastro-oesophageal reflux disorder (GORD)
- Gout
- Guillain-Barré syndrome
- Haemophilia
- Hepatitis
- HIV/AIDS
- Huntington's disease
- Hyperlipidaemia
- Hyperparathyroidism
- Hypertension
- Hyperthyroidism
- Hypopituitarism
- Malabsorption syndrome
- Male hypogonadism
- Meniere's disease
- Menopausal and perimenopausal disorders
- Menorrhagia
- Motor neuron disease
- Multiple sclerosis
- Muscular dystrophy
- Myasthenia gravis
- Neuropathy
- Obsessive compulsive disorder (OCD)
- Osteoarthritis
- Osteoporosis
- Paget's disease
- Paralytic syndromes and associated complications
- Parkinson's disease
- Pemphigus
- Pituitary disorder
- Polyarteritis nodosa
- Polycystic ovarian syndrome
- Polymyalgia rheumatica
- Post-traumatic stress disorders
- Primary/idiopathic thrombocytopaenic purpura
- Psoriasis
- Psoriatic arthritis
- Psychotic conditions
- Pulmonary interstitial fibrosis
- Rheumatoid arthritis
- Rosacae
- Sarcoidosis
- Schizophrenia
- Scleroderma and systemic sclerosis
- Sicca syndrome
- Stroke
- Systemic connective tissue disorders
- Systemic lupus erythromatosus
- Thrombosis and embolism
- Tic disorders
- Tourette's syndrome
- Transient ischaemic attacks
- Trigeminal neuralgia
- Tuberculosis
- Ulcerative colitis
- Urinary tract infection (chronic)
- Urinary incontinence
- Valvular heart disease
- Zollinger-Ellison syndrome

Hospital benefits.

Pre-authorisation required

Clinical funding protocols apply

Get comprehensive cover for the care, services and facilities you need, whether for an emergency or planned hospital admission.

What we cover.

We will pay the hospital bill and associated costs, for example, specialist consultations, anaesthetists, blood tests and X-rays from this benefit.
Please note: Some of these services require that you get pre-authorisation from us.

Hospital treatment and services.

- Hospital accommodation and general nursing services
- Diagnostic and laboratory tests
- In-hospital specialist consultations such as consultations with physicians, surgeons, anaesthetists, and physiotherapists
- Operating theatre charges
- Apparatus, material, ward and theatre medicines used in hospital

Includes:

- High care
  A higher level of treatment, nursing vigilance and monitoring than is available in a general ward.
- Intensive care
  A higher level of treatment, nursing care and monitoring, when medically necessary, than is available in a high care unit.

Medicines to take home once you have been discharged.

- We will pay for 14 days of medication to take home.
- After that, any medicines required will be funded from your day-to-day benefit limits.

Specialised radiology.

Specialised radiology required in hospital or out of hospital, including:

- CT scans
- MRI scans

Ambulance services.

In the case of a medical emergency where:

- the appropriate treatment is available locally, and
- where the injured person cannot be transported in a standard vehicle,

we will pay for road ambulance services to transport the patient to the nearest, appropriate in-country medical facility for treatment.

Non-emergency and cross-border ambulance services are subject to pre-authorisation and clinical funding protocols.

How to access ambulance services in an emergency.

- Contact your local ambulance service.
- At the hospital, present your Liberty Health Cover membership card.
- You or a family member should please notify your local Liberty Health Cover office of the incident **within 48 hours** (or, if the incident occurs on a weekend or public holiday, on the next business day to obtain authorisation for the hospital admission).

Prostheses and devices.

Artificial limbs, and internal (surgically implanted) prostheses, including:

- Orthopaedic prostheses, including hip replacements, bone lengthening devices, spinal plates and screws
- Endovascular devices
- Devices for the central nervous system, cardiac system and ophthalmic system

How to get pre-authorisation.
For more detail about the hospital treatments and services that require pre-authorisation and what you need to do to get pre-authorisation, see page 14.

Major disease benefits.

Pre-authorisation required

Clinical funding protocols apply

Access the specialist, long-term care you need for major diseases and procedures like cancer, kidney disease and organ transplants.

What we cover.

Oncology treatment.

We cover the costs of cancer treatment at a registered out-of-hospital or in-hospital treatment centre.

- Chemotherapy and medicine directly associated with the treatment of your cancer, subject to the available benefits and policy conditions
- Radiotherapy
- Specialised radiology such as CT/MRI scans, PET scans and bone scans
- Consultations
- Pathology
- Palliative or supportive care
- Basic radiology

We also cover treatment for a period of five years after active treatment to allow for adequate follow-up care once a patient is in remission. Once in remission, the type and frequency of healthcare services required for follow-up care will need to be pre-authorised depending on the type of cancer being monitored and the period of time that has elapsed since the initial diagnosis.

Is funding for any oncology treatment limited or excluded?

Our Oncology Benefit provides cover for most treatment. However, please visit our website for lists of medicines that are:

- Limited to certain types of cancer and/or lines of therapy
- Excluded from cover

Renal dialysis.

We cover the costs of renal (kidney) dialysis treatment in hospital or at a registered dialysis centre.

Other costs associated with renal dialysis that we cover include:

- Hospitalisation
- Consultations
- Medication
- Pathology

Organ transplants.

On certain benefit plans, we cover the cost of operations for kidney, heart, liver, lung, cornea or bone marrow transplants where you are the recipient of the transplant.

Other medical costs associated with an organ transplant that we cover include:

- Hospitalisation
- Consultations
- Anti-rejection drugs (in hospital and out of hospital)
- Pathology
- Radiology

What we don't cover.

- Any costs related to or for the organ donor or cadaver, including organ harvesting and donor work-up testing
- Transportation of the patient or organ
- The search or cross-match for the donor match, either locally or internationally

International benefits.

Pre-authorisation required

Clinical funding protocols apply

Access international benefits on select plans that offer you a choice in location of care. Have peace of mind that when medically necessary, critical care and emergency medical evacuation are available.

International emergency medical evacuations.

Available on selected benefit plans.

When this applies.

This benefit applies to a medical emergency where the medically necessary care is not available locally.

What we cover.

- Transportation (ambulance or air travel) to be evacuated from the country where the medical emergency occurred to the nearest, available medical facility within the region of cover for your benefit plan
- Accommodation and food
- Return transport to your country of residence
- Repatriation of mortal remains

What we cover applies to **the patient and one companion** (who may travel with the patient if the patient is a child or unable to travel without assistance)

Important contact numbers.

- 24-hour international emergency medical evacuation: +27 21 657 7740
- In-country emergency contact numbers: see the 'Contact us' section at the end of this guide.

How it works.

1 Emergency incident occurs.

For example, a vehicle accident, premature birth, cardiac arrest

2 Patient hospitalised immediately.

At nearest in-country facility

3 Call made to our 24/7 emergency evacuation line.

The treating doctor, a family member or the in-country office calls +27 21 657 7740

4 We obtain and verify the required information.

This includes verifying membership and benefit information and obtaining clinical information from the treating doctor

5 Our member care case manager liaises with our medical advisor.

By discussing and forwarding relevant information to the medical advisor

6 Our medical advisor assesses the case and makes a decision.

The opinion of the treating doctor and a second opinion are obtained when necessary

7a Feedback is provided and treatment is provided locally, if available.

Ongoing case management is provided

OR

7b Feedback is provided and we arrange the evacuation.

This includes transportation and co-ordinating with the receiving doctor and hospital

8 Member evacuated.

Ongoing case management is provided

Critical care benefit.

Available on selected benefit plans.

When this applies.

This benefit applies to a non-emergency, life-threatening condition, where medically necessary care is not available locally.

What we cover.

- The cost of required treatment in Africa or India – we select the appropriate facility and country for treatment
- A maximum of one follow-up consultation within a year after completion of active treatment
- Transportation and accommodation for the patient and one companion (who may travel with the patient if the patient is a child or unable to travel without assistance)
- Return transport to your country of residence
- Repatriation of mortal remains

What we don't cover.

- Experimental treatment
- Second opinions
- Treatment for the deterioration of a chronic condition
- A specific treatment that is not available in-country where an alternative clinically appropriate treatment is available in-country
- Any treatment that was self-funded outside the region of cover without pre-authorisation
- Standard policy exclusions
- Supportive care

Travel and accommodation cover is subject to pre-authorisation and the available benefits.

Examples of when the Critical Care Benefit will or won't apply.

COVERED		
Condition	A young boy is born with a heart defect that could lead to his death within the next two years if he does not have surgery to correct it.	A teenage girl has abnormal blood vessels in her brain that could lead to sudden death if not treated soon.
Required treatment and availability	• Specialised paediatric surgery that will result in a normal lifespan. • Surgery is not available locally.	• Specialised minimally invasive surgery that will help avoid sudden death and give her a normal lifespan. • Surgery is not available locally.
NOT COVERED		
Condition	A woman suffers from hip or knee arthritis (that is, it's not a life-threatening condition).	A man has a brain tumour, which if not treated would eventually lead to his death.
Required treatment and availability	The necessary surgery may or may not be available locally, but because it's not a life-threatening condition it won't qualify for the Critical Care Benefit.	The necessary brain surgery is available locally, so it won't qualify for the Critical Care Benefit.

Return of a deceased person's remains.

Applicable to both emergency evacuations and critical care.

When this applies.

If you or one of your dependants die outside your home country during an international medical emergency evacuation or critical care transfer.

What we cover.

- Preparation of the mortal remains
- Transportation of the remains from the place of death to the home country, provided that the home country is on the African continent

Elective roaming.

Available on selected benefit plans.

When this applies.

If you choose to seek medical treatment outside your country of residence but within the region of cover for your benefit plan.

What we cover.

The cost of the treatment, based on your available benefits and policy conditions (please note that travel and accommodation costs are for your own account).

Exclusions.

There are certain medical costs and services that are not covered on any of the Liberty Health Cover benefit plans.

While we offer comprehensive benefits across all our plans, like many health insurers, there are certain medical costs and services that we do not cover. These are called exclusions and the most common ones include but are not limited to:

Surgeries and medical treatments.

- Cosmetic treatments and plastic surgery, except for reconstructive surgery
- Services or treatment in any home, spa, hydro-clinic, sanatorium, step-down facilities, hospice, private nursing/ home care, frail care or long-term care facility that is not defined as a hospital
- Tests or treatment related to infertility (except for certain benefit plans in Nigeria), impotence or sexual dysfunction
- Treatment by the member himself/herself or family member or spouse
- All costs relating to a transplant from a donor to a recipient
- Treatment and/or death as a result of self-inflicted injury, suicide or attempted suicide, abuse of alcohol and drug addiction or abuse
- Experimental or pioneering medical and surgical techniques not commonly available that you choose to receive even though treatment for the relevant medical condition is available within the Region of Cover of the benefit plan
- Hospital treatment if the patient could have been treated properly for the condition outside of hospital
- Costs or benefits payable under any legislation or corresponding insurance cover relating to occupational death, injury, illness or disease
- Services or treatments where pre-authorisation should have been obtained and was not

Other exclusions.

General health and fitness.

- Anabolic steroids and testosterone
- Treatment for obesity
- Slimming preparations
- Breast reductions or enlargements and gynaecomastia
- Massages
- Food and nutritional supplements, including baby food and special milk preparations
- Multivitamins and tonics (except where stated in the Liberty Health Cover benefit table)

Hair removal and hair loss.

- Medicated shampoos and conditioners, including those for hair loss
- Treatment for hair removal

Personal care.

- Soaps, scrubs and other cleansers
- Toiletries
- Sunscreening and suntanning preparations
- Humidifiers

Eyecare.

- Sunglasses, readers, coloured contact lenses, contact lens preparations and any optical frames and lenses not used for the purposes of correcting a refractive error
- Refractive eye surgery or laser eye treatment

Other.

- Charges for appointments not kept
- Travel costs or non-medical costs
- Autopsies
- Unregistered medicines
- Sleep therapy
- Search and rescue
- Dental implants
- Anti-smoking preparations

Pre-authorisation.

Have peace of mind that you will receive the most appropriate and cost-effective treatment.

It's important to know when and how to get pre-authorisation, so that you can have peace of mind that the costs of the benefits and services you require will be paid.

Pre-authorisation is granted based on the following:

- The validity of your membership
- Clinical appropriateness of the treatment
- The level of care and the length of your hospital stay (where applicable)
- The Liberty Health Cover policy conditions
- Evidence-based clinical guidelines
- Your available benefits

How to obtain pre-authorisation.

Unless a specific process for obtaining pre-authorisation is given in any of the benefit sections below, please follow this process to obtain pre-authorisation.

You or your treating provider can contact us to obtain pre-authorisation by:

- calling your local Liberty Health Cover office, or
- emailing the required information to us.

For contact details visit www.libertyhealth.net, or see the 'Contact us' section at the end of this guide.

Pre-authorisation does not necessarily guarantee we'll pay for the treatment.

While we make every effort to ensure claims are paid, for example by confirming the validity of your membership and your available benefits, we may not cover the costs if events beyond our control affect the validity of the claim.

Hospital treatments and services.

Treatments and services that we cover once you have pre-authorisation.

- Hospitalisation and standard in-hospital procedures
- Dental surgery, maxillofacial surgery, orthodontics and any specialised dentistry that requires hospitalisation
- Hearing aids, wheelchairs, blood pressure monitors, orthopaedic boots and glucometers
- Cancer/oncology treatment
- Renal (kidney) dialysis
- Organ transplants (selected benefit plans only)
- Specialised radiology, including CT and MRI scans
- Emergency medical transfers, including evacuations

You must get pre-authorisation at least **48 hours before** your planned treatment or before you are admitted to hospital. This gives us time to ask for any additional information from you we may need.

Hospitalisation.

You or the treating provider should supply us with the following information:

- The patient's membership number
- Patient details: name and date of birth
- Treating doctor details: name, telephone number and practice number
- Hospital: name and practice number
- Reason for admission or casualty visit
- Codes: tariff and ICD-10 code(s)
  (ICD-10 codes identify medical diagnoses and help us understand why the care you were provided was necessary.)
- Date of admission and proposed date of the procedure
- If the procedure will be performed out of hospital: the provider's name and practice number

Once you have pre-authorisation you will receive:

- A pre-authorisation number
- The approved number of days in hospital (if a stay is required)

Please provide this information to the treating provider.

What happens if you have to stay in hospital for longer than planned?

The hospital case manager will inform us. We will pay for the additional day(s) if:

- the request meets the relevant clinical criteria and complies with the Liberty Health Cover policy conditions, and
- sufficient benefits are available.

Medical emergencies.

What qualifies as a medical emergency?

An emergency medical condition is a condition that:

- happens suddenly and unexpectedly, and
- requires immediate medical or surgical treatment where failure to provide this treatment would result in serious impairment of bodily functions, serious dysfunction of a bodily organ or part, or would place the person's life in danger.

How to obtain pre-authorisation.

Please contact us according to the instructions on the previous page:

- within 48 hours of the event, or
- if the incident occurs on a weekend or public holiday, contact us on the next working day.

If you are unable to contact us because of the nature of the emergency, a friend or family member can contact us for pre-authorisation.

In-hospital dental procedures.

What we cover.

We will pay your accounts from the hospital, dentist and anaesthetist from the hospital benefit (subject to relevant sub-limits) for the following dental procedures:

- Removal of impacted wisdom teeth
- In-hospital dental trauma that involves treatment related to:
  - Facial fractures
  - Cancers
  - Congenital abnormalities
- Orthodontic treatment for dependants up to the age of 21 years

How to obtain pre-authorisation.

Send us the orthodontic quote and motivation.

Oncology benefits.

How to register for the Oncology Benefit Programme.

If you are diagnosed with a cancerous condition, together with your doctor or specialist, please send the following to oncology@libertyhealth.net or to your local Liberty Health Cover office:

- A completed application form (available on our website, or by emailing oncology@libertyhealth.net)
- The histology report (laboratory results confirming the cancer diagnosis)

Please update us on changes to your treatment.

You and your doctor or specialist should update us on any changes to your treatment. This will help to ensure that your related claims are paid from the appropriate and available benefits.

Chronic medication.

How to register for the Chronic Medicine Benefit.

By registering for the benefit you can prevent claims for your chronic condition being paid from your day-to-day benefits, so your day-to-day benefits last longer. Once the registration has been processed, treatment for your chronic condition will be pre-authorised.

1. Get the application form

You or your doctor can obtain a Chronic Medicine Application Form by:

- emailing chronicmedicine@libertyhealth.net, or
- requesting it from your local Liberty Health Cover office, or
- accessing it from the 'downloads' section of our website.

2. Complete the form

Complete the form together with your doctor or specialist.

3. Submit the form

Submit the completed form to chronicmedicine@libertyhealth.net or to your local Liberty Health Cover office.

Once you have pre-authorisation, the medicines can be dispensed, provided you have a handwritten script from your doctor for the medicines.

Why would the request to pre-authorise my chronic medicines be declined?

Your request might be declined if:

- the medication is not funded as per our clinical funding protocols,
- insufficient information has been supplied, or
- the condition you are applying for is not included on the chronic disease list (see page 8).

If your case was declined because of insufficient information, your doctor should provide the requested information to us and we will reconsider your request.

What to do if your chronic medication changes.

- Notify your local Liberty Health Cover office of the change.
- Your chronic medicine specialist will tell you the requirements, if any, to have the changes activated. We may require additional documents to approve the request.
- Keep in mind that the new medicine may not be covered, for example, if it falls outside our clinical funding protocols.

How to submit a claim for reimbursement.

Simply follow the steps below to submit a claim.

When to claim.

- If you **visit a Network healthcare provider, the provider will claim directly from us**. The provider should give you a copy of the claim to check the details (see below) are correct before submitting it to us to process for payment. You can also keep this copy for your records.
- If you **visit a non-Network healthcare provider**, you may need to pay for treatment upfront (from your own pocket). If your benefit plan covers treatment from non-Network providers, you can **submit a claim for a refund** using the following steps:

01

Check the details on the healthcare provider invoice.

It is your responsibility to verify that you received the treatment that appears on the invoice – only sign the invoice if you agree with the details.

Details that must be on the invoice/claim.

Providing us with the following details on the claims helps us to process them quickly and correctly:

- Your policy/membership number
- Patient's name, surname and date of birth
- Name of treating healthcare provider
- Facility name (for example Africa Medical Clinic)
- Pre-authorisation number (if applicable)
- Date of service (for hospitalisation, please include admission and discharge dates)
- Diagnosis
- Detailed description of treatment/service/medication for each item received/provided, including the quantity (for example 30 Disprin, 3 days in general ward)
- Tariff code (if available)
- Amount charged per service or treatment received
- Total charged (must be the sum of the individual amounts charged on the account)
- Date of the account and account reference number
- Signature of the insured person, or the principal member if the insured person is a minor
- Signature of the healthcare provider

The claim must be clear, detailed and easy to read.

02

Submit your claim within 120 days from the treatment or discharge date.

Email refundclaims@libertyhealth.net or post/hand-deliver the following documents to your local Liberty Health Cover office:

1. The signed invoice from your healthcare provider
2. Proof of payment*
3. Proof of your bank account details if we don't have the correct/latest details on record – see the next page**

* Proof of payment.

We only accept the following as proof of payment:

- A copy of the electronic (EFT) payment
- A debit/credit card transaction slip
- A cash receipt

Please note that we do not accept a written note indicating 'paid' or a 'paid' stamp.

Posted/hand-delivered claims.

If you post or hand-deliver your claim, make a copy of the documents for your records.

03

We will pay your claim according to your available benefits and the Liberty Health Cover policy conditions.

When can you expect payment?

Payments are made weekly and may only reflect in your bank account after a few days, depending on which bank you use.

What if your claim is not paid?

If your claim is only partially paid or rejected as incorrect or unacceptable for payment, please check your statement and resubmit a correct claim within 60 days of the date of notification of rejection.

**How to provide proof of your bank account details.

You can check the banking details we have on record for you by logging on to your online profile (see page 21) or calling your local Liberty Health Cover office. If you need to add or change your bank account details, please send the following (not older than three months) to membership@libertyhealth.net:

- A completed 'Bank Details Form' (get it from the 'downloads' section of our website, request it from membership@libertyhealth.net, or contact your local Liberty Health Cover office)
- A certified copy of your ID, passport or driver's licence

Please note: If the account holder is not a member of Liberty Health Cover, the principal member must please provide us with a signed letter to give consent to pay the refund into the third party's bank account.

How will you know if your claims were paid?

- **Check your emailed statements**
  You will get a weekly statement showing all claims that were processed during that week. (Please make sure that we have your correct email address so that these statements reach you.)
- **Log on to your online profile**
  You can also view your claims history on your secure online profile (see page 21).
- **Contact us**
  Contact your local Liberty Health Cover office.

Managing your membership.

Everything you need to know about managing your membership and your cover under this policy.

Comprehensive health insurance for you and/or your dependants.

Your employer has chosen to take policy cover for its employees and/or dependants with Liberty Health Cover. You and/or your dependants are covered unless one of you:

- is covered under your spouse's benefit plan or medical scheme with another insurer, or
- is already covered by us through another Liberty Health Cover policy.

Can you belong to another health insurer at the same time as Liberty Health Cover?

When it comes to insurance, claims for a particular event should only be claimed from one insurer. Therefore, if you have cover with us, you should terminate your cover with any other insurer. If you are unsure, please consult your Human Resources (HR) department.

Non-disclosure of information in your application.

It's important to answer all questions on the Liberty Health Cover application form honestly and fully.

If you:

- make a false declaration, or
- knowingly fail to disclose that you are suffering from an illness or condition at the time of the application...

...we may, at our discretion and with written confirmation:

- place a waiting period on the policy,
- limit or exclude certain benefits from the policy,
- not pay certain claims, and/or
- cancel the policy.

When you are covered.

When cover starts.

- You will be covered from the start date you filled in on the application form.
- Cover won't start before your employment date.
- In the case of newborns, cover starts from the day of birth provided that you notify us in writing within 60 days from the date of birth.

If you join after the start date of your employer's policy for cover with us, the annual day-to-day benefit limits will be pro-rated on a monthly basis to reflect that cover does not apply for a full year.

When cover ends.

Your cover under this policy will end when any of the following occur:

- Your employer gives us 90 days' written notice to cancel the policy. (Your cover will end at the end of the 90 days' written notice.)
- Your employment is terminated, for example, you resigned, retired, or were dismissed. (Your cover will end at the end of the month of termination.)
- The premiums due under this policy, as per the Liberty Health Cover policy conditions, are not paid.

Your dependants' cover will end when:

- they no longer qualify to be a dependant or child dependant,
- you are no longer insured under the policy, or
- they are covered under another health insurance plan or medical scheme.

Adding dependants to your policy.

How to add dependants to your policy.

If your employer provides Liberty Health Cover to you and your dependants, you can add them to your policy. To do so:

1. Obtain the relevant documents from your HR department.
2. Complete the documents in full and submit them to HR.
3. HR will send us the documents for processing.

Who qualifies as a dependant?

- A spouse or living-in partner of the principal member
- A spouse, living-in partner or child (as defined below) of a deceased principal member (subject to the approval of your employer)
- A natural child, stepchild, legally adopted child, or any child placed in the care and custody of the principal member or the principal member's spouse or living-in partner, or where there is a liability for financial support enforceable by a court of law.

A child dependant must be financially dependent on you and not be earning a living, and be:

- up to the age of 21 (inclusive), or
- between the ages of 22 and 25 (inclusive) and able to provide proof of registration as a full-time student at a recognised educational institution (student cards do not qualify as proof) once a year, or
- dependent on you due to mental or physical disability. (We may request a copy of the doctor's medical report confirming permanent disability.)

When to register dependants for cover under your policy to ensure their cover is not subject to waiting periods.

- A newborn child – within 60 days of the birth date
- An adopted child or child placed in your custody – within 60 days of the adoption or custody date
- A newly married spouse – within 30 days of the marriage date

Waiting periods.

If you and/or your dependants join after your employer's policy start date or your employment date, a condition-specific waiting period may apply:

When it applies.

- From the date that your cover starts. It applies to any members on the policy who have a pre-existing condition.
- The duration of the waiting period will be shown on your member certificate.

A pre-existing condition is a health condition you were diagnosed with, treated for or given advice about before you applied for cover.

What it means.

During this period you are not entitled to claim any benefits relating to the pre-existing condition.

In addition, please note that higher premiums may apply due to the pre-existing condition. We also reserve the right to decline your application based on your occupation, health status and any hobbies you may practise.

Transferring your benefits.

Please note that you may not allow someone else to use your health insurance to pay for their healthcare.

Your membership card.

Your card gives you access to healthcare services according to your cover, so make sure you always have it with you and keep it safe.

What to do if your personal details change.

We always need your latest email address and primary or main mobile number to reach you with important information.

If your details change, contact your Human Resources (HR) department immediately to update the details we have for you on our system and if necessary to send you a new card.

What to do if your card is lost or stolen.

- Inform us immediately by either calling or emailing your local Liberty Health Cover office.
- If you don't, you may be held personally responsible for any claims paid through misuse of your card.

When your cover ends you must return your card to us.

- Your membership card remains the property of Liberty Health Cover and you must please return it to us if your cover ends.
- If your card is used to visit a healthcare provider after your cover has come to an end, you will be responsible for these costs.

Fraud.

What happens if your card is used fraudulently?

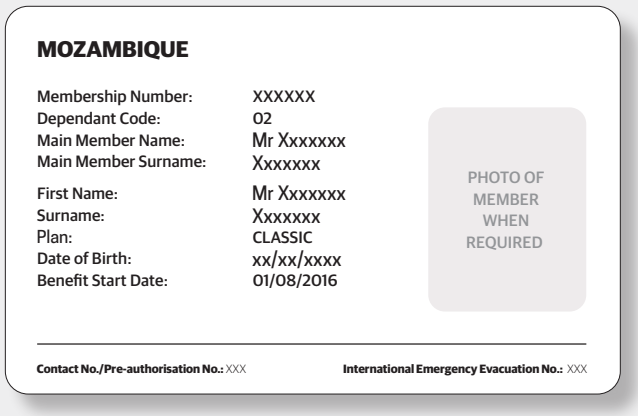
If any claim you submit is found to be false or fraudulent, or if you/your dependants/anyone acting on your behalf use fraudulent means to obtain benefits under your health insurance cover:

- your cover may be cancelled immediately and you may lose all your benefits and premiums paid, or
- your employer's entire policy may be cancelled immediately and all benefits and premiums paid may be lost, and
- we may also take legal action.

How to report suspected fraud.

To report suspected fraud, or any unethical behaviour related to your Liberty Health Cover, please:

- email: fraud@libertyhealth.net, or
- call us on the anonymous hotline number for your country. To find the number, go to www.libertyhealth.net and click on the 'Fraud' link at the bottom of your country's web page. Once you are on the 'Fraud' page, scroll to the bottom to find the hotline for your country.



* Please note that membership cards may look different in certain countries.

Online self-service facilities.

You have secure access to your membership information and helpful wellbeing resources 24/7, all year round.

Available platforms.

Our website.

Visit www.libertyhealth.net to register for the secure online self-service facility

The Liberty Health App.

You can download the app from the Google Play or iOS app stores by clicking on the relevant icons below:

GET IT ON Google Play Available on the App Store

How to register.

1. Click on 'Register'.
2. Enter your personal details and choose a password.

If you need help with the registration process, call your local Liberty Health Cover office or email us at info@libertyhealth.net

What information you can access.

Your membership information.

- Your personal and contact details
- Your bank details
- Information about your dependant(s)

Your benefits.

- Your policy status and joining dates
- Details about any waiting periods for you and/or your dependants

Claims and statements.

- Details of your current claims
- You can also search for claims by date, healthcare provider number or your membership number
- View statements for up to 36 months

Healthcare providers you can visit.

A click-through to the Liberty Wellbeing platform.

You can access the Liberty Wellbeing platform from the website portal or app, or by visiting: https://online.libertyhealth.net/wellbeing.
The platform offers a free online health assessment and helpful information about developing healthy habits, managing your chronic conditions, and improving your quality of life.

(Access may be limited for members in Ghana, Tanzania and the Francophone countries.)

We aim to continuously improve our online tools, so please use this convenient service and submit any suggestions to improve them to info@libertyhealth.net.

Contact us.

If you have any questions or requests, you are welcome to contact us by email, telephone or in writing.

Keep an eye on our website for updated contact details.
If you have difficulty reaching our offices, please visit our website at www.libertyhealth.net. We will post any new contact details on your country's 'Contact us' page.

GHANA

Address	Apex Health Insurance Ltd, #7 Nii Yemoh Avenue, Boundary Road, Shiashie – East Legon PO Box ST 237, Accra, Ghana, Cantonments
Tel	+233 265 380 622
Email	info@apexhealthghana.com
Emergencies (24 hrs)	+233 501 304 156
Pre-authorisation	+233 501 304 156
Claims	Post claims to the physical address above, or email: info@apexhealthghana.com

KENYA

Address	Heritage Insurance Company Ltd, Liberty House (formerly CFC House), Processional Way PO Box 30390 00100 – GPO, Nairobi, Kenya
Tel	+254 711 076 333
Email	info@heritage.co.ke
Emergencies (24 hrs) / Pre-authorisation	+254 711 076 333 +254 728 111 001 +254 728 111 002 +254 733 550 050 +254 728 607 689 healthcareundertakings@heritage.co.ke
Claims	Post claims to the physical address above, or email: claims.medical@heritage.co.ke

LESOTHO

Address	Liberty Life Lesotho, Unit 39, Maseru Mall Thetsane, Maseru, Lesotho
Tel	+266 2231 4589
Email	info@libertyhealth.net
Emergencies (24 hrs)	+266 2231 4590
Pre-authorisation	+266 2231 4590 membercare@libertyhealth.net
Claims	Post claims to the physical address above, or email: claims@libertyhealth.net

MALAWI

Address	Libertas General Insurance Company Limited, Ground Floor, Unit House, Victoria Avenue, Malawi PO Box 354, Blantyre, Malawi
Tel	+265 1833 393 +265 1830 610 +265 1754 810
Email	malawi@libertyhealth.net
Emergencies (24 hrs)	+265 993 921 957
Pre-authorisation	+265 993 921 957 membercare@libertyhealth.net
Membership	+265 999 523 103 +265 999 880 219
Claims	Post claims to the physical address above, or email: malawi@libertyhealth.net

MAURITIUS

Address	Liberty Health C/O Health & Travel Department , Swan General Ltd, 7th Floor, Swan Centre, Intendance Street, Port Louis, Mauritius
Tel	+230 212 2600/2900
Email	mauritius@libertyhealth.net
Emergencies (24 hrs)	+230 5941 7533 / +230 5253 5035
Pre-authorisation	Office hours: +230 212 2600 After hours: +230 5253 5035
Claims	Post claims to the physical address above, or email: mauritius@libertyhealth.net

MOZAMBIQUE

Address	Liberty Blue, Avenida Julius Nyerere nº 1339, Maputo, Mozambique
Tel	+258 84 373 7376/7 800 30 3333
Email	mozambique@libertyhealth.net
Emergencies (24 hrs)	+258 84 390 1289 +258 84 373 7376/7 800 30 3333
Pre-authorisation	Vodacom: +258 84 586 5665 Mcel: +258 82 586 5665 preauthmoz@libertyhealth.net
Claims	Post claims to the physical address above, or email: lhmozmemberclaims@libertyhealth.net

NIGERIA

Address	Total Health Trust, 2 Marconi Road, Palmgrove Estate, Lagos, Nigeria
Tel	+234 1 460 7560 0700 TOTAL HT (+234 (0) 700 868 2548)
Email	contactcentre@totalhealthtrust.com
Pre-authorisation	contactcentre@totalhealthtrust.com
Claims	Post claims to the physical address above, or email: claimsmailroom@totalhealthtrust.com

SOUTH AFRICA

Address	Liberty Health, Liberty Building Estuary Precinct, Century Boulevard Century City, 7441, Western Cape, South Africa
Tel	+27 21 657 7740 Office hours: +27 21 657 2666 After hours: +27 21 657 7740
Email	info@libertyhealth.net
Pre-authorisation	membercare@libertyhealth.net
Oncology pre-authorisation	oncology@libertyhealth.net
Chronic medication pre-authorisation	chronicmedicine@libertyhealth.net

TANZANIA

Addres	Strategis Insurance (T) Limited, Plot No. 1520, Bains Avenue, 1st Floor, Masaki Ikon Building, Msasani Peninsula PO Box 7893, Dar es Salaam, Tanzania
Tel	+255 222 6025 70 +255 222 6025 74 +255 222 6025 81
Email	insurance@strategis.co.tz
Emergencies (24 hrs)	+255 784 555 911 +255 754 777 100
Pre-authorisation	+255 788 483 043 +255 677 744 344 +255 753 844 083 +255 776 331 998 approvals@strategis.co.tz
Claims	Post claims to the postal address above

UGANDA

Address	Liberty Life Assurance Uganda Limited, Madhvani Building, Plot 99-101, Buganda Road, Kampala, Uganda PO Box 22938, Kampala, Uganda
Tel	+256 414 233 794 +256 312 202 695 +256 414 231 983 +256 312 304 000
Email	uganda@libertyhealth.net
Emergencies (24 hrs)	Members: +256 779 558 733 Providers: +256 772 578 323
Pre-authorisation	+256 414 233 794 +256 779 558 733 membercare@libertyhealth.net
Claims	Post claims to the physical address above, or email: uganda@libertyhealth.net

ZAMBIA

Address	Liberty Life Insurance, Kwacha Pension House , 1st Floor, Stand 4604, Tito Road, Rhodes Park, Lusaka, Zambia
Tel	+260 211 255 540/1/36
Email	zambia@libertyhealth.net
Emergencies (24 hrs)	+260 950 397 863 +260 965 205 113 +260 955 256 871
Pre-authorisation	+260 211 255 540 +260 211 255 541 +260 211 255 536 preauthzam@libertyhealth.net
Claims	Post claims to the physical address above, or email: zambia@libertyhealth.net

24-hour international medical emergency evacuation
+27 21 657 7740

FIND US IN AFRICA

Contact us to find out more about how we can help meet your health insurance needs
You can contact the Liberty Health head office using the details below, or visit www.libertyhealth.net for the details of your local in-country office.

Liberty Health head office
T +27 (0) 21 657 7740
+27 (0) 21 657 2300
E info@libertyhealth.net
sales@libertyhealth.net

Liberty Health Cover is brought to you by Liberty Health (Pty) Limited, a company duly registered in the Republic of South Africa.
Registration No: 1998/006414/07

1 Ameshoff Street, Braamfontein, Johannesburg, South Africa, 2001

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