TFG
MEDICAL AID SCHEME

TFG MA'S

TFG HEALTH
BENEFIT GUIDE
2023

WELCOME TO TFG HEALTH

TFG Health offers a range of benefits in and out of hospital up to predetermined limits or unlimited at contracted network service providers, including:

ICON for oncology services, an oncology medicine network of pharmacies, the Dental Risk Company for dental benefits, IsoLeso for optometry and a Hospital Network known as the KeyCare Network Hospital. Services obtained outside the Networks are not covered.

Read this benefit guide to understand more about your benefit plan including:

- What to do when you need to go to a doctor or to a hospital
- How you are covered for preventative screening, medical conditions, medicine and treatments
- Which benefits you need to apply for and if there are any limits for certain benefits
- Tips on how you can use technology to conveniently manage and access all the information you need through the Discovery app and TFG Medical Aid Scheme website at www.tfgmedicalaidscheme.co.za

The benefits explained in this benefit guide are provided by TFG Medical Aid Scheme, registration number 1578, administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial service provider. This benefit guide is only a summary of the key benefits and features of the TFG Health benefit plan, awaiting approval from the Council for Medical Schemes (CMS). In all instances, TFGMAS Rules prevail. Please consult the Scheme Rules on www.tfgmedicalaidscheme.co.za. When reference is made in this brochure to 'we' in the context of benefits, members, payments or cover, this refers to TFGMAS. We are continuously improving our communication to you. The latest version of this benefit guide, as well as detailed benefit information is available on www.tfgmedicalaidscheme.co.za.

CONTACT DETAILS

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

Ambulance and other Emergency services

- Call: 0860 999 911

General queries

- Email: service@discovery.co.za
- Call: 0860 123 077

To send claims

- Email: claims@discovery.co.za; or
- Post your claims to PO Box 652509 Benmore 2010 **or take a photo and submit your claim using the Discovery app** which can be downloaded from the Apple iStore or Google Playstore.

Other services

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

- Call: 0860 123 077

Refunds and Claims

- Email: claims@discovery.co.za
- Post: PO Box 652509, Benmore 2010

Oncology service centre

- Call: 0860 123 077

HIV Care Programme

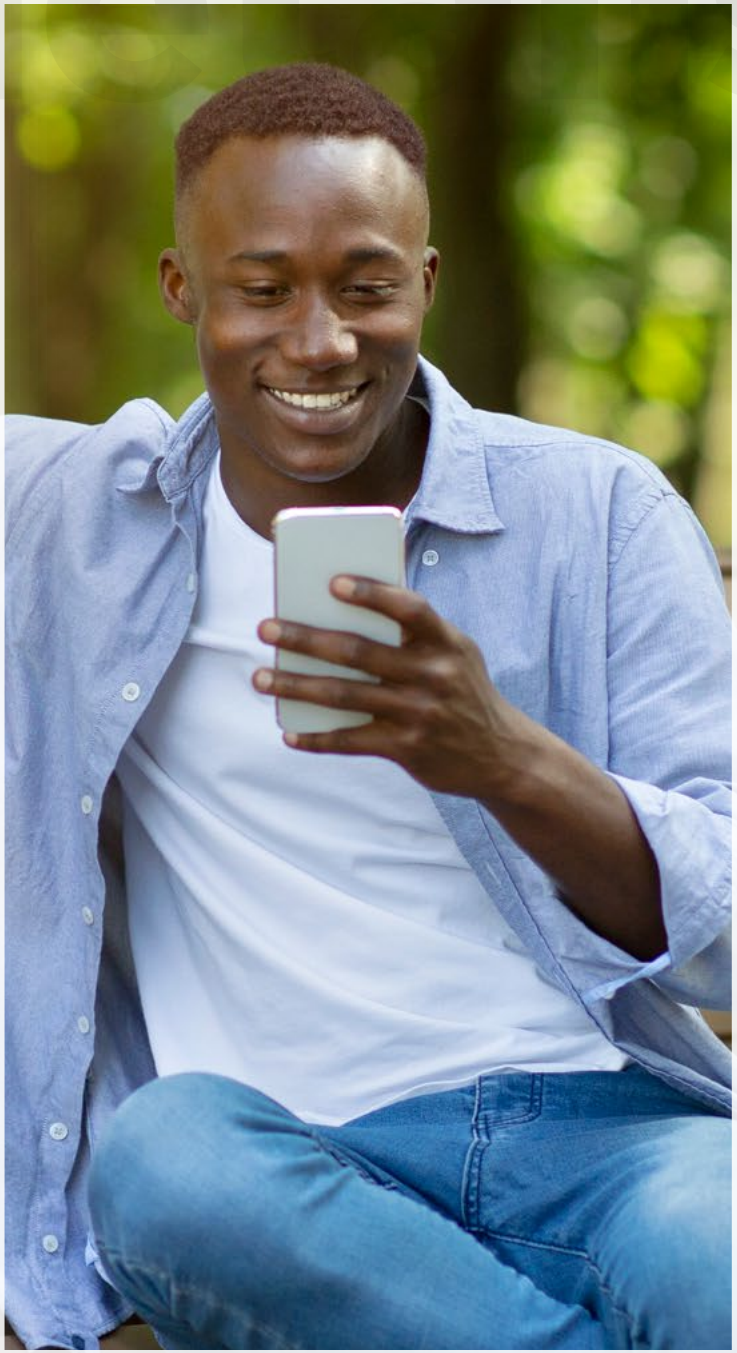
- Call: 0860 123 077

Internet queries

- Call: 0860 100 696

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

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



CONTENTS

KEY TERMS

Throughout this benefit guide you will find references to the terms below.

Chronic Illness Benefit (CIB) cover out of hospital

The Chronic Illness Benefit (CIB) covers you for a defined list of chronic conditions. You need to apply to have your medicine and treatment covered for your chronic condition.

Day-to-Day Benefits

You have cover for a defined set of day-to-day medical expenses such as medically appropriate General Practitioner (GP) consultations, blood tests, X-rays or medicine in the Scheme's networks.

Deductible

This is an amount that you need to pay towards a healthcare service. The amount can vary by the type of covered healthcare service, place of service or if the amount the service provider charges is higher than the rate we cover. If the deductible amount is higher than the amount charged for the healthcare service, you will need to pay for the cost of the healthcare service.

Designated Service Provider (DSP)

This is a doctor, specialist or other healthcare provider that we have reached an agreement with about payment and rates in order to provide treatment or services at a contracted rate. Visit www.tfgmedicalaidscheme.co.za or click on 'Find a Provider' on the Discovery app to view the full list of DSPs of TFGMAS.

Discovery Home Care

Discovery Home Care is an additional service that offers you quality home-based care in the comfort of your home for healthcare services like IV infusions, wound care, post-natal care and advanced illness.

Formulary (Medicine List)

This is 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. We cover these medicines in full for the treatment of approved chronic condition(s).

HealthID

HealthID is an online digital platform that gives your doctor fast, up-to-date access to your health information. Once you have given consent, your doctor can use HealthID to access your medical history, make referrals to other healthcare professionals and check your relevant test results.

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 benefit guide. Examples of expenses covered are theatre and ward fees, X-rays, blood tests and the medicine you use while you are in hospital.

Medicine Rate

This is the rate we pay for medicine. It is the Single Exit Price (SEP) of medicine plus includes the relevant dispensing fee.

Medical emergencies

An emergency medical condition, also referred to as a medical emergency, is the sudden and, at the time, unexpected onset of a health condition that requires immediate medical and surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's life in serious jeopardy.

An emergency does not necessarily require a hospital admission and not all urgent medical treatment falls within the definition of a Prescribed Minimum Benefit (PMB). We may ask you for additional information to determine whether your treatment is to be funded as emergency treatment. **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. 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 R450 of the casualty unit's account is payable by you if you are on TFG Health.**

Networks

You may need to make use of specific hospitals, pharmacies, doctors, specialists or allied healthcare professionals in a network. We have payment arrangements with these providers to ensure you get access to quality care at an affordable cost. By using network providers, you can avoid having to pay additional costs and deductibles yourself.

Hospital Networks

You have chosen a benefit plan with a hospital network and need to make sure you use a hospital in that network to get full cover. The TFG Health Benefit Plan makes use of the **KeyCare Hospital Network** and **KeyCare PMB Hospital Network,** which are two networks of hospitals we have contracted with to provide hospital benefits to members registered on this benefit plan. An **In-Hospital GP Network** was established, which is a defined list of GPs and specialists authorised by us to provide in-hospital services to members as part of the doctor networks servicing members in hospital.

Doctor Networks

You have full cover for GPs, specialists or allied healthcare professionals in our networks who we have payment arrangements with. Your chosen benefit plan makes use of the **KeyCare Health Direct Payment Arrangement (DPA) Specialist Network,** which consists of a list of specialist medical practitioners who have entered into an agreement in respect of services rendered to our members/beneficiaries on the TFG Health Benefit Plan. The TFG Health Benefit Plan also makes use of the **KeyCare Network GPs** who are a list of general practitioners who have contracted with us to be part of a GP Network available to members registered on the TFG Health Benefit Plan.

Day Surgery Networks

Full cover for a defined list of procedures are available in our Day Surgery Network.

Mental Health Network

A defined list of psychologists and/or social workers contracted or nominated by us for purposes of providing treatment to members relating to mental health conditions.

Medicine Networks

Use a pharmacy in our network to enjoy full cover and avoid deductibles when claiming for chronic medicine on the prescribed medicine list.

Payment Arrangements

The Scheme has payment arrangements with various healthcare professionals and providers to ensure that you can get full cover with no deductibles.

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 that we can confirm your membership and available benefits. Without pre-authorisation, you may have a deductible to pay. **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.

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

If you are admitted to hospital in an emergency, we 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 and are based on scientific evidence and research.

Premier Plus GP

A Premier Plus GP is a network GP who has contracted with us to provide you with coordinated care for defined chronic conditions.

Prescribed Minimum Benefits (PMB)

In terms of the Medical Schemes Act of 1998 (Act No. 131 of 1998) and its Regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- An emergency medical condition;
- A defined list of 271 diagnoses
- A defined list of 27 chronic conditions.

To access PMBs, there are rules defined by the Council for Medical Schemes (CMS) that apply:

- Your medical condition must qualify for cover and be part of the defined list of PMB conditions;
- The treatment needed must match the treatments in the defined benefits
- You must use designated service providers (DSPs) in our network. This does not apply in emergencies. Where appropriate and according to the Rules of the Scheme, you may be transferred to a hospital or other service providers in our network, once your condition has stabilised. **If you do not use a DSP we will pay up to 80% of the Scheme Rate. You will be responsible for the difference between what we pay and the actual cost of your treatment where for example you don't use a DSP and your condition is a PMB.**

If your treatment doesn't meet the above criteria, we will pay according to your benefit plan benefits.

Related accounts

Any account other than the hospital account for in-hospital care. This could include the accounts for the admitting doctor, anaesthetist, and any approved healthcare expenses like radiology or pathology.

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 we pay for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant health services. The Scheme Rate is a rate that we negotiate with service providers. In some instances, cover is at 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 guide, for the appropriate benefit to know when claims are paid at 100% of Scheme Rate and when at 80% of Scheme Rate.**

Service providers

A medical practitioner, dentist, pharmacist, hospital, nurse or any other person or entity who is duly registered or licensed, as may be required, to provide relevant health services.

TFG Health Benefit Plan

A benefit plan registered with the Council for Medical Schemes (CMS) in terms of the Medical Schemes Act of 1998 (Act No. 131 of 1998) and its Regulations, the Act. The benefits as set out in the Rules of the Scheme are summarised in this benefit guide.

WHO Global Outbreak Benefit

The WHO Global Outbreak Benefit provides cover for global disease outbreaks recognised by the World Health Organisation (WHO) such as COVID-19. This benefit offers cover for the vaccine, out-of-hospital management and appropriate supportive treatment.

KEY FEATURES

Day-to-day cover

Unlimited cover for medically appropriate GP consultations, blood tests, X-rays or medicine in our GP and pharmacy networks. Dentistry is covered and managed through the Dental Risk Company (DRC) up to agreed rates. An optometry network managed by IsoLeso ensures that your optical needs are covered.

Full cover in hospital and cover up to Scheme Rate out of hospital for specialist services

Guaranteed full cover in hospital for specialists on our specialist network, including an Oncology Network, and up to 100% of the Scheme Rate for other healthcare professionals. A network of radiologists, radiographers, psychologists and social workers were established to minimise out-of-pocket expenditure where specialist services in or out of hospital is to be obtained. Full funding is available through a network of doctors who form part of the Scheme's CADCare programme to manage chronic artery diseases.

Unlimited cover for hospital admissions

Unlimited hospital cover in our KeyCare hospital network, PMB hospital network and in-hospital GP networks. A network of hospitals has also been established to take care of patients' needs living with renal disease.

Emergency cover

A contracted casualty network for guaranteed full cover provides peace of mind during unforeseen emergency events.

Mobility and home-monitoring devices

A mobility network ensures that you are covered for any wheelchairs or mobility devices at agreed and negotiated rates. Home-monitoring devices are covered for clinically appropriate and chronic conditions to allow funding for devices that you may need to monitor your health at home.

KEY BENEFITS

Day-to-day cover

Day-to-day cover at your chosen KeyCare GP. Medicine from our medicine list is covered at a network pharmacy. Specialists are covered up to R5,000 per person per year, if you are referred by your KeyCare Network GP.

Non-emergency casualty visits

Cover for one casualty visit per person per year in any casualty unit at a hospital in the KeyCare network. Unlimited for emergencies. You pay the first R450 of the consultation and must get approval before your visit.

Chronic medicine prescriptions

Your approved chronic medication must be dispensed by your KeyCare GP, or you must get your approved chronic medicine from a pharmacy in the network

Cancer

We cover your treatment if it is a PMB. **You must use a network provider.**

Chronic dialysis

You must use a network provider once you are registered. **If you go out of network, we cover 80% of the Scheme Rate**.

Full cover hospital network

We pay up to the Scheme Rate at 100% of negotiated rates at these facilities

Partial cover hospital network

We pay up to 70% of the hospital account and you must pay the balance of the account at these facilities. If the admission is a PMB, we will pay 80% of the Scheme Rate at these facilities.

Defined list of procedures in a Day Surgery Network

Covered in the KeyCare Day Surgery Network

EMERGENCY COVER

What is a medical emergency?

An emergency medical condition is the sudden and unexpected onset of a health condition that requires immediate medical or surgical treatment.

Failure to provide this treatment would result in:

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

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

What do we pay for?

We pay for all of the following medical services that you may need in an emergency:

- The ambulance (or other medical transport)
- The account from the hospital
- The accounts from the doctor who admitted you to the hospital
- The anaesthetist
- Any other healthcare provider that we approve

It is important that you, a loved one or the hospital let us know about admission as soon as possible, so that we can advise you on how you will be covered for the treatment you receive.

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 999 911**. Treatment must start within 72 hours of exposure and pre-exposure (prep) and post-exposure prophylaxes (pep) requires approval to be funded.

In the event that you are admitted to hospital from casualty, we will cover the costs of the casualty visit from your hospital benefit, provided that we pre-authorised your hospital admission. You must apply for authorisation on the next available working day if the emergency event occurs after hours or over the weekend. The first R450 of the casualty unit's account is payable by you and you will need to make use of the hospitals within our hospital network.

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, which includes Lesotho.

Assistance during or after a traumatic event

You have access to dedicated assistance in the event of a traumatic incident or after a traumatic event. By calling Emergency Assist you and your family have access to trauma support 24 hours a day. This service also includes access to counselling and additional benefits for trauma related to gender-based violence.

PRESCRIBED MINIMUM BENEFITS (PMB)

We established PMB Networks to prevent deductibles being applied when you need to obtain services for Prescribed Minimum Benefit (PMB) conditions.

Cover for Prescribed Minimum Benefits

Prescribed Minimum Benefits are 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:

- 271 diagnoses and their associated treatment
- 27 chronic conditions
- Emergency conditions

In most cases, we 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 (DSPs) 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 payable. You will be responsible for the difference between what we pay and the actual cost of your treatment, where applicable.

Mental Health Network

The Mental Health Network has been created for services to be obtained from social workers, psychologists and registered counsellors in or out of hospital. The network is also applicable where services are claimed from the allied and therapeutic benefits of the Scheme and where services are obtained via the Mental Health Programme.

Members who obtain services from these service providers will experience no balance billing, provided they obtained services as part of the Mental Health Network of service providers. Where a member uses services from a non-network service provider and the provider charges above the Scheme Rate, the payment will be limited to the Scheme Rate and will be paid to the member. In these instances members may be liable for additional payments when settling accounts with the non-network service providers and it is therefore important to contact us to confirm whether your preferred service provider is part of our Mental Health Network before obtaining services for PMB conditions.

Full cover for PMB Hospital Network

Members have access to a PMB Hospital Network to obtain services for PMB at full cover.

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

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

- obtained services at the PMB Hospital Network and
- selected a primary provider who has entered into a Direct Payment Arrangement (DPA) with the Scheme, then all contracted providers will be reimbursed at their contracted rate or at cost for services obtained in the PMB Hospital Network, as referred by your admitting doctor. This applies to all related accounts during the admission as well. Therefore, where a pre-authorisation is approved for a PMB condition, the Scheme will fund the cost of the services obtained as set out in the table below:

	TFG HEALTH	ADDITIONAL INFORMATION/ COMMENTS
Psychology and mental health in and out-of-hospital services for PMB conditions if the service provider is in the Mental Health Network	100% at agreed rate	No deductibles if DSP is used
Psychology and mental health in and out-of-hospital services for PMB conditions voluntarily obtained from a service provider who is not in the Mental Health Network	Up to a maximum of 100% of Scheme Rate	There may be deductibles if non-network service provider is used
In-hospital GP or Specialist services for PMB conditions if admitting GP or Specialists are on the Network/DSP	100% at agreed rate	No deductibles if DSP is used
In and out-of-hospital services for PMB conditions voluntarily obtained from a non-DSP	Up to a maximum of 100% of the Scheme Rate	There may be deductibles if non-DSP is used

In-Hospital GP Network

You have access to the In-hospital General Practitioner (GP) Network.

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

Supplier agreements for surgicals

The Scheme has supplier arrangements for surgicals including:

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

Where members obtain the above appliances from service providers who the Scheme have entered into a Preferred Payment Arrangement, the Scheme will fund the cost of the appliances up to the agreed/negotiated rate and members should have no deductibles. Where members obtain the above appliances from non-DSPs, the payment will be limited up to the maximum of 100% of the Scheme Rate and limited to the annual benefit limit. In these instances members may experience deductibles and may be liable for some of the costs of these appliances.

Please contact us on **0860 123 077** to find out the options available to you before obtaining these appliances.

YOU HAVE ACCESS TO ESSENTIAL SCREENING AND PREVENTION BENEFITS

This benefit pays for certain tests that can detect early warning signs of serious illnesses. We cover various screening tests at our wellness providers, Clicks and/or Dis-Chem, including blood glucose, cholesterol, HIV, Pap smear or HPV test for cervical screening, mammograms and/or ultrasounds and prostate screenings.

Virtual Health Check

You are able to book a Virtual Health Check in the form of a 20-minute online consultation that uses previous Health Check results and other available information to help identify health risks and recommend ways to improve your health and wellness through exercise, nutrition, mental wellbeing and more. Appointments can be scheduled online, helping you to identify the most appropriate and critical screening and prevention checks to get done.

We make health checks available according to your age group and needs. These include:

SCREENING FOR KIDS

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

SCREENING FOR ADULTS

This benefit covers certain tests such as blood glucose, blood pressure, cholesterol, mass index and HIV screening at our wellness providers. We also cover a mammogram or ultrasound of the breast every two years, a Pap smear once every three years or an HPV test once every 5 years, PSA test (prostate screening) each year and bowel cancer screening tests every 2 years for members between 45 and 75 years.

SCREENING FOR SENIORS

In addition to the screening for adults, members aged 65 years and older have cover for a group of age-appropriate screening tests in our defined pharmacy network. Cover includes hearing and visual screening and falls risk assessment.

You may have cover for an additional GP consultation at a Premier Plus GP, depending on your screening test results and if you meet the Scheme's clinical entry criteria. Screening for seniors also includes:

- A holistic view of a member's health; and
- Electronic messaging on interventions, including enrolment into disease management programmes, where needed.

VACCINES FUNDED FROM YOUR SCREENING BENEFITS

TFG Health covers you for the following vaccine benefits in addition to the above screening tests:

- Pneumococcal vaccine funded up to one vaccine per person every 5 years for person under the age of 65 and one vaccine per person per lifetime for persons over the age of 65;
- Seasonal influenza vaccine funded up to one per person per year
- COVID-19 vaccine and administration costs as deemed clinically appropriate in terms of PMB (this vaccine is not funded from the screening and prevention benefits, but paid from your hospital benefit.)

CONNECTED CARE

Connected Care gives you access to quality healthcare from home.

With TFG Medical Aid Scheme you get access to health and wellness services from the comfort of your home. Connected Care is an integrated healthcare ecosystem of benefits, services and connected digital capabilities to help you manage your health and wellness at home.

Virtual consultations and house calls

Due to the COVID-19 pandemic, many members have avoided treatments, screenings, tests, and/or taking their chronic medication, which are all necessary to properly monitor and manage health. To help with this, members registered on the Chronic Illness Benefit (CIB) have access through Connected Care to *Virtual House Call by GPs*. With the use of the Connected Care platform, your nominated GP is enabled to proactively reach out to you with the aim of preventing disease exacerbations and serious admissions. These consultations will not affect other existing day-to-day and available consultation benefits.

Health Monitoring Devices

Access to the latest medical examination and remote monitoring enables you to obtain quality care from home as an alternative to a hospital stay.

Health monitoring devices allow TFG Health members to access the Scheme's innovative Health@Home benefit to monitor a list of defined conditions including chronic obstructive pulmonary diseases (COPD), congestive cardiac failure, diabetes, pneumonia and COVID-19. The Scheme covers up to a limit of R4,250 per person per year, at 100% of the Scheme Rate. Home-based care is possible for follow-up treatments after a hospital admission for these defined conditions.

Based on clinical entry criteria, cover is provided for bedside medicine reconciliation prior to admission discharge, a follow-up consultation with a GP or specialist, and a defined basket of

supportive care at home which includes a face-to-face consultation and virtual consultations with a Discovery Home Care trained nurse.

Point-of-Care (POC) testing

Members registered on certain Care Programmes are also given access to Point-of-Care (POC) testing as a medical diagnostic test that allows for simple medical tests to be done at your bedside. Not only does it mean the shortest possible timeframes for required tests and their results to be made available to your treating doctor, but it also enhances your treating doctor's ability to record your records and results for referral and future reference purposes through HealthID. It provides you and your treating doctor with an integrated solution keeping your medical information confidential and protected at all times.

CONNECTED
CARE (continued)

In addition Connected Care offers members registered on TFG Health:

ELECTRONIC PRESCRIPTIONS

Seamless e-scripting to give you quicker access to your medicine

HOME NURSES

Hospital-related care with home nurses to care for you at home

MEDICINE ORDERING AND TRACKING

Order and track your medicine delivery from dispensary to your door

ONLINE COACHES

Personalised coaching consultations to help you better manage your chronic conditions from home, where your Care Programme requires regular online coaching and monitoring by your treating provider

CONDITION-SPECIFIC INFORMATION

Educational content specific to your condition, at your finger tips

All these functionalities are brought to you through Connected Care and serve as a value add aiming to give you enhanced healthcare access according to your needs.

Visit www.tfgmedicalaidscheme.co.za to view the detailed Connected Care Benefit guide.

DAY-TO-DAY
BENEFITS

	TFG HEALTH	
BENEFIT	**RATE AND BASIS OF COVER: SUBJECT TO PMB**	**TFG HEALTH LIMITS**
DAY-TO-DAY COVER		
Primary care which includes, physical and virtual or online consultations at general practitioners (GP) and specialists. **Radiologists and pathologist visits.** **GP Virtual House calls**	**GP, including consultations and selected small procedures:** Up to a maximum of 100% of the Scheme Rate, subject to **selected** consultation and procedure codes Member has to select a primary care KeyCare Network GP that is part of the Scheme's selected Network on joining the Benefit Plan. **GP visits will only be covered at chosen KeyCare Network GP** Member can elect to change his/her KeyCare Network GP three times per person per year Consultations for chronic conditions: members have to be registered for Chronic Illness Benefits (CIB) and have selected a KeyCare Network GP that is part of the Scheme's selected network. **Specialists:** **KeyCare Health DPA Specialists:** Up to a maximum of the KeyCare Direct Payment Arrangement rate **Other specialists who work within the KeyCare Network Hospitals:** Up to a maximum of 100% of the Scheme Rate **Radiology and pathology services referred as part of the specialist visit:** Up to 100% of the Scheme Rate, **subject to the overall annual specialist benefit limit of R5,000 per person per year** Member must be referred by KeyCare Network GP	In Network limits: Unlimited only at KeyCare Network GP, subject to pre-authorisation after visit 15, per person per year Unscheduled Emergency visits limited to 3 visits per person per year at KeyCare Network GP Baskets of care as set by the Scheme may be applicable. R5,000 per person per year
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	4 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

DAY-TO-DAY
BENEFITS (continued)

	TFG HEALTH	
BENEFIT	**RATE AND BASIS OF COVER: SUBJECT TO PMB**	**TFG HEALTH LIMITS**
Visits to casualty units	The first R450 of the casualty unit's account is payable by the Beneficiary. Subject to pre-authorisation The balance of the casualty unit's account is paid from Health Care Cover up to a maximum of 100% of the Scheme Rate	Unlimited only at KeyCare Network Hospital No cover at Non-Network Hospitals
Primary care: Basic dentistry	Up to a maximum of 100% of the Scheme Rate **Only at KeyCare Network dentist**, subject to a list of codes. In-hospital treatment is excluded Subject to the treatment meeting the Scheme's treatment guidelines and Managed Health Care criteria	Unlimited
Other Healthcare Providers: **Psychiatry and clinical psychology consultations, visits and treatments including psychotherapy**	No cover, unless PMB condition. PMB conditions covered up to 100% of Agreed Rate at Mental Health Network Service Providers. The provisions of PMB and cover for PMB conditions is applicable.	The provisions of PMB and cover for PMB conditions is applicable.
Prescribed Acute Medicine and over the counter (OTC) Medicine	Up to a maximum of 100% of the Scheme Medication Rate	Unlimited within the KeyCare Acute Medicine Formulary and Protocols and **only covered if prescribed by KeyCare Network GP** **TFG Health does not offer over the counter medicine cover.**
Radiology and pathology	**Selected basic X-rays only:** Up to a maximum of 100% of the Scheme Rate **Selected basic blood tests only:** Up to a maximum of 100% of the Scheme Rate Point-of-care pathology testing is subject to meeting the Scheme's treatment guidelines and Managed Health Care criteria	Unlimited **at the Scheme's KeyCare Direct Payment Arrangement practitioners only** Only if requested by Member's chosen KeyCare Network GP, subject to list of procedure codes and PMB
Optometry	Up to a maximum of 100% of the Scheme Rate **only at KeyCare Network optometrist** and subject to Scheme Protocol	One pair of single vision, bifocal or multifocal lenses with a basic frame or a basic set contact lenses per person **every 24 months from their last Date of Service**

DAY-TO-DAY
BENEFITS (continued)

	TFG HEALTH	
BENEFIT	**RATE AND BASIS OF COVER: SUBJECT TO PMB**	**TFG HEALTH LIMITS**
Medical appliances (External Medical Items), mobility devices (wheelchairs, long leg callipers and crutches), including hearing aids and external prosthesis	**Mobility Devices such as wheelchairs, long leg callipers and crutches only:** Up to a maximum of 100% of the Scheme Rate, subject to an approved list of codes **Only if requested by the Member's chosen KeyCare Network GP**, subject to pre-authorisation and that the device or item is obtained from a KeyCare Direct Payment Arrangement practitioner	R5,720 per family per year
Out-of-hospital healthcare services related to pregnancy and delivery	Up to 100% of the Scheme Rate, or Agreed Rate only **for a gynaecologist who practices within the KeyCare Network within the selected KeyCare Network Hospitals** Subject to Scheme health Protocol Paid from Health Care Cover and is subject to applicable limits as set out in this Benefit Table Subject to pre-authorisation and/or registration and the treatment meeting the Scheme's clinical entry criteria 3D and 4D scan will be paid up the maximum of the Cost of a 2D scan Cover for infant consultations up to a maximum of 100% of the Scheme Rate, or Agreed Rate, for Children under the age of 2 years Services in excess of the limit are for the Member's account Limits apply for the duration of the pregnancy The provisions of PMB and cover for PMB conditions is applicable	**Services:** • Antenatal classes and/or postnatal visits: 5 consultations or classes per pregnancy and/or delivery **with a registered nurse** • Antenatal consultations: 8 per pregnancy **with a KeyCare Network GP, gynaecologist or midwife** • Prenatal screening, including chromosome testing or Non Invasive Prenatal Testing (NIPT): 1 per pregnancy • Pregnancy scans: 2 per pregnancy • Blood tests: 1 routine basket of pregnancy tests per pregnancy • Postnatal consultations: 1 per delivery **with the KeyCare Network GP, gynaecologist or midwife** • Dietician nutrition assessment: 1 per delivery • Mental health consultations: 2 per delivery **with a KeyCare Network GP, psychologist in the Mental Health Network or counsellor** • Consultations for infants: 2 per Child **with Paediatrician, ENT or KeyCare Network GP**

DAY-TO-DAY
BENEFITS (continued)

	TFG HEALTH	
BENEFIT	**RATE AND BASIS OF COVER: SUBJECT TO PMB**	**TFG HEALTH LIMITS**
MRI and CT Scans (When authorised)	Up to a maximum of 100% of the Scheme Rate **at the Scheme's KeyCare Direct Payment Arrangement practitioners** Subject to the treatment meeting the Scheme's treatment guidelines and Managed Health Care criteria **Member must be referred by KeyCare Network GP**	Accumulates to the specialist benefit limit of R5,000 per person per year
Due to limited or no benefits available on the TFG Health Benefit Plan in respect of the following benefits, the TFG Health Benefit Plan makes available to Members in addition to the Medical Appliances Benefit and over and above the DTPMB entitlement, cover for certain out-of-hospital healthcare services arising from an Emergency, Trauma-related event resulting in the following PMB conditions: • Paraplegia • Quadriplegia • Near-drowning related injury • Severe anaphylactic reaction • Poisoning • Crime-related injury • Severe burns • External and internal head injuries • Loss of limb **Trauma benefit services covered under this benefit include:** • Allied healthcare services • External medical items • Hearing aids • Prescribed Medicine	Up to a maximum of 100% of the Scheme Rate Paid from Health Care Cover and is subject to applicable limits as set out in this Benefit Table Excludes Over the counter (OTC) Medicines (inclusive of schedule 0, 1 and 2 drugs whether prescribed or not), optometry, antenatal classes and dentistry (other than severe dental and oral procedures contemplated in terms of PMB) Cover applies to 31 December of the following year after the Trauma occurred Subject to authorisation and/or Approval and treatment meeting the Scheme's entry criteria Cover is not restricted to the Scheme's Designated Service Providers	**Services:** • **External medical items** Limited to: R28,900 per family per year, except for prosthetic limbs which shall be subject to a limit of R93,550 per person per year • **Hearing aids** Limited to: R16,500 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: R8,800 M + 1 Dependant: R13,250 M + 2 Dependants: R16,500 M + 3 Dependants or more: R19,850 • **Prescribed Medicine limited to:** Member: R17,150 M + 1 Dependant: R20,300 M + 2 Dependants: R24,100 M + 3 Dependants: R29,300

MATERNITY BENEFITS

TFG Health provides you with cover for maternity and early childhood benefits from a basket of care that is activated using the Discovery app.

How to get the benefit

You can activate the benefit in any of these ways:

- Create your pregnancy profile in the Discovery app or on our website at **www.tfgmedicalaidscheme.co.za**
- When you register your baby as a dependant on the Scheme.

Once you've activated your benefits, you get cover for healthcare services related to your pregnancy and treatment for the first 2 years of your baby's life. This applies from the date of activation of the benefit for each pregnancy and for each child from birth until they are two years old.

During pregnancy

ANTENATAL CONSULTATIONS

We pay for up to eight consultations with your gynaecologist, GP or midwife.

ULTRASOUND SCANS AND SCREENINGS DURING PREGNANCY

You are covered for up to two 2D ultrasound scans, including one nuchal translucency test, 3D and 4D scans are paid up to the rate we pay for 2D scans. You are also covered for one chromosome test or Non-Invasive Prenatal Test (NIPT) if you meet the clinical entry criteria.

FLU VACCINATIONS

We pay for one flu vaccination during your pregnancy.

BLOOD TESTS

We pay for a defined list of blood tests for each pregnancy.

Pre- and Postnatal Care

We pay for a maximum of 5 antenatal or postnatal classes or consultations with a registered nurse up until 2 years after you have given birth. We pay for one breastfeeding consultation with a registered nurse or a breastfeeding specialist.

After you give birth

GP AND SPECIALISTS TO HELP YOU AFTER BIRTH

Your baby under the age of 2 years is covered for two visits to a GP, paediatrician or an ear, nose and throat specialist.

OTHER HEALTHCARE SERVICES

You also have access to postnatal care, which includes a postnatal consultation for complications post-delivery, a nutritional assessment with a dietitian and two mental healthcare consultations with a counsellor or psychologist.

To activate these benefits on TFG Health your chosen GP must refer you.

Visit **www.tfgmedicalaidscheme.co.za** to view the detailed Maternity Benefit guide, by navigating to Find a document > Information guides.

CHRONIC BENEFITS AND CARE PROGRAMMES

You have access to treatment for a list of 27 medical conditions (including HIV) set out in the list of chronic conditions known as the Chronic Disease List (CDL). Your chronic benefit cover aligns with the requirements of the Act and you are covered for all PMB related conditions as listed below.

A

Addison's disease, Asthma

B

Bipolar mood disorder, Bronchietasis

C

Cardiac failure, Cardiomyopathy, Chronic obstructive pulmonary disease (COPD), Chronic renal disease, Coronary artery disease, Crohn's disease

D

Diabetes insipidus, Diabetes mellitus type 1, Diabetes mellitus type 2, Dysrhythmia

E

Epilepsy

G

Glaucoma

H

Haemophilia, HIV (Managed through the HIV Care programme), Hyperlipidaemia, Hypertension, Hypothyroidism

M

Multiple sclerosis

P

Parkinson's disease

R

Rheumatoid arthritis

S

Schizophrenia, Systemic lupus erythematosus

U

Ulcerative colitis

This is what we cover

We pay for medicine on the medicine list (formulary) up to a maximum of the Scheme's medicine rate. This rate is the price of the medicine and the fee for dispensing it. For medicine not on our list, we cover you up to a Generic Reference Price (GRP), which means you will be covered up to the lowest cost medicine of the same kind on our medicine list (formulary) for the condition. There may be a deductible payable depending on the type of medicine and the lowest equivalent formulary listed drug available in a medicine class. You must apply for the Chronic Illness Benefit (CIB) and your doctor must complete a form online or send it to us for approval to CIB_APP_FORMS@discovery.co.za to qualify for this medicine funding. We need to be informed of any changes to your treatment so that we can update your chronic authorisation.

CHRONIC BENEFITS AND CARE PROGRAMMES (continued)

Where to get your medicine

You need to get your approved chronic medicine that is on the Scheme's medicine list from one of our network pharmacies or from your chosen KeyCare GP (if they dispense medicine). You are required to nominate a GP from the KeyCare GP Network to access risk funding for Chronic Disease List conditions. A Premier Practice Network has been introduced for certain Care Programmes – the diabetes and cardiac care programmes remain unchanged. If you visit with a non-nominated treating doctor or obtain your medicine from anywhere else than the Scheme's network pharmacies, a deductible of 20% will apply.

Chronic Dialysis

If you need regular dialysis, we cover these expenses in full if we have approved your treatment plan and you use a provider in our network. **If you go elsewhere, we will pay up to 80% of the Scheme Rate.**

Care Programmes

Condition-specific care programmes exists for diabetes, mental health, HIV and heart conditions.

We cover condition-specific care programmes that help you to manage diabetes, mental health, HIV or heart-related medical conditions. You have to be registered on these condition-specific care programmes to unlock additional benefits and services. You and your Premier Plus GP can track progress on a personalised dashboard to identify the next steps to optimally manage your condition and stay healthy.

MENTAL HEALTH CARE PROGRAMME

Once enrolled on the programme by your network psychologist or Premier Plus GP, you have access to defined cover for the management of major depression. Enrolment on the programme unlocks cover for prescribed medicine, access to either individual or group psychotherapy sessions (virtual and face-to-face therapy) and additional GP consultations to allow for effective evaluation, tracking and monitoring of treatment. Qualifying members will also have access to a relapse prevention programme, which includes additional cover for a defined basket of care for psychiatry consultations, counselling sessions and care coordination services.

CARDIO CARE PROGRAMME

If you are registered on the Chronic Illness Benefit (CIB) for hypertension, hyperlipidaemia or ischaemic heart disease, you have access to a defined basket of care and an annual cardiovascular assessment, if referred by your nominated Premier Plus GP and enrolled on the Cardio Care programme. **If you are also registered for diabetes you need to see your nominated Premier Plus GP to avoid a 20% co-payment.**

DIABETES CARE PROGRAMME

If you are registered on the Chronic Illness Benefit (CIB) for diabetes, your nominated Premier Plus GP can enrol you on the Diabetes Care programme. The programme unlocks cover for additional glucometer strips and consultations with dietitians and biokineticists. You may also have access to a nurse educator to help you with the day-to-day management of your condition. **You have to see your nominated Premier Plus GP to avoid a 20% co-payment.**

CHRONIC BENEFITS
AND CARE PROGRAMMES (continued)

DIABETES-CARDIOMETABOLIC POPULATION HEALTH MANAGEMENT PROGRAMME

Members living with diabetes will have access to an enhanced managed healthcare programme from 2023 which is known as the diabetes-cardiometabolic population health management programme.

The programme is an integrated chronic care programme for members living with diabetes, as well as their related cardiometabolic condition(s). The programme gives you and your Premier Plus doctor access to various tools to monitor and manage your health and to ensure you get high quality coordinated healthcare and the best outcomes.

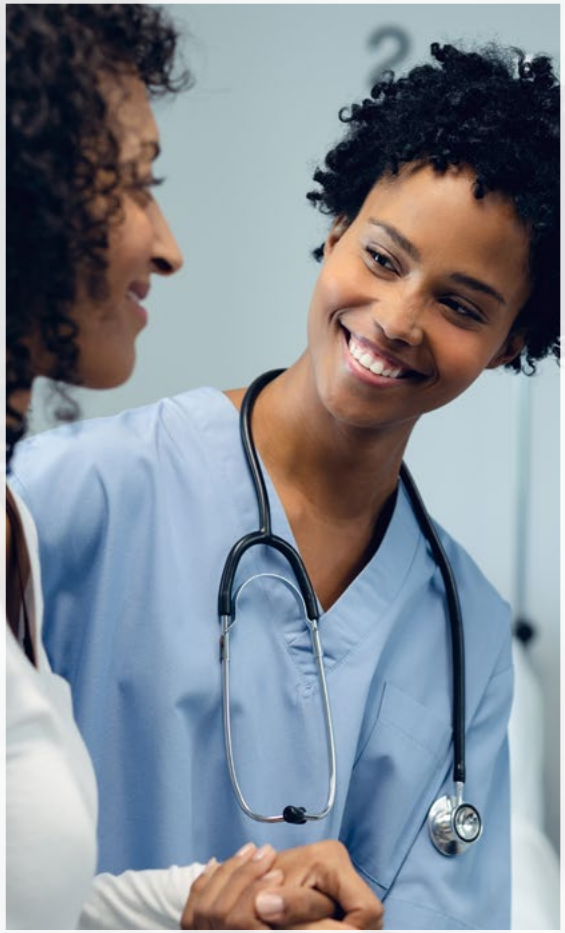
You and your doctor can set goals and earn rewards on your personalised condition management tool. This will help to manage your condition(s) and stay healthy over time.

The programme also unlocks cover for valuable healthcare services from healthcare providers like dietitions, diabetes coaches, podiatrists and biokineticists.

Any member registered on the Chronic Illness Benefit (CIB) for diabetes will be able to join the programme.

HIV CARE PROGRAMME

If you are registered on the HIV programme, you are covered for the care you need, which includes additional cover for social workers. You can be assured of confidentiality at all times. **You have to see a Premier Plus GP to avoid a 20% co-payment. You need to get your medicine from a Designated Service Provider (DSP) to avoid a 20% co-payment.**



YOU HAVE COMPREHENSIVE COVER FOR CANCER TREATMENT

Oncology Benefit

If you are diagnosed with cancer and once we have approved your cancer treatment, you are covered by the Oncology Care Programme over a 12-month cycle, starting from your date of diagnosis. This means you will always have a full year's benefit no matter when in the year you are diagnosed with cancer.

TFG Health members are covered for PMB related cancer treatment up to 100% of the Scheme Rate within the ICON Network of service providers.

When diagnosed with cancer, you will need to register on the oncology management programme and you and/or your treating doctor must contact us to register you on the programme at which time you will receive more information of how your benefit plan covers you for cancer related treatment.

If you choose to use any other provider, we will only cover up to 80% of the Scheme Rate.

You will also be required to obtain your medicine from the Scheme's oncology network of pharmacies to avoid deductibles for which you may be liable.

Colorectal Cancer Surgery

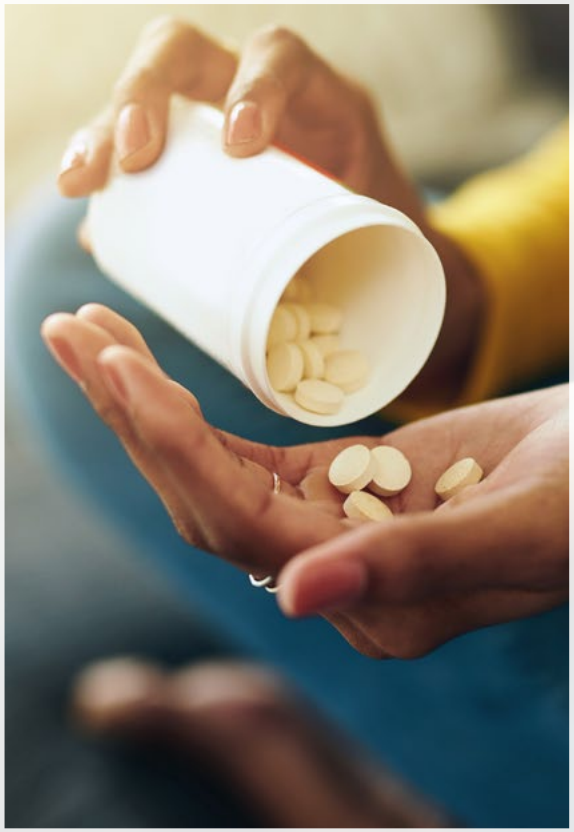
You have full cover for approved colorectal cancer surgeries in our network.

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, care coordination, counselling services and supportive care for appropriate end-of-life clinical and psychologist services. You have access to a GP consultation to facilitate your palliative care treatment plan.

Prescribed Minimum Benefits (PMB) for Cancer

Cancer treatment that is a PMB is always covered in full. On the TFG Health benefit plan we cover cancer treatment in our network. **If you choose to use any other provider, we will only cover up to 80% of the Scheme Rate.**



HOSPITAL COVER ON TFG HEALTH

TFG Health offer cover for hospital stays.
There is no overall limit for the hospital benefit.

If you have to go to hospital, we will pay your hospital expenses. There is no overall hospital limit for the year, however, there are limits to how much you can claim for some treatments. Contact us in good time before you have to go to hospital. We will let you know what you are covered for. If you do not contact us before you go, you may be responsible for some of the costs.

What is the benefit?

This benefit pays the costs when you are admitted into hospital.

What we cover

Unlimited cover in private hospitals approved by the Scheme, subject to the network requirements. You have cover for planned stays in our KeyCare hospital network.

How to get the benefit

GET YOUR PRE-AUTHORISATION CONFIRMATION FIRST

Contact us on 0860 123 077 to confirm your hospital stay before you are admitted (this is known as pre-authorisation).

WHERE TO GO

You have cover for planned admissions in a defined network. For planned admissions at hospitals outside the KeyCare Hospital Network, you either have to pay the full amount or a portion of the hospital account.

View the KeyCare Hospital Network on our website, **www.tfgmedicalaidscheme.co.za**

HOW WE PAY

We pay for planned hospital stays from your hospital benefit. We pay for services related to your hospital stay, including all healthcare professionals, services and medicines authorised by the Scheme for your hospital stay. If you use doctors, specialists and other healthcare professionals that we have an agreement with, we will pay for these services in full. We pay up to the Scheme Rate of other healthcare professionals.

You can avoid deductibles by:

- Going to a hospital in the network of hospitals
- Using healthcare professionals that we have a payment arrangement with

View hospitals in the KeyCare Hospital Network using '***Find a healthcare provider***' on the Discovery app.

HOSPITAL COVER

TFG Health offers unlimited hospital cover. The table below shows how we pay for your approved hospital admissions:

Health Care Cover = Unlimited hospital cover	TFG HEALTH	
BENEFIT	**RATE AND BASIS OF COVER: SUBJECT TO PMB**	**TFG HEALTH LIMITS**
Statutory Prescribed Minimum Benefits	Basis of cover is per legislative requirements in terms of Prescribed Minimum Benefits (PMB). All treatment for PMB conditions accumulate to available limits. Once benefit limits are reached funding in respect of PMB will continue to fund in accordance with the basis of cover as set out in this benefit schedule and the legislative requirements of PMB.	Unlimited
Hospitalisation	**Full Cover KeyCare Network Hospital:** Up to a maximum of 100% of the Scheme Rate of the Network Hospital account. Subject to pre-authorisation and/or approval meeting the Scheme's clinical and Managed Health Care criteria.	Unlimited
	Partial Cover KeyCare Network Hospital: Up to a maximum of 70% of the Scheme Rate of the Network Hospital account. Subject to pre-authorisation and/or approval and meeting the Scheme's clinical and Managed Health Care criteria.	Unlimited
Hospitalisation in Non- Network or non-contracted Hospital **Emergency Admissions**	Up to a maximum of 100% of the Scheme Rate. Subject to pre-authorisation Patient to be transferred to a KeyCare Network Hospital as soon as stabilised, unless otherwise agreed by the Scheme. Subject to PMB	Unlimited
Defined list of procedures in a Day Surgery 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 pre-authorisation and/or approval and the treatment meeting the Scheme's clinical criteria	Unlimited
Hospitalisation in Non-Network Hospital. **Non-emergency admissions**	No cover	No cover

HOSPITAL
COVER (continued)

BENEFIT	TFG HEALTH RATE AND BASIS OF COVER: SUBJECT TO PMB	TFG HEALTH LIMITS
Administration of defined intravenous infusions	Up to a maximum of 100% of the Scheme Rate at the Scheme's KeyCare Direct Payment Arrangement practitioner A 20% deductible shall be payable by the Beneficiary in respect of the Hospital account when treatment is received at a provider who is not a KeyCare Direct Payment Arrangement practitioner Medicines paid at 100% of the Scheme Medication Rate Subject to pre-authorisation and/or approval and the treatment meeting the Scheme's clinical criteria	Unlimited
Hospitalisation for selected members suffering from one or more significant chronic conditions. **Non-emergency admissions**	Up to a maximum of 100% of the Scheme Rate Subject to registration on the Scheme's disease management programme and clinical entry criteria Up to a maximum of 100% of the Scheme Rate and subject to pre-authorisation and/or approval and the Scheme's disease management programme clinical entry criteria Up to a maximum of 80% of the Scheme Rate of the Hospital and related accounts for members who are not registered on the programme	Unlimited
Home-based healthcare for clinically appropriate chronic and acute treatment and conditions that can be treated at home	In addition to PMB cover, up to a maximum of 100% of the Scheme Rate Subject to authorisation and/or approval, the Scheme's preferred provider (where applicable) and the treatment meeting the Scheme's treatment guidelines and clinical and benefit entry criteria. Point-of-care medical devices, up to a maximum of 75% of the Scheme Rate, subject to approval by the Scheme and the Scheme's protocols and clinical and benefit entry criteria.	Basket of Care as set by the Scheme Point-of-care medical devices limited to 1 device per family
Nursing services, Step down and Hospice	The provisions of PMB are applicable.	The provisions of PMB are applicable.
General Practitioners, Specialists and other service providers delivering treatment in hospital and/or in specialists' rooms	**KeyCare Health DPA Specialists:** Up to a maximum of 100% of the KeyCare Direct Payment Arrangement rate **Other specialists who work within the KeyCare Network Hospitals:** Up to a maximum of 100% of the Scheme Rate Member must be referred by KeyCare Network GP	Unlimited In-room procedures limited to a defined list of procedures as determined by the Scheme

HOSPITAL
COVER (continued)

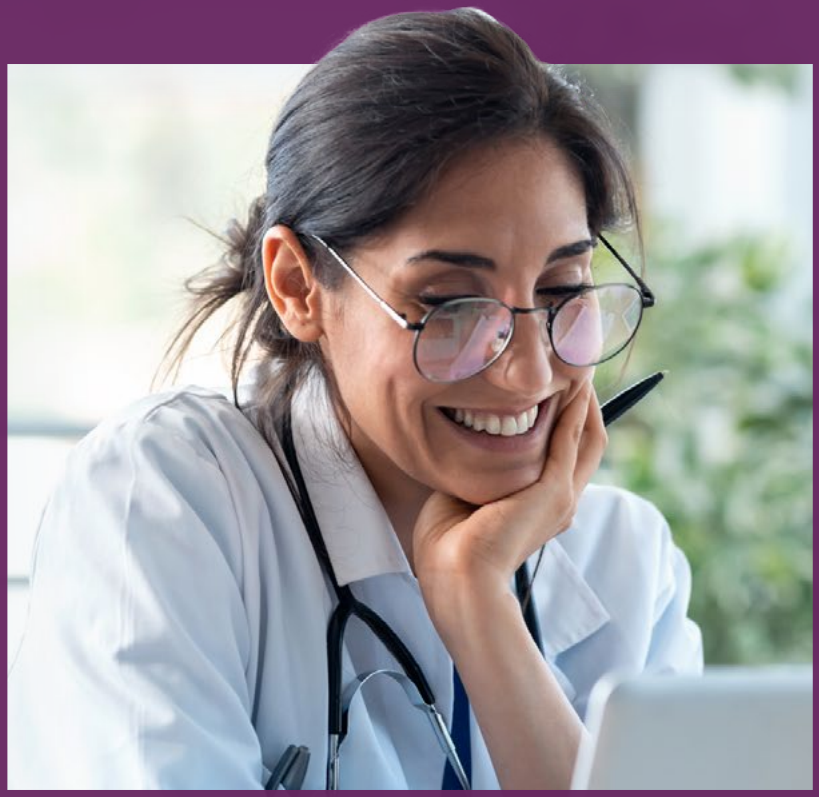
BENEFIT	TFG HEALTH RATE AND BASIS OF COVER: SUBJECT TO PMB	TFG HEALTH LIMITS
General Practitioners, Specialists and other service providers delivering treatment in hospital and/or in specialists' rooms	**Other providers:** Up to a maximum of 100% of the Scheme Rate **Radiology and Pathology:** Up to a maximum of 100% of the Scheme Rate Pathology is subject to a Preferred provider agreement. Where members use a non-preferred provider payment will be made directly to the member Point of care pathology testing is subject to meeting the Scheme's treatment guidelines and Managed Health Care criteria	
Chronic dialysis	Up to a maximum of 100% of the Scheme Rate at the Scheme's KeyCare Direct Payment Arrangement practitioner only Subject to pre-authorisation and/or approval and the treatment meeting the Scheme's treatment guidelines and clinical criteria Drugs paid at 100% of the Scheme Medication Rate	Unlimited
Organ Transplants	Cover is subject to PMB Regulations and members should contact the Scheme at **0860 123 077** to obtain pre-authorisation and approval.	Unlimited
Chemotherapy, Radiotherapy and Oncological treatment	The provisions of PMB is applicable. Up to a maximum of 100% of the Scheme Rate at the Scheme's KeyCare Direct Payment Arrangement practitioner Up to a maximum of 80% of the Scheme Rate at non- KeyCare Direct Payment Arrangement practitioners Subject to pre-authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria	Unlimited, unless to be funded from day-to-day benefits. See details as provided under "Day-to-Day Benefits
Severe dental/maxillo-facial and oral, dental procedures as covered	Up to a maximum of 100% of the Scheme Rate Subject to the treatment meeting the Scheme's treatment guidelines and Managed Health Care criteria	Cover is unlimited for services obtained in hospital
Mental health disorders	Up to a maximum of 100% of the Scheme Rate for related accounts Up to a maximum of 100% of the Scheme Rate for Hospital account in a KeyCare Network Hospital Up to a maximum of 80% of the Scheme Rate for the Hospital and related accounts if a Non-Network Hospital is used	Up to 21 days in hospital, or up to 15 out-of-hospital consultations, for conditions as defined in Annexure A of the Regulations of the Act All other conditions up to 21 days in hospital
Drug and alcohol rehabilitation	Cover is provided as per PMB legislative requirements	21 days in-hospital treatment per person per year

HOSPITAL
COVER (continued)

	TFG HEALTH	
BENEFIT	**RATE AND BASIS OF COVER: SUBJECT TO PMB**	**TFG HEALTH LIMITS**
Cardiac stents	Up to a maximum of 100% of the Scheme Rate Subject to pre-authorisation and the treatment meeting the Scheme's treatment guidelines and clinical criteria The device accumulates to the limit. The balance of the Hospital and related accounts do not accumulate to the annual limit Provisions of PMB is applicable	**Network supplier:** Unlimited if stent is supplied by the Scheme's KeyCare Direct Payment Arrangement practitioner **Non-network supplier:** **Drug-eluting stent:** R7,350 per stent per admission if not supplied by the Scheme's KeyCare Direct Payment Arrangement practitioner; **Bare metal stent limit:** R6,200 per stent per admission if not supplied by the Scheme's KeyCare Direct Payment Arrangement practitioner
Internal prostheses, including spinal care and surgery	This Benefit Plan covers Cardiac Stents as set out in this Benefit Table above and as also set out on page 12	This Benefit Plan covers Cardiac Stents as set out in this Benefit Table above and as also set out on page 12
MRI and CT Scans	Up to a maximum of 100% of the Scheme Rate Where MRI and CT scan is unrelated to the admission it will be covered from the specialist benefit of R5,000 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	Save for cover as per PMB legislation or where indicated and approved for dyspepsia, or for children aged 12 years and younger, cover is provided in a defined list of day care Network facilities Up to 100% of the Scheme Rate from Health Care Cover if done in the doctor's rooms. Cover is subject to pre-authorisation, and/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols. Conservative treatment for dyspepsia is covered up to 100% of the Scheme Rate from Health Care Cover.	Unlimited Funding of conservative treatment for dyspepsia as per basket of care set by the Scheme
To-Take-Out (TTO) Medicine (Medicine to take home)	Up to a maximum of 100% of the Scheme Medication Rate	R200 per hospital admission
Emergency Medical Services within the borders of South Africa (Ambulance services Call 0860 999 911)	Up to a maximum of 100% of the Scheme Rate Inter-hospital transfer subject to pre-authorisation The provisions of PMB and cover for PMB conditions is applicable	Unlimited for PMB conditions and non-PMB conditions are paid up to a maximum of 100% of the Scheme Rate

DAY SURGERY NETWORK

We cover specific procedures that can be done in the Day Surgery Network.



About the benefit

We cover certain planned procedures in a day surgery facility. A day surgery facility may be inside a hospital, in a clinic or at a standalone facility.

How to get the benefit

View the list of day surgery procedures in this guide. You must contact us on 0860 123 077 to get confirmation of your procedure (pre-authorisation).

How we pay

We pay these services from your hospital benefit. We pay for services related to your hospital stay including all healthcare professionals, services, medicine authorised by the Scheme. If you use doctors, specialists and other healthcare professionals that we have a payment arrangement with, we will pay for these services in full.

When you need to pay

If you go to a facility that is not in your plan's Day Surgery Network, you will have to pay the full account.

View all Day Surgery Network facilities on the Discovery app.

List of procedures covered in the Day Surgery Network

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

Biopsies

- Skin, subcutaneous tissue, soft tissue, muscle, bone, lymph, eye, mouth, throat, breast, cervix, vulva, prostate, penis, testes
- Breast Procedures (approved)
- Mastectomy for gynaecomastia
- Lumpectomy (fibroadenoma)

Ear, Nose and Throat Procedures

- Tonsillectomy and/or adenoidectomy
- Repair nasal turbinates, nasal septum
- Simple procedures for nose bleed (extensive cautery)
- Sinus lavage
- Scopes (nasal endoscopy, laryngoscopy)
- Middle ear procedures (tympanoplasty, mastoidectomy, myringoplasty, myringotomy and/or grommets)
- Eye Procedures
- Corneal transplant
- Cataract surgery
- Treatment of glaucoma
- Other eye procedures (removal of foreign body, conjunctival surgery (repair laceration, pterygium), glaucoma surgery, probing & repair of tear ducts, vitrectomy, retinal surgery, eyelid surgery, strabismus repair)

Ganglionectomy

- Gastrointestinal Procedures
- Gastrointestinal scopes (oesophagoscopy, gastroscopy, colonoscopy, sigmoidoscopy, proctoscopy, anoscopy)
- Anorectal procedures (treatment of haemorrhoids, fissure, fistula)
- Gynaecological Procedures
- Diagnostic Dilatation and Curettage
- Endometrial ablation
- Diagnostic Hysteroscopy
- Colposcopy with LLETZ
- Examination under anaesthesia

Orthopaedic Procedures

- Arthroscopy, arthrotomy (shoulder, elbow, knee, ankle, hand, wrist, foot, temporomandibular joint), arthrodesis (hand, wrist, foot)
- Minor joint arthroplasty (intercarpal, carpometacarpal and metacarpophalangeal, interphalangeal joint arthroplasty)
- Tendon and/or ligament repair, muscle debridement, fascia procedures (tenotomy, tenodesis, tenolysis, repair/reconstruction, capsulotomy, capsulectomy, synovectomy, excision tendon sheath lesion, fasciotomy, fasciectomy). Subject to individual case review
- Repair bunion or toe deformity
- Treatment of simple closed fractures and/or dislocations, removal of pins and plates. Subject to individual case review

Removal of foreign body

- Subcutaneous tissue, muscle, external auditory canal under general anaesthesia

Simple superficial lymphadenectomy

- Skin Procedures
- Debridement
- Removal of lesions (dependent on site and diameter)
- Simple repair of superficial wounds

Urological Procedures

- Cystoscopy
- Male genital procedures (circumcision, repair of penis, exploration of testes and scrotum, orchiectomy, epididymectomy, excision hydrocoele, excision varicocele vasectomy)

Some of these procedures are not covered on TFG Health. See page 35 for a list of extra exclusions on TFG Health.

EXTRA BENEFITS ON YOUR PLAN

You get the following extra benefits to enhance your cover.

Claims related to traumatic events

The Trauma Recovery Extender Benefit extends your cover for out-of-hospital claims related to certain traumatic events. Claims are paid from the Trauma Recovery Extender Benefit (TREB) for the rest of the year in which the trauma occurred, as well as the year after the event occurred. You need to apply for this benefit.

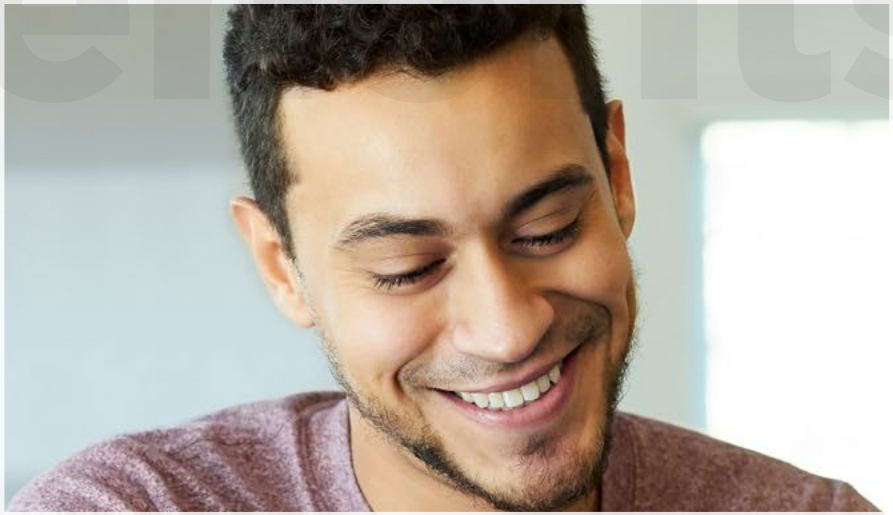
International second opinion services

Through your specialist, you have access to second opinion services from Cleveland Clinic for life-threatening and life-changing conditions. We cover 50% for the cost of the second opinion service.

WHO Global Outbreak Benefit

You have cover up to 100% of the Scheme Rate for relevant healthcare services, as well as a defined basket of care for out-of-hospital healthcare services, related to global World Health Organisation (WHO) recognised disease outbreaks such as COVID-19. This does not affect your day-to-day benefits, where applicable, and is in line with Prescribed Minimum Benefits (PMB).

For COVID-19 you have access to an online risk assessment to determine your risk of exposure, as well as the vaccine, screening consultations, testing, out-of-hospital management and appropriate supportive treatment as long as the treatment meets our benefit entry criteria. In-hospital treatment for approved COVID-19 admissions is covered from the hospital benefit and in accordance with Prescribed Minimum Benefits (PMB).



The Scheme also introduced a basket of care for those diagnosed with Long COVID without affecting day-to-day benefits. Long COVID is diagnosed when symptoms of acute COVID-19 disease persist beyond 21 days after a confirmatory test. The benefit is activated for a period of 6 months from the date of diagnosis by the treating healthcare provider.

In-room procedures

You have cover for a defined list of procedures performed in specialist rooms. Cover is up to an agreed rate, where authorised by the Scheme, from your hospital benefit.

Advanced Illness Benefit

For the management of end of life care, TFG Health makes available an Advanced Illness Benefit (AIB) for members living with advanced cancer or other life-limiting conditions. This allows members to access a dedicated team of care coordinators that assist in accessing the care required including:

- Psychosocial support;
- Medical care from dedicated teams such as hospice; and
- Supportive treatment such as oxygen, pain control and home-based nursing

EXTRA BENEFITS
ON YOUR PLAN (continued)

Coronary Artery Disease Care Project (CADCare Project)

The Scheme has joined the CADCare Project with Discovery Health who have collaborated with the South African Society of Cardiovascular Intervention (SASCI). CADCare serves as a care delivery project, introduced for members at pre-authorisation stage for low and intermediate risk patients where an invasive angiogram was necessary. Prior to the authorisation of an invasive angiogram, a Computed Tomography Coronary Angiography report is requested.

A network of doctors has been established to provide members with full funding at Scheme negotiated rates, thereby limiting out-of-pocket expenses.

Pre-operative outpatient assessments

Members have access to a pre-operative assessment benefit when undergoing the following five major surgeries:

- Colorectal cancer surgery
- Breast cancer surgery
- Prostate cancer surgery
- CABG (coronary artery bypass graft) surgery

Once identified as requiring any of the above surgical procedures, either following the pre-authorisation process or as diagnosed by your treating surgeon, a basket of out-of-hospital benefits become available, which are paid from risk. What is included in this basket of benefits is based on risk level (rated on a predefined pre-operative assessment (POA) out-of-hospital benefit basket matrix and/or clinical evaluation by your treating doctor).

Members not fit for surgery get access to other benefits, based on benefit plan, to support their treatment requirements.

YOUR CONTRIBUTIONS
FROM 1 MAY 2023

Full contributions with effect from 1 May 2023

These contributions (shown in Table 1) are the total amounts due to the Scheme. For active employees, the member's portion of the contributions is dependent on whether the member is on a Total Guaranteed Package (TGP) or Salary Plus structure, as indicated in the tables alongside.

Income verification may be conducted to determine whether you are registered in the correct income band. Income is considered as Pensionable Pay in the case of an employee. In the case of an employee who registers a spouse, it is the higher of the member's Pensionable Pay or spouse's salary or earnings. For all other members, it is 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: ACTIVE EMPLOYEES ON A TGP STRUCTURE

	MONTHLY CONTRIBUTION		
MONTHLY INCOME	PRINCIPAL MEMBER	ADULT DEPENDANT*	CHILD DEPENDANT**
R0 - R6,540	R1,406	R1,406	R496
R6,541 - R10,660	R1,586	R1,586	R502
R10,661 - R20,490	R1,698	R1,698	R538
R20,491 - R35,110	R1,846	R1,846	R592
R35,111 - R52,300	R2,152	R2,152	R674
R52,301 +	R2,342	R2,342	R716

* Child dependant 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 is a registered student at a university or recognised college for higher education and is not self-supporting.

Subsidised contributions with effect from 1 May 2023

These contributions (shown in Table 2) are the member's own contributions after the TFG 50% subsidy is taken into account and applies to active employees on a Salary Plus structure. If you are not entitled to a subsidy, you will need to pay the full contribution as shown in Table 1.

TABLE 2: ACTIVE EMPLOYEES ON A SALARY PLUS STRUCTURE

	MONTHLY CONTRIBUTION		
MONTHLY INCOME	PRINCIPAL MEMBER	ADULT DEPENDANT*	CHILD DEPENDANT**
R0 - R6,540	R703	R703	R248
R6,541 - R10,660	R793	R793	R251
R10,661 - R20,490	R849	R849	R269
R20,491 - R35,110	R923	R923	R296
R35,111 - R52,300	R1,076	R1,076	R337
R52,301 +	R1,171	R1,171	R358

* Adult dependants are only subsidised if they are the main member's spouse or if their adult child is a person with a disability.

** Child dependant 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 is a registered student at a university or recognised college for higher education and is not self-supporting.

TFG HEALTH
EXCLUSIONS

Healthcare services that are not covered on your plan

TFG Medical Aid Scheme has certain exclusions. We do 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).

MEDICAL CONDITIONS DURING A WAITING PERIOD

If we apply waiting periods because you have never belonged to a medical scheme or you have had a break in membership of more than 90 days before joining TFG Medical Aid Scheme, you will not have access to the Prescribed Minimum Benefits (PMB) during your waiting period. This includes cover for emergency admissions. If you had a break in cover of less than 90 days before joining TFGMAS, you may have access to PMB during waiting periods.

THE GENERAL EXCLUSION LIST INCLUDES:

Appliances not part of benefit plan

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.

Anti-smoking preparations.

Aphrodisiacs.

Anabolic steroids.

Accommodation in old age homes.

Accommodation and treatment in spas and resorts.

Appointments not kept.

Ante and post-natal exercise classes as well as lactation consultations.

Accommodation and treatment in headache and stress-relief clinics.

Ambulance transportation and air lifting outside of South Africa (including PMB). International Emergency evacuation is not covered.

Bleaching of teeth that have not had root canal treatment, metal inlays in dentures and front teeth.

Circumcision – no benefits, unless deemed medically necessary.

Convalescing equipment (with the exception of hire of oxygen cylinders) – unless deemed clinically appropriate.

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.

Erectile dysfunction treatment.

Examinations for insurance, school camps and visas.

Growth hormones.

Household remedies.

Holidays for recuperation.

Infertility treatment – unless received from a Designated Service Provider (DSP) facility or as a PMB.

THE GENERAL EXCLUSION LIST (CONTINUED)

Mouth protectors and gold dentures.

Medicine not prescribed and per the approved medicine lists.

Obesity – examinations, consultations and treatment relating to obesity or which may be regarded as for cosmetic purposes.

Replacement batteries for hearing aids (considered consumables).

Sunscreen and tanning agents.

Soaps, shampoos and other topical applications.

Slimming preparations, appetite suppressors, food supplements and patent foods, including baby food.

Stimulant laxatives.

Sunglasses and spectacle cases, as well as over-the-counter reading glasses.

Tonics, nutritional supplements, multi-vitamins, vitamin combinations – except prenatal, lactation and paediatric use – unless authorised as part of a disease management programme.

Travelling Costs.

Unregistered providers.

Vaccines other than specifically provided for in the benefit rules of the Scheme.

EXTRA EXCLUSIONS SPECIFIC TO TFG HEALTH

In addition to the general exclusions that apply to both the TFG Health and the TFG Health Plus benefit plans, TFG Health do not cover the following, except where stipulated as part of a defined benefit or under the Prescribed Minimum Benefits (PMB).

1. **Hospital admissions related to, among others:**

   Back and neck treatment surgery.

   Knee and shoulder surgery.

   Elective Caesarean Section except in cases where it is medically necessary.

   Surgery for oesophaegeal reflux and hiatus hernia repairs.

   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 investigations.

   Nail disorders.

   Arthroscopy.

   Joint replacements, including but not limited to hips, knees, shoulders and elbows.

   Cochlear implants, auditory brain implants and internal nerve stimulators (this includes procedures, devices, processors and hearing aids).

   Functional nasal problems and functional sinus problems.

   Endoscopic procedures

   Cosmetic treatment including, but not limited to, septoplasties, osteotomies and nasal tip surgery.

   Healthcare services that should be done out of hospital and for which an admission to hospital is not necessary.

2. **Non-cancerous breast conditions**
3. **Removal of varicose veins**
4. **Correction of Hallux Valgus/Bunion and Tailor's Bunion/Bunionette**
5. **Refractive eye surgery**

The above list is not to be regarded as full and complete lists as we do not cover the complications or the direct or indirect expenses that arise from any of the exclusions listed here, except where stipulated as part of a defined benefit or under the Prescribed Minimum Benefits.

The benefits outlined in this brochure are a summary of TFG Health Benefit Plan's registered benefits as set out in the TFGMAS 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. Please visit **www.tfgmedicalaidscheme.co.za** for a copy of the Scheme Rules as registered by the Council for Medical Schemes (CMS) each year.

DISCRETIONARY BENEFITS

Discretionary benefits are made available to members through an Ex Gratia Policy as approved by the Board of Trustees of the Scheme.

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.

Should you wish to make application for a discretionary benefit or grant, you can contact the Scheme's Administrator on **0860 123 077** to be provided with the necessary forms and information regarding the process to follow.

COMPLAINTS AND DISPUTES

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:

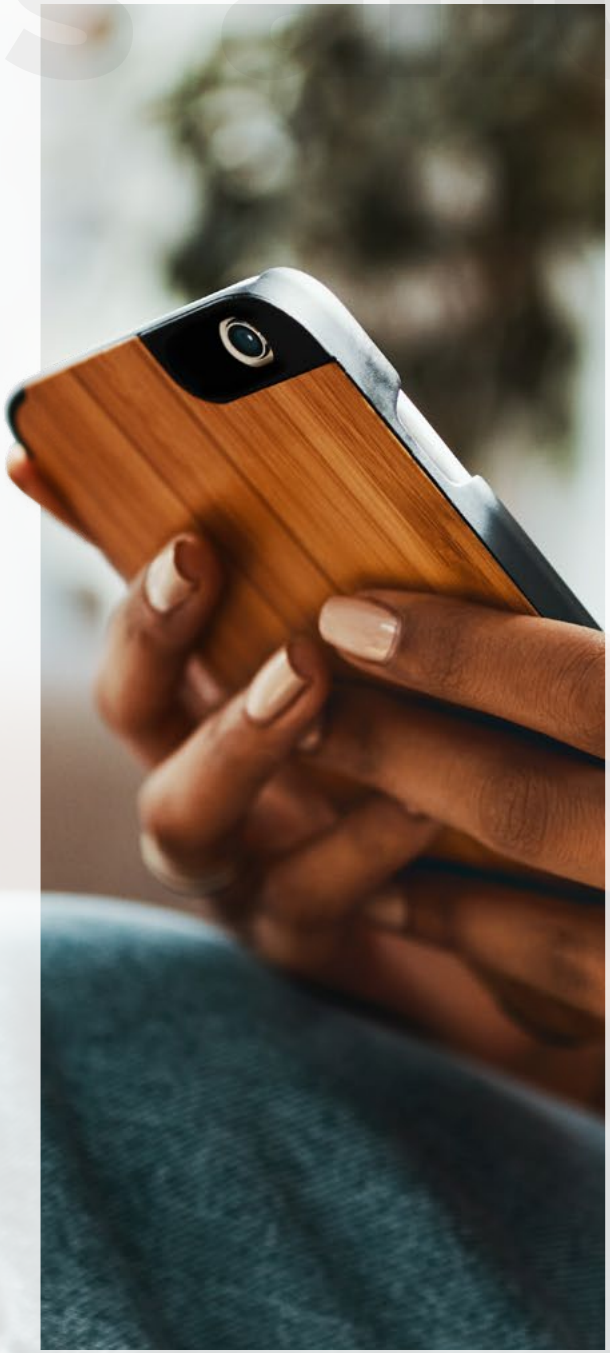
If the matter remains unresolved or the feedback received is not to your satisfaction, the matter can be escalated to the Principal Officer of the Scheme, Ms Caron Harris, who will direct the matter in line with the Disputes Process of the Scheme for resolution.

Step 3:

Once feedback is provided, members who are still in dispute with the Scheme can contact the Council for Medical Schemes.

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

- **Physical address:** Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion 0157.
- **Postal address:** Private Bag X34, Hatfield 0028.
- **Phone number:** 0861 123 267.
- **Fax number:** 086 673 2466.
- **Email:** complaints@medicalschemes.co.za.



MEDICAL AID SCHEME

TFGMAS

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