Medical Aid Scheme

Administered by Discovery Health

TFG Health Plus

BENEFIT GUIDE | 2025

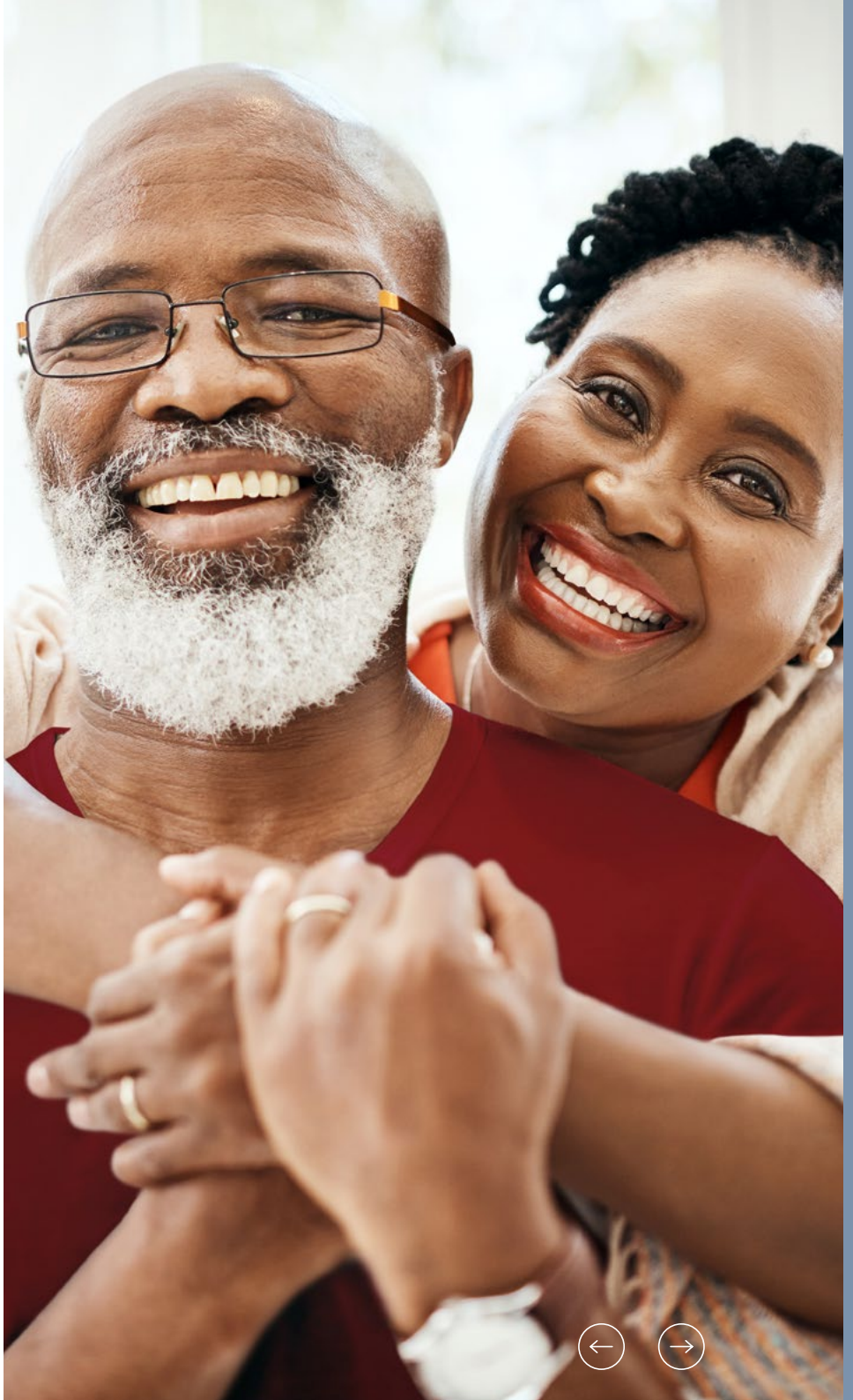
Contents

Welcome to
TFG Health Plus

TFG HEALTH PLUS OFFERS MEMBERS A COMPREHENSIVE RANGE OF BENEFITS, INCLUDING ADDITIONAL IN-HOSPITAL PROCEDURES, COVER FOR AN ADDITIONAL LIST OF CHRONIC CONDITIONS AND ADDITIONAL LIST OF MEDICINE. 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:

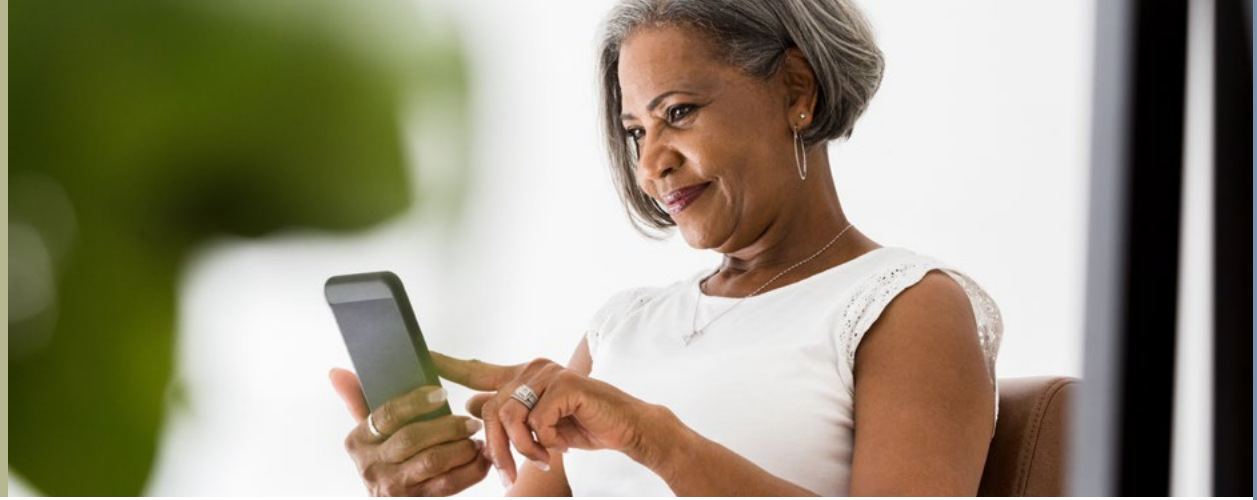
- What to do when you need to go to a doctor or to a hospital.
- How you are covered for preventative screening, medical conditions, medicine and treatments.
- Which benefits you need to apply for and if there are any limits for certain benefits.
- Tips on how you can use technology to conveniently manage and access all the information you need through the Discovery app* and TFG Medical Aid Scheme website at **www.tfgmedicalaidscheme.co.za.**



TFG Medical Aid Scheme is regulated by the Council for Medical Schemes (CMS). The benefits explained in this benefit guide are provided by TFG Medical Aid Scheme, registration number 1578, administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial service provider. This benefit guide is only a summary of the key benefits and features of the TFG Health Plus benefit plan and awaits approval from the CMS. In all instances, TFGMAS Rules prevail. Please consult the Scheme Rules on our website at **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 and detailed benefit information is available at **www.tfgmedicalaidscheme.co.za**.

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

Contact Details



THE SCHEME'S CONTACT INFORMATION THROUGH THE ADMINISTRATOR'S OFFICE IS LISTED BELOW:

Ambulance and other Emergency services

- Call: **0860 999 911**

General queries

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

To send claims

- Email: claims@tfgmedicalaidscheme.co.za
- Post your claims to PO Box 652509, Benmore, 2010 **or take a photo and submit your claim using the Discovery app****. You can download the Discovery app from the App Store or Google Play Store.

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 a description of the alleged fraud.

To preauthorise admission to hospital

- Call: **0860 123 077**

Refunds and Claims

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

Oncology service centre

- Call: **0860 123 077**

HIVCare Programme

- Call: **0860 123 077**

Internet queries

- Call: **0860 100 696**

CONTACT INFORMATION FOR THE TFG EMPLOYER IS SET OUT BELOW:

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

TFGMAS PARTNERSHIP WITH ALEXFORBES HEALTH

TFGMAS partnered with Alexforbes Health* as an independent financial adviser to better equip TFGMAS members with the right information and advice on the benefit plan that best suits them.

If you need assistance and advice choosing the correct benefit plan for you, you can book your consultation using the booking tool: **https://outlook.office365.com/book/HealthConsultingHelpdeskWC1@aforbes.onmicrosoft.com/s/Nt10YQkFKEi7PUtUWCyRqw2**

Alternatively, you can make an enquiry by emailing **TFGmedAdvice@aforbes.com.**

* Alexander Forbes is duly registered with the Financial Advisory Services Board and is qualified to provide financial advisory services to members in terms of the Financial Advisory and Intermediary Services Act 37 of 2002.

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

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) COVER OUT OF HOSPITAL

The Chronic Illness Benefit (CIB) covers you for a defined list of chronic conditions. You need to apply to have your medicine and treatment covered for your chronic condition.

COVER

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

DAY-TO-DAY BENEFITS

You have cover for a defined set of day-to-day medical expenses such as medically appropriate general practitioner (GP) consultations, blood tests, X-rays or medicine. The level of cover for these day-to-day benefits is set out in this benefit guide from page 16.

DEDUCTIBLE/CO-PAYMENT

A co-payment is an amount that you need to pay for 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 amount charged is higher than the amount payable by the Scheme for the healthcare service, you will need to pay for the cost difference charged for the healthcare service. The amount that you must pay upfront to the hospital or day clinic for specific treatments and procedures is referred to as a deductible in this benefit guide. You may need to pay a deductible upfront, while a co-payment is payable retrospectively for services received.

DESIGNATED SERVICE PROVIDER (DSP)

This is a doctor, specialist or other healthcare provider that we have reached an agreement with about payment and rates to provide treatment or services at a contracted rate. Visit **www.tfgmedicalaidscheme.co.za** or click on 'Find a Provider' on the Discovery app* to view the full list of DSPs of TFGMAS.

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

EMERGENCY MEDICAL CONDITION OR MEDICAL EMERGENCIES

A medical emergency is a sudden health issue needing immediate treatment to prevent serious harm or death. 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, if we preauthorise your hospital admission. If an event occurs after hours, you must apply for authorisation on the next available working day.

FIND A HEALTHCARE PROVIDER***

Find a healthcare provider is a medical and provider search tool that is on the Discovery app* or our website at **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 based on clinical effectiveness, safety and cost. We cover these medicines in full for the treatment of approved chronic conditions.

HOME CARE

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.

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 healthcare 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 take while you are in hospital.

MEDICINE RATE

This is the rate we pay for medicine. It is the Single Exit Price (SEP) of medicine and it includes the relevant dispensing fee.

NETWORKS

You may need to use 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 or co-payments 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 social workers contracted or nominated by us to provide treatment to members relating to mental health conditions.

Medicine Networks

Use a pharmacy in our network to enjoy full cover and avoid co-payments 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 of **R2,000** 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 aligns 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.

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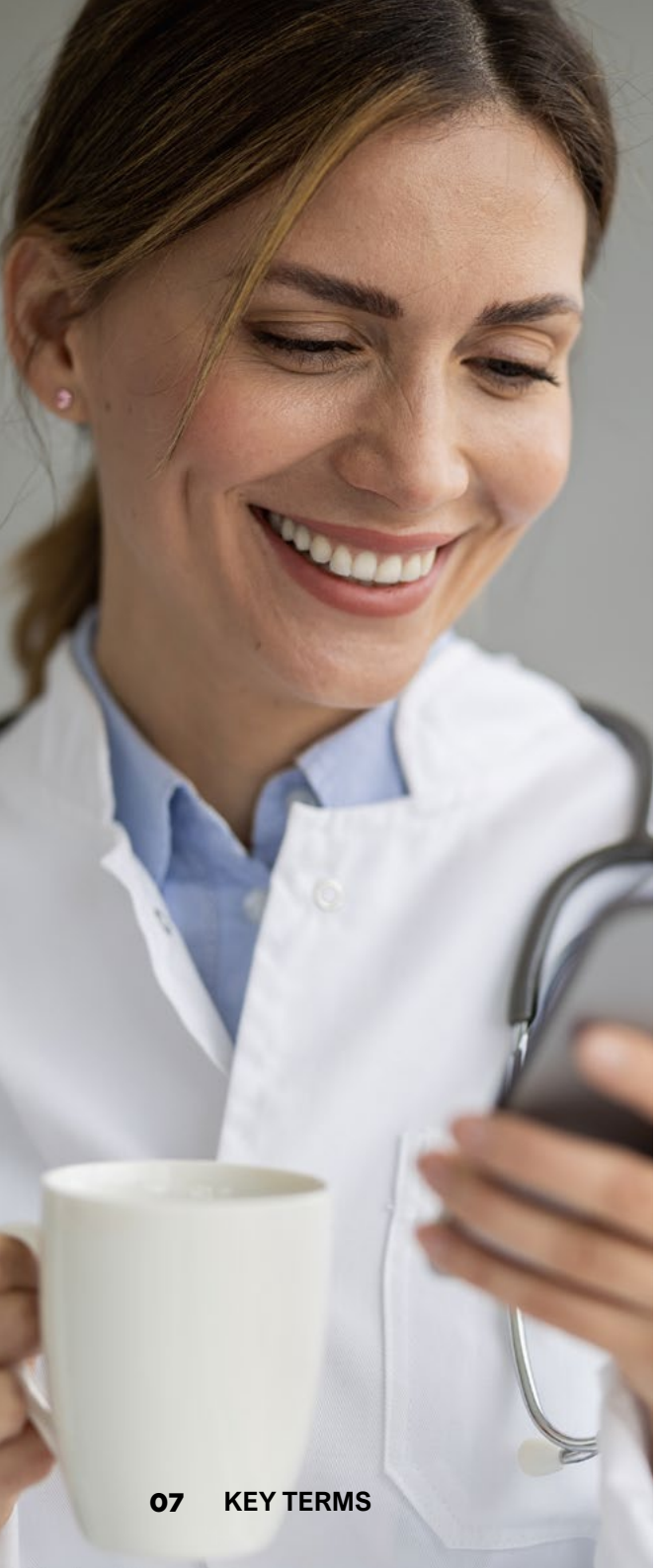


PREFERRED MEDICINE

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 chronic conditions.

PRESCRIBED MINIMUM BENEFITS (PMB)

In terms of the Medical Schemes Act of 1998 (Act 131 of 1998) and its Regulations, all medical schemes must cover the costs related to the diagnosis, treatment and care of:

- An emergency medical condition
- A defined list of 271 diagnoses
- A defined list of 27 chronic conditions (including HIV and AIDS)

To access PMBs, there are rules defined by the Council for Medical Schemes (CMS) that apply:

- Your medical condition must qualify for cover and be part of the defined list of PMB conditions
- The treatment needed must match the treatments in the defined benefits
- You must use designated service providers (DSPs) in our network. This does not apply in emergencies

Where appropriate and according to the Rules of the Scheme, you may be transferred to a hospital or other service providers in our network once your condition has stabilised. If you do not use a DSP, we will pay up to 80% of the Scheme Rate. You will be responsible for the difference between what we pay and the actual cost of your treatment where, for example, you don't use a DSP and your condition is a PMB.

If your treatment doesn't meet the above criteria, we will pay according to your benefit plan benefits.

RELATED ACCOUNTS

Any account other than the hospital account for in-hospital care. This could include the accounts for the admitting doctor, anaesthetist, and any approved healthcare expenses like radiology or pathology.

RELEVANT HEALTH SERVICES

A service as defined in the Act, which is provided for in your chosen benefit plan.

SCHEME RATE

This is the rate we pay for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant health services. The Scheme Rate is a rate that we negotiate with service providers. In some instances, cover is at 80% of Scheme Rate and in other instances, at 100% of the Scheme Rate. **If your doctor charges more than the Scheme Rate or the contracted fee in a Hospital Network Plan, such as TFG Health, we will pay claims at the Scheme Rate 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 131 of 1998) and its Regulations. The benefits as set out in the Rules of the Scheme are summarised in this benefit guide.

WHO GLOBAL OUTBREAK BENEFIT

The WHO Global Outbreak Benefit provides cover for global disease outbreaks recognised by the World Health Organization (WHO) such as COVID-19 or Mpox.

Key Features

COVER FOR CHRONIC MEDICINES

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

DAY-TO-DAY COVER

You have cover for a set of defined day-to-day benefits, including 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.

EXTENSIVE COVER IN HOSPITAL AND COVER UP TO THE 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.

EXTENSIVE COVER FOR PREGNANCY

You get comprehensive benefits for maternity that cover certain healthcare services before birth. 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.

MOBILITY AND HOME MONITORING DEVICES

A mobility network ensures that you are covered for any wheelchairs or mobility devices at agreed and negotiated rates. At-home monitoring devices are covered for clinically appropriate and chronic conditions to allow funding for devices that you may need to monitor your health at home.

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.

Key Benefits

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 you can manage your medical claims within the annual limits available to you as set out in this benefit guide from page 16.

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.

TFGMAS prescribed minimum benefit (PMB) conditions treated with specialised medicines follow funding according to a reference pricing structure.

We continously update the reference prices applied and it is important that you consult with your healthcare provider to ensure that you understand any potential co-payments that you may be responsible for. Only certain specialised and innovation medicines are covered in full.

Cover for chronic conditions

You have extensive cover for 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 24.

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 this 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, GPs and other healthcare professionals is 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 20 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 36 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.

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 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 staff members let us know about the admission as soon as possible, so that we can advise you on how you will be covered for the treatment you receive. If you need HIV medicine to prevent HIV infection, mother-to-child transmission, occupational or traumatic exposure to HIV, including sexual assault, call us immediately on **0860 999 911**. Treatment must start within 72 hours of exposure and pre-exposure (prep) and post-exposure prophylaxes (pep) require approval to be funded.

If you are admitted to hospital from casualty, we will cover the costs of the casualty visit from your hospital benefit, provided that we preauthorised 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. Travelers should always ensure that they obtain additional medical insurance cover when travelling outside the borders of South Africa, which includes Lesotho.

ASSISTANCE DURING OR AFTER A TRAUMATIC EVENT

You have access to dedicated assistance in the event of a traumatic incident or after a traumatic event. By calling Emergency Assist **(0860 999 911)**, you and your family have access to trauma support 24 hours a day. This service also includes access to counselling and additional benefits for trauma related to gender based violence.

Prescribed Minimum Benefits (PMB)

We established PMB Networks to prevent deductibles and co-payments 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. This includes cover for the diagnosis, treatment and cost of ongoing care for a list of conditions. The list of conditions is defined in the Medical Schemes Act 131 of 1998. The prescribed minimum benefits make provision for the cover of the diagnosis, treatment and ongoing care of:

- 271 diagnoses and their associated treatment
- 27 chronic conditions (including HIV and AIDS)
- Emergency conditions

IN MOST CASES, WE OFFER BENEFITS THAT COVER FAR MORE THAN THE PRESCRIBED MINIMUM BENEFITS. TO ACCESS PRESCRIBED MINIMUM BENEFITS, THERE ARE RULES THAT APPLY:

- Your medical condition must qualify for cover and be part of the list of defined prescribed minimum benefit conditions.
- The treatment needed must match the treatments offered in the defined benefits.
- You must use the Scheme's 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 co-payment will be payable. You will be responsible for the difference between what we pay and the actual cost of your treatment, where applicable.

MENTAL HEALTH NETWORK

The Mental Health Network has been created for services to be obtained from social workers, psychologists and registered counsellors in- or out-of-hospital (OOH). The network is also applicable where services are claimed from the allied and therapeutic benefits of the Scheme and where services are obtained through 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. It is therefore important to contact us to confirm whether your preferred service provider is part of our Mental Health Network before obtaining services for PMB conditions

EXTENSIVE 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.

If you're admitted to a PMB Hospital Network facility and use a primary provider who has entered into a Direct Payment Arrangement (DPA) with the Scheme, all services will be reimbursed at the contracted rate or at cost, as referred by your admitting doctor. This applies to all related accounts during the admission as well. Therefore, where a preauthorisation 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 or co-payments 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 or co-payments 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 or co-payments 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 or co-payments 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 has entered into a preferred payment arrangement with, the Scheme will fund the cost of the appliances up to the agreed/negotiated rate and members should have no co-payments. Where members obtain the above appliances from non-DSPs, the payment will be limited up to 100% of the Scheme Rate and limited to the annual benefit limit. In these instances, members may experience co-payments 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.

Screening and Prevention Benefits

This benefit pays for certain tests that can detect early warning signs of serious illnesses. We cover various screening tests at our wellness providers, such as Clicks and Dis-Chem, including blood glucose, cholesterol, HIV, Pap smear or HPV test for cervical screening, mammograms or ultrasounds and prostate screenings.

WHAT WE PAY FOR

We cover various screening tests at our wellness providers.

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

Screening for kids

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

Screening for adults

This benefit covers a health check that includes 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 aged 45 to 75. Additional cover for breast MRI and biopsy, BRCA testing and colonoscopy screening is also funded where deemed clinically appropriate. These tests are paid from the Screening and Prevention Benefit. Consultations that do not form part of PMB will be paid from your available day-to-day benefits.

Screening for senior citizens

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 fall risk assessments. 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.

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
- Administration of the COVID-19 vaccine as deemed clinically appropriate in terms of PMB. This administration of the 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 are an added screening benefit for members registered on the TFG Health Plus benefit plan**

Your Virtual Benefits
and access to Home Care

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

ONLINE PHARMACY

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

MANAGE YOUR BENEFIT PLAN

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

ONLINE COUNSELLING WITH DIGITAL MENTAL HEALTH

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

COVER FOR HOME CARE

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

Services include postnatal care, end-of-life care, IV infusions (drips) and wound care. These services are paid from the hospital benefit, subject to approval. Avoid a 20% co-payment by using Home Care for these infusions.

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

HOME-BASED HOSPITAL NETWORK

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

The Home-based Hospital Network is the designated service provider (DSP) for home-based care for qualifying conditions such as chronic obstructive pulmonary disease, pneumonia, complicated urinary tract infection, heart failure, cellulitis, deep vein thrombosis, asthma and diabetes. Members do not need to use this network in the event of an emergency, or if not deemed clinically appropriate for home-based care according to the treating provider. Members registered on TFG Health Plus will not experience any upfront deductibles for choosing not to make use of this network, even if your treating healthcare provider has recommended it as part of your care. Your admission at our Home-based Hospital Network, though it may be recommended, will remain a voluntarily decision for members registered on TFG Health Plus for the conditions listed.

In choosing our Home-based Hospital Network and if your treatment meets the Scheme's clinical benefit entry criteria, you will have access to:

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

HOME MONITORING DEVICE BENEFIT FOR ESSENTIAL HOME MONITORING

The Home Monitoring Device Benefit gives you access to a range of essential and registered home monitoring devices for certain chronic and acute conditions. Approved cover for these devices is paid up to a limit of **R4,700** per person per year, at 100% of the Scheme Rate and will not affect your day-to-day benefits.

Day-to-Day Benefits

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

Health Care Cover = Unlimited	TFG Health Plus	
Benefit	**Rate and basis of cover: Subject to PMB**	**TFG Health Plus limits**
Primary care, which includes physical and virtual or online consultations at general practitioners (GPs) and specialists (excluding psychiatrists), nurse practitioners and associated health services. **Radiologists and pathologist visits are covered as set out in the 'Rate and basis of cover' table.**	**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 **R32,400** per family per year. The provisions of PMB and cover for PMB conditions are applicable.	Limited to: R5,200 per family per year (M) R7,900 per family per year (M + 1) R10,300 per family per year (M + 2) R12,000 per family per year (M + 3) R13,100 per family per year (M + 4) R13,700 per family per year (M + 5) R14,200 per family per year (M + 6) R14,500 per family per year (M + 7) **PMB conditions:** Additional consultations of up to **four** visits per person per year if registered for chronic conditions (CIB). **Maternity consultations:** Additional **eight** GP or gynaecologist consultations per pregnant person per year. Unscheduled emergency visits limited to **two** 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.

Health Care Cover = Unlimited	TFG Health Plus	
Benefit	**Rate and basis of cover: Subject to PMB**	**TFG Health Plus limits**
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) whose practice is 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: R5,500 per family per year (M)
		R6,700 per family per year (M + 1)
		R7,800 per family per year (M + 2)
		R8,800 per family per year (M + 3)
		R9,700 per family per year (M + 4)
		R10,300 per family per year (M + 5)
		R10,700 per family per year (M + 6)
		R10,800 per family per year (M + 7)

Health Care Cover = Unlimited	TFG Health Plus	
Benefit	**Rate and basis of cover: Subject to PMB**	**TFG Health Plus limits**
Specialised dentistry	Up to a maximum of 100 % of the Scheme Rate. The provisions of PMB and cover for PMB conditions are applicable. Elective maxillo-facial and oral surgery are subject to the maximum annual benefits and funding includes: ▪ Surgical placement and exposure of implants, inclusive of the cost of implant bodies and transmucosal extensions. The subsequent restorative phase will be deemed specialised dentistry and is subjected to the provisions of benefits provided for. ▪ Orthagnathic surgery (surgical repositioning of jaws).	Limited to: R12,200 per family per year (M)
		R16,200 per family per year (M + 1)
		R19,600 per family per year (M + 2)
		R21,500 per family per year (M + 3)
		R22,900 per family per year (M + 4)
		R23,500 per family per year (M + 5)
		R24,100 per family per year (M + 6)
		R24,400 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 R8,800 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. 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 R10,600 per family per year.

Health Care Cover = Unlimited	TFG Health Plus	
Benefit	**Rate and basis of cover: Subject to PMB**	**TFG Health Plus limits**
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). With effect from 1 July 2025, Virtual Physical Therapy (VPT) will be available using digital tools through contracted providers outside of the Scheme's network arrangements.	Limited to R7,800 per family per year.
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 R6,400 per family per year
Prescribed acute medicine and over-the-counter (OTC) medicine	**Acute medicine obtained from a DSP:** Up to a maximum of 100% of the Scheme Medicine Rate. **Acute medicine obtained from a non-DSP:** Up to a maximum of 80% of the Scheme Medicine Rate. **OTC:** Up to a maximum of 80% of the Scheme medicine Rate. Subject to the Scheme's Acute Medicine Formulary and Protocols and preferentially priced generic and brand medicine prices. The provisions of PMB and cover for PMB conditions are applicable. Members to consult the Scheme Rules available on the Scheme's website at **www.tfgmedicalaidscheme.co.za** for conditions of payment of claims.	Acute Medicine limited to: R8,600 per family per year (M) R12,700 per family per year (M + 1) R15,100 per family per year (M + 2) R17,000 per family per year (M + 3) R18,500 per family per year (M + 4) R19,400 per family per year (M + 5) R20,100 per family per year (M + 6) R20,400 per family per year (M + 7) OTC limited to **R250** and further limited to the above Acute Medicine annual limits.

Health Care Cover = Unlimited	TFG Health Plus	
Benefit	**Rate and basis of cover: Subject to PMB**	**TFG Health Plus 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 R32,400 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.
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 and applicable optical procedures are limited and funded from Health Care Cover. **Member's optical cycle start on date of first visit.**	Limited per person per 2-year cycle **Consultation** R980 1 visit **Frames** R1,300 1 visit **Lenses:** Single vision R530 1 pair **OR** **Lenses:** Multifocal R2,450 1 pair **OR** **Lenses:** Bifocal R1,280 1 pair **OR** **Contact lenses** R4,250
Medical appliances (External Medical Items), mobility devices (wheelchairs, long leg callipers and crutches), including hearing aids and external prosthesis *(continue on next page)*	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 item 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 are applicable for PMB conditions.	**Network suppliers:** Unlimited if EMI is supplied by the Scheme's Network Service Provider. **Non-Network supplier:** Limited to R28,900 per family per year if not supplied by the Scheme's Network provider.

Health Care Cover = Unlimited	TFG Health Plus	
Benefit	**Rate and basis of cover: Subject to PMB**	**TFG Health Plus limits**
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 at a DSP. 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. **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 **R32,400** per family per year. The provisions of PMB and cover for PMB conditions are applicable.	**Services:** ▪ Antenatal consultations: **Eight** per pregnancy funded in addition to the primary care consultation limit ▪ Prenatal screening, including chromosome testing or non-invasive Prenatal Testing (NIPT or T21): **One** 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: **One** per child funded from the primary care consultation benefit limit
MRI and CT scans (where authorised)	Where an MRI or CT scan is unrelated to a hospital admission, it will be covered from the radiology and pathology Annual Benefit limit of **R32,400** per family per year.	Where an MRI or CT scan is unrelated to a hospital admission, it will be covered from the radiology and pathology Annual Benefit limit of R32,400 per family per year
Benefit for out-of-hospital management and appropriate supportive treatment of global World Health Organization (WHO) recognised disease outbreaks: Out-of-Hospital healthcare services for COVID-19 and Mpox.	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 PMB requirements and Council for Medical Schemes (CMS) guidelines prevail.

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). A network of providers are contracted for hip, knee and spinal care and cover in the below table is indicative of the amounts payable, while Network and DSP arrangements prevail. 100% of the negotiated rate or cost if the member obtains surgical products from the Scheme's DSP and a co-payment may be applicable. Where network arrangements are applicable, a 20% deductible/co-payment may be applied. 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 where provided by a non-DSP.

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

Total hip replacement	R87,500
Partial hip replacement	R52,300
Spinal surgery prostheses	R44,000 (one level) R88,500 (two or more levels)
Knee replacement	R83,000
Shoulder replacement	R72,150
Bare metal cardiac stents	R18,100 per stent
Drug eluting cardiac stents	R28,850 per stent
Cardiac pacemakers	R106,450
Tissue replacing prostheses	R34,300
Artificial limbs	R52,300
Artificial eyes	R26,150
Cardiac valves	R43,350 per valve
Vascular grafts	R129,750
General overall (Mirena subject to approval)	R34,300

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.

Maternity Benefits

TFG Health Plus provides you with cover related to your pregnancy from your available day-to-day benefits

DURING PREGNANCY

Antenatal consultations

We pay for up to **eight** additional GP or gynaecologist antenatal consultations at a gynaecologist or GP of your choice in addition to the primary care benefit. 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.

Dietician and mental health consultations as available and included in your primary care consultations are easily accessible during and after your pregnancy.

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 of **R32,400** per family per year.

Flu vaccinations

We pay for 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 of **R32,400** per family per year.

PRENATAL AND POSTNATAL CARE

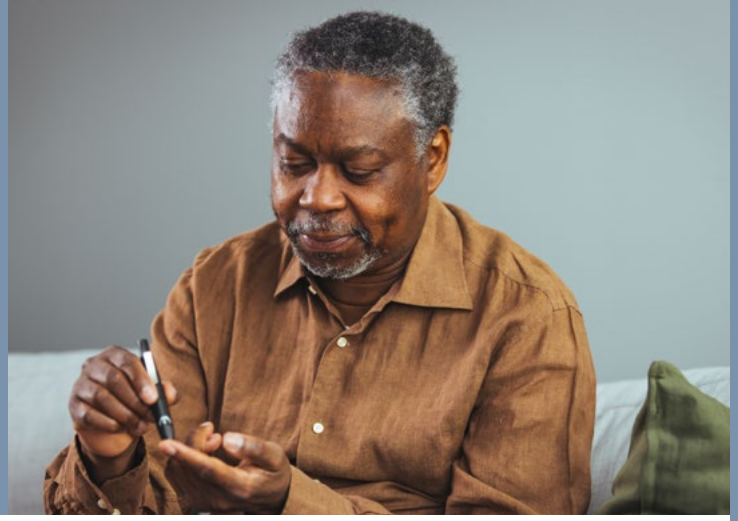
We pay for your antenatal or postnatal classes or consultations with a registered nurse up to 80% of the Scheme Rate from your available consultations benefits, which depends on your family size and the available limits. These consultations include breastfeeding consultations with a registered nurse 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 **two unscheduled emergency visits per child aged 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 are funded up to a maximum of 100% of Scheme Rate.

Chronic Benefits and Care Programmes



You have access to treatment for a list of 27 medical conditions (including HIV) set out in the list of chronic conditions known as the Chronic Disease List (CDL) 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 benefits (PMB) conditions. The PMB related conditions, which are fully covered, are listed below.

A – Addison's disease, Asthma

B – Bipolar mood disorder, Bronchiectasis

C – Cardiac failure, Cardiomyopathy, Chronic obstructive pulmonary disease (COPD), Chronic renal disease, Coronary artery disease, Crohn's disease

D – Diabetes insipidus, Diabetes mellitus type 1, Diabetes mellitus type 2, Dysrhythmia

E – Epilepsy

G – Glaucoma

H – Haemophilia, HIV (managed through the HIV Care programme), Hyperlipidaemia, Hypertension, Hypothyroidism

M – Multiple sclerosis

P – Parkinson's disease

R – Rheumatoid arthritis

S – Schizophrenia, Systemic lupus erythematosus

U – Ulcerative colitis

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

W – Wegener's granulomatosis*

* The above list, as indicated, includes Diagnostic Treatment Pair prescribed minimum benefit (DTPMB) Conditions, which are covered on all benefit plan types where the condition qualifies for PMB. The PMB cover does not extend to medicine management. They are included on the ADL to allow funding for medicines for members on this benefit plan.

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 is subject to a chronic medicine limit of **R35,500** per beneficiary per year and **R97,000** per family per year.*

Members registered on the Chronic Illness Benefit (CIB) also have access to one telemetric device per person per year, which will be funded from your hospital benefit and a second device limited to the medical appliances limit. If approved and subject to the Scheme's protocols and clinical entry criteria, blood glucose monitoring devices are limited to **one** device per beneficiary per year, which is limited to the home monitoring device limit of **R4,700** per person 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@tfgmedicalaidscheme.co.za** to qualify for this medicine funding. We need to be informed of any changes to your treatment so that we can update your chronic authorisation. There is no DSP applicable. Member can obtain medication from any pharmacy or dispensing GP.

MEMBER CARE 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 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 not to 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.**

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

Care Programmes

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

We cover preventative condition-specific care programmes that help you to manage diabetes, mental health, HIV or heart-related medical conditions. You have to be registered on these condition-specific care programmes to unlock **additional preventative benefits and services**. You and your Premier Plus GP can track progress on a personalised dashboard to identify the next steps to optimally manage your condition and stay healthy over time. Cover is subject to the Scheme's clinical entry criteria, treatment guidelines and protocols.

Mental Health Care Programme

Once enrolled on the programme by your network psychologist or Premier Plus GP, you have access to defined cover for the management of major depression. Enrolment on the programme unlocks cover for prescribed medicine, access to 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.

TFGMAS also makes available a digital therapeutic tool, iCBT, that provides increased access to mental healthcare to members and provides additional support to healthcare professionals in managing depression.

To be eligible for access to iCBT, members would need to be:

- Referred by their general practitioner, psychologist, psychiatrist or physician
- Diagnosed with depression or show signs of early symptoms of depression

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

Cardio Care Programme

If you are registered on the Chronic Illness Benefit (CIB) for hypertension, hyperlipidaemia or ischaemic heart disease, you have access to a defined basket of care and an annual cardiovascular assessment if referred by your nominated Premier Plus GP, and enrolled on the Cardio Care Programme. 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 may also have access to a nurse educator to help you with the day-to-day management of your condition. **You have to see your nominated Premier Plus GP to avoid a 20% co-payment.** In addition to the CIB basket of care available to members enrolled on the Diabetes Care Programme, members may choose to embark on a more integrated care programme, which will give you and your Premier Plus doctor access to various tools to monitor and manage your health and to ensure you get high quality coordinated healthcare and the best outcomes. The programme also unlocks cover for valuable healthcare services from healthcare providers like diabetes coaches and podiatrists.

You and your doctor can set goals and earn rewards on your personalised condition management tool. This will help to manage your condition 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.

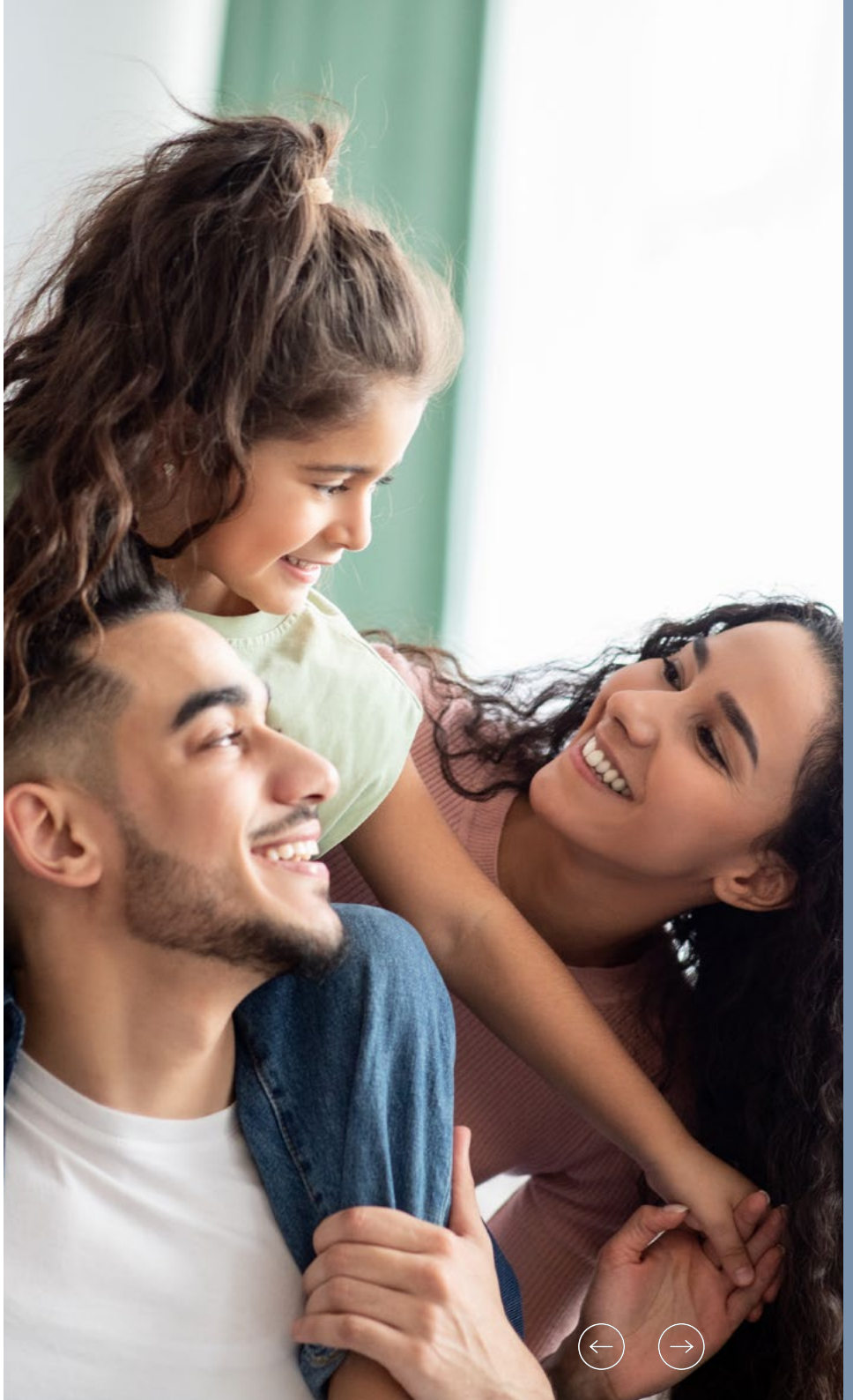
HIVCare Programme

If you are registered on the HIVCare 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.**

CADCare

TFG Health Plus also gives members access to CADCare. CADCare 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.



Cover for
Cancer Treatment

ONCOLOGY/CANCER 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.

With effect from 1 January 2025, members registered on the **TFG Health Plus** benefit plan will have access to a defined list of innovative cancer medicines through the introduction of the Oncology Innovation Benefit (OIB) and medicine costs, if approved, will be paid up to 75% of the Scheme Rate from the first day of treatment (Day 1), limited to the **TFG Health Plus** benefit limits. A co-payment support programme will be made available to assist members in funding the out-of-pocket shortfalls relating to medicines approved as part of this benefit on the **TFG Health Plus** benefit plan.

As part of the OIB, funding of Next Generation Sequencing (NGS), which is a pathology test that identifies cancer genomic drivers, will be paid if authorised. Funding for NGS is paid from the Scheme's hospital benefit and not the oncology benefit.

COLORECTAL CANCER SURGERY

You have full cover for approved colorectal cancer surgeries in our network. Members registered on TFG Health Plus can obtain colorectal cancer surgery at non-network providers. Cover is up to 100% of Scheme Rate and should treatment be obtained at a non-network provider, there may be co-payments payable where providers charge more than the Scheme Rate.

PRESCRIBED MINIMUM BENEFITS (PMB) FOR CANCER

Cancer treatment that is a PMB is covered in full **in our network. If you choose to use any other provider, we will only cover up to 80% of the Scheme Rate.**

ADVANCED ILLNESS BENEFIT (AIB)

Members have access to a comprehensive palliative care programme. This programme offers unlimited cover for approved care at home, care coordination, counselling services and supportive care for appropriate end-of-life clinical and psychologist services. You have access to a GP consultation to facilitate your palliative care treatment plan. In 2025, AIB is enhanced with the introduction of Epilog, which will make available a digital tool for people dealing with advanced illness.

With the introduction of Epilog, members will be provided with early and personalised support based on their needs and life circumstances. Each member successfully enrolled onto the Advanced Illness Management Support Programme (AIMSP) will receive support digitally at a fee paid by TFGMAS per each successful enrollment.

ONCOLOGY PHARMACY DESIGNATED SERVICE PROVIDER (DSP)

Members registered on TFG Health Plus also has access to a well-established DSP of pharmacies and are supported by TFGMAS to manage the cost and access to oncology medicine. The following courier pharmacies (providing oncology specific services) are part of the DSP network offering of TFG Health Plus where members may 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 of pharmacies that are part of the MedXpress Pharmacy Network (including Clicks and Dis-Chem)

Certain dispensing providers, charge the Scheme directly for treatments done in rooms and these practices are exempt from the DSP arrangement. The DSP is also not applicable to in-hospital chemotherapy.

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 enhancement of the DSP ensures a seamless process between the member, your treating provider and the dispensing pharmacy to provide you with the most cost-efficient products, ensuring your oncology benefits go further. For this reason, oncology limits on the TFG Health Plus benefit plan have not been increased since 2023.

A co-payment of 20%, where members obtain oncology related medicine outside of the DSP arrangement, are applicable and members are encouraged to consult with their treating provider to ensure their medicine is prescribed per the benefit rules.

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

HOW WE COVER MEDICINE

You need to get your approved oncology medicine from a designated service provider (DSP) to avoid a 20% co-payment. Speak to your treating doctor to confirm that they are using our DSPs for your medicine and treatment received in rooms or at a treatment facility.

From 1 July 2025, TFGMAS will be introducing drug management and medicines will be approved in line with the TFGMAS approved Reference Price Lists (RPL) and formularies. The RPL will be set at a price of the generic equivalent or clone of a drug. This managed healthcare intervention aims to manage increasing cost trends relating to oncology spend, while providing access to cover in line with industry trends.

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 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 to hospital.

WHAT WE COVER

Unlimited cover in private hospitals approved by the Scheme for planned stays in hospital.

HOW TO GET THE BENEFIT

Get your preauthorisation confirmation first

Contact us on **0860 123 077** to confirm your hospital stay before you are admitted (this is known as preauthorisation).

Where to go

You have cover for **planned** admissions in **any** private hospital approved for funding by the Scheme. Please refer to 'Emergency Cover' to understand your cover in case of an emergency and hospital cover as part of the PMB Hospital Network.

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 allied healthcare workers that we have an agreement with, we will pay for these services in full.** We pay up to 100% of cost for non-DSP if the admitting specialist or doctor is contracted with the Scheme and you are admitted to a network hospital for PMB related treatments. If you choose to voluntarily obtain treatment outside of the PMB Hospital Network and choose to go to healthcare professionals that the Scheme does not have an agreement with, there may be co-payments and upfront deductibles applicable. Be sure to reach out to us on **0860 123 077** to understand how we pay your hospital accounts in these instances.

YOU CAN AVOID DEDUCTIBLES AND CO-PAYMENTS BY:

Going to:

- A hospital that the Scheme has entered into an agreement with
- Healthcare professionals that we have a payment arrangement with

View hospitals that the Scheme has entered into an agreement with by using 'Find a healthcare provider'** in the Discovery app*.

INTRODUCTION OF DA VINCI ROBOTIC-ASSISTED SURGICAL COVER

From 1 January 2025, members registered on the **TFG Health Plus** benefit plan will be able to choose between the conventional laparoscopic surgery for prostatectomies or for the surgery to be done with the assistance of the da Vinci Robotic device.

The da Vinci Robotic-Assisted Prostatectomy procedures will be covered at Scheme Rates at hospitals contracted at preferred and negotiated rates.

Members who obtain surgery outside of the TFGMAS preferred provider arrangements may incur a co-payment should the chosen service provider or hospital charge fees over and above the negotiated rates.

Members must obtain pre-approval and your healthcare service provider will help you submit an application to Discovery Health, the Scheme's contracted administrator. Cover is limited to one procedure per person and funded from your available hospital benefits.

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

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**	**TFG Health Plus limits**
Statutory prescribed minimum benefits	Basis of cover is per legislative requirements in terms of prescribed minimum benefits (PMB). All treatment for PMB conditions accumulates to available limits. Once benefit limits are reached, funding for 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 medicine for duration of hospitalisation at a provincial 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 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 prenatal and postnatal care outside of hospital. Blood transfusions paid up to 100% of the cost, ie, 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

Health Care Cover = Unlimited hospital cover	TFG Health Plus	
Benefit	**Rate and basis of cover: Subject to PMB**	**TFG Health Plus 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 or co-payments.	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 Medicine Rate. Subject to preauthorisation and approval and the treatment meeting the Scheme's clinical criteria.	Unlimited A **R7,000** 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% co-payment 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 Medicine Rate. Subject to preauthorisation and 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

Health Care Cover = Unlimited hospital cover	TFG Health Plus	
Benefit	**Rate and basis of cover: Subject to PMB**	**TFG Health Plus limits**
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 **R4,700** per person per year
Pre-operative assessment for the following list of major surgeries: Athroplasty, colorectal surgery, coronary artery bypass graft, radical prostectomy and mastectomy.	Up to a maximum of 100% of the Scheme Rate paid from Health Care Cover. Subject to authorisation and 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 *(continue on next page)*	**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.	Limited to **R450** per day and **90 days** with an overall annual limit of **R40,500** per person per year

Health Care Cover = Unlimited hospital cover	TFG Health Plus	
Benefit	**Rate and basis of cover: Subject to PMB**	**TFG Health Plus limits**
Nursing services, Step down and Hospice *(continued)*	**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 at 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.	Limited to **R450** per day and **180 days** with an overall annual limit of **R81,000** per person per year
	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 the Council for Medical Schemes. **Note:** Where members' advanced illness benefits (AIB) are depleted, subject to PMB, once these benefit limits are reached, the provisions of PMB are applied.	Unlimited
General practioners, specialists and allied healthcare workers delivering treatment in hospital and approved healthcare service providers providing services 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 to a KeyCare Network Hospital. The conditions of PMB cover are 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

Health Care Cover = Unlimited hospital cover	TFG Health Plus	
Benefit	**Rate and basis of cover: Subject to PMB**	**TFG Health Plus limits**
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 approval and the treatment meeting the Scheme's treatment guidelines and clinical criteria. Drugs paid at 100% of the Scheme Medicine 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 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 for immuno-suppressant and other medicine will be at cost whilst the member is in hospital. Subsequent supplies of immune-suppressant medicine will be covered from the member's Chronic Illness Benefit (CIB).	Unlimited
Chemotherapy, Radiotherapy and Oncological treatment, including consultations and other related healthcare services, as well as chronic medicine for supportive oncology management and care.	Up to a maximum of 100% of the Scheme Rate or generic reference price, whichever is applicable, at the Scheme's designated service providers (DSP) before the benefit limit is reached and of 80% of the Scheme Rate or generic reference price, whichever is applicable, after the benefit limit is reached with no overall limit. The provisions of PMB are applicable. Where radiotherapy and chemotherapy are unrelated to the admission and do 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 approval and the treatment meeting the Scheme's clinical entry criteria.	Limited to **R650,000** per person per rolling **12** months

Health Care Cover = Unlimited hospital cover	TFG Health Plus	
Benefit	**Rate and basis of cover: Subject to PMB**	**TFG Health Plus limits**
Severe dental/maxillo-facial and oral and 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 **R24,500** per family per year for elective maxillo-facial and oral surgery.
Management of mental health disorders	Subject to the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols, 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
Consultation for mental wellbeing	Up to a maximum of 100% of the Scheme Rate at a network psychologist, psychiatrist, physician or Premier Plus GP, following completion of the mental wellbeing assessment. Subject to meeting the Scheme's clinical entry criteria, treatment guidelines and protocols.	One psychotherapy session per person per year paid from existing baskets of care as set by the Scheme. Baskets of care include access to digital therapeutic tools.

Health Care Cover = Unlimited hospital cover	TFG Health Plus	
Benefit	**Rate and basis of cover: Subject to PMB**	**TFG Health Plus limits**
Virtual urgent care consultation (VUC)	With effect from 1 July 2025, in addition to the PMB cover, virtual urgent care consultations are paid up to a maximum of 100% of the Scheme Rate paid from Health Care Cover. Subject to the Scheme's preferred provider (where applicable) and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols. Consultations in excess of the annual limit or those not meeting the Scheme's clinical entry criteria are paid in accordance with primary care benefits or by the member where no benefits are available. In-room consultations are paid for from the Casualty Benefit.	4 consultations per family per year
Drug and alcohol rehabilitation	Cover is provided as per PMB legislative requirements.	**21** days in-hospital treatment per person per year.
In-hospital 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. Baskets 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 does not accumulate to the annual limit and is paid from the hospital benefit. The provisions of PMB are 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 applicable.

Health Care Cover = Unlimited hospital cover	TFG Health Plus	
Benefit	**Rate and basis of cover: Subject to PMB**	**TFG Health Plus limits**
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 or 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 surgery 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 Medicine 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 **R5,800** 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

HOSPITAL@HOME DESIGNATED SERVICE PROVIDER INTRODUCTION

Members registered on the TFG Health Plus benefit plan have access access to the Hospital@Home designated service provider (DSP) for the following conditions:

- Chronic obstructive pulmonary disease (COPD)
- Pneumonia
- Urinary tract infections (UTIs)
- Heart Failure
- Deep Vein Thrombosis
- Cellulitis
- Asthma
- Diabetes

The geographical areas where Hospital@Home is available as a DSP are:

- Durban, KwaZulu-Natal
- Cape Town, Western Cape
- Johannesburg, Gauteng

A standardised operational process introduced for members who are considered eligible for Hospital@Home treatment is to be discussed with your treating doctor. Treatment is aimed to take place at the correct setting providing the correct level of care to members.

Members can obtain more information by reaching out to us on **0860 123 077**.

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 (preauthorisation).

HOW WE PAY

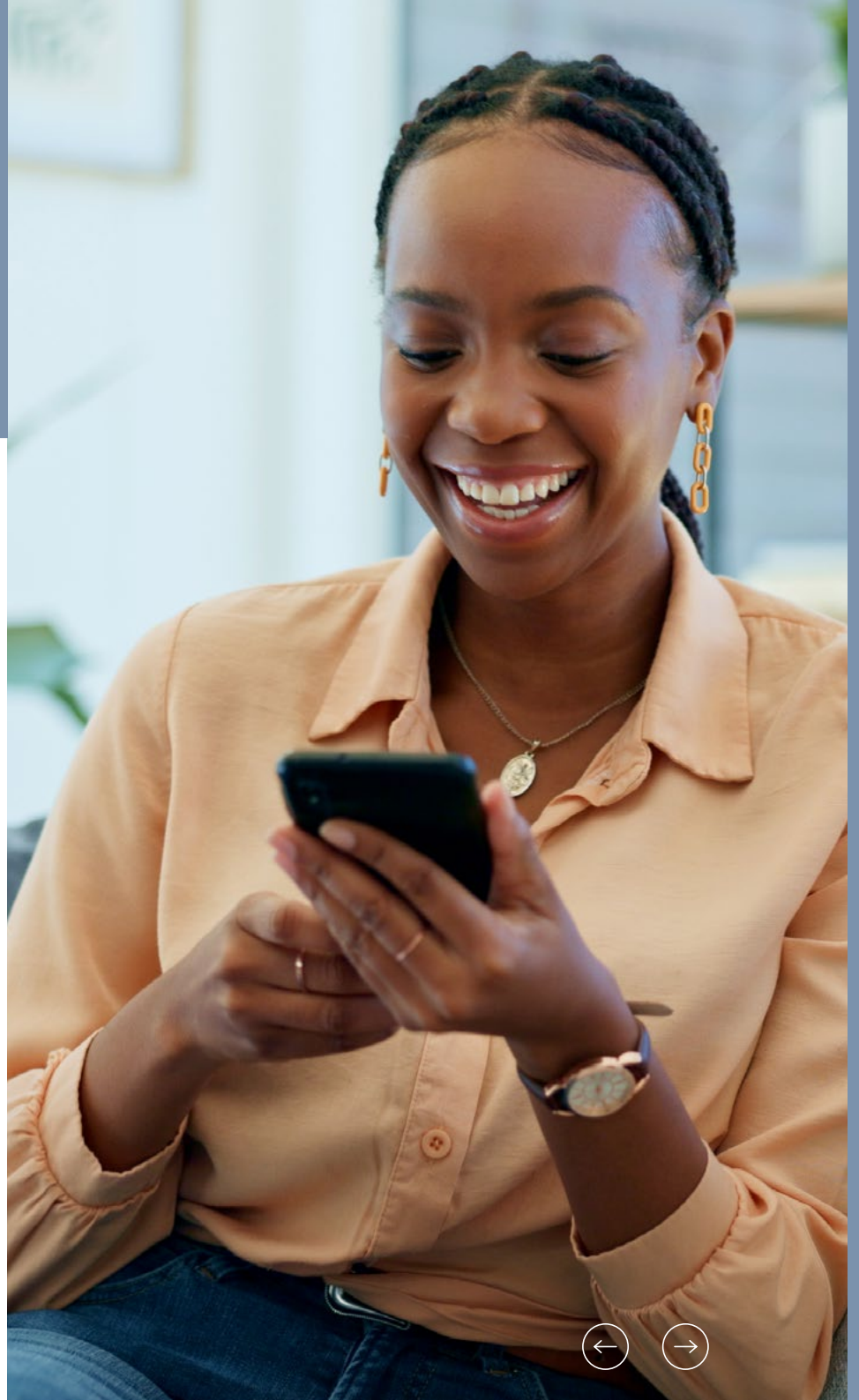
We pay these services from your hospital benefit. We pay for services related to your hospital stay including all healthcare professionals, services and medicine authorised by the Scheme. If you use doctors, specialists and other healthcare professionals that we have a payment arrangement with, we will 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 **R7,000** upfront.

***View all Day Surgery Network facilities in the Discovery app*.**

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



LIST OF PROCEDURES COVERED IN THE DAY SURGERY NETWORK

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

B – Biopsies

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

Breast procedures (approved)

- Mastectomy for gynaecomastia
- Lumpectomy* (fibroadenoma)

E – Ear, nose and throat procedures

- Tonsillectomy and adenoidectomy
- Repair nasal turbinates, nasal septum
- Simple procedures for nosebleeds (extensive cautery)
- Sinus lavage
- Scopes (nasal endoscopy, laryngoscopy)
- Middle ear procedures (tympanoplasty, mastoidectomy, myringoplasty, myringotomy and 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 and repair of tear ducts, vitrectomy, retinal surgery, eyelid surgery, strabismus repair)

G – Ganglionectomy

Gastrointestinal procedures

- Gastrointestinal scopes (oesophagoscopy, gastroscopy, colonoscopy, sigmoidoscopy, proctoscopy, anoscopy)
- Anorectal procedures (treatment of haemorrhoids, fissure, fistula)

Gynaecological procedures

- Diagnostic Dilatation and Curettage
- Diagnostic laparoscopy
- Simple vulval and introitus procedures: Simple hymenotomy, partial hymenectomy, simple vulvectomy, excision bartholin's gland cyst
- Vaginal, cervix and oviduct procedures: Excision vaginal septum, cyst or tumour, tubal ligation or occlusion, uterine cervix cerclage, removal cerclage suture
- Suction curettage
- Uterine evacuation and curettage
- Endometrial ablation
- Diagnostic Hysteroscopy
- Colposcopy with LLETZ
- Examination under anaesthesia

N – Nerve procedures

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

O – Orthopaedic procedures

- Arthroscopy, arthrotomy (shoulder, elbow, knee, ankle, hand, wrist, foot, temporomandibular joint), arthrodesis (hand, wrist, foot)
- Minor joint arthroplasty (intercarpal, carpometacarpal and metacarpophalangeal, interphalangeal joint arthroplasty)
- Tendon and ligament repair, muscle debridement, fascia procedures (tenotomy, tenodesis, tenolysis, repair/reconstruction, capsulotomy, capsulectomy, synovectomy, excision tendon sheath lesion, fasciotomy, fasciectomy). Subject to individual case review
- Repair bunion or toe deformity
- Treatment of simple closed fractures and/or dislocations, removal of pins and plates. Subject to individual case review

R – Removal of foreign body

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

S – Simple superficial lymphadenectomy

Skin procedures

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

Simple hernia procedures

- Umbilical hernia repair
- Inguinal hernia repair

U – Urological procedures

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

Uncomplicated hernia procedures

- Umbilical hernia repair
- Inguinal hernia repair

Extra Benefits

You get the following extra benefits to enhance your cover.

SPINAL CARE PROGRAMME

The Spinal Care Programme 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.

You will 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 benefit plan. We pay up to **R290,000** per person per year. A co-payment 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% of the cost of the second opinion service.

WHO GLOBAL OUTBREAK BENEFIT

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

IN-ROOM PROCEDURES

You have cover for a defined list of procedures performed in specialist rooms. Cover is up to an agreed rate, where authorised by the Scheme, from your hospital benefit.

ADVANCED ILLNESS BENEFIT

Members have access to a comprehensive palliative care programme. This programme offers unlimited cover for approved care at home, care coordination, counselling services and supportive care for appropriate end-of-life clinical and psychologist services. You also have access to a GP consultation to facilitate your palliative care treatment plan.

In 2025, AIB is enhanced with the introduction of Epilog, which will make available a digital tool for people dealing with advanced illness.

With the introduction of Epilog, members will be provided with early and personalised support based on their needs and life circumstances. Each member successfully enrolled onto the Advanced Illness Management Support Programme (AIMSP) will receive support digitally at a fee paid by TFGMAS per each successful enrollment.

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
- Coronary artery bypass graft (CABG) 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 becomes available, which is 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 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.

JOINT ARTHROPLASTY 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 that 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 several days, automatically measures blood glucose levels every 5 – 15 minutes.

The continuous glucose monitoring sensors are funded from Scheme benefits. 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 more than 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 pay 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. If you qualify, you will have access to a readmission prevention programme for clinically appropriate conditions. This programme gives you access to approved follow-up care and a health coaching session within 30 days after you are discharged from hospital.

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

Your contributions from 1 January 2025

FULL CONTRIBUTIONS WITH EFFECT FROM 1 JANUARY 2025

These contributions (shown in Table 1) are the total amounts due to the Scheme. For active employees, the members' portion of the contributions is dependent on whether the member is on a Total Guaranteed Package (TGP) or Salary Plus structure, as indicated in the tables below.

Income verification may be conducted to determine whether you are registered in the correct income band. Income is considered as:

- Pensionable Pay in the case of an employee.
- In the case of an employee who registers a spouse, it is the higher of the member's Pensionable Pay or spouse's salary or earnings.
- For all other members, it is and may include:

- 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 provident fund, and receipt of any financial assistance received from any statutory social assistance programme.

Table 1: Active employees on a TGP structure

TFG Health Plus monthly income	Monthly contribution		
	Principal Member	Adult Dependant*	Child Dependant**
R0 – R6,870	R4,772	R3,054	R1,288
R6,871+	R5,436	R3,968	R1,494

SUBSIDISED CONTRIBUTIONS WITH EFFECT FROM 1 JANUARY 2025

These contributions (shown in Table 2) are the members' own contributions after the TFG 50% subsidy is taken into account and applies to active employees on a Salary Plus structure. If you are not entitled to a subsidy, you will need to pay the full contribution as shown in Table 1.

Table 2: Active employees on a Salary Plus structure

TFG Health Plus monthly income	Monthly contribution		
	Principal Member	Adult Dependant*	Child Dependant**
R0 – R6,870	R2,386	R1,527	R644
R6,871+	R2,718	R1,984	R747

** 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.

* Adult dependants are only subsidised if they are the main member's spouse or if their adult child is a person with a disability.

TFG Health Plus Exclusions

HEALTHCARE SERVICES THAT ARE NOT COVERED ON YOUR BENEFIT PLAN

TFG Medical Aid Scheme has certain exclusions. We do not pay for healthcare services related to the following, except where stipulated as part of a defined benefit or under the prescribed minimum benefits (PMB).

Medical conditions during a waiting period

If we apply waiting periods because you have never belonged to a medical scheme or you have had a break in membership of more than 90 days before joining TFG Medical Aid Scheme, you will not have access to the prescribed minimum benefits (PMB) during your waiting period. This includes cover for emergency admissions. If you had a break in cover of less than 90 days before joining TFGMAS, you may have access to PMB during waiting periods.

THE GENERAL EXCLUSION LIST INCLUDES:

A – Appliances not part of benefit plan:

Purchase or hire of medical or surgical appliances, such as special beds, chairs, cushions, commodes, sheepskins, waterproof sheets, bedpans, special toilet seats, adjustment or repair of sick rooms

Anti-smoking preparations

Aphrodisiacs

Anabolic steroids

Accommodation in old age homes

Accommodation and treatment in spas and resorts

Appointments not kept

Antenatal and postnatal exercise classes as well as lactation consultations

Accommodation and treatment in headache and stress-relief clinics

Ambulance transportation and air lifting outside of South Africa (including PMB)

International Emergency evacuation is not covered

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

C – Circumcision – no benefits, unless deemed medically necessary

Convalescing equipment (except for hire of oxygen cylinders) – unless deemed clinically appropriate

Contact lens solution, kits and consultation for fitting and adjustments

Costs associated with vocational, child and marriage guidance, school therapy or attendance at remedial education facilities

E – Erectile dysfunction treatment

Examinations for insurance, school camps and visas

G – Growth hormones

H – Household remedies

Holidays for recuperation

I – Infertility treatment – unless received from a designated service provider (DSP) facility or as a PMB

M – Mouth protectors and gold dentures

Medicine not prescribed and per the approved medicine lists

O – Obesity – examinations, consultations and treatment relating to obesity or any treatment 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

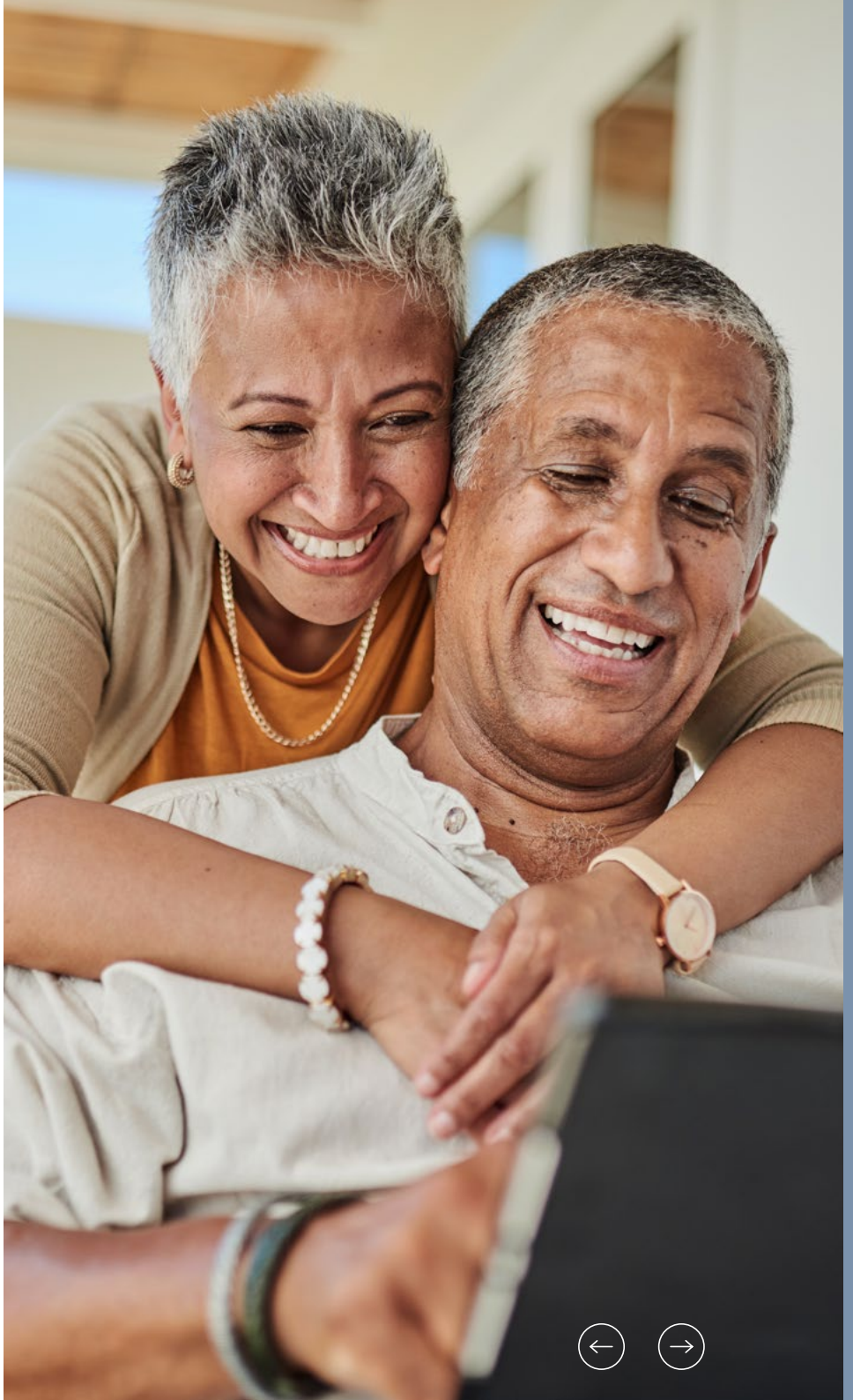
Travelling costs

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.



Discretionary Benefits

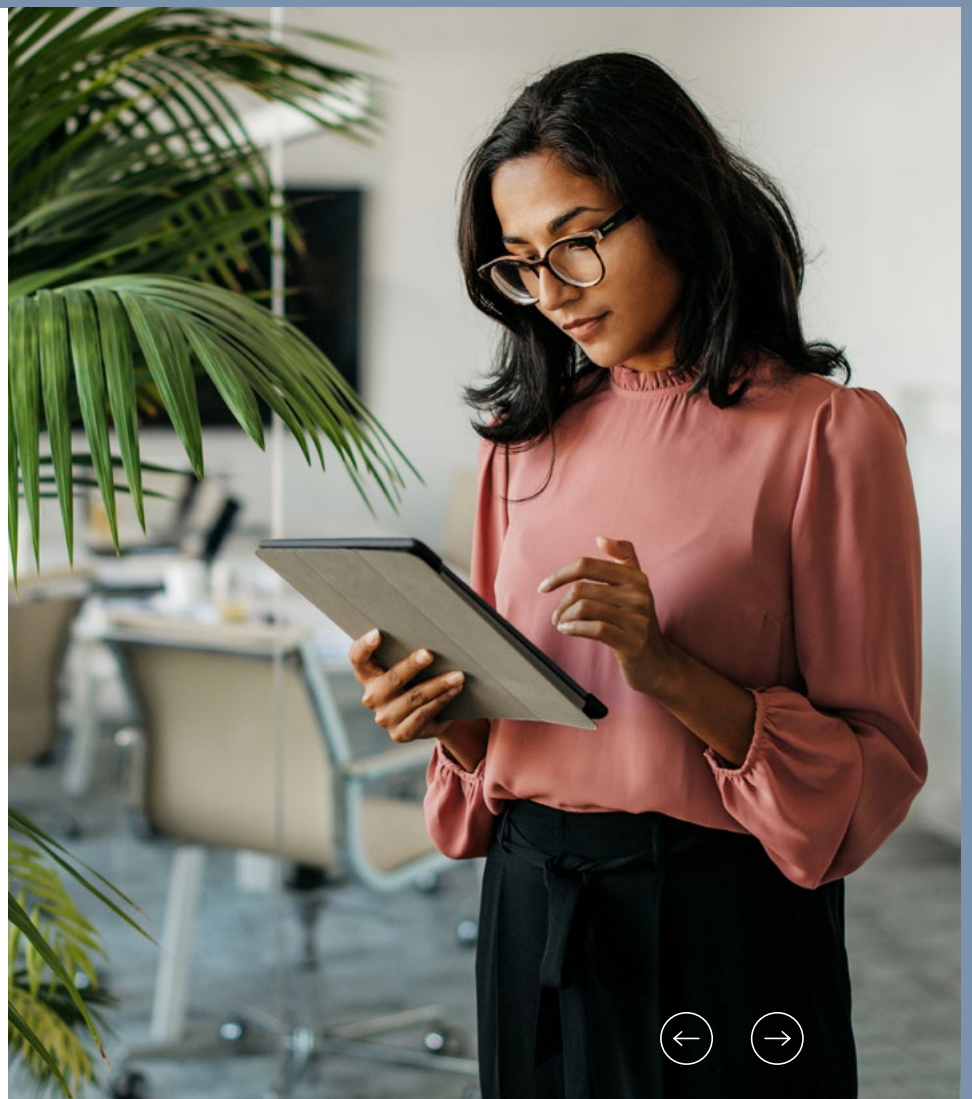
Discretionary benefits are made available to members through an Ex Gratia Policy as approved by the Board of Trustees of the Scheme.

Ex gratia is defined by the Council for Medical Schemes (CMS) as 'a discretionary benefit which a medical aid scheme may consider funding 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 apply for a discretionary benefit or grant, you can contact the Scheme's Administrator on **0860 123 077** to be provided with the necessary forms and information regarding the process to follow.



Complaints and Disputes

The Medical Schemes Act 131 of 1998 (the Act) states that members who are aggrieved with the conduct of a medical scheme or want to dispute a decision taken by their medical scheme have the right to contact the Council for Medical Schemes (CMS) for a dispute resolution. The Act also sets out the complaints procedure that must be followed.

Members must first try to resolve the matter with their Medical Scheme and only contact CMS if they are still in disagreement with the medical scheme. The Scheme's Dispute Resolution Process requires that you follow these steps:

STEP 1:

Contact the Administrator, Discovery Health, through the contact centre on **0860 123 077** or email us at **service@tfgmedicalaidscheme.co.za** and lodge the complaint or dispute.

STEP 2:

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

STEP 3:

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

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

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

Medical Aid Scheme

Administered by Discovery Health

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