LA Health
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LA KEYPLUS

2026

LA KeyPlus

REASONS WHY THE LA KEYPLUS OPTION IS THE BEST FOR YOU

This Option has a Major Medical Benefit for all in-hospital and large expenses. The LA KeyPlus Option provides hospital cover, Prescribed Minimum Benefit 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 all planned Prescribed Minimum Benefits and other procedures/care.

Some care will only be allowed at one of the approved Day Surgery facilities.

When you use the services of providers in the KeyCare Primary Care Network for GP and other care, you have full cover.

PRESCRIBED MINIMUM BENEFITS

Prescribed Minimum Benefits are paid at cost, subject to clinical criteria and the use of the services of the Scheme's Designated Service Providers in the KeyCare Network.

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 medical transport. We pay for this service from the Major Medical Benefit and there is no overall limit. You must call Discovery 911 to authorise and dispatch the emergency medical transport.

Discovery 911
0860 999 911
Real-time emergency care for members

Call Discovery 911 for authorisation.

COVER FOR GPs AND SPECIALISTS IN AND OUT OF HOPSITAL

When you're admitted to a hospital in the KeyCare 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 LA Health Rate for all other specialists working in a hospital in the KeyCare Network.

Certain procedures must be treated in a Day Surgery Network facility.

Out-of-hospital GP visits and selected small procedures are unlimited at a KeyCare Network GP, but you have to get authorisation if you need to go to the GP more than 15 times in a year, from the 15th visit onwards. For unscheduled emergency visits we pay for three visits per person per year at your KeyCare Network GP.

The Out-of-network Benefit pays for 2 clinic-based visits per person per year and selected blood tests, X-rays and acute formulary medicine requested by a nurse at the clinic or, if referred, by a non-network GP.

You have cover of R5 800 per person for out-of-hospital specialist visits, including radiology and pathology done in the KeyCare network, if you are referred by your KeyCare GP.

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. The casualty facility must obtain approval for your casualty visit, if it is not an emergency. The Scheme will only pay for one approved casualty visit per beneficiary per year at a Network provider and you will have to pay a portion of the cost of the visit. If you do not have approval, the Scheme will not pay for the casualty visit.

WE COVER YOU WHEN YOU ARE ADMITTED TO HOSPITAL

When you're admitted to a hospital in the KeyCare 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 LA Health Rate for all other specialists working in a hospital in the KeyCare Network.

Hospitalisation, theatre fees and costs for intensive and high care at a KeyCare hospital and the cost for specific procedures at Day Surgery Network facilities in the Keycare Network have no overall limit, as long as certain clinical entry criteria and protocols are met, and treatment is authorised.

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

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 and getting the medicine from the Scheme's Designated Service Provider 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 a specific limit, 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.

WORLD HEALTH ORGANIZATION (WHO) OUTBREAK BENEFIT

The Scheme provides a basket of care for COVID-19 and Monkeypox, subject to clinical criteria and protocols

WE PAY FOR CERTAIN PREVENTATIVE SCREENING TESTS OR VACCINES

You have cover for a health Screening Check (to check your blood glucose, blood pressure, cholesterol and body mass index) or a flu vaccination at a network pharmacy

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 LA Health Rate, from the Major Medical 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

The Maternity Benefit 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

ADVANCED ILLNESS BENEFIT

Palliative care for patients with end-of-life stage cancer or other terminal illnesses (out-of-hospital)

Paid from the Major Medical Benefit, subject to authorisation and the treatment meeting the Scheme's guidelines and managed care criteria

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

EMERGENCY TRANSPORT

You must call Discovery 911 0860 999 911 Real-time emergency care for members

Ambulance and other emergency medical transport

Paid from Major Medical Benefit; subject to preauthorisation. No overall limit. You must call Discovery 911 to authorise and dispatch the ambulance to you

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. 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 LA Health Rate. If PMB-related treatment or care is involuntarily obtained from non-Network Specialists in a KeyCare hospital, their claims will be paid in full
Preoperative Assessment done out of hospital by an Anaesthetist for members undergoing the following procedures: Breast, Prostate or Colorectal Cancer surgery, or Coronary Artery Bypass Grafting surgery (CABG)	Paid once per hospital admission from the Major Medical Benefit. Subject to authorisation, the use of the services of a Designated Service Provider and a basket of care
GPs	We pay Network GPs at the agreed rate when they provide services in hospital. We pay other GP's providing services in hospital at the Scheme Rate. If PMB-related treatment or care is involuntarily obtained from non-Network GPs in a KeyCare hospital, their claims will be paid in full

Out of Hospital

Specialist visits	Limited to R5 800 per person, only if referred by the 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 Network GP referral, the account will not be paid Consultations with an Opthalmologist: subject to referral by the Network GP or optometrist. In the absence of such a referral, the Scheme will not pay for the consultation, and eye surgery procedures will not be authorised
International clinical review consultations at the Cleveland Clinic	Limited to 75% of the cost, subject to preauthorisation Only for consultations being obtained from specialists at the Cleveland Clinic
GP visits	Covered at a KeyCare Network GP with no overall benefit limit, but if more than 15 visits are needed for any one beneficiary, authorisation is required from the 15th visit onwards. Unscheduled, emergency visits, limited to three visits per person per year at the member's KeyCare Nework GP
Out-of-network benefit	Two out-of-network clinic-based visits per person per year, which includes cover for a blood test, X-ray and/or acute medicine (subject to a formulary) requested by the nurse at the clinic or the non-network GP, if referred by the nurse, 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 HIVCare Programme protocols. We pay up to 80% of the Scheme Rate if a non-Designated Service Provider is used voluntarily

HOME-BASED CARE

Home-based healthcare for clinically appropriate chronic and acute treatment and conditions, including benefits for clinically appropriate home monitoring devices	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, where appropriate. Care for the following conditions is only covered when provided by a provider in the Scheme's Home-Based Care Network of Providers: Chronic Obstructive Pulmonary Disease (COPD), Pneumonia, Urinary Tract Infections (UTIs), Heart Failure, Deep Vein Thrombosis, Cellulitis, Asthma or Diabetes, provided that level of care is supported by the treating healthcare provider

HOSPITALS AND DAY SURGERY PROCEDURES

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

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. 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. We pay up to 80% of the Scheme Rate of 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 LA Health Rate for patients who are not registered on the Programme
Casualty/outpatient Benefit (excluding facility fees) at a KeyCare hospital	Limited to one casualty visit per person per year. Subject to authorisation and the member paying the first R520 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 for non-PMB treatment if not authorised
Day surgery procedures or treatment	Specific operations or treatment are only covered in Day Surgery Network facilities. We will tell you about these when you call us for authorisation. You can also find the list of procedures on www.lahealth.co.za
Pre-operative assessment for the following list of major surgeries: arthroplasty, colorectal surgery, coronary artery bypass graft, radical prostatectomy and mastectomy	Benefits as per a basket of care. Paid up to 100% of the LA Health Rate, from the Major Medical Benefit. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols

MATERNITY BENEFIT

A comprehensive defined basket of maternity and infant benefits. Paid up to 100% of the LA Health Rate, from the Major Medical 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 - No GP referral required

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 one Non-Invasive Prenatal Testing (NIPT) or one T21 chromosome test. 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 • Two mental healthcare consultations with a counsellor or psychologist
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, and one midwife, GP or gynaecologist consultation for post-natal complications

MEDICINE

Prescribed Minimum Benefit Chronic Disease List (PMB CDL) conditions (subject to benefit entry criteria and approval)	We will pay for your approved medicine in full up to the LA Health Medicine Rate if it is on the LA Health medicine list (formulary) and obtained from the Scheme's Designated Service Provider (DSP) pharmacies. If it is not on the list and/or a DSP pharmacy is not used, a co-payment may apply To have full cover for the out-of-hospital management of your registered chronic illness, you must register on the applicable Disease Management Programme for Diabetes, HIV, Hyperlipideaemia or Ischaemic Heart Disease or Depression. If you are not registered, expenses for the out-of-hospital management of your chronic condition will be paid at 80% of the Scheme Rate
Diabetes and Cardio Care Disease Management Programmes	Up to 100% of the LA Health Rate for non-PMB GP-and other related services covered in a treatment basket, subject to registration on the Chronic Illness Benefit and referral by the Scheme's Network Provider. Paid from the Major Medical Benefit
Programme to manage Cardio Metabolic Risk Syndrome	Up to 100% of the LA Health Rate for non-PMB GP-and other related services managed by the Network GP, supported by Dietitians and health coaches. Subject to clinical criteria and the use of the services of the Scheme's preferred providers (where applicable) and registration on the Programme
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. Jointly limited to the home monitoring device limit, of R4 890 per person per year

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 R230 per person per hospital event

MENTAL HEALTH

In-Hospital

Psychiatric hospitals, subject to preauthorisation and case management (in-hospital) or contact sessions with a psychiatrist or psychologist. Subject to Prescribed Minimum Benefits only	A maximum of 21 days in hospital per person or a maximum of 15 out of hospital psychologist or psychiatrist contacts paid from Major Medical Benefit at a Designated Service Provider. The in-hospital treatment days and/or the out of hospital contacts accumulate to an overall allowance of 21 treatment days. Psychiatric care subject to preauthorisation and case management. Where members voluntarily make use of the services of a hospital or provider that is not a Designated Service Provider, the Scheme will pay up to 80% of the Scheme Rate of the hospital account

Out of Hospital - No GP referral required

Psychiatrists	Limited to the Specialist Benefit limit of R5 800
Disease management for major depression for members registered on the Mental Health Care Programme	Up to 100% of the LA Health Rate for GP services covered in a treatment basket, subject to criteria and referral by the Scheme's Designated Service Provider for GP-related services. Paid from the Major Medical Benefit
Internet-based cognitive behavioural therapy (iCBT) for beneficiaries diagnosed with depression	On recommendation by a psychiatrist, psychologist, GP or clinical social worker, subject to a basket of care and clinical entry criteria
Out-of-hospital: Depression Risk Management Programme	Up to 100% of the LA Health Rate for non-PMB GP and other related services covered in a treatment basket of care, subject to clinical criteria, for eligible members identified via a Mental Wellbeing Assessment

ONCOLOGY (CANCER-RELATED CARE)

Oncology Programme (including chemotherapy 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, claims are paid up to 80% of the Scheme Rate Radiology or pathology subject to use of the services of the Designated Service Provider (DSP). If not obtained from DSP, paid up to 80% of the Scheme Rate
Oncology-related PET scans	Paid from the Major Medical Benefit, 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)	Local bone marrow donor searches and transplant paid up to the agreed rate. Cover is subject to clinical protocols, review and approval

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 a KeyCare optician
Cataract surgery	Subject to referral to an ophthalmologist by a network GP or a network Optometrist. If not referred, the Opthalmologist's account will not be paid and the surgery will not be authorised

ORGAN TRANSPLANTS

Hospitalisation	Unlimited. Subject to Prescribed Minimum Benefits, strict clinical entry criteria and preauthorisation. We pay in full for services at a KeyCare Network Hospital and for emergency services. No benefit outside of the network for planned admissions
Medicine for immuno-suppressive therapy	Subject to Prescribed Minimum Benefits

OTHER SERVICES

In Hospital

Auxiliary 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 R5 800 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	PMB cover, and cover for children 12 years and under. Subject to preauthorisation and a defined list of Network facilities. Covered from the Major Medical Benefit

Out of Hospital

MRI and CT scans	Covered by Specialist Benefit up to R5 800, if referred by a 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 R5 800 specialist limit
Endoscopic procedures: Gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy	Subject to PMB's and pre-authorisation. Paid from the Major Medical Benefit

PREVENTIVE CARE

Pharmacy screening benefit: Blood glucose, blood pressure, cholesterol and body mass index (BMI)	Paid once per year at the applicable LA Health Rate per qualifying person for a single or basket of these tests obtained at a Network Pharmacy. Payable from Major Medical Benefit, subject to the use of the services of a Designated Service Provider. LDL cholesterol test paid from Major Medical Benefit, subject to clinical criteria
Screening benefit for children between the ages of 2 and 18: Body Mass Index, including counseling if necessary, basic hearing and dental screenings; and milestone tracking for children between the ages of 2 and 8	Paid once per year at the applicable LA Health Rate per qualifying beneficiary for a single or basket of these tests. Payable from Major Medical Benefit, subject to the use of the services of a Designated Service Provider
Enhanced Screening Benefit for persons 65 years and older: Hearing test, spot vision eye test, frailty assessment and core assessment	Unlimited, subject to clinical entry criteria and the use of the services of a Network provider An additional screening assessment for at-risk beneficiaries, subject to the use of the services of an accredited Network GP and certain clinical entry criteria
Other screening tests: Mammogram, Pap Smear, Prostrate-Specific Antigen (PSA) or Colorectal cancer screenings	Benefits Subject to clinical criteria and PMB 1 Mammogram every 2 years; 1 Pap Smear/HPV testing every 3 years, one PSA test per person per year, one faecal occult blood test or one immunochemical test every 2 years per person for persons aged 45 to 75 years. Self testing kits for cervical and colorectal cancer paid from the Major Medical Benefit Additional cover for Mammogram, Breast MRI, one BRCA test and repeat Pap Smear or one Colonoscopy (for persons identified by the colorectal screening to be at risk) Consultations paid as described for GPs or Specialists
Additional comprehensive screening assessment for at risk persons	One consultation per beneficiary per year, subject to meeting the Scheme's clinical entry criteria and treatment guidelines and the services being provided by an accredited Network GP
Vaccinations: Flu vaccination Pneumococcal vaccination	 One flu vaccination per beneficiary per year Up to two, approved pneumococcal vaccine doses per person per lifetime. Paid from the Major Medical Benefit, subject to clinical criteria

PROSTHESES OR EXTERNAL MEDICAL APPLIANCES

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 limited to the agreed rate for drug-eluting or bare metal stents, per admission. The hospital and related accounts cost do not accumulate to the stent cost limit
Other internal prostheses (subject to clinical protocols)	Paid from Major Medical Benefit subject to preauthorisation

External Medical Appliances

Mobility devices Wheelchairs, long-leg calipers, crutches, etc.	Limited to R6 300 per family per year, if requested by the member's chosen Network GP. Covered in full, up to the limit, if obtained from the Scheme's Designated Provider and up to 80% of the LA Health Rate if another supplier is used
Oxygen rental	Covered in full if provided by the Scheme's Designated Provider and up to 80% of the LA Health Rate if another supplier is used

RENAL CARE

Dialysis and other renal care-related treatment and educational care (includes authorised related medicines)	Cover for chronic dialysis only. Covered at a DSP 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
Detoxification in hospital	Prescribed Minimum Benefits. Three days per person, paid from Major Medical Benefit

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

Allied and therapeutic healthcare services	M	R10 200
	M + 1	R15 300
	M + 2	R19 000
	M + 3+	R22 900
External medical appliances		R33 300
Hearing aids		R18 600
Prescribed medicine	M	R19 800
	M + 1	R23 400
	M + 2	R27 700
	M + 3+	R33 700
Prosthetic limbs (with no further access to the external medical items limit)		R107 800
Counselling sessions with a Psychologist or social worker for beneficiaries indirectly affected by the trauma incident		A total of 6 sessions per beneficiary paid over the period, up to the end of the year after the year in which the trauma occurred

WORLD HEALTH ORGANIZATION (WHO) BENEFITS

Benefit for out-of-hospital management and appropriate supportive treatment and care for Global WHO recognised disease outbreaks 01 | COVID-19, subject to PMB 02 | Monkeypox	Subject to Prescribed Minimum Benefits Limited to a basket of care as set by the Scheme per condition Subject to obtaining the services from the Scheme's preferred providers / DSPs, where applicable, and the condition and treatment meeting certain clinical criteria and protocols

WELLTH *fund*

The WELLTH Fund is a once-off benefit, available for a maximum of two benefit years, in the year of joining and up to the end of the next year.

Be sure to undergo the required screening assessments and make use of this benefit before your access to it expires.

THE WELLTH FUND

Your available WELLTH Fund benefit limit depends on the number of registered dependants on your membership, and their age.

Once you and all your registered dependants have completed the appropriate screening assessment, you will have access to a combined WELLTH Fund benefit of R2 500 for every adult, and R1 250 for every child over the age of two years to a maximum overall limit of R10 000 per membership.

The per beneficiary limit depends on the age of the member or dependant at the date of expiry of the WELLTH Fund. For example:

- Children on the benefit who turn two years old on or before 31 December 2027 receive the child allocation of R1 250.
- Adult beneficiaries on the membership who are 18 years old on or before 31 December 2027, receive the adult benefit value of R2 500.

The maximum allocation per membership is limited to R10 000.

Once activated, the WELLTH Fund is available for use by all registered beneficiaries on your membership, regardless of their age. That means that children who are two years old after 31 December 2027 (in the example above), will not receive a fund value allocation but are still eligible to use the WELLTH Fund.

Qualifying healthcare services are covered up to a maximum of the Scheme Rate, subject to the overall benefit limit.

HEALTHCARE SERVICES THAT WILL BE PAID FROM THE WELLTH FUND

General health	• One GP consultation per beneficiary per year • Dental check-up • Eye check-up • Hearing check-up • Skin cancer screening • Heart consultation • Lung cancer screening for long-term smokers • Medical devices used to monitor blood pressure, blood sugar and cholesterol. The devices must have a registered NAPPI code and be purchased from a registered healthcare provider with a valid practice number (such as a pharmacy dispensary or doctor)
Physical health	• Diet, nutrition, and weight management at a dietitian • Physical movement and mobility management at a biokineticist or physiotherapist • Fitness assessment or high-performance fitness assessment at a provider in the Scheme's Wellness Network • Foot health management at a podiatrist
Mental Health	Mental wellness check-up at a psychologist, nurse, social worker, registered counsellor, or psychiatrist
Women's and men's health	Gynaecological and prostate consultations with your doctor, and a bone density check
Children's Health	Children's wellness visit, which includes growth and appropriate developmental assessments with an occupational therapist, speech therapist or physiotherapist

IMPORTANT THINGS TO REMEMBER

- Network rules apply.
- General Scheme exclusions apply. If cover for specific services is not covered under the Option, you may not claim for them from the WELLTH Fund.
- Medicine or ongoing treatment for a diagnosed condition is not covered from the WELLTH Fund.
- Where healthcare services are also eligible for cover from another defined risk benefit, for example the Screening and Prevention Benefit, we will pay the claim from that benefit first, and then only from the WELLTH Fund in instances where that benefit is depleted or unavailable.
- Claims paid from your WELLTH Fund do not impact your Day-to-day benefits.
- Cover from the WELLTH Fund is subject to the Scheme's entry clinical criteria, treatment guidelines and protocols.

2026 TOTAL CONTRUBUTIONS

	Member	Adult	Child dependant	Maximum for 3 child Dependants
R0 - R12 000	R1 634	R1 427	R597	R1 791
R12 001 - R16 800	R1 722	R1 506	R628	R1 884
R16 801+	R2 593	R2 308	R968	R2 904

WHAT WE DO NOT COVER (EXCLUSIONS)

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 SCHEDULE EXCLUSIONS

There are certain medical expenses and other costs the Scheme does not cover, except when it is a Prescribed Minimum Benefit. We call these exclusions.
LA Health will not cover any of the following, or the direct or indirect consequences of these treatments, procedures or costs incurred by members

CERTAIN TYPES OF TREATMENTS AND PROCEDURES

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

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.

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

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LA-Health LA Health

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