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This handbook has been designed to provide you with important information around your benefits and it is essential that you familiarise yourself with its contents.

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** This Members' Handbook does not replace the Scheme's Rules. The registered Rules are legally binding and will always take precedence.*

Dear Member

Resolution Health Medical Scheme (RHMS) welcomes you and your dependents. You have chosen RHMS as your partner in health-care and we want to assure you of our ongoing commitment to products and services of the highest quality and integrity; as well as professionalism and customer care.

Included with this handbook is your RHMS membership card. Kindly ensure that your details on the card are correct. This card affords you easy access to service providers such as doctors, pharmacies and hospitals for the duration of your membership with RHMS. For your own convenience, kindly ensure that you carry your membership card with you at all times. Please note, a card with incorrect details will deny you access to medical services – hence the importance of checking that your details are correct.

You have also received a “Notification of Membership” document with details regarding waiting periods that may apply to you / your dependants. Should you not have received this information or the details on your membership card are incorrect, kindly call our Client Services department on: 0861 796 6400. You can also send a fax to (011) 796 6439, or an e-mail to clientservices@resomed.co.za.

The following are also provided for your convenience:

Hospital pre-authorisation: 086 111 1778, or e-mail authorisation@resomed.co.za

Evacuation or after hour emergencies: **ER24** 084 124

We want to assure you of our best service at all times and we look forward to having you as part of the Resolution healthcare solution for a very long time.

Kind regards



Daan van der Merwe
Principal Officer

a. Membership details

Membership Cards

All members receive a membership card. The card enables you to obtain services from medical service providers. Should you resign from Resolution Health Medical Scheme, the card must be returned to the Scheme to ensure safety and maintain our service to all members.

NOTE:

It is illegal to use a membership card that does not belong to you. The unauthorised use of a membership card is considered a fraudulent claim on the Scheme's membership privileges and will result in such membership being cancelled immediately.

Eligibility

Membership is open to all individuals and groups and is subject to the Rules of the Scheme.

Retirees

We aim to nurture a long-term relationship with our members. All registered members and their dependants may remain members of the Scheme when they retire, or in the case of termination of employment due to age, ill health or other disability.

Dependants

You should not have to be without comprehensive healthcare cover when a loved one dies. The dependants of a deceased member who are registered with the Scheme at the time of the member's death may retain their membership of the Scheme without any new restrictions, limitations or waiting periods.

Dependants who become orphaned (according to the definition in the Scheme's Rules) as a result of a member's death, will remain a member until they become a member of the Scheme in their own right, or are accepted onto any other registered medical scheme.

Registration of dependants

Members may apply for the registration of their dependants on application for membership, or any time thereafter as they become dependants of the main member.

Newborns / adoptions

The arrival of a new baby is always an exciting event. You can rely on the comfort of Resolution Health to cover medical expenses if the newborn or newly adopted baby is registered within 30 days of birth or adoption. Contributions for the newly registered dependant are due from the first day of the month following the birth or adoption. Benefits will be calculated from the day of birth or adoption provided the necessary documentation is received, together with the application for registration within the required period of 30 days.

NOTE:

If a newborn baby or newly adopted dependant is not registered within 30 days of birth or adoption, benefits will only be available from the date of registration and not retrospectively from the date of birth or adoption.

Spouses

Registered members who marry and apply within 30 days of their marriage to register their spouse as a dependant, will receive benefits for their spouse from the day of the marriage. Increased contributions fall due from the first day of the month following the month of marriage. Similarly, if the marriage is not registered within that 30-day period, benefits for the spouse will only be available from the date of registration and not retrospectively from the date of marriage.

Deregistration of dependants

In order to ensure efficient service, it is important to keep our recorded information up to date. To assist us in doing this, kindly inform us within 30 days of any event that may change the status of a dependant, which may render their membership invalid. When such dependant no longer qualifies for membership, they will be deregistered and will no longer be entitled to any benefits.

NOTE:

When a dependant reaches the age of 21, annual written proof of dependency is needed to maintain their membership as a dependant.

Change of personal details

Kindly inform us of any change in address, contact details or banking details as soon as possible, to ensure continued excellent service to you. The Scheme will not be held responsible if a member's rights are prejudiced or forfeited, should the member not adhere to this rule.

Termination of membership

Membership may be terminated for the following reasons:

- **Resignation from employment**

Members who are members of Resolution Health in terms of their conditions of employment, may not resign from the Scheme while they remain such an employee, without written consent from their employer. On resignation, membership and benefits cease as of the date of resignation, unless members elect to continue membership in their private capacity.

- **Employer resignation from the Scheme**

Members who are members of Resolution Health in terms of their conditions of employment, and whose employer elects to resign from the Scheme, and does not join another Scheme as an employer group, will cease to be members from such date, unless they elect to continue membership in their private capacity.

- **Voluntary Termination**

Members who are not members of Resolution Health in terms of their conditions of employment, may terminate their membership by giving three months' written notice. Employers that wish to terminate their association with the Scheme may do so by giving one-month written notice.

- **Death**

Membership is terminated on death.

- **Failure to pay amounts due to the Scheme**

Members who fail to pay amounts due to the Scheme, may have their membership terminated in terms of the Rules of the Scheme.

- **Abuse of privileges, false claims, misrepresentation and non-disclosure of factual information**

The Scheme may terminate the membership, or exclude a member or dependant from benefits, should they be found guilty of abusing the benefits and privileges of the Scheme by presenting false claims or material misrepresentation, or non-disclosure of information.

All rights or benefits end at midnight of the last day of membership. Claims for services rendered prior to this date and submitted within the required time-frame, will be funded according to Scheme rules. The stipulation as per section C (How to claim) remain applicable.

b. Monthly membership contributions

Membership contributions are due monthly in advance and are payable no later than the 3rd day of the month. Late payments or a build-up of debts can result in suspended benefits or cancellation of membership. Where contributions or any debt owing to the Scheme are not paid within 30 days, the Scheme has the right to suspend all benefits and give the member/employer notice that his membership may be terminated should all debts not be paid within 14 days of such notice.

However, benefits will be reinstated when payments are brought up to date provided that membership has not been cancelled. If payments are not brought up to date, the member will not be entitled to any benefits from the date of default of payment. Any benefit already paid may be recovered by the Scheme.

NOTE:

Except for savings accounts, no refunds or portion of a member's contribution will be paid where membership, or cover in respect of dependants, terminates during the course of a month.

The credit balance of a member's medical savings account remains the property of the member at all times.

NOTE:

In terms of the Rules of the Scheme, the Scheme has the authority to increase or decrease at any time the amount of contributions payable by all members. These steps may be taken to ensure the financial stability of the Scheme.

c. Claims procedure

To submit a claim, sign and forward your original accounts directly to:

Resolution Health Medical Scheme

PO Box 1075

Fontainebleau

2032

Please send all original documents and be sure to include the following essential details:

- Membership number
- Name of the Plan Option
- Member's surname and details
- Surname, initials and other details of the patient
- The practice number, group practice number and individual provider registration number of the service provider; and in case of a group practice, the practice number of the practitioner who provided the service
- Date when the service was rendered
- The nature and cost of services rendered, including the supply of medicine to the member or registered dependant, with the name, quantity and dosage of the medicine - include the net amount payable by the member for the prescribed medicine
- The relevant diagnostic (ICD-10) code, relating to the service. If the ICD-10 code does not appear on the account it should be obtained from the service provider prior to submission
- If the member has already paid the account, the original receipt must be submitted with the claim

Claims must reach us by no later than the last day of the fourth month, following the month in which the service was rendered.

Accounts for treatment of injuries or expenses recovered from third parties must be supported by a statement detailing the circumstances in which the injury was sustained or the accident occurred.

Claims payments to service providers and members take place twice a month. The Scheme will supply the member or the service provider with a detailed claims statement within 30 days of receipt of the claim. Should there be any irregularities on the account, the Scheme will state the reason for the error or why it is unacceptable. The member or service provider then has the opportunity to return the corrected claim within 60 days of such notice.

NOTE:

Certain service providers charge fees above those which are covered per the Benefit Schedule. The Scheme will only remunerate providers at the rate depicted in the Benefit Schedule, usually the National Reference Price List (NRPL), unless otherwise specified. The Benefit Schedule also identifies limits and sublimits for certain services and products. To avoid members being held liable for any shortfall, it is essential they determine what providers charge upfront prior to any services being delivered. The Scheme may also exclude certain services from benefits, as set out in section e (Exclusions).

d. Benefits

Resolution Health Medical Scheme provides a range of benefits to suit your lifestyle and budget that are competitive with similar products in the marketplace.

Members may change benefit plans subject to the following:

- changes may only be made annually from 1 January
- a written application to change your benefit option must reach the Principal Officer by no later than 31 December for the next year

All plans cover the Prescribed Minimum Benefits (PMB's), subject to Scheme protocols. Members and their dependants are entitled to the benefits of their plan during a financial year per the Benefit Schedule listed in the handbook. Once depleted, any additional interventions that qualify as PMB, will be funded according to Scheme protocols.

Members should check the different plan benefits, the list of approved chronic conditions (d.5) and Scheme exclusions (e), to confirm they choose and utilise their plan to get the best possible benefit from their cover for the year.

NOTE:

When joining the Scheme in the middle of the year, all benefits except hospitalisation and related hospitalisation, will be adjusted in proportion to the period of membership. This will be calculated from the date of admission to the Scheme to the end of the year.

Emergency Services

Resolution Health in partnership with ER24 offers you access to emergency assistance on a 24-hour basis. As a member you enjoy benefits including:

- 24-hour activation of a medical emergency by calling 084 124
- 24-hour emergency medical advice while paramedics respond
- 24-hour emergency response using Advanced Life Support paramedics in rapid response vehicles by road, and where necessary, air ambulance
- Treatment and stabilisation at the scene of the emergency
- Medical transportation to the closest appropriate hospital
- Access to Medical Advice and Assistance Hotlines
- Emergency International Evacuation

1. Prescribed Minimum Benefits (PMB)

The Prescribed Minimum Benefits or PMB's are a list of 271 diseases or conditions listed in the Medical Schemes Act which schemes are required to fund. Included in this is the Chronic Disease List or CDL list of chronic conditions that also fall under the umbrella of PMB's. In certain circumstances the Scheme may only provide cover for members and their dependants in Provincial Hospitals or at the Scheme's appointed private Designated Service Provider (DSP) facilities. All PMB conditions will be funded according to Scheme rules and protocols at the appropriate level of care. Where appropriate, PMB's will only be funded out-of-hospital.

Benefits will be restricted to PMB cover in the following circumstances:

- All Fundamental Plan benefits are limited to PMB's. Hospitalisation on the Fundamental Plan will be restricted to provincial facilities or a DSP. Treatment for any other non-PMB condition is not covered on this plan
- Members with waiting periods imposed on joining the Scheme may or may not have cover for PMB conditions. Members should check this on their Conditions of Acceptance letter
- Where a PMB condition requires further treatment but annual benefits have been exhausted
- Where benefits are limited to PMB

NOTE:

A co-payment of 25% will be imposed if a member chooses to use a non-DSP facility and their benefits are limited to PMB conditions only.

2. Dental Benefits

General

Denis, www.denis.co.za, Africa's leading dental funder, manages your dental benefits on behalf of your medical scheme. There is a pre-defined benefit per procedure which is paid at the published National Reference Price List (see www.denis.co.za for the list of dental tariffs.)

Your dentist will also be able to provide information regarding your benefits, as Denis supplies all dentists with a Chairside Guide, which illustrates the dental benefits for 2009.

Benefits for Dentistry are paid on a fee for service basis. This means that for every procedure done by a dentist there is a fee that is charged. These fees may differ from dentist to dentist. Your scheme pays a benefit for each procedure which may differ from the fee charged by your dentist. It is your right to negotiate this difference with your dentist.

The Scheme benefits and protocols are defined below.

Please familiarise yourself with the defined benefits before visiting your dentist. By doing so, you will be fully aware of what your scheme will pay toward your treatment.

You are eligible for benefits, irrespective of which dentist treats you.

The following information illustrates how your benefits are structured so that you know before your treatment is rendered, what is covered and what is not.

For clinical definitions see www.denis.co.za.

Conservative Dentistry Consultations

Two general check-ups (consultations) are covered at the National Reference Price List, per beneficiary per year.

Fillings, Extractions and Root Canal Treatment

Benefit for fillings is available where clinically indicated. Benefit will be granted once per tooth in a three-year period. There is no benefit

for Amalgam (silver) fillings to be replaced with Composite (white filling material). A treatment plan and X-rays will be requested for treatment plans of more than 5 fillings.

Extractions and root canal treatments are covered as required, at the Resolution Health Dental Tariff.

Dentures

Plastic Dentures

There is a benefit on the Progressive and Prestige options, for one set of plastic dentures (an upper and a lower) per beneficiary in a four-year period.

Partial Metal Frame Dentures

There is benefit on the Prestige option, for one metal frame (an upper or a lower), per beneficiary in a five-year period.

Full metal dentures are not covered.

Specialised Dentistry

The following specialised dental benefits must be pre-authorized:

- Crown and Bridge procedures
- Orthodontics
- Implants
- Hospitalisation
- Intravenous Conscious Sedation

Crowns

Crowns are limited in quantity per family, regardless of the type of crown being placed.

There is no crown benefit for members on the Progressive option. Members on the Prestige option have benefit for 2 crowns per family per year.

Benefits for crowns will be granted one per tooth in a five-year period and are covered at the Resolution Health Dental Tariff.

Orthodontics

Orthodontic benefits are available on the Prestige option, subject to pre-authorization.

Benefit on pre-authorization will only be applied to cases assessed as “treatment mandatory”, as per an orthodontic index.

A deposit is paid at the start of treatment and the balance is paid over the estimated treatment period.

Orthodontic benefit protocols

- Benefits for Orthodontic treatment are only available to beneficiaries whose treatment commences before their 18th birthday
- Only one family member may commence orthodontic treatment in a calendar year, except in the case of identically aged siblings
- Orthodontic re-treatment is not covered
- Orthognathic surgery (jaw correction surgery) and the associated hospital admission, is not covered

Implants

There is benefit for two implants per beneficiary, in a five year period on the Prestige option only, subject to pre-authorisation.

Cost of implant components is limited to R1 500 per implant.

All associated procedures, including hospitalisation and surgery are not covered for implantology.

Periodontics

Benefit for gum disease is restricted to conservative, non-surgical therapy only (root planning).

This benefit is only available to those members on the Prestige option who are registered on the Perio Programme.

To apply for the Perio Programme, submit your CPITN score (supplied to you by your dental practitioner), together with your Periodontal treatment plan to perio@denis.co.za - alternatively fax to 021 528 5874.

Further clinical records may be requested to process your application.

Periodontal benefits will be applied to cases assessed as periodontally compromised, as per the CPITN score.

After the treatment plan and x-rays have been assessed and periodontal benefit authorised, an authorisation letter will be sent to your treating dental practitioner.

Surgical periodontics is a scheme exclusion.

Oral Surgery

Oral Surgery in the dental chair:

Oral Surgery in the dental chair is covered at the Resolution Health Dental Tariff.

General Surgery Exclusions (in the dental chair and in hospital) include:

- Bone Augmentations
- Sinus Lifts
- Bone and Tissue regeneration

- Gingivectomies
- Surgical procedures associated with dental implantology

The surgical procedures listed above are not covered by your Scheme. The member is liable for the full account.

Oral Surgery in hospital:

See General Anaesthetic and Hospitalisation

Anxious Patients

Hospitalisation and general anaesthesia is not covered where patients require anxiety control only. Many people are anxious about dental treatment and mild sedation is sometimes required. Benefits are payable for sedation methods such as laughing gas or sedative medications. No pre-authorisation is required for laughing gas or sedative medications.

Conscious sedation (IV sedation) is available for surgical procedures. This requires benefit pre-authorisation and is subject to clinical protocols.

Benefit for laughing gas and conscious sedation are not available on the Hospital Plan.

General Anaesthetic and Hospitalisation

Benefit for hospitalisation for dentistry is not automatically covered and is subject to pre-authorisation.

Hospital Plan

Member liable for procedure and service provider costs.

Hospital Plan and Progressive Plan

Hospitalisation benefits for the removal of impacted teeth are only available to adults.

General Anaesthetic benefits are available for very young children (younger than 5 years of age) for extensive dental treatment (multiple extractions and fillings), subject to admission protocols. Multiple hospital admissions are not covered.

Fundamental Plan

Limited to the CareCross Network.

Prestige Plan

Certain Maxillo-Facial procedures are covered in-hospital subject to pre-authorisation, where admission protocols apply.

General Anaesthetic benefits are available for very young children (younger than 5 years of age) for extensive dental treatment (multiple extractions and fillings), subject to admission protocols. Multiple hospital admissions are not covered.

Hospitalisation protocols:

- Where an underlying medical condition creates a substantially increased risk of treatment in the dentist's rooms and indicates a higher level of care, benefits for hospitalisation will apply. A medical report confirming the medical condition will be requested
- Multiple hospital admissions are not covered
- In some instances, an X-ray or clinical report will be requested in order to process a hospital pre-authorisation
- Removal of impacted teeth in hospital will attract benefit where the tooth is associated with pathology or severe pain. Hospitalisation for teeth impacted by soft tissue only is not covered
- Hospitalisation is not covered where anxiety of dental treatment is the reason for the admission

General in-hospital exclusion summary

The following procedures are not covered in hospital. (The member is liable for the full account.)

- Dectomies
- Apisectomies
- Frenectomies
- Implantology and associated surgical procedures
- Surgical exposure of teeth for orthodontic reasons
- Conservative dental treatment (fillings; extractions and root canal therapy) for adults
- Professional Oral Hygiene Procedures (scale and polish and fluoride treatment)
- Removal of single impactions
- Removal of teeth that are impacted by soft tissue only
- Removal of teeth where their position does not complicate the treatment
- Hospitalisation where pain and pericoronitis is the main reason for such admission

General Benefit Exclusion Summary

The following treatment is not covered. The member is liable for the total cost of these procedures:

General Benefit Exclusion Summary	
• Oral hygiene instructions	• Where the member's mouth is periodontally compromised
• Professionally applied topical fluoride in adults	• Where the tooth has been recently restored to function
• Nutritional and tobacco counselling	• Gingivectomy
• Caries susceptibility and microbiological tests	• Periodontal flap surgery and tissue grafting
• Electrognathographic recordings and other such electronic analyses	• Perio Chip
• Fissure sealants on patients older than 16 years	• Apisectomies in hospital
• Fillings to restore teeth damaged due to toothbrush abrasion	• Orthodontic re-treatment
• Root canal treatment on third molars (wisdom teeth) and primary teeth	• Lingual orthodontics
• Pulp capping (direct and indirect)	• Orthognathic (jaw correction) surgery and the related hospital cost
• Polishing of restorations	• Hospitalisation for dental implantology
• Ozone therapy	• Hospitalisation for surgical tooth exposure for orthodontic reasons
• Metal base to full dentures, including the laboratory cost	• Hospitalisation for any dental treatment ,other than the removal of impacted teeth, on the Progressive option
• Soft base to new dentures	• Sinus lifts
• Diagnostic dentures	• Bone augmentations
• Provisional crowns	• Bone and other tissue regeneration procedures
• Laboratory cost of provisional and emergency crowns	• Dolder bars and associated abutments on implants (including the laboratory cost)
• Three-quarter crowns (cast metal and porcelain)	• Laboratory costs, where the associated dental treatment is not covered
• Resin bonding for restorations charged as a separate procedure	• Laboratory cost associated with mouth guards (including material cost)
• Dental bleaching and porcelain veneers	• Snoring appliances
• Metal, porcelain or resin inlays except where such inlays form part of a bridge	• High impact acrylic
• Crowns on third molars (wisdom teeth)	• Cost of Mineral Trioxide
• Pontics on second molars	• Cost of prescribed toothpastes, mouthwashes (e.g. Corsodyl) and ointments
• Laboratory fabricated crowns on primary teeth	• Cost of gold, precious metal, semi-precious metal and platinum foil
• Where such fixed prosthodontics (crowns) are used to repair teeth damaged due to bruxism (tooth grinding) ; toothbrush abrasion; erosion or fluorosis	• Cost of invisible retainer material
• Where such fixed prosthodontics (crowns) are used to restore teeth for cosmetic reasons	• Cost of bone regeneration material
• Where a reasonable attempt has not been made to restore/replace the tooth conservatively	• Laboratory delivery fees

Supplementary Clinical Protocols

Supplementary Clinical Protocols

- For extensive restorative treatment plans (more than 5 fillings per member) a treatment plan and x rays will be requested.
- If a procedure does not attract benefit; all other treatment associated with the specific event does not receive benefit.
- Benefits for conservative dental restorations will be granted once per tooth in a 3 year period.
- Benefits for amalgam (silver) restorations to be replaced with composite (white filling material) are available where such treatment is necessary to restore cavitation.
- Benefits for crowns will be granted once per tooth in a 5 year period.
- Where root canal treatment has failed; benefits are allocated for a re-root canal treatment on the tooth. In the event that the re-root canal treatment fails, benefits will be available for an apicectomy.
- Claims for oral pathology procedures (biopsies etc...) must be accompanied by a laboratory report.

In the event of a dispute regarding the benefit information illustrated above, the Rules of the Scheme will prevail.

3. Optical Benefits

Optometry – Limited to Scheme Protocols

Iso Leso Preferred Provider

Resolution Health Medical Scheme, through Iso Leso Optics Ltd, provides quality eye care and optical benefits that stretch even further than before. Instead of the whole optical benefit being spent by the first member of the family to visit the optometrist, leaving nothing more for anyone else, we have designed an optical benefit that allows all the members of your family the opportunity to get the spectacles they need. This is a unique negotiated benefit without compromising on the quality of the product.

Resolution Health Medical Scheme members are to submit all optical claims directly to the Iso Leso offices at P.O. Box 2127, Cresta, 2118.

Kindly contact the Iso Leso offices directly on 0860 10 30 50 for further information regarding your optometric benefit and to find the nearest contracted optometrist in your area.

4. International Travel Cover

The International Travel Benefit covers emergency medical treatment that you and your dependants might need while travelling overseas.

The benefit provides cover for 90 days from your date of departure. If you intend to travel for longer than 90 days, you must apply for additional cover.

For additional information please visit www.resomed.co.za or phone 0861 796 6400.







5. Chronic Medication: the Chronic Disease List (CDL) and Resolution Health Chronic Conditions

Reference and MMAP pricing, formularies and co-payments may be applicable. With the exception of the Hospital Plan, chronic medication claims must be submitted electronically. CDL's and Chronic are separated on the Prestige Option. Registration of CDL and Chronic conditions for the Progressive and Prestige Plan can be obtained on 0800 132 345 by your doctor or pharmacist.

Chronic Disease List (CDL) * Conditions (all options)	Resolution Health Chronic Conditions (additional to Prestige Option)
Addison's Disease	Angina Pectoris
Asthma	Ankylosing Spondylitis
Bronchiectasis	Benign Prostatic Hypertrophy
Cardiac Dysrhythmia	Cerebrovascular Accident (Stroke)
Cardiac Failure	Cushing's Syndrome
Cardiomyopathy	Delusional Disorder
Chronic Obstructive Pulmonary Disorders (COPD)	Major Depression
Chronic Renal Failure/Disease	Female Menopause
Crohn's Disease	Gastro-Oesophageal Reflux Disease (GORD)
Diabetes Mellitus Type 1 & 2	Gout
Epilepsy	Hyperthyroidism
Glaucoma	Idiopathic Thrombocytopenic Purpura
Haemophilia	Interstitial Fibrosis of the Lung
Hyperlipidaemia	Meniere's Syndrome
Hypertension	Motor Neuron Disease
Hypothyroidism	Myasthenia Gravis
Ischaemic Heart Disease (Coronary Artery Disease)	Osteoporosis
Parkinson's Disease	Paget's Disease
Rheumatoid Arthritis	Peripheral Vascular Disease
Systemic Lupus Erythematosus	Pituitary Adenoma
Ulcerative Colitis	Psoriasis
	Scleroderma
	Urinary Incontinence
Benefits for the following conditions are limited to Prescribed Minimum Benefit (PMB) algorithms and legislation relevant to PMB	
Bipolar Affective Mood Disorders	
Diabetes Insipidus	
Multiple Sclerosis	
Schizophrenia	
HIV/Aids (DSP Careworks)	

*All CDL conditions are legislated Prescribed Minimum Benefits (PMB) conditions

Chronic Medication Registration Process

 HOSPITAL	 FUNDAMENTAL	 PROGRESSIVE	 PRESTIGE
<p>Limited to the 25 CDL conditions at a State facility</p>	<p>Limited to the 25 CDL conditions at a CareCross facility and subject to CareCross formularies</p>	<p>Limited to the 25 CDL conditions and the Progressive formulary</p>	<p>25 CDL and 23 RHMS chronic conditions limited to the Prestige formulary</p>
	<p>Register at CareCross 0860 102 183</p>	<p>Doctor or pharmacy to phone SwiftAuth Online at 0800 132 345 with ICD-10 codes and relevant test results SwiftAuth hours: Monday to Friday from 08:00-18:30 Saturday 09:00-13:00</p>	

Progressive and Prestige members may also receive their chronic medication by courier through Pharmacy Direct (Tel: 086 002 7800, email care@pharmacydirect.co.za, or fax 086 611 4000/1/2/3).

6. Oncology Benefits

The Oncology benefit covers chemotherapy, radiotherapy, oncologist fees and blood tests within benefit limits, protocols and guidelines. Other investigative work-up is allocated to Out-of-Hospital benefits and thereafter PMB according to Scheme protocols.

Authorisation is subject to the South African Oncology Consortium (SAOC) tier guidelines, with tier 1 applicable to Fundamental and Progressive Plans, and tier 2 to Hospital and Prestige Plans. Application for Oncology benefits requires submission of a treatment plan by the oncologist to oncology@resomed.co.za. Note MMAP pricing will apply from 2009.

7. HIV

CareWorks manages the HIV programme for Resolution Health. CareWorks provides all the out-patient care including consultations, blood tests, counselling and medication. Voluntary counselling and testing (VCT) is also provided by CareWorks, or as part of the preventative care benefit.

CareWorks can be contacted at 0860 101 110.

NOTE:

Hospitalisation for HIV positive members is only funded in a provincial facility if you are not registered and compliant on the CareWorks programme. Thus any admission to a private hospital under these circumstances will only be funded at provincial rates, and members will be financially liable for the shortfall to the private hospital.

To avoid this potential, it is important HIV members register with CareWorks.

e. Exclusions (services or events not covered by the Scheme)

Subject to the Prescribed Minimum Benefits in either a Public Care System or at the facilities of one of the Scheme's Designated Service Providers, as contemplated in Regulation 8 of the Regulations promulgated in terms of the Act, or provided for in a Benefit Option, the Scheme's liability is limited to the cost of medical services as defined in the Act and provided for in the Rules of the Scheme and, further subject to the provisions of rule 1.2 of Annexure B, expenses in connection with any of the following shall not be paid by the Scheme:-

1. Compensation for pain and suffering, loss of income, funeral expenses or claims for damages.
2. Expenditure incurred by a member or his dependants arising from any illegal or criminal act.
3. No benefits shall be payable in respect of services not considered appropriate in terms of Managed Healthcare Principles, or that are not life saving, life sustaining or life supporting, or any complications that might arise from such operation, treatment and / or procedure. The Scheme reserves the right to determine such instances in general or for specific instances at any time at its discretion. The following procedures, treatment and apparatus will specifically be excluded:
 - 3.1 Any breast reconstruction, reduction or augmentation procedures unless related to malignancy (subject to Scheme protocols);
 - 3.2 Gynaecomastia;
 - 3.3 Sympathectomy;
 - 3.4 Eximer laser and radial keratotomy;
 - 3.5 Phakic implants;
 - 3.6 Bariatric surgery;
 - 3.7 Keloid and scar revision treatments;
 - 3.8 Advanced electronic devices;
 - 3.9 Prosthetic discs, dynamic spinal devices;
 - 3.10 Hyperbaric oxygen except for decompression sickness, osteoradionecrosis, carbon monoxide poisoning;
 - 3.11 CT or virtual colonoscopy.
 - 3.12 Excluding Prescribed Minimum Benefits, the following Medications will also be specifically excluded:

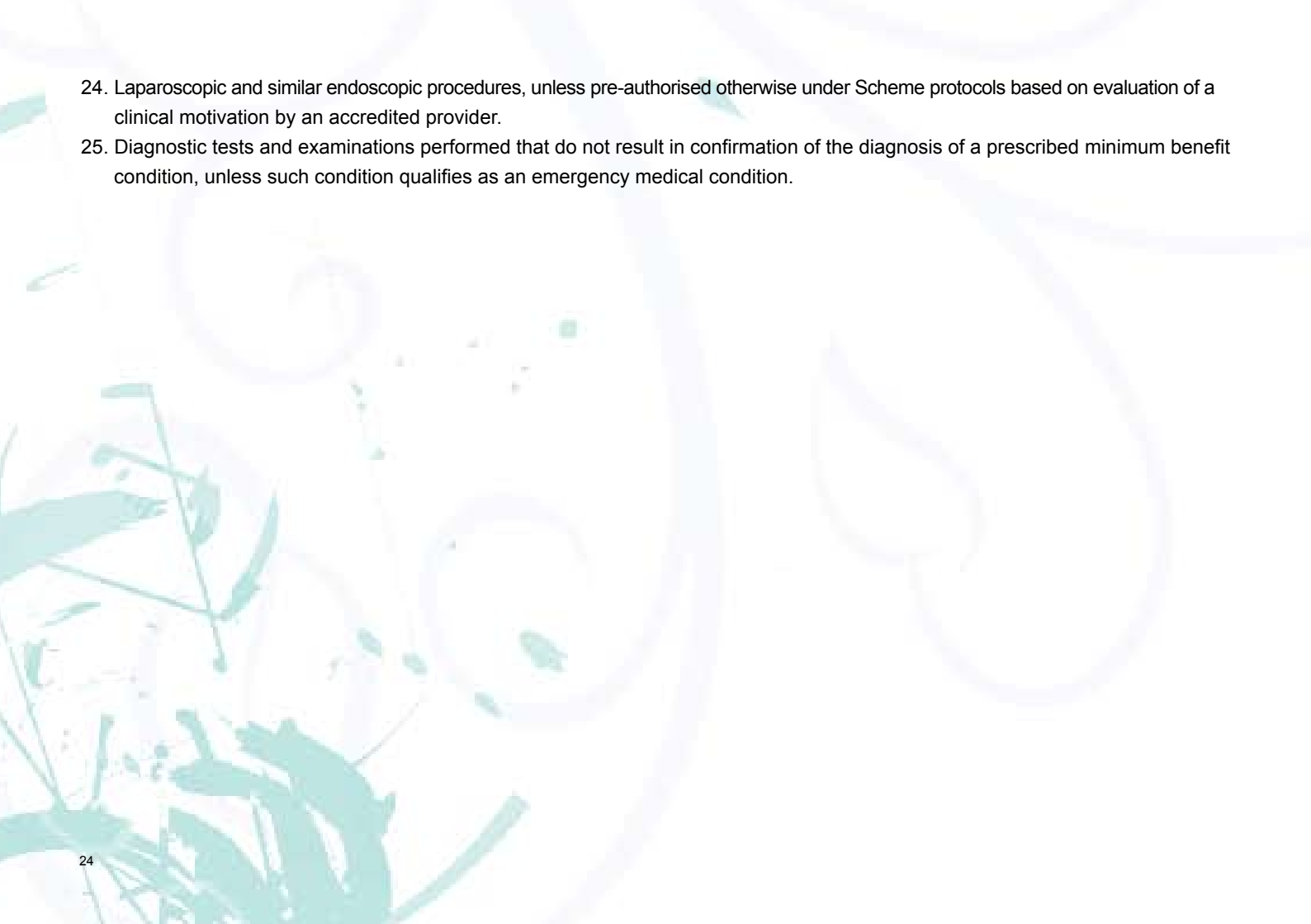
- 3.12.1 Medication used outside their Medicines Control Council registration;
 - 3.12.2 Tumor Necrosis Factor agents, unless in accordance with the Prescribed Minimum Benefit Algorithms;
 - 3.12.3 Tier 3 Oncology Treatment in accordance with the South African Oncology Consortium protocols;
 - 3.12.4 Interferons for chronic Hepatitis C.
 4. Expenses incurred for recuperative or convalescent holidays.
 5. Services provided by a person who is registered in terms of the Chiropractors, Homeopaths and Allied Health Service Professions Act 1982 (Act 63 of 1982), for whom no Medical Scheme Rates exists.
 6. All expenses in respect of illness conditions that were subject to waiting periods when the member joined the Scheme.
- Purchase of:
- 7.1 applicators, toiletries, sunglasses and/or lenses for sunglasses and beauty preparations;
 - 7.2 patented foods and nutritional supplements including baby foods;
 - 7.3 remedies for the treatment of infertility;
 - 7.4 tonics, slimming preparations, appetite suppressants and drugs as advertised to the public for the specific treatment of obesity;
 - 7.5 sunscreen and suntanning lotions;
 - 7.6 soaps and shampoos (medicinal or otherwise);
 - 7.7 household and biochemical remedies which are not promoted by the medical profession;
 - 7.8 cosmetic products (medicinal or otherwise);
 - 7.9 antihabit forming products;
 - 7.10 vitamins and multi-vitamins unless prescribed by a person legally entitled to prescribe;
 - 7.11 remedies for body building purposes;
 - 7.12 aphrodisiacs;
 - 7.13 medicines not registered with the Medicines Control Council and proprietary preparations;
 - 7.14 household bandages, cotton wool, dressings and similar aids.
8. Claims submitted after the last day of the fourth month after the month in which the service was rendered shall not be paid by the Scheme (Rule 15.2, 15.5 and Annexure B paragraph 1.2).
 9. In the event of services arising from an accident or event for which a member or registered dependant has received, or is likely

to receive, compensation from any source whatsoever, the Scheme shall provide benefits, in accordance with its standard practices and protocols, until the third party/ies' liability has been established, at which stage the expenditure shall be recouped from the third party or the member as the case may be.





9.1 In the event of a claim mentioned above not succeeding, the member shall be entitled to those benefits from the Scheme that would normally be applicable to him without regard to the time that has passed;





9.2 For the purposes of subparagraph 9.1 above, rule 4.17.5 shall be *mutatis mutandis* be applicable.





10. Any treatment arising from an accident or event because the member and/or his dependant(s) was/were under the influence of alcohol or drugs, unless prescribed and taken according to the instructions of a medical practitioner.
11. Services rendered by service providers for dependence producing substances, inclusive of services provided by institutions that are registered in terms of section 9 of the Prevention and Treatment of Drug Dependency Act 1992 (Act No. 20 of 1992).
12. Exercise programmes excluding antenatal exercises.
13. Immunosuppressives.
14. Kilometre charges and travelling expenses with the exception of ambulance services.
15. Gold inlays in dentures.
16. Change of sex operations and procedures and other reconstructive surgical procedures of which the execution is likewise not necessitated by functional or physical requirements.
17. Growth Hormone.
18. Examinations and tests for the purpose of application for insurance policies, school camp, visa, employment, emigration or immigration, admission to schools or universities, medical court reports as well as fitness examinations and tests.
19. Charges for appointments not kept.
20. Accommodation in convalescent or old age homes or similar institutions catering for the aged.
21. Costs associated with Vocational Guidance, Child Guidance, Marriage Guidance, School Therapy or attendance at Remedial Education Schools or Clinics.
22. Sleep Therapy and Hypnosis-therapy.
23. All expenses associated with the following will be restricted to the Prescribed Minimum Benefits:
infertility, sterility, artificial insemination of a person as defined in the Human Tissue Act, (Act 65 of 1983), as well as vaso-vasostomies (reversal of sterilisation procedures).





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24. Laparoscopic and similar endoscopic procedures, unless pre-authorized otherwise under Scheme protocols based on evaluation of a clinical motivation by an accredited provider.
 25. Diagnostic tests and examinations performed that do not result in confirmation of the diagnosis of a prescribed minimum benefit condition, unless such condition qualifies as an emergency medical condition.





f. Benefit Schedule

BENEFIT SCHEDULE	 HOSPITAL	 FUNDAMENTAL	 PROGRESSIVE	 PRESTIGE
HOSPITALISATION				
Private Hospitals Including: <ul style="list-style-type: none"> • Ward accommodation • Labour and recovery wards • Intensive care and high care units • Professional fees i.e. surgeon and anaesthetist, including visits and consultations by a specialist/GP while hospitalised • Surgical operations and procedures • Theatre fees • X-rays and pathology • Ultrasound scans (other than for pregnancy) • Blood transfusions • Physiotherapy • Medicine dispensed and used in hospital • Medicine received on discharge from hospital 	Unlimited General Ward 100% of NRPL 100% of NRPL 150% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL Maximum 7 days supply	Limited to PMB at DSP General Ward 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL Maximum 7 days supply	R200 000 (Single) R400 000 (Family) General Ward 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL Maximum 7 days supply	Unlimited General Ward 100% of NRPL 100% of NRPL 200% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL 100% of NRPL Maximum 7 days supply
Provincial Hospitals <ul style="list-style-type: none"> • Diagnosis and treatment in respect of the Prescribed Minimum Benefits (PMB) package (as per Government Regulations) 	Unlimited Subject to Scheme Protocols	Unlimited Subject to Scheme Protocols	Unlimited Subject to Scheme Protocols	Unlimited Subject to Scheme Protocols
ANNUAL SUB-LIMITS (PRIVATE HOSPITALS)				
Casualty Maternity <ul style="list-style-type: none"> • Confinements (Normal Vaginal Delivery) (Excl. Specialist and GP fee) • Confinements (Caesarean Section if clinically appropriate) (Excl. Specialist and GP fee) • Neonatal Intensive Care • Maternity programme • Not registered on the maternity programme 	R1 000 per family per annum. Limited to emergency visits R14 300 per family R17 900 per family Limited to Scheme Protocols Included Limited to DSP	R1 000 per family per annum. Limited to emergency visits Covered by CareCross R14 300 per family R17 900 per family Limited to Scheme Protocols Included Limited to DSP	R1 000 per family per annum Limited to emergency visits R14 300 per family R17 900 per family Limited to Scheme Protocols Included Limited to DSP	R1 000 per family per annum Limited to emergency visits R14 300 per family R17 900 per family Unlimited Included Limited to DSP



BENEFIT SCHEDULE	 HOSPITAL	 FUNDAMENTAL	 PROGRESSIVE	 PRESTIGE
ANNUAL SUB-LIMITS (PRIVATE HOSPITALS)				
<p>Other</p> <ul style="list-style-type: none"> • Psychiatric Disorders • Cochlear implants and all related thereto • Organ Transplants <p>Includes the transportation of the organ, surgically related procedures, professional fees and services as well as immunosuppressant drugs (Services rendered to donor are excluded from benefits)</p> <p>Prosthesis See detailed list on prosthesis limits on page 33</p>	<p>Limited to PMB R50 000 per family R75 000 per family</p> <p>Limited to R40 000 per family Subject to Prosthesis specific limit</p>	<p>Limited to PMB at DSP No Benefit Limited to liver, kidney and heart only where these are provided at Provincial Hospitals</p> <p>Limited to R27 500 per family Subject to Prosthesis specific limit</p>	<p>Limited to PMB No Benefit Limited to a Provincial Hospital and subject to Scheme Protocols</p> <p>Limited to R40 000 per family Subject to Prosthesis specific limit</p>	<p>Limited to PMB R75 000 per family R250 000 per family</p> <p>Limited to R40 000 per family Subject to Prosthesis specific limit</p>
RELATED HOSPITALISATION				
<p>External medical appliances</p> <ul style="list-style-type: none"> • Elastic stockings for control of varicose veins • Artificial eyes • Artificial larynx • Artificial limbs • Back, leg, arm and neck supports • Crutches • Disposable bladder and intestinal excretion bags • External breast prostheses after mastectomy • Glucometers • Home oxygen • Nebulisers • Orthopaedic footwear • Sleep apnoea monitors • Speech and hearing aids • Syringes and needles for the treatment of a chronic illness • Wheelchairs 	No Benefit	No Benefit	100% of NRPL R2 500 per family	100% of NRPL R9 500 per family
<p>Oncology</p> <ul style="list-style-type: none"> • Oncologist • Chemotherapy • Radiotherapy • Oncology - related bloods 	Limited to R150 000 per beneficiary. Covered at the oncology network of doctors, subject to SAOC Protocols Tier 2	Limited to R150 000 per beneficiary. Covered at the oncology network of doctors, subject to SAOC Protocols Tier 1	Limited to R200 000 per beneficiary. Covered at the oncology network of doctors, subject to SAOC Protocols Tier 1	Limited to R250 000 per beneficiary. Covered at the oncology network of doctors, subject to SAOC Protocols Tier 2

BENEFIT SCHEDULE	 HOSPITAL	 FUNDAMENTAL	 PROGRESSIVE	 PRESTIGE
RELATED HOSPITALISATION				
HIV/Aids Primary Care including VCT (Voluntary Counselling Testing)	HIV Management Programme	HIV Management Programme	HIV Management Programme	HIV Management Programme
Hospitalisation if Member is on the Management Programme	Hospitalisation limited to DSP hospitals and subject to Scheme Protocols	Hospitalisation limited to DSP hospitals and subject to Scheme Protocols	Hospitalisation limited to DSP hospitals and subject to Scheme Protocols	Hospitalisation limited to DSP hospitals and subject to Scheme Protocols
Hospitalisation if Member is not on the Management Programme	Limited to a Provincial Facility	Limited to a Provincial Facility	Limited to a Provincial Facility	Limited to a Provincial Facility
Home nursing	No Benefit	No Benefit	100% of NRPL R2 500 per family	100% of NRPL R6 000 per family
Hospice care	R15 000 per family	No Benefit	100% of NRPL R17 500 per family	100% of NRPL R25 000 per family
Specialised radiology CT, MRI, PET and Nuclear Medicine scans	100% of NRPL (In-and-out-of hospital) R6 900 per family per annum	Limited to Network Hospitals or DSP and subject to PMB	100% of NRPL (In- and out-of-hospital) R5 500 per family	100% of NRPL (In- and out-of-hospital) R7 500 per family per annum
Video EEG for epilepsy surgery	No Benefit	No Benefit	No Benefit	R10 000 per family
Haemodialysis	Limited to DSP and subject to PMB	Limited to DSP and subject to Scheme Protocols	Limited to DSP and subject to Scheme Protocols	Unlimited
Emergency evacuation and ambulance services Note: Use preferred provider	100% of NRPL Subject to Scheme Protocols	100% of NRPL Subject to Scheme Protocols	100% of NRPL Subject to Scheme Protocols	100% of NRPL Subject to Scheme Protocols
International Cover	Limited to emergency medical cover up to 90 days R5 000 000 per beneficiary per incident	Limited to emergency medical cover up to 90 days R5 000 000 per beneficiary per incident	Limited to emergency medical cover up to 90 days R5 000 000 per beneficiary per incident	Limited to emergency medical cover up to 90 days R5 000 000 per beneficiary per incident
CHRONIC MEDICATION BENEFIT				
25 PMB CDL's	Limited to Provincial facilities	Subject to registration and approval by CareCross and limited to their Formulary	Subject to Progressive formulary, reference pricing may apply	Subject to Prestige formulary, Reference pricing may apply. PMB unlimited
Resolution Approved Chronic Conditions (Refer to Annexure D of Rules of the Scheme)	No Benefit	No Benefit	No Benefit	Included and limited to: R3 500 (Single member) R7 000 (Family)





BENEFIT SCHEDULE	 HOSPITAL	 FUNDAMENTAL	 PROGRESSIVE	 PRESTIGE
OUT-OF-HOSPITAL SERVICES i) Not limited to OAL				
General Practitioners	No Benefit	Limited to the CareCross network (unlimited)	100% of NRPL M R650 M + 1 R1 250 M + 2 + R1 600	100% of NRPL M R1 600 M + 1 R2 400 M + 2 + R3 200
Specialists	No Benefit	Only for PMB related cases and pre-authorization required	100% of NRPL M R500 M + 1 R500 M + 2 + R1 000	150% of NRPL M R1 500 M + 1 R1 500 M + 2 + R2 250
Dentistry <i>Conservative dentistry</i> Consultations	No Benefit	Subject to CareCross network 2 annual checkups per beneficiary	2 annual check-ups per beneficiary	2 annual check-ups per beneficiary
Fillings	No Benefit	Benefit for fillings is available where such fillings are clinically indicated	A treatment plan and x rays will be requested for treatment plans of more than 5 fillings. Benefit for fillings is available where such fillings are clinically indicated and will be granted once per tooth in a 3 year period. There is no benefit for Amalgam (silver) fillings to be replaced with Composite (white filling material). Covered at the NRPL	A treatment plan and x rays will be requested for treatment plans of more than 5 fillings. Benefit for fillings is available where such fillings are clinically indicated and will be granted once per tooth in a 3 year period. There is no benefit for Amalgam (silver) fillings to be replaced with Composite (white filling material). Covered at the NRPL
Oral Hygiene	No Benefit	2 annual scale and polish treatments per beneficiary	2 annual scale and polish treatments per beneficiary	2 annual scale and polish treatments per beneficiary
Preventative	No Benefit	No benefit for oral hygiene instructions	2 annual scale and polish treatments per beneficiary No benefit for oral hygiene instructions No benefit for adult fluoride	2 annual scale and polish treatments per beneficiary No benefit for oral hygiene instructions No benefit for adult fluoride
Extractions and Root Canal therapy	No Benefit	No Benefit	Fissure Sealant Programme Benefit for one fissure sealant per molar tooth in a 3 year period Limited to individuals younger than 16 years	Fissure Sealant Programme Benefit for one fissure sealant per molar tooth in a 3 year period Limited to individuals younger than 16 years
Plastic Dentures	No Benefit	Limited to CareCross protocols	Covered at the NRPL	Covered at the NRPL
Specialised dentistry Crowns*	No Benefit	No Benefit	One set of plastic dentures (an upper and a lower) per beneficiary in a 4 year period	One set of plastic dentures (an upper and a lower) per beneficiary in a 4 year period
Partial metal frame dentures	No Benefit	Limited to CareCross protocols	Limited to MCA	2 crowns per family per year. Pre-auth is required.
	No Benefit	No Benefit	Limited to MCA	One partial frame (an upper or a lower) per beneficiary in a 5 year period. Full metal dentures are not covered


BENEFIT SCHEDULE	 HOSPITAL	 FUNDAMENTAL	 PROGRESSIVE	 PRESTIGE
OUT-OF-HOSPITAL SERVICES i) Not limited to OAL				
Orthodontics*	No Benefit	No Benefit	Limited to MCA. Call Resolution Health. Orthognathic Surgery is not covered.	Benefit on pre-authorisation will be applied to cases assessed as treatment mandatory, as per orthodontic indices Limited to individuals younger than 18 years. Orthognathic surgery is not covered
Implants*	No Benefit	No Benefit	No Benefit	Benefit on pre-authorisation 2 implants per beneficiary in a five year period Cost of implant components is limited to R 1500 per implant
Periodontics*	No Benefit	No Benefit	No Benefit	Benefit is limited to conservative, non-surgical therapy only (root planing). This benefit will be applied to members who are registered on the Perio Programme. Refer to member guide for more information. Surgical periodontics is scheme exclusion
Surgery	Surgery in hospital: See Dental hospitalisation (Member liable for service provider and procedure costs)	No Benefit	Surgery in the dental chair: Covered at the NRPL. See Surgery Exclusion Summary Surgery in hospital: See Hospitalisation	Surgery in the dental chair: Covered at the NRPL. See Surgery Exclusion Summary Surgery in hospital: See Hospitalisation
Dental Hospitalisation & Anaesthetics	Pre-authorisation required Admission protocols apply Impacted teeth removals only	No Benefit	Pre-auth is required. Admission protocols apply. Impacted teeth removals only	Pre-auth is required. Certain Maxillo Facial procedures are covered in-hospital, subject to admission protocols. See Exclusion Summary
Hospitalisation* (general anaesthetic)	General anaesthetic benefits are available for very young children for extensive dental treatment Multiple hospital admissions are not covered	No Benefit	General anaesthetic benefits are available for very young children (younger than 5 years of age) for extensive dental treatment Multiple hospital admissions are not covered	General anaesthetic benefits are available for very young children (younger than 5 years of age) for extensive dental treatment. Multiple hospital admissions are not covered
Dental Anaesthetics in rooms				
Laughing gas in dental rooms	No Benefit	No Benefit	Covered at the NRPL	Covered at the NRPL
IV conscious sedation in rooms*	No Benefit	No Benefit	Pre-authorisation required. Covered at the NRPL Clinical protocols apply	Pre-authorisation required. Covered at the NRPL Clinical protocols apply

*All specialised dentistry and hospitalisation must be pre-authorized. Contact number: 0860 104 936

BENEFIT SCHEDULE	 HOSPITAL	 FUNDAMENTAL	 PROGRESSIVE	 PRESTIGE
OUT-OF-HOSPITAL SERVICES i) Not limited to OAL				
Optometry	No Benefit	1 consultation per beneficiary per benefit cycle (24 Months)	1 consultation per beneficiary per benefit cycle (24 Months)	1 Consultation per beneficiary per benefit cycle (24 Months)
Examination	No Benefit	1 consultation per beneficiary per benefit cycle (24 Months)	1 consultation per beneficiary per benefit cycle (24 Months)	1 Consultation per beneficiary per benefit cycle (24 Months)
Spectacles	No Benefit	Standard frame as per CareCross Protocols Lenses will be limited to a white mono or bifocal prescription as per CareCross Protocols	One pair of single vision spectacles inclusive of a frame and consultation per beneficiary, to the total value of R700 or one pair of flat top bifocal spectacles inclusive of a frame and consultation per beneficiary, to the total value of R950 or one pair of multifocal spectacles inclusive of a frame and consultation per beneficiary, to the total value of R1200	Frame benefit limited to R600 One pair of either single vision spectacle lenses, bifocal lenses or multifocal lenses, per beneficiary per benefit cycle (24 months) or
Contact lenses	No Benefit	No Benefit	Limited to MCA	Contact lens materials benefit limited to R1330 per beneficiary per benefit cycle
Preventative Care	R2 500 per family Excludes consultations	Limited to services provided by CareCross	R2 500 per family Excludes consultations	R2 500 per family Excludes consultations
1. Blood pressure Blood sugar Cholesterol	R75 per beneficiary over the age of 18 years only at a pharmacy	Limited to services provided by CareCross	R75 per beneficiary over the age of 18 years only at a pharmacy	R75 per beneficiary over the age of 18 years only at a pharmacy
2. Vaccinations	<ul style="list-style-type: none"> Childhood immunisations as recommended by the Department of Health up to 18 months - refer to Notes to the Benefit Schedule Flu vaccination – 1 dose per beneficiary per year HPV (cervical cancer) vaccine – one course (3 doses per registered schedule) per female beneficiary between 9 and 46 years of age per life 	<ul style="list-style-type: none"> Limited to services provided by CareCross HPV – No Benefit 	<ul style="list-style-type: none"> Childhood immunisations as recommended by the Department of Health up to 18 months - refer to Notes to the Benefit Schedule Flu vaccination – 1 dose per beneficiary per year HPV (cervical cancer) vaccine – one course (3 doses per registered schedule) per female beneficiary between 9 and 46 years of age per life 	<ul style="list-style-type: none"> Childhood immunisations as recommended by the Department of Health up to 18 months - refer to Notes to the Benefit Schedule Flu vaccination – 1 dose per beneficiary per year HPV (cervical cancer) vaccine – one course (3 doses per registered schedule) per female beneficiary between 9 and 46 years of age per life
3. HIV Test	1 test per beneficiary per annum	Limited to services provided by CareCross	1 test per beneficiary per annum	1 test per beneficiary per annum
4. Mammogram	1 test per female beneficiary over the age of 25 per annum	Limited to services provided by CareCross	1 test per female beneficiary over the age of 25 per annum	1 test per female beneficiary over the age of 25 per annum
5. Pap smears	1 test per female beneficiary per annum	Limited to services provided by CareCross	1 test per female beneficiary per annum	1 test per female beneficiary per annum
6. PSA (Prostate specific antigen)	1 test per male beneficiary over the age of 35 per annum	Limited to services provided by CareCross	1 test per male beneficiary over the age of 35 per annum	1 test per male beneficiary over the age of 35 per annum
7. Nurse Helpline (including Rape Crisis Centre)	Advice and information regarding any emergency medical condition 084 124 (24 hours)	Advice and information regarding any emergency medical condition 084 124 (24 hours)	Advice and information regarding any emergency medical condition 084 124 (24 hours)	Advice and information regarding any emergency medical condition 084 124 (24 hours)

* Iso LESO contact number: 0860 103 060

BENEFIT SCHEDULE	 HOSPITAL	 FUNDAMENTAL	 PROGRESSIVE	 PRESTIGE
OUT-OF-HOSPITAL SERVICES ii) Limited to OAL				
Overall Annual limits Note: Annual limits are prorated for members who join during the year Benefit sublimits as follows:	No Benefit	Limited to CareCross GP Network, which includes Maternity Scans	M R1 400 M + 1 R1 900 M + 2 + R2 200	M R4 500 M + 1 R6 000 M + 2 + R8 000
Alternative Healthcare Services • Biokinetists • Chiropractors • Chiropractors • Dieticians • Homeopaths • Naturopaths • Occupational Therapists • Osteopaths • Podiatrists • Social Workers	No Benefit	No Benefit	100% of NRPL M R 750 M + 1 R1 000 M + 2 + R1 250 Sublimit subject to overall annual limit	100% of NRPL M R2 000 M + 1 R3 000 M + 2 + R4 000 Sublimit subject to overall annual limit
Radiology and Pathology (Excluding CT, MRI, PET and Nuclear Medicine scans)	Limited to PMB and Subject to Scheme Protocols	Subject to CareCross Protocols	100% of NRPL M R750 M + 1 R1 000 M + 2 + R1 250 Subject to overall annual limit	100% of NRPL M R2 000 M + 1 R2 500 M + 2 + R3 000 Subject to overall annual limit
Physiotherapy	No Benefit	No Benefit	100% of NRPL R400 per family Subject to overall annual limit	100% of NRPL R900 per family Subject to overall annual limit
Speech Therapy and Audiology	No Benefit	No Benefit	100% of NRPL R500 per family Subject to overall annual limit	100% of NRPL R1 000 per family Subject to overall annual limit
Psychology and Psychiatric Treatment	Limited to PMB and Subject to Scheme Protocols	Limited to Provincial facilities and subject to Scheme Protocols	100% of NRPL R500 per family Subject to overall annual limit	100% of NRPL R1000 per family Subject to overall annual limit
Acute Medication	No Benefit	Subject to CareCross Acute Formulary	Subject to Formulary M R 750 M + 1 R1 000 M + 2 + R1 250 Subject to overall annual limit	Subject to Formulary M R2 000 M + 1 R3 000 M + 2 + R4 000 Subject to overall annual limit
Pharmacy Advised Therapy (PAT) (Prescription from pharmacist required)	No Benefit	No Benefit	Subject to Formulary Limited to R80 per script per family per day with: M R 500 M + 1 R 500 M + 2 + R 800 Subject to overall annual limit	Subject to Formulary Limited to R80 per script per family per day with: M R 500 M + 1 R 500 M + 2 + R 800 Subject to overall annual limit

	 PROGRESSIVE (ONLY)										
MEDICAL CURRENT ACCOUNT (MCA)	100% of the Private rates subject to available MCA										
<p>The MCA is a personalised savings account that is used to pay for any excess or additional amounts to the Scheme's benefits. The full annual allocation of monthly MCA contributions is made available for use immediately and will be prorated for members who join during the year. Any unused funds in the MCA are saved and the positive balance can be withdrawn (or transferred to another medical scheme) five months after the termination of membership. Member will be held liable for over-using/spending their savings.</p>	<p>Limited to:</p> <table> <tr> <td>Member</td> <td>R576 per annum</td> </tr> <tr> <td>Adult dependant</td> <td>R576 per annum</td> </tr> <tr> <td>Child dependant</td> <td>R288 per annum</td> </tr> <tr> <td>Child x 2</td> <td>R576 per annum</td> </tr> <tr> <td>Child x 3</td> <td>R864 per annum</td> </tr> </table>	Member	R576 per annum	Adult dependant	R576 per annum	Child dependant	R288 per annum	Child x 2	R576 per annum	Child x 3	R864 per annum
Member	R576 per annum										
Adult dependant	R576 per annum										
Child dependant	R288 per annum										
Child x 2	R576 per annum										
Child x 3	R864 per annum										
General Practitioners	100% of Cost limited to the Private Rate										
Specialists	100% of Cost limited to the Private Rate										
Alternative Healthcare Services <ul style="list-style-type: none"> • Audiologists • Biokinetists • Chiroprodists • Chiropractors • Dieticians • Homeopaths • Naturopaths • Occupational Therapists • Osteopaths • Podiatrists • Social Workers 	100% of the Private Rate										
Radiology and Pathology (Excluding MRI and CAT scans)	100% of the Private Rate										
Basic and Advanced Dentistry	100% of the Private Rate										
Spectacles, Frames and Contact Lenses	100% of the Private Rate										
Acute Medication (Prescription required from a person legally entitled to prescribe)	100% of Cost										
Pharmacy Advised Therapy (PAT) (Pharmacist to advise and dispense over-the-counter medication)	100% of Cost Limited to R80 per script per family per day										
Physiotherapy	100% of the Private Rate										
Speech Therapy	100% of the Private Rate										
Psychiatry and Psychology	100% of the Private Rate										

Contributions Table

	 HOSPITAL	 FUNDAMENTAL	 PROGRESSIVE	 PRESTIGE
CONTRIBUTION TABLE 2009				
Core (Member)	R663	R456	R852	R1 497
MCA	Not Available	Not Available	R48	Not Available
Contribution Payable	R663	R456	R900	R1 497
Core (Adult Dependant)	R489	R375	R810	R1 455
MCA	Not Available	Not Available	R48	Not Available
Contribution Payable	R489	R375	R858	R1 455
Core (Child Dependant)	R153	R159	R252	R384
MCA	Not Available	Not Available	R24	Not Available
Contribution Payable	R153	R159	R276	R384

LATE JOINER PENALTIES

Additional premiums for persons joining medical schemes late in life to be added to the applicable premium rates.

Premium penalties will be applied as follows in respect of persons over the age of 35 years, who were without medical scheme cover for the period indicated hereunder after the age of 30 years:

- 1 – 4 years 0.05 multiplied by the relevant contribution in 1 above
- 5 – 14 years 0.25 multiplied by the relevant contribution in 1 above
- 15 – 24 years 0.5 multiplied by the relevant contribution in 1 above
- 25+ years 0.75 multiplied by the relevant contribution in 1 above

Rule 4.16 "Credible coverage" - any period during which a late joiner was:

- 4.16.1 a member or a dependant of a medical scheme
- 4.16.2 a member or a dependant of any entity doing the business of a medical scheme which, at the time of his membership of such entity, was exempt from the provisions of the Act
- 4.16.3 a uniformed employee of the South African Defence Force, or a department of such employer, who received medical benefits from the South African National Defence Force, or
- 4.16.4 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

TERMINATION OF MEMBERSHIP

As a member of Resolution Health there might be reasons or circumstances that would lead to the termination of your membership, e.g. change in employment.

- **Resignation**
Members who are members of Resolution Health in terms of their conditions of employment may not resign from the Scheme while they remain an employee without written consent from their employer. However, Resolution Health takes care of your medical needs until your membership is cancelled by your employer. Should you wish to remain a member of Resolution Health in your private capacity, you are encouraged to do so to ensure continued medical benefits and cover.
- **Voluntary Termination**
Members who are not members of Resolution Health in terms of their conditions of employment may terminate their membership by giving three (3) months' written notice. Employers that wish to terminate their association with the scheme may do so by giving one month written notice.
- **Death**
Membership is terminated on death.
- **Failure to pay amounts due to the Scheme**
Members who fail to pay amounts due to the Scheme may have their membership terminated in terms of the Rules of the Scheme.
- **Abuse of privileges, false claims, misrepresentation and non-disclosure of factual information will result in the termination of membership.**

NOTE:

The Scheme may terminate the membership or exclude the member or dependant from benefits should he be found guilty of abusing benefits and privileges of the Scheme by misrepresentation or non-disclosure of information or presentation of false claims.

All rights or benefits will end at midnight of the last day of membership. Claims rendered prior to this date and submitted within the required timeframe will be paid.

g. Notes to the Benefit Schedule

Hospitalisation

1. Authorisation must be obtained at least 72-hours in advance from the Scheme for all non-emergency hospital admissions and procedures. In the case of true emergency admissions, authorisation must be obtained within 48-hours or on the first working day after admission. All authorisations are subject to Scheme rules and managed care policies, protocols and formularies.
2. Dental treatment carried out in a hospital operating theatre or unattached operating theatre (day clinic) under general anaesthetic requires pre-authorisation from Denis as above to confirm benefits for theatre, anaesthetist and ward fees. Members on the Hospital Plan are liable for all professional dental surgeons fee.
3. Laparoscopic and similar endoscopic procedures are excluded from benefits, unless pre-authorized otherwise under Scheme Protocols.
4. Admissions for members of the Fundamental Plan will be limited to the conditions as defined in the Prescribed Minimum Benefits.
5. Co-payments. Members need to pay the following amounts upfront to the hospital when they are admitted for the procedures below. Co-payments do not apply if these procedures are performed out of hospital. When two related co-payments are applicable, only the larger will apply.

PROCEDURE (all subject to Protocols)	Co-payments
Arthroscopy	R2 000
Colonoscopy, Sigmoidoscopy, Proctoscopy	R1 000
Conservative Back treatment	R2 000
Excision nailbed	R1 000
Functional nasal surgery	R2 500
Gastroscopy	R1 250
Hysterectomy	R3 000
Hysteroscopy	R2 250
Joint replacements	R2 500
Laparoscopy	R2 500
Myringotomy (grommets)	R1 000
Reflux Surgery	R3 000
Skin lesions	R1 000
Spinal Surgery	R3 000

*Where two related co-payments are applicable, only the larger will apply if admitted to hospital.
Co-payments will not apply for procedures performed out of hospital*

PROSTHESIS SPECIFIC LIMITS

Kindly note: The annual overall limit for prosthesis as outlined in the benefit summary is subject to certain sub-limits per type of prosthesis. These sub-limits are outlined below:

PROSTHESIS	HOSPITAL		FUNDAMENTAL		PROGRESSIVE		PRESTIGE	
Knee	R30 000		R19 000		R25 000		R30 000	
Hip	R28 000		R19 000		R23 000		R28 000	
Shoulder Elbow Ankle	R35 000		27 500		R35 000		R35 000	
External fixator	R40 000		R27 500		R40 000		R40 000	
Spinal Fusion	Cervical	Lumbar, dorsal	Cervical	Lumbar, dorsal	Cervical	Lumbar, dorsal	Cervical	Lumbar, dorsal
1 level	R14 000	R16 000	R13 000	R15 000	R14 000	R16 000	R14 000	R16 000
2 levels	R22 000	R26 000	R21 000	R25 000	R22 000	R26 000	R22 000	R26 000
3 levels	R30 000	R32 000	R25 000	R27 500	R30 000	R32 000	R30 000	R32 000
4 or more levels	R40 000	R40 000	R27 500	R27 500	R40 000	R40 000	R40 000	R40 000
Pelvic floor	R5 000		R5 000		R5 000		R5 000	
Hernia mesh	R5 000		R5 000		R5 000		R5 000	

Note: sublimits for other prostheses determined per case

Related hospitalisation

1. Pre-authorisation must be obtained from the Scheme for chemotherapy, radiotherapy, home nursing, specialised radiology, hospice care, haemodialysis, video EEG and international cover.
2. No benefits shall be granted for (1) the replacement of existing external medical appliances without satisfactory proof that the existing item is obsolete or (2) costs of maintenance, spares or accessories.
3. Hospice care includes hospice accommodation and hospice visits by a medical practitioner.

Out-of-Hospital Benefit

1. For acute medication, a prescription from a person legally entitled to prescribe is required.
2. All dental benefits are paid at the NRPL. This is a unique benefit and can be viewed at your dentist, at www.denis.co.za or by calling (021) 673 6612 for an automatically faxed list.
3. All specialised dentistry must be pre-authorised at 0860 104 936. Please read the member guide for more details on your dental benefits and exclusions.
4. Annual limits are prorated for members who join during the year.

Chronic Medication

1. Chronic medication is subject to the managed care formularies and protocols of RHMS.
2. A prescription from a person legally entitled to prescribe is required.
3. Diagnostic codes (ICD-10) as supplied by the doctor are mandatory for all conditions.
4. The Prestige formulary is more extensive than Progressive. Formularies may be viewed online at www.medikredit.co.za
5. All chronic medication requires pre-authorisation and doctors or pharmacist can phone 0800 132 345 for authorisation.

Childhood immunisations

The following schedule is recommended by the National Department of Health up to the age of 18 months

Age of child	Vaccine needed
At birth	OPV(0) Oral Polio Vaccine
	BCG Bacilles Calmette Vaccine
6 weeks	OPV(1) Oral Polio Vaccine
	DTP/Hib(1) Diptheria, Tetanus, Pertussis & Haemophilus influenza type b Vaccine
	Heb B(1) Hepatitis Vaccine
	PCV(1) Pneumococcal Conjugated Vaccine
10 weeks	OPV(2) Oral Polio Vaccine
	RV (1) Rotavirus Vaccine
	DTP/Hib(2) Diptheria, Tetanus, Pertussis & Haemophilus influenza type b Vaccine
	Heb B(2) Hepatitis Vaccine
14 weeks	PCV(2) Pneumococcal Conjugated Vaccine
	OPV(3) Oral Polio Vaccine
	RV (2) Rotavirus Vaccine
	DTP/Hib(3) Diptheria, Tetanus, Pertussis & Haemophilus influenza type b Vaccine
9 months	Heb B(3) Hepatitis Vaccine
	PCV(3) Pneumococcal Conjugated Vaccine
	Measles Vaccine(1)
18 months	OPV(4) Oral Polio Vaccine
	DTP Diptheria, Tetanus, Pertussis
	Measles Vaccine (2)

Childhood immunisations (continue)

Childhood Immunisation Schedule of DoH	Trade Name
OPV	POLIORAL TRIVALENT; OPV-MERIEUX
TB	BCG Intradermal Infant
DTP	DTP-MERIEUX
Heb B	ENGERIX -B (paed) ; H-B-VAX II; HEBERBIOVAC
Hib	HIBERIX
Measles	ROUVAX
Measles/Mumps/Rubella	PRIORIX ; TRIMOVAX I; Morupar
PCV	Prevenar
RV	Rotarix
Flu Vaccines	Trade Name
	X-flu prefilled 0,5ml syringe
	Influvac 0.5ml
	Vaxigrip single dose 0.5ml pre-filled
	Vaxigrip single dose 0.25ml pref paed
	Mutagrip single dose 0.5ml pref adult
HPV- Human papillomavirus vaccine	Trade Name
	Gardasil
	Cervarix

h. Glossary

Acute Conditions

Acute conditions typically have a fairly rapid onset and are usually of a limited duration. By themselves (e.g. the common cold) or with treatment (e.g. appendicitis) they usually resolve without any long-term effects.

Chronic Conditions

Chronic conditions can also have a fairly rapid onset, but are usually more insidious or even hidden. Examples include hypertension, raised cholesterol and asthma. Although some can resolve (e.g. childhood asthma) they are usually never cured and require ongoing long-term treatment to control their symptoms and prevent future complications.

CDL (Chronic Disease List)

The CDL is a list of 25 chronic conditions which are legislated by the government as part of the list of PMB conditions. The Council of Medical Schemes has published treatment algorithms for these chronic conditions as guidelines for their management.

CML (Chronic Medicines List)

The list or formulary of medication that is available for each of the CDL conditions for each option or plan. This list is updated monthly and can be viewed at www.medikredit.co.za

DSP (Designated Service Provider)

A healthcare provider or group of providers selected by the Scheme as preferred provider/s to provide to the members diagnoses, treatment and care in respect of one or more Prescribed Minimum Benefit conditions.

ICD-10 Codes (International Statistical Classification of Diseases and Related Health Problems)

A comprehensive list published by the World Health Organisation (WHO) that identifies all diseases with unique ICD-10 code. All authorisations and claims require the correct code for processing.

MCA (Medical Current Account)

The MCA is a personalised savings account on the Progressive Plan that may be used to pay for any excess or additional amount to the Scheme's benefits.

MMAP (Maximum Medical Aid Price)

The price a Scheme funds as a representative price for identical active medication ingredients. This is published by MediKredit and can be viewed at www.medikredit.co.za. All medication above the MMAP is subject to a co-payment.

NRPL

The National Reference Price List (NRPL) published by the National Department of Health (NDoH) as pricing guidelines for all health services. Unless superseded by a funding protocol, the Scheme only funds health services to this rate.

OAL (Overall Annual Limit)

The annual sublimit applicable to certain out-of-hospital benefits as listed in the Benefit Schedule.

PAT (Pharmacy Advised Therapy)

The PAT benefit is a sublimit of the Overall Annual Limit that provides for over-the-counter medication prescribed by a pharmacist. This is only provided on the Progressive and Prestige options and also has a daily limit.

PMB (Prescribed Minimum Benefits)

A list of 271 conditions listed in the Medical Schemes Act that schemes are required to fund. The CDL is a specified list of chronic conditions that also form part of the PMB. In certain circumstances the Scheme may only provide cover for members and their dependants in the provincial hospital system or at the Scheme's appointed private Designated Service Provider (DSP) facilities. Scheme protocols and formularies apply.

Protocols:

Funding guidelines directed towards the most cost-effective appropriate care.

Practice Code Numbers

A list of unique numbers allocated by the Board of Healthcare Funders (BHF) for all recognised healthcare service providers. These numbers need to be submitted for all authorisations and claims.

Reference Price

The price that the Scheme sets for certain classes of medication with similar therapeutic effects that applies to CDL conditions and certain other chronic conditions.

Resolution Health Chronic Conditions

A list of 23 chronic conditions that the Scheme funds from the Chronic Medication Benefit, in addition to the CDL conditions only available on the Prestige Plan. Protocols and formularies may apply.

SAOC (South African Oncology Consortium)

The SAOC is a consortium of the majority of oncologists that develop and maintain tiered oncology treatment guidelines. Their Utilisation Review Committee reviews cases according to these guidelines.

i. Contact Details

Head Office Boskruijn Office Park President Fouché Avenue Boskruijn (Entrance Boskruijn Village Centre) website: www.resomed.co.za	PO Box 1555 Fontainebleau 2032
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Loyalty Programme (Voial)	0861 796 6400
HealthCard Call Centre	0861 796 6400
Pre-authorisation	0861 796 6400 0861 111 778
International Travel Cover	0861 796 6400
Emergency Assistance: ER 24	084 124
Dental Benefits: Denis	0860 104 936 resomedenq@denis.co.za
Optometry Benefits: Iso Leso	0860 103 060 (011) 888 4681 (011) 782 0270 (fax) info@isoleso.co.za
Chronic Medication Authorisation (Doctors and Pharmacist only)	0800 132 345
Fundamental Plan Out-of-Hospital: CareCross	0860 102 183
HIV/AIDS Disease Management: CareWorks	0860 101 110
ResoBaby & ResoTot	0861 116 021

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