TFG

MEDICAL AID SCHEME

TFG MASS

TFG HEALTH PLUS

BENEFIT GUIDE 2023

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WELCOME TO TFG HEALTH PLUS

TFG Health Plus offers members a comprehensive range of benefits, including additional in-hospital procedures, an additional list of chronic conditions and additional list of medication. TFG Health Plus allows members freedom of choice, while ensuring full coverage of Prescribed Minimum Benefit (PMB) conditions.

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 (TFGMAS) 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 Plus 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.

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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

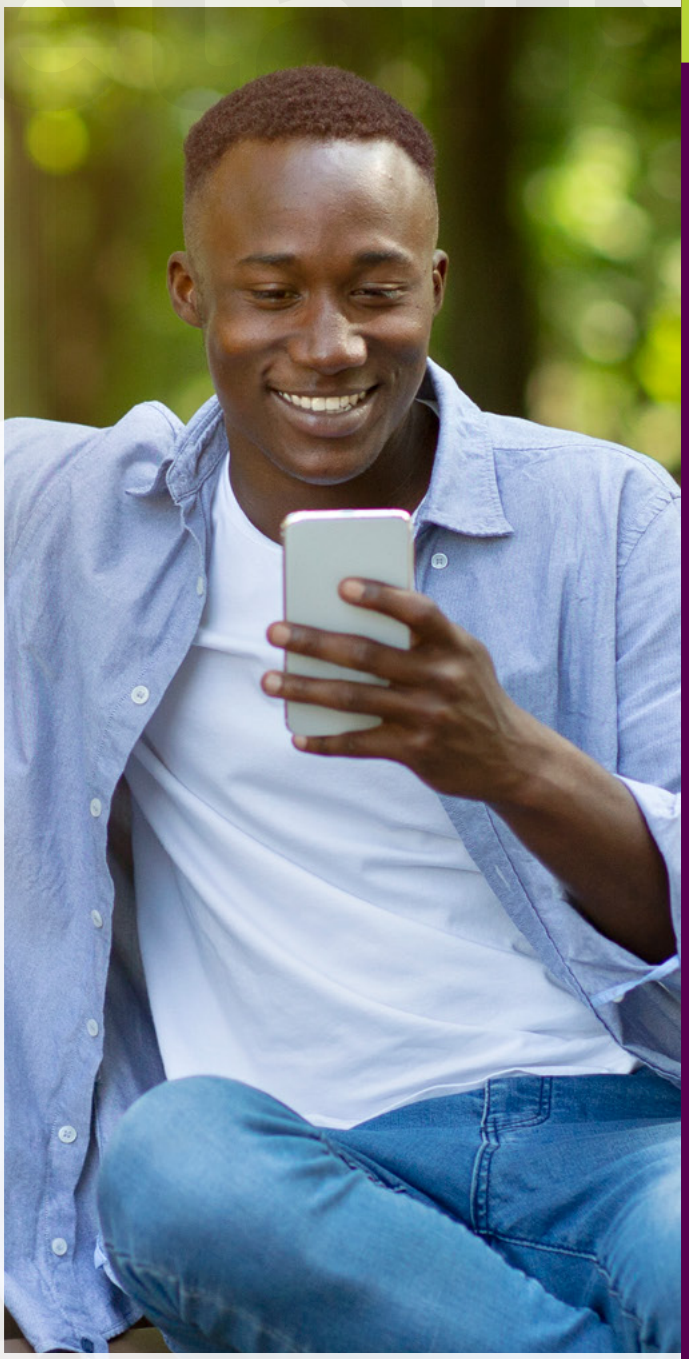
- Call: 0860 123 077

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



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KEY TERMS

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

Additional Disease List (ADL)

Depending on your benefit plan, and once approved on the Chronic Illness Benefit (CIB), you have cover for medicine for an additional list of life-threatening or degenerative conditions, as defined by us.

Chronic Disease List (CDL)

A defined list of chronic conditions we cover according to the Prescribed Minimum Benefits (PMB).

Chronic Drug Amount (CDA)

The Chronic Drug Amount (CDA) is the monthly amount that we pay up to for a medicine class, subject to a member's plan type. This applies to chronic medicine that is not listed on the formulary or medicine list.

Chronic Illness Benefit (CIB)

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 consultation, medicine and hospitals, on your benefit plan.

Day-to-Day Benefits

You have cover for a defined set of day-to-day benefits and the level of day-to-day benefits are set out in this benefit guide from Page 18.

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 healthcare provider (for example doctor, specialist, allied healthcare professional, pharmacists or hospital) who we have an agreement with 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.

Discovery MedXpress

Discovery MedXpress is a convenient and cost-effective medicine ordering and delivery service for your monthly chronic medicine, or you can choose to collect your medicine in-store at a MedXpress Network Pharmacy. Your cover depends on the type of medicine and whether or not you are registered on the chronic illness benefit.

Emergency Medical Condition or Medical Emergencies

An emergency medical condition, also referred to as an 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. We may ask you for additional information to confirm the emergency. **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 level of care. 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.**

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Find a Healthcare Provider

Find a healthcare provider is a medical and provider search tool which is available on the Discovery app or our 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, 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 of medicine plus includes the relevant dispensing fee.

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.

DAY SURGERY NETWORKS

Full cover for a defined list of procedures is 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 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.

Preauthorisation

You need to inform TFGMAS if you plan/are scheduled to be admitted to hospital. Please phone us on **0860 123 077** for preauthorisation, so that we can confirm your membership and available benefits. Without preauthorisation, you may have a deductible cost to pay. **Preauthorisation 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 preauthorisation 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.

Preferred Medicine

Preferred medicine includes preferentially priced generic and branded medicine.

Premier Plus GP

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

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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 270 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, 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 Plus 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 specific global disease outbreaks recognised by the World Health Organisation (WHO) such as COVID-19 and Monkeypox. This benefit offers cover from a basket of care as set by TFGMAS for out-of-hospital management and appropriate supportive treatment as recognised in terms of Prescribed Minimum Benefit (PMB) treatment protocols.

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KEY FEATURES

Connected Care

You have access to remote care at home, including a Home Monitoring Device Benefit for essential home monitoring, home-based care for follow-up treatment after an admission and a Home Care Benefit for quality care in the comfort of your own home.

Comprehensive Day-to-day cover

You have cover for a set of defined day-to-day benefits, that includes cover for medically appropriate GP consultations, blood tests, X-rays or medicine at a GP or pharmacy of your choice. Basic and specialised dentistry, as well as optometry benefits are available up to a set annual limit and you may obtain services from a healthcare service provider of your choice.

Full cover for Chronic Medicines

Full cover for chronic medicine on our formulary for all Chronic Disease List (CDL) conditions. You have access to an additional list of conditions (ADL), as well as the Specialised Medicine Benefit (SMB) which covers specific new treatments and medicines.

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

Guaranteed full cover in hospital for specialists who we have a payment arrangement with and up to 100% of the Scheme Rate for other healthcare professionals for in- or out-of-hospital services obtained. **A network of specialists was established to minimise out-of-pocket expenditure** where members required specialist services in or out of hospital for PMB conditions. 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 Pregnancy

You get comprehensive benefits for maternity that cover certain healthcare services before birth and the TFG Health Plus benefit plan is structured in such a manner that these benefits remain available after birth as part of your day-to-day benefits.

Screening and Prevention

Screening and prevention benefits that cover vital tests to detect early warning signs of serious illness. All required and necessary adult and child vaccinations are covered as part of this benefit as a registered member of TFG Health Plus.

Unlimited cover for hospital admissions

There is no overall limit for hospital cover on the TFG Health Plus benefit plan.

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Primary care benefits/Day-to-day cover and medical care

Day-to-day cover is available at a healthcare service provider of your choice. Medicine from our medicine list or outside of the Scheme's basic medicine formulary is covered at a pharmacy of your choice. Specialists are covered up to 100% of the Scheme Rate at contracted and non-contracted providers. You have access to a wide range of diagnostic tests and X-rays and manage your medical claims within the annual limits available to you as set out in this benefit guide from page 18.

Chronic cover

SPECIALISED MEDICINE BENEFIT

You have cover for a defined list of the latest treatments through the Specialised Medicine Benefit up to R290 000 per person per year.

COVER FOR CHRONIC CONDITIONS

You have full cover chronic medicine on our formulary for all Chronic Disease List (CDL) conditions, as well as cover for an additional list of life-threatening or degenerative conditions called the Additional Disease List (ADL). For more information, turn to page 25.

Cancer cover

We cover the first R650 000 of your approved cancer treatment over a 12-month cycle in full. Thereafter we pay 80% of any additional costs with **no upper limit** and extended cover in full for a defined list of cancers and treatments. You may use a service provider of your choice and is covered up to 100% of Scheme Rate.

Hospital cover

You can go to any private hospital approved by the Scheme and can obtain private day surgery in the TFG Health Plus Day Surgery Network for a defined list of procedures. Cover for specialists, GP and other healthcare professionals are paid up to 100% of the Scheme Rate if contracted service providers are used and 80% of Scheme Rate if non-contracted service providers are used for services in hospital with **no upper limit**.

Optical cover

You can use any optometrist of your choice and are covered up to 100% of Scheme Rate for one comprehensive consultation, lens and frames per person, up to set limits as indicated on page 22 of this benefit guide.

Dental cover

You are covered up to 100% of Scheme Rate for basic and specialised dentistry at a provider of your choice up to set limits as indicated on page 35 of this benefit guide.

Adult and Child Vaccinations

Clinically appropriate, child and adult vaccines are funded at 100% of the Scheme Medicine Rate from your hospital benefit for the cost of the vaccination and injection material administered by a registered nurse, general practitioner and specialists.

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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 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.

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.

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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:

- 270 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 out of hospital (OOH) or in 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 on **0860 123 077** to confirm whether your preferred service provider is part of our Mental Health Network before obtaining services for PMB conditions.

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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 PLUS	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.

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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 year, a Pap smear once every year 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 include:

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

From 2023, TFG Health Plus will make available, to members registered on this benefit plan, a selection of additional screening tests, which will be paid from a basket of care as set by the Scheme for a maximum period of 2 years.

These tests will be available where certain screening benefits available to members of the Scheme, was utilized and additional screening tests are deemed clinically necessary.

The basket of care as set by the Scheme will be limited to:

- R2 500 per adult beneficiary once per lifetime;
- R1 250 per child beneficiary once per lifetime; and
- Up to a maximum of R10 000 per family

VACCINES FUNDED FROM YOUR SCREENING BENEFITS

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

- Two pneumococcal vaccines per person per lifetime.
- 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
- **A selection of adult and child vaccines and related administration costs which is an added screening benefit for members registered on the TFG Health Plus benefit plan.**

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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. 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 Plus 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 000 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 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.

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CONNECTED CARE (continued)

In addition Connected Care offer members registered on TFG Health Plus:

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.

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DAY-TO-DAY BENEFITS

You have access to the following day-to-day cover on TFG Health Plus.

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BENEFIT	**RATE AND BASIS OF COVER: SUBJECT TO PMB**	**TFG HEALTH PLUS**
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:** Up to a maximum of 100% of the Scheme Rate at a Designated Service Provider (DSP) or 80% of Scheme Rate where a non-DSP is used, subject to selected consultation and procedure codes **Specialists:** Up to a maximum of 100% of the Scheme Rate. Specialists in family medicine to be paid 130% of Scheme Rate **Associated Health Services including Osteopaths, Homeopaths and Naturopaths:** Up to a maximum of 80% of the cost. The provisions of Annexure C1 as set out in the Rules is applicable **Registered private nurse practitioners:** Up to a maximum of 80% of the Scheme Rate, provided the supplier of the services is registered with the South African Nursing Council (SANC) **Notes**: Facility fees at out-patient departments of provincial and private hospitals are funded at Scheme Rate, but private facility fees are not covered Radiology and pathology services referred as part of the specialist visit are covered up to 100% of the Scheme Rate, subject to the radiology and pathology annual benefit limit of R29 200 per family per year The provisions of PMB and cover for PMB conditions are applicable	Limited to: R4 800 Per family per year (M) R7 200 Per family per year (M + 1) R9 400 Per family per year (M + 2) R10 900 Per family per year (M + 3) R11 800 Per family per year (M + 4) R12 400 Per family per year (M + 5) R12 900 Per family per year (M + 6) R13 200 Per family per year (M + 7) **PMB Conditions:** Additional consultations of up to 4 visits per person per year if registered for chronic conditions (CIB). **Maternity consultations:** Additional 8 GP or gynaecologist consultations per pregnant person per year Unscheduled emergency visits limited to 2 visits per Child between the age of 0 to 10 Unlimited virtual paediatric consultations for Children aged 1 to 14 per year at a KeyCare Network GP

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GP Virtual House Calls	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 be registered for Chronic Illness Benefits (CIB) and make use of Designated Service Providers (DSP) of the Scheme.	Baskets of Care as set by the Scheme
Specialist In-room procedures	**Specialists:** Up to a maximum of 100% of the Scheme Rate.	In-room procedures limited to a defined list of procedures as determined by the Scheme
Visits to casualty units	Up to a maximum of 100% of the Scheme Rate, subject to the emergency consultation and procedure codes.	Unlimited if treatment is obtained from a General Practitioner (GP) who practice in the emergency rooms at DSP facilities
Primary care: Basic dentistry	Up to a maximum of 100 % of the Scheme Rate The provisions of PMB and cover for PMB conditions are applicable	Limited to: R5 000 Per family per year (M)
		R6 100 Per family per year (M + 1)
		R7 100 Per family per year (M + 2)
		R8 000 Per family per year (M + 3)
		R8 800 Per family per year (M + 4)
		R9 400 Per family per year (M + 5)
		R9 700 Per family per year (M + 6)
		R9 800 Per family per year (M + 7)

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Specialised dentistry	Up to a maximum of 100 % of the Scheme Rate The provisions of PMB and cover for PMB conditions are applicable	Limited to: R11 100 Per family per year (M)
		R14 700 Per family per year (M + 1)
		R17 700 Per family per year (M + 2)
		R19 400 Per family per year (M + 3)
		R20 700 Per family per year (M + 4)
		R21 200 Per family per year (M + 5)
		R21 700 Per family per year (M + 6)
		R22 000 Per family per year (M + 7)
Other Healthcare Providers: Speech therapy, audiology and occupational therapy consultations	Up to a maximum of 100% of Scheme Rate for treatments and consultations. The provisions of PMB and cover for PMB conditions are applicable. Must be prescribed by a medical practitioner and provided the supplier of service is registered with the Health Professions Council of South Africa (HPCSA).	Limited to R8 000 per family per year
Other Healthcare Providers: Psychiatry and clinical psychology consultations, visits and treatments including psychotherapy	Up to a maximum of 100% of Scheme Rate for non- PMB conditions. Up to a maximum of 100% of the agreed rate at Mental Health Network providers for PMB conditions. The provisions of PMB and cover for PMB conditions are applicable.	Limited to R9 600 per family per year.
Other Healthcare Providers: Chiropractor and Physiotherapy, including biokinetics and cardio rehabilitation	Up to a maximum of 100% of Scheme Rate. The provisions of PMB and cover for PMB conditions are applicable. Must be prescribed by a medical practitioner and provided the supplier of service is registered with the Health Professions Council of South Africa (HPCSA).	Limited to R7 100 per family per year

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Other Healthcare Providers: Podiatry and Orthoptics	Up to a maximum of 100% of Scheme Rate. **This benefit covers services related to Orthoptics by Optometrists.** The provisions of PMB and cover for PMB conditions are applicable. Must be prescribed by a medical practitioner and provided the supplier of service is registered with the Health Professions Council of South Africa (HPCSA).	Limited to R5 800 per family per year
Prescribed Acute Medicine and over the counter (OTC) Medicine	**Acute medication obtained from a DSP:** Up to a maximum of 100% of the Scheme Medication Rate **Acute medication obtained from a non-DSP:** Up to a maximum of 80% of the Scheme Medication Rate **OTC:** Up to a maximum of 80% of the Scheme Medication Rate Subject to the Scheme's Acute Medicine Formulary and Protocols and preferentially priced generic and brand medication prices The provisions of PMB and cover for PMB conditions are applicable	Acute Medicine limited to: R7 800 Per family per year (M) R11 500 Per family per year (M + 1) R13 600 Per family per year (M + 2) R15 300 Per family per year (M + 3) R16 700 Per family per year (M + 4) R17 500 Per family per year (M + 5) R18 200 Per family per year (M + 6) R18 400 Per family per year (M + 7) OTC limited to R230 and further limited to the above Acute Medicine annual limits
Radiology and pathology	Up to a maximum of 100% of the Scheme Rate The provisions of PMB and cover for PMB conditions are applicable	Limited to R29 200 per family per year Vacuum-assisted breast biopsies (VAAB) are funded up to 1 test per beneficiary limited to negotiated fees. Thereafter the above day-to-day limit applies.

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BENEFIT	**RATE AND BASIS OF COVER: SUBJECT TO PMB**	**TFG HEALTH PLUS**
Optometry	Up to a maximum of 100% of the Scheme Rate or Cost if Members make use of a registered optometrist, ophthalmologist or supplementary optical practitioner The provisions of PMB and cover for PMB conditions are applicable optical procedures are limited and funded from Health Care Cover	Limited per person per 2-year cycle starting from last Date of Service obtained: **Consultation** R900 1 visit **Frames** R1 200 1 frame **Lenses:** single vision: R490 1 pair **OR** **Lenses:** Bifocal R1 160 1 pair **OR** **Lenses:** Multifocal R2 250 1 pair **OR** **Contact lenses** R3 850
Medical appliances (External Medical Items), mobility devices (wheelchairs, long leg callipers and crutches), including hearing aids and external prosthesis	Up to a maximum of 100% of the cost or agreed rate for PMB conditions where a DSP or formulary item is used or a non-DSP is used **involuntarily** Up to a maximum of 100% of reference price list for PMB conditions where a non-DSP or non-formulary items is used **voluntarily** Up to a maximum of 80% of Cost for non-PMB conditions/items where a non-DSP is used Approval to be obtained from the Scheme, subject to the Scheme Protocols and clinical entry criteria The provisions of PMB cover is applicable for PMB conditions	**Network suppliers:** Unlimited if EMI is supplied by the Scheme's Network Service Provider **Non-Network supplier:** Limited to R26 100 per family per year if not supplied by the Scheme's Network provider
Out-of-Hospital healthcare services related to pregnancy and delivery	**Covered at a GP or gynaecologists:** Up to a maximum of 100% of the Scheme Rate Hospital related accounts are paid from the hospital benefit, subject to preauthorisation and the treatment meeting the Scheme's treatment guidelines and clinical entry criteria Cover for infant consultations up to a maximum of 100% of the Scheme Rate, for children under the age of 2 years	**Services:** • Antenatal classes and/or postnatal visits funded from the primary care consultation limit • Antenatal consultations: 8 per pregnancy funded from the primary care consultation limit

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BENEFIT	**RATE AND BASIS OF COVER: SUBJECT TO PMB**	**TFG HEALTH PLUS**
Out-of-Hospital healthcare services related to pregnancy and delivery	**Midwife Network:** Up to a maximum of 100% of the negotiated rate for services provided by a midwife in the member's home instead of a Hospital Note: A standard fee is paid to the midwife and includes the midwife's professional fee, consumables, equipment and cost of an assistant doula Prenatal screening tests to be made available in addition to the available ultrasound scans up to a maximum of 100% of the Scheme Rate. 3D and 4D scans will be paid up to the maximum of a 2D scan All other scans and tests funded as set out under the out-of-hospital pathology and radiology Annual Benefit limit of R29 200 per family per year The provisions of PMB and cover for PMB conditions are applicable	**Services:** • Prenatal screening, including chromosome testing or non-invasive Prenatal Testing (NIPT or T21): 1 per pregnancy funded from the radiology and pathology limit • Pregnancy scans: See radiology and pathology limit • Blood tests: See radiology and pathology limit • Postnatal consultations: Included in primary care consultations • Dietician nutrition assessment: Included in primary care consultations • Mental health consultations: Included in the psychiatry and clinical psychology limit at a service provider in the Mental Health Network • Lactation consultations for infants: 1 per child funded from the primary care consultation benefit limit
MRI and CT Scans (where authorised)	Where MRI and CT scan is unrelated to a Hospital admission it will be covered from the radiology and pathology Annual Benefit limit of R29 200 per family per year	Where MRI and CT scan is unrelated to a Hospital admission it will be covered from the radiology and pathology Annual Benefit limit of R29 200 per family per year
Benefit for out-of-hospital management and appropriate supportive treatment of global World Health Organisation (WHO) recognised disease outbreaks: Out-of-Hospital healthcare services related to COVID-19: • Vaccine and administration of the vaccine • Screening consultation with a nurse of GP • Defined basket of pathology • Defined basket of X-rays and scans • Consultations with a nurse or GP • Supportive treatment • Contact tracing • Home-based care in lieu of hospitalisation Treatment of complications of rehabilitation for Long Covid.	In addition to PMB cover requirements, up to a maximum of 100% of the Scheme Rate. Cover for testing is subject to referral. Subject to the Scheme's Preferred provider (where applicable), Protocols and the condition and treatment meeting the Scheme's entry criteria and guidelines	Basket of care as set by the Scheme Out-of-Hospital healthcare services related to COVID19: • Screening consultation with a nurse or GP: unlimited • Defined basket of pathology: 2 tests per person per year and up to 4 tests per person per year for registered healthcare providers except where covered as PMB • Unlimited home-based care in lieu of hospitalisation Activation of the benefit and basket of care provided by the Scheme for a period of 6 months from the date of diagnosis by the treating healthcare provider

Extra Day-to-Day Benefits available on TFG Health Plus:

INTERNAL PROSTHESIS LIMITS ON TFG HEALTH PLUS

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

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

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

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

Total hip replacement	R78 650
Partial hip replacement	R47 050
Spinal surgery prostheses	R39 600 (one level) R79 550 (two or more levels)
Knee replacement	R74 600
Shoulder replacement	R64 900
Bare metal cardiac stents	R16 300
Drug eluting cardiac stents	R25 950
Cardiac pacemakers	R95 700
Tissue replacing prostheses	R30 850
Artificial limbs	R47 050
Artificial eyes	R23 550
Cardiac valves:	R39 000
Vascular grafts	R116 650
General overall (Mirena subject to approval)	R30 850

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

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MATERNITY BENEFITS

TFG Health Plus provides you with cover related to your pregnancy from your available day-to-day benefits as set out in more detail on page 16 of this benefit guide.

During Pregnancy

ANTENATAL CONSULTATIONS

We pay for up to 8 additional GP or gynaecologist antenatal consultations at a gynaecologist or, GP of your choice from the primary care benefit and your number of additional visits will depend on your available number of consultations and your family size benefits available under your day-to-day cover.

ULTRASOUND SCANS AND SCREENINGS DURING PREGNANCY

You are covered for 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. These tests are funded from your available radiology and pathology benefits as set out under the day-to-day benefits on page 19 of this benefit guide.

FLU VACCINATIONS

We pay for your flu vaccinations you may need during your pregnancy from the hospital benefit as part of your screening and prevention benefits.

BLOOD TESTS

We pay for a defined list of blood tests for each pregnancy from your available radiology and pathology benefits as set out under the day-to-day benefits on page 19 of this benefit guide.

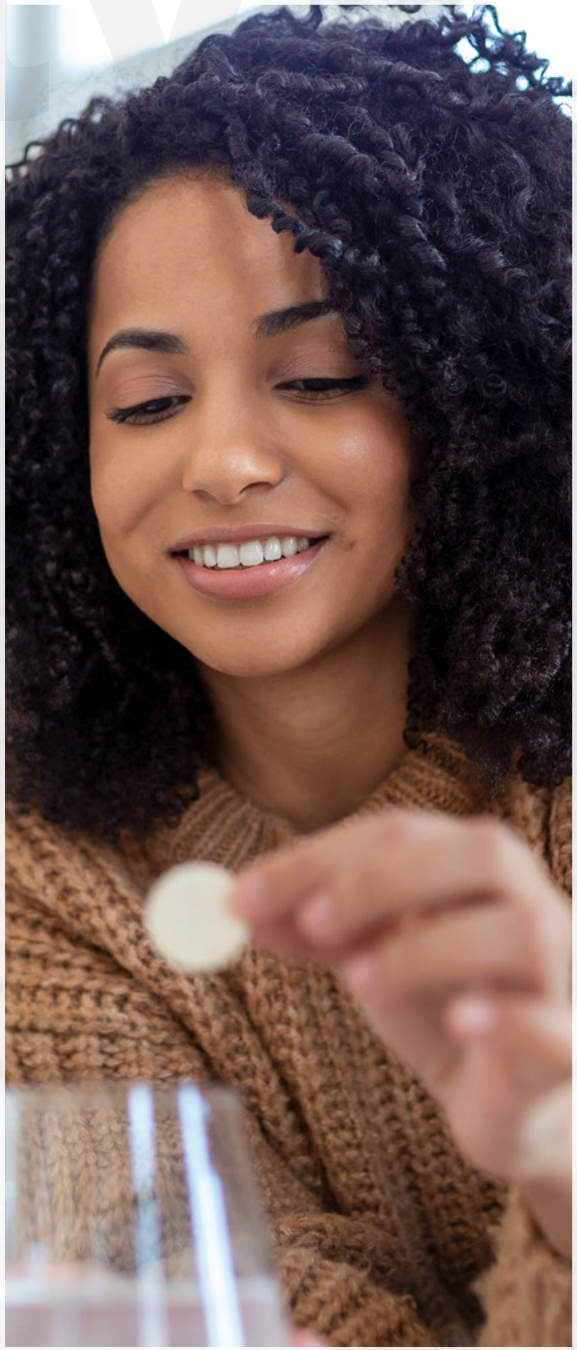
Pre- and Postnatal Care

We pay for your antenatal or postnatal classes or consultations with a registered nurse up to 80% of the Scheme Rate from your available consultations benefits, which depends on your family size and the available limits. These consultations include breastfeeding consultations with a registered nurse or a breastfeeding specialist.

After you give birth

GP AND SPECIALISTS TO HELP YOU AFTER BIRTH

In case of an emergency you have access to 2 unscheduled emergency visits per child between the age of 0 to 10 years, as well as an unlimited number of virtual paediatric consultations for children aged 1 to 14 at a KeyCare Network GP. Specialist visits are funded from your available day-to-day benefit as per your family size benefit and is funded up to a maximum of 100% of Scheme Rate.



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CHRONIC BENEFITS

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) and an additional list of diseases called the Additional Disease List (ADL). The TFG Health Plus benefit plan offers you a richer benefit for chronic conditions than what is required in terms of Prescribed Minimum Benefit (PMB) conditions.

The list of chronic conditions covered as part of the Scheme's CDL is as follows:

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

W

Wegener's granulomatosis

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The list of additional chronic conditions (ADL) that is also covered as part of your chronic benefits on the TFG Health Plus benefit plan is as follows:

A

Ankylosing spondylitis, Attention Deficit Hyperactivity Disorder (ADHD)

B

Behcet's disease

C

Cystic fibrosis

D

Delusional disorder, Dermatopolymyositis

G

Gastro-oesophageal reflux disease, Generalised anxiety disorder, Gout

H

Huntington's disease

I

Isolated growth hormone deficiency in Children < 18 years

M

Major depression, Motor neuron disease, Muscular dystrophy and other inherited myopathies, Myasthenia gravis

O

Obsessive compulsive disorder, Osteoporosis

P

Paget's disease, Panic disorder, Polyarthritis nodosa, Post-traumatic stress disorder, Psoriatic arthritis, Pulmonary interstitial fibrosis

S

Sjogren's syndrome, Systemic sclerosis

This is what we cover

For Chronic Disease List Conditions you have full cover for approved chronic medicine on our medicine list 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 set monthly Chronic Drug Amount (CDA).

Medicine cover for conditions on the Additional Disease List (ADL) are covered up to the set monthly CDA and no medicine list applies.

In addition, non-formulary medicine for CDL conditions and chronic medicine for ADL conditions are subject to a chronic medicine limit of R32 500 per beneficiary per year and R88 000 per family per year.

How to get the benefit

You must apply for the Chronic Illness Benefit (CIB) and your doctor must complete a Chronic Illness Benefit Application form and 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.

Where and how to get your medicine

By using a pharmacy that is part of the Scheme's contracted Designated Service Providers (DSP). You can also order your medicine online using MedXpress to ensure that your chronic medicine is funded in full without any deductible.

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

MemberCare Programme

If you are diagnosed with one or more chronic conditions, you might qualify for our Care Programme. The programme facilitates high-quality, planned, person-centred care and chronic condition management to achieve improved outcomes. We will contact you to confirm if you do qualify. The programme offers organised care to help you 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 to not take part, we will cover the hospital and related accounts up to 80% of the Scheme Rate.

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.

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Care Programmes

Condition-specific care programmes 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 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 you are enrolled on the Cardio Care programme. **You need to see your nominated GP to avoid a 20% co-payment.**

DIABETES CARE PROGRAMME

If you are registered on the Chronic Illness Benefit (CIB) for diabetes, a 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 have to see your nominated GP to avoid a 20% co-payment.**

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 dieticians, 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.**

CAD CARE

TFG Health Plus also gives members access to CAD Care. CAD Care serves as a care delivery programme, introduced as an alternative less invasive procedure for members, where an invasive angiogram may be necessary. The application is assessed at preauthorisation stage for identified low and intermediate risk patients. Prior to the authorisation of an invasive angiogram, a Computed Tomography Coronary Angiography report is requested.

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

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YOU HAVE COMPREHENSIVE COVER FOR CANCER TREATMENT

Oncology Benefit

When 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.

All cancer-related healthcare services are covered up to 100% of the Scheme Rate limited to R650 000 per person. Thereafter we pay 80% of the Scheme Rate for non-Prescribed Minimum Benefit (PMB) treatment. You might have a co-payment if you do not use the Designated Service Provider (DSP) or if your healthcare professional charges above this rate.

Colorectal Cancer Surgery

You have full cover for approved colorectal cancer surgeries in our network and members registered on TFG Health Plus can obtain colorectal cancer surgery at non-network providers as well.

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 Plus 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.**

Oncology Pharmacy Designated Service Provider (DSP) introduction

In oncology, medication is a significant contributor to the total spend and for TFG Medical Aid Scheme it is estimated that 43% of the oncology spend is on medication.

It is therefore important from a risk perspective that we have agreements in place to ensure that we can achieve efficiencies, whilst ensuring sustainable access to a comprehensive oncology benefit offering for our members.

From 2023, the trustees have decided to enhance the TFG Health Plus benefit plan and its well-established DSP arrangements with pharmacies and to improve the management of oncology medication. The following courier pharmacies (providing oncology specific services) are henceforth included in the DSP network offering of TFG Health Plus **where members obtain treatment in the doctor's rooms**, such as injectable and infusional chemotherapy:

- Dis-Chem's Oncology Courier Pharmacy
- Medipost Pharmacy
- Qestmed
- Olsens Pharmacy
- Southern Rx

Certain providers dispensing, charge the Scheme directly for treatments done in rooms and these practices would be exempt from the DSP arrangement. It would also not apply to chemotherapy administered in-hospital.

For medicine scripted and dispensed at a retail pharmacy, oncology and oncology-related medicine (like supportive medicine, oral chemotherapy and hormonal therapy) is usually scripted by the treating doctor to be obtained from your local retail or courier pharmacy. The DSP arrangement for scripted and dispensed medication will henceforth be covered in full at the following pharmacies:

- MedXpress or any MedXpress Network Pharmacy
- Dis-Chem's Oncology Courier Pharmacy
- Medipost Pharmacy
- Qestmed
- Olsen's Pharmacy
- Southern Rx

The enhancement of the DSP for members registered on TFG Health Plus will ensure a seamless process between you and your treating provider and the dispensing pharmacy to provide you with the most cost-efficient products ensuring your oncology benefits go further. For in-rooms treatment there is an agreement that unused treatment is credited back to your oncology benefits, which also ensure that your oncology benefits will go further.

Visit www.tfmedicalaidscheme.co.za to view the detailed Oncology Benefit Guide.

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HOSPITAL COVER ON TFG HEALTH PLUS

TFG Health Plus offers 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 on **0860 123 077** 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 on **0860 123 077** 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 hospital.

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 **any** private hospital approved for funding by the Scheme

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 private hospital approved by the Scheme
- Using healthcare professionals that we have a payment arrangement with

View private hospitals approved by the Scheme using ***Find a healthcare provider*** on the Discovery app per above.

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HOSPITAL COVER

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

Health Care Cover = Unlimited hospital cover	TFG HEALTH PLUS	
BENEFIT	**RATE AND BASIS OF COVER: SUBJECT TO PMB**	**LIMITS**
HOSPITAL COVER		
Statutory Prescribed Minimum Benefits	Basis of cover is per legislative requirements in terms of Prescribed Minimum Benefits (PMB). All treatment for PMB conditions accumulate to available limits. Once benefit limits are reached funding in respect of PMB will continue to fund in accordance with the basis of cover as set out in this benefit schedule and the legislative requirements of PMB.	Unlimited
Hospitalisation, including accommodation, theatre fees, materials used, prescribed medication for duration of hospitalisation at a provincial and/or private hospital	Up to a maximum of 100% of Scheme Rate at a private hospital facility. Up to a maximum of 100% of cost at a provincial hospital facility. Up to a maximum of 100% of Scheme Rate at a non-network facility, if voluntary admission for a PMB condition. If PMB condition and **involuntary** admission for a PMB condition, the benefits as available for 'Hospitalisation at non-network or non-contracted hospital' below is applicable. Subject to preauthorisation and/or approval meeting the Scheme's clinical and Managed Health Care criteria. Benefit includes cover for ward and theatre fees, Benefit includes cover for ward and theatre fees, high care units, drugs and materials, X-rays, pathology, radiology, including cover for confinements, except pre- and post-natal care outside of hospital. Blood transfusions paid up to 100% of the cost i.e. cost of blood, transport, apparatus and operator's Fees Circumcisions paid up to 100% of the Scheme Rate, if preauthorisation obtained and clinically and medically appropriate. Note: Circumcisions are paid from the out-of-hospital consultations and visits limits where not deemed clinically and medically appropriate.	Unlimited

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HOSPITAL COVER
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BENEFIT	TFG HEALTH PLUS RATE AND BASIS OF COVER: SUBJECT TO PMB	LIMITS
Hospitalisation in non-network or non-contracted Hospital Emergency and non-emergency admissions	Up to a maximum of 100% of the cost for involuntary admission if PMB condition Up to a maximum of 100% of the Scheme Rate for involuntary admission if non-PMB condition Subject to preauthorisation In case of a PMB Condition, patient to be transferred to a KeyCare Network Hospital as soon as stabilised, unless otherwise approved by the Scheme. Voluntary continued admission at a non-network facility may attract deductibles	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 preauthorisation and/or approval and the treatment meeting the Scheme's clinical criteria	Unlimited A R6 300 deductible shall be payable by the patient in respect of the hospital account for elective admissions at a facility which is not a network facility
Administration of defined intravenous infusions	Up to a maximum of 100% of the Scheme Rate at the Scheme's Designated Service Provider (DSP) A 20% deductible shall be payable by the patient in respect of the hospital account when treatment is received at a provider who is not a DSP Medicines paid at 100% of the Scheme Medication Rate Subject to preauthorisation and/or approval and the treatment meeting the Scheme's clinical criteria	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 contracted rate or Scheme Rate Subject to the Scheme's preferred provider (where applicable) and the treatment meeting the Scheme's treatment guidelines and clinical and benefit criteria	Basket of care as set by the Scheme
Home-monitoring devices for clinically appropriate chronic and acute conditions	Up to a maximum of 100% of the Scheme Rate paid from Health Care Cover The device must be approved by the Scheme, subject to the Scheme's protocols and clinical and benefit criteria	Up to R4 250 per person per year
Point-of-care medical devices	Up to a maximum of 75% of the Scheme Rate paid from Health Care Cover The device must be approved by the Scheme, subject to the Scheme's protocols and clinical and benefit entry criteria	One device per family

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	TFG HEALTH PLUS	
BENEFIT	**RATE AND BASIS OF COVER: SUBJECT TO PMB**	**LIMITS**
Pre-operative assessment for the following list of major surgeries: Colorectal surgery	Up to a maximum of 100% of the Scheme Rate paid from Health Care Cover Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols	Basket of care as determined by the Scheme
Nursing services, Step down and Hospice	**Nursing services:** Up to a maximum of 100% of the Scheme Rate for nursing services rendered at the patient's residence by a registered nurse or a person from a registered nursing institution, in lieu of hospitalisation. Subject to preauthorisation **Step Down facilities:** Up to a maximum of 50% of the cost of permanently accommodating chronically ill patients in a registered nursing home or hospital No benefit allowed for accommodation in an old-age home Note: Members may claim either for nursing services or frail care facilities, but not both, where such services are provided simultaneously **Hospice:** Terminal care and subsequent admission to a hospice forms part of the treatment and care for certain PMB conditions and will be funded in line with Regulation 8 of the Act and the PMB code of conduct as published by Council **Note**: Where members Advanced Illness Benefits (AIB) are depleted, subject to PMB, once these benefit limits are reached, the provisions of PMB is applied	Limited to R405 per day and 90 days with an overall annual limit of R36 450 per person per year Limited to R405 per day and 180 days with an overall annual limit of R72 900 per person per year Unlimited

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HOSPITAL COVER (continued)

BENEFIT	TFG HEALTH PLUS RATE AND BASIS OF COVER: SUBJECT TO PMB	LIMITS
General Practitioners, Specialists and other service providers delivering treatment in hospital and/or in specialists' rooms	**Premier Rate providers:** Up to a maximum of 100% of the Premier Rate **Classic Direct providers:** Up to a maximum of 100% of the Classic Direct Rate **General Practitioners:** Up to a 100% of the contracted rates or Scheme Rate for admitting GP on the Scheme's DSP list Up to a maximum of 100% of Cost for non-DSP if the admitting specialist or GP is contracted with the Scheme and the Member is admitted in a KeyCare Network Hospital The conditions of PMB cover is applicable in cases of **involuntary** use of a non-DSP and non- network Hospital and in cases of treatment for PMB conditions **Note**: If the patient is admitted for a PMB condition the account and treatments received in hospital will be paid in full for services received in a KeyCare Network Hospital, if the admitting specialist or GP is a DSP	Unlimited
Chronic dialysis	Up to a maximum of 100% of the Scheme Rate or negotiated rates at the Scheme's DSP or at a KeyCare Network Hospital Subject to preauthorisation 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 preauthorisation and approval. Up to a maximum of 100% of the Scheme Rate in private hospital facilities and/or negotiated rates at a KeyCare Hospital Network facility or at cost in a public hospital facility The following provisions apply: • Organ and patient preparation will be paid at 100% of the Scheme Rate • Benefits in respect of the organ donor costs will be funded up to 100% of Scheme Rate in private hospital facilities or 100% of the negotiated rate at a KeyCare Hospital Network facility and at cost in public hospital facilities, provided that the donor is in the Republic of South Africa and benefits are further subject to the recipient being a beneficiary of the Scheme • Benefits in respect of immuno-suppressant and other medication will be at cost whilst the member is in hospital. Subsequent supplies of immune-suppressant medication will be covered from the member's Chronic Illness Benefit (CIB)	Unlimited

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BENEFIT	TFG HEALTH PLUS RATE AND BASIS OF COVER: SUBJECT TO PMB	LIMITS
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 Designated Service Providers (DSP) until benefit limit is reached Once the annual limit is reached all non-PMB conditions and treatment to fund up to a maximum of 80% of the Scheme Rate Up to a maximum of 80% of the Scheme Rate at a non- DSP for non-PMB conditions Where radiotherapy and chemotherapy is unrelated to the admission and does not form part of the hospitalisation, it will be covered up to 100% of the Scheme Rate or 100% of Cost, where no Scheme Rate exists Subject to preauthorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria	Limited to R650 000 per person per rolling 12 months' period
Severe dental/maxillo-facial and oral, dental procedures as covered	**Dentist and related accounts:** Up to a maximum of 100% of the Scheme Rate **Premier Rate providers:** Up to a maximum of the applicable Premier Rate **Classic Direct Anaesthetists:** Up to a maximum of the Classic Direct Rate **Other Anaesthetists:** Up to a maximum of 100% of the Scheme Rate All dental appliances and prostheses and the placement of such appliances/prostheses as well as orthodontics (surgical and non-surgical) are paid from the general internal prosthesis limits up to a maximum of 100% of the Scheme Rate Subject to the treatment meeting the Scheme's treatment guidelines and Managed Health Care criteria	Primary maxillo-facial surgery: Unlimited Limited to R22 500 per family per year for Elective maxillo- facial and oral surgery
Mental health disorders	Up to a maximum of 100% of the Scheme Rate for related accounts Up to a maximum of 100% of the negotiated rate for hospital account in a KeyCare Network Hospital or 100% of Scheme Rate in a non-network hospital or a hospital that is part of the Scheme's DSP list The provisions of PMB and cover for PMB conditions are applicable	Up to 21 days in-hospital, or up to 15 out-of-hospital consultations, for conditions as defined in Annexure A of the Regulations of the Act All other conditions up to 21 days in hospital
Drug and alcohol rehabilitation	Cover is provided as per PMB legislative requirements	21 days in-hospital treatment per person per year

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	TFG HEALTH PLUS	
BENEFIT	**RATE AND BASIS OF COVER: SUBJECT TO PMB**	**LIMITS**
In-and out-of-hospital management for colorectal cancer	Up to a maximum of 100% of the Scheme Rate for the treatment at a network or non-network facility Subject to authorisation and the treatment meeting the Scheme's treatment guidelines and clinical criteria.	Unlimited at a network provider Basket of care as set by the Scheme for out-of-hospital treatment
Cardiac stents	See 'Internal prostheses, including spinal care and surgery' for cover on this benefit plan	See 'Internal prostheses, including spinal care and surgery' for cover on this benefit plan
Internal prostheses, including spinal care and surgery, as well as conservative back pain management	Up to a maximum of 100% of the Scheme Rate for the hospital account and related specialist and healthcare service provider costs if obtained at a network facility and if obtained through a provider in the spinal surgery network Up to a maximum of 80% of the Scheme Rate for the hospital account and related specialist and healthcare service provider costs if obtained at a non-network facility Subject to preauthorisation and treatment meeting the Scheme's treatment guidelines and clinical criteria The devices and prostheses accumulate to the limit, where applicable. The balance of the hospital and related accounts do not accumulate to the annual limit and is paid from the hospital benefit The provisions of PMB is applicable for PMB conditions. Network requirements does not apply to any admissions related to trauma	**Network suppliers:** Unlimited if prosthesis is supplied by the Scheme's Network Service Provider and at a Service Provider in the network for in-hospital treatment **Non-network supplier:** Annual limits are set out on page 22 of this benefit guide if prosthesis is not supplied by the Scheme's Network Service Provider Baskets of Care as set by the Scheme for out-of-hospital conservative treatment is applicable
MRI and CT Scans (when authorised)	Up to a maximum of 100% of the negotiated rate or Scheme Rate if related to an authorised admission Subject to referral by a DSP Where MRI and CT scan is unrelated to the admission it will be covered from the radiology and pathology benefits Subject to the treatment meeting the Scheme's treatment guidelines and Managed Health Care criteria	Unlimited
Gastroscopies, colonoscopies, proctoscopies and sigmoidoscopies	Save for cover as per PMB legislation and children aged 12 years and younger, cover is provided in a defined list of day care network facilities Elective admissions must be performed by a specialist that is a Designated Service Provider (DSP) to be covered in full Up to 100% of the Scheme Rate is paid from the hospital benefit if done in the doctor's rooms and subject to preauthorisation	Unlimited
To-Take-Out (TTO) Medicine (Medicine to take home)	Save for cover as per PMB legislation, up to a maximum of 100% of the Scheme Rate or Medication Rate	Unlimited
Emergency Medical Services within the borders of South Africa (Ambulance services – Call 0860 999 911)	Up to a maximum of 100% of the Scheme Rate Inter-hospital transfer subject to preauthorisation The provisions of PMB and cover for PMB conditions are applicable	Unlimited for PMB conditions. Cover is limited to R5 300 per family per year for non-PMB conditions.
International clinical review service	Up to a maximum of 75% of the cost of the consultation Subject to the Scheme's preferred provider protocols and clinical entry criteria	Unlimited

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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 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 an amount of R6 300 upfront.

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 1997/013480/07, an authorised financial services provider and administrator of medical schemes.

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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)

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EXTRA BENEFITS ON YOUR PLAN

You get the following extra benefits to enhance your cover.

Spinal Care Programme

The Spinal Care Programme was introduced in 2022 and offers a spinal surgery component for members needing spinal surgery, and a conservative care programme for those with severe back pain, but where surgery can be prevented through out-of-hospital care.

If spinal surgery is the only option to manage the back pain, members can access a facility within our Spinal Care Surgery Network. Members are covered for conservative back pain management, which includes consultations with physiotherapists or chiropractors who specialise in the management of back pain and are part of the conservative care network.

With effect from 1 January 2023, you will continue to have full cover for approved spinal surgery admissions if you use a provider in our spinal surgery network. Planned admissions outside of our network will however be funded at up to 80% of the Scheme Rate for the hospital account.

Specialised Medicine Benefit

You have cover for a defined list of the latest treatments through the Specialised Medicine Benefit. This benefit is not available on the TFG Health Plus benefit plan. We pay up to R290 000 per person per year. A deductible of up to 20% applies.

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 75% 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 specific global World Health Organisation (WHO) recognised disease outbreaks such as COVID-19 and Monkeypox. This does not affect your day-to-day benefits, where applicable, and is in line with Prescribed Minimum Benefits (PMB) funded from a basket of care provided by the Scheme.

The Scheme also makes available 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.

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EXTRA BENEFITS
ON YOUR PLAN (continued)

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 Plus 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

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 programme, introduced for members at preauthorisation 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 (CTCA) 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

To improve major surgery outcomes for patients, the Scheme makes available a pre-operative assessment benefit for members undergoing the following five major surgeries:

- Colorectal cancer surgery
- Breast cancer surgery
- Prostate cancer surgery
- CABG (coronary artery bypass graft) surgery
- Elective hip and knee arthroplasty

Once identified as requiring any of the above surgical procedures, either following the preauthorisation 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.

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EXTRA BENEFITS
ON YOUR PLAN (continued)

Joint Athroplasty Network

TFG Health Plus members have access to the Major Joints Network, which is a national network of practices and hospitals that perform hip and knee replacements, based on specific quality requirements. Members have full cover when using one of these network facilities. This network excludes:

- Emergency and trauma-related surgeries
- Bilateral and revision replacements
- Surgeries related to congenital malformation of the joint, septic joints or cancer

Continuous Glucose Monitoring

The TFG Health Plus benefit plan allows members on this benefit plan to defray medical expenditure related to Continuous Glucose Monitoring (CGM) devices. These devices use technology which helps members and their treating doctors to monitor and manage blood sugar levels. A continuous glucose monitoring sensor, which is inserted just under the skin and is left in place for a number of days, automatically measures blood glucose levels every 5 – 15 minutes.

The continuous glucose monitoring sensors are funded from Scheme benefits and funding is limited to 50% of the monthly amount of the device for adults and 75% of the monthly amount of the device for children.

Eligibility criteria include:

- Device prescribed by a CGM network doctor
- Registered on the Chronic Illness Benefit for diabetes type 1
- All claims for these sensors will accumulate to the monthly CGM limit. Members may also obtain these devices from the Centre of Diabetes and Endocrinology (CDE) and would need to present their medical scheme card to obtain these devices at the negotiated medical scheme rates. Any costs in excess of this, associated with the CGM sensors, will be funded from the available appliance limits
- CGM transmitters and readers are funded from your available appliances benefit limits and you will need to be a portion of the expenses out of your own pocket.

Readmissions Management

As part of the TFG Health Plus 'home health initiative', members on this benefit plan have access to the readmissions management initiative, which aims to achieve improvements in readmission rates and improve member experience. Home health ensures that when patients, who are considered to be at high risk of readmission, are discharged from acute care, they do not suffer a relapse or deterioration that may require readmission to hospital.

The benefit has 3 components which will be made available within 10 – 14 days of the member leaving the hospital:

- Homecare, which includes 1 physical visit, 3 virtual consults, and a care coordination aspect
- A doctor follow-up consultation
- A medicine reconciliation done at the point of discharge by the treating doctor

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YOUR CONTRIBUTIONS
FROM 1 JANUARY 2023

Full contributions with effect from 1 January 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 reflected on this page.

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 CONTRIBUTIONS		
MONTHLY INCOME	**PRINCIPAL MEMBER**	**ADULT DEPENDANT***	**CHILD DEPENDANT****
R0 – R6,230	R4,080	R2,526	R1,052
R6,231+	R4,682	R3,306	R1,170

* 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 January 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 CONTRIBUTIONS		
MONTHLY INCOME	**PRINCIPAL MEMBER**	**ADULT DEPENDANT***	**CHILD DEPENDANT****
R0 – R6,230	R2,040	R1,263	R526
R6,231+	R2,341	R1,653	R585

* 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.

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TFG HEALTH PLUS
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:

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 (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.

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.

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THE GENERAL EXCLUSION LIST (CONTINUED)

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.

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

The benefits outlined in this brochure are a summary of TFG Health Plus benefit plan's registered benefits as set out in the TFG Medical Aid 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.

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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 by dialing 0860 123 077 to be provided with the necessary forms and information regarding the process to follow.

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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:

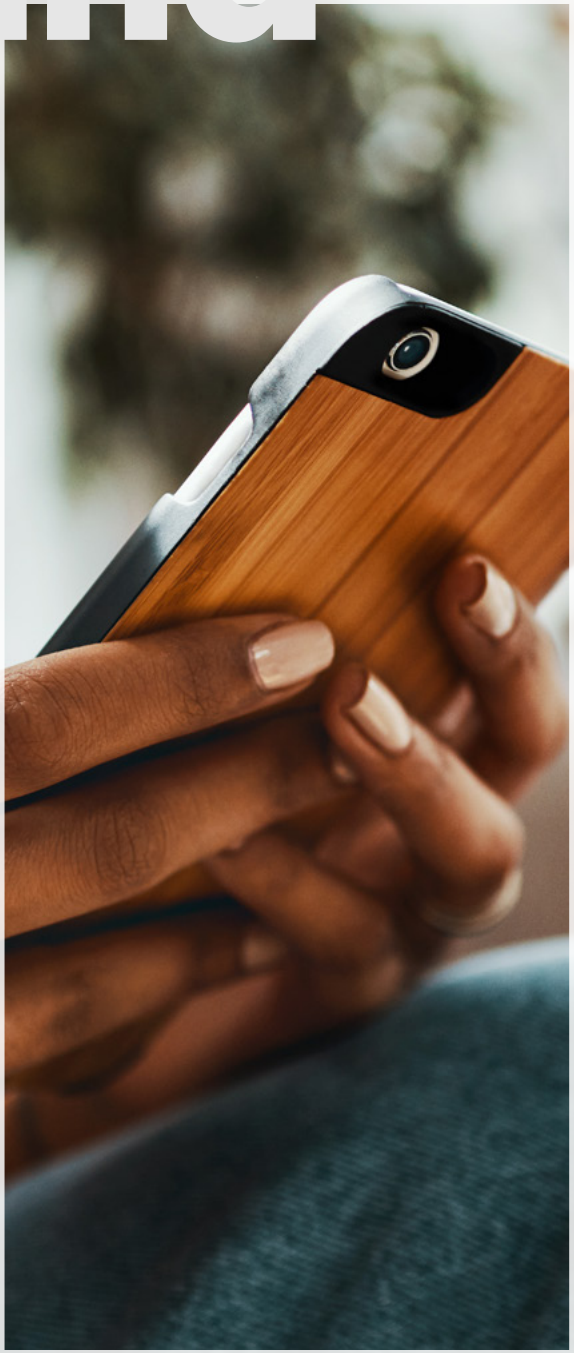
If the matter remains unresolved or the feedback received is not to your satisfaction, the matter can be escalated to the Principal Officer of the Scheme, Ms Caron Harris, who will direct the matter in line with the Disputes Process of the Scheme for resolution.

Step 3:

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

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

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



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MEDICAL AID SCHEME

TFG MAS

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