Medical Aid Scheme

Administered by Discovery Health

TFG Health

BENEFIT GUIDE | 2024

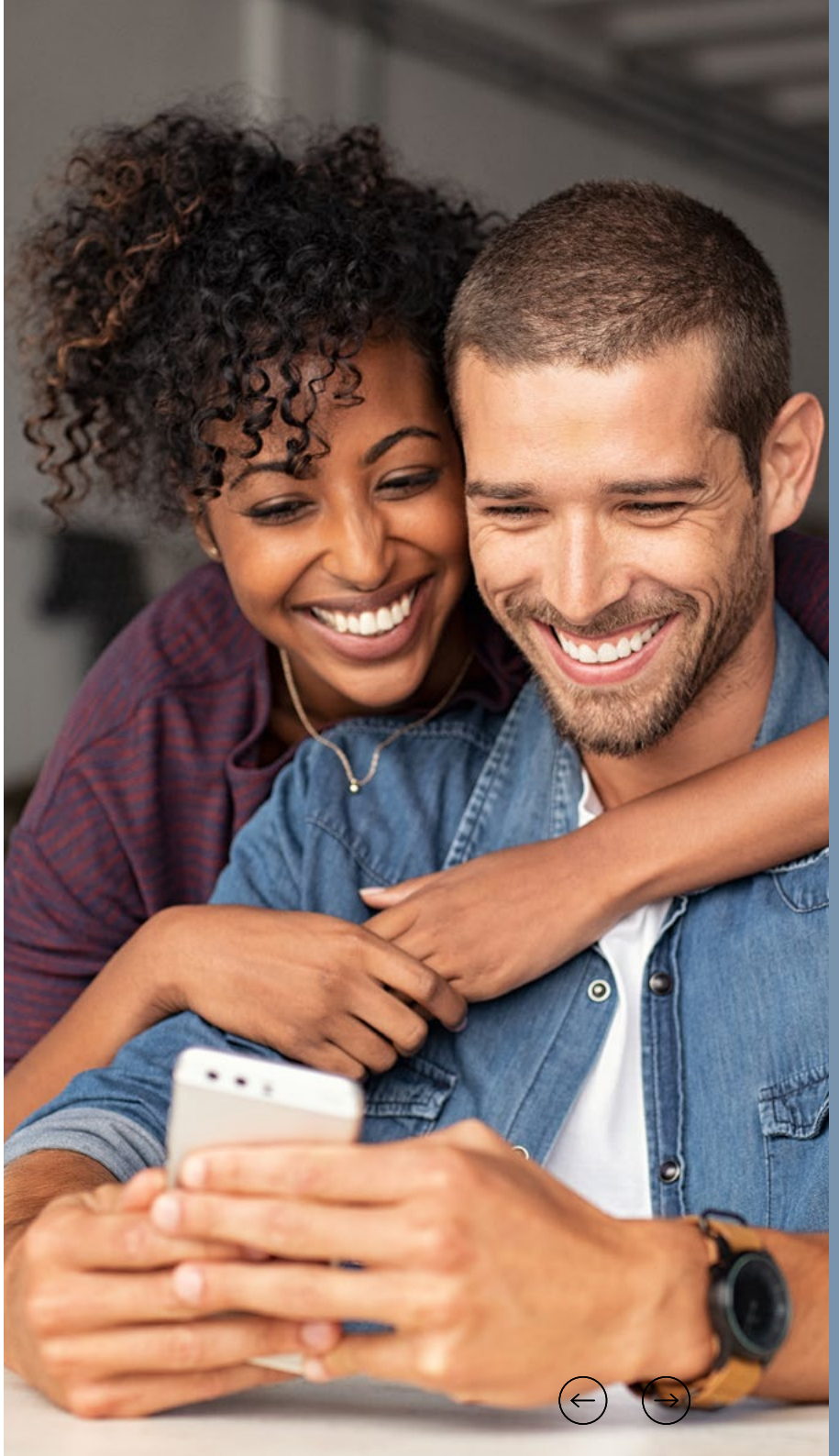
Welcome to TFG Health

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 (customised for TFG Medical Aid Scheme members). 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, diagnoses and treatment of medical conditions
- 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**



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@tfgmedicalaidscheme.co.za
- Call: **0860 123 077**

To send claims

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

Oncology service centre

- Call: **0860 123 077**
- Email: oncology@tfgmedicalaidscheme.co.za

HIVCare Programme

- Call: **0860 123 077**

Internet queries

- Call: **0860 100 696**

CONTACT INFORMATION FOR THE TFG EMPLOYER IS SET OUT BELOW:

- Reach out to The Fuse by logging a ticket via **https://synergy.tfg.co.za**
- Call: **021 937 4742**
- WhatsApp: **060 534 4503**

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.

COVER

Cover refers to the benefits you have access to and how we pay for these healthcare services such as consultations, medicine and hospitals, on your benefit plan.

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/CO-PAYMENT

A co-payment 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. The amount that you must pay upfront to the hospital or day clinic for specific treatments and/or procedures, is referred to as a deductible in this benefit guide. If the upfront amount is higher than the amount charged for the healthcare service, you will have to pay for the cost of the healthcare service. You may need to pay a deductible upfront or retrospective as a co-payment for services received.

DESIGNATED SERVICE PROVIDER (DSP)

This is a doctor, specialist or other healthcare provider that we have reached an agreement with about payment and rates 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.

FIND A HEALTHCARE PROVIDER

Find a healthcare provider* is a medical and provider search tool which is available on the Discovery Health app* or available on the Scheme's website **www.tfgmedicalaidscheme.co.za**.

FORMULARY (MEDICINE LIST)

This is a list of preferred medicines considered by the Scheme to be the most useful in-patient care and based on 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 the relevant dispensing fee.

* 'Find a healthcare provider' and the 'Discovery Health app' are brought to you by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes.

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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 dependants 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, if 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 R475 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 (customised for TFG Medical Aid Scheme members) 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.

Home-based Hospital Network

You have full cover for carefully selected low-acuity conditions if you use a Designated Service Provider in the Home-based Hospital 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 shortfalls.

PRE-AUTHORISATION

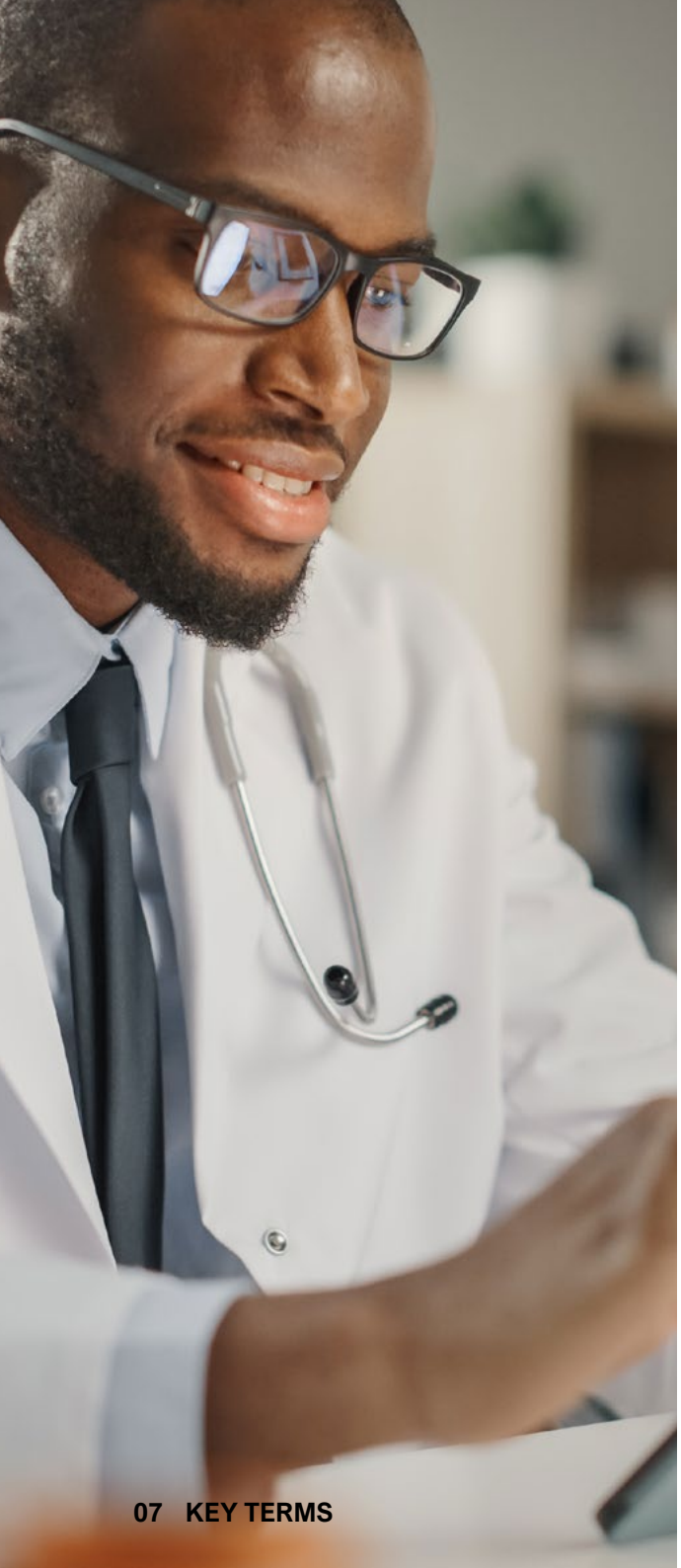
You need to inform TFGMAS if you plan/are scheduled to be admitted to hospital. Please phone us on **0860 123 077** for pre-authorisation, so that we can confirm your membership and available benefits. Without pre-authorisation, you may have a deductible to pay. **Pre-authorisation is not a guarantee 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 must 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 (including HIV and AIDS).

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.

PRIMARY CARE DOCTOR

A primary care doctor helps you take care of your general health. Having one nominated doctor who manages your health and coordinates your care leads to better health outcomes. Your primary care doctor knows your complete medical history and takes the healthcare approach that works best for you.

REFERENCE PRICE

The reference price is the set amount we pay for a medicine category. This applies for medicine that is not listed on the medicine list (formulary).

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 ornegotiated 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 Organization (WHO) such as COVID-19.

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.

EXTENSIVE COVER FOR PREGNANCY

You get comprehensive benefits for maternity and early childhood that cover certain healthcare services before and after birth.

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.

FULL COVER FOR CHRONIC MEDICINE

Essential cover for chronic medicine on the KeyCare Medicine List for all Chronic Disease List (CDL) conditions when you use a Designated Service Provider (DSP).

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.

SCREENING AND PREVENTION

Screening and prevention benefits that cover vital tests to detect early warning signs of serious illness.

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.

THE WELLTH FUND

The WELLTH Fund covers a comprehensive list of additional screening and prevention healthcare services according to your individual health needs.

Key Benefits

DAY-TO-DAY COVER

Day-to-day cover at your chosen KeyCare Network GP. Medicine from our medicine list is covered at a network pharmacy. Specialists are covered up to 100% of the Scheme Rate, subject to the benefit limit of **R5,300** per person per year. You must be referred by your chosen KeyCare Network GP and get a reference number from us before your consultation with the specialist.

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 **R475** of the consultation and must get approval before your visit.

CHRONIC MEDICINE PRESCRIPTIONS

Your approved chronic medication must be dispensed by your chosen KeyCare Network 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 or you can go to a state facility. **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 (CUSTOMISED FOR TFG MEDICAL AID SCHEME MEMBERS)

Covered at 100% of the Scheme Rate 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.

If 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 **R475** 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. Travelers 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 (including HIV and AIDS)
- 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) it 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 at **0860 123 077** to find out the options available to you before obtaining these appliances.

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, such as Clicks and/or Dis-Chem. Tests such as blood glucose, cholesterol, HIV, Pap smear or HPV test for cervical screening, mammograms and/or ultrasounds and prostate screenings are some examples.

WHAT WE PAY FOR

We cover various screening tests at our wellness providers.

These tests are paid from the Screening and Prevention Benefit. Consultations that do not form part of Prescribed Minimum Benefits (PMB) will be paid from your available day-to-day benefits.

Screening for kids

This benefit covers the assessment of your child's growth and development, which includes the measurement of weight, height, body mass index and blood pressure at one of our wellness providers.

Screening for adults

This benefit covers a health check which is made up of certain tests such as blood glucose, blood pressure, cholesterol, body 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, a mental wellbeing assessment every year, PSA test (prostate screening) each year and bowel cancer screening tests every 2 years for members between 45 and 75 years. These tests are paid from the Screening and Prevention Benefit. Consultations that do not form part of PMB will be paid from your available day-to-day benefits.

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 assessment in our defined pharmacy network. You may have cover for an additional falls-risk assessment when referred to a Premier Plus GP, depending on your screening test results and if you meet the Scheme's clinical entry criteria.

Additional tests

Clinical entry criteria may apply to these tests:

- Defined diabetes and cholesterol screening tests.
- Breast MRI or mammogram and once-off BRCA testing for breast screening.
- Colonoscopy for bowel cancer screening.
- Pap smear or HPV test for cervical screening.

Vaccines

Clinical entry criteria may apply to these vaccines:

- Seasonal flu vaccine for members who are pregnant, 65 years or older, registered for certain chronic conditions or healthcare professionals.
- Pneumococcal vaccine for members over the age of 65 or those registered for certain chronic conditions.
- COVID-19 vaccines are covered from the WHO Global Outbreak Benefit and per the guidelines published by the Department of Health (DOH).

YOU HAVE ACCESS TO THE WELLTH FUND

The WELLTH Fund covers a comprehensive list of screening and prevention healthcare services to ensure that you are empowered to take specific action according to your individual health needs.

This benefit is separate from and additional to the Screening and Prevention Benefit and is available once per lifetime for all members and dependants who have completed their health checks. Your WELLTH Fund can be used for appropriate screening and prevention healthcare services up to your WELLTH Fund limit. Cover is subject to the Scheme's clinical entry criteria, treatment guidelines and protocols.

HOW TO GET ACCESS

The Wellth Fund was introduced in 2023 and is available for two benefit years once all beneficiaries over the age of two years complete their age-appropriate health check as described on the previous page at a provider in our Wellness Network. For new joiners, the benefit is available in the year of joining and the year thereafter.

WHAT LIMITS APPLY

The benefit is available once per beneficiary per lifetime. Qualifying healthcare services are covered up to a maximum of the Scheme Rate, subject to the overall benefit limit. Your WELLTH Fund limit is dependant on the size and make up of your family as registered with the Scheme:

- R2,500 per adult dependant.
- R1,250 per child dependant two years and older.
- Up to a maximum of R10,000 per family.

The WELLTH Fund is available to all registered beneficiaries on the membership. The WELLTH Fund will not cover screening and prevention healthcare services already covered by other defined benefits.

These include:

- General health
- Physical health
- Mental health
- Women and men's health
- Children's health
- Medical monitoring devices

Visit **www.tfgmedicalaidscheme.co.za** and navigate to "WHAT WE COVER" > "Wellth Fund" to obtain more information.

Your Virtual **Benefits and access to Home Care**

The Discovery app* gives you access to virtual benefits and easy navigation to manage your health and benefits.

ONLINE PHARMACY

Order your medicine for delivery or shop all other in-store items – delivered to your door.

MANAGE YOUR BENEFIT PLAN

Seamlessly manage your chosen benefit plan – find healthcare providers, submit and track claims, monitor benefits and more.

ONLINE COUNSELLING WITH DIGITAL MENTAL HEALTH

With effect from 1 January 2024, access an on-demand digital mental healthcare platform for evidence-based support programmes and tools with Digital Mental Health. If you are diagnosed with depression your claims will fund from your available PMB, subject to clinical entry criteria. If you do not meet the criteria or have used your benefits, you will need to fund your claims.

COVER FOR HOME CARE**

Discovery Home Care is a service that offers you quality care in the comfort of your own home when recommended by your doctor as an alternative to a hospital stay.

Services include postnatal care, end-of-life care, IV infusions (drips) and wound care. These services are paid from the Hospital Benefit, subject to approval. Discovery Home Care is the Designated Service Provider (DSP) for administration of defined intravenous infusions. Avoid a 20% co-payment by using Discovery Home Care for these infusions

HOME-BASED HOSPITAL NETWORK

If you are admitted to our Home-based Hospital Network Designated Service Provider, you have access to enhanced benefits and services delivered through your personalised care team. We pay all services offered as part of this network from your hospital benefit, if you have a valid pre-authorisation for hospitalisation.

The Home-based Hospital Network is the Designated Service Provider (DSP) for home-based care for qualifying conditions such as chronic obstructive pulmonary disease, pneumonia, complicated urinary tract infection, heart failure, cellulitis, deep vein thrombosis, asthma and diabetes. Members do not need to use this network in the event of an emergency, or if not deemed clinically appropriate for home-based care according to the treating provider.

If you meet the Scheme's clinical benefit entry criteria, you will have access to:

- Physical and virtual 24-hour care delivery facilitated by a dedicated care team.
- Access to a remote monitoring device that automatically transmits information to a hospital-based care team, 24 hours a day, seven days a week.
- Access to an improved range of clinical diagnostic procedures and interventions to manage medical or post-surgical hospital-level care in the home.

Should you choose to not make use of this network once your treating healthcare provider has recommended it as part of your care, an upfront deductible of **R5,000** will apply to the admission.

HOME MONITORING DEVICE BENEFIT FOR ESSENTIAL HOME MONITORING

The Home Monitoring Device Benefit gives you access to a range of essential and registered home monitoring devices for certain chronic and acute conditions. Approved cover for these devices are paid up to a limit of **R4,500** per person per year, at 100% of the Scheme Rate and will not affect your day-to-day benefits.

** Discovery Home Care is a service provider. Practice 080 000 8000190, Grove Nursing Services (Pty) Ltd registration number 2015/191080/07, trading as Discovery HomeCare

* The Discovery app is brought to you by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes.

Day-to-Day Benefits

You have access to the following day-to-day cover on TFG Health. Your KeyCare GP must refer you and you must use providers in your chosen KeyCare GP network, as nominated when you joined this benefit plan.

Health Care Cover = Unlimited	**TFG Health**	
Benefit	**Rate and basis of cover: Subject to PMB**	**TFG Health limits**
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, as well as out-of-hospital consultation codes for virtual visits to meet the digital platform criteria. 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 their chosen 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 300 per person per year**. Member must be referred by chosen KeyCare Network GP.	In Network limits: Unlimited only at chosen 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 chosen KeyCare Network GP. Baskets of care as set by the Scheme may be applicable. R5 300 per person per year.
Out-of-Network visits, including GP consultations, nurse-led consultation with or without video call with a General Practitioner (including acute medicines, radiology and pathology requested by a GP when referred)	Up to a maximum of 100% of the Scheme Rate or Scheme Medication Rate – subject to a list of codes at a KeyCare Network GP or a pharmacy that is contracted as a Designated Service Provider (DSP). **Only acute medicines, radiology and pathology requested by the member's KeyCare Network GP** will be covered under this Benefit.	Two GP consultations and one Nurse-led consultation per person per year, three pathology claims (requested by GP), three radiology claims (requested by GP) and three pharmacy claims (prescribed by GP) per person per year. Subject to PMB.

Health Care Cover = Unlimited	TFG Health	
Benefit	**Rate and basis of cover: Subject to PMB**	**TFG Health limits**
Visits to casualty units	The first R475 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**.

Health Care Cover = Unlimited	TFG Health	
Benefit	**Rate and basis of cover: Subject to PMB**	**TFG Health limits**
Medical appliances (External Medical Items), mobility devices (wheelchairs, long leg calipers and crutches), including hearing aids and external prosthesis	**Mobility Devices such as wheelchairs, long leg calipers 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.	R6,050 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 more than 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**.
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 R5,300 per person per year.

Health Care Cover = Unlimited	TFG Health	
Benefit	**Rate and basis of cover: Subject to PMB**	**TFG Health limits**
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 R99,050 per person per year. ■ **Hearing aids** Limited to: R17,050 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: R9,300 M + 1 Dependant: R14,050 M + 2 Dependants: R17,450 M + 3 Dependants or more: R21,000 ■ **Prescribed Medicine limited to:** Member: R18,150 M + 1 Dependant: R21,500 M + 2 Dependants: R25,500 M + 3 Dependants: R31,050

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 **8** 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 **1** 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 **2** 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 postdelivery, a nutritional assessment with a dietitian and **2** mental healthcare consultations with a counsellor or psychologist.

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

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

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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 fully covered for all PMB related conditions as listed below.

A – Addison's disease, Asthma

B – Bipolar mood disorder, Bronchiectasis

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 HIVCare 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 the therapeutic reference price of the equivalent medicine or group of medicines, 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 co-payment 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) if you want to access cover. You and your doctor must complete a form online or send it to us for approval to CIB_APP_FORMS@tfgmedicalaidscheme.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.

WHERE TO GET YOUR CONSULTATIONS AND MEDICINE

You must nominate a GP in the KeyCare Network to be your primary GP to manage your chronic conditions. To find a doctor and learn more about the nomination process, use the Discovery app or **www.tfgmedicalaidscheme.co.za**.

For full cover of your GP consultations you must visit your chosen KeyCare Network GP. If you see a GP that is not your chosen KeyCare Network GP, you will have to pay a co-payment.

For more information on our Care Programmes and enrolment by your Premier Plus Network GP, please refer to the next page for more information regarding our "Care Programmes".

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 Network GP (if they dispense medicine). If you get your medicine from anywhere else, you will have a 20% co-payment.

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.

MEMBER CARE PROGRAMME

If you are diagnosed with one or more chronic conditions, you might qualify for our Member Care Programme. We will contact you to confirm if you do qualify.

The programme offers organised care to help you to manage your conditions and to get the best quality healthcare.
If you are registered and take part in the programme, we will pay in full for your treatment.

If you choose not to take part, we will cover the hospital and related accounts up to 80% of the Scheme Rate.

MEDICINE TRACKER

You can set up reminders and prompts to assist you with taking your medicine on time and as prescribed. Your approved chronic medicine will automatically be displayed, and you will then be prompted to take your medicine and confirm when each dose is taken.

CARE PROGRAMMES

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

We cover preventative 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 over time. Cover is subject to the Scheme's clinical entry criteria, treatment guidelines and protocols.

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.

As part of TFG Health mental health programme enhancements, TFGMAS has also introduced a digital therapeutic tool, iCBT, with effect from 1 January 2024 to provide increased access to mental healthcare to members, as well as providing additional support to healthcare professionals in managing depression.

To be eligible in gaining access to iCBT members would need to be:

- Referred by their General Practitioner, psychologist, psychiatrist or physician
- Diagnosed with depression or show signs of early symptoms of depression.

The tool will make available to members the equivalent of 1 psychotherapy session that will be paid from the member's available mental health basket of care, through an iCBT 12-month license. A personal supporter to monitor engagement and clinical progress with 24 hours self-harm and suicide support integrated with the South African Depression and Anxiety Group (SADAC) will be available as additional benefits to members.

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 enroll 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**.

In addition to the CIB basket of care available to members enrolled on the Diabetes Care Programme, members may choose to embark on a more integrated care programme, which will give 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 diabetes coaches and podiatrists. Any member registered on the Chronic Illness Benefit (CIB) for diabetes will be able to access the CIB basket of care and join the programme.

Disease Prevention Programme

If you are identified to be at risk of cardio-metabolic risk syndrome, your chosen KeyCare Premier Plus GP can enrol you on the Disease Prevention Programme. Your Premier Plus GP, dietitian and health coach will help coordinate your care.

Enrolled members have access to a defined basket of care, which includes cover for consultations, certain pathology tests and medicine, where appropriate.

You will also have access to health coaching sessions to help you with the day-to-day management of your condition.

HIVCare programme

If you are registered on the HIVCare Programme by your chosen KeyCare Premier Plus GP, 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 must 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**.

Your **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 Care 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 a 20% co-payment. Speak to your treating doctor to confirm that they are using our DSP for your medicine and treatment received in rooms or at a treatment facility.

COLORECTAL CANCER SURGERY

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

ADVANCED ILLNESS BENEFIT (AIB)

Members 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. Your doctor may recommend home-based care as part of your treatment. You will need to make use of our Home-based Hospital Network which is the Designated Service Provider (DSP) for home-based care. If your treating healthcare provider deems it appropriate and you choose not to make use of the DSP, you will need to pay **R5,000** upfront for your admission.

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 must 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 CO-PAYMENTS 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 Health app*.

* 'Find a healthcare provider' and the 'Discovery Health app' are brought to you by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes.

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 accumulates 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

Health Care Cover = Unlimited hospital cover	TFG Health	
Benefit	**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.

Health Care Cover = Unlimited hospital cover	TFG Health	
Benefit	**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 are 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 **14** days out-of-hospital consultations or a combination thereof, plus **1** internet Cognitive Behaviour Therapy (iCBT) license; for conditions as defined in Annexure A of the Regulations of the Act. PMB provisions apply. 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.

Health Care Cover = Unlimited hospital cover	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: R7,550** per stent per admission if not supplied by the Scheme's KeyCare Direct Payment Arrangement practitioner; **Bare metal stent limit: R6,400** 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 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 **R5,300** 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 were indicated and approved for dyspepsia, or for children aged 12 years and younger, cover is provided in a defined list of Day Surgery 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.	**R210** 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 benefit brochure. You must contact us 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*.

* 'Find a healthcare provider' and the Discovery app are brought to you by Discovery Health (Pty) Ltd; registration number 1997/013 480/07, an authorised financial services provider and administrator of medical schemes.

LIST OF PROCEDURES COVERED IN THE DAY SURGERY NETWORK

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

B – Biopsies

- Skin, subcutaneous tissue, soft tissue, muscle, bone, lymph, eye, mouth, throat, breast cervix, vulva, prostate, penis, testes

Breast procedures (if approved)

- Mastectomy for gynaecomastia
- Lumpectomy (fibroadenoma)

E – Ear, Nose and Throat Procedures

- Tonsillectomy and/or adenoidectomy
- Repair nasal turbinates, nasal septum
- Simple procedures for nosebleed (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)

G – 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

O – 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

R – Removal of foreign body

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

S – Simple superficial lymphadenectomy

Skin Procedures

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

U – Urological Procedures

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

LIST OF PROCEDURES COVERED IN THE DAY SURGERY NETWORK

With effect from 1 January 2024, TFG Health is adding additional procedures to the existing lists of procedures that is done in the Day Surgery Network Hospitals and the additions are as follows:

G – Gynaecological Procedures (existing category with new procedures added)

- Diagnostic laparoscopy
- Simple vulval and introitus procedures: Simple hymenotomy, partial hymenectomy, simple vulvectomy, excision bartholin's gland cyst
- Vaginal, cervix and oviduct procedures: Excision vaginal septum, cyst or tumour, tubal ligation or occlusion, uterine cervix cerclage, removal cerclage suture
- Suction curettage
- Uterine evacuation and curettage

S – Simple hernia procedures (new category)

- Umbilical hernia repair
- Inguinal hernia repair

N – Nerve procedures (new category)

Neuroplasty median nerve, ulnar nerve, digital, nerve of hand or foot

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

Extra Benefits

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 and your dependants on your benefit plan have access to six counselling sessions per person per year by a psychologist, clinical social worker or registered counsellor, for the year in which the trauma event occurred and the year after. 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

The WHO Global Outbreak Benefit is available to all members during a declared outbreak period. The benefit provides cover for the administration of vaccinations (where applicable) as well as a defined basket of care for out-of-hospital healthcare services related to outbreak diseases such as COVID-19 and monkeypox.

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

Members 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 also have access to a GP consultation to facilitate your palliative care treatment plan.

MENTAL WELLBEING

Members identified with moderate to severe symptoms of depression following a mental wellbeing assessment, have access to a virtual consultation, where applicable, with a Premier Plus GP or network psychologist. Cover is subject to clinical entry criteria.

FOLLOW-UP TREATMENT AFTER AN ADMISSION

If you qualify, you have access to a readmission prevention programme for clinically appropriate conditions. This programme gives you access to approved follow-up care and a health coaching session within 30 days after you are discharged from hospital.

Cover is subject to our treatment guidelines and clinical entry criteria.

Your contributions from 1 April 2024

FULL CONTRIBUTIONS WITH EFFECT FROM 1 APRIL 2024

These contributions (shown in Table 1) are the total amounts due to the Scheme. For active employees, the members' 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 below.

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.

ACTIVE EMPLOYEES ON A TGP STRUCTURE: TABLE 1

TFG Health monthly income	Monthly contribution		
	Principal Member	Adult Dependant*	Child Dependant**
R0 – R6,870	R1,538	R1,538	R 546
R6,871 - R11,190	R1,734	R1,734	R 554
R11,191 - R21,520	R1,852	R1,852	R 602
R21,521 - R36,870	R2,012	R2,012	R 664
R36,871 - R54,920	R2,342	R2,342	R 762
R54,921 +	R2,546	R2,546	R 814

** 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 APRIL 2024

These contributions (shown in Table 2) are the members' 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.

ACTIVE EMPLOYEES ON A SALARY PLUS STRUCTURE: TABLE 2

TFG Health monthly income	Monthly contribution		
	Principal Member	Adult Dependant*	Child Dependant**
R0 - R6,870	R 769	R 769	R 273
R6,871 - R11,190	R 867	R 867	R 277
R11,191 - R21,520	R 926	R 926	R 301
R21,521 - R36,870	R1,006	R1,006	R 332
R36,871 - R54,920	R1,171	R1,171	R 381
R54,921 +	R1,273	R1,273	R 407

* 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 BENEFIT 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:

A – 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.

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

C – Circumcision – no benefits, unless deemed medically necessary.

Convalescing equipment (except for 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.

E – Erectile dysfunction treatment.

Examinations for insurance, school camps and visas.

G – Growth hormones.

H – Household remedies.

Holidays for recuperation.

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

M – Mouth protectors and gold dentures.

Medicine not prescribed and per the approved medicine lists.

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

R – Replacement batteries for hearing aids (considered consumables).

S – 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.

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

Travelling Costs.

U – Unregistered providers.

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

EXTRA EXCLUSIONS SPECIFIC TO TFG HEALTH

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).

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

The benefits outlined in this brochure are a summary of 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 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@tfgmedicalaidscheme.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

Administered by Discovery Health

TFG Medical Aid Scheme is regulated by the Council for Medical Schemes (CMS). 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.

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