TFG
MEDICAL AID SCHEME

HIV*Care* Programme

Who we are

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

Contact us

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

Overview

This document gives you information about the TFG Medical Aid Scheme HIV*Care* Programme. It explains your cover for HIV-and AIDS- related hospital admissions and HIV medicine. We also give you information on the doctor consultations and laboratory tests and x-rays we cover.

Some of the terms we use in this document

There are a number of terms we refer to in the document that you may not be familiar with, we provide you the meaning of these terms:

Terminology	Description
Day-to-day benefits	These are the funds available in the Primary Care Benefit, if available on your Health Plan option.
Scheme Rate	This is the rate that the Scheme sets for paying claims from healthcare professionals.
Payment arrangements	We have payment arrangements in place with specific specialists to pay them in full, at a negotiated rate.
Chronic Drug Amount (CDA)	The CDA is a maximum monthly amount we pay up to for a medicine class. This applies to medicine that is not listed on the medicine list (formulary). The Chronic Drug Amount includes VAT and the dispensing fee.
MaPS Advisor	MaPS Advisor is a medical and provider search tool which is available on www.tfgmedicalaidscheme.co.za The value-added service - MaPS Advisor - is owned by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes.
Premier Plus GP	A Premier Plus GP is a network GP who has contracted with us to provide you with high quality healthcare for your condition.

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The HIVCare Programme, at a glance

You have access to clinically sound and cost-effective treatment

We base the TFG Medical Aid Scheme HIV*Care* protocols on the Southern African HIV Clinicians' Society and South African Department of Health guidelines. Approval of HIV- related services is subject to Prescribed Minimum Benefit guidelines and your benefits.

We deal with each case with complete confidentiality

HIV or AIDS is a sensitive matter, whether one has the condition or not. Our HIV healthcare team respects your right to privacy and will always deal with any HIV- and AIDS-related query or case with complete confidentiality.

No overall limit for hospitalisation for members who register on the HIVCare Programme

For members who register on the HIV*Care* Programme, there is no limit to the hospital cover. If the Overall Annual Limit has been exhausted and the condition is a Prescribed Minimum Benefit (PMB), we will cover through the limit.

We cover a specified number of consultations and HIV-specific blood tests for your condition

For members who are registered on the HIV*Care* Programme, we pay for four (4) GP consultations and one specialist consultation, for the management of HIV.

We also pay HIV-specific blood tests for members who are registered on the HIV*Care* Programme. These tests are a measure of the extent of the HI virus and are instrumental in managing the patient's response to treatment. The specific tests are listed in the Benefits available for you plan type section.

We cover antiretroviral medicine from our HIV medicine list up to scheme medicine rate.

Members who test positive for HIV have cover for antiretroviral medicines that are on our HIV medicine list (formulary) This includes treatment for prevention of mother-to-child transmission, treatment of sexually transmitted infections and HIV-related (or AIDS-defining) infections. We will fund for supportive medicine whose conditions meet our requirements for cover (clinical entry criteria). Our case managers will coordinate HIV medicine applications and monitor the member's use of antiretroviral treatment to ensure the treatment is effective.

For preventive treatment in the case of sexual assault, mother-to-child transmission, trauma or workman's compensation, any HIV waiting periods do not apply to preventive medicine. Cover is subject to national treatment guidelines and benefit confirmation.

Except for prevention of mother to child transmission of the HI Virus, members do not need to register on the HIV*Care* Programme for this preventive treatment.

We cover nutritional feeds to prevent mother-to-child transmission

Nutritional feeds are covered for babies born to HIV-positive mothers, up to six months old from date of birth, as per Nutritional and Mother to child prevention milk formula list (formulary). We approve the first month upfront however the infant needs to be registered on your health policy in order to qualify for the remaining five months.

Getting the most out of your benefits

Register on the HIVCare Programme to access comprehensive HIV benefits

You need to register on the TFG Medical Aid Scheme HIVCare Programme to access the benefits available on the HIVCare Programme. Call us on 0860 123 077, fax 011 539 3151 or email HIV_Diseasemanagement@discovery.co.za to register.

The HIVCare team will only speak to you as the patient or your treating doctor about any HIV-related query.

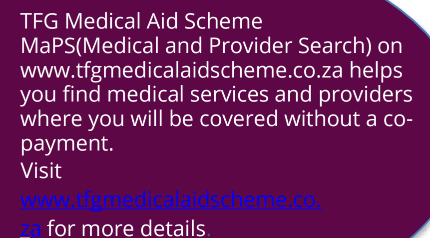
Use approved medicine on our medicine list

TFG Medical Aid Scheme does not cover experimental, unproven or unregistered treatments or practices.

You have full cover if your healthcare provider charges the Scheme Medication Rate. You will be responsible to pay any shortfall from your pocket for medicines not on the list or if the pharmacy charges more than the Scheme Medication Rate.

Get your medicine from a healthcare provider who is part of our network

Members need to get their approved chronic medicine from a HIV Pharmacy Network. If you choose to get your medicine from a pharmacy that is not in our network, you will be responsible for a 20% co-payment.



Use a healthcare provider who participates in our payment arrangements

If the GP, specialist or other healthcare provider participates in out payment arrangements. We will pay the account up to the agreed rate.

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If you don't use a healthcare provider who participates in our payment arrangements, you will be responsible for any shortfall between what the provider charges and what the Scheme pays.
Tell us about where you'll be having your treatment and who your treating doctor is and we'll confirm if the healthcare provider participates in one of our payment arrangements. If you choose to have your treatment at a provider who is in one of our payment arrangements, there will be no shortfall in payment. Remember that any plans benefits still apply in this case.

Take your HIV medicine as prescribed and send test results when we ask for them

We will only fund your HIV treatment if the Scheme has approved it and you remain compliant with your treatment plan. Once you've registered on the HIV*Care* Programme, you'll need to send us follow-up tests, when we ask for them, for us to assist you in the ongoing management of your condition.

Prescribed Minimum Benefit cover

The Prescribed Minimum Benefits are guided by a set list of medical conditions as defined in the Medical Schemes Act of 1998. These conditions include 270 defined diagnoses and their associated treatments, as well as 27 chronic conditions.

All medical schemes in South Africa have to include the Prescribed Minimum Benefits in the health plans they offer to their members. There are, however, certain requirements that a member must meet before he or she can benefit from the Prescribed Minimum Benefits.

These are the requirements that apply to access Prescribed Minimum Benefits

1. Your condition must be part of the list of defined conditions for Prescribed Minimum Benefits. You may need to send us the results of your medical tests and investigations that confirm the diagnosis for your medical condition.

2. The treatment you need must match the treatments included as part of the defined benefits for your medical condition.

3. You must use a doctor, specialist or other healthcare provider with whom the Scheme has negotiated a specific payment arrangement. There are some cases where this is not necessary, for example a life- threatening emergency.

HIV infection is classified as a Prescribed Minimum Benefit condition for members who qualify for cover. However, only certain treatment protocols are available for funding from this benefit.

More information on our approach to Prescribed Minimum Benefits is available at :www.tfgmedicalaidscheme.co.za

Your doctor can appeal for additional cover

We cover certain basic out-of-hospital treatments related to HIV infection as a Prescribed Minimum Benefit. You can ask for additional cover if your condition requires this through an appeals process. Once we have approved the additional cover, we will pay the claims for these treatments in full, if your doctor participates in one of our payment arrangements. You may be responsible to pay part of the claim if your doctor does not participate in one of our payment arrangements.

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We pay all other out-of -hospital treatments from the available funds in your day-to-day benefits. If you have run out of money, you will be responsible to pay these from your pocket.

Benefits available for your Plan type

Health

Hospital Admissions

Cover for all costs while you are hospitalised is not automatic. When you know you are going to hospital, you need to tell us beforehand. You must pre-authorise your admission to hospital at least 48 hours before you go in.

Please phone our Hospital Services on 0860 123 077 and follow the prompts to obtain approval.

When you contact us, please have specific information about your procedure and admission available, so that we are able to assist you.

GP and specialist consultations

For members who have registered on the HIV*Care* Programme, we pay for four (4) consultations including one specialist's consultation, for HIV for each person for the year from your Risk benefit, subject to the overall limit, although PMB's pay through the limit. To avoid a 20% co-payment, you must choose a GP who is on both on the KeyCare and Premier Plus HIV GP Network.

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 a social worker.
You and your Premier Plus GP can track progress on a personalised dashboard displaying your unique management score for your condition.

If you haven't registered, we pay the consultation costs from available funds in the day-to- day benefits.
We pay these claims up to the Scheme Rate. You will be responsible to pay any shortfall from your pocket.

HIV antiretroviral and HIV-supportive medicine

If your approved medicine is on our HIV medicine list (formulary) and you use a designated service provider to get your medicines, we will pay for it in full up to the Scheme Medicine Rate for medicines.
If you do not use our designated service provider, you will have to pay a 20% co-payment on your HIV antiretroviral medicines. This does not apply to the HIV nutritional and mother-to-child prevention milk formulas, supportive medication, Heberbio vaccine and multivitamins in the HIV basket of care.

Approved medicine not on our HIV medicine list will be covered up to a set monthly reference price.

You will be responsible to pay any shortfall from your pocket if your provider is claiming medicines not on the medicine lists and charging more than the Scheme Medication Rate.

Members have cover of up to R535 a person a year for the multivitamins and vaccination shown below.
Flu vaccinations will be paid from the Risk benefit, subject to the overall limit, although PMB's pay through the limit.

Medicine name	Nappi code
Multivitamin forte	715460001
Multivitamin orange	838500005
Multivitamin	799173002
Heberbio HBV sgl dose 1ml adult	701659001

HIV-monitoring blood tests

For members registered on the HIV*Care* Programme, we cover the following blood tests, up to the Scheme Rate:

Test	Number of tests we cover for each person for the year
CD4 count	4
Viral load	4
ALT	3
Full blood count (FBC)	4
Fasting lipogram	1
Fasting glucose	1
Urea and electrolytes (U&E) and creatinine	1
Liver function test (LFT)	1
HIV drug resistance test (genotype)	1 (we only cover this test if we have approved funding before the test is conducted)

For members not registered on the HIV*Care* Programme, we pay these costs from available funds in the day- to-day benefits, if available in your plan type.

HIV drug resistance test

You do not automatically qualify to have this test covered from the Scheme's risk benefits, authorisation for the test is a prerequisite. Authorisation applies for requests for tests done in-hospital and out-of-hospital.

The authorisation process is used to manage risk to ensure that you receive best-practice HIV care, based on clinical evidence, to ensure optimal quality of care and health outcomes. It is important that the authorisation process be followed for every request.

Health Plus

Hospital admissions

Cover for all costs while you are hospitalised, is not automatic. When you know you are going to hospital, you need to tell us beforehand. You must pre-authorise your admission to hospital at least 48 hours before you go in. Please phone our Hospital Services on 0860 123 077 and follow the prompts to obtain approval.

When you contact us, please have specific information about your procedure and admission available so that we are able to assist.

GP and specialist consultations

For members who have registered on the HIV*Care* Programme, we pay four consultations including one specialist's consultation for HIV for each person for the year from the Risk benefit,

The preferred provider is a GP in the Premier Plus HIV Network to manage your condition, you are covered for the care you need, which includes cover for social worker consultation.

HIV antiretroviral and HIV-supportive medicine

If your approved medicine is on our HIV medicine list (formulary) and you use a designated service provider to get your medicines, we will pay for it in full up to the Scheme Medicine Rate for medicines.

If you do not use our designated service provider, you will have to pay a 20% co-payment on your HIV antiretroviral medicines. This does not apply to the HIV nutritional and mother-to-child prevention milk formulas, supportive medicine, Heberbio hbv sgl dose 1ml adult vaccine and multivitamins in the HIV basket of care.

Approved antiretroviral medicine not on our HIV medicine list will be covered up to a set monthly amount (HIV Chronic Drug Amount).
You will be responsible to pay any shortfall from your pocket if your provider is claiming medicines not on the medicine lists and charging more than the Scheme Medication Rate.

Members have cover of up to R535 per person a year, for the multivitamins and vaccination shown below. Flu vaccinations will be paid from the Risk benefit, subject to the overall limit, although PMB's pay through the limit.

Medicine name	**NAPPI code**
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ALT	3
Full blood count (FBC)	4
Fastinglipogram	1
Fasting glucose	1
Urea and electrolytes (U&E) and creatinine	1
Liver function test (LFT)	1
HIV drug resistance test (genotype)	1 (we only cover this test if we have approved funding before the test is conducted)

For members not registered on the HIV*Care* Programme, we pay these costs from available funds in the day- to-day benefits, if available in your plan type.

HIV drug resistance test

You do not automatically qualify to have this test covered from the Scheme's risk benefits, authorisation for the test is a prerequisite. Authorisation applies for requests for tests done in-hospital and out-of-hospital.
The authorisation process is used to manage risk to ensure that you receive best-practice HIV care, based on clinical evidence, to ensure optimal quality of care and health outcomes. It is important that the authorisation process be followed for every request.

Complaints process

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

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

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