LA-HEALTH BENEFITS

PREAMBLE

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1.1 Subject to the provisions contained in these rules, members paying the contributions as specified in the relevant contribution schedule of Annexure A, are entitled to the benefits for themselves and for their registered dependants, as set out in the corresponding benefit schedule hereof.

1.2 Unless specifically provided otherwise in these Rules the Scheme shall provide beneficiaries with full cover (i.e. at 100% of cost) for services rendered by a designated service provider or subject to paragraph 1.4 and 9.3 at 100% of cost up to the LAHR or LAMR whichever is applicable where services are voluntarily obtained from a non-designated service provider in respect of diagnosis, treatment and care for the conditions specified in the Statutory Prescribed Minimum Benefits in at least one service provider or service provider network which shall at all times include the State Hospital system.

1.3 The diagnosis, treatment and care costs of the statutory prescribed minimum benefit conditions will be paid in full if those services are obtained from the designated service provider, or if involuntarily obtained from a provider who is not the designated service provider.

1.4 If services in respect of the prescribed minimum benefit conditions are voluntarily obtained from a provider who is not a designated service provider;

- where the service is rendered in a non-DSP hospital the co-payment will be equal to the difference between the fees that would have been charged by the DSP and that which were actually charged, unless the benefit schedule indicates otherwise. This provision is applicable to all options.

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- a co-payment shall apply if the cost of providing diagnosis, treatment and care in respect of the prescribed minimum benefit condition exceeds the amount that the DSP would have charged for such service. The co-payment will be equal to the difference between the fees that would have been charged by the DSP and that which were actually charged, unless the benefit schedules indicate otherwise.

- no co-payment shall apply if the cost of providing diagnosis, treatment and care in respect of the prescribed minimum benefit condition is less than the amount that the DSP would have charged for such service except where the relevant DSP agreement is either capitation or volume related discount-based.

1.5 A beneficiary will be deemed to have involuntarily obtained a service from a provider other than the designated service provider, if:

(a) the service was not available from the designated service provider or would not be provided without unreasonable delay;

(b) immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from the designated service provider; or

(c) there was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.

1.6 If cover, in terms of these rules, for a condition specified in the prescribed minimum benefits is exhausted while the patient is still undergoing or requires diagnosis, care or treatment for that condition, the Scheme will accept liability for all costs incurred, subject to paragraph 1.4 above.

2 Pre-authorization shall be required before non-emergency hospitalization, surgical procedures and other specified items may qualify for benefits. In the case of an emergency the Scheme must be notified thereof within two working days after such an emergency admission or treatment having been initiated, failing which paragraph 3 (c) of this preamble will apply. Notwithstanding anything to the contrary in these rules contained, the Scheme shall not refuse such authorization or pre-authorization for a prescribed minimum benefit in a public hospital.

3 In respect of benefits set out in this Annexure the following principles shall apply in all cases where pre-authorization is required -

(a) if pre-authorization is obtained and the treatment does not exceed the authorization, the treatment will qualify for the benefits as stated;

(b) if pre-authorization is obtained and the authorization is exceeded, benefits will only accrue for the authorized treatment. The cost pertaining to the treatment in excess of that pre-authorized will be payable by the member. In exceptional cases the Board may agree to a retrospective authorization, subject to such terms and conditions as the Board may determine.

(c) if treatment is undergone without pre-authorization having been obtained, application may be made retrospectively for an authorization. In the event of such authorization being granted the benefit will, except in cases of an emergency medical condition or where from a clinical perspective the required authorization would under normal circumstances have been issued in accordance with the findings of the Scheme's Medical Advisor on the merits of each case, be subject to a co-payment of 30% with a maximum of R1000 per case. If authorization is declined no benefits will accrue: Provided that authorization for prescribed minimum benefits will not be refused, but shall be covered in full as provided for in paragraph 1 above.

4 Claims must be submitted in accordance with the instructions contained in Annexure D.

5 Maximum annual benefits shall be calculated from 1 January to 31 December each year, based on the services rendered during that year.

6 Benefits are not transferable from one financial year to another or from one category to another.

7 The Scheme shall if circumstances so dictate enter into or cause to be entered into such arrangements, agreements or contracts with healthcare professionals, private

hospitals or hospital groups, including but not limited to per diem reimbursements, as may be considered appropriate. Benefit entitlements shall, unless otherwise indicated in the benefit schedules appended hereto, be 100% of the cost according to the arrangement, agreement or contract.

8 DENTAL SERVICES

8.1 Basic Dentistry

Services include:

(a) consultations, including full mouth examination, charting and treatment planning and visits;

(b) full mouth intra-oral radiographs payable once per beneficiary in a 2 year cycle;

(c) intra-oral periapical and occlusal radiographs;

(d) bitewing radiographs – 1 set of bitewing per beneficiary per annum;

(e) panoramic radiographs – payable once per beneficiary in a 2 year cycle;

(f) prophylaxis – 2 per beneficiary per annum;

(g) topical application of fluoride – 1 treatment per annum for a beneficiary up to 18 years of age;

(h) fissure sealants on children up to 18 years only;

(i) endodontics (root canal treatment);

(j) dentures (plastic and partial metal base) – limited to 1 set per arch per beneficiary in a 2 year cycle, excluding gold inlays in dentures; and re-lining & re-basing of dentures;

(k) plastic restoration; and

(l) base metal inlays in posterior teeth only.

(m) extractions and surgical removal of teeth.

8.2 Special Dentistry - subject to pre-authorisation

Services include:

(a) orthodontic treatment;.

(b) periodontic treatment;

(c) prostodontic treatment;

(d) crown and bridge-work.

(e) Gold inlays and gold restorations on permanent teeth only.

8.3 Dental treatment required to be carried out in a Hospital or Day Clinic under general anaesthetic or conscious sedation, shall be subject to the relevant Benefit Schedules.

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9. PRESCRIBED MEDICINE

Services include the cost of medicines and materials for injections and vaccinations, prescribed by a medical practitioner, dentist or any other service provider who is

legally entitled to prescribe medicine for use out of hospital. The benefits provided for in the Annexures appended hereto are subject to:

9.1 The benefit in respect of medicines being restricted per prescription to a maximum of one month's supply of each kind of medicine prescribed or to a maximum of the nearest equivalent standard packaging of each kind of medicine prescribed, as the case may be; and

9.2 If the Maximum Medical Aid Price List of Medicine issued by the Pharmaceutical Society of South Africa contains an equivalent for any medicine prescribed, the benefit in respect of the medicine so prescribed shall be calculated on the maximum medical aid price of such equivalent medicine.

9.3 Chronic Medication

For the purposes hereof the Scheme regards chronic medication, as medicines that are used for the treatment of the chronic disease conditions and for the life threatening conditions which fall within the conditions shown on the CDL. and PMB chronic conditions.

The Chronic Disease List (CDL) appended to the benefit schedules hereto reflects the prescribed minimum benefit conditions. Other chronic conditions where covered by the Scheme are shown in a separate list also, appended to the relevant benefit schedule. This list may be amended by the Board of Trustees from time to time, and any criteria attached to each condition shall be applied in terms of the Scheme's Chronic Medication Programme.

The following further criteria shall pertain:

(a) The medicine must be prescribed by a registered medical practitioner.
(b) The prescribed medicines must, in the opinion of the medical practitioner, be essential to relieve the symptoms or limit the progress of a condition that is ongoing and which could seriously debilitate a person's health.

In Annexure B1 and B2, chronic medication detailed in the CDL is subject to pre-authorisation. PMB conditions have unlimited cover.

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In Annexures B1 to B5, chronic medication detailed in the CDL and PMB is subject to pre-authorisation. PMB conditions have unlimited cover.

PMB conditions and HIV/AIDS treatment is subject to a formulary. Should a beneficiary elect not to use medicine on the formulary or a non-DSP a co-payment equal to the difference between the cost of the formulary medicine and the amount charged for the non-formulary medicine will be applicable.

The DSP for the obtaining of chronic medication is through the Scheme's Pharmacy Networks. Rate of reimbursement as per Annexure G of these Rules.

9.4 Acute Medicines

These are medicines that do not qualify as any of the two aforementioned classifications.

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