MATERNITY BENEFIT TFG HEALTH PLUS

2025

Who we are

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

Overview

This document gives you information about how TFG Health Plus covers pregnancy and childbirth.
It also explains what you need to do to register your baby on TFG Health Plus so he or she is covered.

About some of the terms we use in this document

There may be some terms we refer to in the document that you may not be familiar with. We give you the meaning of these terms.

Terminology	Description
Prescribed Minimum Benefits (PMBs)	A set of conditions that all medical schemes must provide a basic level of cover for. This basic level of cover includes the diagnosis, treatment and costs of the ongoing care of these conditions.
Related accounts	Any account other than the hospital account for in-hospital care. This could be the gynaecologist and anaesthetist's account.
Shortfall or co-payment	The Scheme pays service providers at a set Scheme Rate. If the doctor's accounts are higher than this rate, the member will have to pay the outstanding amount from his or her pocket.

Administered by Discovery Health

The Maternity Benefit, at a glance

We cover out-of-hospital consultations and tests from your day-to-day benefits

We pay all healthcare services related to your pregnancy from your available day-to-day benefits. This includes scans, blood tests and antenatal consultations with a GP, midwife or gynaecologist.

Blood tests are covered at 100% of the Scheme Rate and scans are covered at 100% of the Scheme Rate, cover is subject to available sub-limits for radiology and pathology.

We pay for eight GP or gynaecologist consultations per pregnant person per year which is made available without accumulating to your sub-limit for consultations and visits.

GP's and specialists who are part of a direct payment arrangement for your plan will be covered at 100% of the agreed rate, subject to the available primary care benefit limits. GPs and specialists, who do not take part in a direct payment arrangement, are covered at up to 100% of the Scheme Rate, subject to the available primary care consultation benefit limits. Specialists in Family Medicine is paid up to 130% of Scheme Rate.

You are also covered for one lactation consultation with a registered nurse or lactation specialist payable from the primary care consultation benefit at 80% of the Scheme Rate.

You are covered for one nuchal translucency and Non-Invasive Prenatal Test (NIPT) or T21 Chromosome test, subject to clinical entry criteria, payable from the available radiology and pathology benefits at 100% of the Scheme Rate.

We pay for two 2D pregnancy scans from available day-to-day benefits, subject to funds available in the Primary Care Benefit. Any 3D and 4D scans will add up to this limit and will be paid up to the rate of a 2D scan only. Scans are covered at up to 100% of the Scheme Rate, subject to the sub-limits for radiology.

We do not cover antenatal classes

We pay medicines and supplements for pregnancy from your day-to-day benefits

We pay medicines and supplements that are taken during your pregnancy, like medicines for morning sickness, iron supplements and folic acid, at up to 100% of the Scheme Rate where obtained from the Scheme's Designated Service Provider (DSP) list of pharmacies and up to 80% of the Scheme Rate where obtained outside of the Scheme's DSP list of pharmacies. This is subject to the acute medication sub-limit.

Over-the-counter medicine is limited to R250 per claim and paid up to 80% of the Scheme Medication Rate.

Antiretroviral medicines to prevent mother-to-child transmission

We fund HIV medicines to prevent mother-to-child transmission of HIV. Please refer to the HIV*Care* brochure or call the HIV*Care* team on 0860 123 077.

Administered by Discovery Health

Your cover for your hospital stay depends on the type of delivery

We pay the hospital account and all related accounts, such as the gynaecologist, midwife, anaesthetist and other healthcare services at up to 100% of the Scheme Rate, subject to pre-authorisation. You can maximise your benefit by using healthcare professionals participating in our direct payment arrangements because we will cover their approved procedures in full.

You have cover for three (3) days and two (2) nights for a normal delivery and four (4) days and three (3) nights for a delivery by caesarean section, if approved. Where we confirm cover, we will give you an authorisation number to use when booking your bed at the hospital.

If you need to stay in hospital longer than the number of days we approved, your doctor will need to send a letter to motivate why you need to stay in hospital longer.

We will cover home nursing from your Hospital Benefit if you decide to leave the hospital earlier than the length of stay we normally cover. We will cover the home nursing you received up to the length of stay we normally cover in hospital. Always confirm leaving hospital earlier with your healthcare professional and advise us to avoid possible short payments on claims.

We cover home births with a registered midwife

Home births are covered with a registered midwife up to 100% of the Scheme Rate, for up to three days after the delivery. The midwife has to be registered with the Board of Healthcare Funders (BHF) and has to have a valid practice number.

If you choose to have a water birth in hospital we will pay up to three (3) days and two nights. If you choose to hire a birthing pool outside of what is supplied, you will need to pay this yourself. If you choose to have a water birth at home, we will pay for the cost of the hire of a birthing pool from your Hospital Benefit. This must be hired from a provider who has a registered practice number.

We cover medically necessary circumcisions from the Hospital Benefit

Please preauthorise the procedure with us by calling 0860 123 077.

Circumcisions that are not medically necessary are covered from the available funds in your day-to-day benefits.

Treatment for neonatal jaundice

If your baby needs phototherapy for neonatal jaundice, we will cover the phototherapy lights from the Hospital Benefit, as long as you get preauthorisation from us.

There are certain items we do not cover

We do not cover these items:

- Mother and baby packs that hospitals supply
- The bed-booking fee that some hospitals may require you to pay
- Your lodging or boarding fees if your baby needs to stay in hospital for longer and you choose to stay on.

Getting the most out of your maternity benefits

Tell us about your pregnancy as soon as you are 12 weeks pregnant

TFG Health Plus covers the birth of your baby either in hospital with a doctor or midwife, or at home with the help of a midwife. It is important to call and notify us of your pregnancy as soon as you are 12 weeks pregnant, so that you always know how we cover you for your pregnancy-related healthcare services, whether these are done in or out of hospital. Call us on 0860 123 077.

Understand your benefits

PMBs is a set of conditions which all medical schemes must provide a basic level of cover for. The PMB regulations include funding for antenatal care where it is necessary to hospitalise the mother before she gives birth.

To access full cover for your hospitalisation as a PMB, you must use a doctor, specialist or other healthcare provider who is part of the Scheme's network. We will pay the account in full up to the agreed Scheme Rate. If you chose to use a hospital or healthcare provider who is not on our network, we will pay the hospital or healthcare provider up to 100 % of the Scheme Rate and you will be responsible for any difference between what is charged and what we pay.

Pregnant mothers who need to be admitted during their pregnancy, can apply for in-hospital PMB cover by calling us on 0860 123 077. For more information on PMB's go to our website at www.tfgmedicalaidscheme.co.za

Register your baby within 30 days of the birth

We automatically cover newborns under the parent's name up to the last day of the calendar month in which he or she is born. For example, if your baby is born on 20 May, he or she will have automatic cover from 20 May until 31 May under your name.

To continue cover, the baby must be registered from the next calendar month and we must receive a contribution to TFG Medical Aid Scheme. Please note we may apply underwriting if you do not register your baby within 30 days of the date of birth and cover must start from the date of birth. If you are applying for cover 30 days after birth or you want the cover to start on any other day after the date of birth, we may apply certain conditions to your baby's membership with the Scheme.

To register your newborn on the Scheme, you must inform your employer.

Contact us

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

Complaints

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

Members, who wish to approach the Council for Medical Schemes for assistance, may do so in writing to: Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157 or email complaints@medicalschemes.co.za. Customer Care Centre:
0861 123 267/website www.medicalschemes.co.za.