GUIDE TO PRESCRIBED MINIMUM BENEFITS

2025

Guide to Prescribed Minimum Benefits

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 authorized financial services provider (registration number 1997/013480/07), administers TFG Medical Aid Scheme.

Contact us

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

Administered by Discovery Health

Understanding some of the terms we use in this document

There are some terms we use in the document that you may not know. Here are the meanings of some of them:

Terminology	Description
Prescribed Minimum Benefits (PMBs)	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.
Co-payment	TFG Medical Aid Scheme pays service providers at a set rate, known as the Scheme Rate. If the service providers charge higher fees than this rate, you will have to pay the difference between the Scheme Rate and what the providers charged, from your pocket.
Waiting period	A waiting period can be general or condition-specific and means that you or one of your dependents have to wait for a set time before TFG Medical Aid Scheme will provide benefits, in line with those offered by your benefit plan, for your medical expenses.
Chronic Drug Amount (CDA)	The CDA is a maximum monthly amount we pay up to for a medicine class. This applies to medicine that is not listed on the medicine list (formulary). The Chronic Drug Amount includes VAT and the dispensing fee.
Diagnostic Treatment Pairs Prescribed Minimum Benefit (DTP PMB)	Links a specific diagnosis to a treatment and broadly indicates how each of the PMB conditions should be treated c diagnosis to a treatment and broadly indicates how each of the PMB conditions should be treated
Designated Service Provider	A healthcare provider (for example doctor, specialist, pharmacist or hospital) who we have an agreement with to provide treatment or services at a contracted rate.
Reference Price	Non-formulary medication that falls in the same medicine category and generic group as the formulary medication. Funds up to a Reference Price

What are Prescribed Minimum Benefits (PMBs)?

No matter what benefit plan you decide on, there are some common benefits that apply to all members on all benefit plans. This document tells you how TFG Medical Aid Scheme covers each of its members for a list of conditions called PMBs.

PMBs are guided by a list of medical conditions as defined in the Medical Schemes Act of 1998 According to the Medical Schemes Act 131 of 1998 and its Regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of:

1 | Any life-threatening emergency medical condition
2 | A defined set of 271 diagnoses
3 | 27 chronic conditions (Chronic Disease List (CDL) conditions), including HIV.

Please refer to the Council for Medical Schemes website www.medicalschemes.co.za for a full list of the 271 diagnostic treatment pairs. All medical schemes in South Africa must include the PMBs in the plans they offer to their members.

Requirements you must meet to benefit from PMBs

There are certain requirements before you can benefit from PMBs. The requirements are:

1 | The condition must qualify for cover and be on the list of defined PMB conditions.
2 | The treatment needed must match the treatments in the defined benefits on the PMB list.
3 | You must use the Scheme's DSPs for full cover unless there is no DSP applicable to your benefit plan.

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. This does not apply in emergencies. However, even in these cases, where appropriate and according to Scheme rules, you may be transferred to a hospital or other service providers in our network once your condition has stabilised, to avoid co-payments. If your treatment doesn't meet the above criteria, we will pay according to your benefit plan benefits.

Claims for services received outside of the borders of South Africa will be covered in accordance with your chosen benefit plan benefits and Rules. For more information on cover while travelling, please refer to the guide on the cover for treatment received abroad, available on our website **www.tfgmedicalscheme.co.za** and click on Find a document.

The medical condition must be part of the list of defined conditions for PMB

Members should send the Scheme the results of their medical tests and investigations that confirm the diagnosis of the condition. This will allow us to identify that the member's condition qualifies for the

treatment. The member's treating doctor needs to provide the relevant documentation to assist us in confirming the diagnosis.

The treatment needed must match the treatments included in the defined benefits

There are standard treatments, procedures, investigations, and consultations for each PMB condition on the 271 diagnostic treatment (DT) PMB list. These defined benefits are supported by thoroughly researched, evidence based clinical protocols, medicine lists (formularies) and treatment guidelines.

Please refer to the Council for Medical Schemes website www.medicalschemes.co.za for a full list of the 271 diagnostic treatment pairs.

An example of a PMB provision

Below is an example of a PMB condition and the treatment that qualifies for PMB cover:

Provision	Provision Description	Treatment	ICD-10 code
236K	Iron deficiency; vitamin and other nutritional deficiencies – life-threatening	Medical management	D50.8 - Other iron deficiency anaemias

- The PMB Provision is **236K**. This is one of the listed 271 Provisions (listed 271 conditions) as published in the Medical Schemes Act and Regulations.
- In this example the **Provision Description** lists "Iron deficiency; vitamin and other nutritional deficiencies - life threatening". The provision states that the condition should be life threatening. For this provision, if the diagnosis is not a life-threatening episode, the condition does not qualify for PMB funding.
- The **Treatment** covered as a PMB for this provision includes medical management for example medicine, doctor consultations investigations etc.
- In addition to the above information, the Council for Medical Schemes (CMS) also provides **ICD-10 codes** (e.g., D50.8) that fall within the **236K Provision,** as per the last column in the above table. The ICD-10 codes are an industry guide as to which conditions may qualify for PMB cover, subject to them still meeting the **Provision Description** and **treatment** criteria.

For this example, to qualify for the out-of-hospital PMB (OHPMB) funding, you or your healthcare professional may apply for medical management of life-threatening iron deficiency, vitamin and other nutritional deficiencies. These criteria stated in the Provision description needs to be met to qualify for OHPMB funding related to the treatment as outlined.

Any application for treatment that is not listed in the "treatment" provision for a condition cannot be considered as PMB it does not form part of the prescribed treatment that forms part of PMB level of care. Speak to your healthcare professional to ensure that all criteria for treatment is met before applying for PMB cover.

How we pay claims for PMBs and non-PMB benefits

We pay for confirmed PMBs in full if you receive treatment from a Designated Service Provider (DSP). Treatment received from a non-DSP may be subject to a co-payment if the healthcare provider charges more than the amount we pay.

We have preferred suppliers for suppliers of intermittent catheters, rental oxygen, and other devices such as CPAP machines. Where a non-preferred supplier is used you may have a co-payment.

We pay for benefits not included in the PMBs from your appropriate and available benefit plan benefits, according to the rules of your chosen benefit plan. Visit www.tfgmedicalscheme.co.za or call us on 0860 123 077 to find a participating DSP healthcare provider.

There may be times when you do not have cover under Prescribed Minimum Benefits

This can happen when you join a medical scheme for the first time, with no previous medical scheme membership. Also, if you join a medical scheme more than 90 days after leaving your previous medical scheme. In both these cases, the Scheme will impose a waiting period, during which you and your dependants will not have access to the PMBs, regardless of the conditions you may have. We will communicate with you at the time of applying for your membership if any waiting periods apply to you or your dependants.

Sometimes TFG Medical Aid Scheme will only pay a claim as a Prescribed Minimum Benefit

This happens when you have a waiting period or when you have treatments linked to conditions that are excluded by your benefit plan. This can be a three-month general waiting period or a 12-month condition-specific waiting period. But you might have cover in full, if you meet the requirements stipulated by the PMB regulations.

You and your dependants must register to get cover for PMBs and Chronic Disease List conditions

How to register your chronic or PMB conditions to get cover from the risk benefits

There are different types of PMBs. These include PMB cover for in-hospital admissions, conditions covered under the Chronic Disease List, the out-of-hospital management of PMB conditions, and treatment of PMB conditions such as HIV and oncology.

To apply for out-of-hospital PMBs or cover for a Chronic Disease List (CDL) condition, you must complete the PMB or a Chronic Illness Benefit application form.

- Up to date forms are always available on **www.tfgmedicalscheme.co.za** under Find a document.
- You can also call 0860 123 077 to request any of the above forms.

For more information on the PMB Chronic Disease List conditions, HIV or Oncology and how to register please refer to the relevant benefit guides available on **www.tfgmedicalscheme.co.za** under Find a document.

To confirm your in-hospital cover for PMB conditions, you can call us on 0860 123 077 and request an authorisation. We will then tell you about your cover.

Why it is important to register your PMB or chronic conditions

We pay for specific healthcare services related to each of your approved conditions. These services include approved treatment, medicine, consultations, blood tests and other defined investigative tests. We pay for these services from your PMBs which will not affect your day-to-day benefits.

We will pay for treatment or medicines that fall outside the defined benefits and that are not approved, from your available day-to-day benefits, according to your chosen benefit plan. If your benefit plan does not cover these expenses, you will have to pay these claims.

Who must complete and sign the registration form when applying for PMB of chronic condition cover

The person with the PMB or chronic condition must complete the relevant application form with the help of their treating doctor. The main member must complete and sign the form if the patient is a minor.

Each person with PMB or chronic conditions must register their specific conditions separately. You only have to register once for a chronic condition. If your medicine or other treatment changes, your doctor can let us know about these changes.

For new conditions, you will have to register each new condition before we will cover the treatment and consultations from your PMBs and not from your day-to-day benefits.

Additional documents needed to support the application

You must send the Scheme the results of the medical tests and investigations that confirm the diagnosis of the condition for which you are applying for. This will help us to identify that your condition qualifies for PMB benefits.

Where you must send the completed registration form

You can send the completed **PMB application form**:

- By email to: PMB_APP_FORMS@tfgmedicalaidscheme.co.za

You can send the completed **Chronic application form**:

- By email to: CIB_APP_FORMS@tfgmedicalaidscheme.co.za

We will let you know if we approve your application for PMB cover and what you must do next

We will let you know about the outcome of your application and will send you a letter confirming your cover for the condition, via email. If your application meets the requirements for cover from PMBs, we will automatically pay the associated approved blood tests and other defined investigative tests, treatment, medicine and consultations for the diagnosis and treatment of your condition from your PMBs, and not from your day-to-day benefits.

The treatment needed must match the treatments in the published defined benefits on the PMB list as there are standard treatments, procedures, investigations, and consultations for each condition on the PMB list. These defined benefits are supported by thoroughly researched evidence, based on clinical protocols, medicine lists (formularies) and treatment guidelines.

What happens if you need treatment that falls outside of the defined benefits

If you need treatment that falls outside of the defined benefits you and your healthcare professional can send additional clinical information with a detailed explanation of the treatment that is needed, and we will review it. If this treatment is not approved as PMBs, it can be paid from your available day-to-day benefits, according to your chosen benefit plan. If your benefit plan does not cover these expenses, you will have to pay the costs of these claims.

You can follow the below easy steps to apply for additional cover for out-of-hospital PMB conditions or for Chronic Disease List (CDL) conditions registered on the Chronic Illness Benefit (CIB):

1 | Download the "Request for additional cover for out-of-hospital Prescribed Minimum Benefit conditions" form or "Request for additional cover for Prescribed Minimum Benefit Chronic Disease List condition" form. Up to date forms are always available on **www.tfgmedicalscheme.co.za** under Find a document. You can also call 0860 123 077 to request any of the above forms.
2 | Complete the form with the assistance of your doctor/healthcare professional.
3 | Send the completed, signed form, along with any additional medical information, by email to PMB_APP_FORMS@tfgmedicalaidscheme.co.za or by email to CIB_APP_FORMS@tfgmedicalaidscheme.co.za

For more information on your cover for Chronic or PMB medicine please visit our website **www.tfgmedicalscheme.co.za** and click on Find a document.

What happens if there is a change in your approved medicine

For chronic conditions, your treating doctor or dispensing pharmacist can make changes to your medicine telephonically by calling 0860 123 077 or emailing it to CIB_APP_FORMS@tfgmedicalaidscheme.co.za

For other PMB conditions, the treating doctor or dispensing pharmacist can only make changes to medicine by sending the updated prescription by emailing it to PMB_APP_FORMS@tfgmedicalaidscheme.co.za

If you get your medicine or treatment from a provider of your choice instead of the Scheme's DSPs

You must use doctors, specialists, and other healthcare providers, including pharmacies, who we have a payment arrangement with, to avoid a co-payment. This does not apply in the event of an emergency or where the use of a non-DSP provider is involuntary or when no DSP is available. If you use a healthcare provider who we do not have a payment arrangement with, you will have to pay part of the treatment costs yourself.

In an emergency, you can go directly to hospital and notify the scheme as soon as possible of their admission. In the case of an emergency, members are covered in full for the first 24hrs or until you are stable enough to be transferred.

Go to **www.tfgmedicalscheme.co.za or** call us on 0860 123 077 to find a participating DSP healthcare provider.

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Get the most out of your benefits

Elective admissions for PMB conditions and procedures are covered in full if you choose to use a DSP hospital and DSP treating doctors. Where your primary treating doctor is a DSP, reimbursement will be made in full without any co-payment for any required anaesthetic services you may need during your admission.

The below conditions need to be met for full cover for these providers:

- You are being admitted for a procedure for a PMB condition
- Your chosen hospital or day facility is on the PMB network for your benefit plan
- Your primary treating doctor is on the PMB network for your benefit plan.

If all of the above conditions are met your hospital, doctor and anaesthetist accounts will be covered in full.

Nominate a GP for the management of your PMB chronic conditions

If you are on a TFG Health plan and approved for a chronic PMB condition, you must nominate a General Practitioner (GP) in the Discovery Health GP network for your plan to be your primary care doctor for the management of your chronic conditions. Where a GP has not been nominated for the treatment of a chronic condition you may incur a co-payment.

You can nominate your primary care doctor in three simple steps:

- Log in to the Discovery app or website
- Navigate to nominate your primary care provider
- Follow the prompts in the Care Portal and select your primary care doctor and their associated practice.

You can access your Care portal on the Discovery app or website to update your nominated GP should you need to do so.

What to do if there is no available designated service provider at the time of your request

There are some instances when you will still have full cover if you use a healthcare provider who we do not have a DSP arrangement with. An example of this is in an emergency, cases when the use of a non-DSP is involuntary or when there is no DSP available.

In cases where there are no services or beds available at a DSP when you or one of your dependents need treatment, you can contact us on 0860 123 077 and we will make arrangements for an appropriate facility or healthcare provider to accommodate you.

Cover for Cancer

Depending on your chosen benefit plan, once you are registered on the Oncology Programme, the Scheme covers your approved cancer treatment over a 12-month cycle up to the Scheme Rate, in accordance with your benefit plan benefits.

Cancer treatment that is a PMB, is always covered in full. All PMB treatment costs add up to the oncology cover amount for your benefit plan. If your treatment costs more than the cover amount, we will continue to cover your PMB cancer treatment in full.

For more information on your cover for cancer please visit our website **www.tfgmedicalscheme.co.za** and click on Find a document.

Cover for HIV

When you register for our HIV Care Programme to manage your condition, you are covered for the care you need, which includes additional cover for social workers. You can be assured of confidentiality at all times.

For more information on your cover for HIV please visit our website **www.tfgmedicalaidscheme.co.za** and click on Find a document.

Cover for COVID-19

The WHO Global Outbreak Benefit provides cover for global disease outbreaks recognised by the World Health Organization (WHO) such as COVID-19. This benefit offers cover for the vaccine, out-of-hospital management, and appropriate supportive treatment in the event of you contracting COVID-19.
Please visit our website **www.tfgmedicalaidscheme.co.za** and click on Find a document.

Cover for PMB admissions

You must pre-authorise all hospital admissions. When you call us to pre-authorise, we will tell you how you are covered.

You must use designated services providers 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 stabilized. If you do not use a DSP we will pay up to 80% of the Scheme Rate.

For more information on your in-hospital PMB cover please visit our website **www.tfgmedicalaidscheme.co.za** and click on Find a document.

Complaints process

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

You may, as a last resort, approach the Council for Medical Schemes for assistance. Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157 / 0861 123 267 / complaints@medicalschemes.co.za / www.medicalschemes.co.za