MEDICAL AID SCHEME

TFG Medical Aid Scheme

BENEFIT BROCHURE

2021

Contact Details

TFG Medical Aid Scheme (TFGMAS)

The contact information for the Administrator's office of the Scheme is listed below:

Ambulance and other Emergency services
Call **0860 999 911**

General queries
Email us at **service@discovery.co.za**
Contact 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 app as explained in this brochure on page 44.

Other services

Oncology service centre	**0860 123 077**
HIV Care Programme	**0860 123 077**
Internet queries	**0860 100 696**

If you would like to let us know about suspected fraud, please call our toll-free fraud hotline on **0800 004 500** (callers will remain anonymous). SMS **43477** and include the description of the alleged fraud.

To pre-authorise admission to Hospital

Phone us at **0860 123 077**

Contact information for the TFG Employer office is set out below:

New membership registration

Email	**fuse@tfg.co.za**
Call	**021 937 4742**
WhatsApp	**079 192 5376**

All other queries

Email	**tfgmedicalaidscheme@tfg.co.za**

Refunds and Claims

Email	**claims@discovery.co.za**
Fax	**0860 329 252**
Post	**PO Box 652509, Benmore 2010**

PLEASE NOTE:

Benefits and Contribution amounts are subject to Council for Medical Schemes Approval. The registered Rules are binding and take precedence over the benefit brochure and information contained in the document.

In this benefit brochure words that are typeset starting with a capital letter, are either defined in this benefit brochure under the content contained in the Glossary section on page 1 or are defined in the Main Rules of the Scheme as available on the Scheme's website at www.tfgmedicalaidscheme.co.za. To obtain clarification of these terms and definitions used in the benefit brochure Members are directed to the Glossary section in the benefit brochure or the definitions contained in the Main Rules of the Scheme.

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 Benefit Plan and how to utilise your cover optimally.

Thank you for giving us the opportunity to look after your healthcare cover needs. You can have peace of mind that TFG Medical Aid Scheme (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 brochure to provide you with a summary of information on how to get the most out of your medical scheme. You will 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.

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 **www.tfgmedicalaidscheme.co.za or email compliance@discovery.co.za**. The Rules and benefits explained in this brochure apply to the main Member and registered Dependants. Should you require more information related to this brochure, please email service@discovery.co.za or contact us on **0860 123 077** and we will answer your questions.

CONTENTS

Please visit the website at www.tfgmedicalaidscheme.co.za (Find a document) for the **KeyCare GP Network list**, the Full Cover and Partial Cover Hospital Network and day surgery Network facilities. These Networks and the day surgery procedure list are subject to change and the latest list of facilities and procedures are available on the Scheme's website at **www.tfgmedicalaidscheme.co.za.**

GLOSSARY

Throughout this brochure you will find references to the terms below and terminology and this Glossary of Terms aims to provide an explanation of what these terms used in the brochure means.

Benefit Plan

The benefits as set out in the Rules of the Scheme and summarised in this benefit brochure are on pages 8 to 25.

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 that TFGMAS has reached an agreement with about payment and rates for the purpose of Prescribed Minimum Benefits (PMB).

If you are registered on TFG Health Plus and you use the services of a Designated Service Provider, we pay the provider directly at the Scheme Rate. We pay participating specialists at the Premier, Classic Direct or Scheme Rate for claims. We also pay participating general practitioners at the contracted GP rate for all consultations. You will not have to pay extra from your own pocket for providers who participate in the Premier and Scheme Network arrangements, but may have a Deductible for out-of-hospital visits to specialists on the Classic Direct Payment Arrangement if you are a Member on TFG Health Plus.

KeyCare Health Direct Payment Arrangement (DPA) Specialist

A specialist medical practitioner who has entered into an agreement in respect of services rendered to Members/ beneficiaries on 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 chosen Benefit Plan's benefits as set out in this brochure.

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 and PMB Hospital Network

The Network of Hospitals the Scheme contracted with to provide Hospital benefits to Members registered on TFGMAS. A Network of Hospitals exist on both the TFG Health and TFG Health Plus Benefit Plans which were contracted or nominated by the Scheme established for the provision of services that relates to Prescribed Minimum Benefit (PMB) conditions.

In-Hospital GP Network

A defined list of GP and specialists authorised by the Scheme to provide in-hospital services to Members as part of the Scheme's Premier Practice, KeyCare Network GP and Classic and DPA Specialist Networks.

KeyCare Network GP

A General Practitioner who has contracted with Discovery Health (Pty) Limited and/or TFG Medical Aid Scheme to be part of a GP Network on the TFG Health Benefit Plan.

Medical emergencies

This is a condition that develops quickly, or occurs from An Accident, and for which 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 Prescribed Minimum Benefits (PMB) if the Treatment received aligns with the definition of PMB. Please note that not all Treatment received at casualty units are PMB.**

Mental Health Network

A defined list of psychologists and/or social workers contracted or nominated by the Scheme for purposes of providing Treatment to Members relating to mental health conditions.

Pre-authorisation

You need to inform TFGMAS if you plan/are scheduled to be admitted to Hospital. Please phone us on **0860 123 077** for Pre-authorisation, so we can confirm your membership and available benefits. Without Pre-authorisation, you may have a Deductible for which you will be personally liable. **Pre-authorisation 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 pre-authorise the Treatment.

There are some procedures or Treatments your doctor can do in their consulting rooms. For these procedures you need to get Pre-authorisation. Examples of these are endoscopies and scans.

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. These are based on scientific evidence and research.

Premier Plus GP

A General Practitioner who has contracted with Discovery Health (Pty) Limited and/or TFG Medical Aid Scheme to be part of the Premier Plus Network Service Providers.

Prescribed Minimum Benefits (PMB)

Prescribed Minimum Benefits (PMB) 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. Please turn to page 32 for more information regarding your cover for PMB.

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 TFG Health, we will pay claims at the Scheme Rate or negotiated rates.

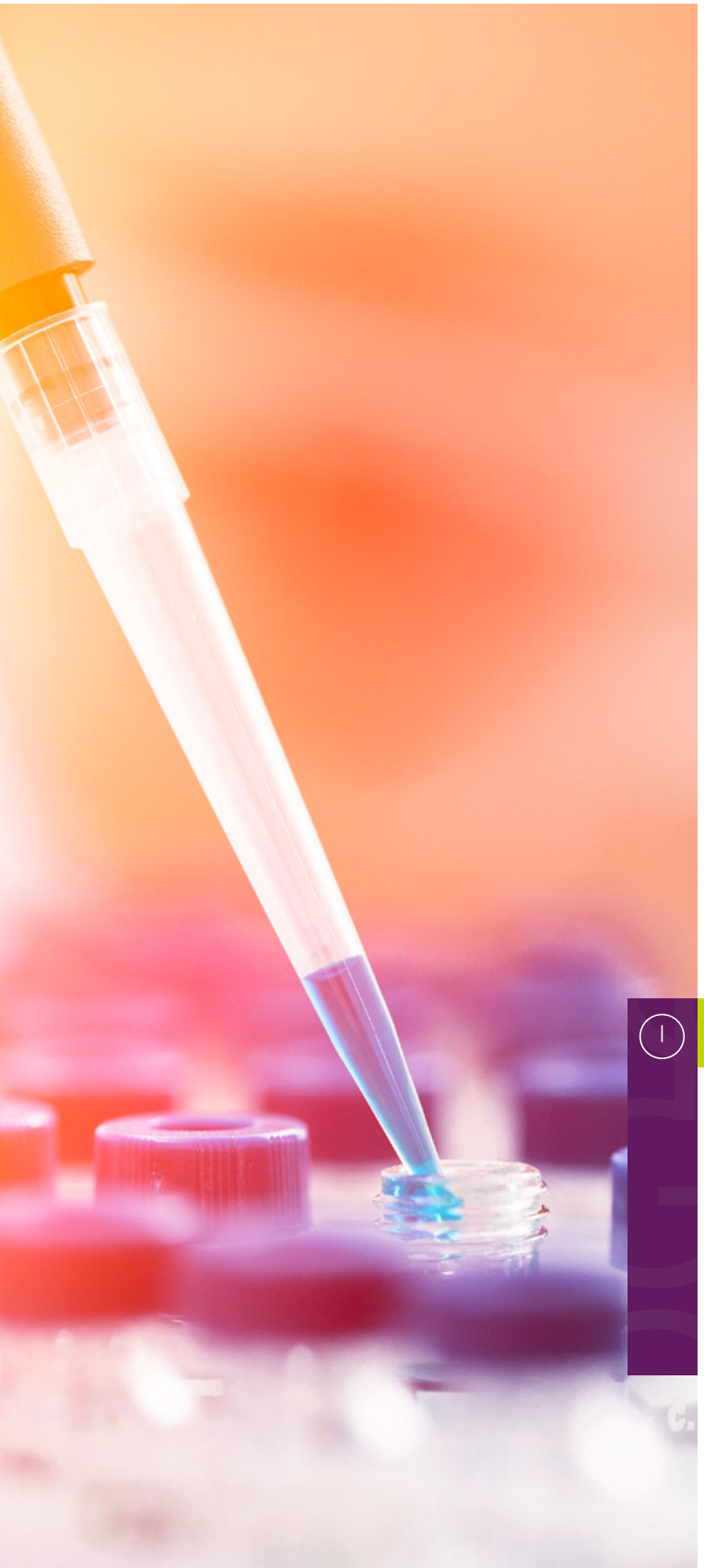
Please consult the 'Rate' column, in the benefit tables provided in this benefit brochure, for the appropriate benefit to know when claims are paid at 100% of Scheme Rate and when at 80% of Scheme Rate.

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.

TFG Medical Aid Scheme
SUMMARY OF BENEFITS

TFG Medical Aid Scheme (TFGMAS) offers two Benefit Plans to its Members that are both affordable, yet different, and this provides Members with an option of low or high cover. Below please find an easy key benefits comparison to use to compare the benefits provided on TFG Health versus the benefits provided on TFG Health Plus for 2021.



TFG Health

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

ICON for Oncology services, the Dental Risk Company for dental benefits, IsoLeso for Optometry and a Hospital Network known as the KeyCare Network Hospital. Please consult this brochure carefully to determine the Benefit Plan that will meet your healthcare cover needs best.

Services obtained outside the Networks are not covered.

TFG Health Plus

TFG Health Plus is the Scheme's premium plan and offers a more comprehensive range of benefits. In addition to all the benefits available on TFG Health, TFG Health Plus covers a more comprehensive range of conditions including additional in-hospital procedures, an additional list of chronic conditions and an additional list of medication.

What sets TFG Health Plus apart is the freedom of choice of Service Providers that it offers Members on this Plan. Whilst Members are able to make use of the PMB Networks to ensure full coverage of PMB conditions, they have the freedom of choice of Service Providers, who are re-imbursed as described in the summary below.

Please contact the Scheme at **0860 123 077** for more information regarding the Networks that you will need to make use of should you choose TFG Health as your preferred Benefit Plan. Notify us by 18 December 2020 if you intend to change your Benefit Plan for 2021, by completing the Benefit Plan change form which can be found under 'Find a document' on the Scheme's website.

The table below provides a high level summary of the differences between the TFG Health vs the TFG Health Plus Benefit Plans.

	Benefit	TFG Health	TFG Health Plus
	Overall annual limit	Unlimited.	Unlimited.
	**Hospital Cover** Cover of Hospital Costs and other accounts, such as accounts from your admitting doctor, anaesthetist or any approved health care expenses, while you are in Hospital.	Specialists in the Scheme Network are covered in full and other healthcare professionals at 100% of Scheme Rate within the Network Hospitals. **Services to be obtained at the Hospitals in the Network to receive full cover.**	Specialists and healthcare professionals are covered up to 100% of Scheme Rate. GP is covered up to 100% of Scheme Rate if contracted providers are used and up to 80% of Scheme Rate if non-contracted providers are used for services in-hospital. **The Member can visit any private Hospital contracted up to 100% of Scheme Rate to avoid Deductibles.**
		Hospital cover for PMB conditions are detailed on pages 29 – 30 of this benefit brochure.	
	**Chronic Medicine**	Essential cover for Chronic Medicine on the TFG Health Medicine list (Formulary) for all Prescribed Minimum Benefits (PMB) Chronic Disease List (CDL) conditions. **Your chosen GP must dispense your Medicine or you can get your approved Medicine from the Network of pharmacies.**	In addition to the essential cover for Chronic Medicine for all Prescribed Minimum Benefits (PMB) Chronic Disease List (CDL) conditions, there is an additional list of chronic conditions covered on this Benefit Plan. **You can choose to obtain your Medicine from your Preferred provider up to benefit limits that applies**. See page 36 for more information in respect of the additional chronic conditions that are covered on this Benefit Plan, as well as the benefit limits within which you can obtain your Chronic Medicine.
	**Primary care benefits/ Day-to-day medical care**	Unlimited cover for medically appropriate GP consultations at your chosen GP, blood tests, X-rays or Medicine from the TFG Health Medicine list. **Services to be obtained from a Network of Service Providers.** Specialists are covered up to a maximum of the KeyCare Direct Payment Arrangement rate.	Your choice of Service Provider for GPs, specialists, registered private nurse practitioners, and a range of diagnostic tests, which includes blood tests and X-rays, which is covered under this Benefit Plan. Members on this Benefit Plan have access to a wider range of diagnostic tests and X-rays, as well as a wider range of Medicines outside of the basic Medicine Formulary to choose from. Specialists are covered up to 100% of Scheme Rate at Network and non-contracted providers.
	**Oncology** Cover to Members diagnosed with cancer from date of diagnosis and registration on the Oncology programme.	Unlimited at a **Network Service Provider for PMB level of care only** at negotiated rates. Please confirm with your health care provider if they are accredited by this Benefit Plan's contracted Service Provider, ICON.	**Cover for PMB and non-PMB level of care at a Preferred provider of your choice**. Claims are paid at 100% of Scheme Rate limited to **R625 000** per person. Once this limit is reached, non-PMB level of care will attract a 20% Deductible.
	**Optical** A biennial benefit available every second benefit year depending on date of first claim received.	One pair of single vision, bifocal or multifocal lenses with basic frame or a basic set contact lenses per person. Services to be obtained from a **Scheme Network optometrist (IsoLeso)** at 100% of Scheme Rate.	Services to be obtained from **a Preferred provider of your choice** at 100% of Scheme Rate for one comprehensive consultation, lens and frames per person, subject to limits as set out in the Benefit Schedule of this Benefit Plan.
	**Dental**	Dentistry up to 100% of the Scheme Rate at a **Scheme Network dentist (DRC)**, subject to a list of codes agreed.	Basic Dentistry and Specialised Dentistry covered up to 80% of Scheme Rate at a **provider of your choice** up to the available limits set out in the Benefit Schedule of this Benefit Plan.
	**Adult and Child Vaccinations**	No benefit.	Clinically appropriate, Child and adult vaccines are funded at 100% of the Scheme Medicine Rate for the Cost of vaccination and injection material administered by a registered nurse, general practitioner or specialists.

2021
CONTRIBUTION TABLES

Full Contributions with effect from 1 January 2021

These Contributions are the **total amounts** 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. Income verification may be conducted to determine whether you are registered on the correct Income band. Income is considered as: The higher of the main Member or registered Spouse or Partner's earnings, commission and rewards from employment; interest from investments; Income from leasing of assets or property; distributions received from a trust, pension and/or provident fund; receipt of any financial assistance received from any statutory social assistance programme.

Table 1

TFG Health	Principal Member	Adult**	Child*
R0 – R5 070	R1 206	R1 206	R426
R5 071 – R8 260	R1 361	R1 361	R430
R8 261 – R15 860	R1 457	R1 457	R462
R15 861 – R27 200	R1 585	R1 585	R509
R27 201 – R40 520	R1 849	R1 849	R579
R40 521+	R2 013	R2 013	R616

TFG Health Plus	Principal Member	Adult**	Child*
R0 – R5 070	R3 664	R2 268	R944
R5 071+	R4 207	R2 971	R1 050

All Contributions shown above are 100% of the total Contribution, without taking into account the 50% company subsidy that may apply to you.

* **Child Contributions are applicable if:**

- 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;

Subsidised Contributions with effect from 1 January 2021 (From 1 March 2021, only applicable to certain job grades)

All Contributions shown in the tables below, marked as Table 2, are the Members' own Contributions after the **TFG 50% subsidy. If you are not entitled to a subsidy, you will have to pay the full Contribution as shown in the first two tables marked as Table 1 above.**

Table 2

TFG Health	Principal Member	Adult**	Child*
R0 – R5 070	R603	R603	R213
R5 071 – R8 260	R680	R680	R215
R8 261 – R15 860	R728	R728	R231
R15 861 – R27 200	R792	R792	R254
R27 201 – R40 520	R924	R924	R289
R40 521+	R1 006	R1 006	R308

TFG Health Plus	Principal Member	Adult**	Child*
R0 – R5 070	R1 832	R1 134	R472
R5 071+	R2 103	R1 485	R525

TFG Health

BENEFITS AND NETWORK SERVICE PROVIDERS

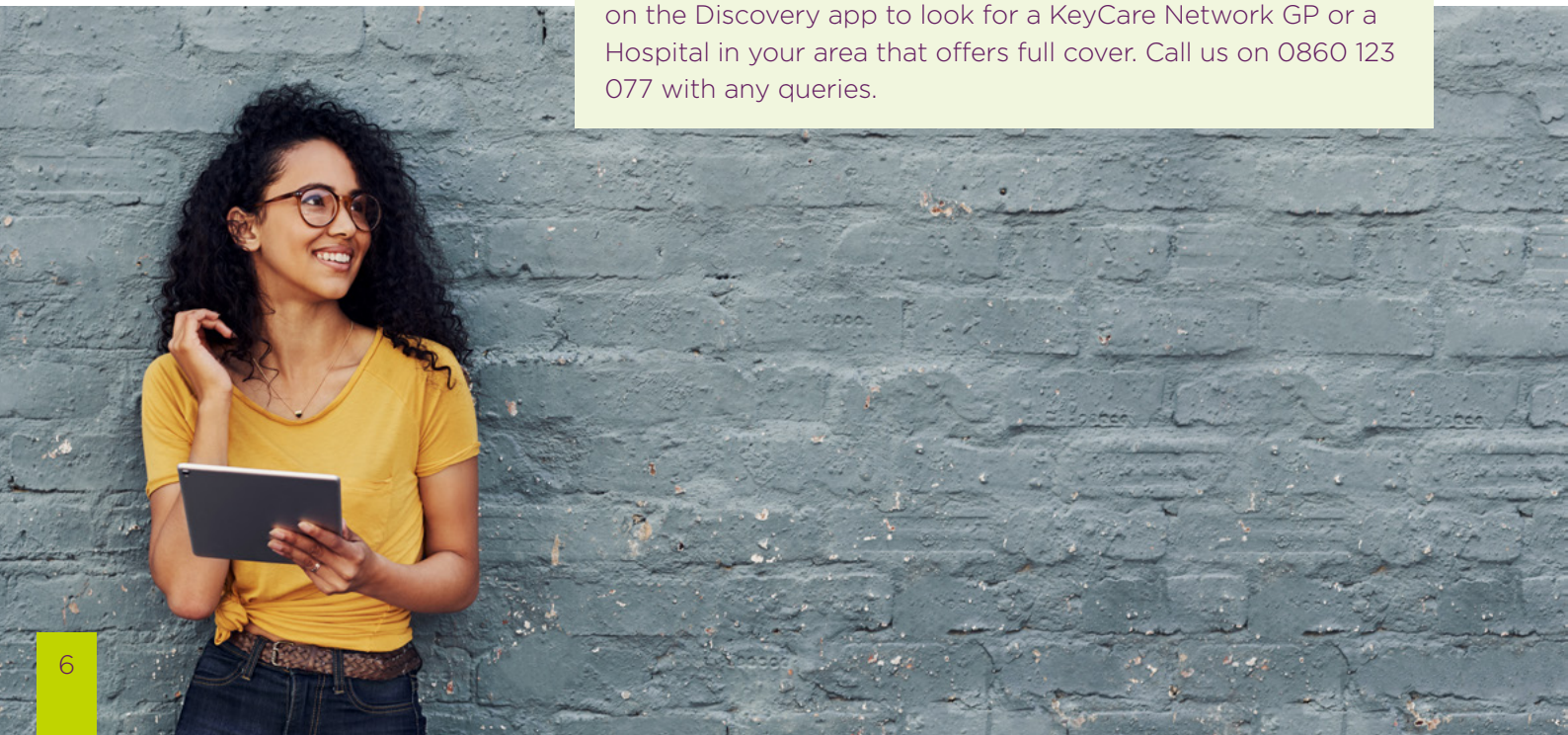
TFG Health is a Network Benefit Plan which offers a range of benefits in and out-of-hospital up to predetermined limits or unlimited at contracted Network Service Providers, such as, but not limited to:

ICON for Oncology services, the Dental Risk Company for dental benefits, IsoLeso for Optometry and a Hospital Network known as the KeyCare Network Hospital. Please consult this brochure carefully to familiarise yourself with this Benefit Plan's restricted Networks to understand how it could serve your healthcare needs the best.
It is important to note that on this Benefit Plan services obtained outside the Networks is not covered.

TFG Health Members are serviced by KeyCare Network of Service Providers only

- GP Network including cover for HIV and chronic conditions.
- Specialist Network including Oncology Network.
- Pharmacy Network for Chronic and Acute Medicine.
- Dental Network managed by Dental Risk Company.
- Optometry Network managed by IsoLeso.
- Radiology and Radiographer, Psychologists and Social Workers Networks.
- Mobility Network.
- Casualty contracted Network for guaranteed full cover.
- Renal Network.
- Full Cover at Hospital Network including a day surgery Network. A partial cover Network also exists on this Benefit Plan.
- A PMB Hospital Network and an In-Hospital GP Network to obtain services related to Prescribed Minimum Benefit (PMB) conditions.

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



TFG Health Plus

BENEFITS AND NETWORK SERVICE PROVIDERS

TFG Health Plus offers Members a choice of Service Providers. Cover is limited to an agreed Scheme Rate or a rate agreed with a Network of Service Providers established for purposes of receiving services related to PMB conditions.

TFG Health Plus has established the following Designated Service Providers (DSP) to limit Deductibles and out-of-pocket expenditure:

A list of contracted Hospitals and in-hospital GP/Specialists to provide services to Members for PMB conditions paid in full. Full cover at a day surgery Network.

A list of specialists that entered into Preferred provider Arrangements with the Scheme where Members receive cover at an agreed Scheme Rate.

A list of psychologists, social workers and midwifes with whom the Scheme entered into Preferred provider Arrangements. Services are paid for at an Agreed/Scheme Rate.

A list of pharmacies to obtain chronic and Acute Medicine from at preferred rates.

IMPORTANT INFORMATION

Scheme Rate = 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 with a Network Rate or Agreed Rate.

Maximum Annual Benefits referred to will be calculated from 1 January 2021 to 31 December 2021, 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 not an Annual Benefit, but a benefit that is available over a two-year period from the date that you receive optical benefits the first time. Oncology benefits are not Annual Benefits but granted from date of diagnosis, following registration on the Oncology Programme. Benefits are made available over a 12 month rolling period from date of diagnosis.

You may only change from one Benefit Plan to another at the end of each year, with effect from 1 January the following year. **In terms of the Rules of the Scheme, you may not change your Benefit Plan during the year**.

The summary of benefits does not overrule the Rules of the Scheme. To refer to the Rules or for more information visit the HR portal or our website at **www.tfgmedicalaidscheme.co.za**.

TFG Health and TFG Health Plus
BENEFIT TABLES FOR 2021

Health Care Cover = Unlimited	TFG HEALTH		TFG HEALTH PLUS	
Benefit	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Limits**	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Plus Limits**
(H) Hospital cover				
Statutory Prescribed Minimum Benefits	Basis of cover is per legislative requirements in terms of Prescribed Minimum Benefits (PMB). All Treatment for PMB conditions accumulate to available limits. Once benefit limits are reached funding in respect of PMB will continue to fund in accordance with the basis of cover as set out in this Benefit Schedule and the legislative requirements of PMB.	Unlimited	Basis of cover is per legislative requirements in terms of Prescribed Minimum Benefits (PMB). All Treatment for PMB conditions accumulate to available limits. Once benefit limits are reached funding in respect of PMB will continue to fund in accordance with the basis of cover as set out in this Benefit Schedule and the legislative requirements of PMB.	Unlimited
Hospitalisation	**Full Cover KeyCare Network Hospital:** Up to a maximum of 100% of the Scheme Rate of the Network Hospital account. Subject to Pre-authorisation and/or Approval meeting the Scheme's clinical and Managed Health Care criteria.	Unlimited	Up to a maximum of 100% of Scheme Rate at a private Hospital facility. Up to a maximum of 100% of Cost at a provincial Hospital facility. For PMB conditions: Up to a maximum of 100% of Scheme Rate at a non-network facility, if voluntary admission for a PMB condition or 100% of Agreed Rate at a KeyCare Hospital Network facility. If PMB condition and **involuntary** admission for a PMB condition at a non-network facility, the provisions of PMB legislation prevails. Subject to Pre-authorisation and/or Approval meeting the Scheme's clinical and Managed Health Care criteria. Benefit includes cover for ward and theatre fees, high care units, drugs and materials, X-rays, pathology, radiology, including cover for confinements, except pre- and post-natal care outside of Hospital. Blood transfusions paid up to 100% of the Cost i.e. Cost of blood, transport, apparatus and operator's fees. Circumcisions paid up to 100% of the Scheme Rate, if Pre-authorisation obtained and clinically and medically appropriate. Note: Circumcisions are paid from the out-of-hospital consultations and visits limits where not deemed clinically and medically appropriate.	Unlimited
	Partial Cover KeyCare Network Hospital: Up to a maximum of 70% of the Scheme Rate of the Network Hospital account. Subject to Pre-authorisation and/or Approval and meeting the Scheme's clinical and Managed Health Care criteria.	Unlimited		

Hospital cover (continued)	TFG HEALTH		TFG HEALTH PLUS	
Benefit	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Limits**	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Plus Limits**
Hospitalisation in Non-Network or non-contracted Hospital **Emergency Admissions**	Up to a maximum of 100% of the Scheme Rate. Subject to Pre-authorisation Patient to be transferred to a KeyCare Network Hospital as soon as stabilised, unless otherwise agreed by the Scheme. Subject to PMB	Unlimited	Up to a maximum of 100% of the Cost for involuntary admission if PMB condition Up to a maximum of 100% of the Scheme Rate for involuntary admission if non-PMB condition Subject to Pre-authorisation. In case of a PMB Condition, patient to be transferred to a KeyCare Network Hospital as soon as stabilised, unless otherwise agreed by the Scheme. Voluntary continued admission at a non-network facility may attract Deductibles	Unlimited
Health care services reflected on page 30 in a defined list of day clinic Network facilities	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 Pre-authorisation and/or Approval and the Treatment meeting the Scheme's clinical criteria	Unlimited	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 Pre-authorisation and/or Approval and the Treatment meeting the Scheme's clinical criteria	Unlimited A R1 500 Deductible shall be payable by the Beneficiary in respect of the Hospital account for Elective admissions at a facility which is not a Network facility
Hospitalisation in Non-Network Hospital. **Non-emergency admissions**	No cover	No cover	Refer to Hospitalisation Benefit. Provisions of PMB applicable.	Refer to Hospitalisation Benefit. Provisions of PMB applicable.
Administration of defined intravenous infusions	Up to a maximum of 100% of the Scheme Rate at the Scheme's KeyCare Direct Payment Arrangement practitioner 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 KeyCare Direct Payment Arrangement practitioner Medicines paid at 100% of the Scheme Medication Rate Subject to Pre-authorisation and/or Approval and the Treatment meeting the Scheme's clinical criteria	Unlimited	Up to a maximum of 100% of the Scheme Rate at the Scheme's Designated Service Provider (DSP) 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 DSP Medicines paid at 100% of the Scheme Medication Rate Subject to Pre-authorisation and/or Approval and the Treatment meeting the Scheme's clinical criteria	Unlimited

	TFG HEALTH		TFG HEALTH PLUS	
Benefit	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Limits**	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Plus Limits**
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 and clinical entry criteria Up to a maximum of 100% of the Scheme Rate and subject to Pre-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	**See Hospitalisation Benefits**	**See Hospitalisation Benefits**
Home-based healthcare for clinically appropriate chronic and acute Treatment and conditions that can be treated at home	In addition to PMB cover, up to a maximum of 100% of the Scheme Rate Subject to the Scheme's Preferred provider (where applicable) and the Treatment meeting the Scheme's Treatment guidelines and clinical and benefit criteria	Basket of Care as set by the Scheme	In addition to PMB cover, up to a maximum of 100% of the contracted rate or Scheme Rate Subject to the Scheme's Preferred provider (where applicable) and the Treatment meeting the Scheme's Treatment guidelines and clinical and benefit criteria	Basket of Care as set by the Scheme
Nursing services, Step down and Hospice	The provisions of PMB is applicable in addition to cover as set out under the 'Advanced Illness Benefit (AIB)'	The provisions of PMB is applicable in addition to cover as set out under the 'Advanced Illness Benefit (AIB)'	**Nursing services:** Up to a maximum of 100% of the Scheme Rate for nursing services rendered at the patient's residence by a registered nurse or a person from a registered nursing institution, in lieu of Hospitalisation. Subject to Pre-authorisation **Step Down facilities:** Up to a maximum of 50% of the Cost of permanently accommodating chronically ill patients in a registered nursing home or Hospital No benefit allowed for accommodation in an old-age home Note: Members may claim either for nursing services or Frail care facilities, but not both, where such services are provided simultaneously **Hospice:** Terminal care and subsequent admission to a hospice forms part of the Treatment and care for certain PMB conditions and will be funded in line with Regulation 8 of the Act and the PMB code of conduct as published by Council Note: Where Members Compassionate Care and Advanced Illness Benefits (AIB) are depleted, subject to PMB, once these benefit limits are reached, the provisions of PMB is applied	Limited to R381 per day and 90 days with an overall annual limit of R34 290 per person per year Limited to R381 per day and 180 days with an overall annual limit of R68 580 per person per year Unlimited

	TFG HEALTH		TFG HEALTH PLUS	
Benefit	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Limits**	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Plus Limits**
General Practitioners, Specialists and Other Service Providers delivering Treatment in Hospital	**KeyCare Health 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 KeyCare Network GP** **Other providers:** Up to a maximum of 100% of the Scheme Rate **Radiology and Pathology:** Up to a maximum of 100% of the Scheme Rate Pathology is subject to a Preferred provider agreement. 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 Health Care criteria	Unlimited	**Premier Rate providers:** Up to a maximum of 100% of the Premier Rate **Classic Direct providers:** Up to a maximum of 100% of the Classic Direct Rate **General Practitioners:** Up to a 100% of the contracted rates or Scheme Rate for admitting GP on the Scheme's DSP list Up to a maximum of 100% of Cost for non-DSP if the admitting specialist or GP is contracted with the Scheme and the Member is admitted in a KeyCare Network Hospital The conditions of PMB cover is applicable in cases of **involuntary** use of a non-DSP and non-network Hospital and in cases of Treatment for PMB conditions **Note:** If the patient is admitted for a PMB Condition the account and Treatments received in Hospital will be paid in full for services received in a KeyCare Network Hospital, if the admitting specialist or GP is a DSP	Unlimited
Chronic dialysis	Up to a maximum of 100% of the Scheme Rate at the Scheme's KeyCare Direct Payment Arrangement practitioner only Subject to Pre-authorisation and/or Approval and the Treatment meeting the Scheme's Treatment guidelines and clinical criteria Drugs paid at 100% of the Scheme Medication Rate	Unlimited	Up to a maximum of 100% of the Scheme Rate or negotiated rates at the Scheme's DSP or at a KeyCare Network Hospital Subject to Pre-authorisation and/or Approval and the Treatment meeting the Scheme's Treatment guidelines and clinical criteria Drugs paid at 100% of the Scheme Medication Rate	Unlimited

	TFG HEALTH		TFG HEALTH PLUS	
Benefit	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Limits**	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Plus Limits**
Organ Transplants	Cover is subject to PMB Regulations and Members should contact the Scheme at 0860 123 077 to obtain Pre-authorisation and Approval.	Unlimited	Cover is subject to PMB Regulations and Members should contact the Scheme at 0860 123 077 to obtain Pre-authorisation and Approval. Up to a maximum of 100% of the Scheme Rate in private Hospital facilities and/or negotiated rates at a KeyCare Hospital Network facility or at Cost in a public Hospital facility The following provisions apply: • Organ and patient preparation will be paid at 100% of the Scheme Rate • Benefits in respect of the organ donor Costs will be funded up to 100% of Scheme Rate in private Hospital facilities or 100% of the negotiated rate at a KeyCare Hospital Network facility and at Cost in public Hospital facilities, provided that the donor is in the Republic of South Africa and benefits are further subject to the recipient being a Beneficiary of the Scheme • Benefits in respect of immuno-suppressant and other medication will be at Cost whilst the Member is in Hospital. Subsequent supplies of immune-suppressant medication will be covered from the Member's Chronic Illness Benefit (CIB)	Unlimited
Chemotherapy, Radiotherapy and Oncological Treatment	The provisions of PMB is applicable. Up to a maximum of 100% of the Scheme Rate at the Scheme's KeyCare Direct Payment Arrangement practitioner Up to a maximum of 80% of the Scheme Rate at non-KeyCare Direct Payment Arrangement practitioners Subject to Pre-authorisation and/or Approval and the Treatment meeting the Scheme's clinical entry criteria	Unlimited, save as provided for elsewhere in these Benefit Tables	The provisions of PMB is applicable Up to a maximum of 100% of the Scheme Rate at the Scheme's Designated Service Providers (DSP) until benefit limit is reached Once the annual limit is reached all non-PMB conditions and Treatment to fund up to a maximum of 80% of the Scheme Rate Up to a maximum of 80% of the Scheme Rate at a non-DSP for non-PMB conditions Where radiotherapy and chemotherapy is unrelated to the admission and does not form part of the Hospitalisation, it will be covered up to 100% of the Scheme Rate or 100% of Cost, where no Scheme Rate exists Subject to Pre-authorisation and/or Approval and the Treatment meeting the Scheme's clinical entry criteria	Limited to R625 000 per person per rolling 12 months' period

Hospital cover (continued)

	TFG HEALTH		TFG HEALTH PLUS	
Benefit	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Limits**	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Plus Limits**
Severe dental/maxillo-facial and oral, dental procedures as covered	Up to a maximum of 100% of the Scheme Rate Subject to the Treatment meeting the Scheme's Treatment guidelines and Managed Health Care criteria	Cover is unlimited for services obtained in Hospital	**Dentist and related accounts:** Up to a maximum of 100% of the Scheme Rate **Premier Rate providers:** Up to a maximum of the applicable Premier Rate **Classic Direct Anaesthetists:** Up to a maximum of the Classic Direct Rate **Other Anaesthetists:** Up to a maximum of 100% of the Scheme Rate All dental appliances and prostheses and the placement of such appliances/prostheses as well as orthodontics (surgical and non-surgical) are paid from the general internal prosthesis limits up to a maximum of 100% of the Scheme Rate Subject to the Treatment meeting the Scheme's Treatment guidelines and Managed Health Care criteria	Primary maxillo-facial surgery: Unlimited Limited to R20 000 per family per year for Elective maxillo-facial and oral surgery
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 KeyCare Network Hospital Up to a maximum of 80% of the Scheme Rate for the Hospital and related accounts if a Non-Network Hospital 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	Up to a maximum of 100% of the Scheme Rate for related accounts Up to a maximum of 100% of the negotiated rate for Hospital account in a KeyCare Network Hospital or 100% of Scheme Rate in a Non-Network Hospital or a Hospital that is part of the Scheme's DSP list The provisions of PMB and cover for PMB conditions is applicable	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 major depression in hospital for Members registered on the Scheme's disease management programme	In addition to PMB cover, up to 100% of the Scheme Rate for services covered in the Scheme's Baskets of Care if referred by the Scheme's DSP Subject to the Treatment meeting the Scheme's Treatment guidelines and Managed Health Care criteria	Baskets of Care as set by the Scheme	In addition to PMB cover, up to 100% of the Scheme Rate for services covered in the Scheme's Baskets of Care if referred by the Scheme's DSP Subject to the Treatment meeting the Scheme's Treatment guidelines and Managed Health Care criteria	Baskets of Care as set by the Scheme
Drug and alcohol rehabilitation	Cover is provided as per PMB legislative requirements	21 days in-hospital Treatment per person per year	Cover is provided as per PMB legislative requirements	21 days in-hospital Treatment per person per year
HIV/AIDS and AIDS related Treatment	Cover is provided as per PMB legislative requirements	Unlimited	Cover is provided as per PMB legislative requirements	Unlimited
Post-exposure HIV prophylaxis following occupational exposure, traumatic exposure or sexual assault	Up to a maximum of 100% of Cost	Unlimited	Up to a maximum of 100% of Cost	Unlimited
Prophylaxis for mother-to-child transmission	Up to a maximum of 100% of Cost	Unlimited	Up to a maximum of 100% of Cost	Unlimited

	TFG HEALTH		TFG HEALTH PLUS	
Benefit	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Limits**	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Plus Limits**
Cardiac stents	Up to a maximum of 100% of the Scheme Rate Subject to Pre-authorisation and the Treatment meeting the Scheme's Treatment guidelines and clinical criteria The device accumulates to the limit. The balance of the Hospital and related accounts do not accumulate to the annual limit Provisions of PMB is applicable	Network supplier: Unlimited if stent is supplied by the Scheme's KeyCare Direct Payment Arrangement practitioner Non-network supplier: **Drug-eluting stent:** R7 350 per stent per admission if not supplied by the Scheme's KeyCare Direct Payment Arrangement practitioner; **Bare metal stent limit**: R6 200 per stent per admission if not supplied by the Scheme's KeyCare Direct Payment Arrangement practitioner	See 'Internal prostheses, including spinal care and surgery' for cover on this Benefit Plan	See 'Internal prostheses, including spinal care and surgery' for cover on this Benefit Plan
Internal prostheses, including spinal care and surgery	This Benefit Plan covers Cardiac Stents as set out in this Benefit Table on page 14	This Benefit Plan covers Cardiac Stents as set out in this Benefit Table on page 14	Up to a maximum of 100% of the Scheme Rate Subject to Pre-authorisation and Treatment meeting the Scheme's Treatment guidelines and clinical criteria The devices and prostheses accumulate to the limit, where applicable. The balance of the Hospital and related accounts do not accumulate to the annual limit and is paid from Health Care Cover at 100% of Scheme Rate The provisions of PMB is applicable for PMB conditions. Network requirements does not apply to any admissions related to Trauma	**Network suppliers:** Unlimited if prosthesis is supplied by the Scheme's Network Service Provider and at a Service Provider in the Network for in-hospital Treatment **Non-network supplier:** Annual limits are set out on page 25 of this benefit brochure if prosthesis is not supplied by the Scheme's Network Service Provider Baskets of Care as set by the Scheme for out-of-hospital conservative Treatment is applicable
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 as per the requirements of PMB legislation R49 650 per person per lifetime for all claims, payment of PMB claims accumulate to this threshold	Up to a maximum of 100% of the Scheme Rate	Unlimited for PMB scope and level of Treatment as per the requirements of PMB legislation R50 370 per person per lifetime for all claims, payment of PMB claims accumulate to this threshold
Advanced Illness Benefit (AIB) for oncology patients	Up to a maximum of 100% of the Scheme Rate Subject to Pre-authorisation and the Treatment meeting the Scheme's guidelines and Managed Health Care criteria	Unlimited	Up to a maximum of 100% of the Scheme Rate Subject to Pre-authorisation and the Treatment meeting the Scheme's guidelines and Managed Health Care criteria	Unlimited

	TFG HEALTH		TFG HEALTH PLUS	
Benefit	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Limits**	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Plus Limits**
MRI and CT Scans	Up to a maximum of 100% of the Scheme Rate Where MRI and CT scan is unrelated to the admission it will be covered from the specialist benefit of R4 530 per person per year Subject to the Treatment meeting the Scheme's Treatment guidelines and Managed Health Care criteria Scan must be performed by a specialist at a KeyCare Network Hospital	Unlimited	Up to a maximum of 100% of the negotiated rate or Scheme Rate if related to an authorised admission Subject to referral by a DSP Where MRI and CT scan is unrelated to the admission it will be covered from the radiology and pathology benefits Subject to the Treatment meeting the Scheme's Treatment guidelines and Managed Health Care criteria	Unlimited
Gastroscopies, colonoscopies, proctoscopies and sigmoidoscopies	Save for cover as per PMB legislation and Children aged 12 years and under, cover is provided in a defined list of day care Network facilities Up to 100% of the Scheme Rate from Health Care Cover if done in the doctor's rooms. Cover is subject to Pre-authorisation	Unlimited	Save for cover as per PMB legislation and Children aged 12 years and under, cover is provided in a defined list of day care Network facilities Elective admissions must be performed by a specialist that is a Designated Service Provider (DSP) to be covered in full Up to 100% of the Scheme Rate from Health Care Cover if done in the doctor's rooms. Cover is subject to Pre-authorisation	Unlimited
To-Take-Out (TTO) Medicine (Medicine to take home)	Up to a maximum of 100% of the Scheme Medication Rate	R180 per Hospital admission	Save for cover as per PMB legislation, up to a maximum of 100% of the Scheme Rate or Medication Rate	Unlimited
Emergency Medical Services within the borders of South Africa (Ambulance services)	Up to a maximum of 100% of the Scheme Rate Inter-hospital transfer subject to Pre-authorisation The provisions of PMB and cover for PMB conditions is applicable	Unlimited for PMB conditions and non-PMB conditions are paid up to a maximum of 100% of the Scheme Rate	Up to a maximum of 100% of the Scheme Rate Inter-hospital transfer subject to Pre-authorisation The provisions of PMB and cover for PMB conditions is applicable	Unlimited for PMB conditions. Cover is limited to R4 800 per family per year for non-PMB conditions.
International clinical review service	Up to a maximum of 50% of the Cost of the consultation Subject to the Scheme's Preferred provider, Protocols and clinical entry criteria	Unlimited	Up to a maximum of 50% of the Cost of the consultation Subject to the Scheme's Preferred provider, Protocols and clinical entry criteria	Unlimited
Screening Benefit A - Group of tests consisting of blood glucose test, blood pressure test, cholesterol test and Body Mass Index (BMI)	Save for cover as per PMB legislation, up to a maximum of 100% of the Scheme Medication Rate for group of tests **at a Network Service Provider** Subject to meeting the Scheme's clinical entry criteria	Unlimited	Save for cover as per PMB legislation, up to a maximum of 100% of the Scheme Medication Rate Subject to meeting the Scheme's clinical entry criteria	Unlimited

	TFG HEALTH		TFG HEALTH PLUS	
Benefit	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Limits**	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Plus Limits**
Screening Benefit B - Defined diabetes and cholesterol screening tests	Up to a maximum of 100% of the Scheme Rate for test code Subject to meeting the Scheme's clinical entry criteria Note: Consultation paid from available day-to-day benefits or by the Member where no benefits are available. Where the consultation relates to a PMB the consultation will be paid from Health Care Cover	Unlimited	Up to a maximum of 100% of the Scheme Rate for test code Subject to meeting the Scheme's clinical entry criteria Note: Consultation paid from available day-to-day benefits or by the Member where no benefits are available. Where the consultation relates to a PMB the consultation will be paid from Health Care Cover	Unlimited
Screening Benefit C - Consist of appropriate tests as determined by the Scheme: HIV screening, Mammogram, Prostate-Specific Antigen (PSA), colorectal and cervical cancer screening	Up to a maximum of 100% of the Scheme Rate for test code Subject to meeting the Scheme's clinical entry criteria Note: Consultation paid from available day-to-day benefits, or by the Member where no benefits are available. Where the consultation relates to a PMB the consultation will be paid from Health Care Cover	Appropriate HIV screening tests as determined by the Scheme – Unlimited One Mammogram every **2 years**, one Pap Smear every **3 years** or one HPV test **every 5 years** per female Beneficiary and one PSA test per male Beneficiary **per year** One faecal occult blood test or immunochemical test every 2 years per person for persons between the ages of 45 to 75 years	Up to a maximum of 100% of the Scheme Rate for test code Subject to meeting the Scheme's clinical entry criteria Note: Consultation paid from available day-to-day benefits, or by the Member where no benefits are available. Where the consultation relates to a PMB the consultation will be paid from Health Care Cover	Appropriate HIV screening tests as determined by the Scheme – Unlimited One Mammogram and one Pap Smear **every year** or one HPV test **every 5 years** per female Beneficiary One PSA test per male Beneficiary **every year** One colorectal screening per person every year One faecal occult blood test or immunochemical test every 2 years per person for persons between the ages of 45 to 75 years
Screening Benefit D - Additional cover for Mammogram, breast MRI, BRCA testing, colonoscopy and cervical cancer screening	Up to a maximum of 100% of the Scheme Rate for test code. Subject to meeting the Scheme's clinical entry criteria **Note**: Consultation paid from available day-to-day benefits, or by the Member where no benefits are available. Where the consultation relates to a PMB the consultation will be paid from Health Care Cover	Basket of Care as set by the Scheme Once off BRCA testing and colonoscopy	Up to a maximum of 100% of the Scheme Rate for test code Subject to meeting the Scheme's clinical entry criteria **Note**: Consultation paid from available day-to-day benefits, or by the Member where no benefits are available. Where the consultation relates to a PMB the consultation will be paid from Health Care Cover. **Additional cervical cancer screening is covered under Screening Benefit C on this Benefit Plan**	Basket of Care as set by the Scheme One BRCA test and colonoscopy per year
Screening Benefit E - Group of age appropriate tests including but not limited to growth assessment, blood pressure and health and milestone tracking	Up to a maximum of 100% of the Scheme Rate at a KeyCare Direct Payment Arrangement practitioner, for Children between the ages of 2 and 18 Subject to meeting the Scheme's clinical entry criteria	Unlimited	Up to a maximum of 100% of the Scheme Rate at a Designated Service Provider (DSP), for Children between the ages of 2 and 18 Subject to meeting the Scheme's clinical entry criteria	Unlimited
Screening Benefit F – Group of age appropriate screening tests	Up to a maximum of 100% of the Scheme Rate at a KeyCare Direct Payment Arrangement practitioner, for Members 65 years and older Subject to meeting the Scheme's clinical entry criteria	Unlimited	Up to a maximum of 100% of the Scheme Rate at a DSP, for Members 65 years and older Subject to meeting the Scheme's clinical entry criteria	Unlimited

Benefit	TFG HEALTH		TFG HEALTH PLUS	
	Rate and Basis of Cover: Subject to PMB	**TFG Health Limits**	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Plus Limits**
Screening Benefit G - Additional screening assessment or consultation	Up to a maximum of 100% of the Scheme Rate at an accredited KeyCare Network GP Subject to meeting the Scheme's clinical entry criteria and Treatment guidelines	One consultation per person per year	Up to a maximum of 100% of the Scheme Rate at a DSP Subject to meeting the Scheme's clinical entry criteria and Treatment guidelines	One consultation per person per year
Preventative Benefit - Pneumococcal vaccination	Up to a maximum of 100% of the Scheme Medication Rate for the vaccination **Note**: Pneumococcal vaccines in excess of the annual limit, consultation and other healthcare services to administer the vaccine, paid by the Member Subject to the Scheme's Protocols and clinical entry criteria	One vaccine per person every 5 years for persons under the age of 65 and one vaccine per person per lifetime for persons over the age of 65	Up to a maximum of 100% of the Scheme Medication Rate for the vaccination **Note**: Pneumococcal vaccines in excess of the annual limit, consultation and other healthcare services to administer the vaccine, paid by the Member Subject to the Scheme's Protocols and clinical entry criteria	One vaccine per person every 5 years for persons under the age of 65 and one vaccine per person per lifetime for persons over the age of 65
Preventative Benefit - Seasonal influenza vaccination	Up to a maximum of 100% of the Scheme Medication Rate for the vaccination Seasonal flu vaccines in excess of annual limit is payable by the Member Subject to Scheme Protocols and clinical entry criteria **Note**: Consultation and other healthcare services to administer the vaccine, paid from available day-to-day benefits or by the Member where no benefits are available	One seasonal influenza vaccine per person per year	Up to a maximum of 100% of the Scheme Medication Rate for the vaccination Seasonal flu vaccines in excess of annual limit is payable by the Member Subject to Scheme Protocols and clinical entry criteria **Note**: Consultation and other healthcare services to administer the vaccine, paid from available day-to-day benefits, or by the Member where no benefits are available	One seasonal influenza vaccine per person per year
Preventative Benefit – Child and adult vaccinations	No benefit	No benefit	Up to a maximum of 100% of the Scheme Medication Rate for the Cost of the vaccination and injection material administered by a registered nurse, general practitioner or specialist that is part of the Scheme's DSP Subject to Scheme Protocols and clinical entry criteria **Note**: Consultation and other healthcare services to administer the vaccine, paid from available day-to-day benefits, or by the Member where no benefits are available	**Adult vaccinations per Beneficiary include:** Tetanus/Diphtheria, Hepatitis A, Hepatitis B, Measles, Mumps, Rubella, Chickenpox, Shingles and Meningococcal **Child vaccinations per Beneficiary include:** Polio, TB, Hepatitis B, Rotavirus, Diphtheria, Tetanus, Acellular pertussis, Haemophilus, Influenza Type B, Chickenpox, Measles, Mumps and Rubella
Preventative Benefit – HPV vaccinations	No benefit	No benefit	Up to a maximum of 100% of the Scheme Medication Rate for the vaccination Subject to Scheme Protocols and clinical entry criteria **Note**: Consultation and other healthcare services to administer the vaccine, paid from available day-to-day benefits, or by the Member where no benefits are available	One per person per year (between the ages of 9 and 26 years)

	TFG HEALTH		TFG HEALTH PLUS	
Benefit	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Limits**	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Plus Limits**
Chronic Illness Benefit				
Medication for the chronic Prescribed Minimum Benefit conditions	Chronic Medication is covered as prescribed for PMB conditions only Subject to the Scheme Protocols, benefit entry criteria and Medicine utilisation review	The provisions of PMB is applicable	Chronic Medication is covered as prescribed for PMB conditions only Subject to the Scheme Protocols, benefit entry criteria and Medicine utilisation review	The provisions of PMB is applicable All PMB accumulates to the available benefits as set out under the Additional Disease List of chronic conditions benefit limit
Chronic Illness Benefit (CIB) Additional Disease List (ADL) of chronic conditions	No benefit	No benefit	A Chronic Drug Amount (CDA) per drug class as set by the Scheme is applied A list of these conditions and the payment of Chronic Medication is set out on page 36 of this benefit brochure	R29 000 per person subject to an overall annual limit (OAL) of R79 000 per Member Family per year
Specialised Medicine Benefit	No cover	No cover	Up to a maximum of 100% of the Scheme Medication Rate The Scheme will pay between 80% and 100% of the Scheme Medication Rate or up to a maximum of the Reference Price List (RPL) for preferentially priced Medicine Subject to the Scheme Protocols, benefit entry criteria and Medicine utilisation review	Limited to R260 000 per person per year
Diabetes Care, Cardio Care and Mental Health Care Programmes – we cover condition specific care programmes that help you manage your mental health, diabetes and heart-related medical conditions. You have to be registered on these condition-specific care programmes to unlock additional benefits and services. You can read more about these programmes on the website www.tfgmedicalaidscheme.co.za	Up to 100% of the Scheme Rate for services covered in the Scheme's Baskets of Care if referred by the Scheme's DSP	Baskets of Care as set by the Scheme	Mental Health Care Programme not applicable on this Benefit Plan Note: Up to 100% of the Scheme Rate for services covered in the Scheme's Baskets of Care if referred by the Scheme's DSP	Baskets of Care as set by the Scheme
HIV management for Members registered on the Scheme's disease management programme	Basis of cover is per PMB legislation Up to 100% of the Scheme Rate for services covered in the Scheme's Baskets of Care if referred by the Scheme's DSP	Baskets of Care as set by the Scheme	Basis of cover is per PMB legislation Up to 100% of the Scheme Rate for services covered in the Scheme's Baskets of Care if referred by the Scheme's DSP	Baskets of Care as set by the Scheme
Bluetooth enabled blood glucose monitoring device/ Telemetric glucometer 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	1 per Beneficiary per year	Any Beneficiary approved and registered on the Scheme's Chronic Illness Benefit for Diabetes is covered up to 100% of the Scheme Rate The device must be approved by the Scheme, subject to the Scheme Protocols and clinical entry criteria	1 per person per year limited to Health Care Cover and second device limited to medical appliances limit

	TFG HEALTH		TFG HEALTH PLUS	
Benefit	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Limits**	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Plus Limits**
Day-to-day cover				
Primary care which includes, physical and virtual or online consultations at general practitioners (GP) and specialists. **Radiologists and pathologist visits.**	**GP, including 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 care KeyCare Network 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 KeyCare Network GP three times per person per year **Specialists:** **KeyCare Health DPA Specialists:** Up to a maximum 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 **Radiology and pathology services referred as part of the specialist visit:** Up to 100% of the Scheme Rate, **subject to the overall annual specialist benefit limit of R4 530 per person per year** Member must be referred by KeyCare Network GP	In Network limits: Unlimited only at KeyCare Network GP, subject to Pre-authorisation after visit 15, per person per year Unscheduled Emergency visits limited to 3 visits per person per year at KeyCare Network GP R4 530 per person per year	**GP:** Up to a maximum of 100% of the Scheme Rate at a Designated Service Provider (DSP) or 80% of Scheme Rate where a non-DSP is used, subject to selected consultation and procedure codes **Specialists:** Up to a maximum of 100% of the Scheme Rate. Specialists in Family Medicine to be paid 130% of Scheme Rate **Associated Health Services including Osteopaths, Homeopaths and Naturopaths:** Up to a maximum of 80% of the Cost. The provisions of Annexure **C1** is applicable **Registered private nurse practitioners:** Up to a maximum of 80% of the Scheme Rate, provided the supplier of the services is registered with the South African Nursing Council (SANC) **Notes**: Facility fees at out-patient departments of provincial and private Hospitals are funded at Scheme Rate, but private facility fees are not covered Radiology and pathology services referred as part of the specialist visit are covered up to 100% of the Scheme Rate, **subject to the radiology and pathology Annual Benefit limit of R26 200 per family per year** The provisions of PMB and cover for PMB conditions is applicable	Limited to: R4 300 Per family per year (M) R6 500 Per family per year (M + 1) R8 400 Per family per year (M + 2) R9 700 Per family per year (M + 3) R10 600 Per family per year (M + 4) R11 100 Per family per year (M + 5) R11 600 Per family per year (M + 6) R11 800 Per family per year (M + 7) PMB Conditions: Additional consultations of up to 4 visits per person per year if registered for chronic conditions (CIB). **Maternity consultations:** Additional 8 GP or gynaecologist consultations per pregnant person per year Unscheduled Emergency visits limited to 2 visits per Child between the age of 0 to 10 Unlimited virtual paediatric consultations for Children aged 1 to 14 per year at a KeyCare Network GP
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	Not applicable This Benefit Plan does not require Network consultations and Primary care is covered under the Primary care Consultations Benefit	Not applicable This Benefit Plan does not require Network consultations and Primary care is covered under the Primary care Consultations Benefit

	TFG HEALTH		TFG HEALTH PLUS	
Benefit	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Limits**	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Plus Limits**
Visits to casualty units	The first R405 of the casualty unit's account is payable by the Beneficiary. Subject to Pre-authorisation 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 Hospital No cover at Non-Network Hospitals	Cover for emergencies only and if admitted to Hospital paid from Health Care Cover	Cover for emergencies only and if admitted to Hospital paid from Health Care Cover
Primary care: Basic dentistry	Up to a maximum of 100% of the Scheme Rate **Only at KeyCare Network dentist**, subject to a list of codes. In-Hospital excluded Subject to the Treatment meeting the Scheme's Treatment guidelines and Managed Health Care criteria	Unlimited	Up to a maximum of 80% of the Scheme Rate The provisions of PMB and cover for PMB conditions is applicable	Limited to: R4 500 Per family per year (M) R5 400 Per family per year (M + 1) R6 400 Per family per year (M + 2) R7 200 Per family per year (M + 3) R7 900 Per family per year (M + 4) R8 400 Per family per year (M + 5) R8 700 Per family per year (M + 6) R8 800 Per family per year (M + 7)
Specialised dentistry	No cover	No cover	Up to a maximum of 80% of the Scheme Rate The provisions of PMB and cover for PMB conditions is applicable	Limited to: R9 900 Per family per year (M) R13 200 Per family per year (M + 1) R15 900 Per family per year (M + 2) R17 400 Per family per year (M + 3) R18 500 Per family per year (M + 4) R19 000 Per family per year (M + 5) R19 500 Per family per year (M + 6) R19 800 Per family per year (M + 7)

Day-to-day cover (continued)

	TFG HEALTH		TFG HEALTH PLUS	
Benefit	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Limits**	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Plus Limits**
Other Healthcare Providers: Speech therapy, audiology and occupational therapy consultations	No cover	No cover	Up to a maximum of 100% of Scheme Rate for Treatments and consultations. The provisions of PMB and cover for PMB conditions is applicable. **Must be prescribed by a medical practitioner** and provided the supplier of service is registered with the Health Professions Council of South Africa (HPCSA).	Limited to R7 200 per family per year
Other Healthcare Providers: Psychiatry and clinical psychology consultations, visits and Treatments including psychotherapy	No cover, unless PMB condition. PMB conditions covered up to 100% of Agreed Rate at Mental Health Network Service Providers. The provisions of PMB and cover for PMB conditions is applicable.	The provisions of PMB and cover for PMB conditions is applicable.	Up to a maximum of 100% of Scheme Rate for non-PMB conditions. Up to a maximum of 100% of the Agreed Rate at Mental Health Network providers for PMB conditions. The provisions of PMB and cover for PMB conditions is applicable.	Limited to R8 600 per family per year.
Other Healthcare Providers: Chiropractor and Physiotherapy, including biokinetics and cardio rehabilitation	No benefit	No benefit	Up to a maximum of 100% of Scheme Rate. The provisions of PMB and cover for PMB conditions is applicable. **Must be prescribed by a medical practitioner** and provided the supplier of service is registered with the Health Professions Council of South Africa (HPCSA).	Limited to R6 400 per family per year
Other Healthcare Providers: Podiatry and Orthoptics	No benefit	No benefit	Up to a maximum of 100% of Scheme Rate. **This benefit covers services related to Orthoptics by Optometrists.** The provisions of PMB and cover for PMB conditions is applicable. **Must be prescribed by a medical practitioner** and provided the supplier of service is registered with the Health Professions Council of South Africa (HPCSA).	Limited to R5 200 per family per year

	TFG HEALTH		TFG HEALTH PLUS	
Benefit	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Limits**	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Plus Limits**
Prescribed Acute Medicine and over the counter (OTC) Medicine	Up to a maximum of 100% of the Scheme Medication Rate	Unlimited within the KeyCare Acute Medicine Formulary and Protocols and **only covered if prescribed by KeyCare Network GP** **This benefit doesn't include over-the-counter medication**	**Acute medication obtained from a DSP:** Up to a maximum of 100% of the Scheme Medication Rate **Acute medication obtained from a non-DSP:** Up to a maximum of 80% of the Scheme Medication Rate **OTC:** Up to a maximum of 80% of the Scheme Medication Rate Subject to the Scheme's Acute Medicine Formulary and Protocols and preferentially priced generic and brand medication prices The provisions of PMB and cover for PMB conditions is applicable	Acute Medicine limited to: R7 000 Per family per year (M) R10 300 Per family per year (M + 1) R12 200 Per family per year (M + 2) R13 800 Per family per year (M + 3) R15 000 Per family per year (M + 4) R15 700 Per family per year (M + 5) R16 300 Per family per year (M + 6) R16 500 Per family per year (M + 7) OTC limited to R210 and further limited to the above Acute Medicine annual limits
Radiology and pathology	**Selected basic X-rays only:** Up to a maximum of 100% of the Scheme Rate **Selected basic blood tests only:** Up to a maximum of 100% of the Scheme Rate Point-of-care pathology testing is subject to meeting the Scheme's Treatment guidelines and Managed Health Care criteria	Unlimited **at the Scheme's KeyCare Direct Payment Arrangement practitioners only** Only if requested by Member's chosen KeyCare Network GP, subject to list of procedure codes and PMB	Up to a maximum of 100% of the Scheme Rate The provisions of PMB and cover for PMB conditions is applicable	Limited to R26 200 per family per year
Optometry	Up to a maximum of 100% of the Scheme Rate **only at KeyCare Network optometrist** and subject to Scheme Protocol	One pair of single vision, bifocal or multifocal lenses with a basic frame or a basic set contact lenses per person **every twenty-four months from their last Date of Service**	Up to a maximum of 100% of the Scheme Rate or Cost if Members make use of a registered optometrist, ophthalmologist or supplementary optical practitioner The provisions of PMB and cover for PMB conditions is applicable Optical procedures are limited and funded from Health Care Cover	Limited **per person per 2-year cycle starting from last Date of Service obtained**: **Consultation** R800 1 visit **Frames** R1 100 1 frame **Lenses**: single vision R440 1 pair **OR** **Lenses**: Bifocal R1 040 1 pair **OR** **Lenses**: Multifocal R2 000 1 pair **OR** **Contact lenses** R3 450

	TFG HEALTH		TFG HEALTH PLUS	
Benefit	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Limits**	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Plus Limits**
Medical appliances (External Medical Items), mobility devices (wheelchairs, long leg callipers and crutches), including hearing aids and external prosthesis	**Mobility Devices such as wheelchairs, long leg callipers and crutches only:** 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 KeyCare Direct Payment Arrangement practitioner	R5 400 per family per year	Up to a maximum of 100% of the Cost or Agreed Rate for PMB conditions where a DSP or Formulary item is used or a non-DSP is used **involuntarily** Up to a maximum of 100% of Reference Price List for PMB conditions where a non-DSP or non-formulary items is used **voluntarily** Up to a maximum of 80% of Cost for non-PMB conditions/items where a non-DSP is used Approval to be obtained from the Scheme, subject to the Scheme Protocols and clinical entry criteria The provisions of PMB cover is applicable for PMB conditions	**Network suppliers:** Unlimited if EMI is supplied by the Scheme's Network Service Provider **Non-Network supplier:** Limited to R23 400 per family per year if not supplied by the Scheme's Network provider
Out-of-Hospital healthcare services related to pregnancy and delivery	Up to 100% of the Scheme Rate, or Agreed Rate only **for a gynaecologist who practices within the KeyCare Network within the selected KeyCare Network Hospitals** Subject to Scheme health Protocol Paid from Health Care Cover and is subject to applicable limits as set out in this Benefit Table Subject to Pre-authorisation and/or registration and the Treatment meeting the Scheme's clinical entry criteria 3D and 4D scan will be paid up the maximum of the Cost of a 2D scan Cover for infant consultations up to a maximum of 100% of the Scheme Rate, or Agreed Rate, for Children under the age of 2 years Services in excess of the limit are for the Member's account Limits apply for the duration of the pregnancy The provisions of PMB and cover for PMB conditions is applicable	**Services:** • Antenatal classes and/or postnatal visits: 5 consultations or classes per pregnancy and/or delivery **with a registered nurse** • Antenatal consultations: 8 per pregnancy **with a KeyCare Network GP, gynaecologist or midwife** • Prenatal screening, including chromosome testing or Non Invasive Prenatal Testing (NIPT): 1 per pregnancy • Pregnancy scans: 2 per pregnancy • Blood tests: 1 routine basket of pregnancy tests per pregnancy • Postnatal consultations: 1 per delivery **with the KeyCare Network GP, gynaecologist or midwife** • Dietician nutrition assessment: 1 per delivery • Mental health consultations: 2 per delivery **with a KeyCare Network GP, psychologist in the Mental Health Network or counsellor** • Consultations for infants: 2 per Child **with Paediatrician, ENT or KeyCare Network GP**	**Covered at a GP or gynaecologists:** Up to a maximum of 100% of the Scheme Rate Hospital related accounts are paid from Health Care Cover, subject to Pre-authorisation and the Treatment meeting the Scheme's Treatment guidelines and clinical entry criteria Cover for infant consultations up to a maximum of 100% of the Scheme Rate, for Children under the age of 2 years **Midwife Network:** Up to a maximum of 100% of the negotiated rate for services provided by a midwife in the Member's home instead of a Hospital **Note**: A standard fee is paid to the midwife and includes the midwife's professional fee, consumables, equipment and Cost of an assistant doula Prenatal screening tests to be made available in addition to the available ultrasound scans up to a maximum of 100% of the Scheme Rate. 3D and 4D scans will be paid up to the maximum of a 2D scan All other scans and tests funded as set out under the out-of-hospital pathology and radiology **Annual Benefit limit of R26 200 per family per year** The provisions of PMB and cover for PMB conditions is applicable	**Services:** • Antenatal classes and/or postnatal visits funded from the primary care consultation limit • Antenatal consultations: 8 per pregnancy funded from the primary care consultation limit • Prenatal screening, including chromosome testing or Non Invasive Prenatal Testing (NIPT or T21): 1 per pregnancy funded from the radiology and pathology limit • Pregnancy scans: See radiology and pathology limit • Blood tests: See radiology and pathology limit • Postnatal consultations: Included in primary care consultations • Dietician nutrition assessment: Included in primary care consultations • Mental health consultations: Included in the psychiatry and clinical psychology limit at a Service Provider in the Mental Health Network • Lactation consultations for infants: 1 per Child funded from the primary care consultation benefit limit

	TFG HEALTH		TFG HEALTH PLUS	
Benefit	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Limits**	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Plus Limits**
MRI and CT Scans	Up to a maximum of 100% of the Scheme Rate **at the Scheme's KeyCare Direct Payment Arrangement practitioners** Subject to the Treatment meeting the Scheme's Treatment guidelines and Managed Health Care criteria **Member must be referred by KeyCare Network GP**	Accumulates to the specialist benefit limit of R4 530 per person per year	Where MRI and CT scan is unrelated to a Hospital admission it will be covered from the radiology and pathology **Annual Benefit limit of R26 200 per family per year**	Where MRI and CT scan is unrelated to a Hospital admission it will be covered from the radiology and pathology **Annual Benefit limit of R26 200 per family per year**
Due to limited or no benefits available on the TFG Health Benefit Plan in respect of the following benefits, the TFG Health Benefit Plan makes available to Members in addition to the Medical Appliances Benefit and over and above the DTPMB entitlement, cover for 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 as set out in this Benefit Table Excludes Over the counter (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 contemplated in terms of PMB) 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 Designated Service Providers	**Services:** • **External medical items:** Limited to R27 250 per family per year, except for prosthetic limbs which shall be subject to a limit of R88 250 per person per year • **Hearing aids:** Limited to R15 200 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: R8 300 M+1 Dependant: R12 500 M+2 Dependants: R15 550 M+3 Dependants or more: R18 750 • **Prescribed Medicine limited to:** Member: R16 200 M+1 Dependant: R19 150 M+2 Dependants: R22 750 M + 3 Dependants: R27 650	Day-to- day cover on the TFG Health Plus Benefit Plan provides benefits to Members as per the requirements of PMB legislation and additional benefits are not provided over and above the day-to-day cover on this Benefit Plan for Medical Appliances as a result of Trauma or Emergency related incidents	Day-to- day cover on the TFG Health Plus Benefit Plan provides benefits to Members as per the requirements of PMB legislation and additional benefits are not provided over and above the day-to-day cover on this Benefit Plan for Medical Appliances as a result of Trauma or Emergency related incidents

Day-to-day cover (continued)	TFG HEALTH		TFG HEALTH PLUS	
Benefit	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Limits**	**Rate and Basis of Cover: Subject to PMB**	**TFG Health Plus Limits**
Benefit for out-of-hospital management and appropriate supportive Treatment of global World Health Organisation (WHO) recognised disease outbreaks: Out-of-Hospital healthcare services related to COVID-19: • Screening consultation • Defined basket of pathology • Defined basket of X-rays and scans • Consultations with a nurse or GP • Supportive Treatment • Contact tracing • Accommodation in accredited isolation facilities	In addition to PMB cover requirements, up to a maximum of 100% of the Scheme Rate Cover for testing is subject to referral Up to a maximum of R400 per day for accommodation in an accredited isolation facility and up to a 100% of the Scheme Rate for registered healthcare providers Subject to the Scheme's Preferred provider (where applicable), Protocols and the condition and Treatment meeting the Scheme's entry criteria and guidelines	Basket of care as set by the Scheme Out-of-Hospital healthcare services related to COVID19: • Screening consultation with a nurse or GP: unlimited • Defined basket of pathology: 2 tests per person per year and up to 4 tests per person per year for registered healthcare providers except where covered as PMB • Up to a maximum of 14 days' accommodation per person per year	In addition to PMB cover requirements, up to a maximum of 100% of the Scheme Rate Cover for testing is subject to referral Up to a maximum of R400 per day for accommodation in an accredited isolation facility and up to a 100% of the Scheme Rate for registered healthcare providers Subject to the Scheme's Preferred provider (where applicable), Protocols and the condition and Treatment meeting the Scheme's entry criteria and guidelines	Basket of care as set by the Scheme Out-of-Hospital healthcare services related to COVID19: • Screening consultation with a nurse or GP: unlimited • Defined basket of pathology: 2 tests per person per year and up to 4 tests per person per year for registered healthcare providers except where covered as PMB • Up to a maximum of 14 days' accommodation per person per year

INTERNAL PROSTHESIS LIMITS ON TFG HEALTH PLUS

Members are required to obtain surgical products from the Scheme's contracted Designated Service Providers (DSP).

100% of the negotiated rate or Cost the Member obtain surgical products from the Scheme's DSP. A Reference Price List (RFP) will be applied if products are obtained from a non-DSP.

The following sub-limits per family per year will apply for where provided by non-DSP.

These sub-limits include the associated materials used with prostheses.

- Total hip replacement: R70 550
- Partial hip replacement: R42 200
- Spinal surgery prostheses: R35 550 (one level)
  R71 350 (two or more levels)
- Knee replacement: R66 900
- Shoulder replacement: R58 200
- Bare metal cardiac stents: R14 600 per stent
- Drug eluting cardiac stents R23 250 per stent
- Cardiac pacemakers: R85 800
- Tissue replacing prostheses: R27 650
- Artificial limbs: R42 200
- Artificial eyes: R21 100
- Cardiac valves: R34 950 per valve
- Vascular grafts: R104 650
- General overall R27 650

Where clinically appropriate and Pre-authorisation obtained, the Mirena contraceptive device will be funded from the General Internal Prostheses limit. Consultations in the doctors' rooms will be funded from the General Practitioners and Specialists benefits.

GENERAL EXCLUSIONS – APPLICABLE ON BOTH TFG HEALTH AND TFG HEALTH PLUS

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 (PMB).

- Examinations, consultations and Treatment relating to obesity or which may be regarded as for cosmetic purposes.
- No benefit will be paid for circumcision unless Medically necessary.
- Costs of infertility unless Treatment received from a Designated Service Provider (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.
- Convalescing equipment (with the exception of hire of oxygen cylinders), unless clinically appropriate.
- Unregistered providers.
- Sunscreen 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.
- Contraceptives, except the Mirena device where pre-approved and clinically appropriate.
- Mouth protectors and gold dentures.
- Vaccines other than specifically provided for in the benefit Rules of the Scheme.
- Examinations for insurance, school camps and visas.
- Stimulant laxatives.
- Medicine not prescribed and per the approved Medicine lists.
- 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 lactation consultations.
- Sunglasses and spectacle cases, as well as over-the-counter reading glasses.
- Replacement batteries for hearing aids (what is considered consumables).
- 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.
- Accommodation and Treatment in headache and stress-relief clinics.
- Payment for ambulance transportation and air lifting outside of South Africa (including PMB). International Emergency evacuation is not covered.

Additional exclusions of 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. Arthroscopy.
8. Back surgery.
9. Neck surgery.
10. Knee and shoulder surgery.
11. 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.
12. Surgery for oesophaegeal reflux and hiatus hernia repairs.
13. Removal of Varicose Veins.
14. Correction of Hallux Valgus/Bunion and Tailor's Bunion/Bunionette.
15. Surgery and other healthcare services to correct refractive errors of the eye, except for specific benefits provided under this Benefit Plan in this regard.
16. 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.

The above list is subject to change and you are directed to the Scheme Rules to ensure that you familiarise yourself with the full list of exclusions on TFG Health. Please visit www.tfgmedicalaidscheme.co.za for a copy of the Scheme Rules as registered by the Council for Medical Schemes (CMS) each year.

It is important to take note of the additional list of exclusions applicable on TFG Health.

The above lists are not to be regarded as full and complete lists as we 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 brochure are a summary of the Benefit 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.

Cover for medical
EMERGENCIES IN SOUTH AFRICA

What is a medical Emergency?

An Emergency medical condition, also referred to as an Emergency, is the sudden and unexpected onset of a health condition that requires immediate medical or surgical Treatment. Failure to provide this Treatment would result in:

- Serious impairment to bodily functions.
- Serious dysfunction of a bodily organ or part.
- The person's life being placed in serious jeopardy.

An Emergency does not necessarily require a Hospital admission. We may ask you or your treating provider for additional information to confirm the Emergency.

Cover when 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 – pre-exposure (prep) and post-exposure prophylaxes (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 **subject to Approval.**

Cover when 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 pre-authorise your Hospital admission. If an event occurs after hours, you must apply for authorisation on the next available working day. The first **R405** of the casualty unit's account is payable by you if you are registered on TFG Health and you will need to make use of the Hospitals in this Benefit Plan's Hospital Network.

If you go to a casualty or Emergency room and you are not admitted to Hospital, TFGMAS will pay the Costs from your available Primary Care Benefit Limits if you are registered on TFG Health Plus. The Network provisions if you are registered on TFG Health will be applicable.

In certain instances we may not cover the facility fee charged by some institutions.

Cover under the Prescribed Minimum Benefits in case of an Emergency

In an Emergency, we will cover you in full at any provider until your condition is stable. You may have a Deductible 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 your Treatment to be an Emergency, it may not be classified as an Emergency under the Prescribed Minimum Benefits.**

COVER OUTSIDE SOUTH AFRICA

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

Hospital **BENEFITS**

The table below summarises in an easy to understand format your Hospital Cover on the TFG Health and TFG Health Plus Benefit Plans of TFGMAS. Please note that your GP may not be authorised to admit you to Hospital. Please contact the Scheme at 0860 123 077 to enquire in this regard and ensure that you pre-authorise your stay in Hospital.

	TFG Health	TFG Health Plus
Hospital Cover		
Hospital cover and Day Clinics	Please obtain services at the Scheme's Day Clinic Network. Contact us on **0860 123 077** for a list of the services that should be obtained in the Scheme's Day Clinic Network or visit the website at www.tfgmedicalaidscheme.co.za.	Cover at 100% of the Scheme Rate or services obtained in a Hospital of **your choice.** Some procedures may be required to be obtained in the Scheme's Day Clinic Network, to avoid a Deductible from applying. Please contact us on **0860 123 077** for more details.
KeyCare Full cover Hospital Network	Cover in full at the rate agreed with a KeyCare Network Hospital	On this Benefit Plan Members are not limited to obtaining services in a Network Hospital, unless PMB conditions. A PMB Hospital Network is available to Members to ensure that they don't experience any Deductibles when obtaining Treatment for PMB conditions.
KeyCare Partial cover Hospital Network	Cover up to a maximum of 70% of the Hospital account and you must pay the balance of the account. If the admission is a Prescribed Minimum Benefit (PMB), we will pay 80% of the Scheme Rate	On this Benefit Plan Members are not limited to obtaining services in a Network Hospital, unless PMB conditions. A PMB Hospital Network is available to Members to ensure that they don't experience any Deductibles when obtaining Treatment for PMB conditions.
Non-Network Hospitals	No cover if you are admitted to a non-network Hospital for a Planned admission. If the admission is a PMB, we will pay 80% of the Scheme Rate	On this Benefit Plan Members are not limited to obtaining services in a Network Hospital, unless PMB conditions. A PMB Hospital Network is available to Members to ensure that they don't experience any Deductibles when obtaining Treatment for PMB conditions.
Related accounts		
Specialists and healthcare professionals in our Network	Full cover	If you make use of a healthcare professional that is a DSP or in our Network your account will be covered in full. Non-DSP and non-network providers may charge more than 100% of the Scheme Rate.
Specialists and healthcare professionals not in our Network	100% of the Scheme Rate. If the Service Provider charges above the Scheme Rate you must pay the balance of the account.	If you make use of a healthcare professional that is a DSP or in our Network your account will be covered in full. Non-DSP and non-network providers may charge more than 100% of the Scheme Rate.
Radiology and pathology	100% of the Scheme Rate	100% of the Scheme Rate

Your approved Hospital admission is subject to your available cover on your chosen Benefit Plan as summarised in the Benefit Tables in this benefit brochure. TFGMAS Members may opt to receive IV-infusions, wound care and postnatal care in the comfort of the Member's home. These services are provided by professional nurses and care workers who are trained for purposes of providing services or support to Members in this regard. In these instances the IV-infusions, wound care and postnatal care will be paid unlimited at 100% of the Scheme Rate, if funding is approved and it is confirmed that Hospital admission is not required, from the Hospital benefit. The provisions of PMB is applicable.

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 'Related accounts' in the table on page 29 for more information about how your chosen Benefit Plan covers you for accounts from your doctor and other healthcare services obtained in Hospital.

Please contact us to pre-authorise 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 and who may refer you to a specialist for admission to Hospital.
- Make sure you know how the account from your admitting doctor will be covered.
- Choose which Hospital you want to be admitted to by using the MAPS tool available or consult the list of Scheme Network Hospitals as available on the Scheme website, **www.tfgmedicalaidscheme.co.za**.
- Find out how we cover other healthcare professionals, for example, your anaesthetist.
- Call us on **0860 123 077** to pre-authorise 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 Deductible will be levied on the Hospital account if Pre-authorisation 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 entry criteria. There are some expenses that you may incur while you are in Hospital that your Hospital benefit does not cover. **Familiarise yourself with the Scheme Rate applicable per your chosen Benefit Plan and the possible Deductibles where you are being serviced by a provider who is not on the Network or contracted with the Scheme.** Please be aware that certain procedures, Medicines or new technologies need separate Approval while you are in Hospital.

Please discuss your admission with your Service Provider or the Hospital. Use our online MaPS Advisor, available on **www.tfgmedicalaidscheme.co.za** to find a provider that is contracted with the Scheme.

DAY SURGERY

About the Benefit

We cover certain Planned Procedures in a day surgery facility. A day surgery facility may be inside a Hospital, in a clinic or at a standalone facility.

How to get the Benefit

The list of day surgery procedures are set out in this benefit brochure. You must contact us to get confirmation of your procedure (called Pre-authorisation).

How we pay

We pay these services from your Hospital Benefit. We pay for services related to your Hospital stay including all healthcare provessionals, services, Medicine authorised by the Scheme.

If you use doctors, specialists and other healthcare professionals that we have a Payment Arrangement with, we will pay for these services in full.

When you need to pay

If you are registered on the TFG Health Plus Benefit Plan and if you go to a facility that is not in the day surgery Network, you will have to pay an upfront amount of R1 500.

View all day surgery Network facilities using Find a healthcare provider on the Discovery app.

List of procedures covered in the day surgery Network

The following is a list of procedures that we cover in a day surgery facility:

1. Ear, Nose and Throat Procedures
    - Tonsillectomy and/or adenoidectomy
    - Repair nasal turbinates*, nasal septum*
    - Simple procedures for nose bleed (extensive cautery)
    - Sinus lavage*
    - Scopes (nasal endoscopy*, laryngoscopy)
    - Middle ear procedures (tympanoplasty, mastoidectomy, myringoplasty, myringotomy and/or grommets)
2. Gastrointestinal Procedures
    - Gastrointestinal scopes (oesophagoscopy, gastroscopy, colonoscopy, sigmoidoscopy, proctoscopy, anoscopy)*
    - Anorectal procedures (Treatment of haemorrhoids, fissure, fistula)

3. Urological Procedures
    - Cystoscopy
    - Male genital procedures (circumcision, repair of penis, exploration of testes and scrotum, orchiectomy, epididymectomy, excision hydrocoele, excision varicocoele vasectomy)
4. Orthopaedic Procedures
    - Arthroscopy, arthrotomy (shoulder, elbow, knee, ankle, hand, wrist, foot, temporomandibular joint), arthrodesis (hand, wrist, foot)*
    - Minor joint arthroplasty (intercarpal, carpometacarpal and metacarpophalangeal, interphalangeal joint arthroplasty*)
    - Tendon and/or ligament repair, muscle debridement, fascia procedures (tenotomy, tenodesis, tenolysis, repair/reconstruction, capsulotomy, capsulectomy, synovectomy, excision tendon sheath lesion, fasciotomy, fasciectomy) (For TFG Health only funded if not via a scope first). Subject to individual case review
    - Repair bunion or toe deformity*

* Treatment of simple closed fractures and/or dislocations, removal of pins and plates. Subject to individual case review

5. Gynaecological Procedures
    - Diagnostic Dilatation and Curettage
    - Endometrial ablation
    - Diagnostic Hysteroscopy
    - Colposcopy with LLETZ
    - Examination under anaesthesia
6. Eye Procedures
    - Corneal transplant*
    - Cataract surgery
    - Treatment of glaucoma
    - Other eye procedures (removal of foreign body, conjunctival surgery (repair laceration, pterygium), glaucoma surgery, probing & repair of tear ducts, vitrectomy, retinal surgery, eyelid surgery, strabismus repair)
7. Ganglionectomy
8. Simple superficial lymphadenectomy
9. Approved Breast Procedures
    - Mastectomy for gynaecomastia*
    - Lumpectomy* (fibroadenoma)
10. Skin Procedures
    - Debridement
    - Removal of lesions* (dependent on site and diameter)
    - Simple repair of superficial wounds
11. Biopsies: skin*, subcutaneous tissue, soft tissue, muscle, bone, lymph, eye, mouth, throat, breast, cervix, vulva, prostate, penis, testes
12. Removal of foreign body (subcutaneous tissue, muscle, external auditory canal under general anaesthesia)

* Subject to TFG Health exclusions as set out in this benefit brochure.

MEDICAL AID SCHEME

Prescribed Minimum **BENEFITS (PMB)**

The TFG Medical Aid Scheme has contracted and established the following additional Networks with effect from 1 January 2021 in an effort to prevent Deductibles being applied when obtain services for Prescribed Minimum Benefit (PMB) conditions.

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
- 26 chronic conditions
- Emergency conditions.

In most cases, TFG Medical Aid Scheme offer benefits that 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 Deductible will be levied. You will be responsible for the difference between what we pay and the actual Cost of your Treatment, where applicable.

Mental Health Network

The Scheme identified a gap in options available to Members to obtain full cover for mental health Treatment from allied providers such as social workers, psychologists and registered counsellors.

The Mental Health Network has been created for these providers and applies across both Benefit Plans with effect from 1 January 2021 where these providers bill for Treatment i.e. out-of-hospital (OOH) benefits and in-hospital related accounts. The Network is also applicable where services are claimed from the allied and therapeutic benefits of the Scheme and where services are obtained via the Mental Health Programme available on both Benefit Plans.

Members who obtain services from these Service Providers will experience no balance billing, provided they obtained services as part of the Mental Health Network of Service Providers. Where a Member obtain services from a non-network Service Provider and the provider charge above the Scheme Rate, the payment will be limited to the Scheme Rate and will be paid to the Member. In such instances Members may be liable for additional payments when settling accounts with the non-network Service Providers and it is therefore important to contact us to confirm whether your preferred Service Provider is part of the Mental Health Network of the Scheme before obtaining services for PMB conditions to ensure that your account is paid in full.

Implementation of a PMB Hospital Network and a PMB in Hospital full cover model

With effect from 1 January 2021, Members will have access to a PMB Hospital Network to obtain services for PMB at full cover.

That means no more balance billing for Members where the admitting Service Provider is on the Scheme's Designated Service Provider list (DSP) or GP/Specialist Network and services are obtained from a Hospital in the PMB Hospital Network.

Once you have been admitted to one of these facilities and if you

- obtained services at the PMB Hospital Network and
- selected a primary provider who has entered into a Direct Payment Arrangement (DPA) with the Scheme for your particular Benefit Plan type, i.e. admitting doctor is on the Benefit Plan's DPA.

then all contracted providers will be reimbursed at their contracted rate or at Cost for services obtained in the PMB Hospital Network, as referred by your admitting doctor. This applies to all related accounts during the admission as well.

Therefore, where a Pre-authorisation is approved for a PMB condition, the Scheme will fund the Cost of the services obtained as set out in the table below:

	TFG Health	TFG Health Plus	Additional information/ Comments
Hospital Cover			
Psychology and mental health in and out-of-hospital services for PMB conditions if the Service Provider is in the Mental Health Network	100% at Agreed Rate	100% at Agreed Rate	No Deductibles if DSP is used
Psychology and mental health in and out-of-hospital services for PMB conditions voluntarily obtained from a Service Provider who is not in the Mental Health Network	Up to a maximum of 100% of Scheme Rate	Up to a maximum of 100% of Scheme Rate	There may be Deductibles if non-network Service Provider is used
In-Hospital GP or Specialist services for PMB conditions if admitting GP or Specialists is on the Network/DSP	100% at Agreed Rate	100% at Agreed Rate	No Deductibles if DSP is used
In and out-of-hospital services for PMB conditions voluntarily obtained from a non-DSP	Up to a maximum of 100% of the Scheme Rate	Up to a maximum of 100% of the Scheme Rate	There may be Deductibles if non-DSP is used

In-Hospital GP Network

In addition to the current Premier Practice, Classic Direct and KeyCare Health DPA Specialist Networks, the Scheme introduced an 'In-Hospital General Practitioner (GP) Network' for both Benefit Plans.

Should you obtain in-hospital services for PMB conditions from a GP with admitting rights to your chosen facility or the Network Hospitals, the GP or Specialist will be reimbursed in full with no balance billing above the agreed tariffs. In-Hospital claims billed above the agreed tariff will be paid up to the agreed tariff and the difference will be for your account.

Midwife Fixed Fee Arrangement

The Scheme has adopted a Midwife Network effective 1 January 2021 for Members on the TFG Health Plus Benefit Plan.

This arrangement will allow the midwives to use a single billing code for their services, if the midwife belongs to the Network. The Network will also be introduced as the default PMB DSP Network for midwifes on this Benefit Plan.

Members can elect to deliver the baby with the help of a midwife at a birthing home (this is a non-registered 'home' set up for mothers wanting to experience a home birth in a controlled environment) or at the Member's own home.

The arrangement does not apply to a birthing facility/unit, such as Genesis or Femina.

The Member will receive cover for the midwife's professional fee, consumables, equipment and the Cost of an assistant (including a Doula), up to a minimum of one hour after the delivery, excluding Medicines if Service Providers in this Network is used.

Supplier Agreements for Surgicals

The Scheme has implemented supplier arrangements on both Benefit Plans from 1 January 2021 for:

- Induction of Labour medical and surgical equipment
- Cardiac stents
- Oxygen appliances
- Intermittent catheters and
- Breathing devices such as CPAP, APAP and BIPAP machines

Where Members obtain the above appliances from Service Providers who the Scheme entered into Preferred Payment Arrangements with, the Scheme will fund the Cost of the appliances up to the agreed/negotiated rate and Members should experience no Deductibles.

Where Members obtain the above appliances from non-DSP the payment will be limited up to the maximum of 100% of the Scheme Rate and limited to the Annual Benefit limit of the Member's chosen Benefit Plan as may be applicable. In such instances Members may experience Deductibles and may be liable for some of the Costs of these appliances.

Please contact us at 0860 123 077 to be advised of the options available to you before obtaining these appliances without consulting with us.

NOTE: FUNDING OF EMERGENCY PMB CLAIMS

In cases of emergencies, all approved PMB claims will fund at Cost

Patient
MANAGEMENT PROGRAMMES

You have access to patient management programmes to get the best care on both TFG Health and TFG Health Plus as follows:

Diabetes Care Programme

The Diabetes Care Programme is designed to offer our diabetic Members the optimal care from the best Service Providers in a coordinated network, to ensure the best outcomes and quality of life for our Members. To access the programme, you need to be registered on the Chronic Illness Benefit with either Type 1 or Type 2 Diabetes. A GP in the Premier Plus GP network can enroll you onto the programme. The Diabetes Care Programme is based on clinical and lifestyle guidelines. The programme gives you and your Premier Plus GP access to various tools to monitor and manage your condition and to ensure you have access to high-quality coordinated care. You and you GP can track your progress on a personalised dashboard. This will help you to identify the steps you should take to manage your condition and remain healthy over time. In addition to the standard Treatment basket of procedures and consultations available to Members registered on the Chronic Illness Benefit with Diabetes Members who join the Diabetes Care Programme will have access to an additional dietician and one biokineticist consultation per year. For more information, please contact the **Scheme** at **0860 123 077.**

Cardio Care Programme

The Cardio Care Programme is designed to offer our Members approved for certain heart-related conditions the optimal care from the best Service Providers in a coordinated network, to ensure the best outcomes and quality of life for our Members.. To access the programme, you need to be 18 years or older and registered on the Chronic Illness Benefit with hypertension, hyperlipidaemia and/or ischaemic heart disease. A GP in the Premier Plus GP network can enroll you onto the programme. The Cardio Care Programme is based on clinical and lifestyle guidelines. The programme gives you and your Premier Plus GP access to various tools to monitor and manage your condition and to ensure you have access to high-quality coordinated care. You and your GP can track your progress on a personalised dashboard. This will help you to identify the steps you should take to manage your condition and remain healthy over time.

HIV Care Programme

The HIV Care Programme, together with your Premier Plus GP, will help you actively manage your condition. 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.

A Premier Plus GP is a KeyCare Network GP who has contracted with us to provide you with high quality healthcare for your condition.

When you register for our HIV Care Programme and choose a Premier Plus GP to manage your condition, you are covered for the care you need, which includes additional cover for social workers.

To register on the HIV Care Programme:
Call us on 0860 123 077
email: **HIV_Diseasemanagement@discovery.co.za**

Mental Health Care Programme

The Mental Health Care Programme is designed to offer our Members diagnosed with acute or episodic Major depression the optimal care from the best Service Providers in a coordinated network, to ensure the best outcomes and quality of life. To access the programme, you need to be diagnosed with acute or episodic Major depression. A GP in the Premier Plus GP network can do the assessment to confirm the diganosis and enroll you onto the programme. The Programme, which will be active for 6 months from the date of enrollment, will give your Premier Plus GP access to tools to monitor and manage your condition and to ensure you have access to high-quality coordinated care. By Joining the Mental Health Care Programme, you will have access to 3 GP consultations and certain first line anti-depressant therapy.

This programme is only applicable on TFG Health.

Mental Health Network

The Scheme has also introduced a Mental Health Network for Members who require Treatment for PMB conditions and more information in this regard is available in the benefit brochure under ‘Prescribed Minimum Conditions’ on page 33.

Chronic
ILLNESS BENEFITS (CIB)

On both the TFG Health and TFG Health Plus Benefit Plans you have access to Treatment for a list of medical conditions under the Prescribed Minimum Benefit (PMB) conditions. PMB cover the 27 chronic conditions (including HIV and AIDS) set out in the list of chronic conditions known as the Chronic Disease List (CDL). On TFG Health Plus, you have cover for a further set of chronic conditions known as the Additional Disease List (ADL).

What we cover

Prescribed Minimum Benefit (PMB) conditions

The PMB CDL conditions covered on both Benefit Plans are:

- Addison's disease
- Asthma
- Bipolar mood disorder
- Bronchietasis
- 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 (Managed through the HIV Care programme)
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- Ulcerative colitis

We will pay your approved Medicine in full if it is on our Medicine list, which we refer to as the 'Formulary'. You may have a Deductible if you choose to use Medicine not on the Medicine list. If your approved Medicine is not on our Medicine list (Formulary), we will pay your Chronic Medicine up to a set monthly Chronic Drug Amount (CDA) for each Medicine class.

If you use more than one Medicine in the same Medicine class, where both Medicines are not on the Medicine list or where one Medicine is on the Medicine list and the other is not, we will pay for both Medicines up to the one monthly CDA for that Medicine class.

On TFG Health you will also need to ensure that you obtain your approved chronic Medicine from one of our Network pharmacies or from your chosen KeyCare GP (if he or she is a dispensing GP). If you obtain your Medicine from any other pharmacy, you will have a 20% Deductible. On TFG Health Plus you can obtain your approved chronic Medicine from any pharmacy or dispensing GP, however, the provisions of choosing Medicine on the Medicine list and within the Formulary and funding up to the appropriate CDA will remain applicable. It is therefore better to obtain your Medicine from the Scheme's preferred list of pharmacies to prevent unnecessary co-payments and Deductibles.

You need to let us know when your Treatment plan changes

You do not have to complete a new Chronic Illness Benefit application form when your treating doctor changes your Medicine during the management of your approved chronic condition, however, you do need to let us know when your doctor makes these changes to your Treatment so that we can update your chronic authorisation. You can email the Prescription for changes to your Treatment plan for an approved chronic condition to CIB_APP_FORMS@discovery.co.za or fax it to 011 539 700. Alternatively, your doctor can submit changes to your Treatment plan through HealthID, provided that you have given consent to do so. If you do not let us know about changes to your Treatment plan, we may not pay your claims from the correct benefit.

Should you be diagnosed with a new chronic condition, a new Chronic Illness Benefit application form would need to be completed.

If your PMB CDL condition is approved, the Chronic Illness Benefit will automatically open access to cover for a limited number of selected tests, procedures and/or specialist consultations for the diagnosis and ongoing management of your condition. You will also have cover for four (4) GP consultations related to your approved PMB CDL conditions per year.

The number of tests and consultations are calculated based on the number of months left in the year at the time your condition is approved. If you have cover for the same procedures or tests for more than one condition, funding will be limited to the basket that gives you the most procedures or tests. On TFG Health Plus you have further cover for Medicine for ADL conditions. There is no Medicine list (Formulary) for these ADL conditions. Approved Medicine for these conditions will be funded up to the monthly CDA for that Medicine class, up to an annual limit as set out in the Benefit Tables of this Benefit Plan.

To make sure that we pay your claims from the correct benefit, we need the claims from your healthcare providers to be submitted with the relevant ICD-10 diagnosis code(s). Please ask your doctor to include your ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete when they refer you to the pathologists and/or radiologists. This will enable pathologists and radiologists to include the relevant ICD-10 diagnosis code(s) on the claims they submit to ensure that we pay your claims from the correct benefit.

The Additional Disease List (ADL) conditions are:

- Ankylosing spondylitis
- Attention Deficit Hyperactivity Disorder (ADHD)
- Behcet's disease
- Cystic fibrosis
- Delusional disorder
- Dermatopolymyositis
- Gastro-oesophageal reflux disease
- Generalised anxiety disorder
- Gout
- Huntington's disease
- Isolated growth hormone deficiency in Children < 18 years
- Major depression
- Motor neuron disease
- Muscular dystrophy and other inherited myopathies
- Myasthenia gravis
- Obsessive compulsive disorder
- Osteoporosis
- Paget's disease
- Panic disorder
- Polyarthritis nodosa
- Post-traumatic stress disorder
- Psoriatic arthritis
- Pulmonary interstitial fibrosis
- Sjogren's syndrome
- Systemic sclerosis
- Wegener's granulomatosis

How to get the benefit

You must apply for the Chronic Illness Benefit. Your doctor must complete the form online or send it to us for review.

For a condition to be covered from the Chronic Illness Benefit, there are certain benefit entry criteria that needs to be met. You or your doctor may need to provide certain test results or additional information with the Chronic Illness Benefit application form.

Remember, if you leave out any information or do not provide medical test results or documents needed with the application form, cover will start from the date we receive the outstanding information.

You can get your latest Chronic Illness Benefit application form on the website **www.tfgmedicalaidscheme.co.za**

Visit **www.tfgmedicalaidscheme.co.za** to view the detailed Chronic Illness Benefit guide.

Cancer
BENEFITS

You have comprehensive cover for cancer

Oncology Benefit

If you are diagnosed with cancer and once we have approved your cancer Treatment, you are covered for Oncology cover over a 12-month cycle.

Notwithstanding your chosen Benefit Plan, you will always be covered for Treatment that is recognized as a Prescribed Minimum Benefit (PMB).

On TFG Health you will need to obtain services and Treatment at a Network Provider (ICON Network). If you use a cancer specialist who is not in the Network, the Scheme will pay 80% of the Scheme Rate and you will need to pay the balance from your pocket.

TFG Health Plus provides a more extensive cover and benefit amount available to its Members and you are not restricted to a Network of Service Providers. Please consult the Benefit Tables in this benefit brochure for more information with regard to how you are covered for cancer on the TFG Health Plus Benefit Plan.

It is important to note that on both Benefit Plans cancer Treatment that falls within PMB is always covered in full, with no Deductibles, provided that you make use of the Service Providers or Network Providers who we have a payment arrangement with. 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**.

The Scheme also covers pathology, radiology, Medicine and other approved cancer-related Treatment that is provided by healthcare professionals other than your cancer specialist, 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 may be excluded from cover.

Advanced Illness Benefit (AIB) for cancer patients

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

You need to get your approved oncology Medicine on our Medicine list from a Designated Service Provider (DSP) or Network Provider to avoid Deductibles. Speak to your treating doctor to confirm that they are using our DSP for your Medicine and Treatment received in rooms or at a Treatment facility that is approved by the TFG Health Oncology Network. Visit **www.tfgmedicalaidscheme.co.za** to view the detailed Oncology Benefit guide

Other
BENEFITS AVAILABLE

To enhance your cover you receive the following additional benefits on TFG Medical Aid Scheme.

Home Care

Home care is a service that offers you quality care in the comfort of your own home when recommended by your doctor as an alternative to a Hospital stay for services such as IV infusions (drips), wound care and postnatal care. These services are available to all Members on both Benefit Plans and is provided by accredited nurses or care workers, funded from your Hospital Benefit, if funding is approved. Visit our website at **www.tfgmedicalaidscheme.co.za** for more information regarding these benefits.

International Second Opinion Services

As a Member of the TFG Medical Aid Scheme (TFGMAS) you also have access to the International clinical review service benefit.

TFG Medical Aid Scheme recognises 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.

Where Members have multiple severe illnesses and want an international team to review their case, the Members 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 Medical Aid Schemes 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 GP or contact the Scheme at **0860 123 077**.

Compassionate Care

The Compassionate Care Benefit gives you access to holistic home-based end-of-life care, which is not cancer-related. For more information regarding this Benefit, please consult the Benefit Tables in this benefit brochure.

WHO Global Outbreak Benefit

You have cover up to 100% of the Scheme Rate for relevant healtcare services, as well as a defined basket of care for out-of-hospital healthcare services, realted to global World Health Organisation (WHO) recognised disease outbreaks such as COVID-19. This does not affect your day-to-day benefits where applicable. You have access to screening consultations, testing and out-of-hospital management and appropriate supportive Treatment related to the outbreak disease, as long as they meet our benefit entry criteria. In-hospital Treatment related to the outbreak disease for approved admissions is covered from the Hospital benefit based on your chosen health Benefit Plan and in accordance with Prescribed Minimum Benefits (PMB) where applicable.

Screening and **PREVENTION BENEFITS**

You have access to essential screening and prevention benefits on both TFG Health and TFG Health Plus

Preventative screening is important to ensure that medical conditions are detected early.

As a TFG Medical Aid Scheme Member, you have access to certain tests that can detect early warning signs of serious illnesses. We cover various screening tests at our wellness providers, for example, blood glucose, cholesterol, HIV, Pap smears, mammograms and prostate screenings.

Screening for kids

This benefit covers growth assessment tests, including height, weight, head circumference and health and milestone tracking at any one of our wellness providers.

How we pay

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 they relate to a Prescribed Minimum Benefit diagnosis.

The tests do not affect your day-to-day benefits as they are paid from the Screening and Prevention Benefit. Consultations that do not form part of PMB will be paid from your available day-to-day benefits.

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. For more information please consult the FAQ available on the website at **www.tfgmedicalaidscheme.co.za.**

If you attend a Premier Wellness Event, you may qualify for the following additional tests:

- Defined set of diabetes and cholesterol screening tests.
- Breast MRI or mammogram and once-off BRCA testing for breast screening.
- Pap smear for cervical screening.
- Colorectal screening test and colonoscopy
- Seasonal flu vaccine for Members:
  - during pregnancy.
  - 65 years or older.
  - registered for certain chronic conditions.

If you are registered on TFG Health Plus you will also receive funding from the Screening and Prevention Benefit for the following vaccines in line with the latest clinical guidelines and entry critera:

The vaccines below are covered if you are a Member of TFG Health Plus.

Adult vaccines:

- Tetanus/diphtheria
- Hepatitis A
- Hepatitis B
- Measles, mumps and rubella
- Chickenpox
- Shingles
- Meningococcal.

Child vaccines:

- Polio
- TB
- Hepatitis B
- Rotavirus
- Tetanus/diphtheria
- Accellular pertusis
- Haemophilus
- Influenza Type B
- Chickenpox
- Measles, mumps and rubella.

Please note that clinical entry criteria may apply to some of these tests. Pneumococcal Vaccines are available on both Benefit Plans and the Scheme will fund one vaccine per person every 5 years for persons under the age of 65 and one vaccine per person per lifetime for persons over the age of 65. One seasonal influenza vaccine per person per year are also available on both Benefit Plans from the screening and prevention benefits.

From effect 1 January 2021 the Scheme has also introduced an HPV test for female beneficiaries as an alternative to the Pap smear test for cervical screening. Please consult with your healthcare provider for more information in this regard.

Screening for Seniors

In addition to the screening for adults, Members aged 65 years and older have cover for a group of age appropriate screening tests at our Preferred provider pharmacies and Networks. Cover includes hearing and visual screening and a falls risk assessment, for Members 65 years and older. You may have cover for an additional GP consultation at a Premier Plus GP, depending on your screening test results and if you meet the Scheme's clinical entry criteria.

TFGMAS and the application of **WAITING PERIODS (WP) AND LATE JOINER PENALTIES (LJP)**

The Medical Schemes Act 131 of 1998, as amended, allows medical aid schemes to impose the following waiting periods and Late Joiner penalties on Members applying to join a medical aid 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 applies 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 a break of more than 90 days in membership since resigning from their previous medical aid scheme.

1.2 Category B

Applicants who have had less than two years' cover and applied to join TFGMAS less than 90 days after resigning from their previous medical aid scheme.

1.3 Category C

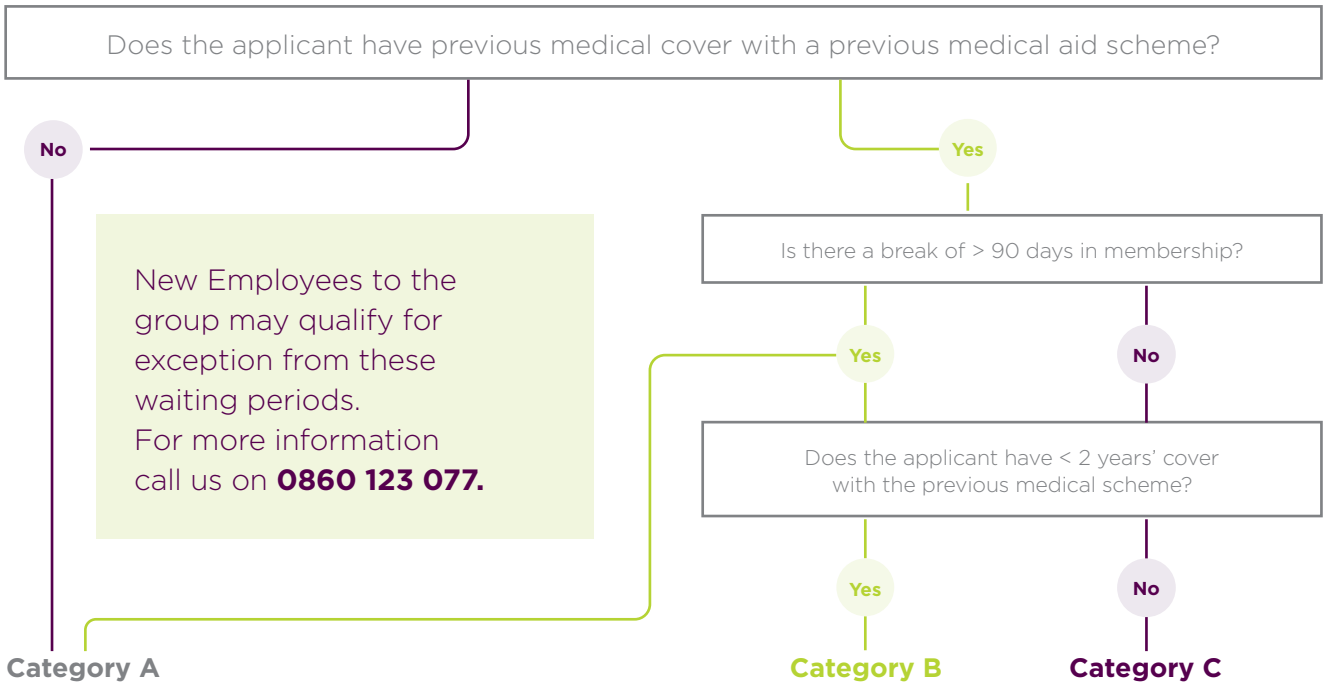
Applicants who have had two years' or more cover and applied for cover less than 90 days since the date of resigning from their previous medical aid scheme.

The applicable waiting periods therefore depend on the category the Members/Dependants fall in.

The flowchart below sets out for illustrative purposes, the categories, per legislation, that are used in determining whether a waiting period and Late Joiner penalty (LJP) may be applied.

1

It is important to note that TFGMAS does not apply waiting periods on new Employees who have not been Members of a medical scheme in the past when applying for employment and membership of TFGMAS at the same time.



New Employees to the group may qualify for exception from these waiting periods.
For more information call us on **0860 123 077.**

2. Late Joiner penalties

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

Late Joiner penalties can be applied where:

- An applicant, or Dependant of an applicant is aged 35 years or older at the time of registration and
- The date of employment and date of registrations is not the same and
- Proof of membership with a medical aid scheme on 1 April 2001 cannot be provided and
- Date of joining the Scheme is not within 90 days of resigning from the previous medical aid scheme and/or
- More than 90 days' consecutive break in coverage between medical aid schemes exist.

The Late Joiner penalty could be imposed on the Contributions payable. 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. TFG 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%

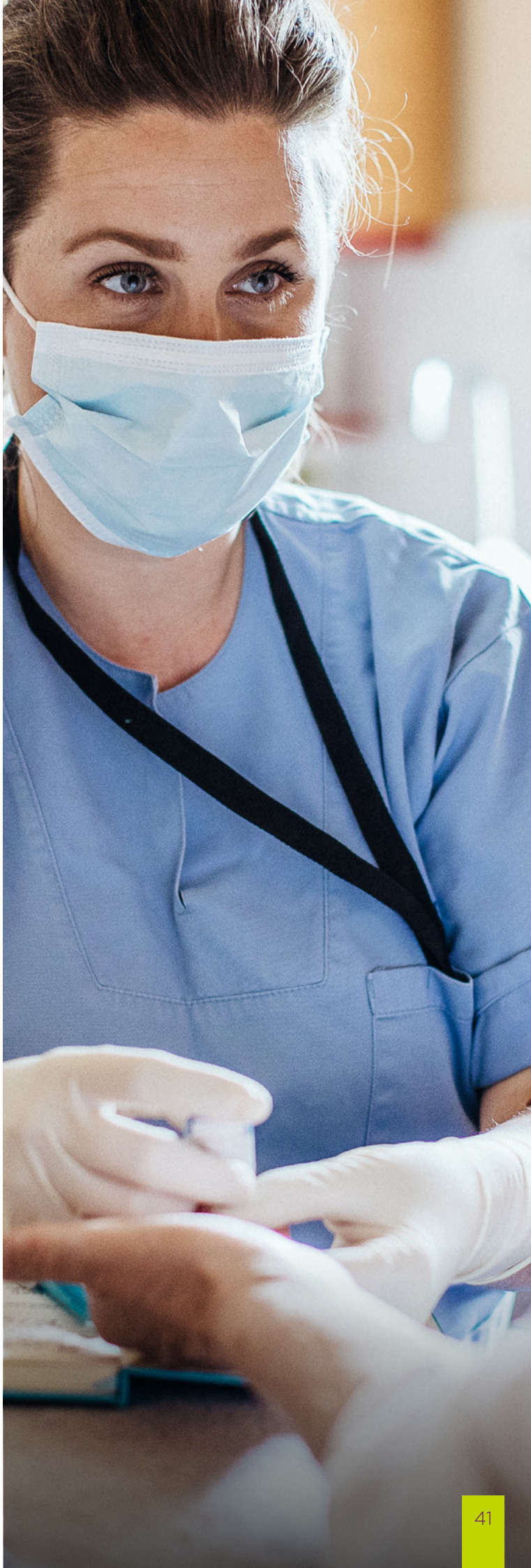
2.2 Calculation of uncovered years

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 scheme 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. This document is used by the Administrator when receiving applications for processing.



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.

The Board has appointed an *ex gratia* committee who reviews these applications received and this committee is mandated to make decisions on behalf of the Trustees and the Scheme in this regard. Decisions taken by this committee are final and are not subject to appeal or dispute.

Find it all on TFG Medical Aid Scheme Website

You can find the application forms you need on TFG Medical Aid Scheme website, www.tfgmedicalaidscheme.co.za, click on 'TFGMAS' and choose 'find a document'.

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. 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 Benefit Plans we offer, your benefits and cover, our wellness programmes, 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.

‘How to’
ARTICLES

A

HOW TO 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.
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 on **0860 123 077**

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

Always reference your TFGMAS membership number in your email subject line should you make contact with us via email.

B

HOW TO ACCESS YOUR BENEFIT PLAN INFORMATION USING THE DISCOVERY APP AND TFGMAS WEBSITE

The Discovery smartphone app puts you fully in touch with your health Benefit Plan no matter where you are. If your mobile device is with you, so is your Benefit Plan. The Discovery smartphone app can be downloaded at the Apple iStore and Google Playstore.

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

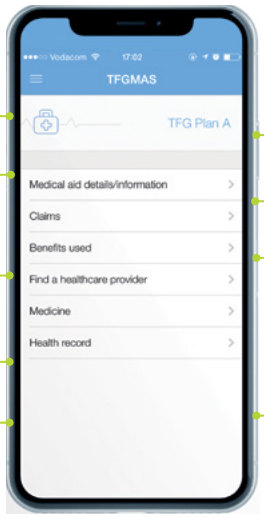
Submit claims by taking a photo of your claims using your smartphone camera and submit. You can also view a detailed history of your claims.

Track your day-to-day medical spend and benefits

Access important benefit information about your specific Benefit 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 at Network Rates.

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 Benefit 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

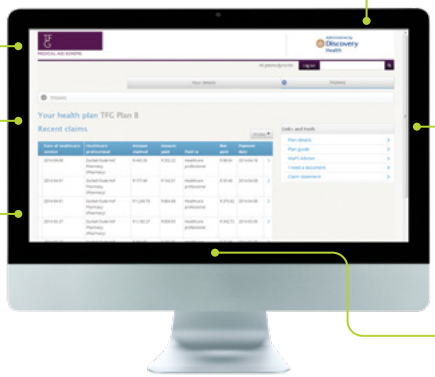
Our website has been designed to work on a variety of different digital devices – your computer, your tablet and your cellphone. No matter what size the screen, the information will always be customised to your particular device making it easy to read.

Keeping track of your benefits

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

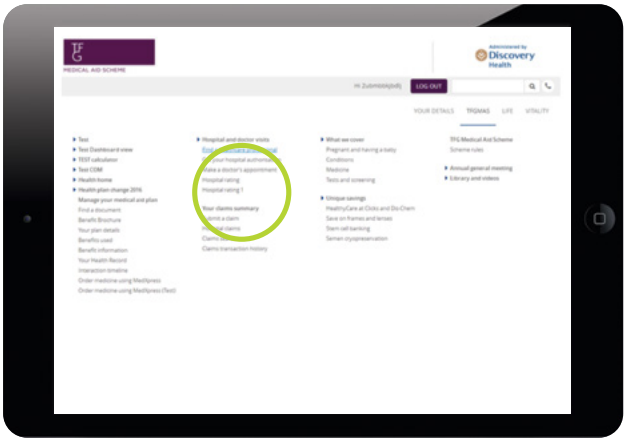
Finding a healthcare professional

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 Deductible on your consultation. You can even filter your search by speciality and area and the results will be tailored to your requirements.

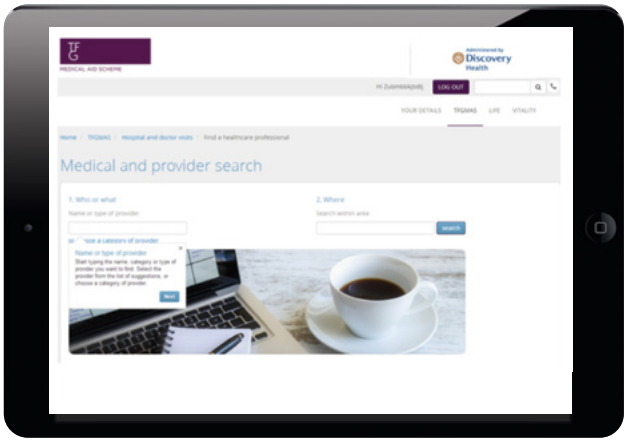
C

HOW TO FIND A NETWORK SERVICE PROVIDER USING THE MaPS TOOL AND OUR WEBSITE

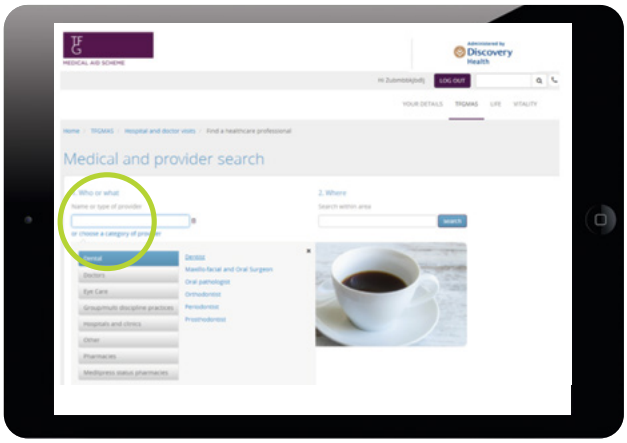
Go to www.tfgmedicalaidscheme.co.za and log in with your username and password.



If you are looking for the nearest doctor or Hospital, click on TFGMAS tab. Look under Hospital and doctor visits and click on find a healthcare professional



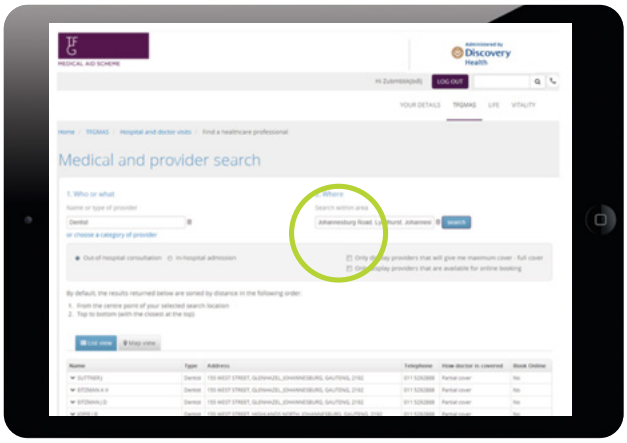
The page will open in the MaPs Medical and Provider Search functionality.



There are two sections:

1. Provider (Who or What)
2. Location (Where)

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, 'Dentist'.



Next to 'Provider' is the location field for location, s(province, city or suburb). After filling in all your requirements, for example:

Provider > Dentist > Rosslyn > and then clicking on 'Search', you will be able to see a list of all the available Network dentists in your area. All registered doctors' information will displayed and you can select one.

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

D

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 Deductible

Remember these important points so you can claim correctly and avoid Deductibles:

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'.

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

Sending your claim is easy

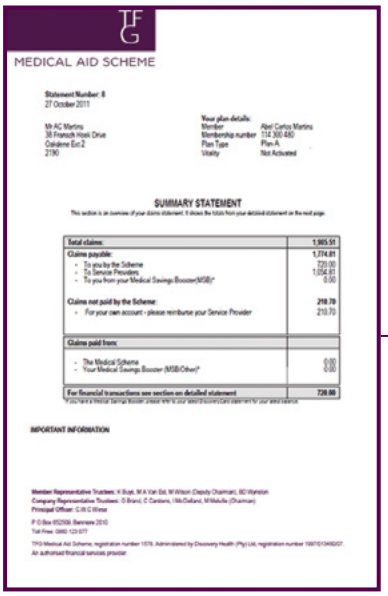
There are many ways for you to send us your claims. You can choose the way that is easiest for you from the list below:

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 Discovery app.

E

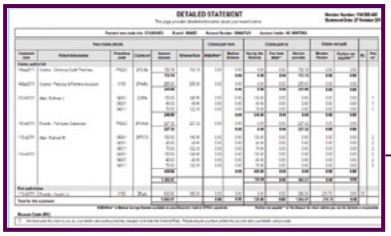
HOW TO GET THE MOST OUT OF YOUR CLAIM STATEMENT

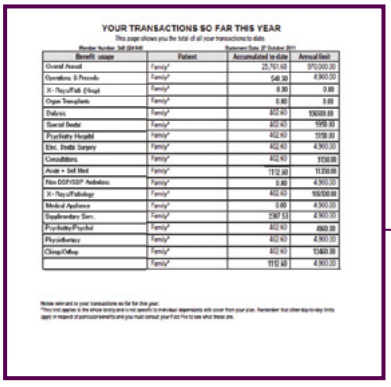
Every time you submit a claim to TFG Medical Aid Scheme, you will receive a claim notice by email, which will tell you how we processed your claim. Your claims statement gives you more details of how we have paid your claims and what your available benefits are.


MEDICAL AID SCHEME

SUMMARY STATEMENT

IMPORTANT INFORMATION


DETAILED STATEMENT


YOUR TRANSACTIONS SO FAR THIS YEAR

Note: Your medical information is confidential

1. On the first page, you'll see an overview of your Benefit Plan 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 whom 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.

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 under your secure login on the Scheme's website at www.tfgmedicalaidscheme.co.za; or
- By calling TFG Medical Aid Scheme contact centre on 0860 123 077.

Complaints **AND DISPUTES**

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 want 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 requires that you follow the following steps:

Step 1:

Contact the Administrator, Discovery Health, through the contact centre on **0860 123 077** or email us at **service@ discovery.co.za** and lodge the complaint or dispute.

Step 2:

If the matter remains unresolved or the feedback received is not to your satisfaction, the matter can be escalated to the Principal Officer of the Scheme, Ms Caron Harris, who will direct the matter in line with the Disputes Process of the Scheme for resolution.

Step 3:

Once feedback is provided, Members who thereafter are still 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: **086 673 2466.**
- Email: **complaints@medicalschemes.co.za.**

Notes

Notes

MEDICAL AID SCHEME

The TFGMAS video is available on the website
http://www.tfgmedicalaidscheme.co.za/schemes/tfg/

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