MEDICAL AID SCHEME

TFG Medical Aid Scheme 2023 Annexures

TFG MEDICAL AID SCHEME

ANNEXURE A: RATES OF CONTRIBUTION AND APPLICATION OF PENALTIES

1. MONTHLY CONTRIBUTION RATES EFFECTIVE 1 MAY 2023

TFG HEALTH - SCHEDULE 1 - MEMBERS AND PENSIONERS

GROUP	A	B	C	D	E	F
SALARY PER MONTH	**R0 – R6 540**	**R6 541 – R10 660**	**R10 661 – R20 490**	**R20 491 – R35 110**	**R35 111 – R52 300**	**R52 301+**
Principal	R1 406	R1 586	R1 698	R1 846	R2 152	R2 342
Adult (**)	R1 406	R1 586	R1 698	R1 846	R2 152	R2 342
Child (*)	R 496	R 502	R 538	R 592	R 674	R716

TFG HEALTH PLUS - SCHEDULE 2 - MEMBERS AND PENSIONERS

GROUP	A	B					
SALARY PER MONTH	**R0 – R6 540**	**R6 541 +**					
Principal	R4 080	R4 682					
Adult (**)	R2 526	R3 306					
Child (*)	R1 052	R1 170					

(*) Child contributions are applicable where:

- A dependant is under the age of 21;
- A dependant is over the age of 21, but not over the age of 25 and a registered student at a University or recognised college for higher education and is not self supporting;
- A dependant is over the age of 21, but not over the age of 25 and is dependent upon the principal member due to mental or physical disability.

(**) Adult contributions are applicable where:

- A principal member's dependant is over the age of 21 and does not qualify for child contribution rates as set out above.

REGISTERED BY ME ON

2023/05/26

REGISTRAR OF MEDICAL SCHEMES

2. CONTRIBUTION PENALTIES FOR PERSONS JOINING LATE IN LIFE.

The Board may in addition to the contributions in (1) above with effect from 1 January 2003, impose contribution penalties up to the ratio shown hereunder, in respect of a late joiner. See definition of "late joiner" below.

Penalty Bands	**Maximum Penalty**
1 – 4 years	0.05 x contribution
5 – 14 years	0.25 x contribution
15 – 24 years	0.5 x contribution
25 + years	0.75 x contribution

Any years of creditable coverage which can be demonstrated by the applicant or his or her dependant shall be subtracted from his or her current age in determining the applicable penalty.

"Creditable coverage" means any period in which a late joiner was -

- A member or a dependant of a medical scheme;
- A member or a dependant of an entity doing the business of a medical scheme which, at the time of his or her membership of such entity, was exempt from the provisions of the Act;
- A uniformed employee of the South African National Defence Force; or
- A member or a dependant of the Permanent Force Continuation Fund;

But excluding any period of coverage as a dependant under the age of 21 years

"Late joiner", means an applicant or the adult dependant of an applicant who, at the date of application for membership or admission as a dependant, as the case may be, is 35 years of age or older, but excludes any beneficiary who enjoyed coverage with one or more medical scheme/s as from a date preceding 1 April 2001, without a break in coverage exceeding three consecutive months since 1 April 2001.

REGISTERED BY ME ON

2023/05/26

REGISTRAR OF MEDICAL SCHEMES

CS

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

TFG HEALTH BENEFIT PLAN – RULE 33 2023

PREAMBLE

a. Subject to the provisions contained in these Rules, Members and their registered Dependants shall be entitled to the benefits as set out below, which may include Prescribed Minimum Benefits ("PMB"). Where the benefits as set out below do not provide for a specific PMB or only provides limited benefits in respect of PMB, a Beneficiary is entitled to obtain benefits as described and set out in Annexure **B**.

b. No Member shall be entitled to assign, transfer, pledge, hypothecate or cede his benefits or his rights to benefit in or from the Scheme.

c. Maximum annual benefits shall be calculated from 1 January to 31 December of the same year, based on the services rendered during the Annual Financial Year and shall be subject to pro rata apportionment calculated from the Admission Date to the end of that Annual Financial Year, excluding Optometry and Oncology or where a chosen Benefit Plan specifies otherwise. Benefits are not transferable from one financial year to another or from one category to another.

d. Prolonged treatment may be subject to review and case management and limits as imposed by or on behalf of the Board. Benefits shall be further limited as indicated in these Rules and Pre-authorisation shall be required 48 hours before hospitalisation, to qualify for benefits, provided that in the case of an emergency the Scheme shall be notified thereof within 24 hours after such an emergency admission or treatment having been initiated.

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

M Wilson pb

CH

e. **Emergency treatment rendered outside the rand monetary area**

Members submitting claims for emergency treatment obtained outside the rand monetary area must provide proof of travel and ensure that the claims reflect the amount(s) in the equivalent South African currency and the rate of exchange used for conversion and shall bear a detailed description, in English, of each service rendered. Benefits on such claims shall be calculated as if the services had been rendered in the Republic of South Africa, and paid at Scheme Rate and not at Cost. Healthcare costs associated with a PMB will be paid at Scheme Rate and limited to the benefit limits set out in these Rules, if a member incurred these costs outside the borders of South Africa.

f. In respect of benefits set out in these Rules the following principles will apply in all cases where Pre-authorisation is required:

(i) If the Scheme's contracted Managed Healthcare Organisation grants a Pre-authorisation, it is deemed to have been authorised as set out in Rule 4.68 of the main body of the rules.

(ii) Payment of benefits for a procedure or Treatment in respect of which a Pre-authorisation was granted, will always be subject to:

- Rules of the Scheme in particular any maximum, exclusions and waiting periods
- Proviso that the Beneficiary qualifies for Benefits

(iii) If Pre-authorisation is obtained and the Treatment does not exceed the Approval, the Treatment will qualify for the benefits as stated;

(iv) If Pre-authorisation is obtained and the Approval is exceeded, benefits will only accrue for the authorised Treatment. The Cost pertaining to the Treatment in excess of that Pre-authorisation will be payable by the Member.

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

M Wilson pb CH

(v) If a procedure or Treatment is undergone after Pre-authorisation has been refused, no benefits are payable for hospitalisation and all services associated with the procedure or Treatment will be payable by the Member.

g. All claims must be submitted in accordance with Rule 15.

Health Care Cover provided as set out in Rule 33.1 below is provided under the following conditions and limitations:

The calculation of the amount payable by the Scheme in respect of the hospital benefits may be based on:

- The Billing Guidelines applicable to the Service Provider concerned and/or
- Depending on the contracted arrangements entered into by the Scheme with the Service Providers and/or
- The Cost of the Relevant health services (or a percentage of such Cost;) and/or
- The applicable Scheme Rate in respect of the Relevant health services (or a percentage of such Scheme Rate); and/or
- A fixed amount per Relevant health service rendered as shown in the Table below; and/or
- A global fee; and/or
- A per diem payment.

The Scheme's liability in respect of hospital benefits shall be limited in each financial year to the amount, expressed in days, rands or frequency, applicable in terms of the relevant section of the below Table, except where Prescribed Minimum Benefits (PMB) apply. The basis of cover in respect of PMB is set out in Annexure **B4**.

The Scheme shall pay the claims in respect of the hospital benefits in accordance with Rule 16 of the main body of the Rules.

TFG Health members are serviced by KeyCare network providers only. These networks are as follows:

- KeyCare Network Hospitals (PMB Network Hospital) and Casualty units
- KeyCare Network GP
- KeyCare Health DPA Specialist
- Premier Plus GP
- Independent Clinical Oncology Network (ICON)

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

pb

M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

	- A defined list of pharmacies the Scheme has contracted with known as DSP - Dental Network (Dental Risk Company/DRC) - KeyCare Network optometrists (IsoLeso) - A defined list of Radiologists, Radiographers, Psychologists and Social Workers with whom the Scheme has entered into a Preferred Provider agreement with - An out-of-hospital Mobility Network and Renal Network the Scheme has entered into a Preferred Provider agreement with - Day-surgery Network - A defined list of oncology pharmacies to obtain medicine related to oncology treatment The above Networks are defined in the main body of the rules and the voluntarily use of services outside of the TFG Health Benefit Plan's contracted network providers and facilities, will attract Deductibles. The basis of cover for PMB conditions and circumstances within which the Scheme will make Payment in Full is set out in Annexure **B4** of these rules.		
	RULE 33.1 – HOSPITAL BENEFITS		
	Health Care Cover - Unlimited		
Sub-rule	**Health Care Services Covered**	**Basis of Cover: Subject to Prescribed Minimum Benefits**	**Annual Limits**
33.1.1	Statutory Prescribed Minimum Benefits	Basis of cover as set out in this document and in Annexure B4 is applicable. All Prescribed Minimum Benefits (PMB) to accumulate to available limits. Once benefit limits are reached funding in respect of PMB will continue to fund in accordance with the basis of cover as set out in this document and in Annexure **B4**.	Unlimited

pb
M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
33.1.2	Hospitalisation in Full Cover KeyCare Network Hospital	Up to a maximum of 100% of the Scheme Rate of the hospital account. Subject to authorisation and/or approval meeting the Scheme's clinical and Managed Health Care criteria.	Unlimited
33.1.3	Hospitalisation in Partial Cover KeyCare Network Hospital	Up to a maximum of 70% of the Scheme Rate of the hospital account. Subject to authorisation and/or approval and meeting the Scheme's clinical and Managed Health Care criteria.	Unlimited
33.1.4	Hospitalisation in Non-Network Hospital. Emergency Admissions	Up to a maximum of 100% of the Scheme Rate. Subject to authorisation. Patient to be transferred to a KeyCare Network Hospital as soon as stabilised, unless otherwise agreed by the Scheme. Subject to PMB.	Unlimited
33.1.5	Health care services reflected in Annexure **B3** in a defined list of network facilities	Up to a maximum of 100% of the Scheme Rate at the Scheme's defined list of day-surgery providers. Up to a maximum of 100% of the Scheme Rate for related accounts. Medicines paid at 100% of the Scheme Medication Rate. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical criteria.	Unlimited
33.1.6	Hospitalisation in Non-Network Hospital. Non-emergency admissions	No cover.	No cover

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

pb

M Wilson

CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
33.1.7	Administration of defined intravenous infusions	Up to a maximum of 100% of the Scheme Rate at the Scheme's KeyCare Direct Payment Arrangement practitioner. A 20% Deductible shall be payable by the beneficiary in respect of the hospital account when treatment is received at a provider who is not a KeyCare Direct Payment Arrangement practitioner. Medicines paid at 100% of the Scheme Medication Rate. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical criteria.	Unlimited
33.1.8	Hospitalisation for selected members suffering from one or more significant chronic conditions. Non-emergency admissions	Up to a maximum of 100% of the Scheme Rate. Subject to registration on the Scheme's disease management programme. Up to a maximum of 100% of the Scheme Rate and subject to authorisation and/or approval and the Scheme's disease management programme clinical entry criteria. Up to a maximum of 80% of the Scheme Rate of the hospital and related accounts for members who are not registered on the programme.	Unlimited REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES
33.1.9	Home-based healthcare for clinically appropriate chronic and acute treatment and conditions that can be treated at home	In addition to cover contained in Annexure **B4**, up to a maximum of 100% of the Scheme Rate. Subject to authorisation and/or approval, the Scheme's preferred provider (where applicable) and the treatment meeting the Scheme's treatment guidelines and clinical and benefit entry criteria.	Basket of Care as set by the Scheme

pb

M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
33.1.9.1	Home-monitoring devices for clinically appropriate chronic and acute conditions	Up to a maximum of 100% of the Scheme Rate paid from Health Care Cover. The device must be approved by the Scheme, subject to the Scheme's protocols and clinical and benefit criteria.	Up to R4 250 per person per year
33.1.10	Pre-operative assessment for the following list of major surgeries: Arthroplasty, colorectal surgery, coronary artery bypass graft, radical prostatectomy and mastectomy	Up to a maximum of 100% of the Scheme Rate paid from Health Care Cover. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols.	Basket of care as determined by the Scheme
33.1.11	Specialists and in-room procedures	KeyCare Health DPA Specialists: Up to a maximum of 100% of the KeyCare Direct Payment Arrangement rate. Other specialists who work within the KeyCare Network Hospitals: Up to a maximum of 100% of the Scheme Rate. Member must be referred by KeyCare Network GP.	Unlimited In-room procedures limited to a defined list of procedures as determined by the Scheme
33.1.12	Other providers	Up to a maximum of 100% of the Scheme Rate.	Unlimited
33.1.13	Radiology and Pathology	Up to a maximum of 100% of the Scheme Rate. Pathology is subject to a Preferred Provider agreement. Where members use a non-preferred provider payment will be made directly to the member. Point of care pathology testing is subject to meeting the Scheme's treatment guidelines and Managed Health Care criteria.	Unlimited

pb
M Wilson
CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
33.1.14	Chronic dialysis	Up to a maximum of 100% of the Scheme Rate at the Scheme's KeyCare Direct Payment Arrangement practitioner only. Subject to authorisation and/or approval and the treatment meeting the Scheme's treatment guidelines and clinical criteria. Drugs paid at 100% of the Scheme Medication Rate.	Unlimited
33.1.15	Organ Transplant	Cover only in contracted facilities according to the PMB, subject to Regulation 8 (3).	Unlimited
33.1.16	Chemotherapy, Radiotherapy and Oncological treatment	To be read in conjunction with Annexure **B2**. Up to a maximum of 100% of the Scheme Rate at the Scheme's KeyCare Direct Payment Arrangement practitioner. Up to a maximum of 80% of the Scheme Rate at non-KeyCare Direct Payment Arrangement practitioners. Provisions of PMB apply as set out in Annexure **B4** is applicable. Medication to be scripted and dispensed in accordance with the oncology preferred product list. Where a non-preferred product is used, funding will be approved up to a maximum of 80% of Scheme Rate, the balance will be for the members own pocket. Medication must be dispensed through a designated service provider. Where a non-network provider is used, funding will be approved up to a maximum of 80% of the Scheme Rate and the balance will be for the member's own pocket. Annexure **B4** is applicable. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria.	Unlimited, save as provided for elsewhere in these Rules

pb

M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
33.1.17	Mental health disorders	Up to a maximum of 100% of the Scheme Rate for related accounts. Up to a maximum of 100% of the Scheme Rate for hospital account in a KeyCare Network Hospital. Up to a maximum of 80% of the Scheme Rate for the hospital and related accounts if a Non-Network Hospital is used.	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
33.1.18	Disease management for major depression for members registered on the Scheme's disease management programme	In addition to the cover contained in Annexure **B4** up to 100% of the Scheme Rate for services covered in the Scheme's Baskets of Care if referred by the Scheme's DSP. Subject to the treatment meeting the Scheme's treatment guidelines and Managed Health Care criteria.	Baskets of Care as set by the Scheme
33.1.19	Disease Management for cardio-metabolic risk syndrome for members registered on the Scheme's Disease Management Programme	Up to a maximum of 100% of the Scheme Rate. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols.	Basket of care as set by the Scheme.
33.1.20	Drug and alcohol rehabilitation	Basis of cover contained in Annexure **B4**.	21 days in-hospital treatment per person per year
33.1.21	HIV / AIDS and AIDS related treatment	Basis of cover contained in Annexure **B4**.	Unlimited
33.1.22	Post-exposure HIV prophylaxis following occupational exposure, traumatic exposure or sexual assault	Up to a maximum of 100% of cost.	Unlimited
33.1.23	Prophylaxis for mother-to-child transmission	Up to a maximum of 100% of cost.	Unlimited

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

pb

M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
33.1.24	In-and out-of-hospital management for colorectal cancer	Up to a maximum of 100% of the Scheme Rate for the treatment at a network facility. Up to 80% of the Scheme Rate for the hospital account if performed at a non-network facility. Subject to authorisation and the treatment meeting the Scheme's treatment guidelines and clinical criteria.	Unlimited at a network provider. Basket of care as set by the Scheme for out-of-hospital treatment.
33.1.25	Cardiac stents REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES	Up to a maximum of 100% of the Scheme Rate. Subject to authorisation and the treatment meeting the Scheme's treatment guidelines and clinical criteria. The device accumulates to the limit. The balance of the hospital and related accounts do not accumulate to the annual limit. Provisions of PMB as set out in Annexure **B4** is applicable.	Network supplier: Unlimited if stent is supplied by the Scheme's KeyCare Direct Payment Arrangement practitioner Non-network supplier: Drug-eluting stent: R7 350 per stent per admission if not supplied by the Scheme's KeyCare Direct Payment Arrangement practitioner; Bare metal stent limit: R6 200 per stent per admission if not supplied by the Scheme's KeyCare Direct Payment Arrangement practitioner.
33.1.26	Advanced Illness Benefit	Up to a maximum of 100% of the Scheme Rate. Subject to authorisation and the treatment meeting the Scheme's guidelines and managed care criteria.	Unlimited

pb
M Wilson
CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

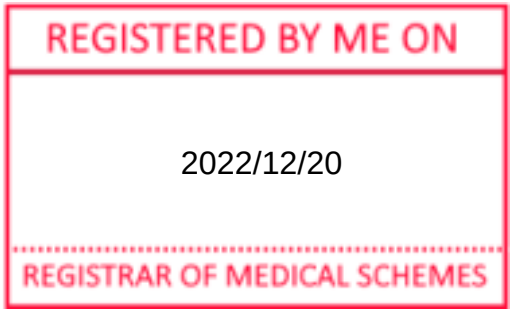
ANNEXURE B

	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
33.1.27	MRI and CT Scans	Up to a maximum of 100% of the Scheme Rate for in-hospital scans performed in respect of treatment related to an authorised admission. Where MRI and CT scan is unrelated to the admission it will be covered, up to a maximum of 100% of the Scheme Rate, from the specialist benefit subject to the specialist benefit limit of R5 000 per person per year. Subject to the treatment meeting the Scheme's treatment guidelines and Managed Health Care criteria. Scan must be performed by a specialist at a KeyCare Network Hospital.	Unlimited REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES
33.1.28	Gastroscopies, colonoscopies, proctoscopies and sigmoidoscopies	Save for cover as contained in Annexure **B2**, or where indicated and approved for dyspepsia or for children aged 12 years and under, subject to PMB in a defined list of network facilities as contained in Annexure **B3**. Up to 100% of the Scheme Rate from Health Care Cover if done in the doctor's rooms. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols.	Unlimited
33.1.28.1	Conservative treatment for dyspepsia	Up to a maximum of 100% of the Scheme Rate.	Basket of care as set by the Scheme
33.1.29	TTO medicine (medicine to take home)	Up to a maximum of 100% of the Scheme Medication Rate.	R200 per hospital admission

pb
M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
33.1.30	Emergency Medical Services within the borders of South Africa	Up to a maximum of 100% of the Scheme Rate. Inter-hospital transfer subject to pre-authorisation.	Unlimited
33.1.31	Dentistry	No cover.	Not applicable
33.1.32	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
33.1.33	Screening Benefit A - Group of tests consisting of blood glucose test, blood pressure test, cholesterol test and Body Mass Index (BMI)	Save for cover contained in Annexure **B4**, up to a maximum of 100% of the Scheme Medication Rate for group of tests at a network provider. Subject to meeting the Scheme's clinical entry criteria.	Unlimited
33.1.34	Defined diabetes and cholesterol screening tests	Up to a maximum of 100% of the Scheme Rate for test code. Subject to meeting the Scheme's clinical entry criteria. Note: Consultation paid from available day-to-day benefits as set out in **Rule 33.3**, or by the member where no benefits are available. Where the consultation relates to a PMB the consultation will be paid from Health Care Cover. 	Unlimited

pb

M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
33.1.35	Screening Benefit B - Consist of appropriate tests as determined by the Scheme: HIV screening, Mammogram, Prostate-Specific Antigen (PSA), colorectal and cervical cancer screening	Up to a maximum of 100% of the Scheme Rate for test code. Subject to meeting the Scheme's clinical entry criteria. Note: Consultation paid from available day-to-day benefits as set out defined in **Rule 33.3**, or by the member where no benefits are available. Where the consultation relates to a PMB the consultation will be paid from Health Care Cover.	Appropriate HIV screening tests as determined by the Scheme – Unlimited One Mammogram every 2 years, one Pap Smear every 3 years or one HPV test every 5 years and one PSA test per person per year One faecal occult blood test or immunochemical test every 2 years per person for persons between the ages of 45 to 75 years
33.1.36	Additional cover for Mammogram, breast MRI, BRCA testing, colonoscopy and cervical cancer screening	Up to a maximum of 100% of the Scheme Rate for test code. Subject to meeting the Scheme's clinical entry criteria. Note: Consultation paid from available day-to-day benefits as set out defined in **Rule 33.3**, or by the member where no benefits are available. Where the consultation relates to a PMB the consultation will be paid from Health Care Cover.	Basket of Care as set by the Scheme Once off BRCA testing and colonoscopy
33.1.37	Screening Benefit C - Group of age appropriate tests including but not limited to growth assessment, blood pressure and health and milestone tracking	Up to a maximum of 100% of the Scheme Rate at a KeyCare Direct Payment Arrangement practitioner, for children between the ages of 2 and 18. Subject to meeting the Scheme's clinical entry criteria.	Unlimited

pb
M Wilson
CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

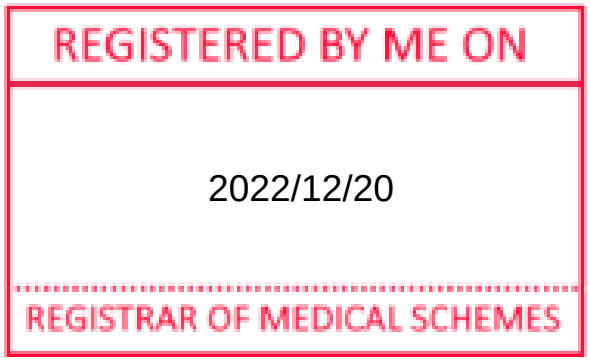
	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
33.1.38	Screening Benefit D – Group of age appropriate screening tests	Up to a maximum of 100% of the Scheme Rate at a KeyCare Direct Payment Arrangement practitioner, for members 65 years and older. Subject to meeting the Scheme's clinical entry criteria.	Unlimited
33.1.39	Additional screening assessment or consultation	Up to a maximum of 100% of the Scheme Rate at an accredited KeyCare Network GP or accredited provider. Subject to meeting the Scheme's clinical entry criteria and treatment guidelines.	One consultation per person per year in person or one 20-minute online consultation
33.1.40	Preventative Benefit - Pneumococcal vaccination	Up to a maximum of 100% of the Scheme Medication Rate for the vaccination. Note: Pneumococcal vaccines in excess of the annual limit, consultation and other healthcare services to administer the vaccine, paid by the member. Subject to the Scheme's Protocols and clinical entry criteria.	Up to 2 pneumococcal vaccine doses per person per lifetime
33.1.41	Preventative Benefit - Seasonal influenza vaccination	Up to a maximum of 100% of the Scheme Medication Rate for the vaccination. Seasonal flu vaccines in excess of annual limit is payable by the member. Subject to Scheme Protocols and clinical entry criteria. Note: Consultation and other healthcare services to administer the vaccine, paid from available day-to-day benefits as set out in **Rule 33.3**, or by the member where no benefits are available.	One seasonal influenza vaccine per person per year REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES

pb
M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
33.1.42	Additional screening benefit for: - Primary healthcare screening services for visual, hearing, dental and skin conditions - Physical well-being screening at a dietician, biokinetisist and/or physiotherapist - Women and men's screening and prevention healthcare services - Screening and prevention healthcare services for children - Cover for a defined list of registered screening and health monitoring devices	Up to a maximum of 100% of the Scheme Rate, subject to completion of the group of tests as set out in Screening Benefit A and Screening Benefit C, as applicable and stipulated in this benefit table. The benefit is available for a maximum of 2 years. For any beneficiary joining the Scheme, the benefit is available in the year of joining and the year thereafter. Subject to the Scheme's clinical entry criteria, treatment guidelines and protocols.	Basket of care as set by the Scheme limited to: R2 500 per adult beneficiary once per lifetime; R1 250 per child beneficiary once per lifetime; up to a maximum of R10 000 per family



pb
M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

Health Care Cover provided as set out in Rule 33.2 below is provided under the following conditions and limitations:

A member and/or his dependants shall subject to being clinically diagnosed as suffering from a chronic illness condition and having met all the Scheme's required clinical criteria, be entitled to the Chronic Illness Benefits ("CIB") as set out in **Rule 33.2** below, provided that a separate CIB application form is completed and submitted to the Scheme.

The calculation of the amount payable by the Scheme in respect of CIB as set out in **Rule 33.2** below may be based on:

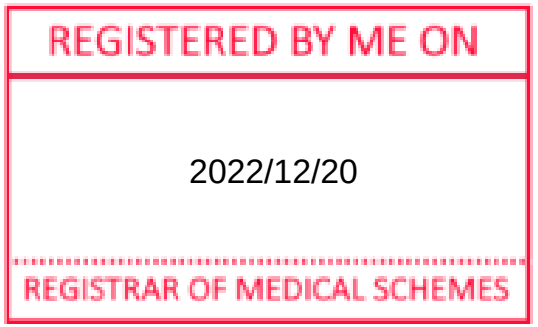
- The Billing Guidelines applicable to the Service Provider concerned and/or
- Depending on the contracted arrangements entered into by the Scheme with the Service Providers and/or;
- The applicable Scheme Rate or Scheme Medication Rate in respect of the Relevant health services (or a percentage of such Scheme Rate or Scheme Medication Rate); and/or
- A fixed amount per Relevant health service rendered as set out in **Rule 33.2** and Annexure **B4**.

The Scheme's liability will be limited in each financial year in terms of the relevant sections of **Rule 33.2** and will also be subject to the provisions of the Act and its Regulations.

The determination of whether a member and/or his dependants is entitled to Chronic Illness Benefits shall be:

- Based on the clinical diagnosis of the prescribing medical practitioner or a specialist specified by the medical panel of the Scheme;
- Based on the opinion of the medical panel of the Scheme or the appropriate organisation approved by the Scheme; and
- In terms of the relevant section of **Rule 33.2** as set out below.

The Scheme shall pay the claims in respect of CIB in accordance with **Rule 16** of the main body of the Rules.



pb

M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

TFG HEALTH PLAN – RULE 33 2023			
RULE 33.2 – CHRONIC ILLNESS BENEFIT			
	Healthcare Services Covered	**Basis of Cover: Subject to Prescribed Minimum Benefits**	**Annual Limits**
33.2.1	Medication for the chronic Prescribed Minimum Benefit condition	Save for medication contemplated in **Rule 16** of the main body of the rules, basis of cover is contained in Annexure **B4**. Subject to the Scheme Protocols, clinical entry criteria and medicine utilisation review.	As contained in Annexure **B4**
33.2.2	Specialised Medicine and Technology treatment contemplated in Rule 16.14 of the main body of the rules	No cover.	Not applicable
33.2.3	Diabetes management for members registered on the Scheme's disease management programme	Basis of cover is contained in Annexure **B4**. Up to 100% of the Scheme Rate for services covered in the Scheme's Baskets of Care if referred by the Scheme's DSP.	Baskets of Care as set by the Scheme
33.2.4	HIV management for members registered on the Scheme's disease management programme	Basis of cover is contained in Annexure **B4**. Up to 100% of the Scheme Rate for services covered in the Scheme's Baskets of Care if referred by the Scheme's DSP.	Baskets of Care as set by the Scheme
33.2.5	Cardiovascular disease management for members registered on the Scheme's disease management programme	Basis of cover is contained in Annexure **B4**. Up to 100% of the Scheme Rate for services covered in the Scheme's Baskets of Care.	Baskets of Care as set by the Scheme
33.2.6	Blood glucose monitoring device	Any beneficiary approved and registered on the Scheme's Chronic Illness Benefit for Diabetes is covered up to 100% of the Scheme Rate, paid from Health Care Cover. The device must be approved by the Scheme, subject to the Scheme Protocols and clinical entry criteria.	1 per beneficiary per year limited to the home-monitoring device limit as stipulated in Rule 33.1.9.1.

pb
M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

	TFG HEALTH PLAN – RULE 33 2023		
	RULE 33.3 – OUT OF HOSPITAL BENEFIT		
	Healthcare Services Covered	**Basis of Cover: Subject to Prescribed Minimum Benefits**	**Annual Limits**
33.3.1	GP, includes consultations and selected small procedures	Up to a maximum of 100% of the Scheme Rate, subject to selected consultation and procedure codes, as well as out-of-hospital consultation codes for virtual visits to meet the digital platform criteria. Member has to select a primary care KeyCare Network GP that is part of the Scheme's selected network on joining the Benefit Plan. GP visits will only be covered at chosen KeyCare Network GP. Member can elect to change his/her KeyCare Network GP three times per person per year.	Unlimited only at KeyCare Network GP, subject to pre-authorisation after visit 15, per person per year Unscheduled emergency visits limited to 3 visits per person per year at KeyCare Network GP
33.3.2	Specialists	KeyCare Health DPA Specialists: Up to a maximum of the KeyCare Direct Payment Arrangement rate. Other specialists who work within the KeyCare Network Hospitals: Up to a maximum of 100% of the Scheme Rate. Radiology and pathology services referred as part of the specialist visit up to 100% of the Scheme Rate, subject to the overall annual specialist benefit limit. Member must be referred by chosen KeyCare Network GP. Subject to authorisation and/or approval and treatment meeting the Scheme's treatment guidelines and entry criteria.	R5 000 per person per year REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES

pb

M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

	Healthcare Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
33.3.3	Visits to casualty units at KeyCare Network Hospitals	The first R450 of the casualty unit's account is payable by the beneficiary. Subject to pre-authorisation. The balance of the casualty unit's account is paid from Health Care Cover up to a maximum of 100% of the Scheme Rate.	Unlimited if treatment is obtained from a General Practitioner ("GP") who practise in the emergency rooms at KeyCare Network Hospitals
33.3.4	Visits to casualty units at Non-Network Hospitals	No cover.	No cover
33.3.5	Acute medicine	Up to a maximum of 100% of the Scheme Medication Rate. Subject to the KeyCare Acute Medicine Formulary and Protocols only covered if prescribed by KeyCare Network GP.	Unlimited within the KeyCare Acute Medicine Formulary and Protocols
33.3.6	Selected basic x-rays at the Scheme's KeyCare Direct Payment Arrangement practitioners	Up to a maximum of 100% of the Scheme Rate at the Scheme's KeyCare Direct Payment Arrangement practitioners. Only if requested by member's chosen KeyCare Network GP, subject to list of procedure codes and PMB.	Unlimited
33.3.7	Selected basic blood tests	Up to a maximum of 100% of the Scheme Rate. Only if requested by member's chosen KeyCare Network GP, subject to list of procedure codes and PMB. Point-of-care pathology testing is subject to meeting the Scheme's treatment guidelines and Managed Health Care criteria.	Unlimited

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

pb

M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

	Healthcare Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
33.3.8	Out-of-Network visits, including GP consultations, acute medicines, radiology and pathology requested by a GP	Up to a maximum of 100% of the Scheme Rate or Scheme Medication Rate – subject to a list of codes. Only Acute Medicines, radiology and pathology requested by a GP will be covered under this benefit.	Four GP claims, four pathology claims (requested by GP), four radiology claims (requested by GP) and four pharmacy claims (prescribed by GP) per person per year Subject to PMB.
33.3.9	Dentistry	Up to a maximum of 100% of the Scheme Rate. Only at KeyCare Network dentist, subject to a list of codes. In-hospital excluded. Subject to the treatment meeting the Scheme's treatment guidelines and Managed Health Care criteria.	Unlimited
33.3.10	Optometry	Up to a maximum of 100% of the Scheme Rate. Only at KeyCare Network optometrist and subject to Scheme Protocol. REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES	One pair of single vision, bifocal or multifocal lenses with a basic frame or a basic set contact lenses per person every twenty-four months from their last date of service

pb

M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

	Healthcare Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
33.3.11	MRI and CT Scans	Up to a maximum of 100% of the Scheme Rate at the Scheme's KeyCare Direct Payment Arrangement practitioners. Subject to the treatment meeting the Scheme's treatment guidelines and Managed Health Care criteria. Member must be referred by KeyCare Network GP.	Accumulates to the specialist benefit limit of R5 000 per person per year
33.3.12	Mobility Devices: wheelchairs, long leg callipers and crutches	Up to a maximum of 100% of the Scheme Rate, subject to an approved list of codes. Only if requested by the member's chosen KeyCare Network GP, subject to pre-authorisation and that the device or item is obtained from a KeyCare Direct Payment Arrangement practitioner.	R5 720 per family per year

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

pb

M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

	Healthcare Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
33.3.13	Over and above the DTPMB entitlement, this benefit also covers certain out-of-hospital healthcare services arising from an emergency, trauma-related event resulting in the following PMB conditions: – Paraplegia – Quadriplegia – Near-drowning related injury – Severe anaphylactic reaction – Poisoning – Crime-related injury – Severe burns – External and internal head injuries – Loss of limb Trauma benefit services covered under this benefit include: – Allied healthcare services – External medical items – Hearing aids – Prescribed Medicine	Up to a maximum of 100% of the Scheme Rate. Paid from Health Care Cover (**Rule 33.1**) and is subject to applicable limits. Excludes Over the counter (OTC) medicines (inclusive of schedule 0, 1 and 2 drugs whether prescribed or not), optometry, antenatal classes and dentistry (other than severe dental and oral procedures contemplated in Annexure **B1**). Cover applies to 31 December of the following year after the trauma occurred. Subject to authorization and / or approval and treatment meeting the Scheme's entry criteria. Cover is not restricted to the Scheme's Designated Service Providers as stipulated in Annexure **B4**. Healthcare services related to counselling is applicable to all registered beneficiaries. REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES	Services: – External medical items: Limited to R28 900 per family per year, except for prosthetic limbs which shall be subject to a limit of R93 550 per person per year – Hearing aids: Limited to R16 100 per family per year – Allied and therapeutic healthcare services including: acousticians, biokineticists, chiropractors, dieticians, homeopaths, nursing providers, occupational therapists, physiotherapists, podiatrists, psychologists, psychometrics, counsellors, social workers, speech and hearing therapists limited to: Member: R8 800 M+1 dependant: R13 250 M+2 dependants: R16 500 M+3 dependants or more: R19 850 – Prescribed Medicine limited to: Member: R17 150 M+1 dependant: R20 300 M+2 dependants: R24 100 M + 3 dependants: R29 300

pb

M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Limits
33.3.14	Out-of-hospital healthcare services related to pregnancy and delivery: – Antenatal classes and/or postnatal visits with a registered nurse – Antenatal consultations with the KeyCare Network GP, gynaecologist or midwife – Prenatal screening or Non Invasive Prenatal Testing (NIPT) or defined chromosome testing – Pregnancy scans – A defined basket of pregnancy blood tests – Postnatal consultation with the KeyCare Network GP, gynaecologist or midwife – Dietician nutrition assessment – Postnatal mental health consultation with a KeyCare Network GP, psychologist or counsellor – Paediatrician, ENT or KeyCare Network GP consultations for infants	Up to 100% of the Scheme Rate, or agreed rate. Only for a gynaecologist who practices within the KeyCare Network within the selected KeyCare Network Hospitals. Subject to Scheme health Protocol. Paid from Health Care Cover (**Rule 33.1**) and is subject to applicable limits. Subject to pre-authorisation and/or registration and the treatment meeting the Scheme's clinical entry criteria. 3D and 4D scan will be paid up the maximum of the cost of a 2D scan. Cover for infant consultations up to a maximum of 100% of the Scheme Rate, or agreed rate, for children under the age of 2 years. Services in excess of the limit are for the member's account. Limits apply for the duration of the pregnancy.	Services: – Antenatal classes and/or postnatal visits: 5 consultations or classes per pregnancy and/or delivery – Antenatal consultations: 8 per pregnancy – Prenatal screening, including chromosome testing or Non Invasive Prenatal Testing (NIPT): 1 per pregnancy – Pregnancy scans: 2 per pregnancy – Blood tests: 1 routine basket of pregnancy tests per pregnancy – Postnatal consultations: 1 per delivery – Dietician nutrition assessment: 1 per delivery – Mental health consultations: 2 per delivery – Consultations for infants: 2 per child

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

pb

M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH BENEFIT PLAN RULE 33

ANNEXURE B

	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
33.3.15	- Benefit for out-of-hospital management and appropriate supportive treatment of specific global World Health Organisation (WHO) recognised disease outbreaks: COVID-19 - Monkeypox	In addition to cover contained in Annexure **B4**, up to a maximum of 100% of the Scheme Rate. 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 per condition. PMB requirements and Council for Medical Schemes ("CMS") guidelines prevail.

pb

M Wilson CH

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

TFG MEDICAL AID SCHEME
ANNEXURE B1: TFG Health: Severe Dental and Oral Surgery – 1 January 2021

The following list reflects those dental and maxillo-facial procedures covered under Health Care Cover on the TFG Health Plan. The Scheme applies for this Benefit Plan the definitions reflected below and services are managed by the Scheme's dental network, Dental Risk Company (DRC) –

1. **Severe life threatening infections** - Severe life threatening infections in the mouth, face and neck area, which manifests itself by acute symptoms of sufficient severity that the absence of immediate hospital admission with medical and surgical intervention could result in serious jeopardy to the member's health. This definition will therefore not include examples such as an apicectomy, root canal treatment, drainage of dental abscess, treatment of pericoronitis, surgical and ordinary tooth extractions/removal, periodontal flap procedures, treatment of septic socket, removal of dental cyst and/or granulation tissue.

2. **Internal TM joint surgical procedures** - Internal joint surgical procedures refers to surgical reconstruction to the Temporomandibular joint (the joint that connects the lower jaw to the skull).

3. **Cancer-related surgery** – Cancer-related surgery is surgery done to remove cancer of the oral cavity and will include reconstruction surgery of the bone as part of the cancer-related surgery. This will not include periodontal soft tissue procedures, orthodontics and placement of dental implants and superstructures, crowns, bridges or dentures to replace lost teeth or previous dental restorative appliances and restorations.

4. **Severe trauma-related surgery** - Trauma is defined as acute, sudden, unforeseen physical trauma or injury of the facial bones and for oral tissues (both soft and hard), which manifests itself by acute symptoms of sufficient severity that the absence of hospital admission with surgical intervention within the first 24 hours thereafter could result in serious jeopardy to the person's health or serious impairment to bodily functions. Severe trauma-related surgery will include surgery done within the initial trauma admission as well as admission(s) related to post-traumatic reconstruction surgery of the bone. This will not include periodontal soft tissue procedures, orthodontics, placement of dental implants and superstructures, crowns, bridges or dentures to replace lost teeth or previous dental restorative appliances and restorations.

5. **Cleft palate repair** - Cleft palate repair refers to surgical repair of a cleft palate and cleft lip during infancy.

REGISTERED BY ME ON
2020/12/04
Mashilo Leboho
12/12/2020 14:53:31 (UTC+02:00)
Signed by Mashilo Leboho
m.leboho@medicalschemes.co.za
REGISTRAR OF MEDICAL SCHEMES

TFG MEDICAL AID SCHEME
ANNEXURE B2: TFG Health: Oncology Treatment Programme – 1 January 2021

1. In this Annexure, the following definitions apply:

   1.1. **"SAOC"** means the South African Oncology Consortium Limited.

   1.2. **"ICON"** means the Independent Clinical Oncology Network.

   1.3. TFG Medical Aid Scheme Oncology Basket of Care, Supportive Formulary and Protocols in respect of Prescribed Minimum Benefits means the Scheme's Baskets of Care, Formularies, preferred product list and protocols and the treatment regimens and Baskets of Care for supportive requirements –

      1.3.1. as may be provided as contemplated in the Regulations; or

      1.3.2. defined as treatment included as Tier 1 in the SAOC treatment guidelines or as essential level of care in the ICON protocols, subject to such exclusions or exceptions as may be determined by the Scheme in accordance with principles of cost-effectiveness, affordability and evidence-based medicine.

   1.4. Treatment in respect of non-Prescribed Minimum Benefit includes the Scheme Oncology Baskets of Care, Formularies, preferred product list and protocols as well as treatment regimens as outlined in the SAOC or ICON guidelines. Treatment regimens defined by SAOC or ICON are subject to such exclusions/exceptions as may be determined by the Scheme in accordance with principles of cost-effectiveness, affordability and evidence-based medicine.

2. Scope of Cover in respect of the TFG Health Benefit Plan is limited to Prescribed Minimum Benefits or treatment within the agreed ICON Network. Annexure B4 has reference.

3. Registration is a prerequisite to accessing the Oncology Programme and benefits will commence on registration. If the member does not register on the programme, cover will be subject to the member's available day-to-day benefits.

4. Any oncology-related episode (i.e. investigation and/or treatment) must be authorised and/or approved at least 48 hours prior to performing such investigation, or receiving such treatment. Failure to authorise in this manner may result in the application of a non-notification penalty equal to 30% of the total cost of the requested investigation or treatment plan.

5. The Oncology baskets of care apply only in respect of and during the course of an active oncology episode.

6. Claims in respect of any health service relating to an oncology episode rendered at a "in-hospital" setting shall be processed with regard to the Rules set out in Annexure B Rule 33.

REGISTERED BY ME ON
2020/12/04
Mashilo Leboho
12/12/2020 14:53:10 (UTC+02:00)
Signed by Mashilo Leboho,
m.leboho@medicalschemes.co.za
REGISTRAR OF MEDICAL SCHEMES

TFG MEDICAL AID SCHEME
ANNEXURE B3: TFG Health and TFG Health Plus: Day-Case Procedures – 1 January 2023

Save for Prescribed Minimum Benefit entitlement, a list of day surgery procedures is covered in the day surgery facilities. These healthcare services will be covered in terms of Rule 33 and Rule 34 under the TFG Health and TFG Health Plus Benefit Plans. Where members are registered on the TFG Health Plus Benefit Plan, a Deductible amount of R6 300.00 shall be payable by the beneficiary in respect of the hospital account for elective admissions at a facility which is not in the network. A clinical exceptions process applies to all cases with complex presentations and those procedures that may require an extended length of stay. Members will be transferred to the appropriate facility where required.

The list of procedures are:

1. Ear, Nose and Throat Procedures
   - Tonsillectomy and/or adenoidectomy
   - Repair nasal turbinates*, nasal septum*
   - Simple procedures for nose bleed (extensive cautery)
   - Sinus lavage*
   - Scopes (nasal endoscopy*, laryngoscopy)
   - Middle ear procedures (tympanoplasty, mastoidectomy, myringoplasty, myringotomy and/or grommets)

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

3. Urological Procedures
   - Cystoscopy
   - Male genital procedures (circumcision, repair of penis, exploration of testes and scrotum, orchiectomy, epididymectomy, excision hydrocoele, excision varicocoele vasectomy)

4. Orthopaedic Procedures
   - Arthroscopy, arthrotomy (shoulder, elbow, knee, ankle, hand, wrist, foot, temporomandibular joint), arthrodesis (hand, wrist, foot)*
   - Minor joint arthroplasty (intercarpal, carpometacarpal and metacarpophalangeal, interphalangeal joint arthroplasty*)
   - Tendon and/or ligament repair, muscle debridement, fascia procedures (tenotomy, tenodesis, tenolysis, repair/reconstruction, capsulotomy, capsulectomy, synovectomy, excision tendon sheath lesion, fasciotomy, fasciectomy) (For TFG Health only funded if not via a scope first). Subject to individual case review
   - Repair bunion or toe deformity*
   - Treatment of simple closed fractures and/or dislocations, removal of pins and

M Wilson pb CH

plates. Subject to individual case review

5. Gynaecological Procedures
   - Diagnostic Dilatation and Curettage
   - Endometrial ablation
   - Diagnostic Hysteroscopy
   - Colposcopy with LLETZ
   - Examination under anaesthesia

6. Eye Procedures
   - Corneal transplant*
   - Cataract surgery
   - Treatment of glaucoma
   - Other eye procedures (removal of foreign body, conjunctival surgery (repair laceration, pterygium), glaucoma surgery, probing & repair of tear ducts, vitrectomy, retinal surgery, eyelid surgery, strabismus repair)

7. Ganglionectomy

8. Simple superficial lymphadenectomy

9. Approved Breast Procedures
   - Mastectomy for gynaecomastia*
   - Lumpectomy* (fibroadenoma)

10. Skin Procedures
    - Debridement
    - Removal of lesions* (dependent on site and diameter)
    - Simple repair of superficial wounds

11. Biopsies: skin*, subcutaneous tissue, soft tissue, muscle, bone, lymph, eye, mouth, throat, breast, cervix, vulva, prostate, penis, testes

12. Removal of foreign body (subcutaneous tissue, muscle, external auditory canal under general anaesthesia)

*Subject to TFG Health exclusions per Annexure D1.

M Wilson pb CH

Annexure B4
TFG Medical Aid Scheme: TFG Health Cover for Prescribed Minimum Benefits: 2023

PREAMBLE

The benefits in respect of the Prescribed Minimum Benefits (PMB) are funded as set out in this Annexure.

The Scheme's contracted Designated Service Providers (DSP/DPA), which includes the following networks, are:

- KeyCare Network Hospitals (PMB Network Hospital) and Casualty units
- KeyCare Network GP
- KeyCare Health DPA Specialist
- Premier Plus GP
- Independent Clinical Oncology Network (ICON)
- A defined list of pharmacies the Scheme has contracted with known as DSP
- Dental Network (Dental Risk Company/DRC)
- KeyCare Network optometrists (IsoLeso)
- A defined list of Radiologists, Radiographers, Phycologists and Social Workers with whome the Scheme has entered into a Preferred Provider agreement with
- An out-of-hospital Mobility Network and Renal Network the Scheme has entered into a Preferred Provider agreement with
- Day-surgery Network
- A defined list of oncology pharmacies to obtain medicine related to oncology treatment

A beneficiary will be deemed to have involuntarily obtained a service from a provider other than the abovementioned contracted network providers or DSP, if -

(i) the service was not available from the DSP or would not be provided without unreasonable delay;

(ii) immediate medical or surgical Treatment for a PMB benefit condition was required under circumstances or at locations which reasonably precluded the Beneficiary from obtaining such treatment from a DSP;or

(iii) if there was no DSP within reasonable proximity to the Beneficiary's ordinary place of business or personal residence.

The below tables set out the manner in which the Scheme will fund PMB conditions if:

a) a Beneficiary uses the DSP or involuntarily uses a non-DSP or
b) a Beneficiary voluntarily does not use the DSP.

M Wilson CH
pb

Annexure B4
TFG Medical Aid Scheme: TFG Health Cover for Prescribed Minimum Benefits: 2023

TFG HEALTH			
Type	**Designated Service Provider ("DSP")**	**a) Reimbursement Rate if the Beneficiary uses the DSP or involuntarily uses a non-DSP**	**b) Reimbursement Rate if the Beneficiary Voluntarily does not use the DSP**
Chronic Disease List ("CDL"): Out-of-Hospital Consultations	**Cases Requiring Specialists:** Any specialist participating in a KeyCare Health DPA Specialist Network except where there is no KeyCare Health DPA Specialist, in which case any specialist practicing in a KeyCare Network Hospital who has agreed to charge the Premier Rate.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate. The Deductible, which the member is liable for, is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
	GPs The member's chosen GP participating in the KeyCare Network or Premier Plus GP Network. **Diabetes:** The member's nominated Premier Plus GP who is also a KeyCare Network GP. **HIV:** The member's chosen KeyCare Network GP participating in the Premier Plus GP Network.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate. The Deductible, which the member is liable for, is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
CDL - Diagnosis	**Cases Requiring Specialists:** Any specialist participating in a KeyCare Health DPA Specialist Network except where there is no contracted specialist, in which case any specialist practicing in a KeyCare Network Hospital who has agreed to charge the Premier Rate.	The Scheme shall pay healthcare treatment, subject to Scheme's diagnostic basket in full. This is subject to the member making application to the Scheme.	The Scheme shall pay healthcare treatment, subject to Scheme's diagnostic basket up to 80% of the Scheme Rate. This is subject to the member making application to the Scheme. The Deductible, which the member is liable for, is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.

pb CH
M Wilson

Annexure B4
TFG Medical Aid Scheme: TFG Health Cover for Prescribed Minimum Benefits: 2023

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary Uses the DSP or involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary Voluntarily does not use the DSP
CDL - Diagnosis	**GPs** The member's chosen GP participating in the network defined as KeyCare Network GP. **Diabetes:** The member's nominated Premier Plus GP who is also a KeyCare Network GP. **HIV:** The member's chosen KeyCare Network GP participating in the Premier Plus GP Network.	The Scheme shall pay healthcare treatment, subject to Scheme's diagnostic basket in full. This is subject to the member making application to the Scheme.	The Scheme shall pay healthcare treatment, subject to Scheme's diagnostic basket up to 80% of the Scheme Rate. This is subject to the member making application to the Scheme. The Deductible, which the member is liable for, is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
CDL - Medicine	**GPs** The Designated Service Provider (DSP) is a defined list of contracted pharmacies or the member's chosen GP participating in the network defined as KeyCare Network GP or chosen GP participating in the Premier Plus GP Network.	For drugs on the Scheme's Formulary, the Scheme will pay in full. For drugs not listed on the Formulary the Scheme will pay up to a maximum of the Therapeutic Reference Price ("TRP"). Payment is subject to Regulations 15H(c) and 15I(c).	The Scheme may, at its discretion, impose a Deductible and pay up to a maximum of 80% of the Scheme Medication Rate. This is subject to Regulations 15H(c) and 15I(c). Where DSP charges more than the Scheme Medication Rate, an additional Deductible may apply.
CDL - Pathology	A defined list of providers that has contracted with the Scheme.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate.
CDL - Radiology	A defined list of providers that has contracted with the Scheme.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate.

pb CH

M Wilson

Annexure B4
TFG Medical Aid Scheme: TFG Health Cover for Prescribed Minimum Benefits: 2023

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary Uses the DSP or involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary Voluntarily does not use the DSP
Diagnostic Treatment Pairs PMB ("DTPMB"): Out-of-Hospital Consultations	**GPs** The member's chosen GP participating in the network defined as the KeyCare Network GP or Premier Plus GP.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate. The Deductible, which the member is liable for, is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
	Cases Requiring Specialists: Any specialist participating in a KeyCare Health DPA Specialist Network except where there is no KeyCare Health DPA Specialist, in which case any specialist practicing in a KeyCare Network Hospital who has agreed to charge the Premier Rate. Subject to Regulation 8(3)(a)(b).	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate. The Deductible, which the member is liable for, is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
DTPMB - Diagnosis	Any provider that has contracted with the Scheme in respect of the Member's chosen Benefit Plan and where it is appropriate for such diagnosis to be made by the provider.	The Scheme shall pay healthcare treatment, subject to Scheme's diagnostic basket in full. This is subject to the member making application to the Scheme.	The Scheme shall pay healthcare treatment, subject to Scheme's diagnostic basket up to 80% of the Scheme Rate. This is subject to the member making application to the Scheme. The Deductible, which the member is liable for, is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

M Wilson pb CH

Annexure B4
TFG Medical Aid Scheme: TFG Health Cover for Prescribed Minimum Benefits: 2023

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary Uses the DSP or involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary Voluntarily does not use the DSP
DTPMB: In-Hospital Consultations	Any GP participating in the network defined as the KeyCare Network GP and practicing in a KeyCare Network Hospital, contracted with the Scheme. Subject to Regulation 8(3)(a) and (b).	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Where a member voluntarily uses a non-DSP we pay at 80% of the Scheme Rate or the Benefit Plan entitlement subject to available benefits. The Deductible, which the member is liable for, is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
	Cases Requiring Specialists: Any specialist participating in a KeyCare Health DPA Specialist Network except where there is no contracted specialist, in which case any specialist practicing in a KeyCare Network Hospital who has agreed to charge the Premier Rate, and/or any specialist contracted with the Scheme. Subject to Regulation 8(3)(a) and (b).	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Where a member voluntarily uses a non-DSP we pay at 80% of the Scheme Rate or the Benefit Plan entitlement subject to available benefits. The Deductible, which the member is liable for, is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
DTPMB – Medicine	The DSP is a defined list of contracted pharmacies or the member's chosen dispensing GP participating in the network defined as the KeyCare Network GP or chosen GP participating in the Premier Plus GP Network. .	For drugs on the Scheme's Formulary, the Scheme will pay in full up to a maximum of the Scheme Medication Rate. For drugs not listed on the Formulary the Scheme will pay up to a maximum of the TRP. Payment is subject to Regulations 15H(c) and 15I(c).	The Scheme may, at its discretion, impose a Deductible and pay up to a maximum of 80% of the Scheme Medication Rate. This is subject to Regulations 15H(c) and 15I(c). Where the DSP charges more than the Scheme Medication Rate, an additional Deductible may apply.

pb CH
M Wilson

Annexure B4
TFG Medical Aid Scheme: TFG Health Cover for Prescribed Minimum Benefits: 2023

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary Uses the DSP or involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary Voluntarily does not use the DSP
DTPMB – Out-of-hospital Medical appliances (External Medical Appliances)	A defined list of providers that has contracted with the Scheme.	The Scheme shall pay the costs of PMB in full for involuntarily use of non-DSP and up to the agreed rate for appliances obtained from a DSP or where the items used is on the Formulary.	Where a Member voluntarily obtains appliances from a non-DSP or a non-Formulary item is used, the Scheme shall pay up to the Reference Price List (RPL) only.
DTPMB - Pathology	A defined list of providers that has contracted with the Scheme.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate.
DTPMB - Radiology	A defined list of providers that has contracted with the Scheme.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate.
DTPMB – Hospital admissions	Any KeyCare Network Hospital contracted with the Scheme. Subject to Regulation 8(3)(a) and (b).	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Where a member voluntarily uses a non-DSP we pay at 80% of the Scheme Rate or the Benefit Plan entitlement subject to available benefits. The Deductible, which the member is liable for, is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate/agreed rate and any amount the provider charges above the Scheme Rate.

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

M Wilson pb CH

Annexure B4
TFG Medical Aid Scheme: TFG Health Cover for Prescribed Minimum Benefits: 2023

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary Uses the DSP or involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary Voluntarily does not use the DSP
DTPMB – Mental Illness	**Drug and Alcohol abuse facilities:** Any facility and/or provider contracted with the Scheme.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP up to a maximum of 21 days in-hospital.	The Scheme may, at its discretion, impose a Deductible and pay up to a maximum of 80% of the Scheme Rate or the Benefit Plan entitlement up to a maximum of 21 days in-hospital.
	All other conditions: Equivalent of up to a maximum of 21 days in-hospital, or 12 or 15 out-of-hospital consultations for conditions as defined in Annexure of the Regulations. Any provider contracted with the Scheme and/or a defined list of hospitals with a psychiatric ward and is contracted with the Scheme, subject to the condition meeting clinical entry criteria and the Scheme's Basket of Care.	The Scheme shall pay the costs of PMBs in full subject to the rate contracted with the hospital for a psychiatric ward/facility.	Where a member voluntarily uses a non-DSP we pay at 80% of the Scheme Rate or the Benefit Plan entitlement subject to available benefits. The Deductible, which the member is liable for, is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate/agreed rate and any amount the provider charges above the Scheme Rate.
DTPMB – Major hip and knee joint replacements	A defined list of hospitals and providers that has contracted with the Scheme.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme may, at its discretion, impose a Deductible and pay up to a maximum of 80% of the Scheme Rate or the Benefit Plan entitlement subject to available benefits.
DTPMB - Spinal Surgery	A defined list of hospitals and providers that has contracted with the Scheme.	The Scheme shall pay the costs of PMBs in full for involuntary use or non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme may, at its discretion, impose a co-payment and pay up to the maximum of 80% of the Scheme Rate/agreed rate of the Benefit Plan entitlement subject to available benefits.

M Wilson pb CH

Annexure B4
TFG Medical Aid Scheme: TFG Health Cover for Prescribed Minimum Benefits: 2023

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary Uses the DSP or involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary Voluntarily does not use the DSP
DTPMB – Terminal Care facilities	Hospice and any other compassionate care facility.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme will pay up to 100% of the Scheme Rate up to the Benefit Plan entitlement subject to available benefits.
Oncology: Out-of-Hospital Treatment	**Specialists:** The DSP is a defined list of oncology providers that has contracted with the Scheme.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate. The Deductible, which the member is liable for, is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
	GPs: The DSP is a defined list of oncology providers that has contracted with the Scheme.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate. The Deductible, which the member is liable for, is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
Oncology - Chemotherapy	The DSP is a defined list of oncology providers contracted with the Scheme.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate.
Oncology - Pathology	The DSP is a defined list of oncology providers contracted with the Scheme.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate.

M Wilson pb CH

Annexure B4
TFG Medical Aid Scheme: TFG Health Cover for Prescribed Minimum Benefits: 2023

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary Uses the DSP or involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary Voluntarily does not use the DSP
Oncology - Radiology	A defined list of providers that has contracted with the Scheme.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate.
HIV: Out-of-Hospital Consultations	The member's chosen GP participating in the KeyCare Network.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate. The Deductible, which the member is liable for, is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
	Cases Requiring Specialists: Any specialist participating in a KeyCare Health DPA Specialist Network except where there is no TFG Health DPA Specialist, in which case any specialist practicing in a KeyCare Network Hospital who has agreed to charge the Premier Rate.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate. The Deductible, which the member is liable for, is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
HIV - Pathology	A defined list of providers that has contracted with the Scheme.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate.
HIV - Radiology	A defined list of providers that has contracted with the Scheme.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate.

M Wilson pb CH

Annexure B4
TFG Medical Aid Scheme: TFG Health Cover for Prescribed Minimum Benefits: 2023

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary Uses the DSP or involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary Voluntarily does not use the DSP
HIV - Medicine	The DSP is a defined list of contracted pharmacies or the member's chosen GP participating in the network defined as the KeyCare Network GP or chosen GP participating in the Premier Plus GP Network. .	For drugs on the Scheme's Formulary, the Scheme will pay in full up to a maximum of the Scheme Medication Rate. For drugs not listed on the Formulary the Scheme will pay up to a maximum of the TRP. Payment is subject to Regulations 15H(c) and 15I(c).	The Scheme may, at its discretion, impose a Deductible and pay up to a maximum of 80% of the Scheme Medication Rate for a drug listed on the Formulary. This is subject to Regulations 15H(c) and 15I(c). Where the DSP charges more than the Scheme Medication Rate, an additional Deductible may apply.
HIV - VCT	Any vendor that has contracted with the Scheme.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate.
RENAL – Specifically to regard to Chronic Renal Dialysis, Pathology and Drugs	Contracted provider, applicable to member's Benefit Plan, in respect of chronic renal dialysis.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate/agreed rate or the Benefit Plan entitlement subject to available benefits. The Deductible, which the member is liable for, is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

M Wilson

pb CH

Annexure B4
TFG Medical Aid Scheme: TFG Health Cover for Prescribed Minimum Benefits: 2023

Oncology Treatment Programme 2023		
Prescribed Minimum Benefit (PMB) Cover : Applicable to TFG HEALTH		
Health Care Services Covered	**Basis of Cover**	**Limits / Thresholds**
Statutory Prescribed Minimum Benefits	As specified herein As per the Scheme's oncology Baskets of Care, Formularies and/or protocols for Prescribed Minimum Benefits. Inclusion of chemotherapy, radiotherapy, and other health care services fundable from the Oncology Treatment Programme will be subject to consideration of evidence-based medicine, cost-effectiveness and affordability. Access to Benefit is subject to: • Authorisation and/or approval 48 hours before a planned hospital admission • Treatment must be accessed within a network of Designated Service Provers. o Where a member or beneficiary voluntarily uses a non-Network Provider, funding will be approved up to a maximum of 80% of the Scheme Rate and the balance will be for the member's own pocket. • TFGMAS Prescribed Minimum Benefit Oncology Baskets of Care, supportive Formularies and /or Protocols • Meeting Clinical Entry Criteria as specified or adopted by the Scheme • Subject to peer-review by a Scheme appointed external panel of specialists • Generic substitution and substitution or switching to a cost-effective therapeutic equivalent (drug utilisation review) • Medication to be scripted and dispensed in accordance with the Oncology preferred product list. Where a non-preferred product is used, funding will be approved up to a maximum of 80% of the Scheme Rate, the balance will be for the member's own account. • Medication must be dispensed through a Designated Service Provider. Where a non-network provider is used, funding will be approved up to a maximum of 80% of the Scheme Rate and the balance will be for the member's own pocket.	• Unlimited • Deductible only as contemplated in Regulation 8 of the Act and as set out in this Annexure • Deductible of R3 300 for PET-CT scans where there is voluntary use of a non-DSP • Stem Cell / Bone Marrow Transplant: - Autologous transplant only or • - allogeneic bone marrow transplant with HLA matched family donor only

pb CH

M Wilson

Annexure B4
TFG Medical Aid Scheme: TFG Health Cover for Prescribed Minimum Benefits: 2023

Notes:

1. For approved PMB conditions, all treatment codes and procedure codes must accord with the Scheme's Baskets of Care. The Scheme may have regard to Regulations 15H(c) and 15I(c).

2. "SAOC" means the South African Oncology Consortium.

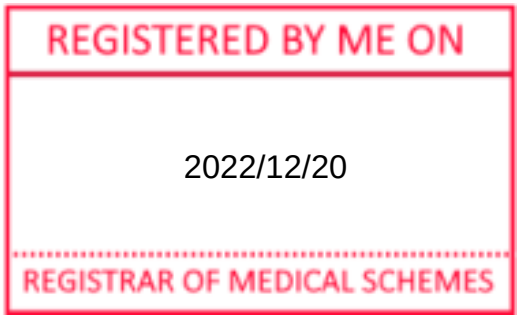
3. In accordance with what is stated in the main body to these Rules, no healthcare costs associated with a PMB will be paid if such costs are voluntarily incurred outside of the territory of the Republic of South Africa and other territories within the Rand Monetary Area.

4. Where claims are paid in full, Beneficiaries will not be required to make any payments not reimbursable by the Scheme.

5. CDA (Chronic Drug Amount) is the reference price applied by the Scheme to all off-formulary medication claims. Therapeutic Reference Price ("TRP") is the reference price applied by the Scheme to all non-formulary medication claims.

6. Baskets of Care, is a list of consultations, investigations and other procedures that pertain to the care of a CDL condition (Chronic Disease List condition as per the Medical Schemes Act and its relevant regulations and amendments for Prescribed Minimum Benefits), over a period of time which may be adaptable to the patient's specific needs through a process of interaction and consultation with the Scheme's contracted Managed Care Organisation and/or medical advisors and which will be associated, where applicable, with the drugs as listed in the PMB CDL Algorithms for the specific CDL conditions.

7. PMB services will accumulate to insured limits where these limits exist. Once depleted, the remaining PMB entitlement will apply.



M Wilson pb CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

TFG HEALTH PLUS BENEFIT PLAN – RULE 34 2023

PREAMBLE

a. Subject to the provisions contained in these Rules, Members and their registered Dependants shall be entitled to the benefits as set out below, which may include Prescribed Minimum Benefits ("PMB") and which may be obtained at any chosen healthcare provider, unless otherwise specified. Where the benefits as set out below do not provide for a specific PMB or only provides limited benefits in respect of PMB, a Beneficiary is entitled to obtain benefits as described and set out in Annexure **C**.

b. No Member shall be entitled to assign, transfer, pledge, hypothecate or cede his benefits or his rights to benefit in or from the Scheme.

c. Maximum annual benefits shall be calculated from 1 January to 31 December of the same year, based on the services rendered during the Annual Financial Year and shall be subject to pro rata apportionment calculated from the Admission Date to the end of that Annual Financial Year, excluding Optometry and Oncology or where a chosen Benefit Plan specifies otherwise. Benefits are not transferable from one financial year to another or from one category to another.

d. Prolonged treatment may be subject to review and case management and limits as imposed by or on behalf of the Board. Benefits shall be further limited as indicated in these Rules and Pre-authorised shall be required 48 hours before hospitalisation, to qualify for benefits, provided that in the case of an emergency the Scheme shall be notified thereof within 24 hours after such an emergency admission or treatment having been initiated, failing which paragraph f (vi) of this preamble will apply.

e. **Emergency treatment rendered outside the rand monetary area**

M Wilson pb
CH

	Members submitting claims for emergency treatment obtained outside the rand monetary area must provide proof of travel and ensure that the claims reflect the amount(s) in the equivalent South African currency and the rate of exchange used for conversion and shall bear a detailed description, in English, of each service rendered. Benefits on such claims shall be calculated as if the services had been rendered in the Republic of South Africa, and paid at Scheme Rate and not at Cost. Healthcare costs associated with a PMB will be paid at Scheme Rate and limited to the benefit limits set out in these Rules, if a member incurred these costs outside the borders of South Africa. f. In respect of benefits set out in these Rules the following principles will apply in all cases where Pre-authorisation is required: (i) If the Scheme's contracted Managed Healthcare Organisation grants a Pre-authorisation, it is deemed to have been authorised as set out in Rule 4.68 of the main body of the rules. (ii) Payment of benefits for a procedure or Treatment in respect of which a Pre-authorisation was granted, will always be subject to: - Rules of the Scheme in particular any maximum, exclusions and waiting periods - Proviso that the Beneficiary qualifies for Benefits (iii) If Pre-authorisation is obtained and the Treatment does not exceed the Approval, the Treatment will qualify for the benefits as stated; (iv) If Pre-authorisation is obtained and the Approval is exceeded, benefits will only accrue for the authorised Treatment. The Cost pertaining to the Treatment in excess of that Pre-authorisation will be payable by the Member. (v) If a procedure or Treatment is undergone after Pre-authorisation has been refused, no benefits are payable for hospitalisation and all services associated with the procedure or Treatment will be payable by the Member.

(vi) If Treatment is undergone without Pre-authorisation having been obtained, application may be made retrospectively for an Approval. In the event of such Approval being granted the benefit will (except in cases of Emergency) be subject to a Deductible of R2 000 per case. If Approval is declined no benefits will accrue for hospitalisation and all services associated with the procedure or Treatment will be payable by the Member.

g. All claims must be submitted in accordance with Rule 15.

Health Care Cover as set out in Rule 34.1 below is provided under the following conditions and limitations:

The calculation of the amount payable by the Scheme in respect of the Hospital benefits may be based on:

- The Billing Guidelines applicable to the Service Provider concerned and/or
- Depending on the contracted arrangements entered into by the Scheme with the Service Providers and/or
- The Cost of the Relevant health services (or a percentage of such Cost;) and/or
- The applicable Scheme Rate in respect of the Relevant health services (or a percentage of such Scheme Rate); and/or
- A fixed amount per Relevant health service rendered as shown in the Table below; and/or
- A global fee; and/or
- A per diem payment.

The Scheme's liability in respect of Hospital benefits shall be limited in each financial year to the amount, expressed in days, rands or frequency, applicable in terms of the relevant section of the below Table, except where Prescribed Minimum Benefits (PMB) apply. Basis of cover in respect of PMB is set out in Annexure **C2**.

The Scheme shall pay the claims in respect of the Hospital benefits in accordance with Rule 16 of the main body of the Rules.

pb

M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

	TFG Health Plus members may make use of any hospital facility, however to ensure members do not experience deductibles in the case of PMB conditions, the following Network and Designated Service Providers (DSP) are in place to service members: - KeyCare Network Hospitals (PMB Network Hospital) - KeyCare Network GP - A list of Specialists contracted as Designated Service Providers (Classic Direct Payment Arrangements) - Premier Plus GP - A defined list of pharmacies the Scheme has contracted with known as DSP - A defined list of Phycologists, Social workers and Midwifes with whom the Scheme has entered into a Preferred Provider agreements with - An out-of-hospital Mobility Network the Scheme has entered into a Preferred Provider agreement with - Day-surgery Network - A defined list of oncology pharmacies to obtain medicine related to oncology treatment The above Networks are defined in the main body of the rules and the voluntarily use of services outside of the TFG Health Plus Plan's contracted network providers and facilities, may attract Deductibles. The basis of cover for Prescribed Minimum Benefit (PMB) conditions and circumstances within which the Scheme will make Payment in Full is set out in Annexure **C2** of these rules.		
	RULE 34.1 – HOSPITAL BENEFITS		
34.1	**Health Care Cover – Unlimited**		
Sub- Rule nr	**Health Care Services Covered**	**Basis of Cover: Subject to Prescribed Minimum Benefits**	**Annual Limits**
34.1.1	Statutory Prescribed Minimum Benefits	Basis of cover as set out in this document is applicable and Annexure **C2** has reference. All Prescribed Minimum Benefits (PMB) to accumulate to available limits. Once benefit limits are reached funding in respect of PMB will continue to fund in accordance with the basis of cover as set out in this document and in Annexure **C2**.	Unlimited

pb
M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

Sub- Rule nr	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
34.1.2	Accommodation, theatre fees, materials used, prescribed medication for duration of hospitalisation at a provincial and /or private Hospital	Up to a maximum of 100% of contracted rates at a KeyCare Hospital Network facility or 100% of Scheme Rate at other private hospital facilities. 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, Rule 34.1.3 is applicable and Annexure **C2** has reference. Subject to Pre-authorisation and/or approval meeting the Scheme's clinical and Managed Health Care criteria. Benefit includes cover for ward and theatre fees, high care units, drugs and materials, x-rays, pathology, radiology, including cover for confinements, except pre- and post-natal care outside of Hospital. Blood transfusions paid up to 100% of the Cost i.e. Cost of blood, transport, apparatus and operator's fees. Circumcisions paid up to 100% of the Scheme Rate, if Pre-authorisation 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

M Wilson pb

CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

Sub- Rule nr	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
34.1.3	Hospital Benefit in Non-Network or non-contracted Hospital. 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 Pre-authorisation. In case of a PMB Condition, patient to be transferred to a KeyCare Network Hospital as soon as stabilised, unless otherwise Approved by the Scheme. Voluntary continued admission at a non-network facility may attract Deductibles.	Unlimited
34.1.4	Health care services reflected in Annexure **B3** in a defined list of day clinic network facilities	Up to a maximum of 100% of the Scheme Rate at the Scheme's defined list of day-surgery providers. A R6 300 Deductible shall be payable by the beneficiary in respect of the hospital account for elective admissions at a facility which is not a network facility. Up to a maximum of 100% of the Scheme Rate for related accounts. Medicines paid at 100% of the Scheme Medication Rate. Subject to Pre-authorisation and/or Approval and the treatment meeting the Scheme's clinical criteria.	Unlimited

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

pb

M Wilson

CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

Sub- Rule nr	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
34.1.5	Administration of defined intravenous infusions	Up to a maximum of 100% of the Scheme Rate at the Scheme's Designated Service Provider. A 20% Deductible shall be payable by the Beneficiary in respect of the hospital account when treatment is received at a provider who is not a DSP. Medicines paid at 100% of the Scheme Medication Rate. Subject to Pre-authorisation and/or approval and the treatment meeting the Scheme's clinical criteria.	Unlimited
34.1.6	Home-based healthcare for clinically appropriate chronic and acute treatment and conditions that can be treated at home	In addition to cover contained in Annexure **C2**, 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
34.1.6.1	Home-monitoring devices for clinically appropriate chronic and acute conditions	Up to a maximum of 100% of the Scheme Rate paid from Health Care Cover. The device must be approved by the Scheme, subject to the Scheme's protocols and clinical and benefit criteria.	Up to R4 250 per person per year

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

pb

M Wilson

CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

Sub- Rule nr	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
34.1.7	Pre-operative assessment for the following list of major surgeries: Arthroplasty, 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/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols.	Basket of care as determined by the Scheme
34.1.8	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 Pre-authorisation.	Limited to R405 per day and 90 days with an overall annual limit of R36 450 per person per year
34.1.9	Step Down facilities	Up to a maximum of 50% of the Cost of permanently accommodating chronically ill patients in a registered nursing home or Hospital. No benefit allowed for accommodation in an old-age home. Note: Members may claim either for nursing services or frail care facilities, but not both, where such services are provided simultaneously.	Limited to R405 per day and 180 days with an overall annual limit of R72 900 per person per year

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

pb

M Wilson

CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

Sub- Rule nr	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
34.1.10	Hospice	Terminal care and subsequent admission to a hospice forms part of the treatment and care for certain PMB conditions and will be funded in line with Regulation 8 of the Act and the PMB code of conduct as published by Council. Note: Where members' Advanced Illness Benefits (AIB) are depleted, subject to PMB, once these benefit limits are reached, the provisions of PMB is applied.	Unlimited
34.1.11	General Practitioners, Specialists and Allied Healthcare workers providing Treatment in Hospital	Premier Rate providers: Up to a maximum of the Premier Rate. Classic Direct providers: Up to a maximum of the Classic Direct Rate. General Practitioners: Up to a 100% of the contracted rates or Scheme Rate for admitting GP on the Scheme's DSP list. Up to a maximum of 100% of Cost for non-DSP if the admitting specialist or GP is contracted with the Scheme and the member is admitted in a KeyCare Network Hospital. Annexure **C2** is applicable in cases of involuntary use of a non-DSP and non-network Hospital and in cases of treatment for PMB conditions. Note: If the patient is admitted for a PMB Condition the account and Treatments received in Hospital will be paid in full for services received in a KeyCare Network Hospital, if the admitting specialist or GP is a DSP.	Unlimited

pb
M Wilson
CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

Sub- Rule nr	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
34.1.12	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 Pre-authorisation and/or approval and the treatment meeting the Scheme's treatment guidelines and clinical criteria. Drugs paid at 100% of the Scheme Medication Rate.	Unlimited

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

pb
M Wilson
CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

Sub- Rule nr	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
34.1.13	Organ Transplants	Cover in accordance with the PMB provisions, subject to Regulation 8 (3) in respect of cornea-, heart-, lung-, heart-and-lung-, bone-marrow-, kidney-, pancreas- and liver transplants. Pre-authorisation to be obtained. Up to a maximum of 100% of the Scheme Rate in private Hospital facilities and/or negotiated rates at a KeyCare Hospital Network facility or at Cost in a public Hospital facility. The following provisions apply: - Organ and patient preparation will be paid at 100% of the Scheme Rate. - Benefits in respect of the organ donor costs will be funded up to 100% of Scheme Rate in private Hospital facilities or 100% of the negotiated rate at a KeyCare Hospital Network facility and at Cost in public Hospital facilities, provided that the donor is in the Republic of South Africa and benefits are further subject to the recipient being a Beneficiary of the Scheme. - Benefits in respect of immuno-suppressant and other medication will be at Cost whilst the member is in Hospital. Subsequent supplies of immune-suppressant medication will be covered from the member's chronic illness benefit.	Unlimited

M Wilson pb

CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

Sub- Rule nr	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
34.1.14	Chemotherapy, Radiotherapy and Oncological treatment	Up to a maximum of 100% of the Scheme Rate at the Scheme's Designated Service Providers (DSP) until benefit limit is reached. If PMB the provisions as set out in Annexure **C2** is applicable. Once the annual limit is reached all non-PMB conditions and Treatment to fund up to a maximum of 80% of the Scheme Rate. Up to a maximum of 80% of the Scheme Rate at a non-DSP for non-PMB conditions. Where radiotherapy and chemotherapy is unrelated to the admission and does not form part of the hospitalisation, it will be covered up to 100% of the Scheme Rate or 100% of Cost, where no Scheme Rate exists. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria. REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES	Limited to R650 000 per person per rolling 12 months' period.

pb
M Wilson
CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

Sub- Rule nr	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
34.1.15	Maxillo-facial and oral, dental procedures covered in Annexure **C1**	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 (Annexure **C1**) 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.	Limited to R22 500 per family per year for elective maxillo-facial & oral surgery. Primary maxillo-facial surgery Unlimited
34.1.16	Mental health disorders	Up to a maximum of 100% of the Scheme Rate for related accounts. Up to a maximum of 100% of the negotiated rate for Hospital account in a KeyCare Network Hospital or 100% of Scheme Rate in a Hospital that is part of the Scheme's DSP list. Up to a maximum of 100% of the Scheme Rate for the Hospital and related accounts if a Non-Network Hospital is used. The provisions of PMB and cover for PMB conditions as set out in Annexure **C2** is 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

pb
M Wilson
CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

Sub- Rule nr	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
34.1.17	Disease management for major depression for members registered on the Scheme's disease management programme	In addition to the cover contained in Annexure **C2** up to 100% of the Scheme Rate for services covered in the Scheme's Baskets of Care if referred by the Scheme's DSP. Subject to the treatment meeting the Scheme's treatment guidelines and Managed Health Care criteria.	Baskets of Care as set by the Scheme
34.1.18	Disease Management for cardio-metabolic risk syndrome for members registered on the Scheme's Disease Management Programme	Up to a maximum of 100% of the Scheme Rate. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols.	Basket of care as set by the Scheme.
34.1.19	Drug and alcohol rehabilitation	Basis of cover contained in Annexure **C2**.	21 days in-hospital treatment per person per year
34.1.20	HIV / AIDS and AIDS related treatment	Basis of cover contained in Annexure **C2**.	Unlimited
34.1.21	Post-exposure HIV prophylaxis following occupational exposure, traumatic exposure or sexual assault	Up to a maximum of 100% of Cost.	Unlimited
34.1.22	Prophylaxis for mother-to-child transmission	Up to a maximum of 100% of Cost.	Unlimited

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

pb

M Wilson

CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

Sub- Rule nr	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
34.1.23	In-and out-of-hospital management for colorectal cancer	Up to a maximum of 100% of the Scheme Rate for the treatment at a network or non-network facility. Subject to authorisation and the treatment meeting the Scheme's treatment guidelines and clinical criteria.	Unlimited at a network provider. Basket of care as set by the Scheme for out-of-hospital treatment.
34.1.24	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 networkfacility and if obtained through a provider in the spinal surgery network. Funding will be limited to up to 80% of the Scheme Rate at a non-network facility and if services obtained from providers outside the spinal surgery network. Subject to Pre-authorisation and Treatment meeting the Scheme's treatment guidelines and clinical criteria. The devices and prostheses accumulate to the limit, where applicable. The balance of the hospital and related accounts do not accumulate to the annual limit and is paid from Health Care Cover at 100% of Scheme Rate. The provisions of Annexure **C2** is applicable for PMB conditions. Network does not apply to any admissions related to trauma.	<u>Network suppliers:</u> Unlimited if prosthesis is supplied by the Scheme's network provider and at a Network provider for in-hospital treatment <u>Non-network supplier:</u> Annual limits are set out in Annexure **C1** if prosthesis is not supplied by the Scheme's network provider Baskets of Care as set by the Scheme for out-of-hospital conservative treatment is applicable
34.1.25	Advanced Illness Benefit (AIB)	Up to a maximum of 100% of the Scheme Rate. Subject to Pre-authorisation and the treatment meeting the Scheme's guidelines and managed care criteria.	Unlimited

M Wilson pb

CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

Sub- Rule nr	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
34.1.26	MRI and CT Scans	Up to a maximum of 100% of the negotiated rate or Scheme Rate, for in-hospital scans performed in respect of treatment related to an authorised admission. Subject to referral by a DSP. Where MRI and CT scan is unrelated to the admission it will be covered up to a maximum of 100% of the Scheme Rate from the radiology and pathology benefit as set out in these rules. Subject to the Treatment meeting the Scheme's treatment guidelines and Managed Health Care criteria.	Unlimited
34.1.27	Gastroscopies, colonoscopies, proctoscopies and sigmoidoscopies	Save for cover as contained in Annexure **B2** and children aged 12 years and under, subject to PMB. 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 from Health Care Cover if done in the doctor's rooms and subject to Pre-authorisation.	Unlimited
34.1.28	Medication and materials billed by Hospital as TTO medicine (medicine to take home)	Save for cover contained in Annexure **C2**, up to a maximum of 100% of the Scheme Rate or Medication Rate.	Unlimited
34.1.29	Emergency Medical Services within the borders of South Africa (Ambulance services)	Up to a maximum of 100% of the Scheme Rate. Inter-hospital transfer subject to Pre-authorisation. The provisions of PMB and cover for PMB conditions as set out in Annexure **C2** is applicable.	Limited to R5 300 per family per year

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

pb

M Wilson

CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

Sub- Rule nr	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
34.1.30	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
34.1.31	Screening Benefit A - Group of tests consisting of blood glucose test, blood pressure test, cholesterol test and Body Mass Index (BMI)	Save for cover contained in Annexure **C2**, up to a maximum of 100% of the Scheme Medication Rate. Subject to meeting the Scheme's clinical entry criteria.	Unlimited
34.1.32	Screening Benefit B - Defined diabetes and cholesterol screening tests	Up to a maximum of 100% of the Scheme Rate for test code. Subject to meeting the Scheme's clinical entry criteria. Note: Consultation paid from available day-to-day benefits as set out in **Rule 34.3**, or by the member where no benefits are available. Where the consultation relates to a PMB the consultation will be paid from Health Care Cover. REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES	Unlimited

pb
M Wilson
CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

Sub- Rule nr	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
34.1.33	Screening Benefit C - Consist of appropriate tests as determined by the Scheme: HIV screening, Mammogram, Prostate-Specific Antigen (PSA), colorectal and cervical cancer screening	Up to a maximum of 100% of the Scheme Rate for test code. Subject to meeting the Scheme's clinical entry criteria. Note: Consultation paid from available day-to-day benefits as set out defined in **Rule 34.3**, or by the member where no benefits are available. Where the consultation relates to a PMB the consultation will be paid from Health Care Cover. REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES	Appropriate HIV screening tests as determined by the Scheme – Unlimited One Mammogram and one Pap Smear every year or one HPV test every 5 years per female Beneficiary One PSA test per male Beneficiary every year One colorectal screening per person every year One faecal occult blood test or immunochemical test every 2 years per person for persons between the ages of 45 to 75 years
34.1.34	Screening Benefit D - Additional cover for breast MRI, BRCA testing and colonoscopy	Up to a maximum of 100% of the Scheme Rate for test code. Subject to meeting the Scheme's clinical entry criteria. Note: Consultation paid from available day-to-day benefits as set out defined in **Rule 34.3**, or by the member where no benefits are available. Where the consultation relates to a PMB the consultation will be paid from Health Care Cover.	Basket of Care as set by the Scheme One BRCA test and colonoscopy per year

pb
M Wilson
CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

Sub- Rule nr	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
34.1.35	Screening Benefit E - Group of age appropriate tests including but not limited to growth assessment, blood pressure and health and milestone tracking	Up to a maximum of 100% of the Scheme Rate at a Designated Service Provider (DSP), for children between the ages of 2 and 18. Subject to meeting the Scheme's clinical entry criteria.	Unlimited
34.1.36	Screening Benefit F – Group of age appropriate screening tests	Up to a maximum of 100% of the Scheme Rate at a DSP, for members 65 years and older. Subject to meeting the Scheme's clinical entry criteria.	Unlimited
34.1.37	Screening Benefit G - Additional screening assessment or consultation	Up to a maximum of 100% of the Scheme Rate at a DSP or accredited provider. Subject to meeting the Scheme's clinical entry criteria and treatment guidelines.	One consultation per person per year in person or one 20-minute online consultation
34.1.38	Preventative Benefit - Pneumococcal vaccination	Up to a maximum of 100% of the Scheme Medication Rate for the vaccination. Note: Pneumococcal vaccines in excess of the annual limit, consultation and other healthcare services to administer the vaccine, paid by the member. Subject to the Scheme's Protocols and clinical entry criteria.	Up to 2 pneumococcal vaccine doses per person per lifetime

M Wilson pb

CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

Sub- Rule nr	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
34.1.39	Preventative Benefit - Seasonal influenza vaccination	Up to a maximum of 100% of the Scheme Medication Rate for the vaccination. Seasonal flu vaccines in excess of annual limit is payable by the member. Subject to Scheme Protocols and clinical entry criteria. Note: Consultation and other healthcare services to administer the vaccine, paid from available day-to-day benefits as set out in **Rule 34.3**, or by the member where no benefits are available.	One seasonal influenza vaccine per person per year
34.1.40	Preventative Benefit – Child and adult vaccinations	Up to a maximum of 100% of the Scheme Medication Rate for the cost of the vaccination and injection material administered by a registered nurse, general practitioner or specialist that is part of the Scheme's DSP. Subject to Scheme Protocols and clinical entry criteria. Note: Consultation and other healthcare services to administer the vaccine, paid from available day-to-day benefits as set out in **Rule 34.3**, or by the member where no benefits are available.	- Adult vaccinations per beneficiary include: Tetanus/Diphtheria, Hepatitis A, Hepatitis B, Measles, Mumps, Rubella, Chickenpox, Shingles and Meningococcal. - Child vaccinations per beneficiary include: Polio, TB, Hepatitis B, Rotavirus, Diphtheria, Tetanus, Acellular pertussis, Haemophilus, Influenza Type B, Chickenpox, Measles, Mumps and Rubella.

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

pb
M Wilson

CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

Sub- Rule nr	Health Care Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
34.1.41	Preventative Benefit – HPV vaccinations	Up to a maximum of 100% of the Scheme Medication Rate for the vaccination. Subject to Scheme Protocols and clinical entry criteria. Note: Consultation and other healthcare services to administer the vaccine, paid from available day-to-day benefits as set out in **Rule 34.3**, or by the member where no benefits are available.	One per person per year (between the ages of 9 and 26 years)
34.1.42	Additional screening benefit for: - Primary healthcare screening services for visual, hearing, dental and skin conditions - Physical well-being screening at a dietician, biokinetisist and/or physiotherapist - Women and men's screening and prevention healthcare services - Screening and prevention healthcare services for children - Cover for a defined list of registered screening and health monitoring devices	Up to a maximum of 100% of the Scheme Rate, subject to completion of the group of tests as set out in Screening Benefit A and Screening Benefit C, as applicable and stipulated in this benefit table. The benefit is available for a maximum of 2 years. For any beneficiary joining the Scheme, the benefit is available in the year of joining and the year thereafter. Subject to the Scheme's clinical entry criteria, treatment guidelines and protocols.	Basket of care as set by the Scheme limited to: R2 500 per adult beneficiary once per lifetime; R1 250 per child beneficiary once per lifetime; up to a maximum of R10 000 per family

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

pb

M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

Benefits as set out in Rule 34.2 below is provided under the following conditions and limitations:

A member and/or his dependants shall subject to being clinically diagnosed as suffering from a chronic illness condition and having met all the Scheme's required clinical criteria, be entitled to the Chronic Illness Benefits ("CIB") as set out in **Rule 34.2** below, provided that a separate CIB application form is completed and submitted to the Scheme.

The calculation of the amount payable by the Scheme in respect of CIB as set out in **Rule 34.2** below may be based on:

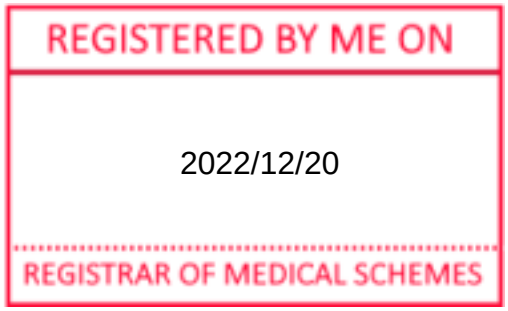
- The Billing Guidelines applicable to the Service Provider concerned and/or
- Depending on the contracted arrangements entered into by the Scheme with the Service Providers and/or;
- The applicable Scheme Rate or Scheme Medication Rate in respect of the Relevant health services (or a percentage of such Scheme Rate or Scheme Medication Rate); and/or
- A fixed amount per Relevant health service rendered as set out in **Rule 34.2** and Annexure **C2**.

The Scheme's liability will be limited in each financial year in terms of the relevant sections of **Rule 34.2** and will also be subject to the provisions of the Act and its Regulations.

The determination of whether a member and/or his dependants is entitled to Chronic Illness Benefits shall be:

- Based on the clinical diagnosis of the prescribing medical practitioner or a specialist specified by the medical panel of the Scheme;
- Based on the opinion of the medical panel of the Scheme or the appropriate organisation approved by the Scheme; and
- In terms of the relevant section of **Rule 34.2** as set out below.

The Scheme shall pay the claims in respect of CIB in accordance with **Rule 16** of the main body of the Rules.



M Wilson pb CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

TFG HEALTH PLUS – RULE 34 2023			
RULE 34.2 – CHRONIC ILLNESS BENEFIT (CIB)			
Sub-Rule nr	**Healthcare Services Covered**	**Basis of Cover: Subject to Prescribed Minimum Benefits**	**Annual Limits**
34.2.1	Chronic Illness Benefit (CIB): Medication for the chronic Prescribed Minimum Benefit conditions, as well as an Additional Disease List (ADL) of chronic conditions. Annexure **C1** has reference.	Save for medication contemplated in **Rule 16** of the main body of the rules, basis of cover is contained in Annexure **C1 and C2**. Subject to the Scheme Protocols, clinical entry criteria and medicine utilisation review. Chronic Drug Amount (CDA) per drug class as set by the Scheme is applied. PrEP medication as preventative treatment of HIV within clinical guidelines and protocols are funded within this benefit limit.	R32 500 per person subject to an overall annual limit (OAL) of R88 000 per member family per year.
34.2.2	Specialised Medicine contemplated in Rule 16.14 of the main body of the rules	Up to a maximum of 100% of the Scheme Medication Rate. The Scheme will pay between 80% and 100% of the Scheme Medication Rate or up to a maximum of the Reference Price List for preferentially priced medicine. Subject to the Scheme Protocols, clinical entry criteria and medicine utilisation review. PMB conditions where all other alternative treatment has been exhausted will be fund at Cost or the maximum of the Reference Price List (RPL) for preferentially priced medicine (biosimilars), where deemed clinically appropriate.	Limited to R290 000 per person per year

pb
M Wilson
CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

Sub-Rule nr	Healthcare Services Covered	Basis of Cover: Subject to Prescribed Minimum Benefits	Annual Limits
34.2.3	Diabetes management for members registered on the Scheme's disease management programme	Basis of cover is contained in Annexure **C2**. Up to 100% of the Scheme Rate for services covered in the Scheme's Baskets of Care if referred by the Scheme's DSP.	Baskets of Care as set by the Scheme
34.2.4	HIV management for members registered on the Scheme's disease management programme	Basis of cover is contained in Annexure **C2**. Up to 100% of the Scheme Rate for services covered in the Scheme's Baskets of Care if referred by the Scheme's DSP.	Baskets of Care as set by the Scheme
34.2.5	Cardiovascular disease management for members registered on the Scheme's disease management programme	Basis of cover is contained in Annexure **C2**. Up to 100% of the Scheme Rate for services covered in the Scheme's Baskets of Care.	Baskets of Care as set by the Scheme
34.2.6	Telemetric glucometer device	Any beneficiary approved and registered on the Scheme's Chronic Illness Benefit for Diabetes is covered up to 100% of the Scheme Rate. The device must be approved by the Scheme, subject to the Scheme Protocols and clinical entry criteria.	Telemetric device: 1 per person per year limited to Health Care Cover (Rule 34.1) and second device limited to medical appliances limit.
34.2.6.1	Blood glucose monitoring devices	Any beneficiary approved and registered on the Scheme's Chronic Illness Benefit for Diabetes is covered up to 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 entry criteria.	1 per beneficiary per year limited to the home-monitoring device limit of R4 250 per person per year

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

pb

M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

	TFG HEALTH PLUS PLAN – RULE 34 2023		
	RULE 34.3 – OUT OF HOSPITAL and PRIMARY CARE BENEFITS		
Sub-Rule nr	**Healthcare Services Covered**	**Basis of Cover: Subject to Prescribed Minimum Benefits**	**Annual Limits**
34.3.1	Primary care: Physical and virtual or online consultations at general practitioners (GP), specialists (excluding psychiatrists), nurse practitioners and associated health services	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** 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. The provisions of PMB and cover for PMB conditions as set out in Annexure **C2** is applicable.	Limited to: R4 800 Per family per year (M) R7 200 Per family per year (M + 1) R9 400 Per family per year (M + 2) R10 900 Per family per year (M + 3) R11 800 Per family per year (M + 4) R12 400 Per family per year (M + 5) R12 900 Per family per year (M + 6) R13 200 Per family per year (M + 7) PMB Conditions: Additional consultations of up to 4 visits per person per year if registered for chronic conditions (CIB). Maternity consultations: Additional 8 GP or gynaecologist consultations per pregnant person per year. Unscheduled emergency visits limited to 2 visits per child between the age of 0 to 10. Unlimited virtual paediatric consultations for children aged 1 to 14 per year at a KeyCare Network GP

pb
M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

	TFG HEALTH PLUS PLAN – RULE 34 2023		
	RULE 34.3 – OUT OF HOSPITAL and PRIMARY CARE BENEFITS		
Sub-Rule nr	**Healthcare Services Covered**	**Basis of Cover: Subject to Prescribed Minimum Benefits**	**Annual Limits**
34.3.1.2	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
34.3.1.3	Visits to casualty units	Up to a maximum of 100% of the Scheme Rate, subject to the emergency consultation and procedure codes.	Unlimited if treatment is obtained from a General Practitioner ("GP") who practice in the emergency rooms at DSP facilities
34.3.2	Primary care: Basic dentistry	Up to a maximum of 100% of the Scheme Rate. Annexure **C1** has reference. The provisions of PMB and cover for PMB conditions as set out in is applicable.	Limited to: R5 000 – Per family per year (M) R6 100 – Per family per year (M + 1) R7 100 – Per family per year (M + 2) R8 000 – Per family per year (M + 3) R8 800 – Per family per year (M + 4) R9 400 – Per family per year (M + 5) R9 700 – Per family per year (M + 6) R9 800 – Per family per year (M + 7)

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

pb

M Wilson

CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

<table>
<tr><td></td><td colspan="3">TFG HEALTH PLUS PLAN – RULE 34 2023</td></tr>
<tr><td></td><td colspan="3">RULE 34.3 – OUT OF HOSPITAL and PRIMARY CARE BENEFITS</td></tr>
<tr><td>Sub-Rule nr</td><td>Healthcare Services Covered</td><td>Basis of Cover: Subject to Prescribed Minimum Benefits</td><td>Annual Limits</td></tr>
<tr><td>34.3.3</td><td>Specialised dentistry</td><td>Up to a maximum of 100% of the Scheme Rate.

Annexure C1 has reference.

The provisions of PMB and cover for PMB conditions as set out in Annexure C2 is applicable.

REGISTERED BY ME ON
2022/12/20
REGISTRAR OF MEDICAL SCHEMES</td><td>Limited to:<table><tr><td>R11 100</td><td>Per family per year (M)</td></tr><tr><td>R14 700</td><td>Per family per year (M + 1)</td></tr><tr><td>R17 700</td><td>Per family per year (M + 2)</td></tr><tr><td>R19 400</td><td>Per family per year (M + 3)</td></tr><tr><td>R20 700</td><td>Per family per year (M + 4)</td></tr><tr><td>R21 200</td><td>Per family per year (M + 5)</td></tr><tr><td>R21 700</td><td>Per family per year (M + 6)</td></tr><tr><td>R22 000</td><td>Per family per year (M + 7)</td></tr></table></td></tr>
</table>

pb

M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

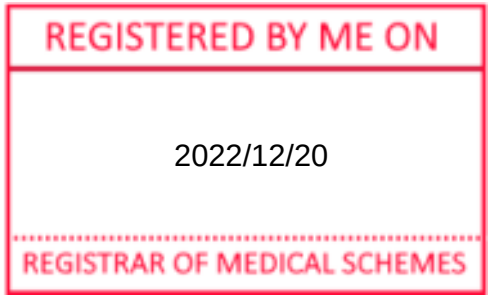
	TFG HEALTH PLUS PLAN – RULE 34 2023		
	RULE 34.3 – OUT OF HOSPITAL and PRIMARY CARE BENEFITS		
Sub-Rule nr	**Healthcare Services Covered**	**Basis of Cover: Subject to Prescribed Minimum Benefits**	**Annual Limits**
34.3.4	Other Healthcare Providers: Speech therapy, audiology and occupational therapy consultations	Up to a maximum of 100% of Scheme Rate for Treatments and consultations. The provisions of PMB and cover for PMB conditions as set out in Annexure **C2** is applicable. Must be prescribed by a medical practitioner and provided the supplier of service is registered with the Health Professions Council of South Africa (HPCSA).	Limited to R8 000 per family per year
34.3.5	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 negotiated rate at contracted network providers. The provisions of PMB and cover for PMB conditions as set out in Annexure **C2** is 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 R9 600 per family per year.

pb
M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

	TFG HEALTH PLUS PLAN – RULE 34 2023		
	RULE 34.3 – OUT OF HOSPITAL and PRIMARY CARE BENEFITS		
Sub-Rule nr	**Healthcare Services Covered**	**Basis of Cover: Subject to Prescribed Minimum Benefits**	**Annual Limits**
34.3.6	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 as set out in Annexure **C2** is applicable. Must be prescribed by a medical practitioner and provided the supplier of service is registered with the Health Professions Council of South Africa (HPCSA).	Limited to R7 100 per family per year
34.3.7	Other Healthcare Providers: Podiatry and Orthoptics (including services by Optometrists)	Up to a maximum of 100% of Scheme Rate. The provisions of PMB and cover for PMB conditions as set out in Annexure **C2** is applicable. Must be prescribed by a medical practitioner and provided the supplier of service is registered with the Health Professions Council of South Africa (HPCSA).	Limited to R5 800 per family per year



pb
M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

<table>
<tr><td></td><td colspan="3">TFG HEALTH PLUS PLAN – RULE 34 2023</td></tr>
<tr><td></td><td colspan="3">RULE 34.3 – OUT OF HOSPITAL and PRIMARY CARE BENEFITS</td></tr>
<tr><td>Sub-Rule nr</td><td>Healthcare Services Covered</td><td>Basis of Cover: Subject to Prescribed Minimum Benefits</td><td>Annual Limits</td></tr>
<tr><td>34.3.8</td><td>Prescribed acute medicine and over the counter (OTC) medicine</td><td><u>Acute medication obtained from a DSP:</u> Up to a maximum of 100% of the Scheme Medication Rate.

<u>Acute medication obtained from a non-DSP:</u> Up to a maximum of 80% of the Scheme Medication Rate.

<u>OTC</u>: Up to a maximum of 80% of the Scheme Medication Rate.

Subject to the Scheme’s Acute Medicine Formulary and Protocols and preferentially priced generic and brand medication prices.

Annexure C1 as reference.

The provisions of PMB and cover for PMB conditions as set out in Annexure C2 is applicable.</td><td>Acute Medicine limited to:
<table><tr><td>R7 800</td><td>Per family per year (M)</td></tr><tr><td>R11 500</td><td>Per family per year (M + 1)</td></tr><tr><td>R13 600</td><td>Per family per year (M + 2)</td></tr><tr><td>R15 300</td><td>Per family per year (M + 3)</td></tr><tr><td>R16 700</td><td>Per family per year (M + 4)</td></tr><tr><td>R17 500</td><td>Per family per year (M + 5)</td></tr><tr><td>R18 200</td><td>Per family per year (M + 6)</td></tr><tr><td>R18 400</td><td>Per family per year (M + 7)</td></tr></table>
OTC limited to R230 and further limited to the above Acute Medicine annual limits</td></tr>
</table>

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

pb

M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

<table>
<tr><td></td><td colspan="3">TFG HEALTH PLUS PLAN – RULE 34 2023</td></tr>
<tr><td></td><td colspan="3">RULE 34.3 – OUT OF HOSPITAL and PRIMARY CARE BENEFITS</td></tr>
<tr><td>Sub-Rule nr</td><td>Healthcare Services Covered</td><td>Basis of Cover: Subject to Prescribed Minimum Benefits</td><td>Annual Limits</td></tr>
<tr><td>34.3.9</td><td>Radiology and pathology</td><td>Up to a maximum of 100% of the Scheme Rate.

The provisions of PMB and cover for PMB conditions as set out in Annexure C2 is applicable.</td><td>Limited to R29 200 per family per year

Vacuum-assisted breast biopsies (“VAAB”) are funded up to 1 test per beneficiary limited to negotiated fees. Thereafter the above day-to-day limit applies.</td></tr>
<tr><td>34.3.10</td><td>Optometry

REGISTERED BY ME ON
2022/12/20
REGISTRAR OF MEDICAL SCHEMES</td><td>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.

Annexure C1 has reference.

The provisions of PMB and cover for PMB conditions as set out in Annexure C2 is applicable.

Optical procedures are limited and funded from Health Care Cover.

Member’s optical cycle start on date of first visit.</td><td>Limited per person per 2-year cycle:

<table>
<tr><td>Consultation</td><td>R900</td><td>1 visit</td></tr>
<tr><td>Frames</td><td>R1 200</td><td>1 frame</td></tr>
<tr><td>Lenses: single vision</td><td>R490</td><td>1 pair</td></tr>
<tr><td colspan="3">OR</td></tr>
<tr><td>Lenses: Bifocal</td><td>R1 160</td><td>1 pair</td></tr>
<tr><td colspan="3">OR</td></tr>
<tr><td>Lenses: Multifocal</td><td>R2 250</td><td>1 pair</td></tr>
<tr><td colspan="3">OR</td></tr>
<tr><td>Contact lenses</td><td>R3 850</td><td></td></tr>
</table>
</td></tr>
</table>

pb

M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

	TFG HEALTH PLUS PLAN – RULE 34 2023		
	RULE 34.3 – OUT OF HOSPITAL and PRIMARY CARE BENEFITS		
Sub-Rule nr	**Healthcare Services Covered**	**Basis of Cover: Subject to Prescribed Minimum Benefits**	**Annual Limits**
34.3.11	Medical appliances (External Medical Items), mobility devices (wheelchairs, long leg callipers and crutches), including hearing aids and external prosthesis	Up to a maximum of 100% of the Cost or agreed rate for PMB conditions where a DSP or Formulary item is used or a non-DSP is used involuntarily. Up to a maximum of 100% of Reference Price List for PMB conditions where a non-DSP or non-Formulary items is used voluntarily. Up to a maximum of 80% of Cost for non-PMB conditions/items. Approval to be obtained from the Scheme, subject to the Scheme Protocols and clinical entry criteria. The provisions of Annexure **C2** is applicable for PMB conditions.	Network suppliers: Unlimited if EMI is supplied by the Scheme's network provider Non-network supplier: Limited to R26 100 per family per year if not supplied by the Scheme's network provider.

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

pb

M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

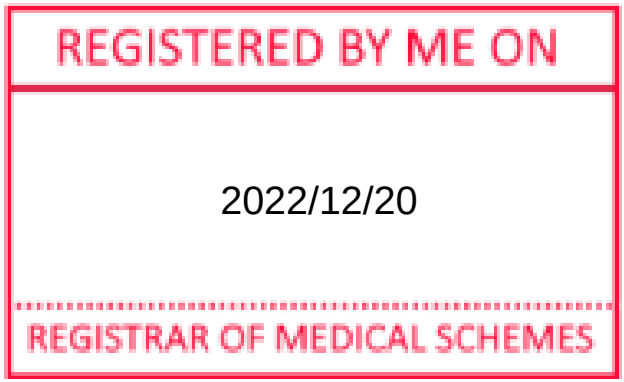
	TFG HEALTH PLUS PLAN – RULE 34 2023		
	RULE 34.3 – OUT OF HOSPITAL and PRIMARY CARE BENEFITS		
Sub-Rule nr	**Healthcare Services Covered**	**Basis of Cover: Subject to Prescribed Minimum Benefits**	**Annual Limits**
34.3.12	Maternity Benefit REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES	GP or gynaecologists: Up to a maximum of 100% of the Scheme Rate at a Designated Service Provider (DSP). Hospital related accounts are paid from Health Care Cover, subject to Pre-authorisation 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 benefit limit in this set of rules. The provisions of PMB and cover for PMB conditions as set out in Annexure **C2** is applicable.	Services: – Antenatal consultations: 8 per pregnancy funded from the primary care consultation limit – Prenatal screening, including chromosome testing or Non Invasive Prenatal Testing (NIPT): 1 per pregnancy funded from the radiology and pathology limit – Pregnancy scans: See radiology and pathology limit – Blood tests: See radiology and pathology limit – Postnatal consultations: Included in primary care consultations – Dietician nutrition assessment: Included in primary care consultations – Mental health consultations: Included in the psychiatry and clinical psychology limit – Lactation consultations for infants: 1 per child funded from the primary care consultation benefit limit

pb
M Wilson CH

TFG MEDICAL AID SCHEME: BENEFIT PLAN TABLE TFG HEALTH PLUS BENEFIT PLAN RULE 34

ANNEXURE C

	TFG HEALTH PLUS PLAN – RULE 34 2023		
	RULE 34.3 – OUT OF HOSPITAL and PRIMARY CARE BENEFITS		
Sub-Rule nr	**Healthcare Services Covered**	**Basis of Cover: Subject to Prescribed Minimum Benefits**	**Annual Limits**
34.3.13	Benefit for out-of-hospital management and appropriate supportive treatment of specific global World Health Organisation (WHO) recognised disease outbreaks: - COVID-19 - Monkeypox	In addition to cover contained in Annexure **C2**, up to a maximum of 100% of the Scheme Rate. 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 per condition. PMB requirements and Council for Medical Schemes ("CMS") guidelines prevail.



M Wilson pb

CH

ANNEXURE C1

TFG HEALTH PLUS: SUPPORTING ANNEXURE TO RULE 34

Effective 1 January 2023

A. MAXILLO-FACIAL AND ORAL SURGERY (DENTAL SURGERY)

The following reflects those dental and maxillo-facial procedures, as well as dental surgery covered under Health Care Cover.

1. Conservative dentistry under anaesthetics in respect of patients not older than 7 years;
2. Primary maxillo-facial and oral surgery, which includes:

2.1.1 treatment of cysts, tumours and salivary gland conditions, including complications.

2.1.2 intra and extra-oral drainage of abscesses and surgery to infected bone not specified in basic and specialised dentistry.

2.1.3 treatment of trauma including fractures of jaws and facial structures as well as associated skeletal complications.

2.1.4 treatment of conditions of the tempero-mandibular (jaw) joint, excluding orthagnathic surgery, see elective maxillo-facial and oral surgery.

2.1.5 removal of teeth and associated complications.

3. Elective maxillo-facial and oral surgery

Subject to the maximum annual benefit specified in Rule 34 of Annexure C, funding includes:

3.1.1 Surgical placement and exposure of implants, inclusive of the Cost of implant bodies and transmucosal extensions.

Note: The subsequent restorative phase will be deemed Specialised Dentistry and will be subject to the provisions of benefits provided for Specialised Dentistry as set out in Rule 34.

3.1.2 Orthagnathic surgery (surgical repositioning of jaws).

M Wilson

pb CH

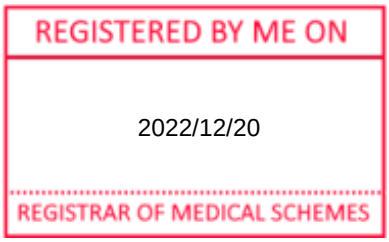
B. INTERNAL PROSTHESIS

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

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

The following sub-limits per family per year will apply for where provided by non-DSP. These sub-limits include the associated materials used with prostheses.

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



Where clinically appropriate and pre-authorisation 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.

C. CHRONIC MEDICATION

Chronic medication is paid from the Chronic Illness Benefit (CIB) of the Scheme.

Chronic medication benefits will make provision for the following Additional Disease List (ADL) which are a set of non-PMB chronic conditions, in addition to the PMB Chronic Disease List (CDL) conditions.

M Wilson

The additional chronic conditions for which funding for medicines up to a monthly Chronic Drug Amount (CDA) are provided on this Benefit Plan are listed below:

pb CH

Ankylosing spondylitis
Attention Deficit Hyperactivity Disorder (ADHD)
Behcet's disease
* Cystic fibrosis
* Delusional disorder
Dermatopolymyositis
* Generalised anxiety disorder
Gastro-oesophageal reflux disease
* Gout
* Huntington's disease
Isolated growth hormone deficiency in children
* Major depression
Motor neuron disease
* Muscular dystrophy and other inherited myopathies
* Myasthenia gravis
Obsessive compulsive disorder
* Osteoporosis
Paget's disease
Panic disorder
Polyarthritis nodosa
Post-traumatic stress disorder
Psoriatic arthritis
Pulmonary interstitial fibrosis
Sjogren's syndrome
Systemic sclerosis
* 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.

PrEP medicine for the preventive treatment of HIV within clinical guidelines and protocols is funded from the chronic medicine limits as set out in Rule 34.

M Wilson

Members may use the supplier of their choice. Once the chronic medication limit specified in Rule 34 has been reached, the Scheme's appointed Designated Service

pb CH

Provider (DSP) in respect of PMB CDL chronic medication only, shall be, dispensing Network GPs, MedXpress and the Scheme's contracted pharmacy Network only.

Subject to the approval of the Scheme and further subject to the maximum annual limit specified in Rule 34 of Annexure C, the benefit for those members who apply for non-PMB chronic medication benefits for conditions appearing on the additional chronic conditions list as approved by the Scheme shall be:

- 100% of the Scheme Medication Rate per prescription or repeat prescription per person, of approved medicines supplied by an accredited supplier/suppliers as chosen by the Beneficiary for the supply of chronic medication.

- Subject to the approval of the Scheme and further subject to the maximum annual limit specified in Rule 34 of Annexure C, the benefit for those members who qualify for PMB CDL chronic medication benefits shall be:

- Unlimited and 100% of the Scheme Medication Rate per prescription or repeat prescription per person, of approved PMB CDL chronic medicines if supplied by the Scheme's appointed DSP or if involuntarily obtained from a provider other than the appointed DSP, subject to Baskets of Care and the applicable formulary in use by the Scheme for this Benefit Plan.

- Each prescription or repeat prescription is limited to one month's supply per person and the Scheme shall only consider claims for medicine obtained on the written prescription of a person legally entitled to prescribe medicine.

- Benefits may be claimed under this heading from the date of approval of the prescription by the Scheme.

D. SPECIALISED DENTISTRY

100% of the Scheme Rate, for the following subject to the maximum annual benefit specified in Rule 34 of Annexure C:

1. metal bases to dentures
2. soft bases to dentures
3. metal, porcelain and resin inlays apart from metal inlays on front teeth

M Wilson

pb CH

4. root canal treatment

5. periodontal treatment;

6. restorative phase of implants, inclusive of implant components;

7. crown and bridge work;

8. bleaching of root canal treated teeth;

9. orthodontic treatment.

Bleaching of teeth that have not been root canal treated, metal inlays in dentures and front teeth and Mandibular Advancement Devices (MAD), are excluded from benefits.

E. OPTICAL

1. The following services which are restricted to the maximum benefit specified in Rule 34 are covered over a two-year cycle period calculated according to the Scheme's Benefit period:

- comprehensive consultations, including tonometry and field vision examinations; and one contact lens re-examination per person per benefit cycle.
- frames or prescription lens enhancements (i.e. hard coating, anti-reflex coating and/or tinting).
- prescribed contact lenses (as an alternative to glasses) and spectacle lenses, which may be either single vision or bi-focal or multi-focal, including extra-large lenses, prism correction;

Provided that:

a. Benefits for the consultation, frames and lenses combined are restricted to the maximum benefit specified in Rule 34, over a two-year period calculated according to the Scheme's Benefit period.

b. No benefit will be allowed for the supply of plano sunglasses or for spectacle cases.

c. A maximum of one visual examination per person per benefit cycle may be claimed as a benefit. Subject to the approval of the Scheme, benefits may be allowed for more than one visual examination per person, per year, in cases of progressive myopia, post-operative conditions and diabetes mellitus.

M Wilson pb CH

d. No benefit will be allowed for excimer laser treatment / refractive surgery, unless it is a PMB, in which case, benefits will be covered under the provisions relating to the Prescribed Minimum Benefits.

e. In the case of contact lenses, no benefit will be allowed for solutions, kits and the fee associated with subsequent fittings and adjustments.

f. The benefit for a visual examination, if done by an ophthalmol in accordance with the Specialists benefits available.

F. BASIC DENTISTRY

100% of the Scheme Rate, subject to the maximum annual benefit limit specified in Rule 34 for:

a. examination, preventative dentistry and x-rays;

b. fillings i.e. plastic restorations and acid etch restorations including pin reinforcement;

c. acrylic full and partial dentures - following allocation of benefits for a first denture per jaw, benefits for subsequent dentures in the same jaw within a two-year period, will be subject to the discretion of the Board or its appointee;

d. addition of teeth to dentures and repairs to dentures.

Note: Extraction of teeth is deemed maxillo-facial and oral surgery. Mandibular Advancement Devices (MAD) are excluded from benefits.

G. ACUTE MEDICATION

Subject to the maximum annual benefit specified in Rule 34 of Annexure C, the benefit for acute medication shall be:

1. 100% of the Scheme Medication Rate, per prescription or repeat prescription per person, of medicines supplied by the network of pharmacies with which the Scheme has contracted arrangements;

M Wilson pb CH

2. 80% of the Scheme Medication Rate for medicines per prescription or repeat prescription per person where medicines are supplied by pharmacies which fall outside the network of pharmacies with which the Scheme has contracted arrangements.

3. Each prescription or repeat prescription is limited to one month's supply per person and the Scheme shall only consider claims for medicine obtained on the written prescription of a person legally entitled to prescribe medicine and dispensed by such person or by a registered pharmacist.

4. Where the Scheme has an agreement with any person, company or organisation, the account may be rendered to the Scheme through the machinery of that association for direct payment and collection of the portion due by the Member shall be in accordance with the provisions as set out in the main rules to this Annexure.

5. Where medicine is dispensed by a dispensing doctor, a fully specified account detailing the name, strength, quantity, cost and, where possible, the National Pharmaceutical Product interface (NAPPI) Code, may, subject to the approval of the Scheme, be submitted for direct payment and collection of the portion due by the Member shall be in accordance with the provisions as set out in the main rules to this Annexure.

6. Where the Service Supplier does not have an agreement with the Scheme or where the Member elects to pay the full amount to either the pharmacist or dispensing doctor, the Scheme will, in the case of a pharmacy account, refund the benefit to the Member upon receipt of the pharmacy's certified copy of the prescription and a copy of the corresponding signed doctor's prescription (obtainable from the pharmacist) supported by proof of payment. In the case of a dispensing doctor, the Scheme will refund the benefit to the Member upon receipt of a fully specified account from the dispensing doctor.

H. OVER THE COUNTER MEDICATION

80% of the Scheme Medication Rate for non-prescribed schedule 1 and 2 medicine, supplied by a pharmacist, to treat an ailment and subject to the maximum annual benefit specified in Rule 34 of Annexure C.

pb
M Wilson CH

Claims for benefits under this paragraph must be submitted to the Scheme by the pharmacists in accordance with the procedure as set out in the main rules of the Scheme.

I. ASSOCIATED HEALTH SERVICES

Benefits in respect of fees charged for treatment by Osteopaths, Homeopaths and Naturopaths will be limited to 80% of the cost and subject to the maximum annual benefit specified in Rule 34 of Annexure C.

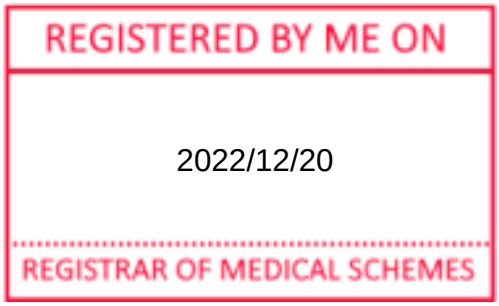
Provided that:

1. the Scheme's share will be refunded to the Member who will be responsible for direct settlement of the account;

2. the fees must have been incurred for a definite complaint and the treatment therefore must be for curative purposes only;

3. the Board may require a Member to state the period of time that he has suffered from that particular complaint and what previous medical treatment he had received for it;

4. no benefit will be allowed in respect of accommodation or treatment received for health, slimming, chiropractic, homeopathic, herbal or other purposes in spas and resorts.



pb CH

M Wilson

Annexure C2
TFG Health Plus Cover for Prescribed Minimum Benefits: 2023

PREAMBLE

The benefits in respect of the Prescribed Minimum Benefits (PMB) are funded as set out in this Annexure.

The Scheme's contracted Designated Service Providers (DSP/DPA), which includes the following network providers are listed below:

- KeyCare Network Hospitals (PMB Network Hospital)
- KeyCare Network GP
- A list of Specialists contracted as Designated Service Providers (Classic Direct Payment Arrangements)
- Premier Plus GP
- A defined list of pharmacies the Scheme has contracted with known as DSP
- A defined list of Phycologists, Social workers and Midwifes with whom the Scheme has entered into a Preferred Provider agreement with
- An out-of-hospital Mobility Network the Scheme has entered into a Preferred Provider agreement with
- Day-surgery Network
- A defined list of oncology pharmacies to obtain medicine related to oncology treatment

A Beneficiary will be deemed to have involuntarily obtained a service from a provider other than the abovementioned contracted network providers or DSP, if -

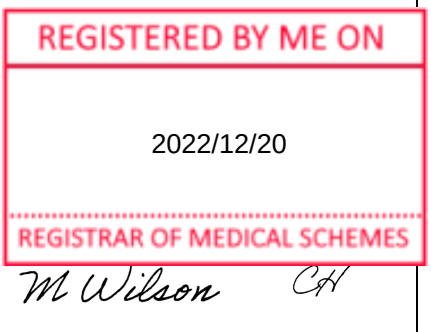
(i) the service was not available from the DSP or would not be provided without unreasonable delay;

(ii) immediate medical or surgical Treatment for a PMB benefit condition was required under circumstances or at locations which reasonably precluded the Beneficiary from obtaining such treatment from a DSP; or

(iii) if there was no DSP within reasonable proximity to the Beneficiary's ordinary place of business or personal residence.

The below tables set out the manner in which the Scheme will fund PMB conditions if:

a) a Beneficiary uses the DSP or involuntarily uses a non-DSP or
b) a Beneficiary voluntarily does not use the DSP.



Annexure C2
TFG Health Plus Cover for Prescribed Minimum Benefits: 2023

TFG HEALTH PLUS			
Type	**Designated Service Provider ("DSP")**	**a) Reimbursement Rate if the Beneficiary uses the DSP or involuntarily uses a non-DSP**	**b) Reimbursement Rate if the Beneficiary voluntarily does not use a DSP /uses a non-DSP**
Chronic Disease List ("CDL") and Diagnostic Treatment Pairs Prescribed Minimum Benefits ("DTPMB") : – **Out-of-Hospital Consultations**	**Specialists:** Any specialist participating in the KeyCare or Premier Rate Specialist Network.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP. The Scheme shall pay the costs of PMB at 100% of the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 80% of the Scheme Rate. The co-payment, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
	GPs: Any GP participating in the Scheme's GP Network.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP. The Scheme shall pay the costs of PMB at 100% of the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 80% of the Scheme Rate. The co-payment, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
CDL and DTPMB: **Out-of-Hospital Diagnosis**	**Specialists:** Any specialist participating in the KeyCare or Premier Rate Specialist Network. **GPs:** Any GP participating in the Scheme's GP Network.	The Scheme shall pay the costs of PMB in full, subject to the Scheme's diagnostic Basket of Care and the member making application to the Scheme for CDL and/or DTPMB cover.	The Scheme shall pay the costs of PMB up to a maximum of 80% of the Scheme Rate, subject to the Scheme's diagnostic Basket of Care and the member making application to the Scheme for CDL and/or DTPMB cover.

M Wilson pb CH

Annexure C2
TFG Health Plus Cover for Prescribed Minimum Benefits: 2023

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary uses the DSP or involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary voluntarily does not use a DSP /uses a non-DSP
CDL: **Out-of-Hospital Medicine**	The DSP is a defined list of contracted pharmacies and/or providers.	The Scheme shall pay the costs of PMB medication in full, subject to the Scheme's Formulary. If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to the maximum of the chronic drug amount (CDA) as specified per Benefit Plan and subject to the Scheme's Medication Rate. This is subject to Regulations 15 H (c) and 15 I (c).	The Scheme shall pay the costs of PMB medication up to the Scheme Medication Rate for medication obtained voluntarily from a non-DSP, subject to the Scheme's Formulary. This is subject to Regulations 15 H (c) and 15 I (c). If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to CDA. Where the pharmacy and/or provider charges more than the Scheme Medication Rate, an additional Deductible may apply.
DTPMB: **Out-of-Hospital Medicine**	The DSP is a defined list of contracted pharmacies and/or providers.	The Scheme shall pay the costs of PMB medication in full, subject to the Scheme's Formulary. If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to the maximum of the chronic drug amount (CDA) as specified per Benefit Plan and subject to the Scheme's Medication Rate. This is subject to Regulations 15 H (c) and 15 I (c).	The Scheme shall pay the costs of PMB medication up to the Scheme Medication Rate for medication obtained voluntarily from a non-DSP, subject to the Scheme's Formulary. If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to the maximum of CDA.
DTPMB: **Out-of-Hospital Medical appliances (External Medical Appliances)**	A defined list of providers that has contracted with the Scheme.	The Scheme shall pay the costs of PMB in full for involuntary use of non-DSP and up to the agreed rate for appliances obtained from a DSP or where the item is on the Formulary used.	Where a Member voluntarily obtains appliances from a non-DSP or a non-Formulary item is used, the Scheme shall pay up to the Reference Price List only.

pb
M Wilson CH

Annexure C2
TFG Health Plus Cover for Prescribed Minimum Benefits: 2023

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary uses a DSP or involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary voluntarily does not use a DSP /uses a non-DSP
CDL and DTPMB: **Out-of-Hospital Pathology**	Any provider that the Scheme has an agreement with for Pathology services.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP. The Scheme shall pay 100% of the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 80% of the Scheme Rate for voluntary use of a non-DSP. The Deductible, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
CDL and DTPMB: **Out-of-Hospital Radiology**	Any provider charging the Scheme Rate for Radiology services.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP. The Scheme shall pay the costs of PMB up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 80% of the Scheme Rate for voluntary use of a non-DSP. The Deductible, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
DTPMB: **In-hospital admissions**	Any KeyCare Network Hospital facility as contracted with the Scheme. Subject to Regulation 8 (3) (a) and (b).	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP. The Deductible, which the member is liable for is equal to any amount the provider charges above the Scheme Rate.

M Wilson pb CH

Annexure C2
TFG Health Plus Cover for Prescribed Minimum Benefits: 2023

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary uses a DSP or involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary voluntarily does not use a DSP /uses a non-DSP
DTPMB: **In-Hospital Consultations**	**Specialists:** Any specialist participating in the KeyCare or Premier Rate Specialist Network. **GPs:** Any GP participating in the Scheme's GP Network and practicing in a KeyCare Network Hospital facility. Subject to Regulation 8 (3) (a) and (b).	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP. REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP. The Deductible, which the member is liable for is equal to any amount the provider charges above the Scheme Rate.
DTPMB: **Mental Illness**	**Drug and Alcohol abuse facilities:** Any facility and/or provider contracted with the Scheme.	The Scheme shall pay the costs of PMB in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP up to a maximum of 21 days in-hospital.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP, subject to a maximum of 21 days. The Deductible, which the member is liable for is equal to any amount the provider charges above the Scheme Rate.
	All other conditions: Any provider contracted with the Scheme and/or a defined list of hospitals with a psychiatric ward as contracted with the Scheme. Subject to the condition meeting clinical entry criteria and the Scheme's Baskets of Care.	The Scheme shall pay the costs of PMB in full, subject to the rate contracted with the hospital for a psychiatric ward/facility. Payment will be equivalent of up to a maximum of 21 days in-hospital, or 12 or 15 days out-of-hospital consultations for conditions as defined in Annexure A of the Regulations.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP. The Deductible, which the member is liable for is equal to any amount the provider charges above the Scheme Rate.
DTPMB: **Major hip and knee joint replacements and spinal surgery**	A defined list of hospitals and providers that has contracted with the Scheme.	The Scheme shall pay the costs of PMB in full for involuntarily use of non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP. M Wilson pb CH

Annexure C2
TFG Health Plus Cover for Prescribed Minimum Benefits: 2023

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary uses a DSP or involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary voluntarily does not use a DSP /uses a non-DSP
DTPMB: **Terminal Care facilities**	Hospice and any other compassionate care facility.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP. The Deductible, which the member is liable for is equal to any amount the provider charges above the Scheme Rate.
Oncology: **Out-of-Hospital Treatment**	**Specialists:** Any Oncologist who has agreed to charge the Premier Rate and/or any specialist contracted with the Scheme. Subject to Regulation 8 (3) (a) and (b).	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 80% of the Scheme Rate for voluntary use of a non-DSP. The Deductible, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
	GPs: Any GP on the Scheme's GP Network who is a SAOC member;	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 80% of the Scheme Rate for voluntary use of a non-DSP. The Deductible, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
Oncology: **Chemotherapy**	Any provider who the Scheme has an agreement with for Chemotherapy services;	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP. REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES	The Scheme shall pay the costs of PMB up to a maximum of 80% of the Scheme Rate for voluntary use of a non-DSP. The Deductible, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.

M Wilson pb CH

Annexure C2
TFG Health Plus Cover for Prescribed Minimum Benefits: 2023

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary uses a DSP or involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary voluntarily does not use a DSP /uses a non-DSP
Oncology: **Pathology**	Any provider that the Scheme has an agreement with for Pathology services;	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 80% of the Scheme Rate for voluntary use of a non-DSP. The Deductible, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
Oncology: **Radiology**	Any provider charging the Scheme Rate for Radiology services;	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 80% of the Scheme Rate for voluntary use of a non-DSP. The Deductible, which the member is liable for is equal to 20% of Scheme rate and any amount the provider charges above the Scheme Rate.
HIV: **Out-of-Hospital Consultations**	**Specialists:** Any specialist participating in the KeyCare or all specialists who have agreed to charge the Premier Rate.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 80% of the Scheme Rate for voluntary use of a non-DSP. The Deductible, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
	GPs: Any Premier Plus GP who has contracted with the Scheme.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 80% of the Scheme Rate for voluntary use of a non-DSP. The Deductible, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

M Wilson pb CH

Annexure C2
TFG Health Plus Cover for Prescribed Minimum Benefits: 2023

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary uses a DSP or involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary voluntarily does not use a DSP /uses a non-DSP
HIV: **Pathology**	Any provider that the Scheme has an agreement with for Pathology services.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 80% of the Scheme Rate for voluntary use of a non-DSP. The Deductible, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
HIV: **Radiology**	Any provider charging the Scheme Rate for Radiology services.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 80% of the Scheme Rate for voluntary use of a non-DSP. The Deductible, which the member is liable for is equal to any amount the provider charges above the Scheme Rate.
HIV: **Medicine**	The DSP is a defined list of contracted pharmacies and providers.	The Scheme shall pay the costs of PMB medication in full for involuntary use of a non-DSP, subject to the Scheme's Formulary. If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to maximum of the chronic drug amount (CDA) as specified per Benefit Plan and subject to the Scheme's Medication Rate. This is subject to Regulations 15 H (c) and 15 I (c).	The Scheme shall pay the costs of PMB medication up to the Scheme Medication Rate for medication obtained voluntarily from a non-DSP, subject to the Scheme's Formulary. If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to CDA.
HIV: **VCT**	Any vendor that has contracted with the Scheme.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay up to a maximum of 80% of the Scheme Rate for voluntary use of a non-DSP. The Deductible, which the member is liable for is 20% of the Scheme Rate and any amount the provider charges above Scheme Rate.

M Wilson pb CH

Annexure C2
TFG Health Plus Cover for Prescribed Minimum Benefits: 2023

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary voluntarily does not use a DSP /uses a non-DSP
RENAL: **Specifically, as regard to Chronic Renal Dialysis, Pathology and Drugs**	Contracted provider, applicable to Member's Benefit Plan, in respect of the Scheme's chronic renal dialysis network.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay up to 100% of the Scheme Rate for voluntary use of a non-DSP. The Deductible, which the member is liable for is any amount the provider charges above Scheme Rate.

Notes:

1. For approved PMB conditions, all treatment codes and procedure codes must accord with the Scheme's Baskets of Care. The Scheme may have regard to Regulations 15H(c) and 15I(c).

2. "SAOC" means the South African Oncology Consortium.

3. In accordance with what is stated in the main body to these Rules, no healthcare costs associated with a PMB will be paid if such costs are voluntarily incurred outside of the territory of the Republic of South Africa and other territories within the Rand Monetary Area.

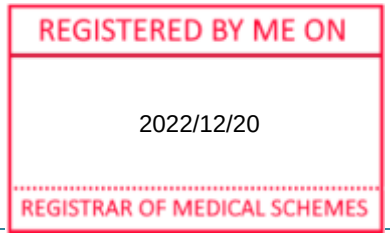
4. Where claims are paid in full, Beneficiaries will not be required to make any payments not reimbursable by the Scheme.

5. CDA (Chronic Drug Amount) is the reference price applied by the Scheme to all off-formulary medication claims.

6. Baskets of Care, is a list of consultations, investigations and other procedures that pertain to the care of a CDL condition (Chronic Disease List condition as per the Medical Schemes Act and its relevant regulations and amendments for Prescribed Minimum Benefits), over a period of time which may be adaptable to the patient's specific needs through a process of interaction and consultation with the Scheme's contracted Managed Care Organisation and/or medical advisors and which will be associated, where applicable, with the drugs as listed in the PMB CDL Algorithms for the specific CDL conditions.

7. PMB services will accumulate to insured limits where these limits exist. Once depleted, the remaining PMB entitlement will apply.

8. In accordance with what is stated in the Scheme's main body of the rules, the Beneficiary must authorise all voluntary DTPMB hospital admissions, which admissions include, but are not limited to, Mental Illness admissions, HIV and Oncology admissions, within 48 hours of the required elective procedure/treatment. Failure to so will entitle the Scheme to apply a Deductible of R2 000.



pb

M Wilson CH

TFG MEDICAL AID SCHEME

ANNEXURE D: GENERAL EXCLUSIONS AND LIMITATIO

D1 Subject to the provisions of Regulation 8 of the Act, and as agreed and set out in the Code of Conduct in respect of Prescribed Minimum Benefits ("PMB") dated 31 July 2010, any benefit option that is offered by a medical scheme must pay in full, without Deductible or the use of deductibles, the diagnosis, treatment and care costs of PMB conditions, provided that services are obtained from a designated service provider in respect of that condition as set out in Regulation 8 (2) of the Act. A Deductible or deductible, as set out in the Rules and Annexures to the Rules, may be imposed on a member if that member or his or her dependant obtains such services from a provider other than a designated service provider, provided that no Deductible or deductible is payable by a member if the service was involuntarily obtained from a provider other than a designated service provider. Furthermore, when a formulary includes a drug that is clinically appropriate and effective for the treatment of a PMB condition suffered by a beneficiary and that beneficiary knowingly declines the formulary drug and opts to use another drug instead, the Scheme may impose a Deductible on the relevant member as set out in Regulation 8 (5) of the Act.

Therefore provided that the above provisions in terms of PMB conditions are adhered to, no benefits shall, unless the Board decides otherwise, be payable in respect of:

D.1.1. Examinations, consultations and the treatment related to obesity (including bariatric surgery);

D.1.2. Operations, treatment and procedure for cosmetic purposes, which includes gender re-alignment for personal reasons and not directly caused by or related to illness, accident or disorder . However, a Member may apply to the Board for benefits relating to operations, treatments or procedures for cosmetic purposes on medical grounds, and the Board's prior approval must be obtained for any such expenses in respect of treatment and operations of a cosmetic or reconstructive nature.

An application for benefits in respect of said treatment and/or operations shall be accompanied by a medical report stating the reasons therefor and the estimated costs thereof. The Board may request the beneficiary to consult a medical practitioner nominated by the Board for a Second Opinion, before making a decision and may in its discretion pay the whole or any part of such expenditure. The cost of such Second Opinion shall be borne by the Scheme;

M Wilson

D.1.3. No benefit will be payable for circumcision unless medically necessary;

D.1.4 Consultations, investigations, examinations and the treatment of infertility and the artificial insemination of a person as defined in the Human Tissue Act, 1983 (Act 65 of 1983) unless such costs incurred are PMB's and services are obtained via the Scheme's designated service provider.

D.1.5. Services for which benefits are in excess of the maximum benefits to which the Member is entitled in terms of these rules;

D.1.6. The purchase or hire of medical or surgical appliances such as special beds, chairs, cushions, commodes, sheepskins, waterproof sheets for beds, bedpans, special toilet seats, or the repairs or adjustments of sick room or convalescing equipment with the exception of the hire of oxygen cylinders;

D.1.7. The cost of services by persons not registered in terms of any law;

D.1.8. The purchase of:

D.1.8.1. Medicines, other than medicines on the written prescription of a person legally entitled to prescribe except as provided for in paragraph 17 of Annexure B;

D.1.8.2. Sun-screening and tanning agents;

D.1.8.3. Soaps, shampoos and other topical applications, medicated or otherwise;

D.1.8.4. Household remedies or preparation of the type advertised to the public;

D.1.8.5. Slimming preparations, appetite suppressants food supplements and patent foods including baby foods;

D.1.8.6. Growth hormones;

D.1.8.7. Tonics, nutritional supplements, multi-vitamin preparations and vitamin combinations, except for prenatal, lactation and paediatric use

D.1.8.8. Anti-smoking preparations

M Wilson

D.1.8.9. Aphrodisiacs

D.1.8.10. Anabolic steroids

D.1.8.11. Treatment of erectile dysfunction, e.g. Sildenafil and/or similar remedies

D.1.8.12. Contraceptives, except the Mirena device where pre-approved and clinically appropriate

D.1.8.13.Vaccines other than the influenza and human papillomavirus (HPV) vaccination, as well as child and adult vaccinations as provided for in Annexure B of these Rules.

D.1.9. Mouth protectors and gold in dentures, devices and materials such as floss, tooth brushes and tooth paste;

D.1.10. Examinations for insurance, school camp, visa, employment or similar purposes;

D.1.11. Travelling costs incurred by Members or their Dependants;

D.1.12. Accommodation in convalescent or old age homes or similar institutions catering for the aged;

D.1.13. Accommodation and treatment in spas and resorts for health, slimming, chiropractic, homeopathic or other similar purposes;

D.1.14. The cost of holidays for recuperative purposes, whether deemed medically necessary or not;

D.1.15. Charges for appointments not kept;

D.1.16. Charges for ante- and post-natal exercise classes, mother craft and breast feeding instructions;

D.1.17. Over-the-counter reading glasses; sunglasses and spectacle cases as stipulated in the benefit schedules;

D.1.18. Replacement batteries for hearing aids as stipulated in the benefit schedules; and

D.1.19. In the case of contact lenses, the cost of solution and kits as well as the fee associated with fittings and adjustments.

D.1.20. No benefit will be payable in respect of costs associated with Vocational Guidance, child guidance, marriage guidance, school therapy or attendance at remedial education schools or clinics.

D.1.21. Bleaching of teeth that have not been root canal treated, and metal inlays in dentures and front teeth.

D.1.22. Accommodation and/or treatment in headache and stress-relief clinics, spas and resorts for health, slimming, recuperative or other similar purposes. For the purposes of this rule, "accommodation" shall include all related expenses and meals, and "treatment" shall include any of the following: examinations, consultations, investigations, diagnosis, tests, procedures, operations, the supply of any pharmacological or pharmaceutical product or food, the supply and/or fitting of any prosthesis, splint or device, and generally shall include any service or supply by any such enterprise or practice intended to confer a health benefit.

D.1.23. Payment of benefit for ambulance transportation and air lifting outside borders of RSA. This exclusion also applies to PMB cases.

REGISTERED BY ME ON
Mashilo Leboho
06/12/2024 13:42:52 (UTC+02:00)
Signed by Mashilo Leboho,
m.leboho@medicalschemes.co.za
REGISTRAR OF MEDICAL SCHEMES

M Wilson

TFG MEDICAL AID SCHEME
ANNEXURE D1: TFG HEALTH ADDITIONAL EXCLUSIONS: 1 JANUARY 2021

With due regard to the Prescribed Minimum Benefits, the exclusions listed in Annexure D and Rule 16.8 of the Main Body to these Rules will automatically apply to TFG Health. In addition, the following exclusions will apply to this Benefit Plan:

1. All cosmetic treatment including, but not limited to, septoplasties, osteotomies and nasal tip surgery
2. Benign breast disease
3. All costs relating to cochlear implants, processors and hearing aids
4. All costs relating to auditory brain implants
5. All costs relating to internal nerve stimulators
6. All costs relating to joint replacements
7. Arthroscopy
8. Back surgery
9. Neck surgery
10. Knee and shoulder surgery
11. In-Hospital management of:
    - Conservative back treatment
    - Conservative neck treatment
    - Dentistry (services of surgical procedures which involve the hard or soft tissues of the mouth)
    - Skin disorders (non- life-threatening) including benign growths and lipomas
    - Nail disorders
    - Investigations and diagnostic work-up
    - Endoscopic procedures
    - Functional nasal problems and functional sinus problems
12. Surgery for oesophaegeal reflux and hiatus hernia repairs
13. Removal of Varicose Veins
14. Correction of Hallux Valgus/Bunion and Tailor's Bunion/Bunionette
15. Surgery and other healthcare services to correct refractive errors of the eye, save as provided for in the relevant Benefit Plan set out in Rule 33
16. Elective Caesarean Section except in cases where it is medically necessary

The Scheme will also not cover any healthcare expenses related directly or indirectly to these healthcare services.

Nothing contained in this Annexure will be construed to exclude the application of the general exclusions set out in Annexure D.

MEDICAL AID SCHEME

REGISTERED BY ME ON

2023/05/26

REGISTRAR OF MEDICAL SCHEMES

Rules Resolution 2 of 2023

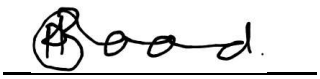
Certified as having been adopted in terms of the rules, this serves to confirm the income category changes in respect of TFG Health and TFG Health Plus to take effect 1 May 2023.

These changes were agreed per an electronic Round Robin Resolution on 13 April 2023 and to be ratified at a Board of Trustees meeting to take place on 25 April 2023.

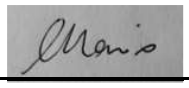
The Board of Trustees agreed to amend the income categories by 5% on both benefit plans in order to avoid and minimise "bracket creep" as a result of the increase in salaries that will take effect 1 April 2023. This amendment will further ensure that there will be alignment with the Scheme's budget and actuarial assumptions submitted to the Council for Medical Schemes ("CMS") as part of the benefit year-end Rule submissions concluded in September 2022 with minimal impact on the Scheme's estimated income for the 2023 benefit year.

No changes in contribution amounts will be effected and these amounts are confirmed to remain unchanged.

The amended **Annexure A** is included for your review and approval.

Chairperson  (Mr P Barnard)

Trustee  (Mr C Singh)

Principal Officer  (Ms C Harris)

Date: 15 May 2023