LA Health
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2025

LA Core

REASONS WHY THE LA CORE OPTION IS THE BEST FOR YOU

This option has a Major Medical Benefit for all in-hospital and large expenses. It provides cover for medicine for Chronic Disease List conditions that form part of the Prescribed Minimum Benefits, as well as for several additional chronic conditions. It pays for Day-to-day expenses from a Medical Savings Account, with Extended Day-to-day Benefits for GPs, specialists, dentists, acute medicine, radiology, pathology and optical benefits.

In Hospital

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 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 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.

We pay the hospital and other claims up to 100% of the LA Health Rate from the Major Medical Benefit

WE COVER CERTAIN PROCEDURES AT DAY SURGERY FACILITIES

You must preauthorise your day surgery treatment or care

Certain procedures are covered in full when you have the treatment at a Day Surgery facility in the Scheme's Network.
If not, a deductible will apply. You will have to pay the deductible to the provider.

You can find the list of Day Surgery procedures on www.lahealth.co.za. We will also tell you about this when you preauthorise the procedure.

WE COVER YOU WHEN YOU NEED EMERGENCY MEDICAL TRANSPORT

The Scheme covers you for emergency medical transport. We pay for this service from the Major Medical Benefit and there is no overall limit.

Out of Hospital

IF THE TREATMENT OR CARE IS A PRESCRIBED MINIMUM BENEFIT (PMB)

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.

IF THE TREATMENT OR CARE IS NOT A PRESCRIBED MINIMUM BENEFIT (PMB)

Out-of-hospital benefits are paid up to 100% of the Scheme Rate, subject to clinical criteria, the use of the Scheme's Network and/or Preferred Providers, and applicable limits. We pay these claims from the Medical Savings Account or the Extended Day-to-day Benefit.

You can enjoy the best of care during your pregnancy

No overall limit applies when you're admitted to hospital as long as you get preauthorisation for the admission. We pay certain out-of-hospital benefits for the mother and baby from the Major Medical Benefit, if the mother registers on the Scheme's Maternity Programme. If not registered, all pregnancy-related benefits will be paid from the available benefits in the Medical Savings Account or Extended Day-to-day Benefit.

Cover for chronic and acute medicine

You have medicine cover for all approved Prescribed Minimum Benefit Chronic Disease List conditions, paid in full from the Major Medical Benefit up to the LA Health Medicine Rate for listed medicine. Medicine that is not on the medicine list is paid up to a Chronic Drug Amount.

Medicine, for approved Additional Disease List conditions, is paid up to a Chronic Drug Amount up to an annual limit. This is up to a specific amount based on your family size.

Prescribed, acute medicine on the preferred list are paid from the available funds in your Medical Savings Account, or from the Extended Day-to-day Benefit at 100% of the LA Health Rate for medicine and those on the non-preferred list are paid at 90% of the LA Health Rate for medicine.

You also have cover for over-the-counter (schedule 0, 1 and 2) medicine, whether prescribed or not, at 100% of the cost from the available funds in your Medical Savings Account or from the Extended Day-to-day Benefit. Specific limits apply.

When you are discharged from hospital after an admission, we pay for take-home medicine from the available funds in your Medical Savings Account or from the Extended Day-to-day Benefit at 100% of the LA Health Rate for medicine on the preferred list and at 90% for medicine on the non-preferred list.

The Scheme pays for the completion of the Chronic Illness Benefit application form by your provider, if the condition is approved.

We pay for certain preventive screening tests or vaccines

The Major Medical Benefit provides cover for:

- A screening test (to check your blood glucose, blood pressure, cholesterol and body mass index), or a flu vaccination at one of the Scheme's designated service providers or a network pharmacy. We also pay for additional screening tests for seniors and children.
- A once-off specific pneumococcal vaccination in a qualifying beneficiary's lifetime.
- Pap smears, mammograms, prostate-specific antigen tests and certain colorectal cancer screenings, subject to clinical criteria.

We pay these costs from the Major Medical Benefit up to 100% of the LA Health Rate.

We pay for the consultation and other related costs from your Medical Savings Account, or from the Extended Day-to-day Benefit. If these are needed as part of Prescribed Minimum Benefit, we pay the costs from the Major Medical Benefit.

World Health Organization (WHO) Outbreak Benefit

The Scheme pays for screening, testing, consultations and other PMB-related COVID-19 treatment and care – whether the care is required in or out of hospital. This includes benefits for vaccinations and the treatment and care of long COVID-19.

The Scheme also provides a basket of care benefits for treatment and care related to Monkeypox.

OVERALL ANNUAL LIMITS

Hospital	No overall limit		
	Member	Spouse/Adult	Child (max 3)
Extended Day-to-day Benefit	R8 245	R5 758	R2 243
Medical Savings Account	R13 236	R11 568	R5 316

Advanced Illness Benefit

Out of hospital palliative care for members with life-limiting conditions, including cancer

Subject to PMB Paid from the Major Medical Benefit, subject to clinical criteria and authorisation

Advanced Illness Member Support Programme

For patients with advanced illnesses, requiring support at a time when they are trying to manage their symptoms,and understand their healthcare needs

Paid from Major Medical Benefit. Subject to a basket of care, authorisation, clinical criteria and guidelines

Ambulance services – *must call Discovery 911 (0860 999 911) for authorisation*

Emergency Medical Transport

Paid from Major Medical Benefit, up to 100% of the LA Health Rate subject to authorisation. No overall limit

Blood transfusions and blood products

Blood transfusions and blood products

Subject to Prescribed Minimum Benefits. Paid from Major Medical Benefit. No overall limit

Colorectal cancer care and surgery

In and out of hospital management of colorectal cancer and related surgery

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. If the services of a non-DSP provider are used, the claim will be paid up to 80% of the LA Health Rate. Related accounts paid from Major Medical Benefit

Dentistry

In and Out-of-Hospital

Basic dental trauma procedures: for a sudden and unanticipated impact injury because of an accident or injury to teeth and the mouth, resulting in partial or complete loss of one or more teeth that requires urgent care in- or out-of-hospital	Subject to a joint limit of R68 250 per person per year for treatment in- or out-of-hospital. **In-Hospital** Paid from the Major Medical Benefit. Subject to preauthorisation, clinical entry criteria, treatment guidelines and protocols. Members will have to make an upfront payment (deductible) to the hospital or Day Clinic

Hospital	Younger than 13 years	R2 620
	Older than 13 years	R6 620
Day clinics	Younger than 13 years	R1 280
	Older than 13 years	R4 340

In- and Out-of-Hospital
Dentist and related accounts paid from the Major Medical Benefit, up to 100% of the Scheme Rate

Dental appliances and prostheses
All dental appliances and prostheses, and the placement thereof, paid from the Major Medical Benefit.

In Hospital

Maxillo-facial procedures: certain severe infections, jaw-joint replacements, cancer-related and certain trauma-related surgery, cleft-lip and palate repair	Subject to preauthorisation. Paid from Major Medical Benefit. No overall limit
Specialised dentistry	Members will have to make an upfront payment (deductible)

Hospital	Younger than 13 years	R2 620
	Older than 13 years	R6 620
Day clinics	Younger than 13 years	R1 280
	Older than 13 years	R4 340

Hospital and related hospital accounts paid from Major Medical Benefit, up to 100% of the LA Health Rate Related, non-hospital accounts (for dentists, anaesthetists, etc), subject to a limit of R38 660 per person per year

Basic dentistry

Members will have to make an upfront payment (deductible)

Hospital	Younger than 13 years	R2 620
	Older than 13 years	R6 620
Day clinics	Younger than 13 years	R1 280
	Older than 13 years	R4 340

Hospital account paid from the Major Medical Benefit. Related accounts (for dentists, anaesthetists, etc), paid from and limited to available funds in the Medical Savings Account and the Extended Day-to-day Benefit

Out of Hospital

Specialised dentistry	Paid from and limited to funds in Medical Savings Account and Extended Day-to-day Benefit
Basic dentistry	Paid from and limited to funds in Medical Savings Account and Extended Day-to-day Benefit

Diabetes and cardio care

Disease Prevention Programme for pre-diabetic beneficiaries with cardio-metabolic risk syndrome (not registered on the Diabetes Management Programme)	Coordinated by the beneficiary's Primary Care provider, and supported by dieticians and health coaches, subject to a basket of care and clinical entry criteria
Diabetes Care and Cardio Care Disease Management Programmes	Up to 100% of the LA Health Rate for non-PMB and other GP-related services covered in a treatment basket, subject to registration on the Chronic Illness Benefit and referral by the by the Scheme's Network GP Paid from the Major Medical Benefit
Continuous blood glucose monitoring	Subject to registration on the Scheme's Diabetes Management Programme, authorisation and clinical criteria Readers and/or transmitters paid from the Medical Savings Account, limited to R5 150 per device. Sensors paid from the Major Medical Benefit, limited to R1 890 per beneficiary per month, from a DSP pharmacy. The following annual co-payments apply: Adult beneficiary R1 370 / Paediatric beneficiary R1 890

GPs and specialists

In Hospital

Visits paid from Major Medical Benefit up to 100% of the LA Health Rate. No overall limit

Out of Hospital

GP and specialist visits: actual, virtual and tele consultations or emergency room visits	Paid from Medical Savings Account or Extended Day-to-day Benefit
Virtual paediatrician consultations for children aged 14 years and younger from a network paediatrician consulted in the six months before the virtual consultation	Paid from the Major Medical Benefit once the Medical Savings Account and Extended Day-to-day Benefits are depleted. Subject to clinical criteria
Trauma-related casualty visits for children when normal Day-to-day benefits are exhausted	Paid from Major Medical Benefit Two trauma-related casualty visits at a provider in the Scheme's Casualty Network for children aged 10 and under, once the members' Medical Savings Account and Extended Day-to-day Benefits has been depleted. Includes the cost of the emergency casualty consultation, facility fees and all consumables
International clinical review consultations	Paid from the Major Medical Benefit to a maximum of 75% of the cost of the consultation at the Cleveland Clinic. Subject to preauthorisation

HIV or AIDS

HIV prophylaxis (rape or mother-to-child transmission)	Prescribed Minimum Benefits. Paid from Major Medical Benefit. No overall limit
HIV- or AIDS-related illnesses	Prescribed Minimum Benefits. Paid from Major Medical Benefit. No overall limit, subject to clinical entry criteria and HIVCare Programme protocols
HIV- or AIDS-related consultations	Prescribed Minimum Benefits. Covered with no overall limit from the Scheme's Designated Service Provider. Paid up to 80% of the Scheme Rate if the services of a non-DSP are used

Home-based Care

Home-based care for clinically appropriate chronic and acute treatment and conditions that can be treated at home, including clinically appropriate 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 and benefits defined in a basket of care

Hospitals and Day Surgery Procedures

all planned procedures must be preauthorised

Pre-operative assessment

Pre-operative assessment for the following major surgeries: Arthroplasty, colorectal surgery, coronary artery bypass graft, radical prostatectomy and mastectomy	Paid once per hospital admission from the Major Medical Benefit up to 100% of the LA Health Rate according to a benefit basket. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols.

Hospitalisation, Theatre Fees, Intensive and High Care

Hospitals	No overall limit. Paid from the Major Medical Benefit. Subject to preauthorisation and clinical guidelines
Prescribed Minimum Benefit-related treatment and procedures	Emergency in-hospital care subject to Prescribed Minimum Benefits Paid at 100% of the cost for services provided in a KeyCare Network Hospital, the Scheme's Designated Service Provider for Prescribed Minimum Benefits, when a Specialist in the KeyCare hospital, a Discovery Health Network GP or a Premier A or Premier B Specialist admits the member If Prescribed Minimum Benefit-related services are not obtained at a Designated Service Provider Hospital and the admitting doctor is not a Designated Service Provider, PMB claims will be paid up to the LA Health Rate only
Non-Prescribed Minimum Benefit planned in-hospital treatment and procedures	Non-Prescribed Minimum Benefit planned in-hospital treatment and procedures: paid up to 100% of the LA Health Rate

Day Surgery Procedures

Defined list of day surgery procedures paid from Major Medical Benefit, up to 100% of the LA Health Rate, subject to authorisation, clinical criteria and the services being obtained at a facility in the Scheme's Designated Service Provider Network. If the services of non-Designated Service Providers are used voluntarily, a R7 000 deductible applies

Maternity benefit

In Hospital

Paid from the Major Medical Benefit, up to 100% of the LA Health Rate. Subject to preauthorisation

Out of Hospital

Maternity Programme

Paid from the Major Medical Benefit, up to 100% of the LA Health Rate. Subject to registration on the Programme. If not registered on the Programme, benefit for mother and baby subject, and limited to benefits from Medical Savings Account and Extended Day-to-day Benefit

Cover during Pregnancy Antenatal visits, ultrasounds and scans, selected blood tests, pre- or post-natal classes, GP and Specialist consultations	• 8 Antenatal consultations with a gynaecologist, GP or midwife • One Nuchal translucency or one non-invasive prenatal test (NIPT) or one T21 Chromosome test, subject to clinical entry criteria • Two 2D ultrasound scans • A defined basket of blood tests • 5 pre- or post-natal classes or consultations with a registered nurse
Cover for the mother before or for up to two years after the birth	2 mental health consultations with a counsellor or psychologist
Cover for the newborn baby for up to two years after birth	2 visits to a GP, paediatrician or ear, nose and throat (ENT) specialist
Cover for the mother of the newborn baby for up to two years after the birth	• A post-birth consultation at a GP or gynaecologist for post-natal complications • One nutritional assessment at a dietitian • One lactation consultation with a registered nurse or lactation specialist
Antenatal classes	If not registered on the Maternity Programme: Limited to funds in the Medical Savings Account
Doulas Services rendered by Doulas	Paid from the Medical Savings Account

Medicine

Prescribed Minimum Benefit Chronic Disease List conditions (subject to benefit entry criteria and approval)	We will pay your approved medicine in full if it is on our medicine list (formulary), if it is not we will pay for it up to a set monthly amount, called the Chronic Drug Amount (CDA). If you use more than one medicine from the same medicine catergory, we will pay up to the monthly CDA, whether they are on the medicine list or not
Additional chronic conditions (subject to approval and a defined list of conditions)	Paid up to the applicable monthly Chronic Drug Amount (CDA), limited to: Member: R14 210 Member +1: R28 205
Prescribed/acute medicine	Paid from and limited to funds in the Medical Savings Account or Extended Day-to-day Benefit. Paid at 100% of the LA Health Rate for medicine on the preferred medicine list and at 90% for medicine on the non-preferred medicine list
Over-the-counter (OTC) medicine (Schedules 0, 1 and 2, and other scheduled medicine deemed to be OTC medicine, generic or non-generic, whether prescribed or not)	100% of the cost. Paid from the Medical Savings Account and Extended Day-to-day Benefit. Limited to R2 500 for a single member and R4 500 for a family
Take-home medicine (when discharged from hospital) TTOs	Limited to funds in the Medical Savings Account or Extended Day-to-day Benefit. Paid at 100% of the LA Health Rate for medicine on the preferred medicine list and at 90% for medicine on the non-preferred medicine list

Mental health

Prescribed Minimum Benefits	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 DSP. 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 that is not a Designated Service Provider, a 20% co-payment will apply to the hospital account
Out-of-hospital: Psychologists, psychiatrists, art therapy and social workers (non-PMB)	Limited to funds in the Medical Savings Account, subject to Prescribed Minimum Benefits
Out-of-hospital: Disease management for major depression for members registered on the Mental Health Care 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 and referral by the Scheme's Network GP. Paid from the Major Medical Benefit
Out-of-hospital: 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.

Oncology (cancer-related care)

Oncology Programme (including chemotherapy and radiotherapy)	No overall limit in a 12-month cycle, subject to approval of a treatment plan and the use of the services of the Scheme's DSP. All oncology claims accumulate to a threshold of R500 000. Before the threshold is reached, non-PMB claims pay up to the LA Health Rate and thereafter a 20% co-payment applies. Prescribed Minimum Benefits are paid in full without any co-payments
Oncology-related PET scans	Paid from Major Medical Benefit, subject to the Oncology threshold of R500 000 in a 12 month cycle. Scans must be done at the Scheme's Designated Service Provider, subject to preauthorisation. The claim will be paid up to 80% of the LA Health Rate if the services of a Designated Service Provider are not used
Oncology Innovation Benefit providing access to cover for a defined list of non-PMB novel and ultra-high cost cancer treatment	Paid at 50% or 75% of the Scheme Medicine Rate, depending on the medicine used, before and after the Oncology threshold of R500 000, with no overall limit. Subject to meeting certain clinical criteria and peer review by a Scheme-appointed panel of specialists
Stem cell transplants	You have access to local and international bone marrow donor searches and transplants up to the agreed rate. Your cover is subject to clinical protocols, review and approval

Optical

Optometry consultations	Limited to funds in the Medical Savings Account or Extended Day-to-day Benefit
Spectacles, frames, contact lenses and refractive eye surgery	Limited to funds in the Medical Savings Account or Extended Day-to-day Benefit

Organ transplants

Hospitalisation and harvesting of organ for donor transplants	Paid from the Major Medical Benefit in full at the Scheme's Designated Service Provider, subject to preauthorisation and Prescribed Minimum Benefits. Claims paid up to the LA Health Rate if non-DSP services are used
Medicine for immuno-suppressive therapy	Paid according to Prescribed Minimum Benefits, subject to the Chronic Illness Benefit Chronic Drug Amount

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, nurse practitioners, etc)	Limited to funds in the Medical Savings Account
Alternative healthcare practitioners (chiropodists, homeopaths, naturopaths and chiropractors)	Limited to funds in the Medical Savings Account
Unani-Tibb therapy	Limited to funds in the Medical Savings Account

Pathology and Radiology

In Hospital

MRI and CT scans (referred by a specialist); ultrasounds, X-rays, pathology	Paid from Major Medical Benefit. No overall limit, subject to preauthorisation. Basic pathology services subject to the use of the services of the Scheme's Designated Service Provider
PET scans	Subject to clinical criteria, motivation and authorisation. Paid from Major Medical Benefit
Endoscopic procedures: gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy (including hospital and related accounts, if done in hospital)	Paid from Major Medical Benefit. No overall limit, subject to preauthorisation

Out of Hospital

MRI and CT scans (referred by a specialist) subject to preauthorisation	Paid from Major Medical Benefit. No overall limit
Radiology (including X-rays and ultrasounds) and pathology, including point of care pathology testing	Paid from Medical Savings Account or Extended Day-to-day Benefit. Point of care pathology testing subject to test result submission via Scheme accredited devices only. Clinical criteria and guidelines apply
Endoscopic procedures: gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy	Scopes codes only: Paid from Major Medical Benefit. Unlimited, subject to preauthorisation. Related accounts paid from and limited to funds in the Medical Savings Account/Extended Day-to-day Benefit

Preventive care

Pharmacy screening benefit: Blood glucose, blood pressure, cholesterol and body mass index (BMI) OR Flu vaccination	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. One flu vaccination per beneficiary per year
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	One Mammogram every 2 years; one 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 colo-rectal screening to be at risk)	Benefits Subject to clinical criteria and PMB. Consultations paid as described for GPs or Specialists
Vaccinations: Pneumococcal vaccination	One specific, approved pneumococcal vaccine every 5 years for persons under the age of 65 or one vaccine per person per lifetime for persons over the age of 65. Paid from the Major Medical Benefit, subject to clinical criteria

Prostheses or external medical appliances

Internal Prostheses

Cochlear implants, implantable defibrillators, internal nerve stimulators and auditory brain implants	Paid from Major Medical Benefit up to R261 000 per person per year, subject to preauthorisation
Shoulder replacement prostheses	Paid from Major Medical Benefit. Unlimited if obtained from the Scheme's Preferred Provider limited to the applicable negotiated rate per device, per admission if obtained from a non-Preferred Provider
Major joint replacements, including hip and knee replacements	Paid from the Major Medical Benefit. Subject to the use of the Scheme's DSP hospital. If service is voluntarily obtained at a non-DSP hospital, the Scheme will pay up to 80% of the hospital account. Devices for hip or knee replacements unlimited from the Scheme's Preferred Provider limited to the applicable negotiated rate per device, per admission if obtained from a non-Preferred Provider
Spinal prostheses/devices	Paid from the Major Medical Benefit Unlimited if obtained from the Scheme's Network Provider If the devices or prostheses are not obtained from the Scheme's Network Provider, paid up to the negotiated rate per level up to a maximum of two levels per beneficiary per year. Only one procedure per year will be authorised
Other internal prostheses	Paid from Major Medical Benefit, subject to preauthorisation and clinical criteria

External Medical items

Crutches, wheelchairs, hearing aids, artificial limbs, stoma bags, wigs (non-oncology or alopecia), low vision devices, etc.	Limited to funds in Medical Savings Account. Wigs for alopecia (not cancer related), subject to a dermatologist requesting such wig, or as prescribed.
Oxygen rental	Paid from the Major Medical Benefit in full at the Scheme's Designated Service Provider, subject to preauthorisation. Paid up to the LA Health Rate if not obtained from the Scheme's Designated Provider

Renal care

Dialysis and other renal care-related treatment and educational care (includes authorised related medicine)	Paid from Major Medical Benefit. No overall limit. Subject to a treatment plan and use of the Scheme's Designated Service Provider. Co-payments will apply if the services of the Designated Service Provider are not used

Spinal Care and Surgery

In and out of hospital management of spinal care or surgery for a defined list of clinically appropriate procedures, which includes Lumbar or Cervical Fusion, Laminectomy or Laminotomy	Paid in full from the Major Medical Benefit from the Scheme's Designated Service Provider, subject to preauthorisation. If services are not obtained from the Scheme's Designated Service Provider, the Scheme will pay up to 80% of the LA Health rate. Related accounts paid from the Major Medical Benefit Out of hospital conservative treatment subject to the benefits in a basket of care

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

Cover for specific trauma-related incidents. The benefit is paid up to the end of the year following the one in which the traumatic event occurred.

Benefits are paid according to general Rules applicable to this Option in terms of Designated Service Providers and clinical entry criteria

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	R24 600
	M + 1	R33 400
	M + 2	R40 800
	M + 3+	R47 300
External medical appliances		R47 700
Hearing aids		R25 100
Prescribed medicine	M	R27 000
	M + 1	R32 900
	M + 2	R39 500
	M + 3+	R43 200
Prosthetic limbs (with no further access to the external medical items limit)		R103 800
Counselling sessions with a Psychologist or social worker for beneficiaries indirectly affected by the trauma incident		6 sessions per beneficiary

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	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, from 1 January 2024 until 31 December 2025 if you joined the Scheme before January 2024.

If you joined the Scheme after 1 January 2024, the WELLTH Fund will be available in the year of joining and up to the end of the next year

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 if the benefit was activated in 2024:

- Children who turn two years old on or before 31 December 2025 receive the child allocation of R1 250.
- Beneficiaries who are 18 years old on or before 31 December 2025, receive the adult benefit value of R2 500.
- Children who are two years old after 31 December 2025 will not receive a fund value allocation but are still eligible to use the WELLTH Fund.

Once activated, the WELLTH Fund is available for use by all registered beneficiaries on your membership, regardless of their age. 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

Healthcare services that will be paid from the WELLTH Fund (continued)

General health (continued)	• 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, paediatrician, 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.

TOTAL MONTHLY CONTRIBUTIONS INCLUDING YOUR MEDICAL SAVINGS ACCOUNT FOR 2025

	Member	Adult	Child dependant	Maximum for 3 child Dependants
Total monthly contributions	R7 621	R6 879	R2 277	R6 831

WHAT WE DO NOT COVER (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.

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).

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.

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.

LA Health
Powered by Discovery

This is a summary of the LA Core 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.

- **CLIENT SERVICES 0860 103 933**
- **SERVICE@LAHEALTHMS.CO.ZA**
- **WWW.LAHEALTH.CO.ZA**

LA-Health LA Health

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.

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