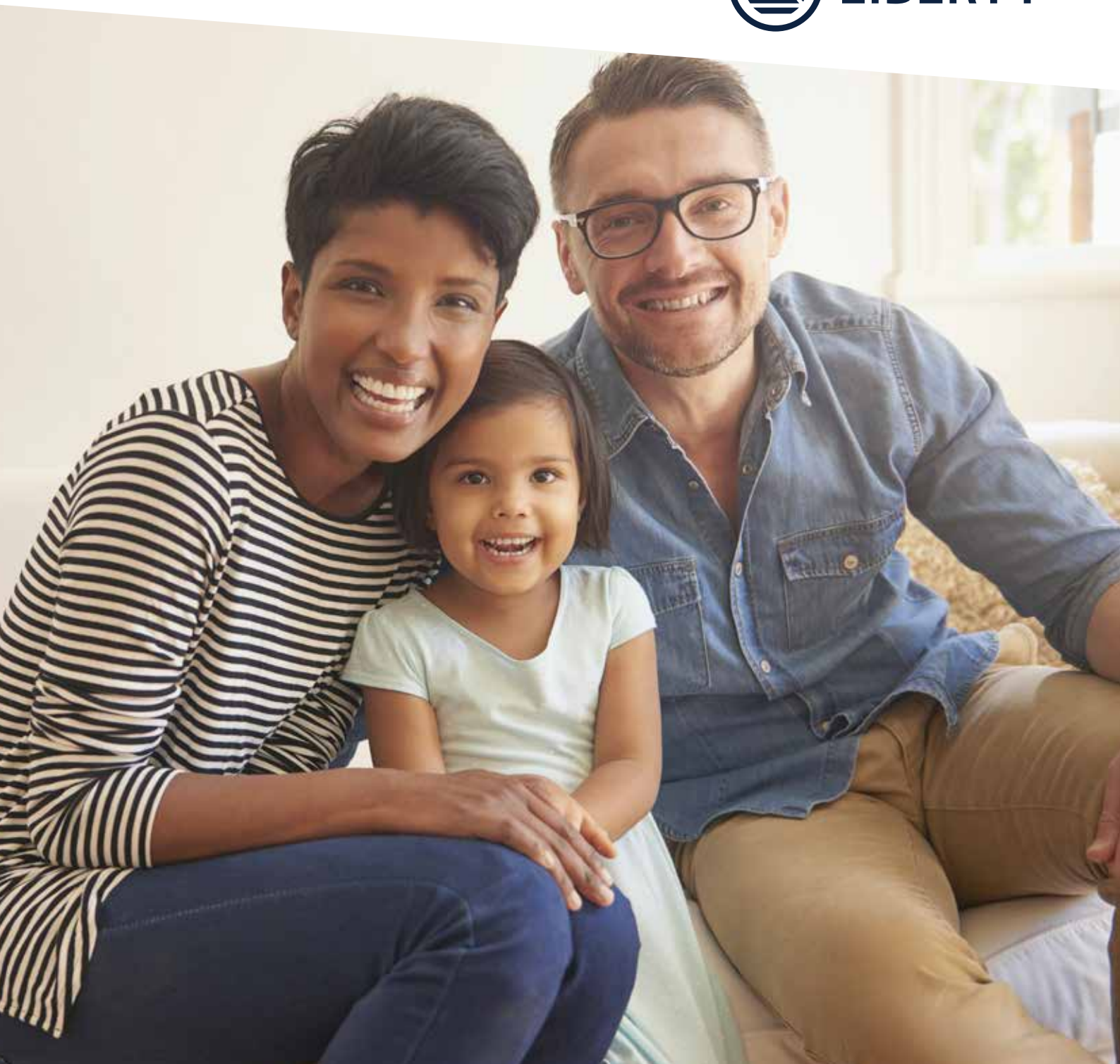
LIFE INVESTMENTS **HEALTH** CORPORATE PROPERTIES ADVICE

LIBERTY MEDICAL SCHEME

MEMBERSHIP GUIDE 2016

LIBERTY



In this Member Guide

Our core principles

01

Access to quality treatment

LMS is dedicated to giving you access to quality treatment and care. We want your option choice to deliver the best healthcare benefits you can afford. Most importantly, we want to give you peace of mind about what benefits are available to you when you need them. We keep up to date with the latest medical technology so that we can provide you with optimal care and cover in line with recognised treatments.

02

Affordable cover and value for money

Liberty Medical Scheme (LMS) aims to help you make informed choices about choosing the medical cover that will best suit your needs.

Your contributions determine your level of benefits, the rate at which we reimburse your claims and your freedom of choice when it comes to selecting your healthcare providers. We believe that value for money is about offering affordable, quality benefits. This means that even when increases in medical costs are unavoidable, we work hard to manage these increases along with our healthcare partners to keep your healthcare choices affordable.

03

We are here for you when you need us to make caring for your health easier

We take your needs to heart and focus on providing you with the best possible service and member care. We strive to provide you with regular updates and information to help you make the most of your health and your medical care. You can also access your latest membership information using our self-service tools at www.libmed.co.za. See page 45 for more information.

04

Healthcare option choices based on your preferences

We understand that you have different needs and preferences. Our option choices have been carefully designed to suit a range of different needs and to meet those needs with quality care. We continually review our benefit design to ensure we have everything you need to make the best healthcare decisions for you and your family.

LMS is focused on offering members healthcare options that are truly relevant to each stage of their life.

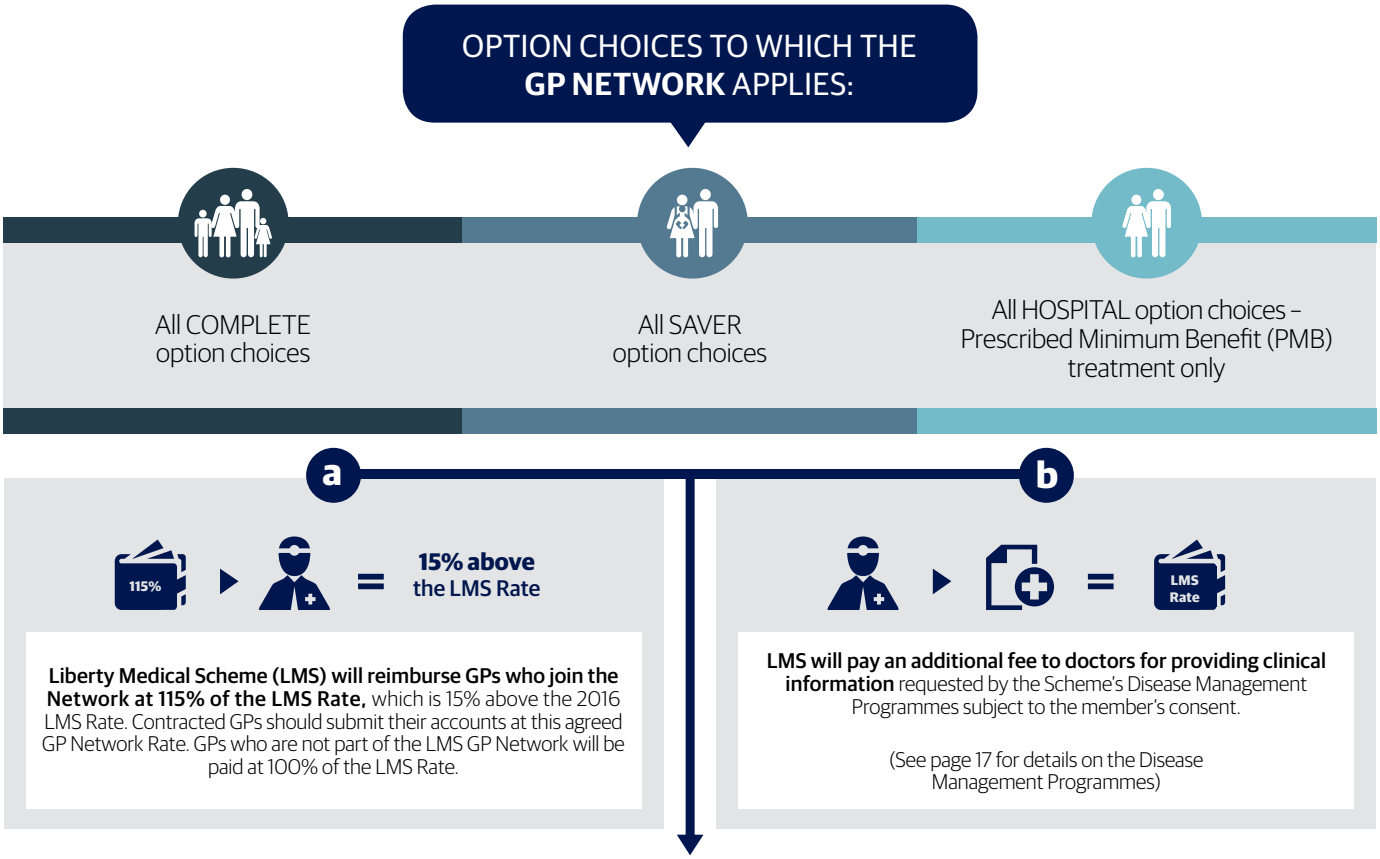
The importance of your family doctor or GP as your co-ordinator of care

We believe that your GP or family doctor is best placed to co-ordinate your care. General Practitioners, or GPs, play a central role in how primary healthcare is delivered. Thanks to government initiatives and global trends to provide better quality primary and preventative care (and reduce your cost of care), GPs will play an increasingly important role in the future. They understand your and your family's needs and have a much more rounded view of your healthcare and wellness. We therefore consider them to be the best people to know when you need more expertise in the form of a specialist, or have unique needs that we can help meet through our various clinical programmes, such as our Disease Management Programmes (please refer to page 17).

GPs play an important role in how your healthcare is managed

The LMS GP Network and how it works for you

LMS established the LMS GP Network to give each member access to a Network GP within 10km of where they live. The LMS GP Network applies to all our option choices except the TRADITIONAL option range. For example, on the TRADITIONAL Standard option choice, members make use of the CareCross primary care network. The following information explains the main features and benefits of the LMS GP Network:



We pay for two additional consultations per family at any LMS Network GP at 115% of the LMS Rate from the Major Medical Benefit (MMB), once your Savings are depleted, or if you are on a COMPLETE option choice, once you reach the Self-Payment Gap (SPG).

We also pay for two additional consultations at an LMS Network GP from the MMB for children under 2 years of age. The additional consultations apply to all COMPLETE and SAVER option choices.

The Network also serves as the Designated Service Provider (DSP) for PMBs for all three options listed in the diagram above.
If a member uses a non-Network GP for PMB services, payment will be at the LMS Rate only and not at cost.

Members can find LMS Network GPs in their area by using the Health Directory on the LMS website, **www.libmed.co.za.**

Co-payments do not apply when members use a LMS GP Network Practice.

The LMS GP Network is not applicable to practices charging patients cash.

Why do we support GPs, and why an LMS GP Network?

We believe that supporting and improving primary care is an essential building block in the provision of healthcare to you, our member.

Effective primary care and lifestyle changes play an important role in promoting health, preventing illness and reducing the extent to which hospitalisation is required as a result of complications from chronic diseases.

Your GP is at the centre of these general healthcare trends. We therefore aim to provide GPs, within the LMS GP Network, with better support to take the hassle out of healthcare administration so that they are freed up to focus on your care.

In fact we believe that the LMS GP Network saves you time and expense as you benefit from:

- Better value for money because on certain LMS option choices, two additional GP Network visits will be paid for at 115% of the LMS Rate, from your Major Medical Benefit (MMB) once your Medical Savings Facility is depleted
- Better quality and more rounded care for you, because we provide the support of our case managers and trained nurses for those who are part of our Disease Management Programmes – in consultation with your LMS Network GP
- Members on the qualifying options, and registered with the Chronic Disease Programme will have their visits included in their unique treatment plan.
- Better records of your improvements and changes over time

**Most importantly, we encourage you to develop a long-term relationship with your GP.
We encourage you to seek his or her advice and to use him or her as a consistent co-ordinator of care for all your healthcare needs.**

The LMS Specialist Network and how it works for you

The LMS Specialist Network is a preferred provider network giving you choice and access to Specialist services within a reasonable distance of where you live. Specialists in this Network then charge the Scheme a negotiated rate that is often lower than what you would usually pay.

The LMS Specialist Network applies to all our option choices except the TRADITIONAL option range.

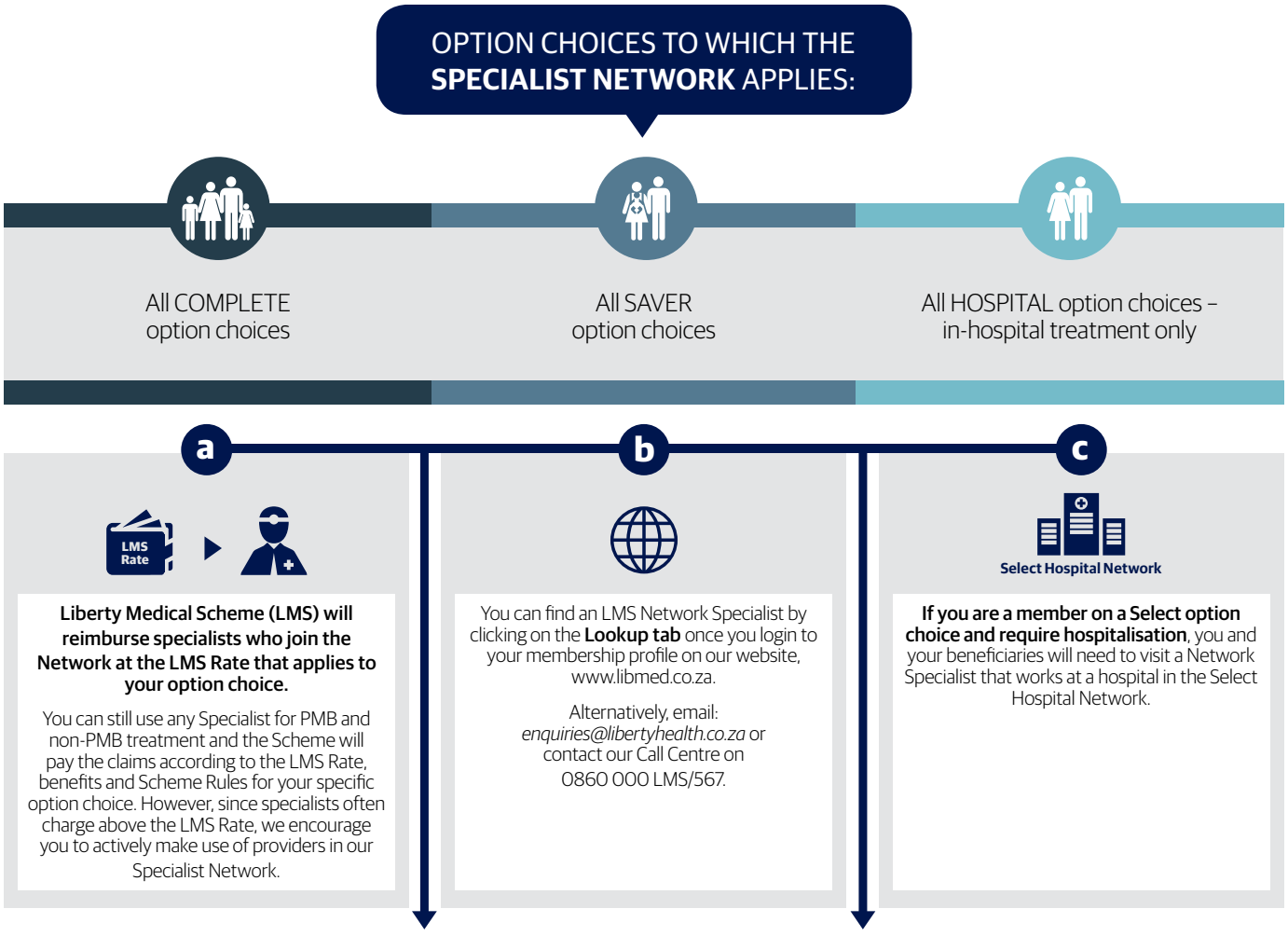
The Network does not apply to TRADITIONAL Ultimate, while members on the TRADITIONAL Standard option choice use the CareCross primary care network for specialist referrals (please see the last page of your option choice summary for the specialist referral process). The LMS Specialist Network includes most of the various discipline groups. We also assure you that we will continuously contract additional specialists to best match our membership footprint.

Why do we support Specialists, and why an LMS Specialist Network?

In addition to supporting and improving primary care, at times you and your dependants may need to see a healthcare provider that specialises in a specific field. As a result:

- LMS introduced the Specialist Network to ensure that you have affordable access to specialist care when you need it.
- We also introduced the Network to ensure you get specialist care whilst helping you to prevent out-of-pocket expenses.
- The Network also allows the Scheme to manage the increasing cost of PMB treatment, which in turn may lead to lower contribution increases than you would otherwise experience.

The following information explains the main features and benefits of the LMS Specialist Network:



Liberty Medical Scheme (LMS) will reimburse specialists who join the Network at the LMS Rate that applies to your option choice.

You can still use any Specialist for PMB and non-PMB treatment and the Scheme will pay the claims according to the LMS Rate, benefits and Scheme Rules for your specific option choice. However, since specialists often charge above the LMS Rate, we encourage you to actively make use of providers in our Specialist Network.

You can find an LMS Network Specialist by clicking on the **Lookup tab** once you login to your membership profile on our website, www.libmed.co.za.

Alternatively, email: *enquiries@libertyhealth.co.za* or contact our Call Centre on 0860 000 LMS/567.

If you are a member on a Select option choice and require hospitalisation, you and your beneficiaries will need to visit a Network Specialist that works at a hospital in the Select Hospital Network.

You may use a non-Network Specialist in the case of an emergency or when there is no Network Specialist available in your area.

If there is no Network Specialist available in your area, the Scheme will pay your claim according to the relevant Scheme Rules and available benefits that apply to your option choice. In the case where this is for PMB-related treatment, the Scheme will pay the claim subject to the relevant treatment protocols and guidelines. Please refer to the **Prescribed Minimum Benefits (PMBs) section on page 13,** which explains what is considered a PMB and how PMB treatment is paid.

In the case of a qualifying emergency medical condition, we will cover claims in full. A qualifying emergency medical condition is defined as: a medical condition that starts suddenly and unexpectedly and requires immediate medical or surgical treatment at a time when 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.

Understanding the differences between the LMS option choices

When you have to choose an option choice, it's important to consider the main features that set them apart from each other:

- The **level of hospital cover** (whether you can choose where to go for treatment, overall annual limits, who pays for what, and what is covered when, including specific exclusions)
- Whether you can choose your **healthcare provider or you are limited to using certain networks**
- **How much we will pay based on our agreed tariffs**, relative to industry norms (this is known as our LMS Rate – read more about this on page 47) and **how much you have to pay**
- Level of **day-to-day out-of-hospital cover**
- How many **defined chronic conditions** we cover

Understanding the concepts

Choice of Provider vs Network options

Choice of provider is whether you want the freedom to choose where to go and who to see as your healthcare provider, or if you prefer to choose providers that fall within a particular network. Either way, both choices offer a high standard of quality care but may differ in price.

Self-funded

You pay all day-to-day expenses from your own pocket.

Medical Savings Facility (MSF)

Your day-to-day claims (for example consultations, optometry and dentistry),on certain option choices, are paid from your Medical Savings Facility.

Above Threshold Benefit (ATB)

This is a 'safety-net', available on the COMPLETE option choices, that provides cover for your day-to-day expenses once your Savings have been depleted and your total day-to-day claims have reached the pre-determined Threshold Level.

How your day-to-day expenses will be funded

The Liberty Medical Scheme (LMS) day-to-day benefits cover your everyday medical expenses such as visits to the dentist, prescription glasses, and acute medication. Depending on the option, your day-to-day expenses are:

TRADITIONAL

Ultimate	Standard
Insured by the Scheme	
R 23 000 per beneficiary Sub-limits apply to certain benefits	CareCross Network
	Primary Care covered from the Risk contribution • GP Consultations • Minor Procedures • Basic Radiology and Pathology • Chronic Medication • Acute Medication • Basic Dentistry • Optometry

COMPLETE

Plus	Standard	Select
Funded from your Medical Savings Facility (MSF) + insured by the Scheme via the Above Threshold Benefit (ATB)		
Medical Savings Facility (MSF)		
Member: R 8 796 Adult: R 6 528 Child: R 2 532	Member: R 4 668 Adult: R 3 744 Child: R 1 260	Member: R 4 668 Adult: R 3 744 Child: R 1 260
Self-Payment Gap (SPG)		
Member: R 2 010 Adult: R 1 535 Child: R 675	Member: R 1 425 Adult: R 1 205 Child: R 305	Member: R 1 425 Adult: R 1 205 Child: R 305
Threshold Level (THL)		
Member: R10 806 Adult: R8 063 Child: R3 207	Member: R6 093 Adult: R4 949 Child: R1 565	Member: R6 093 Adult: R4 949 Child: R1 565
Above Threshold Benefit (ATB)		
No Limit, Subject to sub-limits	Member: R 3 950 Adult: R 2 330 Child: R 1 010 (Limited to 3 child dependants)	

SAVER

Plus	Standard	Select
Funded from your Medical Savings Facility (MSF)		
Medical Savings Facility (MSF)		
Member: R 3 456 Adult: R 3 108 Child: R 1 116	Member: R 3 540 Adult: R 2 904 Child: R 1 308	Member: R 3 540 Adult: R 2 904 Child: R 1 308
(Limited to 3 child dependants)		
Funded from your Own Pocket when your MSF is depleted		

HOSPITAL

Plus	Standard	Select
Funded from your own pocket		

You can access your **Above Threshold Benefit** once you reach the **Threshold Level.** To reach your Threshold Level, you need to submit your qualifying day-to-day claims which will be paid from your Savings and will accumulate towards your Threshold Level. Once you deplete your Savings, you will pay further day-to-day costs from your own pocket. However, please continue to submit all claims so that the qualifying claim costs will accumulate towards the Threshold Level. Once you reach your Threshold Level, you can access the Above Threshold Benefit subject to the relevant sub-limits. For more information on what type of claims do not accumulate to the Threshold Level, please see page 23.

2016 Benefit Summary for Liberty Medical Scheme

		TRADITIONAL		COMPLETE			SAVER			HOSPITAL		
		Ultimate	Standard	Plus	Standard	Select	Plus	Standard	Select	Plus	Standard	Select
		All choices in the TRADITIONAL Option provide various levels of cover at stated limits from a single Risk contribution		COMPLETE is a comprehensive option that has a Medical Savings Facility (MSF) and an Above Threshold Benefit (ATB) for extensive day-to-day cover			The SAVER Option offers a Medical Savings Facility (MSF) for day-to-day expenses, which makes sense to younger members			The HOSPITAL Option is for you if you prefer to be hands-on with your medical cover		
MAJOR MEDICAL BENEFITS (pre-authorisation required)	Overall Annual Limit	Unlimited	R 1 260 000 per family	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
	Choice of Hospital / Day Clinic	Choice	Choice	Choice	Choice	Select Network	Choice	Choice	Select Network	Choice	Choice	Select Network
	LMS Rate	up to 300%	DSP Rate	up to 200%	100%	100%	up to 200%	100%	100%	up to 200%	100%	100%
	Chronic conditions covered	69	27	69	31	31	31	31	31	27	27	27
	Formulary for chronic medication		CareCross	Extended	Standard	State	Standard	Standard	State	Standard	Standard	State
	Chronic medication*	Preferred Pharmacy Network	CareCross	Preferred Pharmacy Network	Preferred Pharmacy Network	State Facility	Preferred Pharmacy Network	Preferred Pharmacy Network	State Facility	Preferred Pharmacy Network	Preferred Pharmacy Network	State Facility
	Day procedures	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
	Co-payments may apply for certain procedures		✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
DAY-TO-DAY BENEFITS (how your day-to-day expenses will be funded)	Day-to-day Benefits	Insured by Scheme: R 23 000 per beneficiary Sub-limits apply to certain benefits	Insured by Scheme: Primary Care covered from Risk contribution Subject to Overall Annual Limit and sub-limits apply to certain benefits	Actively saved for via your Medical Savings Facility (MSF) + Insured by the Scheme via the Above Threshold Benefit (ATB) once out of the Self-Payment Gap (SPG)			Actively saved for via the Medical Savings Facility (MSF)			Funded from your Own Pocket		
ADDITIONAL BENEFITS / EXTENDER BENEFITS (paid from your Risk contribution and not Savings)	Casualty Benefit	✔		✔	✔	✔	✔	✔	✔	✔	✔	✔
	Crime Trauma Benefit	✔		✔	✔	✔	✔	✔	✔	✔	✔	✔
	MRI/CT Scans (out-of-hospital)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
	Preventative Care Benefits (PCBs)	✔	Basic tests used in primary care	✔	✔	✔	✔	✔	✔	✔	✔	✔
	LMS GP Network Consultations when Savings are finished			2 consultations	2 consultations	2 consultations	2 consultations	2 consultations	2 consultations			
	LMS GP Network Consultations for children under the age of 2			2 consultations	2 consultations	2 consultations	2 consultations	2 consultations	2 consultations			
	Dentistry	Subject to the Day-to-Day Benefit	Basic only	1 consultation per child under the age of 21	✔	✔	Subject to MSF	1 consultation per child under age of 21	1 consultation per child under age of 21			
	Emergency Transport Services	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
	Member Care	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
ADDITIONAL SERVICES	Liberty Baby	✔		✔	✔	✔	✔	✔	✔			
	International Care	✔		✔	✔	✔	✔	✔	✔	✔	✔	✔
MONTHLY CONTRIBUTIONS	Principal Member	R 6 416	R 1 583	R 4 889	R 2 598	R 2 108	R 2 886	R 1 972	R 1 580	R 2 343	R 1 488	R 1 246
	Adult Dependant	R 5 650	R 1 212	R 3 632	R 2 081	R 1 688	R 2 595	R 1 617	R 1 297	R 2 108	R 1 255	R 1 050
	Child Dependant *A dependant child under the age of 21, or a child who is a student at a recognised educational institution, up to and including age 26 (proof of study to be supplied annually)*	R 1 523	R 466	R 1 410	R 705	R 571	R 936	R 728	R 583	R 758	R 566	R 474

*LMS has negotiated preferred rates with these providers to help you save on dispensing fees and avoid or limit co-payments. **Contributions for child dependants are not limited to 3 dependants and are charged for each child.
Please note: The above information is high level only. Please refer to the relevant option choice summary for full details

Major Medical Benefits (MMBs)

Overview of your Major Medical Benefits

Your Major Medical Benefits provide cover for treatment including hospitalisation, prosthesis, chronic medicines, oncology, specialised radiology/ scans, in-hospital dentistry, and admission to any medical facility including casualty.

Please ensure that you pre-authorise all your treatment to ensure we can process your claims for payment against the Major Medical Benefit. Please see page 29 for all the contact details and processes you need to know.

Hospital Benefit

Your Hospital Benefit covers the cost of admission to any hospital* including private hospitals (subject to pre-authorisation and the relevant managed healthcare programme). You can use any GP or specialist for in-hospital visits**. However, we encourage you to use one of the specialists in the LMS Specialist Network (see page 6-7) to benefit from the negotiated rate that we have with them and to avoid out of pocket expenses.

Liberty Medical Scheme will pay the cost of your hospital admission and associated costs, for example specialist consultations, anaesthetists, blood tests and x-rays, from the Hospital Benefit. Some of these services are subject to further pre-authorisation. Please check your option choice summary for full details on your Hospital Benefit and how to pre-authorise your hospital stay, including emergency admissions.

Please note that co-payments and sub-limits apply to certain benefits. You will also need to pay for services and costs that are higher than the LMS Rate or the relevant sub-limit, from your own pocket. For more details, please refer to the information below and to your option choice summary.

Note ▶

* Except for members on the Select option choices who need to make use of the LMS Select Hospital Network for planned procedures (see pages 55-57), and who need to make use of specialists within the LMS Specialist Network to avoid any co-payments.

**If you are a member on TRADITIONAL Standard, please make use of the GPs and specialists (pre-authorisation required) within the CareCross Network.

Cover for associated costs during hospitalisation

100% of LMS Rate	Up to 200% of LMS Rate	Up to 300% of LMS Rate
All COMPLETE and SAVER option choices as well as the HOSPITAL Standard and HOSPITAL Select option choices	HOSPITAL Plus	TRADITIONAL Ultimate
	SAVER Plus	
TRADITIONAL Standard	COMPLETE Plus	

Co-payments

When co-payments apply

1. Certain hospital procedures are subject to co-payments on all option choices, except COMPLETE Plus and TRADITIONAL Ultimate. Please see the table below for a list of co-payments that apply to your option choice. If you are unsure if there is a co-payment for your procedure prior to admission, please check your option choice summary, or contact the LMS Call Centre to speak to our pre-authorisation staff (see page 29 for details).
2. **For the Select option choices only:** A R8 500 co-payment applies if you use a non-Network hospital or day-clinic for planned hospital admissions.
3. **For TRADITIONAL Standard:** A co-payment of R850 applies for all procedures performed endoscopically. These procedures include but are not limited to: arthroscopy, bronchoscopy, colonoscopy, cytoscopy, gastroscopy, hysteroscopy, laparoscopy, proctoscopy and sigmoidoscopy. There is no benefit for day procedures unless pre-authorised and subject to the relevant managed healthcare programme.

Note ▶ If any procedure in the table below is performed in a doctor's room, day-clinic, attached theatre or public hospital, it will be covered without a co-payment and according to the benefits and limits that apply to your option choice.

How co-payments work

- You will be responsible for paying the co-payment directly to the hospital at the time of your admission. We will pay all the other approved services related to the procedure from the Hospital Benefit.
- If you undergo more than one of the procedures in the table below in a single day, only the highest of the applicable co-payments will apply. In other words, if two procedures are performed, the co-payments for the procedures will not be added together, only the larger of the two will apply.
- No co-payment applies in the event of trauma-related surgery.
- The co-payments below do not apply to day procedures performed in a doctor's room, attached theatre, day clinic or public hospital.

Co-payments					
Procedures	**HOSPITAL Standard / Select**	**HOSPITAL Plus**	**SAVER Standard / Select**	**SAVER Plus**	**COMPLETE Standard / Select**
Colonoscopy, Sigmoidoscopy, Proctoscopy, Gastroscopy, Diagnostic Cystoscopy	R1 700	R1 700	R1 700	R1 700	No co-payment applies
Removal of Wisdom Teeth, Conservative Spinal Treatment, Needle Aspiration of Joint, Bursa or Ganglion	R1 700	R1 700	R1 700	R1 700	No co-payment applies except for conservative spinal treatment where the co-payment is R1 600
Arthroscopy, Laparoscopy, Hysteroscopy, Endometrial Ablation	R4 100	R4 100	R4 100	R4 100	No co-payment applies
Functional nasal procedures, Hysterectomy (non-cancer related)	R4 100	R4 100	R4 100	R4 100	No co-payment applies
Joint Replacements	Benefits only for qualifying PMB treatment	R 9 600	Benefits only for qualifying PMB treatment	R 9 600	R 7 750
Spinal Surgery	R 7 750	R 7 750	R 7 750	R 7 750	R 7 750
Nissen Fundoplication (reflux surgery)	R 7 750	R 7 750	R 7 750	R 7 750	No co-payment applies

Maternity admissions

Maternity benefits apply to all option choices as follows:

- All benefits are subject to pre-authorisation and the relevant managed healthcare programme.
- Benefits include delivery by a GP or medical specialist and the services of the attendant paediatrician and/or anaesthetist.
- The global obstetric fee will be paid and includes post-natal care by a GP or medical specialist up to and including the six-week post-natal consultation.
- Benefits are limited to one admission per year and only in the event of an actual delivery.
- There is no benefit in respect of false labour.
- Where applicable, this benefit includes the cost of the water birth, including the cost of hire of the birth bath, oxygen, medicine, dressings and materials supplied by a midwife. This benefit applies to a delivery by a midwife *in lieu* of hospitalisation.
- Post-natal midwife consultations are limited to four and are paid from the Medical Savings Facility (MSF), where applicable.
- There are no benefits for elective caesarean deliveries for members on TRADITIONAL Standard, except where the beneficiary is registered on the HIV Management Programme (see page 35 for more information).
- Private ward accommodation is limited to R1 900 per day on TRADITIONAL Ultimate and on all the SAVER and COMPLETE option choices.

Note ▶ Please see your option choice summary for more details on your maternity benefits, for example, number of ultrasound scans. Members on certain option choices also qualify for the Liberty Baby Programme (see page 54).

Prescribed Minimum Benefits (PMBs)

What are PMBs?

PMBs were introduced to the Medical Schemes Act to ensure that members of medical schemes would not run out of benefits for the treatment of certain conditions. PMBs therefore ensure continued quality care when you need it most.

The Department of Health took various factors into account when deciding on the diseases to be covered under PMBs: the nature of the disease and how that disease would affect the quality of life of the individual, the most common conditions, the affordability of the treatment and the financial impact on medical schemes.

PMBs include:

- A set of 270 medical conditions. The list of 270 PMB conditions and their Diagnostic and Treatment Pairs (DTPs) is available on the Council for Medical Schemes website, www.medicalschemes.com/medical_schemes_pmb/conditions_covered.htm
- 27 chronic conditions.
- Any emergency medical condition (a medical condition that starts suddenly and unexpectedly and that requires immediate medical or surgical treatment at a time when 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 cover do you get for PMBs?

- According to the Medical Schemes Act, medical schemes have to cover the costs related to the diagnosis, treatment and care of a PMB condition, as defined in the Act. The Scheme thus decides to authorise treatment as PMB treatment, and at the accepted level of care, based on the Act and subsequent related regulations.
- This means not all treatment qualifies as PMB treatment and that not all treatment related to a PMB condition is covered.
- For example, a hernia is included in the PMB list, but is only funded as a PMB under specific circumstances – for example, when the condition is complicated.
- In this case, clinical proof in the form of x-rays, blood tests and scans must be sent by your healthcare provider to the LMS Clinical Department to review and to confirm whether it qualifies as PMB treatment. An ICD-10 code (a unique code for each condition) is therefore not the only requirement for a PMB diagnosis.
- In addition, if a PMB condition can be appropriately treated on an out-patient basis, in-hospital treatment will not be pre-authorised.
- If you receive treatment for a PMB condition, it is crucial that your healthcare provider codes the level of care and pre-authorisations appropriately in order for the Scheme to identify these as possible PMB claims.
- If you are in a waiting period for a pre-existing condition related to a PMB, please note that there is no PMB cover during this period and LMS is not liable for payment.

PMB treatment is paid from available benefit limits and once these limits are exceeded, further treatment of PMB conditions is paid strictly in accordance with the treatment prescribed by the Act.

PMBs are not subject to annual benefit limits.

Each case will be assessed in terms of the Act and in accordance with our managed healthcare programmes and clinical protocols.

PMB chronic conditions covered – applicable to all option choices

Addison's Disease
Asthma
Bipolar Mood Disorder
Bronchiectasis
Cardiac Failure
Cardiomyopathy
Chronic Obstructive Pulmonary Disease
Emphysema
Chronic Renal Failure
Coronary Artery Disease
Angina
Ischaemic Heart Disease
Crohn's Disease
Diabetes Insipidus
Diabetes Mellitus Type 1
Diabetes Mellitus Type 2
Dysrhythmias
Cardiac Arrhythmias
Epilepsy
Glaucoma
Haemophilia
HIV/Aids
Hyperlipidaemia
Hypercholesterolaemia
Hypertension
Hypothyroidism
Multiple Sclerosis
Parkinson's Disease
Rheumatoid Arthritis
Schizophrenia
Systemic Lupus Erythematosus
Discoid Lupus Erythematosus
Ulcerative Colitis

Note: All conditions depicted in italics are sub-conditions.
For additional chronic conditions covered on certain option choices, please see page 15.

Additional chronic conditions covered also on certain option choices

TRADITIONAL Ultimate

Acne
Allergic Dermatitis/Eczema
Allergic Rhinitis
Alzheimer's Disease
Ankylosing Spondylitis
Anorexia Nervosa
Attention Deficit Disorder
Barrett's Oesophagitis
Bulimia Nervosa
Cerebrovascular Accident-Stroke
Conn's Disease
Cushing's Disease
Deep Vein Thrombosis
Delusional Disorders
Depression
Dermatomyositis
Generalised Anxiety Disorder
Huntington's Disease
Hypoparathyroidism
Motor Neuron Disease
Muscular Dystrophy
Myasthenia Gravis
Narcolepsy
Obsessive Compulsive Disorder
Obstructive/Reflux Nephropathy
Osteoporosis
Paget's Disease
Pancreatic Disease
Panic Disorder
Paraplegia/Quadriplegia
Pemphigus
Peripheral Vascular Disease
Pituitary Adenomas
Polyarteritis Nodosa
Post-traumatic Stress Disorder
Pulmonary Interstitial Fibrosis
Systemic Sclerosis
Thromboangiitis Obliterans
Thrombocytopaenic Purpura
Tourette's Syndrome
Valvular Heart Disease
Zollinger-Ellison Syndrome

COMPLETE Plus

Alzheimer's Disease
Ankylosing Spondylitis
Anorexia Nervosa
Barrett's Oesophagitis
Bulimia Nervosa
Cerebrovascular Accident-Stroke
Conn's Disease
Cushing's Disease
Deep Vein Thrombosis
Delusional Disorders
Depression
Dermatomyositis
Generalised Anxiety Disorder
Huntington's Disease
Hypoparathyroidism
Motor Neuron Disease
Muscular Dystrophy
Myasthenia Gravis
Narcolepsy
Obsessive Compulsive Disorder
Obstructive/Reflux Nephropathy
Osteoporosis
Paget's Disease
Pancreatic Disease
Panic Disorder
Paraplegia/Quadriplegia
Pemphigus
Peripheral Vascular Disease
Pituitary Adenomas
Polyarteritis Nodosa
Post-Traumatic Stress Disorder
Pulmonary Interstitial Fibrosis
Systemic Sclerosis
Thromboangiitis Obliterans
Thrombocytopaenic Purpura
Tourette's Syndrome
Valvular Heart Disease
Zollinger-Ellison Syndrome

The following four conditions are also included for children under the age of 21:

Attention Deficit Disorder
Allergic Dermatitis/Eczema
Acne
Allergic Rhinitis

SAVER, COMPLETE Standard and COMPLETE Select option choices for children under the age of 21

Attention Deficit Disorder
Allergic Dermatitis/Eczema
Acne
Allergic Rhinitis

Organ and bone marrow transplants

Organ transplant procedures are covered only if both the recipient and donor are beneficiaries of LMS and if the procedure and search are conducted in South Africa. Payment of the work up and transplant is subject to pre-authorisation and the relevant managed healthcare programme.

- PMB solid organ and bone marrow transplants (including immunosuppressants) are paid at 100% of Cost if obtained from a Designated Service Provider (DSP), subject to pre-authorisation and the relevant managed healthcare programme. Live donor costs, other than for a donor who is a beneficiary of the Scheme, are limited to treatment costs in the first week following the donation.
- Organ transplants other than PMB transplants (including immunosuppressants) are paid according to the LMS Rate that applies to your option choice, subject to pre-authorisation and the relevant managed healthcare programme. The organ donor procedure is covered only if both the recipient and the donor are beneficiaries of the Scheme.

Member Care

(Excluding TRADITIONAL Standard)

Our priority is to offer you affordable, sustainable and high-quality care

Our Member Care philosophy is to ensure access to appropriate and quality care for our members when they need it most. Our services are care driven and, unlike the general healthcare market, which focuses mainly on reducing healthcare costs, we aim to maximise your health outcomes through delivery of the following Member Care programmes:

Disease Management Programmes

Our Member Care team identifies high-risk beneficiaries living with some of the most common chronic conditions. Once a beneficiary agrees to take part in one of our programmes, he or she will receive regular monitoring, education and support from our team of dedicated professionals, who work in collaboration with your medical practitioner. For more information on our Disease Management Programmes, please see page 19.

Pre- and post-surgery assessment

This programme helps to ensure that identified patients, who are at high risk of complications, are in the best possible shape to successfully undergo and recover from surgery.

Pathology 'packages of care'

Our pathology 'packages of care' are groups of pathology tests that need to be done for certain pre-planned surgical procedures. These packages are pre-approved by the Scheme, subject to available benefits and limits, so that you and your healthcare providers know, prior to going to surgery, exactly what blood or other laboratory tests will be covered by the Scheme.

Post-hospitalisation support

We provide post-hospitalisation support to identified high-risk members, who require additional follow-up, by working with the appropriate healthcare providers to arrange the necessary support and care.

Qualifying beneficiaries will be registered on the appropriate Member Care programmes subject to the relevant clinical criteria being met.

Disease Management Programmes

(Excluding TRADITIONAL Standard)

What are these programmes about?

Our Disease Management Programmes help provide the care you need to live a healthy and full life. There are programmes for: hypertension, ischaemic heart disease, coronary artery disease, hyperlipidaemia, diabetes I and II, asthma, depression, bipolar disorder, epilepsy and chronic obstructive pulmonary disease (COPD).

We give members registered on these programmes education, advice and support from registered healthcare professionals, and review the medication that they use. These programmes keep you informed about your condition and assist you to manage your condition confidently to lead a better quality life.

How do you join a Disease Management Programme?

A case manager identifies you as an eligible candidate by considering the following:

- Does your condition seem particularly severe?
- Have you been hospitalised as a result of the condition?

Examples of how our programmes work for you

Asthma support

Most people with asthma should be able to enjoy a normal lifestyle, including getting a good night's sleep and participating in sport and other normal daily activities. Our Asthma Support Programme enables you to achieve this by focusing on the appropriate use of medication, while providing education and counselling to help you understand and manage your disease.

Education and support includes:

- How to manage your condition, including the best way to use your inhalers and peak flow meters
- How to reduce your asthma symptoms without affecting your lifestyle
- How to reduce the number of hospital and emergency room visits you might make

Diabetic support

The Diabetic Support Programme aims to help you control your blood sugar and addresses the importance of screening tests and lifestyle adjustments, which can greatly improve the wellbeing of diabetic patients. The programme also educates you on correct medicine management and monitoring.

Education and support includes:

- How you can achieve good glucose control
- Addressing potential risk factors for cardiovascular disease
- Discussing screening tests that may help to prevent long-term complications

Note ▶ For more information on the Oncology and HIV Management Programmes, please refer to pages 34 and 35.

Medication

Overview of your medication benefits

Liberty Medical Scheme provides benefits for acute and chronic medication. The type of medication we cover depends on your benefits and the formulary that applies to your option choice.

In this section, we explain the difference between brand and generic medication, the formularies that apply and which pharmacies to use to get your medication to benefit from the dispensing fees we have negotiated on your behalf.

Types of medication

Brand name medication

Brand name medication is developed under patent protection. A drug company may spend years on research and testing before bringing a new drug to market. A manufacturer's initial price for a new medication includes all the development costs it incurred for the drug and is usually more expensive.

Generic medication

When a medication patent is about to expire, any drug manufacturer (including the one that produced the brand name version) may apply for permission to produce a generic version of the medication.

Companies making generics do not have to do or pay for:

- The research that was needed to originally develop the medicine.
- Clinical trials to make sure that the medicine is safe and that it works.
- The initial marketing campaigns to promote the medicine.

Excluding these three factors from the cost of manufacturing means generic medication can be sold at a far lower price than the brand name version.

A generic medicine must:

- Contain the same active ingredient as the branded product.
- Be identical in strength, dose and route of administration (whether given by injection, mouth etc.)
- Be used for the same treatment as the branded product.
- Meet the same manufacturing requirements for identity, strength, purity and quality as the branded product.
- Be manufactured according to the same strict Good Manufacturing Practice (GMP) regulations required by the South African Medicines Control Council (MCC) for both brand name and generic drugs.

Understanding a medicine formulary

What is a formulary and how does it benefit you?

A formulary is a list of prescription medicines, both generic and brand name, for which the Scheme will pay. The purpose of the formulary is to steer you to the most cost-effective medicines that are sufficiently effective for treating your health condition. This means that you will get the quality medication you need to care for your health, but at a reasonable and managed cost.

The table below shows which formulary applies to your option choice. We review these formularies regularly due to changes in medicines available on the market, and each formulary is subject to change throughout the year.

Standard Formulary	Extended Formulary	No Formulary	CareCross Formulary
COMPLETE Standard and COMPLETE Select, and all SAVER and HOSPITAL option choices	COMPLETE Plus	TRADITIONAL Ultimate (except for oncology)	TRADITIONAL Standard

Please refer to the Member section of our website, www.libmed.coza, for more information on the formulary lists.

Where to get your medication

We have negotiated preferred rates with specific pharmacy groups to help you save on dispensing fees. We will pay up to the maximum negotiated dispensing fee for chronic and acute medication at these providers. These providers make up the **LMS Pharmacy Preferred Provider Network (PPPN).** You can use any service provider, but it is in your best interest to use a provider in our Network to avoid or limit co-payments.

We have Designated Service Provider (DSP) arrangements in place with Pharmacy Direct (for anti-retroviral medication). Please note that if you voluntarily obtain your anti-retroviral medication from a provider other than the contracted DSPs, a penalty will apply i.e. the benefit will be limited to 50% of the Generic Reference Price (GRP).

Members on the **Select option choices** are reminded to obtain their chronic and antiretroviral medicines from a State facility or the benefit is limited to 50% of the LMS Rate or the Generic Reference Price (GRP), if obtained through another pharmacy.

Members on **TRADITIONAL Standard** should get their medicines from their contracted Network GP or a Network-contracted pharmacy - subject to the Network treatment protocols and formularies, and registration on the Chronic Disease Programme. Only medication prescribed by a Network GP will be covered.

LMS Pharmacy Preferred Provider Network – also applies to the HOSPITAL option choices for PMB treatment only

Pharmacy group	Retail pharmacy services	Courier pharmacy services	**Acute medicines	**Chronic medicines (excl. Select option choices)	Customer contact number and/or website
Clicks (including CLICKS DIRECT MEDICINES)	Yes	* Yes	Yes	Yes	0860 254 257 www.clicks.co.za
Dis-Chem	Yes	Yes	Yes	Yes	0860 DISCHEM / 347 2436 www.dischem.co.za
Pharmacy Direct***	No	Yes	No	Yes	0860 027 800 www.pharmacydirect.co.za
Scriptnet	Yes	No	Yes	Yes	010 591 0150 www.scriptnet.co.za

* Normal courier or delivery of a 'patient-ready parcel' at Clicks stores.
** Up to the maximum negotiated dispensing fee of 26% / R28 (Excluding VAT).
*** Pharmacy Direct is the DSP for antiretrovirals.

Please make any co-payment at the point of service, as it cannot be paid from the Medical Savings Facility (MSF).
We pay for medicines subject to the Generic Reference Price (GRP).

Chronic medication

General guidelines: What we cover at what cost

- Cover requires registration and pre-authorisation with the Chronic Disease Programme.
- We apply all relevant clinical protocols, guidelines and medicine formularies to the treatment of chronic conditions covered by your option choice.
- We will pay for **In - Formulary (IF) medicines**, authorised by the Chronic Disease Programme, subject to the Generic Reference Price (GRP). TRADITIONAL Ultimate is not subject to a formulary.
- There is a **Motivation Required (MR)** for certain medicines in the formularies. These medicines require specific clinical criteria to be met for the Scheme to consider pre-authorisation. If approved, claims will be paid subject to the Generic Reference Price (GRP) and available benefits.
- **Out-of-Formulary (OF) medicines** are products that the Scheme does not favour to manage a specific chronic condition. Usually, these products are much more costly than other preferred treatment options, yet do not offer any additional clinical benefit. Liberty Medical Scheme members may use these medicines, but benefits for Out-of-Formulary (OF) medicines are limited to 50% of the Generic Reference Price (GRP).

Useful definitions

Preferred Provider Pharmacy Network (PPPN)
These are providers with whom the Scheme has negotiated preferred dispensing fees. If a member uses them, no co-payment applies, subject to members obtaining medicines within the applicable formulary.

Designated Service Provider (DSP)
A healthcare provider or group of providers selected by LMS to provide specified healthcare services to its members. If a member voluntarily uses a non-DSP, a co-payment may apply.

Generic Reference Price (GRP) or Maximum Medicine Reference Price (MMRP)
A reference pricing system that uses a benchmark (reference) price for generically similar products. We pay a maximum of that benchmark price when you claim for a generically similar product. It helps us to manage the cost of prescription medication.

Chronic medicine exclusions

We do not pay for the following type of medicines:

- Medication not proven to have relevant clinical benefit
- Medication that is more expensive than equally effective and safe alternatives
- Medication likely to lead to abuse
- Some combination products, where it is more appropriate to use single ingredient products
- New medication not approved by the Medicines Control Council (MCC), or existing medication not approved by the MCC for a specific condition
- Some expensive chronic medications which are subject to strict clinical protocols and guidelines, and that require additional pre-authorisation

Please refer to page 58 for a summary of the most common Scheme exclusions.

Day-to-day benefits

Overview of your day-to-day benefits

Your day-to-day benefits cover the cost of your qualifying* claims, up to the LMS Rate, for items such as:

- GP and Specialist consultations
- Acute medication
- Optometry
- Pathology
- Basic radiology
- Mental health services
- Auxiliary services
- Basic and specialised dentistry (excluding COMPLETE Standard and COMPLETE Select, where these services are paid from your Major Medical Benefit, subject to clinical guidelines)

* Qualifying claims include claims for day-to-day medical costs listed in your option choice summary; not listed under exclusions; unrelated to conditions for which you have a specific waiting period; and, not incurred during a general waiting period.

Depending on the option, your day-to-day benefits are:

TRADITIONAL	COMPLETE	SAVER	HOSPITAL
Insured by the Scheme	Funded from your Medical Savings Facility (MSF) + insured by the Scheme via the Above Threshold Benefit (ATB)	Funded from your Medical Savings Facility (MSF)	Funded from your own pocket

When do we pay and when do you pay?

03

Above Threshold Benefits (ATB) paid at the LMS Rate

- Applies only to the COMPLETE option choices, and subject to available sub-limits.
- This is a 'safety-net' that provides cover for your day-to-day expenses once your Savings are depleted and your total day-to-day claims have reached the Threshold Level.

THRESHOLD LEVEL (THL)

The Threshold Level (THL) is the amount you need to reach before being able to claim from the ATB. This amount is determined at the start of the benefit year and is based on the number of dependants that you have. Certain types of claims do not accumulate to the THL (see page 23).

02

Self-Payment Gap (SPG)

- Applies only to the COMPLETE option choices.
- When your Savings are depleted, you pay your day-to-day expenses from your own pocket until you reach the Threshold Level (THL).
- Ensure that you submit all qualifying claims to LMS while you are in the SPG.

01

Medical Savings Facility (MSF)

- Applies only to the COMPLETE and SAVER options.
- Qualifying day-to-day medical claims are paid from your Savings.
- The annual MSF is made available in advance for immediate use.

An example of how the Above Threshold Benefit works

A family consisting of a principal member and an adult dependant on COMPLETE Standard have an amount of R8 412 in their Medical Savings Facility for 2016. The family needs to reach a Threshold level of R11 042 before they can access the Above Threshold Benefit of R6 280. Once the Savings are depleted, the family will need to pay the next R2 630 of qualifying medical claims from their own pocket until they reach the Threshold Level. The difference between your annual Savings amount and the Threshold Level amount is called the Self-payment Gap.

Medical Savings Facility (MSF)

A percentage of your monthly contribution is allocated to the MSF:	
Option	**MSF allocation**
COMPLETE Plus and COMPLETE Standard	15%
COMPLETE Select	18.2%
SAVER Plus	10%
SAVER Standard	15%
SAVER Select	18.4%

Availability of your annual MSF:

- Your annual MSF is made available in advance for immediate use.
- The amount available to pay for benefits consists of positive Savings and credit Savings, provided that the MSF funds are not used to pay for the costs of PMB treatment. In addition, credit Savings (annual Savings made available upfront on 1 January each year) may not be used to pay for your claims before the start of the financial year.
- Your MSF is pro-rated if you join LMS after 1 January, in accordance with the number of months remaining in the year.
- As the year progresses, your monthly contributions to the MSF are offset against your advanced credit amount.
- Your MSF is pro-rated if any of your dependants resign during the benefit year.
- The MSF is used to pay for those medical expenses that qualify - please see your option choice summary for more details.

Positive Savings will be used to pay for:

- Co-payments as a result of the difference between what the Scheme will pay and what your healthcare provider charges. This excludes co-payments for chronic and acute medicines, and hospital co-payments. Please refer to your option choice summary for these co-payments.
- On request by a member, certain medical services not funded by the Scheme, such as dental implants, etc.

Please note: These payments will not accumulate to the Threshold Level (COMPLETE option only).

The money in your MSF remains available to you at all times:

- Any positive balance left over at the end of each year is carried over to the following year, after four months of the new year.
- If you are on an option choice that has a MSF and you move to a non-Savings option choice on LMS, any positive balance will be refunded to you in the fifth month after the option choice change.
- If you have a negative MSF balance at the end of the year, you will need to pay this balance back to us before 31 December of that year.

What happens to your Savings when you end your LMS membership?

- If you terminate your membership and become a member of another medical scheme on a Savings option, the positive balance will be transferred to your new scheme in the fifth month after your resignation date. You need to supply us with your new scheme's information, bank details and your new membership number to make this transfer possible.
- If you terminate your membership and do not become a member of another medical scheme, or if you become a member of a scheme on an option that does not provide a medical savings facility, any positive balance will be refunded to you in the fifth month after your resignation date.
- If you have a negative MSF balance when you terminate your membership, you will need to pay this balance back to LMS by the date of termination. Any amounts due by you will be offset against any positive MSF balance on your termination date.

Self-Payment Gap (SPG) and Above Threshold Benefit (ATB)

The Self-payment Gap (SPG) is the period after your Medical Savings Facility (MSF) has been depleted when you pay for day-to-day medical expenses from your own pocket, and until you reach the Threshold Level (THL). You can access the Above Threshold Benefit (ATB) once you reach the Threshold Level.

1 How does it work?

The SPG and ATB apply to all the COMPLETE option choices.

When the money in your MSF is depleted, you will go through a period when you need to pay for claims for day-to-day treatment from your own pocket. This is called the Self-Payment Gap (SPG).

You must continue to submit claims to us while you are in the SPG even if the claims are paid from your own pocket. Qualifying claims will accumulate to your Threshold Level (THL).

We will keep track of these out-of-pocket expenses until you reach your Threshold Level (THL).

Once you reach the THL, your Above Threshold Benefit (ATB) becomes available. The THL is simply the sum of your MSF and SPG.

2 How we determine your MSF, SPG and THL

These amounts are determined at the start of the year and are based on the number of registered dependants you have. Any THL will be pro-rated if a member or a dependant joins after the beginning of the financial year or should dependants be added or deregistered during the year, provided that no pro-ration will apply during the last three months of a benefit year.

Please refer to your option choice summary for the amounts that apply to your option choice.

Certain expenses will not accumulate to the Threshold Level but will be paid from available benefits in the MSF. These include:

- Expenses that are more than the LMS Rate
- Expenses for over-the-counter medication
- Claims in excess of benefit sub-limits
- Medication expenses that are more than the Generic Reference Price (GRP)
- Expenses in respect of LMS exclusions (see page 58).

Threshold Level (THL) and the Above Threshold Benefit (ATB)

The ATB applies to all the COMPLETE option choices.

You can access your Above Threshold Benefit once you reach the Threshold Level. To reach your Threshold Level, you need to submit your qualifying day-to-day claims, which will be paid from your Savings and will accumulate towards your Threshold Level. Once you deplete your Savings, you will pay further day-to-day costs from your own pocket. However, please continue to submit all your claims to LMS so that the qualifying claim costs will accumulate towards the Threshold Level. Once you reach your Threshold Level, you can access the Above Threshold Benefit subject to the relevant sub-limits. For more information on what type of claims do not accumulate to the Threshold Level, please see the last block in the diagram above.

Extender Benefits

Access more benefits

All option choices offer Extender Benefits, which cover a variety of essential day-to-day costs from the Major Medical Benefits so you can enjoy even more benefits without depleting your Savings, or having to pay these costs from your own pocket. Extender Benefits cover costs related to tests and immunisations, casualty, crime trauma and out of hospital MRI/CT/Radio-isotope scans on all option choices, except for TRADITIONAL Standard, which has its own set list of benefits.

Please refer to your TRADITIONAL Standard option choice summary for details of benefits covered through the Extender Benefits.

Preventative Care Benefits (PCBs)

Why PCBs are important

This benefit focuses on the early detection of serious medical conditions. These benefits apply to TRADITIONAL Ultimate, and the COMPLETE, SAVER and HOSPITAL options. In addition, all childhood immunisations listed on page 25 are also available to members on TRADITIONAL Standard.

What we do and don't cover under PCBs

- LMS will pay for the first test or immunisation per beneficiary, in each of the benefit categories listed in the tables to follow, at 100% of the LMS Rate or the Generic Reference Price (GRP). Immunisations specific to babies and children are listed on page 25.
- The PCBs do not cover the consultation cost associated with the test or other associated costs. These costs will be paid either from available day-to-day benefits or by you.
- The following tables show you the tests and immunisations we include in the Preventative Care Benefits. You can have the tests once a year unless stated otherwise in the tables.

Preventative Care Benefits				
Benefits	**Age limits**	**Gender**	**Nappi/Tariff codes**	**Description**
Pap Smear (1 liquid-based pap smear, every 3 years. If you have a liquid-based pap smear, the Scheme will not cover a normal pap smear in the same year)	From 18-60 years 1 per beneficiary	Females	4566 4559	Vaginal or cervical smears
Cholesterol Test	From 16 years 1 per beneficiary	All	4027 0013**	Total cholesterol Blood Cholesterol and/or Triglycerides
Blood Glucose Test	All 1 per beneficiary	All	4050 4057 0012**	Glucose Strip-test Glucose: Quantitative Blood Glucose
Childhood Immunisations	Up to age 6	All	See table 2 on next page	See table 2 on next page
TB Test	All 1 per beneficiary	All	0221 872938	Allergy: Skin-prick tests Tubercilin PPD
Bone Density Test, once every 3 years	From 50 years 1 per beneficiary	Females	3604 39173 50120	Bone densitometry Bone densitometry X-ray bone densitometry
Prostate Test, once every 3 years	From 45 years 1 per beneficiary	Males	4519	Prostate-specific antigen

Preventative Care Benefits (continued)				
Benefits	**Age limits**	**Gender**	**Nappi/Tariff codes**	**Description**
Chlamydia Test	<25 years 1 per beneficiary	Females	3906	Identification: Chlamydia
Flu Vaccinations	All 1 per beneficiary	All	732826 812307 813338 838853 711345 711737	Influvac Agrippal S 1 prefilled syringe Vaxigrip single dose prefilled Mutagrip single dose prefilled adult Fluvax Fluarix
HIV Test	All 1 per beneficiary	All	3932 4614 0016 0017	Antibodies to human immunodeficiency virus (HIV): ELISA Rapid Blood Test Pre-test counselling Post-test counselling
Eye Test: 1 per year (only SAVER Select, SAVER Standard and COMPLETE option choices)	Child dependant <21 years	All	11001 11081 11021 11041	Optometric Examination Optometric Examination and Visual Fields Optometric Re-examination within six months of 11001/11081 Consultation: 15 mins including the optometric examination
Dental Check-up (only SAVER Select, SAVER Standard and COMPLETE option choices) 1 per child under the age of 21	Child dependant <21 years	All	8101 8901 8104	Oral examination Consultation at consulting rooms Limited oral examination
Mammogram, once every 2 years*	From 40 years 1 per beneficiary	Females	3605 34100 39175 34101	Mammography: Unilateral or bilateral, including ultrasound X-ray mammography including ultrasound Mammography: Unilateral or bilateral X-ray mammography universal, including ultrasound
Pneumococcal Vaccine	From 65 years Under 65 years with co-morbidities 1 per beneficiary	All	836699 755826	Imovax pneumo 23 Pneumovax vaccine

* The 2-year period applies irrespective of whether a member moves between HOSPITAL Standard and HOSPITAL Select, SAVER Standard and SAVER Select, or COMPLETE Standard and COMPLETE Select.

** For services obtained at a pharmacy.

Childhood Immunisations							
Vaccinations available to babies and children							
Vaccine method	**Age of child**						
	At birth	**6 weeks•**	**10 weeks•**	**14 weeks•**	**9 months**	**18 months•**	**6 years**
BCG	✔						
Oral Polio Vaccine	✔	✔					
Rotavirus Vaccine		✔		✔			
Diphtheria, Tetanus and Whooping Cough Polio Vaccine, Haemophilus Influenzae B, Hepatitis B		✔	✔	✔		✔	
Hepatitis B		✔	✔	✔			
Pneumococcal Conjugated Vaccine		✔		✔	✔		
Measles (measles or measles/mumps/rubella (MMR) vaccinations)					✔		
Measles						✔	
Tetanus, Diphtheria, reduced strength							✔

• The Diphtheria, Tetanus and Whooping Cough, Polio, Haemophilus Influenzae B and Hepatitis B vaccines given at 6, 10, 14 weeks and 18 months may be administered as a 6-in-1 combined preparation (e.g. Hexaxim).

Nappi/Tariff codes for childhood immunisations

Nappi/Tariff codes are supplied to assist you in the billing process		
Nappi/Tariff code	**Description**	**Immunisation type**
700356 701658 715349 701657 873179	Engerix-b paediatric (new) monodose Heberbiovac HB single dose paediatric Euvax b vial Heberbiovac HB m/dose 10 dose paediatric Hepaccine-b paediatric single dose	Hepatitis B Vaccine
714133 710935	Rotarix Rotateq	Rotavirus
825522	Rouvax single dose syringe	Measles
700772 792004 879452	Priorix single dose w/pf syringe + dilutant Trimovax single prefilled syringe Morupar single dose	Measles, Mumps & Rubella (MMR)
872962	BCG intradermal infant 20 dose	Tuberculosis Vaccines (BCG)
703226 834203 813206	Actacel-pasteur Combact-hib single dose syringe Act-hib single dose syringe	Haemophilus Influenzae B Vaccines
812331 823678	Polioral 10 dose trivalent Opv-merieux 10 dose	Poliovirus Vaccine
705032 714999 715858	Prevenar Synflorix Prevenar 13	Pneumococcal Vaccines
708854 703335	Imovax polio TD polio	Diphtheria, Polio and Tetanus
700768	Tritanrix-hb single dose	Diphtheria, Polio, Tetanus & Hepatitis B
825158 703994	DTP-merieux single dose syringe Infanrix prefilled syringe	Diphtheria, Tetanus & Whooping Cough
711258	Tetraxim prefilled syringe	Diphtheria, Tetanus, Whooping Cough & Polio
707285	Infanrix hexa	Diphtheria, Tetanus, Whooping Cough, Haemophilus Influenzae B, Hepatitis B & Polio
719637	Hexaxim prefilled syringe	Diphtheria, Tetanus, Whooping Cough, Polio Vaccine, Haemophilus Influenzae B, Hepatitis B

Note ▶ Please contact the LMS Call Centre on 0860 000 LMS / 567 to confirm the correct Nappi/Tariff code before your appointment. The list of vaccinations and immunisations is a guideline only and is subject to change.

Crime Trauma Benefit

(Excluding TRADITIONAL Standard)

The Crime Trauma Benefit aims to help beneficiaries of the Scheme, who have witnessed or are victims of crime trauma, by covering the costs of related out-of-hospital medical expenses from the Major Medical Benefit (MMB). This means you don't have to use your own money or the money in your Medical Savings Facility (MSF) to pay for these services.

You can register for the Crime Trauma Benefit after reporting the crime to the police. Contact the LMS Call Centre on 0860 000 LMS / 567 with the name of the police station and the case number to activate this benefit.

Benefit conditions

- Medical expenses incurred as a result of the following events will be covered from this benefit:
    - Hijacking and attempted hijacking
    - Attempted murder
    - Assault or attempted assault, including sexual assault
    - Rape or attempted rape
    - Robbery (including armed robbery) or attempted robbery
- The Crime Trauma Benefit must be accessed within a 12-month period from the date of the event.
- This benefit is subject to the relevant managed healthcare programme.

What the benefit covers

HIV prophylaxis in the event of rape

- If you or one of your beneficiaries has been raped, HIV prophylaxis is payable under the Crime Trauma Benefit. HIV prophylaxis is treatment to help prevent HIV infection.
- Payment of the HIV prophylaxis is subject to registration on, and management by the Liberty Health HIV Management Programme (see page 35).

Counselling by psychologists, psychiatrists and social workers

The benefit applies when:

- You or one of your beneficiaries has experienced or witnessed one of the crimes listed above, and
- The crime results in the need for counselling by a registered psychologist, psychiatrist or social worker due to the trauma associated with the crime.

Casualty Benefit

(Excluding TRADITIONAL Standard)

This benefit covers the facility fee, consultations, medication, radiology and pathology associated with admissions to the emergency room, casualty ward of a registered casualty facility, or treatment in a doctor's room. This is for treatment for genuine emergencies and physical injuries or wounds resulting from external force requiring immediate treatment.

Note ▶ Treatment in an emergency room or casualty ward that leads to pre-authorised hospitalisation will be covered from your Hospital Benefit.

Benefit conditions

- You need to contact the LMS Call Centre on 0860 000 LMS/567 for pre-authorisation within 48 hours of treatment, or if it is a weekend or public holiday, on the first working day thereafter.
- If not pre-authorised, payment is subject to available funds in the MSF/ATB, or from your own pocket.
- We will assess each case on its merits to ensure that there is no abuse of these benefits – for example, where members can use their doctor instead of the casualty facility. Claims for non-emergency care, such as earache, will not be covered.

What the benefit covers

Treatment in casualty after hours and away from home is covered up to 100% of the LMS Rate limited to R1 625 per beneficiary per year for most LMS option choices, except TRADITIONAL Ultimate, which provides this benefit at 200% of the LMS Rate subject to the Day-to-day Benefit.

The member requires immediate care in the following circumstances to qualify:

- Emergency treatment (for example, treatment for asthma where a nebuliser is required)
- Out-of-business hours doctor consultations (between 7pm and 7am)
- If you are more than 200km away from your normal residence and doctor (for example when on holiday). In this case, the 7pm to 7am limits don't apply

Treatment in casualty for physical injury is unlimited

Treatment includes x-rays, stitching of deep wounds and setting of bones that have been broken.

Dentistry

(COMPLETE Standard and COMPLETE Select)

COMPLETE Standard and COMPLETE Select have a dental benefit uniquely designed to pay from the Extender Benefits and not from the MSF or the ATB. LMS has contracted with the **Dental Risk Company (DRC)** to provide dental management services related to this benefit.

Note ▶ Please see page 29 for the necessary pre-authorisation process to access these benefits. In addition, if a dental procedure coincides with a hospital admission, contact the LMS Call Centre on 0860 000 LMS / 567 for pre-authorisation.

Out-of-hospital MRI/CT/Radio-isotope Scans

(Excluding TRADITIONAL Standard)

LMS offers superior benefits by funding two out-of-hospital scans and one radio-isotope scan per family paid from the MMB for all COMPLETE, SAVER and HOSPITAL options. However, these may only be requested by a referring Specialist and are always subject to pre-authorisation whether done in or out of hospital.

Out-of-hospital MRI/CT/Radio-isotope Scans are paid at 100% of the LMS Rate for TRADITIONAL Ultimate.

Note ▶ Please contact the LMS Call Centre on 0860 000 LMS / 567 for pre-authorisation.

Additional LMS GP Network Consultations

(Excluding TRADITIONAL Standard)

LMS GP Network

We pay for two extra consultations per family at any LMS Network GP at 115% of the LMS Rate, from the MMB, when your Medical Savings Facility (MSF) is depleted or you are in the Self Payment Gap (SPG) (COMPLETE option choices). We also pay for two additional consultations for children under two years of age from the MMB.

Pre-authorisation

Overview of pre-authorisation

You need to obtain pre-authorisation for medical treatment such as prosthesis, chronic medicines, oncology, specialised radiology/ scans, in-hospital dentistry, and admission to any medical facility including casualty, to ensure that related claims can be processed against your Major Medical Benefit.

Unfortunately, no benefits will be paid unless you obtain pre-authorisation. The pre-authorisation process ensures you receive appropriate, quality treatment at the best rate, ultimately improving your health outcomes and managing the cost for both you and the Scheme.

The pre-authorisation process alerts LMS that a member is scheduled for certain types of treatment such as hospitalisation. The member, doctor and hospital can also be informed beforehand to what extent the treatment will be covered by LMS.

In addition to information in this Membership Guide, please refer to your option choice summary for all benefits that require pre-authorisation.

Pre-authorisation is granted based on:

- The validity of your membership
- Clinical appropriateness of the treatment
- The level of care and the length of your hospital stay
- The LMS Scheme Rules
- Evidence-based clinical guidelines
- Your available benefits

Hospitalisation

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

For admission to hospital and registered medical institutions, please use the following contact details:

TRADITIONAL Ultimate, COMPLETE, SAVER and HOSPITAL options
Tel 0860 000 LMS / 567, or 0860 690 900 (TRADITIONAL Ultimate)
Fax 021 657 7711
Email approvals@libertyhealth.co.za

TRADITIONAL Standard (Incl. Specialist pre-authorisation)
Tel 0860 103 491
Email crc@carecross.co.za

Note ▶ Members on the Select option choices need to use specialists that work in the LMS Select Hospital Network for planned procedures.

What information to supply

- Your membership number
- Patient details: name and date of birth
- Treating doctor details: name 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

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

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 LMS and we will pay for the additional day(s) provided that:

- The request meets clinically-appropriate criteria
- Treatment is within the Scheme Rules
- You have benefits available

Pre-authorisation does not guarantee payment

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

Even though you cannot claim against your benefits during the general waiting period, we may cover your emergency trauma treatment during this time subject to the Scheme Rules and benefits that apply to your option choice.

Pre-authorisation for emergencies

What qualifies as an emergency?

An 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 situation and cannot phone us?

In the case of an emergency hospital admission, you should ask a friend or family member to call for pre-authorisation within two business days of admission to ensure that your claims are paid.

Note ▶ Waiting periods will apply. See page 39.

In-hospital dental procedures, orthodontic treatment and basic dentistry

In-hospital dental procedures covered
(Excluding TRADITIONAL Standard*)

We will pay your hospital, dentist and anaesthetist claims from the Hospital Benefit, subject to certain sub-limits for the following dental procedures:

- Basic dentistry under general anaesthetic for children under the age of 8 years, limited to one admission per year for the HOSPITAL, SAVER and TRADITIONAL Ultimate option choices. Admission is once every three years for the COMPLETE Standard and COMPLETE Select option choices.
- Apicectomies
- Removal of impacted wisdom teeth (co-payment applicable on certain option choices), removal of teeth and roots, or exposure of teeth for orthodontic reasons
- In-hospital treatment for dental trauma (unlimited), as a result of:
    - Facial fractures
    - Cancers
    - Congenital abnormalities in the case of children born into LMS

*** If you belong to the TRADITIONAL Standard option choice, please check your option choice summary for in-hospital and basic dentistry procedures.**

Orthodontic treatment covered
(Excluding TRADITIONAL Standard)

LMS covers orthodontic treatment for dependants under the age of 21 years, subject to pre-authorisation and receipt of the orthodontic quote and motivation.

If you join LMS and your dependant's treatment has already started, pre-authorisation will be based on the treatment plan and benefit rates that would have applied when the treatment started.

Co-payments apply on certain option choices, so please check your option choice summary for further details.

Pre-authorisation for dental procedures

All SAVER option choices
LMS Call Centre 0860 000 LMS / 567
Email approvals@libertyhealth.co.za

COMPLETE Select and COMPLETE Standard
Dental Risk Company (DRC) Contact Centre
Tel 086 137 2343 or 012 741 5101
Email auth@dentalrisk.com

TRADITIONAL Ultimate Service Centre
Tel 0860 690 900

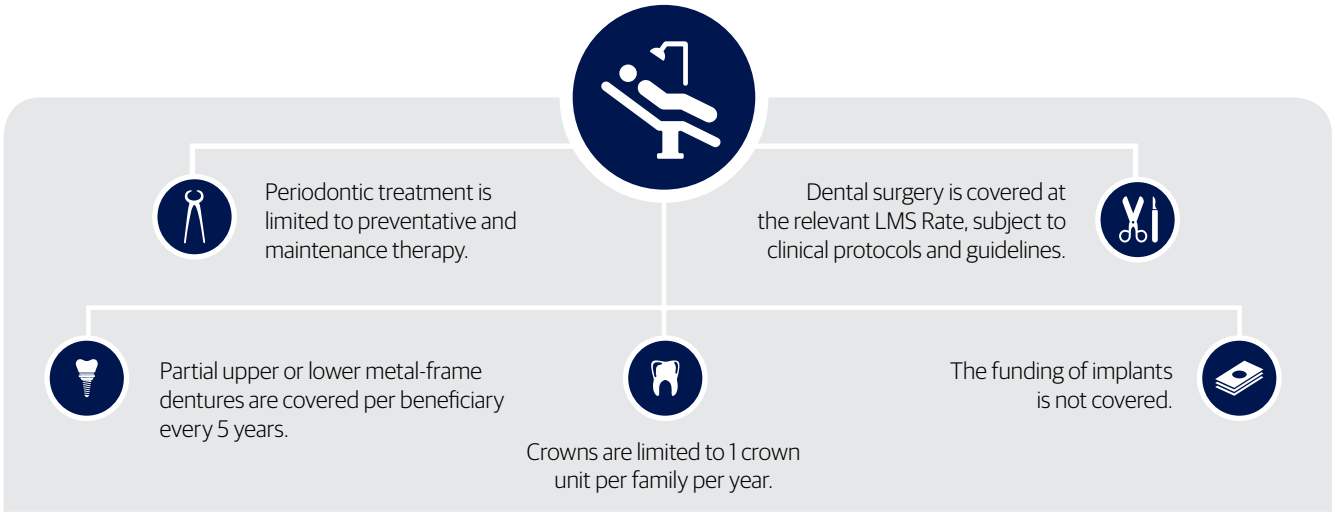
A written quote and motivation must be submitted.

Dentistry

(COMPLETE Standard and COMPLETE Select)

On the COMPLETE Standard and COMPLETE Select option choices, the following dentistry benefits are paid from your Major Medical Benefits (MMBs) and not from your Savings.

Full mouth examinations are limited to 1 per beneficiary per year. Basic dentistry is unlimited but managed according to limitations and protocols. A motivation and pre-authorisation may be requested for extensive treatment.



Orthodontic treatment is subject to pre-authorisation:

35 A 35% co-payment on the relevant LMS Rate will apply.

21 This benefit is limited to beneficiaries younger than 21 years.

For pre-authorisation and dental enquiries please call:

The Dental Risk Company (DRC)
Contact Centre: 086 137 2343 or 012 741 5101
Authorisations email: auth@dentalrisk.com
Claim queries: claims@dentalrisk.com

Chronic Medication

Chronic registration process for TRADITIONAL Ultimate, and all the COMPLETE, SAVER and HOSPITAL option choices, except the Select and TRADITIONAL Standard option choices (see page 33)

The following process applies to you if:

- You are a first-time applicant, or
- You need changes or additions to your current authorisation

1 Your doctor or pharmacist must contact the LMS Chronic Disease Programme and submit specific information relating to your condition and medication.

2 The LMS Chronic Disease Programme team, which includes experienced pharmacists, will review the application. If necessary, they will contact your doctor for additional information.

3 Once you have pre-authorisation, your medicines can be dispensed, provided you have a hand-written script from your doctor for the medicines that have been authorised.

Please refer to your option choice summary for the list of chronic conditions covered by your option choice.

Process for members on the Select option choices:

1. Consult with a GP or Specialist at a **State facility** to confirm your diagnosis.
2. The GP or Specialist must give you a script for your chronic medication.
   The script must include your membership number, date of birth and ICD-10 codes.
3. Email the script to LMS at **chronicmed@libertyhealth.co.za.**
4. Once authorised, you can collect your chronic medication from the State facility.
   Please note: The pharmacy at a State facility will not accept a script from a private practitioner.
5. If you choose to use a non-State Facility to obtain your chronic medicine, your benefit will be limited to 50% of the Generic Reference Price (GRP) and may be subject to additional non-formulary co-payments.

What happens if you don't get pre-authorisation?

- Your request might be declined if, for example, the medication is not in the relevant LMS formulary, or if insufficient information has been supplied.
- We will send a letter of explanation to you and a copy to your prescribing doctor.
- If your case is declined because of insufficient information, your doctor should provide the requested clinical information (where relevant) to our Chronic Disease Programme.
- For telephonic pre-authorisations, your doctor should contact the Chronic Disease Programme Call Centre.
- 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 LMS Chronic Disease Programme of the change.
- Your Chronic Medicine Specialist will tell you the requirements, if any, to get the changes activated.
- Additional documentation, depending on clinical protocols, may be required.
- Keep in mind that there is a possibility that the new medicine may not be not covered if, for example, it is not in the relevant LMS formulary or it falls outside the medicine management clinical protocols.

Chronic Disease Programme Call Centre

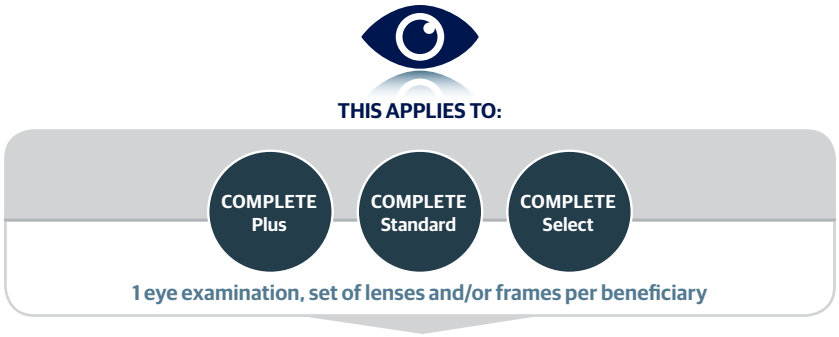
TRADITIONAL Ultimate, and the COMPLETE, SAVER and HOSPITAL options
Tel 0860 000 LMS / 567
Fax 021 657 7681
Email chronicmed@libertyhealth.co.za

If you are a member of TRADITIONAL Standard, please contact CareCross to pre-authorise your chronic medication.

Tel 0860 103 491
Email liberty@carecross.co.za

Optometry

(Subject to payment from the MSF or the ATB)



The LMS-contracted service provider for optometry is the Preferred Provider Negotiators (PPN) Network. This network consists of **over 2500 optometrists across the country.** Using PPN-contracted providers can save you a lot of money on optometry expenses. Please contact PPN for pre-authorisation to benefit from the rates that they offer.

Please visit **www.ppn.co.za** or contact them on **0861 103 529** to locate an optometrist in your area, or for assistance on your available benefits.

The following applies to all the COMPLETE option choices:

- One eye examination, lenses and/or frames per beneficiary every 12 months for COMPLETE Plus and every 24 months for COMPLETE Standard and COMPLETE Select. The 12- or 24-month cycle applies from the last claim date and not from the beginning of a new financial year. It applies irrespective of whether a member moves from one option choice to the other.
- The benefit for frames can be used for lens enhancements if you use your old frame.
- The following standard lens enhancements apply: fixed tints up to 35% of the PPN tariff. We will pay for transitions up to the PPN PGX pricing.
- No contact lenses are covered for children under the age of 16 years unless motivated. No single vision rx < 0.50 diopter will be paid or considered for payment. No bifocal/varifocal adds for less than 1 diopter will be paid or considered for payment.
- Bifocal/varifocal lenses for adults under the age of 40 years old must be motivated. No varifocals for children under age 18 years will be paid or considered for payment with the exception of post-cataract surgery.
- Claims will be paid from available benefits in your Medical Savings Facility or where you have reached your Threshold Level, from the Above Threshold Benefit.
- Please refer to your option choice summary for detailed limits and information on consultations, frames and lenses covered.
- **Benefits are subject to use of the preferred service provider.**

Oncology

(Excluding TRADITIONAL Standard)

Our Oncology Programme helps members who need to receive cancer treatment.

What process to follow to pre-authorise your treatment plan:

1. Upon diagnosis, your doctor should contact us with your treatment plan by calling **0860 000 LMS / 567,** or emailing us at: **oncology@libertyhealth.co.za**. We will review the treatment plan and, if necessary, contact your doctor to discuss alternatives that may be more appropriate and/or cost-effective for you.

2. We will send a pre-authorisation letter to you and your doctor including the following:
   - A pre-authorisation number
   - The pre-authorised treatment for which we will pay
   - The quantities for which we will pay
   - The period for which the pre-authorisation is valid

3. If your treatment changes in any way, your doctor must contact LMS to update your pre-authorisation. This is to prevent your claim from being rejected or paid from an incorrect benefit (for example, your Medical Savings Facility).

See page 35 for how to pre-authorise oncology-related procedures that are not included in your treatment plan.

If you are a member of TRADITIONAL Standard, please contact CareCross to register with their HIV Management Programme.
See contact details on page 63.

Important

You need separate pre-authorisation for procedures not specified in your approved treatment plan.

In addition to the authorisation from the LMS Oncology Programme team, you will need to get separate pre-authorisation from LMS for any hospitalisation, specialised radiology (for example MRI/CT scans and angiography) or private nursing/hospice services that you may need during the course of your oncology treatment.

TRADITIONAL Standard members should contact Carecross.

HIV Management Programme

The Liberty Health HIV Management Programme is available to all active beneficiaries on all option choices if you are HIV positive, or have been accidentally exposed to HIV.

The registration and pre-authorisation process for all option choices except the Select and TRADITIONAL Standard option choices is as follows:

1. You or your doctor must contact the **Liberty Health HIV Management Programme** to ask for a registration form:

   Tel 0860 000 LMS/567, select option 7
   Email care@libertyhealth.co.za
   Fax 021 657 7785
   SMS 'Please call me' to 082 740 6845
   Website www.libmed.co.za/hiv-aids

2. You and your doctor must complete the registration form and send the form, your prescription* and blood test results to the Liberty Health HIV Management Programme.

3. One of the Liberty Health HIV Management team members will review the form and if necessary discuss the treatment plan with your doctor.

4. One of the Liberty Health HIV Management team members will send a treatment plan to your doctor, setting out your treatment plan and medication.

5. A dedicated Liberty Health HIV Management team member will contact you on a regular basis to provide you with assistance, support and advice about your condition. He/she will also remind you of the importance of using your medication exactly as prescribed and of doing the necessary blood tests related to your disease. The greatest care will be taken to ensure confidentiality when interacting with you and your healthcare provider.

6. If your treatment needs to change, your doctor needs to contact us to update your pre-authorisation to prevent your claims from being rejected or paid from the incorrect benefit.

*** Antiretroviral medication must be obtained via Pharmacy Direct, the Designated Service Provider (DSP). If you get your antiretroviral medication from a non-DSP, the benefit may be limited to 50% of the Generic Reference Price (GRP). You can find the contact details for the DSP on page 19.**

If you are a member of TRADITIONAL Standard, please contact CareCross to register with their HIV Management Programme. See contact details on page 63.

The pre-authorisation process to follow for all Select option choices is as follows:

1. Consult a clinic or doctor at a **State facility**. If you are not sure where your nearest State facility is, contact the **Liberty Health HIV Management Programme:**

   Tel 0860 690 909
   Fax 021 673 8779
   SMS 'Please call me' to 082 740 6845
   Email care@libertyhealth.co.za

2. Either you or the treating doctor must contact the Liberty Health HIV Management Programme to ask for a registration form. You and your doctor must complete the registration form and send the form, your prescription and blood test results to the Liberty Health HIV Management Programme.

3. One of the dedicated team members from the Liberty Health HIV Management Programme will review the registration form and if additional information, depending on the clinical protocols and guidelines, is required, they will contact your treating doctor.

4. A dedicated team member will contact you to provide counselling and advice related to your care. You can rest assured that your information is confidential at all times.

5. Your medication will be provided to you by the State facility. If you get your HIV medication from your local pharmacy, a 50% co-payment will apply.

6. If your treatment needs to change, your doctor needs to contact us to update your pre-authorisation. This is to prevent your claims from being rejected or paid from the incorrect benefit.

Managing your membership

Understanding your membership

Membership to LMS is open to anyone who wishes to join, whether as an individual or as part of an employer group. Every medical scheme has certain rules, regulations and conditions that govern membership of the scheme.

In this section, we explain our general membership terms and conditions, how to add new dependants to your membership or to ensure that you pay the relevant type of contributions for your dependants. We also explain how to ensure payment of your contributions or claims debt that may arise.

General membership terms and conditions

- No person, whether a member or dependant, may be a beneficiary of more than one medical scheme at the same time.
- You may not cede (give away), transfer, pledge (promise) or make over to any third party any benefit, claim, or part thereof that you have against LMS.
- The relationship between LMS and its members is at all times one of trust and good faith. When you become a member, you acknowledge and agree to give LMS all and any information that may affect a decision that concerns you, your dependants or your claims.
- Whether you use your benefits or not, you must pay your contributions every month.
- Pro-ration of benefits may occur if you join during a benefit year. The benefit year runs from 1 January to 31 December.

Spouses and partners as dependants

- A spouse is the person to whom the main member is married in terms of any law or recognised custom.
- Ex-spouses do not qualify for registration as dependants, unless they qualify as partners.
- Spouses and partners will be charged adult dependant rates, even if they are under the age of 21.

Adding dependants to your membership

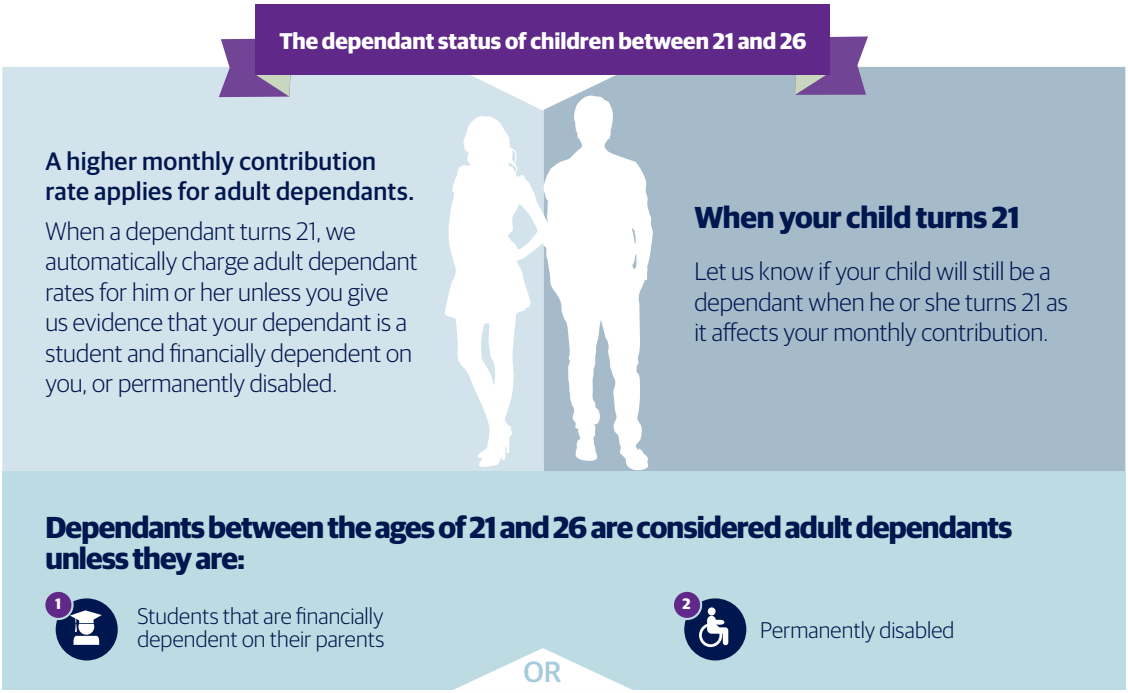
- You will need to submit a Dependant Registration form signed by the principal member to add a dependant to your membership.
- When adding new dependants to your membership, your contributions will be increased and will be due from the first day of the registration month.
- When adding your natural newborn child to your membership, your contributions will be increased and will be due from the first of the month following the birth, provided the baby is registered within 30 days of birth, although your benefits will be available immediately.

Children or minors as principal members

If parents or legal guardians want to make a minor child a principal member to ensure that he or she has medical cover without the parents or legal guardian necessarily having cover, we need to receive the following:

- An affidavit from the legal guardian or parent confirming that Liberty Medical Scheme may register the minor as a principal member, and
- Confirmation that the legal guardian or parent will sign the necessary documents on behalf of the child principal member.

Principal member rates still apply even though the principal member is younger than 21 years old.



What to do when your dependant turns 21

If your dependant is over 21 and you want to pay child dependant rates, you need to submit one of the following documents to us as proof that he/she still qualifies for these rates:

- Proof of registration at a recognised educational institution. Student cards do not qualify as proof.
- A copy of your doctor's disability report confirming permanent disability (not older than 6 months).
- We will make the change to your dependant's status on your membership in the month after we receive the relevant documents. No backdating will be allowed.

A **permanently disabled adult dependant** can remain on their parent's membership **after the age of 27** provided we receive a doctor's report (not older than six months) confirming their disability. Adult Dependant Rates will apply.

Important

If we do not receive the above documents, we will automatically charge the adult dependant contribution rates for your dependant up to and including age 26. This is the age at which your dependant needs to become a principal member in his or her own right.

Documents you must provide to add dependants to your LMS membership

Document(s) required	Lawful spouse	Partner	Child* under the age of 21***	Child* 21 years and older ****	Biological parent of applicant *****	Biological sibling of applicant *****
Copy of ID/passport (only if not SA citizen)/birth certificate/hospital confirmation reflecting the baby's name	✔	✔	✔	✔	✔	✔
Copy of marriage certificate	✔					
Copy of the latest payslip/salary advice	✔	✔		✔	✔	✔
Copy of membership certificate(s)/affidavit detailing previous medical scheme cover**	✔	✔	✔	✔	✔	✔
LMS Declaration**** confirming financial dependency of adult dependants. Sharing a common household and if unemployed, a copy of payslip of dependant indicating the monthly income of the dependant including State grants, or a certified copy of the dependant's IRP5*****				✔		✔
Proof of studies (current proof of registration at a recognised educational institution. Student cards will not be accepted)*****				✔		✔
Copy of your doctor's disability report (if applicable) indicating permanent disability (not older than 6 months)				✔		✔
Proof of legal adoption or fostering (if applicable)				✔		✔

* Child means an applicant's natural child, child by virtue of a surrogate motherhood agreement as provided for in the Children's Act (Act 38 of 2005), a stepchild or legally adopted child and who is not a beneficiary of any other medical scheme.
** Copy of Membership Certificate(s)/Affidavit detailing previous cover (registration date, benefit date, resignation date, any/all waiting periods and late joiner penalties). Membership cards or copies thereof will not be accepted. If not attached, a Late Joiner Penalty may apply.
*** Affidavit stamped by the Commissioner of Oaths, completed by the parent or court-appointed legal guardian granting Liberty Medical Scheme authorisation to register a minor, younger than age 18, as a principal member.
**** LMS Declaration templates are available at www.libmed.co.za.
***** Subject to annual review.

Waiting periods

When do waiting periods apply?

If you have not been a member of a medical scheme for at least 90 days before you apply for LMS membership, we can give you a 3-month waiting period and/or a 12-month condition-specific waiting period. This includes a waiting period for treatment of Prescribed Minimum Benefit (PMB) conditions.

Category	3-month general waiting period	12-month condition-specific waiting period	Applied to PMB
New beneficiaries who have not had medical cover for 90 days or more preceding their application	Yes	Yes	Yes
Applicants who were beneficiaries of a medical scheme for less than 2 years and apply within 90 days of leaving their previous scheme	No*	Yes*	No*
Applicants who were beneficiaries of a medical scheme for more than 2 years and apply within 90 days of leaving their previous scheme	Yes	No	No
Change of option choice at the beginning of the benefit year	No*	No*	No*
Child dependant born during period of membership and registered within 30 days	No	No	No
Change of employment and application within 90 days**	No*	No*	No*

* Balance of unexpired waiting period may be applied.
** Resulting in moving from a closed / restricted medical scheme to an open scheme only.

Three-month general waiting period

- This period applies for three months from the date that your LMS cover starts.
- You must pay your monthly contributions during the waiting period.
- We may also decide to apply the remaining period of a valid general waiting period imposed by a previous scheme, or that was applied on a previous LMS option choice.
- A three-month 'general waiting period' is a period during which you are not entitled to claim any benefits with the exception of treatment for PMB conditions.
- A three-month 'PMB waiting period' is a period during which you are not entitled to claim any benefits, including treatment for PMB conditions. PMBs are a set of defined benefits to ensure that all members have access to certain minimum health services, for which medical schemes have to cover the costs related to the diagnosis, treatment and care of any emergency medical condition, a limited set of 270 medical conditions and 27 chronic conditions.
- If you need emergency trauma* treatment during the three-month waiting period, this will be covered, subject to the LMS Rules and the benefits of your option choice.

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

12-month condition-specific waiting period

- This period applies for 12 months from the date that your LMS cover starts and applies to the principal member or any dependant who has a pre-existing condition.
- A pre-existing condition is a condition for which you were diagnosed, treated or given advice in the 12 months before you applied for LMS membership.
- We may also decide to apply the remaining period of a current condition-specific waiting period applied by a previous medical scheme, or that was applied on a previous LMS option choice.
- If you have any questions about pre-existing conditions, please contact the LMS Call Centre on 0860 000 LMS / 567.Late-joiner penalties.

Late-joiner penalties

Who must pay late-joiner penalty fees?

We may apply late-joiner penalties on a new member or a dependant of a member if:

- The person is 35 years or older and has not been a continuous member of a medical scheme prior to 1 April 2001, or
- If the person had a break in medical scheme cover of more than three consecutive months after this date.

How late-joiner penalties are calculated

- The late-joiner penalty is calculated as a percentage of your contribution (see the table below). It applies for life, even when you transfer to another medical scheme.
- We base our decisions on our underwriting policy when applying late-joiner penalties, and in some cases, our policy is less strict than the guidelines given by the law as shown in the table below.

Note ▶ It is your responsibility to provide adequate proof of previous medical scheme cover when you apply for LMS membership to avoid late-joiner penalty fees.

Number of years applicant was not a member of a medical scheme after age 35	Maximum penalty
0–4	5%
5–14	25%
15–24	50%
25+ years	75%

Removing late-joiner penalties

Late-joiner penalties can be reviewed if you provide us with one of the following:

- A membership certificate as proof of your current cover if you are a beneficiary of a medical scheme at the time of application to LMS.
- A sworn affidavit, clearly stating the name(s) of the medical scheme(s) and period(s) of cover by previous schemes if you don't have, for example, a membership certificate as proof of cover.

The penalty will be removed from the first of the month after we receive the above proof.

Changing your option choice

Changes in option choice are effective from 1 January each year. The benefit year runs from 1 January to 31 December each year.

Individual members

Once LMS communicates the start of the annual option choice change period, you can change your option choice online by visiting **www.libmed.co.za** for more details, or by contacting the **LMS Call Centre on 0860 000 LMS / 567**. Unfortunately, option changes are not allowed during the benefit year.

Employer Group members

Once LMS communicates the start of the annual option choice change period, you can submit your option choice changes via your HR Department. Option choice changes sent by the HR Department must include the following information:

- A letter on the official company letterhead, signed by the HR Manager/Managing Director confirming the option choice changes for employees effective 1 January the following year.
- An Excel spread sheet with the following details for each person who has an option choice change:
  - Employee name
  - Employee number
  - Membership number
  - ID number
  - New option choice
  - Proof of income for employees who are on an income-based option choice

Terminating or ending your LMS membership

Notice period for terminating membership

- Only you, as the principal member, may terminate or end your LMS membership. You can end your membership by providing the Scheme with one calendar month written notice. You can send this written notice directly to the Scheme or via your Financial Adviser. However, if belonging to LMS is a condition of employment, you may not terminate your LMS membership, unless you get written consent from your employer.
- If a dependant no longer satisfies the conditions on which he or she was accepted as a dependant on LMS, you must give written notice to LMS within 30 days of the event. The written notice of termination must come from the principal member or through his or her appointed Financial Adviser.
- Employer groups may terminate their membership by giving three months written notice to LMS.

Automatic membership termination

Your membership will be terminated automatically under the following circumstances:

- If you owe money to LMS and fail to pay your debt within 60 days of notification of the debt owed to us.
- If LMS finds you guilty of abusing privileges, making false claims, misrepresentation or non-disclosure of factual information relating to any medical condition. LMS may also require a refund from you of any medical payments paid out as a result of these actions.
- When a dependant is no longer eligible for registration as a dependant, he or she will not be entitled to any benefits, regardless of whether or not LMS has been informed.

Membership after retirement or death

As stated by the Medical Schemes Act (Act No 131 of 1998), all medical schemes must provide for continuation of membership when a principal member retires from employment, or in the event of his/her death, to allow the surviving beneficiaries to remain or become principal members.

The following documentation is required in the event of death:

- Certified copy of the death certificate of the principal member, who is deceased
- Certified copy of ID of the deceased principal member
- Certified copy of ID of the new principal member
- Letter from the surviving spouse/dependants indicating the new principal member
- Banking details of the new principal member for contribution collection
- Signed declaration of the new principal member (Section 6 of the membership application form)

Reinstating your membership

If you voluntarily terminate your membership and want to be reinstated, the following applies:

- If you ask to be reinstated after the final termination date (when your membership officially ends), you must reapply for new membership, and underwriting may apply.
- If you ask to be reinstated before the final termination date (when your membership officially ends), your membership will be reinstated without a break in continuity.

Contributions

How contributions are calculated

We calculate your contributions based on the option choice you choose, the number of your dependants, and late-joiner penalties (where applicable).

When and how contributions must be paid

- Your membership application is subject to a debit order instruction signed by you.
- In the case of split billing (that is, a member portion and employer/pension fund portion), the member is liable or responsible to ensure payment of the full contribution.
- Contributions must be paid monthly in advance and not later than the third day following the due date each month.

LMS Banking Details for Contribution payments only

Account holder	Liberty Medical Scheme
Bank	Standard Bank
Branch	Claremont
Branch code	025109
Account number	240402235

Debts

What happens if you owe us money?

Please be aware that any amounts owed to LMS will be recovered in the following cases:

1. **No payment received by the due date – we can suspend your benefits**
   - When contributions or any other debt owed to LMS have not been paid by the due date, LMS will suspend your membership and all benefit payments that we owe you, regardless of when you claimed for the benefit.
   - We will also give you and/or your employer notice that if contributions are not paid by the due date, your membership benefits shall be suspended.

2. **If you pay your debt within 30 days, your membership will be reinstated**
   If you make the outstanding payments before the 30 days, we will reinstate your benefits without any break in your membership. However, we have the right to charge a reasonable fee to cover any expenses related to recovering your debt.

3. **If you fail to pay your debt within 30 days, your membership will remain suspended**
   If you do not make the outstanding payment(s) within 30 days, your membership will remain suspended and in the case where your contribution was not paid, a double deduction will be placed on your next debit order.

4. **After 60 days of non-payment, your membership will be terminated**
   - If you do not make the outstanding payments within 60 days, your membership will be terminated.
   - If your membership is terminated, you can re-apply for membership, on condition that all debts owed to the Scheme have been paid in full. Underwriting may also apply.

5. **After 90 days, we may hand the matter over to the debt collectors**
   - If the debt is still due after 90 days, we may hand the matter over to the debt collectors to collect the amount(s) owed by you.
   - LMS allows payment arrangements for a maximum of three months only, provided you have submitted a signed Acknowledgement of Debt Form.

Advanced overspent debt on the MSF

If your option choice has a Medical Savings Facility (MSF), you and your dependants will have access to your entire annual MSF amount, in advance, from 1 January each year for your immediate use. We then allocate a portion of your monthly contribution to offset this advance by that amount each month over the course of the benefit year.

The following changes to your membership could result in the value of claims paid for you and your dependants exceeding the portion of monthly contributions allocated to your MSF:

- a resignation of one of your dependants mid-year that lowered your contributions and the related MSF limit, and/or
- a dependant status change mid-year (to child rates) that changed your contributions and reduced your MSF limit for the year.

If debt results on the MSF due to the above reasons, we can deduct the outstanding amount from your bank account or you can pay the amount owed directly into the LMS bank account. This amount must be paid before 31 December of the benefit year. An LMS consultant will contact you if this happens.

LMS Banking Details for Savings/Claims debt payments only

Account holder	Liberty Medical Scheme
Bank	Standard Bank
Branch	Claremont
Branch code	025109
Account number	240402294

Accessing your Membership Information

In these busy times, isn't it a welcome relief to have access to services that enable you to get the latest information on your medical scheme option, according to your schedule and not just during office hours? This is why LMS has invested in technology to ensure that you can access your information wherever you are, whenever you want.

WEBSITE SELF-SERVICE FACILITY

How to Register

1. Go to **www.libmed.co.za**
2. Click on **'Register'** on the top right of the page and follow the easy steps

If you are having trouble, contact the LMS Call Centre on **0860 000 LMS / 567,** or if you are a member of **TRADITIONAL Ultimate**, contact your Service Centre on **0860 690 900**

Once you have registered on the website, you will be able to:

1. Check or update your contact details
2. Monitor all the transactions on your account
3. View claims submitted and the payment status of all claims
4. View your Savings and other benefit balances
5. Look up the contact details and address of a medical provider in your area

Note ▶ **Members on the TRADITIONAL Standard option choice must access the CareCross website.**

EMAIL SELF-SERVICE FACILITY

To use this facility, register by contacting the LMS Call Centre on **0860 000 LMS / 567**, or as a member of **TRADITIONAL Ultimate**, please contact your Service Centre on **0860 690 900**

Our email service is available **24 hours a day**

All you have to do is send a blank email to **webmail@libertyhealth.co.za**

You will get a return email with the following information:

1. Your membership details
2. Contributions to date
3. Your claims history
4. Benefits used to date
5. A copy of your latest claims statement
6. A copy of your current tax letter

Note ▶ **Members on the TRADITIONAL Standard option choice must access the CareCross website.**

MOBILE SELF-SERVICE FACILITY

To receive your key membership information on your cellphone, simply SMS the relevant two-letter code – from the list on the right – to **39372**. (SMSes are charged at standard SMS rates) ▶

Important:

To use this facility, you must register your cellphone number with the LMS Call Centre on **0860 000 LMS / 567**

1. To confirm your membership details: **SMS 'DE'**
2. To request your Financial Adviser's details: **SMS 'BR'**
3. To get a list of self-help instructions: **Send a blank SMS**
4. To request a copy of your current tax letter: **SMS 'TX'** *(The letter will be emailed to you or sent to your registered postal address)*
5. To get a summary of your most recent claims: **SMS 'CL'**
6. To get your benefit balances: **SMS 'BN'**

Note ▶ **Members on the TRADITIONAL Standard option choice will be able to access their membership details and other limited services using the above system.**

Making the most of your cover

Overview

Whether you are single or responsible for your family, you know how important it is to manage your medical scheme benefits and costs without compromising on the quality of your care.

In this section, we explain how LMS negotiates rates on your behalf to help you save costs. We also give you several suggestions on how to make your medical cover last longer.

What is the LMS Rate?

Liberty Medical Scheme pays qualifying claims at the LMS Rate. The LMS Rate is the tariff or cost that we will pay for a particular healthcare service (e.g., consultations, medicines, procedures and examinations). The LMS Rate varies between 100% and 300% depending on your option choice (your option choice summary will tell you what LMS Rate applies to each of your benefits). For a more detailed definition of the LMS Rate, please refer to the Glossary on page 60.

The LMS Rate does not necessarily confirm the amount that will be paid. The exact amount paid is subject to the relevant Scheme Rules, clinical protocols and guidelines, as well as your available benefits at the time we process your claim.

Because of the number of healthcare services, it is not practical to publish a list of all the tariffs. If you or your doctor want to know what the LMS Rate is for a particular healthcare service, please contact the LMS Call Centre on 0860 000 LMS / 567, or members of TRADITIONAL Ultimate can contact their Service Centre on 0860 690 900. Have the treatment/tariff code(s) information ready so you can ask what the LMS Rate is for that treatment or service. Members on the TRADITIONAL Standard option choice must contact CareCross if they want to know at what Network Rate a specific service will be reimbursed.

Every healthcare provider is allowed to set his/her own fees and thus not all healthcare providers will charge the LMS Rate. Please check what rate your healthcare provider charges. LMS also negotiates directly with certain provider groups, for example hospitals, pathologists and radiologists, to ensure competitive rates for our members.

Note ▶ If your healthcare provider charges more than the LMS Rate, you will have to pay the difference between the LMS Rate and the amount charged. We therefore encourage you to discuss the fees that will be charged with your healthcare provider before you have treatment.

As a patient, it is your right to negotiate the fees for any service you receive. Many providers will charge the LMS Rate or lower their fees if you pay cash at the time of service.

Selecting a healthcare provider

When choosing a service provider, always consider the following:

- The service providers' medical credentials, experience and reputation in the field.
- Do they charge LMS or Network rates (CareCross only), or do they charge more?
- Is the service provider willing to tell you their rates upfront (prior to treatment)?
- Will they give you a discount for immediate or early payment?
- Do they require payment immediately after providing you with their services or will they send the account directly to the Scheme?
- Are they electronically linked to submit claims on your behalf? This will ensure quicker and more efficient processing and/or payment of your claims.

LMS Rates and paying your healthcare provider

- If your doctor stated that he/she does charge the LMS Rate or Network Rate, check your monthly claims statement to see if he/she charged the correct amount. If yes, then the amount charged will be reflected as equal to the benefit amount.
- Providers who charge the LMS or Network rates will be paid directly by LMS or CareCross respectively. However, certain providers may still require that you pay them directly and claim back from LMS.
- If your doctor does not charge LMS Rates, try to negotiate a lower fee or offer to pay a discounted fee in cash at the time. You can claim this amount back, subject to available benefits.
- If you are required to pay the account upfront and claim the money back from your available benefits, please refer to the section 'How to claim' on page 49.
- For the TRADITIONAL Standard option choice, the Network Rate is the lower of cost or the tariff as agreed with by CareCross.
- Members on the TRADITIONAL Standard option choice must follow the CareCross reimbursement process.

CareCross process:

You will be required to pay the accounts upfront before submitting for reimbursement. For reimbursement, members should submit the following documents to CareCross by email at reimbursements@carecross.co.za, or by post to CareCross Health, P.O. Box 44991, Claremont, 7735:

- The fully detailed account
- A copy of proof of payment
- A completed Member Reimbursement Form (available on the CareCross website or by contacting the CareCross Call Centre).

Managing your healthcare provider expenses

You may be able to save costs on medical expenses by doing the following:

- Getting a second opinion before incurring large medical costs or agreeing to surgery.
- If your doctor asks for blood tests, confirm that all the tests are medically necessary. If you have had a similar test done recently, inform your doctor and find out if a re-test is still necessary.
- Consult a General Practitioner (GP) before going to a specialist. Members on the TRADITIONAL Standard option must always be referred by a nominated Network GP or contracted Network Specialist.
- If you receive a prescription for medication, always ask if a generic is available.

General guidelines

- Always have your membership card with you, especially if you are a member of the TRADITIONAL Standard option choice.
- Try to know and stay within your providers' practice hours or you may be charged higher fees for visiting the provider outside their normal practice hours.
- If you need blood tests, x-rays and similar diagnostic tests, always check with your GP if these are covered, as he or she may need to get pre-authorisation for a test that is not covered.
- Ask your doctor questions if you need more information or if you are unsure of the treatment.
- You will be liable for the cost of services outside the list of benefits given in your option choice summary.
- The benefits shall apply only in respect of services obtained within the borders of the Republic of South Africa. Services obtained from practitioners in Lesotho or Swaziland who have a valid South African practice number will also qualify.

What LMS does not cover

Like other medical schemes, there are certain benefits that LMS does not cover at all. These are known as exclusions.

Refer to page 58 for a summary of most common Scheme exclusions. Since this list changes from time to time, you can find the latest information by visiting: www.libmed.co.za.

How to claim

An overview on submitting claims

We have made the claims process as simple as possible for you. The diagram below lists all the details needed when submitting a claim to LMS.

Information that MUST be on the claim

- The correct membership number
- Member's last name and initials
- Full name of the patient
- Date of birth of the patient
- The correct dependant code
- The date of service
- Treatment code (Tariff/Nappi)
- The amount charged
- ICD-10 code on every item listed on the claim
- The service provider's name and practice number

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.

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

*** Proof of payment must be submitted with any refund that needs to be paid to a member. A written note indicating 'paid by member' or a 'paid' stamp will no longer be accepted. If the correct proof of payment is not attached, the account will be rejected.**

Sending claims to LMS

Electronically: Most service providers have the ability to send claims to us electronically, ensuring a very short processing time.

Email: claims@libertyhealth.co.za

Post: Private Bag X3, Century City, 7446

Sending claims to TRADITIONAL Standard

Electronically: Most service providers have the ability to send claims to CareCross electronically, ensuring a very short processing time.

Email: liberty@carecross.co.za

Post: P.O. Box 44991, Claremont, 7735

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 the Scheme), and to check your account compared to the services you received.

Basic claim guidelines

- We need to get claims within four months following the month in which the services were provided. After that a claim becomes a stale claim and will not be paid. Please see more information on stale claims on page 50.
- 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 the Scheme.
- If your provider expects you to pay for the services upfront and then claim from the Scheme, please send us the fully detailed and signed claim (not just the receipt).
- The Scheme needs the details of what is being claimed for to make sure that we process your claim quickly and correctly.

Stale claims

- If you submit a claim after the end of the fourth month following the month in which the services were provided, as stated on the claim, LMS or CareCross (TRADITIONAL Standard only) will regard it as stale and will not pay the claim.
- If you submit a claim within the four-month period and it is partially paid, or 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.
- If not, the claim will be regarded as stale and no payment will be made.
- LMS or CareCross (TRADITIONAL Standard only) will not cover any interest or legal fees that are levied on a claim that is submitted late.

How will you know if your claims were paid?

- After you submit a claim, you will get an SMS notification once it has been received and/or processed provided that we have your correct cell phone number on record.
- Should we have your email address on record, you will also get an email confirmation that it has been processed. This will summarise both approved and rejected claims.
- You will get a monthly detailed statement that summarises all the contributions and claims transactions that occur throughout the month.
- You can view your statements online at www.libmed.co.za, or members on TRADITIONAL Standard can view their statements at www.carecross.co.za.

Please make sure we have your correct email address and/or cell phone number so that the above information will reach you.

When to expect payment

- LMS and CareCross (TRADITIONAL Standard only) have a weekly payment cycle for members and providers. However, payment into your bank account may only reflect after a few days, depending on which bank you use. Weekly payment is subject to meeting the relevant submission cut off times.
- Payment is subject to available benefits and submission of complete and correct information.

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 updates@libertyhealth.co.za or fax them to (021) 673-9587.
- 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 certified copy of the account holder's identity document, and
    - A stamped bank statement or a letter from the bank confirming the account number.

Note ▶ You can update your contact details at any time, online using your membership profile login or by contacting the LMS Call Centre on 0860 000 567/LMS. See page 45 on how to register your online profile.

Third party claims

Please inform LMS when another party may be liable for medical expenses due to motor vehicle or work-related injuries.

Work-related injuries

If you are treated for injuries because of an accident at work, these costs should be covered by the Workman's Compensation Fund. Please consult your HR practitioner to find out the steps.

Road Accident Fund (RAF) claims

If you have been involved in a motor vehicle accident, please contact the LMS Call Centre for assistance to process a possible claim with the RAF.

As LMS or CareCross (TRADITIONAL Standard) will settle this claim on your behalf in the case of a motor vehicle accident, you must reimburse this amount to LMS at your earliest convenience once you receive payment from the RAF.

Fraud and abuse

Fraud continues to be a major concern for most medical schemes, costing millions of Rands each year. As you know, the more fraud there is, the higher contributions become to cover these losses.

We have measures in place to detect and manage fraud and the abuse of benefits. You can contribute to this effort by contacting our Fraud Hotline anonymously if you are aware of any provider or patient abusing the system. We urge all members to check their monthly claims statements and to verify the claims information to ensure that all details are true and correct. Report anything suspicious.

Contact details

Third party claims:
LMS Call Centre 0860 000 567/LMS

Liberty Health Fraud Hotline:
Tel 0800 212 638

Additional services

ER24 – Emergency Transport Services

ER24 is the Designated Service Provider (DSP) to LMS for the management of any medical emergency. This service applies within the borders of South Africa, Lesotho and Swaziland.

Services included

- 24-hour emergency response, in rapid response vehicles by road and, where necessary, air ambulance.
- Emergency transportation to the closest and most appropriate hospital.
- Emergency telephonic medical advice, while paramedics are on their way, available 24-hours a day.
- 24-hour Crisis Counselling Line with support from trained healthcare professionals on issues such as HIV/Aids, trauma, bereavement and rape.
- Treatment and stabilisation at the scene of the emergency before transport to an appropriate hospital.

Note ▶ If for some reason a service provider other than ER24 was used for emergency transportation, you must still inform ER24 of the emergency.

ER24 contact details

084 124

The ER24 contact details are:
Medical emergencies in South Africa 084 124 or 0860 00 HELP / 4357
Medical emergencies in Lesotho and Swaziland +27 010 205 3081

Website www.er24.co.za

ER24 – International Care Programme

All active beneficiaries of Liberty Medical Scheme excluding beneficiaries on TRADITIONAL Standard who travel internationally (outside the borders of South Africa) for leisure may qualify for medical cover, through our International Care Programme.

AVAILABLE TO MEMBERS ON THE FOLLOWING OPTION CHOICES:

TRADITIONAL Ultimate | COMPLETE Plus | COMPLETE Standard | COMPLETE Select | SAVER Plus | SAVER Standard | SAVER Select | HOSPITAL Plus | HOSPITAL Standard | HOSPITAL Select

Medical cover*

The policy provides medical cover up to a maximum of R5 million per trip (the TRADITIONAL Ultimate option choice provides up to R10 million cover) for up to 90 days per trip, irrespective of how many trips are made during the year.

Additional insurance* is required for:

- Ancillary (non-medical) benefits
- Beneficiaries over the age of 80 wanting to travel
- Beneficiaries travelling in excess of 90 days per trip
- Beneficiaries taking part in hazardous pursuits such as mountain climbing, scuba diving, any contact sports, motorcycling, skiing, etc.

*Terms and conditions apply.

Before you travel:

1. Contact ER24, the LMS Service Provider for the International Care Programme, to apply or to arrange additional cover if needed.
2. You can call ER24, Monday to Friday, from 8:00 - 17:00, on: 011 319 6500, or you can email ER24 at travel@er24.co.za.
3. Please make sure you have your LMS membership number on hand so that ER24 can complete the application process with you.
4. Should you need a letter for the embassy as proof of cover to obtain your visa, please call Zurich Insurance on: 0860 329 329.

While you are away:

5. Should you need any medical assistance while travelling, please contact the ER24 emergency number on: +27 10 205 3100.

ER24 EMERGENCY MEDICAL CARE
084 124

ER24 is the designated service provider for the International Care Programme

Liberty Baby Programme

Liberty Medical Scheme's Baby and Maternity Programme is designed to help educate, support and give sound advice to moms- and dads-to-be.

LIBERTY BABY IS AVAILABLE TO MEMBERS ON THE FOLLOWING OPTION CHOICES:

TRADITIONAL Ultimate | COMPLETE Plus | COMPLETE Standard | COMPLETE Select | SAVER Plus | SAVER Standard | SAVER Select

Benefits of the Programme

Having children is one of life's exciting adventures. To help expectant parents cope with all the aspects of pregnancy and childbirth, our Liberty Baby and Maternity Programme offers various information and commercial assistance services, such as:

- A free copy of the 'Having your baby' pregnancy book, a book covering the health of mother and baby upon registration
- A baby gift bag filled with goodies for mom and baby, including discount vouchers at leading suppliers and other exciting products in the third trimester
- Access to a 24-hour medical advice line, with support from trained professionals
- Access to the Liberty Baby website: **www.libmedbaby.co.za**, giving you general tips and advice
- A phone call to you every trimester from Liberty Baby to make sure that mom and baby are making healthy progress
- Weekly emails on what to expect at different stages of your pregnancy

Educate, support, advise

In cases where there is a risk of complications during pregnancy or delivery, our experienced staff will engage with parents-to-be to minimise risks and ensure appropriate ante-natal care.

Note ▶ One baby bag per pregnancy is sent to registered members in the third trimester after our follow up call.

Please register as soon as possible after the 12th week of your pregnancy to qualify for the above benefits.

Hospital and Day-Clinic Network for Select Option Choices

We have carefully selected the facilities in the **LMS Select Hospital Network** to provide you with the best value for money if you are a member on one of the HOSPITAL Select, SAVER Select or COMPLETE Select option choices. If you belong to one of these option choices, you should also ensure that you use GPs and specialists who work in this Network.

Please note that in the case of a true emergency, you will still be able to use the closest and most appropriate hospital to you (even if the hospital is not in the Network).

Private General Hospitals				
Province	**Hospital**	**Group**	**Town**	**Practice Nr**
Eastern Cape	St Dominic's Hospital	Life Healthcare	East London	5808294
	Beacon Bay	Life Healthcare	East London	357669
	St James Hospital	Life Healthcare	East London	5703816
	Greenacres Hospital	Netcare	Port Elizabeth	5807875
Free State	Rosepark Hospital	Life Healthcare	Bloemfontein	5808014
	Kroon Hospital	Netcare	Kroonstad	5808383
	Universitas Private Hospital	Netcare	Bloemfontein	0131938
Gauteng	Lesedi Clinic	Clinix	Soweto	5807816
	Brenthurst Clinic	Life Healthcare	Johannesburg	5803349
	Carstenhof Clinic	Life Healthcare	Halfway House	5808170
	Robinson Hospital	Life Healthcare	Johannesburg	5804655
	Roseacres Clinic	Life Healthcare	Germiston	5806968
	Suikerbosrand Clinic	Life Healthcare	Heidelberg	5808987
	Wilgeheuwel Hospital	Life Healthcare	Roodepoort	5808839
	Wilgers Hospital	Life Healthcare	Pretoria	5808650
	Mediclinic Emfuleni	Mediclinic	Vanderbijlpark	5808375
	Mediclinic Legae	Mediclinic	Mabopane	5808499
	Mediclinic Medforum	Mediclinic	Pretoria	5807867
	Mediclinic Morningside	Mediclinic	Sandton	5807824
	Bougainville Private Hospital	Netcare	Pretoria	5808952
	Clinton Clinic	Netcare	Alberton	5708877
	N17 Hospital	Netcare	Springs	5809029
	Netcare Waterfall City Hospital	Netcare	Midrand	0426024
	Rand Clinic	Netcare	Berea	5804620
	Arwyp Medical Centre	NHN	Kempton Park	5807891
	Lenmed Clinic Limited	NHN	Lenasia	5808324
	Midvaal Private Hospital	NHN	Vereeniging	5808898

Private General Hospitals				
Province	Hospital	Group	Town	Practice Nr
KwaZulu-Natal	Chatsmed Garden Hospital	Life Healthcare	Chatsworth	5808219
	Hilton Private Hospital	Life Healthcare	Pietermaritzburg	0604429
	Westville Hospital	Life Healthcare	Durban	5807832
	St Anne's Hospital	Netcare	Pietermaritzburg	5808197
	St Augustine's Hospital	Netcare	Durban	5802563
	The Bay Hospital	Netcare	Richards Bay	5808472
	Ethekwini Hospital and Heart Centre	NHN	Durban	305251
	Hibiscus Hospital	NHN	Port Shepstone	5808901
	Lenmed La Verna Hospital	NHN	Ladysmith	5808235
	Lenmed Nu-Shifa Hospital	NHN	Durban	5808464
	Midlands Medical Centre	NHN	Pietermaritzburg	5708605
	Newcastle Hospital	Mediclinic	Newcastle	5808871
Mpumalanga	Mediclinic Nelspruit	Mediclinic	Nelspruit	5808340
	Mediclinic Secunda	Mediclinic	Secunda	0540110
	Lowveld Private Hospital	NHN	Nelspruit	0463345
Northern Cape	Mediclinic Upington	Mediclinic	Upington	5808804
Western Cape	Kingsbury Hospital	Life Healthcare	Claremont	5808480
	Vincent Pallotti Hospital	Life Healthcare	Pinelands	5801443
	Mediclinic Cape Town	Mediclinic	Cape Town	5808995
	Mediclinic George	Mediclinic	George	5807905
	Mediclinic Geneva	Mediclinic	George	5709059
	Mediclinic Vergelegen	Mediclinic	Somerset West	5808030
	Blaauwberg Hosptial	Netcare	Milnerton	0253863
	Kuils River Private Hospital	Netcare	Kuils River	5888978
	N1 City Hospital	Netcare	Goodwood	5808537
	Melomed Bellville Medical Centre	NHN	Bellville	5802881
	Melomed Gatesville Medical Centre	NHN	Gatesville	5808103
North West	Ferncrest Hospital	Netcare	Rustenburg	5808391

Private Day-Clinics				
Province	Hospital	Group	Town	Practice Nr
Free State	Bethlehem Medical Centre Day Theatre	NHN	Bethlehem	7700792
	Citymed Day Theatre	NHN	Bloemfontein	7700938
	Welkom Medical Centre	NHN	Welkom	0399337
Gauteng	Sandton Day Clinic	NHN	Sandton	0537756
	Brooklyn Hospital	Life Healthcare	Brooklyn	7700318
	Pretoria North Surgical Centre	Life Healthcare	Pretoria	7700156
	Wilgeheuwel Day Clinic	Life Healthcare	Roodepoort	0150010
	Constantia Clinic	Netcare	Wilgeheuwel	7700547

Private Day-Clinics				
Province	Hospital	Group	Town	Practice Nr
Gauteng (continued)	MediCross Boksburg	Netcare	Boksburg	7700741
	MediCross Garsfontein	Netcare	Pretoria	7700733
	MediCross Germiston	Netcare	Germiston	7700768
	MediCross Greymont	Netcare	Greymont	7700660
	MediCross Kempton Park	Netcare	Kempton Park	7700571
	MediCross Randburg	Netcare	Randburg	7700652
	MediCross Silverton	Netcare	Pretoria	7700776
	MediCross The Berg	Netcare	Roodepoort	0246743
	Optimed	Netcare	Alberton	7700903
	Protea Clinic	Netcare	Krugersdorp	7700369
	Randburg Clinic	Netcare	Randburg	7700091
	Birchmed Day Clinic	NHN	Kempton Park	7700504
	Centurion Clinic For Cosmetic Surgery & Dental Surgery	NHN	Centurion	0207047
	Cure Day Clinics - Erasmuskloof	NHN	Pretoria	0448087
	Cure Day Clinics - Medkin	NHN	Pretoria	7700121
	Cure Day Clinics - Midstream	NHN	Midrand	0423556
	Edenvale Day Clinic	NHN	Edenvale	7700202
	Fauchard Clinic	NHN	Florida	7700415
	Fordsburg Day Clinic	NHN	Selby	7700083
	Kilnerpark Anaesthetic Clinic	NHN	Pretoria	7700172
	Mayo Clinic	NHN	Florida	7700164
	Medgate Day Clinic	NHN	Helderkruin	7700016
	Vitalab (Centre for Gynaecological endoscopy)	NHN	Morningside	0451576
KwaZulu-Natal	MediCross Bluff	Netcare	Durban	7700687
	MediCross Malvern	Netcare	Durban	7700695
	MediCross Pinetown	Netcare	Pinetown	7700954
	Shelly Beach Day Hospital	NHN	Shelly Beach	0380059
North West	MediCross Potchefstroom	Netcare	Potchefstroom	7700784
Western Cape	Orthopaedic Hospital Pinelands	Life Healthcare	Pinelands	5801443
	Sports Science Orthopaedic Surgical Day Centre Newlands	Life Healthcare	Newlands	0331570
	MediCross Langeberg	Netcare	Kraaifontein	7700709
	MediCross Parow	Netcare	Parow	7700717
	MediCross Tokai	Netcare	Tokai	7700725
	Monte Vista Clinic (Pty) Ltd	Netcare	Monte Vista	0516473
	Cape Dental Clinic	NHN	Wynberg	0419249
	Kango Clinic	NHN	Oudtshoorn	7700431

Note ▶ For the most recent list, please visit our website on www.libmed.co.za

Exclusion List

Like other medical schemes, there are certain medical costs that LMS does not cover.
These are called exclusions and the most common ones that apply to all option choices are listed below.

If you are a member of TRADITIONAL Standard, please see page 59 for additional exclusions that apply to your option choice.

Summary of the most common exclusions - All option choices	
4D and 3D pregnancy scans (unless pre-authorised for appropriate medical conditions)	Infertility treatment, reversal of vasectomy and reversal of tubal ligation
Abdominoplasties	Insulin and morphine pumps (Unless you are on the COMPLETE Plus and TRADITIONAL Ultimate option choices)
Accommodation and services provided in a geriatric hospital, old age home, frail care facility or similar institution	Intestinal flora (Unless you are on TRADITIONAL Ultimate, or you have positive Savings available)
All costs related to wilful and/or self-inflicted injuries	Iridology
Anabolic steroids	Keloid surgery and revision of scars, except following burns or for functional impairment
Anti-addiction and anti-habit agents	Massages
Any institution, nursing home or similar institution, not registered in terms of any law	Medicated shampoos and conditioners
Any medical or surgical treatment of impotence and sexual dysfunction	Medicines used to treat alcohol and substance abuse
Appointments not kept	Nebulisers
Aphrodisiacs	Obesity-related surgical treatment
Aromatherapy	Orthodontic treatment over the age of 21 years
Art therapy	Orthognathic surgery (to correct jaw misalignment)
Autopsies	Otoplasties (Bat Ears)
Ayurvedics	Pain-relieving machines
Back rests, chair seats, beds, mattresses, orthopaedic shoes and boots, arch supports and shoe inserts	Persons not registered with a professional body constituted in terms of an Act of Parliament
Biological and specialised medicines used for both oncology and chronic indications unless considered a Prescribed Minimum Benefit (PMB) and pre-authorised.	Physiotherapy not covered under admission to a psychiatric facility
Blood pressure monitors	CPAP machine
Breast augmentations, reductions and reconstruction	Reflexology
Bulk-forming and stimulant laxatives	Registered tonics and stimulants
Cochlear implants other than for beneficiaries born into the Scheme and who are beneficiaries of the TRADITIONAL Ultimate option choice	Repairs to devices or prostheses
Contact lense preparations	Repairs of any appliances (excluding dentures), external accessories or orthotics
Contraceptives and devices to prevent pregnancy (Unless you are on the TRADITIONAL Ultimate option choice)	Rhinoplasties for cosmetic purposes
Cosmetic procedures	Services for the treatment of any sickness, condition or injury sustained by a beneficiary for which any other party may be liable
Cosmetic preparations, emollients/moisturisers	Sleep therapy
Dental implants	Sleep studies/Polysomnogram
Epilation treatment (hair removal)	Slimming preparations
Erythropoietin	Soaps, scrubs and other cleansers
Evening primrose oil and fish-liver oil preparations and combinations	Specialised and biological medicines used for both oncology and chronic indications unless considered a Prescribed Minimum Benefit (PMB) and pre-authorised
Food, nutritional supplements	Sunglasses, readers, repairs to spectacle frames, coloured contact lenses
Gender realignment, including counselling	Sunscreen and sun-tanning preparations
Growth hormones	Surrogate pregnancies
Holidays for recuperative purposes;	Telephone consultations
Homeopaths and homeopathic medicines	Topical and oral acne preparations
Humidifiers	Travelling expenses
Hyperbaric oxygen treatment	Veterinary products
Immunosuppressives and immunostimulants	Vitamin and mineral supplements
	Treatment/tests related to Integrative Functional Medicine or 'Anti-Ageing Medicine'

Additional exclusions specific to TRADITIONAL Standard
Any non-Network generated claim apart from those covered under "out of Network"
Injuries arising from participation in professional sport, bungee jumping, parachute jumps or any extreme sport
Root canal treatment, dentures and other advanced dentistry
Services obtained from acupuncturists, biokineticists, chiropractors, herbalists or naturopaths
Services for chronic psychiatric conditions and mental disorders except as stated in the Scheme Rules
Treatment and operations of choice, and non-essential medical items
Teaching aids for handicapped children

Glossary

Useful Definitions	
Above Threshold Benefit (ATB)	This is a 'safety-net' that provides cover for your day-to-day expenses once your Savings are depleted and your total qualifying day-to-day claims reach the Threshold Level. This Threshold Level is based on the number and type of dependants a principal member has. LMS pays day-to-day expenses from the Above Threshold Benefit at the LMS Rate.
Beneficiary	A member and any of his/her registered dependants who are entitled to benefits.
Co-payment	When a member is liable for a portion of the costs incurred for treatment and/or medication received.
Co-morbidities	These are other conditions that you have that impact your current condition.
Cost	The actual amount charged by the service provider for services rendered.
Credit Savings	The advanced annual Savings that LMS makes available on 1 January of every year, even if you haven't yet made the full annual contribution to the MSF.
Designated Service Provider (DSP)	A healthcare provider or group of providers selected by LMS to provide specified healthcare services to its members. If a member voluntarily uses a non-DSP, a co-payment may apply.
Extender Benefits	This is a collection of out-of-hospital benefits that are paid from your Major Medical Benefit rather than from your Savings or from your own pocket.
Formulary list	A defined list of medicines for which LMS will pay. The list is based on clinical evidence and protocols.
Generic medicine	A more cost-effective version of the branded medicine that contains the same active ingredients and is identical in strength.
Generic Reference Price (GRP)	A reference pricing system that uses a benchmark (reference) price for generically similar products. We pay a maximum of that benchmark price when you claim for a generically similar product. The Generic Reference Price is also referrred to as the Maximum Medicine Reference Price (MMRP)
ICD-10 code	The compulsory diagnostic code used by providers to indicate the medical diagnosis for treatment received. Claims that do not contain an ICD-10 code cannot be paid in terms of current legislation.
LMS Rate	The rate at which the Scheme will pay for a particular healthcare service and which is either: the tariff or cost as agreed with a provider; or in respect of healthcare services obtained from a public hospital, the lower of cost or the Uniform Patient Fee Schedule (UPFS) for public hospitals; or in any other instance, the lower of cost or the tariff as approved by the LMS Board of Trustees and which is based on the billing rules and tariff codes of the 2006 National Health Reference Price List published by the Council for Medical Schemes (CMS) and adjusted annually taking into account the Consumer Price Index (CPI) as published by Statistics South Africa.
Major Medical Benefits (MMB)	This is a collection of high-cost benefits, such as hospitalisation, certain day procedures, oncology (cancer) treatment, costs incurred due to crime trauma, local emergency transport and more.
Maximum Medicine Reference Price (GRP)	The maximum reimbursable price for a medicine or group of medicines according to a generic reference pricing system that allocates a price to a group of drugs that are similar in efficacy, safety and quality. The Maximum Medicine Reference Price (MMRP) is also referred to as the Generic Reference Price (GRP).
Medical Savings Facility (MSF)	Qualifying day-to-day medical claims are paid from your Medical Savings Facility (MSF) subject to the Scheme Rules. Please check your option choice summary for details. The annual MSF is made available in advance for immediate use. Contributions to the MSF are set at a percentage of total contributions.
Medicine exclusions	A list of categories of drugs NOT covered by LMS. See page 58.
Medicine management protocols	Clinical guidelines and protocols formulated for the provision of care and treatment related to specific diseases.

Useful Definitions	
Members	Members refers to main members and dependants of the Scheme.
Member Care	The clinical and financial risk assessment and management of healthcare to ensure appropriate and cost-effective use of relevant treatment and services. This is based on relevant scheme rules and managed care principles of the LMS disease management programmes.
Negotiated dispensing fee	A charge agreed to between the Scheme and dispensers and providers for dispensing of registered medicines.
Network Rate	In this Membership Guide when we refer to Network Rate, we refer to the Rate that applies to TRADITIONAL Standard, i.e. the CareCross Network Rate.
Positive Savings	The monthly Savings contributions that LMS has received, but have not yet been used by you. This includes Savings carried over from previous years.
Pre-authorisation	Notifying the Scheme at least 48 hours before admission to hospital or receiving certain services as provided for in the Scheme Rules for non-emergency events, or within two business days after admission or treatment in an emergency.
Preferred providers	These are providers with whom the Scheme has negotiated preferred rates. If a member uses them, no co-payment applies.
Prescribed Minimum Benefits (PMBs)	The benefits contemplated in section 29(1) (o) of the Act and that include the provision of the diagnosis, treatment and care costs of: • The diagnosis and treatment pairs listed in Annexure A of the Regulations, subject to any limitations specified therein; and • Any emergency medical condition. Refer to page 13 for further details.
Prescribed Minimum Benefit condition	A condition contemplated in the diagnosis and treatment pairs listed in Annexure A of the regulations or any emergency medical condition.
Preventative Care Benefits (PCBs)	Cover for certain tests and immunisations that help you to monitor your health and prevent possible future illness. Refer to pages 24 to 25 of this Guide for a list of qualifying expenses.
Pro-rating of benefits	When a member joins later than 1 January, benefits for the first year are decreased in accordance with the number of months remaining in the year.
Qualifying expenses	Medical expenses that are: • specifically included in the benefits listed in your option choice summary, • not listed under "exclusions", • unrelated to conditions for which a specific waiting period is in effect, and • incurred during a general waiting period.
Risk benefits	All the benefits under Major Medical Benefits: Hospitalisation, Chronic Cover, Disease Management, Extender Benefits and Above Threshold Benefits. These are subject to the rate and limits specified in the Benefit Schedule in your option choice summary. Unused benefits cannot be carried over to the following year.
Self-Payment Gap (SPG)	The period after the MSF has been depleted where you may have to pay for day-to-day expenses from of your own pocket, until the Threshold Level is reached.
Threshold Level (THL)	This is the amount you need to reach before being able to claim from the ATB. This amount is determined at the start of the benefit year and is based on the number of dependants that you have. Certain types of claims do not accumulate to the THL (see page 25).

Contact Details

Contact Details		
COMPLETE, SAVER and HOSPITAL options	**TRADITIONAL Ultimate**	**TRADITIONAL Standard**
Contact our dedicated Call Centre to assist you with queries and information, 08:00 - 17:00, Monday to Friday, excluding public holidays: **Tel** 0860 000 LMS / 567 **Fax** 021 657 7571 **Email** enquiries@libertyhealth.co.za **Website** www.libmed.co.za **Postal address** Private Bag X3, Century City, 7446	Contact our dedicated Call Centre to assist you with queries and information, 24 hours, 7 days a week: **Tel** 0860 690 900 **Email** ultimateservice@libertyhealth.co.za **Website** www.libmed.co.za **Postal address** Private Bag X3, Century City, 7446	TRADITIONAL Standard members should contact CareCross with queries, 8:00–17:00, Monday to Friday, excluding public holidays: **Tel** 0860 103 491 **Email** liberty@carecross.co.za **Website** www.libmed.co.za / www.carecross.co.za (Except for membership and contribution queries in which case contact the LMS Call Centre)

Banking Details
Account holder Liberty Medical Scheme **Bank** Standard Bank **Branch** Claremont **Branch code** 025109 **Account number** 240402235

Claims		
COMPLETE, SAVER and HOSPITAL options	**TRADITIONAL Ultimate**	**TRADITIONAL Standard**
For processing of claims in less than 24 hours, insist that the healthcare provider submits your claims electronically to LMS. Alternatively, submit claims via email or post.		
Email claims@libertyhealth.co.za **Postal address** LMS Claims, Private Bag X3, Century City, 7446	**Email** ultimateservice@libertyhealth.co.za **Postal address** TRADITIONAL Ultimate Claims, Private Bag X3, Century City, 7446	**Email** liberty@carecross.co.za **Postal address** TRADITIONAL Standard Claims, PO Box 44991, Claremont, 7735
Proof of payment must be submitted with any request to refund a member. A written note indicating 'paid by member' or a 'paid' stamp will no longer be accepted. If the correct proof of payment is not attached, the account will be rejected. The only document we will accept as proof of payment is a receipt or proof of Electronic Funds Transfer (EFT) payment.		

Registration of New Dependants
Please submit a Dependant Registration Form, available on www.libmed.co.za, signed by the principal member, to add a dependant including newborns to your membership using the details below. Please ensure that you send any additional documentation to the New Business team. See page 39 for a list of these requirements. **Email** newbusiness@libertyhealth.co.za **Fax** 021 657 7651

Hospital Pre-authorisations	
TRADITIONAL Ultimate, and the COMPLETE, SAVER and HOSPITAL options	**TRADITIONAL Standard (incl. Specialist pre-authorisation)**
Tel 0860 000 LMS / 567 or 0860 690 900 (TRADITIONAL Ultimate) **Fax** 021 657 7711 **Email** approvals@libertyhealth.co.za **Please note:** Members on the Select option choices are required to use the Network list of hospitals and day clinics on page 55 for planned procedures.	**CareCross** **Tel** 0860 103 491 **Email** crc@carecross.co.za

Chronic Disease Programme	
TRADITIONAL Ultimate, and the COMPLETE, SAVER and HOSPITAL options	**TRADITIONAL Standard**
Requests for the registration and approval of treatment options related to chronic medicine.	
Tel 0860 000 LMS / 567 or 0860 690 900 (TRADITIONAL Ultimate) **Fax** 021 657 7681 **Email** chronicmed@libertyhealth.co.za	**CareCross** **Tel** 0860 103 491 **Email** liberty@carecross.co.za

Oncology Management Programme	
TRADITIONAL Ultimate, and the COMPLETE, SAVER and HOSPITAL options	**TRADITIONAL Standard**
Requests for the registration and approval of treatment options related to oncology.	
Tel 0860 000 LMS / 567 or 0860 690 900 (TRADITIONAL Ultimate) **Fax** 021 657 7621 **Email** oncology@libertyhealth.co.za	**CareCross** **Tel** 0860 103 491 **Email** liberty@carecross.co.za

HIV Management Programme		
All option choices except the Select option choices	**Select option choices**	**TRADITIONAL Standard**
You or your doctor must contact the Liberty Health HIV Management Programme. **Tel** 0860 000 LMS/567, select option 7 **Fax** 021 657 7785 **Email** care@libertyhealth.co.za **SMS 'Please call me'** to 082 740 6845 **Website** www.libmed.co.za/hiv-aids	You or your doctor must contact the LMS HIV Department. **Tel** 0860 690 909 **Fax** 021 673 8779 **Email** care@libertyhealth.co.za **SMS 'Please call me'** to 082 740 6845	**CareCross** **Tel** 0860 103 491 **Email** liberty@carecross.co.za

Disease Management Programmes

TRADITIONAL Ultimate, and the COMPLETE, SAVER and HOSPITAL options	TRADITIONAL Standard
Our Disease Management Programmes help provide the care you need to live a healthy and full life.	
Tel 0860 000 LMS / 567 or 0860 690 900 (TRADITIONAL Ultimate) **Fax** 021 657 7681 **Email** diseasemanagement@libertyhealth.co.za	**CareCross** **Tel** 0860 103 491 **Email** liberty@carecross.co.za

Dental Management Programme (COMPLETE Standard and COMPLETE Select only)

To reach our Dental Management Programme, simply contact the:

Dental Risk Company (DRC) Contact Centre 086 137 2343 or 012 741 5101
Email auth@dentalrisk.com

Optometry Management Programme (COMPLETE option choices only)

Please visit the Preferred Provider Negotiators (PPNs) Network at ***www.ppn.co.za*** or contact them on ***0861 103 529*** to locate an optometrist in your area, or for assistance on your available benefits.

ER24 - Emergency Transport Services

Applicable to all LMS options

Medical emergencies within the borders of South Africa 084 124 or 0860 00 HELP / 4357
Medical emergencies in Lesotho and Swaziland +27 (0)10 205 3081
Website www.er24.co.za

ER24 - International Care Programme

Applicable to beneficiaries on TRADITIONAL Ultimate, and the COMPLETE, SAVER and HOSPITAL options

To get policy wording details, contact ER24 on:

Local 010 205 3100
International +27 10 205 3100

For medical emergencies:

Local 010 205 3100
International +27 10 205 3100

Liberty Baby Programme

Available on TRADITIONAL Ultimate, and the COMPLETE and SAVER options

Tel 0861 116 019
Alternative Tel 011 704 2151
Fax 011 704 4645
Email info@babyhealth.co.za
Website www.libmedbaby.co.za

Contact details for the Council for Medical Schemes (CMS)

According to the Council for Medical Schemes (CMS), any complaints about your medical scheme should first be lodged with the scheme. Should all efforts fail to resolve an issue with your scheme, you can submit your complaint to the CMS Complaints Unit using the following details:

Customer Care Centre 0861 123 267
Fax 012 431 0608
Email complaints@medicalschemes.com
Postal address Private Bag X34, Hatfield, 0028
Website https://www.medicalschemes.com

We encourage you to always seek financial advice about your choices.
For more information, contact your Financial Adviser or call 0860 000 LMS / 567
or visit our website www.libmed.co.za.

Liberty Medical Scheme
Private Bag X3, Century City, 7446
Call Centre: 0860 000 LMS / 567
www.libmed.co.za

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