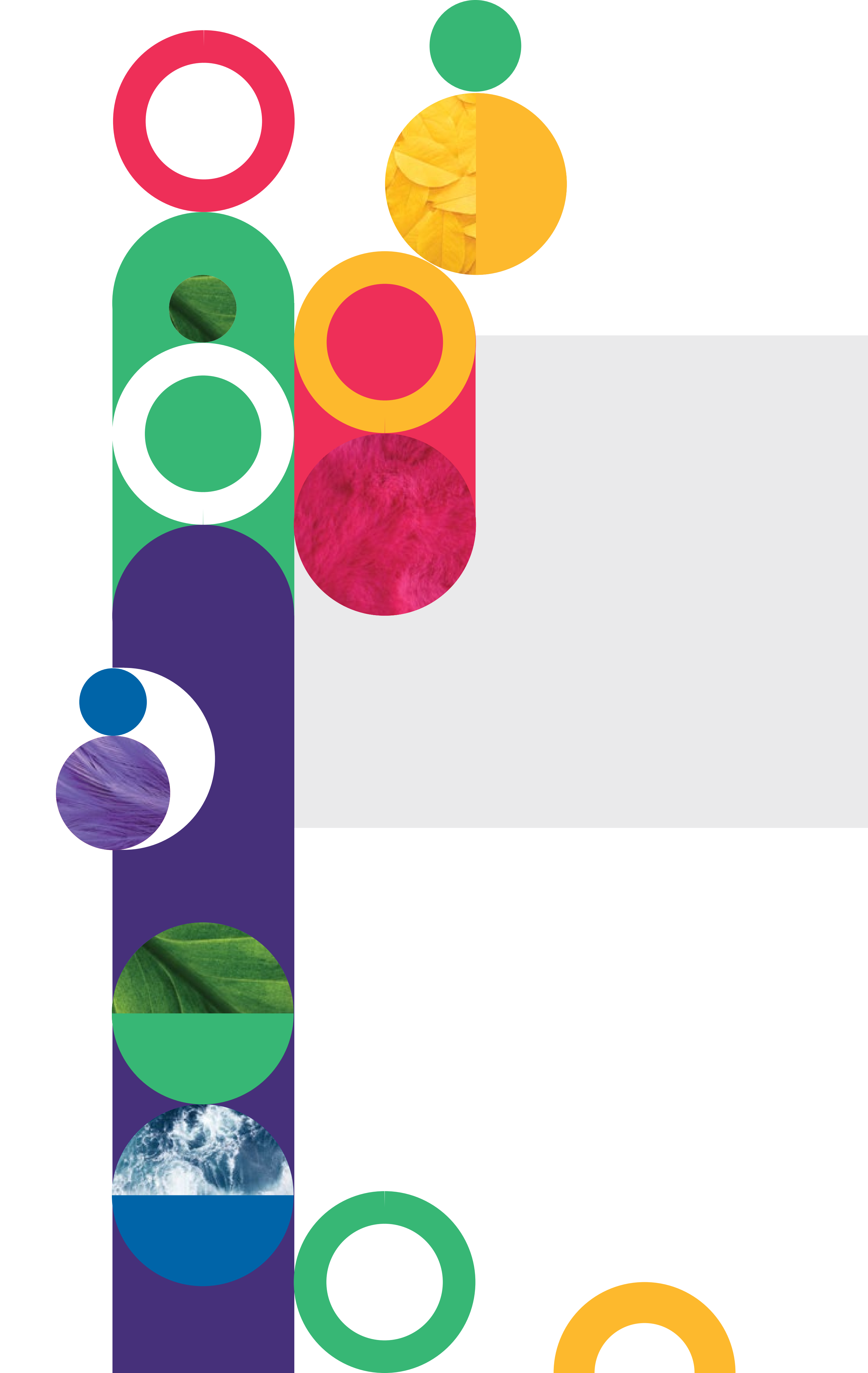
# Benefit Brochure

2025

WE'RE IN IT FOR YOUR HEALTH



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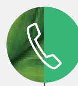
*LA Health Medical Scheme makes the healthcare you and your family need affordable. However, there are limits to how much the Scheme will pay and what it will pay for. This booklet tells you about your medical cover. If you need more detail, please let us know.*

## IF YOU NEED TO TALK TO US



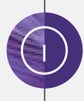
**Phone** 0860 103 933

**Email** service@lahealthms.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). These Benefit Schedules are made available separately.
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 Designated Providers and applicable limits.

## FIVE STEPS TO MAKE THE MOST OF LA HEALTH

1. Contact us 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 and ask your doctor to prescribe the most cost-effective medicine possible.
3. 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).
4. Send us all your claims, even for items that we will not pay for.
5. When you look after your health and make use of the Pharmacy Screening Benefit for blood glucose, blood pressure, cholesterol and weight assessments, you qualify for more wellness benefits.

## VALID CONTACT DETAILS

### VALID CONTACT DETAILS

We need valid contact details for you and every adult member of the family. If we do not have the right information, we will not be able to keep you informed and you may not benefit as you should from all the benefits offered by LA Health. We need a personal email address (not one ending in .gov), your cellphone number and a valid postal address.

Please log on to the website at www.lahealth.co.za to update your details and ask your adult beneficiaries to do to the same. Or call us on 0860 103 933.

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; use day-to-day preferentially priced medicine, do blood tests, or when going to DSP 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.

You unlock more benefits for you and your family when you look after your health. You and your registered dependants just need to make use of the Pharmacy Screening Benefit to unlock the rewards.

### COMPREHENSIVE HOSPITAL COVER

Once you have authorised your stay in hospital, the Scheme provides cover without any overall monetary limits for the hospital costs.

### EMERGENCY COVER WITH FAST, LIFE-SAVING EMERGENCY CARE FOR YOU AND YOUR FAMILY

### 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 through our call centres, website and app. Should you wish to contact us, call us on 0860 103 933. If you need more information on benefits or need a form or your tax certificate, log on to www.lahealth.co.za or download the Discovery app.

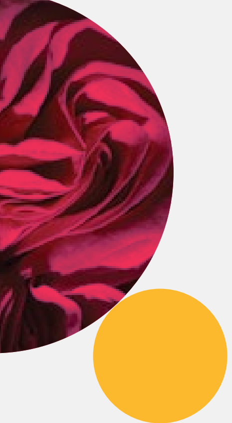
### DAY-TO-DAY BENEFITS TO SUIT YOUR NEEDS

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, 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 lower 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. If you want to ensure your Prescribed Minimum Benefit treatment or care in hospital is covered in full, you must be admitted by a Designated Service Provider GP or Specialist to one of the KeyCare Hospitals. If these conditions are not met, you may have to make co-payments when providers charge above the Scheme Rate.
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.

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

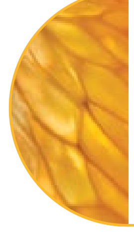
You must apply for cover for treatment for a chronic condition – read more about this in the section that explains how your benefits work and in the section about the Chronic Illness Benefit. Once you are registered, you may also have access to a programme that will give you enhanced benefits for certain chronic conditions.

### MANAGE TREATMENT FOR CANCER, HIV OR AIDS, DIABETES, MENTAL HEALTH 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.

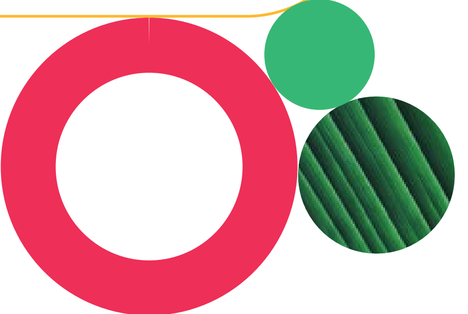
### CLAIMING

Send us your claims as soon as possible, but at least within three months of the treatment. You can email **claims@lahealthms.co.za.** 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. You don't have to send us anything if your doctor will be submitting the claim.



### DOCTORS VISITS, MEDICATION 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 is on the Scheme's list. You will find the details in the Benefit schedule for your Option that is distributed to you separately.



YOU HAVE RECEIVED THIS BOOKLET
BECAUSE YOU ARE A MEMBER OF

## 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 the members and looked after by elected trustees. This money is used to pay for medical expenses and, by law, may not be used for any other purpose.

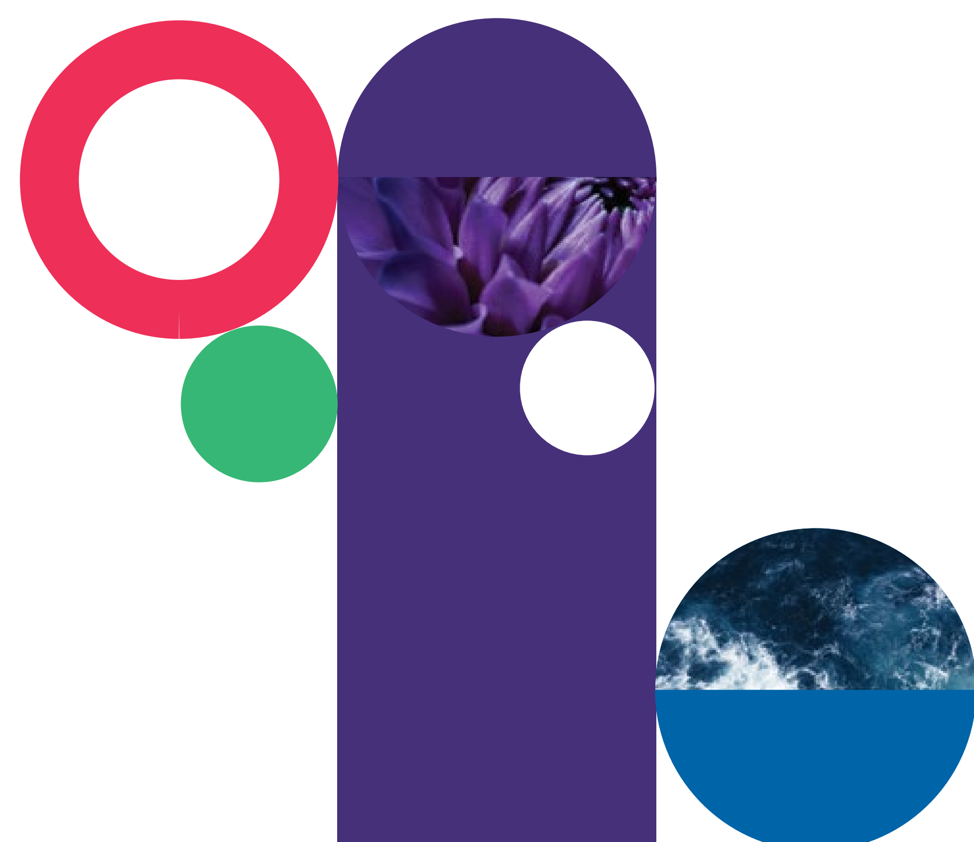
*A 'contribution' is the amount that members pay to the Scheme each month. Your contribution is added to contributions from all other members to form a pool of money. The Scheme uses the money to pay out claims – in a fair and consistent way.*

## 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 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@lahealthms.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 as applicable for the specific 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.

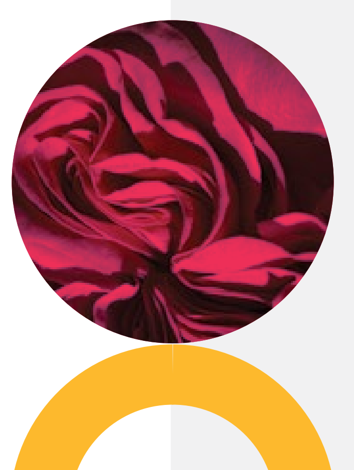
## HOW YOUR BENEFIT WORKS

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 accessing your information on the Discovery app, reading your welcome letter (if you are a new member), or by reading the information sent to you at year end.

You can also request a membership certificate from the website or call centre. You can log in to www.lahealth.co.za or download the app and 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.



KEYPLUS

*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 cover for Prescribed Minimum Benefit (PMB) chronic conditions. You only have benefits for treatment that is given in South Africa.*

*Prescribed Minimum Benefits are paid in full subject to benefit entry criteria and the use of the Scheme's Designated Service Providers (DSPs).*

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.

## 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** get the details on the app, or by calling us on **0860 103 933.** If you do not use the network hospitals for your planned treatment, certain deductibles will apply.

## OPERATIONS AND PROCEDURES ONLY COVERED IN DAY-CARE FACILITIES

The procedures listed in Part B of this brochure, 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.

*You can always find the latest information about the procedures we only cover in day surgery facilities on the website at www.lahealth.co.za or on the app.*

## PRESCRIBED MINIMUM BENEFITS

We cover a standard list of Prescribed Minimum Benefit chronic conditions. 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 benefit entry criteria.

## 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.

***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***

### WE PAY FOR:

- 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 when tests 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 and a flu vaccination if it is done at one of the Scheme's network pharmacies. We also pay for one specific Pneumococcal vaccination up to 2 doses per person per lifetime.

### 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 Major Medical Benefit, not affecting the day-to-day benefits.

| IN HOSPITAL | OUT-OF HOSPITAL | |
|---|---|---|
| Theatre fees, intensive and high care unit costs. Subject to preautorisation | Antenatal consultations | Up to 8 consultations at your KeyCare gynaecologist, GP or midwife |
| No overall limit in a KeyCare Hospital | 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 |
| | 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 |
| | 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 |

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.

## 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, CARDIO AND MENTAL HEALTH CARE

### 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 South African Oncology Consortium (SAOC) provider, but will then have to pay 20% of the cost from your own pocket.

### MENTAL HEALTH, DIABETES OR CARDIO CARE

We cover condition-specific care programmes that help you to manage mental health, diabetes or heart-related medical conditions. You have to be registered on these condition-specific care programmes to unlock additional benefits and services. You can read more about these programmes in the Benefits section of this booklet.

### HIV OR AIDS

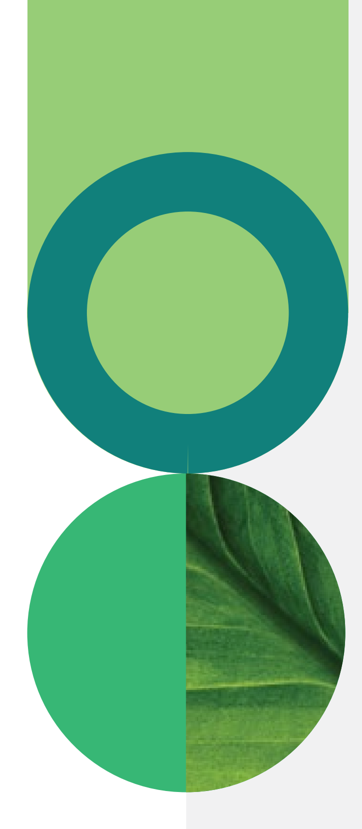
We pay for treatment and medicine related to HIV or AIDS. You must go to one of the doctors in the KeyCare network and you must get the medicine from one of the Scheme's Designated Service Provider pharmacies.

## 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 or RAMOT for all alcohol and drug rehabilitation services
- The KeyCare GP Network
- Any specialist working in a KeyCare hospital
- 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.
- A facility in the Day Surgery Network if you have to undergo one of the listed Day Surgery conditions.

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.

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

*Note that, in some cases, you might be covered for conditions listed as exclusions 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.*

FOCUS

*LA Focus provides benefits nationally, across all the Provinces in South Africa. You must use certain network hospitals for Prescribed Minimum and other treatment and care while you are in hospital. You also have cover for other large medical costs, including those that are related to Maternity care, from the Major Medical Benefit. We 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 benefit entry criteria and the use of the Scheme's Designated Service Providers (DSPs).*

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.

## HOSPITAL STAYS

<table>
<tr><th colspan="3">IF THE TREATMENT OR CARE IS A PRESCRIBED MINIMUM BENEFIT (PMB)</th></tr>
<tr><td rowspan="2">PMB at a Designated Service Provider (DSP) hospital in the Scheme's Network<br><br>The Scheme's DSPs are hospitals in the KeyCare Network if you live in a province with a coastline, or a LA Focus Network Hospital that is also a KeyCare Network Hospital, if you live in Gauteng, North West, Limpopo, Mpumalanga or the Free State</td><td>If the admitting Dr is a Specialist in the Network Hospital, a Network GP or Premier A or B Network Specialist</td><td>We pay the claims in full<br>This includes payment for treating providers who are not Designated Service Providers</td></tr>
<tr><td>If the admitting doctor is NOT working in the Network Hospital, NOT a Network GP or NOT a Premier A or B Network Specialist</td><td>We pay the hospital and other claims up to the LA Health Rate</td></tr>
<tr><td rowspan="2">PMB at a non-Network Hospital</td><td>If the admitting Dr is a Specialist in the KeyCare Hospital, Network GP or Premier A or B Network Specialist</td><td>We pay the hospital and other claims up to the LA Health Rate</td></tr>
<tr><td>If the admitting Dr is NOT working in the Network Hospital, NOT a Network GP or NOT a Premier A or B Network Specialist</td><td>We pay the hospital and other claims up to the LA Health Rate</td></tr>
<tr><th colspan="3">IF THE TREATMENT OR CARE IS NOT A PRESCRIBED MINIMUM BENEFIT (PMB)</th></tr>
<tr><td colspan="3">For all non-Prescribed Minimum Benefit care, you must go to a LA Focus network hospital. These are all hospitals in a province with a coastline and specific hospitals in the remaining South African provinces. When you're admitted to a hospital, there is no overall limit that applies for the hospital, GP / Specialist visits and other associated costs.<br>We pay the network hospital and other claims up to 100% of the LA Health Rate from the Major Medical Benefit.<br>If you do not use the services of one of these network hospitals for planned procedures, you will have to pay a portion of the costs from your own pocket (a deductible).</td></tr>
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You can find out about your nearest KeyCare Network Hospital (for Prescribed Minimum Benefits, and all other care in provinces without a coastline) and find a DSP Network GP or Specialist at **www.lahealth.co.za > Find a healthcare professional** or by calling us on 0860 103 933.

## DAY SURGERY PROCEDURES

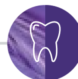
Certain procedures must be performed at one of the day surgery facilities in the list of the Scheme's Designated Service Providers. Please see the list of procedures in the Benefits section of this booklet. You will find details of the Day Surgery facilities near you on the website at www.lahealth.co.za

If you choose to undergo treatment or care for one of the day surgery procedures at a facility that is not on the Scheme's list a deductible applies to the facility account.

## 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 | Basic dental codes used as part of a Specialised or Basic Dentistry procedure is unlimited, and paid from the Major Medical Benefit | Payment of all basic dental codes is unlimited, and paid from the Major Medical Benefit |
| When you do not use the services of a Dentist in the LA Focus Dental Network (DRC) | Basic dentistry codes that form part of a Specialised Dentistry procedure, paid from Major Medical Benefit and limited per person per year. | Basic dentistry codes, including those that form part of Specialised Dentistry treatments, are paid from and limited to available funds in the Medical Savings Account |



## 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 that is 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 that basic care.

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

**For Basic Dentistry:**
All treatment in-hospital and 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, CARDIO AND MENTAL HEALTH 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 HIVCare Programme and it is very important that you contact us before you use your HIV or AIDS benefits. You can read more about this Programme in the Benefits section of this booklet.

### DIABETES, CARDIO AND MENTAL HEALTH CARE

We cover condition-specific care programmes that help you to manage mental health, diabetes or heart-related medical conditions. You have to be registered on these condition-specific care programmes to unlock additional benefits and services. You can read more about these programmes in the Benefits section of this booklet.

## DAY-TO-DAY MEDICAL EXPENSES

Out-of-hospital Prescribed Minimum Benefits are paid in full, subject to the use of the Scheme's Designated Service Providers, or at cost when there are no Designated Service Providers.

For non-PMB treatment or care, 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

## 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 the Scheme's Designated Service Providers and 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 providers in the Benefits section of this booklet.

## WHAT WE DO NOT COVER ON LA FOCUS

There are conditions and treatments that are not covered by the Scheme. These general exclusions are listed in the Benefits section (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.

| IN HOSPITAL | OUT-OF-HOSPITAL | |
|---|---|---|
| Theatre fees, intensive and high care unit costs. Subject to preautorisation | Antenatal consultations | Up to 8 consultations at a gynaecologist, GP or midwife |
| No overall limit in LA Focus KeyCare Network hospitals only | **Prenatal screening**<br>• 2 D Ultrasound scans<br>• 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<br>• 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<br>• 2 mental healthcare consultations with a counsellor or psychologist |
| | 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<br>• 1 nutritional assessment with a dietician<br>• 1 GP or gynaecologist consultation for post-natal complications |

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.

ACTIVE

*LA Active covers hospital treatment at private hospitals, 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 Benefits are based on the size and composition of your family.*

*The Benefit Option provides covers for Prescribed Minimum Benefits (PMB) chronic conditions. Prescribed Minimum Benefits are paid in full subject to benefit entry criteria and the use of the Scheme's Designated Service Providers (DSPs).*

## HOSPITAL STAYS

| IF THE TREATMENT OR CARE IS A PRESCRIBED MINIMUM BENEFIT (PMB) | | |
|---|---|---|
| PMB at a Designated Service Provider (DSP) hospital in the Scheme's Network<br>*The Scheme's DSPs are hospitals in the KeyCare Network* | If the admitting Dr is a Specialist in the KeyCare Hospital, DH Network GP or Premier A or B Network Specialist | We pay the claims in full<br>This includes payment for treating providers who are not Designated Service Providers |
| | If the admitting doctor is NOT working in the KeyCare Hospital, NOT a DH Network GP or NOT a Premier A or B Network Specialist | We pay the hospital and other claims up to the LA Health Rate |
| PMB at a non-Network Hospital | If the admitting Dr is a Specialist in the KeyCare Hospital, DH Network GP or Premier A or B Network Specialist | We pay the hospital and other claims up to the LA Health Rate |
| | If the admitting Dr is NOT working in the KeyCare Hospital, NOT a DH Network GP or NOT a Premier A or B Network Specialist | We pay the hospital and other claims up to the LA Health Rate |

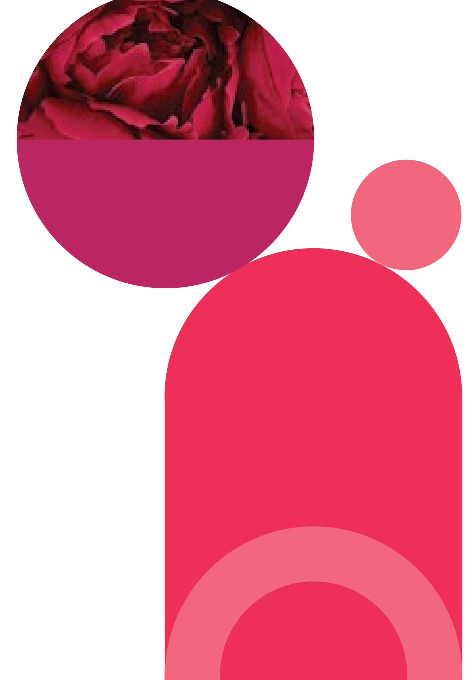
| IF THE TREATMENT OR CARE IS NOT A PRESCRIBED MINIMUM BENEFIT (PMB) |
|---|
| You may go to any hospital for treatment or care. When you're admitted to a hospital, there is no overall limit that applies for the hospital, GP / Specialist visits and other associated costs.<br>We pay the hospital and other claims up to 100% of the LA Health Rate from the Major Medical Benefit |

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 hospital account 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 SURGERY PROCEDURES

Certain procedures must be performed at one of the day surgery facilities in the list of the Scheme's Preferred Providers. Please see the list of procedures in the Benefits section of this booklet. If you choose to undergo treatment or care for one of the day surgery procedures at a facility that is not on the Scheme's list, a deductible applies to the facility account. You will find details of the Day Surgery facilities near you on the website at www.lahealth.co.za



### DAY-TO-DAY MEDICAL EXPENSES

Out-of-hospital Prescribed Minimum Benefits are paid in full, subject to the use of the Scheme's Designated Service Providers, or at cost when there are no Designated Service Providers.

For non-PMB treatment or care, 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.

### 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. We calculate the value of this benefit 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.

### 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.

### 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.

## 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, CARDIO CARE AND MENTAL HEALTH 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 HIVCare Programme and it is very important that you contact us before you use your HIV or AIDS benefits. You can read more about this Programme in the Benefits section of this booklet.

### DIABETES, CARDIO AND MENTAL HEALTH CARE

We cover condition-specific care programmes that help you to manage mental health, diabetes or heart-related medical conditions. You have to be registered on these condition-specific care programmes to unlock additional benefits and services. 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 services of the Scheme's Designated Service Providers, 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.

## MATERNITY BENEFIT

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.

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.

| In Hospital | Out-of-hospital | |
|---|---|---|
| Theatre fees, intensive and high care unit costs. Subject to preautorisation | Antenatal consultations | Up to 8 consultations at a gynaecologist, GP or midwife |
| No overall limit | **Prenatal screening**<br>• 2 D Ultrasound scans<br>• 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<br>• 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<br>• 2 mental healthcare consultations with a counsellor or psychologist |
| | 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<br>• 1 nutritional assessment with a dietician<br>• 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

CORE

*LA Core covers hospital treatment at private hospitals, 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.*

*This Benefit Option provides cover for Prescribed Minimum Benefit (PMB) and other, non-PMB, chronic conditions. Prescribed Minimum Benefits are paid in full subject to benefit entry criteria and the use of the Scheme's Designated Service Providers (DSPs).*

## HOSPITAL STAYS

| IF THE TREATMENT OR CARE IS A PRESCRIBED MINIMUM BENEFIT (PMB) | | |
|---|---|---|
| PMB at a Designated Service Provider (DSP) hospital in the Scheme's Network<br>*The Scheme's DSPs are hospitals in the KeyCare Network* | If the admitting Dr is a Specialist in the KeyCare Hospital, DH Network GP or Premier A or B Network Specialist | We pay the claims in full<br>This includes payment for treating providers who are not Designated Service Providers |
| | If the admitting doctor is NOT working in the KeyCare Hospital, NOT a DH Network GP or NOT a Premier A or B Network Specialist | We pay the hospital and other claims up to the LA Health Rate |
| PMB at a non-Network Hospital | If the admitting Dr is a Specialist in the KeyCare Hospital, DH Network GP or Premier A or B Network Specialist | We pay the hospital and other claims up to the LA Health Rate |
| | If the admitting Dr is NOT working in the KeyCare Hospital, NOT a DH Network GP or NOT a Premier A or B Network Specialist | We pay the hospital and other claims up to the LA Health Rate |

| IF THE TREATMENT OR CARE IS NOT A PRESCRIBED MINIMUM BENEFIT (PMB) |
|---|
| You may go to any hospital for treatment or care. When you're admitted to a hospital, there is no overall limit that applies for the hospital, GP / Specialist visits and other associated costs.<br>We pay the hospital and other claims up to 100% of the LA Health Rate from the Major Medical Benefit |

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 hospital account 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 SURGERY PROCEDURES

Certain procedures must be performed at one of the day surgery facilities in the list of the Scheme's Preferred Providers. Please see the list of procedures in the Benefits section of this booklet. If you choose to undergo treatment or care for one of the day surgery procedures at a facility that is not on the Scheme's list, a deductible applies to the facility account. You will find details of the Day Surgery facilities near you on the website at www.lahealth.co.za

## DAY-TO-DAY MEDICAL EXPENSES

Out-of-hospital Prescribed Minimum Benefits are paid in full, subject to the use of the Scheme's Designated Service Providers, or at cost when there are no Designated Service Providers.

For non-PMB treatment or care, this Benefit Option provides day-to-day benefits from the Medical Savings Account and the Extended Day-to-day Benefit.

### CURRENT YEAR MEDICAL SAVINGS ACCOUNT

Your current year Medical Savings Account pays for all your day-to-day expenses, 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.

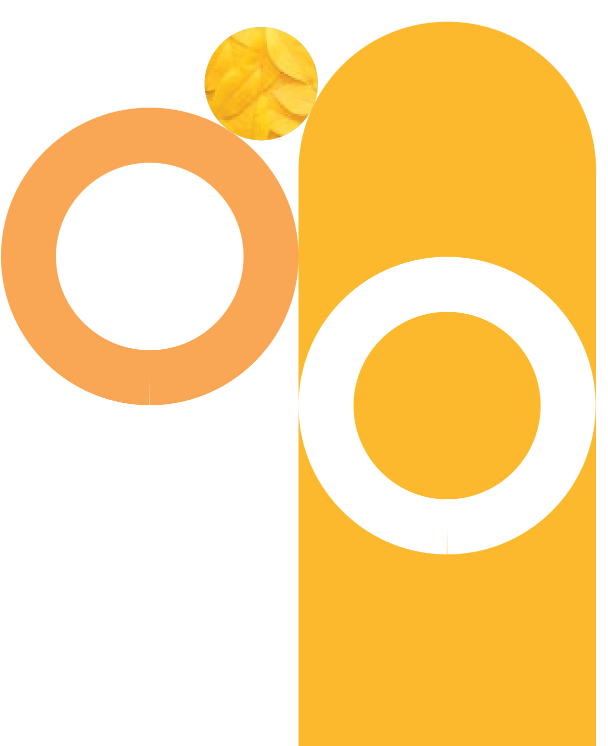
### WHAT HAPPENS ONCE YOU HAVE USED YOUR CARRIED-OVER MEDICAL SAVINGS

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.

### CLAIMS THAT ARE NOT PAID FROM THE 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. Some limits may apply.

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.



## 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, CARDIO CARE AND MENTAL HEALTH 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 HIVCare Programme and it is very important that you contact us before you use your HIV or AIDS benefits. You can read more about this Programme in the Benefits section of this booklet.

### DIABETES, CARDIO AND MENTAL HEALTH CARE

We cover condition-specific care programmes that help you to manage mental health, diabetes or heart-related medical conditions. You have to be registered on these condition-specific care programmes to unlock additional benefits and services. 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 services of the Scheme's Designated Service Providers, 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.

## MATERNITY BENEFIT

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.

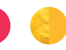
The Scheme will pay for specific maternity-related benefits for the mother and baby from the Major Medical Benefit. All claims will be paid up to 100% of the Scheme Rate. If your doctor charges above the Scheme Rate, and you have elected that claims should pay at cost from your Medical Savings Account,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

| In Hospital | Out-of-hospital | |
|---|---|---|
| Theatre fees, intensive and high care unit costs. Subject to preautorisation | Antenatal consultations | Up to 8 consultations at a gynaecologist, GP or midwife |
| | **Prenatal screening**<br>• 2 D Ultrasound scans<br>• 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<br>• 1 test, subject to clinical criteria |
| | Blood tests | A defined basket of routine blood tests per pregnancy |
| No overall limit | 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<br>• 2 mental healthcare consultations with a counsellor or psychologist |
| | 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<br>• 1 nutritional assessment with a dietician<br>• 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.*

*LA Comprehensive covers hospital treatment at private hospitals 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.*

This Benefit Option provides cover for Prescribed Minimum Benefit (PMB) and other, non-PMB, chronic conditions. Prescribed Minimum Benefits are paid in full subject to benefit entry criteria and the use of the Scheme's Designated Service Providers (DSPs).



## HOSPITAL STAYS

You must preauthorise your in-hospital treatment or care

| IF THE TREATMENT OR CARE IS A PRESCRIBED MINIMUM BENEFIT (PMB) | | |
|---|---|---|
| PMB at a Designated Service Provider (DSP) hospital in the Scheme's Network<br>*The Scheme's DSPs are hospitals in the KeyCare Network* | If the admitting Dr is a Specialist in the KeyCare Hospital, DH Network GP or Premier A or B Network Specialist | We pay the claims in full<br>This includes payment for treating providers who are not Designated Service Providers |
| | If the admitting doctor is NOT working in the KeyCare Hospital, NOT a DH Network GP or NOT a Premier A or B Network Specialist | We pay the hospital and other claims up to the LA Health Rate |
| PMB at a non-Network Hospital | If the admitting Dr is a Specialist in the KeyCare Hospital, DH Network GP or Premier A or B Network Specialist | We pay the hospital and other claims up to the LA Health Rate |
| | If the admitting Dr is NOT working in the KeyCare Hospital, NOT a DH Network GP or NOT a Premier A or B Network Specialist | We pay the hospital and other claims up to the LA Health Rate |

| IF THE TREATMENT OR CARE IS NOT A PRESCRIBED MINIMUM BENEFIT (PMB) |
|---|
| You may go to any hospital for treatment or care. When you're admitted to a hospital, there is no overall limit that applies for the hospital, GP / Specialist visits and other associated costs.<br>We pay the hospital and other claims up to 100% of the LA Health Rate from the Major Medical Benefit |

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 SURGERY PROCEDURES

Certain procedures must be performed at one of the day surgery facilities in the list of the Scheme's Preferred Providers. Please see the list of procedures in the Benefits section of this booklet. If you choose to undergo treatment or care for one of the day surgery procedures at a facility that is not on the Scheme's list, a deductible applies to the facility account. You will find details of the Day Surgery facilities near you on the website at www.lahealth.co.za

## DAY-TO-DAY MEDICAL EXPENSES

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

### CURRENT YEAR MEDICAL SAVINGS ACCOUNT

Your current year Medical Savings Account pays for 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 certain day-to-day medical expenses from the Above Threshold Benefit. Some benefits may have specific limits once you have reached the 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.

### 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, CARDIO CARE AND MENTAL HEALTH 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 HIVCare Programme and it is very important that you contact us before you use your HIV or AIDS benefits. You can read more about this Programme in the Benefits section of this booklet.

### DIABETES, CARDIO AND MENTAL HEALTH CARE

We cover condition-specific care programmes that help you to manage mental health, diabetes or heart-related medical conditions. You have to be registered on these condition-specific care programmes to unlock additional benefits and services. 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.

## ASSISTED REPRODUCTIVE THERAPY

The Scheme pays certain services related to assisted reproductive therapy at 75% of the LA Health Rate, up to a limit. Where applicable, the services of the Scheme's Designated Service Providers must be used during the treatment process. 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 PROVIDER TO USE FOR LA COMPREHENSIVE

To make the best use of the benefits offered by your Option, you should use the Scheme's Designated Service Providers, 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.

## MATERNITY BENEFIT

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.

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.

| In Hospital | Out-of-hospital | |
|---|---|---|
| Theatre fees, intensive and high care unit costs. Subject to preautorisation | Antenatal consultations | Up to 8 consultations at a gynaecologist, GP or midwife |
| | **Prenatal screening**<br>• 2 D Ultrasound scans<br>• One Nuchal translucency test or one Non-Invasive Prenatal (NIPT) test or one T21 Chromosome test, subject to clinical entry criteria | <br>• Up to 2 scans<br>• 1 test, subject to clinical criteria |
| | Blood tests | A defined basket of routine blood tests per pregnancy |
| No overall limit | 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<br>• 2 mental healthcare consultations with a counsellor or psychologist |
| | 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<br>• 1 nutritional assessment with a dietician<br>• 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.*

HOW WE PAY FOR

# 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 and Day Surgery facilities 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, Day Surgery and major expenses obtained from a hospital/facility in the LA Focus hospital network). KeyCare 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)
- Basic dentistry obtained from a dentist in the LA Focus Dental network

## LA ACTIVE

- Major Medical Benefit (for hospital and major expenses). Designated Service Provider facilities for Day Surgery procedures. KeyCare Network Hospitals 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)
- Extended Day-to-day Benefit (for certain day-to-day medical expenses)

## LA CORE

- Major Medical Benefit (for hospital and major expenses). Designated Service Provider facilities for Day Surgery procedures. KeyCare Network Hospitals are the Scheme's Designated Service Providers for Prescribed Minimum Benefits
- 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 certain day-to-day medical expenses)

## LA COMPREHENSIVE

- Major Medical Benefit (for hospital and major expenses). Designated Service Provider facilities for Day Surgery procedures. KeyCare Network Hospitals are the Scheme's Designated Service Providers for Prescribed Minimum Benefits
- Prescribed Minimum Benefits, including 26 chronic conditions
- Additional, non-Prescribed Minimum Benefit, chronic conditions
- Reproductive health benefits, which include: Maternity-related benefits for the mother and newborn baby for up to two years after the birth and benefits for Assisted Reproductive Therapy
- 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 treatment or care, 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 register 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.

### CHRONIC ILLNESS 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 Option. On this Option we cover up to the Reference Price, which is the set monthly amount we will pay up to for a medicine category. This applies to medicine that is not on the medicine list (formulary).

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 (or Reference Price for LA KeyPlus Option) 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.

**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 when 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. Your doctor can also apply for authorisation via HealthID.

**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 benefit entry criteria that need to be met. You or your doctor may need to provide certain test results or extra information 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.

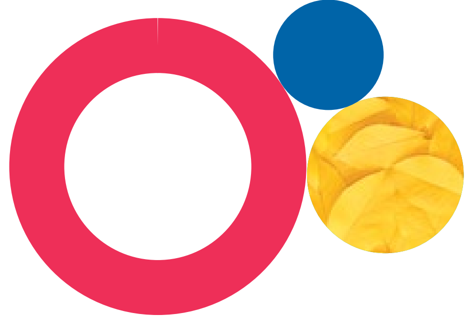
When you have just joined the Scheme, LA Health will not pay for treatment of these conditions when a general waiting period applies to your membership, or when a 12-month waiting period applies for the specific condition. If your membership was activated without Waiting Periods you have cover for these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

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.

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

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



## ADDITIONAL CHRONIC CONDITIONS THAT ARE ONLY COVERED FOR LA CORE AND LA COMPREHENSIVE MEMBERS

Medicine for approved Additional Disease List conditions is funded up to the Chronic Drug Amount (CDA).

- 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
- Psoriatic Arthritis
- Pulmonary Fibrosis
- Scleroderma and other collagen-vascular diseases
- Trigeminal neuralgia
- Urinary incontinence
- Zollinger Ellison syndrome

## DIABETES AND CARDIO CARE PROGRAMMES

If we have authorised Chronic Illness Benefits for your Diabetes or heart-related condition, you will have access to the Diabetes Care or Cardio Care Programme. Your Network GP will need to register you. Your Primary Care doctor may also register you on the Scheme's prevention programme to manage Cardio-metabolic risk syndrome.

## MENTAL HEALTH CARE PROGRAMME

If you meet the Scheme's clinical entry criteria, you have access to defined cover for the management of episodes of major depression. Enrolment on the programme unlocks cover for prescribed medicine, and additional baskets of care to allow for effective evaluation, tracking and monitoring of treatment.

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.**

## MEDICAL SAVINGS ACCOUNT (LA FOCUS, LA ACTIVE, LA CORE AND LA COMPREHENSIVE)

This is a benefit that is used for day-to-day medical expenses, such as doctors' visits and medicine. The benefit amount in the Medical Savings Account is determined by your family size and the composition of the membership.

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

If you don't use all the benefits in the Medical Savings Account, you carry it over to the next year. If you leave LA Health Medical Scheme and you have benefits left in the Medical Savings Account, the 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 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 Medical Savings Account from previous years or from the following year's Medical Savings Account allocation, at the beginning of the next year.**

## EXTENDED DAY-TO-DAY BENEFIT (LA CORE AND LA ACTIVE ONLY)

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

**On LA Core and LA Active the Extended Day-to-day Benefit pays for your visits to GPs and Specialists, Dental and Optical costs, Radiology and Pathology tests and 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.

## HIVCARE PROGRAMME FOR HIV OR AIDS BENEFITS

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

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

You have to register on the HIVCare Programme to access these benefits. Call us on **0860 103 933** or send an email to: **hiv_diseasemanagement@lahealthms.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 Designated Service Provider GPs or Specialists to treat the disease. If the services of a Designated Service Provider is not used, you will have to make a 20% out-of-pocket co-payment.

### ABOVE THRESHOLD BENEFIT (LA COMPREHENSIVE ONLY)

This benefit pays for day-to-day costs when the benefits 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 you have used the benefits in your Medical Savings Account 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 and you will have to pay more out of your pocket. Your claims statement shows when you would be likely to start paying for day-to-day medical expenses from your own pocket.

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

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

REMEMBER

Except for over-the-counter medicine, 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

The Scheme's Oncology 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.

You must use the services of the Scheme's Designated Service Providers for full cover for Prescribed Minimum 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 at the LA Health Rate. 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 more details about cover for cancer.

### PET SCANS

Oncology-related PET scans are paid at the agreed rate 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.

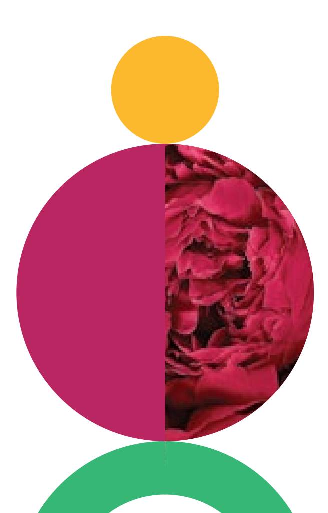
### STEM CELL TRANSPLANTS

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.

### END OF LIFE CARE

The Member Support Programme and Advanced Illness Benefit provides access to specific benefits for this treatment phase.



## MATERNITY 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 of 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 for qualifying claims. Otherwise, you may have to pay the shortfall from your own pocket.

If you are registered on the LA KeyPlus Option, you must use the services of your chosen KeyCare GP or Specialist.

You have access to certain Assisted Reproductive Therapy benefits on the LA Comprehensive Option

## 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 benefits of the specific 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.

We also pay for counseling sessions for any of your family (who are registered beneficiaries) who may have been indirectly affected by the traumatic event.

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

### THE BENEFIT PAYS:

Day-to-day claims following the traumatic onset of:

- Paraplegia
- Quadriplegia
- Tetraplegia
- Hemiplegia.

Day-to-day claims for conditions resulting from the following traumatic incidents:

- Near drowning
- Severe anaphylactic reaction
- Poisoning
- Crime-related injuries.

Day-to-day claims relating to severe burns.

Day-to-day claims following the traumatic onset of an internal or external head injury.

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.

## PREFERRED PROVIDERS

### PROSTHESES

The Scheme has 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.

## 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 for the continuation of care after discharge from hospital and if you are discharged from hospital earlier to continue the treatment at home. If your chronic condition is registered on the Chronic Illness Benefit (CIB), for specific conditions, you also have access to specific benefits and care at home. These benefits are subject to entry criteria.

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

## DESIGNATED PROVIDERS FOR PRESCRIBED MINIMUM BENEFITS HOW THEY APPLY TO THE BENEFIT OPTIONS

There are different Designated Service Providers (DSP) 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.

| BENEFIT | DESIGNATED SERVICE PROVIDER | BENEFIT OPTION IT APPLIES TO |
|---|---|---|
| Hospitals | KeyCare Network Hospitals | **LA KeyPlus** |
| | KeyCare Network Hospitals for Prescribed Minimum Benefits | **LA Focus, LA Active, LA Core and LA Comprehensive** |
| Accredited providers who perform Colorectal Surgery | Discovery Colorectal Network of Providers | **All LA Health Benefit Options** |
| Accredited Day Surgery providers | Discovery Day Surgery Network of Providers | **All LA Health Benefit Options** |
| 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** |

| BENEFIT | DESIGNATED SERVICE PROVIDER | BENEFIT OPTION IT APPLIES TO |
|---|---|---|
| General Practitioners | KeyCare GP network | **LA KeyPlus** |
| | Discovery GP network (Premier Plus GPs for PMBs and other specific care) | **LA Focus, LA Active, LA Core and LA Comprehensive** |
| General Practitioners and Specialists who treat HIV or AIDS, Diabetes, Cardio and Mental Health Care | 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 | ICON Network | **All LA Health Benefit Options** |
| Oncology medicine | Pharmacies in the Oncology Pharmacy Network | **All LA Health Benefit Options** |
| PET Scans | At the Scheme's PET Scan Network. A 20% co-payment applies if you make use of a non-network provider | **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** |
| Spinal Care (in- and out-of-hospital) | Discovery Spinal Care Network of Providers | **LA Comprehensive, LA Core, LA Active and LA Focus** |
| Oxygen rental | VitalAire | **All LA Health Benefit Options** |
| In-hospital Pathology | Contracted Service Providers | **All LA Health Benefit Options** |

# Day surgery procedures

*The Scheme has identified certain day surgery facilities as Designated Service Providers for specific procedures. If you do not go to one of the facilities in the Scheme's list for one of the procedures listed below, a Rand value deductible will apply. We will advise you who these providers are when you preauthorise your procedure.*

## DAY SURGERY NETWORK FOR CERTAIN PROCEDURES OR OPERATIONS

Certain procedures will be covered in full if the treatment or procedure is obtained at a Designated Service Provider facility. When you preauthorise the procedure, the Scheme will tell you about this requirement and will help find the nearest facility to you.

If you are a LA KeyPlus member, you must have the listed procedures done at one of these accredited Day Surgery facilities as they are the Designated Service Providers for the Option. If you don't, the Scheme will not pay for the treatment or care, unless it is considered a Prescribed Minimum Benefit.

The Scheme's accredited Day Surgery facilities are also the Designated Service Providers for the listed procedures for LA Focus, LA Active, LA Core and LA Comprehensive members. If you do not go to one of the Scheme's designated facilities, a deductible will apply.

### REMEMBER

When you preauthorise the procedure, the Scheme will tell you about the requirement to go to a Day Surgery facility for your procedure and will help find the nearest accredited facility to you.

## LIST OF DAY SURGERY PROCEDURES

### EAR, NOSE AND THROAT PROCEDURES

- Tonsillectomy and/or adenoidectomy
- Repair nasal turbinates*, nasal septum*
- Simple procedures for nose bleed (extensive cautery)
- Scopes, nasal endoscopy*, (laryngoscopy)
- Middle ear procedures (mastoidectomy, myringoplasty, stapedectomy, myringotomy and/or grommets)
- Sinus lavage*.

### GASTROINTESTINAL PROCEDURES

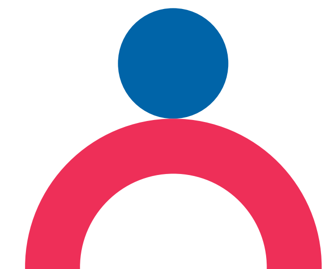
- Gastrointestinal scopes (oesophagoscopy, gastroscopy, colonoscopy, sigmoidoscopy, proctoscopy, anoscopy*)
- Anorectal procedures (treatment of haemorrhoids, fissure, fistula).

### UROLOGICAL PROCEDURES

- Cystoscopy
- Male genital procedures (circumcision, repair of penis, exploration of testes and scrotum, orchiectomy, epididymectomy, excision hydrocoele, excision varicocoele vasectomy).

### ORTHOPAEDIC PROCEDURES

- Tendon and/or ligament repair, muscle debridement, fascia procedures (tenotomy, tenodesis, tenolysis, repair/reconstruction, capsulotomy, capsulectomy, synovectomy, excision tendon sheath lesion, fasciotomy, fasciectomy). (For LA KeyPlus only funded if not first done via an endoscopic procedure). Subject to individual case review.
- Treatment of simple closed fractures and/or dislocations, removal of pins and plates. Subject to individual case review.
- Repair of bunion toe deformity*



- Arthroscopy, arthrotomy (shoulder, elbow, knee, ankle, hand, wrist, foot, temporomandibular joint), arthrodesis (hand, wrist, foot)*
- Minor joint arthroplasty (intercarpal, carpometacarpal and metacarpophalangeal, interphalangeal joint arthroplasty*)

### GYNAECOLOGICAL PROCEDURES

- Colposcopy with large loop excision of the transformation zone (LLETZ)
- Diagnostic Dilatation and Curettage
- Diagnostic laparoscopy
- Endometrial ablation
- Diagnostic Hysteroscopy
- Examination under anaesthesia
- Simple vulval and introitus procedures: Simple hymenotomy, partial hymenectomy, simple vulvectomy, excision Bartholin's gland cyst
- Suction curettage
- Uterine evacuation and curettage
- Vaginal, cervix and oviduct procedures: Excision vaginal septum, cyst or tumour, tubal ligation or occlusion, uterine cervix cerclage, removal cerclage suture.

### EYE PROCEDURES

- Cataract surgery
- Treatment of glaucoma
- Other eye procedures: (removal of foreign body, conjunctival surgery (repair laceration, pterygium), glaucoma surgery, probing and repair of tear ducts, vitrectomy, retinal surgery, eyelid surgery, strabismus repair). (Note: on LA KeyPlus no refractive eye surgery is funded)
- Corneal transplant*.

### GANGLIONECTOMY

### SIMPLE SUPERFICIAL LYMPHADENECTOMY

### APPROVED BREAST PROCEDURES

- Mastectomy for gynaecomastia*
- Lumpectomy* (fibroadenoma)

### SKIN PROCEDURES

- Debridement
- Simple repair of superficial wounds
- Removal of lesions* (dependent on site and diameter).

### BIOPSIES

- Skin*, soft tissue, muscle, bone, lymph, eye, mouth, throat, breast, cervix, vulva, prostate, penis, testes

### INCISION AND DRAINAGE OF ABSCESS AND/OR CYST:

- Subcutaneous tissue, soft tissue, bone, bursa, mouth, tonsil, pilonidal, ovary, Bartholin's gland, vagina

### REMOVAL OF FOREIGN BODY

- Subcutaneous tissue, muscle, external auditory canal under general anaesthesia

### HERNIA PROCEDURES (SIMPLE)

- Umbilical hernia repair
- Inguinal hernia repair

### NERVE PROCEDURES

- Neuroplasty median nerve
- Ulnar nerve
- Digital
- Nerve of hand or foot
- Brachial plexus.

Services marked with * are not available on the LA KeyPlus option

### VIRTUAL AND TELEPHONIC PROVIDER CONSULTATIONS

You will be able to make online appointments and book after-hour virtual consultations with your Network GP, Specialists and other providers, as may be appropriate. The Scheme also pays for telephone consultations.

# YOU HAVE ACCESS TO THE WELLTH *fund*

Available to LA Comprehensive, LA Core, LA Active and LA Focus members, who joined after 1 January 2024 and LA KeyPlus members in the year of them joining the Scheme and up to the end of the next year.

## GENERAL HEALTH

You have access by primary healthcare screening which include services for visual, hearing, dental and skin conditions. You also have access to one GP screening consultation.

## PHYSICAL HEALTH

You have access to physical wellbeing screening at a dietician, chiropractor, biokinetisist and/or physiotherapist

## MENTAL HEALTH

You have access to a mental wellness check-up to support mental wellbeing.

## WOMEN AND MEN'S HEALTH

You have access to a range of women and men's screening and prevention healthcare services.
These include for example a:

- Gynaecological, prostate and/or heart consultation with your doctor
- Bone density check

## CHILDREN'S HEALTH

You have access to a children wellness visit which include growth and developmental milestones assessments with a occupational therapist, speech therapist and/or physiotherapist.

## MEDICAL MONITORING DEVICES

You have access to certain medical monitoring devices which helps measure for example blood pressure, cholesterol, blood sugar and respiratory.

## HOW TO GET ACCESS

The WELLTH Fund is available for two benefit years, once all beneficaries who are older than 2 years complete their age-appropriate screening assessments at a provider in our Wellness Network. For new joiners, the benefit is available in the year of joining and the year thereafter.

### WHAT LIMITS APPLY

The benefit is available once per beneficiary per lifetime. Qualifying healthcare services are covered up to a maximum of the LA Health Rate, subject to the overall benefit limit.

Your WELLTH Fund limit is dependant on the size and make up of your family on your membership:

- R2,500 per adult dependant
- R1,250 per child dependant two years and older
- Up to a maximum of R10,000 per family

The WELLTH Fund is available to all registered beneficiaries on the membership. The WELLTH Fund will not cover screening and prevention healthcare services already covered by other defined benefits.

## WHAT WE DO NOT COVER

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:

## EXCLUSIONS

### 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 AUTHORISED IN A BASKET OF CARE:

- 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 practitioners 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@lahealthms.co.za**
- 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 a Claims Notification email, or you can look at your claims by logging in to **www.lahealth.co.za > Claims transaction history**

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

You can also find all your claims transaction information on the website at www.lahealth.co.za

## 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@lahealthms.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@lahealthms.co.za 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 or find the information by using the app.

## 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** or find the information by using the app

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** or find the information by using the app

## DOWNLOAD THE DISCOVERY APP

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

- your electronic membership card, which can also be downloaded to your phone
- 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 virtual after-hour consultations.

## 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

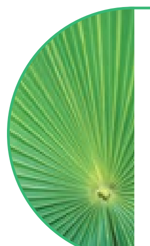
Ask your employer to stamp the documents as proof that they are aware of the information supplied to the Scheme.

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 a Prescribed Minimum Benefit Chronic Disease List chronic illness, this applies to medicine that is not listed on the medicine list (formulary). Medicine for ADL conditions is covered up to the CDA. The CDA is not applicable to LA KeyPlus. On this Option we cover up to the Reference Price, which is the set monthly amount we will pay up to for a medicine category.

### 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 you to the provider. A deductible cannot be paid from the Medical Savings Account.

### DESIGNATED SERVICE PROVIDER

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

### LA KEYPLUS

To have full cover for your operation or treatment, you must always go to a KeyCare Hospital or one of the accredited Day Surgery facilities for specific procedures or treatment.

If you need to see a Specialist, your chosen LA KeyPlus Network GP must refer you to a Specialist in the LA KeyPlus Network, who works in a KeyCare Hospital. And that LA KeyPlus Specialist must admit you to the KeyCare Hospital.

If you don’t go to a KeyCare Hospital for a Prescribed Minimum Benefit condition, we will only pay the Hospital costs up to 80% of the Scheme Rate and you will have to pay the difference between the cost of the care in the non-Network Hospital and what the Scheme paid.

You can find out about your nearest KeyCare Network Hospital or Day Surgery facility at www.lahealth.co.za > Find a healthcare professional or by calling us on 0860 103 933.

### LA FOCUS

If you live in **Gauteng, North West, Limpopo, Mpumalanga or the Free State:**

You must ALWAYS make use of the services of one of the LA Focus Network Hospitals. All of these hospitals are KeyCare Network Hospitals and the Scheme’s Designated/Network Service Providers.

When you are admitted to one of these Network Hospitals by a Discovery Health Network GP or a Specialist who charges the Premier Rate, or a KeyCare Network GP or Specialist, (these providers are the Scheme’s Designated Service Providers for Prescribed Minimum Benefits), we will pay all claims related to your authorised hospital treatment and care in full.

We will pay all PMB treatment and care up to the Scheme Rate only when you choose to go to a hospital that is not in the Network and/or when the GP or Specialist who admits you to that hospital is not a Designated Service Provider. Any shortfalls will have to be paid by you from your own pocket.

When the in-hospital treatment and care is not related to Prescribed Minimum Benefits, we will pay the Network Hospital’s account and that of any provider with whom the Scheme have negotiated agreed rates in full, and all other claims up to the Scheme Rate.

If you go to a non-network hospital and/or if the providers treating you are not contracted to the Scheme, we will pay claims up to the Scheme Rate only and you will be responsible to pay all shortfalls.

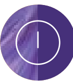
If you live in **the Eastern Cape, KwaZulu Natal, the Northern Cape or the Western Cape:**

You must make use of the services of a KeyCare Network Hospital for Prescribed Minimum Benefit treatment and care, as those hospitals are the Scheme's Designated Service Providers for prescribed benefits.

When you are admitted to one of these Network Hospitals by a Discovery Health Network GP or a Specialist who charges the Premier Rate, or a KeyCare Network GP or Specialist (these providers are the Scheme's Designated Service Providers for Prescribed Minimum Benefits) we will pay all claims related to your authorised hospital treatment and care in full.

For non-Prescribed Minimum Benefit in-hospital care, you may go to any hospital in your Province. It will still be important for you to ensure that the doctors and specialists treating you are contracted to the Scheme, to ensure we can pay their claims in full.

If you choose not go to a KeyCare Network Hospital via referral by a Discovery Health or Keycare GP or a Premier Rate or Keycare Specialist for Prescribed Minimum Benefit treatment or care, or if any of the providers you use for other types of in-hospital care are not contracted with the Scheme, we will pay claims up to the Scheme Rate only and you will be responsible for the shortfalls.



You can find out about your nearest KeyCare Network Hospital (for Prescribed Minimum Benefits, and all other care in provinces without a coastline, at www.lahealth.co.za > ***Find a healthcare professional*** or by calling us on ***0860 103 933.***

## LA ACTIVE, LA CORE AND LA COMPREHENSIVE

You must make use of the services of a KeyCare Network Hospital for Prescribed Minimum Benefit treatment and care, as those hospitals are the Scheme's Designated Service Providers for prescribed benefits.

When you are admitted to one of these Network Hospitals by a Discovery Health Network GP or a Specialist who charges the Premier Rate, or a KeyCare Network GP or Specialist (these providers are the Scheme's Designated Service Providers for Prescribed Minimum Benefits) we will pay all claims related to your authorised hospital treatment and care in full.

For non-Prescribed Minimum Benefit in-hospital care, you may go to any hospital. It will still be important for you to ensure that the doctors and specialists treating you are contracted to the Scheme to ensure we can pay their claims in full.

If you choose not go to a KeyCare Network Hospital via referral by a Discovery Health, or KeyCare Network GP or a Premier Rate, or KeyCare Network Specialist for Prescribed Minimum Benefit treatment or care, or if any of the providers you use for other types of in-hospital care are not contracted with the Scheme, we will pay claims up to the Scheme Rate only and you will be responsible for the shortfalls.

You can find out about your nearest KeyCare Network Hospital for Prescribed Minimum Benefits, at www.lahealth.co.za > Find a healthcare professional or by calling us on 0860 103 933.

## 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

You must use the services of these providers to ensure payment in full. LA Health has hospital, day surgery, 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

You must use specific hospitals to avoid co-payments or shortfalls. 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).

### PREFERRED PROVIDERS

The Scheme has agreements with Preferred Providers (PP) and prefer that you use their services. They are for example the suppliers of devices for hip and knee replacements. If you do not use their services, we may only pay claims up to a limit, or at the rate we would pay our Preferred Provider.

### POSITIVE MEDICAL SAVINGS ACCOUNT BALANCES PAID OUT

A 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 to you.

### PREAUTHORISATION

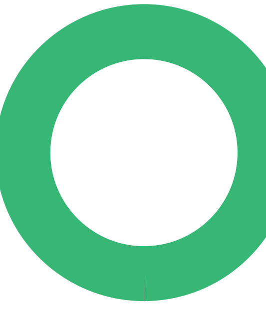
- **Planned admissions:** You must let us know beforehand if you plan to be admitted to hospital. Please call us on **0860 103 933** for preauthorisation, so that we can check your membership and help you make sure about your benefits. If you do not preauthorise your benefits, you might have to pay a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



# Fraud

## 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.

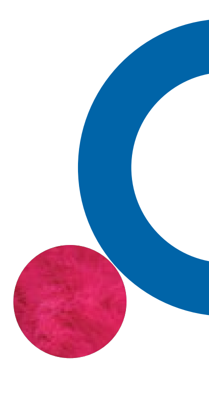
Financial advisers found to be involved in fraud will have their licenses revoked and be reported to the Financial Services Board and the Registrar for Medical Schemes.

## 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
- 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.



PROTECTING YOUR

# Personal Information

Personal information about you, your spouse and your dependants include information about their health, financial status, gender, age, contact numbers and addresses. When you become a member of the Scheme, you trust us with personal information about yourself and your dependants.

We are committed to protecting your right to privacy. We collect, use, share and otherwise process your personal information in line with the Protection of Personal Information Act (POPIA) to:

- Administer your benefits.
- Provide managed care services to you.
- Provide relevant information to a contracted third party who requires the information to provide a healthcare service to you.
- To analyse risks, trends, and profiles.
- To allow external health care providers to evaluate certain clinical information when you require medical treatment.

## EXAMPLES OF THIS INCLUDE

- Getting your personal information from other relevant sources, including healthcare providers, contracted service providers and processing the information to assess and value a claim for medical expenses.
- Verifying with the relevant sources that your personal information is true, correct, and complete.
- Getting information from and sharing information with your employer that is relevant to your membership, with due regard for considerations of confidentiality in respect of your state of health.
- Communicating with you about any benefit or contribution changes.

If a third party, even your own spouse, asks the Scheme or Administrator for any of your personal information, we will share it with them only if:

- You have already given your consent for the disclosure of this information to that third party.
- We have a legal or contractual duty to give the information to that third party.
- We need to share it with them for risk analytical or fraud detection, prevention or recovery purposes.

## YOU HAVE THE RIGHT TO KNOW WHAT PERSONAL INFORMATION THE SCHEME AND ADMINISTRATOR HOLDS ABOUT YOU.

If you wish to receive this information, please complete an 'Access Request Form', attached to the PAIA manual on the Scheme's website, and specify the information you would like to receive. We will take all reasonable steps to confirm your identity before providing details of your personal information. We are entitled to charge a fee for this service and will let you know what it is at the time of your request.

If you believe we failed to adequately protect your information, we encourage you to first follow the Scheme's internal complaints process to resolve the complaint. We explain the complaints and disputes process on www.lahealth.co.za. If you are not satisfied after this process, you have the right to lodge a complaint with the Information Regulator.

**If you allow a third party to engage with the Scheme on your behalf, whether it is your child, your parent or your broker, we need you to authorise us to do so, by completing a Third-Party Disclosure form. You can obtain this form from the website or ask for it from the call centre.**

If you have in the past shared your member login details with your dependants, please ask them to create their own member profiles.

**If you have previously shared your Electronic Health Record (EHR) with a healthcare professional, you now need to authorise the Scheme to do so again via the Electronic Health Record function on the website or Discovery App.**

Get to know how we treat your personal information. In the footer of the Scheme website you can find a link to the privacy page where we compiled information for you on the topic.

# Contact us

## GENERAL QUESTIONS AND SERVICES

- Email **service@ lahealthms.co.za**
- Website **www.lahealth.co.za**
- 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
- Gqeberha Discovery, BPO Building, Coega IDZ - Zone 4

## DISCOVERY MOBILE

SMS the keyword to **31347**

## AMBULANCE AND OTHER MEDICAL EMERGENCY SERVICES

0860 999 911

## SEND YOUR CLAIMS

- Email **claims@lahealthms.co.za**
- Post to **PO Box 652509, Benmore 2010** OR **Postnet Suite 116, Private Bag X19, Milnerton 7435**

## TO CONFIRM YOUR BENEFITS FOR A HOSPITAL STAY

- 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**

## COMPLAINTS AND APPEALS PROCESS

If you are not satisfied with the manner in which your claims were processed or wish to lodge a complaint, the process you need to follow is:

1. Contact the Scheme's Client Service Department during office hours and try to resolve your query.
2. If the result is not considered to be satisfactory by you, you may ask that it be escalated to more senior resources in the Administrator's Service Team, such as a Team Leader or Manager.
3. If you are not satisfied, you may in writing request the Principal Officer of the Scheme to attend to the matter. You can send the query to the normal email or postal addresses of the Scheme, but address it to the Principal Officer.
4. Should you not accept the outcome of the escalation process to the Principal Officer, you may lodge a complaint in writing, for the attention of the Scheme's Disputes Committee, c/o The Principal Officer, (the details are available on the website). The Disputes Committee will meet to decide on your complaint or dispute, and determine the procedure to be followed. You have the right to be heard at these proceedings, either in person or through a representative.
5. If you are still dissatisfied after the decision made by the Disputes Committee, you may take your appeal further by approaching the Council for Medical Schemes (CMS) for resolution:

   **Council for Medical Schemes**

   Block A Eco Glades 2 Office Park

   420 Witch-Hazel Street

   Ecopark

   Centurion 0157

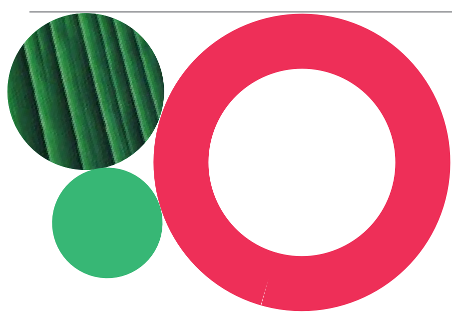
   Telephone: 012 431 0500

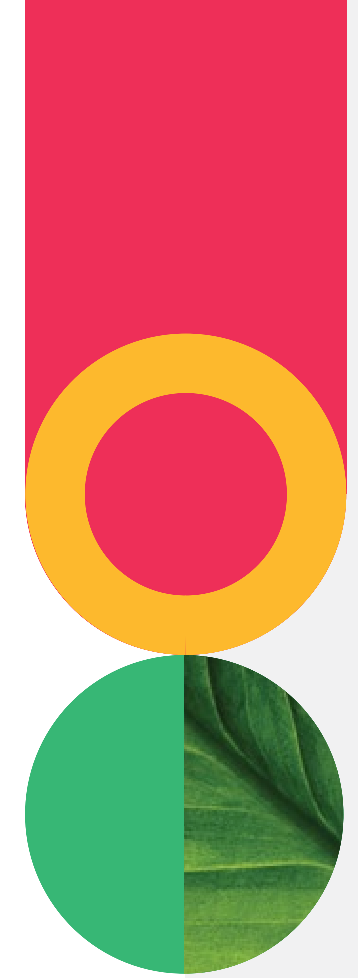
   Fax: (086) 673 2466

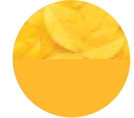
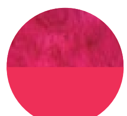
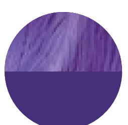
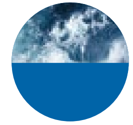
   Customer care call number: 0861 123 267

   Email address: complaintsmedicalschemes.co.za

# Notes





WE'RE IN IT FOR YOUR HEALTH

**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 2025. 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** **WWW.LAHEALTH.CO.ZA**

**SERVICE@LAHEALTHMS.CO.ZA** **REPORT FRAUD ANONYMOUSLY 0800 004 500**

LA Health Medical Scheme, registration number 1145, is administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07. Discovery Health (Pty) Ltd is an authorised financial services provider.