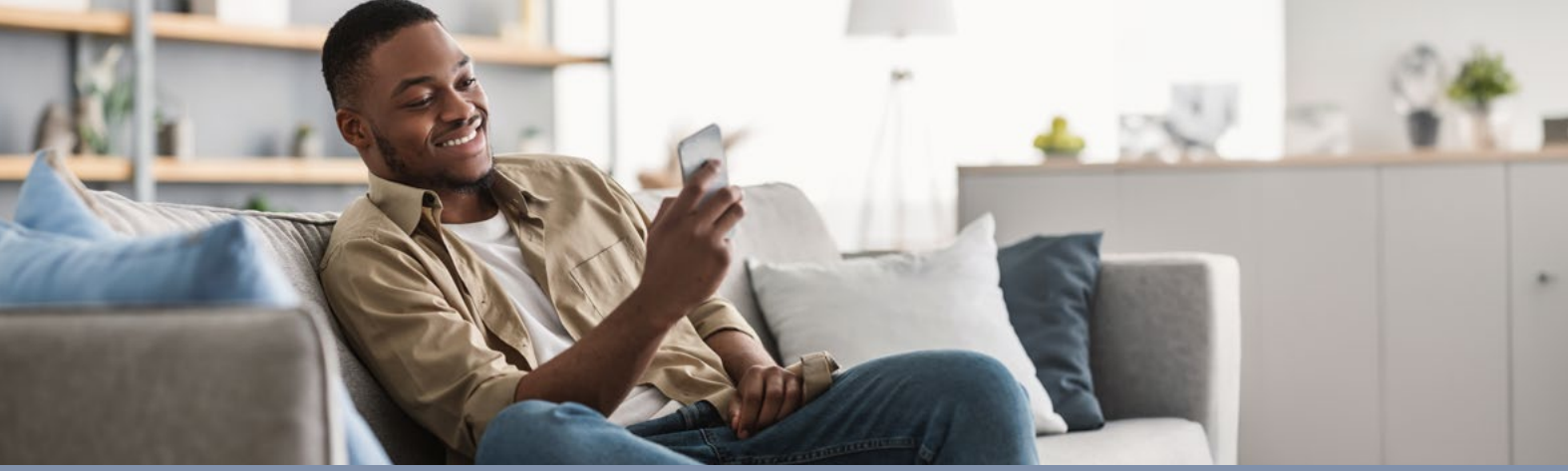
Medical Aid Scheme

Administered by Discovery Health

Newsletter

1ST EDITION | 2024



New claims submission and member query email address

This year, our claims and general queries email addresses have changed. Read the Facts and Actions sections below to find out how this change will affect you.

THE FACTS

- From 2024, TFG Medical Aid Scheme has a new claim submission and general query email address that you can start using right away.
- Please do not be concerned if you have recently sent an email to claims@discovery.co.za or service@discovery.co.za as we will still receive your email until 30 May 2024.
- The new email addresses you should note going forward are outlined below with the relevant turn-around times for us to respond.

THE ACTIONS

- For general queries and if you have any questions about your membership or benefits, you can email us at service@tfgmedicalaidscheme.co.za. You will receive a reference number in response acknowledging receipt of your query and you may use this reference number for any follow-up queries. We will respond to your query within two to three working days.
- If you need to send us a claim, take a photo of the claim using your phone or scan the claim and email it to Refunds and Claims at claims@tfgmedicalaidscheme.co.za. You can also submit your claim using the Discovery App. We will respond to your query within two to three working days.

Screening and Prevention Benefit & The WELLTH Fund

Prevention or early detection of a chronic condition and early lifestyle interventions can prevent the need for chronic medicine and hospital stays. This can result in a longer, healthier and more active life. As a TFG Medical Aid Scheme member, you have access to the WELLTH Fund, which helps you to better understand your health by providing additional cover for screening and preventive tests.

THE FACTS

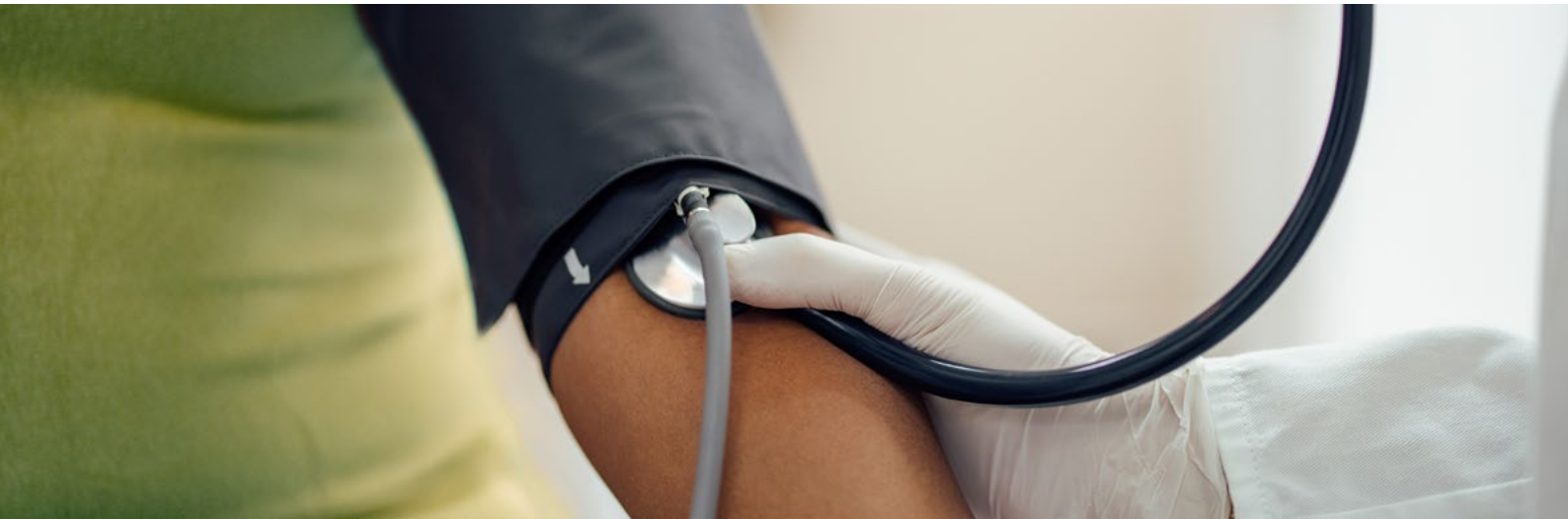
- The WELLTH Fund is activated for the family after all members on the benefit plan complete their Health Check. **All family members on the benefit plan** must complete a Health Check at one of the Scheme's network providers within a 12-month period. The Fund can be used for a defined list of screening and prevention healthcare services, up to your benefit limit. More information regarding your screening and prevention benefits available to you are set out in the lists and tables below. You can also find more information regarding your screening and prevention benefits in the Scheme's benefit guides which are available by visiting "FIND A DOCUMENT" and navigating to "Guides, applications and newsletters".
- The WELLTH Fund is a once-off benefit available for a limited period. This benefit will expire on 31 December 2024 if your TFGMAS benefit plan was activated in 2023. If your TFGMAS benefit plan was activated with the Scheme after January 2023, the benefit will expire on 31 December of the year after you join the Scheme.
- Eligible claims that would typically be paid from day-to-day benefits will be paid from the WELLTH Fund first

The following table sets out your available annual screening benefits depending on the benefit plan you are registered on. These benefits are available to you and your family whether you activate the WELLTH Fund or not:

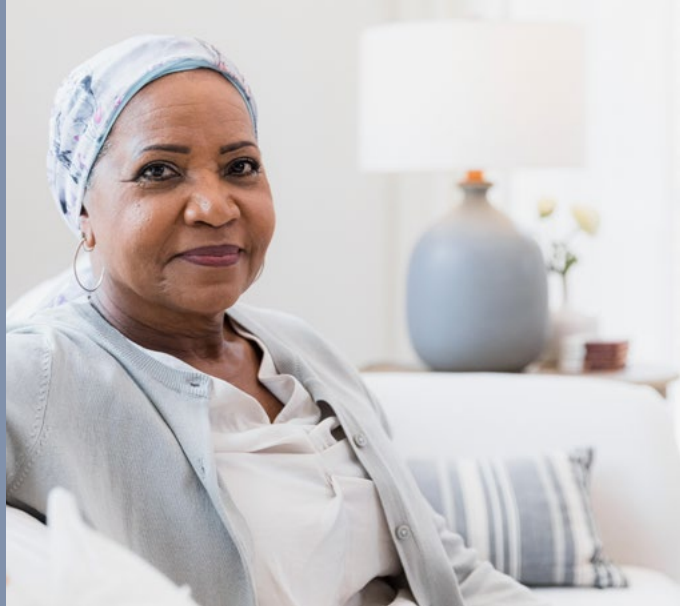
Annual screening benefits	TFG Health	TFG Health Plus
Screening for children	Growth assessment tests, including height, weight, head circumference and health and milestone tracking.	Screening benefits for children aged 2 to 18 are paid from the Screening and Prevention Benefit. The tests will include: ▪ One BMI measurement **per year per child** ▪ One hearing test (each ear) **per year per child** ▪ One dental check-up at a dentist **per year per child** ▪ One online milestone tracking **per year per child**
Screening for adults	▪ Blood glucose, blood pressure, cholesterol, body mass index (BMI) and HIV screening at our wellness providers ▪ A mammogram or ultrasound of the breast every two years ▪ A Pap smear once every three years or an HPV test once every five years ▪ Prostate screening test (PSA) each year ▪ Bowel cancer screening tests every two years for members 45 to 75 years old	▪ Blood glucose, blood pressure, cholesterol, BMI and HIV screening at our wellness providers ▪ 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 **each year** ▪ Bowel cancer screening tests every two years for members 45 to 75 years old
Screening for seniors	In addition to the screening for adults, members aged 65+ have cover for a group of age-appropriate screening tests in our defined pharmacy network. Cover includes hearing and visual screening and a 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.	

THE ACTIONS

- Make sure all the members on your benefit plan go for their Health Check to activate your family's WELLTH Fund. You can book a health check at Dis-Chem, Clicks or any Discovery Store near you.



Your cover for emergency hospital admissions



TFG Medical Aid Scheme (TFGMAS) offers members two plan options to choose from: TFG Health and TFG Health Plus. We outline the differences between the two in the Facts section below:

THE FACTS

- An emergency does not necessarily require a hospital admission and not all urgent medical treatment falls within the definition of Prescribed Minimum Benefits (PMB). We may ask you for additional information to determine whether your treatment can be funded as an emergency treatment. If you or any members of your family on your chosen plan 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 is in line with PMB legislation.
- In case of an emergency, you can go to any hospital and we cover you at **cost for the first 24 hours** or until you're stabilised. If you need further hospital treatment, you may be moved to a network hospital. If you choose to remain at a non-network hospital, depending on your chosen benefit plan, you may be responsible to pay a portion of the hospital account if registered on the TFG Health Plus benefit plan. You will not be covered for funding outside of the network arrangement if you are registered on the TFG Health benefit plan.
- Hospital admissions are funded from your chosen benefit plan's hospital benefit. This benefit covers your hospital costs and other accounts that are part of your admission. This could include accounts from your admitting doctor, anaesthetist or any other approved healthcare expenses.
- See the table below for more information:

	TFG Health	TFG Health Plus
Hospital Networks and In-Hospital GP Network	If you are registered on the **TFG Health benefit plan**, you have chosen a benefit plan with a hospital network and need to make sure you use a hospital in that network to get full cover. The **TFG Health benefit plan** uses the KeyCare Hospital Network. We also established an In-Hospital GP Network and pharmacies that are designated service providers (DSP).	If you are registered on the **TFG Health Plus benefit plan**, you have access to designated service providers (DSP) at agreed and contracted Scheme Rates. The **TFG Health Plus benefit plan** uses the KeyCare Hospital and In-Hospital GP network for **full cover of PMB treatment**. This means no deductible can apply where the admitting service provider is either on the Scheme's DSP or In-Hospital GP Network or In-Hospital Specialist Network and you get these services from a hospital in the KeyCare Hospital Network.
Emergency medical condition	An emergency medical condition is the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment. Should you not receive the treatment, this would result in serious impairment to bodily functions, serious dysfunction of a bodily organ, or part, or would place the person's life in serious jeopardy.	
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.	

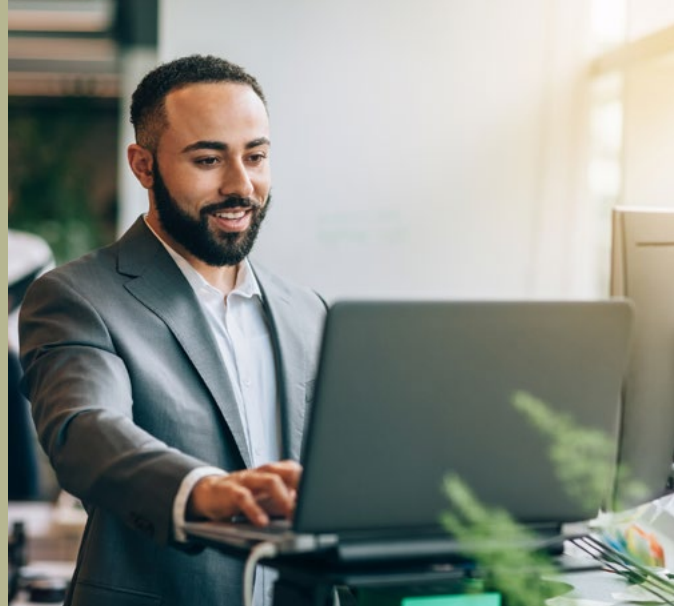
- When you are admitted to hospital from casualty for a medical emergency:

TFG Health	TFG Health Plus
The first R450 of the casualty unit's account is payable by you.	If you are admitted to hospital from casualty, we will cover the costs of the casualty visit in full from your hospital benefit as long as we have pre-authorised your hospital admission. We must be notified within 24 hours to pre-authorise the claim(s) for payment.

THE ACTIONS

- Make sure you understand your chosen plan type and the benefits available to you.
- Read our updated **Hospital Network list** to see which hospital you should go to when necessary.
- ***If you are admitted to hospital as a result of an emergency or after hours, we must be notified the next available working day or within 24 hours after the emergency admission or treatment started.*** **This way, we can authorise payment of your medical expenses.**
- To pre-authorise admission to hospital, please call us on **0860 123 077**. We will give you an authorisation number that you must give to the relevant healthcare provider and ask them to include this on the claims they submit. Please make sure you understand what is included in the authorisation and how we will pay your claims.
- For a comprehensive list of the TFGMAS Hospital Network, visit **www.tfgmedicalaidscheme.co.za** and navigate to Find a Document > Information Guides > TFGMAS Hospital Network.

Keep the price of healthcare down – SAY NO to fraud!



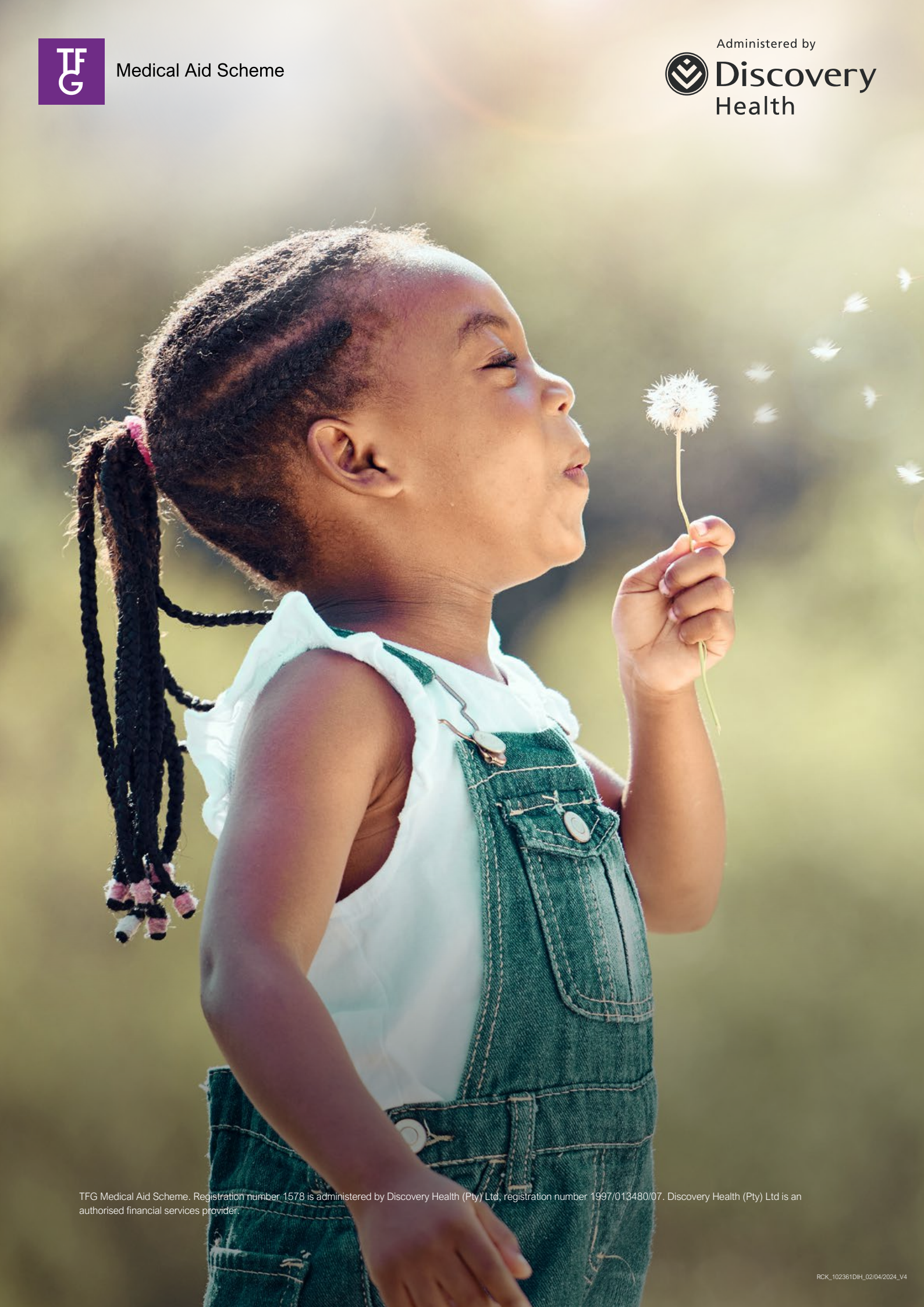
Medical aid fraud is one of the largest and fast growing problems that we are faced with in South Africa, as it contributes to the overall high cost of healthcare and occurs at all levels. Fraud can significantly reduce the amount available in the Scheme to pay your claims. It causes your contributions to be higher to cover any losses and the costs to the Scheme of maintaining fraud management processes. Let's learn more about medical aid fraud and what you can do to help prevent it.

THE FACTS

- Medical aid fraud involves deliberate deception made for personal gain or to harm another individual. In the context of healthcare, it specifically refers to misrepresentations or false statements that could result in unauthorised benefits for an individual, entity or another party.
- People who commit fraud don't just steal from the Scheme, they steal from you and other members.
- TFGMAS subscribes to a whistle-blowing approach, which advocates the principles of the South African Protected Disclosures Act 26 of 2000. Therefore, in terms of this approach, all whistle-blowing reports are treated as confidential. **TFGMAS has a zero tolerance approach to fraud.**
- You play a vital role in ensuring that the funds in your medical scheme are not subject to fraud.

THE ACTIONS

- For details on the types of fraud and how they are committed, please **visit our website** here.
- If you suspect any fraudulent behaviour relating to your healthcare cover, you can remain anonymous and use the following details to contact us:
  - Toll-free phone number: **0800 004 500**
  - SMS number: **43477**
  - Toll-free fax number: **0800 007 788**
  - Email: discovery@tip-offs.com or forensics@discovery.co.za directly to investigate the matter
  - Post: Freepost DN298, Umhlanga Rocks 4320



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