This brochure will give you a short summary of the LA Health Benefit Options. For more details, visit www.lahealth.co.za or speak to your LA Health broker.
Welcome to LA Health. We believe in giving you the power to manage your health. We also give you access to a unique wellness programme, excellent cover for your healthcare expenses, and we offer you peace of mind when you need it most.

LA Health has five Benefit Options: LA KeyPlus, LA Focus, LA Active, LA Core and LA Comprehensive.

- **LA KeyPlus**
  - Hospital Benefit at any hospital in the KeyCare network
  - Chronic Illness Benefit for Prescribed Minimum Benefit conditions
  - Oncology Programme at a Designated Service Provider
  - Day-to-day expenses covered by the Major Medical Benefit at network GPs or other specific Preferred Providers

- **LA Focus**
  - Hospital Benefit at any private hospital in a coastal province
  - Chronic Illness Benefit for Prescribed Minimum Benefit conditions
  - Oncology Programme
  - Day to day expenses covered by the
    - Medical Savings Account

- **LA Active**
  - Hospital Benefit at any private hospital
  - Chronic Illness Benefit for Prescribed Minimum Benefit conditions
  - Oncology Programme
  - Day-to-day expenses covered by the
    - Medical Savings Account; and
    - Insured Procedures Benefit.

- **LA Core**
  - Hospital Benefit at any private hospital
  - Chronic Illness Benefit for Prescribed Minimum Benefit and other conditions
  - Oncology Programme
  - Day to-day expenses covered by the
    - Medical Savings Account; and
    - Insured Procedures Benefit.

- **LA Comprehensive**
  - Hospital Benefit at any private hospital
  - Chronic Illness Benefit for Prescribed Minimum Benefit and other conditions
  - Oncology Programme
  - Day-to-day expenses covered by the
    - Medical Savings Account; and
    - Above Threshold Benefit (from Major Medical Benefit).
Discovery 911

In a medical emergency, you can call Discovery 911 on 0860 999 911. You can do this at any time of the day or night. The emergency personnel from ER24 provide this service. If you need a helicopter or ambulance, they will send one to you. The cost is covered by your Major Medical Benefit – even if you are not admitted to hospital, but you must call Discovery 911 to get the service.

Full emergency cover

We will cover your medical expenses if your life is in danger. This means that if you are in a life-threatening situation, we will cover you even if you have run out of benefits, reached a benefit limit, or if you are admitted to a non-network hospital. We will pay for your hospital expenses until your life is no longer in danger.

Cover for going to casualty

We will cover the cost of your casualty visit from your Major Medical Benefit if you are admitted to hospital from casualty. You must call us and authorise the hospital visit within 48 hours of being admitted. If you are not admitted to hospital, we still cover the casualty cost, but from your day-to-day benefits. On LA KeyPlus you will have to pay a portion of the account and any pathology, radiology and medicine is subject to the LA KeyPlus formularies.

We do not cover the casualty ward’s facility fee.

Cover for trauma on LA KeyPlus

The Trauma Recovery Benefit covers the medical expenses if you or your family experienced serious trauma. The cover is for expenses incurred for the rest of the benefit year (until 31 December) in which the trauma happened. These benefits are limited for the following treatment categories:

- Prescribed Medicine (Schedule 3 to 7)
- Consultations with a psychiatrist or psychologist
- Private nursing
- External medical items
- Hearing aids, and
- Prosthetic limbs
How the Major Medical Benefit works

This benefit covers your approved medical expenses when you are in hospital. It also covers your chronic medicine, some procedures done out of the hospital and other expensive healthcare costs. Your cover depends on your Benefit Option.

When you need an operation or hospital treatment

Please call us at least 48 hours before a planned hospital stay to get authorisation.

If you call us, we cover the stay at the rate we agreed with the hospital and there is no overall limit on the cover. This benefit covers theatre and general ward fees, x-rays, blood tests and the medicine you have to take in hospital. If you do not call us for authorisation, you will have to pay a portion of the in hospital costs from your own pocket. If you are a LA KeyPlus member, and it is not an emergency we will not pay your hospital costs if your procedure is not preauthorised.

If you are a LA Focus or LA KeyPlus member, you must go to a network hospital.

Day surgery procedures

On LA KeyPlus, the procedures listed below will only be covered in our network of day-case facilities.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthrocentesis</td>
<td>Myringotomy with intubation (grommets)</td>
</tr>
<tr>
<td>Adenoidectomy</td>
<td>Proctoscopy</td>
</tr>
<tr>
<td>Cataract surgery</td>
<td>Prostate biopsy</td>
</tr>
<tr>
<td>Cautery of vulva warts</td>
<td>Removal of pins and plates</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Simple abdominal hernia repair</td>
</tr>
<tr>
<td>Cystourethroscopy</td>
<td>Simple nasal procedures for nose bleeding (i.e. nasal plugging and nasal cautery)</td>
</tr>
<tr>
<td>Diagnostic D &amp; C</td>
<td>Tonsillectomy</td>
</tr>
<tr>
<td>Gastroscopy</td>
<td>Treatment of Bartholins gland cyst/abscess</td>
</tr>
<tr>
<td>Hysteroscopy</td>
<td>Vasectomy</td>
</tr>
<tr>
<td>Myringotomy</td>
<td>Vulva biopsy/cone biopsy</td>
</tr>
</tbody>
</table>

Remember, the Hospital Benefit only covers you for a general ward, not a private ward.

Prescribed Minimum Benefits

All medical schemes in South Africa must cover a minimum set of medical treatments for certain conditions – even when scheme exclusions apply, you are in a waiting period (other than a general waiting period), or when you have reached the limit for a benefit. LA Health must pay for these minimum benefits and the money in your Medical Savings Account cannot be used to pay for these expenses.

The Prescribed Minimum Benefits is a list of medicine and treatments for specific chronic conditions, as well as HIV and AIDS treatment. It also covers the diagnosis, treatment and care for other specific procedures.

We will pay for Prescribed Minimum Benefits in full if you get the treatment at one of our Designated Service Providers. If you do not use the Scheme’s Designated Service Providers, you could have a co-payment. This means you will have to pay a portion of the cost from your own pocket. This does not apply in an emergency.

Designated Service Providers

Each Benefit Option has different Designated Service Providers for the diagnosis, treatment and care of Prescribed Minimum Benefit illnesses and injuries. If you use one of these providers for Prescribed Minimum Benefit conditions, we pay the expenses in full. We will add more Designated Service Providers to the list as and when they become available.
Designated Service Providers continued

**KeyPlus**
- Hospitals in the KEYCARE NETWORK
- SANCA and RAMOT for alcohol and drug rehabilitation
- KeyCare GP Network
- Pharmacies dispensing at the LA Health Rate
- National Renal Care for renal care, including dialysis
- VitalAire for oxygen rental

**Focus**
- Any private hospital in a Coastal province
- SANCA and RAMOT for alcohol and drug rehabilitation
- The Discovery GP Network
- The Premier Specialist Network
- Pharmacies dispensing at the LA Health Rate
- National Renal Care for renal care, including dialysis
- VitalAire for oxygen rental

**Active**
- SANCA and RAMOT for alcohol and drug rehabilitation
- The Discovery GP Network
- The Premier Specialist Network
- Pharmacies dispensing at the LA Health Rate
- National Renal Care for renal care, including dialysis
- VitalAire for oxygen rental

**Care**
- SANCA and RAMOT for alcohol and drug rehabilitation
- The Discovery GP Network
- The Premier Specialist Network
- Pharmacies dispensing at the LA Health Rate
- National Renal Care for renal care, including dialysis
- The Centre for Diabetes and Endocrinology for diabetic care
- VitalAire for oxygen rental

**Comprehensive**
- SANCA and RAMOT for alcohol and drug rehabilitation
- The Discovery GP Network
- The Premier Specialist Network
- Pharmacies dispensing at the LA Health Rate
- National Renal Care for renal care, including dialysis
- The Centre for Diabetes and Endocrinology for diabetic care
- VitalAire for oxygen rental

Points to note about Designated Service Providers for Prescribed Minimum Benefits and non-Prescribed Minimum Benefits

- You can also visit any provider in the public or state sector.
- There are more than 3 000 GPs (general practitioners) in the Discovery GP Network.
- You do not have to make any co-payments if you use a Designated Service Provider.
- National Renal Care provides all renal care, including dialysis. If you do not use them, the Scheme will only pay the claim up to the rate we would have paid at the Designated Service Provider and you may have co-payments.
- SANCA and RAMOT must be used for all treatment related to drug and alcohol rehabilitation, including accommodation, therapeutic sessions, consultations by psychologists and psychiatrists and medicine relating to withdrawal management and aftercare.
- Centres of Excellence (chosen by the Scheme from time to time) – PET scans and stem cell transplants are covered at these Designated Service Providers.
- VitalAire must be used for all oxygen. If this Designated Service provider is not used, you may have a co-payment. On LA KeyPlus, we will not pay for the oxygen if VitalAire is not used.
- Oncology - When you obtain approval for your cancer treatment, the Scheme will advise you about its registered Designated Service Provider.

Make sure you are using a Designated Service Provider by calling 0860 103 933 to confirm, or visit www.lahealth.co.za
Preferred Providers

The Centre for Diabetes and Endocrinology

The Centre provides services and treatment to registered diabetic patients on LA Core and LA Comprehensive. This includes education and information, a podiatrist and optometrist visit once a year, access to a specialised dietitian and GP, continuous medical care and advice, and Active Managed Care during hospitalisation.

Specific providers/manufacturers of:

- Cardiac stents
- Spinal prosthetics

You can find more information about our Preferred Providers on www.lahealth.co.za or when you call 0860 103 933.

Limits, clinical guidelines and policies apply to some healthcare services and procedures. Please check the Benefit Option tables in this brochure for more information.
CHRONIC ILLNESS BENEFITS
If you have a chronic illness

You have cover for the diagnosis, treatment and care of certain chronic conditions. These are paid as Prescribed Minimum Benefits. We cover all tests, consultations and ongoing management for the Prescribed Minimum Benefit Chronic Disease List conditions.

We cover the following conditions in full under the Chronic Illness Benefit on all five Benefit Options

<table>
<thead>
<tr>
<th>Addison's disease</th>
<th>Chronic renal disease</th>
<th>Epilepsy</th>
<th>Multiple sclerosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>Coronary artery disease</td>
<td>Glaucoma</td>
<td>Parkinson's disease</td>
</tr>
<tr>
<td>Bipolar mood disorder</td>
<td>Crohn’s disease</td>
<td>Haemophilia</td>
<td>Rheumatoid arthritis</td>
</tr>
<tr>
<td>Bronchiectasis</td>
<td>Diabetes insipidus</td>
<td>HIV and AIDS</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Cardiac failure</td>
<td>Diabetes mellitus type 1</td>
<td>Hyperlipidaemia</td>
<td>Systemic lupus erythematosus</td>
</tr>
<tr>
<td>Cardiomyopathy</td>
<td>Diabetes mellitus type 2</td>
<td>Hypertension</td>
<td>Ulcerative colitis</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>Dysrhythmia</td>
<td>Hypothyroidism</td>
<td></td>
</tr>
</tbody>
</table>

For us to cover your chronic medicine from the Chronic Illness Benefit, your condition must be one of these chronic conditions, your diagnosis must meet our clinical entry criteria, and the medicine must be cost-effective and treat the condition.

We also approve medicine for immuno-suppressants when you have had an organ transplant. You must follow the chronic illness benefit process to get approval.

Please note: We do not cover all medicine from the Chronic Illness Benefit. If we do not approve your medicine under this benefit, we can pay for it from your day-to-day benefits, depending on your Benefit Option.
Other Prescribed Minimum Benefit conditions we cover

We also provide cover for other Prescribed Minimum Benefit conditions and treatments on all the Benefit Options

- Anticoagulant therapy
- Cushing's disease
- Depression
- Haematological disorders
- Hyperthyroidism
- Hypoparathyroidism
- Lipidosis and other lipid storage disorders
- Major psychiatric disorders (psychiatrist must motivate)
- Organ transplants
- Paraplegia
- Pemphigus (dermatologist must motivate)
- Peripheral arteriosclerotic disease
- Pituitary disorders
- Quadriplegia
- Stroke (cerebro-vascular accident)
- Thrombocytopenic purpura
- Valvular heart disease

Additional chronic conditions that are only covered on LA Core and LA Comprehensive

Other life-threatening or serious conditions that are not Prescribed Minimum Benefits are only covered on LA Core and LA Comprehensive. The Scheme pays for this medicine up to 90% of the LA Health Medicine Rate and the benefit is limited.

**Additional Disease List**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Motivation Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ankylosing spondylitis</td>
<td>Physician must motivate</td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
</tr>
<tr>
<td>Attention deficit disorder (hyperactivity)</td>
<td>Specialist must motivate</td>
</tr>
<tr>
<td>Benign prostatic hypertrophy</td>
<td>Urologist must motivate</td>
</tr>
<tr>
<td>Chronic urticaria</td>
<td>Dermatologist must motivate</td>
</tr>
<tr>
<td>Conn's syndrome</td>
<td></td>
</tr>
<tr>
<td>Cystic fibrosis</td>
<td></td>
</tr>
<tr>
<td>Depression (according to the depression rating scale)</td>
<td></td>
</tr>
<tr>
<td>Eczema (only if severe)</td>
<td>Dermatologist must motivate</td>
</tr>
<tr>
<td>Gastro-oesophageal reflux disease</td>
<td>Gastroenterologist or surgeon must confirm</td>
</tr>
<tr>
<td>Gout (uric acid level must be tested and physician must motivate)</td>
<td></td>
</tr>
<tr>
<td>Ménière’s disease</td>
<td></td>
</tr>
<tr>
<td>Migraine</td>
<td>Physician must motivate</td>
</tr>
<tr>
<td>Motor neuron disease</td>
<td></td>
</tr>
<tr>
<td>Myasthenia gravis</td>
<td></td>
</tr>
<tr>
<td>Narcolepsy (motivated by physician)</td>
<td></td>
</tr>
<tr>
<td>Osteoporosis (only if confirmed by industry standard BMD readings)</td>
<td></td>
</tr>
<tr>
<td>Paget’s disease</td>
<td></td>
</tr>
<tr>
<td>Psoriasis (only if severe)</td>
<td>Dermatologist must motivate</td>
</tr>
<tr>
<td>Scleroderma and other collagen-vascular diseases</td>
<td></td>
</tr>
<tr>
<td>Trigeminal neuralgia</td>
<td></td>
</tr>
<tr>
<td>Urinary incontinence</td>
<td></td>
</tr>
<tr>
<td>Zollinger Ellison syndrome</td>
<td></td>
</tr>
</tbody>
</table>
THE ONCOLOGY PROGRAMME
The Oncology Programme

LA Health has a special cancer programme known as the Oncology Programme. This programme helps members who have cancer. If you have been diagnosed with cancer, you should register for this programme to get the most out of your benefits.

We work with the patient and the doctor to make sure the treatment is affordable and effective. We pay claims for cancer treatment from the Major Medical Benefit and, in some cases, from your day-to-day benefits.

If your cancer is on the Prescribed Minimum Benefit list, the treatment is always covered in full if you use a Designated Service Provider. You will then not have to make any co-payments.

You are covered on the Oncology Programme according to your Option’s benefits. Please read through your benefit schedule to see how you are covered.

We also cover approved radiology (x-rays) and pathology (blood tests) for cancer treatment.

*If you have been diagnosed with cancer, you have to register on the Oncology Programme.*

PET scans

PET scans are covered with no overall limit for 12 months, from the first treatment.

You must use a Designated Service Provider and get authorisation for your treatment. If you don’t, you will have to make a co-payment (pay for some of the cost yourself) or if you are a LA KeyPlus member, we will not pay for the benefit.

Stem cell transplants

Depending on your Benefit Option, stem cell transplants are covered with no overall limit if you have registered on the Oncology Programme and you use a Designated Service Provider. If you do not use a Designated Service Provider, a limit of R1 million applies to this procedure.

On LA KeyPlus, stem cell transplants will only be covered from your Major Medical Benefit if obtained from a state hospital or the Scheme’s Designated Service Provider, subject to Prescribed Minimum Benefit requirements and clinical protocols.
How we take care of your daily medical expenses

We pay for some daily medical expenses from your day-to-day benefits. Examples of these expenses are doctors’ visits, prescribed medicine, dentistry and other treatments you receive outside of the hospital. These expenses are paid according to your Option’s benefits.

The Medical Savings Account

This benefit pays for your visits to the doctor, the prescribed medicine you get at the pharmacy and any other daily medical expenses. If you do not use all the money in your Medical Savings Account, we add interest to it and carry it over to the next year.

If you leave the Scheme and you have money left in your Medical Savings Account, we will transfer the money to your new medical scheme or give you the money back if you are moving to a scheme without a savings account.

The LA KeyPlus Option does not have a Medical Savings Account.

The Insured Procedures Benefit

If you are on LA Core or LA Active, this benefit pays for certain healthcare costs when the money in your Medical Savings Account runs out. All payments from this benefit add up to the yearly limit. This limit depends on the number of people in your family. The Insured Procedures Benefit pays for:

- Acute medicine
- GP visits
- Specialist visits
- Optometry (eye care)
- Radiology (x-rays)
- Pathology (blood tests)
- Dentistry
The Above Threshold Benefit and Self-payment Gap on LA Comprehensive

This benefit is a ‘safety net’ for when you have used all the money in your Medical Savings Account. Your expenses add up to a threshold when you reach this threshold, LA Health starts paying for your claims at the LA Health Rate from the Above Threshold Benefit.

If your Medical Savings Account has no money left and you have not reached the Annual Threshold, you need to pay claims from your own pocket for a while. This is called a Self-payment Gap.

What is the Self-payment Gap?

If a LA Comprehensive member runs out of funds in the Medical Savings Account before the medical expenses add up to the Annual Threshold, it causes a Self-payment Gap. This means you have to pay for your daily medical expenses from your own pocket until these expenses reach the Annual Threshold. A Self-payment Gap can happen when:

- The total amount for the Medical Savings Account is lower than the Annual Threshold.
- You have claimed for over-the-counter medicine (which does not count to the Annual Threshold).
- Some of the previous year’s claims have been paid from the current year’s Medical Savings Account.
- You have chosen to have your day-to-day claims paid at Cost, instead of at the Scheme Rate.

All claims paid from the Medical Savings Account that do not add up to the Annual Threshold will increase the Self-payment Gap. Your claims statement shows when you would be likely to start paying for daily medical expenses from your own pocket.

Please note: You have to send your claims to LA Health even if you are in a Self-payment Gap, otherwise your claims cannot count towards the threshold amount.

At the beginning of the year, the Above Threshold Benefit for you (and your family) is worked out by counting the number of dependants on your membership. If you join LA Comprehensive during the year, the Annual Threshold will be worked out over the number of months that are left in that year.

The Specialised Medicine and Technology Benefit

This benefit covers a specific list of new and advanced medicines and treatments for members on the LA Comprehensive option. This is a limited benefit and there may be some co-payments that you will have to pay, depending on the medical condition and the type of medicine that is used. You need authorisation to qualify for this benefit.
### Overall annual limits

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>No overall limit applies at KeyCare network hospitals</td>
</tr>
<tr>
<td>Ambulance services (member must call Discovery 911 for authorisation)</td>
<td>Paid from Major Medical Benefit, no overall limit applies</td>
</tr>
<tr>
<td>Emergency transport</td>
<td>Paid from Major Medical Benefit, no overall limit applies</td>
</tr>
<tr>
<td>Blood transfusions and blood products</td>
<td>Paid from Major Medical Benefit, no overall limit applies</td>
</tr>
<tr>
<td>Dentistry</td>
<td>Paid from Major Medical Benefit, no overall limit applies</td>
</tr>
<tr>
<td>Maxillo-facial procedures: certain severe infections, jaw-joint replacements, cancer-related and certain trauma-related surgery, cleft-lip and palate repairs</td>
<td>Paid from Major Medical Benefit, no overall limit applies</td>
</tr>
<tr>
<td>Basic dentistry out of hospital</td>
<td>Covered with no overall benefit limit, subject to a list of procedures performed by a dentist in the KeyCare network</td>
</tr>
</tbody>
</table>

### GPs and specialists

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-hospital visits</td>
<td>No overall limit applies at a network hospital. Specialists must be working in a KeyCare hospital</td>
</tr>
<tr>
<td>Out-of-hospital GP visits</td>
<td>Covered with no overall benefit limit, only at the member’s chosen GP working in the Designated Service Provider network</td>
</tr>
<tr>
<td>Out-of-hospital specialist visits</td>
<td>Limited to R2 550 per person, only if referred by the chosen KeyCare GP (including radiology and pathology done in the KeyCare network)</td>
</tr>
<tr>
<td>Out-of-network benefit</td>
<td>One out-of-network GP visit per person per year, and selected blood tests, x-rays and acute medicine (subject to a formulary) requested by the non-network GP</td>
</tr>
</tbody>
</table>

### HIV and AIDS

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV prophylaxis (rape or mother-to-child transmission)</td>
<td>Paid from Major Medical Benefit, with no overall limit</td>
</tr>
<tr>
<td>HIV and AIDS-related illnesses</td>
<td>No overall limit, subject to clinical entry criteria and certain protocols</td>
</tr>
<tr>
<td>HIV and AIDS-related medicine</td>
<td>Covered with no overall limit from the Scheme’s Designated Service Provider</td>
</tr>
</tbody>
</table>

### Hospitals

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalisation, theatre fees, intensive and high care costs</td>
<td>No overall limit applies, subject to clinical entry criteria and certain protocols</td>
</tr>
<tr>
<td>Provincial and state hospitals</td>
<td>Paid from Major Medical Benefit for treatment authorised in a KeyCare Network hospital. No benefit outside of the network for planned admissions</td>
</tr>
<tr>
<td>Private hospitals</td>
<td>First R205 paid by member at a casualty unit at any of the KeyCare Network Hospitals. Pathology, radiology, medicine and specialist consultations subject to applicable formularies</td>
</tr>
</tbody>
</table>

### Maternity Benefit

<table>
<thead>
<tr>
<th>In-hospital</th>
<th>Baths for use during water births</th>
<th>Limited to R1000 per bath per pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of hospital</td>
<td>GP and specialist consultations</td>
<td>Four gynaecology specialist visits per person per year, subject to the Specialist Benefit of R2 550 per person</td>
</tr>
<tr>
<td>Pregnancy scans</td>
<td>One 2D scan per person per pregnancy</td>
<td></td>
</tr>
<tr>
<td>Blood tests</td>
<td>Selected blood tests per pregnancy (must be requested by the chosen KeyCare GP)</td>
<td></td>
</tr>
</tbody>
</table>

### Medicine

<table>
<thead>
<tr>
<th>Prescribed Minimum Benefit Chronic Disease List conditions, subject to approval of your condition and certain clinical criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribed/acute medicine</td>
</tr>
<tr>
<td>Take-home medicine (when discharged from hospital)</td>
</tr>
</tbody>
</table>

### Mental health

<table>
<thead>
<tr>
<th>In hospital</th>
<th>Psychiatric hospitals, subject to preauthorisation and case management</th>
<th>21 days per person, paid from Major Medical Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of hospital</td>
<td>Psychiatrists only</td>
<td>Covered subject to the R2 550 Specialist Benefit limit per person</td>
</tr>
</tbody>
</table>

### Oncology (cancer-related care requires authorisation)

| The Oncology Programme, including PET scans | Chemo- and radiotherapy only. Covered if rendered by an oncologist in the KeyCare Network, subject to strict protocols paid from Major Medical Benefit |
| Stem cell transplants | Covered from Major Medical Benefit if obtained from a state hospital or the Scheme’s Designated Service provider, subject to Prescribed Minimum Benefit requirements and clinical protocols |

### Optical

| Optometry consultations | One consultation only at an optometrist working in the KeyCare network |
| Spectacles, frames and contact lenses | One pair of mono or bi-focal glasses per person every 24 months at a KeyCare optician |
## Organ transplants
Hospitalisation and harvesting of organ for donor transplants
Medicine for immuno-suppressive therapy

Unlimited. Only in a state hospital, subject to strict clinical entry criteria and preauthorisation.
As per the Prescribed Minimum Benefits formulary.

## Pathology and radiology
**In hospital (subject to preauthorisation)**
- MRI and CT scans (referred by a specialist)
  - Covered subject to preauthorised event and scan related to the hospital admission, only at KeyCare hospital.
- X-rays and pathology
  - Paid from Major Medical Benefit, with no overall limit at a KeyCare hospital.
- Endoscopic procedures: gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy (including hospital and related accounts, if done in hospital)
  - Covered with no overall limit in a KeyCare hospital, if referred by a specialist. Subject to preauthorisation.

**Out of hospital**
- MRI and CT scans (these must be referred by a specialist) subject to preauthorisation.
- Radiology (including x-rays and ultrasounds) and pathology
  - Paid according to a formulary, only if requested by the member’s chosen KeyCare GP. Requests from specialists covered up to the R2 550 specialist limit.
- Endoscopic procedures: gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy
  - Covered with no overall benefit limit subject to preauthorisation and the use of a Day Care facility.

## Prostheses
**Internal prostheses**
- Paid from Major Medical Benefit subject to preauthorisation. Subject to certain protocol limits.

**Spinal devices**
- Covered in full at the Scheme’s Designated Service Provider, subject to pre-authorisation.

**External medical items**
- Mobility devices (wheelchairs, calipers, crutches, walkers and commodes)
  - Limited to R4 200 per family per year from the Scheme’s Designated Service Providers. If the DSP is not used, then no benefit.
- Oxygen rental
  - Covered in full at the Scheme’s Designated Service Provider. If the DSP is not used, then no benefit.

## Preventive care
**Vitality Check at a network pharmacy:** blood glucose test, blood pressure test, cholesterol test and body mass index (BMI)
- OR
- One Flu Vaccination

R135 per person per year for one or all of the 4 listed screening tests, if performed at the same time or a flu vaccination. Payable from Major Medical Benefit only if one of the Scheme’s contracted providers is used.

## Renal care
Dialysis and other renal care-related treatment and educational care (includes authorised related medicines)

No overall limit, subject to a treatment plan and use of the Scheme’s Designated Service Provider, National Renal Care. Co-payments will apply if the network is not used.

## Substance abuse
**Alcohol and drug rehabilitation**
- 21 days per person, paid from Major Medical Benefit.

**Detoxification in hospital**
- 3 days per person, paid from Major Medical Benefit.

## Terminal Care Benefit
**Hospice (excluding frail care)**
- Covered up to R22 000 per person per year from Major Medical Benefit.

## Trauma Recovery Benefit
Cover for specific trauma-related incidents
- Paid per family per year up to the following limits:
  - External appliances: R33 000
  - Hearing Aids: R10 500
  - Mental Health: R12 000
  - Private Nursing: R 7 000
  - Prosthetic limbs: R61 000
  - Prescribed medicine: R 8 600 (M), R10 150 (M1), R12 050 (M2), R14 600 (M3+)

### LA KeyPlus – Total monthly contributions for 2013

<table>
<thead>
<tr>
<th>Income</th>
<th>Member</th>
<th>Adult</th>
<th>Child dependant</th>
<th>Maximum for child dependants</th>
</tr>
</thead>
<tbody>
<tr>
<td>R0 – R6 300</td>
<td>R 740</td>
<td>R 646</td>
<td>R271</td>
<td>R 813</td>
</tr>
<tr>
<td>R6 301 – R8 500</td>
<td>R 781</td>
<td>R 683</td>
<td>R285</td>
<td>R 855</td>
</tr>
<tr>
<td>R8 501+</td>
<td>R1 176</td>
<td>R1 046</td>
<td>R439</td>
<td>R1 317</td>
</tr>
<tr>
<td>R 0 – R6 300</td>
<td>R6 301 – R8 500</td>
<td>R8 501+</td>
<td>R 0 – R6 300</td>
<td>R6 301 – R8 500</td>
</tr>
</tbody>
</table>
This Option has a Major Medical Benefit for in-hospital treatment and cover for high-cost care and provides Prescribed Minimum Benefit Chronic Disease List cover. It pays for some day-to-day expenses from a Medical Savings Account. This Option provides cover specifically for members in a province with a coastline (a co-payment applies for non-Prescribed Minimum Benefits care in hospitals that are not in coastal provinces). All major treatments, especially if provided in hospital, must be preauthorised.

### Overall limits

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital</strong></td>
<td>No overall limit applies. Members must use hospitals in coastal provinces</td>
</tr>
<tr>
<td><strong>Medical Savings Account</strong></td>
<td>Member: R4 620; Spouse/adult: R2 976; Child: R1 356</td>
</tr>
<tr>
<td><strong>Ambulance services</strong></td>
<td>Paid from Major Medical Benefit. No overall limit</td>
</tr>
<tr>
<td><strong>Blood transfusions and blood products</strong></td>
<td>Paid from Major Medical Benefit. No overall limit</td>
</tr>
<tr>
<td><strong>Dentistry</strong></td>
<td>Paid from Major Medical Benefit. No overall limit</td>
</tr>
<tr>
<td><strong>Basic dentistry out of hospital</strong></td>
<td>Paid from and limited to funds in Medical Savings Account, subject to the joint overall dental limit of R16 100 per person</td>
</tr>
<tr>
<td><strong>GPs and specialists</strong></td>
<td>Paid at 150% of the LA Health Rate. No overall limit</td>
</tr>
<tr>
<td><strong>Hospitalisation, theatre fees, intensive and high care costs</strong></td>
<td>No overall limit, subject to preauthorisation</td>
</tr>
</tbody>
</table>

### Maternity Benefit

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In hospital</strong></td>
<td>No overall limit. Related accounts paid at 150% of the LA Health Rate</td>
</tr>
<tr>
<td><strong>Out of hospital, GP and specialist consultations, pregnancy scans, blood tests and antenatal classes</strong></td>
<td>Limited to funds in Medical Savings Account</td>
</tr>
</tbody>
</table>

### Medicine

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescribed Minimum Benefit Chronic Disease List conditions</strong></td>
<td>All Prescribed Minimum Benefit Chronic Disease List conditions covered from Major Medical Benefit based on a formulary, subject to approval and use of Scheme's Designated Service Provider. The Scheme pays up to a Chronic Drug Amount if non-formulary medicine is used</td>
</tr>
<tr>
<td><strong>Prescribed/acute medicine</strong></td>
<td>Paid from and limited to funds in the Medical Savings Account up to 90% of the LA Health Medicine Rate</td>
</tr>
<tr>
<td><strong>Medicine bought over-the-counter at a pharmacy</strong> (schedule 0, 1 and 2 and generic or non-generic, whether prescribed or not)</td>
<td>Limited to funds in Medical Savings Account up to 100% of the cost</td>
</tr>
<tr>
<td><strong>Take-home medicine</strong> (when discharged from hospital) TTOs</td>
<td>Limited to funds in the Medical Savings Account and paid at 90% of the LA Health Medicine Rate</td>
</tr>
</tbody>
</table>

### Mental health

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychiatric hospitals, subject to preauthorisation and case management</strong></td>
<td>21 days per person, paid from Major Medical Benefit</td>
</tr>
<tr>
<td><strong>Out of hospital</strong></td>
<td>Limited to funds in the Medical Savings Account</td>
</tr>
<tr>
<td><strong>Psychologists, psychiatrists, art therapy and social workers; alcohol and drug rehabilitation</strong></td>
<td>Limited to funds in the Medical Savings Account</td>
</tr>
</tbody>
</table>

### Oncology (cancer-related care)

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oncology Programme (including chemo- and radiotherapy)</strong></td>
<td>No overall limit in a 12-month cycle, subject to approval of a treatment plan, paid up to the Scheme Rate. All claims accumulate to a threshold of R228 000. A 20% co-payment applies after this. Prescribed Minimum Benefit related oncology care is paid in full without any co-payments</td>
</tr>
<tr>
<td><strong>PET scans</strong></td>
<td>No overall limit in a 12-month cycle. Scan must be done at the Scheme's Designated Service Provider, subject to preauthorisation. A co-payment of R2 750 will apply if a Designated Service Provider is not used</td>
</tr>
<tr>
<td><strong>Stem cell transplants</strong></td>
<td>No overall limit at the Designated Service Provider, subject to registration on the Scheme's Oncology Programme. Limited to R1 million, if Designated Service Provider is not used</td>
</tr>
</tbody>
</table>
## Optical
- Optometry consultations: Limited to funds in the Medical Savings Account
- Spectacles, frames, contact lenses and refractive eye surgery: Limited to funds in the Medical Savings Account

## Other services
- Auxiliary services (physiotherapy, occupational therapy, homeopaths, audiologists, psychologists, etc): Limited to funds in the Medical Savings Account
- Alternative healthcare practitioners (chiroprody, homeopaths, naturopaths and chiropractors): Limited to funds in the Medical Savings Account
- Nurse practitioners: Limited to funds in the Medical Savings Account

## Organ transplants
- Hospitalisation and harvesting of organ for transplant: No overall limit. Related accounts paid at 150% of the LA Health Rate
- Medicine for immuno-suppressive therapy: As per Chronic Illness Benefit Chronic Drug Amount

## Pathology and radiology
### In hospital (subject to preauthorisation)
- MRI and CT scans (referred by a specialist): Paid from Major Medical Benefit. No overall limit
- Endoscopic procedures: gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy (including hospital and related accounts, if done in hospital): First R1 900 of hospital account paid from Medical Savings Account and the rest of the account paid from Major Medical Benefit. Related accounts limited to funds in Medical Savings Account

### Out of hospital
- MRI and CT scans: First R1 900 of the scan paid from and limited to funds in Medical Savings Account and the rest of the account paid from Major Medical Benefit
- Radiology (including x-rays and ultrasounds) and pathology: Limited to funds in the Medical Savings Account
- Endoscopic procedures: gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy: First R950 of hospital account paid from Medical Savings Account and the rest of the account paid from Major Medical Benefit.

## Prostheses
### Internal prostheses
- Cochlear implants, implantable defibrillators, internal nerve stimulators and auditory brain implants: Paid from Major Medical Benefit up to R155 000 per person per year
- Other internal prostheses: Paid from Major Medical Benefit subject to preauthorisation and clinical protocols
- Implantable cardiac stents: Limited to R10 900 per bare metal stent and R17 300 per drug-eluting stent
- Spinal devices: Limited to R23 000 per level, with an overall annual limit of R46 000 for two or more levels. Limited to one authorised procedure per benefit year per person

## External medical items
- Crutches, wheelchairs, hearing aids, artificial limbs, stoma bags, etc.: Limited to funds in Medical Savings Account
- Oxygen rental: Covered in full at the Scheme’s Designated Service Provider, subject to preauthorisation

## Preventive care
- Vitality Check at a network pharmacy: blood glucose, blood pressure, cholesterol and body mass index (BMI)
  - OR
  - One Flu vaccination
  - Screening benefit at other providers: mammograms, Pap smear, prostate-specific antigen test
  - R135 per person per year for one or all of the 4 listed screening tests, if performed at the same time or a flu vaccination. Payable from Major Medical Benefit only if one of the Scheme’s contracted provider is used
  - Limited to one Pap smear, mammogram and Prostate-specific antigen test per person per year, paid from Major Medical Benefit. Consultations, other related costs and procedures, paid from Medical Savings Account

## Renal care
- Includes dialysis and other renal care-related treatment and educational care (includes authorised related medicines)
  - No overall limit, subject to a treatment plan and use of the Scheme’s Designated Service Provider, National Renal Care. Co-payments will apply if the network is not used

## Substance abuse
- Alcohol and drug rehabilitation
  - 21 days per person, paid from Major Medical Benefit
- Detoxification in hospital
  - 3 days per person, paid from Major Medical Benefit

## Terminal Care Benefit
- Hospice (excluding frail care)
  - Covered up to R28 550 per person per year from Major Medical Benefit

## LA Focus – Total monthly contributions, including your Medical Savings Account for 2013

<table>
<thead>
<tr>
<th></th>
<th>Member</th>
<th>Adult</th>
<th>Child dependant</th>
<th>Maximum for child dependants</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1 541</td>
<td>R994</td>
<td>R452</td>
<td>R1 356</td>
<td>R1 356</td>
</tr>
</tbody>
</table>
This Option has a Major Medical Benefit with no overall annual limit for in-hospital treatment and high cost care and provides Prescribed Minimum Benefit Chronic Disease List cover. It pays for some day-to-day expenses from a Medical Savings Account and then for specific disciplines through the Insured Procedures Benefit. These disciplines are: GPs, specialists, acute medicine, radiology, pathology and optical benefits. All major treatments, especially if provided in hospital, must be preauthorised.

### Overall limits

<table>
<thead>
<tr>
<th>Section</th>
<th>Benefit Members</th>
<th>Family Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital</strong></td>
<td>R3 168</td>
<td>R2 220, R624</td>
</tr>
<tr>
<td><strong>Insured Procedures Benefit</strong></td>
<td>R4 284</td>
<td>R3 120, R1 800</td>
</tr>
<tr>
<td><strong>Medical Savings Account</strong></td>
<td>R4 284</td>
<td>R3 120, R1 800</td>
</tr>
<tr>
<td><strong>Emergency transport</strong></td>
<td>Paid from Major Medical Benefit</td>
<td>No overall limit</td>
</tr>
<tr>
<td><strong>Blood transfusions and blood products</strong></td>
<td>Paid from Major Medical Benefit</td>
<td>No overall limit</td>
</tr>
<tr>
<td><strong>Dentistry</strong></td>
<td>Paid from Major Medical Benefit</td>
<td>No overall limit</td>
</tr>
<tr>
<td><strong>GP visits</strong></td>
<td>Paid from Medical Savings Account or Insured Procedures Benefit</td>
<td>Paid from Medical Savings Account or Insured Procedures Benefit</td>
</tr>
<tr>
<td><strong>HIV</strong></td>
<td>Paid from Medical Savings Account or Insured Procedures Benefit</td>
<td>Paid from Medical Savings Account or Insured Procedures Benefit</td>
</tr>
<tr>
<td><strong>Hospitals (all planned procedures must be preauthorised)</strong></td>
<td>Subject to preauthorisation, No overall limit</td>
<td>Subject to preauthorisation, No overall limit</td>
</tr>
</tbody>
</table>

### Maternity Benefit

<table>
<thead>
<tr>
<th>Section</th>
<th>Benefit Members</th>
<th>Family Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In hospital</strong></td>
<td>No overall limit</td>
<td>Limited to funds in Medical Savings Account or Insured Procedures Benefit</td>
</tr>
<tr>
<td><strong>Out of hospital</strong></td>
<td>Limited to funds in Medical Savings Account or Insured Procedures Benefit</td>
<td>Limited to funds in Medical Savings Account or Insured Procedures Benefit</td>
</tr>
<tr>
<td><strong>Ultrasounds</strong></td>
<td>Limited to funds in Medical Savings Account, except for Prescribed Minimum Benefits</td>
<td>Limited to funds in Medical Savings Account or Insured Procedures Benefit</td>
</tr>
<tr>
<td><strong>Blood tests</strong></td>
<td>Limited to funds in Medical Savings Account or Insured Procedures Benefit</td>
<td>Limited to funds in Medical Savings Account or Insured Procedures Benefit</td>
</tr>
<tr>
<td><strong>Antenatal classes</strong></td>
<td>Limited to funds in Medical Savings Account</td>
<td>Limited to funds in Medical Savings Account</td>
</tr>
</tbody>
</table>

### Medicine

<table>
<thead>
<tr>
<th>Section</th>
<th>Benefit Members</th>
<th>Family Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescribed Minimum Benefit Chronic Disease List conditions</strong></td>
<td>All Prescribed Minimum Benefit Chronic Disease List conditions covered from Major Medical Benefit based on a formulary and subject to approval. The Scheme pays up to a Chronic Drug Amount amount if non-formulary medicine is used</td>
<td>Limited to funds in the Medical Savings Account or Insured Procedures Benefit up to 90% of the LA Health Medicine Rate</td>
</tr>
<tr>
<td><strong>Prescribed/acute medicine</strong></td>
<td>Paid from and limited to funds in the Medical Savings Account or Insured Procedures Benefit up to 90% of the LA Health Medicine Rate</td>
<td>Limited to funds in Medical Savings Account or Insured Procedures Benefit up to 100% of the cost</td>
</tr>
<tr>
<td><strong>Medicine bought over-the-counter</strong></td>
<td>Limited to funds in the Medical Savings Account or Insured Procedures Benefit up to 100% of the cost</td>
<td>Limited to funds in the Medical Savings Account or Insured Procedures Benefit and paid at 90% of the LA Health Medicine Rate</td>
</tr>
<tr>
<td><strong>Take-home medicine (When discharged from hospital)</strong></td>
<td>Limited to funds in the Medical Savings Account or Insured Procedures Benefit and paid at 90% of the LA Health Medicine Rate</td>
<td>Limited to funds in the Medical Savings Account or Insured Procedures Benefit and paid at 90% of the LA Health Medicine Rate</td>
</tr>
</tbody>
</table>

### Mental health

<table>
<thead>
<tr>
<th>Section</th>
<th>Benefit Members</th>
<th>Family Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychiatric hospitals</strong>, subject to case management</td>
<td>21 days per person, paid from Major Medical Benefit</td>
<td>Limited to funds in the Medical Savings Account</td>
</tr>
<tr>
<td><strong>Psychologists, psychiatrists, art therapy and social workers; alcohol and drug rehabilitation</strong></td>
<td>Limited to funds in the Medical Savings Account</td>
<td>Limited to funds in the Medical Savings Account</td>
</tr>
</tbody>
</table>

### Oncology (cancer-related care)

<table>
<thead>
<tr>
<th>Section</th>
<th>Benefit Members</th>
<th>Family Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oncology Programme</strong>, including chemo- and radiotherapy**</td>
<td>No overall limit in a 12-month cycle, subject to approval of a treatment plan, paid up to the Scheme Rate. All oncology claims accumulate to a threshold of R228 000. A 20% co-payment applies after this. Prescribed Minimum Benefit oncology-related care is paid in full without any co-payments</td>
<td>Limited to funds in the Medical Savings Account</td>
</tr>
<tr>
<td><strong>PET scans</strong></td>
<td>Limited to funds in the Medical Savings Account</td>
<td>Limited to funds in the Medical Savings Account</td>
</tr>
<tr>
<td><strong>Stem cell transplants</strong></td>
<td>Limited to funds in the Medical Savings Account</td>
<td>Limited to funds in the Medical Savings Account</td>
</tr>
</tbody>
</table>

---

### Ambulance services (member must call Discovery 911 for authorisation)

- Paid from Major Medical Benefit. No overall limit

### Blood transfusions and blood products

- Paid from Major Medical Benefit. No overall limit

### Dentistry

- Maxillo-facial procedures: certain severe infections, jaw-joint replacements, cancer-related and certain trauma-related surgery, cleft-lip and palate repair
  - Paid from Major Medical Benefit. No overall limit

- Specialised dentistry in hospital
  - First R 900 of hospital account is paid from Medical Savings Account. Remainder of hospital account paid from Major Medical Benefit. All related, non-hospital accounts paid from and limited to funds in the Medical Savings Account or Insured Procedures Benefit.
  - All dental costs subject to overall dental limit of R16 100 per person

- Basic dentistry out of hospital
  - First R 610 per family, covered from Major Medical Benefit. Thereafter paid from and limited to funds in the Medical Savings Account or Insured Procedures Benefit. All basic dentistry subject to the joint overall annual dental limit of R16 100 per person

### GPs and Specialists

<table>
<thead>
<tr>
<th>Section</th>
<th>Benefit Members</th>
<th>Family Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-hospital visits</strong></td>
<td>No overall limit</td>
<td>Limited to funds in Medical Savings Account or Insured Procedures Benefit</td>
</tr>
<tr>
<td><strong>Out of hospital</strong> GP and specialist visits</td>
<td>Limited to funds in Medical Savings Account or Insured Procedures Benefit</td>
<td>Limited to funds in Medical Savings Account or Insured Procedures Benefit</td>
</tr>
</tbody>
</table>

### HIV and AIDS

<table>
<thead>
<tr>
<th>Section</th>
<th>Benefit Members</th>
<th>Family Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIV Prophylaxis</strong> (rape or mother-to-child transmission)**</td>
<td>Paid from Major Medical Benefit, no overall limit</td>
<td>Paid from Major Medical Benefit, no overall limit</td>
</tr>
<tr>
<td><strong>HIV and AIDS-related illnesses</strong></td>
<td>No overall limit, subject to clinical entry criteria HIVCare</td>
<td>No overall limit, subject to clinical entry criteria HIVCare</td>
</tr>
<tr>
<td><strong>HIV and AIDS-related medicine</strong></td>
<td>Covered with no overall limit from the Scheme’s Designated Service Provider</td>
<td>Covered with no overall limit from the Scheme’s Designated Service Provider</td>
</tr>
</tbody>
</table>

---

21
**Optical**
Optometry consultations
Limited to funds in the Medical Savings Account or Insured Procedures Benefit
Spectacles, frames, contact lenses and refractive eye surgery

**Other services**
Auxiliary services (physiotherapy, occupational therapy, homeopaths, audiologists, psychologists, etc)
Limited to funds in the Medical Savings Account
Alternative healthcare practitioners (chiroprops, homeopaths, naturopaths, and chiropractors)
Nursing practitioners

**Organ transplants**
Hospitalisation and harvesting of organ for donor transplants
Harvesting of organ for transplant
No overall limit. Subject to preauthorisation

**Pathology and radiology**
In hospital (subject to preauthorisation)
MRIs and CT scans (referred by a specialist); ultrasounds, x-rays, pathology
Endoscopic procedures: gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy (including hospital and related accounts, if done in hospital)
MRI and CT scans (referred by a specialist) subject to preauthorisation
First R1 900 of scan account paid from Medical Savings Account and the rest of the account paid from Major Medical Benefit.
Radiology (including x-rays and ultrasounds)
Endoscopic procedures: gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy

**Prostheses**
Internal prostheses
Cochlear implants, implantable defibrillators, internal nerve stimulators and auditory brain implants
Implantable cardiac stents
Spinal devices
Other internal prostheses
Paid from Major Medical Benefit up to R155 000 per person per year
Limited to R10 900 per bare metal stent and R17 300 per drug-eluting stent
Limited to R23 000 per level, with an overall annual limit of R46 000 for two or more levels. Limited to one authorised procedure per person per benefit year
Paid from Major Medical Benefit, subject to preauthorisation and clinical protocols

**External medical items**
Crutches, wheelchairs, hearing aids, artificial limbs, stoma bags, etc
Oxygen rental
Limited to funds in Medical Savings Account
Covered in full at the Scheme’s Designated Service Provider, subject to preauthorisation

**Preventive care**
Vitality Check at a network pharmacy: blood glucose test, blood pressure test, cholesterol test and body mass index (BMI)
OR
One flu vaccination
R135 per person per year for one or all of the 4 listed screening tests, if performed at the same time or a flu vaccination. Payable from Major Medical Benefit only if one of the Scheme’s contracted providers is used.
Limited to one Pap smear, mammogram and prostate-specific antigen test per person per year, paid from Major Medical Benefit. Consultations, other related costs and procedures paid from Medical Savings Account

**Renal care**
Dialysis and other renal care-related treatment and educational care (includes authorised related medicines)
No overall limit. Subject to a treatment plan and use of the Scheme’s Designated Service Provider, National Renal Care. Co-payments will apply if the network is not used

**Substance abuse**
Alcohol and drug rehabilitation
Detoxification in hospital
21 days per person, paid from Major Medical Benefit
3 days per person, paid from Major Medical Benefit

**Terminal Care Benefit**
Hospice (excluding frail care)
Covered up to R28 550 per person per year from Major Medical Benefit

**Total monthly contributions, including your Medical Savings Account for 2013**

<table>
<thead>
<tr>
<th>Category</th>
<th>Member</th>
<th>Adult</th>
<th>Child dependant</th>
<th>Maximum for child dependants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R1 960</td>
<td>R1 254</td>
<td>R618</td>
<td>R1 854</td>
</tr>
</tbody>
</table>

---

**Maximum for child dependants**
R1 854
This Option has a Major Medical Benefit with no overall annual limit for in-hospital treatment and high-cost care. It provides cover for the Prescribed Minimum Benefit Chronic Disease List as well as for several Additional Chronic conditions. It pays for some day-to-day expenses from a Medical Savings Account and for specific disciplines through the Insured Procedures Benefit. These are: GPs, specialists, acute medicines, radiology, pathology and optical benefits. All major treatments, especially if provided in hospital, must be preauthorised.

### Overall limits

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>No overall limit</td>
</tr>
<tr>
<td>Insured Procedures Benefit</td>
<td>Member: R4 212, Spouse/adult: R2 028, Child: R1 118</td>
</tr>
<tr>
<td>Medical Savings Account</td>
<td>Member: R5 544, Spouse/adult: R4 848, Child: R2 244</td>
</tr>
</tbody>
</table>

### Ambulance services (members must call Discovery 911 for authorisation)

- **Emergency transport**: Paid from Major Medical Benefit. No overall limit

### Blood transfusions and blood products

- Paid from Major Medical Benefit. No overall limit

### Dentistry

- Paid from Major Medical Benefit. No overall limit
- Maxillo-facial procedures; certain severe infections, jaw-joint replacements, cancer-related and certain trauma-related surgery; cleft-lip and palate repairs
- First R1 900 of hospital account is paid from Medical Savings Account and the rest of the account paid from Major Medical Benefit. All related, non-hospital accounts paid from and limited to funds in the Medical Savings Account or Insured Procedures Benefit. All dental costs subject to overall dental limit of R21 300 per person
- Basic dentistry out of hospital: Paid from and limited to funds in Medical Savings Account or Insured Procedures Benefit, subject to the joint overall dental limit of R21 300 per person

### GPs and specialists

- **In-hospital visits**: No overall limit
- **Out of hospital**: Paid from Medical Savings Account or Insured Procedures Benefit

### HIV and AIDS

- **HIV prophylaxis (rape or mother-to-child transmission)**: Paid from Major Medical Benefit. No overall limit
- **HIV and AIDS-related illnesses**: No overall limit, subject to clinical entry criteria and HIVCare Programme protocols
- **HIV and AIDS-related medicine**: Covered with no overall limit from the Scheme's Designated Service Provider

### Hospitals

#### Hospitalisation, theatre fees, intensive and high care costs

- Provincial, state and private hospitals
- Subject to preauthorisation. No overall limit

### Maternity Benefit

#### In hospital

- No overall limit

#### Out of hospital

- Limited to funds in Medical Savings Account or Insured Procedures Benefit

### Medicine

#### Prescribed Minimum Benefit Chronic Disease List

- All Prescribed Minimum Benefit Chronic Disease List conditions covered based on a formulary and subject to approval. The Scheme pays up to a Chronic Drug Amount amount if non-formulary medicine is used

#### Additional Chronic Conditions (subject to approval)

- Paid at 90% of the LA Health Medicine Rate Limited to:
  - Member: R7 315
  - Member 1+: R14 520

#### Prescribed/acute medicine

- Paid from and limited to funds in the Medical Savings Account or Insured Procedures Benefit up to 90% of the LA Health Medicine Rate

#### Medicine bought over-the-counter at a pharmacy

- (schedule 0, 1 and 2 and generic or non-generic, whether prescribed or not)
- Limited to funds in Medical Savings Account or Insured Procedures Benefit up to 90% of the LA Health Medicine Rate

#### Take-home medicine (When discharged from hospital)

- TTO’s

#### Mental health

- Psychiatric hospitals, subject to preauthorisation and case management
  - 21 days per person, paid from Major Medical Benefit
- Psychologists, psychiatrists, art therapy and social workers, alcohol and drug rehabilitation (out of hospital)
  - Limited to funds in the Medical Savings Account
### Oncology (cancer-related care)

**The Oncology Programme, including chemo-and radiotherapy**
No overall limit in a 12-month cycle, subject to approval of treatment plan and paid at Scheme Rate. All oncology claims accumulate to a threshold of R456 000. A 20% co-payment applies after this. Prescribed Minimum Benefit oncology-related care is paid in full, without any co-payments.

**PET scans**
No overall limit in a 12-month cycle. Scans must be done at the Scheme's Designated Service Provider, subject to preauthorisation. A co-payment of R2 750 will apply if a Designated Service Provider is not used.

**Stem cell transplants**
No overall limit at the Designated Service Provider, subject to registration on the Scheme's Oncology Programme. Limited to R1 million, if Designated Service Provider is not used.

### PET scans

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>PET scans</td>
<td>No overall limit in a 12-month cycle. Scans must be done at the Scheme's Designated Service Provider, subject to preauthorisation. A co-payment of R2 750 will apply if a Designated Service Provider is not used.</td>
</tr>
</tbody>
</table>

### Preventive care

**Vitality Check at a network pharmacy:** blood glucose test, blood pressure test, cholesterol test and body mass index (BMI) OR One Flu vaccination
R135 per person per year for one or all of the 4 listed screening tests, if performed at the same time or a flu vaccination. Payable from Major Medical Benefit only if one of the Scheme's contracted providers is used.

**Screening benefit at other providers:** mammogram, Pap smear, prostate-specific antigen test
Limited to one pap smear, mammogram and prostate-specific antigen test per person per year, paid from Major Medical Benefit. Consultations, other related costs and procedures paid from Medical Savings Account or Insured Procedures Benefit, except for Prescribed Minimum Benefits.

### Renal care

**Dialysis and other renal care-related treatment and educational care (includes authorised related medicines)**
Subject to a treatment plan and use of the Scheme's Designated Service Provider, National Renal Care. Co-payments will apply if the network is not used.

### Substance abuse

**Alcohol and drug rehabilitation**
21 days per person, paid from Major Medical Benefit.

**Detoxification in hospital**
3 days per person, paid from Major Medical Benefit.

### Terminal Care Benefit

Hospice (excluding frail care)
No overall limit. Paid from Major Medical Benefit.

### Total monthly contributions, including your Medical Savings Account for 2013

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Member</td>
<td>R2 891</td>
</tr>
<tr>
<td>Child dependant</td>
<td>R957</td>
</tr>
<tr>
<td>Maximum for child dependants</td>
<td>R2 871</td>
</tr>
</tbody>
</table>
Overall limits

<table>
<thead>
<tr>
<th></th>
<th>Hospital</th>
<th>Above Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Savings Account</td>
<td>Member</td>
<td>R6 732</td>
</tr>
<tr>
<td>Ambulance services (members must call Discovery 911 for authorisation)</td>
<td>Emergency transport</td>
<td>Paid from Major Medical Benefit. No overall limit</td>
</tr>
</tbody>
</table>

Blood transfusions and blood products

- Blood transfusions and blood products: Paid from Major Medical Benefit. No overall limit

Dentistry

- Maxillo-facial procedures: certain severe infections, jaw-joint replacements, cancer-related and certain trauma-related surgery, cleft lip and palate repairs: Paid from Major Medical Benefit. No overall limit
- Specialised dentistry in hospital: First R1 900 of hospital account paid from Medical Savings Account and the rest of the account paid from Major Medical Benefit. All related, non-hospital accounts paid from and limited to funds in the Medical Savings Account or Above Threshold Benefit. All related, hospital accounts paid from and limited to funds in the Medical Savings Account or Above Threshold Benefit. All related, non-hospital accounts paid from and limited to funds in the Medical Savings Account or Above Threshold Benefit. All related, hospital accounts paid from and limited to funds in the Medical Savings Account or Above Threshold Benefit.
- Basic dentistry out of hospital: Paid from and limited to funds in Medical Savings Account or Above Threshold Benefit, subject to the joint overall dental limit of R21 300 per person

GP's and specialists

- In-hospital visits: No overall limit
- Out of hospital GP and specialist visits: Paid from Medical Savings Account or Above Threshold Benefit
- HIV and AIDS
  - HIV Prophylaxis (rape or mother-to-child transmission): Paid from Major Medical Benefit. No overall limit
  - HIV and AIDS-related Illnesses: No overall limit, subject to clinical entry criteria and HIVCare Programme protocols
  - HIV and AIDS-related medicine: Covered with no overall limit from the Scheme's Designated Service Provider

Hospitals

- Hospitalisation, theatre fees, intensive and high care costs: Subject to preauthorisation. No overall limit
- Provincial, state and private hospitals: Subject to preauthorisation. No overall limit

Maternity Benefit

<table>
<thead>
<tr>
<th></th>
<th>In-hospital</th>
<th>Out of hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-hospital</td>
<td>No overall limit</td>
<td>Paid from Medical Savings Account or Above Threshold Benefit</td>
</tr>
<tr>
<td>Out of hospital</td>
<td>GP and specialist consultations and blood tests</td>
<td>Limited to the cost of two 2D scans per pregnancy, paid from Medical Savings Account or Above Threshold Benefit</td>
</tr>
<tr>
<td>Ultrasounds</td>
<td>Limited to the cost of two 2D scans per pregnancy, paid from Medical Savings Account or Above Threshold Benefit</td>
<td></td>
</tr>
<tr>
<td>Antenatal classes</td>
<td>Limited to R1 075 per person and paid from Medical Savings Account or Above Threshold Benefit</td>
<td></td>
</tr>
</tbody>
</table>

Medical

- Prescribed Minimum Benefit Chronic Disease List conditions: All Prescribed Minimum Benefit Chronic Disease List conditions covered based on a formulary and subject to approval. The Scheme pays up to a Chronic Drug Amount amount if non-formulary medicine is used.
- Additional Chronic Conditions (subject to approval) Limited to: All Chronic Disease List conditions covered based on a formulary and subject to approval. The Scheme pays up to a Chronic Drug Amount amount if non-formulary medicine is used.
- Prescribed/acute medicine: Paid at 90% of the LA Health Medicine Rate from MSA/ATB
- Specialised Medicine and Technology Benefit for biologics: Subject to authorisation. Paid at the LA Health Medicine Rate up to R228 000 per person per year with a variable co-payment up to a maximum of 20% of the cost of the medicine or technology, based on the actual condition and medicine applied for.
- Take-home medicine: Limited to funds in the Medical Savings Account or Above Threshold Benefit and paid at 90% of the LA Health Medicine Rate.
- Medicine bought over-the-counter (schedule 0,1 and 2 and generic or non-generic, whether prescribed or not): Limited to funds in the Medical Savings Account up to 100% of the cost
- Take-home medicine: Limited to funds in the Medical Savings Account or Above Threshold Benefit and paid at 90% of the LA Health Medicine Rate

Mental health

- Psychiatric hospitals, subject to case management: 21 days per person, paid from Major Medical Benefit
- Psychologists, psychiatrists, art therapy and social workers: Limited to funds in the Medical Savings Account or Above Threshold Benefit. Limited to R12 850 per family per year with a sub-limit of R4 300 per person for alcohol and drug rehabilitation
**Oncology (cancer-related care)**

- **Oncology Programme (including chemo- and radiotherapy)**
  - No overall limit in a 12-month cycle, subject to approval of a treatment plan, paid up to the Scheme Rate. All oncology claims accumulate to a threshold of R456 000. A 20% co-payment applies after this. All Prescribed Minimum Benefit claims are paid in full without a co-payment.

- **PET scans**
  - No overall limit in a 12-month cycle. Scans must be done at the Scheme’s Designated Service Provider, subject to preauthorisation. A co-payment of R7 500 will apply if a Designated Service Provider is not used.

- **Stem cell transplants**
  - No overall limit at the Designated Service Provider, subject to registration on the Scheme’s Oncology Programme. Limited to R1 million, if Designated Service Provider is not used.

**Optical**

- **Optometry consultations**
  - Limited to funds in the Medical Savings Account or Above Threshold Benefit.

- **Spectacles, frames, contact lenses and refractive eye surgery**
  - Paid from the Medical Savings Account or Above Threshold Benefit up to a limit of R3 060 per person.

**Other services**

- **Auxiliary services (physiotherapy, occupational therapy, homeopaths, audiologists, psychologists, etc)**
  - Limited to funds in the Medical Savings Account or Above Threshold Benefit.

- **Alternative healthcare practitioners (chiroprody, homeopathies, naturopathies, and chiropractors)**
  - Paid up to a limit of R7 500 per family from Medical Savings Account or Above Threshold Benefit.

- **Nurse practitioners**
  - Paid from the Medical Savings Account or Above Threshold Benefit.

**Organ transplants**

- **Hospitalisation and harvesting of organ transplant medicine for immuno-suppressive therapy**
  - No overall limit. Subject to preauthorisation.

**Pathology and radiology**

- **In hospital**
  - **MRI and CT scans (these must be referred by a specialist), x-rays, pathology and ultrasounds**
    - Endoscopic procedures: gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy (including hospital and related accounts, if done in hospital)
    - Paid from Major Medical Benefit. No overall limit.

- **Out of hospital**
  - **MRI and CT scans**
    - Paid from Medical Savings Account or Above Threshold Benefit.

  - **Radiology, including x-rays and ultrasounds and pathology**
    - Endoscopic procedures: gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy
    - Paid from Major Medical Benefit. No overall limit.

**Prostheses**

- **Internal prostheses**
  - Cochlear implants, implantable defibrillators, internal nerve stimulators and auditory brain implants
  - Paid from Major Medical Benefit up to R1 556 000 per person per year.

  - Implantable cardiac stents
  - Limited to R10 900 per bare metal stent and R17 300 per drug-eluting stent.

**Spinal devices**

- Limited to R23 000 per level, with an overall annual limit of R46 000 for two or more levels. Limited to one authorised procedure per person per benefit year.

- Paid from Major Medical Benefit, subject to preauthorisation and clinical protocols.

**External medical items**

- **Crutches, wheelchairs, hearing aids, artificial limbs, stoma bags, etc.**

- **Oxygen rental**
  - Covered in full at the Scheme’s Designated Service Provider, subject to preauthorisation.

**Preventive care**

- **Vitality Check at a network pharmacy**: blood glucose test, blood pressure test, cholesterol test and body mass index (BMI)
  - OR
  - **One Flu vaccination**

  - Limited to R135 per person per year for one or all of the 4 listed screening tests, if performed at the same time or a flu vaccination. Payable from Major Medical Benefit only if one of the Scheme’s contracted providers is used.

- **Screening Benefit at other providers**: mammograms, Pap smear, prostate-specific antigen test
  - Limited to one Pap smear, mammogram and prostate-specific antigen test per person per year, paid from Major Medical Benefit. Consultations, other related costs and procedures paid from Medical Savings Account or Above Threshold Benefit, except Prescribed Minimum Benefits.

**Renal care**

- **Dialysis and other renal care-related treatment and educational care (includes authorised related medicines)**
  - No overall limit. Subject to a treatment plan and use of the Scheme’s Designated Service Provider, National Renal Care. Co-payments will apply if the network is not used.

**Substance abuse**

- **Alcohol and drug rehabilitation**
  - 21 days per person, paid from Major Medical Benefit.

- **Detoxification in hospital**
  - 3 days per person, paid from Major Medical Benefit.

**Terminal Care Benefit**

- **Hospice (excluding frail care)**
  - Paid from Major Medical Benefit. No overall limit.

---

**Total monthly contributions, including your Medical Savings Account for 2013**

<table>
<thead>
<tr>
<th>Category</th>
<th>Member</th>
<th>Adult</th>
<th>Child dependant</th>
<th>Maximum for child dependants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R4 189</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>R3 200</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>R1 016</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>R3 048</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
What the Scheme does not cover

There are certain medical expenses the Scheme does not cover. We call these exclusions. LA Health will not cover the direct or indirect consequences of the following, except as stipulated in the Prescribed Minimum Benefits:

- Cosmetic procedures, for example otoplasty for jug ears, portwine stains, blepheroplasty (eyelid surgery), keloid scars, hair removal, nasal reconstruction (including septoplasties, osteotomies and nasal tip surgery) and enamel micro abrasion
- Breast reductions and implants
- Obesity
- Frail care
- Infertility
- Willfully self-inflicted illness or injury
- Injuries sustained during participation in a willful and material violation of the law
- Injuries sustained during willful participation in war, terrorist activity, riot, civil commotion, rebellion or insurrection
- Experimental, unproven or unregistered treatment or practices
- Any costs where a third party is legally responsible
- CT angiogram of the coronary vessels and CT colonoscopy
- Facility fees at casualty facilities.

LA KeyPlus benefit exclusions

Apart from the Scheme exclusions already mentioned, LA KeyPlus has the following exclusions, except as stipulated in the Prescribed Minimum Benefits:

- In-hospital management of:
  - Dentistry
  - Conservative back treatment
  - Diagnostic work-up and investigative procedures
  - Hearing disorders
- Skin disorders
- Obesity
- Sexual dysfunction
- Incontinence
- Functional and nasal surgery
- Refractive eye surgery
- Brachytherapy for prostate cancer
- Surgery for oesophageal reflux, hiatus hernia repair and nissen funduplication
- Spinal surgery for back and neck
- Cochlear implants, auditory brain implants and internal nerve stimulators (procedures, devices and processors)
- All joint replacements, including hip and knee replacements
- Non-cancerous breast conditions
- Any claim incurred beyond local borders
- Elective caesarian section
- Arthroscopies
- Bunionectomy
- Removal of varicose veins

All our rules are available on request

This brochure is only a summary of information about LA Health Medical Scheme’s benefits and procedures. If you want the full set of rules, please email compliance@discovery.co.za or ask for it when calling the call centre. If anything in this brochure is different from the rules, the rules of the Scheme will always apply.
Adding a dependant

If you want to add a dependant to your existing membership, you have to complete an additional dependant application form. Please attach a copy of the additional dependant’s ID document to the application form.

You must send the completed and signed form to monitor your employer for approval first. Otherwise, you can send it to your broker, who can monitor the status of your application. You can also call the call centre on 0860 100 345 to find out where in the process your application is.

Please make sure the application form is fully completed and that the following information for the new dependant is on it:

- Full names
- Date of birth and ID number
- The dependant’s relationship to you (spouse, common-law spouse, child, step child, legally adopted child, adult dependant)
- Gender (male or female)
- The month in which the new dependant will be joining LA Health – always on the first day of a month.

Also send us copies of these documents with the form:

- Copy of marriage certificate for adding a spouse. If you are not legally married to your partner, you must please complete the partnership declaration form and submit it with your application form.
- Birth certificate or adoption papers for adding a child dependant.

Changing your Benefit Option

You cannot make any Benefit Option changes during the year – you can only do so at the end of each year. If you are still actively employed, be sure to get approval from your employer first.

If you are not submitting the change of Benefit Option through your employer on their prescribed forms, you must complete a Benefit Option change form. You can get this form from the call centre on 0860 103 933 or from the website at www.lahealth.co.za

Applying for your chronic illness medicine or other PMB medicine

If you would like to use the Chronic Illness Benefit or apply for ongoing use of other Prescribed Minimum Benefit medicine, you must fill in the application form that is available on the website at www.lahealth.co.za or call 0860 103 933 to get the form. If necessary, you or your doctor may have to give extra motivation or copies of certain documents to the Scheme to finalise your application.

When will your chronic illness cover start?

Your cover will start depending on when the doctor completed the form.

<table>
<thead>
<tr>
<th>When your doctor completed the form</th>
<th>When cover will start</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than three months ago</td>
<td>From the date the doctor completed the form</td>
</tr>
<tr>
<td>A month or more before you joined the Scheme</td>
<td>From the day you join the Scheme</td>
</tr>
<tr>
<td>More than three months after you filled in the form</td>
<td>The date we got the form</td>
</tr>
</tbody>
</table>

Remember: If you leave out any information or do not provide copies of reports for previous medical tests or documents needed with the application, cover will start only from the date we get the outstanding documents or information.
If you are joining LA Health from one of the other accredited schemes and had approval for one of the LA Health chronic conditions, please give us a copy of that scheme’s approval letter.

**Preauthorisation**

Before you go to hospital for a planned procedure, remember to get authorisation first. Here are the steps:

- Visit your doctor. He or she will decide if it is necessary for you to go to hospital.
- Find out which doctor is going to admit you to hospital. Sometimes, your own doctor will refer you to another doctor or specialist.
- Choose the hospital you want to go to, but remember that not all procedures are done in all hospitals. Your doctor can give you advice on this. (If you are on LA KeyPlus or LA Focus, you must use specific network hospitals.)
- Preauthorise your hospital admission. Do this by calling us on 0860 103 933 at least 48 hours before you go to hospital. When we have considered your request, we will tell you how we will pay for your hospital stay.
- If you do not confirm your admission, you would have to make a co-payment (pay some of the cost yourself). If you are on LA KeyPlus we may also not make any payments if the Network hospitals are not used.

**Registering for our online services**

- Make sure we have your email address on our system. Please note that an e-mail address ending with ‘.gov’ will not be paid since those sites reject information we send to you.
- Go to www.lahealth.co.za
- Click on ‘Register’
- Complete the registration process
- Once you are registered, you will have electronic access to your benefit information
- If you need help to register, please call us on 0860 100 696.

**Submitting claims**

When sending claims to the Scheme, please make sure you do the following:

- Check all your details against your membership card, especially your membership number.
- Ask your doctor if he or she charges the LA Health Rate. Negotiate with him or her to rather charge the LA Health Rate if their rates are higher. If they don’t agree, you will have to pay the difference.
- If your doctor sends the claim to the Scheme electronically, you do not need to send a copy to us.
- If you send your claim to the Scheme, please send the original copy with your correct membership number.
- Make sure your membership number and the doctor’s details and practice number are clearly visible on the claim.

Choose from several ways to send claims

There are various ways of sending claims to the Scheme for processing:

1. Send your claim by email to claims@discovery.co.za or fax it to 0860 329 252.
2. Drop off your claim at Discovery Health’s offices or put it in any other Discovery Health claims box. You can find these boxes at Virgin Active or Planet Fitness gyms, Dis-Chem pharmacies and most private hospitals.
3. Post your claim to the Scheme.

What happens after you send your claim

Once we get your claim, we scan it and capture it on our system. We then assess the claim and make sure all the information on the claim matches the information we have on record for the patient. The turnaround time for processing claims is 72 hours – from the time we receive a claim to the time we process it. It is then approved for payment or declined.
Once we have made the payment, and if we have your email address, you will receive a claims payment notification that will give you all the information about the latest claims we have processed for you. It will tell you how it was assessed against your available benefits, how it was paid and what the latest balances are – Medical Savings Account or others. Please log in to www.lahealth.co.za and update your information. If you do not have access to emails, you will still see the details on your claims statement.

How to check on the status of your claim

To see the status of your claim, you can check your claim statement or use the Claims Tracker tool on our website at www.lahealth.co.za. You can also get your details on your cellphone: go to the WAP site, www.discoveryinfo.mobi on your phone or SMS “Claim” to 31347.

What to do when you have a complaint

You can lodge a complaint about a claims payment, the management of your contributions, our communication to you or poor service received from the Scheme by emailing us at service@discovery.co.za, faxing your letter to 021 527 1923, or you can post it to us.

If you are not satisfied, you can ask that the response be reviewed.

Process to complain

1. Lodge a complaint in writing to the administrator via email, fax or post.

2. Escalate the complaint and unsatisfactory resolution to a Team Leader or Service/Fund Manager at the administrator.
   - Quote the reference numbers of the initial complaint lodged or supply the date and details of when the initial complaint was lodged.

3. If the complaint is still unresolved or unsatisfactorily resolved, lodge the complaint in writing to the Principal Officer of the Scheme at Postnet Suite 116, Private Bag X19, Milnerton 7435.

4. If you still feel that your complaint has not been satisfactorily resolved, you can lodge a dispute with the Dispute Committee of the Scheme.

Appeal process

Once you have exhausted the process to complain and the dispute process, you have the right to appeal to the Council for Medical Schemes (CMS). The CMS will look into the merits of the facts of both the complainant and the respondent (be it the Principal Officer or the administrator on behalf of the Principal Officer) and tell the member and the Principal Officer what their ruling is.

The process that must be followed to lodge an appeal to the Council for Medical Schemes is set out in the Medical Schemes Act (Act 131 of 1998). You can find details about this process on the CMS Website at www.medicalschemes.com.
TOOLS TO HELP YOU
Tools to help you

The LA Health website offers many helpful tools – you find the information you need, when you need it.

1. MaPS
   MaPS (Medical and Provider Search) helps you find medical services and healthcare professionals where you will be covered without a co-payment.
   MaPS allows you to search for specific types of medical services in your area. When you select a province, city and provider type, MaPS will give you a list of medical services filtered according to options you selected.

2. Find out more about your cover
   The website also helps you find out how you are covered, how your claims have been paid and what benefits you have available.
   Track your claims: You can see how each claim has been paid, see a history of your claims and find copies of previous claim statements.
   Track your benefits: Know what benefits you have available with real-time benefit and limit tracking.

3. Electronic Health Record
   The Electronic Health Record is our electronic solution to the storage of your health records. We store your medical information in a central place and you can access it from any location that has web access.
   Your health records are confidential, which is why only you can access them – unless you give your permission to allow emergency staff or your doctor access to them.
Benefit Option
The Benefit Option is the cover you choose to buy from the Scheme. LA Health gives you a choice of five Benefit Options: LA KeyPlus, LA Focus, LA Active, LA Core and LA Comprehensive.

Chronic drug amount (CDA)
The CDA is a monthly amount we pay up to for a medicine class. This applies to medicine that is not listed on the medicine list (formulary). The CDA includes VAT and the dispensing fee.

Co-payment
An amount you have to pay towards a healthcare service as stipulated in the Benefit Schedules. We ask you to pay a portion on top of what we will be paying to cover your medical expenses.

Designated Service Provider
A Designated Service Provider is a doctor, specialist or other healthcare professional with whom LA Health has reached an agreement about payment and rates. When you use the services of a Designated Service Provider, we pay the provider directly and in full.

Exclusions
Exclusions are certain expenses that the Scheme does not cover (pay for).

LA Health Rate
This is the rate at which we pay your medical claims. The LA Health Rate is based on specific rates that we negotiated with healthcare professionals. Unless we state differently, claims are paid at 100% of the LA Health Rate. If your doctor charges more than the LA Health Rate, we will pay the claim to you at the LA Health Rate and you will have to pay the provider.

LA Health Medicine Rate
This is the maximum amount the Scheme will pay for medicine and is normally based on the Single Exit Price [SEP] + relevant dispensing fee.

Major Medical Benefit
The Major Medical Benefit covers your expenses for serious illness and high-cost care while you are in and out of hospital.

Medical emergency
A medical emergency is a condition that develops very fast, or an accident, for which you immediately need medical treatment or an operation. In a medical emergency, your life could be in danger if you are not treated, or you could lose a limb or an organ.

Network hospitals
Members on the LA KeyPlus and LA Focus Benefit Options can use specific hospitals to avoid a co-payment for planned procedures. LA Health has made special arrangements with these hospitals to make sure that you get good, affordable healthcare. In an emergency, you can however go to the nearest hospital. You may be transferred to a network hospital once you are in a stable condition.

Person
When we refer to ‘person’ in this brochure, we refer to a member or a person admitted as a dependant of a member (beneficiary).

Preauthorisation
- **Planned admissions:** You must let us know beforehand if you plan to be admitted to hospital.
  Please call us on 0860 103 933 for preauthorisation, so that we can check your membership and help you make sure about your benefits. If you do not preauthorise your benefits, you might have to pay a co-payment or we wont pay any of the expenses.

- **Emergencies:** If you are admitted to hospital in an emergency, you must let us know about it as soon as possible so that we can authorise payment of your medical expenses. We make use of certain clinical policies when we decide whether to approve hospital admissions.

Pro-rated benefits
We calculate your benefits and limits according to the number of months left in the calendar year, if you do not join the Scheme at the beginning of the year.

Related accounts
This type of account is separate from the hospital account. Related accounts include the accounts from doctors or other healthcare professionals, like that of the anaesthetist and for pathology or radiology tests when you are treated in hospital.
CONTACT US

General queries
Email service@discovery.co.za
Website www.lahealth.co.za
Sharecall 0860 103 933

Physical addresses:
**Cape Town:**
Knowledge Park, Heron Crescent, Century City

**Johannesburg:**
16 Fredman Drive, Sandton

**Durban:**
41 Imvubu Park Place, Riverhorse Valley Business Estate, Nandi Drive

**Centurion:**
Corner of Oak and Tegel Avenues, Highveld Techno Park

**Port Elizabeth:**
Discovery, BPO Building, Coega IDZ – Zone 4

Ambulance and other emergency services
0860 999 911 or Discovery 911

Discovery Mobile
SMS the keyword to 31347

Send your claims
Email claims@discovery.co.za
Fax 0860 329 252
Post PO Box 652509, Benmore 2010
or Postnet Suite 116, Private Bag X19, Milnerton 7435

Hand drop your claim in any blue Discovery claims box

To confirm your benefits for a hospital stay
Email preauthorisations@discovery.co.za
Call 0860 103 933

To arrange approval for your chronic medicine
Call 0860 103 933

For anonymous fraud tips
Fraud hotline 0800 004 500

Extra services
Oncology service centre 0860 103 933
HIVCare Programme 0860 103 933
Internet queries 0860 103 933
LA Health Medical Scheme. Registration number 1145. Administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07.
An authorised financial services provider.