LA Health
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LA KEYPLUS

2019

ABOUT THIS **BENEFIT OPTION**

Reasons why the LA KeyPlus Option is the best choice for you

The LA KeyPlus Option provides hospital cover, Prescribed Minimum Benefit Chronic Disease List cover and Day-to-day medical expense benefits. The KeyCare Network of hospitals is the Designated Service Provider for non-emergency and other procedures. Some care will only be allowed at one of the approved Day Care facilities. When members use the services of providers in the KeyCare Primary Care Network for GP and other care, they have full cover.

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.

We cover you in an emergency

LA KeyPlus covers you for emergency transport, when you need it. We pay for this service from the Major Medical Benefit and there is no overall limit. Call Discovery 911 for authorisation.

Cover for GPs and specialists in- and out-of-hospital

When you're admitted to a hospital in the KeyPlus Network, no overall limit applies. We pay up to 100% of the Direct Payment Arrangement Rate for specialists at a KeyCare hospital who have agreed to these rates. We pay up to 100% of the Scheme Rate for all other specialists working in a hospital in the KeyPlus Network.

Out-of-hospital GP visits and selected small procedures are unlimited at your chosen GP working in the Designated Service Provider Network, but you have to get authorisation if you need to go to the GP more than 15 times in a year. For unscheduled emergency visits we pay for three visits per person per year at your chosen GP. You have cover of R4 050 per person for out-of-hospital specialist visits, including radiology and pathology done in the KeyCare network, if you are referred by your chosen KeyCare GP.

The Out-of-network Benefit pays for four GP visits per person per year, and selected blood tests, X-rays and acute formulary medicine requested by the non-network GP.

We cover you when you have to go to hospital

Hospitalisation, theatre fees and costs for intensive and high care at private hospitals and the cost for specific procedures at designated Day Care Facilities in the Keycare Network have no overall limit, as long as certain clinical entry criteria and protocols are met.

We pay planned, authorised admissions for treatment in a KeyCare Network hospital or day clinic from the Major Medical Benefit.

In an emergency, the Casualty Outpatient Benefit covers you for pathology, radiology, medicine and specialist consultations (subject to applicable formularies) at a casualty unit at any of the KeyCare Network Hospitals.

Your KeyCare GP must obtain approval for your casualty visit, if it is not an emergency. If you do not have approval, the Scheme will not pay for the casualty visit.

Get your chronic medicine from specific pharmacies and we will pay it at cost

You are covered for all Prescribed Minimum Benefit Chronic Disease List conditions based on a formulary, if your chosen KeyCare GP prescribes it, and you obtain the medicine from the Scheme's Designated Service Provider courier pharmacy. You also have cover with no overall limit for prescribed acute medicine obtained from the Designated Service Provider. When you are discharged from hospital after an admission, we pay for take-home medicine up to R160 per person per event. The Scheme pays for the completion of the *Chronic Illness Benefit application form* by your treating doctor, if the condition is approved.

We pay for certain screening tests or a flu vaccine

You have cover for a Screening Check (to check your blood glucose, blood pressure, cholesterol and body mass index) or a flu vaccination at one of the Scheme's contracted providers or a network pharmacy. We also pay for one specific pneumococcal vaccination once per lifetime for qualifying members.

Comprehensive maternity and post-birth benefits

The Scheme pays specific pre- and postnatal care for the mother, for up to two years after the birth. The benefit also pays for baby, or toddler up to the age of two. Specific benefits will be paid up to 100% of the Scheme Rate, from the Hospital Benefit, and will not affect other day-to-day benefits:

- Antenatal consultations
- Selected blood tests
- Ultrasound scans and Pre- and postnatal care
- Prenatal screening
- GP and specialist care after birth

Benefits will be activated when you authorise the delivery, when you create a pregnancy profile on **www.lahealth.co.za,** or when you register your baby on the Scheme.

SCHEDULE OF BENEFITS

Overall annual limits	**Must call Discovery 911 for authorisation**		
	Emergency transport		Paid from Major Medical Benefit; subject to preauthorisation. No overall limit
Blood transfusions and blood products	Blood transfusions and blood products, subject to authorisation		Prescribed Minimum Benefits. Paid from Major Medical Benefit; no overall limit
Dentistry	Maxillo-facial procedures: Certain severe infections, jaw-joint replacements, cancer-related and certain trauma-related surgery, cleft-lip and palate repairs, subject to preauthorisation		Subject to Prescribed Minimum Benefits. Paid from Major Medical Benefit; no overall limit
	Basic dentistry out-of-hospital		Covered with no overall benefit limit, subject to a list of procedures and performed by a dentist in the KeyCare network
GPs and specialists	**Provides full cover at General Practitioners or Specialists who are participating in a payment arrangement**		
	In-hospital	In Hospital Specialists	No overall limit if services are provided by a specialist working in a KeyCare Network Hospital. For the account to be paid, your chosen KeyCare Network GP must refer you to the Specialist. If you go to a Specialist without a referral, the account will not be paid. We pay Specialists with whom we have a payment arrangement in full, at the arranged rate. We pay other Specialists working in a KeyCare Network Hospital at the Scheme Rate.
		GPs	We pay Network GPs at the agreed rate when they provide services in the hospital
	Out-of-hospital	Specialist visits	Limited to R4 050 per person, only if referred by the chosen KeyCare GP (including radiology and pathology done in KeyCare network). We pay Network specialists in full, at the agreed rate. If you go to a specialist without a GP referral, the account will not be paid.
		International clinical review consultations	Limited to 50% of the cost, subject to preauthorisation. Only for consultations being obtained from specialists at the Cleveland Clinic
		GP visits	Covered with no overall benefit limit, but if more than 15 visits are needed for any one beneficiary, authorisation is required for those additional visits. Only at the member's chosen GP working in the KeyCare network. Unscheduled, emergency visits, limited to three visits per person per year at member's chosen GP
		Out-of-network benefit for GPs	Four out-of-network GP visit per person per year, limited to 4 each of selected blood tests, X-rays and acute medicine(subject to a formulary) requested by the non-network GP per person per year
HIV or AIDS	HIV prophylaxis (rape or mother-to-child transmission) and all HIV or AIDS-related consultations and treatment		Prescribed Minimum Benefits. Paid from Major Medical Benefit; no overall limit when obtaining treatment from a Designated Service Provider and subject to clinical entry criteria and certain HIV*Care* Programme protocols. A 20% co-payment applies if a non-Designated Service Provider is used voluntarily
Home-based care	Includes wound care, end-of-life care, IV infusions and postnatal care		Paid from Major Medical Benefit, up to 100% of the LA Health Rate, subject to authorisation, clinical criteria and management by the Scheme's Designated Service Providers

Hospitals

All planned procedures must be preauthorised. Authorisation via KeyCare Specialist only, unless otherwise motivated

Hospitalisation, theatre fees, intensive and high-care unit	
Hospitals subject to authorisation	No overall limit and paid from Major Medical Benefit for treatment authorised in a KeyCare network hospital. We pay in full for services at a KeyCare Network Hospital, and for emergency services. We pay at 70% of the Scheme Rate at a Partial Network Hospital. No benefit outside of the network for planned admissions
Administration of defined intravenous infusions and medicine used during the procedure	Subject to authorisation and clinical criteria, from a Network provider. A 20% copayment applies to the hospital account for treatment obtained from a non-Network provider
Non-emergency hospital admissions for selected members suffering from one or more significant chronic conditions	Unlimited, subject to the Scheme's Disease Management Programme, authorisation and clinical criteria. Paid up to 80% of the Scheme rate for patients who are not registered on the Programme
Operations and procedures only covered in Day-Care Facilities, subject to authorisation	Specific operations and procedures are only covered in day-care facilities. We will tell you about these when you call us for authorisation
Casualty/outpatient Benefit (excluding facility fees)	Subject to authorisation and the member paying the first R355 of the claim to the hospital. Pathology, radiology or medicine subject to clinical guidelines, and specialist care subject to the applicable benefit limit. No benefit if not authorised

Maternity benefit

A comprehensive defined basket of maternity and infant benefits. Paid up to 100% of the LA Health Rate, from the Hospital Benefit, not affecting the other day-to-day benefits. Benefits must be activated by preauthorising the delivery, creating a pregnancy profile on the our website at www.lahealth.co.za or by registering your baby on the Scheme.

In-hospital	Theatre fees, intensive and high-care unit costs. Subject to preauthorisation	No overall limit in a KeyCare Hospital
Out-of-hospital	Antenatal consultations at a gyneacologist, GP or midwife	Up to 8 consultations at your gynaecologist, GP or midwife
	Ultrasound scans and prenatal screening	Up to two 2D ultrasound scans and one nuchal translucency or Non-Invasive Prenatal Testing (NIPT) screening. We pay 3D or 4D scans as if they are 2D scans
	Blood tests (prenatal)	A defined basket of pregnancy-related blood tests per pregnancy
	Pre- and postnatal care	Up to five pre- or postnatal classes or consultations, up until two years after birth, with a registered nurse
	GP and specialist care for babies and toddlers who are younger than 2 years	Two visits to the chosen KeyCare GP, paediatrician or ear-nose and throat specialist (ENT)
	Post-natal healthcare services for the mother	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 midwife, GP or gynaecologist consultation for post-natal complications

Medicine

Prescribed Minimum Benefit Chronic Disease List conditions (PMB CDL)	All Prescribed Minimum Benefits Chronic Disease List conditions covered based on a formulary if prescribed by the member's chosen KeyCare GP, subject to approval and the use of the Scheme's Designated Service Provider courier pharmacy. If the Designated Service Provider courier pharmacy is not used, a co-payment applies
Diabetes, Cardiovascular and HIV Management for persons registered on the Disease Management Programme	Subject to clinical criteria and registration on referral by the KeyCare network GP. Limited to services in a defined basket of care for the condition
Bluetooth-enabled blood glucose monitoring device	Subject to authorisation and clinical criteria and limited to one device per qualifying person who is registered on the Chronic Illness Benefit for Diabetes
Prescribed/acute medicine	Covered with no overall limit from Designated Service Provider. Prescribed medicine only for acute and non-Prescribed Minimum Benefits chronic conditions, subject to a formulary and only covered if prescribed by the member's chosen KeyCare Network GP
Take-home medicine (when discharged from hospital)	Limited to R160 per person per hospital event

Mental health

In-hospital	Psychiatric hospitals, subject to preauthorisation and case management (in-hospital)	Prescribed Minimum Benefits. 21 days per person, paid from Major Medical Benefit, subject to obtaining services from a Designated Service Provider hospital. A co-payment of 20% of the hospital account applies when a non-network hospital is used voluntarily
Out-of-hospital	Psychiatrists	Limited to the Specialist Benefit limit of R4 050
	Disease management for episodes of Major Depression for persons registered on the Scheme's Disease Management Programme	Limited to benefits in a defined basket of care and paid up to the Scheme rate from the Major Medical Benefit. Subject to treatment meeting the Scheme's treatment guidelines and managed care criteria

Oncology (cancer-related care)		Oncology, including chemo- and radiotherapy	Chemo- and radiotherapy only covered if provided by an oncologist in the KeyCare network, subject to the Prescribed Minimum Benefits protocols. Paid from Major Medical Benefit. If a non-network provider is used voluntarily, a 20% co-payment will be applied
		PET scans	Up to a maximum of 4 scans per person per treatment cycle, subject to authorisation, clinical criteria, review and the scan being done by a Network provider.
		Brachytherapy treatment for prostate cancer (PMB)	Covered from Major Medical Benefit from Network Hospital identified by the Scheme, subject to preauthorisation
		Stem cell transplants (local searches only)	You have access to local bone marrow donor searches and transplant up to the agreed rate. Your cover is subject to clinical protocols, review and approval.
		Advanced Illness Benefit for patients with end-of-life stage cancer (out-of-hospital)	Paid from Major Medical Benefit Subject to a basket of care and registration on the Oncology Programme by the treating doctor
Optical		Optometry consultations	One eye test per person per year at an optometrist in the KeyCare optometry network
		Spectacles, frames, contact lenses and refractive eye surgery	One pair of clear mono- or bi-focal glasses or contact lenses per person every two years from the last date of service at KeyCare optician
Organ transplants		Hospitalisation	Unlimited. Subject to Prescribed Minimum Benefits, strict clinical entry criteria and preauthorisation
		Medicine for immuno-suppressive therapy	Subject to Prescribed Minimum Benefits
Other services	In-hospital	Auxilliary Services (physiotherapy, occupational therapy, audiology, psychology, etc)	Paid from Major Medical Benefit, subject to preauthorisation and clinical criteria
	Out-of-hospital	Auxilliary Services (physiotherapy, occupational therapy, audiology, psychology, etc)	No benefit
Pathology and Radiology	In-hospital	MRI and CT scans, including ultrasounds: Must be referred by specialist and is subject to preauthoristion	Covered subject to a preauthorised event and scan related to the hospital admission only at KeyCare hospital. If not related to the admission, subject to the Specialist limit of R4 050 per person per year
		Radiology (X-rays) and pathology subject to preauthorisation	Paid from Major Medical Benefit; no overall limit at a KeyCare network hospital, subject to use of services of Preferred Provider and treatment guidelines and clinical criteria
		Endoscopic procedures: Gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy, subject to preauthorisation	Subject to PMB only
	Out-of-hospital	MRI and CT scans, subject to preauthorisation	Covered by Specialist Benefit up to R4 050, if referred by specialist
		Radiology, (including X-rays and ultrasounds) and pathology	Paid according to a list of procedure codes, subject to PMBs and only if requested by the member's chosen KeyCare GP. Requests from specialists covered up to the R4 050 specialist limit
		Endoscopic procedures: Gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy, subject to preauthorisation	Subject to PMB only
Prostheses		**Internal prostheses**	
		Cardiac stents	Covered in full from the Scheme's Network Provider. Subject to preauthorisation and clinical criteria. If the Stent is supplied by a non-Network supplier, the following limits apply per stent per admission: Drug-eluting stent: R6 825; Bare metal stent: R5 775
		Other internal prostheses (subject to clinical protocols)	Paid from Major Medical Benefit subject to preauthorisation
		External medical items	
		Oxygen rental	Covered in full at the Scheme's Designated Service Provider. If the Designated Service Provider is not used, a 20% co-payment will apply
		Mobility Benefits: Crutches, wheelchairs, artificial limbs, stoma bags, etc.	Limited to R5 400 per family from the Scheme's Designated Service Provider. If the Designated Service Provider is not used, then no benefit will be payable. Must be requested by the chosen KeyCare network GP
Preventive care		Pharmacy screening benefit at a network pharmacy: Blood glucose, blood pressure, cholesterol and body mass index (BMI) or One flu vaccination	Paid once per year at the applicable Scheme Rate per qualifying person for a single or basket of these tests or for one flu vaccination. Payable from Major Medical Benefit only if the services of one of the Scheme's Designated Service Providers is used. HbA1C and LDL cholesterol tests paid from Major Medical Benefit, subject to clinical criteria.
		Pneumococcal vaccination	Eligible members have access to one specific approved pneumococcal vaccine every 5 years paid from the Major Medical Benefit, subject to clinical criteria
		Screening benefit for children between the ages of two and 18: Body Mass Index, including counseling if necessary, basic hearing and dental screenings; and milestone tracking for children between the ages of two and eight years old	Paid once per year at the applicable Scheme Rate per qualifying beneficiary for a single or basket of these tests. Payable from Major Medical Benefit only if one of the Scheme's Designated Service Providers is used
		Mammogram, Pap Smear and Prostrate-Specific Antigen (PSA) screenings	1 Mammogram every 2 years; 1 Pap Smear every 3 years and one PSA test per person per year subject to clinical criteria and PMB. Consultations paid as described for GPs or Specialists.
		Additional cover for Mammogram, Breast MRI, BRCA testing and repeat Pap Smear	Subject to meeting the Scheme's clinical criteria. BRCA testing limited to one test. Consultations paid as described for GPs or Specialists

Renal care

Dialysis and other renal care-related treatment and educational care (includes authorised related medicines)	Cover for chronic dialysis only. Covered at DSP, National Renal Care. Co-payments will apply if the network is not used

Substance abuse

Alcohol and drug rehabilitation	Prescribed Minimum Benefits. 21 days per person, paid from Major Medical Benefit
Detox: In hospital	Prescribed Minimum Benefits. Three days per person, paid from Major Medical Benefit

Terminal Care Benefit

Hospice (excluding frail care)	Unlimited for Prescribed Minimum Benefits. Paid from Major Medical Benefit, subject to clinical entry criteria and preauthorisation. Limited to R44 050 for non-PMB in-patient and home-based care

Trauma recovery benefit

Covers certain medical expenses after you or your family experienced severe trauma. The benefit is paid up to the end of the year following the one in which the traumatic event occurred

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

Allied and therapeutic healthcare services	M	**R 7 350**
	M + 1	**R11 100**
	M + 2	**R13 800**
	M + 3+	**R16 650**
External medical appliances		**R27 400**
Hearing aids		**R14 100**
Prescribed medicine	M	**R14 400**
	M + 1	**R17 000**
	M + 2	**R20 200**
	M + 3+	**R24 550**
Prosthetic limbs (with no further access to the external medical items limit)		**R82 000**

LA KeyPlus contributions

40% in-service member's portion of contributions if a 60% subsidy applies. Maximum subsidy of R4 218.17

Income Category	R0 – R8 700	R8 701 – R12 000	R12 001+
	R 430	R 454	R 683
+	R 805	R 850	R1 291
+ +	R 962	R1 016	R1 546
+ + +2	R1 120	R1 182	R1 801
+ + +3	R1 277	R1 347	R2 056
+	R 587	R 619	R 938
+ +2	R 744	R 785	R1 193
+ +3	R 901	R 950	R1 448

2019 Total contributions

Income Category	R0 – R8 700	R8 701 – R12 000	R12 001+
	R1 075	R1 135	R1 708
	R 939	R 992	R1 520
	R 393	R 414	R 638
+3	R1 179	R1 242	R1 914

What we do not cover on LA KeyPlus

There are conditions and treatments that are not covered by the Scheme.

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

Below are some of the conditions and treatments that we specifically do not cover for LA KeyPlus members. We also do not cover any healthcare expenses related directly or indirectly to these healthcare services.

- **In-hospital management of:**
  - Dentistry
  - Skin disorders, including benign growths and lipomas
  - Conservative back and neck treatment in hospital
  - Diagnostic work-up and investigative procedures
  - Hearing disorders
  - Functional and nasal or sinus problems
  - Nail disorders
  - Endoscopic procedures
- Refractive eye surgery
- Surgery for oesophageal reflux or hiatus hernia repair
- Spinal surgery for back, neck and shoulders
- Cochlear implants, auditory brain implants and internal nerve stimulators (procedures, devices, hearing aids 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

General Scheme exclusions

There are certain medical expenses and other costs the Scheme does not cover on any of the benefit options, including LA KeyPlus. LA Health will not cover any of the following, or the direct or indirect consequences of these treatments, procedures or costs incurred by members:

Certain types of treatments and procedures:

- Cosmetic procedures, for example, otoplasty for jug ears; portwine stains; blepheroplasty (eyelid surgery); keloid scars; hair removal; nasal reconstruction (including septoplasties, osteotomies and nasal tip surgery) and 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
- CT angiogram of the coronary vessels and CT colonoscopy

The purchase of the following, unless prescribed:

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

Unless otherwise decided by the Scheme, benefits in respect of these items, on prescription, are limited to one month's supply for each 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)

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.

This is a summary of the LA KeyPlus benefits and features, submitted to the Registrar of Medical Schemes.
If there is any discrepancy between this document and the registered Rules, the Rules will always apply.

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