Libcare

MEMBER GUIDE 2023

CONTENTS

This is an overview and summary of the Libcare services and benefits. Every attempt has been made to ensure complete accuracy of this Member Guide. However, in the event of a conflict between this guide and the registered Rules of the Scheme, the Rules will prevail. E & OE.

Introduction

Libcare 2023

Libcare is a restricted membership medical scheme registered under the Medical Schemes Act 131 of 1998. Libcare provides cover for eligible full-time permanent staff members and eligible retirees of the Liberty Group, and their eligible dependants. Cover is provided within the common monetary area of Southern Africa.

This Guide has been prepared for new and existing Libcare members in respect of Benefits and Contributions for 2023. Every care has been taken to ensure that as much useful- and accurate information as possible has been included. At the time of publishing, the Contributions for 2023 were approved by the CMS and the Scheme Rules are subject to approval.

The Guide is nevertheless an overview and summary of Libcare services and benefits. In the event of a conflict between this Guide and the registered Rules of Libcare, the Rules will prevail.

Nothing in this Guide is intended as, nor should be construed as, medical or other advice of a personal or general nature. For any advice, you should consult the appropriate professional(s).

If any changes are made to this Guide after printing, the updated version will be available on our website: **www.libcare.co.za.**

If you need more information, please contact the Libcare Contact Centre on:

0800 12 CARE (2273) (08h00 – 17h00)
Monday to Friday, excluding public holidays

Send an enquiry to **enquiries@libcare.co.za.**

Libcare Trustees and Principal Officer

ZANELE DWAYI
Member-elected Trustee

REINHARDT ERASMUS
Board-appointed Trustee

NEIL GOVENDER
Board-appointed Trustee

PHULA SEOOE
Deputy Chairman
Company-appointed Trustee

TLOU THEMA
Member-elected Trustee

ATHINI TSHONGWENI
Chairman
Company-elected Trustee

TRACEY UNSER
Principal Officer

You would use our 0800 12 CARE (2273) number in the first instance to access all Libcare services, as all your day-to-day queries and administration are dealt with there. If you wish to raise any matter/escalation with the Scheme, you may do so through the Principal Officer at **tracey.unser@liberty.co.za.**

Fraud Awareness

MANAGING YOUR CLAIMS – BE ALERT

LIBCARE pays millions of rands in member claims every year. These claims are funded by the contribution income that you as a member make to the Scheme. Fraud can significantly reduce the amount available in the Scheme to pay your claims, and also causes your contributions to be higher to cover any losses and the costs to the Scheme of maintaining fraud management processes.

LIBCARE subscribes to a whistle-blowing approach which advocates the principles of the South African Protected Disclosures Act, 26 of 2000. Therefore, in terms of this approach, all whistle-blowing reports are treated as confidential. LIBCARE has a zero tolerance approach to fraud.

You play a vital role in ensuring that the funds in your medical scheme are not subject to fraud.

Understand the claims process and check your claims

Members and dependants obtain the health service they require in accordance with their benefits, and the service provider or the member submits the resulting claims to LIBCARE. The Claims Department receives, assesses and approves payment of valid claims subject to LIBCARE rules and your available benefits.

To find out more about how to submit and check your claims for the required details, see page 39 'How to Claim'. Also, keep your membership card safe and your medical scheme details confidential.

What is LIBCARE doing to protect my benefits?

Claim alerts have been implemented to ensure that all members have sight of claims which have been received against their membership. These alerts can be distributed by email or SMS, if we have your current details on our system. We would like to encourage you to subscribe to receive news and updates on **www.libcare.co.za** in the My Details tab. **You need to check your claims statement thoroughly for any irregularities and check these with us as quickly as possible at 0800 12 CARE (2273), Mon – Fri from 08:00 to 17:00, excluding public holidays.**

Types of fraud

Medical aid fraud is one of the largest and growing problems that we are faced with in South Africa, as it contributes to the overall high cost of healthcare and occurs at all levels. The healthcare industry has identified the sources of fraud as including:

- Members and dependants
- Healthcare providers
- Employees of medical scheme administrators, and
- Other parties (e.g. non-members, or through cyber means).

If you suspect any fraud has been committed, report it to Libcare's confidential Fraud Hotline 0800 004 500.

Examples of types of fraud committed by these sources:

- Manipulating duplicate claims.
- Billing for services not provided.
- Cash arrangements – for example, healthcare providers handing out cash to members for submitting a claim to the medical scheme.
- Dispensing merchandise to patients. For example, pharmacies dispensing groceries to members and then claiming for medicine from the medical scheme.
- Provider syndicates sharing members' numbers and submitting false claims for members never consulted with.
- Billing for brand name medicine while providing the member with cheaper generic medicine.
- Altering or tampering with prescriptions by pharmacies – for example, two types of medicine are prescribed, recorded on the script and dispensed. The pharmacy enters two additional types of medicine on the script and claims for more.
- Re-submitting claims that have been rejected previously. For example, changing the claims information on rejected claims and re-submitting until these meet the scheme rules and are paid.
- Kickbacks – the healthcare provider receiving cash paybacks for referring patients to a specific hospital or healthcare provider.
- Charging more than once for the same service.
- Claiming for services already paid for by the medical scheme.
- Dispensing sunglasses but claiming for optical lenses or contact lenses.
- Over servicing, for example, the healthcare provider requests patients to come back for a follow up visit unnecessarily.
- Using invalid tariff codes.
- Inflating of claims.
- Billing for different medicine package sizes to that dispensed.
- Disguised treatment.
- Dispensing excessive quantities of medicine.
- Medical scheme card fraudulently used – for example, a member lending out his medical scheme card to family members or friends who are not registered to use the benefits of the medical scheme.
- Collusion with other parties to defraud the medical scheme.
- Abuse of benefits.
- Fraudulent foreign claims.
- Enrolling or maintaining the registration of ineligible dependants.
- Failing to notify the scheme when a member/dependant is no longer eligible to remain registered.
- Dual membership, e.g. member or dependant belonging to more than one medical aid scheme at the same time.
- Non-disclosure of prior ailments/treatment on an application form.
- Disclosure of incorrect or misleading information on an application form.

Useful Information

LIBCARE RATE

National Health Reference Price List (NHRPL)

Following a Court ruling in September 2010, and at date of printing this Guide, there is no National Health Reference Price List to which medical schemes and medical services providers can make reference in terms of how much will be reimbursed for medical services. There is therefore more likelihood that what various medical service providers charge for their services will be different to what medical schemes reimburse for those services, and that, to avoid having to keep a database of what each medical scheme reimburses, some providers may start to charge patients on a cash up-front basis.

Libcare Rate

- For eligible claims, Libcare reimburses at the lower of the cost or the Libcare rate, and subject to the available benefits for the period.
- The Libcare Rate means the maximum amount of money the Scheme will pay for a particular medical expense (e.g. consultations, medicines, procedures, examinations, etc).
- Libcare consults and reviews the information issued by a range of experts to arrive at the Libcare Rate. These include the South African Medical Association, the Department of Health, Libcare actuaries and other expert sources.
- The Libcare Rate for every single expense is determined annually as medical costs change.
- Because there are so many different medical expenses, there is no printed list of the Libcare Rates. If you want to know what the Libcare Rate is for a particular item or procedure, please phone Libcare on 0800 12 CARE (2273) and make sure you have the treatment/tariff code(s) on hand*.

* Note: This is an indication of the amount that could be payable, but is not confirmation of payment, as payment is subject to all codes charged and the availability of benefits at the time the claim is submitted.

Some healthcare providers charge within the Libcare Rate and some don't

- If your provider charges more than the Libcare Rate, you must pay the difference between the Libcare Rate and his or her fee.
    - If you have a positive balance in your Medical Savings Facility, the difference charged may be paid out automatically from your positive savings balance in your Medical Savings Facility.
    - If you do not have a positive balance in your Medical Savings Facility, you will have to pay for these expenses out of your own pocket.
- You have the power to try to negotiate fees. Many providers will charge the Libcare Rate, or at least lower their fees, if you ask them to or if you pay cash at the time of service.

BENEFIT AVAILABILITY

Make sure you can afford the treatment

- It is up to you to confirm with Libcare if you are eligible and have available benefits for a particular investigation, treatment or procedure in terms of the Scheme Rules. You may also confirm with your provider or hospital what they will charge for your investigation, treatment or procedure to determine if you have available benefits to cover the costs.
- Remember, there are limits on certain categories of expenses, and you will be personally responsible for any amount over those limits.
- If other claims are processed before the claim for the treatment confirmed as above comes in, then that will affect the resulting payment of the confirmed claims.
- For all treatment requiring pre-authorisation, if you do not obtain an authorisation, claims will not be processed in terms of the available benefits.
    - In the event of a planned in-hospital procedure or treatment, you must obtain pre-authorisation before the hospital admission. Failure to do so will result in a 30% co-payment.
    - In the event of an emergency where you are unable to obtain authorisation prior to the hospital admission, you must obtain authorisation within 48 hours after the admission. Failure to do so will result in a 30% co-payment.
    - In the event of a treatment or procedure in a casualty facility, you must obtain pre-authorisation within 48 hours after the event. Failure to do so will result in claims being reimbursed from available funds in your Medical Savings Facility.

- In the event of a planned in-doctors' room treatment or procedure, you must obtain pre-authorisation before the event. Failure to do so will result in claims being reimbursed from available funds in your Medical Savings Facility.

Informed Consent about Your Treatment and Associated Costs

When you consult with a health professional, they are in the best position to provide you with information about your health and any investigations, treatment, screening or research that they wish to undertake. The Health Professions Council of South Africa (HPCSA) has Ethical Guidelines for health professionals. In particular, the Ethical Guidelines for Informed Consent set out the principles of good practice which all health care practitioners are expected to follow when seeking patients' informed consent to investigations, treatment, screening or research. These guidelines also make reference to the National Health Act, which requires patients to be given information about:

- The patient's health status, except in circumstances where there is substantial evidence that the disclosure of the patient's health status would be contrary to the best interests of the patient;
- The range of diagnostic procedures and treatment options generally available to the patient;
- The benefits, risks, costs and consequences generally associated with each option; and
- The patient's right to refuse health services, and an explanation of the implications, risks and obligations of such refusal.
- Patients have a right to information about any condition or disease from which they are suffering. This information should be presented in a language that the patient understands. The information which patients want or ought to know, before deciding whether to consent to treatment or an investigation, includes:
- Details of the diagnosis and prognosis, and the likely prognosis if the condition is left untreated;
- Uncertainties about the diagnosis, including options for further investigation prior to treatment;
- Options for treatment or management of the condition, including the option not to treat;
- The purpose of a proposed investigation or treatment; details of the procedures or therapies involved, including subsidiary treatment such as methods of pain relief; how the patient should prepare for the procedure; and details of what the patient might experience during or after the procedure including common and serious side effects;
- For each option, explanations of the likely benefits and the probabilities of success; and discussion of any serious or frequently-occurring risks, and of any lifestyle changes which may be caused or necessitated by the treatment;
- Advice about whether a proposed treatment is experimental;
- How and when the patient's condition and any side effects will be monitored or re-assessed;
- The name of the doctor who will have overall responsibility for the treatment and, where appropriate, names of the senior members of his or her team;
- Whether students will be involved, and the extent to which students may be involved in an investigation or treatment;
- A reminder that patients can change their minds about a decision at any time;
- A reminder that patients have a right to seek a second opinion;
- Where applicable, details of costs or charges which the patient may have to meet.

[Source: HPCSA Ethical Guidelines Booklet 4 www.hpcsa.co.za accessed November 2017]. For further information, you may also refer to the HPCSA website www.hpcsa.co.za

MEDICINE PRICING

Branded vs Generic Medication

- Ethical/branded/original (in this section collectively referred to as 'branded') medicines are those which are patented and can only be manufactured and marketed by the patent holder. When the patent expires after a statutory period of 20 years, other players may then manufacture similar products under a different name.
- These similar products are known as generic substitutes – medicines within a specific generic group are either identical to one another (except for their appearance or their packaging) or otherwise very similar (for example, only the inactive ingredients differ slightly). Therefore, a given illness can be treated with any one medicine within such a group. Generics are usually considerably cheaper than the original brand, sometimes even up to 50% less, since the manufacturer does not bear the costs of research and development of the original product.
- The prescribing doctor is not always aware of new alternatives, whereas the pharmacist should be on the cutting edge of developments in the industry. Thus the onus is on your pharmacist, not your doctor, to tell you that there are generic alternatives to drugs you have been prescribed.
- Libcare funds chronic and acute medicine subject to Generic Reference Pricing. Generic Reference Pricing is a system that uses a benchmark (reference) price for generically similar products. It is a guide for the maximum amount that Libcare will pay.

Co-payments

Note: It is possible to incur co-payments on your chronic medication.

- Clinical protocols and guidelines apply to the treatment of – and funding for a chronic condition. These take into consideration cost-effectiveness and clinical appropriateness. The application of these protocols and guidelines could mean that the funding of the treatment is different to what has been claimed for payment.
- You will have to self-fund amounts over the Generic Reference Price, as this difference in price may not be paid from your Medical Savings Facility.
- To avoid such co-payments, please discuss the use of generics with your doctor or pharmacist.

PRESCRIBED MINIMUM BENEFITS (PMBs)

Definition

The Prescribed Minimum Benefits (PMBs) are a set of defined benefits to ensure that all medical scheme members have access to certain minimum health services, regardless of the benefit option they have selected on their medical aid. Libcare has to cover the minimum health services related to the diagnosis, treatment and care of:

- any emergency medical condition, as defined;
- a limited set of 271 medical conditions (defined in the 'Diagnosis Treatment Pairs' in legislation);
- and 26 chronic conditions (defined in the Chronic Disease List).

Each of the 271 PMB conditions is linked to a broadly-defined treatment protocol referred to as Diagnosis Treatment Pairs (DTPs). The treatment standards in question are the public sector practice and protocols. In the case of the chronic diseases specified in the Chronic Disease List (CDL), the treatment algorithms that have been published in the Government Gazette are the minimum treatment requirement.

Out-Of-Hospital PMB Cover

Libcare pays for specific healthcare services related to each of these defined lists of conditions. These healthcare services may include specified treatment, acute medicine, consultations, blood tests and other investigative tests.

However, it is not always possible for Libcare to tell from the information on the claims submitted, whether the services should be covered under PMB or not. In general, when we receive claims with ICD-10, procedure and modifier codes that match the treatment guidelines and protocols, we are able to automatically process these for PMB cover. In cases where there are no clear indications from the Regulator on which codes should be covered as PMBs, nor indication on the actual claim, then the claim may be processed from available day-to-day benefits instead of from PMB.

If your claim is possibly related to PMB but was not processed as such, you or your healthcare provider can log a request for a review of the claim by contacting the Libcare Contact Centre on 0800 12 CARE (2273) or email **enquiries@libcare.co.za**. The Contact Centre is operational Monday to Friday from 08:00 to 17:00, excluding public holidays. If the review confirms that the requirements for cover as PMB have been met, we will re-process the associated claims for the approved blood tests and other defined investigative tests, treatment, medicine and consultations for the diagnosis and treatment as PMB, and not from available day-to-day benefits.

ICD-10

ICD-10 stands for International Classification of Diseases and Related Health Problems (10th revision). These codes are used to inform medical schemes about what conditions their members were treated for so that claims can be settled correctly.

e.g. J03.9 is the ICD-10 code for acute tonsillitis.

Because ICD-10 codes provide accurate information on the condition you have been diagnosed with, these codes help the medical scheme to determine which benefits you are entitled to and how these benefits could be paid. In terms of legislation, your treating provider must include the ICD-10 code on your account.

This becomes very important if you have a PMB condition, as these can only be identified by the correct ICD-10 codes. Therefore, if the incorrect ICD-10 codes are provided, your PMB-related services might be paid from the incorrect benefit (such as from your Medical Savings Facility), or it might not be paid at all if your day-to-day or in-hospital benefit limits have been exhausted.

Co-payments

- There are no co-payments on PMB conditions except when members choose not to make use of the Scheme's listed treatments and medicines. Members either have to pay the difference between the actual cost and what the Scheme would have paid, or the percentage co-payment as registered in the Scheme Rules.
- In terms of legislation, co-payments for PMB claims cannot be recovered from the Medical Savings Facility.

Should you or your dependant(s) have more than 24 months' continuous cover with a registered South African Medical Scheme and the break between leaving the latest scheme and date of application to Libcare is less than 90 days, a 3-month general waiting period will be applied but you/affected dependant will be entitled to claim for Prescribed Minimum Benefits.

If you or your dependant(s) were not previously on a medical scheme when you apply to register on Libcare, or if your break between leaving your last scheme and applying to join Libcare is more than 90 days, there will be no cover for Prescribed Minimum Benefits during waiting periods that may be applied.

For more information on PMBs, see the Council for Medical Schemes (CMS) website **www.medicalschemes.co.za.**

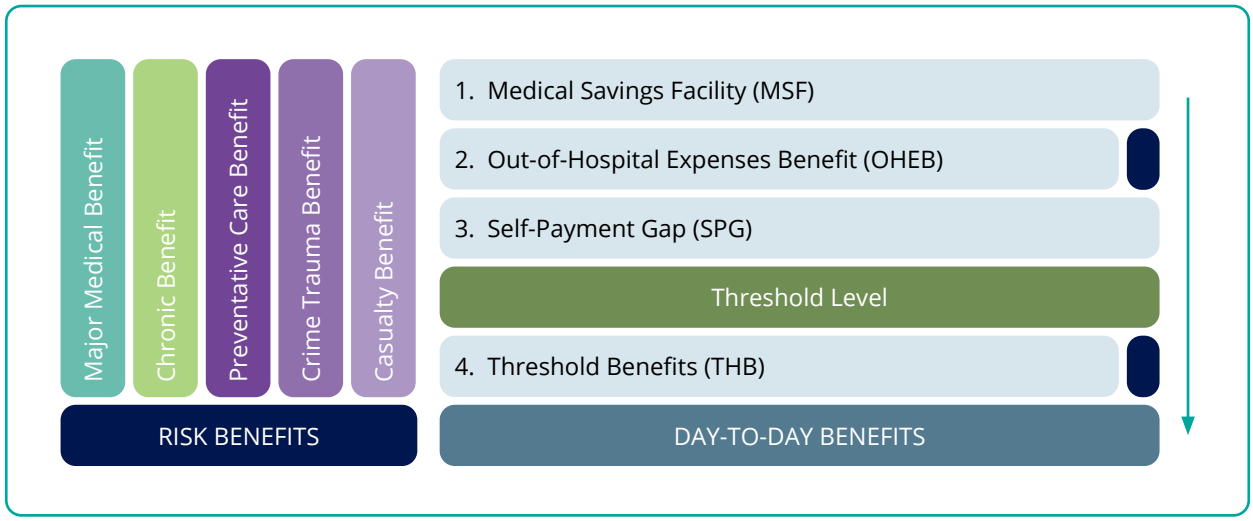
EX GRATIA ASSISTANCE

Ex Gratia Assistance is discretionary assistance (i.e. is not a benefit entitlement) which a medical scheme may consider providing in membership, clinical or other cases, where a member suffers undue hardship. Medical schemes are not obliged to grant ex gratia requests and members have no statutory right thereto.

[Source: CMS Consumer FAQ – www.medicalschemes.com accessed December 2015]

Libcare has an Ex Gratia Sub-Committee which considers ex gratia requests. There is no guarantee of a positive grant of assistance if a request is made through this forum, but it is the appointed governance route for such requests. You may request an Ex Gratia Assistance Application Form from the Libcare Contact Centre on 0800 12 CARE (2273).

Libcare 2023: Benefit Design



The arrow shows the order – from 1 to 4 – in which eligible day-to-day claims are paid from each available benefit as they are received, and how these claims accumulate to the Threshold Level from 1 to 3.

Risk Benefits include the Day-to-Day Benefits in the purple block.

Each of the benefits in the diagram is explained in more detail in the following sections:

- Risk Benefits – refer to page 12.
- Day-to-Day Benefits – refer to page 29.

Risk Benefits

MAJOR MEDICAL BENEFITS

Examples of expenses covered by this benefit are:

- Hospitalisation
- Disease Management
- Day Procedures
- Dental Surgery
- MRI/CT and/or Radio-Isotope scans (in-hospital and out-of-hospital)
- Emergency Transport

What is not covered under this benefit

You will be responsible for any amount that is billed in excess of the Libcare rate or that exceeds available benefits, if applicable, as well as any components that had not been pre-approved for your hospital stay, and co-payments that may be applied due to not obtaining pre-authorisation on time. Your portion of the costs will be automatically drawn from your Medical Savings Facility, if you have a positive balance available, otherwise you will have to pay them from your own pocket. There are specific medical expenses that Libcare does not cover, not even from a positive balance in your Medical Savings Facility. For more information please also check the summary of exclusions on page 54 of this Guide or contact Libcare.

Cover while you're in hospital

Libcare will pay up to a maximum of the Libcare Rate (and up to the available benefit limit, if applicable) for approved procedures and consultations during your stay in hospital, including:

- ward rates (Libcare will pay for a general ward in a private hospital)
- GP and Specialist (e.g. anaesthetist) fees
- medicines obtained on the same day you are discharged, subject to the sub-limit.

How to manage your Major Medical Benefits and claims:

- Confirm that the particular procedure is covered in terms of the Scheme Rules, and obtain pre-authorisation for the procedure and hospital stay.
- Confirm that you have funds available by checking your available benefit limits on **www.libcare.co.za** or calling Libcare. Refer to the Benefit Table on page 44 as there are limits for certain benefit categories. You will be personally responsible for any amount over your available limits.
- Ask the doctor, surgeon and anaesthetist what they will charge for your procedure. Remember – you have to pay for costs above the Libcare Rate yourself. For some claims where the provider charges more than the Libcare rate, the difference may be paid from your Medical Savings Facility, should you have a positive balance. If you do not have a positive balance in your Medical Savings Facility, you will have to pay for these expenses out of your own pocket.
- There are specific medical expenses that Libcare does not cover, even from a positive balance in your Medical Savings Facility. For more information please also check the summary of exclusions on page 54 of this Guide.
- See also page 8 – Benefit Availability.

How to request pre-authorisation

Libcare will only pay if you obtain pre-authorisation for surgical and diagnostic procedures in doctors' rooms, Major Medical Procedure/s and/or admission to hospital. The pre-authorisation process alerts Libcare that a member/dependant is scheduled for a Major Medical Procedure, procedure in doctors' rooms and/or admission to hospital, and you, the doctor and hospital can be informed beforehand to what extent the treatment will be covered by Libcare. Please note that in-hospital specialised radiology services (MRI/CT and/or Radio-Isotope scans) require additional, separate pre-authorisation.

In some cases, even if authorisation is granted after the event, you could be liable for a 30% co-payment for failure to obtain authorisation on time prior to the event.

DOCTOR/MEMBER CONTACTS LIBCARE HOSPITAL APPROVALS

MEDICAL EMERGENCY

Contact Libcare within 48 hours after admission or, if it is a weekend or public holiday, on the next working day. If you do not, your treatment might not be covered.

PLANNED PROCEDURES

Contact Libcare at least 48 hours prior to admission. Certain procedures may require additional information to be submitted for the pre-authorisation process. Therefore, you should allow sufficient time for this before your admission.

Please note: Should you know of a procedure that will be taking place, contact the pre-authorisation department well in advance, in case additional information is required.

0800 12 CARE (2273)

approvals@libcare.co.za

PLANNED PROCEDURES

The following information MUST be provided:

- Your membership number
- The name and date of birth of the member or dependant for whom authorisation is required
- The reason for admission and the applicable treatment/tariff code(s) for the proposed procedure (the doctor or hospital should be able to provide the treatment/tariff code(s)
- The date of admission and/or proposed date of the procedure
- The name of the doctor and his or her telephone and practice number
- The name of the hospital and its telephone and practice numbers
- The provider's name and practice number, if the procedure (e.g. an MRI or dialysis) will be performed on an outpatient/outside a hospital basis
- The relevant ICD 10 diagnostic code(s)

If your request for pre-authorisation is granted, you will receive these details:

- an authorisation number, which you will need to provide to the hospital admissions clerk, doctor's office etc.
- the approved number of days in hospital (if a stay is required)
- the approved treatment/tariff code(s)

If you need to stay in the hospital longer than your initial approved length of stay, your doctor, the hospital case manager or a family member must inform Libcare ahead of the increase in length of stay.
Additional days may be approved during your hospital stay:

- if the request meets clinically-appropriate criteria
- if within the Scheme Rules
- if benefits are available

Dental Surgery

- Only the specified procedures (including all costs, e.g. day clinic, hospital, dentist or surgeon and anaesthetist) will be covered up to the limit, subject to pre-authorisation, whether done in- or out-of-hospital.
- Note: Orthognatic surgery for cosmetic purposes (e.g. jaw alignment) is an exclusion in terms of the Scheme rules.
- Note: For dental implants, pre-authorisation is required and all related clinical information as well as a full quotation must be supplied for assessment. Pre-authorisation is strictly subject to the benefit limit and funds available at the time of the procedure, and in no way guarantees payment in full.
- Impacted wisdom teeth: the evaluation of whether to fund the removal of these teeth will be based on the provision of the clinical information, x-rays and a motivation substantiating the removal of symptomatic impacted wisdom teeth. Impacted wisdom teeth are molars at the back of the mouth that do not have enough room to emerge or develop normally. Symptomatic impacted wisdom teeth are teeth that may have one or more of the following symptoms; swelling and ulceration of the gums around the wisdom teeth, damage to the roots of the adjacent teeth, gum and bone disease around the adjacent teeth and development of cysts and tumours.

Out-of-Hospital MRI/CT and/or Radio-Isotope scans

- The first two out-of-hospital MRI/CT and/or Radio-Isotope scans per family may be paid from the Major Medical Benefit subject to pre-authorisation and clinical protocols.
- Thereafter, if you or a dependant require a MRI/CT and/or Radio-Isotope scan, it will be payable from the available Medical Savings Facility (MSF) and Out-of-Hospital Expenses Benefit (OHEB). If at the time of requiring these further scans you are in your Threshold Benefit, these claims will be for your own pocket.

Crime Trauma Benefit

This benefit is designed to help you cover the costs of medical expenses and treatment incurred as a result of the following events, as long as it is charged for in line with the Libcare Rate:

- Hijacking and/or attempted hijacking
- Murder or attempted murder
- Assault or attempted assault including sexual assault
- Rape or attempted rape
- Robbery (including armed robbery) or attempted robbery

Medical expenses and treatment for the following will be paid (refer to page 45 for specific limits):

- Consultations with registered psychologists, psychiatrists and social workers
- HIV prophylaxis (prevention) treatment following rape
- Rehabilitation directly related to the crime trauma
- Cover is limited to a maximum of 12 months after the event, and, if treatment proceeds into a new benefit year, the new year's Rules will apply.

If you have been a victim of any of the events listed

- Report the crime to the police
- Contact Libcare on 0800 12 CARE (2273) or
- Email the police-stamped case number and the name of the police station to **crime_trauma@libcare.co.za** to authorise payment from the Crime Trauma Benefit.

Casualty Benefit: After-hours emergencies and physical injury emergencies

Normally, if you are treated at a casualty facility, this is regarded as an out-of-hospital event. Fees would therefore be paid from of your available day-to-day benefits (MSF, OHEB or Threshold) and not from the Major Medical Benefit. Treatment in an emergency room or casualty facility that leads to pre-authorised hospitalisation will be covered from your hospitalisation benefit. If not authorised, it will be subject to your other available day-to-day benefits. All claims will be processed in line with the Libcare Rate.

However, for after-hours emergencies and authorised physical injury emergency treatment obtained at any time, Libcare provides cover to pay for consultations associated with visits to the emergency room or casualty facility of a private hospital (refer to page 45), under the following conditions:

- Cover under this benefit for after-hours emergencies is linked to the time treatment is obtained and the treatment codes for the event. 'After-hours' is the period that falls outside of doctors' consulting hours (18:00 to 08:00 weekdays and public holidays).
- Cover excludes claims for non-emergency care, such as routine consultations.

Authorisation

You must obtain an authorisation number within 48 hours of the event, in order for the treatment to be covered from the Casualty Benefit. The ICD-10 code (International Classification of Diseases Code) will drive the authorisation as it gives the exact diagnosis and nature of emergency. Refer to page 13 for the authorisations process.

Claims payment

Some hospitals/casualty facilities will send the account to Libcare, others will ask for payment at the time of service. If you pay the hospital/casualty facility, forward the paid account with a receipt attached, to Libcare for reimbursement from your available benefits.

Day Procedures

Certain day procedures can be done in the Doctors' rooms e.g. vasectomy, gastroscopy and needle aspiration of joint, bursa or ganglion (refer to page 45). **As of 1 January 2023, you are required to obtain pre-authorisation from Libcare for these procedures. Please refer to the pre-authorisation process on page 13**. Please contact Libcare on 0800 12 CARE (2273) to check whether your day procedure will be covered from the Major Medical Benefit.

Emergency Transport

As a member of Libcare, you have access to emergency response and evacuation. Netcare 911 provides emergency transport in South Africa as well as in Namibia, Botswana, Swaziland, Lesotho or Mozambique (as far north as Beira or Vilan Culos along the coast).

Their services include:

- emergency medical response by road or air to the scene of a medical emergency.
- transfer of life-saving medication and emergency blood to the scene of an accident.
- transfer by road or air to the most appropriate medical facility when medically justified according to Netcare 911 medical protocols.
- inter-hospital transfers (one way), when medically justified according to Netcare 911 medical protocols and motivated by a medical practitioner.

Please note: If you use the services of another provider for emergency transportation, you must notify Netcare 911 within 48 hours. Failure to do so may result in you being held liable for payment of the service.

Cover when travelling overseas

Libcare cover only extends to the common monetary area of Southern Africa. If you or your dependants are travelling out of South Africa, you need to arrange your travel insurance privately. Contact your travel agency in this regard.

DISEASE MANAGEMENT PROGRAMMES

The following list of programmes is available to you or your dependants on all the various treatments available for you to manage your condition/s.

0800 12 CARE (2273)

chronicmed@libcare.co.za

www.libcare.co.za

Cancer/Oncology Management Programme

This programme manages benefits for members and dependants with cancer, once the patient is registered on the Cancer/ Oncology Management Programme. If the patient is not registered, Libcare may reject the claims or pay them from the day- to-day cover (which could deplete those benefits very quickly). Once you are registered on the programme for the benefit year, Libcare provides cover up to the limits shown on the Benefit Table on page 44.

Bone Marrow Transplants

For Bone Marrow Transplants, the harvesting, transplantation and anti-rejection medication will fall under the Major Medical Benefit. Treatment prior to transplantation, such as Chemotherapy and Radiotherapy, are categorised under the Oncology Benefit. Prior approval from Libcare is required before commencing any work-up for the Bone Marrow Transplant. The treating Doctor has to send a treatment plan and any supporting documentation to the Libcare Oncology Management Department. Once approved, a letter of authorisation will be sent to you and to the Doctor. You will then need to contact Libcare Approvals on **approvals@libcare.co.za** to obtain authorisation for admission to hospital. Donor-search cover is limited to the Republic of South Africa.

Please note: No benefits will be granted without pre-authorisation having been obtained for hospitalisation and treatment for Bone Marrow Transplants. Should you have any queries with regard to the above, please contact the Libcare Oncology Management Department.

CANCER/ONCOLOGY – HOW TO REGISTER

Upon diagnosis, the Doctor sends your confirmation of diagnosis and a treatment plan to Libcare

0800 12 CARE (2273)

oncology@libcare.co.za

The treatment plan is reviewed by the Libcare Oncology Management Department

After the team has assessed and approved your treatment plan, they will send authorisation letters to you and your Doctor indicating:

- the treatment authorised
- the approved quantities, and
- the period for which the authorisation is valid.

Your Doctor must advise Libcare of any change in your treatment, as the doctor will need to re-assess and update your authorisation. Failure to do this may result in Libcare rejecting your claims or paying them from an incorrect benefit (e.g. your Medical Savings Facility or other day-to-day benefit), as there will not be a matching oncology authorisation.

Please note:
In addition to the authorisation from the Libcare Cancer/ Oncology Management team, you will also need to get separate pre-authorisation from Libcare Approvals for any hospitalisation, specialised radiology (e.g. CT scans, MRI scans and angiography) or private nursing/hospice services which you may need during the course of your oncology treatment. (Email: **approvals@libcare.co.za**)

Diabetic Management Programme through the Centre for Diabetes and Endocrinology (CDE)

The CDE Diabetic Management Programme (DMP) aims to help you cope with the daily demands of living with diabetes, this process will not change without the typical co-payments associated with this condition.

The CDE DMP provides you with the following minimum services per year

- 2 Doctors consultations (including specialists)
- 1 Dietician consultation
- 2 Diabetes educator consultants
- 1 Podiatry (footcare) screening
- 1 Retinal (eye) screening
- CDE Emergency Hotline access
- Diabetes educational material
- Diabetes medication and consumables
- Diabetes related blood tests

CDE has established a nationwide network of over 200 'Centres of Diabetes Excellence', each dedicated to providing optimum care at the appropriate level to individuals with diabetes. CDE DMP aims to improve management of blood glucose control, blood pressure and cholesterol, through this highly trained network.

Once you have registered, CDE will refer you to a Centre of Excellence or CDE-Accredited doctor near you.

- For more information on this benefit, contact Libcare on 0800 12 CARE (2273).
- For more information on CDE or to register, contact them on:
- Tel: 011 053 4400 (08:30 to 16:30, Monday to Thursday and 16:00 Friday)
- Email: Members@CDEDiabetes.co.za
- Web: www.CDEDiabetes.co.za

HIV/AIDS Management Programme – Confidential assistance for HIV positive beneficiaries

This programme provides access to benefits for treatment and counselling to all Scheme beneficiaries who are HIV positive, or who are exposed to the HIV virus and are at risk of infection. This includes:

- Counselling
- Adherence monitoring
- Authorisation and access to Anti-Retroviral Treatment (ART)
- Authorisation and access to monitoring tests
- Authorisation and access to treatment for Opportunistic Infections (OIs)
- Authorisation for access to multivitamins and vaccinations
- Authorisation for Post-Exposure Prophylaxis (PEP) following accidental and unintended potential exposure to HIV
- Authorisation for Prevention of Mother-To-Child Transmission (PMTCT), including milk formula

HOW TO REGISTER IF YOU ARE HIV POSITIVE OR MAY HAVE BEEN ACCIDENTALLY EXPOSED TO THE VIRUS

PLEASE CONTACT LIBCARE'S ADMINISTRATORS FOR AN APPLICATION FORM	Tel: 0800 12 CARE (2273) Email: care@libcare.co.za
THE DOCTOR COMPLETES THE FORM AND MEMBER SIGNS CONSENT	Please send the signed form, blood test results and a prescription to care@libcare.co.za.
LIBCARE'S ADMINISTRATORS REVIEW THE CLINICAL INFORMATION RECEIVED	The treating Doctor will be contacted if necessary to discuss treatment options.
A MEDICATION AUTHORISATION AND TREATMENT PLAN WILL BE ISSUED TO YOU AND YOUR DOCTOR	The HIV team will maintain contact with you for support, and to answer any questions you have.

If you are a new applicant for Libcare membership, you do not have to disclose your HIV status on the Libcare Membership Application Form. Once you have submitted your Libcare Membership Application Form, please contact the confidential HIV Management department on 0800 12 CARE (2273) during office hours, or email **care@libcare.co.za.**

CARE COORDINATION PROGRAMME (CCP)

The programme provides members and dependants who have complex medical conditions and are at high-risk, with holistic treatment from a team of medical experts and therapists in a sub-acute or rehabilitation facility.

A Care Coordinator (qualified nurse) works onsite with the facility teams, the patients and their families to optimise their care and plan for an optimal transitional care plan

Requests for admission to contracted sub-acute and rehabilitation facilities are via the Contact Centre where the discharge coordinators will approve an authorisation for qualifying patients. They will then hand the patient over to the allocated CCP Care Coordinator at the chosen facility.

The CCP is now operational across most major centres in South Africa. It is currently available in Pretoria, Johannesburg, Western Cape, Durban, Pietermaritzburg, Bloemfontein, George and Port Elizabeth.

The enrolment process

All members and registered dependants are eligible for the programme as long as:

- They meet the clinical entry criteria
- Their care provider is contracted to the CCP network
- The member/member's family consents to being part of the programme and chooses to be admitted to a CCP network facility.

Members are primarily selected for the programme whilst they are in an acute hospital setting. This is where incidents of rehabilitation needs, extended length of stay, ventilated patients, multiple complex conditions and other factors that could hamper a patient's progress to health, can be identified.

Should a doctor wish to enroll their patient onto the programme and the programme is active in their region, the provider should call the dedicated CCP Contact Centre on 0860 44 55 66 option 1 then option 3 to obtain authorisation for an admission to a CCP facility. The team will also determine if the patient meets criteria to be enrolled on the programme. The onsite Care Coordinator will obtain consent for the programme and will work with the facility team during their admission.

Note: This programme is **not** a Scheme benefit. However, it is intended to operate as a discretionary service to assist patients with the highest needs, efficiently and effectively.

Chronic Benefits

A chronic condition:

Lasts 3 months or more and is generally permanent.

Is usually life-threatening or life-limiting if not managed on an ongoing basis.

Requires medication to be taken regularly.

Chronic Benefit Limit

The Chronic Benefit Limit for each member or dependant is listed in the Benefit Table on page 44. Costs that accumulate toward this limit include:

- Approved medicines for the conditions listed in List A and B below.
- Certain related expenses for conditions in List A will come from your Chronic Benefit Limit if approved by Libcare as part of a registered treatment plan.

Other related expenses for conditions in List A, as well as those for conditions in List B, will come from your day-to-day benefits (as long as you have funds available and up to the benefit sub-limits).

Libcare will pay above the Chronic Benefit Limit for:

- Medicines for conditions in List A if approved by the Libcare Chronic Medicine Management Department.
- Certain related expenses for conditions in List A.

Payment for any chronic condition requires:

- Registering with the Libcare Chronic Medicine Management Department.
- Supplying the correct diagnostic ICD 10 code(s) when your Doctor submits claims related to the condition, subject to relevant clinical protocols and guidelines.

Libcare covers the following chronic conditions:

- List A is the legislated list of Prescribed Minimum Benefits (PMBs), which all medical schemes must cover.
- List B is the additional 38 conditions that Libcare covers.

LIST A			
Addison's Disease	Chronic Renal Failure	Epilepsy	Multiple Sclerosis
Asthma	Coronary Artery Disease	Glaucoma	Parkinson's Disease
Bipolar Mood Disorder	Crohn's Disease	Haemophilia	Rheumatoid Arthritis
Bronchiectasis	Diabetes Insipidus	Hyperlipidaemia	Schizophrenia
Cardiac Failure	Diabetes Mellitus Type 1	Hypertension	Systemic Lupus Erythematosus
	Diabetes Mellitus Type 2		
Cardiomyopathy	Dysrhythmia	Hypothyroidism	Ulcerative Colitis
Chronic Obstructive Pulmonary Disease	Anti-retrovirals for HIV/AIDS		

LIST B			
Allergic Rhinitis	Dystonia	Myasthenia Gravis	Prostatic Hypertrophy (benign)
Alzheimer's Disease	Eczema	Narcolepsy	Psoriasis
Ankylosing Spondylitis	Endocarditis	Osteoarthritis	Psychosis
Aplastic Anaemia	Peptic Ulcer Disease	Osteoporosis	Scleroderma
Attention Deficit Hyperactivity Disorder	Gastro Oesophaegal Reflux Disease (GORD)	Paget's Disease	Thrombocytopaenia
Barrett's & Erosive Oesophagitis	Gout	Para-/Quadriplegia	Thyroid disorders (other than Hypothyroidism, which is covered in List A above)
Cushing's Syndrome	Hyperuricaemia	Pemphigus	Tourette's Syndrome
Cystic Fibrosis	Hypoparathyroidism	Peripheral Vascular Disease	TB (Tuberculosis)
Depression	Menopause Management	Pituitary Adenomas	
Dermatomyositis	Motor Neuron Disease	Post-Traumatic Stress Disorder	

Managing your chronic conditions

Chronic conditions are often expensive to manage, so it is important that you register for the Libcare Chronic Benefit to ensure your claims for your condition are paid from the correct benefits.

CHRONIC BENEFIT REGISTRATION OR CHANGES TO CURRENT AUTHORISATION/PRESCRIPTION

DOCTOR/PHARMACIST CONTACTS LIBCARE CHRONIC MEDICINE MANAGEMENT DEPARTMENT

Tel: 0800 12 CARE (2273)

Email: chronicmed@libcare.co.za

Doctor/Pharmacist provides specific information relating to your condition and medication.

THE REQUEST IS REVIEWED BY LIBCARE CHRONIC MEDICINE MANAGEMENT DEPARTMENT

The Chronic Medicine Management team will review the application, and if necessary, your doctor will be contacted for additional information.

IF EVERYTHING IS IN ORDER, PRE- AUTHORISATION IS GIVEN

The medicines can be dispensed, provided you have a valid prescription from your South African registered Doctor for the medicines listed as per your authorisation.

CONFIRMATION LETTER

Libcare Chronic Medicine Management Department will send you a confirmation letter

Preventative Care Benefits

Libcare can help you by paying for a variety of annual consultations, procedures and vaccinations from the Preventative Care Benefit.

This means that the cost will not affect your Medical Savings Facility or Out-of-Hospital Expense Benefit as long as it is charged for within the Libcare Rate, using the tariff codes listed below.

TABLE 1

Benefits	Age limits	Gender	Tariff codes	Description
Pap smear 1 per beneficiary	18+ years	Females	4566 4559	Vaginal or cervical smears
Cholesterol 1 per beneficiary	15+	All	0013 4027 4025	Total cholesterol blood test
Blood glucose 1 per beneficiary	All	All	4050 4057 0012	Glucose strip test Glucose : Quantitative
Immunisation for children	up to age 7	All	See table 4	See tables 3 and 4
First visit to GP 1 per beneficiary	All	All	0190 0191 0192	
Mental health 1 GP, psychiatrist or psychologist consultation per beneficiary per annum	All	All	GP 0190 0191 0192 Psychiatrist 0161 Psychologist 86202	
Dental service 1 per beneficiary	All	All	8104 8190 8101 8341 8163 8159	1 dental check up. 1 x 1 surface filling and 2 scale and polishes. Maximum of 4 fissure sealants per quadrant (children 12 years and younger)
2D pregnancy scans (months 3 and 6) 2 per beneficiary	All	Females	3615 3617	
Pneumonia vaccination 1 per beneficiary	65+ years	All	See table 2	See tables 3 and 4

Pneumococcal conjugated vaccine e.g. Prevenar	6 weeks to 9 months	All	See table 4	
Bone density scan 1 per beneficiary	50+	Females	3604 50120	Bone densitometry Bone densitometry
Prostate pathology test 1 per beneficiary	50+	Males	4519	Prostate specific antigen
Mammogram 1 per beneficiary	40+	Females	3605 34100 39175 34101	Mammography: unilateral or bilateral, including ultrasound X-ray mammography including ultrasound Mammography: unilateral or bilateral
Eye test 1 per beneficiary	Up to age 21	All	11001	
Tuberculosis (allergy, skin prick test) 1 per beneficiary	All	All	0221	
HIV counselling and testing (HCT)	All	All	0016 0017 4614	
Faecal occult blood test 1 per beneficiary	50+	All	4352	
Glaucoma screening 1 per beneficiary	55+	All	3014	
Flu vaccination	All	All	See table 2	
HPV vaccine	9 to 18 years	Females	See table 2	
Female contraceptives	All	Females	2565 2442	Oral and Injectable Contraceptives. Intrauterine Contraceptive Devices and Implanon NXT implants (inclusive of device and insertion)

TABLE 2

Benefits	Age limits	Gender	Description
Flu vaccines	All	All	Limited to one per beneficiary per annum
Pneumonia vaccines	65 years and older	All	Limited to one per beneficiary per annum
HPV vaccine	9 to 18 years	Females only	Limited to one course per beneficiary per annum
TB test	All	All	Limited to one per beneficiary per annum
COVID-19 vaccine	12 years and older	All	Limited to one per beneficiary per annum

TABLE 3

Age	Vaccine
Birth	BCG
	Oral Polio Vaccine
6 weeks	Oral Polio Vaccine
	Rotavirus Vaccine*
	Diphtheria$
	Tetanus
	Whooping Cough
	Inactivated Polio Vaccine
	Haemophilus influenzae B
	Hepatitis B
	Pneumococcal Conjugated Vaccine
10 weeks	Diphtheria$
	Tetanus
	Whooping Cough
	Inactivated Polio Vaccine
	Haemophilus influenzae B
	Hepatitis B
14 weeks	Rotavirus Vaccine*
	Diphtheria$
	Tetanus
	Whooping Cough
	Inactivated Polio Vaccine
	Haemophilus influenzae B
	Hepatitis B
	Pneumococcal Conjugated Vaccine
9 months	Measles#
	Pneumococcal Conjugated Vaccine
18 months	Measles
	Diphtheria$
	Tetanus
	Whooping Cough
	Inactivated Polio Vaccine
	Haemophilus influenzae B
5 years	Tetanus
	Diphtheria, reduced strength

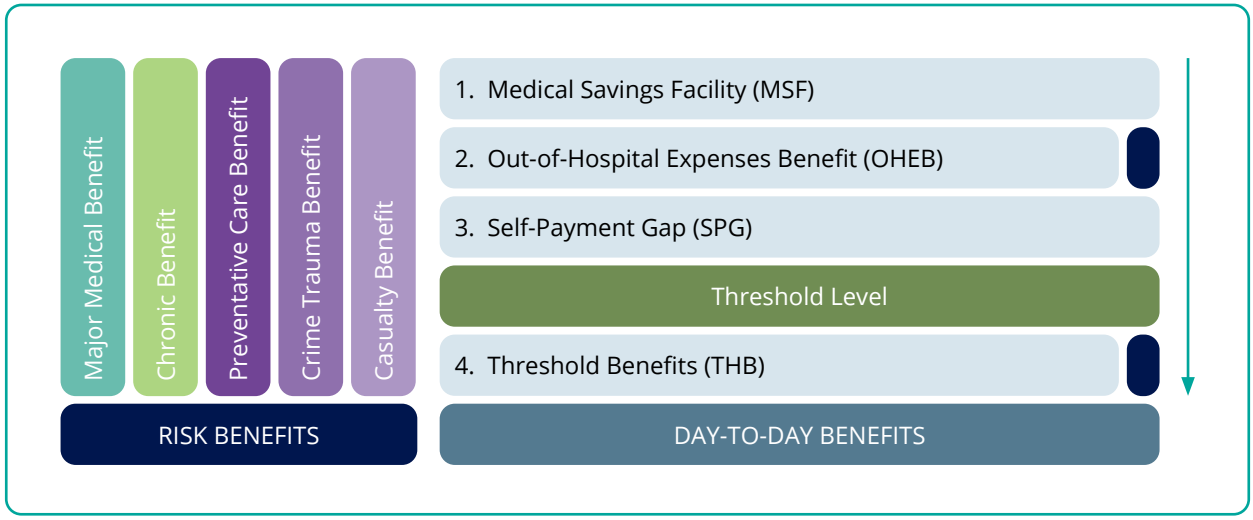
* Rotavirus vaccine should not be administered after 24 weeks of age.
$ Diphtheria, tetanus, whooping cough, inactivated polio, 'Hepatitis B' and Haemophilus influenzae B vaccines may be administered as a 6-in-1 combined preparation.
# Measles vaccine may be administered as measles only OR as the Measles, Mumps and Rubella (MMR) vaccine.

Note: The vaccination schedule (Table 3) and list of vaccines (Table 4) are guidelines only and are subject to change during the year.

TABLE 4

Nappi Code	Description	Immunisation Type
872962	BCG intradermal infant vial powder for reconstitution	BCG Vaccine
708854	Imovax polio	Diphtheria, Polio, Tetanus
703335	Td polio 0.5ml	Diphtheria, Polio, Tetanus and Hepatitis B
700768	Tritanrix-hb 0.5ml single dose	Diphtheria, Polio, Tetanus and Whooping Cough
825158	DTP-merieux single dose syringe	Diphtheria, Tetanus and Whooping Cough
703994	Infanrix prefilled syringe 0.5ml	
711258	Tetraxim prefilled syringe 0.5ml	Diphtheria, Tetanus, Whooping Cough and Polio
707285	Infanrix hexa	Diphtheria, Tetanus, Whooping Cough, Haemophilus influenzae B, Hepatitis B and Polio
707522	Pentaxim prefilled syringe 0.5ml	Diphtheria, Tetanus, Whooping Cough, Polio and Haemophilus influenzae B
703226	Actacel-pasteur 0.5ml	Haemophilus influenzae B
813206	Act-hib single dose syringe	
834203	Combact-hib single dose syringe	
700356	Engerix-b paed (new) monodose 0.5ml	Hepatitis B
715349	Euvax b 0.5ml vial	
701657	Heberbiovac hb m/dose 10 dose 5ml paed	
701658	Herberbiovac hb sgi dose 0.5ml paediatric	
825522	Rouvax single dose syringe	Measles
879452	Morupar single dose	Measles, Mumps and Rubella
700772	Priorix single dose 0.5ml w/pd/syr + dil	
792004	Trimovax single prefilled syringe	
823678	Opv-merieux 10 dose	Oral Polio Vaccine
812331	Polioral 10 dose trivalent	
715858	Prevenar 13 prefilled syringe 0.5ml	Pneumococcal Conjugated Vaccine
705032	Prevenar prefilled syringe 0.5ml	
714999	Synflorix	
714133	Rotarix liquid oral	Rotavirus Vaccine
710935	Rotateq 2ml	

Day-to-Day Benefits



The arrow shows the order – from 1 to 4 – in which eligible day-to-day claims are processed from each available benefit as they are received, and how these claims accumulate to the Threshold Level from 1 to 3.

Examples of day-to-day expenses covered by this benefit are:

- GP & Specialist Consultations
- Basic & Advanced Dentistry
- Optical
- Acute Medication
- Physiotherapy
- Pathology
- Radiology

How Libcare pays for these expenses:

Eligible day-to-day claims are first paid from the Medical Savings Facility. When this amount is exhausted, Libcare automatically pays from the Out-of-Hospital Expenses Benefit. You will experience a Self-Payment Gap if you exhaust the Medical Savings Facility and Out-of-Hospital Expenses Benefit. If the total amount of eligible self-paid claims reach the Threshold Level value, Libcare will again provide funding up to the limits in the various Threshold Benefits and your available benefits in each category. Claims are paid up to the Libcare Rate and also accumulate to the Threshold Level up to the Libcare Rate.

If the medical service provider charges you more than the Libcare Rate, the difference charged may be paid automatically from your Positive Savings balance in your Medical Savings Facility if you have a positive balance. If such amount is paid from your Positive Savings, this payment will not accumulate to the Threshold Level.

SELF-PAYMENT GAP

There are various reasons why you need to pay claims from your own pocket before Libcare starts paying again from the Threshold Benefit including:

- If the combined value of your Medical Savings Facility (MSF) and Out-of-Hospital Expenses Benefit (OHEB) is less than the pre-determined Threshold Level.
- If you use healthcare providers who charge more than the Libcare Rate, only the value of the Libcare Rate accumulates towards your Threshold Level. The balance may be paid from your positive balance in the Medical Savings Facility. This will increase the Self Payment Gap.
- If a dependant leaves the Scheme during the year, your Threshold Level stays where it is, but your monthly contributions to your MSF will be lower. This will increase the Self Payment Gap.
- If you submit claims from late 2022 at the beginning of 2023, the expense accumulates towards your 2022 benefit limits. If you submit claims for a benefit category that you've already exceeded, then these claims will not accumulate toward your Threshold Level.
- If you submit claims for items only payable from Positive Savings, these claims do not accumulate towards your Threshold Level. This will increase the Self Payment Gap.

MEDICAL SAVINGS FACILITY (MSF)

- **16%** of your total contribution (excluding any late-joiner penalties) is allocated to the MSF
- Refer to page 56 to calculate your MSF
- Eligible day-to-day claims are firstly paid from the MSF, at the Libcare Rate
- Claims above the Libcare rate may be funded from your available positive savings

Credit savings:

Refers to the advanced annual savings that Libcare makes available on the 1st of January (or pro-rated should you join later in the calendar year), even if you haven't yet made the full contribution to the MSF.

Positive savings balance:

- The monthly savings contributions that Libcare has received and which have not been used by you.
- Interest on positive balances on the Medical Savings Facility (MSF) shall be allocated at the rate of return earned effective at the beginning of each month following the applicable earnings period.
- Rolls over to the following year.
- If you leave the Scheme, a positive savings balance must be transferred to your new medical aid if it has a Medical Savings Facility. Please send details of your new medical aid to Libcare (scheme name, your new membership number and the scheme bank details). This transfer is made within four months after your Libcare membership termination date.
- If you are not joining a scheme which has a Medical Savings Facility, the balance can be paid in cash to you, and you will have to declare it for tax purposes. This payment is made in the fifth month after your Libcare membership termination date, to cater for any outstanding claims which may come through up until four months after termination date, but which relate to treatment costs incurred whilst you were still a member.

Negative savings balance:

- Arises when your claimed amount exceeds the savings contributions that Libcare has received from you for the benefit year.
- If you leave the Scheme before contributing the credit you've used, you will owe Libcare the difference.
- If a dependant's registration is terminated during the year and you have used more credit savings than your reduced contribution will pay for, you will owe Libcare the difference.
- Negative savings balances are debts which you must repay to Libcare by the end of the same benefit year in which you incurred the debt.
- Payment arrangements can be offered provided you sign an Acknowledgement of Debt form, but the debt must be repaid in full by the end of the same benefit year in which you incurred the debt.
- The Libcare Debt Management department can deduct/debit the outstanding amount from your bank account or you can pay the amount directly into the Libcare bank account.
  A consultant will contact you if the outstanding amount is going to be debited/deducted from your bank account.

OUT-OF-HOSPITAL EXPENSES BENEFIT (OHEB)

- Refer to page 56 to calculate your OHEB
- Claims are paid from OHEB up to the Libcare Rate

- Your eligible day-to-day expenses will be paid from this benefit when the MSF is depleted. If you have dependants on Libcare, your combined limits are available to you as a family. This means that one person in the family may claim more than their allocated amount, but then less of the total benefit will be available to the others.

SELF-PAYMENT GAP (SPG)

- Your Minimum SPG = Threshold Level – (MSF + OHEB)
- Your self payment gap will increase if there are non-accumulating claims that fund from your positive Medical Savings Facility (MSF).

- Arises when both MSF and OHEB benefits are depleted and the accumulated value of your eligible claims does not equate to your Threshold Level.
- You are responsible for the payment of day-to-day expenses in the SPG.
- Claims and receipts must still be submitted to Libcare for processing purposes and for accumulation to the Threshold Level.
- Eligible claims accumulate to the Threshold Level at the Libcare Rate.
- Please note that claims submitted whilst in your Self-Payment Gap will still accumulate to the applicable benefit sublimit, although the claim is not payable by the Scheme.
- As soon as you have submitted claims (at the Libcare Rate) to the value of the SPG, Threshold Benefits become available.

THRESHOLD LEVEL

THRESHOLD BENEFITS (THB)

Refer to page 44 for a list of Threshold Benefits and Limits

- Claims are paid from THB up to the Libcare Rate

- This benefit works as a 'safety-net' by paying for your eligible day-to-day medical treatment if your claims reach the pre-determined Threshold Level. There are maximum benefit sub-limits allowed annually per benefit category.
- These sub-limits are the maximum the Scheme will fund for a particular benefit once you've reached the Threshold Level. If you've previously claimed for a benefit out of MSF and/or OHEB and exceeded the sub-limit, then no further benefits will be available in that benefit category when you are in Threshold. Example: If you've used your MSF and OHEB to fund e.g. physiotherapy claims, even though the claims may be paid in full in those benefits, if the total exceeds the THB sub-limit for physiotherapy, no further physiotherapy claims can be paid if you are in the THB.

Membership Information

ELIGIBILITY TO JOIN LIBCARE

Libcare is a restricted-membership medical scheme for eligible full-time, permanent employees and eligible agents of the Liberty Group, for whom membership of Libcare is a condition of their contract with the Company. For most Liberty Group companies, it is company policy that you join Libcare at the date that you take up full-time permanent employment with the Company, unless you are a dependant on your spouse's medical aid.

There will be no underwriting (Waiting Periods and/or Condition-Specific Exclusions) imposed, if your date of registration on Libcare coincides exactly with your employment/agency contract date. If these dates do not coincide, the level of underwriting [i.e. whether a General Waiting Period and/or a Condition-Specific Exclusion] imposed will be based on the information you submit related to your prior medical scheme membership.

If you are registered on your spouse's medical aid and you decide to join Libcare during your employment based on your employment contract eligibility, but at a date later than your employment/agency contract date, you are still eligible to join Libcare, but underwriting and/or Late Joiner Penalties may be imposed on your membership. See the section below 'Waiting periods, Exclusions and Late Joiner Penalties'.

All relevant documentation requirements for registration as a new member or amendments to your existing membership must be submitted via your payroll administrator.

NON-DISCLOSURE OF INFORMATION

Non-disclosure is when you intentionally or unintentionally do not disclose or give certain details about yourself and your dependants you wish to have registered, when you complete the application form to join Libcare Medical Scheme. This could lead to your medical aid membership being terminated when you need it most.

Examples of material information you must disclose accurately and in full:

- Any medical condition(s) that you or a dependant have at the date of application
- Any medical condition(s) diagnosed in the past 12 months – this includes conditions that were diagnosed but managed with lifestyle changes e.g. change in diet
- Any medical condition for which medical advice or treatment was sought in the past 12 months, even if medical advice was not obtained from a doctor but from another healthcare service provider such as pharmacist.

What will this mean for you or your dependants?

Libcare requires you to provide all medical information about you and your dependants on the application form. It is very important when you join a medical scheme to disclose all medical conditions you may have had or for which you or your dependants currently receive medical treatment or advice for.

What will happen if you don't disclose all material medical information on the application form?

- Libcare may terminate your membership immediately, and reverse all claims that have been paid from the date that you joined the Scheme
- The Scheme may impose waiting periods on your re-joining, and depending on the circumstances, may also take criminal or civil legal action in certain cases (e.g. fraud)

How do you avoid non-disclosure?

- Read all questions carefully
- Be honest and disclose all relevant and required information
- Give as many details as possible when answering the health questions on the application form

All relevant documentation and/or requirements for registration as a new member or amendments to your existing membership must be submitted via your payroll administrator.

WHO CAN BE REGISTERED ON LIBCARE?

You can apply to register the following dependants

- Your spouse or partner.
- Your natural and/or legally-adopted and/or foster children and/or stepchildren up to 21 years of age.
- Your natural and/or legally-adopted and/or foster children and/or stepchildren age 21 or over if they are mentally or physically disabled, not employable, and/or they are dependent on you for family care and support. Note that registration of such a dependant is not automatic as each case will be evaluated individually relative to the Libcare Rules.
- Other family members (such as siblings, parents, but excluding in-laws) who live with you, are not employable, and are dependent on you for family care and support. Note that registration of such a dependant is not automatic as each case will be evaluated individually relative to the Libcare Rules.

How to apply to register a dependant

You will need to complete an application form and submit it together with all the supporting documentation to your payroll administrator in the first instance, and they in turn will submit the forms to Libcare.

You can get this form from your Payroll Administrator or from the Libcare Contact Centre. You will also need to note requirements as follows:

To apply to register a child

- Please apply to register babies within 30 days of birth or adoption. After 30 days, Libcare may impose underwriting.
- There is also a risk that all claims associated with the baby's medical care will be rejected if he/she isn't registered.
- Documentation required: A hospital registration certificate [if the birth certificate is not immediately available] followed by a birth certificate, an adoption certificate for a child adopted during your membership, or a certified ID document for an older child. In the case of a foster child, a certified copy of the Court Order placing the child in your custody is required. For all child dependants, where the surname is different to yours, you will need to supply an unabridged birth certificate on which you are listed as one of the parents as registered with Home Affairs. Where the child has previously been registered on another medical aid(s), please supply all membership certificates from the prior medical aid membership(s) as well.

In addition, for children aged 19 and over: An affidavit describing the child's circumstances and why they are dependent on you, and proof that the dependant's income is not more than the maximum social pension. Note that registration of such dependant is **not automatic** as each case will be evaluated individually relative to the Libcare Rules.

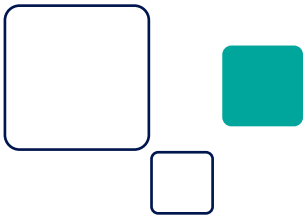
- As individual cases may vary in circumstances, Libcare will advise you if additional information is required.

To apply to register a spouse or partner

- A certified copy of the ID document.
- A certified copy of the marriage certificate, civil union certificate, or similar document if the marriage is performed under traditional African law or Asiatic or Islamic law.
- In the case of a partner, a sworn affidavit attesting to the nature of the relationship, duration to date, confirmation of shared household and any other relevant details.
- Certified copies of all membership certificate(s) confirming previous medical cover.
- New spouse dependants must be registered within 30 days of marriage/legal union to avoid underwriting.
- As individual cases may vary in circumstances, Libcare will advise you if additional information is required.
- Ex-spouses cannot be/remain registered on Libcare.

To apply to register 'other' dependants

- A certified copy of the ID document.
- A sworn affidavit with full details pertaining to your reasons for requesting registration of the dependant.
- Proof of dependant's income.
- Certified copies of all membership certificate(s) confirming previous medical cover.
- As individual cases may vary in circumstances, Libcare will advise you if additional information is required.
- Registration of such dependants is not automatic as each case will be evaluated individually relative to the Libcare rules.
- The Trustees will assess all applications to register "other" dependants and you will be notified as to whether registration has been approved or not.



Note: The requirement to provide affidavits is so that you have the opportunity to describe the dependant's particular circumstances, and these dependency circumstances will be further evaluated against the Scheme Rules.

The continued registration of all children aged 21 and over, and of 'other' dependants, is not necessarily permanent and will be reviewed annually.

The Scheme *may* require additional verifiable proof from you, including confirmation that:

- a blood relationship exists between you and immediate family concerned and
- the dependant is unemployable and that you are liable for family care and support of the immediate family member concerned, and the reason for such liability.

DOCUMENTS REQUIRED FOR REGISTRATION

Document(s) required	Principal Member	Spouse	Partner	Child under the age of 21	Child 21 years and older
Certified copy of National Identity Document/ Birth Certificate/ hospital confirmation reflecting the baby's name	●	●	●	●	●
Certified copy of Marriage Certificate, civil union certificate or customary union certificate. For life-partnerships, a sworn affidavit		●	●		
Copy of all Membership Certificate(s)/ Affidavit detailing previous medical scheme cover	●	●	●	●	●
Declaration confirming details of reasons for financial dependency of adult dependants					●
Proof of studies (current proof of full-time registration at a RSA recognised educational institution) for children aged over 18				●	●
Affidavit describing child's circumstances and details of reasons for financial dependency, for children aged 19 and over, who are not a full-time student at a RSA recognised educational institution				●	●
Copy of Doctor's Disability Report (if applicable) indicating permanent disability				●	●
Proof of legal adoption (if applicable)				●	●
Proof of court order for foster children				●	●

You may be requested to provide additional documents if the standard documents do not clearly indicate the eligible dependency relationship/status. For all child dependants, where the surname is different to yours, you will need to supply a certified copy of an unabridged birth certificate on which you are listed as the parent.

WAITING PERIODS, EXCLUSIONS AND LATE JOINER PENALTIES

Underwriting

The following can be applied to members and/or their eligible dependants in terms of medical scheme legislation:

General Waiting Periods

A general waiting period of three months from date of registration on Libcare can be imposed on you and/or your dependants, during which cover is restricted but contributions are still payable. The underwriting is based on when application is made to be registered on Libcare, and if the application is in respect of a person who:

- has never been a member/dependant of any South African-registered medical scheme;
- was not a member/dependant of a South African-registered medical scheme for at least 90 days before Libcare application;
- is applying to join Libcare for reasons not due to change in employment which forces a change in medical aid;
- is a child dependant who was not registered on Libcare at your date of employment or within 30 days of birth;
- is your spouse/partner who was not registered on Libcare at your date of employment or within 30 days of date of marriage/ legal union.

Libcare can also apply the balance of an unexpired general waiting period that has been imposed by a previous medical aid. In certain circumstances during waiting periods, Libcare will still provide cover for the legislated Prescribed Minimum Benefits. This will be confirmed when the underwriting decision is issued to you.

Condition-Specific Waiting Periods

A condition-specific waiting period of 12 months from date of registration on Libcare can be imposed on you and/or your dependants, in respect of a pre-existing condition or related conditions. A pre-existing condition is one for which a member/ dependant was diagnosed, treated or given advice in the 12 months prior to application to Libcare. Cover is excluded for these conditions during this waiting period but contributions are still payable. The underwriting is based on when the application is made to be registered on Libcare, and if the application is in respect of a person who:

- has never been a member/dependant of any South African-registered medical scheme;
- was not a member/dependant of a South African-registered medical scheme for at least 90 days before Libcare application;
- does not have at least 24 continuous months' prior registration on any South African-registered medical schemes;
- is applying to join Libcare for reasons not due to change in employment which forces a change in medical aid;
- is a child dependant who was not registered on Libcare at your date of employment or within 30 days of birth;
- is your spouse/partner who was not registered on Libcare at your date of employment or within 30 days of date of marriage/ legal union.

Libcare can also apply the balance of an unexpired condition-specific waiting period that has been imposed by a previous medical aid. In certain circumstances during waiting periods, Libcare will still provide cover for the legislated Prescribed Minimum Benefits. This will be confirmed when the underwriting decision is issued to you.

Late-Joiner Penalties

Libcare will impose Late-Joiner Penalties on a new member/adult dependant, if the person is 35 years or older, if they, at date of application:

- are 35 years of age or older, and were not a member of a medical scheme before 1 April 2001, or
- were a member of a medical scheme before 1 April 2001 but had a break in membership of more than three months after 1 April 2001.

Libcare may increase late joiners' risk contributions by between 5% and 75%, depending on their age at date of application, and if insufficient evidence [by way of membership certificates] is provided showing that they had creditable cover on medical schemes prior to joining Libcare. The penalty is calculated according to the following formula:

Number of Years without Creditable Cover/ Evidence of Creditable Coverage	Late-Joiner Penalty Added to the Risk Contribution
1 – 4 years	0.05 multiplied by the risk contribution
5 – 14 years	0.25 multiplied by the risk contribution
15 – 24 years	0.50 multiplied by the risk contribution
25 years and more	0.75 multiplied by the risk contribution

A = B – (35 PLUS C)

Where:

A MEANS The number of years referred to in the first column of the table above.

B MEANS The age of the late joiner at the time of his/her application for membership or admission as a dependant.

C MEANS The number of years of creditable coverage which can be demonstrated by the late joiner.

It is therefore very important that you attach membership certificates of prior medical scheme membership in respect of yourself and your dependants. Note that there is a legal obligation on all medical schemes to provide you with your membership certificate on request and as promptly as possible. If you provide membership certificates subsequent to a Late-Joiner Penalty being applied, then any resulting revision of the Late-Joiner Penalty will only be made from the date the certificates are provided [i.e. will not be backdated].

Creditable Coverage means any period in which a late joiner was:

a. a member or a dependant of a South African-registered medical scheme;

b. a member or a dependant of an entity doing the business of a medical scheme which, at the time of his or her membership of such entity, was exempt of the provisions of the Medical Schemes Act;

c. a uniformed employee of the South African National Defence Force, or a dependant of such employee, who received medical benefits from the South African National Defence Force; or

d. a member or a dependant of the Permanent Force Continuation Fund, but excluding any period of coverage of a dependant under the age of 21 years.

Affidavits

If you or the dependant(s) you wish to register were registered on a medical scheme(s) that no longer exists, and/ or reasonable efforts to obtain a certificate(s) of membership from that scheme(s) have failed, then you must complete and submit a sworn affidavit attesting to the name(s) of the scheme(s) and the related period(s) of registration (start and end date(s)).

HOW TO REMOVE A DEPENDANT

To remove a dependant from Libcare, for example if you get divorced or your child gets a job or is otherwise no longer eligible for cover, you must complete a Member Withdrawal Request Form and submit it to your Payroll Administrator. You can obtain this form by accessing the website on **www.libcare.co.za**, by contacting Libcare or from your Payroll Administrator.

Note: ex-spouses cannot be registered, nor can they remain registered on the Scheme if you become divorced during your membership. His or her membership should cease at the end of the month in which the divorce becomes final, and you will need to notify your Payroll Administrator and Libcare in such event.

Note: In all instances, the onus is on you as the principal member to notify Libcare [through your Payroll Administrator] as soon as there are changes in your details or status, or that of your registered dependants. You need to inform the Scheme within 30 days of the occurrence of any event which results in you or any one of your dependants no longer satisfying the conditions in terms of which you/they may be registered on Libcare.

MEMBERSHIP FOR RETIREES

If you are a Libcare member when you retire, you may continue to be a member as long as you:

- Have retired from employment with the Liberty Group in terms of the applicable rules of the Liberty staff retirement funds;
- Have contributed to Libcare or any other medical scheme for five consecutive years (or any shorter period that may be provided for in the Libcare Rules) prior to retirement, or have paid contributions in respect of any shortfall in the required period of membership.

If you elect not to continue your Libcare membership or resign from membership in retirement, you cannot rejoin the Scheme.

WHAT HAPPENS IF YOU RESIGN OR ARE RETRENCHED

If you resign or are retrenched, your Libcare membership will stop at the end of your last month of employment provided your contributions payments are up to date. Libcare will process all claims with service dates prior to the termination date, provided that these claims are received within four months of the termination date and provided you have sufficient benefits available. At the end of four months, no further claims will be processed. If you have a negative savings balance or other debt owing to Libcare, a consultant will contact you to make the necessary arrangements to repay the Scheme.

WHAT HAPPENS IF YOU DIE

If you die, your registered dependants may continue the Libcare membership as long as they:

- were registered as Libcare dependants at the time of your death, and
- at the date of your death, had been registered on Libcare or another previous medical scheme for five consecutive years (or any shorter period that may be provided for in the Libcare Rules);
- meet the other membership requirements outlined previously. The general eligibility rules will continue to be applied

e.g. in respect of children aged 21 and over, 'other' dependants, etc.

Your surviving spouse or partner may remain on the Scheme until he/she:

- cancels their membership in writing, or
- is registered as a dependant on a new spouse's/partner's medical scheme.
- If you have a negative savings balance, the balance outstanding will remain on your membership for the new principal member.
- Negative balances can be claimed from your estate, details must be provided to the Scheme.
- A consultant will contact your surviving beneficiaries to make the necessary arrangements to repay the Scheme.

Note: Once a surviving dependant elects not to become a continuation member or terminates Libcare membership, when he/she becomes a member, or a dependant, of another medical scheme, the dependant cannot re-join the Scheme.

OTHER CHANGES

A separate form must be completed for each of the following:

- Update your Personal Information Form
- Permission to Change Bank Details Form
- Member Withdrawal Request Form
- Application to Add Dependants Form
- Application for Registration of a Newborn Baby Form

Registration and amendments are strictly subject to the Rules and approval of the Scheme.

WEB-BASED FACILITIES

If you have internet access, you can obtain a real-time,

online view of your statements, claims history, contribution payments, personal information and more. You can also view your benefits and update certain personal details, by simply registering at **www.libcare.co.za.** The following services are available:

Online Information and Updating

This facility allows you to view your current benefits and available limits, as well as track your claims status or view your latest statement which is published on the website every month. You can also update your personal details, such as address and contact information. This is ideal for managing quick updates if your details have changed.

If you need to see your Doctor or Dentist urgently, or require a prescription from your chemist, you can easily access a full database of healthcare providers country-wide and access their relevant contact details. Note that any changes which affect your salary or company pension e.g. adding/removing a dependant, must first be sent to your Payroll Administrator at the company.

REGISTER ON THE WEBSITE BY FOLLOWING THE STEPS BELOW OR CONTACT US ON 0800 12 CARE (2273) TO ASSIST YOU IN REGISTERING WHILE YOU WAIT:

01 Go to **www.libcare.co.za.**

02 Click on Register at the top of the page, which will take you to the online registration process.

03 For technical assistance, if you encounter any problems, contact Libcare on 0800 12 CARE (2273) or email **enquiries@libcare.co.za.**

Self-help Services

HOW TO CLAIM

Please take note of the process you must follow when claiming from the Scheme.

ENSURE THAT THE FOLLOWING INFORMATION IS ON THE CLAIM

- The correct membership number
- Member's last name and initials
- Full name of patient (as indicated on your membership card, not a nickname)
- The correct dependant code
- Date of birth of the patient
- Date of service
- Treatment code (Tariff/Nappi)
- The applicable ICD 10 diagnostic code on every claim line
- The amount charged
- The service provider's name and practice number

WHAT YOU NEED TO CHECK BEFORE SENDING YOUR CLAIM TO LIBCARE

- 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, your credit card slip or proof of Electronic Funds Transfer (EFT)*.
- Make a copy of the above documents for your own records.

* 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 not be accepted. If the correct proof of payment is not attached, the account will be rejected.

Note: Please ensure your proof of payment is attached to the relevant claim when submitting.

SENDING CLAIMS TO LIBCARE

ELECTRONICALLY		Most service providers have the ability to send claims to us electronically, ensuring a shorter processing time.
EMAIL		claims@libcare.co.za
POST		PO Box 653418, Benmore, 2010
WEB		Upload a claim on www.libcare.co.za

BASIC CLAIM GUIDELINES

- We need to receive claims within at most four months following the date on which the services were provided. After that time, a claim becomes a stale claim and will not be paid.
- 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 Libcare.
- If your provider expects you to pay for the services upfront and then claim from Libcare, please send us the fully detailed and signed claim including the receipt.
- Libcare needs the details of what is being claimed 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, Libcare will regard it as stale and will not pay the claim. For example, the date of the consultation is 01 January 2023, you have up to the end of four months in which to submit your claim to Libcare. The claim will be deemed stale if Libcare thereafter received it after 31 May 2023.
- Once you have submitted your claim within the four-month period and Libcare partially pays or rejects the claim as incorrect or unacceptable for payment, you have 60 days in which to resubmit an amended claim for processing or query the nonpayment of the claim. The reason for the partially paid or rejected claim can be viewed on your claims statement.
- If you fail to resubmit an ammended claim or query the partial/non-payment of a claim within 60 days following the date of notification, the claim will be regarded as stale and will not be paid.
- Libcare 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 receive an SMS notification once the claim has been received and/or processed.
- You will also receive an email confirmation that it has been processed. This will summarise both approved and rejected claims.
- You will receive a monthly detailed statement via email that summarises all the contributions and claims transactions that occur throughout the month.
- You can view your statements online at **www.libcare.co.za**, via your confidential login.
- 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

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

YOUR BANK DETAILS

- Please make sure we have your correct bank account details for electronic payment of your claim refunds.
- If you add or change your bank account details to which we should refund your claims, please send us the following documents (not older than three months):
    - A completed Permission to Change Banking Details Form, obtainable at **www.libcare.co.za**, and
    - A certified copy of the account holder's identity document,
    - A stamped bank statement or a letter from the bank confirming the account number.
- You can scan and email these details to **enquiries@libcare.co.za.** You may also update your bank account details online at **www.libcare.co.za**, via your confidential login.

LIBCARE DIGITAL MEMBERSHIP CARD AT YOUR FINGERTIPS

We have introduced a digital membership card.
This means you now have access to your membership details on your smartphone or smart device (Android and iOS).

This is a safe and secure way to store, access and view your details. The digital card serves the same purpose as the plastic card, except it is always with you and contains your most up-to-date membership information. You can use your digital card at any healthcare provider as proof of Libcare membership.

Why use a digital membership card?

- You no longer need to carry around a physical card.
- It's easy to access using your smartphone.
- There's no risk of losing your card.
- You run a lower risk of fraud as you use your log-in details to access the card securely.

How does the digital card work?

It works in exactly the same way as the plastic card. You can use your digital card whenever you visit a healthcare provider like a doctor or pharmacy. They can use the details on the card to confirm your Libcare membership.

To use the digital card, you must be registered on the Libcare website. You will use the same username and password as for the Libcare website. If you are not yet registered, **https://www.libcare.co.za/portal/libcare/**register register now.

This secure link allows you to view and download your digital card. The link cannot be accessed by any other third party. By utilising this secure link you do not give Libcare or Discovery Administration Services consent to share or use this information for any other means.

How can I access my digital card?

Using the website:

- Go to **https://www.libcare.co.za/d2hp/ui/login** and click on Login.
- Log in using the same username and password as for the Libcare website.
- A tab shows your digital membership card. Tap on it to access your Libcare digital membership card.

You can add the digital card icon to your smartphone's home screen for quick access

How can I add a photo to my digital card?

When you upload a photo, you can choose to use a photo from your mobile device's photo library, or take a new photo with your phone's camera.

The photo needs to meet the following criteria:

- The image must be only of the member for whom the card has been created. No other person is allowed to be in the image.
- The image must be clear and needs to clearly show the facial features of the member.
- The image must consist of the member's head and shoulders only and must fill more than 80% of the image, leaving very little background.
- In the photo, the member must not wear sunglasses, a hat, a wig, face paint, or hold any object that covers the member's face.
- The image may not be edited.
- Age may not be edited.

FRAUD AND ABUSE

Fraud continues to be a major concern for most medical schemes, costing millions of rands each year. The more fraud there is, the higher medical scheme 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. If you identify anything suspicious, please report it. More information on Fraud can be found on page 5 of this Member Guide.

ANONYMOUS TOLL FREE
FRAUD HOTLINE: 0800 004 500

THIRD PARTY CLAIMS (ROAD ACCIDENT CLAIMS)

Libcare has appointed an external firm for the recovery of third-party claims. This external claims recovery service provider is involved with member claims submitted to the Road Accident Fund (RAF) for reimbursement of funds paid by Libcare Medical Scheme, and the service provider acts on behalf of Libcare in these matters.

While Libcare does not accept liability for the payment of claims that can be recovered from a third party, it can pay members' medical expenses in terms of the benefit structure, pending recovery of funds by the appointed claims recovery provider from the third party funders.

You have a duty of care to disclose all and any information that might have a bearing on decisions by the Scheme relating to your claims. If this is not done, exclusions will apply.

Contact Libcare's third-party claims recovery service provider on:

011 764 2366

reception@kelaw.co.za

Motor vehicle accident claim process

LIBCARE MOTOR VEHICLE CLAIMS PROCESS

The Road Accident Fund (RAF) is a public entity set up to pay compensation to people injured as a result of road accidents due to negligent driving of a motor vehicle within South Africa.

The RAF is liable for compensation of damages and medical treatment costs arising from a Motor Vehicle Accident (MVA).

MVA claims are third party claims and in terms of Libcare Scheme Rules, the beneficiaries of the Scheme are required to assist the Scheme in the recovery of any benefits for which a third party may be liable.

In the event that you or your dependant is involved in an MVA, Libcare will have a claim against the RAF for medical costs incurred as a result of the accident. Therefore, monies recovered from the RAF for your medical expenses that are not due to you MUST be refunded to Libcare Medical Scheme.

Libcare has appointed an external third party claims recovery firm to administer the MVA claims recovery process on its behalf. To proceed with the claim, you or you dependant will be required to complete an Accident Report Form and an Indemnity Form (this is an undertaking that you will reimburse the Scheme at finalisation of the claim.)

BELOW IS THE STEP BY STEP MVA CLAIM PROCESS:

Based on the claims received, Libcare will inform the claims recovery service provider of your accident, and they in turn will contact you to verify the details of the incident.

→

You will be required to complete an Accident Report and an indemnity Form. This is for confirming that you undertake to lodge a claim against the RAF and reimburse Libcare any monies recovered from the RAF at finalisation of the claim.

↓

In the event that you do not have a personal attorney, the claims recovery service provider can refer you or your dependant to a network of attorneys which specialises in third party claims, to assist you with the claim.

←

The completed documents must be sent to:

reception@kelaw.co.za

↓

The claims recovery service provider will continue to update your claim and liaise with your attorneys to ensure that all medical-related claims are included and are submitted to the RAF.

WHAT IS THE ROAD ACCIDENT FUND?

The Road Accident Fund (RAF) is a public entity set up by an Act of Parliament, namely, the Road Accident Fund Act, 1996 (Act No. 56 of 1996), as amended. The RAF covers and compensates people injured in road accidents, due to the negligent driving of a motor vehicle by another person.

What and who does it cover?

The cover is compulsory and extends to all users of South African roads. It indemnifies the driver or owner of a motor vehicle who has wrongfully caused damages or losses to victims following a motor vehicle accident (MVA), from being held liable for such losses or death suffered as a result of the accident.

How are contributions to the RAF collected?

The contributions for the cover are collected through a levy which is included in the price of fuel.

What are the General Guidelines of lodging a claim with the RAF?

The RAF system is fault-based, which means that if the victim has contributed to the occurrence of the accident, the amount that the victim can claim will be reduced in relation to his/her contributory negligence. This means that the victim may get partial payment if he/she was partly responsible for the accident.

The claim must be lodged within the prescribed period stipulated below:

- Identified claims (claims where the identity of the driver or owner of the contributory negligent motor vehicle is known) must be lodged with the Fund within 3 years from the date of the accident;
- Hit and Run claims (claims where the identity of the driver or owner of the contributory negligent motor vehicle is unknown) must be lodged with the Fund within 2 years from the date of the accident; and
- Future medical undertaking claims must be lodged and finalised within 5 years from the date on which services were rendered to the victim.

Please note, if the above statutory requirements are not met when claims are lodged, the claim will not be considered by the RAF.

What can be claimed from the RAF?

- Medical expenses – (Past and Future)
- Funeral expenses
- Compensation for pain and suffering
- Loss of earnings if the victim is unable to work as a result of the injuries sustained in the accident
- See **www.raf.co.za**

Therefore, the monies recovered from the RAF for your medical expenses are not due to you but MUST be refunded to the Libcare Medical Scheme. This is in terms of the common law principle of Subrogation, which also protects the long-term financial soundness of medical schemes.

2023 Benefit Table

Note: Please refer to page 52 for notes applicable to a specific benefit. In general, items falling under the Risk Benefit require prior Scheme approval. Call 0800 12 CARE (2273) (office hours) at least 48 hours in advance of your intended event.

2023 BENEFIT TABLE

Benefit category p.b. = per beneficiary p.f. = per family	Benefit sub-category	Benefit limit (MA = Scheme Medical Advisor)	Covered by the Major Medical Benefit	Covered by MSF, OHEB and/or THB
Up to 100% of Libcare Rate payable unless otherwise indicated				
Annual limit		No overall annual limit		
Alternative healthcare providers (see note 1 on page 53)	Registered homeopaths, naturopaths, osteopaths, physiotherapists, acupuncturists	Included in out-of-hospital consultation limit (see below)		●
External appliances, prostheses and devices	General and surgical, including but not limited to non-motorised wheelchairs (1 per beneficiary every 4 years), glucometers, large orthopaedic orthotics (e.g. back braces), low-vision appliances, hearing aids: 2 hearing aids (1 per ear) can be claimed limited to R21 490 per hearing aid, per family, every 2 years	R21 490 per family	●	
	Repair of Appliances	R1 630 per family p.a. subject to Risk benefit	●	
	Stoma products	R28 350 per family	●	
	Home oxygen, cylinders, concentrators and ventilation expenses, CPAP for treating sleep apnoea	R28 350 per family Subject to MA approval	●	
	External prostheses	R100 000 p.b. pa Subject to MA and motivation required	●	
	Artificial limbs	R66 900 p.b., every 2 years and subject to the annual external prostheses limit		
	Long-leg calipers	R8 900 p.b pa and subject to the annual external prostheses limit		
	Artificial eyes	R46 800 p.b., every 2 years and subject to the annual external prostheses limit		
	Post-Mastectomy Prosthesis (every 2 years)	R8 300 p.b.	●	
	Internal prostheses (surgically implanted) (Sub-limits apply, see note 2 on page 53)	R221 500 p.b.	●	

2023 BENEFIT TABLE

Benefit category p.b. = per beneficiary p.f. = per family	Benefit sub-category	Benefit limit (MA = Scheme Medical Advisor)	Covered by the Major Medical Benefit	Covered by MSF, OHEB and/or THB
Up to 100% of Libcare Rate payable unless otherwise indicated				
Blood, blood equivalents and blood products	Blood, blood products and transportation	R411 500 p.b.	●	
Casualty (see note 3 on page 53)	Emergency after-hours casualty treatment	R2 600 p.b.	●	
Consultations and visits (out-of- hospital)	GPs, nurses, specialists, alternative healthcare providers, antenatal classes by a registered nurse	R9 650 p.b./ R19 100 per family		●
Consultations and visits (in-hospital)	GPs, specialists and dental specialists	Unlimited	●	
Crime trauma (see note 4 on page 53)	HIV prophylaxis for rape victims	Unlimited	●	
	Rehabilitation related directly to crime trauma	R41 700 per family	●	
	Psychologists, psychiatrists and social workers	R5 530 p.b.	●	
Day procedures that are performed in doctors' rooms (see note 5 on page 53)	Routine diagnostic upper and lower gastro-intestinal fibre-optic endoscopy (excl. rigid sigmoidoscopy and anoscopy); cyctoscopy; laser tonsillectomy; vasectomy; needle aspiration of joint, bursa or ganglion; prostate needle biopsy; breast fine needle biopsy; 24-hour oesophageal pH studies; oesophageal motility studies; circumcision	Unlimited	●	

2023 BENEFIT TABLE

Benefit category p.b. = per beneficiary p.f. = per family	Benefit sub-category	Benefit limit (MA = Scheme Medical Advisor)	Covered by the Major Medical Benefit	Covered by MSF, OHEB and/or THB
Up to 100% of Libcare Rate payable unless otherwise indicated				
Dentistry (see note 6 on page 53)	Basic (out-of-hospital) – Consultations, removal of teeth and roots, plastic dentures, dental technician, etc.	R13 500 p.b./ R20 800 per family		●
	Advanced (out-of-hospital) – Inlays, crowns, bridges, orthodontic treatment (younger than 21 years, and subject to pre-authorisation), oral surgery, etc.	R26 400 per family		●
	Dental Surgery (in-hospital and out-of-hospital) – All costs relating to dental implants, the removal of impacted wisdom teeth, apicectomies and basic dentistry under general anaesthetic for children eight years and younger	R23 200 p.b./ R34 600 per family	●	
	Surgical removal of impacted wisdom teeth – All costs related to general anesthetic, conscious analgo sedation for dentistry and hospitalisation (subject to managed healthcare clinical criteria and pre- authorisation)	Unlimited	●	
Emergency transport	Local (only if provided by Netcare 911)	Unlimited	●	
Hospitalisation (General Ward rates apply)	Accommodation, intensive care, high care, theatre fees, apparatus and material and medication used in hospital	Unlimited	●	
	Medicines to take out (TTO)	R1 505 per admission	●	
	Alternatives to hospitalisation, such as physical rehabilitation facilities (excludes frail care)	R52 200 per family	●	
	Hospice services in lieu of hospitalisation	Unlimited	●	
	Sub-acute facilities in lieu of hospitalisation	Unlimited	●	
	Nursing services (excluding midwifery services) in lieu of hospitalisation	Unlimited	●	
Immune Deficiency Syndrome related to HIV infection (see note 7 on page 53)	Antiretroviral medicines, related medicines, pathology and related consultations	Unlimited, subject to PMB guidelines and registering on HIV/ AIDS Management Programme	●	
	Preventative treatment, e.g. mother-to-child, needle stick injury, accidental exposure to blood		●	

2023 BENEFIT TABLE

Benefit category p.b. = per beneficiary p.f. = per family	Benefit sub-category	Benefit limit (MA = Scheme Medical Advisor)	Covered by the Major Medical Benefit	Covered by MSF, OHEB and/or THB
Up to 100% of Libcare Rate payable unless otherwise indicated				
Maternity	Confinement for normal birth and Caesarean section, in-and out-of-hospital	Unlimited	●	
Maxillo-facial surgery (in- hospital)	Facial fractures, trauma, cancer and sepsis, tumours, neoplasms and congenital abnormalities of children born into the Scheme	Unlimited	●	
Medicine (Members must obtain their medicine from a network pharmacy (see note 8 on page 53). You may be liable for a co-payment on the dispensing fee if you do not make use of pharmacy within the network)	Routine/acute, including homeopathic medicine dispensed by a registered homeopath	R9 750 p.b./ R28 200 per family		●
	Over-the-counter medicine and pharmacy-advised therapy	R1 650 per family		●
	Chronic medication (see note 9 on page 53)	R42 900 p.b.	●	
	Specialised drugs for the treatment of Multiple Sclerosis, inflammatory arthritis, inflammatory bowel disease and chronic hepatitis	Subject to MA and Trustee approval	●	
Mental health	In-hospital (all costs for psychologists, psychiatrists and social workers, including rehabilitation for substance abuse)	R59 700 per family	●	
	Out-of-hospital consultations and visits	R13 400 p.b./ R20 250 per family		●
Non-surgical procedures and tests	In-hospital	Unlimited	●	
	Out-of-hospital (applying Plaster of Paris, stitches, etc.)	R5 910 p.b./ R15 100 per family		●
Oncology (see note 10 on page 53)	Radiotherapy, chemotherapy and oncology medication. PET and PET-CT scans are limited to one per member family and restricted to staging of malignant tumours	R768 000 p.b.	●	
	Specialised medicines, e g, Herceptin, subject to clinical guidelines, protocols and managed healthcare programme	R527 500 p.b. (included in above limit of R768 000)	●	
	Associated diagnostics	R77 400 p.b. (included in above limit of R768 000 and further limited to 12 months post- active treatment)	●	

2023 BENEFIT TABLE

Benefit category p.b. = per beneficiary p.f. = per family	Benefit sub-category	Benefit limit (MA = Scheme Medical Advisor)	Covered by the Major Medical Benefit	Covered by MSF, OHEB and/or THB
Up to 100% of Libcare Rate payable unless otherwise indicated				
Optometry (note: Readers are excluded)	Eye examination	R790 p.b.		●
	Frames (including repairs)	R2 435 p.b.		●
	Lenses and/or contact lenses	R6 240 p.b./ R15 350 per family		●
	Refractive surgery	Included in limit above, subject to the approval of the MA and the Scheme		●
Organ transplants	Harvesting, transplantation and anti-rejection medication	Unlimited	●	
Paramedical services	In-hospital	Unlimited	●	
	Out-of-hospital (audiology, dietetics, genetic counselling, hearing aid acoustics, occupational therapy, orthoptics, physiotherapy, podiatry, speech therapy, social workers, frail care at registered sick bay facilities)	R8 300 p.b./ R11 830 per family		●
Pathology and medical technology	In-hospital	Unlimited	●	
	Out-of-hospital	R8 300 p.b./ R11 830 per family		●
Physiotherapy	In- and out-of-hospital Includes biokinetics and out-of-hospital chiropractics	Included in paramedical services (see above)		
Preventative Care Benefit	Specified consultations, examinations, procedures and vaccinations as outlined on page 25 of this Member Guide.	No overall limit, but specified costs paid up to the Libcare Rate. Costs exceeding the Libcare Rate will come from your positive MSF	●	
	Oral and injectable contraceptives	R3 160 p.b.	●	
	Intrauterine Contraceptive Devices and Implanon NXT® implants (inclusive of device and insertion)	R3 590 p.b.	●	

2023 BENEFIT TABLE

Benefit category p.b. = per beneficiary p.f. = per family	Benefit sub-category	Benefit limit (MA = Scheme Medical Advisor)	Covered by the Major Medical Benefit	Covered by MSF, OHEB and/or THB
Up to 100% of Libcare Rate payable unless otherwise indicated				
Radiology (see note 11 on page 53)	In-hospital (general and specialised)	Unlimited	●	
	In-hospital (MRI/CT and/or Radio-Isotope scans)	R45 900 per family	●	
	Out-of-hospital (general and specialised)	R8 000 p.b./ R11 830 per family		●
	Out-of-hospital (MRI/CT and/or Radio-Isotope scans)	2 per family from MMB, then MSF/OHEB, up to Libcare Rate	●	
Renal dialysis	Chronic haemodialysis	R461 300 p.b.	●	
	Chronic peritoneal dialysis	R385 500 p.b.	●	
	Acute renal dialysis	Subject to MMB, unlimited	●	
Robotic assisted laparoscopic procedures	100% of the negotiated fee, cost Libcare Rate or UPFS as applicable limit to: Radical Prostatectomy Hemicolectomy Partial Nephrectomy	 R155 700 R155 300 R104 000	●	
Sleep studies (Polysomnogram)		No overall limit, but specified costs paid up to the Libcare Rate Subject to MMB	●	

APPLIANCES – INTERNAL PROSTHESES AND DEVICES

Subject to pre-authorisation and clinical protocols. The sub-limits include:

System/devices	Device	Sub-limit per prosthesis per annum
Central nervous system	Neuro-stimulation/ablation devices	R82 000
	Vagal stimulator for intractable epilepsy (including the carrier)	R69 100
	Neurostimulation for faecal and urinary incontinence	R52 600
	Neurostimulation for chronic pain syndromes	R104 700
Orthopaedic prostheses and devices	Ankle replacement	R70 000
	Shoulder replacement	R70 000
	Elbow replacement	R70 000
	Hip replacement	R70 000
	Knee replacement	R70 000
	Bone lengthening devices	R70 000
	Spinal plates and screws	R70 000
	Other approved spinal implantable devices and intervertebral discs	R72 000
Ophthalmic system	Intraocular lens post cataract removal	R4 800
	Cornea	R50 900
Endo-vascular devices	Carotid stents	R33 500
	Aorta stent grafts	R86 900
	Peripheral arterial stent grafts	R57 800
	Embolic protection devices	R82 000
	Detachable platinum coils	R82 000
Other	Internal prostheses and devices not listed	R52 600
Cardiac system	Cardiac stents (including carrier)	R89 000 (max 2 p.b.per annum)
	Cardiac valves	R70 800
	Cardiac pacemakers	R86 900

Notes

1. ALTERNATIVE HEALTHCARE PROVIDERS

Providers must have valid, registered practice numbers.

2. APPLIANCES – INTERNAL PROSTHESES AND DEVICES

Subject to pre-authorisation and clinical protocols.

3. CASUALTY

If you are treated in hospital casualty, this is regarded as an out-of-hospital event. Fees would therefore be paid out of your available day-to-day benefit (MSF, OHEB or Threshold) and not from the Major Medical Benefit.

If approved hospital admission immediately follows casualty, the casualty fee will be paid from the Major Medical Benefit up to the Libcare Rate.

Note: Authorisation is still required for a hospital admission which follows casualty – you or the hospital or the attending doctor must phone Hospital Authorisations on 0800 12 CARE (2273). Some hospitals will send the account to Libcare, others will ask for payment at the time of service. If you pay the hospital, forward the paid account with a receipt attached to Libcare for reimbursement from your available benefits.

After-hours casualty – If you require emergency after-hours treatment at a registered casualty facility and you obtain an authorisation number within 48 hours of the event, the treatment may be covered from the Major Medical Benefit (see page 14).

4. CRIME TRAUMA

To access this benefit you will need to provide a valid police case number as well as the name of the police station when requesting authorisation. See page 14.

5. DAY PROCEDURES THAT ARE PERFORMED IN DOCTORS' ROOMS

Day procedures listed in the Benefit Table (e.g. gastroscopy, colonoscopy) may be covered in full up to the Libcare Rate under the Major Medical Benefit. Day procedures that are performed in Doctor's rooms in lieu of hospitalisation, need to be authorised as per the hospital pre-authorisation process on page 13. Please consult the authorisation/approvals department 0800 12 CARE (2273) during office hours, to check whether your day procedure will be covered.

6. DENTISTRY

- Only the specified procedures (including all costs, e.g. hospitalisation, day clinic, anaesthetist) will be covered up to the limit, subject to prior authorisation, whether done in- or out-of-hospital.
- Orthognatic surgery for cosmetic purposes is excluded from the benefit in terms of the Scheme Rules.
- For dental implants, a full quotation is required at the time of pre-authorisation. All associated costs are subject to your available Dental Surgery limit.
- You will be informed of any motivation documents required, at the time of requesting a pre-authorisation.
- Pre-authorisation is strictly subject to the benefit limit and funds available at the time of the procedure, and in no way guarantees payment in full.

7. HIV/AIDS (SUBJECT TO REGISTRATION WITH HIV/AIDS MANAGEMENT PROGRAMME)

The HIV Preventative Benefit provides cover for prophylactic drugs for the prevention of HIV transmission from mother- to-child (during pregnancy); from needle-stick injury; or from accidental exposure to blood or HIV-infected body fluids.

8. NETWORK PHARMACY

Click **here** to access the network pharmacy list. Alternatively, you can access the network pharmacy list on the Libcare website, or by contacting the Libcare Contact Centre on 0800 12 CARE (2273) during office hours, or email **enquiries@libcare.co.za.**

9. CHRONIC BENEFITS

Refer to page 20 for a full explanation of your Chronic Benefits and the list of chronic conditions that Libcare covers.

10. CANCER/ONCOLOGY AND ASSOCIATED DIAGNOSTICS

Associated diagnostics (e.g. specified radiology and pathology) will only be payable from the associated diagnostics oncology benefit during active treatment. Cover for other scans and tests may be available for the next 12 months, but are subject to registration with the Cancer/Oncology Management Programme and pre-authorisation. See page 17.

Palliative Care

Palliative care is specialised health care that is essential for people living with advanced stages of cancer. The goal of palliative care is to relieve suffering and provide the best possible quality of life for both patient and family. This is achieved by treating and managing the symptoms, to help one gain the strength to carry on with daily life. Symptoms that could be treated or managed include pain, shortness of breath, fatigue, constipation, nausea, loss of appetite and difficulty in sleeping. It also involves the provision of nursing, emotional and spiritual support.

How to obtain Palliative Care approval

- Doctor has to request palliative care services and email the request to **approvals@libcare.co.za.**
- Doctor may also advise member on palliative services available in the area e.g. hospice
- Once the request has been received, the case manager will contact the member or family and advise on the resources that may be required and initiate these resources on behalf of the member.

Curative Treatment

The aim of curative treatment is to attempt a permanent control of the disease or tumour using aggressive forms of treatment, depending on the histology and grade of the disease or tumour. There are varied treatment options, such as chemotherapy, radiotherapy and surgery.

11. MRI/CT AND/OR RADIO-ISOTOPES SCAN (OUT-OF-HOSPITAL)

The first two out-of-hospital MRI/CT and/or Radio-Isotope scans per family may be paid from the Major Medical Benefit subject to pre-authorisation and clinical protocols. Thereafter, if a member requires an MRI/CT and/or Radio-Isotope scan it will be payable from the available day-to-day benefit (MSF and OHEB).

12. NEONATAL PROTOCOL

We have a neonatal protocol, whereby our Hospital Case Managers monitor all babies admitted as patients in their own right from birth to discharge from hospital.

Exclusions

WHAT LIBCARE DOES NOT COVER

In terms of the Scheme Rules, the Scheme shall pay in full, without any co-payment or use of deductibles, the diagnosis, treatment and care costs of the Prescribed Minimum Benefits as per Regulation 8 of the Medical Schemes Act. Furthermore, where a protocol or formulary drug preferred by the Scheme has been ineffective or would cause harm to a beneficiary, the Scheme will fund the cost of the appropriate substitution treatment without a penalty to the beneficiary as required by Regulation 15H and 15I of the Act.

Further in terms of the Scheme Rules, there are certain medical expenses and other costs the Scheme does not cover at all. Libcare will not cover any of the following, or the direct or indirect consequences of these treatments, procedures or costs incurred by members, except where stipulated as part of a defined Scheme benefit or covered under the Prescribed Minimum Benefits' requirements. For a full list of exclusions, refer to the Scheme Rules available at www.libcare.co.za or contact Libcare on 0800 12 CARE (2273).

- 4D pregnancy scans
- Abdominoplasties
- Accidents that happen at work
- Acne preparations (oral)
- All expenses incurred outside the common monetary area of Southern Africa (cover should be organised through your travel agent). See page 16
- Anabolic steroids
- Anti-addiction and anti-habit agents
- Appointments not kept
- Aromatherapy
- Art therapy
- Autopsies
- Ayurvedics
- Back rests, chair seats, beds, mattresses, orthopaedic shoes, boots, arch support and inner soles
- Bite plates and mouth (gum) guards
- Blood pressure monitors
- Breast augmentation and reductions
- Stimulant laxatives
- Cochlear implants
- Cosmetic preparations, emollients/moisturisers
- Cryo-storage of foetal stem cells and sperm
- Drugs for the treatment of impotence and sexual dysfunction, aphrodisiacs
- Epilation treatment for hair removal
- Erectile dysfunction surgical procedures
- Evening primrose oil and fish liver oil preparations and combinations
- Food and nutritional supplements
- Gender re-alignment
- Growth hormones
- Bite plates and mouth (gum) guards
- Humidifiers
- Hyperbaric oxygen treatment
- Immuno-suppressives and immuno-stimulants
- Infertility treatment, except as specified in the Medical Schemes Act
- Insulin pumps and consumables
- Iridology
- Keloid surgery and revision of scars, except following burns and functional impairment occurring during the period of cover under Libcare
- Massages
- Medicated shampoos and conditioners, including those for hair loss
- Motorised wheelchairs
- MRI scans ordered by a GP
- Obesity – certain surgical treatment
- Organ donations to any person other than a member or dependant of a member of Libcare
- Orthodontic treatment for patients over the age of 21 years
- Orthognatic surgery for cosmetic purposes (to correct jaw misalignment)
- Otoplasties
- Pain-relieving machines
- Pathology investigations pertaining to anti-ageing
- Reflexology
- Reversal of tubal ligation
- Reversal of vasectomy
- Rhinoplasties
- Sleep therapy
- Slimming preparations
- Soaps, scrubs and other cleansers
- Stimulant laxatives
- Sunglasses, readers, coloured contact lenses
- Sunscreening and suntanning preparations
- Telephone consultations
- Travelling expenses incurred by the member or dependant
- Writing of a script without being present at a consultation
- Veterinary products
- Vitamin and mineral supplements

Contributions

Below is the contribution table for 2023. A few pointers will help you understand this table:

- Your contribution rate is based on your income level (pensionable base).
- You can see how much you're paying each month by checking your salary slip or by contacting Libcare.
- The table below shows the full contribution and does not take into account any subsidy you may receive from the company.
- 'Late-joiners' pay more – see page 35 for definitions of late joiners.
- Your total monthly contribution will depend on how many dependants you have registered on the Scheme.
- To calculate your total monthly contribution, use the contributions calculator below.
- For children who have been allowed to be registered post the age of 23 you pay Adult Dependant rates.
- For spouses or partners younger than 21, you pay Adult Dependant rates.

Pensionable Salary/ Income Band	Band Code	Principal Member	Adult Dependant	Child Dependant
R0 – R7 189	220	R1 836	R1 684	R470
R7 190 – R8 759	275	R1 977	R1 824	R505
R8 760 – R10 699	330	R2 141	R1 977	R546
R10 700 – R12 309	385	R2 641	R2 427	R665
R12 310 – R14 119	440	R2 996	R2 755	R755
R14 120 – R17 899	550	R3 260	R3 005	R817
R17 900 – R21 419	660	R3 550	R3 258	R898
R21 420 – R24 609	770	R3 831	R3 520	R972
R24 610 – R35 699	800	R4 150	R3 817	R1 050
R35 700+	999	R4 522	R4 150	R1 141

Contribution calculator: Use the following table to calculate your monthly contribution rate

Type of beneficiary (e.g. principal, spouse, child)	Monthly contribution from table above	Multiply by no. of dependants at this rate	Total amount per category of dependant
Add the amounts in the last column to get your monthly rate:			

Calculate your Day-to-Day benefits

Medical Savings Facility (MSF), Out-of-Hospital Expenses Benefit (OHEB), Self-Payment Gap (SPG) and Threshold Level (THL)

- Sixteen percent (16%) of your contributions is allocated to the MSF for your (and your family's) use only.
- Your MSF will be adjusted if you add or remove a dependant during the year.
- The benefit will be pro-rated if you join Libcare and/or add a dependant after January in the benefit year.
- If you have dependants on Libcare, your combined limits are available to you as a group. This means that one member may claim more than their allocated contribution, but then less will be available to the others.

ANNUAL MEDICAL SAVINGS FACILITY (MSF)

Pensionable Salary/Income Band	Principal Member	Adult Dependant	Child Dependant
R0 – R7 189	R3 528	R3 240	R912
R7 190 – R8 759	R3 804	R3 504	R972
R8 760 – R10 699	R4 116	R3 804	R1 056
R10 700 – R12 309	R5 076	R4 668	R1 284
R12 310 – R14 119	R5 760	R5 292	R1 452
R14 120 – R17 899	R6 264	R5 772	R1 572
R17 900 – R21 419	R6 816	R6 264	R1 728
R21 420 – R24 609	R7 356	R6 768	R1 872
R24 610 – R35 699	R7 968	R7 332	R2 016
R35 700+	R8 688	R7 968	R2 196

ANNUAL OUT-OF-HOSPITAL EXPENSES BENEFIT (OHEB)

- Your day-to-day expenses will be paid from this benefit when the MSF is depleted. Claims will be paid – up to the Libcare Rate – from this benefit until you reach your limit.
- If you have dependants on Libcare, your combined limits are available to you as a group. This means that one member may claim more than their allocated limit, but then less will be available to the others.
- Your total OHEB will be adjusted upward if you add a dependant during the year.
- The benefit will be pro-rated if you join Libcare and/or add a beneficiary after January in the benefit year.

Income Band	Principal Member	Adult Dependant	Child Dependant
All income Bands	R2 892	R1 224	R1 044

CALCULATE YOUR MINIMUM ANNUAL SELF-PAYMENT GAP (SPG)

- You are responsible for the payment of Day-to-Day expenses when the OHEB is depleted.
- All claims and receipts must still be submitted to the Scheme for processing purposes.

Total MSF for the family	R
Total OHEB for the family	+ R
ADD MSF + OHEB	R
Total Threshold Level for the family	R
DEDUCT MSF + OHEB	– R
Total MINIMUM SPG	R

NOTE: The SPG may increase during the year based on your claims and any financial changes made on your membership. See more information on the Self Payment Gap on page 29.

ANNUAL THRESHOLD LEVEL

- This level is a rand value to be reached before claims for Day-to-Day medical expenses are paid out by Libcare from the Threshold Benefits.
- Eligible Day-to-Day medical claims paid from the MSF, OHEB or self-funded are processed and will accumulate towards reaching the Threshold Level.
- Once the accumulated claims reach the Threshold Level, the Scheme will start to pay further day-to-day claims at specified rates and subject to limits from the Threshold Benefits.
- Your Threshold Level is not adjusted if you add or remove a dependant – it is fixed in January each year.

Pensionable Salary/Income Band	Principal Member	Adult Dependant	Child Dependant
R0 – R7 189	R10 224	R7 284	R3 276
R7 190 – R8 759	R10 656	R7 680	R3 384
R8 760 – R10 699	R11 760	R8 724	R3 696
R10 700 – R12 309	R12 360	R9 264	R3 804
R12 310 – R14 119	R12 768	R9 660	R3 912
R14 120 – R17 899	R13 488	R10 296	R4 104
R17 900 – R21 419	R14 028	R10 800	R4 260
R21 420 – R24 609	R14 628	R11 364	R4 356
R24 610 – R35 699	R15 360	R12 000	R4 572
R35 700+	R16 068	R12 648	R4 716

Glossary

USEFUL DEFINITIONS	
Beneficiary	A person who is entitled to benefits, including any principal member and any of his/her registered dependants.
Co-payment	When a member is liable for a portion of the costs incurred for treatment and/or medication received.
Cost	The actual amount charged by the service provider for services rendered.
Eligible expenses	Medical expenses per the Scheme Rules that are specifically included in the 2023 Libcare benefit schedule; that are not listed under 'exclusions'; that are unrelated to conditions for which specific waiting periods are in effect; and that are not incurred during general waiting periods.
Formulary medicine	A defined list of medicines for which Libcare will pay. The list is based on clinical evidence and protocols.
Generic medicine	More cost-effective versions of the branded medicines that contain the same active ingredients and are identical in strength.
ICD-10 code	The compulsory diagnostic code used by providers to indicate what the medical diagnosis is for which treatment is received. Claims that do not contain an ICD-10 code cannot be paid in terms of current legislation.
Libcare Rate/Scheme Rate	The Libcare Rate means the maximum amount of money the Scheme will pay for a particular medical expense. The Rate is determined by the Board of Trustees. If your healthcare provider charges more than the Scheme Rate, you must pay the difference, either from your Medical Savings Facility or out of your own pocket. This difference does not accumulate to your Threshold Level.
Major Medical Benefit (MMB)	A type of cover that pays for high-cost medical risks such as hospitalisation, certain day procedures, oncology (cancer) treatment, emergency transport and more.
Maximum Medicine Reference Price	The maximum reimbursable price for a medicine or group of medicines according to a reference pricing system that allocates a price to a group of drugs that are similar in efficacy, safety and quality.
Medical Savings Facility (MSF)	This is used for eligible day-to-day expenses as specified in Libcare's Rules. Contributions to MSF are set at 16% of the total contributions.
Medicine Management Protocols	Clinical guidelines and protocols formulated for the provision of care and treatment related to specific disease.
Prescribed Minimum Benefits (PMBs)	The benefits contemplated in Section 29(1)(0) of the Medical Schemes 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.
Positive Savings	The monthly Savings contributions that Libcare has received, but have not yet been used by you. This includes Savings carried over from previous years.

Preferred Providers	These are providers with whom the Scheme has negotiated preferred rates.
Preventative Care Benefit (PCB)	Cover for certain tests and immunisations that help you to monitor your health and prevent possible future illness. Refer to page 24 of this guide for a list of eligible expenses.
Pro-rating of Benefits	When a member and/or beneficiary joins later than 1 January, benefits for the first year are reduced in accordance with the number of months remaining in the year.
Reference Pricing	A medicine reference pricing system that allocates a price to a group of drugs that are similar in efficacy, safety and quality.
Risk Benefits	All the benefits under Major Medical cover, Chronic cover, Preventative Care cover, Threshold cover and the Out-of-Hospital Expenses Benefit. These are subject to the rate and limits specified in the benefit schedule. Unused Risk Benefits cannot be carried over to the following year.
Self-Payment Gap (SPG)	The period after MSF and OHEB have been depleted and before Threshold cover applies, during which you may have to pay for day-to-day expenses out of your own pocket.
Take-out Medication (TTO)	The medication received on discharge from hospital.
Threshold Benefit (THB)	This provides additional cover once total eligible day-to-day expenses reach a particular level. This level is based on the number and type of dependants a principal member has. Once your day-to-day expenses have reached this level, Libcare pays further day-to-day eligible expenses from the Threshold benefit.

ABBREVIATIONS

CDL	Chronic Disease List. A list of chronic illnesses covered by Libcare as part of its Prescribed Minimum Benefits (PMBs).
EDI	Electronic Data Interchange. Used by providers to electronically submit claims for payment.
OHEB	Out-of-Hospital Expenses Benefit
PAT	Pharmacy Advised Therapy – Over-the-counter medicines bought at a pharmacy.
PMBs	Prescribed Minimum Benefits – A series of benefits that all medical schemes are obliged to provide.

Contact details

Thank you for taking the time to familiarise yourself with Libcare.

For further information please call 0800 12 CARE (2273) (office hours) or visit ***www.libcare.co.za.***

LIBCARE CONTACT CENTRE	0800 12 CARE (2273) (08:00-17:00 Mon-Fri excluding public holidays)
LIBCARE EMAIL QUERIES	enquiries@libcare.co.za
TO SUBMIT YOUR CLAIMS	Email: claims@libcare.co.za Post your paper claims to: Libcare, PO Box 653418, Benmore, 2010
HOSPITAL, CASUALTY AND OTHER SCHEME AUTHORISATIONS	Tel: 0800 12 CARE (2273) (08:00-17:00 Mon-Fri) Email: approvals@libcare.co.za
CHRONIC MEDICINE MANAGEMENT	Tel: 0800 12 CARE (2273) (08:00-17:00 Mon-Fri) Email: chronicmed@libcare.co.za
CANCER/ONCOLOGY MANAGEMENT PROGRAMME	Tel: 0800 12 CARE (2273) (08:00-17:00 Mon-Fri) Email: oncology@libcare.co.za
CENTRE FOR DIABETES AND ENDOCRINOLOGY (CDE)	Tel: 011 053 4400 Email: Members@CDEDiabetes.co.za Web: www.CDEDiabetes.co.za
HIV/AIDS MANAGEMENT PROGRAMME	Tel: 0800 12 CARE (2273) (08:00-17:00 Mon-Fri) Email: care@libcare.co.za
CONFIDENTIAL FRAUD HOTLINE	0800 004 500
ROAD/THIRD PARTY ACCIDENT CLAIMS	Tel: 011 764 2366 Email: reception@kelaw.co.za

NETCARE 911 FOR EMERGENCIES WITHIN SOUTH AFRICA	082 911 Email: netcare911.customerservice@netcare.co.za Web: www.netcare911.co.za
NETCARE 911 FOR EMERGENCIES IN NEIGHBOURING COUNTRIES	082 911
MEMBERSHIP APPLICATIONS AND AMENDMENTS	Liberty Payroll | Mylife@work Tel: 0800 12 CARE (2273) (08:00-17:00 Mon – Fri)
COUNCIL FOR MEDICAL SCHEMES	Tel: 0861 123 267 Web: www.medicalschemes.co.za Postal address Private Bag X34 Hatfield 0028 Physical address Block A, Eco Glades 2 Office Park, 420 Witch – Hazel Avenue, Eco Park, Centurion, 0157
LIBCARE BANKING DETAILS FOR DEBT REPAYMENT	Account Holder: Libcare Medical Scheme Bank: First National Bank Branch code: 255 055 Account number: 62900432288

Notes

Notes

Libcare

0800 12 CARE (2273) | enquiries@libcare.co.za | www.libcare.co.za

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