LA Health

Powered by Discovery

YOUR BENEFITS 2020

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

LA Health Medical Scheme, makes the healthcare you and your family need, affordable. However, there are limits to how much the 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**

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

What you need to know about the information in this booklet

1. Specific limits that may apply to benefits are reflected in each of the Benefit Options' Benefit Schedules (one Pagers).
2. Prescribed Minimum Benefits are paid at cost, subject to clinical criteria and the use of the services of the Scheme's Designated Service Providers.

   Non-PMB Benefits are paid up to 100% of the Scheme Rate, subject to clinical criteria, the use of the Scheme's Network or Preferred Providers, and applicable limits.

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 mammogram every two years).
5. Send us all your claims, even for items that we will not pay for.

LA HEALTH

WHY YOUR BEST CHOICE IS LA HEALTH MEDICAL SCHEME

A range of affordable Benefit Options to choose from

We offer five benefit options to choose from, so you can find one that is exactly right for you and your family's healthcare needs.

A wide network of healthcare providers for hospital and day-to-day cover

Our extensive networks of healthcare providers, combined with unique management tools, means you can avoid co-payments when visiting a specialist or GP; on day-to-day preferentially priced medicine, blood tests, or when going to hospitals

Fantastic benefits if you belong to our wellness programme

Being a LA Health member, you have the opportunity to join the world's leading science-based wellness programme that both encourages and rewards healthy behaviour.

We help you to stay healthy

We believe prevention is better than cure, and so we actively encourage you to detect and treat illness as early as possible. That's why we cover a range of preventative tests from cholesterol to HIV screening. We also cover vaccinations to prevent serious illnesses.

Comprehensive Hospital cover

Once you have authorised your stay in hospital, the Scheme provides comprehensive cover without an overall annual limit.

Emergency cover with fast, life-saving emergency care for you and your family

We provide you with life-saving emergency support.

We give you access to the most advanced medical care

You have excellent cover for cancer treatment. In addition, on the LA Comprehensive Benefit Option, you get extra cover for new and expensive medicine.

Excellent administration

The best service and support from the Scheme's call centres across South Africa.

Day-to-day Benefits to suit your needs

Our benefit options offer just the right combination of day-to-day benefits to provide for your specific needs. You can get some of the best dental benefits on offer in the market, X-rays and scans and you can save up to 20% on frames and lenses if you get glasses from one of our network providers.

Great benefits for you and your baby

You have access to all the necessary day-to-day care, paid for by the Scheme, before the birth and comprehensive cover for you and your newborn during and after the birth. (whether in hospital or even at home).

By preauthorising your confinement, you also qualify to access a wealth of educational information and practical, safe and useful products at unprecedented prices.

WHAT TO DO...

Medical emergencies

If you are in a life-threatening medical emergency, phone **0860 999 911** immediately. We will send an ambulance 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 follow 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. You 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.

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. You will find the details of what your specific Benefit Option offers in the benefit schedule that is distributed to you seperately.

Going to hospital is stressful – if yours is a planned procedure, contact us well in advance to help you get the information you need and to help you understand your cover. It will be one less thing to worry about.

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

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. Once you are registered, you may also have access to a programme that will give you enhanced benefits for your diabetes or cardio care.

Manage treatment for cancer, HIV or AIDS, Diabetes, Mental and Cardiovascular Care

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 as soon as possible, but at least 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. Please send us your claims even if you know your benefits are depleted or we won't pay for it.

LA HEALTH

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 to 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 sector, can belong to the Scheme.

Members pay contributions to the Scheme

Each member pays an amount of money (called a contribution) every month. All contributions are paid to the Scheme, creating a pool of money that is jointly owned by its members and looked after 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 to 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 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, and your Option's benefit schedule, give 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, some day-to-day costs and Prescribed Minimum Benefits from the Major Medical Benefits. Prescribed Minimum Benefits are paid in full, subject to clinical criteria and the use of the Scheme's Designated Service Providers (DSP); and
- most 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.

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. You can also request a membership certificate from the call centre. You can log in to www.lahealth.co.za where you will be able to find very comprehensive details of your membership and benefits. Each Benefit Option has different Rules – so what is paid for under one Benefit Option might not be paid for under another one.

About each **BENEFIT OPTION**

ABOUT THE LA KEYPLUS OPTION

LA KeyPlus covers hospital treatment (you must use only specific hospitals), other large medical costs related to Maternity care, 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 KeyCare network (network 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 > Find a healthcare professional** or by calling us on **0860 103 933**. If you do not use the network 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, you will have a shortfall on your accounts.

Operations and procedures only covered in day-care facilities

Certain procedures will only be covered if the treatment is provided in a day-care facility. We will not cover a stay in hospital.

We will tell you about this requirement when you call us for authorisation of the procedure or treatment.

Some of the procedures or treatment we only cover at day care facilities are:

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

Prescribed Minimum Benefits

There is a standard list of Prescribed Minimum Benefit chronic conditions that we cover treatment for. You can find the list of conditions in Part B: 'The Benefits' in 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 general practitioners you chose as your Network Provider. If you need to see your chosen GP more than 15 times in a year, you will have to ask for authorisation after the 15th visit. We cover four visits 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.

We pay for: (Continue)

- 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 LA 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 if you make use of our preferred suppliers.
- 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. We also pay for one specific Pneumococcal vaccination every 5 years for persons under the age of 65 or once in a lifetime for persons older than 65 years.

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: 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.

Make sure your doctor is on the Scheme's network – look on the ***Find a healthcare professional*** tool on the LA Health website at **www.lahealth.co.za**

Maternity Benefit

The Scheme will pay for specific maternity-related benefits for the mother and baby from the Major Medical Benefit. All claims will be paid up to 100% of the Scheme Rate from the Hospital Benefit, not affecting the other day-to-day benefits.

The Maternity Benefit will become available to you when you:

- preauthorise the delivery,
- create a pregnancy profile on the Scheme's website www.lahealth.co.za, or
- by registering your baby on the Scheme.

Maternity Benefit	In-hospital	Theatre fees, intensive and high-care unit costs. Subject to preauthorisation	No overall limit in a KeyCare Hospital
	Out-of-hospital	Antenatal consultations	Up to 8 consultations at your KeyCare gynaecologist, GP or midwife
		Ultrasound scans and prenatal screening	Up to two 2D ultrasound scans and one Nuchal translucency test or one Non-Invasive Prenatal (NIPT) test or one T21 chromosome test, subject to clinical entry criteria
		Blood tests	A defined basket of blood tests per pregnancy
		Pre- and postnatal care for the birthing mother	Up to five pre- or postnatal classes or consultations, up until two years after birth, with a registered nurse
		GP and specialist care for babies and toddlers who are younger than 2 years	Two visits to the chosen KeyCare GP, paediatrician or ear-nose and throat specialist (ENT)
		Other healthcare services for the mother	**Postnatal care:** one lactation consultation with a registered nurse or lactation specialist, one nutritional assessment with a dietitian, two mental healthcare consultations with a counsellor or psychologist and one GP or gynaecologist consultation for post-natal complications

LA KEYPLUS

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 ICON network. You may use a SAOC provider, but will incur a 20% co-payment.

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:

- Hospitals in the KeyCare Network Please see details on the website: www.lahealth.co.za > ***Find a healthcare professional***
- 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
- The KeyCare Dental Network Please see details on the website: **www.lahealth.co.za** > ***Find a healthcare professional***
- KeyCare Renal Network 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.

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 Part B: (What we do not cover – exclusions) of this booklet, they also apply to you.

Note that, in some cases, you might be covered for a condition listed as an exclusion 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.

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

- In-hospital management of:
  - All cosmetic treatment including septoplasies, osteoplasties, osteotomies and nasal tip surgery
  - Dentistry
  - Skin disorders, including benign growths and lipomas
  - Conservative back and neck treatment
  - Obesity
  - Diagnostic work-up and investigative procedures
  - Sexual dysfunction
  - Hearing disorders
  - Functional nasal and sinus problems
  - Nail disorders
- Refractive eye surgery
- Brachytherapy for prostate cancer
- Surgery for oesophageal reflux, hiatus hernia repair and shoulders
- 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
- Bunionectomy
- Removal of varicose veins
- Correction of Hallux Valgus/ Bunion and Tailor's Bunion or Bunionette

ABOUT THE LA FOCUS OPTION

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, including those that are related to Maternity care, from the Major Medical Benefit. We also pay for basic dentistry services, obtained from one of the Scheme's network dentists, from the Major Medical Benefit. Other Day-to-day Benefits, and basic dentistry services obtained from non-network providers, are covered from the Medical Savings Account. The Medical Savings Account is a set amount, which is based on your family's size and composition. This benefit option provides cover for Prescribed Minimum Benefit chronic conditions. Prescribed Minimum Benefits are paid in full subject to clinical criteria and the use of the Scheme's Designated Service Providers (DSPs).

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 > *Find a healthcare professional*** for a list of these hospitals or call us at **0860 103 933** to find out about your nearest network hospital. This is paid from the Major Medical Benefit up to 100% of the LA Health Rate. The network hospitals are also the Scheme's Designated Service Providers for all Prescribed Minimum Benefit treatment and care.

H

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

Day-to-day medical expenses are paid from your Medical Savings Account (MSA), unless stated otherwise. You must pay out of your own pocket if you have used all your Medical Savings Account monies. We will not pay any deductibles from your Medical Savings Account.

Claims paid from your Medical Savings Account can either be paid up to 100% of the LA Health 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.

Basic dentistry

To get the best value from this benefit, you must use the services of a dentist in the LA Focus dental network.

	In Hospital	Out of Hospital
When you use the services of a Dentist in the LA Focus Dental Network (DRC) Subject to managed care rules	All **basic dental codes** used as part of a Specialised or Basic Dentistry procedure is unlimited and paid from Major Medical Benefit	All **basic dental codes** is unlimited and paid from Major Medical Benefit
When you do not use the services of a Dentist in the LA Focus Dental Network (DRC)	**Specialised Dentistry:** all non-hospital accounts, inclusive of any basic dentistry codes that form part of the Specialised Dentistry procedure, paid from Major Medical Benefit and limited per person per year.	**Basic dentistry codes that form part of Specialised Dentistry treatment** paid from and limited to available funds in the Medical Savings Account
	Basic Dentistry: Paid from and limited to funds in the Medical Savings Account	**Basic Dentistry:** Paid from and limited to available funds in the Medical Savings Account

LA FOCUS

The Scheme will pay for basic dentistry when you go to a network dentist

When you visit a dentist in the LA Focus dental network, the Scheme pays the following basic dentistry services:

- General dentist consultations,
- Cleaning and preventative care, such as scaling, polishing, and fluoride treatment (every 180 days), infection control, and sterilisation,
- Extractions and emergency pain relief,
- Intra-oral radiographs and local anaesthetic,
- Fillings, and
- Plastic dentures once every four years (with cover for repairs and re-lining at any time during the four years).

When basic dentistry will be paid from your Medical Savings Account

If you do not make use of the services of a dentist in the LA Focus dental network or if you have a procedure not covered as part of the LA Focus dental network list of codes, basic dentistry services will be paid from your Medical Savings Account.

Advanced dentistry services will always be paid from your Medical Savings Account

Should you need any of the following services, it will always be paid from your Medical Savings Account, even if it is performed by a network dentist:

- Root canal treatment
- Orthodontic treatment
- Crowns or bridges
- Periodontic treatment
- Implants
- Or any other service not covered in the Scheme's agreement with DRC.

You must preauthorise all in-hospital dentistry. If your dentist is a LA Focus Network dentist, and you have basic dentistry treatment in-hospital, the Scheme will pay the costs of this basic care.

For Specialised Dentistry: All other treatment in-hospital and also basic dentistry provided by a non-network dentist, will be limited and paid by the Scheme.

For Basic Dentistry: All other treatment in-hospital and also basic dentistry provided by a non-network dentist, will be paid subject to available Medical Savings Account.

Chronic Illness Benefit

You have cover for the Prescribed Minimum Benefit Chronic Disease List conditions, including the treatment and care associated with these conditions. Please see the Benefits section of this booklet for more details about the Scheme's Chronic Illness Benefits.

Cancer, HIV or Aids, Diabetes or Cardio Care

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 HIV*Care* 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.

Diabetes or Cardio Care

We have special programmes for members with Diabetes or one of the Cardiovascular conditions on the Prescribed Minimum Benefits Chronic Disease List. You can read more about these programmes 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 best use of your Option, you should use the services of Scheme's Network Providers, or the Preferred Providers. If you do not, you will either have to pay more out of your own pocket, or we will pay the claims from your Medical Savings Account, for example for Basic Dentistry.

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

LA FOCUS

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 (PART B: What we do not cover – exclusions) of this booklet, they also apply to you.

Maternity Benefit

The Scheme will pay for specific maternity-related benefits for the mother and baby from the Major Medical Benefit. All claims will be paid up to 100% of the Scheme Rate. If your doctor charges above the Scheme Rate, and you have elected that claims should pay at cost from your Medical Savings Account, any amounts in excess of the Scheme Rate will be paid from your available Medical Savings for specific benefits.

The Maternity Benefit will become available to you when you:

- preauthorise the delivery,
- create a pregnancy profile on the Scheme's website www.lahealth.co.za, or
- by registering your baby on the Scheme.

Maternity Benefit	In-hospital	Theatre fees, intensive and high care unit costs. Subject to preautorisation	No overall limit in LA Focus Network hospitals only
	Out-of-hospital	Antenatal consultations	Up to 8 consultations at a gynaecologist, GP or midwife
		Prenatal screening • 2 D Ultrasound scans • One Nuchal translucency test or one Non-Invasive Prenatal (NIPT) test or one T21 Chromosome test, subject to clinical entry criteria	• Up to 2 scans • 1 test, subject to clinical criteria
		Blood tests	A defined basket of routine blood tests per pregnancy
		Pre-and postnatal care for the birthing mother	Up to 5 pre- or post-natal classes or consultations, up until 2 years after the birth, with a registered nurse
		GP and specialist care for babies and toddlers who are younger than 2 years	2 visits to the GP, paediatrician or ear-nose and throat specialist (ENT)
		Other Postnatal care services for the birthing mother	• 1 lactation consultation with a registered nurse or lactation specialist • 1 nutritional assessment with a dietician • 2 mental healthcare consultations with a counsellor or psychologist • 1 GP or gynaecologist consultation for post-natal complications

If you are not registered on the Maternity Programme, day-to-day expenses will be paid from the Medical Savings Account.

ABOUT THE LA ACTIVE OPTION

LA Active covers hospital treatment at any private hospital, and other large medical costs, including those that are related to Maternity care, from the Major Medical Benefit. 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 Benefits. 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 covers for PMB chronic conditions. Prescribed Minimum Benefits are paid in full subject to clinical criteria and the use of the Scheme's Designated Service Providers (DSPs).

Hospital stays

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

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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 Extended Day-to-day Benefit.

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

The Scheme pays from the Major Medical Benefit for the mother's care before and after the birth, and care for the baby after the birth, from the Maternity Benefit, subject to registration and specific limits and criteria.

Current year Medical Savings Account

Your current year Medical Savings Account pays for all your day-to-day expenses, including further basic dentistry or maternity care (once the initial Major Medical limits for dentistry or the Maternity Benefit are 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 LA Health 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 GPs 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 day-to-day 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: 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.

LA ACTIVE

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 Benefit

You have cover for the Prescribed Minimum Benefit Chronic Disease List conditions, including the treatment and care associated with these conditions. Please see the Benefits section of this booklet for more details about the Scheme's Chronic Illness Benefits.

Cancer, HIV or Aids, Diabetes or Cardio Care

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 HIV*Care* 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.

Diabetes or Cardio Care

We have special programmes for members with Diabetes or one of the Cardiovascular conditions on the Prescribed Minimum Benefits Chronic Disease List. You can read more about these programmes 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 the benefits offered by your Option, you should use the Scheme's Network 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 ACTIVE

Maternity Benefit

The Scheme will pay for specific maternity-related benefits for the mother and baby from the Major Medical Benefit. All claims will be paid up to 100% of the Scheme Rate. If your doctor charges above the Scheme Rate, and you have elected that claims should pay at cost from your Medical Savings Account, any amounts in excess of the Scheme Rate will be paid from your available Medical Savings for specific benefits.

The Maternity Benefit will become available to you when you:

- preauthorise the delivery,
- create a pregnancy profile on the Scheme's website www.lahealth.co.za, or
- by registering your baby on the Scheme.

Maternity Benefit	In-hospital	Theatre fees, intensive and high care unit costs. Subject to preautorisation	No overall limit
	Out-of-hospital	Antenatal consultations	Up to 8 consultations at a gynaecologist, GP or midwife
		Prenatal screening • 2 D Ultrasound scans • One Nuchal translucency test or one Non-Invasive Prenatal (NIPT) test or one T21 Chromosome test, subject to clinical entry criteria	• Up to 2 scans • 1 test, subject to clinical criteria
		Blood tests	A defined basket of routine blood tests per pregnancy
		Pre-and postnatal care for the birthing mother	Up to 5 pre- or post-natal classes or consultations, up until 2 years after the birth, with a registered nurse
		GP and specialist care for babies and toddlers who are younger than 2 years	2 visits to the GP, paediatrician or ear-nose and throat specialist (ENT)
		Other Postnatal care services for the birthing mother	• 1 lactation consultation with a registered nurse or lactation specialist • 1 nutritional assessment with a dietician • 2 mental healthcare consultations with a counsellor or psychologist • 1 GP or gynaecologist consultation for post-natal complications

If you are not registered on the Maternity Programme, day-to-day expenses will be paid from the Medical Savings Account.

ABOUT THE LA CORE OPTION

LA Core covers hospital treatment at any private hospital, and other large medical costs, including those that are related to Maternity care, from the Major Medical Benefit. 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. The day-to-day benefit limits for the Medical Savings Account and Extended Day-to-day 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. Prescribed Minimum Benefits are paid in full subject to clinical criteria and the use of the Scheme's Designated Service Providers (DSPs).

Hospital stays

We pay for treatment at any private 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, 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.

Certain pregnancy and birth-related benefits are paid from Major Medical Benefit through the Maternity Benefit.

Current year Medical Savings Account

Your current year Medical Savings Account pays for all your day-to-day expenses, and for further maternity care once the Maternity Benefit 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 LA Health 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 GPs 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: 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.

LA CORE

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 Benefit

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

Cancer, HIV or Aids, Diabetes or Cardio Care

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 HIV*Care* 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.

Diabetes or Cardio Care

We have special programmes for members with Diabetes or one of the Cardiovascular conditions on the Prescribed Minimum Benefits Chronic Disease List. You can read more about these programmes 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 the benefits offered by your Option, you should use the Scheme's Network 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 CORE

Maternity Benefit

The Scheme will pay for specific maternity-related benefits for the mother and baby from the Major Medical Benefit. All claims will be paid up to 100% of the Scheme Rate. If your doctor charges above the Scheme Rate, and you have elected that claims should pay at cost from your Medical Savings Account, any amounts in excess of the Scheme Rate will be paid from your available Medical Savings for specific benefits.

The Maternity Benefit will become available to you when you:

- preauthorise the delivery,
- create a pregnancy profile on the Scheme's website www.lahealth.co.za, or
- by registering your baby on the Scheme.

Maternity Benefit	In-hospital	Theatre fees, intensive and high care unit costs. Subject to preautorisation	No overall limit
	Out-of-hospital	Antenatal consultations	Up to 8 consultations at a gynaecologist, GP or midwife
		Prenatal screening • 2 D Ultrasound scans • One Nuchal translucency test or one Non-Invasive Prenatal (NIPT) test or one T21 Chromosome test, subject to clinical entry criteria	• Up to 2 scans • 1 test, subject to clinical criteria
		Blood tests	A defined basket of routine blood tests per pregnancy
		Pre-and postnatal care for the birthing mother	Up to 5 pre- or post-natal classes or consultations, up until 2 years after the birth, with a registered nurse
		GP and specialist care for babies and toddlers who are younger than 2 years	2 visits to the GP, paediatrician or ear-nose and throat specialist (ENT)
		Other Postnatal care services for the birthing mother	• 1 lactation consultation with a registered nurse or lactation specialist • 1 nutritional assessment with a dietician • 2 mental healthcare consultations with a counsellor or psychologist • 1 GP or gynaecologist consultation for post-natal complications

If you are not registered on the Maternity Programme, day-to-day expenses will be paid from the Medical Savings Account.

ABOUT THE LA COMPREHENSIVE OPTION

LA Comprehensive covers hospital treatment at any private hospital and other large medical costs, including those that are related to Maternity care, 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. Prescribed Minimum Benefits are paid in full subject to clinical criteria and the use of the Scheme's Designated Service Providers (DSPs).

Hospital stays

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

H

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.

The Scheme pays for the mother's care before and after the birth, and care for the baby after the birth, from the Maternity Benefit, subject to specific limits and criteria.

Current year Medical Savings Account

Your current year Medical Savings Account pays for 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 LA Health 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 cover for day-to-day medical expenses from the Above Threshold Benefit. Some benefits may have specific limits once you are in your Above Threshold.

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

Once the monies in your Above Threshold Benefit is exhausted for the specific limited benefits only, some 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.

LA COMPREHENSIVE

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 Benefit

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

Cancer, HIV or Aids, Diabetes or Cardio Care

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 HIV*Care* 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.

Diabetes or Cardio Care

We have special programmes for members with Diabetes or one of the Cardiovascular conditions on the Prescribed Minimum Benefits Chronic Disease List. You can read more about these programmes 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.

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.

Which healthcare providers to use for LA Comprehensive

To make the best use of the benefits offered by your Option, you should use the Scheme's Network Providers or the Preferred Providers. If you do not, you will have to pay any excess costs out of your own pocket.

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

LA COMPREHENSIVE

Maternity Benefit

The Scheme will pay for specific maternity-related benefits for the mother and baby from the Major Medical Benefit. All claims will be paid up to 100% of the Scheme Rate. If your doctor charges above the Scheme Rate, and you have elected that claims should pay at cost from your Medical Savings Account, any amounts in excess of the Scheme Rate will be paid from your available Medical Savings for specific benefits.

The Maternity Benefit will become available to you when you:

- preauthorise the delivery,
- create a pregnancy profile on the Scheme's website www.lahealth.co.za, or
- by registering your baby on the Scheme.

Maternity Benefit	In-hospital	Theatre fees, intensive and high care unit costs. Subject to preautorisation	No overall limit
	Out-of-hospital	Antenatal consultations	Up to 8 consultations at a gynaecologist, GP or midwife
		Prenatal screening • 2 D Ultrasound scans • One Nuchal translucency test or one Non-Invasive Prenatal (NIPT) test or one T21 Chromosome test, subject to clinical entry criteria	• Up to 2 scans • 1 test, subject to clinical criteria
		Blood tests	A defined basket of routine blood tests per pregnancy
		Pre-and postnatal care for the birthing mother	Up to 5 pre- or post-natal classes or consultations, up until 2 years after the birth, with a registered nurse
		GP and specialist care for babies and toddlers who are younger than 2 years	2 visits to the GP, paediatrician or ear-nose and throat specialist (ENT)
		Other Postnatal care services for the birthing mother	• 1 lactation consultation with a registered nurse or lactation specialist • 1 nutritional assessment with a dietician • 2 mental healthcare consultations with a counsellor or psychologist • 1 GP or gynaecologist consultation for post-natal complications

If you are not registered on the Maternity Programme, day-to-day expenses will be paid from the Medical Savings Account.

The BENEFITS

LA HEALTH

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:

LA KEYPLUS

- Major Medical Benefit (for hospital and major expenses). Only hospitals in the KeyCare Network will provide full cover for planned procedures. The KeyCare Network Hospitals are the Scheme's Designated Service Providers for all Prescribed Minimum Benefits
- Prescribed Minimum Benefits, including 26 chronic conditions
- Maternity-related benefits for the mother and newborn baby for up to two years after the birth
- Day-to-day benefits: limited and from the Scheme's Network Providers

LA FOCUS

- Major Medical Benefit (for hospital and major expenses obtained from a hospital in the LA Focus hospital network and basic dentistry obtained from a dentist in the LA Focus Dental Network). Hospitals in the LA Focus Hospital Network are the Scheme's Designated Service Providers for Prescribed Minimum Benefits
- Prescribed Minimum Benefits, including 26 chronic conditions
- Maternity-related benefits for the mother and newborn baby for up to two years after the birth
- Medical Savings Account (for day-to-day medical expenses)

LA ACTIVE

- Major Medical Benefit (for hospital and major expenses)
- Prescribed Minimum Benefits, including 26 chronic conditions
- Maternity-related benefits for the mother and newborn baby for up to two years after the birth
- 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 Benefits, including 26 chronic conditions
- Additional, non-Prescribed Minimum Benefit, chronic conditions
- Maternity-related benefits for the mother and newborn baby for up to two years after the birth
- 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 Benefits, including 26 chronic conditions
- Additional, non-Prescribed Minimum Benefit, chronic conditions
- Maternity-related benefits for the mother and newborn baby for up to two years after the birth
- 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 in-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 from this Major Medical Benefit.

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

Chronic Illness 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.lahealth.co.za > Find a document** 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 five benefit options

PRESCRIBED MINIMUM BENEFITS

The Chronic Illness Benefit covers approved medicine for the 26 Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions. We will pay your approved medicine in full if it is on our medicine list (formulary). If your approved medicine is not on our medicine list, we will pay your chronic medicine up to a set monthly amount, called the Chronic Drug Amount (CDA), for each medicine class. The CDA does not apply to the LA KeyPlus Benefit Option.

If you use more than one medicine in the same medicine class, where both medicines are not on the medicine list, or where one medicine is on the medicine list and the other is not, we will pay for both medicines up to the one monthly CDA for that medicine class.

If you choose to use medicine that is not on our medicine list, you may have a co-payment. You will need to pay these co-payments yourself.

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.

TESTS, PROCEDURES AND CONSULTATIONS

If your PMB CDL condition is approved, the Chronic Illness Benefit will automatically open access to cover for a limited number of selected tests, procedures and/or specialist consultations for the diagnosis and ongoing management of your condition. You will also have cover for four (4) GP consultations related to your approved PMB CDL condition(s) per year (We call this a 'treatment basket').

The number of tests and consultations are calculated based on the number of months left in the year at the time your condition is approved. If you have cover for the same procedures or tests for more than one condition, funding will be limited to the basket that gives you the most procedures or tests.

If you want to access cover from the Chronic Illness Benefit, you must apply for it. You need to complete a Chronic Illness Benefit Application form with your doctor and submit it for review. You can get your latest application form on the website www.lahealth.co.za > Find a document or call **0860 103 933** to get one.

YOU MUST PROVIDE INFORMATION TO GET ACCESS TO THE CHRONIC ILLNESS BENEFIT

For a condition to be covered from the Chronic Illness Benefit, there are certain clinical criteria that need to be met. You or your doctor may need to provide certain test results or extra information and motivation to finalise your application. The application form will give you the details as to which documents and extra information you will need to submit. Please ensure that these documents are submitted with your application.

Remember, if you leave out any information or do not provide medical test results or documents needed with the application, cover will start from the date we receive the outstanding information.

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 membership, 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.

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

LA HEALTH

Here is the list of Prescribed Minimum Benefit Chronic Disease List conditions covered on all Benefit Options:

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

Diabetes or Cardio Care Programmes

If we have authorised Chronic Illness Benefits for your Diabetes or heart-related condition, you will have access to the Diabetes or Cardio Care Programme. Your Network GP will need to register you.

For more information about the conditions we cover as chronic illnesses, visit **www.lahealth.co.za > Benefits and cover > Prescribed Minimum Benefits > Chronic Illness Benefit** or phone **0860 103 933.**

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

- Ankylosing spondylitis
- Arthritis
- Attention deficit hyperactivity disorder
- Chronic urticaria
- Cystic fibrosis
- Depression
- Eczema
- Gastro-oesophageal reflux disease
- Gout
- Ménière's disease
- Migraine
- Motor neuron disease
- Myasthenia gravis
- Narcolepsy
- Osteoporosis
- Paget's disease
- Psoriasis
- Scleroderma and other collagen-vascular diseases
- Trigeminal neuralgia
- Urinary incontinence
- Zollinger Ellison syndrome

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 medicine. The amount of money in the Medical Savings Account is determined by the family size and the composition of the membership.

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, your positive Medical Savings Account balance is paid out in the fifth month after you resign from LA Health. It is paid to your new scheme if you move to an option with a medical savings account. If your new option does not have a Savings Account, or if you don't join another scheme, we pay it back to you.

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. This may result in debt due to the Scheme.

Any amounts paid out by the Scheme for unfunded claims will be recovered from you - either through the Scheme's debt collection process, from your unused, accumulated MSA from previous years or from the following year's MSA allocation, at the beginning of the next year.

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

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

On LA Core and LA Active the Extended Day-to-day Benefit 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.

If any out-of-hospital treatment qualify for benefits under the Prescribed Minimum Benefits, you may apply for cover from the Major Medical Benefit.

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. Some limits apply for specific benefits, such as acute medicine.

At the beginning of the year, the Above Threshold 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.

LA HEALTH

- 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.

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.

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 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 you in your Benefit Schedule for mores details about cover for cancer.

PET Scans

Oncology-related PET scans are paid in full when you have not reached the Oncology Threshold amount and you are using the services of a provider in the Scheme's PET Scan Network. Once you have reached the threshold, or if you obtain services from a non-Network provider, and your claim is not related to a Prescribed Minimum Benefit, the Scheme will pay at 80% of the Scheme Rate from R1.

Stem Cell Transplants

You have access to local and international bone marrow donor searches and transplant up to the agreed rate. Your cover is subject to clinical protocols, review and approval.

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

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

You have to register on the HIV*Care* Programme to access these benefits. Call us on **0860 103 933** 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 will 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). You must make use of the services of a Designated Service Provider to obtain the HIV or AIDS medicine. If you don't, you may have to pay a co-payment from your own pocket.

You must make use of the services of one of the Scheme's DSP GPs or Specialists to treat the disease. If the services of a DSP provider is not used, you will have to make a 20% out-of-pocket co-payment.

DURING PREGNANCY AND AFTER THE BIRTH

Benefits for you and your baby

To ensure you qualify for your pregnancy-related care, and care for your newborn baby to be paid from the Maternity Benefit please:

- preauthorise the delivery, or
- create a pregnancy profile on the DiscoveryApp or the Scheme's website www.lahealth.co.za, or
- register your baby on the Scheme.

We pay specific benefits from a defined basket or care, as explained under your specific Benefit Option description.

For members on the LA Comprehensive, LA Core, LA Active and LA Focus Options: If you make use of the services of one of the Scheme's Network providers or if your doctor charges at the Scheme Rate, we will pay the claims in full. If it is not a Network provider, or charges are not at the Scheme Rate, we will pay the shortfall from your available Medical Savings Account monies for qualifying claims. Otherwise, you may have to pay the shortfall from your own pocket.

Members on the LA KeyPlus Option must use the services of their chosen KeyCare GP or Specialist.

Trauma recovery benefit

Trauma Recovery Benefits are paid in addition to any relevant Prescribed Minimum Benefits from the Major Medical Benefit and are limited, based on the specific Benefit Option.

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 Benefit Options and pays:

1. Day-to-day claims following the traumatic onset of:
   - Paraplegia
   - Quadriplegia
   - Tetraplegia
   - Hemiplegia.
2. Day-to-day claims for conditions resulting from the following traumatic incidents:
   - Near drowning
   - Severe anaphylactic reaction
   - Poisoning
   - 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.

Cover for going to casualty

We will cover the cost of your casualty visit from the Major Medical Benefit if you are admitted to hospital from casualty. You must call us to authorise the hospital stay.

If you are not admitted to hospital from casualty, we will still cover the casualty cost, but from your day-to-day benefits (excluding the treatment and care of a Prescribed Minimum Benefit condition).

On LA KeyPlus you are entitled to one casualty visit, at a designated service provider, per beneficiary, per year and will have to pay a portion of the account and any pathology, radiology and medicine will be paid subject to the LA KeyPlus lists of procedures and formularies.

Designated service providers

Each Benefit Option has different Designated Service Providers for the diagnosis, treatment and care of the 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.

Home-based care

Certain services, that are normally provided in the hospital, can safely be obtained at home. If authorised, and the services of the Scheme's Network Providers are used, the Scheme will pay for these services from the Major Medical Benefit. We pay wound care, end-of-life care, IV infusions and postnatal care services from this benefit.

***Remember** to obtain authorisation before you obtain these benefits in your home to ensure we pay for it from the Major Medical benefit.*

LA HEALTH

Designated Providers and for Prescribed Minimum Benefits 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, RAMOT and Nishtara	All LA Health Benefit Options
	General Practitioners	KeyCare GP network	LA KeyPlus
		Discovery GP network	LA Focus, LA Active, LA Core and LA Comprehensive
	General Practitioners and Specialists who treat HIV or AIDS	Premier Plus GP or Premier Specialist Network	All LA Health Benefit Options
	Specialists	KeyCare Specialists	Any Specialist working in a KeyCare Network Hospital
		Premier Specialist network	LA Focus, LA Active, LA Core and LA Comprehensive
	Dentists	Dental Risk Company (DRC)	LA KeyPlus and LA Focus
	Medicine	Pharmacies dispensing at the LA Health Medicine Rate	All LA Health Benefit Options
	Medicine for HIV or AIDS	Preferred providers: Clicks, Dis-Chem, MediRite, Pick n Pay, Netcare Medicross, Mediclinic and MedXpress	All LA Health Benefit Options
	Oncology medicine	Pharmacies dispensing at the LA Health Medicine Rate	All LA Health Benefit Options
	PET Scans	At the Scheme's PET Scan Network	All LA Health Benefit Options
	Renal Care, including dialysis	KeyCare Renal Network (if you use another provider, we will pay up to the DSP rate only)	LA KeyPlus
		National Renal Care; Fresenius; B. Braun; Kwa-Zulu Natal Dialysis; Richards Bay Medical Institute and Esmé de Beer	LA Comprehensive, LA Core, LA Active and LA Focus
	Oxygen rental	VitalAire	All LA Health Benefit Options
	In-hospital Pathology	At the Scheme's Designated Service Providers	All LA Health Benefit Options

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 preauthorise treatment where these devices will be used. To avoid a 20% deductible, you should also make use of the services of the Scheme's network provider when you need a PET Scan. We will tell you who the nearest Network Provider is when you authorise the scan.

Virtual GP consultations

You will be able to make online appointments and book after-hour virtual consultations with your Network GP.

International clinical review consultations

The Scheme will pay 50% of the cost of a second-opinion consultation with a specialist at the Cleveland Clinic, one of the world's top centres of medical expertise. You will have to preauthorise this procedure.

What we do not cover (exclusions)

There are certain medical expenses and other costs the Scheme does not cover. We call these exclusions. Except where Prescribed Minimum Benefits apply, 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; removal of portwine stains; blepharoplasty (eyelid surgery); removal of keloid scars; hair removal; nasal reconstruction (including septoplasties, osteotomies and nasal tip surgery); healthcare services related to gender reassignment
- Breast reductions and implants
- Treatment for obesity
- Treatment for infertility, subject to Prescribed Minimum Benefits
- Frail care
- Experimental, unproven or unregistered treatment or practices

The purchase of the following, unless prescribed:

- applicators, toiletries and beauty preparations;
- bandages, cotton wool and other consumable items;
- patented foods, including baby foods;
- tonics, slimming preparations and drugs
- household and biochemical remedies
- anabolic steroids and
- sunscreen agents.

Unless otherwise decided by the Scheme, benefits in respect of these items, on prescription, are limited to one month's supply for every prescription or repeat thereof.

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), unless stated differently for specific benefits

Always check with us

Please contact us if you have one of the conditions we exclude 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.

HOW TO CLAIM AND MANAGE YOUR MEMBERSHIP

Send LA Health your claims

You must make sure your doctor or other healthcare practitioner has your LA Health membership number and 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. Send the original account, and a receipt (if you paid), and make sure your membership number 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 by logging in to **www.lahealth.co.za > Claims transaction history**

Statements will be posted to you if you do not have access to email.

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 four 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 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.

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 log in to **www.lahealth.co.za > Health Records** for more information.

Manage your membership

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

- Call us on **0860 103 933**
- Log in to **www.lahealth.co.za > Find a healthcare professional**

Track your claims or review what benefits you have available

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

- Call us on **0860 103 933**
- Log in to **www.lahealth.co.za > Claims search**

Download the Discovery app

By using the Discovery app on your smartphone, you will have access to:

- your electronic membership card
- your medical scheme details
- Claims information, including your recent claims, submitting a claim and looking for a specific claim
- your health record, etc.

You will also be able to make a GP appointment online and book your virtual after-hour consultations.

LA HEALTH

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 > Find a document** 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, ask your broker to hand it in at your employer or send it to the contact details given on the form.

If you are asked to provide proof of ongoing eligibility for your child dependants between the ages of 21 and 27

Ask your employer to stamp the documents as proof that they are aware of the information supplied to the Scheme.

Submit the documents to the Scheme within the required timeframes as we will not make any backdated changes to your dependant's status.

If you do not supply the proof as required, your dependant will pay contributions at adult rates from the 1st of the month, following the month of his/her birthday (21-26).

From their 27th birthday your child dependants are no longer eligible to pay contributions at child rates

The Scheme will automatically charge contributions at adult rates from the 1st of the month after the child's 27th birthday.

Change your benefit option

You can change to one of the other Benefit Options offered by the Scheme 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 > Find a document** or ask your payroll department for the correct form.

ADDITIONAL INFORMATION

Quick A – 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. For Prescribed Minimum Benefit Chronic Disease List chronic illness, this applies to medicine that is not listed on the medicine list (formulary). For the Additional Chronic Diseases the CDA allows members access to full cover, depending on their choice of medicine within a specific drug class. The CDA includes VAT and the dispensing fee. The CDA is not applicable to LA KeyPlus.

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 for Prescribed Minimum Benefits. 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 the LA Health Rate and you will have to pay the provider.

LA Health Medicine Rate

This is the maximum amount the Scheme will pay for medicine and is normally based on the Single Exit Price [SEP] 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, subject to clinical criteria.

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 providers

Members must use the services of the providers to ensure payment in full. LA Health has GP, Specialist and other networks. When you don't use their services, we normally pay the claim to you at the Scheme Rate, and you must then pay the amount charged to the provider.

Network hospitals

Members on the LA KeyPlus and LA Focus Benefit Options must use specific hospitals to avoid a co-payment for planned procedures. LA Health has made special arrangements with these hospitals to make sure 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).

LA HEALTH

Preferred providers

The Scheme has agreements with these preferred providers (PP) and prefer that you use their services, such as the suppliers of devices for hip and knee replacements. If you do not use their services, we will only pay up to a limit , or at the rate we would pay our PP.

Positive medical savings account balances paid out

Your positive Medical Savings Account balance is paid out in the fifth month after you resign from LA Health. It is paid to your new scheme if you move to an Option with a Medical Savings Account. If your new Option does not have a Medical Savings Account, or if you don't join another scheme, we pay it back to you.

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, non-hospital 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.

Combating fraud

Healthcare provider claims are paid in good faith. Claiming patterns and behaviour are only properly reviewed and validated after payment has been made. Discovery Health has a large database, which allows for detection of unusual conduct or discrepancies. If an irregularity warrants an investigation by the Forensic Department, the relevant provider or member is always given the opportunity to respond.

If, however, it becomes clear from the investigation that someone has committed fraud, the perpetrator may face criminal or civil charges. If a healthcare professional is involved, fraudulent activity may result in the provider losing a career in healthcare by having their required professional registration canceled. The Scheme may also no longer pay the provider directly, or not at all.

Members guilty of fraud could lose their healthcare cover altogether and employees could face disciplinary action and be fired.

Financial advisers found to be involved in fraud will have their licenses revoked and be reported to the Financial Services Board and the Registrar for Medical Schemes

How you can help combat fraud

If you have even the slightest suspicion that someone is committing fraud, report all information you have to the Discovery fraud hotline, using any of the following contact details:

- Toll-free phone: **0800 004 500**
- SMS: **43477**
- Toll-free fax: **0800 007 788**
- Email: **discovery@tip-offs.com**
- Post: **Freepost DN298, Umhlanga Rocks. 4320**
- Or send an email to our fraud department directly to **discovery@tip-offs.com**

You may remain anonymous and we will handle all calls and contact in strict confidentiality. We will list any person found guilty of committing fraud on a register and take steps to recover any money members or the Scheme may have lost in the process.

Contact us

General questions and services

- Email **service@discovery.co.za**
- Website **www.lahealth.co.z**a
- Call centre **0860 103 933**

Physical addresses

- Cape Town, Sable Park, Bridgeways Precinct, Century City
- Johannesburg 1 Discovery Place, Sandton 2196
- Durban 41 Imvubu Park Place, Riverhorse Valley Business Estate, Nandi Drive
- Port Elizabeth Discovery, BPO Building, Coega IDZ - Zone 4

Discovery mobile

SMS the keyword to **31347**

Ambulance and other emergency services

0860 999 911

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**
- Log in to the **Discovery App**

To arrange approval for your chronic medicine

Call **0860 103 933**

For anonymous fraud tips

Fraud hotline **0800 004 500**

This brochure is a summary of the benefits and features of LA Health Medical Scheme, pending formal approval from the Council for Medical Schemes for 2020. The information in this brochure does not replace the Scheme Rules. The registered Rules are legally binding and will always take precedence.

● Client Services 0860 103 933 ● Fax 011 539 7276 ● www.lahealth.co.za ● service@discovery.co.za ●
Report fraud anonymously 0800 004 500

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