TFG
MEDICAL AID SCHEME

YOUR BENEFIT BROCHURE FOR 2015

VALUE OFFERING OF
TFG MEDICAL AID SCHEME (TFGMAS)

This brochure provides you with the most important information and tools you need to know about your health plan and how to make the most of your cover.

Thank you for giving us the opportunity to look after your healthcare cover needs. You can have peace of mind that TFGMAS places you first with a focus on comprehensive benefits, value for money and services to improve the quality of care available to you.

As a TFGMAS member, you have access to excellent healthcare cover.

We have designed this guide to provide you with a summary of information on how to get the most out of your medical scheme. You'll find online tools that help you choose full cover options for specialists, chronic medicine and GP consultations.

We are here to help and guide you in making the best choices when it comes to your healthcare.

OUR SCHEME RULES ARE AVAILABLE

This brochure is a summary of the benefits and features of TFGMAS, pending formal approval from the Council for Medical Schemes (CMS).

This brochure does not overrule the registered rules of the Scheme. If you want to refer to the full set of rules, please visit our website at tfgmedicalaidscheme.co.za or email compliance@discovery.co.za

The rules and benefits explained in this guide apply to the main member and registered dependants. If there is anything in this brochure you need explained further, please email tfgmedicalaidscheme.co.za and we will answer your questions.

CONTENTS

BENEFIT RICHNESS AND VALUE
OFFERING OF TFG MEDICAL AID SCHEME

During its recent benefit and contribution review, the trustees of TFGMAS reviewed the benefits and contributions on offer in comparison to similar medical scheme options available in the market.

The benefit richness and value offering was evaluated in consultation with Alexander Forbes. An independent technical/statistical tool was used to determine the percentage of claims that will be paid on average for a family by a specific comparable medical scheme option. The results were compared with the percentage of claims that would've been paid for the same family on TFGMAS.

The findings of Alexander Forbes reported that:

- The benefit richness of Plan A vs the industry was reviewed across alternative comparable options available in the market across the different income bands of TFGMAS.

  It was confirmed that TFGMAS Plan A provides a 9% higher richness across all income bands to its members, as reflected in graph A.

  Graph A demonstrate that across the income bands, TFGMAS families in the lower income categories were found to contribute 34% on average less than the market comparable alternative option, which represented 4% of the members of TFGMAS on this option. **Those families who contribute more in the higher income brackets, may find that with the company subsidy structure provided, the offering remains attractive in comparison with an alternative medical scheme.**

- The benefit richness of Plan B vs the industry was reviewed across alternative comparable options available in the market across the different income bands of TFGMAS.

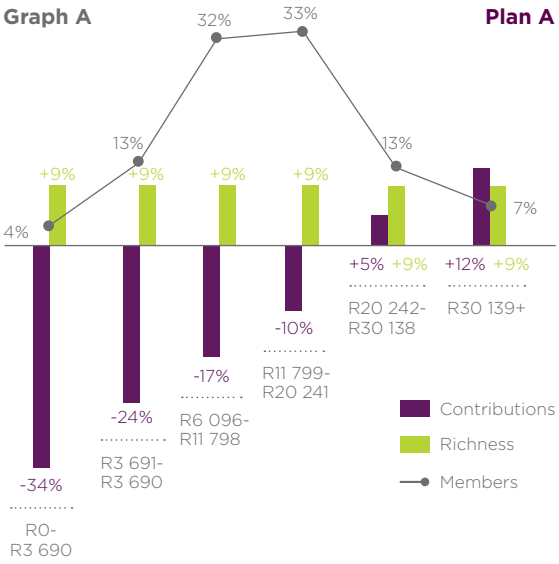
  It was confirmed that TFGMAS Plan B provides a 5% higher richness across all income bands to its members, as reflected in graph A.

  As shown in graph B, the lower income categories were found to contribute 37% on average less than the market comparable alternative option, which represented 10% of the members of TFGMAS on this option. **Those families who contribute more in the higher income brackets, may find that with the company subsidy structure provided, the offering remains attractive in comparison with an alternative medical scheme.**

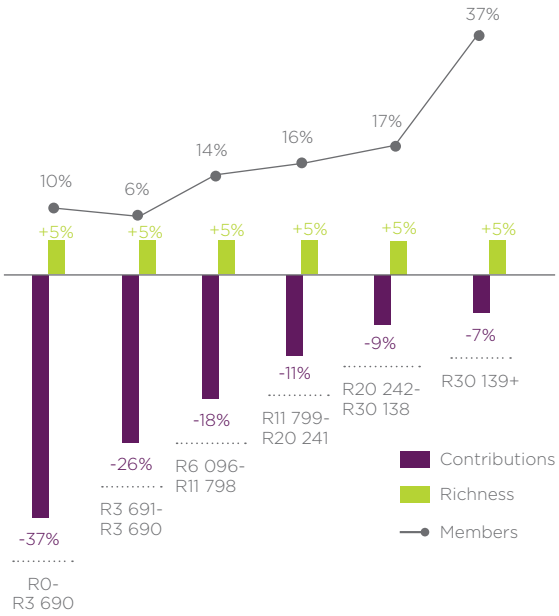
Overall the findings confirmed that TFGMAS options:

- Offered a similar or higher level of benefits, but at a lower contribution in most income bands;
- Members were receiving good value for their money;

Graph A **Plan A**



Graph B **Plan B**



- There was no need for major benefit enhancements based on competitor analysis or benefit richness analysis, however, as set out in this benefit brochure certain benefits were improved.

So this means that for every R1 you pay in contributions you have more cover than if you had utilised another medical aid scheme's benefits

FREQUENTLY ASKED QUESTIONS

1

Do I need to get a preauthorisation number for specialised dentistry?

When you need to receive dental services in hospital you will need to contact us by calling 0860 123 077 to preauthorise your hospital admission at least 48 hours before you go into hospital. It is always better to contact the contact centre and to verify your benefits to determine whether you will have a co-payment and whether or not a particular treatment will be covered or not before obtaining services for specialised dentistry.

2

How do I find the details of the doctors in TFGMAS network?

Go to the www.tfgmedicalaidscheme.co.za website and log in with your username and password. If you are looking for the nearest doctor, go to "Your Details" on the left of the screen and click on "MaPS (Medical and Provider Search)". You can search by healthcare professional name or by area. See page 15 for detailed website navigation.

3

What do I do when a claim or query is not resolved to my satisfaction?

Contact us by calling 0860 123 077 and request that a complaint be lodged and recorded for feedback and resolution.

The contact centre will escalate the matter and ensure that the matter is reported to the Scheme, where necessary. Please see more information regarding the Complaints and Disputes Procedure of the Scheme in this guide.

4

How do I determine whether I'm entitled to a subsidy on my monthly contribution amount?

Your nearest Human Resources (HR) and Payroll office will be able to assist and provide further information to you with regard to the employer's employment and subsidy policies.

5

I need to lodge a claim, how do I do that?

Various options of submitting your claims to the Scheme are available to you:

- Download the Discovery Smartphone Application and submit your claims by taking a photo of your claims using your smartphone camera and submit.
- Send your claims in hard copy to PO Box 652509, Benmore, 2010
- Email your claim to claims@discovery.co.za
- Fax your claim to 0860 329 252
- Drop your claim in any blue Discovery Health claims box available at TFG Stanley Lewis Building in Parow or at any hospital or Virgin Active Gym.

6

What happens if my contributions or claims debt due to the Scheme is not paid?

When obtaining services from a service provider, a service contract is entered into between yourself and the service provider and you will remain liable for any amounts due to the service provider until it is either settled by the Scheme on your behalf or paid by yourself. Please therefore follow-up on payment reminders received from service providers and amounts that remain outstanding and do not ignore any letters of demand received from healthcare providers. Call the contact centre at 0860 123 077 and enquire the reason(s) for non-payment and determine whether you are responsible for any co-payments and ensure that your accounts are settled and/or credits are processed by the healthcare service provider, where necessary.

FREQUENTLY ASKED QUESTIONS
(CONTINUED)

7

Can I cancel my membership with the Scheme, while an employee of TFG?

Yes, only if you can prove that you are joining a different medical scheme or your spouse's scheme if you are employed per the employer grading system between grade 1-9. **Please enquire with your HR and payroll office about the implications in respect of future employer subsidies that may no longer be available to you if you choose to re-instate your membership with the Scheme at a future date or time.**

8

Does my contribution increase when my salary increase each year?

Your contribution is based on your salary. Your contribution could increase when your salary increases.

9

Will I have a waiting period when joining the Scheme?

Depending on whether there was a break in your membership with a previous medical scheme or when you were employed at TFG and decided to join the Scheme, a waiting period may be applicable. Please consult page 7 of this Benefit Brochure for more information in respect of waiting periods and when it may be applied and/or contact the contact centre at 0860 123 077 to obtain more information.

10

What does late-joiner penalty (LJP) mean and why was an LJP applied when I joined the Scheme?

Late joiner means an applicant or the adult dependant of an applicant who, at the date of application for membership, is 35 years old or older and has not been a member or a dependant of a member of any medical scheme for two years immediately before applying for membership. This definition excludes any beneficiary who enjoyed coverage with one or more medical schemes preceding 1 April 2001, without a break in coverage exceeding three consecutive months since 1 April 2001 (Please refer to the information as set out from page 7).

11

How do I access my claims statement?

You can obtain your claims statement as follows:

- Following a claim submission, an email will be sent to the email address registered with the Scheme to confirm the receipt and the amounts processed and paid/not paid;
- Download the Discovery Smartphone application and use the application to request a copy of your claims statement;
- You can also view a detailed history of your claims history using the Discovery Smartphone application functionalities.

12

Who do I ask about the formulary applied to chronic conditions?

You need to contact the Scheme at 0860 123 077 and for more details please visit www.tfgmedicalaidscheme.co.za More information is also provided on page 17 of this guide.

FIND IT ALL ON **TFG MEDICAL AID SCHEME WEBSITE**

New and current members can find the application forms they need on TFG website, www.tfgmedicalaidscheme.co.za Simply go online and choose the right application form to suit your needs. You can download the application form or simply view it as a PDF. You can also apply electronically online by submitting your application form using the website.

On the website, you can get application forms to join TFG Medical Aid Scheme, add dependants or change registrations, add to or manage your beneficiaries, as well as forms to manage other aspects of your membership.

More information at your fingertips

There is also information available on the plans we offer, your benefits and cover, our wellness programme, claims and loads more.

If you still can't find what you're looking for, please give us a call on 0860 123 077. All our other contact details are also available on the website.

TFGMAS AND THE APPLICATION OF WAITING PERIODS AND LATE-JOINER PENALTIES (LJP)

The Medical Schemes Act 131 OF 1998, as amended, allows schemes to impose the following waiting periods and late-joiner penalties on members applying to join a medical scheme:

- A general waiting period no longer than three months
- A condition-specific waiting period no longer than 12 months
- A late-joiner penalty.

TFGMAS apply legislation when members and their dependants join the Scheme by dividing applicants into three groups for underwriting, as follows:

1. Waiting periods (WP)

1.1 Category A

Applicants that have had no previous medical cover or have allowed more than 90 days break in membership since resigning from their previous scheme.

1.2 Category B

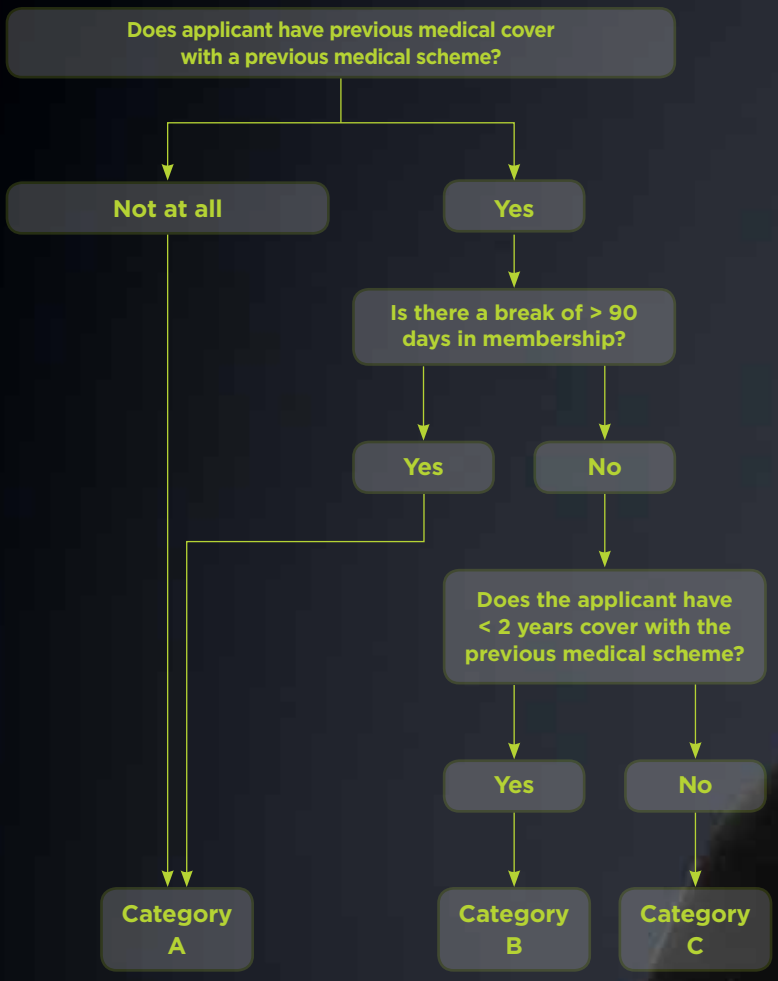
Applicants who have had less than two years cover and applied to the medical scheme less than 90 days after resigning from the previous scheme.

1.3 Category C

Applicants who have had two years or more cover and applied for cover less than 90 days since the date of resigning from the previous scheme.

The applicable waiting periods therefore depend on the category the members/dependants fall in.

For illustrative purposes, the categories that are used in **determining whether a WP and/or LJP may be applied are set out below:**



Waiting periods and LJPs are applied depending on the Category the member falls in. For more information call us on 0860 123 077.

2. Late-joiner penalties

A late joiner means an applicant or the adult dependant of an applicant who, at the date of application for membership, is 35 years old or older and has not been a member or a dependant of a member of any medical scheme for two years immediately before applying for membership.

The Council for Medical Schemes defines a late joiner as follows:

"A late joiner is an applicant or the adult dependant of an applicant who at the date of application for membership of admission as a dependant, as the case may be, is 35 years of age or older, but excludes any beneficiary who enjoyed coverage with one or more medical schemes preceding 1 April 2001, without a break in coverage exceeding three consecutive months since 1 April 2001."

What this means

- An applicant, or dependant of an applicant, aged 35 years or older at the time of registration, whose date of employment and date of registration is not the same;
- Who did not belong to a medical scheme on 1 April 2001;
- Who did not join the Scheme within 90 days of resigning from the previous medical scheme; and
- Who had more than 90 days consecutive break in coverage between medical schemes.

The penalty does not affect benefits, but will increase contributions for the duration of the membership. The penalty is only calculated on the member or dependant's portion of the contribution. The employer does not subsidise the LJP.

The penalty will apply for the duration of the membership.

2.1 Penalty bands

Penalty bands	Maximum penalty
1-4 uncovered years	5%
5-14 uncovered years	25%
15-24 uncovered years	50%
25+ uncovered years	75%

2.2 Calculation of uncovered years

Age of member minus (35 + creditable coverage) = uncovered years.

For instance, if the applicant is 58 years old on the date of registration and belonged to another medical aid for 12 years (membership certificate attached as proof), the following LJP penalty band would apply:

58 – (35+12) = 11 uncovered years = 25% LJP

To ensure fairness and consistency, TFGMAS board of trustees approved an Underwriting and Eligibility Policy that is used by the Administrator when receiving applications for processing.

A SUMMARY OF NEW BENEFITS INTRODUCED FOR 2015 AND HOW YOUR BENEFITS WORK

"...Make sure you understand the benefits you have on the plan you chose..."

The **Hospital Benefit** covers you if you are admitted to hospital and TFG Medical Aid Scheme has preauthorised admission and treatment before you are admitted.

You have extensive cover for a list of certain **chronic conditions** and cover for **cancer,** and **HIV and AIDS**.

We pay your day-to-day expenses from the **Primary Care Benefit**.

According to the **Prescribed Minimum Benefits**, you have the right to a guaranteed level of cover for a list of medical conditions and treatments even if your health plan benefits have run out.

These benefits include cover for a list of conditions, including the 27 Chronic Disease List Conditions (CDLs) and HIV and AIDS.

Medical Schemes must provide cover for the diagnosis, treatment and cost of ongoing care for these conditions according to the Scheme's rules and guidelines.

To find out how you can access your **Prescribed Minimum Benefits**, go to **www.tfgmedicalaidscheme.co.za** or contact us for more information.

If you want to change your plan

You may only change from one plan to another at the end of each year with effect from 1 January the following year. You may not change your plan during the year.

Detailed explanations of our benefits are available on the Scheme's website **www.tfgmedicalaidscheme.co.za** or you can contact us on **0860 123 077**.

EXCITING NEW BENEFITS FOR 2015

Some of the new benefits introduced by the Scheme for 2015 are summarised below:

- Virtual GP consultations: Online bookings and virtual consultations can be done by using the Discovery app to book and connect with a doctor online, where the doctor is contracted with the Scheme. The consultations will be payable from the normal GP consultation benefit available.
- Structured benefits for specialised drugs on Plan B with between 20% to no co-payments applicable, depending on the type of medicine.
- A preventative and screening benefit for both options have also been introduced, and from next year members will have access to the following preventative and screening benefits over and above the day-to-day amounts funded by the Scheme:
  - One mammogram per female beneficiary per year;
  - One pap smear per female beneficiary per year;
  - One prostate-specific antigen test per male beneficiary per year;
  - HIV testing;
  - Blood glucose screening, blood pressure measurement, body mass index (BMI) measurement and cholesterol tests;
  - One flu vaccine, per chronic beneficiary and per beneficiary older than 65, per year;
  - Funding of the Cervarix® or Gardasil® vaccines as preventative treatment against the infection of virus types 16 and 18 of the human papillomavirus (HPV). This vaccine is available to female beneficiaries between the ages of 9 and 26 years;
  - One pneumococcal vaccine per annum for identified high-risk members in line with clinical protocols;
- The funding of a telemetric glucometer device to enable patients diagnosed with diabetes to manage their condition with the use of their cellphone;
- Female members 35 years and older, and where medically appropriate, will now have access to the funding of the Mirena contraception device, provided a member undergoes the procedure in the gynaecologist's rooms.
- Pre-approved international second opinion services are offered to members and their beneficiaries giving them second opinion services which are clinically appropriate. These services can be obtained from the Cleveland Clinic at 50% of the cost of the second opinion service for certain conditions such as cancer and other life threatening conditions.

This Benefit Brochure explains in detail the benefits and processes that apply to your membership. Please read through it carefully to ensure that you understand the benefits offered by the Scheme.

COVER FOR MEDICAL EMERGENCIES

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a health condition that needs immediate medical or surgical treatment, where failure to provide this treatment would result in:

- Serious impairment to bodily functions, or
- Serious dysfunction of a bodily organ or part, or
- Would place the person's life in serious jeopardy.

Cover for medical emergencies in South Africa

Cover for going to hospital

In an emergency, go straight to hospital. If you need medically equipped transport, call **0860 999 911**. This line is managed by highly qualified emergency personnel who will send air or road emergency evacuation transport to you, depending on which is most appropriate. It is important that you, a loved one or the hospital let us know about your admission as soon as possible, so that we can advise you on how you will be covered for the treatment you receive.

Cover for HIV medicines – post-exposure prophylaxis (PEP)

If you need HIV medicine to prevent HIV infection, mother-to-child transmission, occupational or traumatic exposure to HIV including sexual assault, call us immediately on 0860 123 077. Treatment must start within 72 hours of exposure.

Cover for going to casualty

If you are admitted to hospital from casualty, we will cover the costs of the casualty visit from your Hospital Benefit, as long as we preauthorise your hospital admission. If you go to a casualty or emergency room and you are not admitted to hospital, we will pay the costs from your available Primary Care benefits. We do not cover the facility fee charged by same institutions.

Cover under the Prescribed Minimum Benefits

In an emergency, we will cover you in full at any provider until your condition is stable. You may have a co-payment once your condition is stable and you receive treatment from a non designated service provider who charges more than the Scheme Rate. Please remember that even though you or your doctor may consider this to be an emergency, it may not be classified as an emergency under the Prescribed Minimum Benefits.

Cover outside of South Africa

Cover outside South Africa is limited to territories within the rand monetary area and will be covered according to the Scheme rules. Travellers should always ensure that they obtain additional medical insurance cover when travelling outside of the borders of South Africa.

HOSPITAL BENEFIT

Your approved hospital admission is subject to your available cover on your plan. You can go to any private hospital for emergency and planned admissions. You can receive full cover for Prescribed Minimum Benefit (PMB) treatment and care.

Important information about your hospital cover

We cover the hospital cost and other accounts, like accounts from your admitting doctor, anaesthetist or any approved healthcare expenses, while you are in hospital.

Limits, clinical guidelines and policies apply to some healthcare services and procedures in hospital.

How we pay the hospital account

We pay the hospital account (the ward and theatre fees) in full at the rate agreed with the hospital. You have cover for a general ward, not a private ward.

Accounts from your doctor and other healthcare services

Your doctor or treating healthcare professional's accounts are separate from the hospital account and are called related accounts. Related accounts include any account other than the hospital account. Examples of related accounts are the account from the admitting doctor, anaesthetist and any approved healthcare expenses, like radiology or pathology, that you incur during your hospital stay. Refer to the section on how we cover your healthcare professional's, found later in this brochure. Please contact us to preauthorise your benefits before you receive treatment or extend your hospital stay.

Before you go to hospital for any planned procedure, you must:

- See your doctor who will decide if it is necessary for you to be admitted
- Make sure you know how the account from your admitting doctor will be covered
- Choose which hospital you want to be admitted to
- Find out how we cover other healthcare professionals, for example, your anaesthetist
- Call us on **0860 123 077** to preauthorise your hospital admission at least **48 hours** before admission. We will give you information that is relevant to how we will pay for your hospital stay. **A co-payment of R2 000 will be levied on the hospital account if preauthorisation is not obtained, except in an emergency.**
- Please refer to the cover for medical emergencies for more information.

Cover is subject to the Scheme rules

We pay medically appropriate claims. Your cover is subject to our Scheme rules, funding guidelines and clinical rules.

There are some expenses that you may incur while you are in hospital that your Hospital Benefit does not cover, for example, private ward costs. Please be aware that certain procedures, medicines or new technologies need separate approval while you are in hospital. Please discuss this with your doctor or the hospital.

Use our online MaPS Advisor, available on www.tfgmedicalaidscheme.co.za to find a provider in the network.

YOUR HEALTH PLAN AT YOUR FINGERTIPS

The Discovery smartphone app puts you fully in touch with your health plan no matter where you are. If your mobile device is with you, so is your plan.

Electronic membership card

View your electronic membership card with your membership number and tap on the emergency medical numbers on your card to call for emergency assistance.

Submit and track your claims

Submit claims by taking a photo of your claims using your smartphone camera and submit. You can also view a detailed history of your claims history.

Track your day-to-day medical spend and benefits

Access important benefit information about your specific plan. You can also keep track of your available benefits.

Access your health records

View a full medical record of all doctor visits, health metrics, past medicines, hospital visits and dates of x-rays or blood tests. It is all stored in an organised timeline that is easy and convenient to use.

Give consent to your doctor accessing your medical records

Give consent to your doctor to get access to your medical records on HealthID. This information will help you doctor understand your medical history and assist you during a consultation.

Find a healthcare provider

Find your closest healthcare providers who we have a payment arrangement with such as pharmacies and hospitals, specialists or GPs and be covered in full.

Request a document

Need a copy of your membership certificate, latest tax certificate or other important medical scheme documents? Request it on our app and it will be emailed directly to you.

Access the procedure library

View information of hospital procedures in our comprehensive series of medical procedure guides. You can also view a list of your approved planned hospital admissions.

Update your emergency details

Update your blood type, allergies and emergency contact information.

Managing your health plan online is now more convenient than ever. Everything from simply checking your benefits to authorising a hospital admission is now even easier than picking up the phone.

A website that responds to your device

Our website has been designed to work on a variety of different digital devices – your computer, your tablet and your cellphone. No matter what size the screen, the information will always be customised to your particular device making it easy to read.

Keeping track of your benefits

You can keep track of your available benefits online. You can access all important benefit information about your plan.

Ordering medicine

Our convenient medicine delivery service allows you to order or re-order your medicine online. You can also check medicine prices, your cover on those medicines and if there are more cost-effective alternatives available.

www.tfgmedicalaidscheme.co.za

Keep track of your claims

We have securely stored information about your claims. You can submit your claim online, view your claims statement, do a claims search if you are looking for a specific claim, see a summary of your hospital claims and even view your claims transaction history.

Accessing important documents

We have securely stored documents so that they are available when you need them most. If you are looking for your tax certificate, membership certificate or simply looking for an application form. We have them all stored on our website.

Finding a healthcare professional

You can use our Medical and Provider Search tool to find a healthcare professional. You can also find one who we cover in full so that you don't have a co-payment on your consultation. You can even filter your search by speciality and area and the results will be tailored to your requirements.

PRESCRIBED MINIMUM BENEFIT

Cover for 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. The list of conditions is defined in the Medical Schemes Act 131 of 1998.

The Prescribed Minimum Benefits make provision for the cover of the diagnosis, treatment and ongoing care of:

- 270 diagnoses and their associated treatment
- 27 chronic conditions
- Emergency conditions.

In most cases, TFG Medical Aid Scheme plans offer benefits which cover far more than the Prescribed Minimum Benefits. To access Prescribed Minimum Benefits, there are rules that apply:

- Your medical condition must qualify for cover and be part of the list of defined Prescribed Minimum Benefit conditions.
- The treatment needed must match the treatments offered in the defined benefits.
- If you are outside of the benefit limit you must use designated service providers in the network. This does not apply in life-threatening emergencies.

  However, even in these cases, where appropriate and according to the rules of the Scheme, you may be transferred to a designated service provider, otherwise a co-payment will be levied. You will be responsible for the difference between what we pay and the actual cost of your treatment.

COVER FOR HEALTHCARE PROFESSIONALS

Get wise and use providers in our network

We at TFG Medical Aid Scheme believe in comprehensive healthcare. That's why we want to ensure that you don't have shortfalls in your benefit cover. We do this by offering you the choice of using healthcare providers in our network.

Full cover for specialists who are on our network

Visiting specialists in our network will protect you against shortfalls in your benefit cover when it's time to claim. We've provided you with this choice by working together with our administrator, Discovery Health and participating healthcare professionals, to create benefit structures and payment arrangements that reduce gaps in your benefit cover.

Providers in our network are providers we have an agreement with to charge you no more than the Scheme Rate. When you use these healthcare providers, you won't have shortfalls in benefit cover and no out-of-pocket expenses, subject to your available benefit and annual limits.

Cover to give you peace of mind

We offer you the choice to have full cover for hospitalisation, specialists in hospital, chronic medicine and GP consultations. We pay healthcare providers in our network directly, saving you the hassle. In hospital we cover you up to 100% of the Scheme Rate. We cover GPs who are on our network in full. If a specialist who does not participate in the payment arrangement treats you in hospital or if you visit a non-network general practitioner (GP), we will cover you up to **80%** of the Scheme Rate.

How to find your nearest provider for the Full Cover Choice.

You can use our Medical and Providers Search Advisor (MaPS Advisor) on the Scheme website to find a healthcare professional who we have an agreement with.

HOW TO USE THE MAPS TOOL
ON OUR WEBSITE

Go to TFG Medical Aid Scheme website and log in with your username and password.

If you are looking for the nearest doctor or hospital, go to Your Details on the left of the screen and click on TFG Medical Aid Scheme. Now you can click on MaPS (Medical and Provider Search):

The page will open in the MaPs Medical and Provider Search functionality.

There are three sections:

1. Plan
2. Provider
3. Location

Next to “Plan” you will be able to see your plan option, for example, TFG Medical Aid Scheme Plan A.

The “Provider” section gives you two options. You have to select the category of provider you are looking for. This can be “Doctors”, “Private Hospitals” or “Provincial Hospitals”. If you are looking for a doctor, you will have to indicate what type of healthcare provider (doctor) you need, for example, “Psychiatrist”.

If you are looking for a private hospital, you will have to indicate in the next field if you need a private hospital with less than 100 beds or more than 100 beds.

Next to “Location” you will find three fields for region/ province, city and suburb respectively.
After filling in all your requirements, for example:

Doctors >> Psychiatrist >> Western Cape >> Cape Town >> Observatory ...

and then clicking on “Search”, you will be able to see a list of all the available network psychiatrists in your area.

The doctor’s details will include the practice name, practise number, physical address and even GPS coordinates.

The colours green or grey will explain exactly how we will cover you and what rate the doctor is charging. It will also warn you of possible co-payments.

HOW TO SUBMIT CLAIMS

Claiming correctly is essential because when you submit a claim incorrectly there is always a possibility that you will be held responsible for a co-payment. Remember these important points so you can claim correctly and avoid co-payments:

1. Check your personal file with your doctor.
2. Check all your details against your membership card, especially your membership number.
3. Ask if your doctor charges the Scheme Rate or a higher rate.
4. If your doctor submits the claim electronically, you don’t need to send a duplicate copy to us.
5. If you are sending your claim, please send the original copy with your correct member number.
6. Make sure you send us a detailed claim and not just a receipt. We need the details so we can process your claim. Make sure you have the following details:
   - Your membership number
   - The service date
   - Your healthcare professional’s details and practice number
   - The amounts charged
   - The relevant consultation, procedure, NAPPI or diagnostic (ICD-10) codes
   - For a dependant, the name and birth date of the dependant who received treatment
   - If paid, attach your receipt or make sure the claim is stamped ‘paid’.

Sending your claim is easy

There are many ways for you to send us your claims. You can choose the way that is easiest for you from the list below:

1. Your doctor can send the claim to us.
2. Send your claim by fax to 0860 329 252.
3. Send your claim by email to claims@discovery.co.za.
4. Post your claim to: PO Box 652509, Benmore, 2010.
5. Drop off your claim in any Discovery Health claims box found at Virgin Active and Planet Fitness Gyms as well as all hospitals, any Discovery office and Stanley Lewis building in Parow.
6. Take a picture and send it using the Smartphone application.

Remember to keep copies of your claim.
To see the status of your claim, you need to log in to www.tfgmedicalaidscheme.co.za

COVER FOR CHRONIC CONDITIONS

You have extensive cover for chronic conditions, HIV and AIDS and cancer.

Chronic Illness Benefit

The Chronic Illness Benefit (CIB) covers approved medicine for a list of 27 conditions (including HIV and AIDS) called the Chronic Disease List conditions. We will pay your approved chronic medicine in full if it is on our medicine list (formulary). If your approved chronic medicine is not on our medicine list, we will pay your chronic medicine up to a set monthly amount (Chronic Drug Amount) for each medicine category. You will be responsible to pay any shortfall yourself.

If you use a combination of medicine in the same medicine category, where one medicine is on the medicine list and the other is not, we will pay for the medicines up to the one monthly Chronic Drug amount for that medicine category.

Chronic Disease List (CDL) Prescribed Minimum Benefit conditions covered on both plan types.

The cover for medicine is subject to the Scheme medicine list (formulary) or the monthly Chronic Drug Amount.

- 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
- HIV and AIDS
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosis
- Ulcerative colitis

Additional Chronic Cover

Additional Chronic Conditions covered on Plan B.

On Plan B, you have cover for a defined list of additional chronic conditions. There is no medicine list (formulary) for these conditions. We pay approved medicines for these conditions up to the monthly Chronic Drug Amount,

- Ankylosing spondylitis
- Behcet's disease
- Cystic fibrosis
- Delusional disorder
- Dermatopolymyositis
- Generalised anxiety disorder
- Gastro-oesophageal reflux disease
- Gout
- Huntington's disease
- Isolated growth hormone deficiency in children
- Major depression
- Motor neuron disease
- Muscular dystrophy and other inherited myopathies
- Myasthenia gravis
- Obsessive compulsive disorder
- Osteoporosis
- Paget's disease
- Panic disorder
- Polyarteritis nodosa
- Post-traumatic stress disorder
- Psoriatic arthritis
- Pulmonary interstitial fibrosis
- Sjogren's syndrome
- Systemic sclerosis
- Wegener's granulomatosis

We need to approve your application

We need to approve your application before we cover your condition and medicine from the Chronic Illness Benefit (CIB).

To apply, contact us to get an application form or go to www.tfgmedicalaidscheme.co.za. Complete the relevant application form with your doctor and send it to us. We will send you a letter detailing the cover available to you.

The Scheme Medicine Rate is the legislated price of medicine as well as the fee for dispensing it. Use a pharmacy that has agreed to charge the Scheme Medicine Rate, to avoid co-payments on your medicine.

If you use a pharmacy outside of the Scheme's Pharmacy Network, you may have a co-payment if the pharmacy charges you a dispensing fee that is higher than that agreed with network pharmacies.

CHRONIC CONDITIONS
(CONTINUED)

Use our online MaPS Advisor at www.tfgmedicalaidscheme.co.za to find a network pharmacy.

Please note that the Scheme's approved Medicine List and Chronic Drug Amounts are updated from time to time based on regulatory changes and continued clinical appropriateness.

If you want to use the Chronic Illness Benefit, you must apply for it. You must complete a chronic application form with your doctor and summit it for review. You can get the latest application form on the website at www.tfgmedicalaidscheme.co.za

For a condition to be covered from the Chronic Illness Benefit, there are certain benefit entry criteria that the member needs to meet. If necessary, you or your doctor may have to give extra motivation or copies of certain documents to TFG Medical Aid Scheme to finalise your application. If you leave out any information or do not provide the medical test results or documents needed with the application, cover will start only from the date we get the outstanding documents or information.

YOUR COVER FOR **CANCER TREATMENT**

On Plan A, cover for oncology is included with and subject to the overall annual limit for each family for approved cancer treatment. On Plan B, a sub-limit for oncology is available and only once this limit is depleted are costs incurred funded from the overall annual limit, provided the patient is treated in line with PMB protocols and clinical guidelines. Plan A members receive a family limit and Plan B members a per person or beneficiary limit.

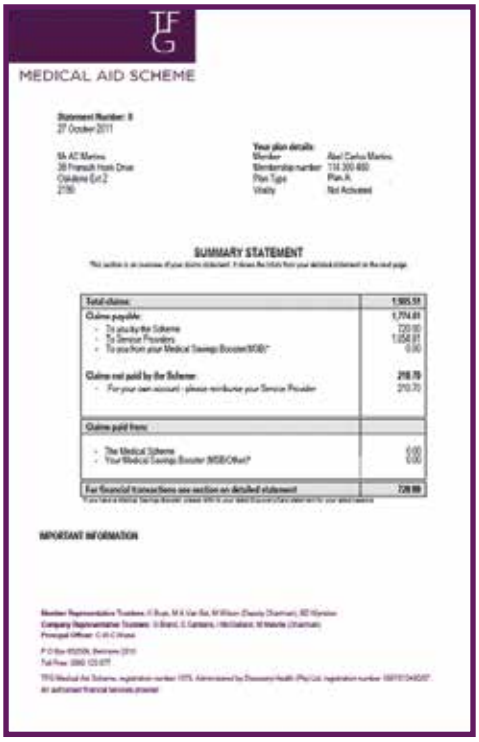
We cover chemotherapy and oncology-related medicines up to the Scheme Medicine Rate. We pay for treatment in hospital, consultations, radiotherapy, radiology, pathology, scopes and scans at 100% of the Scheme Rate, subject to the overall annual limit. We pay for treatment out of hospital provided by non-designated service providers at 80% of the Scheme Rate.

Cancer treatment that qualifies as a Prescribed Minimum Benefit is always covered in full if you use a designated service provider (DSP). Please call us to register on the Oncology Programme.

Visit www.tfgmedicalaidscheme.co.za for a detailed explanation of the cover offered through the Oncology Programme.

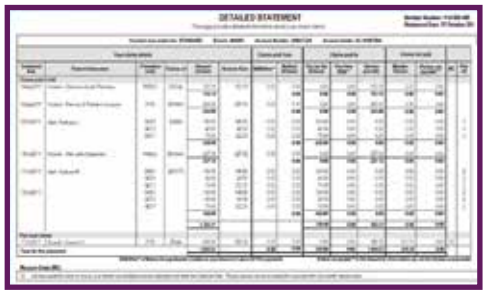
HOW TO GET THE MOST OUT
OF YOUR CLAIM STATEMENT

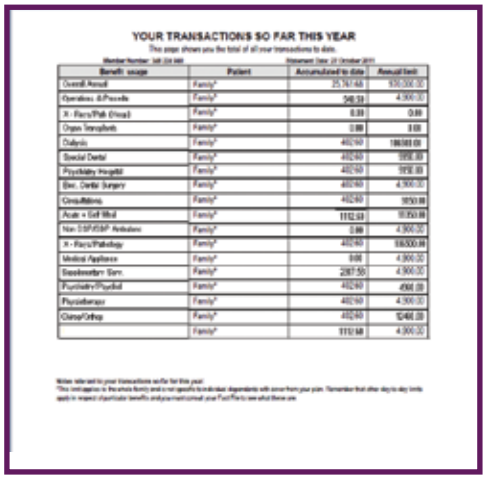
Every time you submit a claim to TFG Medical Aid Scheme, you will receive a claim notice by email, which tells you how we have processed your claim. Your claims statement gives you more details of how we have paid your claims and what your available benefits are.


MEDICAL AID SCHEME

SUMMARY STATEMENT

IMPORTANT INFORMATION


DETAILED STATEMENT


YOUR TRANSACTIONS SO FAR THIS YEAR

1. On the first page, you'll see an overview of your Plan A or B details. You'll also see a summary of your statement, showing a total value of the claims paid, or not paid, to you or your provider.
2. Here you are given a breakdown of what claims were paid in full (at the Scheme Rate), in part or not paid, along with reasons. The second page is a detailed statement in one table, showing all your claims for each service provider and the name of the patient / dependant to who the claim relates.
3. The final section shows an overview of your non-hospital claims and benefit related financial transactions to the date of the statement, if applicable. This further detail ensures that you are better able to manage your benefits.

Your medical information is confidential

We have received some queries about why medicine names aren't specified on claims statements. It is important for us to protect your privacy by not giving out confidential medical information.

Although all the medicine details are on the pharmacy's statement, we also keep the detailed information on our system and will be able to provide it to you. You can get it from us in one of the following ways:

- A Claims Processed Notification, which is sent to you by email as soon as we have processed your claim for payment;
- By finding the information on the Scheme's website at **www.tfgmedicalaidscheme.co.za** or
- By calling TFG Medical Aid Scheme call centre.

DAY TO DAY COVER

Day-to-day cover

Day-to-day claims are expenses that you incur without being admitted to hospital. We cover these claims through the Primary Care Benefit. Examples of day-to-day expenses are consultations at healthcare professionals (for example, GPs, specialists and physiotherapists), prescribed medicine, radiology, pathology performed out of hospital, and conservative dentistry.

Please refer to the benefit schedule for the details on how these benefits are covered and the sub-limits that are applied.

Pregnancy/ Maternity Consultations

There are two consultations at a GP per pregnant beneficiary per pregnancy, paid at 100% of the Scheme Rate if a provider in the Scheme's network is used or 80% of the Scheme rate where a non-network provider is used.

Cover for acute medicine

For acute medicine, we pay up to 80% of the Scheme Medicine Rate, subject to acute medicine limits. The Scheme Medicine Rate is the price of medicine as well as a fee for dispensing it.

If you use a pharmacy outside of the Scheme's Pharmacy Network, you will have to pay part of the dispensing fee charged by the pharmacy.

Use our online MaPS Advisor on www.tfgmedicalaidscheme.co.za or contact us on 0860 123 077 to find a network pharmacy.

GENERAL EXCLUSIONS

TFG Medical Aid Scheme has certain exclusions. We will not pay for healthcare services related to the following, except where stipulated as part of a defined benefit or under the prescribed minimum benefits.

- Examinations, consultations and treatment relating to obesity or which may be regarded as for cosmetic purposes
- Attempted suicide, willfully inflicted injuries, or sickness conditions arising due to body piercing or their complications outside of PMB requirements
- Costs of drug abuse, unless treatment is received in State facilities, SANCA, Ramot or Nishtara covered as PMB only
- Costs of infertility unless treatment is received in a DSP facility or as a PMB
- Purchase or hire of medical or surgical appliances such as special beds, chairs, cushions, commodes, sheepskins, waterproof sheets, bedpans, special toilet seats, adjustment or repair of sick rooms or convalescing equipment (with the exception of hire of oxygen cylinders), unless clinically appropriate
- Unregistered providers
- Sun-screen and tanning agents
- Soaps, shampoos and other topical applications
- Household remedies
- Slimming preparations, appetite suppressors, food supplements and patent foods including baby food
- Growth hormones
- Tonics, nutritional supplements, multi-vitamins, vitamin combinations – except prenatal, lactation and paediatric use – unless authorised as part of a disease management programme
- Anti smoking preparations
- Aphrodisiacs
- Anabolic steroids
- Treatment for erectile dysfunction
- Mouth protectors and gold dentures
- Examinations for insurance, school camps and visas
- Stimulant laxatives
- Anti-diarrheal micro-organisms replacement therapy for natural gut flora
- Travelling costs
- Accommodation in old age homes
- Accommodation and treatment in spas and resorts
- Holidays for recuperation
- Appointments not kept
- Ante and post-natal exercise classes as well as breast feeding instruction
- Sunglasses and spectacle cases
- Replacement batteries for hearing aids

- Contact lens solution, kits and consultation for fitting and adjustments
- Costs associated with vocational, child and marriage guidance, school therapy or attendance at remedial education facilities
- Bleaching of teeth that have not had root canal treatment, metal inlays in dentures and front teeth
- Injuries during professional, hazardous sports and activities unless such injuries constitute a PMB condition
- Accommodation and treatment in headache and stress-relief clinics
- Payment for ambulance transportation and air lifting outside of South Africa (including PMB's)

We also do not cover the complications or the direct or indirect expenses that arise from any of the exclusions listed here, except where stipulated as part of a defined benefit or under the Prescribed Minimum Benefits.

The benefits outlined in this guide are a summary of the plans registered in the medical scheme rules. These benefits are reviewed every year and amended in line with the requirements of the Medical Schemes Act and also take into account the requirements of the Consumer Protection Act where it relates to the business of a medical scheme.

KEEP YOUR PERSONAL DETAILS UP TO DATE

Keeping your details up to date will mean that you get the best service and your claims will be processed quickly and efficiently. With the correct personal details, we will:

1. Always know how and where to contact you or your family in an emergency;
2. Know where to pay any money due to you; and
3. Communicate important information to help you make the best health decisions.

We are waiting to hear from you

You can check and update your details by:

- Logging in to www.tfgmedicalaidscheme.co.za;
- Calling us at 0860 123 077; or
- Emailing us at service@discovery.co.za

Please give us any details that may have changed, like your postal address, email address, phone numbers, account numbers and other personal details.

QUICK CONTACT REFERENCES

For ambulance and other emergency services

call 0860 999 911

General queries

service@discovery.co.za / call centre 0860 123 077

To send claims

Email us at claims@discovery.co.za or

Fax it to 0860 329 252

Drop off your claim in any blue Discovery Health claims box, or post it to **PO Box 652509 Benmore 2010** or take a photo and submit your claim using the Discovery Smartphone application as set out in this brochure on page 13.

Other services

Oncology service centre 0860 123 077

HIVCare Programme 0860 123 077

Internet queries 0860 100 696

If you would like to let us know about suspected fraud, please call our fraud hotline on 0800 004 500 (callers will remain anonymous).

To preauthorise admission to hospital email us at preauthorisations@discovery.co.za or phone us from a landline at 0860 123 077

You are also welcome to visit one of our walk-in centres at:

- Knowledge Park, Heron Crescent, Century City, **Cape Town**
- 16 Fredman Drive, **Sandton**
- 41 Imvubu Park Place, Riverhouse Valley Business Estate, Nandi Drive, **Durban**
- Corner of Oak and Tegel Avenues, Highveld Techno Park, **Centurion**
- BPO Building Zone 4 – IDZ Coega, **Port Elizabeth**

www.tfgmedicalaidscheme.co.za

YOUR BENEFITS FOR 2015

When you reach a benefit limit, we only pay for approved treatment related to the Prescribed Minimum Benefits.

BENEFIT	RATE	PLAN A	PLAN A
A R2 000 excess will be charged if you do not get preauthorisation from the Scheme at least 48 hours before a hospital admission or treatment. Please note you may not receive payment in full even if you have obtained preauthorisation. We can advise you on the rate of payment before admission to hospital if you submit the known procedure codes to us for pre-assessment.			
		Overall annual limit of R520 000 per family	**Overall annual limit of R1 670 000 per family**
1. Hospital and hospital-related benefits			
Operations, procedures and surgery	100% of Scheme Rate	Subject to overall annual limit	Subject to overall annual limit
Ward and theatre fees	100% of Scheme Rate	Subject to overall annual limit	Subject to overall annual limit
X-rays	100% of Scheme Rate	Subject to overall annual limit	Subject to overall annual limit
Pathology	100% of Scheme Rate	Subject to overall annual limit	Subject to overall annual limit
Radiotherapy	100% of Scheme Rate	Subject to overall annual limit	Subject to overall annual limit
Blood transfusion	100% of Scheme Rate	Subject to overall annual limit	Subject to overall annual limit
Organ transplants	100% of Scheme Rate	Subject to overall annual limit	Subject to overall annual limit
Renal dialysis	100% of Scheme Rate	R125 100 per family per year (subject to overall annual limit)	R134 600 per family per year (subject to overall annual limit)
Hospitalisation for psychiatric treatment	100% of Scheme Rate	21 days per member per year (subject to overall annual limit)	21 days per member per year (subject to overall annual limit)
Elective maxillo-facial and oral surgery	100% of Scheme Rate	R12 700 per family per year (subject to overall annual limit)	R14 300 per family per year (subject to overall annual limit)
Internal prostheses	100% of cost	Subject to annual sub-limits	Subject to annual sub-limits
- Total hip replacement	100% of cost	R51 400 per family	R51 400 per family
- Partial hip replacement	100% of cost	R30 750 per family	R30 750 per family
- Spinal prostheses per level (includes fusion and disc replacement)	100% of cost	R25 950 for one level R51 950 for two or more levels	R25 950 for one level R51 950 for two or more levels
- Knee replacement	100% of cost	R48 750 per family	R48 750 per family
- Shoulder replacement	100% of cost	R42 400 per family	R42 400 per family

BENEFIT	RATE	PLAN A		PLAN B	
- Cardiac stents	100% of cost	R10 600 per bare metal stent R16 950 per drug eluting stent		R10 600 per bare metal stent R16 950 per drug eluting stent	
- Cardiac pacemakers	100% of cost	R62 550 per family		R62 550 per family	
- Tissue replacing prostheses	100% of cost	R20 150 per family		R20 150 per family	
- Artificial limbs	100% of cost	R30 750 per family		R30 750 per family	
- Artificial eyes	100% of cost	R15 350 per family		R15 350 per family	
- Cardiac valves	100% of cost	R25 450 per valve		R25 450 per valve	
- Vascular grafts	100% of cost	R76 300 per family		R76 300 per family	
- General	100% of cost	R20 150 per family		R20 150 per family	
Post-exposure prophylaxis	100% of Scheme Rate	Subject to overall annual limit		Subject to overall annual limit	
Oncology (including hospitalisation, chemotherapy and oncology-related medicine, consultations, radiotherapy, pathology, scopes and scans)	100% of Scheme Rate	Subject to overall annual limit		R520 000 per beneficiary and subject to overall annual limit	
2. Chronic medicine	100% of Scheme Medicine Rate for formulary medicine for CDL conditions Off-formulary medicine for CDL conditions and medicine for ADL conditions subject to CDA	Prescribed Minimum Benefits only		R20 650 per beneficiary with an overall limit of R57 250 per family per year, thereafter Prescribed Minimum Benefits only	
3. Specialised dentistry	80% of Scheme Rate unless services are received from a specialist in the Scheme Network where cover is at 100% of Negotiated Rate*	M M+1 M+2 M+3 M+4 M+5 M+6 M+7	R1 590 R2 700 R4 190 R4 930 R5 350 R5 510 R5 720 R5 940	M M+1 M+2 M+3 M+4 M+5 M+6 M+7	R7 210 R9 650 R11 550 R12 670 R13 460 R13 830 R14 200 R14 470
4. Primary care benefits	80% of Scheme Rate	Subject to overall annual limits and the following sub-limits		Subject to overall annual limits and the following sub-limits	
Consultations and visits (general practitioners, specialists [excluding psychiatrists], registered private nurse practitioners and associated health services, for example, art therapists; medical scientists, dieticians, psychometry, social workers, phytotherapy, acupuncturists, chinese medicine, osteopaths, naturopaths and homeopaths)	80% of Scheme Rate unless services are received from a GP or specialist in the Scheme Network where cover is at 100% of Negotiated Rate	M M+1 M+2 M+3 M+4 M+5 M+6 M+7	R1 750 R2 150 R2 500 R2 750 R2 950 R3 150 R3 250 R3 350	M M+1 M+2 M+3 M+4 M+5 M+6 M+7	R2 750 R4 150 R5 400 R6 200 R6 800 R7 150 R7 500 R7 550
Pregnancy/Maternity Consultations	Paid at 100% of the Scheme Rate if a provider in the Scheme's network is used	Two consultations at a GP per pregnant beneficiary per pregnancy			

BENEFIT	RATE	PLAN A		PLAN B	
Basic dentistry	80% of Scheme Rate	M	R1 480	M	R3 290
		M+1	R1 800	M+1	R3 980
		M+2	R2 070	M+2	R4 610
		M+3	R2 390	M+3	R5 300
		M+4	R2 540	M+4	R5 830
		M+5	R2 650	M+5	R6 100
		M+6	R2 760	M+6	R6 360
		M+7	R2 860	M+7	R6 410

BENEFIT	RATE	PLAN A	PLAN B
Optical per beneficiary, per 2-year cycle.			
Comprehensive consultation, inclusive of tonometry, glaucoma and visual screening	100% of Scheme Rate	100% of Scheme Rate for one comprehensive consultation per beneficiary, subject to a limit of R550	100% of Scheme Rate for one comprehensive consultation per beneficiary, subject to a limit of R550
Glasses (frames/ prescription lens enhancements) **OR** Contact lenses (as an alternative to glasses)		100% of Scheme Rate for a pair of single vision lenses per beneficiary, subject to a limit of R350 per lens and R610 for a frame (or prescription lens enhancements) **OR** 100% of Scheme Rate for a pair of bifocal lenses per beneficiary, subject to a limit of R760 per lens and R610 for a frame (or prescription lens enhancements) **OR** 100% of Scheme Rate for a pair of multifocal lenses per beneficiary, subject to a limit of R1 430 per lens and R610 for a frame (or prescription lens enhancements) **OR** Contact lenses (alternative to glasses) are subject to a total limit of R2 330 per beneficiary	100% of Scheme Rate for a pair of single vision lenses per beneficiary, subject to a limit of R350 per lens and R780 for a frame (or prescription lens enhancements) **OR** 100% of Scheme Rate for a pair of bifocal lenses per beneficiary, subject to a limit of R780 per lens and R760 for a frame (or prescription lens enhancements) **OR** 100% of Scheme Rate for a pair of multifocal lenses per beneficiary, subject to a limit of R1 430 per lens and R780 for a frame (or prescription lens enhancements) **OR** Contact lenses (alternative to glasses) are subject to a total limit of R2 330 per beneficiary
Radiology and pathology	80% of Scheme Rate for radiology 100% of Scheme Rate for pathology	R13 250 per family	R19 080 per family
Psychiatry and clinical psychology	80% of Scheme Rate unless psychiatrist is on the Scheme Network where cover is at 100% of Negotiated Rate	R2 760 per family	R6 250 per family

BENEFIT	RATE	PLAN A		PLAN B	
Acute medicine	80% of Scheme Medicine Rate	M	R2 230	M	R4 980
		M+1	R3 230	M+1	R7 310
		M+2	R4 030	M+2	R8 750
		M+3	R4 510	M+3	R9 860
		M+4	R4 880	M+4	R10 710
		M+5	R5 090	M+5	R11 240
		M+6	R5 250	M+6	R11 610
		M+7	R5 300	M+7	R11 820
		Please note: an over-the-counter medicine sub-limit of R100 per claim is applicable.		Please note: an over-the-counter medicine sub-limit of R150 per claim is applicable.	
Ambulance	100% of Scheme Rate if PP used or 80% of Scheme Rate if non-preferred provider is used	R3 070 per family Unlimited if PP used		R3 500 per family Unlimited if PP used	
Medical appliances	80% of Scheme Rate	R8 590 per family		R17 000 per family	
Speech therapy, occupational therapy and audiology*	80% of Scheme Rate	R3 500 per family		R5 300 per family	
Physiotherapy and chiropractic therapy*	80% of Scheme Rate	R2 700 per family		R4 660 per family	
Podiatry and orthoptics (including orthoptic services by optometrists)*	80% of Scheme Rate	R2 390 per family		R3 920 per family	
Specialised medicine This benefit covers a specific list of new medicines for members on Plan B. This is a limited benefit and there may be some co-payments that you may have to pay, depending on the medical condition and the type of medicine that is used. You need authorisation to qualify for this benefit.	100% or 80% of Scheme Rate	Not applicable		Cover of up to R200 000 per beneficiary per annum of the latest and most advanced specialised medicine is available. A co-payment of 20% apply to this benefit.	

* Both in-hospital and out-of-hospital.

Benefits and contribution amounts are subject to Council for Medical Schemes approval. The registered rules are binding and take precedence over the brochure and benefit schedule.

Please refer to page 10 for more information on the screening and preventative benefits and also other new benefits introduced for the Scheme from 1 January 2015.

Home nursing and/or step down facility benefits are made available and more information can be obtained from the contact center.

PP = preferred provider (the Scheme's preferred provider for ambulance services is Discovery 911)

Scheme Rate = This is the amount of money the Scheme pays for a specific type of medical procedure, treatment or consultation. There are, however, certain healthcare professionals with whom the Scheme has negotiated rates. The negotiated rate replaces the Scheme Rate in those instances.

Maximum annual benefits referred to will be calculated from 1 January 2015 to 31 December 2015, based on the services provided during the year and will be subject to pro rata apportionment calculated from the joining date to the end of the benefit period. Benefits are not transferable from one benefit period to another or from one category to another. Optical benefits are not applied on a pro-rata basis. This is a biennial benefit (in other words this is not an annual benefit, but a benefit that is available over a two year period from the date that you join the Scheme).

CONTRIBUTIONS FOR 2015

These contributions are the total amounts due to the Scheme. **The member's portion of the contributions, payable after taking the employer's subsidy into account, is shown in the second set of tables below.**

Contributions - before employer subsidy

PLAN A						
SALARY BAND	**A**	**B**	**C**	**D**	**E**	**F**
MONTHLY SALARY	**R0-R3 930**	**R3 931-R6 491**	**R6 492-R12 565**	**R12 566-R21 557**	**R21 558-R32 097**	**R32 098+**
Principal member	R1 251	R1 412	R1 512	R1 644	R1 920	R2 087
Adult (**)	R782	R988	R1 103	R1 201	R1 389	R1 459
Child (*)	R397	R400	R430	R472	R537	R571

PLAN B						
SALARY BAND	**A**	**B**	**C**	**D**	**E**	**F**
MONTHLY SALARY	**R0-R3 930**	**R3 931-R6 491**	**R6 492-R12 565**	**R12 566-R21 557**	**R21 558-R32 097**	**R32 098+**
Principal member	R2 206	R2 556	R2 809	R2 988	R3 076	R3 142
Adult (**)	R1 366	R1 754	R1 933	R2 111	R2 156	R2 202
Child (*)	R573	R573	R641	R746	R792	R792

All contributions are 100% of total contribution without taking the 50% company subsidy that may apply to you.

(*) Child contributions are applicable where:

- A dependant is under the age of 21;
- A dependant is over the age of 21, but not over the age of 25 and a registered student at a university or recognised college for higher education and is not self supporting;
- A dependant is over the age of 21, but not over the age of 25 and is dependent upon the principal member due to mental or physical disability.

(**) Adult contributions are applicable where:

- A principal member's dependant is over the age of 21 and does not qualify for child contribution rates as set out above.

Contributions - after employer subsidy

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

PLAN A						
SALARY BAND	**A**	**B**	**C**	**D**	**E**	**F**
MONTHLY SALARY	**R0-R3 930**	**R3 931-R6 491**	**R6 492-R12 565**	**R12 566-R21 557**	**R21 558-R32 097**	**R32 098+**
Principal member	R626	R706	R756	R822	R960	R1 044
Adult (**)	R391	R494	R552	R601	R695	R730
Child (*)	R199	R200	R215	R236	R269	R286

PLAN B						
SALARY BAND	**A**	**B**	**C**	**D**	**E**	**F**
MONTHLY SALARY	**R0-R3 930**	**R3 931-R6 491**	**R6 492-R12 565**	**R12 566-R21 557**	**R21 558-R32 097**	**R32 098+**
Principal member	R1 103	R1 278	R1 405	R1 494	R1 538	R1 571
Adult (**)	R683	R877	R967	R1 056	R1 078	R1 101
Child (*)	R287	R287	R321	R373	R396	R396

All contributions shown in these two tables are the member's own portions after the employer's 50% subsidy was taken into account. If you are not entitled to a subsidy, you will have to pay the full contribution as shown in the first two tables on this page. Your HR department will be able to confirm whether you qualify for a medical aid subsidy.

EX GRATIA POLICY

Ex gratia is defined by the Council for Medical Schemes (CMS) as "a discretionary benefit which a medical aid scheme may consider to fund in addition to the benefits as per the registered Rules of a medical scheme. Schemes are not obliged to make provision there for in the rules and members have no statutory rights thereto".

The board of trustees may in its absolute discretion increase the amount payable in terms of the rules of the Scheme as an ex gratia award.

As ex gratia awards are not registered benefits, but are awarded at the discretion of the board of trustees, the board has appointed an ex gratia committee who review ex gratia applications received and this committee is mandated to act on behalf of the board in making decisions regarding ex gratia applications. Decisions taken by this committee in respect of ex gratia are final and is not subject to appeal or dispute.

COMPLAINTS

What to do when you have a query or complaint that remains unresolved

The Medical Schemes Act 131 of 1998 (the Act) states that members who are aggrieved with the conduct of a medical scheme or wants to dispute a decision taken by their medical scheme have the right to contact the Council for Medical Schemes (CMS) for a dispute resolution. The Act also sets out the complaints procedure that must be followed.

Members must first try to resolve the matter with their medical scheme and only contact CMS if they are still in disagreement with the medical scheme.

The Scheme's Dispute Resolution Process require that you contact the administrator, Discovery Health, through the contact centre on 0860 123 077 and lodge the complaint or dispute.

If the matter remains unresolved or the feedback received not be to the satisfaction, the matter can be escalated to the Principal Officer of the Scheme, Ms Carin Wiese, who will direct the matter to the Disputes committee of the Scheme for resolution.

Members who thereafter continue to remain in dispute with their Scheme can contact the Council for Medical Schemes.

The contact details for the Council for Medical Schemes are as follows:

- Physical address: Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157
- Postal address: Private Bag X34, Hatfield 0028
- Phone number: 0861 123 267
- Fax number: 012 431 7644
- Email: complaints@medicalschemes.com

TFG MEDICAL AID SCHEME

TFG Medical Aid Scheme, registration number 1578. Administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07.
An authorised financial services provider.

GM_30335DIH_02/04/2015_V3