LIFE INVESTMENTS **HEALTH** CORPORATE PROPERTIES ADVICE

LIBERTY HEALTH COVER

MEMBERSHIP GUIDE

2017/2018

LIBERTY

Contents

Policy Benefits

We offer you a range of benefits through your health insurance policy.

All benefits are paid up to the relevant benefit limit according to the Liberty Health Cover Benefit Table. Please see the table below for a list of the type of benefits usually included in our benefit plans.

The benefits are divided according to the categories listed below. To access the benefit information for your specific plan, please login to your online profile on our website (see page 17 for details), or contact your Human Resources Department.

In-patient (In-hospital) Benefits

- Hospital treatment and services
- Maternity cover
- High care
- Intensive care
- Psychiatric hospitalisation
- Prosthesis
- External medical appliances
- Specialised radiology
- Medicines to take home

Out-patient (Out-of-hospital) Benefits

- GP and specialist consultations
- Minor procedures
- Acute prescribed medicines
- Chronic medicines
- Basic dentistry
- Specialised dentistry
- Out-of hospital maternity cover (pre-natal and post-natal)
- Ancillary services
- Optical services

Emergency Medical Evacuations

- International emergency medical evacuations on select benefit plans (ambulance and air travel)
- Transfer to country of residence
- Return of the remains of the deceased

Major Disease Benefit

- Oncology
- Organ transplants
- Renal dialysis

In-patient (In-hospital) Benefits

Your In-Patient Benefits* cover the cost of your hospital admission and associated costs.

***subject to pre-authorisation.**

We will pay the hospital bill and associated costs, for example specialist consultations, anaesthetists, blood tests and x-rays, from this benefit. Some of these services are subject to further pre-authorisation.

Hospital treatment and services

This refers to all the medical treatment and services you need that are provided by, or ordered by, a treating provider when you are admitted to the hospital, including:

- hospital accommodation and general nursing services
- diagnostic and laboratory tests
- in-hospital fees for physicians, specialists, surgeons, anaesthetists, physiotherapists and other relevant specialist consultations provided in hospital
- operating theatre charges
- apparatus, material, ward and theatre medicines used in-hospital
- medicines to take home (limited to 14 days' supply)

High care

High care is care that requires a higher level of treatment, nursing vigilance and monitoring than is available in a general ward.

Intensive care

Intensive care is care that requires a higher level of treatment, nursing vigilance and monitoring, when medically necessary, than is available in a high care unit.

Major Disease Benefit

This refers to the cost of treatment (in-hospital and out-of-hospital) for oncology (cancer), organ transplants and renal (kidney) dialysis up to the Major Disease Benefit limit and subject to clinical/treatment protocols.

Oncology

We cover the costs of cancer treatment received at either a registered in-patient or out-patient cancer treatment centre, including:

- chemotherapy and oncology medication
- radiotherapy
- specialised radiology such as CT scans, MRI scans and angiography
- consultations
- pathology
- hospitalisation for in-patient cancer treatment

Organ transplants

On select 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 are covered include:

- hospitalisation
- consultations
- anti-rejection drugs (in-hospital and out-of-hospital)
- pathology
- radiology

The cover excludes:

- 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
- search or cross-match for the donor match, either locally or internationally

Renal dialysis

We will cover the treatment costs for renal (kidney) dialysis irrespective of whether such treatment is received as a registered in-patient or as an out-patient at a legally registered dialysis centre. Other medical costs associated with renal dialysis that are covered include:

- hospitalisation (for in-patient treatment)
- consultations
- medication
- pathology

Maternity cover

In-hospital maternity cover applies as follows:

- confinement, the period of pregnancy when a woman would be confined to bed rest (in an effort to reduce risk of premature delivery)
- midwives and childbirth
- pregnancy complications
- premature childbirth, and a separate neonatal limit
- an emergency or elective caesarean section delivery that was clinically necessary

Psychiatric hospitalisation

This policy benefit pays for the costs of psychiatric treatment received as an in-patient in a psychiatric unit of a hospital. All treatment must be administered under the direct supervision of a registered psychiatrist.

Prosthesis

This refers to artificial limbs, and internal (surgically implanted) prostheses, such as:

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

Specialised radiology

This refers to specialised radiology required in-hospital or out-of-hospital, such as computed tomography (CT) scans and magnetic resonance imaging (MRI) scans. All specialised radiology (in-hospital and out-of-hospital) is subject to pre-authorisation.

Medicines to take home

These are 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 the Outpatient limits.

Important: Pre-authorisation requests

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

- Calling your nearest local office
- Emailing the required information to us

Please see the Contact details at the end of this Guide.

Pre-authorisation

Pre-authorisation allows us to ensure you receive the most appropriate treatment at the most appropriate cost.

It also allows us to monitor the quality of the care that you need. If you do not obtain pre-authorisation, you may be held personally liable for the medical costs of treatments and services.

To make use of the following benefits and services included in your cover, you must obtain pre-authorisation from us.

Treatments and services that require pre-authorisation

For the following hospital treatments and services you must get pre-authorisation from us beforehand if you want to claim the costs:

- hospitalisation and in-patient 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
- specialised radiology, including CT and MRI scans
- emergency medical transfers, including evacuations
- hospice and step-down facilities
- private nursing

How to get pre-authorisation for normal in-patient procedures

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

- calling the nearest Liberty Health Cover office
- emailing the required information to us

For contact information, please see the Contact details at the end of this Guide. **Please ensure that the information reaches us at least 48 hours before the treatment is required.**

Pre-authorisation is granted based on:

- the validity of your membership
- clinical appropriateness of the treatment
- the level of care and the length of hospital stay
- the policy conditions
- evidence-based clinical guidelines
- your available benefits

Hospitalisation pre-authorisation

You must get pre-authorisation at least 48 hours before you are admitted to hospital. This allows us time to request any necessary additional information from you if we need it. **If pre-authorisation is not obtained, claims will not be paid.**

What information must be supplied by you or the treating provider

- Your policy 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)
- Date of admission and proposed date of the procedure
- If the procedure (for example MRI scan or dialysis) will be performed out of hospital: The provider's name and practice number

What you will receive once you have pre-authorisation

- Pre-authorisation number
- The approved number of days in hospital (if a stay is required)
- The tariff and ICD-10 code(s)

Give this information to the treating provider.

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

If your hospital stay is extended, the hospital case manager will inform us.

We will pay for the additional day(s) if:

- the request meets clinically appropriate criteria
- it is within the policy conditions
- benefits are available

Important: Pre-authorisation is issued in terms of the policy conditions

While every effort is made to establish member eligibility and availability of funds, pre-authorisation is not a guarantee of payment.

Pre-authorisation for medical emergencies

What qualifies as a medical emergency?

Any emergency medical condition that:

- happens suddenly and unexpectedly.
- 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 serious danger.

What happens if you are admitted in an emergency medical situation and cannot phone us?

In the case of an emergency hospital admission, you should ask a friend or family member to contact us for pre-authorisation, **within 48 working hours of the event,** to ensure that your claims are paid. Or, if it is a weekend or public holiday, they should contact us on the next working day.

Pre-authorisation for in-hospital dental procedures

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

- Removal of impacted wisdom teeth
- In-hospital dental trauma which provides cover for treatment related to:
  - Facial fractures
  - Cancers
  - Congenital abnormalities

Cover for orthodontic treatment

We cover orthodontic treatment for dependants up to the age of 21 years. You must send us the orthodontic quote and motivation to obtain pre-authorisation.

Chronic Medication

When do I qualify for the Chronic Medicine Benefit?

Chronic medicines are used to treat chronic conditions, that:

- require medication and treatment for more than three (3) continuous months
- are listed in the Chronic Diseases List (see page 7), and
- are included in the clinical protocols

How to register with the Chronic Disease Programme

If you are diagnosed with a chronic condition, together with your doctor or specialist, please complete and submit a Chronic Medicine Application Form to **chronicmedicines@libertyhealth.net** or to your in-country office.

You or your provider can obtain the application form by emailing your request to: **chronicmedicines@libertyhealth.net**, or by asking our in-country office. By registering, you can prevent claims for your chronic condition being paid from your Day-to-day Benefits.

Registration on the Programme is not automatic, so please apply as soon as possible.

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

What happens if you don't get pre-authorisation for your chronic medicines?

- Your request might be declined if, for example, the medication is not in the relevant medicine clinical protocols, or if insufficient information has been supplied.
- If your case was declined because of insufficient information, your doctor should provide the requested clinical information (where relevant) to us.
- Your request will be reconsidered once all the relevant information has been received.

What happens when your pre-authorised chronic medication changes?

- You must notify the local office of the change.
- Your chronic medicine specialist will tell you the requirements, if any, to have the changes activated.
- Additional documentation, depending on clinical protocols, may be required.
- Keep in mind that there is a possibility that the new medicine is not covered if, for example, it falls outside the medicine management clinical protocols.

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

What isn't covered

There are certain costs that are not covered on any of the Liberty Health Cover plans. These include:

- 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, 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 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 which the member chooses to receive even though treatment usually and customarily provided for the medical condition concerned is available within the Area of Cover of the health plan.
- Travel costs or non-medical costs.
- Hospital inpatient treatment if the member could have been treated properly for the condition as an outpatient.
- Charges for appointments not kept.
- 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
  - Anabolic steroids and testosterone
  - Autopsies
  - Humidifiers
  - Medicated shampoos and conditioners, including those for hair loss
  - Unregistered medicines
  - Massages
  - Multivitamins and tonics (except where stated in the Liberty Health Cover benefit table)
  - Treatment for obesity
  - Sleep studies
  - Slimming preparations
  - Soaps, scrubs and other cleansers
  - Sunglasses, readers, coloured contact lenses, contact lens preparations
  - Sun screening and sun tanning preparations
  - Toiletries
  - Treatment for hair removal
  - Breast reductions or enlargements and gynaecomastia
  - Search and rescue
  - Dental implants
  - Refractive eye surgery or laser eye treatment
  - Food and nutritional supplements, including baby food and special milk preparations
  - Anti-smoking preparations.

Emergency Medical Transfers and Evacuations

In-country ambulance services

In the case of a medical emergency, where the appropriate treatment is available locally, we will pay for an in-country ambulance to transport you from the scene of the medical emergency to the nearest available medical facility for treatment.

A medical emergency that requires ambulance services

- Contact your local ambulance services to attend to the medical emergency immediately. If the injured person can be transported in a standard vehicle, drive the patient to the nearest medical emergency facility.
- At the hospital, present the Insured Person's Liberty Health Cover membership card.
- You or a family member should notify your local Liberty Health Cover office of the incident within 48 hours as described above.

International emergency medical evacuations (ambulance and air travel)

What we pay

In the case of a medical emergency, where treatment is not available locally, we will pay for your transportation costs to be evacuated from the country where the medical emergency occurred to the nearest, available medical facility within the area of cover for your benefit plan.

We will pay the cost of one economy class return airfare and all ancillary charges (accommodation, food and transport only) up to the limit stated in the benefit table. This will fund the costs for a family member to join an Insured Person who requires international medical emergency evacuation. This family member joining the Insured Person does not necessarily have to be covered under the policy but there is a restriction to one family member only.

Approval of an international medical emergency evacuation

- International medical evacuation is subject to the approval of the Liberty Health Cover Medical Adviser.
- Our Medical Adviser will, in consultation with the treating medical professionals and subject to our internal evacuation criteria, determine whether your medical condition is a serious or life-threatening medical emergency that requires immediate evacuation so that you can get treatment to avoid death or serious impairment to your immediate or long-term health.
- The seriousness of the medical condition will be judged within the context of your geographical location and local availability of treatment or medical facilities.

Transfer to country of residence

Following an international medical emergency evacuation, we will pay for the costs to transport you back to your country of residence on the African continent, provided that these costs are first pre-authorised by us.

Return of a deceased's remains

- If you or one of your dependants die outside your home country during an international medical emergency evacuation, we will pay for:
  - The preparation of your mortal remains.
  - Transportation of your remains from the place of death to the home country provided that the home country is on the African continent.
- We must pre-authorise these costs before we will pay.

Important: International emergency medical evacuation (24 hours): **+27 21 657 7740.**

Please see the contact details at the end of this Guide for the in-country emergency contact number(s).

Out-patient (Out-of-hospital) Benefits

This benefit category covers medical treatment that does not require hospitalisation.

GP and specialist consultations

- General Practitioner (GP) consultations
- specialist consultations

Minor Procedures

The following procedures are covered under this policy:

- pathology, that is, blood tests requested by a physician
- 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

Acute prescribed medicines

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

Chronic medicines

These are medicines for chronic conditions, that:

- require medication and treatment for more than three (3) continuous months
- are listed in the Chronic Diseases List (page 7), and
- are included in the clinical protocols

All chronic medication must be pre-authorised by Liberty Health Cover. Chronic medicines not pre-authorised will be considered acute medicines (with the exception of HIV medicines). We will not pay for HIV/Aids medicines without pre-authorisation.

Please see page 6 on how to pre-authorise your chronic medication.

Vaccinations

We cover several vaccinations for children and adults that are known to work, are cost effective, and are recommended for administration in line with local and international health guidelines. We cover the cost of the vaccines below from the Acute Conditions Benefit.

Childhood vaccinations

In addition to our rich maternity benefits, we provide cover for the following extended list of childhood vaccinations (up to and including age 6).

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

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

Other vaccinations

We cover vaccinations for members, older than age 7, against the following illnesses and disease:

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

Basic dentistry

- Basic dentistry, including dental consultations.
- Basic dental procedures such as:
  - removal of teeth and roots
  - fillings
  - preventative treatment
  - scaling and polishing
  - X-rays

Important: Medical treatment covered by the Out-patient Benefits is paid at the Liberty Tariff.

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

▶ **Please note:**
The costs related to in-hospital dental treatment such as ward and theatre fees will be paid from the In-hospital benefits, subject to standard pre-authorisation requirements.

Out-of-hospital maternity cover (pre-natal and post-natal)

- consultations with obstetricians, mid-wives and physicians
- routine ultrasounds
- general tests including blood count, haemoglobin count, Venereal Disease Research Laboratory (VDRL) test, glucose test, blood group test and Rh antigen tests

Ancillary services

- physiotherapy
- biokinetic and chiropractic services
- psychology
- occupational therapy
- speech therapy/audiology
- hearing aid acoustician
- podiatry
- dietician services
- orthotist and prosthetist services

Optical services

- eye examinations
- new frames and spectacle lenses (including contact lenses)

How to Claim

We have made the claims process as simple as possible for you and your treating provider.

The diagram below lists all the details needed when submitting a claim to us either by you or your treating provider.

Information that must be on the claim

- Policy number
- Insured Person's name and surname
- Date of birth
- Diagnosis
- Date of service (for hospital, please include admission and discharge dates)
- Detailed treatment or service description for each item received/provided (e.g., name of medicine, ward level)
- Quantity (e.g., 30 Disprin, 3 days in General Ward)
- Tariff code (if available)
- Amount charged per service or treatment received
- Name of treating healthcare professional
- Facility name (e.g., Africa Medical Clinic)
- Total charged (which must add up to the sum of the individual amounts charged on the account)
- Pre-authorisation number (if applicable)
- Proof of payment (receipt or proof of electronic (EFT) payment), in the case of a refund request for the principal member
- Signature of the Insured Person or principal member if the Insured Person is a minor
- Signature of the provider
- Date of the account and account reference number

Sending claims to us

The claim must be submitted to the Liberty Health Cover office which is nearest to you. The claim can be submitted to us by you or your healthcare provider.

When submitting claims

- The claim must be clear, detailed and easy to read.
- If you have settled the account, please submit proof of payment in the form of a receipt or proof of Electronic Funds Transfer (EFT)*.
- Make a copy of the above documents for your own records.

▶ Please note:

The only document we will accept as proof of payment is a receipt or proof of electronic (EFT) payment.

Proof of payment must be submitted with any refund that needs to be paid to the principal member.

A written note indicating 'paid' or a 'paid' stamp will not be accepted. If the correct proof of payment is not attached, the account will be rejected.

It is your responsibility to ensure claims are submitted for payment, to get a copy of the claim (even when the service provider submits directly to us), and to check your account compared to the services you received.

Period of submission

- To qualify for the payment of benefits, a claim must reach us within 120 (one hundred and twenty) days of the treatment or discharge date. A claim submitted after 120 days will not be paid.
- If you submit a claim within the 120-day period and it is partially paid, rejected as incorrect or unacceptable for payment, it is your responsibility to check your statement(s) and resubmit a correct claim within 60 days following the date of notification of rejection. Claims submitted after these timelines will not be paid.

Basic claim guidelines

- **It is ultimately your responsibility – not your healthcare provider's responsibility – to ensure claims are submitted for payment.**
- If your healthcare provider has claimed electronically and you receive a copy of the claim (for your information), you do not need to send the copy to us.
- If your provider expects you to pay for the services upfront and then claim from us, please submit the fully detailed and signed claim (not just the receipt).
- Providing us with the correct details of what is being claimed ensures that we process your claim quickly and correctly.

How will you know if your claims were paid?

- You will get a monthly detailed statement that summarises all the claims transactions that occur throughout the month.
- **Please make sure that we have your correct email address so that the above information will reach you.**

When to expect payment

- There is a weekly payment cycle for members. However, payment into your bank account may only reflect after a few days, depending on which bank you use.
- Payment is subject to the correct information being supplied and meeting submission cut-off times.

Your bank details

- Please make sure we have your correct bank account details for electronic payment of your claim refunds. You can email these details to your nearest local office. See the list of email addresses and contact information at the end of this Guide.
- If you add or change your bank account details to which we should refund your claims, please send us the following documents (not older than three months):
    - a completed Bank Details Form
    - a copy of the identity document/passport of the account holder
    - if the bank details provided are not those of the Principal Member, a signed letter from the Principal Member giving consent to pay the refund to the third party's bank account
    - a copy of a cancelled cheque for the related bank account, OR a letter stamped by the Bank, not older than 3 months, confirming the bank details.

How to submit a claim for a refund

1

If you pay cash for treatment at a service provider, you have 120 days from the treatment or discharge date to submit the claim for reimbursement.

No claims will be refunded after the 120 days.

2

It is your responsibility to verify that you received the treatment that appears on your healthcare services invoice.

Please only sign the invoice if you agree that the services were provided.

3

Following services/treatment, claims **(including the invoice, proof of payment* and your banking details)** can be submitted to us either by:

Email: Please check the Contact details at the end of this Guide for the relevant email address.

OR

Post/hand delivery: To your nearest Liberty Health Cover office. Please check the Contact details at the end of this Guide.

Claims received will be processed and settled according to your health plan benefits and policy conditions.

NB

***Please note:**
The only document accepted as proof of payment is a receipt or proof of electronic (EFT) payment.

Proof of payment must be submitted with your claim for reimbursement, which will be paid to the principal member.

A written note indicating 'paid' or a 'paid' stamp will not be accepted. If the correct proof of payment is not attached, the account will be rejected.

NB

Your bank details

- Please make sure we have your correct bank account details for electronic payment of your claim refunds.
- If you add or change your bank account, please send us the following documents (not older than three months):
  - A completed Bank Details Form
  - A copy of the identity document/passport of the account holder
  - If the bank details provided are not those of the Principal Member, a signed letter from the Principal Member giving consent to pay the refund to the third party's bank account
  - A copy of a cancelled cheque for the related bank account, OR a letter stamped by the Bank, not older than 3 months, confirming the bank details.

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When to expect payment

- Payment is subject to the correct information being supplied and meeting submission cut-off times.
- There is a weekly payment cycle for members. However, payment into your bank account may only reflect after a few days, depending on which bank you use.

Managing Your Membership and Your Policy Cover

Compulsory cover for employer groups/ employees

It is compulsory for employees and their dependants to be covered under this policy at the policy commencement date or employment date unless the employee and dependants are covered under a spouse's health insurance plan or medical scheme.

When cover starts

On the information form, you will be asked to complete the date from which cover should commence, we will start cover from this date. Cover cannot commence prior to the employment date.

In the case of newborns, cover will commence from the first day of birth provided that notification is made in writing within 60 days from the date of birth and approved by us.

How to add dependants under this policy

To add dependants to your Liberty Health Cover policy, please obtain the relevant information from your Human Resources (HR) representative. Once you have provided HR with the required information, HR will send the information to Liberty Health Cover for processing.

When cover ends

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

Voluntary policy cancellations

- The Policyholder must give us 90 days written notice to cancel the policy. The cover on all beneficiaries will end on the date the policy is cancelled.
- If the Insured Person is an employee, cover will end at the end of the month that his or her employment is terminated, for example by resignation, retirement or dismissal.
- If the Insured Person is a dependant, cover will end when:
  - the dependant no longer qualifies to be a beneficiary of the employee.
  - the employee is no longer insured under this policy.
  - the dependant is covered under another health insurance plan or medical scheme.
- If the premiums due under this policy are not paid as per your Policy Conditions.

Who qualifies as a dependant?	

Dependant	A dependant refers to any of the following persons:
	• 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
	• 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 partner, or where there is a liability for financial support enforceable by a court of law.
	• A child dependant must be:
	  • up to the age of 21 (inclusive), or
	  • between the ages of 22 and 25 (inclusive) provided that he or she can provide proof of registration as a full-time student at a recognised educational institution (student cards do not qualify), or
	  • dependent on the principal member due to mental or physical disability. (A copy of the doctor's medical report confirming permanent disability may be requested)

Waiting periods

Waiting periods may apply to your cover:

When do waiting periods apply?	
Employees and dependants joining after commencement date	If employees and/or their dependants decide to join after the commencement date or employment date, cover under this policy may be subject to the following underwriting: • **a general waiting period** in respect of all claims from the date of commencement of cover for the beneficiary in question, and • **a condition-specific waiting period** in respect of pre-existing conditions. Such underwriting shall not apply where the member can prove that they; had previous health insurance or medical scheme cover terminating less than 90 days prior to joining Liberty Health Cover; and, that they were not subject to any waiting periods or exclusions when they left the scheme.
Newborn children	In the case of a newborn, the newborn must be registered for coverage under this policy within sixty (60) days of the birth date in order to obtain coverage with no underwriting.
Adopted child or child placed in the custody of an Insured Person	In the case of an adopted child or child placed in the custody of an Insured Person, the child must be registered for coverage under this policy within sixty (60) days of the adoption or custody date in order to obtain coverage with no underwriting.
Newly married spouse	In the case of a newly married spouse, the spouse must be registered for coverage under this policy within thirty (30) days of the marriage date in order to obtain coverage with no underwriting.

General waiting period

- This period applies from the date that your cover starts.
- A general waiting period is a period during which you are not entitled to claim any benefits with the exception of hospital treatment related to an accident.
- If you need emergency trauma*/accident treatment during the waiting period, this will be covered, subject to the policy rules.

* Trauma is defined as an event caused by accidental, violent, external and visible means, where failure to provide the medical attention would place the patient's health at serious risk.

Condition-specific waiting period

- This period applies from the date that your cover starts and applies to the principal member or dependant(s) who has a pre-existing condition.
- A pre-existing condition is a condition for which you were diagnosed, treated or given advice before you applied for cover.

Non-disclosure of information

Non-disclosure of information may result in underwriting, limitation or exclusion of benefits, or cancellation of your policy.

Applicants must answer all questions on the information form honestly and fully. The policy may be subject to underwriting at our discretion if an applicant:

- makes a false declaration.
- knowingly fails to disclose that he/she has or is suffering from an illness or condition at the time of the application.

If any of the events in the list above is evident, we may, with written confirmation:

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

Transferring your benefits

You cannot allow someone else to use this policy to get benefits or cover.

Renewing your policy

Every year when the policy is renewed, we have the right to change the policy conditions including benefits, exclusions and premium rates. We will give the Policyholder 90 days notice of the renewal terms in writing.

When policy benefits will be pro-rated

If you join the health plan between policy renewal dates, the annual out-patient policy benefit limits will be prorated on a monthly basis to reflect that cover does not apply for a full year.

Online self-service facilities

Liberty Health has made it a priority to improve and enhance correspondence and communications with its policyholders. For this reason, we have two easy ways for you to access your policy and benefit information, 24/7.

Webmail

With webmail you have all of your policy information at your fingertips, day or night, simply by sending us an email.

1

When submitting your initial information form, include your email address. We will automatically sign you up for our webmail service using your email address.

2

Access your policy information

When you need to access your policy information, all you have to do is send a blank email to **webmail@libertyhealth.net**

We will reply with the following information:

- Policy information
- Claims history
- Benefit usage

3

If you are already a member and have not given us your email address, please send an email to **info@libertyhealth.net** to request activation.

Interactive website

Our interactive website has a secure login facility where you can view and amend your policy information.

The website is the most efficient way to get answers to any questions you might have. You can:

- access and update your personal information
- track the status of your submitted claims
- find a service provider in your area
- get general health information
- check your benefit usage to date

1

Visit **www.libertyhealth.net** to register on the website.

2

How to register

1. Click on 'Register'.
2. Enter your personal details. We will send you a password.

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

NB

Access your policy information

With your secure login facility you can view, and amend some of, the following:

- Your personal contact details
- Dependant(s) information
- Your benefits
- Your policy status and joining dates
- Claims received and processed

How to Use Your Membership Card

When you join, you will receive your membership card

You need your card to access services at healthcare providers, so make sure that you have your card with you at all times.

Important: Your card remains the property of Liberty Health Cover and you must 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.

What to do if your card is lost or stolen

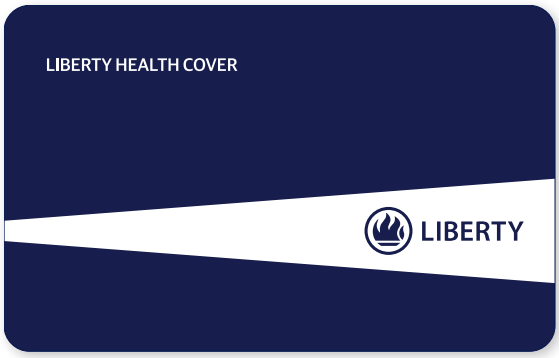
Inform us immediately either by calling your nearest Liberty Health Cover office or emailing us. If you do not inform us, you may be held personally liable for any claims paid through misuse of your card.

Fraud

If any claim you submit is false or fraudulent in any way, or if fraudulent means or devices are used by you or anyone acting on your behalf to use a benefit under this policy, the policy may be cancelled immediately and all policy benefits and premiums forfeited after the Policyholder has reviewed the matter. Legal action may also be taken against the parties involved.

Applicable law

The terms and conditions of this policy are governed, determined and enforced by, and understood in accordance with the local country law.



* The details in the membership card above are not those of a real person but are for example purposes only.

Contact Details

Ghana

Apex Health Insurance Ltd,
7 Nii Yemoh Avenue, OIC Road, Shiashie - East Legon
PO Box ST 237, Accra, Ghana, Cantonments

T + 233 265 380 622
E info@apexhealthghana.com
Emergencies (24 hrs) +233 501 304 156

Pre-authorisation (24hrs)
+233 501 304 156
Post claims to the postal address above, or email:
info@apexhealthghana.com

Kenya

Heritage Insurance Company Ltd,
Liberty House (formerly CFC House), Mamlaka Road,
PO Box 30390 00100 – GPO, Nairobi, Kenya

T +254 711 076 333
E info@heritage.co.ke

Emergencies (24 hrs) +254 733 750 004/+254 728 111 002

Pre-authorisation
+254 20 278 3000
+254 20 272 6439
+254 20 272 6440
healthcareundertakings@heritage.co.ke

Post claims to the postal address above, or email:
claims.medical@heritage.co.ke

Lesotho

Liberty Life Lesotho, Unit 39, Maseru Mall
Thetsane, Maseru, Lesotho

T + 266 2221 2719
E info@libertyhealth.net
Emergencies (24 hrs) +266 2231 4590

Pre-authorisation
+266 2231 4590
membercare@libertyhealth.net

Post claims to the physical address above, or email:
claims@libertyhealth.net

Malawi

Liberty Health, Medical Aid Society of Malawi (MASM)
MASM House, 1254 Lower Scalter Road
PO Box 1254, Blantyre, Malawi

T +265 1833 393
+265 1830 610
E malawi@libertyhealth.net

Emergencies (24 hrs) +265 993 921 957

Pre-authorisation
+265 993 921 957
membercare@libertyhealth.net

Post claims to the postal address above, or email:
malawi@libertyhealth.net

Mauritius

Liberty Health C/O Health & Travel Department
Swan General Ltd, 11th Floor, Swan Centre,
Intendance Street, Port Louis, Mauritius

T +230 212 2600/2900
E mauritius@libertyhealth.net

Emergencies (24 hrs) +230 5253 5035

Pre-authorisation
+230 212 2600
+230 5253 5035 (after hours)

Post claims to the physical address above, or email:
claims@libertyhealth.net

Mozambique

Emose Building, Av 25 de Setembro no. 1383,
5th Floor, Office No. 507 & 508, Maputo,
Mozambique

T +258 84 373 7376/7 / +258 84 390 1289
E mozambique@libertyhealth.net

Emergencies (24 hrs) +258 84 390 1289

Pre-authorisation
+258 84 586 5665 (Vodacom)
+258 82 586 5665 (Mcel)
preauthmoz@libertyhealth.net

Post claims to the physical address above, or email:
lhmozclaims@libertyhealth.net

Contact Details

Nigeria

Total Health Trust, 2 Marconi Road,
Palmgrove Estate, Lagos, Nigeria

Queries, Emergencies, Pre-authorisation
T +234 1 460 7560
+234 1 448 2105
+234 708 068 7600
E info@totalhealthtrust.com

Pre-authorisation
medical@totalhealthtrust.com
casemanagement@totalhealthtrust.com

Post claims to the physical address above, or email:
claimsmailroom@totalhealthtrust.com

South Africa

Liberty Health, Liberty Building
Estuary Precinct, Century Boulevard
Century City, 7441, Western Cape,
South Africa

T +27 21 657 7740
E info@libertyhealth.net

Tanzania

Strategis Insurance (T) Limited, Plot 48 A,
House No. 10, Mkadini Street, Oyster Bay Area,
PO Box 7893, Dar es Salaam, Tanzania

T +255 782 700 800 / +255 788 599 511
+255 782 000 200 / +255 788 599 644
E insurance@strategistz.com

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@strategistz.com

Post claims to the postal address above

Uganda

Liberty Life Assurance Uganda Limited,
Mariba Building, 3rd Floor, Plot 17,
Golf Course Road, Kololo, PO Box 22938,
Kampala, Uganda

T +256 414 233 794
+256 312 202 695
+256 414 231 983
E uganda@libertyhealth.net

Emergencies (24 hrs)
+256 779 558 733 (members)
+256 772 578 323 (providers)

Pre-authorisation
+256 414 233 794/+256 779 558 733
membercare@libertyhealth.net

Post claims to the postal address above, or email:
uganda@libertyhealth.net

Zambia

Liberty Life Insurance, Kwacha Pension House
1st Floor, Stand 4604, Tito Road,
Rhodes Park, Lusaka, Zambia

T +260 211 255 540/1/36
E zambia@libertyhealth.net

Emergencies (24 hrs) +260 950 397 863
+260 965 205 113
+260 955 256 871

Pre-authorisation
+260 211 255 540/1/36
membercare@libertyhealth.net

Post claims to the physical address above, or email:
claims@libertyhealth.net

Zimbabwe

Liberty Health, FBC Insurance Building,
Cnr Jason Moyo & 4th Street, Harare,
Zimbabwe

T +263 4707 172/3 or +263 4797 504
E info@libertyhealth.net

Emergencies (24 hrs) +263 777 766 999

Pre-authorisation
+263 4707 172/3 (am calls)
+263 777 733 999 (pm calls)
preauthzim@libertyhealth.net

Post claims to the physical address above, or email:
zimbabwe@libertyhealth.net

International emergency medical evacuation (24 hrs)
+27 21 657 7740

Notes

Disclaimer

The Liberty Health Cover product is licenced through a registered insurer in the countries where it is distributed.

Every attempt has been made to ensure complete accuracy of the information provided in this document, but we do not guarantee its accuracy. If there is a conflict between this document and the terms and conditions of a Liberty Health Cover Policy issued as a result of the information provided herein, the Policy Conditions will prevail. If there is a dispute regarding the accuracy of the information provided, but a Liberty Health Cover Policy was not issued, the information as confirmed by an actuary of the insurer will prevail.

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