MEDICAL AID SCHEME

2019

TFG HEALTH BENEFIT GUIDE

INTRODUCTION

The benefits explained in this guide are provided by TFG Medical Aid Scheme, registration number 1578, administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider. This guide is only a summary of the key benefits and features of the TFG Medical Aid Scheme TFG Health Benefit Plan. In all instances, TFG Health Medical Aid Scheme Rules prevail.

Please consult the Scheme Rules on **www.tfgmedicalaidscheme.co.za.** When reference is made in this guide to 'we' in the context of benefits, members, payments or cover, this refers to TFG Medical Aid Scheme.

TFG Health is a Hospital Network Plan which offers a range of benefits in and out of hospital up to predetermined limits or unlimited at contracted network providers, such as, but not limited to:

ICON for Oncology services, the Dental Risk Company for dental benefits and IsoLeso for Optometry and a hospital network. Please consult this guide carefully to familiarise yourself with this Benefit Plan's restricted networks and how it could serve your healthcare cover needs best. **It is important to note that on this Benefit Plan, services obtained outside the networks are not covered.**

This guide must be read in conjunction with the TFG Medical Aid Scheme 2019 Benefit Brochure.

On TFG Health you will receive the following key benefits:

A

Palliative care benefits

- Advanced Illness Benefit (AIB);
- Compassionate*Care* Benefit.

B

Maternity benefits which includes

- Cover for pregnancy and childbirth.

C

Day-to-day benefits, which include amongst others:

- General practitioner and Specialist benefits in a GP Network and Specialist Referral process.
- Cleveland Clinic MyConsult (International clinical review service benefit).
- Cover for alcohol, substance and drug rehabilitation.
- Dental and Oral benefits.
- Diabetes*Care* Programme.
- Optical benefit at network providers only.
- Screening and Prevention Benefit.
- Trauma Recovery Extender Benefit.
- HIV*Care* Programme.
- Mental Health Programme.

D

Hospital benefits in a hospital network, including a casualty benefit.

E

Chronic Illness Benefit (CIB).

F

Oncology benefits as part of an Oncology Programme.

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For the latest network information please visit **www.tfgmedicalaidscheme.co.za** and use the MaPS tool to look for a hospital in your area that offers full or partial cover. Your day surgery network may also change and you are advised to use the MaPS tool or the Discovery app to find the latest and most updated network information of TFG Health.

GLOSSARY

Throughout this guide you will find references to the below. This glossary aims to provide an explanation of what these terms mean.

BENEFIT PLAN

The benefits as set out in the Scheme Rules and summarised in this guide on pages 5 to 9.

DEDUCTIBLE

A specific payment for which a member or beneficiary is personally liable which may be a percentage or a specific amount as stipulated in the rules of the Scheme.

DESIGNATED SERVICE PROVIDER (DSP)

This is a doctor, specialist or other healthcare provider TFGMAS has reached an agreement with about payment and rates for the purpose of Prescribed Minimum Benefits (PMB).

DIRECT PAYMENT ARRANGEMENT (DPA) SPECIALIST

A specialist medical practitioner who has entered into an agreement in respect of beneficiaries on the TFG Health.

FORMULARY

A list of preferred medicines considered by the Scheme to be the most useful in patient care, rated on the basis of clinical effectiveness, safety and cost.

HOSPITAL BENEFIT

The Hospital Benefit covers hospital costs and other accounts, like accounts from your admitting doctor, anaesthetist or any approved health care expenses, while you are in hospital, per your this Benefit Plan's benefits as set out in this guide.

Examples of expenses covered are theatre and ward fees, X-rays, blood tests and the medicine you use while you are in hospital.

HOSPITAL NETWORK

The network of hospitals the Scheme contracted with to provide hospital benefits to members registered on TFGMAS.

MEDICAL EMERGENCIES

This is a condition that develops quickly, or occurs from an accident, and you need immediate medical treatment or an operation. In a medical emergency, your life could be in danger if you are not treated, or you could lose a limb or organ. Not all urgent medical treatment falls within the definition of PMB. If you or any members of your family visit an after-hours emergency facility at the hospital, it will only be considered as an emergency and covered as a PMB if the treatment received aligns with the definition of PMB. Remember not all treatment received at casualty units are PMB.

NETWORK GP

A General Practitioner who has contracted with TFG Medical Aid Scheme to be part of the KeyCare Network.

PREAUTHORISATION

You have to let us know if you plan to be admitted to hospital. Please call us on **0860 123 077** for preauthorisation, so we can confirm your membership and available benefits. Without preauthorisation, you may have a deductible for which you will be personally liable. **Preauthorisation is not a guarantee of payment as it only aims to confirm that the treatment to be received in hospital is clinically appropriate and aligned with the benefits available**. We advise members to talk to their treating doctor so they know whether or not they will be responsible for out of pocket expenses, when they preauthorise their treatment.

There are some procedures or treatments your doctor can do in their rooms. For these procedures you also have to get preauthorisation.

If you are admitted to hospital in an emergency, TFGMAS must be notified as soon as possible so that we can authorise payment of your medical expenses. We use certain clinical policies and protocols when we decide whether to approve hospital admissions. These give us guidance about what is expected to happen when someone is treated for a specific condition. They are based on scientific evidence and research.

PREMIER PLUS GP

A General Practitioner who has contracted with TFGMAS to be part of the Premier Plus network service providers.

PRESCRIBED MINIMUM BENEFITS

Prescribed Minimum Benefits is a set of minimum benefits that, by law, must be provided to all medical scheme members. The cover it gives includes the diagnosis, treatment and cost of ongoing care for a list of conditions.

RELEVANT HEALTH SERVICES

A service as defined in the Act which is provided for in your chosen Benefit Plan.

SCHEME RATE

This is the rate in terms of an agreement between the Scheme and its service providers at which payment of relevant health services are paid. The Scheme Rate is a rate that we negotiate with service providers. In some instances, cover is at, for example, 80% of Scheme Rate and in other instances at 100% of the Scheme Rate. If your doctor charges more than the Scheme Rate or the contracted fee in a Hospital Network Plan, such as the TFG Health Plan, we will pay available benefits to you at the Scheme Rate or negotiated rates and you will have to pay the healthcare provider.

Please consult your Benefit under the 'Rate' column to know when are claims paid at 100% of Scheme Rate and when at 80% of Scheme Rate.

SERVICE PROVIDERS

A medical practitioner, dentist, pharmacist, hospital, nurse or any other person or entity who is duly registered or licensed, as may be required, to provide relevant health services.

YOUR 2019 CONTRIBUTIONS

TFG HEALTH

The Contribution Table below reflects your contributions in total due to the Scheme. The member's portion of the contributions, payable after taking the TFG subsidy into account, are shown in the second set of tables below.

THE CONTRIBUTION TABLES BELOW ARE **BEFORE** TFG SUBSIDY

TFG Health	Principal Member	Adult	Child
Income Band	R	R	R
R0 – R4 720	1 064	1 064	376
R4 721 – R7 800	1 200	1 200	379
R7 801 – R15 110	1 286	1 286	408
R15 111 – R25 910	1 398	1 398	448
R25 911 – R38 590	1 632	1 632	510
R38 591+	1 775	1 775	542

The Contribution Tables below are after TFG subsidy.

These contributions are the members' portions of the contributions, **payable after taking the TFG subsidy into account**.

SUBSIDISED 2019 CONTRIBUTIONS

Income Bands	Principal Member	Adult	Child
	R	R	R
R0 – R4 720	532	532	188
R4 721 – R7 800	600	600	190
R7 801 – R15 110	643	643	204
R15 111 – R25 910	699	699	224
R25 911 – R38 590	816	816	255
R38 591+	887	888	271

TFG HEALTH BENEFITS

Benefit	Rate	Limits
Hopital Cover		
Statutory Prescribed Minimum Benefits.	Basis of cover is per legislative requirements in terms of Prescribed Minimum Benefits. All Prescribed Minimum Benefits accumulate to available limits first.	Unlimited.
Hospitalisation in Full Cover Network Hospital.	Up to a maximum of 100% of the Scheme Rate of the hospital account. Subject to authorisation and/or approval meeting the Scheme's clinical and managed care criteria.	Unlimited.
Hospitalisation in Partial Cover Network Hospital.	Up to a maximum of 70% of the Scheme Rate of the hospital account. Subject to authorisation and/or approval meeting the Scheme's clinical and managed care criteria.	Unlimited.
Hospitalisation in non-Network Hospital. Emergency Admissions.	Up to a maximum of 100% of the Scheme Rate. Subject to authorisation. Patient to be transferred to a Network Hospital as soon as stabilised, unless otherwise agreed by the Scheme. Subject to PMB.	Unlimited.
Health care services in the KeyCare Day Surgery Network.	Up to a maximum of 100% of the Scheme Rate at the Scheme's defined list of day-surgery providers. Up to a maximum of 100% of the Scheme Rate for related accounts. Medicines paid at 100% of the Scheme Medication Rate. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical criteria.	Unlimited.
Hospitalisation in non-Network Hospital. Non-emergency admissions.	No cover.	No cover.
Administration of defined intravenous influsions.	Up to a maximum of 100% of the Scheme Rate at the Scheme's network provider. A 20% deductible shall be payable by the beneficiary in respect of the hospital account when treatment is received at a provider who is not a network provider. Medicines paid at 100% of the Scheme Medication Rate. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical criteria.	Unlimited.
Hospitalisation for selected members suffering from one or more significant chronic conditions. Non-emergency admissions.	Up to a maximum of 100% of the Scheme Rate. Subject to registration on the Scheme's Disease Management Programme. Up to a maximum of 100% of the Scheme Rate and subject to authorisation and/or approval and the Scheme's Disease Management Programme clinical entry criteria. Up to a maximum of 80% of the Scheme Rate of the hospital and related accounts for members who are not registered on the programme.	Unlimited.
Specialists.	DPA Specialists. Up to a maximum of 100% of the KeyCare direct payment arrangement rate. Other Specialists who work within the KeyCare Network Hospitals: Up to a maximum of 100% of the Scheme Rate. **Member must be referred by chosen GP**.	Unlimited.
Other providers.	Up to a maximum of 100% of the Scheme Rate.	Unlimited.

TFG HEALTH BENEFITS (CONTINUED)

Benefit	Rate	Limits
Radiology and Pathology.	Up to a maximum of 100% of the Scheme Rate. Pathology is subject to a preferred provider network. Where members use a non-preferred provider payment will be made directly to the member. Point of care pathology testing is subject to meeting the Scheme's treatment guidelines and managed care criteria.	Unlimited.
Chronic dialysis.	Up to a maximum of 100% of the Scheme Rate at the Scheme's network provider only. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical criteria. Drugs paid at 100% of the Scheme Medication Rate.	Unlimited.
Organ Transplant.	Cover only in a public facility according to the PMB, subject to Regulation 8 (3).	Unlimited.
Chemotherapy, Radiotherapy and Oncological treatment.	**Subject to the provisions of PMB at the Scheme's contracted network provider only**. Up to a maximum of 100% of the Scheme Rate the Scheme's network provider. Up to a maximum of 80% of the Scheme Rate at non-network providers in terms of the provisions of PMB. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria.	Unlimited, unless limits apply as provided elsewhere in the Benefit Tables.
Severe dental and oral procedures as defined in the Scheme Rules.	Up to a maximum of 100% of the Scheme Rate. Subject to the treatment meeting the Scheme's treatment guidelines and managed care criteria.	Unlimited.
Mental health disorders.	Up to a maximum of 100% of the Scheme Rate for related accounts. Up to a maximum of 100% of the Scheme Rate for hospital account in a network facility. Up to a maximum of 80% of the Scheme Rate for the hospital and related accounts if a non-network facility is used.	Up to 21 days in-hospital or up to 15 out-of-hospital consultations for conditions as defined in Annexure A of the Regulations of the Act. All other conditions up to 21 days in-hospital.
Disease Management for episodes of major depression for members registered on the Scheme's Disease Management Programme.	Up to 100% of the Scheme Rate for services covered in the Scheme's basket of care. Subject to the treatment meeting the Scheme's treatment guidelines and managed care criteria.	Basket of care as set by the Scheme.
Drug and alcohol rehabilitation.	Basis of cover is limited to PMB level of care.	21 days in-hospital treatment per person per year.
HIV/AIDS and AIDS related treatment.	Basis of cover is limited to PMB level of care.	Unlimited.
Post-exposure HIV prophylaxis following occupational exposure, traumatic exposure or sexual assault.	Up to a maximum of 100% of cost.	Unlimited.
Prophylaxis for mother-to-child transmission.	Up to a maximum of 100% of cost.	Unlimited.
Cardiac stents.	Up to a maximum of 100% of the Scheme Rate. Subject to authorisation and the treatment meeting the Scheme's clinical criteria. The device accumulates to the limit. The balance of the hospital and related accounts do not accumulate to the annual limit.	Network supplier: Unlimited if stent is supplied by the Scheme's network provider. Non-network supplier: Drug-eluting stent: R6 825 per stent per admission if not supplied by the Scheme's network provider; Bare metal stent limit: R5 775 per stent per admission if not supplied by the Scheme's network provider.

TFG HEALTH BENEFITS (CONTINUED)

Benefit	Rate	Limits
Compassionate Care Benefit for non-oncology patients (in-patient care and home care visits).	Up to a maximum of 100% of the Scheme Rate.	Unlimited for PMB scope and level of treatment. R40 450 per person per lifetime for all claims, payment of PMB claims accumulate to this limit.
Advanced Illness Benefit (AIB) for oncology patients.	Up to a maximum of 100% of the Scheme Rate. Subject to authorisation and the treatment meeting the Scheme's guidelines and managed care criteria.	Unlimited.
MRI and CT Scans.	Up to a maximum of 100% of the Scheme Rate. Scan must be performed by a specialist at a Network Hospital. Where MRI and CT scan is unrelated to the admission it will be covered from the Specialist Benefit subject to the Specialist Benefit limit of R3 860 per person per year.	Unlimited.
TTO medicine (medicine to take home).	Up to a maximum of 100% of the Scheme Medication Rate.	R150 per hospital admission.
Emergency Medical Services within the borders of South Africa.	Up to a maximum of 100% of the Scheme Rate. Inter-hospital transfer subject to preauthorisation.	Unlimited.
Dentistry.	No cover.	Not applicable.
International clinical review service.	Up to a maximum of 50% cost of the consultation. Subject to the Scheme's preferred provider, protocols and clinical entry criteria.	Unlimited.

The screening and prevention benefit cover on this Benefit Plan is explained from page 13 and not repeated in this section. Note that the screening and prevention benefit is paid from your hospital/risk benefit where authorised meeting the Scheme's clinical entry criteria.

Chronic Illness Benefit

Benefit	Rate	Limits
Specialised Medicine and Technology treatment.	No cover.	Not applicable
Diabetes Management for members registered on the Scheme's Disease Management Programme, Diabetes*Care* Programme.	PMB level of care. Up to 100% of the Scheme Rate for services covered in the Scheme's basket of care if referred by the Scheme's DSP. Up to 80% of the Scheme Rate for services obtained from non-contracted providers.	Basket of care as set by the Scheme. Where registered on the Diabetes*Care* programme, an additional biokineticists and dietitian consultation per year included in the basket of care.
HIV Management for members registered on the Scheme's Disease Management Programme.	PMB level of care. Up to 100% of the Scheme Rate for services covered in the Scheme's basket of care if referred by the Scheme's DSP.	Basket of care as set by the Scheme.
Cardiovascular Disease Management for members registered on the Scheme's Disease Management Programme.	PMB level of cover. Up to 100% of the Scheme Rate for services covered in the Scheme's basket of care.	Basket of care as set by the Scheme
Bluetooth enabled blood glucose monitoring device.	Any beneficiary approved and registered on the Scheme's Chronic Illness Benefit for Diabetes is covered up to 100% of the Scheme Rate, paid from Health Care Cover. The device must be approved by the Scheme, subject to the Scheme protocols and clinical entry criteria.	Not applicable.

TFG HEALTH BENEFITS (CONTINUED)

Benefit	Rate	Limits
Out of hospital benefit day-to-day cover		
GP, includes consultations and selected small procedures.	Up to a maximum of 100% of the Scheme Rate, subject to selected consultation and procedure codes. **Member has to select a primary GP that is part of the Scheme's selected network on joining the Benefit Plan. GP visits will only be covered at chosen KeyCare Network GP**. Member can elect to change his/her chosen GP three times per person per year.	Unlimited only at chosen GP, subject to preauthorisation after visit 15, per person per year. Unscheduled emergency visits limited to 3 visits per person per year at chosen GP.
Specialists.	DPA Specialists: Up to a maximum of the KeyCare direct payment arrangement rate. Other specialists who work within the Network Hospitals: Up to a maximum of 100% of the Scheme Rate. **Member must be referred by chosen GP**.	R3 860 per person per year.
Visits to casualty units in KeyCare Network Hospitals.	The first R355 of the casualty unit's account is payable by the beneficiary. Subject to preauthorisation. The balance of the casualty unit's account is paid from Health Care Cover up to a maximum of 100% of the Scheme Rate.	Unlimited only at KeyCare Network Hospitals.
Visits to casualty units at non- KeyCare Network Hospital.	No cover.	No cover.
Acute medicine.	Up to a maximum of 100% of the Scheme Medication Rate. Subject to the KeyCare Acute Medicine Formulary and protocols only covered if prescribed by chosen GP.	Unlimited within the KeyCare Acute Medicine Formulary.
Selected basic X-rays at the Scheme's network providers.	Up to a maximum of 100% of the Scheme Rate at the Scheme's network providers. Only if requested by member's chosen KeyCare Network GP, subject to list of procedure codes and PMB.	Unlimited.
Selected basic blood tests.	Up to a maximum of 100% of the Scheme Rate. Only if requested by member's chosen KeyCare Network GP, subject to list of procedure codes and PMB. Point of care pathology testing is subject to meeting the Scheme's treatment guidelines and managed care criteria.	Unlimited.
Out-of-Network visits, including GP consultations, acute medicines, radiology and pathology requested by a GP.	Up to a maximum of 100% of the Scheme Rate or Scheme Medication Rate – subject to a list of codes. Only acute medicines, radiology and pathology requested by a GP will be covered under this benefit.	Four GP claims, four pathology claims (requested by GP), four radiology claims (requested by GP) and four pharmacy claims (prescribed by GP) per person per year. Subject to PMB.
Basic dentistry.	Up to a maximum of 100% of the Scheme Rate. Only at DRC Network dentist, subject to a list of codes. In-hospital excluded. Subject to the treatment meeting the Scheme's treatment guidelines and managed care criteria.	Unlimited.
Optometry.	Up to a maximum of 100% of the Scheme Rate. Only at IsoLeso Network optometrist and subject to Scheme protocol.	One pair of single vision, bifocal or multifocal lenses with basic frame or a basic set contact lenses per person every twenty-four months from their last date of service.

TFG HEALTH BENEFITS (CONTINUED)

Benefit	Rate	Limits
MRI and CT Scans.	Up to a maximum of 100% of the Scheme Rate at the Scheme's network providers. Member must be referred by chosen GP.	Accumulates to the Specialist Benefit limit of R3 860 per person per year.
Mobility Devices: wheelchairs, long leg callipers and crutches.	Up to a maximum of 100% of the Scheme Rate, subject to an approved list of codes. Only if requested by the member's chosen KeyCare Network GP, subject to pre-authorisation and that the device or item is obtained from a network provider.	R5 400 per family per year.
Over and above the DTPMB entitlement, this benefit also covers certain out-of-hospital healthcare services arising from an emergency, trauma-related event resulting in the following PMB conditions: • Paraplegia • Quadriplegia • Near-drowning related injury • Severe anaphylactic reaction • Poisoning • Crime-related injury • Severe burns • External and internal head injuries • Loss of limb. Trauma benefit services covered under this benefit include: • Allied healthcare services • External medical items • Hearing aids • Prescribed medicine.	Up to a maximum of 100% of the Scheme Rate Paid from Health Care Cover and is subject to applicable limits. Excludes OTC medicines (inclusive of schedule 0, 1 and 2 drugs whether prescribed or not), optometry, antenatal classes and dentistry (other than severe dental and oral procedures as set out under the Hospital Benefit of this Benefit Plan). Cover applies to 31 December of the following year after the trauma occurred. Subject to authorisation and/or approval and treatment meeting the Scheme's entry criteria. Cover is not restricted to the Scheme's DSP's.	Services: External Medical Items: Limited to R26 450 per family per year, except for prosthetic limbs which shall be subject to a limit of R78 300 per person per year. Hearing aids: Limited to R13 500 per family per year. Allied and therapeutic healthcare services including: acousticians, biokineticists, chiropractors, dieticians, homeopaths, nursing providers, occupational therapists, physiotherapists, podiatrists, psychologists, psychometrics, counsellors, social workers, speech and hearing therapists limited to: Member: R6 750 M+1 dependant: R10 200 M+2 dependants: R12 700 M+3 dependants or more: R15 300 Prescribed Medicine limited to: Member: R13 250 M+1 dependant: R15 700 M+2 dependants: R18 550

A

PALLIATIVE CARE BENEFITS

The Palliative Care Benefits available on TFG Health includes the Advanced Illness Benefit (AIB) and the Compassionate*Care* Benefit.

Advanced Illness Benefit (AIB)

Members with cancer have access to a comprehensive palliative care programme. This programme offers unlimited cover for approved care at home.

Compassionate*Care*

The Compassionate*Care* Benefit gives you access to holistic home-based end-of-life care up to R40 450 for each person in their lifetime.

B

MATERNITY BENEFITS

A basket of maternity benefits for members during their pregnancy and for a defined period after childbirth as detailed below:

During your pregnancy

Antenatal consultations

You are covered for 8 visits at your gynaecologist, chosen KeyCare Network GP or midwife.

Ultrasound scans and prenatal screening

You are covered for up to two 2D ultrasound scans including one nuchal translucency test. Should you choose to have a 3D or 4D scan, you will be responsible for the cost difference above the Scheme Rate of the 2D scan. You are also covered for one Non-Invasive Prenatal Test (NIPT) if you meet the clinical entry criteria.

Blood tests

A defined basket of blood tests per pregnancy are included in the maternity benefit.

Antenatal classes or consultations with a nurse

You are covered for up to five pre- or postnatal classes (including online antenatal classes) or consultations with a registered nurse.

Up to two years after birth

GP and specialist visits

Your baby is covered for up to two visits with your chosen KeyCare Network GP.

Six week consultation

You are covered for one six week post-birth consultation with a midwife, your chosen GP or gynaecologist for post-delivery complications.

Nutrition assessment

You are covered for one nutrition assessment with a dietitian.

Mental health

You are covered for up to two mental health consultations with a counsellor or psychologist.

Lactation consultation

You are covered for one lactation consultation with a registered nurse or lactation specialist.

C

DAY-TO-DAY BENEFITS

GP Consultations and the Specialist Referral Process

TFG Health provides consultation benefits at network General Practitioners, once they have been chosen/ registered as your designated primary healthcare provider. You will need to allocate a primary and a secondary GP for each of your dependants. Please enquire with your GP whether he/she is a dispensing doctor. To visit a specialist, your chosen GP will need to refer you to a specialist. To access your consultation benefits on this Benefit Plan you will need to familiarise yourself with the following:

What you need to know:

Appointments with a specialist must only be made once the referral has been approved by your chosen KeyCare GP and you have received a specialist authorisation number. Routine check-ups should be done by your chosen KeyCare GP. You will have to get authorisation for routine check-ups from a specialist that you have been referred to by your chosen KeyCare GP.

If you need to be admitted to hospital after your approved visit to the specialist – you need to phone us before you are admitted to get a hospital authorisation number. Call us on **0860 123 077** to get hospital preauthorisation.

If you have had surgery done in hospital and your specialist requires a follow up visit you don't need to get another authorisation number as long as the visit is within the 30 days after your admission. For any other treatment you need to visit your chosen KeyCare GP for a follow up visit, or when the consultation date falls outside the 30 day period.

The specialist visit, once approved, will be covered subject to the specialist benefit limit of R3 860 per person each year. This limit applies to the consultation with the specialist including procedures performed in the specialist rooms, any medication prescribed by the specialist (subject to the TFG Health medicine list), and investigations requested by the specialist. This limit does not apply to approved in-hospital events. The authorisation is only valid for the specific specialist visit and the 30 day period thereof. If you need to visit another specialist, you will need another authorisation for this visit.

The GP to specialist referral process is the decision of your chosen KeyCare GP. Your chosen GP will only refer you if he/she feels that you need to see a specialist.

Should you visit a specialist without a valid authorisation from us, you will have to pay and any treatment prescribed will be for your own pocket.

Once your chosen KeyCare GP sends through the request to see a specialist out of hospital, we will sms/email you within 2 – 3 working days. Please ensure that your contact details are updated with us.

What you need to do:

Your chosen KeyCare GP must complete the KeyCare GP to Specialist referral form. Your GP should add any relevant test results and or motivations for the visit. You can find the form on **www.tfgmedicalaidscheme.co.za.**

You or your GP can fax the completed form and documentation to **011 539 2839** or email it to **keycareauth@discovery.co.za** for review. We will review the request for confirmation of a specialist visit and provide feedback of the decision to you and your GP within two to three working days after we receive the form.

Your GP must give the form to you at time of consultation and you must take the form to the specialist if the referral is approved.

Urgent specialist referral

If there is clinical reason for you to see the specialist the same day you saw the GP then your GP must contact us on **0860 123 077** or refer you to casualty at a KeyCare Network Hospital, subject to authorisation.

Important to remember

Specialist claims will not be considered for reimbursement if there is no approved specialist referral prior to the visit. You will be liable for the specialist and related accounts in such instances.

Cleveland Clinic MyConsult

As a member of the TFG Medical Aid Scheme (TFGMAS) you also have access to the International clinical review service benefit if you are registered on TFG Health.

TFG Medical Aid Scheme recognise that South African specialists offer exceptional quality of care through their high levels of expertise and knowledge, however, there are times when a specialist may want to collaborate with other experts in a certain field of medicine, especially when their patients are facing life-threatening and life-changing conditions, particularly when this involves the use of new treatment modalities.

In some cases, a patient may ask their specialist to assist them in obtaining a second opinion for these conditions and for those that affect the quality of their life.

As a TFG Health member you have the opportunity to get an online second opinion from a Cleveland Clinic physician specialist. For more information please consult with your chosen Network GP or contact the Scheme at **0860 123 077.**

The Alcohol, Substance and Drug Rehabilitation Benefit

As a TFG Health member you will receive cover for in-hospital alcohol, substance and drug detoxification and rehabilitation as a Prescribed Minimum Benefit (PMB).

The in-hospital management of alcohol, substance and drug, detoxification and rehabilitation are Prescribed Minimum Benefits, in terms of the Medical Schemes Act 131 of 1998, and will be covered.

As such the TFG Medical Aid Scheme covers alcohol, substance and drug detoxification in full at one of our DSP's for a maximum of three days for each approved admission. If you are admitted for alcohol, substance and drug detoxification, it must always be followed by an admission for rehabilitation.

We also cover alcohol, substance and drug rehabilitation at one of our DSP's for a maximum of 21 days in hospital each year. This is the maximum allowable days for each person on the Benefit Plan per year. Members can choose to be in treatment for a period shorter than 21 days in consultation with a healthcare provider.

Cover for alcohol, substance and drug detoxification and rehabilitation according to the Prescribed Minimum Benefits includes only in-hospital management. TFG Medical Aid Scheme does not pay for the out-of-hospital management and treatment for detoxification and rehabilitation on TFG Health, as it is not included as part of the Prescribed Minimum Benefits.

The Scheme has **designated service providers (DSPs)** for in-hospital alcohol, substance and drug detoxification and rehabilitation and you can visit the TFG Medical Aid

Scheme website at www.tfgmedicalaidscheme.co.za to access the list of DSPs for treatment on this Benefit Plan as a PMB where you will need to receive services to avoid deductibles.

The agreed rate that we pay these DSPs for includes cover for:

- Accommodation at the facility.
- Therapeutic sessions.
- Psychologist and/or psychiatrist consultations.
- Medicine for withdrawal management and aftercare.

If you choose to use a facility that is not a DSP, we will pay for alcohol, substance and drug detoxification and rehabilitation up to 80% of the Scheme Rate or negotiated global fee.

You will be liable to pay the difference. Your co-payment may be higher than 20% if your service provider charges more than the Scheme Rate.

Only where there is no DSP facility within a reasonable proximity to the place where you usually work or live, you may use any other accredited service provider and we may then consider to pay your treatment in full. Please discuss this with us when you contact us to preauthorise your treatment. We will tell you under what circumstances we pay the claims for alcohol, substance and drug detoxification and rehabilitation in full without any deductibles.

Dental and Oral Benefits

On TFG Health you have access to out of hospital dental treatment at a KeyCare Network provider (DRC). You'll also receive cover for severe dental surgery as part of the *Severe Dental and Oral Surgery Benefit* as set out below.

Severe Dental and Oral Surgery is subject to preauthorisation and the treatment meeting the Scheme's treatment guidelines and managed care criteria.

We cover a defined list of maxillo-facial procedures on the Severe Dental and Oral Surgery Benefit

The procedures that are included in the Severe Dental and Oral Surgery Benefit which are paid from the Hospital Benefit are:

- Internal temporomandibular joint (TMJ) surgery
- Cleft lip and palate repairs
- Surgery for severe life-threatening infections
- Cancer-related surgery
- Severe trauma-related surgery.

You have full cover for specialists who we have a payment arrangement with

You can benefit by using specialists who we have a payment arrangement with, because we will cover their approved procedures in full.

You may have a deductible if you use other specialists

If you are treated in hospital by a specialist who we do not have a payment arrangement with, we cover you up to 100% of the Scheme Rate

How we cover other healthcare professionals

We cover GPs and other healthcare services up to 100% of the Scheme Rate from the Hospital Benefit.

How we cover radiology and pathology

We cover radiology and pathology up to 100% of the Scheme Rate.

All other dental treatment in hospital (excluding severe oral and dental surgery)

You don't need to call us before having dental treatment.

For all other in-hospital dental treatment, other than those covered from the Severe Dental and Oral Surgery Benefit, there is no need to call us before having treatment even if you are admitted to hospital, as your procedure or treatment will not be covered in hospital.

On TFG Health we will pay up to 100% of the Scheme Rate for out-of-hospital dental treatment for a selected basic set of treatments such as consultations, fillings and extractions, provided you obtain services from a **KeyCare Network provider**.

Please note that we do not cover in-hospital dental treatment on this Benefit Plan

Your Cover on TFG Health summarised

Severe Dental and Oral Surgery Benefit

The Severe Dental and Oral Surgery Benefit covers a defined list of procedures, with no upfront payment and no overall limit. This benefit is subject to authorisation and the Scheme's rules.

You must preauthorise your admission to hospital at least 48 hours before you go in. Please call **0860 123 077**. You can also apply for approval by sending an email to **preauthorisations@discovery.co.za**

For planned hospital admissions, you have full cover for the hospital account in the Full Cover Hospital Network and up to 70% of the Scheme Rate in the Partial Cover Hospital Network. If you use a hospital outside the network you will have to pay these costs from your pocket.

Diabetes*Care* Programme

The Diabetes*Care* Programme, together with your Premier Plus GP, will help you actively manage your diabetes. The programme gives you and your Premier Plus GP access to various tools to monitor and manage your condition and to ensure you get high quality coordinated healthcare and the best outcomes.

Diabetes mellitus (diabetes) is a chronic condition which, if left untreated, can result in serious complications like blindness, kidney failure and heart attacks. However, it is generally accepted that good control of diabetes will reduce the occurrence of these complications. The Diabetes*Care* Programme is designed to offer members optimal diabetic cover from service providers in a coordinated network that ensures the best quality care and best outcomes.

About joining the Diabetes*Care *programme

Members on TFG Health may join the Diabetes*Care* Programme. To have access to the Diabetes*Care* Programme, you must consult with a Premier Plus GP and be registered on the Chronic Illness Benefit for type 1 or type 2 diabetes.

Your Premier Plus GP can apply for registration on the Chronic Illness Benefit through HealthID if you have given consent.

As a TFG Health member you will need to choose a doctor who is on both the KeyCare GP Network and Premier Plus GP network for management of your diabetes, to avoid a 20% deductible.

Please use the MaPS Advisor tool on **www.tfgmedicalaidscheme.co.za** to find a doctor on the network or consult the enclosed document to appoint your chosen GP on the Network.

Optical benefit

As a TFG Health member you are covered for optical benefits as follows:

- One eye test
- One pair of white single vision, bifocal or multifocal lenses, or
- Basic contact lenses (clear contact lenses with no added colour, tints or designs).

This cover is only available every two benefit years (24 months from last date of service) when making use of a network optometrist who is part of the Iso Leso Optics group. You can find optometrists in the Iso Leso Optics group on **www.tfgmedicalaidscheme.co.za**

Screening and Prevention Benefit

As a member of the TFG Medical Aid Scheme and registered on TFG Health, your Screening and Prevention Benefit is important in making sure you detect medical conditions early so you can get the best care.

The Screening and Prevention Benefit covers preventive tests, screenings and a seasonal flu vaccination (during pregnancy, for members registered for certain chronic conditions and members older than 65 years).

Having these specific tests (up to the specified number) does not affect your day-to-day benefits and you should not have any deductibles. Those instances where you *may* have deductibles are discussed further on, in this document.

The preventive tests, screening and flu vaccinations must be referred and done by an appropriately registered healthcare professional, and network provider where applicable.

The Screening and Prevention Benefit does not cover the cost of any related consultations.

Consultations are covered from the available funds in your day-to-day benefits, unless it relates to a Prescribed Minimum Benefit diagnosis.

Tests that the Screening and Prevention Benefit covers

We will not use your available day-to-day benefits to pay for these screening tests. Consultations and related costs are paid from your available day-to-day benefits, unless it relates to a PMB diagnosis.

Once you have reached the frequency limit for the tests, any additional screening and preventive tests will be paid from your available day-to-day benefits.

We will pay for these healthcare services as long as you use a provider who is appropriately registered with the Board of Healthcare Funders (BHF), and provided that this healthcare service or product has a valid tariff code or NAPPI code, ICD-10 code and price.

SCREENING AND PREVENTION

BENEFITS

THE FOLLOWING TESTS ARE COVERED ON TFG HEALTH

	Cover
Mammogram.	**One mammogram every two years, up to a maximum of the Scheme Rate.** For members that are at high risk, we provide access to yearly screening so that they can schedule their regular follow up's for appropriate screening. **High risk members also have access to additional tests where they meet our clinical entry criteria**. These tests are: • A breast MRI scan. • BRCA testing (once-off) for those with a genetic risk. Members that are at high risk for breast cancer have: • A strong family history of breast cancer this would include first degree relatives (mother, sister or daughter) and second degree relatives (aunt, uncle, nieces, nephews, grandparents, grandchildren). • A genetic predisposition to breast cancer (BRCA positive). • A personal history of breast cancer.
Seasonal flu vaccine.	One seasonal flu vaccine each year if you are pregnant, older than 65 years or you if are registered for one of the following chronic conditions: • Asthma • Bronchiectasis • Cardiac failure • Cardiomyopathy • Chronic obstructive pulmonary disease (COPD) • Chronic renal disease • Coronary artery disease • Diabetes (Types 1 and 2) • HIV. Members who do not meet these criteria can still have a flu vaccination and this will be covered from the available funds in your day-to-day benefits, where applicable.
HIV blood tests such as the Rapid, ELISA and Western blot.	Unlimited amount of HIV screening tests up to a maximum of the Scheme Rate.

You have cover of up to a maximum of the Scheme Rate for a group of tests.

The group of tests include:

- Blood glucose
- Blood pressure
- Cholesterol
- Body mass index or weight assessment.

You may qualify for the following additional tests if you meet the clinical entry criteria:

- Defined set of diabetes and cholesterol screening tests.

You can have one test a year at a pharmacy in our Wellness Network. Any additional tests will be paid from your available day-to-day benefits.

We also cover some growth assessment tests for children at any one of our network pharmacies, at the agreed rate.

This consists of tests including:

- Height
- Weight
- Head circumference
- Health and milestone tracking.

You can have one test a year at a pharmacy in our Wellness Network. Any additional tests will be paid from your available day-to-day benefits.

Important things to remember

The preventive tests, screening and flu vaccinations must be referred and done by an appropriately registered healthcare professional, and network provider where applicable.

The Screening and Prevention Benefit does not cover the cost of any related consultations.

Consultations are covered from the available funds in your day-to-day benefits, unless it relates to a PMB diagnosis.

You may be responsible for any shortfall or payment if the healthcare provider charges more than the Scheme Rate, or is not one of our Wellness Network providers.

What you need to do to find a provider

1. Find a pharmacy in our Wellness Network on **www.tfgmedicalaidscheme.co.za.**
2. Have the tests at a registered healthcare professional and make sure your pathology and radiology tests have been appropriately referred. You can visit any pathologist or radiologist to have the tests done.

Trauma and Recovery Extender Benefit (TREB)

As a TFG Health member you will have access to the Trauma Recovery Extender Benefit (TREB).

This benefit helps to provide access to funds after certain traumatic events by giving you access to cover for certain day-to-day treatment after you are discharged from hospital. The benefit pays the day-to-day medical care costs of the traumatic event in the year it happened and in the year after it happened from a list of sub-limits.

You will not qualify for the Trauma Recovery Extender Benefit if the traumatic event happened in a previous benefit year while you were on a plan type that did not offer this benefit or while you were a member of another medical scheme. You have to be a member of the TFG Medical Aid Scheme and registered on TFG Health at the time that the trauma happens to qualify for cover from the Trauma Recovery Extender Benefit.

The benefit covers only the claims for the member who is registered for the benefit and claims that are related to the original diagnosis after the specific trauma. Members must meet the clinical entry criteria to access cover on the Trauma Recovery Extender Benefit. If the event meets the clinical entry criteria the benefit will be activated after you have been admitted for one of the specific traumas and the event has been appropriate reviewed and the benefits approved.

THE FOLLOWING DAY-TO-DAY COSTS WILL BE COVERED ON TREB ON TFG HEALTH

Day-to-day costs you are covered for	Professional medical services
Allied, therapeutic and psychology healthcare services.	Limited to Acousticians, Biokineticists, Chiropractors, Counsellors, Dietitians, Homeopaths, Nurses, Occupational therapists, Physiotherapists, Podiatrists, Psychologists, Psychometrists, Social workers, Speech and hearing therapists (Speech-language therapists and audiologists).
Prescribed medicine.	Schedule 3 and above medicine.
Radiology.	Including X-rays and scans.
Pathology.	Blood tests and other tests done in the laboratory.
Medical devices and limb prostheses.	External devices including wheelchairs and hearing aids.

TFG Health has a list of sub-limits specifically available as a Trauma Recovery Extender Benefit. These limits are detailed in the Benefits available for your Benefit Plan as set out in this document on page 17.

Please note that if you join the Scheme after 1 January, you won't get the full limit for prescribed medicine and allied, therapeutic and psychology healthcare services limits because these limits are calculated by counting the remaining months in the year.

We pay for radiology and pathology services with no limit

Your treating medical professional must refer you for radiology (including X-rays and scans) and pathology (blood and other tissue) tests.

Certain healthcare services are not covered on the Trauma Recovery Extender Benefit

- The Trauma Recovery Extender Benefit does not cover the cost of dentistry, optometry, antenatal classes or over-the-counter (schedule 0, 1 and 2) medicine.
- The general scheme exclusions apply to the Trauma Recovery Extender Benefit.

About how we pay accounts from the Trauma Recovery Extender Benefit

- The Trauma Recovery Extender Benefit provides cover up to the Scheme Rate, unless stated otherwise.
- We will pay prescribed medicine (that is schedule 3 and above) from the benefit according to the benefits of TFG Health.

Please consult your Benefit Plan's cover in respect of Medicine and the Medicine Rate that will be applicable for more information in this regard.

Your TREB benefit at a glance:

Cover for Specialists and other healthcare professionals on TFG Health from TREB

We pay accounts for specialists, GPs and other healthcare professional claims, including pathology and radiology up to 100% of the Scheme Rate. If you use a healthcare professional who we have a payment arrangement with, the agreed rate will apply and we will pay them direct.

You must visit your chosen KeyCare Network GP

You have unlimited specialist visits for the treatment after the trauma (these do not add up to the Specialist Benefit).

You need to contact us for a reference number to confirm your benefits. Get your GP to contact us to see if you need to visit a specialist.

You will have unlimited radiology and pathology cover and no formularies apply. All other day-to-day services rules remain the same for cover from the Trauma Recovery Extender Benefit.

How we pay allied, therapeutic and psychology healthcare professionals

We pay accounts for the following allied, therapeutic and psychology healthcare professionals up to an annual limit for your family. These allied, therapeutic and psychology healthcare services are paid up to the limit:

- Acousticians
- Physiotherapists

- Biokineticists
- Podiatrists
- Chiropractors
- Psychologists (clinical, counselling, educational and industrial)
- Counsellors
- Psychometrists
- Dietitians
- Registered nurses
- Homeopaths
- Social workers
- Occupational therapists
- Speech and hearing therapists (Speech-language therapists and audiologists)

The annual limit varies, depending on your family size. For Allied and therapeutic healthcare services these limits for 2019 are:

Single member	With one dependant	With two dependants	With three or more dependants
R6 750	R10 200	R12 700	R15 300

We pay prescribed medicine (schedule 3 and above) up to the annual limit for prescribed medicine. The annual limit varies, depending on your family size. The limits for 2019 as part of the Allied and therapeutic healthcare limits are:

Single member	With one dependant	With two dependants	With three or more dependants
R13 250	R15 700	R18 550	R22 550

If you join after January, you won't get the full limit for prescribed medicine because these limits are calculated by counting the remaining months in the year.

How we pay for medical items, hearing aids and prosthetic limbs

We pay for medical items such as wheelchairs and crutches up to an annual limit of R26 450 for your family.

For hearing aids, we pay up to an annual limit R13 500 for your family.

We pay artificial limbs (prostheses) up to an overall limit of R78 300 per person where the loss of the limb was as a result of trauma.

D

HOSPITAL BENEFITS IN A HOSPITAL NETWORK, INCLUDING A CASUALTY BENEFIT

As a member of TFG Health you will have to obtain services in hospital within the Scheme's Hospital Network.

Please note that your GP is not be permitted to admit you into hospital. Only specialists can admit you into hospital for treatment which should be preauthorised.

Please consult the Benefit Table in this document from page 5 to understand your cover at a Full Cover and Partial Cover Hospital.

Please note that, unless an emergency, you will not be covered in a non-network hospital on this Benefit Plan.

Your casualty benefit on TFG Health

If your chosen GP is not available and your out of area network visit has been used, then you must visit a casualty unit at a KeyCare Network hospital to access your casualty benefits. You must obtain prior authorisation. You pay R355 towards the facility fee upfront to the casualty unit, for each person for each event. In the event of an emergency you will not have to pay the R355 towards the facility fee.

The balance of the casualty unit's account is paid from your Hospital Benefit up to a maximum of 100% of the Scheme Rate.

The Casualty Benefit covers:

- The GP consultation at the Scheme Rate.
- Certain blood tests and basic X-rays.
- Material used for your casualty treatment.
- Specialist claims are paid from the Specialist Benefit subject to the annual specialist benefit limit.

How to find a network hospital

Use the MaPS tool on www.tfgmedicalaidscheme.co.za or on the Discovery app to look for a hospital in your area that offers full cover. Call us on **0860 123 077** with any queries.

E

CHRONIC ILLNESS BENEFIT (CIB)

Prescribed Minimum Benefit (PMB) conditions

You have access to treatment for a list of medical conditions under the Prescribed Minimum Benefits (PMB). The PMB cover the 26 chronic conditions on the Chronic Disease List (CDL).

These conditions are:

- Addison's disease
- Asthma
- Bipolar mood disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy
- Chronic obstructive pulmonary disease (COPD)
- Chronic renal disease
- Coronary artery disease
- Crohn's disease
- Diabetes insipidus
- Diabetes mellitus type 1
- Diabetes mellitus type 2
- Dysrhythmia
- Epilepsy
- Glaucoma
- Haemophilia
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosis
- Ulcerative colitis.

Chronic Illness Benefit (CIB) cover on TFG Health

If you are registered on TFG Health you will only receive cover for the above PMB list of chronic conditions.

We need to approve your application before we cover your condition from CIB.

You have cover for the above list of chronic conditions, as long as your chronic medicine is on the TFG Health medicine list formulary.

Your chosen KeyCare GP must prescribe your approved chronic medicine. You need to get your approved chronic medicine that is on the TFG Health medicine list from one of our network pharmacies or from your chosen KeyCare GP (if he or she dispenses medicine).

If you get your medicine anywhere else, you will have to pay 20% of the Scheme Rate for your medicine. If you use chronic medicine that is not our medicine list, you will have to pay for it yourself.

We pay for your medicine up to the maximum of the Scheme Medication Rate, which is the single exit price plus the appropriate professional fee.

F

ONCOLOGY BENEFITS

As a TFG Health member you need to familiarise yourself with the cover you receive as a cancer patient on the Scheme's Oncology Programme. You need to understand what you need to do when you are diagnosed with cancer and the options available to you if you are diagnosed with cancer.

In this article we provide information about your benefits for cancer treatments under the Prescribed Minimum Benefits and how we cover consultations with cancer-treating GPs and specialists, in and out of hospital.

What you need to do before your treatment

- If you are diagnosed with cancer, you need to register on the Oncology Programme.
- In order to register, you or your treating doctor must send us a copy of your laboratory results confirming your diagnosis and your treatment plan.
- Call us on **0860 123 077** for assistance.

On TFG Health you will receive treatment that is recognised as a Prescribed Minimum Benefit (PMB) at a Network Provider.

You have cover for approved chemotherapy, radiotherapy and other treatment prescribed by your cancer specialist in the TFG Health Network (ICON network) from the Oncology Benefit. If you use a cancer specialist who is not in the Network, the Scheme will pay 80% of the Scheme Rate and you need to pay the balance from your pocket.

The Scheme also covers pathology, radiology, medicine and other approved cancer-related treatment that is provided by healthcare professionals other than your cancer specialist.

The Scheme must approve your treatment before we can pay it from the Oncology Benefit. This treatment must be in line with agreed protocols and medicine lists (formularies).

Cancer treatment that falls within the Prescribed Minimum Benefits is always covered in full, with no deductible. This is if you use service providers who we have a payment arrangement with and if they do not charge above the agreed rate. Refer to the section You have full cover in our designated service provider network and for doctors who we have a payment arrangement with for more details.

Approved hospital admissions with administration of chemotherapy or radiotherapy for your cancer

Claims for the oncologist, appropriate pathology, radiology and medicine as well as radiation therapy will add up to the Oncology Benefit. You must use a hospital in the TFG Health Hospital Network.

Surgery for your cancer

We pay the medical expenses incurred during an approved hospital admission from the Hospital Benefit and not the Oncology Benefit. You must use a hospital in the TFG Health Hospital Network.

Bone marrow donor searches and transplantation

On TFG Health you are covered for local bone marrow donor searches and transplants up to the agreed rate, once we have approved your transplant procedure and treatment.

PET-CT scans

We cover PET-CT scans subject to using our designated services providers and certain terms and conditions. You need to preauthorise PET-CT scans with us before having it done. Your condition determines how many PET-CT scans will be covered.

Approved PET-CT scans will be paid up to the agreed rate, subject to the use of a PMB PET-CT scan facility in our network.

You need to pay for wigs

You must pay the cost for wigs from your pocket.

Inclusion of chemotherapy, radiotherapy and other healthcare services paid from the Oncology Benefit will be subject to consideration of evidence-based medicine, cost effectiveness and affordability.

Healthcare services that are deemed by the Scheme as unaffordable and/or not cost effective and/or lacking clinical evidence to demonstrate efficacy are excluded from cover.

Check what benefits apply to your specific treatment by discussing your treatment plan with your treatment doctor.

The Scheme pays for certain treatments from your day-to-day benefits

Other needs related to your condition and treatment that is not covered from the Oncology Benefit will be paid from the available funds in your day-to-day benefits.

You have cover for bone marrow donor searches and transplants

Bone marrow transplant costs do not add up to cancer treatment.

We need the appropriate ICD-10 and morphology codes on accounts

All accounts for your cancer treatment must have a relevant and correct ICD-10 and morphology code for us to pay it from the Oncology Benefit. To ensure there is no delay in paying your doctor's accounts, it would be helpful if you double check to make sure that your doctor has included the ICD-10 and morphology codes.

You have full cover in our designated service provider networks and for providers who we have a payment arrangement with

You can benefit by using doctors and other healthcare providers like hospitals, pharmacies, radiologists and pathologists we have a payment arrangement with, because the Scheme will cover their approved procedures/ services in full. If your healthcare provider charges more than what the Scheme pays, you need to pay the difference from your pocket for professional services such as consultations.

To find healthcare service providers we have a payment arrangement with, use the MaPS tool on **www.tfgmedicalaidscheme.co.za** or call us on **0860 123 077.**

Remember

Please use our DSPs for approved oncology medicine claims to avoid a 20% co-payment. Speak to your treating doctor and confirm that they are using our DSPs for your medicine and treatment received in rooms or in a treatment facility.

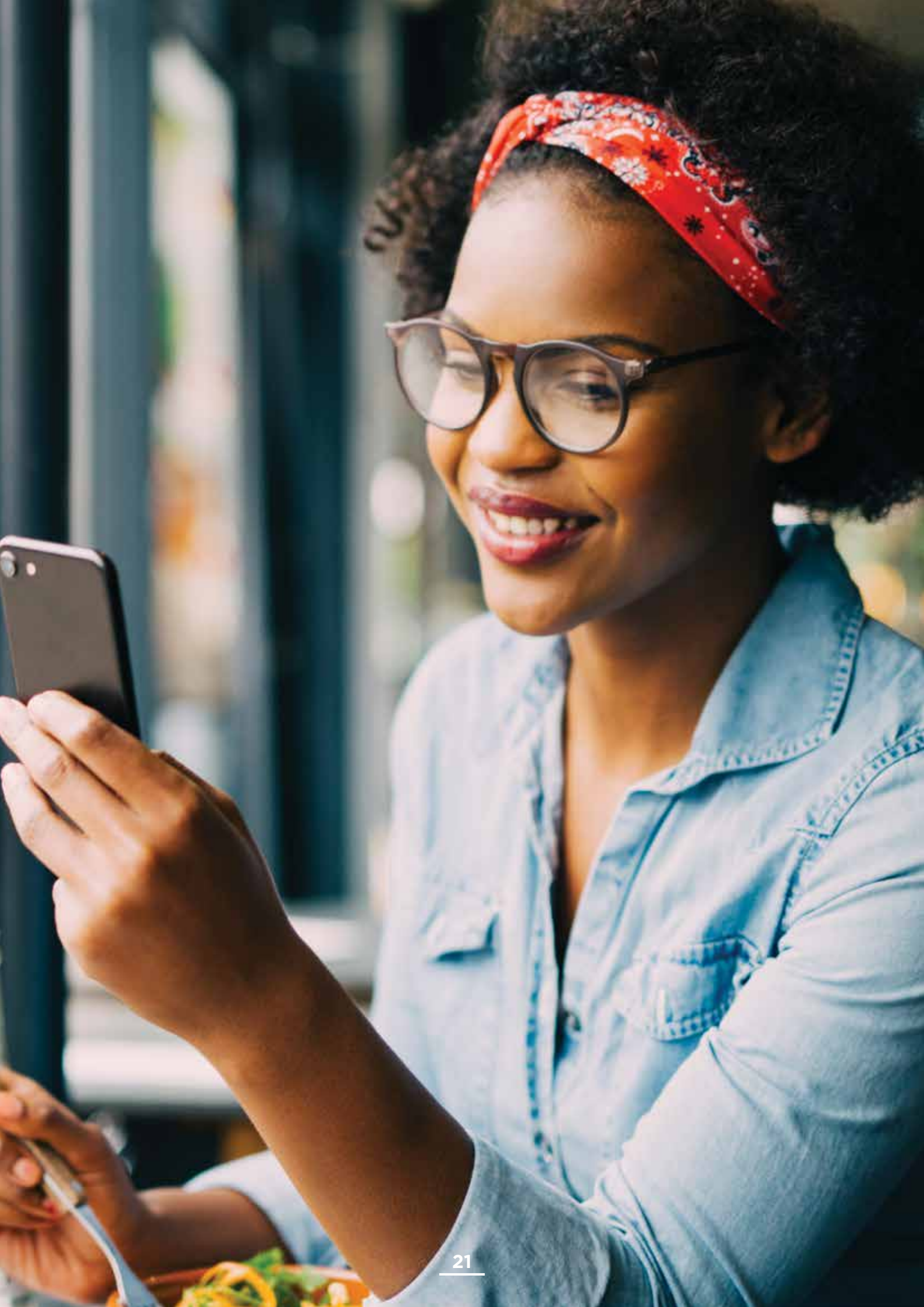
For approved oncology-related medicine where your doctor has provided a script please use a MedXpress Network Pharmacy.

ADDITIONAL EXCLUSIONS ON TFG HEALTH

With due regard to the Prescribed Minimum Benefits, and the General Exclusions the exclusions listed below will automatically apply to TFG Health.

1. All cosmetic treatment including, but not limited to, septoplasties, osteotomies and nasal tip surgery.
2. Benign breast disease.
3. All costs relating to cochlear implants, processors and hearing aids.
4. All costs relating to auditory brain implants.
5. All costs relating to internal nerve stimulators.
6. All costs relating to joint replacements.
7. Back surgery
8. Neck surgery.
9. Knee and shoulder surgery.
10. In-Hospital management of
    - Conservative back treatment.
    - Conservative neck treatment.
    - Dentistry (services of surgical procedures which involve the hard or soft tissues of the mouth).
    - Skin disorders (non-life-threatening) including benign growths and lipomas
    - Nail disorders.
    - Investigations and diagnostic work-up.
    - Functional nasal problems and functional sinus problems.
    - Endoscopic procedures.
11. Surgery for oesophaegeal reflux and hiatus hernia repairs.
12. Removal of Varicose Veins.
13. Correction of Hallux Valgus/Bunion and Tailor's Bunion/ Bunionette.
14. Surgery and other healthcare services to correct refractive errors of the eye.
15. Elective Caesarean Section except in cases where it is medically necessary.

The Scheme will also not cover any healthcare expenses related directly or indirectly to these healthcare services.



TFG HEALTH

KEYCARE HOSPITAL NETWORKS

The lists apply to members on TFG Health. You must go to one of these hospitals for planned hospital admissions. If you do not use one of these hospitals for a planned admission, you will need to pay for these claims.

Please note that the network list may change from time to time. The latest version of this network list is available on www.tfgmedicalaidscheme.co.za.

FULL COVER HOSPITAL NETWORK

We cover you in full at the rate agreed with the hospitals listed below

Eastern Cape

East London

Life Beacon Bay Hospital

Life East London Private Hospital*

Life St James Operating Theatres*

Life St Dominic's Private Hospital

Humansdorp

Life Isivivana Private Hospital

Port Elizabeth

Life Mercantile Hospital

Queenstown

Life Queenstown Private Hospital

Uitenhage

Netcare Cuyler Clinic

Umtata

Life St Mary's Private Hospital

Free State

Bethlehem

Mediclinic Hoogland

Bloemfontein

Horizon Eye Care Centre

Netcare Pelonomi Private Hospital

Life Rosepark Hospital

Life Pasteur Hospital*

Netcare Universitas Private Hospital*

Sasolburg

Netcare Vaalpark Hospital

Welkom

Mediclinic Welkom

St Helena Hospital

Gauteng

Benoni

Life The Glynnwood Hospital

Sunshine Hospital

Netcare Optiklin Eye Hospital

Brakpan

Life Dalview Hospital

Germiston

Life Roseacres Hospital

Heidelberg

Life Suikerbosrand Hospital

Johannesburg

Netcare Rand Hospital

Netcare Garden City Hospital

Life Brenthurst Hospital

Midrand

Life Carstenhof Hospital

Pretoria

Netcare Bougainville Private Hospital

Life Eugene Marais Hospital

Netcare Jakaranda Hospital*

Mediclinic Legae*

Mediclinic Medforum

Mediclinic Muelmed

Pretoria Eye Institute

Randfontein

Life Robinson Private Hospital

Lenmed Randfontein Private Hospital

Saxonwold

Life Genesis Clinic

Soshanguve

Botshilu Private Hospital

Soweto

Clinix Tshepo-Themba Private Hospital

Dr S K Matseke Memorial Hospital

Springs

Life Springs Parkland Hospital

Life St Mary's Maternity Hospital*

Tembisa

Lenmed Zamokuhle Private Hospital

Vanderbijlpark

Mediclinic Emfuleni

Ocumed

Vereeniging

Clinix Naledi-Nkanyezi Private Hospital

Midvaal Private Hospital

Vosloorus

Clinix Botshelong-Empilweni Private Hospital

KwaZulu-Natal

Amanzimtoti

Netcare Kingsway Hospital

Chatsworth

Life Chatsmed Garden Hospital

Durban

JMH City Hospital

Life Entabeni Hospital

Empangeni

Life Empangeni Garden Clinic

* **Hospitals with no casualty unit**

Isipingo

JMH Isipingo Clinic

Kokstad

Kokstad Private Hospital

Ladysmith

Lenmed Health La Verna Hospital

Newcastle

Mediclinic Newcastle

Phoenix

Life Mount Edgecombe Hospital

Pietermaritzburg

Netcare St Anne's Hospital

Pinetown

Life Crompton Hospital

Port Shepstone

Hibiscus Hospital

Richards Bay

Netcare The Bay Hospital

Tongaat

Mediclinic Victoria

Limpopo

Bela-Bela

St Vincent's Hospital

Polokwane

Mediclinic Limpopo

Thabazimbi

Mediclinic Thabazimbi

Tzaneen

Mediclinic Tzaneen

Mpumalanga

Barberton

Mediclinic Barberton

Emalahleni

Life Cosmos Hospital

Ermelo

Mediclinic Ermelo

Middelburg

Life Midmed Private Hospital

Nelspruit

Mediclinic Nelspruit

Piet Retief

Life Piet Retief Hospital

Trichardt

Mediclinic Highveld

North West

Brits

Mediclinic Brits

Carletonville

The Fountain Private Hospital

Klerksdorp

Life Anncron Hospital

Mafikeng

Victoria Private Hospital*

Potchefstroom

Mediclinic Potchefstroom

Rustenburg

Life Peglerae Hospital

Vryburg

Vryburg Private Hospital

Northern Cape

Kathu

Lenmed Health

Kathu Private Hospital

Kimberley

Mediclinic Kimberley

Finsch Mine Hospital*

Upington

Mediclinic Upington

Western Cape

Bellville

Melomed Bellville

Mediclinic Louis Leipoldt

Cape Eye Hospital

Cape Town

Netcare Christiaan Barnard Memorial Hospital

Netcare UCT Medical Centre*

Ceres

Netcare Ceres Hospital

Gatesville

Melomed Gatesville

George

Mediclinic Geneva*

Mediclinic George

Hermanus

Mediclinic Hermanus

Kuils River

Netcare Kuils River Hospital

Milnerton

Mediclinic Milnerton

Mitchells Plain

Melomed Mitchells Plain

Mossel Bay

Life Bayview Hospital

Oudtshoorn

Mediclinic Klein Karoo

Paarl

Mediclinic Paarl

West Coast

Life West Coast Private Hospital

Worcester

Mediclinic Worcester

Lesotho

Willies Hospital*

*** Hospitals with no casualty unit**

PARTIAL COVER HOSPITAL NETWORK

We pay up to a maximum of 70% of the hospital account, you must pay the balance of the account. If the admission is a Prescribed Minimum Benefit, we will pay 80% of the Scheme Rate.

Gauteng

Kempton Park

Arwyp Medical Centre

Lenasia

Lenmed Health Ahmed Kathrada Private Hospital

Pretoria

Louis Pasteur Hospital
Zuid-Afrikaans Hospital

KwaZulu-Natal

Pietermaritzburg

Midlands Medical Centre

Sydenham

Lenmed Health Shifa Hospital

TFG HEALTH

KEYCARE CASUALTY NETWORK 2019

On TFG Health you are covered in any network casualty unit at one of the KeyCare network hospitals. You have to pay the first R355 of the consultation and cover is subject to authorisation. If you use a casualty unit outside of the KeyCare Casualty Network, you will have to pay the difference between what the Scheme pays and what is charged.

Eastern Cape

Port Elizabeth

Life Mercantile Hospital

East London

Life Beacon Bay Hospital

Life St Dominic's Private Hospital

Free State

Bloemfontein

Life Rosepark Hospital

Sasolburg

Netcare Vaalpark Mediclinic Centre

Gauteng

Benoni

Sunshine Hospital

Germiston

Life Roseacres Hospital

Johannesburg

Life Brenthurst Hospital

Netcare Garden City Clinic

Midrand

Life Carstenhof Hospital

Krugersdorp

Protea Clinic

Pretoria

Mediclinic Muelmed

Springs

Life Springs Parkland Hospital

Roodepoort

Mayo Clinic

Tembisa

Lenmed Zamokuhle Private Hospital

Vosloorus

Clinix Botshelong-Empilweni Private Hospital

Vereeniging

Midvaal Private Hospital

KwaZulu Natal

Durban

JMH City Hospital Ltd

Chatsworth

Life Chatsmed Garden Hospital

Amanzimtoti

Netcare Kingsway Hospital

Ladysmith

Lenmed La Verna Hospital

Newcastle

Mediclinic Newcastle

Richards Bay

Netcare The Bay Hospital

Limpopo

Polokwane

Mediclinic Limpopo

Thabazimbi

Mediclinic Thabazimbi

Mpumalanga

Emalahleni

Life Cosmos Hospital

Nelspruit

Mediclinic Nelspruit

Middelburg

Life Midmed Private Hospital

Secunda

Mediclinic Highveld

North West

Brits

Mediclinic Brits

Klerksdorp

Life Anncron Hospital

Vryburg

Vryburg Private Hospital

Northern Cape

Kathu

Lenmed Kathu Private Hospital

Kimberley

Mediclinic Kimberley

Western Cape

Bellville

Mediclinic Louis Leipoldt

Melomed Bellville

Cape Town

Netcare Christiaan Barnard Memorial Hospital

Paarl

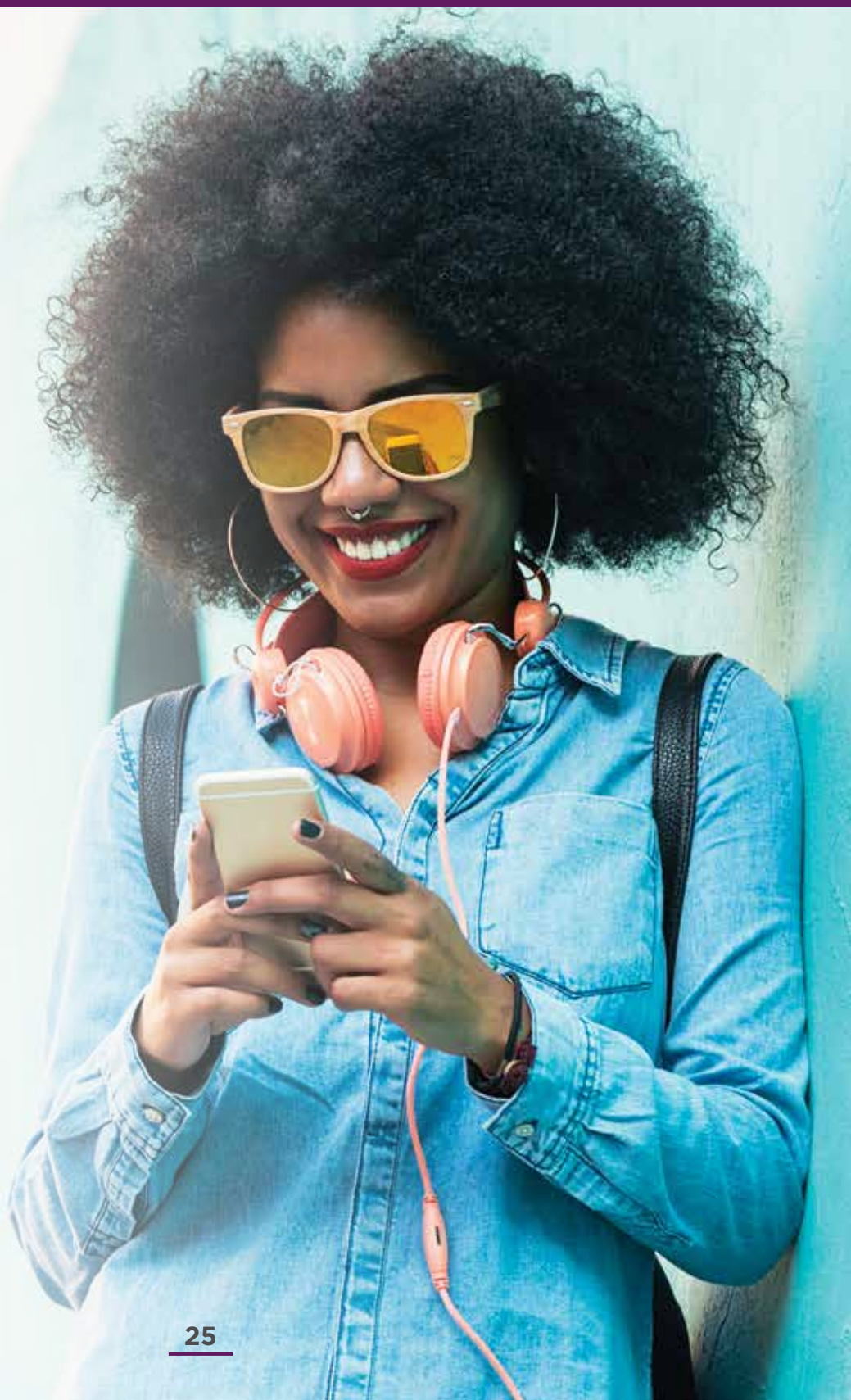
Mediclinic Paarl

TFG HEALTH

KEYCARE DAY SURGERY NETWORK 2019

Please visit the website at **www.tfgmedicalaidscheme.co.za** for a list of the day surgery procedures that is covered in the Day Surgery Network facilities.

The Day Surgery Network is subject to change and the latest list of facilities are available on the Scheme's website at **www.tfgmedicalaidscheme.co.za**



TFG MEDICAL AID SCHEME

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