Guide to Prescribed Minimum Benefits 2019

Who we are

TFG Medical Aid Scheme (referred to as "the Scheme"), registration number 1578, is a non-profit organisation, registered with the Council for Medical Schemes.
Discovery Health (Pty) Ltd (referred to as "the Administrator"), is a separate company who is registered as an authorized financial services provider (registration number 1997/013480/07), administers TFG Medical Aid Scheme.

Contact us

You can call us on **0860 123 077** or visit **www.tfgmedicalaidscheme.co.za** for more information.

No matter what plan you decide on, there are some common benefits that apply to all members on all plans

This document tells you how TFG Medical Aid Scheme covers each of its members for a list of conditions called Prescribed Minimum Benefits (PMBs).

Understanding some of the terms we use in this document

There are some terms we use in the document that you may not know. Here are the meanings of some of them:

Terminology	Description
Prescribed Minimum Benefits (PMBs)	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.
Shortfall	TFG Medical Aid Scheme pays service providers at a set rate, known as the Scheme Rate. If the service providers charge higher fees than this rate, you will have to pay the difference between the Scheme Rate and what the providers charged, from your pocket.
Waiting period	A waiting period can be general or condition-specific and means that you or one of your dependents have to wait for a set time before TFG will provide benefits, in line with those offered by your plan, for your medical expenses.

Chronic Drug Amount (CDA)	The CDA is a maximum monthly amount we pay up to for a medicine class. This applies to medicine that is not listed on the medicine list (formulary). The Chronic Drug Amount includes VAT and the dispensing fee.
Diagnostic Treatment Pairs Prescribed Minimum Benefit (DTP PMB)	Links a specific diagnosis to a treatment and broadly indicates how each of the PMB conditions should be treated.
Designated Service Provider	A healthcare provider (for example doctor, specialist, pharmacist or hospital) who we have an agreement with to provide treatment or services at a contracted rate.
Reference Price	Non-formulary medication that falls in the same medicine category and generic group as the formulary medication. Funds up to a Reference Price.

Understanding the Prescribed Minimum Benefits

What are Prescribed Minimum Benefits (PMBs)?

According to the Medical Schemes Act 131 of 1998 and its Regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- A life-threatening emergency medical condition
- A defined list of 270 diagnoses
- A defined list of 27 chronic conditions (Chronic Disease List conditions).

Please refer to the Council for Medical Schemes website (http://www.medicalschemes.com) for a full list of the diagnoses and chronic conditions.

All medical schemes in South Africa have to include the Prescribed Minimum Benefits in the health plans they offer to their members.

How TFG Medical Aid Scheme pay claims for PMBs and non-PMB benefits

We pay for PMBs in full from the risk benefits if you receive treatment from a designated service provider (DSP). Treatment received from a non-DSP may be subject to a co-payment if the healthcare provider charges more than what we pay. We pay for benefits not included in the PMBs from your day-to-day benefits, according to the rules and benefits of your chosen health plan.

Requirements you must meet to benefit from PMBs

There are certain requirements before you can benefit from the Prescribed Minimum Benefits. The requirements are:

01 |The condition must qualify for cover and be on the list of defined PMB conditions
02 |The treatment needed must match the treatments in the published defined benefits on the PMB list
03 |You must use the Scheme's designated service providers. 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 hospital or facility.

If the treatment does not meet the above criteria, we will pay the claims up to the Scheme Rate, which is a set rate at which the Scheme pays service providers. If the service provider charges above this rate, you will have to pay the outstanding amount from your pocket. This amount you have to pay is called a co-payment.

TFG Medical Aid Scheme plans offer benefits richer than that of the Prescribed Minimum Benefits

All TFG Medical Aid Scheme plans cover more than just the minimum benefits required by law. Some plans cost more but offer more comprehensive benefits while others have lower contributions with fewer benefits.

Sometimes TFG Medical Aid Scheme will only pay a claim as a Prescribed Minimum Benefit
This happens when you are in a waiting period, when the annual limit has been reached or when you have treatments linked to conditions that are excluded by your plan. This can be a general three-month waiting period or a 12-month condition-specific waiting period. But you can still have cover in full, if you meet the requirements stipulated by the Prescribed Minimum Benefit regulations.

There may be times when you do not have cover under Prescribed Minimum Benefits
There are some circumstances where you do not have cover for the Prescribed Minimum Benefits. This can happen when you join a medical scheme for the first time, with no medical scheme membership before that.

It can also happen if you join a medical scheme more than 90 days after leaving your previous medical scheme. In both these cases, the Scheme would impose a waiting period, during which you and your dependents will not have access to the Prescribed Minimum Benefits, no matter what conditions you might have.

You and your dependants must register to get cover for PMBs and Chronic Disease List conditions

How to register your chronic or PMB conditions to get cover from the risk benefits

There are different types of claims for Prescribed Minimum Benefits. There are claims for hospital admissions, chronic conditions and other conditions treated out of hospital.

If you want to apply for out-of-hospital Prescribed Minimum Benefits or cover for a chronic condition on the Chronic Disease List, you must get a *Prescribed Minimum Benefit* or a *Chronic Illness Benefit a*pplication form.

- Both forms are available to download and print from www.tfgmedicalaidscheme.co.za. Log on to the website using your username and password. Go to *Find a document* and click on *Application forms*.
- You can also call 0860 123 077 to request any of the above forms.

We will also let you know about the outcome of the application. We will send you a letter confirming your cover for that condition.

If your application meets the requirements to benefit from Prescribed Minimum Benefits, we will automatically pay the associated approved blood tests and other investigative tests, treatment, medicine and consultations for that condition from the risk benefits.

If you want to apply for in-hospital Prescribed Minimum Benefit cover, you must call us on 0860 123 077 to request an authorisation.

Why it is important to register your PMB or chronic conditions

The Scheme pays for specific healthcare services related to each of your approved conditions. These services include treatment, medicine, consultations, blood tests and other investigative tests. s. All payments for PMB claims will accumulate to the relevant limits. Once the limit is reached, the PMB claims will continue to pay through the limit.

We will pay for treatment or medicine that falls outside the defined benefits and that is not approved, from your available day-to-day benefits according to your chosen health plan. If your health plan does not cover these expenses, you will have to pay the claims.

There are times when you need to apply for cover under the Prescribed Minimum Benefits. Once your healthcare professional confirms the diagnosis as a Prescribed Minimum Benefit condition, you can apply to us for payment of the claims from risk benefits. Once approved, we will automatically recognise that the medical services you are claiming for fall under the Prescribed Minimum Benefits.

When you do not register your condition as a PMB or chronic condition

We will pay all the consultations, blood tests, other investigative tests, medicine and treatment for the PMB or chronic condition from your day-to-day benefits.

Who must complete and sign the registration form when applying for PMB cover?

The individual with the PMB or chronic condition, must complete the application form with the help of the treating doctor. The main member must complete and sign the form if the patient is a minor (younger than 18 years).

Additional documents needed to support the application

You may need to send the Scheme the results of the medical tests and investigations that confirm the diagnosis of the condition for which you are applying for cover. This will help us to identify that your condition qualifies for the chronic medicine.

Where you must send the completed registration form

You can send the completed **PMB application form**:

- By fax to: 011 539 2780
- By email to: PMB_APP_FORMS@discovery.co.za
- By post to: TFG Medical Aid Scheme, PMB Department, PO Box 652509, Benmore, 2010

You can send the completed **Chronic application form**:

- By fax to: 011 539 7000
- By email to: CIB_APP_FORMS@discovery.co.za
- By post to: TFG Medical Aid Scheme, CIB Department, PO Box 652509, Benmore, 2010

We will let you know if we approve your application for PMB cover and what you must do next

We will inform you of our decision by fax or email (as you have indicated on your application form). The treatment needed must match the treatments in the published defined benefits on the PMB list as there are standard treatments, procedures, investigations and consultations for each condition on the Prescribed Minimum Benefit list. These defined benefits are supported by thoroughly researched evidence, based on clinical protocols, medicine lists (formularies) and treatment guidelines.

About what happens if you need treatment that falls outside of the defined benefits?

The Scheme is only required to cover the defined benefits. If treatment that falls outside the defined benefits is not approved, it will be paid from your available day-to-day benefits according to your chosen health plan. If your health plan does not cover these expenses, you will be responsible to pay the claims.

If you need treatment that falls outside of the defined benefits and you send additional clinical information with a detailed explanation of why the treatment is needed, the Scheme will review it and may choose to approve the treatment. If we decline the request, you may contact us to lodge a formal dispute by following the dispute process detailed on the website at www.tfgmedicalaidscheme.co.za

We cover approved medicine on our medicine list (formulary) in full

We pay medicine on the medicine list (formulary) up to the Scheme Rate for medicines. There will be no co-payment for medicine selected from the medicine list.

If we approve chronic medicine that is not on the medicine list, we will pay it up to a set monthly rand amount called the Chronic Drug Amount (CDA) or up to a Reference Price. You may have a co-payment if the cost of the medicine is greater than the Chronic Drug Amount or Reference Price.

This is unless the medicine is a substitute for one that has been ineffective or has caused an adverse reaction. In that case you and your doctor can appeal the funding decision. If the appeal is successful there will be no co-payment.

To appeal for PMB cover or cover for chronic medicine/treatment:

1. Download and print the “PMB Appeal Form” or “The Chronic Illness Benefit Appeal form”, available on www.tfgmedicalaidscheme.co.za. Members can also call 0860 123 077 to request any of the above forms
2. Complete the appeal form with the assistance of your healthcare professional
    - Send the completed, signed appeal form, along with any additional medical information, by email to PMB_APP_FORMS@discovery.co.za or by fax 011 539 2780 or by email to CIB_APP_FORMS@discovery.co.za by fax to: 011 539 7000

3. If we approve the requested medicine/treatment on appeal, we will automatically pay from risk benefits. If the appeal is unsuccessful the member can lodge a formal dispute by following Discovery Health Medical Scheme’s internal disputes process on the website.

When you need to get more than one month's supply of medicine

You can get more than one month's supply of approved chronic medicine if you are travelling outside the borders of South Africa. You need to fill in an *Extended Supply of Medicine* form that you can find on www.tfgmedicalaidscheme.co.za and send it to us on the details provided on the form. The Scheme will review your request and tell you if they have approved it.

We will tell you if we make changes to the medicine list and it affects you

Because there are regular changes to our medicine list, we only inform those members who will be affected by the changes. For example, we will only inform members who are registered for high blood pressure about changes to high blood pressure medicines on the medicine list.

About who must register to receive chronic medicine for their PMB or chronic conditions

The main member and all dependents with PMB or chronic conditions must register. Each individual must register their specific conditions.

You only have to register once for a chronic condition. If your medicine or other treatment changes, your doctor can just let us know about the changes.

For new conditions, you have to register for each new condition before we will cover the treatment and consultations from the risk benefits.

About what happens if there is a change in your approved medicine

For chronic conditions, the treating doctor or dispensing pharmacist can make changes to medicines telephonically by calling 0860 123 077. You can also fax an updated prescription to 011 539 7000 or email it to CIB_APP_FORMS@discovery.co.za

For PMB conditions, the treating doctor or dispensing pharmacist can make changes to medicines by sending the updated prescription by fax to 011 539 2780 or email it to PMB_APP_FORMS@discovery.co.za

What are designated service providers (DSPs) and how to find them

A designated service provider (DSP) is a healthcare provider (for example doctor, specialist, pharmacist or hospital) who we have a payment arrangement with. According to this arrangement, they will provide treatment or services at a contracted rate. This will make sure that you do not have any co-payments when you use their services.

You can use the MaPS Advisor on www.tfgmedicalaidscheme.co.za, the Discovery app or call us on 0860 123 077 to find a healthcare service provider we have a DSP payment arrangement with.

What to do if there is no available designated service provider at the time of your request

There are some cases where it is not necessary to use designated service providers, but you will still have full cover. An example of this is in a life-threatening emergency.

In cases where there are no services or beds available within the designated service provider when you or one of your dependents needs treatment, you must contact us on 0860 123 077 and we will intervene and make arrangements for an appropriate facility or healthcare provider to accommodate you.

About what happens if you get your medicine from a provider of your choice instead of the Scheme's designated service providers (DSPs)

All medical schemes must make sure their members do not experience co-payments when they use designated service providers. You must use doctors, specialists and other healthcare providers who we have a DSP payment arrangement with, so that you do not experience a co-payment.

If you do not use healthcare providers who we have a DSP payment arrangement with, you will have to pay part of the treatment costs yourself. This amount you have to pay is called a co-payment.

Go to www.tfgmedicalaidscheme.co.za for the latest copy of the treatment guidelines or contact us on 0860 123 077 and we will send you a copy.

Get preauthorisation for hospitalisation and other procedures

What preauthorisation is and what it means

Preauthorisation is the approval of certain procedures and any planned admission to a hospital before the procedure or admission takes place. It includes associated treatment or procedures performed during hospitalisation.

You also need specific preauthorisation for MRI and CT scans, radio-isotope studies, and for certain endoscopic procedures, whether during hospitalisation or not.

Whenever your doctor plans a hospital admission for you, you must let us know 48 hours before you go to hospital.

Benefits that require preauthorisation

You need to get preauthorisation from us for:

- Hospitalisation
- Day-clinic admissions
- Special procedures (like a scopes, MRI and CT scans).

Who you must contact for preauthorisation

Call us on 0860 123 077 to get preauthorisation. We will give you an authorisation number. Please give the authorisation number to the relevant healthcare provider and ask them to include it when they submit their claim.

Please make sure you understand what is included in the authorisation and how we will pay the claims.

We will ask for the following information when you request preauthorisation

- Your membership number
- Details of the patient (name and surname, ID number, and more)
- Reason for the procedure or hospitalisation
- Diagnostic codes (ICD-10 codes), tariff codes and procedure codes (you must get these from your treating doctor).

Please note:
- If you don't preauthorise your admission, a R2 000 non-notification penalty will be charged.
- Certain plans give full cover only if you use a network hospital. Please find out if the hospital you plan to use, is part of the network applicable to your health plan.

Preauthorisation does not guarantee payment of all claims

Your hospital cover is made up of:

- Cover for the account from the hospital (the ward and theatre fees) at the Scheme Rate, and
- Cover for the accounts from your treating healthcare professionals (such as the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology), which are separate from the hospital account and are called related accounts.

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

There are some expenses you may incur while you are in hospital that we don't cover. Also, certain procedures, medicines or new technologies need separate approval. Please discuss this with your doctor or the hospital.

Find out more about our clinical rules and policies for cover by contacting us on 0860 123 077 or log in to our website to view "what we cover".

What happens once you are admitted to hospital

Your cover is subject to the Scheme rules, funding guidelines and clinical rules. There are some expenses you may have in hospital as part of a planned admission that your Hospital Benefit does not cover.

Certain procedures, medicines and new technologies need separate approval. It is important that you discuss this with your doctor or the hospital.

Complaints process

You may lodge a complaint or query with TFG Medical Aid Scheme directly on 0860 123 077 address a complaint in writing to the Principal Officer at the Scheme's registered address. Should your complaint remain unresolved, you may lodge a formal dispute by following the TFG Medical Aid Scheme internal disputes process.

You may, as a last resort, approach the Council for Medical Schemes for assistance.
Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157 / 0861 123 267 / complaints@medicalschemes.com / www.medicalschemes.com