YOUR BENEFITS 2013

LA Health
Powered by Discovery

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.

CONTENTS

An introduction to LA Health's Benefit Options

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**
  - Major Medical Benefit for limited dental care;
  - 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).

LA Health
Powered by Discovery

MEDICAL EMERGENCIES

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

MAJOR MEDICAL BENEFIT

LA Health
Powered by
Discovery

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.

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

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

LA 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

LA 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

LA 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

LA Core

- **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

LA 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.

LA Health
Powered by Discovery

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

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

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

- Ankylosing spondylitis
- Arthritis
- Attention deficit disorder (hyperactivity) *(specialist must motivate)*
- Benign prostatic hypertrophy *(urologist must motivate)*
- Chronic urticaria *(dermatologist must motivate)*
- Conn's syndrome
- Cystic fibrosis
- Depression *(according to the depression rating scale)*
- Eczema (only if severe) *(dermatologist must motivate)*
- Gastro-oesophageal reflux disease *(gastroenterologist or surgeon must confirm)*
- Gout *(uric acid level must be tested and physician must motivate)*
- Ménière's disease
- Migraine *(physician must motivate)*
- Motor neuron disease
- Myasthenia gravis
- Narcolepsy (motivated by physician)
- Osteoporosis *(only if confirmed by industry standard BMD readings)*
- Paget's disease
- Psoriasis (only if severe) *(dermatologist must motivate)*
- Scleroderma and other collagen-vascular diseases
- Trigeminal neuralgia
- Urinary incontinence
- Zollinger Ellison syndrome

THE ONCOLOGY PROGRAMME

The Oncology Programme

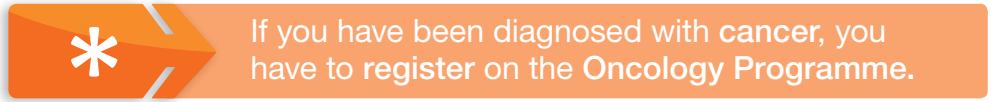
LA Health has a special cancer programme known as the Oncology Programme. This programme helps members who have cancer. If you have been diagnosed with cancer, you should register for this programme to get the most out of your benefits.

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.



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.

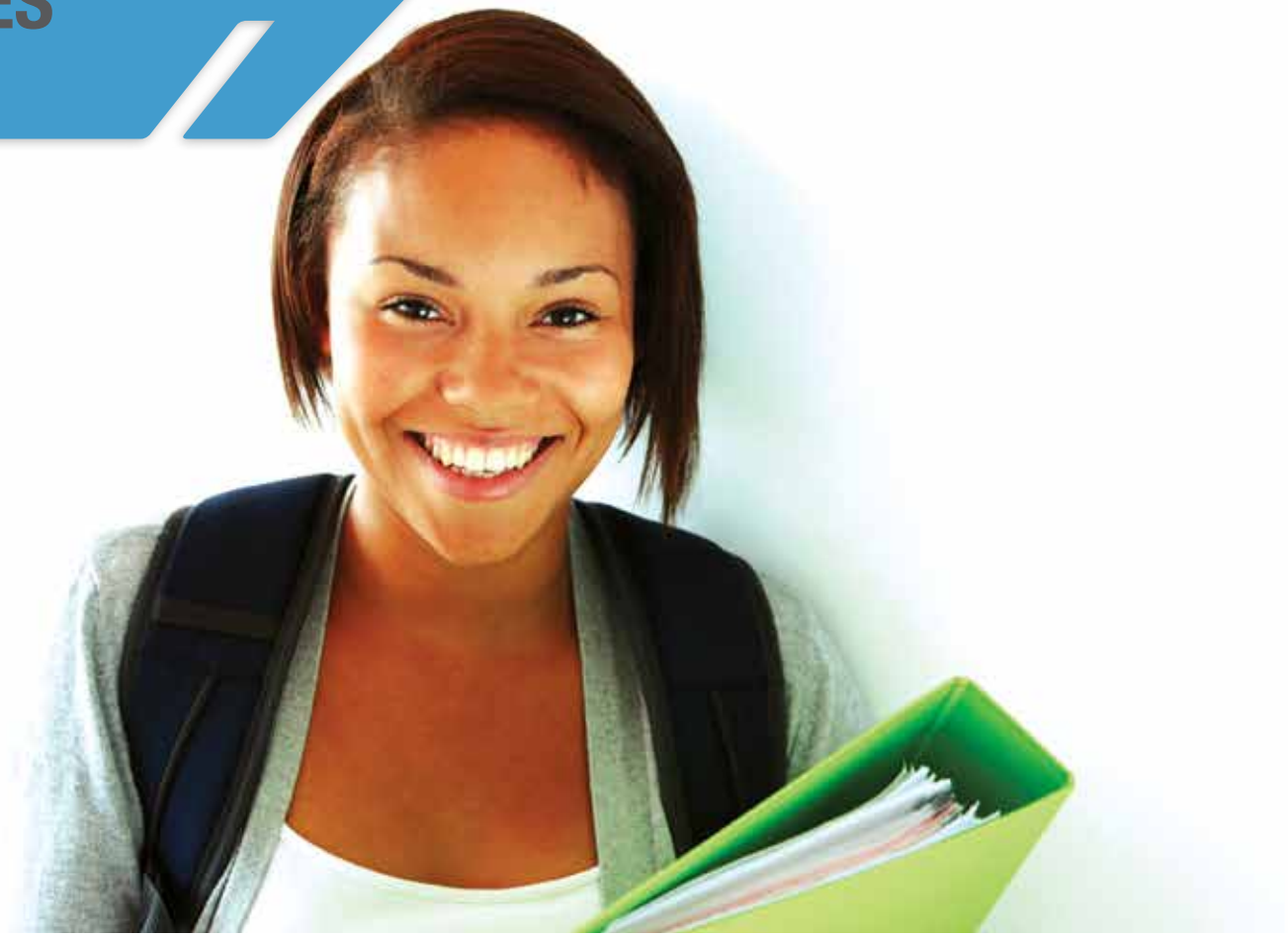
Stem cell transplants

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.

LA Health
Powered by
Discovery

DAILY MEDICAL EXPENSES



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.

BENEFIT OPTIONS COMPARISON

LA Health
Powered by Discovery

KeyPlus

This Option has a Major Medical Benefit for in-hospital treatment and cover for high-cost care, Prescribed Minimum Benefit chronic medicine benefits and covers certain day-to-day medical benefits. It has a Designated Service Provider for in-hospital and out of hospital benefits in the KeyCare network. If a KeyCare hospital is not used for non-emergency Prescribed Minimum Benefit and other procedures, no benefit will be payable. All major treatments, especially if provided in hospital, must be preauthorised.

Overall annual limits	
Hospital	No overall limit applies at KeyCare network hospitals
Ambulance services (member must call Discovery 911 for authorisation)	
Emergency transport	Paid from Major Medical Benefit. No overall limit applies
Blood transfusions and blood products	
Blood transfusions and blood products	Paid from Major Medical Benefit. No overall limit applies
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 applies
Basic dentistry out of hospital	Covered with no overall benefit limit, subject to a list of procedures performed by a dentist in the KeyCare network
GPs and specialists	
In-hospital visits	No overall limit applies at a network hospital. Specialists must be working in a KeyCare hospital
Out-of-hospital GP visits	Covered with no overall benefit limit, only at the member's chosen GP working in the Designated Service Provider network
Out-of-hospital specialist visits	Limited to R2 550 per person, only if referred by the chosen KeyCare GP (including radiology and pathology done in the KeyCare network)
Out-of-network benefit	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
HIV and AIDS	
HIV prophylaxis (rape or mother-to-child transmission)	Paid from Major Medical Benefit, with no overall limit
HIV and AIDS-related illnesses	No overall limit, subject to clinical entry criteria and certain 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 and state hospitals	No overall limit applies, subject to clinical entry criteria and certain protocols
Private hospitals	Paid from Major Medical Benefit for treatment authorised in a KeyCare Network hospital. No benefit outside of the network for planned admissions
Casualty outpatient benefit	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

Maternity Benefit	
In hospital	
Baths for use during water births	Limited to R1000 per bath per pregnancy
Out of hospital GP and specialist consultations	No overall limit applies at GP working in the KeyCare network. Four gynaecology specialist visits per person per year, subject to the Specialist Benefit of R2 550 per person
Pregnancy scans	One 2D scan per person per pregnancy
Blood tests	Selected blood tests per pregnancy (must be requested by the chosen KeyCare GP)
Medicine	
Prescribed Minimum Benefit Chronic Disease List conditions, subject to approval of your condition and certain clinical criteria	All Prescribed Minimum Benefit Chronic Disease List conditions covered based on a formulary if prescribed by the member's chosen KeyCare GP. The Scheme's Designated Service Provider courier pharmacy must be used. If not, a co-payment applies
Prescribed/acute medicine	Covered with no overall limit from Designated Service Provider. Prescribed medicine only for acute and non-Prescribed Minimum Benefits chronic conditions, subject to a formulary and only covered if prescribed by the member's chosen GP working in the KeyCare network
Take-home medicine (when discharged from hospital)	Limited to R100 per person per event
Mental health	
In hospital: Psychiatric hospitals, subject to preauthorisation and case management	21 days per person, paid from Major Medical Benefit
Out of hospital: Psychiatrists only	Covered subject to the R2 550 Specialist Benefit limit per person
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	Unlimited. Only in a state hospital, subject to strict clinical entry criteria and preauthorisation
Medicine for immuno-suppressive therapy	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	Covered by Specialist Benefit up to the R2 550 limit
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 Schemes 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

Income	Member	Adult	Child dependant	Maximum for child dependants
R0 – R6 300	R 740	R 646	R271	R 813
R6 301 – R8 500	R 781	R 683	R285	R 855
R8 501+	R1 176	R 1046	R439	R1 317

LA Focus

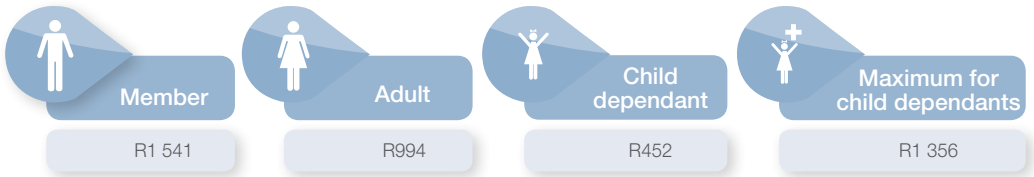
This Option has a Major Medical Benefit for in-hospital treatment and cover for high-cost care and provides Prescribed Minimum Benefit Chronic Disease List cover. It pays for some day-to-day expenses from a Medical Savings Account. This Option provides cover specifically for members in a province with 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			
Hospital	No overall limit applies. Members must use hospitals in coastal provinces		
Medical Savings Account	Member R4 620	Spouse/adult R2 976	Child R1 356
Ambulance services (members must call Discovery 911 for authorisation)			
Emergency transport	Paid from Major Medical Benefit. No overall limit		
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 is paid from Medical Savings Account and the rest if the account paid from Major Medical Benefit. All related, non-hospital accounts paid from and limited to funds in the Medical Savings Account. All dental costs subject to overall dental limit of R16 100 per person		
Basic dentistry out of hospital	Paid from and limited to funds in Medical Savings Account, subject to the joint overall dental limit of R16 100 per person per year		
GPs and specialists			
In-hospital visits	Paid at 150% of the LA Health Rate. No overall limit		
Out of hospital GP and specialist visits	Paid from Medical Savings Account		
HIV and AIDS			
HIV prophylaxis (rape or mother-to-child transmission)	Paid from Major Medical Benefit. No overall limit, subject to clinical entry criteria and certain protocols		
HIV and AIDS-related illnesses	Unlimited, subject to 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 coastal hospital (full cover only at hospitals in coastal provinces)	No overall limit, subject to preauthorisation		

Maternity Benefit	
In hospital, subject to preauthorisation	No overall limit. Related accounts paid at 150% of the LA Health Rate
Out of hospital, GP and specialist consultations, pregnancy scans, blood tests and antenatal classes	Limited to funds in Medical Savings Account
Medicine	
Prescribed Minimum Benefit Chronic Disease List conditions	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
Prescribed/acute medicine	Paid from and limited to funds in the Medical Savings Account 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 up to 100% of the cost
Take-home medicine (when discharged from hospital) TTOs	Limited to funds in the Medical Savings Account and paid at 90% of the LA Health Medicine Rate
Mental health	
Psychiatric hospitals, subject to preauthorisation and case management	21 days per person, paid from Major Medical Benefit
Out of hospital Psychologists, psychiatrists, art therapy and social workers; alcohol and drug rehabilitation	Limited to funds in the Medical Savings Account
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 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
PET scans	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
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
Spectacles, frames, contact lenses and refractive eye surgery	
Other services	
Auxilliary services (physiotherapy, occupational therapy, homeopaths, audiologists, psychologists, etc)	Limited to funds in the Medical Savings Account
Alternative healthcare practitioners (chiropody, homeopaths, naturopaths and chiropractors)	
Nurse practitioners	
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
X-rays and pathology	
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	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
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
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



LA Active

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			
Hospital	No overall limit		
Insured Procedures Benefit	Member R3 168	Spouse/adult R2 220	Child R624
Medical Savings Account	Member R4 284	Spouse/adult R3 120	Child R1 800

Ambulance services (member must call Discovery 911 for authorisation)	
Emergency transport	Paid from Major Medical Benefit. No overall limit

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 repair	Paid from Major Medical Benefit. No overall limit
Specialised dentistry in hospital	First R1 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 R2 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	
In-hospital visits	No overall limit
Out of hospital GP and specialist visits	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 HIVCare Programme protocols
HIV and AIDS-related medicine	Covered with no overall limit from the Scheme's Designated Service Provider

Hospitals (all planned procedures must be preauthorised)	
Hospitalisation, theatre fees, intensive and high care unit costs	
Provincial, state and private hospitals	Subject to preauthorisation. No overall limit

Maternity Benefit	
In hospital	No overall limit
Out of hospital – GP, specialist consultations and blood tests	Limited to funds in Medical Savings Account or Insured Procedures Benefit
Ultrasounds	Limited to funds in Medical Savings Account, except for Prescribed Minimum Benefits
Blood tests	Limited to funds in Medical Savings Account or Insured Procedures Benefit
Antenatal classes	Limited to funds in Medical Savings Account

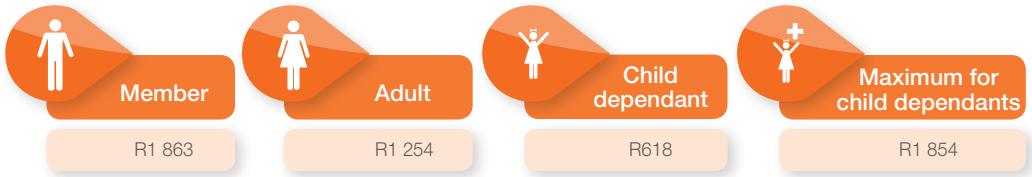
Medicine	
Prescribed Minimum Benefit Chronic Disease List conditions	All Prescribed Minimum Benefit Chronic Disease List conditions covered from Major Medical Benefit based on a formulary and subject to approval. The Scheme pays up to a Chronic Drug Amount amount if non-formulary medicine is used
Prescribed/acute 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 (schedule 0,1 and 2 and generic or non-generic, whether prescribed or not) at a pharmacy	Limited to funds in Medical Savings Account or Insured Procedures Benefit up to 100% of the cost
Take-home medicine (When discharged from hospital) TTO's	Limited to funds in the Medical Savings Account or Insured Procedures 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
Out of hospital Psychologists, psychiatrists, art therapy and social workers; alcohol and drug rehabilitation	Limited to funds in the Medical Savings Account

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 R228 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. 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
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 Insured Procedures Benefit
Spectacles, frames, contact lenses and refractive eye surgery	
Other serivices	
Auxilliary services (physiotherapy, occupational therapy, homeopaths, audiologists, psychologists, etc)	Limited to funds in the Medical Savings Account
Alternative healthcare practitioners (chiropody, homeopaths, naturopaths, and chiropractors)	
Nursing practitioners	
Organ transplants	
Hospitalisation and harvesting of organ for donor transplants	No overall limit. Subject to preauthorisation
Harvesting of organ for transplant	
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); ultrasounds, x-rays, pathology	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 or Insured Procedures Benefit
Out of 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 scope account paid from Major Medical Benefit.
Radiology (including x-rays and ultrasounds) and pathology	Paid from Medical Savings Account or Insured Procedures Benefit
Endoscopic procedures: gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy	First R950 of account paid from Medical Savings Account. Remainder of scope 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
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
Other internal prostheses	Paid from Major Medical Benefit, subject to preauthorisation and clinical protocols
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 Schemes 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.
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
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 R28 550 per person per year from Major Medical Benefit

Total monthly contributions, including your Medical Savings Account for 2013



LA Core

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

Hospital	No overall limit		
Insured Procedures Benefit	Member R4 212	Spouse/adult R2 928	Child R1 116
Medical Savings Account	Member R5 544	Spouse/adult R4 848	Child R2 244

Ambulance services (members must call Discovery 911 for authorisation)

Emergency transport	Paid from Major Medical Benefit. No overall limit

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 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 GP and specialist visits	Paid from Medical Savings Account or Insured Procedures Benefit

HIV and AIDS

HIV prophylaxis (rape or mother-to-child transmission), subject to preauthorisation	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 GP and specialist consultations and blood tests	Limited to funds in Medical Savings Account or Insured Procedures Benefit
Antenatal classes and ultrasounds	Limited to funds in Medical Savings Account

Medicine

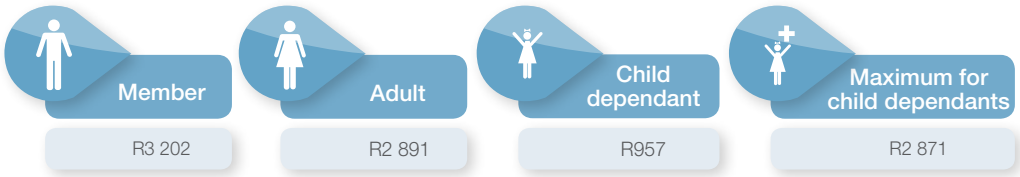
Prescribed Minimum Benefit Chronic Disease List conditions	All Prescribed Minimum Benefit Chronic Disease List conditions covered based on a formulary and subject to approval. The Scheme pays up to a Chronic Drug Amount amount if non-formulary medicine is used
Additional Chronic Conditions (subject to approval)	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 100% of the cost
Take-home medicine (When discharged from hospital) TTO's	Limited to funds in the Medical Savings Account or Insured Procedures Benefit and paid at 90% of the LA Health Medicine Rate

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
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	
Auxilliary services (physiotherapy, occupational therapy, homeopaths, audiologists, psychologists, etc)	Limited to funds in the Medical Savings Account
Alternative healthcare practitioners (chiropody, homeopaths, naturopaths and chiropractors)	
Nurse practitioners	
Organ transplants	
Hospitalisation and harvesting of organ for transplant	No overall limit. Subject to preauthorisation
Medicine for immuno-suppressive therapy	As per Chronic Illness Benefit Chronic Drug Amount
Pathology and radiology	
In hospital	
MRI and CT scans (referred by a specialist); ultrasounds and x-rays and pathology	Paid from Major Medical Benefit. No overall limit
Endoscopic procedures: gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy (including hospital and related accounts, if done in hospital)	
Out of hospital	
MRI and CT scans	Paid from Major Medical Benefit. No overall limit
Endoscopic procedures: gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy	
Radiology (including x-rays and ultrasounds) and pathology	Paid from Medical Savings Account or Insured Procedures 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
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
Other internal prostheses	Paid from Major Medical Benefit subject to preauthorisation and clinical protocols
External medical items	
Crutches, wheelchairs, hearing aids, artificial limbs, stoma bags, etc	Limited to funds in the Medical Savings Account
Oxygen rental	Covered in full at the Schemes 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
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



LA Comprehensive

This Option has a Major Medical Benefit with no overall annual limit for in-hospital treatment and high-cost expenses. It provides cover for the Prescribed Minimum Benefit Chronic Disease List as well as for Additional Chronic conditions. It pays for day-to-day expenses from a Medical Savings Account, with further cover through the Above Threshold Benefit, subject to specific limits. All major treatments, especially if provided in hospital, must be preauthorised.

Overall limits

Hospital	No overall limit		
Above Threshold	Member R11 005	Spouse/adult R7 505	Child R3 305
Medical Savings Account	Member R6 732	Spouse/adult R3 912	Child R1 716

Ambulance services (members must call Discovery 911 for authorisation)

Emergency transport	Paid from Major Medical Benefit. No overall limit

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 Benefitt. 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 orAbove Threshold 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 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	
Provincial, state and private hospitals	Subject to preauthorisation. No overall limit

Maternity Benefit

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

Medicine

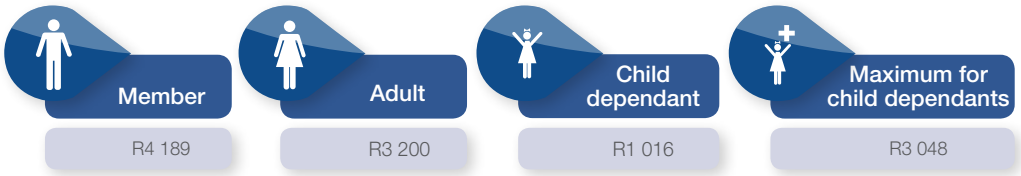
Prescribed Minimum Benefit Chronic Disease List conditions	All Prescribed Minimum Benefit Chronic Disease List conditions covered based on a formulary and subject to approval. The Scheme pays up to a Chronic Drug Amount amount if non-formulary medicine is used
Additional Chronic Conditions (subject to approval)	Paid at 90% of the LA Health Medicine Rate Limited to: Member R3 575 / Member +1 R7 200 / Member +2 R8 335 / Member +3 R9 470 / Member +4 R10 265 / Member +5+ R11 285
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
Prescribed/acute medicine	Paid at 90% of the LA Health Medicine Rate from MSA/ATB Limited to: Member R6 695 / Member +1 R8 565 / Member +2 R10 320 / Member +3 R11 910 / Member +4 R13 610
Medicine bought over-the-counter (schedule 0,1 and 2 and generic or non-generic, whether prescribed or not)	Limited to funds in Medical Savings Account up to 100% of the cost
Take-home medicine (When discharged from hospital) TTO's	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
Out of hospital Psychologists, psychiatrists, art therapy and social workers; alcohol and drug rehabilitation	Paid from 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 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
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	
Auxilliary services (physiotherapy, occupational therapy, homeopaths, audiologists, psychologists, etc).	Limited to funds in the Medical Savings Account or Above Threshold Benefit
Alternative healthcare practitioners (chiropody, homeopaths, naturopaths, and chiropractors)	
Nurse practitioners	Paid up to a limit of R7 500 per family from Medical Savings Account or Above Threshold Benefit
Organ transplants	
Hospitalisation and harvesting of organ transplant	No overall limit. Subject to preauthorisation
Medicine for immuno-suppressive therapy	As per Chronic Illness Benefit Chronic Drug Amount
Pathology and radiology	
In hospital	
MRI and CT scans (these must be referred by a specialist), x-rays, pathology and ultrasounds	Paid from Major Medical Benefit. No overall limit
Endoscopic procedures: gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy (including hospital and related accounts, if done in hospital)	
Out of hospital	
MRI and CT scans	Paid from Major Medical Benefit. No overall limit
Radiology, including x-rays and ultrasounds and pathology	Paid from Medical Savings Account or Above Threshold Benefit
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 R155 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
Other internal prostheses	Paid from Major Medical Benefit, subject to preauthorisation and clinical protocols
External medical items	
Crutches, wheelchairs, hearing aids, artificial limbs, stoma bags, etc	Limited to R19 550 per family with a sub-limit of R13 050 per family for hearing aids from Medical Savings Account or Above Threshold Benefit
Oxygen rental	Covered in full at the Schemes 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
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



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
- Search and rescue
- 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.

LA Health
Powered by Discovery

A GUIDE TO...

A quick guide to

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.

When your doctor completed the form	When cover will start
Less than three months ago	From the date the doctor completed the form
A month or more before you joined the Scheme	From the day you join the Scheme
More than three months after you filled in the form	The date we got the form

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 you 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 your personal file with your doctor to make sure all your details are up to date.
- 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.
- Send us a detailed claim and not just a receipt. We need the details so we can process your claim.
- 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:

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.

Disputes process

1. Member informs the Principal Officer that he is lodging a dispute and the Principal Officer calls together the Scheme's Independent Disputes Committee.
2. Any decision that is related to the matter under dispute, taken up to this stage will be suspended, pending the decision of the Disputes Commmitee.
3. The disputes committee consists of independent experts that are appointed by the Annual General Meeting. Their decision is binding on 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**

LA Health
Powered by Discovery

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.

Quick A to Z

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
HIV*Care* Programme	0860 103 933
Internet queries	0860 103 933

Notes

Notes

Notes

Notes

Client Services 0860 103 933
Fax 011 539 7276
www.lahealth.co.za
service@discovery.co.za

LA Health
Powered by
Discovery

GM_17809DLA_23/10/12