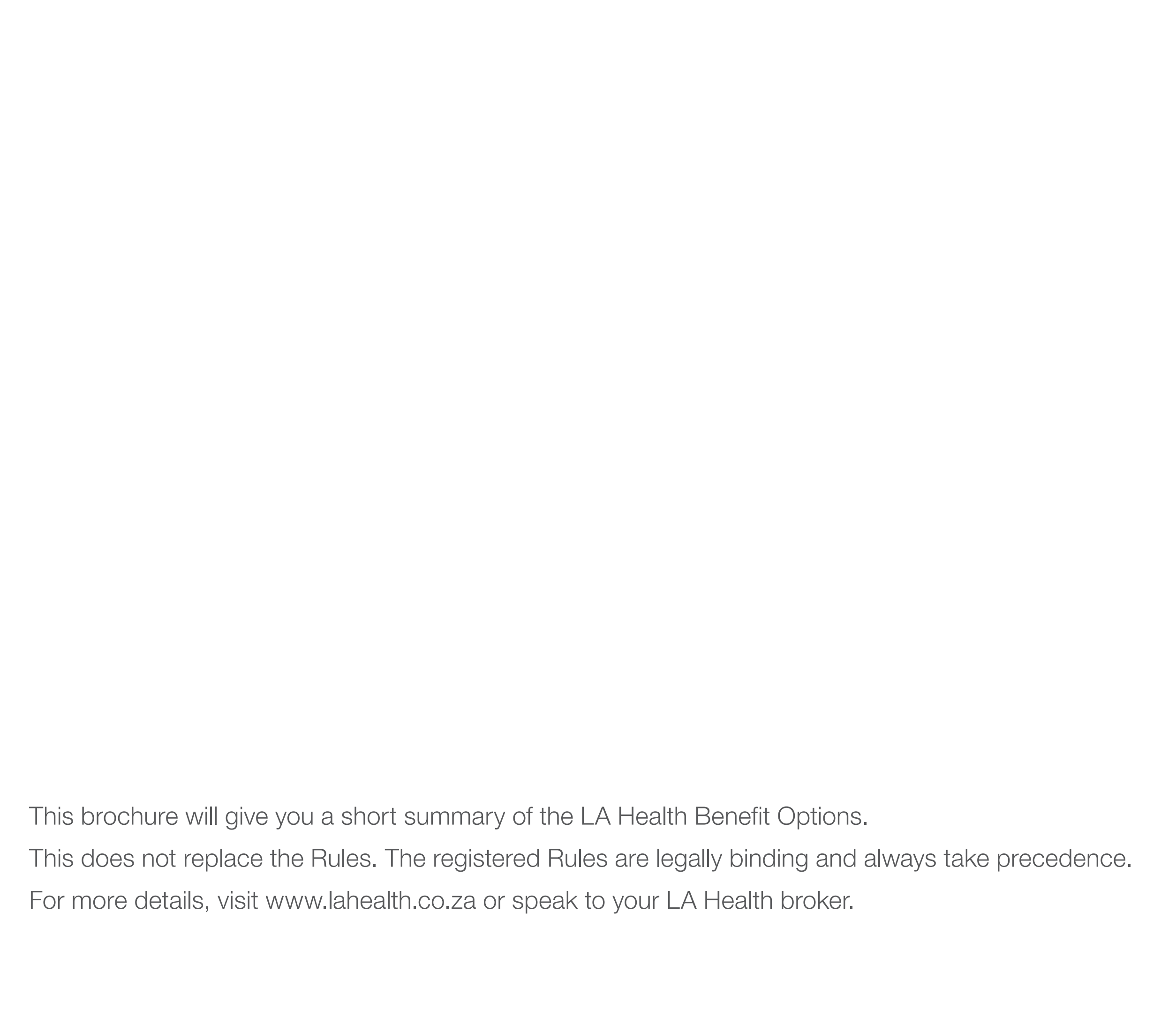
YOUR BENEFITS 2014



This brochure will give you a short summary of the LA Health Benefit Options.

This does not replace the Rules. The registered Rules are legally binding and always take precedence.

For more details, visit www.lahealth.co.za or speak to your LA Health broker.

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As a member of LA Health Medical Scheme, you have support in being able to afford the healthcare that you and your family need. However, there are limits to how much the medical scheme will pay out and what it will pay for. This booklet tells you about your medical cover. If you need more detail, please let us know.

If you need to talk to us

Phone 0860 103 933

Email: service@discovery.co.za

For emergency treatment, phone 0860 999 911 or Discovery 911

To get started on our website, visit www.lahealth.co.za and click register.

Five steps to make the most of LA Health

1. Contact us well before you have to go to hospital.
2. Use a doctor, hospital or healthcare provider that has an agreement with the Scheme to ensure your claims will be paid in full.
3. Ask your doctor to prescribe the most cost-effective medicine possible.
4. Look after yourself – eat well, exercise and have all the medical tests and vaccinations that your doctor recommends (for example, women over 40 years old should have a yearly mammogram).
5. Send us all your claims, even for items that we will not pay for.

Medical emergencies

If you are in a life-threatening medical emergency, phone 0860 999 911 or Discovery 911 immediately. We will send an ambulance (ER 24) and you will be taken to hospital if you need to be admitted.

Hospital stays

Speak to us about your hospital stay as soon as you can

If your doctor plans to admit you into hospital, please take these five steps:

1. Ask for the names of the healthcare practitioners (for example, doctors, specialists or surgeons) that will look after you when you are in hospital and ask which hospital your doctor recommends.
2. Check if your Benefit Option covers the condition, the treatment, the healthcare professional and the hospital. Your might have to go to another healthcare practitioner or hospital to get the most cover possible. Contact us if you are unsure.
3. Get authorisation from LA Health. Phone 0860 103 933 as soon as you can, but at least 48 hours before you go to hospital.
4. We will review the details, tell you what we will and will not pay for, and give you an authorisation number.
5. Take the authorisation number and your LA Health membership card with you when you go to hospital.

Going to hospital is stressful – if yours is a planned procedure, contact us well in advance so that you can rest assured that you understand your cover. It'll be one less thing to worry about.

If it is an emergency admission, please ensure you, a family member or the hospital, let us know as soon as possible.

Doctor visits, medicines and tests

Read the section of this booklet that applies to your Benefit Option to find out what your Benefit Option covers. Make sure you have chosen a healthcare practitioner that we provide cover for.

Getting treatment for a chronic condition

You must apply for cover for treatment for a chronic condition – read more about this in the section that explains how your benefits work and in the section about the Chronic Illness Benefit.

Manage treatment for cancer, HIV or AIDS

Join our special programmes for these conditions so that we can work with you to manage your treatment and recovery. You can read more about it in the Benefits section of this booklet.

Claiming

Send us your claims within three months of the treatment. You can email claims@discovery.co.za or fax 0860 329 252. The process is explained in the How to claim section of this booklet.

You are a member of LA Health Medical Scheme

You have received this booklet because you are a member of LA Health Medical Scheme.

LA Health Medical Scheme is the largest restricted medical scheme in Local Government, providing cover for more than 110 000 Local Government members and their families.

Not anyone can join LA Health. Only Local Government employees and employees affiliated through their employment or other relevant links to that industry, can belong to the Scheme.

Members pay contributions into the Scheme

Each member pays an amount of money (called a contribution) every month. All contributions are paid into the Scheme, which is a pool of money that is jointly owned by its members and governed by elected trustees. This money is used to pay for medical expenses and by law, it may not be used for any other purpose.

A "contribution" is the amount that members pay into the Scheme each month. Your contribution is added to contributions from all other members to form a pool of money. The Scheme uses the money to pay out claims – in a fair and consistent way.

The Scheme pays for members' medical expenses according to a set of Rules

By putting everyone's money together, medical schemes help to make private healthcare cover accessible for everyone who can afford to pay the monthly contributions.

Medical schemes are strictly regulated in an effort to ensure there is always enough money in the medical scheme to pay for members' claims. The Rules set out which medical expenses the Scheme will pay for. LA Health has an important responsibility to treat all members equally and to be consistent in which claims it will pay for and which claims it will not pay for.

This booklet gives a summary of the Scheme Rules. If you need more information, email service@discovery.co.za or call 0860 103 933. If anything in this booklet differs from the rules of the Scheme, the rules of the Scheme apply.

How to use this booklet

Part A of this booklet gives you general information about each Benefit Option.

Part B tells you about how we pay for your claims. Depending on your Benefit Option, we pay from a set of benefits. We pay

- for hospital, other major costs or for Prescribed Minimum Benefits from the Major Medical Benefit; and
- day-to-day medical expenses from the Medical Savings Account, the Extended Day-to-day Benefit or the Above Threshold Benefit on some of the Options.
- day-to-day benefits for LA KeyPlus from the Major Medical Benefit.

Part C gives instructions on how to claim and how to manage your membership.

Part D of this booklet gives detailed tables that show what is covered by each Benefit Option. Use this part if you want to compare Benefit Options.

How your benefit works

When you become a LA Health member, you choose a Benefit Option (LA KeyPlus, LA Focus, LA Active, LA Core or LA Comprehensive). When you use this guide, you must make sure that you are reading the information that applies to your Benefit Option.

If you cannot remember, you can find out which Benefit Option you have, by reading your welcome letter (if you are a new member) or by reading the letter sent to you at year end. Each Benefit Option has different Rules – so what is paid for under one Benefit Option might not be paid for under another one.

LA KeyPlus

LA KeyPlus covers hospital treatment (you must use only specific hospitals), other large medical costs, visits to the doctor that you have chosen, and a limited set of chronic conditions. You only have benefits for treatment that is given in South Africa.

Hospital stays

We pay for treatment at private hospitals in the Key Care network (network hospitals). We also cover treatment in public or state hospitals.

These are paid from the Major Medical Benefit. You can read more about it in the "About each Benefit Option" section of this booklet.

You can find out about your nearest KeyCare Hospital at www.lahealth.co.za or by calling us on 0860 103 933. If you do not use the network or state hospitals for your planned treatment, certain deductibles will apply.

If your procedure is planned, you must contact us before you are admitted into hospital. If you do not contact us at least 48 hours before you are admitted to hospital, we will not pay any of the costs.

Operations and procedures only covered in day-care facilities

If you need any of the following procedures, we only cover you in a day-care facility. We will not cover a stay in hospital.

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. (Nasal plugging and nasal cautery)
Diagnostic D & C	Tonsillectomy
Gastroscopy and Sigmoidoscopy	Treatment of Bartholin's gland cyst/ abscess
Hysteroscopy	Vasectomy
Myringotomy	Vulva biopsy/cone biopsy

Chronic conditions (Prescribed Minimum Benefit)

There is a standard list of Prescribed Minimum Benefit chronic conditions that we cover treatment for. You can find the list of conditions in the "About each Benefit Option" section of this booklet.

We will give you access to this benefit by authorising your medicine based on certain clinical criteria.

Day-to-day medical expenses

We pay for:

- Day-to-day (out-of-hospital) visits to the doctor(s) you chose as your Designated Service Provider(s). We cover one visit to a GP that is not in the network each year.
- Visits to specialists are covered if your chosen GP has referred you to that specialist and there is a limit.
- Medicine, if your doctor or specialist prescribes it, only up to the LA Health Medicine Rate. You will have to pay the difference between the LA Health Medicine Rate and the cost of the medicine, if there is any.
- Radiology or pathology tests and procedures done, or required by one of the LA KeyPlus doctors, if it is on the LA KeyPlus list. You have to pay for procedures and medicines that are not on the LA KeyPlus list or are done at healthcare providers that are not in the network. Your KeyPlus doctor has the list of procedures.
  If a specialist requests tests and procedures, the costs will be covered from, and be limited to, the specialist benefit limit.
- Eye care. We cover one consultation for each person each year at an optometrist in the KeyCare network, and one pair of glasses or contact lenses every 24 months.
- Certain external medical items such as wheelchairs or calipers, that help you to be mobile, are covered up to a limit.
- Dentistry is paid if your dentist is on the KeyCare network of dentists and when that dentist performs procedures that are on the LA KeyPlus list. Your dentist has this list.
- Prevention is better than cure and we pay for certain screening tests or a flu vaccination if it is done at one of the Scheme's network pharmacies.

Maternity

When you are pregnant, we will pay for your care from the day-to-day benefits. As long as you use the services of your GP in the KeyCare network and the other providers that have agreements with the Scheme, you will not have to make any co-payments. Your visits to your chosen GP are unlimited.

We will also pay for four visits to a gynaecologist from your specialist benefit. This benefit is limited.

You can have one 2D scan per pregnancy and we also pay for specific blood tests when it is requested by your KeyCare GP.

You will not have any co-payments if you go to a KeyCare network hospital and use the services of specialists working at the KeyCare hospital or those of your KeyCare GP. We also pay for baths used during water births, up to a limit.

Recovering from a trauma

When we have authorised it, we cover some medical expenses if you or your family experience serious trauma, for specific events. The benefit is paid up to the end of the year following the one in which the traumatic event occurred. We cover the following items: Prescribed medicines (schedule 3 to 7); visits to psychiatrists or psychologists, private nursing, hearing aids, other external appliances and prosthetic limbs.

Note that specific limits apply to these benefits, when you are recovering from a trauma.

Cancer, HIV or AIDS

Cancer

We have a special Oncology Programme and it is very important that you contact us before you have treatment for cancer.

On LA KeyPlus we only cover the treatment for the kinds of cancer that are listed as Prescribed Minimum Benefits. This means we only cover some types of the chemotherapy and radiotherapy. Your oncologist must be on the KeyCare network.

When you call us to get authorisation, we will give you advice and tell you which oncologists are on the network in your area.

HIV or AIDS

We pay for treatment and medicine related to HIV or Aids. You must go to one of the doctors in the KeyCare network and you must get the medicine from one of the Scheme's Designated Service Provider pharmacies.

Which healthcare providers to use for LA KeyPlus

Use the following healthcare providers.

- Any provider in the public or state sector
- Hospitals in the KeyCare Network (contact us for the list)
- SANCA, Nishtara and RAMOT for all alcohol and drug rehabilitation services
- The KeyCare GP Network
- Pharmacies dispensing at the LA Health Medicine Rate. You must use specific pharmacies for HIV or AIDS medicine
- National Renal Care for dialysis and all renal care (a co-payment will apply at other providers)
- VitalAire for oxygen rental. Covered in full at VitalAire, subject to pre authorisation
- Cancer treatment through providers that we have authorised
- Authorised providers of transplantation services
- Stents and prosthetics through providers that we have authorised

If you use healthcare providers that do not have agreements with the Scheme, you may have to pay more out of your own pocket, or we will not pay for the care you received.

What we do not cover on LA KeyPlus:

There are conditions and treatments that are not covered by the Scheme. These general exclusions are listed in the Benefits section (What we do not cover – exclusions) of this booklet. They also apply to you.

Below are some of the conditions and treatments that we specifically do not cover for LA KeyPlus members.

- In-hospital management of:
  - Dentistry
  - Skin disorders
  - Conservative back treatment
  - Obesity
  - Diagnostic work-up and investigative procedures
  - Sexual dysfunction
  - Incontinence
  - Hearing disorders
  - Functional and nasal surgery
- Refractive eye surgery
- Brachytherapy for prostate cancer
- Surgery for oesophageal reflux, hiatus hernia repair and nissen fundoplication
- 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 outside of the South African borders
- Elective caesarian section
- Arthroscopies
- Bunionectomy
- Removal of varicose veins

Note that, in some cases, you might be covered for these conditions if they are part of Prescribed Minimum Benefits. Please contact us if you have one of the conditions, so we can let you know if there is any cover.

LA Focus

LA Focus provides benefits nationally, across all the Provinces in South Africa. LA Focus covers hospital treatment in a network of hospitals (all coastal hospitals and specific hospitals in Provinces without a coastline) and other large medical costs from the major medical benefit. All day-to-day benefits are covered from the medical savings account, a set amount which is based on the size and composition of the member's family.

The benefit option provides cover for PMB chronic conditions.

Hospital stays

We pay for treatment at any private hospital in a coastal province and at specific hospitals in the other provinces in South Africa. Go to www.lahealth.co.za for a list of these hospitals or call us at 0860 103 933 to find out about your nearest network hospital. We also cover treatment in public or state hospitals. This is paid from the Major Medical Benefit up to 100% of the LA Health Rate.

You must contact us before you are admitted into hospital. If you do not contact us at least 48 hours before you are admitted to hospital, or if you do not use one of the network hospitals for a planned procedure, you will have to pay some of the costs out of your own pocket (a deductible).

Day-to-day medical expenses

All day-to-day medical expenses, for example, visits to doctors are paid from your Medical Savings Account, which is limited. We will pay all claims up to 100% of the LA Health Rate.

You must pay out of your own pocket if you have used all your Medical Savings Account. We will not pay any deductibles from your Medical Savings Account.

Claims paid from your Medical Savings Account can either be paid at the Scheme Rate, or you can instruct the Scheme that it should be paid at cost.

If you choose payment at the LA Health Rate and your provider charges more than that Rate, you will have to pay the difference from your own pocket.

Chronic illness benefits

You have benefits for the Prescribed Minimum Benefits list of chronic illnesses, including the treatment and care associated with these diseases. Please see the Benefits section of this booklet for more details about the Scheme's Chronic Illness Benefits.

Cancer, HIV or Aids

Cancer

We have a special Oncology Programme and it is very important that you contact us before you have treatment for cancer. You can read more about this Programme in the Benefits section of this booklet.

HIV or AIDS

We have a special HIVCare Programme and it is very important that you contact us before you use your HIV or AIDS benefits. You can read more about this Programme in the Benefits section of this booklet.

Recovering from a trauma

When we have authorised it, we cover some medical expenses if you or your family experience serious trauma, for specific events. The benefit is paid up to the end of the year following the one in which the traumatic event occurred. You can read more about this in the Benefits section of this booklet.

Which healthcare providers to use for LA Focus

To make the best use of your Option, you should use the Scheme's Designated Service Providers or the Preferred Providers. If you do not, you will have to pay more out of your own pocket.

We have included a list of these providers in the Benefits section of this booklet.

What we do not cover on LA Focus

There are conditions and treatments that are not covered by the Scheme. These general exclusions are listed in the Benefits section (What we do not cover – exclusions) of this booklet. They also apply to you.

LA Active

LA Active covers hospital treatment at any private hospital, and other large medical costs from the Major Medical Benefit. It also pays for treatment in State Hospitals.

You first have cover for day-to-day medical expenses, for example the cost of visiting a doctor, from the Medical Savings Account and then from the Extended Day-to-day Benefit (previously known as the Insured Procedures Benefit).

The day-to-day benefit limits for the Medical Savings Account and the Extended Day-to-day Benefit are based on the size and composition of your family.

The Benefit Option provides cover for PMB chronic conditions.

Hospital stays

We pay for treatment at any private, public or state hospital from the Major Medical Benefit, up to 100% of the LA Health Rate.

You must contact us before you are admitted into hospital for a planned procedure. If you do not contact us at least 48 hours before you are admitted to hospital, you will have to pay a portion of the amount out of your own pocket (a deductible).

In the case of an emergency, you or the hospital must contact us as soon as possible once you are admitted to hospital.

Day-to-day medical expenses

This benefit option provides day-to-day benefits from the Major Medical Benefit, the Medical Savings Account and the Extended Day-to-day Benefit.

The Scheme first pays basic dentistry from the Major Medical Benefit up to a specific limit.

Current year Medical Savings Account

Your current year Medical Savings Account pays for all your day-to-day expenses, including further basic dentistry (once the initial Major Medical limit for dentistry is used). The Medical Savings Account is limited, based on your family size and composition.

Claims paid from your Medical Savings Account can either be paid at the Scheme Rate, or you can instruct the Scheme that it should be paid at cost.

If you choose payment at the LA Health Rate and your provider charges more than that Rate, you will have to pay the difference from your own pocket.

We will not pay any deductibles from your Medical Savings Account.

Extended Day-to-day Benefit

Once you have used all the funds in your current year Medical Savings Account, you have further limited cover for day-to-day medical expenses from the Extended Day-to-day Benefit. The value of this benefit is based on your family size and composition.

The Extended Day-to-day Benefit pays claims for GP and specialists; dental and optical costs, radiology and pathology tests and acute prescribed medicine.

Claims are paid up to 100% of the LA Health Rate from your Extended Day-to-day Benefit.

Once you have used up your Extended Day-to-day Benefit, we will pay these claims from Medical Savings monies you may have carried over from the previous year.

Claims that are not paid from the Extended Day-to-day Benefit

The following expenses are not paid from your Extended Day-to-day Benefit, but can be paid from any Medical Savings Account monies you have carried over from the previous year, once the current year Medical Savings Account is used up: antenatal classes; mental care obtained from psychologists, art therapy, social workers and drug and alcohol rehabilitation; auxiliary services such as physiotherapy and occupational therapy; alternative healthcare practitioners (chiropodists, homeopaths, naturopaths and chiropractitioners); and nursing services.

What happens once you have used your carried-over Medical Savings

Once the monies carried over from your previous year's Medical Savings Account is exhausted, all further day-to-day costs will be for your own pocket.

Chronic illness benefits

You have benefits for the Prescribed Minimum Benefits list of chronic illnesses, including the treatment and care associated with these diseases. Please see the Benefits section of this booklet for more details about the Scheme's Chronic Illness Benefits.

Cancer, HIV or Aids

Cancer

We have a special Oncology Programme and it is very important that you contact us before you have treatment for cancer. You can read more about this Programme in the Benefits section of this booklet.

HIV or AIDS

We have a special HIVCare Programme and it is very important that you contact us before you use your HIV or AIDS benefits. You can read more about this Programme in the Benefits section of this booklet.

Recovering from a trauma

When we have authorised it, we cover some medical expenses if you or your family experience serious trauma, for specific events. The benefit is paid up to the end of the year following the one in which the traumatic event occurred. You can read more about this in the Benefits section of this booklet.

Which healthcare providers to use for LA Active

To make the best use of your Option, you should use the Scheme's Designated Service Providers or the Preferred Providers. If you do not, you will have to pay more out of your own pocket. We have included a list of these providers in the Benefits section of this booklet.

What we do not cover on LA Active

There are conditions and treatments that are not covered by the Scheme. These general exclusions are listed in the Benefits section (What we do not cover – exclusions) of this booklet. They also apply to you.

LA Core

LA Core covers hospital treatment at any private hospital, and other large medical costs from the Major Medical Benefit. It also pays for treatment in State Hospitals.

You first have cover for day-to-day medical expenses, for example the cost of visiting a doctor, from the Medical Savings Account and then from the Extended Day-to-day Benefit (previously known as the Insured Procedures Benefit).

The day-to-day benefit limits for the Medical Savings Account and Extended Day-today Benefit are based on the size and composition of your family.

The Benefit Option provides cover for Prescribed Minimum Benefit (PMB) and other, non-PMB, chronic conditions.

Hospital stays

We pay for treatment at any private, public or state hospital from the Major Medical Benefit, up to 100% of the LA Health Rate.

You must contact us before you are admitted into hospital for a planned procedure. If you do not contact at least 48 hours before you are admitted to hospital, you will have to pay a portion of the amount out of your own pocket (a deductible).

In the case of an emergency, you, a family member or the hospital must contact us as soon as possible once you are admitted to hospital.

Day-to-day medical expenses

This Benefit Option provides day-to-day benefits from the Medical Savings Account and the Extended Day-to-day Benefit.

Current year Medical Savings Account

Your current year Medical Savings Account pays for all your day-to-day expenses. The Medical Savings Account is limited, based on your family size and composition.

Claims paid from your Medical Savings Account can either be paid at the Scheme Rate, or you can instruct the Scheme that it should be paid at cost.

If you choose payment at the LA Health Rate and your provider charges more than that Rate, you will have to pay the difference from your own pocket.

We will not pay any deductibles from your Medical Savings Account.

Extended Day-to-day Benefit

Once you have used all the funds in your current year Medical Savings Account, you have further limited cover for day-to-day medical expenses from the Extended Day-to-day Benefit. The value of this benefit is based on your family size and composition.

Claims are paid up to 100% of the LA Health Rate from your Extended Day-to-day Benefit.

The Extended Day-to-day Benefit pays claims for GP and specialists; dental and optical costs, radiology and pathology tests and acute prescribed medicine.

Once you have used up your Extended Day-to-day Benefit, we will pay these claims from any Medical Savings monies you may have carried over from the previous year.

Claims that are not paid from the Extended Day-to-day Benefit

The following expenses are not paid from your Extended Day-to-day Benefit, but can be paid from any Medical Savings Account monies you have carried over from the previous year, once the current year Medical Savings Account is used up: antenatal classes; mental care obtained from psychologists, art therapy, social workers and drug and alcohol rehabilitation; auxiliary services such as physiotherapy and occupational therapy; alternative healthcare practitioners (chiropodists, homeopaths, naturopaths and chiropractitioners); nursing services and external medical items.

What happens once you have used your carried-over Medical Savings

Once the monies carried over from your previous year's Medical Savings Account is exhausted, all further day-to-day costs will be for your own pocket.

Chronic illness benefits

You have benefits for the Prescribed Minimum Benefits list of chronic illnesses, including the treatment and care associated with these diseases.

You also have cover for other chronic diseases identified in the Scheme's Additional Chronic Diseases List. Please see the Benefits section of this booklet for more details about the Scheme's Chronic Illness Benefits.

Cancer, HIV or Aids

Cancer

We have a special Oncology Programme and it is very important that you contact us before you have treatment for cancer. You can read more about this Programme in the Benefits section of this booklet.

HIV or AIDS

We have a special HIVCare Programme and it is very important that you contact us before you use your HIV or AIDS benefits. You can read more about this Programme in the Benefits section of this booklet.

Recovering from a trauma

When we have authorised it, we cover some medical expenses if you or your family experience serious trauma, for specific events. The benefit is paid up to the end of the year following the one in which the traumatic event occurred. You can read more about this in the Benefits section of this booklet.

Which healthcare providers to use for LA Core

To make the best use of your Option, you should use the Scheme's Designated Service Providers or the Preferred Providers. If you do not, you will have to pay more out of your own pocket.

We have included a list of these providers in the Benefits section of this booklet.

What we do not cover on LA Core

There are conditions and treatments that are not covered by the Scheme. These general exclusions are listed in the Benefits section (What we do not cover – exclusions) of this booklet. They also apply to you.

LA Comprehensive

LA Comprehensive covers hospital treatment at any private hospital or in State hospitals, and other large medical costs from the Major Medical Benefit.

The Option first covers day-to-day medical expenses, for example the cost of visiting a doctor, from the Medical Savings Account and then, once a threshold is reached, from the Above Threshold Benefit.

The available day-to-day benefits in the Medical Savings Account and Above Threshold Benefit are based on your family size and composition.

The Benefit Option provides cover for Prescribed Minimum Benefit (PMB) and other chronic conditions.

Hospital stays

We pay for treatment at any private, public or state hospital from the Major Medical Benefit, up to 100% of the LA Health Rate.

You must contact us before you are admitted into hospital for a planned procedure. If you do not contact us at least 48 hours before you are admitted to hospital, you will have to pay a portion of the amount out of your own pocket (a deductible).

In the case of an emergency, you or the hospital must contact us as soon as possible once you are admitted to hospital.

Day-to-day medical expenses

This benefit option provides day-to-day benefits from the Medical Savings Account and the Above Threshold Benefit.

Current year Medical Savings Account

Your current year Medical Savings Account pays for all your day-to-day expenses. The Medical Savings Account is limited, based on your family size and composition.

Claims paid from your Medical Savings Account can either be paid at the Scheme Rate, or you can instruct the Scheme that it should be paid at cost.

If you choose payment at the LA Health Rate and your provider charges more than that Rate, you will have to pay the difference from your own pocket.

We will not pay any deductibles from your Medical Savings Account.

Above Threshold Benefit

Once you have used all the funds in your current year Medical Savings Account, and you have reached the Annual Threshold, you have further limited cover for day-to-day medical expenses from the Above Threshold Benefit. The value of this benefit is based on your family size and composition, and some benefits may have specific limits.

Claims are paid up to 100% of the LA Health Rate from your Above Threshold Benefit.

Please read more about the Above Threshold Benefit in the Benefits section of this booklet.

What happens once you have used your Above Threshold Benefit (ATB)

Once the monies in your Above Threshold is exhausted, all further day-to-day costs will be for your own pocket or will be paid from any Medical Savings Account balance carried over from the previous year.

Chronic illness benefits

You have benefits for the Prescribed Minimum Benefits list of chronic illnesses, including the treatment and care associated with these diseases. You also have cover for other chronic diseases identified in the Scheme's Additional Chronic Diseases List. Please see the Benefits section of this booklet for more details about the Scheme's Chronic Illness Benefits.

Cancer, HIV or Aids

Cancer

We have a special Oncology Programme and it is very important that you contact us before you have treatment for cancer. You can read more about this Programme in the Benefits section of this booklet.

HIV or AIDS

We have a special HIVCare Programme and it is very important that you contact us before you use your HIV or AIDS benefits. You can read more about this Programme in the Benefits section of this booklet.

Recovering from a trauma

When we have authorised it, we cover some medical expenses if you or your family experience serious trauma, for specific events. The benefit is paid up to the end of the year following the one in which the traumatic event occurred. You can read more about this in the Benefits section of this booklet.

Which healthcare providers to use for LA Comprehensive

To make the best use of your Option, you should use the Scheme's Designated Service Providers or the Preferred Providers. If you do not, you will have to pay more out of your own pocket.

We have included a list of these providers in the Benefits section of this booklet.

What we do not cover on LA Comprehensive

There are conditions and treatments that are not covered by the Scheme. These general exclusions are listed in the Benefits section (What we do not cover – exclusions) of this booklet. They also apply to you.

How we pay for medical expenses

When you become a member, we set aside an amount of money to pay for your medical expenses. To make sure that we cover medical expenses consistently and fairly, we organise the Scheme according to benefits. Each benefit pays for a set of medical expenses.

Not all the benefits apply to each Benefit Option. See which benefits apply to you by using this table:

LA KeyPlus	Major Medical Benefit (for hospital and major expenses) Prescribed Minimum Benefit (for 27 chronic conditions) Day-to-day benefits: limited and from the Scheme's Designated Providers
LA Focus	Major Medical Benefit (for hospital and major expenses) Prescribed Minimum Benefit (for 27 chronic conditions) Medical Savings Account (for day-to-day medical expenses)
LA Active	Major Medical Benefit (for hospital and major expenses) Prescribed Minimum Benefit (for 27 chronic conditions) Medical Savings Account (for day-to-day medical expenses) Extended Day-to-day Benefit (for day-to-day medical expenses)
LA Core	Major Medical Benefit (for hospital and major expenses) Prescribed Minimum Benefit (for 27 chronic conditions) Additional chronic conditions Medical Savings Account (for day-to-day medical expenses) Extended Day-to-day Benefit (for day-to-day medical expenses)
LA Comprehensive	Major Medical Benefit (for hospital and major expenses) Prescribed Minimum Benefit (for 27 chronic conditions) Additional chronic conditions Medical Savings Account (for day-to-day medical expenses) Above Threshold Benefit (for day-to-day medical expenses)

Major Medical Benefit

This is used for hospital and other major, expensive costs, for example, the expenses of medical emergencies and of operations that we cover under your Benefit Option. We pay for theatre and general ward fees, X-rays, blood tests and the medicine you have to take while you are in hospital.

It also covers your chronic medicine, some procedures that get done out of hospital and other expensive healthcare costs.

Chronic Illness Benefit

You must apply for cover before you can claim for this benefit.

There is a list of chronic conditions that we give cover for. Before we cover any of these chronic conditions, you must apply to us for the Chronic Illness Benefit. If we have not accepted your application for this benefit, we will pay these expenses from your day-to-day benefits.

Ask us or visit www.lahealtlh.co.za for the forms you have to fill in. You and your doctor may have to give extra information for LA Health to accept your application.

Conditions covered by all benefit options

Prescribed Minimum Benefits

LA Health pays for diagnosing and treating all the conditions listed as Prescribed Minimum Benefits. The cover for chronic medicine is subject to the Scheme's medicine lists (formularies) or monthly Chronic Drug Amount (Chronic Drug Amount not applicable to KeyPlus Benefit Option).

If a condition is listed as a Prescribed Minimum Benefit, by law all medical schemes must cover the medicine and certain treatment and care for the condition.

You must apply for chronic cover by completing a chronic application form with your doctor and submitting it for review.

For a condition to be covered from the Chronic Illness Benefit, there are certain benefit entry criteria for the condition.

Prescribed Minimum Benefits (continued)

We pay only for:

- Conditions that are on the list of Prescribed Minimum Benefits and if your diagnosis meets the clinical entry criteria
- Medicines and treatments that are specified for each listed condition. If the medicine you use is not in the medicine list, you will get a monthly amount (called the Chronic Drug Amount). In these cases you might have to pay an amount out of your own pocket (deductible).
  If the medicine is not authorised to pay from the Chronic Illness Benefit, it will be paid from the available benefits for day-to-day medical expenses on your Benefit Option.
- Visits and treatments from healthcare providers that have agreements with the Scheme (Designated Service Providers). If you use a healthcare provider that does not have an agreement with LA Health, you will have to pay an amount out your own pocket (deductible).

When you have just joined the Scheme, LA Health will not pay for treatment of these conditions when a general waiting period applies to your Benefit Option, or when a 12-month waiting period applies for the specific condition. If your membership was activated without Waiting Periods you have cover for these conditions from day one.

Here is the list of conditions covered by the Prescribed Minimum Benefits:

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

Additional conditions that are only covered for LA Core and LA Comprehensive members

Medicine for other serious conditions, that are not Prescribed Minimum Benefits, are only covered on LA Core and LA Comprehensive. LA Health pays for the medicine for these conditions on the Additional Diseases List at 90% of the LA Health Medicine Rate. Limits apply on both Options.

Additional Disease list

- Ankylosing spondylitis
- Arthritis
- Attention deficit disorder* (hyperactivity)
- Chronic urticaria**
- Conn's syndrome
- Cystic fibrosis
- Depression
- Eczema** (only if severe)
- Gastro-oesophageal reflux disease#
- Gout * (uric acid level must be tested)
- Ménière's disease
- Migraine*
- Motor neuron disease
- Myasthenia gravis
- Narcolepsy*
- Osteoporosis (only if confirmed by industry-standard BMD readings)
- Paget's disease
- Psoriasis** (only if severe)
- Scleroderma and other collagen-vascular diseases
- Trigeminal neuralgia
- Urinary incontinence
- Zollinger Ellison syndrome

* Medicine must be prescribed by a specialist
** Medicine must be prescribed by a dermatologist
# Medicine must be prescribed by a gastroenterologist or surgeon

For more about the conditions we cover as chronic illnesses, visit www.lahealth.co.za or phone 0860 103 933.

Medical Savings Account (LA Focus, LA Active, LA Core and LA Comprehensive)

This is an amount of money that is mostly used for day-to-day medical expenses, such as doctors' visits and medicines. The amount of money in the Medical Savings Account is determined by the member's family size and composition.

We add interest to members' positive medical savings account balances on a monthly basis.

If you don't use all the money in your Medical Savings Account, you carry it over to the next year. If you leave LA Health Medical 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.

If one of your dependants leave the Scheme during the year, your available Medical Savings Account for the rest of the year will be lower than expected as we adjust it downward.

Extended Day-to-day Benefit (LA Core and LA Active only)

This benefit pays for the day-to-day healthcare costs once you have used all the funds in your current year Medical Savings Account, from the Extended Day-to-day Benefit. The value of this benefit is based on your family size and composition.

LA Core and LA Active have a safety net for when the Medical Savings Account runs out – this is called the Extended Day-to-day Benefit, and it covers most day-to-day medical expenses. The Extended Day-to-day Benefit pays for your visits to GPs and Specialists, Dental and Optical costs, Radiology and Pathology tests and prescribed acute medicine.

Claims are paid up to 100% of the LA Health Rate from your Extended Day-to-day Benefit.

Claims that are not paid from the Extended Day-to-day Benefit

The following expenses are not paid from your Extended Day-to-day Benefit, but can be paid from any Medical Savings Account monies you have carried over from previous years, once the current year Medical Savings Account is used up: antenatal classes; mental care obtained from psychologists, art therapy, social workers and drug and alcohol rehabilitation; auxiliary services such as physiotherapy and occupational therapy; alternative healthcare practitioners (chiropodists, homeopaths, naturopaths and chiropractitioners); nursing services and external medical items

Above Threshold Benefit (LA Comprehensive only)

This benefit pays for day-to-day costs when the money in your Medical Savings Account runs out. From 1 January each year, day-to-day expenses paid from your Medical Savings Account add up to a rand value threshold. When you reach this threshold, LA Health starts paying for your claims at the LA Health Rate from the Above Threshold Benefit.

At the beginning of the year, the Above Threshold Benefit for you (and your family) is worked out by the size and composition of your family and allocated for 12 months.

If you join LA Comprehensive during the year, the Annual Threshold is worked out over the number of months that is left in that year. It will therefore not be the full 12 month's worth.

Self-payment Gap (LA Comprehensive only)

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 until you reach the Annual Threshold. This is called a Self-payment Gap. This Self-payment Gap is increased when claims that do not add up to the threshold, are paid from the Medical Savings Account.

The following expenses create a Self-payment Gap as they do not add to the threshold. To avoid a Self-payment Gap:

- Do not claim for over-the-counter medicine.
- Do not use your current year Medical Savings Account to pay for claims from a previous year.
- Do not choose to have your day-to-day claims paid at Cost, instead of at the LA Health Rate.
- Do not ask the Scheme to pay for items that are not normally covered from your Medical Savings Account.

Remember: All claims paid from the Medical Savings Account that do not add up to the Annual Threshold increases the Self-payment Gap – and the amount you have to pay from your own pocket. Your claims statement shows when you would be likely to start paying for day-to-day medical expenses from your own pocket.

You must send your claims to LA Health even if you are in a Self-payment Gap. If you do not, your medical expenses will not count towards the annual threshold – so you'll have to pay out of your own pocket for longer.

The Oncology programme

Cancer

LA Health has a special 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 you get the right treatment at the right price.

You must discuss your treatment with us in detail, so that we can help you to understand what we will pay for and what we will not pay for.

We might not cover the costs if we have not agreed to the treatment plan for you.

Once your treatment plan is approved, we will cover treatment for the kinds of cancer that are covered by Prescribed Minimum Benefits without co-payments. If the cancer is not covered by the Prescribed Minimum Benefits, you will have to pay some of the costs out of your own pocket once a Rand value threshold is reached. Please see the section that applies to your Benefit Option for more details about cover for cancer.

PET Scans

To avoid any co-payments, you must make use of the Scheme's Designated Service Provider for PET scans. If you do not use the services of the appointed provider, you will have to pay a co-payment from your own pocket.

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 (DSP). If you do not use a DSP, the benefit is limited.

On LA KeyPlus Stem Cell Transplants will only be covered if the treatment is related to a PMB condition and the services of the Scheme's Designated Service Providers are used.

HIV*Care* Programme for HIV or AIDS benefits

We have a special HIVCare Programme and it is very important that you contact us before you have treatment for HIV or AIDS. Our HIVCare healthcare team respects your right to privacy and will deal with you in complete confidentiality.

The HIVCare team will only speak to you as the patient or your treating doctor, about any HIV-related query.

You have to register on the HIVCare Programme to access these benefits. Call us on 0860 116 116 or send an email to HIV_Diseasemanagement@discovery.co.za or a fax to 011 539 3151 to register.

If your condition meets our requirements (benefit entry criteria) for cover, you have cover for antiretroviral medicine. This includes supportive medicine and medicine for prevention of mother-to-child transmission, treatment of sexually transmitted infections and HIV-related (or AIDS-defining) infections that are on our HIV medicine list (formulary).

Trauma Recovery Extender Benefit

LA Health provides cover from the Major Medical Benefit for day-to-day medical expenses related to a traumatic incident or for members who suffered a loss of, or functionality of, an acute nature and who are left with a standard level of residual inability after discharge from hospital or other rehabilitation facilities. The benefit is paid up to the end of the year following the one in which the traumatic event occurred. The benefit is offered on all the Options and pays:

1. Day-today claims following the traumatic onset of:
   - Paraplegia;
   - Quadriplegia;
   - Tetraplegia; or
   - Hemiplegia.
2. Day-to-day claims for conditions resulting from the following traumatic incidents:
   - Near drowning;
   - Severe anaphylactic reaction;
   - Poisoning; or
   - Crime-related injuries.
3. Day-to-day claims relating to severe burns.
4. Day-to-day claims following the traumatic onset of an internal or external head injury.
5. Day-to-day claims due to the loss of limb, or part thereof, as a result of trauma.

Benefits are paid from the Major Medical Benefit and are limited, based on the specific Option, unless stipulated differently in the benefit schedules in this booklet.

Designated Service Providers

Each Benefit Option has different Designated Service Providers for the diagnosis, treatment and care of Prescribed Minimum Benefit (PMB) conditions. If you use one of these providers for PMB treatment and care, we will pay the expenses in full. Over time we will add more DSPs to the list to ensure you receive full cover at more and more providers.

The LA Health Designated Providers and how they apply to the Benefit Options

Benefit	Designated Service Provider	Benefit Option it applies to
Hospitals	KeyCare Network	LA KeyPlus
	Hospitals in coastal Provinces and specific hospitals in the other Provinces	LA Focus
Alcohol and drug rehabilitation, including accommodation, therapeutic sessions, consultations by psychologists and psychiatrists and medicine relating to withdrawal management and after care	SANCA and RAMOT	All LA Health Benefit Options
General Practitioners	KeyCare GP network	LA KeyPlus
	Discovery GP network (there are more than 3 000 GPs in this network)	LA Focus, LA Active, LA Core and LA Comprehensive
Specialists	KeyCare Specialists	Any Specialist working in a KeyCare Network Hospital
	Premier Specialist network	LA Focus, LA Active, LA Core and LA Comprehensive
Medicine	Pharmacies dispensing at the LA Health Medicine Rate	All LA Health Benefit Options
Medicine for HIV or AIDS	Optipharm	LA KeyPlus
Renal Care, including dialysis	National Renal Care (if you use another provider, we will pay up to the DSP rate only)	All LA Health Benefit Options
Oxygen rental	VitalAire	All LA Health Benefit Options

If you want to find out who your nearest Designated Service Provider is, you can call us or find the information on www.lahealth.co.za

Preferred Providers

The Centre for Diabetes and Endocrinology (CDE) provides services and treatment to registered diabetic patients on LA Core and LA Comprehensive. Their services include education and information about the disease, 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.

The Scheme has also identified specific providers or manufacturers as preferred providers for cardiac stents and hip, knee and spinal prostheses. We will advise you who these providers are when you pre-authorise treatment where these devices will be used.

What we do not cover (exclusions)

There are certain medical expenses and other costs the Scheme does not cover. We call these exclusions.

LA Health will not cover any of the following, or the direct or indirect consequences of these treatments, procedures or costs incurred by the members:

Certain types of treatments and procedures

Cosmetic procedures, for example, otoplasty for jug ears; portwine stains; blepharoplasty (eyelid surgery); keloid scars; hair removal; nasal reconstruction (including septoplasties, osteotomies and nasal tip surgery); enamel micro abrasion

Breast reductions and implants

Treatment for obesity

Treatment for infertility

Frail care

Experimental, unproven or unregistered treatment or practices

CT angiogram of the coronary vessels and CT colonoscopy

Certain types of injuries

Wilfully self-inflicted illness or injury

Injuries that happen while you are purposefully breaking the law

Injuries that happen while you are purposefully taking part in war, terrorist activity, riot, civil commotion, rebellion or insurrection

Certain costs

Costs of search and rescue

Any costs that another party is legally responsible for

Facility fees at casualty facilities (these are administration fees that are charged directly by the hospital or other casualty facility)

Always check with us

Please contact us if you have one of the conditions so we can let you know if there is any cover. In some cases, you might be covered for these conditions if they are part of Prescribed Minimum Benefits.

Part C: How to claim and how to manage your membership

How to claim

Send LA Health your claims

You must make sure your doctor or other healthcare practitioner has all the correct information about you and your Benefit Option. Ask your doctor if they will send the claim to us. If they will not, you must send us the claim yourself. Send the original account, and a receipt (if you paid), and make sure your membership and the practice details are clear.

You can:

- Email scanned-in copies of the claim to claims@discovery.co.za
- Fax to 0860 329 252
- Put your claim in one of the boxes at the Discovery offices, Virgin Active or Planet Fitness gyms, Dis-Chem pharmacies or most private hospitals.
- Post it to: PO Box 652509, Benmore 2010 or Postnet Suite 116, Private Bag X19, Milnerton 7435.

As soon as we have the claim, it takes about 72 hours to know how we will pay it. You will get an email, or you can look at your claims on www.lahealth.co.za, visit www.discoveryinfo.mobi on your phone or SMS the word 'Claim' to 31347.

Time limit for claims submission

You must send in your claim within three months of the treatment month. If we do not process and pay it within four months after the treatment date, it will not be valid and we will not pay it.

If you disagree with a decision about your membership or a claim

When you have questions about any of your benefits or contributions, please call us at 0860 103 933 or email service@discovery.co.za. If you do not lodge a query within 4 months of the Scheme first informing you of how that claim was paid, your query will no longer be valid, so try and do it as soon as possible after receiving your claims notification or statement.

If you are not satisfied that your enquiry or complaint was resolved, email service@discovery.co.za or send a fax to 021 527 1923 and ask that a Team Leader or the Fund Manager must look into your case and give them all the details that they ask for.

If your query is still not resolved: Write to the Principal Officer of LA Health at Postnet Suite 116, Private Bag X19, Milnerton 7435.

The Disputes Committee of LA Health, a group of independent experts, can help with cases that have not been resolved when you inform the Principal Officer that you want to lodge a dispute.

You can also lodge an appeal with the Council for Medical Schemes. Read more about this process on www.medicalschemes.com.

Manage your membership

Find out which healthcare practitioners are Designated Service Providers or the Scheme's Preferred Providers:

- Telephone 0860 103 933
- Log-in to www.lahealth.co.za and go to MaPs (Medical and Provider Search)

Track your claims or review what benefits you have available:

To follow up on a claim you have sent to us, you can:

- Telephone 0860 103 933
- Log in to www.lahealth.co.za

Review your health records online

We have an online service called Electronic Health Records where you can review your medical records in one place, and also allow doctors and emergency staff to view them. This helps to make sure that your doctors all have the most comprehensive and up-to-date information about your health.
Please visit www.lahealth.co.za for more information.

Add a dependant

A dependant is a person who is also covered under your membership of LA Health Medical Scheme. There are rules about who can be a dependant. To add a dependant:

1. Contact us or visit www.lahealth.co.za for the application form.
2. Fill in the details and attach the information we ask for. For example, we'll need the ID document of each dependant and a marriage certificate for spouses.
3. Send the form to your employer, hand it to your broker or send it to the contact details given on the form.

Change your Benefit Option

You can change your Benefit Option at the end of every year. You will need approval from your employer if you are in active employment. Contact us, visit www.lahealth.co.za or ask your company's HR department for the correct form.

LA KeyPlus

- You have to use a network of hospitals and doctors for treatment whether you are in hospital or out of hospital, for LA Health to pay your accounts.
- If it is not an emergency and you use hospitals or doctors that are not in the network, LA Health will not pay your claims.
  - Call us to preauthorise all major medical treatments, especially those done in a hospital.

Overall annual limits	
Hospital	No overall limit applies at KeyCare network hospitals
Ambulance services (member must call Discovery911 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
Out-of-hospital basic dentistry	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 750 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 R225 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 R1 000 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 750 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 R110 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 750 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
Brachytherapy treatment for prostate cancer (PMB)	Covered from Major Medical Benefit from Network Hospital identified by the Scheme
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

In-hospital: Opthalmology	Covered from the Major Medical Benefit if performed at a Designated Service Provider facility
Out-of-hospital: 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 750 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 750 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 450 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	R145 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 R28 500 per person per lifetime from Major Medical Benefit

Trauma Recovery Benefit

Cover for specific trauma-related incidents.

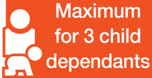
The benefit is paid up to the end of the year following the one in which the traumatic event occurred.

Paid from the Major Medical Benefit up to 100% of the LA Health Rate per family up to the following limits for the benefits listed below:

Allied and therapeutic healthcare services	M M+1 M+2 M+3+	R 4 790 R 7 190 R 8 980 R 10 780
External medical items		R 23 800
Hearing aids		R 11 100
Prescribed Medicine	M M+1 M+2 M+3+	R 9 350 R 11 050 R 13 100 R 15 900
Prosthetic limbs (with no further access to the external medical items limit)		R 64 500

Benefits are paid according to general Rules applicable to this Benefit Option in terms of Designated Service Providers and clinical entry criteria.

LA KeyPlus – Total monthly contributions for 2014



Income	Member	Adult	Child dependant	Maximum for 3 child dependants
R 0 – R 6 500	R 807	R 705	R 296	R 888
R 6 501 – R 9 000	R 852	R 745	R 311	R 933
R 9 001+	R 1 282	R 1 141	R 479	R 1 437

LA Focus

The LA Focus provides cover nationally in all South African Provinces

- This Benefit Option has no annual limit for Major Medical Treatment, including in-hospital treatment.
- We will pay hospital costs in full at any LA Focus network hospital. These network hospitals are all hospitals in a Province with a coastline and specific hospitals in the remaining South African Provinces. If you do not use the services of one of the network hospitals for planned procedures, you will have to pay a portion of the costs from your own pocket (deductible).
  - Call us to preauthorise all major medical treatments, especially those done in a hospital.
- Your day-to-day medical expenses are paid from your Medical Savings Account.
- Major Medical Benefit claims on this Option are paid up to 100% of the LA Health Rate or the LA Health Medicine Rate. You may choose to have your Medical Savings Account claims paid at the LA Health Rate or at cost.

Overall limits	
Hospital	No overall limit applies. Members must use network hospitals
Medical Savings Account	Member R5 064; Spouse/adult R3 264; Child R1 488
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
In-hospital Specialised dentistry	Deductibles payable by the member from own pocket for all specialised dentistry performed in-hospital (see table below). Hospital and related accounts paid from Major Medical Benefit, up to 100% of the LA Health Rate. Related accounts (for dentists, anaesthetists, etc) subject to a limit of R16 100 per person per year.
In-hospital Basic dentistry	Deductibles payable by the member from own pocket (see table below). Hospital account paid up to 100% of the LA Health Rate, from Major Medical Benefit. Related accounts (for dentists, anaesthetists, etc) paid from Medical Savings Account.
Out-of-hospital Specialised dentistry	Paid from and limited to funds in Medical Savings Account.
Out-of-hospital Basic dentistry	Paid from and limited to funds in Medical Savings Account.

In-hospital specialised dentistry deductibles:

Hospital	Younger than 13 years	R 1 450
	Older than 13 years	R 3 650
Day Clinics	Younger than 13 years	R 700
	Older than 13 years	R 2 400

In-hospital basic dentistry deductibles:

Hospital	Younger than 13 years	R 1 450
	Older than 13 years	R 3 650
Day Clinics	Younger than 13 years	R 700
	Older than 13 years	R 2 400

GPs and specialists	
In-hospital visits	Paid from Major Medical Benefit up to 100% 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 hospitals in the LA Focus Hospital Network	No overall limit, subject to preauthorisation
Maternity Benefit	
In-hospital, subject to preauthorisation	No overall limit.
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 (subject to benefit entry criteria and approval)	Medicine for all Prescribed Minimum Benefit Chronic Disease List conditions covered from Major Medical Benefit. The Scheme pays in full up to the medicine rate for formulary medicine and up to a monthly 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	
Auxiliary 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 100% 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 R2 000 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 R2 000 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	Paid from Major Medical Benefit. Unlimited Related accounts limited to funds in Medical Savings Account
Prostheses	
Internal prostheses	
Cochlear implants, implantable defibrillators, internal nerve stimulators and auditory brain implants	Paid from Major Medical Benefit up to R170 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
Hip, knee and shoulder prostheses	Unlimited and paid from the Major Medical Benefit if obtained from the Scheme's Preferred Provider. A limit of R35 000 per prosthesis will apply if the Preferred Provider is not used
Spinal devices	Paid from the Major Medical Benefit. Limited to R24 500 per level, with an overall annual limit of R49 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	Paid from the Major Medical Benefit 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	R145 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

LA Focus

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

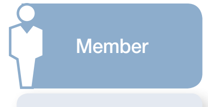
Terminal Care Benefit	
Hospice (excluding frail care)	Limited to R40 000 per person per lifetime. Paid from the Major Medical Benefit

Trauma Recovery Benefit	
Cover for specific trauma-related incidents. The benefit is paid up to the end of the year following the one in which the traumatic event occurred.	Paid from the Major Medical Benefit up to 100% of the LA Health Rate per family up to the following limits for the benefits listed below:

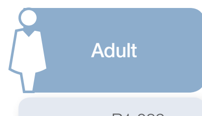
Allied and therapeutic healthcare services	M M+1 M+2 M+3+	R 4 790 R 7 190 R 8 980 R 10 780
External medical items		R 23 800
Hearing aids		R 11 100
Prescribed Medicine	M M+1 M+2 M+3+	R 9 350 R 11 050 R 13 100 R 15 900
Prosthetic limbs (with no further access to the external medical items limit)		R 64 500

Benefits are paid according to general Rules applicable to this Benefit Option in terms of Designated Service Providers and clinical entry criteria.

LA Focus – Total monthly contributions, including your Medical Savings Account for 2014


Member

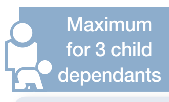
R1 688


Adult

R1 089

Child dependant

R496


Maximum for 3 child dependants

R1 488

LA Active

- This Option has a Major Medical Benefit with no overall annual limit for in-hospital treatment and high cost care
  - Call us to preauthorise all major medical treatments, especially those done in a hospital.
- Major Medical and Extended Day-to-day claims on this Option are paid up to 100% of the LA Health Rate. Medical Savings Account claims can be paid up to the LA Health Rate or at cost, according to the member's choice.
- You have cover for the Prescribed Minimum Benefit Chronic Diseases.
- Day-to-day expenses are paid as follows:

Benefit Category	Benefit	More Benefits
Major Medical Benefit (MMB)	Without first using any of the other day-to-day benefits, you have limited cover up to a Rand value for Basic dentistry from the Major Medical Benefit. When this benefit is used up, basic dentistry is paid from MSA.	
Current year Medical Savings Account (MSA)	All day-to-day claims are paid from the current year MSA until it is used up.	
Extended Day-to-day Benefit	Claims for GPs, Specialists, Dental and Optical costs, Radiology, Pathology and Prescribed or acute medicine are paid from this benefit up to the LA Health Rate.	
Previous year's Medical Savings monies brought forward to current year	Antenatal classes, mental care drug and alcohol rehabilitation treatment, auxiliary services, alternative healthcare practitioners and nursing services are paid from any available Savings brought forward from the previous year.	Once the Extended Day-to-day Benefit is used up, claims for the care listed under Extended Day-to-day Benefit can be paid from available MSA monies brought forward from the previous year.

- Once the Extended Day-to-day Benefit and the previous year's Medical Savings Account monies are used up, day-to-day costs must be paid from your own pocket.

Overall limits

Hospital	No overall limit		
Extended Day-to-day Benefit	Member R3 384	Spouse/adult R2 376	Child R 672
Medical Savings Account	Member R4 644	Spouse/adult R3 372	Child R1 944

Ambulance services (member must call Discovery911 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
In-hospital Specialised dentistry	Deductibles payable by the member from own pocket Hospital – Younger than 13 years – R 1 450 Hospital – Older than 13 years – R 3 650 Day Clinics – Younger than 13 years – R 700 Day Clinics – Older than 13 years – R 2 400 Hospital and related accounts paid from the Major Medical Benefit, up to 100% of the LA Health Rate. Related accounts (for dentists, anaesthetists, etc) subject to a limit of R16 100 per person per year.
In-hospital Basic dentistry	Deductibles payable by the member from own pocket Hospital – Younger than 13 years – R 1 450 Hospital – Older than 13 years – R 3 650 Day Clinics – Younger than 13 years – R 700 Day Clinics – Older than 13 years – R 2 400 Hospital account paid from the Major Medical Benefit. Related accounts (for dentists, anaesthetists, etc) paid from and limited to available funds in the Medical Savings Account and the Extended Day-to-day Benefit.
Out-of-hospital Specialised dentistry	Paid from and limited to funds in Medical Savings Account and Extended Day-to-day Benefit .
Out-of-hospital Basic dentistry	First R2 610 per family per year paid from Major Medical Benefit. Thereafter paid from and limited to funds in Medical Savings Account and Extended Day-to-day Benefit.

GPs and Specialists

In-hospital visits	No overall limit. Paid from Major Medical Benefit up to 100% of the LA Health Rate.
Out-of-hospital GP and specialist visits	Paid from Medical Savings Account or Extended Day-to-day 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 (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. Paid from Major Medical Benefit up to 100% of the LA Health Rate

Maternity Benefit

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

Medicine

Prescribed Minimum Benefit Chronic Disease List conditions (subject to benefit entry criteria and approval)	Medicine for all Prescribed Minimum Benefit Chronic Disease List conditions covered from Major Medical Benefit. The Scheme pays in full up to the Medicine Rate for formulary medicine and up to a monthly 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 Extended Day-to-day 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 Extended Day-to-day Benefit up to 100% of the cost
Take-home medicine (When discharged from hospital) TTOs	Limited to funds in the Medical Savings Account or Extended Day-to-day 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, 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 Extended Day-to-day Benefit
Spectacles, frames, contact lenses and refractive eye surgery	

Other services

Auxiliary services (physiotherapy, occupational therapy, homeopaths, audiologists, etc)	Limited to funds in the Medical Savings Account
Alternative healthcare practitioners (chiropody, 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 R2 000 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 Extended Day-to-day Benefit
Out-of-hospital	
MRI and CT scans (referred by a specialist) subject to preauthorisation	First R2 000 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) and pathology	Paid from Medical Savings Account or Extended Day-to-day Benefit
Endoscopic procedures: gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy	Paid from Major Medical Benefit. Unlimited Related accounts limited to funds in Medical Savings Account or Extended Day-to-day Benefit

Prostheses

Internal prostheses	
Cochlear implants, implantable defibrillators, internal nerve stimulators and auditory brain implants	Paid from Major Medical Benefit up to R170 000 per person per year
Implantable cardiac stents	Paid from Major Medical Benefit. Limited to R10 900 per bare metal stent and R17 300 per drug-eluting stent
Hip, knee and shoulder prostheses	Paid from Major Medical Benefit. Unlimited if obtained from the Scheme's Preferred Provider. A limit of R35 000 per prosthesis will apply if the Preferred Provider is not used
Spinal devices	Paid from Major Medical Benefit. Limited to R24 500 per level, with an overall annual limit of R49 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	Paid from Major Medical Benefit. 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	R145 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)	Paid from Major Medical Benefit. 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)	Limited to R40 000 per person per lifetime. Paid from Major Medical Benefit

Trauma Recovery Extender Benefit

Cover for specific trauma-related incidents.

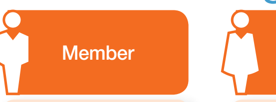
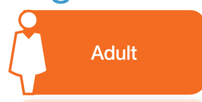
The benefit is paid up to the end of the year following the one in which the traumatic event occurred.

Paid from Major Medical Benefit up to 100% of the LA Health Rate per family up to the following limits for the benefits listed below:

Allied and therapeutic healthcare services	M M+1 M+2 M+3+	R 4 790 R 7 190 R 8 980 R 10 780
External medical items		R 23 800
Hearing aids		R 11 100
Prescribed Medicine	M M+1 M+2 M+3+	R 9 350 R 11 050 R 13 100 R 15 900
Prosthetic limbs (with no further access to the external medical items limit)		R 64 500

Benefits are paid according to general Rules applicable to this Benefit Option in terms of Designated Service Providers and clinical entry criteria

Total monthly contributions, including your Medical Savings Account for 2014

Member	Adult	Child dependant	Maximum for 3 child dependants
R2 020	R1 359	R670	R2 010

- This Option has a Major Medical Benefit with no overall annual limit for in-hospital treatment and high cost care
  - Call us to preauthorise all major medical treatments, especially those done in a hospital.
- Major Medical and Extended Day-to-day claims on this Option are paid up to 100% of the LA Health Rate. Medical Savings Account claims can be paid up to the LA Health Rate or at cost, according to the member's choice.
- You have cover for the Prescribed Minimum Benefit (PMB) Chronic Diseases and an Additional List of non-PMB Chronic Diseases.
- Day-to-day expenses are paid as follows:

Benefit Category	Benefit	More Benefits
Current year Medical Savings Account (MSA)	All day-to-day claims are first paid from the current year MSA until it is used up.	
Extended Day-to-day Benefit	Claims for GPs, Specialists, Dental and Optical costs, Radiology, Pathology and Prescribed or acute medicine are paid from this benefit once the current year MSA is used up.	
Previous year's Medical Savings (MSA) monies brought forward to current year	Once the current year MSA is used up, claims for Antenatal classes, mental care drug and alcohol rehabilitation treatment, auxiliary services, alternative healthcare practitioners and nursing services are paid from any available unused MSA monies brought forward from the previous year.	Once the Extended Day-to-day Benefit is used up, claims for the care listed under Extended Day-to-day Benefit can be paid from MSA monies brought forward from the previous year.

- Once the Extended Day-to-day Benefit and the previous year's Medical Savings Account monies are used up, day-to-day costs must be paid from your own pocket.

Overall limits

Hospital	No overall limit		
Extended Day-to-day Benefit	Member R4 512	Spouse/adult R3 132	Child R1 200
Medical Savings Account	Member R6 072	Spouse/adult R5 304	Child R2 448

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
In-hospital Specialised dentistry	Deductibles payable by the member from own pocket Hospital – Younger than 13 years – R 1 450 Hospital – Older than 13 years – R 3 650 Day Clinics – Younger than 13 years – R 700 Day Clinics – Older than 13 years – R 2 400 Hospital and related accounts paid from Major Medical Benefit, up to 100% of the LA Health Rate. Related accounts (for dentists, anaesthetists, etc) subject to a limit of R21 300 per person per year
In-hospital Basic dentistry	Deductibles payable by the member from own pocket Hospital – Younger than 13 years – R 1 450 Hospital – Older than 13 years – R 3 650 Day Clinics – Younger than 13 years – R 700 Day Clinics – Older than 13 years – R 2 400 Hospital account paid from Major Medical Benefit. Related accounts (for dentists, anaesthetists, etc) paid from Medical Savings Account and Extended Day-to-day Benefit.
Out-of-hospital Specialised dentistry	Paid from and limited to funds in Medical Savings Account and Extended Day-to-day Benefit
Out-of-hospital Basic dentistry	Paid from and limited to funds in Medical Savings Account and Extended Day-to-day Benefit

GPs and specialists

In-hospital visits	Paid from Major Medical Benefit up to 100% of the LA Health Rate. No overall limit
Out-of-hospital GP and specialist visits	Paid from Medical Savings Account or Extended Day-to-day 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	Paid from Major Medical Benefit up to 100% of the LA Health Rate. 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 Extended Day-to-day Benefit
Antenatal classes and ultrasounds	Limited to funds in Medical Savings Account

Medicine

Prescribed Minimum Benefit Chronic Disease List conditions (subject to benefit entry criteria)	Medicine for all Prescribed Minimum Benefit Chronic Disease List conditions covered from Major Medical Benefit. The Scheme pays in full to the Medicine Rate for formulary medicine and up to a monthly 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 825 Member +1 R15 535
Prescribed/acute medicine	Paid from and limited to funds in the Medical Savings Account or Extended Day-to-day 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 Extended Day-to-day Benefit up to 100% of the cost
Take-home medicine (When discharged from hospital) TTOs	Limited to funds in the Medical Savings Account or Extended Day-to-day 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	Paid from Major Medical Benefit. 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	Paid from Major Medical Benefit. 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	Paid from Major Medical Benefit. 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 Extended Day-to-day 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 (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 Extended Day-to-day Benefit

LA Core

Prostheses

Prostheses	
Internal prostheses	
Cochlear implants, implantable defibrillators, internal nerve stimulators and auditory brain implants	Paid from Major Medical Benefit up to R170 000 per person per year
Implantable cardiac stents	Paid from Major Medical Benefit. Limited to R10 900 per bare metal stent and R17 300 per drug-eluting stent
Hip, knee and shoulder prostheses	Paid from Major Medical Benefit. Unlimited if obtained from the Scheme's Preferred Provider. A limit of R35 000 per prosthesis will apply if the Preferred Provider is not used.
Spinal devices	Paid from Major Medical Benefit. Limited to R24 500 per level, with an overall annual limit of R49 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	Paid from Major Medical Benefit. Covered in full at the Schemes Designated Service Provider, subject to preauthorisation

Preventive care

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	R145 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 Extended Day-to-day Benefit, except for Prescribed Minimum Benefits

Renal care

Renal care	
Dialysis and other renal care-related treatment and educational care (includes authorised related medicines)	Paid from Major Medical Benefit. 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

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

Terminal Care Benefit	
Hospice (excluding frail care)	Paid from Major Medical benefit. Limited to R40 000 per person per lifetime

Trauma Recovery Extender Benefit

Cover for specific trauma-related incidents.

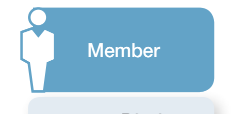
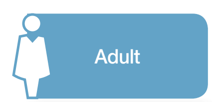
The benefit is paid up to the end of the year following the one in which the traumatic event occurred.

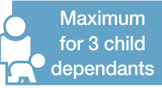
Paid from Major Medical Benefit up to 100% of the LA Health Rate up to the following limits for the benefits listed below:

Benefit	Family size	Limit
Allied and therapeutic healthcare services	M M+1 M+2 M+3+	R 11 950 R 16 180 R 19 770 R 22 870
External medical items		R 33 300
Hearing aids		R 15 700
Prescribed Medicine	M M+1 M+2 M+3+	R 13 100 R 15 900 R 19 150 R 20 900
Prosthetic limbs (with no further access to the external medical items limit)		R 64 500

Benefits are paid according to general Rules applicable to this Benefit Option in terms of Designated Service Providers and clinical entry criteria.

Total monthly contributions, including your Medical Savings Account for 2014



Member	Adult	Child dependant	Maximum for 3 child dependants
R3 507	R3 166	R1 048	R3 144

LA Comprehensive

- This Option has a Major Medical Benefit with no annual overall limit for in-hospital and other high cost expenses.
  - Call us to preauthorise all major medical treatments, especially those done in a hospital.
- You have cover for the Prescribed Minimum Benefit (PMB) Chronic Diseases and an Additional List of non-PMB Chronic Diseases.
- The Option pays for day-to-day benefits from a Medical Savings Account with further cover from Above Threshold Benefit.
- Major Medical and Above Threshold claims on this Option are paid up to 100% of the LA Health Rate. Medical Savings Account claims can be paid up to the LA Health Rate or at cost, according to the member's choice.

Overall limits

Hospital	No overall limit		
Above Threshold	Member R11 772	Spouse/adult R8 028	Child R3 540
Medical Savings Account	Member R7 368	Spouse/adult R4 284	Child R1 872

Ambulance services (members must call Discovery911 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

In-hospital
Specialised dentistry

Deductibles payable by the member from own pocket

Hospital	Younger than 13 years	R 1 450
	Older than 13 years	R 3 650
Day Clinics	Younger than 13 years	R 700
	Older than 13 years	R 2 400

Hospital and related accounts paid from Major Medical Benefit, up to 100% of the LA Health Rate. Related accounts (for dentists, anaesthetists, etc) subject to a joint limit of R21 300 for in- and out-of-hospital specialised dentistry.

In-hospital
Basic dentistry

Deductibles payable by the member from own pocket

Hospital	Younger than 13 years	R 1 450
	Older than 13 years	R 3 650
Day Clinics	Younger than 13 years	R 700
	Older than 13 years	R 2 400

Hospital accounts paid from Major Medical Benefit. Related accounts (for dentists, anaesthetists, etc.) paid from the Medical Savings Account and the Above Threshold Benefit, subject to a joint limit of R11 000 for in- and out-of-hospital basic dentistry. Claims are paid up to 100% of the LA Health Rate from MMB and the Above Threshold Benefit.

Out-of-hospital Specialised dentistry	Paid from and limited to funds in Medical Savings Account and Above Threshold Benefit, subject to a joint limit of R21 300 per person per year for specialised dentistry, performed in- or out-of-hospital
Out-of-hospital Basic dentistry	Paid from and limited to funds in Medical Savings Account and Above Threshold Benefit, subject to a joint limit of R11 000 per person per year for basic dentistry, performed in- or out-of-hospital

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	Paid from Major Medical Benefit. 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 150 per person and paid from Medical Savings Account or Above Threshold Benefit

Medicine

Prescribed Minimum Benefit Chronic Disease List conditions (subject to benefit entry criteria and approval)	Medicine for all Prescribed Minimum Benefit Chronic Disease List conditions covered from Major Medical Benefit. The Scheme pays in full to the Medicine Rate for formulary medicine and up to a monthly 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	Member +1	Member +2	Member +3	Member +4	Member +5+
R3 825	R7 705	R8 920	R10 135	R10 985	R12 075

Specialised Medicine and Technology Benefit for biologics	Subject to authorisation. Paid from Major Medical Benefit 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 Medical Savings Account or Above Threshold Benefit, limited to:

Member	Member +1	Member +2	Member +3	Member +4
R7 165	R9 165	R11 040	R12 745	R14 565

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) TTOs	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 R13 750 per family per year with a sub-limit of R4 600 per person for alcohol and drug rehabilitation

Oncology (cancer-related care)

Oncology Programme (including chemo- and radiotherapy)	Paid from Major Medical Benefit. 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	Paid from Major Medical Benefit. 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	Paid from Major Medical Benefit. 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 270 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 (chiropody, homeopaths, naturopaths, and chiropractors)	
Nurse practitioners	Paid up to a limit of R8 050 per family from Medical Savings Account or Above Threshold Benefit

Organ transplants

Hospitalisation and harvesting of organ transplant	Paid from Major Medical Benefit. 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 R170 000 per person per year
Implantable cardiac stents	Paid from Major Medical Benefit. Limited to R10 900 per bare metal stent and R17 300 per drug-eluting stent
Hip, knee and shoulder prostheses	Paid from Major Medical Benefit. Unlimited if obtained from the Scheme's Preferred Provider. A limit of R35 000 per prosthesis will apply if the Preferred Provider is not used.
Spinal devices	Paid from Major Medical Benefit. Limited to R24 500 per level, with an overall annual limit of R49 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

LA Comprehensive

External medical items	
Crutches, wheelchairs, hearing aids, artificial limbs, stoma bags, etc	Limited to R20 900 per family with a sub-limit of R13 950 per family for hearing aids from Medical Savings Account or Above Threshold Benefit
Oxygen rental	Covered in full from the Major Medical Benefit 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	R145 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)	Paid from Major Medical Benefit. 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. Limited to R40 000 per lifetime per person

Trauma Recovery Extender Benefit

Cover for specific trauma-related incidents.

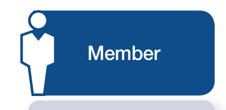
The benefit is paid up to the end of the year following the one in which the traumatic event occurred.

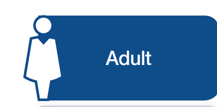
Paid from Major Medical Benefit up to 100% of the LA Health Rate per family up to the following limits for the benefits listed below:

Benefit	Family size	Limit
Allied and therapeutic healthcare services	M	R 11 950
	M+1	R 16 180
	M+2	R 19 770
	M+3+	R 22 870
External medical items		R 33 300
Hearing aids		R 15 700
Prescribed Medicine	M	R 13 100
	M+1	R 15 900
	M+2	R 19 150
	M+3+	R 20 900
Prosthetic limbs (with no further access to the external medical items limit)		R64 500

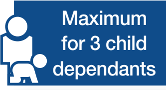
Benefits are paid according to general Rules applicable to this Benefit Option in terms of Designated Service Providers and clinical entry criteria.

Total monthly contributions, including your Medical Savings Account for 2014


Member
R4 591


Adult
R3 507

Child dependant
R1 113


Maximum for 3 child dependants
R3 339

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.

Deductible

An amount that is always payable by the member to the provider. A deductible cannot be paid from the Medical Savings Account.

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 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 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] plus the relevant dispensing fee.

Major Medical Benefit

The Major Medical Benefit covers your expenses for serious illnesses 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 need immediate 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 (a 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 won’t pay any of the expenses.
- **Emergencies:** If you are admitted to hospital in an emergency, please ensure you, a family member or the hospital 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 treating you when you undergo a procedure in-hospital, for example, an account from an anaesthetist.

Contact us

General questions and services

Email service@discovery.co.za

Website www.lahealth.co.za

Call centre 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

Discovery Mobile: SMS the keyword to 31347

Ambulance and other emergency services

0860 999 911 or Discovery 911

Send your claims

Email claims@discovery.co.za

Fax 0860 329 252

Post to: 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

This brochure is a summary of the benefits and features of LA Health Medical Scheme, pending formal approval from the Council for Medical Schemes.

Client Services 0860 103 933
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www.lahealth.co.za
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LA Health Medical Scheme. Registration number 1145. Administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07. An authorised financial services provider.

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