1. BACKGROUND TO MAKOTI

The Makoti Medical Scheme is known for its innovative and ground-breaking solutions and is celebrating 21 years of caring and sound service delivery to members.

The Makoti Medical Scheme was developed with the following in mind:

- To provide high quality medical care at affordable cost
- To introduce control measures in order to sustain the plan for a long period
- To prevent illness wherever possible by dealing with healthcare issues in the community we serve

2. BENEFITS YOU ARE ENTITLED TO

Makoti offers two benefit options. You need to choose the option that:
You can afford and that suits your healthcare needs
OPTION 1: PRIMARY OPTION

Day to day benefits (0860 00 24 00) 24 Hour call centre number for pre-authorisation.

- **GP’s:** Unlimited primary healthcare from your chosen general practitioner
- **Medicines:** Unlimited medicine as per formulary – acute and chronic
- **Over the counter medicine (OTC) and homeopathic medicine limited to R300 per family per annum with no limit on an event.**

The following benefits are unlimited subject to **pre-authorisation:**

- **Specialists:** Prescribed Minimum Benefits only in State Hospitals
- **Radiology:** CXR, suspected fractures of extremities and two obstetric sonars per pregnancy.
- **Pathology:** Basic Pathology only, PAP smear single slide, Glucose, Hb, HbA1c, WCC, Platelets RPR, Blood Group.
- **Ambulance services** for medical emergencies. The Scheme has contracted Lifemed ambulance **0861 08 69 11** as its preferred provider for ambulance services.
- **Optometry:** Limited to **R786** per beneficiary every 24 months including the cost of eye test, frames and lenses. Services must be authorised via the call center **0860 00 24 00** and must be necessary for correcting significant visual impairment problems. Lenses are subject to a refraction error and equal to, or more than 0.5 diopter. Replacement of lost spectacles is not covered.
- **Dentistry:** Benefit for consultations, fillings, extractions and prevention are unlimited. All dentistry must be provided by an accredited dentist or dental therapist, after the dentist has obtained authorisation via **Dental Information Systems (Pty) Ltd** at **0860 104 925.** No benefits for specialised dentistry and dentures.

**In-Hospital Benefits**

Statutory Prescribed Minimum Benefits are covered in full as authorised, in respect of the relevant health services as described in terms of section 67(1)(g) of the Medical Schemes Act. An **Emergency Stabilisation Benefit** in a Private Hospital (casualty only) introduced on 1 January 2018 at a benefit of **R10 000** per family per year.

**Services accessed in State Hospitals,** except for a **maternity benefit** introduced on 1 January 2018 for access to Private Hospitals for confinement up to a maximum of **R25 000** per pregnancy. **Subject to registration on the maternity benefit programme before 16 weeks pregnant.**

Another benefit enhancement for 2018 includes a benefit for **Internal Prostheses** at a limit of **R43 000** per family per year.

Experienced risk managers review all hospital admissions to optimize care and expenditure.
OPTION 2: COMPREHENSIVE OPTION

Day to day benefits (0860 00 24 00) 24 Hour call centre number for pre-authorisation.

- **GP’s**: Unlimited primary healthcare from your chosen general practitioner
- **Medicines**: Unlimited medicine as per formulary – acute and chronic
- **Over the counter medicine (OTC) and homeopathic medicine** limited to R300 per family per annum with no limit on an event.

The following benefits are unlimited subject to pre-authorisation:

- **Specialists** - subject to exclusions
- **Radiology**
- **Pathology** - allergy tests not covered (only Phadiatop-Allergy screen)
- **Ambulance services** for medical emergencies. The Scheme has contracted Lifemed ambulance 0861 08 69 11 as its preferred provider for ambulance services.

The following benefits are provided by accredited providers and are subject to limits:

- **Optometry**: Limited to R2 118 per beneficiary every 24 months including the cost of eye test, frames and lenses. Multi focal lenses and contact lenses are included in this limit. Services must be authorised via the call center 0860 00 24 00 and must be necessary for correcting significant visual impairment problems. Lenses are subject to a refraction error equal to, or more than 0.5 diopter. Replacement of lost spectacles is not covered.

- **Dentistry**: Benefit for consultations, fillings, extractions and prevention are unlimited. All dentistry must be provided by an accredited dentist or dental therapist, after the dentist has obtained authorisation via Dental Information Systems (Pty) Ltd at 0860 104 925. **Specialised dentistry** is subject to an annual limit of R 2 862 per family, including root canal treatment and all periodontal treatment.

Other Services

- **Clinical Psychology**
  Limited to 8 consultations per family per year and subject to pre-authorisation.

- **Hearing Aids**
  Limited to R 2 774 per beneficiary every 4 years and subject to pre-authorisation.

- **External Prosthesis / Appliances**
  A maximum of R 2 747 per member per annum for external orthopaedic prosthesis and subject to pre-authorisation.

- **Internal Prosthesis**
  A maximum of R 43 000 per family per annum for internal prosthesis and subject to pre-authorisation. Limited to 3 stents – 1 per lesion.

- **Physiotherapy and Occupational Therapy**
  A maximum of 20 consultations per family per annum and subject to pre-authorisation.

In-Hospital Benefits

- The Scheme provides unlimited Hospitalisation in Private Hospitals and step down care as appropriate. The Benefit is subject to pre-authorisation and PMB’s.
- Experienced risk managers review all hospital admissions to optimise care and expenditure.

Statutory Prescribed Minimum Benefits (PMB’s)

Statutory Prescribed Minimum Benefits as authorised, in respect of the relevant health services as described in terms of Section 67(1) (g) of the Medical Schemes Act of 1998 and the Regulations to it are paid in full.
Exclusions (Applicable to Primary and Comprehensive options)

The Makoti Medical Scheme will NOT cover the following costs subject to provisions in the Prescribed Minimum Benefits:

- The treatment of obesity and its direct complications
- Items or treatments that are not medically indicated
- Wilfully self-inflicted injuries (e.g. suicide attempts)
- Injuries arising from professional sport and speed contests
- The hire of medical, surgical and other appliances
- The cost of surgical stockings
- Medical services provided by any person not registered with the Health Professions Council of South Africa, the South African Nursing Council or the Pharmacy Council
- Recuperative holidays
- Dental Extractions for non-medical purposes
- Gold inlays
- Unproven or experimental treatment
- Cosmetic and reconstructive surgery, treatment and appliances
- Frail care and convalescence
- Employee medical examinations initiated by employer
- Items or treatments which are not medically essential
- Injuries where another party is responsible for the costs (e.g. Road Accident Fund or Workmen’s Compensation claims)
- Roaccutaine and Retin A for the treatment of skin conditions
- Podiatry, acupuncture, homeopathy, naturopathy, Chinese medicine and chiropractic are not covered
- Non-emergency visits to out-patient facilities at hospitals /casualties
- Pathology tests for allergies (except Phadiatop-Allergy screen)
- Infertility treatment (except in terms of PMB rules)
- Contraceptives and devices

Third party claims

If you are involved in a motor accident, your medical aid administrator will have a claim against the third party for medical expenses incurred. In order to go ahead with this claim, you or your dependant will be required to complete an “Accident Report” form.
## 3. CONTRIBUTIONS

**Contribution Table Effective**

1 January 2018

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4. YOUR SERVICE PROVIDERS

Your Accredited General Practitioner

You should carefully consider who you would like to have as your regular doctor. You need to select a general practitioner of your choice who is easily accessible to you. Enablemed will conclude an agreement with him or her to provide you with the services as offered by the Scheme. NB: It is important to understand that this will then be the only general practitioner you will be able to see (except in emergencies).

We believe that staying with one provider has many advantages. Among others you will build a relationship of trust with your doctor who will get to know you and your particular needs better. Conflicting treatments and medicine can also occur when seeing different doctors. If you wish to change your regular provider you can do so through your HR department by completing a new doctor choice form. Dental providers are arranged through the Dental call number 0860 104 925.

5. MANAGED HEALTHCARE

Managed healthcare has the following aims:

- To provide you and your dependants with high quality healthcare protocols that have been developed by the Scheme which need to be followed to access your benefits
- To keep healthcare affordable to as many people as possible
- This will be done for you through your doctor and the staff of the call centre

NB: All services are subject to pre-authorisation unless an arrangement has been made with your doctor. Please make sure your general practitioner, hospital or other supplier is willing to provide you with the authorised service at the Makoti Medical Scheme tariff. Please call 0860 00 24 00 for all services.

When visiting your doctor

When visiting your doctor please take your Makoti Membership Card and your ID document for positive identification. Also make sure you take your health records such as Baby Clinic or Family Planning Cards.

Making appointments

Some doctors and practices prefer you to make appointments to be seen. This will help to:
- Ensure that you will see the doctor that you need to see
- Plan your day better
- Minimise your waiting time

Chronic Care Program

Patients are encouraged to join the program for care of any chronic illness by going to their chosen general practitioner to register their condition. The registration process assists the general practitioner and the patient, so that the patient receives optimal care with minimum administration. The chronic care benefit covers all 27 CDL conditions. Medication is covered as per the formulary. HIV/AIDS is also included in the 27 CDL conditions and members can enjoy full cover once registered by their general practitioner on the chronic program.
What medicines and laboratory tests will be used?

Makoti has carefully chosen quality medicines. These medicines have been chosen to treat and prevent diseases. They need to be used in the correct manner and according to the correct dosage to regain or maintain health. It is very important to use medicines in the correct dosages, because if they are used incorrectly, they can cause a great deal of harm or even death.

The majority of these medicines are proven quality generics. If a patient insists on a more costly alternative the additional cost will be for the member to pay directly to the pharmacy. Medicine commonly requested that is not on the formulary include: Vitamins, laxatives and proton pump inhibitors.

Clinically appropriate laboratory tests are accessed subject to protocol and after pre-authorisation only.

6. YOUR MEMBERSHIP AND ADMINISTRATION

Universal Healthcare (Pty) Ltd is responsible for registering new members and dependants. The Scheme will apply underwriting as allowed by the Medical Schemes Act to all new entrants.

The following persons are allowed as dependants to the principal member:

A spouse or partner, biological children, adopted children and immediate family members that are dependent on the member for family care and support are eligible.

Cover for children as dependants

Your children may remain on the Makoti Medical Scheme as your dependants, until they

• Become employed, or
• Reach the age of 21 years
• After 21 years of age your children may remain as adult dependants up to 25 (subject to proof of admission and registration as a student at an accredited institution)

Adding adult dependants

If you wish to add adult dependants underwriting will be done according to the Medical Schemes Act.

How many medical aid schemes can a person belong to?

You may not belong to more than one medical aid.

How often can I change my option?

Once a year, at the end of the year, change effective 1 January. The option change form must reach Makoti by 30 November.
Your membership status

Please report the following changes to your membership status to the human resources department of your company.
• The birth or legal adoption of a child (within 30 days after birth)
• The new ID number of a dependant
• Passing away of a dependant
• Removal of a dependant from the Makoti Medical Scheme
• Divorce
• Addition of dependants
• Change of option may only be done once a year by 30 November effective 1 January
• Change of address

Changes in dependant status must be recorded in order for a new card to be issued. You need to check all the details on your membership card to make sure they are correct.

Any mistakes must be reported as soon as possible so that a new card can be issued to you. Change of status forms can be collected from your human resources by 1 November the previous year.

Your membership cards

Each member is issued with a membership card.

Contributions

Contributions to the Makoti Medical Scheme will be deducted from your wages/salary. These are paid each month in advance by your employer to the Scheme.

Accounts

It is the member’s responsibility to ensure that Enablemed receives all accounts immediately. Accounts received four months after the service date will not be paid by the Scheme and become the member’s responsibility.
Complaints and disputes:

Members may lodge their complaints telephonically, or in writing, to the Scheme. The Scheme’s dedicated telephone number for dealing with telephonic complaints is 011 208 1000.

Call centre agents will assist the member immediately if possible. All unresolved telephone complaints or complaints received in writing will be responded to by the Scheme in writing within 30 days of receipt thereof.

Any dispute, which may arise between a member, prospective member, former member or a person claiming by virtue of such membership and the Scheme or an officer of the Scheme, must be referred by the principal officer to a disputes committee (appointed by the Board of Trustees) for adjudication.

On receipt of a request in terms of this rule, the principal officer must convene a meeting of the disputes committee by giving not less than 21 days’ notice in writing to the complainant and all the members of the disputes committee, stating the date, time and venue of the meeting and particulars of the dispute. The disputes committee may determine the procedure to be followed.

The parties to any dispute have the right to be heard at the proceedings, either in person or through a representative. An aggrieved person has the right to appeal to the Council for Medical Schemes against the decision of the disputes committee. Such appeal must be in the form of an affidavit and directed to Council and shall be furnished to the Registrar not later than three months after the date on which the decision concerned was made.

CMS: 086 112 326 and e-mail: complaints@medicalschemes.com

DEFINITIONS

Acute medication

Medicine that is used for the treatment of short term illnesses such as flu.

Chronic medication

Medicine that is prescribed for an ongoing period longer than 3 months to manage a chronic condition such as diabetes.

PMB’s

Prescribed Minimum Benefits (PMB) is a set of defined benefits to ensure that all medical Scheme members have access to certain minimum health services. PMB’s are a feature of the Medical Schemes Act, in terms of which medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- any emergency medical condition;
- a limited set of 270 medical conditions (defined in the Diagnosis Treatment Pairs);
- and 26 chronic conditions (defined in the Chronic Disease List).
Step down facilities

Treatment facilities when a member has recovered well enough not to be treated in hospital but still needs care. The Scheme can request the doctor to move the member out of hospital to a step down facility.

Accredited provider

Enablemed has a network of doctors that they have contracted and accredited to deliver healthcare services.

Healthcare protocols

Healthcare protocols are documented medical guidelines which assist with decisions and criteria regarding diagnosis, management, and treatment in specific areas of healthcare to ensure best clinical outcomes.

Makoti Medical Scheme tariff

This is the maximum amount per procedure that the Scheme will pay for services provided by the healthcare providers.

In case of an emergency
contact Enablemed 24 Hour Call Centre on:
0860 00 24 00

or the Ambulance Services: Lifemed on
0861 086 911

This booklet is a guide to your Scheme’s rules. It gives you extracts of the main rules for easy reference.

PLEASE NOTE: The rules of the Scheme override the extracts in this booklet.
Contact details

Administered by:

Universal House
15 Tambach Road
Sunninghill Park
Sandton
2157

Private Bag X47
Rivonia 2128
Tel: (011) 208 1000
Fax: (011) 208 1028

Clinically managed by Enablemed

E-mail: admin@enablemed.com / Web: www.enablemed.com
Fax line: 086 660 7023