LA Health
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2023

LA KEYPLUS

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 all planned Prescribed Minimum Benefits and other procedures. Some care will only be allowed at one of the approved Day Surgery Network 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

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, 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 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 defined procedures must be treated in a Day Surgery Network facility.

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, from the 15th visit onwards. For unscheduled emergency visits we pay for three visits per person per year at your chosen 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 a non-network GP.

You have cover of R5 000 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.

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 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 facilities 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.

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.

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 you obtain 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.

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 screening tests or a flu vaccine

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 one of the Scheme's contracted providers or 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

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

ADVANCED ILLNESS BENEFIT		
	Palliative care for patients with end-of-life stage cancer or other terminal illnesses (out-of-hospital)	Paid from 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		
MUST CALL DISCOVERY 911 FOR AUTHORISATION		
	Ambulance and other emergency medical transport	Paid from Major Medical Benefit; subject to preauthorisation. No overall limit
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 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 benefits. 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 the hospital. We pay other GP's providing services in hospital at the Scheme Rate. If PMB 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 000 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 75% of the cost, subject to preauthorisation Only for consultations being obtained from specialists at the Cleveland Clinic
	GP visits	Covered at the member's chosen KeyCare 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 member's chosen GP
	Out-of-network benefit for GPs	Four out-of-network GP visits 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

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

HOSPITALS/DAY SURGERY FACILITIES

ALL PLANNED PROCEDURES MUST BE PREAUTHORISED. AUTHORISATION VIA 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. A 20% co-payment 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 LA Health Rate for patients who are not on the Programme for non-PMB conditions
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 R450 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
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
	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 (PMB CDL) conditions (subject to benefit entry criteria and approval)	We will pay 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
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
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 250 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 R200 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, a 20% co-payment will apply to the hospital account
OUT-OF-HOSPITAL	Psychiatrists	Limited to the Specialist Benefit limit of R5 000
	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

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
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

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	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 R5 000 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 000, 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 R5 000 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 as-sessment 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.	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. 1 Mammogram every 2 years; 1 Pap Smear 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. 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
Additional screening benefit for 1. Primary healthcare screening services for visual, hearing, dental and skin conditions 2. Physical well-being screening at a dietician, biokinetisist and/or physiotherapist 3. Women and men's screening and prevention healthcare services 4. Screening and prevention healthcare services for children 5. Cover for a defined list of registered screening and health monitoring devices	Basket of care as set by the Scheme limited to: R2 500 per adult beneficiary once per lifetime; R1 250 per child beneficiary once per lifetime; up to a maximum of R10 000 per family. Subject to completion of the group of tests as set out in the pharmacy screening benefit and/or the enhanced Screening Benefit for persons who are 65 years or older. The benefit is available for a maximum of 2 two years, from 2023, for existing members and for new members joining the Scheme, in the year of joining and the year thereafter. Subject to the Scheme's clinical entry criteria, treatment guidelines and protocols.
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

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: R7 350; Bare metal stent: R6 200
Other internal prostheses (subject to clinical protocols)	Paid from Major Medical Benefit subject to preauthorisation

MEDICAL EQUIPMENT BENEFIT

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 720 per family from the Scheme's Designated Service Provider. If the Designated Service Provider is not used a 20% co-payment will apply. Must be requested by the chosen KeyCare network GP

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

Allied and therapeutic healthcare services	M M + 1 M + 2 M + 3+	**R 8 800** **R13 250** **R16 500** **R19 850**
External medical appliances		**R28 900**
Hearing aids		**R16 100**
Prescribed medicine	M M + 1 M + 2 M + 3+	**R17 150** **R20 300** **R24 100** **R29 300**
Prosthetic limbs (with no further access to the external medical items limit)		**R93 550**
Counselling sessions with a psychologist or social worker	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) OUTBREAK BENEFIT

Benefit for out-of-hospital management and appropriate supportive treatment and care for Global WHO recognised disease outbreaks 1. COVID-19 2. 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

LA KEYPLUS CONTRIBUTIONS

2023 TOTAL CONTRIBUTIONS

INCOME CATEGORY	MEMBER	ADULT	CHILD DEPENDANT	MAXIMUM FOR 3 CHILD DEPENDANTS
R0 - R10 600	R1 310	R1 144	R 479	R1 437
R10 601 - R14 700	R1 381	R1 208	R 504	R1 512
R14 701 +	R2 080	R1 851	R 777	R2 331

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; 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.

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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LA-Health LA Health

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