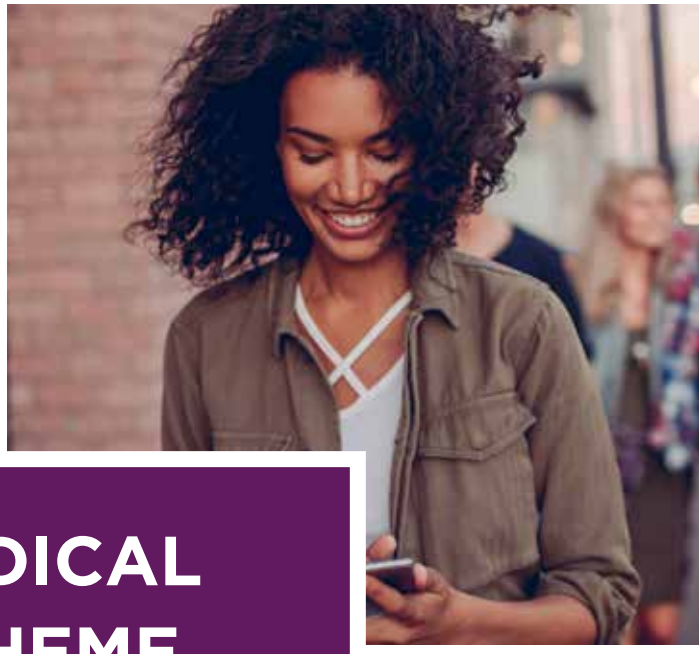
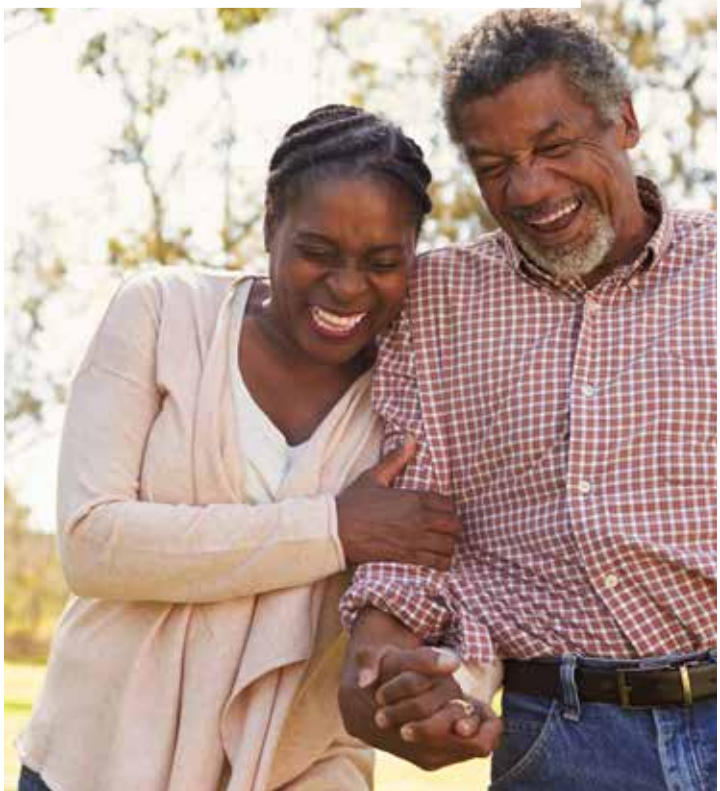
TFG
MEDICAL AID SCHEME



TFG MEDICAL AID SCHEME

BENEFIT BROCHURE

2020



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.

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 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 12 and 24.

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

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

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

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

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. Please turn to page 35 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.

Frequently asked Questions

For more FAQ please go to **www.tfgmedicalaidscheme.co.za**

01

Do I need to get a pre-authorisation number for special dentistry?

Yes. When you need to receive dental services in hospital, you will need to contact us by calling **0860 123 077** to pre-authorise your hospital admission, at least 48 hours before you go into hospital. It is advisable to contact the contact centre to confirm whether you will have a Deductible and whether or not a particular treatment will be covered before obtaining services for specialised dentistry.

02

How do I find the details of the Service Providers that are contracted on the KeyCare Network if I am a member of TFG Health?

Go to our website **www.tfgmedicalaidscheme.co.za** and log in with your username and password. If you are looking for the nearest doctor, click on 'TFGMAS' and then click 'on' 'Find a healthcare professional'. You can search by healthcare professional name or by area. See page 43 for more information on how to navigate the website to search for a healthcare professional that is in the Scheme network.

03

How do I find the details of the Service Providers that are contracted with the Scheme if I am a TFG Health Plus member?

Go to our website **www.tfgmedicalaidscheme.co.za** and log in with your username and password. If you are looking for the nearest doctor, click on 'TFGMAS' and then click on 'Find a healthcare professional'. You can search by healthcare professional name or by area. See page 43 for more information on how to navigate the website to search for a healthcare professional that is in the Scheme network.

04

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

Your employer office will be able to assist and provide further information to you.

05

What is a network provider and why should I use one?

The Scheme negotiates rates with Service Providers on your behalf and makes sure that these providers follow certain rules. We call service providers we have a payment agreement with the Scheme a 'network provider' and TFGMAS refer in its Rules to the following network providers:

- DPA Specialists;
- KeyCare Network GPs;
- TFG Health (KeyCare) Network Hospitals;
- KeyCare Premier Plus GPs;
- Preferred providers; or
- Designated Service Providers (DSP).

Depending on your chosen Benefit Plan you may be liable for a deductible should you visit a Partial Cover or non-network provider.

To find a network provider, log in to **www.tfgmedicalaidscheme.co.za** and click on 'TFGMAS' followed by clicking on **'Find a healthcare professional'**

06

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

Please see page 46 for more information regarding the complaints and disputes procedure of the Scheme.

07

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

When obtaining services from a Service Provider, a service contract is entered into between yourself and the Service Provider and you will remain liable for any amounts due to the Service Provider until it is either settled by the Scheme on your behalf, or paid by yourself. Call the contact centre at **0860 123 077** and find out the reasons for non-payment, determine whether you are responsible for any Deductible and ensure that your accounts are settled and credits are processed by the Service Provider, where necessary.

08

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

Yes you can. Please note that if medical scheme membership is a condition of your employment you need to prove that you are joining a different medical scheme or your spouse's scheme.

Please enquire with your HR Manager or the Medical Aid Policy on the TFG employer portal about the may no longer be available to you if you choose to re-instate your membership with the Scheme at a future date or time.

09

Does my contribution increase when my salary increases each year?

Contributions are reviewed annually. Please refer to the Contribution Table on page 9 available in this benefit brochure to determine your contribution payable per your salary band, number of members and Benefit Plan of choice.

10

Will I have a waiting period when joining the Scheme?

Depending on whether there was a break in your membership with a previous medical scheme, or when you were employed at TFG and when you decided to join the Scheme, a waiting period may be applicable. Please consult page 38 and 39 of this benefit brochure for more information in respect of waiting periods and when it may be applied. You can also call the contact centre on **0860 123 077** to obtain more information.

11

How to nominate a GP on TFG Health?

Once you have found a GP on the network list that you would like to choose you can:

1. Send an email to **service@discovery.co.za**. Please include your membership number, full names and practice numbers of your primary and secondary GP (where applicable), as well as the names and practice numbers of the primary and secondary GP for each of your dependants, or
2. Speak to your financial advisor, or
3. If you do not have access to the website or do not have a financial advisor, please call our call centre at **0860 123 077** and our call centre agent will help you choose a GP.

12

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

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

13

How do I access my claims statement?

You can obtain your claims statement as follows:

- After a claim submission, an email will be sent to the email address registered with the Scheme to confirm the receipt and the amounts processed and paid.
- Download the Discovery app and use it to request a copy of your claims statement.
- You can also view your claims history using the Discovery app.
- Claim statements may also be viewed and downloaded via the website, **www.tfgmedicalaidscheme.co.za.**

14

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

You need to contact the Scheme at **0860 123 077**. For more details please visit **www.tfgmedicalaidscheme.co.za.** More information is also provided on pages 21 and 28 of this brochure.

15

What do you mean when you say you pay at the Scheme Rate?

We use 'Scheme Rate' as an umbrella term for all the rates we've negotiated with network providers. For example, if we say we pay for a visit to the GP at the Scheme Rate, we pay the GP at the rate we've negotiated for GP consultations. See also 'Scheme' under 'Glossary' on page 1 of this benefit brochure.

16

I will be travelling outside the borders of South Africa. Does TFGMAS provide benefits for healthcare services I receive in other countries?

Cover outside South Africa is limited to countries that accept the South African Rand as legal tender and will be paid according to the Scheme rules. If you are travelling outside the borders of South Africa, you should always take out additional medical insurance cover. Please note that this includes cover for members travelling into Lesotho.

17

What must I do if there is an emergency and someone in my family needs an ambulance?

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 transport to you, depending on which is most appropriate. If you are admitted to hospital, 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.

18

Do I have cover if I have a medical emergency and I need to go to a casualty room?

Please consult this benefit brochure on page 32 for more information in this regard.

19

Who do I contact for pre-authorisation?

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

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. You may incur a Deductible if you do not obtain pre-authorisation as required.

20

What is an MRI scan?

MRI is short for magnetic resonance imaging, which is a procedure that creates images of the human body without the use of X-rays. It is an imaging technique used to view internal structures of the body, particularly soft tissue.

21

What is a CT scan?

A CT scan is a special radiographic technique that uses a computer to incorporate X-ray images of the body into a two-dimensional image.

22

Do I have cover for MRI and CT scans?

MRI and CT scans will only be paid if a specialist refers you for the scan and in line with your chosen Benefit Plan's available benefits. Please contact the Scheme at **0860 123 077** for more information and to pre-authorise for these scans beforehand.

23

What is a nuclear scan and does TFGMAS cover the costs for a nuclear scan?

A nuclear medicine scan is a test (diagnostic technique) in which radioactive material (called an isotope) is injected into the body and used to highlight the structure of a specific organ or bone to create an image of it. Please contact the Scheme at **0860 123 077** for more information and to pre-authorise for these scans beforehand.

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 2020.

TFG Health

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

ICON for Oncology services, the Dental Risk Company for dental benefits, 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 offers a more comprehensive range of benefits at predetermined limits or unlimited at providers of your choice.

This Benefit Plan offers you the choice of service providers. You can avoid Deductibles in most instances by using a contracted Service Provider, however, you may visit and consult with any service provider of your choice. Be aware that the cover will be limited up to an agreed Scheme Rate with potential Deductibles payable by yourself.

Please consult this brochure and/or 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 13 December 2019 if you intend to change your Benefit Plan for 2020.

TFG Health vs TFG Health Plus

	Benefit	TFG Health	TFG Health Plus
	Overall annual limit	Unlimited.	Unlimited.
	**Hospital Cover** Cover of hospital costs and other accounts, like 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 in hospital. **Services to be obtained at the Hospitals in the Network to receive full cover.**	Specialists, radiology and pathology are covered up to 100% of the Scheme Rate. Other healthcare professionals are covered at 80% of Scheme Rate if non-contracted providers are used for services. These providers are covered up to 100% of Scheme Rate if contracted with the Scheme. **The member can visit any private hospital contracted up to 100% of Scheme Rate to avoid Deductibles.**
	**Chronic Medicine**	Essential cover for chronic medicine on the TFG Health medicine list for all 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.**	An additional list of Chronic Conditions are covered on this Benefit Plan. **You can obtain your medicine from your Preferred provider up to benefit limits that applies**. See pages 28 – 29 for more information in respect of the CDL conditions that are covered on this Benefit Plan, as well as the benefit limits within which you can obtain your Chronic Medicine at 100% of Scheme Rate.
	**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.** Private specialist cover up to a limit of R4 400 for each person.	This benefit on this Benefit Plan includes consultations and visits to GPs, specialists, registered private nurse practitioners and associated health services **of your preferred choice**. Specialists: 100% of Scheme Rate at network and non-contracted providers. Other: 80% of Scheme Rate at non-contracted providers and 100% of Scheme Rate at 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 ICON.	**Cover for PMB and non-PMB level of care at your Preferred provider of your choice**. Claims are paid at 100% of Scheme Rate limited to **R600 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 **your 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 up to limits set out in the Benefit Schedule.
	**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.

2020 Contribution tables

Full contributions with effect from 1 January 2020

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

Salary Band	TFG Health	Principal Member	Adult**	Child*
A	R0 – R5 070	R1 132	R1 132	R400
B	R5 071 – R8 260	R1 278	R1 278	R404
C	R8 261 – R15 860	R1 368	R1 368	R434
D	R15 861 – R27 200	R1 488	R1 488	R478
E	R27 201 – R40 520	R1 736	R1 736	R544
F	R40 521+	R1 890	R1 890	R578

Salary Band	TFG Health Plus	Principal Member	Adult**	Child*
A	R0 – R5 070	R3 440	R2 130	R886
B	R5 071+	R3 950	R2 790	R986

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;
- A dependant is over the age of 21, but not over the age of 25 and is dependent upon the principal member due to mental or physical disability.

** **Adult contributions are applicable if:**

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

Subsidised Contributions with effect from 1 January 2020

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

Salary Band	TFG Health	Principal Member	Adult**	Child*
A	R0 – R5 070	R566	R566	R200
B	R5 071 – R8 260	R639	R639	R202
C	R8 261 – R15 860	R684	R684	R217
D	R15 861 – R27 200	R744	R744	R239
E	R27 201 – R40 520	R868	R868	R272
F	R40 521+	R945	R945	R289

Salary Band	TFG Health Plus	Principal Member	Adult**	Child*
A	R0 – R5 070	R1 720	R1 065	R443
B	R5 071+	R1 975	R1 395	R493

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 **www.tfgmedicalaidscheme.co.za.**

TFG Health
2020 Benefit Tables

*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 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 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 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.

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 Benefit Table 2020

Benefit	Rate	Limits
Hospital cover		
Statutory Prescribed Minimum Benefits.	Basis of cover is per legislative requirements in terms of Prescribed Minimum Benefits. All Prescribed Minimum Benefits accumulate to available limits. 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.	Unlimited.
Hospitalisation in Full Cover Network Hospital.	Up to a maximum of 100% of the Scheme Rate of the hospital account. Subject to authorisation and/or approval, meeting the Scheme's clinical and Managed Health Care criteria.	Unlimited.
Hospitalisation in Partial Cover Network Hospital.	Up to a maximum of 70% of the Scheme Rate of the hospital account. Subject to authorisation and/or approval meeting the Scheme's clinical and Managed Health Care criteria.	Unlimited.
Hospitalisation in non-Network Hospital. Emergency Admissions.	Up to a maximum of 100% of the Scheme Rate. Subject to authorisation. Patients to be transferred to a KeyCare Network Hospital as soon as stabilised, unless otherwise agreed by the Scheme. Subject to PMB.	Unlimited.
Health care services in the KeyCare Day Surgery Network (The specified list of Day Surgery Procedures should be done in the day surgery network. It cannot be done in the full cover network).	Up to a maximum of 100% of the Scheme Rate at the Scheme's defined list of day-surgery providers. Up to a maximum of 100% of the Scheme Rate for related accounts. Medicines paid at 100% of the Scheme Medication Rate. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria.	Unlimited. If a network provider is not used, a deductible of R1 500 will be applicable.
Hospitalisation in non-Network Hospital. Non-emergency admissions.	No cover.	No cover
Administration of defined intravenous influsions.	Up to a maximum of 100% of the Scheme Rate at the Scheme's 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 are paid at 100% of the Scheme Medication Rate. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical criteria.	Unlimited.
Hospitalisation for selected members suffering from one or more significant chronic conditions. Non-emergency admissions.	Up to a maximum of 100% of the Scheme Rate. Subject to registration on the Scheme's disease management programme and clinical entry criteria. Up to a maximum of 80% of the Scheme Rate of the hospital and related accounts for members who are not registered on the programme.	Unlimited.
Specialists.	KeyCare Health DPA Specialists. Up to a maximum of 100% of the TFG Health direct payment arrangement rate. Other Specialists who work within the KeyCare Network Hospitals: Up to a maximum of 100% of the Scheme Rate. Member must be referred by chosen KeyCare Network GP.	Unlimited.
Other providers.	Up to a maximum of 100% of the Scheme Rate.	Unlimited.

Benefit	Rate	Limits
Radiology and Pathology.	Up to a maximum of 100% of the Scheme Rate. Pathology is subject to a Preferred provider network. Where members use a non-Preferred provider payment will be made directly to the member. Point of care pathology testing is subject to meeting the Scheme's treatment guidelines and Managed Health Care criteria.	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 authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria. Drugs paid at 100% of the Scheme Medication Rate.	Unlimited.
Organ Transplant.	Cover only in a public facility according to the PMB, subject to Regulation 8 (3).	Unlimited.
Oncological treatment, including Chemotherapy and Radiotherapy.	Subject to the provisions of PMB at the Scheme's contracted network provider only. Up to a maximum of 100% of the Scheme Rate the Scheme's KeyCare Direct Payment Arrangement practitioner. Up to a maximum of 80% of the Scheme Rate at non-KeyCare Direct Payment Arrangement practitioner in terms of the provisions of PMB. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria.	Unlimited.
Severe dental and oral procedures as defined in the Scheme rules.	Up to a maximum of 100% of the Scheme Rate. Subject to the treatment meeting the Scheme's treatment guidelines and Managed Health Care criteria.	Unlimited.
Mental health disorders.	Up to a maximum of 100% of the Scheme Rate for related accounts. Up to a maximum of 100% of the Scheme Rate for hospital account in a KeyCare Hospital Network facility. Up to a maximum of 100% of the Scheme Rate for the hospital and related accounts if a non-network facility is used.	Up to 21 days in-hospital or up to 15 out-of-hospital consultations for conditions as defined in Annexure A of the Regulations of the Act. All other conditions up to 21 days in-hospital.
Disease Management for episodes of major depression for members registered on the Scheme's disease management programme.	Up to 100% of the Scheme Rate for services covered in the Scheme's basket of care. Subject to the treatment meeting the Scheme's treatment guidelines and Managed Health Care criteria.	Basket of care as set by the Scheme.
Drug and alcohol rehabilitation.	Basis of cover is limited to PMB level of care.	21 days in-hospital treatment per person per year.
HIV/AIDS and AIDS related treatment.	Basis of cover is limited to PMB level of care.	Unlimited.
Post-exposure HIV prophylaxis following occupational exposure, traumatic exposure or sexual assault.	Up to a maximum of 100% of Scheme Rate.	Unlimited.
Prophylaxis for mother-to-child.	Up to a maximum of 100% of cost.	Unlimited.

Benefit	Rate	Limits
Cardiac stents.	Up to a maximum of 100% of the Scheme Rate. Subject to authorisation and the treatment meeting the Scheme's clinical criteria. The device accumulates to the limit. The balance of the hospital and related accounts do not accumulate to the annual limit.	**Network supplier**: Unlimited if stent is obtained from the Scheme's contracted KeyCare Direct Payment Arrangement practitioner. **Cover at Non-network supplier will be as follows:** Drug-eluting stent: R7 130 per stent per admission if not supplied by the Scheme's KeyCare Direct Payment Arrangement practitioner; Bare metal stent limit: R6 030 per stent per admission if not supplied by the Scheme's KeyCare Direct Payment Arrangement practitioner.
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. R48 200 per person per lifetime for all claims, payment of PMB claims accumulate to this limit.
Advanced Illness Benefit (AIB) for oncology patients.	Up to a maximum of 100% of the Scheme Rate. Subject to the treatment meeting the Scheme's treatment guidelines and Managed Health Care criteria.	Unlimited.
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 subject to the Specialist Benefit limit of R4 400 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.
Gastroscopies, colonoscopies, proctoscopies and sigmoidoscopies	Cover for Oncology and as per the Day Cases and Network requirements and save for children aged 12 years and under. Subject to PMB in a defined list of network facilities in Day Surgery Network Hospitals as may be applicable.	Up to 100% of the Scheme Rate if done in the doctor's rooms and subject to authorisation. Unlimited
TTO medicine (medicine to take home).	Up to a maximum of 100% of the Scheme Medication Rate.	R175 per hospital admission.
Emergency Medical Services within the borders of South Africa.	Up to a maximum of 100% of the Scheme Rate. Inter-hospital transfer subject to pre-authorisation.	Unlimited.
Basic Dentistry.	No cover.	Not applicable.
International clinical review service.	Up to a maximum of 50% of the consultation. Subject to the Scheme's Preferred provider, Protocols and clinical entry criteria.	Unlimited.

Chronic Illness Benefit

Specialised Medicine treatment.	No cover.	Not applicable
Diabetes Management for members registered on the Scheme's disease management programme, Diabetes Care Programme.	PMB level of care. Up to 100% of the Scheme Rate for services covered in the Scheme's Basket of Care if referred by the Scheme's DSP.	Basket of care as set by the Scheme.
HIV Management for members registered on the Scheme's disease management programme.	PMB level of care. Up to 100% of the Scheme Rate for services covered in the Scheme's Basket of Care if obtained by the Scheme's DSP.	Basket of care as set by the Scheme.
Cardiovascular Disease Management for members registered on the Scheme's disease management programme.	PMB level of cover. Up to 100% of the Scheme's Rate for services covered in the Scheme's Basket of Care.	Basket of care as set by the Scheme.
Bluetooth enabled blood glucose monitoring device.	Any beneficiary approved and registered on the Scheme's Chronic Illness Benefit for Diabetes is covered up to 100% of the Scheme Rate. The device must be approved by the Scheme, subject to the Scheme Protocols and clinical entry criteria.	1 per person per year.

Benefit	Rate	Limits
Out of Hospital benefit day-to-day cover		
GP, includes consultations and selected small procedures.	Up to a maximum of 100% of the Scheme Rate, subject to selected consultation and procedure codes. Member has to select a primary care KeyCare GP that is part of the KeyCare network on joining the Benefit Plan. GP visits will only be covered at chosen KeyCare Network GP. Member can elect to change his/her chosen GP three times per person per year.	Unlimited only at chosen GP, subject to pre-authorisation after visit 15, per person per year. Unscheduled emergency visits limited to 3 visits per person per year at chosen GP. Visits to a non-chosen GP limited to 3 visits 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 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 400. Member must be referred by chosen GP.	R4 400 per person per year.
Visits to casualty units at KeyCare network Hospitals.	The first R390 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 up to a maximum of 100% of the Scheme Rate.	Unlimited only at KeyCare Network Hospital.
Visits to casualty units at Non-scheme Network Hospitals.	No cover.	No cover.
Acute medicine.	Up to a maximum of 100% of the Scheme Medication Rate. Subject to the Scheme Acute Medicine Formulary and Protocols only covered if prescribed by chosen GP.	Unlimited within the Scheme Acute Medicine Formulary.
Selected basic X-rays at the the Scheme's KeyCare Direct Payment Arrangement practitioners.	Up to a maximum of 100% of the Scheme Rate at KeyCare Direct Payment Arrangement practitioners. Only if requested by member's chosen KeyCare Network GP, subject to list of procedure codes and PMB.	Unlimited.
Selected basic blood tests.	Up to a maximum of 100% of the Scheme Rate at the Scheme's network providers. Only if requested by member's chosen KeyCare Network GP, subject to list of procedure codes and PMB. Point of care pathology testing is subject to meeting the Scheme's treatment guidelines and Managed Health Care criteria.	Unlimited.
Out-of-Network visits, including GP consultations, acute medicines, radiology and pathology requested by a GP.	Up to a maximum of 100% of the Scheme Rate or Scheme Medication Rate – subject to a list of codes. Only acute medicines, radiology and pathology requested by a GP will be covered under this benefit.	Four GP claims, four pathology claims (requested by GP), four radiology claims (requested by GP) and four pharmacy claims (prescribed by GP) per person per year. Subject to PMB.
Basic Dentistry.	Up to a maximum of 100% of the Scheme Rate. Only at 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.
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 basic frame or a basic set contact lenses per person every twenty-four months from their last date of service.
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 chosen GP.	Accumulates to the Specialist Benefit limit of R4 400 per person per year.

Benefit	Rate	Limits
Mobility Devices: wheelchairs, long leg callipers and crutches.	Up to a maximum of 100% of the Scheme Rate, subject to an approved list of codes. Only if requested by the member's chosen KeyCare Network GP, subject to pre-authorisation and that the device or item is obtained from a KeyCare Direct Payment Arrangement practitioner.	R5 400 per family per year.
Over and above the DTPMB entitlement, this benefit also covers certain out-of-hospital healthcare services arising from an emergency, trauma-related event resulting in the following PMB conditions: • Paraplegia • Quadriplegia • Near-drowning related injury • Severe anaphylactic reaction • Poisoning • Crime-related injury • Severe burns • External and internal head injuries • Loss of limb. Trauma benefit services covered under this benefit include: • Allied healthcare services • External medical items • Hearing aids • Prescribed medicine.	Up to a maximum of 100% of the Scheme Rate, and is subject to applicable limits. 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 as set out under the Hospital benefit of this Benefit Plan). Cover applies to 31 December of the following year after the trauma occurred. Subject to authorisation and/or approval and treatment meeting the Scheme's entry criteria. Cover is not restricted to the Scheme's DSP's.	Services: External Medical Items: Limited to R26 450 per family per year, except for prosthetic limbs which shall be subject to a limit of R85 700 per person per year. Hearing aids: Limited to R14 750 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 050 M + 1 dependant: R12 150 M + 2 dependants: R15 100 M + 3 dependants or more: R18 200 Prescribed Medicine limited to: Member: R15 750 M + 1 dependant: R18 600 M + 2 dependants: R22 100 M + 3 dependants or more: R26 850

As a TFG Health member you will need to familiarise yourself with the following benefits available on this Benefit Plan and the restrictions in terms of the Networks and benefits covered on this Benefit Plan.

On this Benefit Plan you will receive the following key benefits:

A

Palliative care benefits

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

B

Maternity benefits which includes

- Cover for pregnancy and childbirth.

C

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

- General practitioner and Specialist benefits in a KeyCare GP Network and Specialist Referral process.
- Cover for alcohol, substance and drug rehabilitation as PMB.
- Dental and Oral benefits (no in hospital cover).
- Optical benefit at network providers only.
- Trauma Recovery Extender Benefit.

D

Hospital benefit and Casualty Benefit in a Hospital network.

E

Chronic Illness Benefit (CIB).

F

Oncology benefits as part of an Oncology Programme.

A

Palliative care benefits of TFG Health

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

Advanced Illness Benefit (AIB)

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

CompassionateCare

The CompassionateCare Benefit gives you access to holistic home-based end-of-life care up to **R48 200** for each person in their lifetime.

B

Maternity benefits of TFG Health

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

During your pregnancy

Antenatal consultations

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

Ultrasound scans and prenatal screening

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

Blood tests

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

Antenatal classes or consultations with a nurse

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

For two years after birth

GP and specialist visits

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

Six week consultation

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

Nutrition assessment

You are covered for one nutrition assessment with a dietitian.

Mental health

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

Lactation consultation

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

C

Day-to-day benefits of TFG Health

GP Consultations and the Specialist Referral Process

TFG Health provides consultation benefits at General Practitioners in the KeyCare Network which you will need to choose and register as your designated primary healthcare provider. You will need to allocate a primary and a secondary GP for each of your dependants. Please enquire with your GP whether he/she is a dispensing doctor. To visit a Specialist your chosen GP will need to refer you to a Specialist contracted with the Scheme. To access your consultation benefits on this Benefit Plan you will need to familiarise yourself with the following:

What you need to know:

Appointments with a specialist must only be made once the referral from your chosen KeyCare GP has been approved by the Scheme **and you have received a specialist authorisation number.** Routine check-ups should be done by your chosen KeyCare GP.

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

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

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

What you need to do:

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

Urgent specialist referral

If there is clinical reason for you to see the specialist the same day you consulted the GP then your GP must contact us on **0860 123 077** or refer you to casualty at a Keycare Network hospital.

Important to remember

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

The Alcohol, Substance and Drug Rehabilitation Benefit as PMB

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

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

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

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

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

The Scheme has Designated Service Providers (DSPs) for in-hospital alcohol, substance and drug detoxification and rehabilitation and you can visit the TFG Medical Aid Scheme website at **www.tfgmedicalaidscheme.co.za** to access the list of DSPs for treatment on this Benefit Plan as a PMB where you will need to receive services to avoid Deductibles.

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

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

If you choose to use a facility that is not a DSP, we will pay for alcohol, substance and drug detoxification and rehabilitation up to 80% of the Scheme Rate. You will be liable to pay the difference. Your Deductible may be higher than 20% if your service provider charges more than the Scheme Rate.

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

Dental and Oral Benefits

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

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

Your Cover on TFG Health summarised:

Severe Dental and Oral Surgery Benefit

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

You must pre-authorise your admission to hospital at least 48 hours before you go in. Please call **0860 123 077**.

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

Other dental treatment in hospital

In-hospital dental treatment is not covered on TFG Health.

Optical benefit

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

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

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

Trauma and Recovery Extender Benefit (TREB)

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

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

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

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

Your TREB benefit in a glance:

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

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

You must visit your chosen KeyCare Network GP.

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

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

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

How we pay allied, therapeutic and psychology healthcare professionals

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

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

The annual limit varies, depending on your family size. The limits are set out in the Benefit Schedule.

If you join after January, you do not qualify for the full limit for prescribed medicine because these limits are calculated by counting the remaining months in the year.

For medicine on our Preferred Medicine List, we will pay up to 100% of the Scheme Medicine Rate for medicines, and for medicine not on our Preferred Medicine List we will pay up to 75% of the TFG Health Rate for medicines.

D

Hospital benefit and Casualty Benefit in a Hospital network of TFG Health

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

Your chosen GP can admit you to hospital if he is the admitting and treating doctor on the hospital authorisation request. Specialists can admit you into hospital for treatment which should be pre-authorised.

Please consult the Benefit Table in this document on page 12 to understand your cover at a Full Cover and Partial Cover KeyCare Hospital.

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

Your casualty benefit on TFG Health

If your chosen GP is not available and your out of area network visit has been used, then you must visit a casualty unit at a KeyCare Network hospital to access your casualty benefits. Subject to pre-authorisation, you pay **R390** towards the facility fee upfront to the casualty unit, for each person for each event. In the event of an emergency you will not have to pay the **R390** towards the facility fee.

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

The Casualty Benefit covers:

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

How to find a KeyCare Network hospital

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

E

Chronic Illness Benefit (CIB) of TFG Health

Prescribed Minimum Benefit (PMB) conditions

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

PMB CDL conditions covered:

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

Chronic Illness Benefit (CIB) cover on TFG Health (continued)

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

We will pay your approved medicine in full if it is on our medicine list (Formulary). You may have a Deductable if you choose to use medicine not on the medicine list.

You need to 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% Deductable.

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.

If you want to access cover from the Chronic Illness Benefit, you must apply for it. You need to complete a Chronic Illness Benefit application form with your doctor and submit it for review to **CIB_APP_FORMS@discovery.co.za.** You can get your latest application form on the website **www.tfgmedicalaidscheme.co.za.**

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 KeyCare GP may need to provide certain test results or extra information and motivation to finalise your application. The application form will give you the details as to which documents and extra information you will need to submit. Please ensure that these documents are submitted with your application.

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

F

Oncology Benefits of TFG Health

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

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

What you need to do before your treatment

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

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

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

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

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

Cancer treatment that falls within the Prescribed Minimum Benefits is always covered in full, with no Deductible. **This is if you use Service Providers who we have a payment arrangement with** and if they do not charge above the agreed rate.

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

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

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

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

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

Remember

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

For approved oncology-related medicine where your doctor has provided a script please use a MedXpress Network Pharmacy. More information regarding the Oncology management programme and funding of your oncology-related medicine will be send to you when you are registered on this programme by your doctor in the event that you are diagnosed with cancer.

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. Back surgery.
8. Neck surgery.
9. Knee and shoulder surgery.
10. In-Hospital management of
    - Conservative back treatment.
    - Conservative neck treatment.
    - Dentistry (services of surgical procedures which involve the hard or soft tissues of the mouth).
    - Skin disorders (non-life-threatening) including benign growths and lipomas.
    - Nail disorders.
    - Investigations and diagnostic work-up.
    - Functional nasal problems and functional sinus problems.
    - Endoscopic procedures.
11. Surgery for oesophaegeal reflux and hiatus hernia repairs.
12. Removal of Varicose Veins.
13. Correction of Hallux Valgus/Bunion and Tailor's Bunion/Bunionette.
14. Surgery and other healthcare services to correct refractive errors of the eye.
15. Elective Caesarean Section except in cases where it is medically necessary.

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

The above list is subject to change and you are directed to the Scheme Rules to ensure that you familiarize 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.

TFG Health Plus
2020 Benefit Table

Benefit	Rate	Limits	
Excess for failure to pre-authorise.		**R2 000**	
Overall annual limit.		**Unlimited.**	

(H) **Hospital and hospital related benefits**

Benefit	Rate	Limits	Additional comments
Ward and theatre fees.	100% of scheme or contracted rate.	Unlimited	
X-rays.	100% of Scheme Rate.	Unlimited	
Pathology.	100% of Scheme Rate.	Unlimited	
Radiotherapy.	100% of Scheme Rate.	Unlimited	
Blood transfusions.	100% of cost.	Unlimited	
Organ transplants.	100% of cost in state and 100% of Scheme Rate in private facilities.	Unlimited	per live donor. per cadaver.
Renal dialysis.	100% of Scheme Rate.	Funded per PMB requirements	per family per year.
Psychiatric treatment.	100% of Scheme Rate.	21 days per person per year.	
Elective maxillo-facial and oral surgery.	100% of scheme or Network rate.	R19 000	per family per year.
Internal prostheses.	100% of negotiated rate.	There is no limit applied if the member gets their prosthesis from a preferred supplier If they choose not to then the following sub-limits apply:	No authorisation is required for external prostheses
• Total hip replacement.	100% of negotiated rate.	R67 450	per family per year.
• Partial hip replacement.	100% of negotiated rate.	R40 350	per family per year.
• Spinal prostheses.	100% of negotiated rate.	R34 000	for one level.
		R68 200	for two or more levels.
• Knee replacement.	100% of negotiated rate.	R63 950	per family per year.
• Shoulder replacement.	100% of negotiated rate.	R55 650	per family per year.
• Cardiac stents.	100% of negotiated rate.	R13 950	per bare metal stent.
		R22 250	per drug eluting stent.
• Cardiac pacemakers.	100% of negotiated rate.	R82 050	per family per year.
• Tissue replacing prosthesis.	100% of negotiated rate.	R26 450	per family per year.
• Artificial limbs.	100% of negotiated rate.	R40 350	per family per year.
• Artificial eyes.	100% of negotiated rate.	R20 150	per family per year.
• Cardiac valves.	100% of negotiated rate.	R33 400	per valve.
• Vascular grafts.	100% of negotiated rate.	R100 050	per family per year.
• General (Mirena subject to approval).	100% of negotiated rate.	R26 450	per family per year.

Benefit	Rate	Limits	Additional comments
Post-exposure prophylaxis.	100% of Scheme Rate.	Subject to overall annual limit.	
Oncology.	100% of Scheme Rate at DSPs and 80% of Scheme Rate at non-DSPs.	R600 000	per person per rolling 12 month period from date of diagnosis. A Deductible of 20% applies to non-PMB once limit is reached.
International second opinion.	50% of cost or negotiated rates.	Pre-approval required. Applies to specified conditions only.	
Compassionate Care.	100% of Scheme Rate.	R48 200	per person per lifetime.
Chronic medicine			
Chronic medicine.	100% of scheme Medicine rate for Formulary medicine and CDL conditions.	R27 500	per person per year
	Non-formulary medicine for CDL conditions and medication for ADL conditions are subject to a monthly Chronic Drug Amount.	R76 000	per family per year.
Cardiovascular Disease Management for members registered on the Scheme's disease management programme.	PMB level of care. Up to 100% of the Scheme Rate for services covered in the Scheme's Basket of Care if referred by the Scheme's DSP.	Basket of care as set by the Scheme.	
Diabetes Management for members registered on the Scheme's disease management programme, Diabetes Care Programme.	PMB level of care. Up to 100% of the Scheme Rate for services covered in the Scheme's Basket of Care if referred by the Scheme's DSP.	Basket of care as set by the Scheme.	
Specialised dentistry			
Specialised dentistry.	80% of Scheme Rate.	R9 500	per family per year. (M)
		R12 600	per family per year. (M + 1)
		R15 200	per family per year. (M + 2)
		R16 600	per family per year. (M + 3)
		R17 700	per family per year. (M + 4)
		R18 200	per family per year. (M + 5)
		R18 600	per family per year. (M + 6)
		R18 900	per family per year. (M + 7)

Benefit	Rate	Limits	Additional comments
Primary care consultations			
Consultations at GPs, specialists, nurse practitioners and associated health services (including virtual consultations).	Specialists: 100% of Scheme Rate at non-network providers and 100% of the Scheme or negotiated rate at network providers. Other: 80% of Scheme Rate at non-network providers and 100% the Scheme or negotiated rate at network providers.	R4 100	per family per year. (M)
		R6 200	per family per year. (M + 1)
		R8 000	per family per year. (M + 2)
		R9 300	per family per year. (M + 3)
		R10 100	per family per year. (M + 4)
		R10 600	per family per year (M + 5)
		R11 100	per family per year. (M + 6)
		R11 300	per family per year. (M + 7)
		Unlimited virtual paeditatric consultations for children aged 0 to 14 at a KeyCare Network GP.	
Additional consultations for PMB conditions.	100% of the Scheme or negotiated rate at network providers.	4 GP consultations	per person registered on the CIB per year.
Additional consultations for pregnancies.	100% of the Scheme or negotiated rate at network providers.	4 GP or gynaecologist consultations	per pregnant beneficiary per year.
Additional emergency facility consultations.	100% of the Scheme or negotiated rate at network providers.	2 consultations	per child aged 0 to 10.
Basic dentistry.	80% of Scheme Rate.	R4 300	per family per year. (M)
		R5 200	per family per year. (M + 1)
		R6 100	per family per year. (M + 2)
		R6 900	per family per year. (M + 3)
		R7 600	per family per year. (M + 4)
		R8 000	per family per year. (M + 5)
		R8 300	per family per year. (M + 6)
		R8 400	per family per year. (M + 7)
Optometry			
• Consultation.	100% of Scheme Rate or cost.	R750	per person per cycle and limited to 1 visit per beneficiary per cycle.
• Frames.	100% of Scheme Rate or cost.	R1 050	per frame and limited to 1 frame per person per cycle.
• Lenses: single vision.	100% of Scheme Rate or cost.	R420	per lense and limited to 1 pair per person per cycle.

Benefit	Rate	Limits	Additional comments
• Lenses: bifocal.	100% of Scheme Rate or cost.	R990	per lense and limited to 1 pair per person per cycle.
• Lenses: Multifocal.	100% of Scheme Rate or cost.	R1 900	per lense and limited to 1 pair per person per cycle.
• Contact lenses.	100% of Scheme Rate or cost.	R3 300	per person per cycle.
Benefits are provided for either glasses or contact lenses, but not both. The optical benefit cycle is a two year period.			
Other			
Radiology and pathology.	80% of Scheme Rate for radiology and 100% of Scheme Rate for pathology.	R25 000	per family per year.
Psychiatry and clinical psychology.	80% of Scheme Rate at non-network providers and 100% of the negotiated rate at network providers.	R8 200	per family per year.
Acute medicine. Subject to the overall annual limit	100% of Scheme Medicine Rate.	R6 700	per family per year. (M)
Sub-limit of:		R9 800	per family per year. (M + 1)
		R11 700	per family per year. (M + 2)
		R13 200	per family per year. (M + 3)
		R14 300	per family per year. (M + 4)
		R15 000	per family per year. (M + 5)
		R15 600	per family per year. (M + 6)
		15 800	per family per year. (M + 7)
		R200	per claim for over-the-counter medicine.
Ambulance.	80% of Scheme Rate at non-network providers and 100% of the Scheme or negotiated rate at network providers.	R4 600	per family per year. Unlimited if Discovery 911 is used.
Medical appliances.	80% of cost.	R22 400	per family per year.
Telemetric glucometer devices.	100% of cost.	1 device per person per year if obtained from contracted providers. Additional devices are subject to the medical appliances benefit.	
Speech therapy, occupational therapy and audiology.	80% of Scheme Rate.	R6 900	per family per year.
Physiotherapy and chiropractic therapy.	80% of Scheme Rate.	R6 100	per family per year.
Podiatry and orthoptics.	80% of Scheme Rate.	R5 000	per family per year.
Specialised medicine.	Deductibles may apply.	R250 000	per person per year for approved medicine. A 20% Deductible applies for certain medicine.

TFG **Health Plus**

A

Palliative Care Benefits of TFG Health Plus

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

Advanced Illness Benefit (AIB)

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

CompassionateCare

The CompassionateCare Benefit gives you access to holistic home-based end-of-life care up to **R48 200** for each person in their lifetime.

B

Chronic Illness Benefit cover of TFG Health Plus

Members living with a chronic illness get adequate and extensive cover for chronic conditions.

PMB CDL conditions covered:

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

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

We will pay your approved medicine in full if it is on our medicine list (Formulary). If your approved medicine is not on our medicine list, we will pay your chronic medicine up to a set monthly amount, called the the Chronic Drug Amount (CDA), for each medicine class.

If you use more than one medicine in the same medicine class, where both medicine 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.

You can obtain your approved chronic medicine from any pharmacy or dispensing GP.

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.

If you want to access cover from the Chronic Illness benefit, you must apply for it. You need to complete a Chronic Illness Benefit Application form with your doctor and submit it for review to **CIB_APP_FORMS@discovery.co.za.** You can get your latest application form on the website **www.tfgmedicalaidscheme.co.za.**

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 extra information and motivation to finalise your application. The application form will give you the details as to which documents and extra information you will need to submit. Please ensure that these documents are submitted with your application.

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

On TFG Health Plus, you have further cover for medicine for Additional Disease List (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.

The additional list of conditions are:

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

C

Maternity Benefit Cover of TFG Health Plus

For members on TFG Health Plus, you have a choice to obtain services from your GP or gynaecologist and these benefits include the Consultation, as well as Radiology and Pathology Benefits on this Benefit Plan.

Four GP or gynaecologist consultations, in addition to the Consultation Benefit on TFG Health Plus, are automatically unlocked for pregnant mothers once their pregnancy has been confirmed. Ultrasound scans and prenatal screening, as well as blood tests are covered from the Radiology and Pathology Benefit on this Benefit Plan.

Members are not restricted to a Network and can obtain services at a contracted designated service provider at 100% of Scheme Tariff.

Important information relating to both the **TFG Health and the TFG Health Plus Benefit Plans**

On TFG Health Plus, home nursing and step down facility benefits are made available and more information can be obtained from the contact centre in respect of the cover available on this Benefit Plan.

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.

Maximum annual benefits referred to will be calculated from 1 January 2020 to 31 December 2020, 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 an annual benefit 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.

A

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.

The above list is not to be regarded as a full and complete list 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.

In addition to the above General Exclusions that is applicable on both Benefit Plans, it is important to take note of the additional list of exclusions applicable on TFG Health as set out from page 23 of this benefit brochure.

B

Cover for medical emergencies

What is a medical emergency?

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

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

Cover for medical emergencies in South Africa

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 **R390** 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 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.

C

Hospital benefit TFG Health and TFG Health Plus

*The table below sets out and explain 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.	Not applicable.
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.	Not applicable.
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.	Not applicable.
Related accounts		
Specialists and healthcare professionals in our network	Full cover.	100% of the Scheme Rate. If the Service Provider charges above the Scheme Rate you must pay the balance of the account.
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.	100% of the Scheme Rate. If the Service Provider charges above the Scheme Rate you must pay the balance of the account.
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 trained by Discovery Health. 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 33 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 rules. 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.

We cover a list of procedures in our Day Surgery Network and you will need to consult the rules of the Scheme available on the website at www.tfgmedicalaidscheme.co.za to familiarise yourself with the list of procedures to be obtained in the Day Surgery Network of the Scheme. Alternatively, you can contact us on 0860 123 077 to obtain more information.

If a Day Surgery Network provider is not used, a Deductible of R1 500 will be applicable.

D

Prescribed Minimum Benefits (PMB)

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.

E

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

Our Diabetes Care programme together with your Premier Plus GP, will help you manage your condition and you will be registered on this programme by your GP. A Premier Plus GP is a contracted GP who will provide you with high quality healthcare for your condition.

You and your GP can track progress on a personalised dashboard displaying your unique management score for your condition. This helps to identify the next steps to optimally manage your condition and stay health over time.

The Diabetes Care programme also unlocks cover for additional services from dietitians and biokineticists. Any member registered on the Chronic Illness Benefit for diabetes can join the Diabetes Care programme.

Members on TFG Heath will have to use a KeyCare Premier Plus GP to manage their condition to avoid a 20% deductible.

Cardio Care Programme

The Cardio Care Programme enables your Premier Plus GP to diagnose and initiate appropriate treatment while managing your risk factors with the support of a high functioning multidisciplinary care team.

About joining the Cardio Care Programme

To have access to the Cardio Care Programme, you must consult with a Premier Plus GP and be registered on the Chronic Illness Benefit (CIB) for one or more of the following conditions:

- Hypertension
- Ischemic heart disease
- Hyperlipidemia.

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

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**

F

Cleveland Clinic and Home Care

Home Care

TFG Medical Aid Scheme introduced an added home-based service to members with effect from 1 January 2020. The introduction of this service allows for management of patients who normally would need to receive IV infusions (drips), wound care and postnatal care in an acute in-hospital setting from the comfort of their home. 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.

Cleveland Clinic MyConsult

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 Scheme 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**.

G

Screening and Prevention Benefits

You get 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 screening and prevention benefits at any one of our wellness providers. Please contact us on **0860 123 077** to advise you further in terms of who these service providers are. The preventive tests, screening and flu vaccinations must be referred and done by an appropriately registered healthcare professional, and network provider where applicable.

Tests that the Screening and Prevention Benefit covers: Blood glucose test, blood pressure test, cholesterol test and body mass index (BMI) tests.

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 below vaccines 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.***

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.

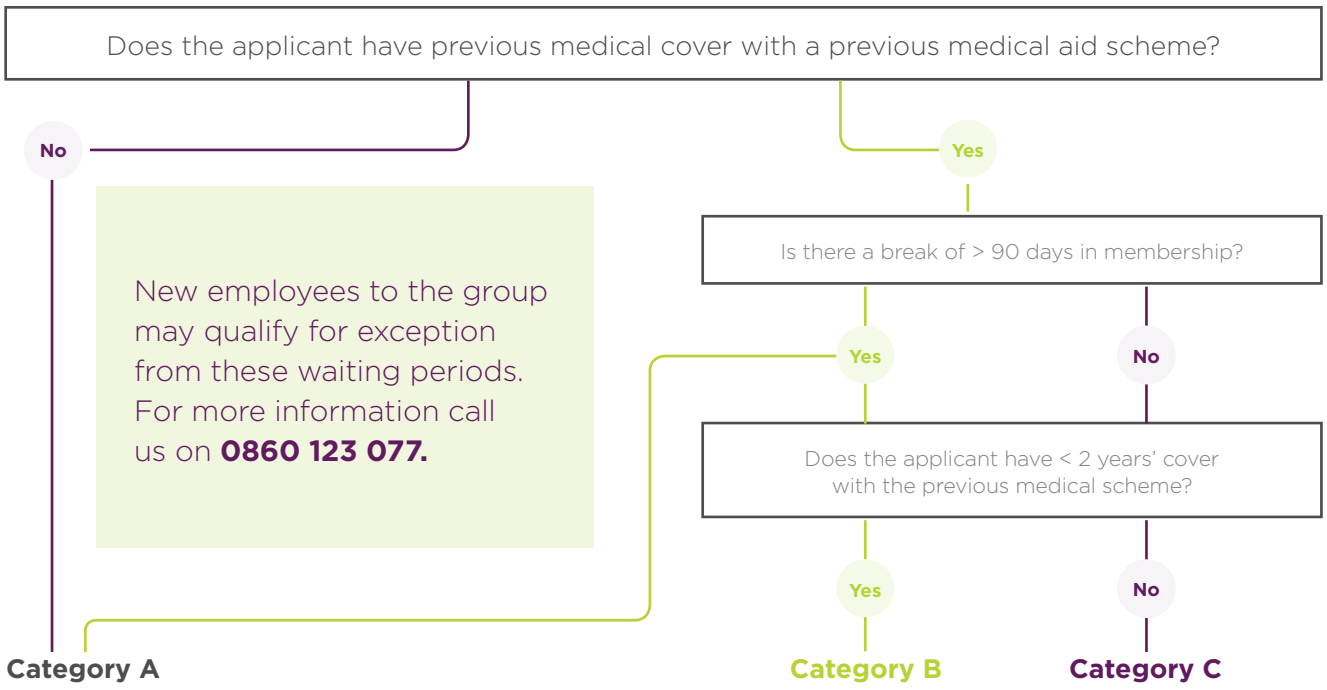
1.3 Category C

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.

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.



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.

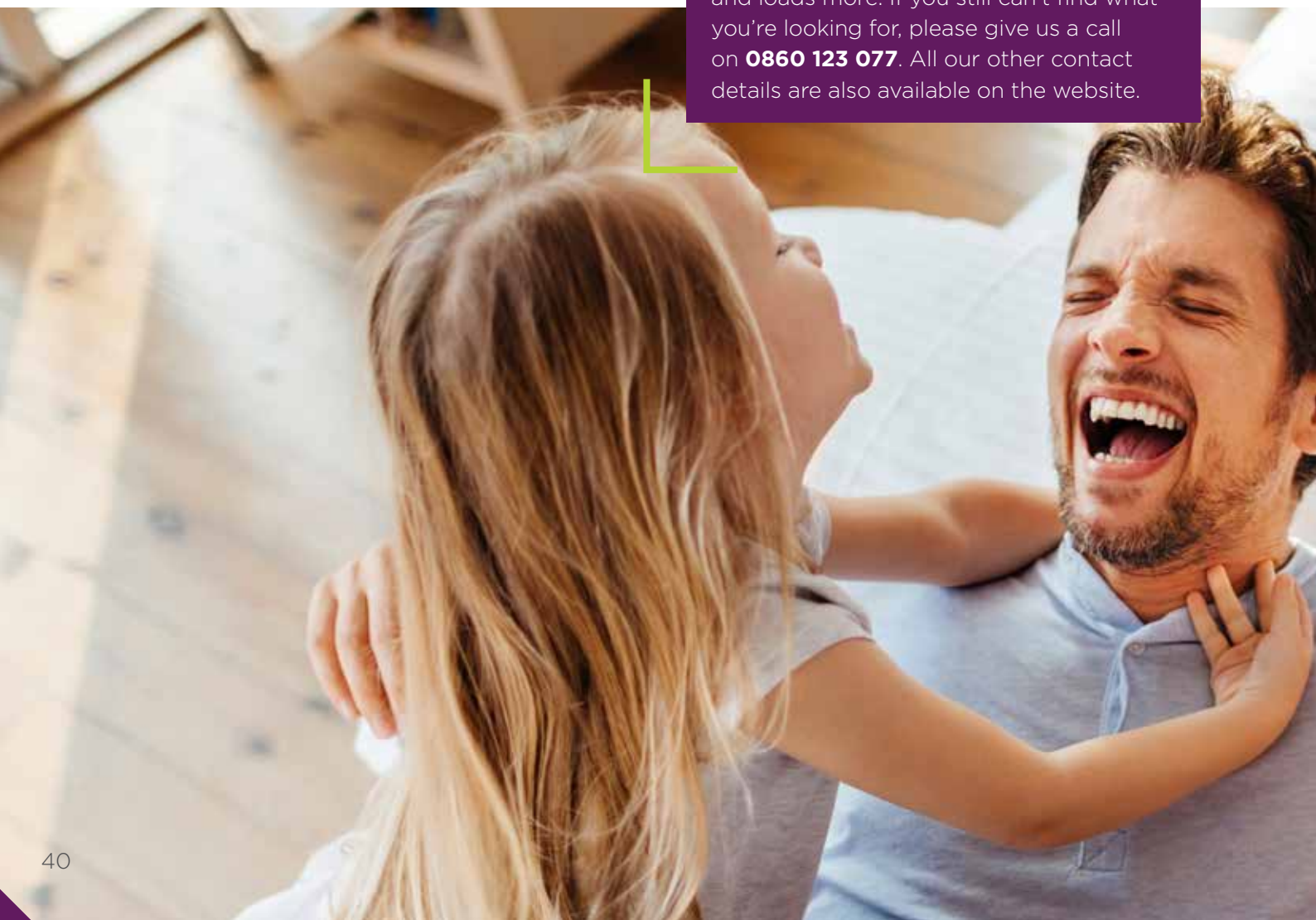
Find it all on TFG Medical Aid Scheme Website

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

he 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

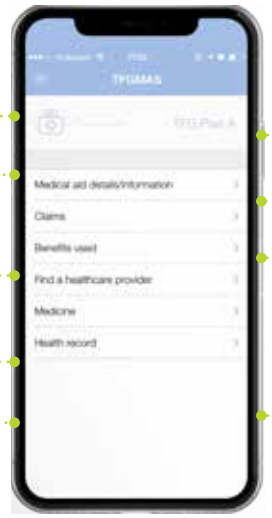
Submit claims by taking a photo of your claims using your smartphone camera and submit. You can also view a detailed history of your claims.

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.

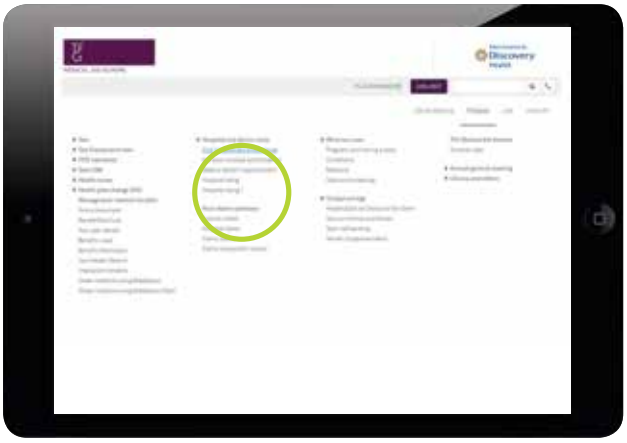
Finding a healthcare professional

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

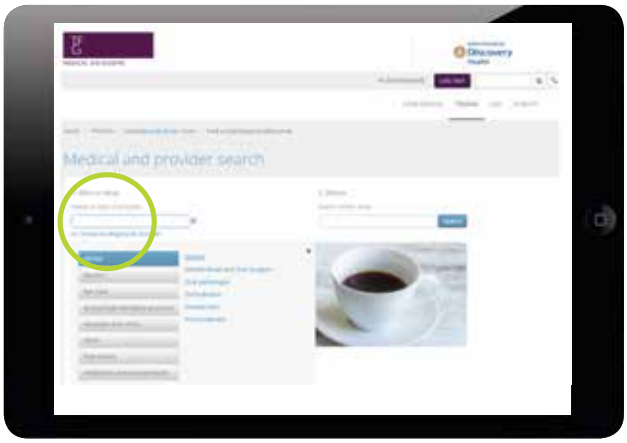
How to find a network Service Provider using the MaPS tool and our website

*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

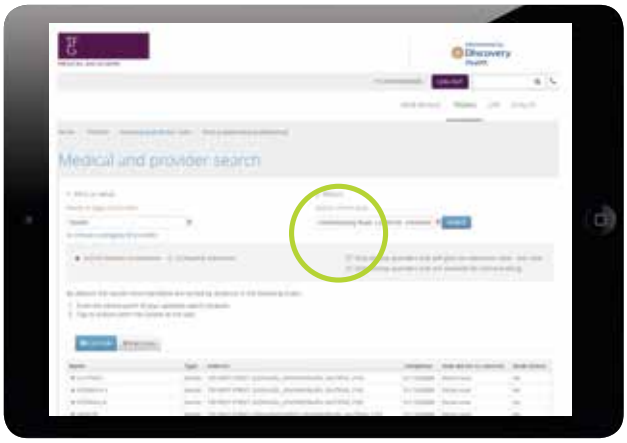
The page will open in the MaPs Medical and Provider Search functionality.



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

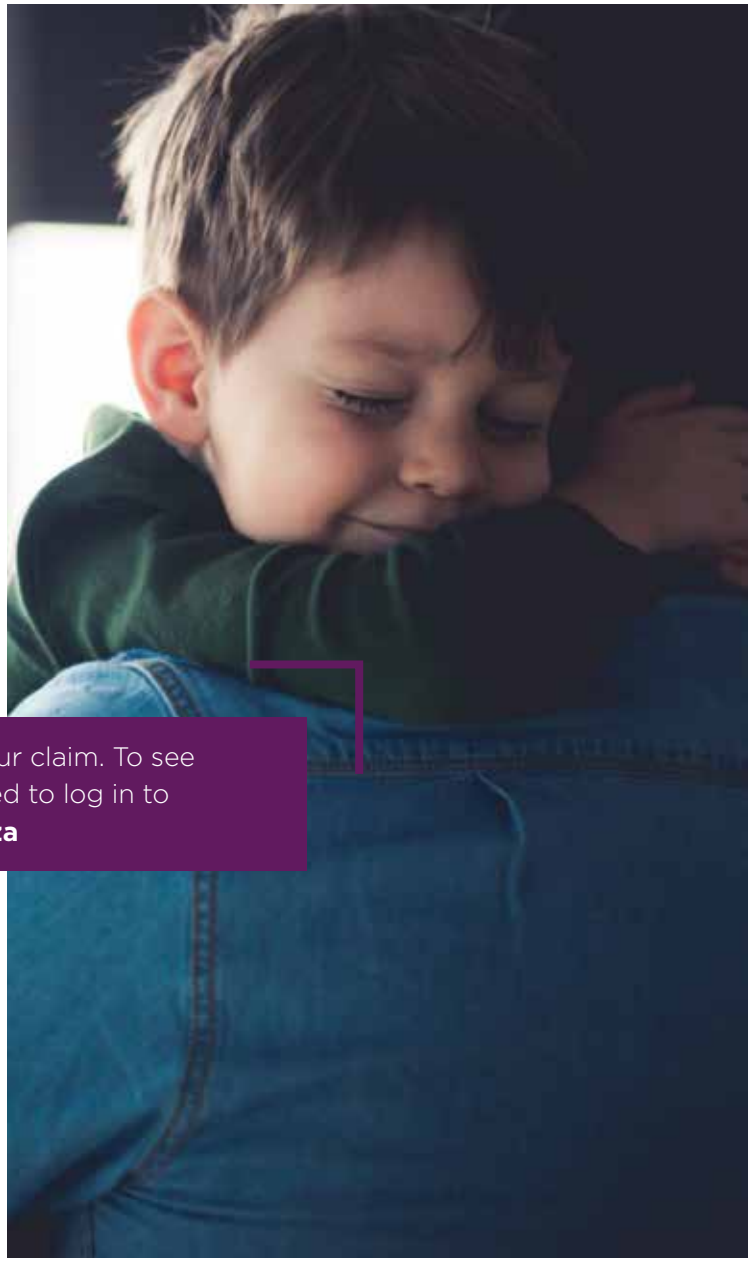
Remember these important points so you can claim correctly and avoid Deductibles:

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'.

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.



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

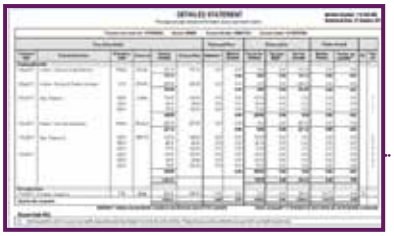
E

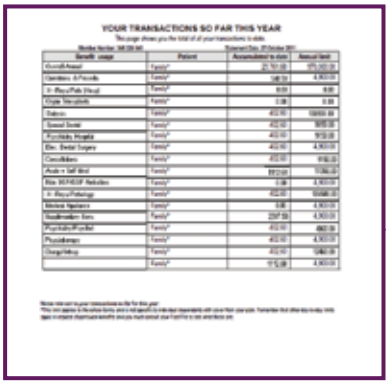
How to get the most out of your claim statement

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




YOUR TRANSACTIONS SO FAR THIS YEAR

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.**

Note: Your medical information is confidential

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.com.**

TFG MEDICAL AID SCHEME

RCK_61383DIH_21/11/2019_V9