Benefit Guide

2024

We're about you

pmr.africa

Diamond Arrow Award

Highest rated medical aid in Namibia 2010 - 2023

Administered by

Medscheme Namibia

Table of contents

Disclaimer

E & OE (errors and omissions excepted).

Whilst every care has been taken to ensure that the information in this document is correct, errors and omissions may occur and the Fund cannot be held accountable for any reliance placed on the information contained herein.

The Fund's Client Services may be contacted to confirm any information contained in this document.

The new Benefits, Contributions and Rules of the NHP Fund for 2024, as approved by the Fund's Board of Trustees, are subject to final approval by the Registrar of Medical Aid Funds/NAMFISA. Members are advised that the new Benefits and Contributions became effective on 1 January 2024 as approved by the Registrar/NAMFISA, despite possible dissemination of revised information to the market before the effective date.

Should any proposed changes to Benefits and Contributions not be approved, members will be informed accordingly.

Members first

Over the years, NHP has grown sustainably, enabling us to build a reputable name in the medical aid industry. Our focus is to provide 'value-for-money' healthcare benefits designed to cover the members' needs. We offer services of exceptional quality to a growing membership base from senior management to the entry-level worker.

It is gratifying for NHP to be honoured with the PMR.africa Diamond Arrow Award in the following category, namely:

- For excellence in the Namibia medical aid industry for the 14th consecutive year (2010 to 2023).

Through the awards, PMR.africa wants to acknowledge contributions and initiatives, strategies, effort and hard work. PMR.africa also wants to acknowledge a company's vision, integrity, values, competence and 'empathy' that contributes to ethical and sustainable business practices. The purpose of the awards is to enhance competitiveness – locally and internationally, to create a global and unique marketing tool for a company, department and/or institution, to create unique sales tools for sales teams, to enhance excellence and to set a benchmark in the industry.

We thank our members and corporate employer groups for their loyal and continued support throughout the years and look forward to serving our members into the future with the same level of passion and dedication.

NHP represents a membership base of approximately 38 000 principal members providing healthcare benefits to over 79 000 lives.

Whilst many things change, our core principles remain the same

Access to quality treatment

NHP is dedicated to giving member access to quality treatment and healthcare. We want members' choice of benefit option to deliver the best healthcare benefits they can afford. Most importantly, we want to give members peace of mind about what benefits are available - when members need them.

Affordable cover and value for money

NHP aims to help members make informed decisions about choosing the medical cover that will best suit their needs. Member contributions determine the level of benefits, the rate at which we reimburse claims and freedom of choice when it comes to selecting healthcare providers. We believe that value for money is about offering affordable, quality benefits. This means that even when increases in medical costs are unavoidable, we work hard to manage these increases to keep members healthcare choices affordable.

We are here for members when in need to make caring for their health easier

We take the needs of our members to heart and focus on providing the best possible service and member care. We strive to provide members with regular updates and information to help make the most of their health and medical care. We continually review our benefit design structure to ensure we have everything needed to make the best healthcare decisions for the member and his/her family possible. NHP focuses on offering members access to quality healthcare through efficient and sustainable management of resources, for life.

Rules of the Fund

The rules will assist members to understand the Fund and to make the best use of benefits. It is very important for members to have a clear understanding of the rules in order to avoid misunderstandings and prevent resultant mistakes.

New members will receive a copy of the User Guide upon joining the Fund. In the event of a dispute, the latest official Fund rules, as registered, will apply.

The User Guide is a summary of the latest Fund rules. All members have access to the latest version of the Benefit Guide and User Guide on www.nhp.com.na.

The annual Summary of Changes document notifies members of changes to benefit options and the increase in monthly contributions for the following benefit year. It is important to retain the annual summary of changes for future reference.

NHP Governance Assessment

The NHP Board of Trustees and management participates annually in a voluntary process of self-evaluation to ensure that it maintains the highest levels of corporate governance whilst benchmarking itself against the compliance standards set by the Council of Medical Schemes (CMS) as well as King III.

The Governance Assessment was completed on-line with the assistance of the Administrator and the Global Platform. The outcome of the assessment reflects a 100% compliance with the CMS assessment and an AAA compliance with the King III assessment criteria.

The governance assessment will be performed on an annual basis in order to retain its validity and to ensure that the Fund continues to subscribe to the principles of good corporate governance in the interest of the Fund and its members.

Blow the whistle on fraud

Fraud, waste and abuse against the Fund

NHP adopts a zero tolerance towards fraud.

NHP's objective is to curb incidences of fraud and other inappropriate behaviour while building member awareness. It is estimated that between 5 and 15 percent of the total cost of medical expenditure (i.e. claims paid on behalf of members) can be attributed to either fraud, waste and abusive behaviour of members and/or healthcare providers.

NHP actively investigates all allegations and tip-offs relating to fraud such as unethical behaviour, abuse and over servicing in terms of the utilisation of benefits. If you suspect fraud by a fellow member or healthcare provider please report it to NHP using the contact details below. You can choose to remain anonymous or to provide your personal details. Please note that all your personal information will be treated confidentially.

Fraud is defined as the wilful misrepresentation of the facts in order to illegally obtain financial gain at the expense of someone else.

Waste is the useless expenditure or consumption (money, goods, time, effort, resources) for which no true value is received.

Abuse is an act that is inconsistent with sound medical or business practice.

Should you have information of any of the above mentioned examples please do not hesitate to report these to the Fund. All information received will be treated in strict confidence.

Members should be on the lookout for these most common types of fraud and abuse:

- Over servicing.
- Duplication of claims.
- Unbundling - Incorrect reporting of diagnoses or procedures.
- NAMAF benchmark tariff manipulation.
- Alteration of treatment dates - falsifying documents.
- Unnecessary treatments or dispensing of medications.
- False claims.
- Collusion.
- Claiming for supposed procedures.
- Corruption - kickbacks and/or bribery.

The majority of these types of fraud and abuse can be found on the member's monthly remittance statement and, if required, members may even request a detailed statement should the information on the statement not be sufficient. In other words, does the statement or claim correspond with the service or medication received?

Report any suspicious activity to our Whistleblower Hotline. Fraud Hotline: 0800 647 000 or email fraud@nhp.com.na.

Members should always read their monthly remittance statements and any other written documents, provided by the healthcare providers, hospital, or pharmacy:

- Read and understand any explanation of benefits received.
- Take note of the amount claimed. Is it unusually high in charges, compared to regular services?

Report any suspicious activity on membership or services provided:

- We need all NHP members to help in identifying possible cases of fraud and abuse.
- The member only knows of the services received.
- If members see any discrepancy on any document, contact the Fund to question it.

Members should note that the Fund reserves the right to implement the following procedures against members and healthcare providers guilty of fraudulent or abusive practices:

- Criminal proceedings will commence in the event of fraudulent claims submitted by member(s) and/or healthcare provider(s).
- The Fund will institute civil litigation against the member(s) and/or healthcare provider(s) in order to recoup any money forfeited by means of such fraudulent acts.
- The Fund will terminate membership with immediate effect, if found guilty of any fraudulent or abusive behaviour.
- The Fund will contact the employer about the employee's abusive and/or fraudulent behaviour.
- Members' and/or healthcare providers details, if found guilty of fraudulent or abusive behaviour, are given to NAMAF for potential listing with other medical aid funds.

It is in your best interest to report any instances of possible fraudulent, wasteful and abusive claiming practices. Save your benefits for a better tomorrow!

We're about you

NHP! Your Medical Aid Fund

14x PMR.africa Diamond Arrow Award winner!

NHP has yet again been awarded the PMR.africa Diamond Arrow Award for excellence, with the highest rated score within the medical aid fund industry in Namibia for 14 consecutive years (2010 to 2023).

The PMR.africa Awards, held annually, are intended to enhance and set a benchmark for excellence and is testament to NHP's dedication to unsurpassed member-centric approach to service delivery.

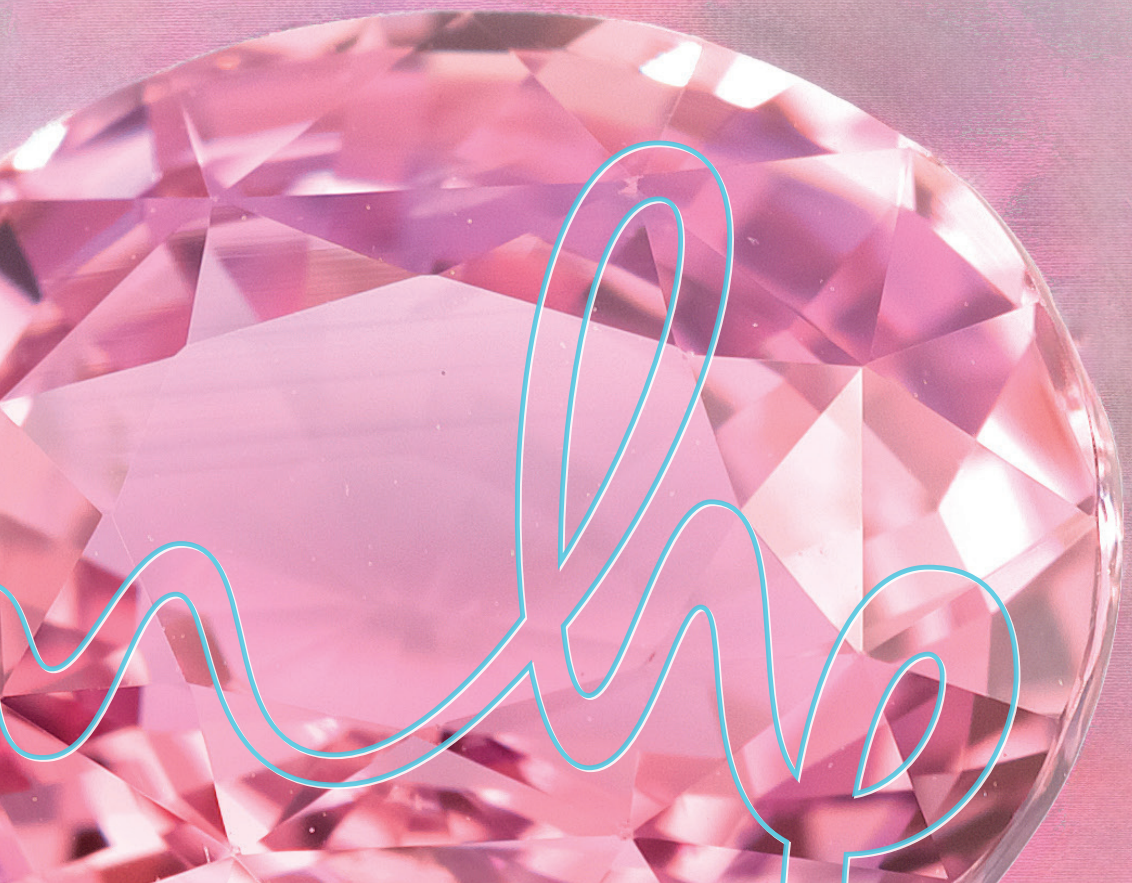
The award also serves as an acknowledgment to staff, that their hard work and dedication toward the Fund does not go unnoticed.

NHP wants to thank all its members, client's, health care providers and all other stakeholders for choosing the Fund as the industry leader.

Maintaining consistently high service levels in addition to affordable yet comprehensive benefit options has enabled NHP to become the choice medical aid fund in Namibia!

We're about you!
Contact NHP today and become a member of Namibia's leading medical aid fund!

pmr.africa
Diamond Arrow Award
Highest rated medical aid in Namibia 2010 - 2023



tel 061 285 5400
website www.nhp.com.na

Traditional benefit options

Gold | Platinum | Titanium

Three benefit options

Our Traditional benefit options are Gold, Platinum and Titanium.

Peace of mind

Typically aimed at families requiring the security of a structured benefit package and is best suited for members whose health risk is high.

Comprehensive cover

Ideal if you need comprehensive cover for both Major Medical and Day-to-Day Expenses.

Family benefit

Day-to-Day benefits are not reserved on a per beneficiary basis but rather quantified on a per family basis, allowing members of the family access to the entire family benefit.

Chronic Lifestyle Disease extender

Provides additional healthcare cover for Day-to-Day Expenses associated with chronic lifestyle diseases such as diabetes, cholesterol and hypertension. This benefit is only available on the Traditional benefit options.

Roll-Over benefit

When you claim less than a certain threshold amount included in your Day-to-Day benefits, you will build-up a Roll-Over benefit which can be used to pay for healthcare treatment and medical costs.

Gold

Major medical benefits: Expense limit per category		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Overall Annual Limit (OAL)				**Unlimited**		
1.	**Healthcare provider or medical specialists**					**SPA**
1.1	Consultations or visits: In-hospital	150%				
1.2	Procedures: In-hospital	150%				
2.	**Chronic medicine**		**34 200**		**69 100**	
2.1	Chronic medicine approved: Min levy of N$ 30 - subject to prior registration on the Chronic Care programme	80%				No benefit without registration
3.	**Hospital services**					**SPA**
3.1	Accommodation and theatre	100%				
3.2	Blood transfusions	100%				
3.3	Dialysis	100%				
3.4	Medication	100%				
3.5	Accommodation: Private wards	100%	28 800		58 300	
3.6	Accommodation other than a recognised hospital or medical institution: SA only	100%			875 per day	
3.7	Appliances and prosthesis: Surgical	100%	80 300		130 000	
3.8	Refractive surgery: Full procedure - a waiting period of 12 months will apply	100%	34 400		42 500	
3.9	Organ transplants: Full procedure	100%			725 000	
3.10	Private nursing	100%	77 900		77 900	
3.11	Oncology	100%			905 000	
4.	**Radiology**					**SPA**
4.1	Radiology: Specialised MRI and CT scans - In-and-out of hospital combined	100%			45 500	SPA
4.2	Basic Radiology: In-hospital	100%				
5.	**Pathology**					
5.1	Pathology: In-hospital	100%				
6.	**Dentistry**					**SPA**
6.1	Oral surgery: Full procedure	100%			70 300	
6.2	Maxillo facial surgery: Non-elective only	100%				
6.3	Dental Implants					OAL
6.3.1	Hospitalisation	100%			20 400	
6.3.2	Implant: Consultation, procedure and cost	100%			22 000	4 410 per implant
7.	**Psychiatric treatment**		**37 200**		**68 800**	**SPA**
7.1	Hospitalisation or institutionalisation	100%				
7.2	Rehabilitation of alcohol and drug addiction or abuse	100%				SPA
8.	**Maternity**					
8.1	Confinement: Full procedure - subject to pre-authorisation	100%				SPA
8.2	Antenatal consultations	100%			12 Visits	OAL
8.3	Sonar scans: 2D	100%			2 Scans	OAL
8.4	Amniocentesis	100%				SPA
8.5	Panorama Prenatal test	100%				SPA
9.	**Preventative care**					**OAL**
9.1	Preventative care benefits: As per list	100%				
10.	**Specified illness conditions**			**57 300**		**OAL**
10.1	HIV/AIDS: Including the cost of pathology tests	100%				SPA
10.2	Sexually transmitted diseases	100%	7 190		9 660	SPA
11.	**Ambulance services: Only for medical or trauma emergencies**					**SPA**
11.1	Emergency evacuation: Air	100%				
11.2	Ambulance services	100%				
11.3	Ambulance services: Inter-hospital transfer	100%	5 140	5 140		
11.4	Other transportation	80%				
12.	**Artificial limbs or eyes**					**SPA**
12.1	Artificial limbs	100%		74 300		
12.2	Artificial eyes	100%		29 700		
13.	**Heart surgery: Rehabilitation**	**100%**			**24 800**	**OAL/SPA**
14.	**Insertion Mirena device: All inclusive - every 3 years**	**100%**		**7 400**		**OAL/SPA**
15.	**Stoma Care products**	**100%**			**34 700**	**OAL/SPA**
16.	**Back and Neck Rehabilitation Programme**	**100%**	**Subject to DBC protocol**			**OAL/SPA**

OAL = Overall Annual Limit SPA = Subject to pre-authorisation DBC = Document Based Care

Gold

Day-to-Day benefits: Expense limit per category		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Out-of-hospital: Sub-limit						**OAL**
1.	**Healthcare provider or medical specialists**		**19 100**	**5 200**		
1.1	Consultations or visits: Out-of-hospital	100%	Unlimited	Unlimited		
1.1.1	Virtual consultations	100%	5	5		
1.2	Procedures: Out-of-hospital services	100%				
1.3	Pathology or Radiology: Out-of-hospital	100%				
1.4	Chronic Lifestyle Disease Extender benefit	100%	Additional benefits as specified			OAL
2.	**Medicine and injections**					
2.1	Acute medicine		11 100	6 450		
2.1.1	Acute medicine: Pharmacy dispensed - min levy of N$ 30	80%				
2.1.2	Acute medicine: Doctors dispensed - min levy of N$ 30	80%				
2.1.3	Self medication: Over-the-counter - no levy. Subject to acute medicine limit	100%	2 050	510		255 per claim
2.1.4	Vitamins, homeopathic and phytotherapy medicines: min levy of N$ 30 - subject to acute medicine limit	80%	1 100	300		255 per claim
3.	**Dentistry**		**22 900**		**45 400**	
3.1	Basic dentistry: Subject to sub-limit	100%	12 900	4 420		
3.2	Dental technicians	100%				
3.3	Advanced dentistry					
3.3.1	Orthodontics	100%				
3.3.2	Dental implants: Full procedure	100%	OAL: Refer to 6.3			
4.	**Optical**		**6 920**	**2 580**		
4.1	Eye tests	100%				Frame limited to 2 500
4.2	Spectacles or lenses - Frames every 2nd year	100%				
4.3	Orthoptics	100%				
5.	**Auxiliary services**		**21 600**	**6 370**		
5.1	Chiropody	100%		15 Visits		5 VC
5.2	Clinical psychology	100%		15 Visits		5 VC
5.3	Dietician	100%		15 Visits		5 VC
5.4	Homeopathy: Consultation only	100%		15 Visits		5 VC
5.5	Occupational therapy	100%		15 Visits		5 VC
5.6	Social Workers	100%		15 Visits		5 VC
5.7	Appliances: Non-surgical	100%				SPA
5.8	Physiotherapy	100%		15 Visits		5 VC
5.9	Biokinetics	100%		15 Visits		5 VC
5.10	Audiology or Speech therapy	100%		15 Visits		5 VC
5.11	Chiropractic	100%		15 Visits		5 VC
5.12	Podiatry	100%		15 Visits		5 VC
6.	**Diabetic Devices benefit**					**OAL**
6.1	Insulin Pumps/Glucose Monitoring System/Glucose reader	80%			46 300	
6.2	Diabetes related consumables for insulin pumps/Glucose Monitoring System/Glucose reader	80%	44 400	44 400		
7.	**Smart Saver benefit**					
7.1	Health Risk Assessment	100%			1 050	
7.2	Preventative Care incentives	100%	155	155		
8.	**Roll-Over benefit**	**100%**	**8 350**	**2 130**	**2 130**	

- Flu vaccines are covered as part of the Preventative Care benefit.
- 1 COVID-19 vaccine regimen per year is covered as part of the Preventative Care benefit for all beneficiaries older than 16 years.
- Vitamins under specific conditions to be authorised from the chronic medication benefit.
- Limited benefit for vitamins available under 2.1.4. above, without a prescription.
- NHP pays for contraceptives (oral and injections) limited to N$ 255 per claim.
- Sunblock may be purchased at pharmacies under the Self-medication benefit.
- Pre-authorised travelling costs for specialist referrals in Namibia partly covered if residing more than 150km from Windhoek - accommodation included, limited to N$ 875 per night, maximum of 2 nights per family per annum.
- No basic dentistry will be covered under the Oral Surgery benefit.
- Intra ocular lenses included in Appliances and Prosthesis Surgical benefit - limited to N$ 7 000 per lens. Refer to 3.7.
- Blood pressure monitor: N$ 635 per beneficiary.
- Auxiliary services - 15 consultations inclusive of 5 virtual consultations per listed specialities. Subject to available benefits.
- A Smart Saver benefit is added to a family's Accumulated Roll-Over benefit on completion of: (1) A Health Risk assessment by the principal member or an adult dependant at any of the Fund's Wellness Days or at a qualifying pharmacy. (2) Any of the preventative care benefits offered by the Fund by a qualifying beneficiary.

Roll-over benefit

For diligent management of your healthcare expenditure	
Principal	8 350
Adult/Spec dep	2 130
Child	2 130
Example of Roll-Over benefit (Principal member + spouse + 2 children) per year	= 14 740

Spec dep = Special dependant
VC = Virtual Consultations

Gold contribution tables

Employer group rates				Individual rates			
Age	Principal	Adult/spec dep	Child dep	Age	Principal	Adult/spec dep	Child dep
0 - 25	3 927	2 936	1 632	0 - 25	4 778	3 710	1 942
26 - 30	4 466	3 603	1 632	26 - 30	5 366	4 510	1 942
31 - 35	4 889	4 010	1 632	31 - 35	6 010	4 947	1 942
36 - 40	5 677	4 816	1 632	36 - 40	7 003	6 168	1 942
41 - 45	6 153	5 421	1 632	41 - 45	7 472	6 737	1 942
46 - 50	6 485	5 635	1 632	46 - 50	8 060	7 037	1 942
51 - 55	6 708	5 948	1 632	51 - 55	8 338	7 429	1 942
56 - 60	7 051	6 183	1 632	56 - 60	8 737	7 837	1 942
61 - 65	7 846	6 687	1 632	61 - 65	9 902	8 547	1 942
66+	8 156	6 883	1 632	66+	10 350	8 877	1 942

Platinum

Major medical benefits: Expense limit per category		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Overall Annual Limit (OAL)				**Unlimited**		
1.	**Healthcare provider or medical specialists**					**SPA**
1.1	Consultations or visits: In-hospital	150%				
1.2	Procedures: In-hospital	150%				
2.	**Chronic medicine**		**20 000**		**36 800**	
2.1	Chronic medicine approved: Min levy of N$ 30 - subject to prior registration on Chronic Care programme	80%				No benefit without registration
3.	**Hospital services**					**SPA**
3.1	Accommodation and theatre	100%				
3.2	Blood transfusions	100%				
3.3	Dialysis	100%				
3.4	Medication	100%				
3.5	Accommodation: Private wards	100%	18 200		36 700	
3.6	Accommodation other than a recognised hospital or medical institution: SA only	100%			875 per day	
3.7	Appliances and prosthesis: Surgical	100%	72 300		86 400	
3.8	Refractive surgery: Full procedure - a waiting period of 12 months will apply	100%	26 100		34 400	
3.9	Organ transplants: Full procedure	100%			359 000	
3.10	Private nursing	100%	54 100		54 100	
3.11	Oncology	100%			679 000	
4.	**Radiology**					**SPA**
4.1	Radiology: Specialised MRI and CT scans - In-and-out of hospital combined	100%			39 500	SPA
4.2	Basic Radiology: In-hospital	100%				
5.	**Pathology**					
5.1	Pathology: In-hospital	100%				
6.	**Dentistry**					**SPA**
6.1	Oral surgery: Full procedure	100%			63 100	
6.2	Maxillo facial surgery: Non-elective only	100%				
6.3	Dental Implants					OAL
6.3.1	Hospitalisation	100%			14 900	
6.3.2	Implant: Consultation, procedure and cost	100%			16 900	4 410 per implant
7.	**Psychiatric treatment**		**30 200**		**55 000**	**SPA**
7.1	Hospitalisation or institutionalisation	100%				
7.2	Rehabilitation of alcohol and drug addiction or abuse	100%				SPA
8.	**Maternity**					
8.1	Confinement: Full procedure - subject to pre-authorisation	100%				SPA
8.2	Antenatal consultations	100%			12 Visits	OAL
8.3	Sonar scans: 2D	100%			2 Scans	OAL
8.4	Amniocentesis	100%				SPA
8.5	Panorama Prenatal test	100%				SPA
9.	**Preventative care**					**OAL**
9.1	Preventative care benefits: As per list	100%				
10.	**Specified illness conditions**			**57 300**		**OAL**
10.1	HIV/AIDS: Including the cost of pathology tests	100%				SPA
10.2	Sexually transmitted diseases	100%	5 390		7 190	SPA
11.	**Ambulance services: Only for medical or trauma emergencies**					**SPA**
11.1	Emergency evacuation: Air	100%				
11.2	Ambulance services	100%				
11.3	Ambulance services: Inter-hospital transfer	100%	5 140	5 140		
11.4	Other transportation	80%				
12.	**Artificial limbs or eyes**					**SPA**
12.1	Artificial limbs	100%		52 000		
12.2	Artificial eyes	100%		26 100		
13.	**Heart surgery: Rehabilitation**	**100%**			**20 800**	**OAL/SPA**
14.	**Insertion Mirena device: All inclusive - every 3 years**	**100%**		**7 400**		**OAL/SPA**
15.	**Stoma Care products**	**100%**			**34 700**	**OAL/SPA**
16.	**Back and Neck Rehabilitation Programme**	**100%**	**Subject to DBC protocol**			**OAL/SPA**

OAL = Overall Annual Limit SPA = Subject to pre-authorisation DBC = Document Based Care

Platinum

Day-to-Day benefits: Expense limit per category		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Out-of-hospital: Sub-limit						**OAL**
1.	**Healthcare provider or medical specialists**		**16 100**	**3 350**		
1.1	Consultations or visits: Out-of-hospital	100%	Unlimited	Unlimited		
1.1.1	Virtual consultations	100%	5	5		
1.2	Procedures: Out-of-hospital services	100%				
1.3	Pathology or Radiology: Out-of-hospital	100%				
1.4	Chronic Lifestyle disease extender benefit	100%	Additional benefits as specified			OAL
2.	**Medicine and injections**					
2.1	Acute medicine		10 900	2 690		
2.1.1	Acute medicine: Pharmacy dispensed - min levy of N$ 30	80%				
2.1.2	Acute medicine: Doctors dispensed - min levy of N$ 30	80%				
2.1.3	Self medication: Over-the-counter - no levy. Subject to acute medicine limit	100%	1 790	300		255 per claim
2.1.4	Vitamins, homeopathic and phytotherapy medicines: min levy of N$ 30 - subject to acute medicine limit	80%	855	250		255 per claim
3.	**Dentistry**		**16 600**		**30 200**	
3.1	Basic dentistry: Subject to sub-limit	100%	9 050	2 080		
3.2	Dental technicians	100%				
3.3	Advanced dentistry					
3.3.1	Orthodontics	100%				
3.3.2	Dental implants: Full procedure	100%	OAL: Refer to 6.3			
4.	**Optical**		**6 080**	**1 520**		
4.1	Eye tests	100%				Frame limited to 2 160
4.2	Spectacles or lenses: Frames every 2nd year	100%				
4.3	Orthoptics	100%				
5.	**Auxiliary services**		**18 500**	**5 950**		
5.1	Chiropody	100%		15 Visits		5 VC
5.2	Clinical psychology	100%		15 Visits		5 VC
5.3	Dietician	100%		15 Visits		5 VC
5.4	Homeopathy: Consultation only	100%		15 Visits		5 VC
5.5	Occupational therapy	100%		15 Visits		5 VC
5.6	Social Workers	100%		15 Visits		5 VC
5.7	Appliances: Non-surgical	100%				SPA
5.8	Physiotherapy	100%		15 Visits		5 VC
5.9	Biokinetics	100%		15 Visits		5 VC
5.10	Audiology or speech therapy	100%		15 Visits		5 VC
5.11	Chiropractic	100%		15 Visits		5 VC
5.12	Podiatry	100%		15 Visits		5 VC
6.	**Diabetic devices benefit**					**OAL**
6.1	Insulin Pumps/Glucose Monitoring System/Glucose reader	80%			43 600	
6.2	Diabetes related consumables for insulin pumps/Glucose Monitoring System/Glucose reader	80%	41 800	41 800		
7.	**Smart Saver benefit**					
7.1	Health Risk Assessment	100%			1 050	
7.2	Preventative Care incentives	100%	155	155		
8.	**Roll-Over benefit**	**100%**	**6 310**	**1 620**	**1 620**	

- Flu vaccines are covered as part of the Preventative Care benefit.
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- Vitamins under specific conditions to be authorised from the Chronic medication benefit.
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- Sunblock may be purchased at pharmacies under the Self-medication benefit.
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- No basic dentistry will be covered under the Oral Surgery benefit.
- Intra ocular lenses included in Appliances and prosthesis surgical benefit - limited to N$ 7 000 per lens. Refer to 3.7.
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Roll-over benefit	
For diligent management of your healthcare expenditure	
Principal	6 310
Adult/Spec dep	1 620
Child	1 620
Example of Roll-Over benefit (Principal member + spouse + 2 children) per year	= 11 170

Spec dep = Special dependant
VC = Virtual Consultations

Platinum contribution tables							
Employer group rates				Individual rates			
Age	Principal	Adult/spec dep	Child dep	Age	Principal	Adult/spec dep	Child dep
0 - 25	3 305	2 441	1 242	0 - 25	3 742	3 042	1 610
26 - 30	3 633	2 661	1 242	26 - 30	4 205	3 510	1 610
31 - 35	3 913	2 830	1 242	31 - 35	4 765	4 279	1 610
36 - 40	4 406	3 251	1 242	36 - 40	5 270	4 662	1 610
41 - 45	4 836	3 743	1 242	41 - 45	5 865	5 174	1 610
46 - 50	5 256	3 952	1 242	46 - 50	6 377	5 520	1 610
51 - 55	5 594	4 492	1 242	51 - 55	6 980	6 002	1 610
56 - 60	6 037	5 133	1 242	56 - 60	7 449	6 235	1 610
61 - 65	6 282	5 524	1 242	61 - 65	7 904	6 662	1 610
66+	6 791	5 800	1 242	66+	8 807	7 601	1 610

Titanium

Major medical benefits: Expense limit per category		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Overall Annual Limit (OAL)			1 620 000		2 420 000	
1.	**Healthcare provider or medical specialists**					**SPA**
1.1	Consultations or visits: In-hospital	150%				
1.2	Procedures: In-hospital	150%				
2.	**Chronic medicine**		**9 470**		**14 900**	
2.1	Chronic medicine approved: Min levy of N$ 30 - subject to prior registration on Chronic Care programme	80%				No benefit without registration
3.	**Hospital services**					**SPA**
3.1	Accommodation and theatre	100%				
3.2	Blood transfusions	100%				
3.3	Dialysis	100%				
3.4	Medication	100%				
3.5	Accommodation: Private wards	100%	12 600		24 700	
3.6	Accommodation other than a recognised hospital or medical institution: SA only	100%			875 per day	
3.7	Appliances and prosthesis: Surgical	100%	56 100		64 800	
3.8	Refractive surgery: Full procedure - a waiting period of 12 months will apply	100%	7 430		9 670	
3.9	Organ transplants: Full procedure	100%			121 000	
3.10	Private nursing	100%	29 400		29 400	
3.11	Oncology	100%			644 000	
4.	**Radiology**					**SPA**
4.1	Radiology: Specialised MRI and CT scans - In-and-out of hospital combined	100%			23 300	
4.2	Basic Radiology: In-hospital	100%				
5.	**Pathology**					
5.1	Pathology: In-hospital	100%				
6.	**Dentistry**					**SPA**
6.1	Oral surgery: Full procedure	100%			56 000	
6.2	Maxillo facial surgery: Non-elective only	100%				
6.3	Dental Implants					
6.3.1	Hospitalisation	100%	Subject to Advanced dentistry - Day-to-day			
6.3.2	Implant: Consultation, procedure and cost	100%				
7.	**Psychiatric treatment**		**24 800**		**45 900**	**SPA**
7.1	Hospitalisation or institutionalisation	100%				
7.2	Rehabilitation of alcohol and drug addiction or abuse	100%				SPA
8.	**Maternity**					
8.1	Confinement: Full procedure - subject to pre-authorisation	100%				SPA
8.2	Antenatal consultations	100%			12 Visits	OAL
8.3	Sonar scans: 2D	100%			2 Scans	OAL
8.4	Amniocentesis	100%				SPA
8.5	Panorama Prenatal test	100%				SPA
9.	**Preventative care**					**OAL**
9.1	Preventative care benefits: As per list	100%				
10.	**Specified illness conditions**			**42 800**		**OAL**
10.1	HIV/AIDS: Including the cost of pathology tests	100%				SPA
10.2	Sexually transmitted diseases	100%	3 700		4 890	SPA
11.	**Ambulance services: Only for medical or trauma emergencies**					**SPA**
11.1	Emergency evacuation: Air	100%				
11.2	Ambulance services	100%				
11.3	Ambulance services: Inter-hospital transfer	100%	5 140	5 140		
11.4	Other transportation	80%				
12.	**Artificial limbs or eyes**					**SPA**
12.1	Artificial limbs	100%		29 700		
12.2	Artificial eyes	100%		14 900		
13.	**Heart surgery: Rehabilitation**	**100%**			**18 000**	OAL
14.	**Intra Uterine device: All inclusive - every 3 years**	**100%**		**7 400**		OAL
15.	**Stoma Care products**	**100%**			**34 700**	OAL
16.	**Back and Neck Rehabilitation Programme**	**100%**	**Subject to DBC protocol**			OAL

OAL = Overall Annual Limit SPA = Subject to pre-authorisation DBC = Document Based Care

Titanium

Day-to-Day benefits: Expense limit per category		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Out-of-hospital: Sub-limit						OAL
1.	**Healthcare provider or medical specialists**		**9 720**	**2 110**		
1.1	Consultations or visits: Out-of-hospital	100%	Unlimited	Unlimited		
1.1.1	Virtual consultations	100%	5	5		
1.2	Procedures: Out-of-hospital services	100%				
1.3	Pathology or Radiology: Out-of-hospital	100%				
1.4	Chronic Lifestyle Disease Extender benefit	100%	Additional benefits as specified			OAL
2.	**Medicine and injections**					
2.1	Acute medicine		5 800	720		
2.1.1	Acute medicine: Pharmacy dispensed - min levy of N$ 30	80%				
2.1.2	Acute medicine: Doctors dispensed - min levy of N$ 30	80%				
2.1.3	Self medication: Over-the-counter - no levy subject to acute medicine limit	100%	1 220	240		255 per claim
2.1.4	Vitamins, homeopathic and phytotherapy medicines - min levy of N$ 30 - subject to acute medicine limit	80%	675	220		255 per claim
3.	**Dentistry**		**11 600**		**20 900**	
3.1	Basic dentistry: Subject to sub-limit	100%	6 600	1 650		
3.2	Dental technicians	100%				
3.3	Advanced dentistry					
3.3.1	Orthodontics	100%				
3.3.2	Dental implants: Full procedure	100%				
4.	**Optical**		**4 040**	**1 210**		
4.1	Eye tests	100%				Frame limited to 1 460
4.2	Spectacles or lenses: Frames every 2nd year	100%				
4.3	Orthoptics	100%				
5.	**Auxiliary services**		**13 100**	**730**		
5.1	Chiropody	100%		15 Visits		5 VC
5.2	Clinical psychology	100%		15 Visits		5 VC
5.3	Dietician	100%		15 Visits		5 VC
5.4	Homeopathy: Consultation only	100%		15 Visits		5 VC
5.5	Occupational therapy	100%		15 Visits		5 VC
5.6	Social Workers	100%		15 Visits		5 VC
5.7	Appliances: Non-surgical	100%				SPA
5.8	Physiotherapy	100%		15 Visits		5 VC
5.9	Biokinetics	100%		15 Visits		5 VC
5.10	Audiology or speech therapy	100%		15 Visits		5 VC
5.11	Chiropractic	100%		15 Visits		5 VC
5.12	Podiatry	100%		15 Visits		5 VC
6.	**Diabetic devices benefit**					**OAL**
6.1	Insulin Pumps/Glucose Monitoring System/Glucose reader	80%			38 100	
6.2	Diabetes related consumables for insulin pumps/Glucose Monitoring System/Glucose reader	80%	39 200	39 200		
7.	**Smart Saver benefit**					
7.1	Health Risk Assessment	100%			785	
7.2	Preventative Care Incentives	100%	105	105		
8.	**Roll-Over benefit**	**100%**	**4 250**	**880**	**880**	

- Flu vaccines are covered as part of the Preventative Care benefit.
- 1 COVID-19 vaccine regimen per year is covered as part of the Preventative Care benefit for all beneficiaries older than 16 years.
- Vitamins under specific conditions to be authorised from the Chronic Medication benefit.
- Limited benefit for vitamins available under 2.1.4. above, without a prescription.
- NHP pays for contraceptives (oral and injections) limited to N$ 255 per claim.
- Sunblock may be purchased at pharmacies under the Self-medication benefit.
- Pre-authorised travelling costs for specialist referrals in Namibia partly covered if residing more than 150km from Windhoek - accommodation included, limited to N$ 875 per night, maximum of 2 nights per family per annum.
- No basic dentistry will be covered under the Oral surgery benefit.
- Intra ocular lenses included in Appliances and prosthesis surgical benefit - limited to N$ 7 000 per lens. Refer to 3.7.
- Blood pressure monitor: N$ 635 per beneficiary.
- Auxiliary services - 15 consultations inclusive of 5 virtual consultations per listed specialities. Subject to available benefits.
- A Smart Saver benefit is added to a family's Accumulated Roll-Over benefit on completion of: (1) A Health Risk assessment by the principal member or an adult dependant at any of the Fund's Wellness Days or at a qualifying pharmacy. (2) Any of the preventative care benefits offered by the Fund by a qualifying beneficiary.

Roll-over benefit

For diligent management of your healthcare expenditure	
Principal	4 250
Adult/Spec dep	880
Child	880
Example of Roll-Over benefit (Principal member + spouse + 2 children) per year	= 6 890

Spec dep = Special dependant
VC = Virtual Consultations

Titanium contribution tables

Employer group rates				Individual rates			
Age	Principal	Adult/spec dep	Child dep	Age	Principal	Adult/spec dep	Child dep
0 - 25	2 823	1 741	929	0 - 25	3 107	2 098	1 123
26 - 30	3 038	2 054	929	26 - 30	3 415	2 434	1 123
31 - 35	3 354	2 133	929	31 - 35	3 839	2 845	1 123
36 - 40	3 660	2 352	929	36 - 40	4 295	3 178	1 123
41 - 45	4 041	2 657	929	41 - 45	4 667	3 589	1 123
46 - 50	4 303	2 847	929	46 - 50	5 005	3 861	1 123
51 - 55	4 533	3 204	929	51 - 55	5 237	4 107	1 123
56 - 60	4 924	3 412	929	56 - 60	5 807	4 441	1 123
61 - 65	5 283	4 132	929	61 - 65	6 139	4 845	1 123
66+	5 881	4 339	929	66+	6 590	5 034	1 123

Introducing the NHP Health Risk Assessment (HRA) Incentive

We're about you

What is the NHP HRA?

HRA's provide an early warning for disease management. The Fund's approach towards preventative care is to proactively manage the health of its members by increasing access to the HRA. The HRA will include clinical screenings to measure blood pressure, blood sugar levels, cholesterol, body mass index (BMI) and waist to hip ratio.

Objectives of a NHP HRA

To provide members with an evaluation of their health risks and quality of life by the early identification of common risk factors that could be managed through lifestyle changes or therapy.

To inform 'at risk' members who have been detected through the HRA. These members will be contacted and referred to their family doctor and advised to access the appropriate Fund programmes.

The NHP HRA Incentive

NHP members on the qualifying benefit options will receive an incentive upon the completion of a Health Risk Assessment (HRA). Members may go to any of the Fund's wellness days or it can be claimed at the rate of N$ 187 per screening at a network pharmacy. The incentive will be transferred to the members accumulated Roll-Over benefit.

The maximum amount for which a member may qualify for the successful completion of a number of HRA's per family is:

Option	Smart Saver benefit per family
Gold	N$ 1 050
Platinum	N$ 1 050
Titanium	N$ 785
Silver	N$ 785
Bronze	N$ 525
Hospital	N$ 525
Blue Diamond	No benefit
Litunga	No benefit

The HRA benefit is limited to one incentive per family per annum and will not be granted on a per beneficiary basis.

pmr.africa

Diamond Arrow Award

Highest rated medical aid in Namibia 2010 - 2023

tel 061 285 5400 | website www.nhp.com.na

New Generation benefit options

Silver | Bronze

Two benefit options

Our New Generation benefit options are Silver and Bronze.

Moderate cover

Best suited to members whose health risk can be described as low, requiring moderate medical cover with comprehensive benefits for both Major Medical and pooled Day-to-Day Expenses.

Family benefit

Day-to-Day benefits are not reserved on a per beneficiary basis, but rather per family, allowing members of the family access to the entire family benefit.

Pooled benefits

Day-to-Day benefits are not subject to sub-category limits, but rather pooled and further limited according to family size.

Roll-Over benefit

When you claim less than a certain threshold amount included in your Day-to-Day benefits, you will build-up a Roll-Over benefit which can be used to pay for healthcare treatment and medical costs.

Silver

Major medical benefits: Expense limit per category		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Overall Annual Limit (OAL)			1 270 000		2 030 000	
1.	**Healthcare provider or medical specialists**					**SPA**
1.1	Consultations or visits: In-hospital	150%				
1.2	Procedures: In-hospital	150%				
2.	**Chronic medicine**		**9 470**		**14 900**	
2.1	Chronic medicine approved: Min levy of N$ 30 - subject to prior registration on Chronic Care programme	80%				No benefit without registration
3.	**Hospital services**					**SPA**
3.1	Accommodation and theatre	100%				
3.2	Blood transfusions	100%				
3.3	Dialysis	100%				
3.4	Medication	100%				
3.5	Accommodation: Private wards	100%	12 600		24 700	
3.6	Accommodation other than a recognised hospital or medical institution: SA only	100%			875 per day	
3.7	Appliances and prosthesis: Surgical	100%	56 100		64 800	
3.8	Refractive surgery: Full procedure - a waiting period of 12 months will apply	100%	7 430		9 670	
3.9	Organ transplants: Full procedure	100%			121 000	
3.10	Private nursing	100%	29 400		29 400	
3.11	Oncology	100%			644 000	
4.	**Radiology**					**SPA**
4.1	Radiology: Specialised MRI and CT scans - In-and-out of hospital combined	100%			23 300	
4.2	Basic Radiology: In-hospital	100%				
5.	**Pathology**					
5.1	Pathology: In-hospital	100%				
6.	**Dentistry**					**SPA**
6.1	Oral surgery: Full procedure	100%			56 000	
6.2	Maxillo facial surgery: Non-elective only	100%				
6.3	Dental Implants					
6.3.1	Hospitalisation	100%	Subject to Advanced dentistry - Day-to-Day			
6.3.2	Implant: Consultation, procedure and cost	100%				
7.	**Psychiatric treatment**		**24 800**		**45 900**	**SPA**
7.1	Hospitalisation or institutionalisation	100%				
7.2	Rehabilitation of alcohol and drug addiction or abuse	100%				
8.	**Maternity**					
8.1	Confinement: Full procedure - Subject to pre-authorisation	100%				SPA
8.2	Antenatal consultations	100%			12 Visits	OAL
8.3	Sonar scans: 2D	100%			2 Scans	OAL
8.4	Amniocentesis	100%				SPA
8.5	Panorama Prenatal test	100%				SPA
9.	**Preventative care**					**OAL**
9.1	Preventative care benefits: As per list	100%				
10.	**Specified illness conditions**			**42 800**		**OAL**
10.1	HIV/AIDS: Including the cost of pathology tests	100%				SPA
10.2	Sexually transmitted diseases	100%	3 700		4 890	SPA
11.	**Ambulance services: Only for medical or trauma emergencies**					**SPA**
11.1	Emergency evacuation: Air	100%				
11.2	Ambulance services	100%				
11.3	Ambulance services: Inter-hospital transfer	100%	5 140	5 140		
11.4	Other transportation	80%				
12.	**Artificial limbs or eyes**					**SPA**
12.1	Artificial limbs	100%		29 700		
12.2	Artificial eyes	100%		14 900		
13.	**Heart surgery: Rehabilitation**	**100%**			**18 000**	**OAL/SPA**
14.	**Insertion Mirena Device: All Inclusive - every 3 years**	**100%**		**7 400**		**OAL/SPA**
15.	**Stoma Care products**	**100%**			**34 700**	**OAL/SPA**
16.	**Back and Neck Rehabilitation Programme**	**100%**	**Subject to DBC protocol**			**OAL/SPA**

OAL = Overall Annual Limit SPA = Subject to pre-authorisation DBC = Document Based Care

Silver

Day-to-Day benefits: Expense limit per category		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
	Out-of-hospital: Sub-limit		18 800	3 900		OAL
1.	**Healthcare provider or medical specialists**					
1.1	Consultations or visits: Out-of-hospital	100%				
1.1.1	Virtual GP consultations	100%	5	5		
1.2	Procedures: Out-of-hospital services	100%				
1.3	Pathology or Radiology: Out-of-hospital	100%				
1.4	Chronic Lifestyle disease extender benefit	No benefit				
2.	**Medicine and injections**					
2.1	Acute medicine					
2.1.1	Acute medicine: Pharmacy dispensed - min levy of N$ 30	80%				
2.1.2	Acute medicine: Doctors dispensed - min levy of N$ 30	80%				
2.1.3	Self medication: Over-the-counter - no levySubject to acute medicine limit	100%	1 210	240		255 per claim
2.1.4	Vitamins, homeopathic and phytotherapy medicines - min levy of N$ 30 - subject to acute medicine limit	80%	595	210		255 per claim
3.	**Dentistry**		**10 400**		**20 600**	
3.1	Basic dentistry: Subject to sub-limit	100%				
3.2	Dental technicians	100%				
3.3	Advanced dentistry					
3.3.1	Orthodontics	100%				
3.3.2	Dental implants: Full procedure	100%				
4.	**Optical**		**3 570**	**895**		
4.1	Eye tests	100%				Frame limited to 1 370
4.2	Spectacles or lenses: Frames every 2nd year	100%				
4.3	Orthoptics	100%				
5.	**Auxiliary services**					
5.1	Chiropody	100%		15 Visits		5 VC
5.2	Clinical psychology	100%		15 Visits		5 VC
5.3	Dietician	100%		15 Visits		5 VC
5.4	Homeopathy, Naturopathy and Phytotherapy: Consultation only	100%		15 Visits		5 VC
5.5	Occupational therapy	100%		15 Visits		5 VC
5.6	Social workers	100%		15 Visits		5 VC
5.7	Appliances: Non-surgical	100%				SPA
5.8	Physiotherapy	100%		15 Visits		5 VC
5.9	Biokinetics	100%		15 Visits		5 VC
5.10	Audiology or speech therapy	100%		15 Visits		5 VC
5.11	Chiropractic	100%		15 Visits		5 VC
5.12	Podiatry	100%		15 Visits		5 VC
6.	Smart Saver benefit					
6.1	Health Risk Assessment	100%			785	
6.2	Preventative Care incentives	100%	105	105		
7.	**Roll-over benefit**	**100%**	**4 250**	**880**	**880**	

- Flu vaccines are covered as part of the Preventative Care benefit.
- 1 COVID-19 vaccine regimen per year is covered as part of the Preventative Care benefit for all beneficiaries older than 16 years.
- Vitamins under specific conditions to be authorised from the Chronic Medication benefit.
- Limited benefit for vitamins available under 2.1.4. above, without a prescription.
- NHP pays for contraceptives (oral and injections) limited to N$ 255 per claim.
- Sunblock may be purchased at pharmacies under the Self-medication benefit.
- Pre-authorised travelling costs for specialist referrals in Namibia partly covered if residing more than 150km from Windhoek - accommodation included, limited to N$ 875 per night, maximum of 2 nights per family per annum.
- No basic dentistry will be covered under the Oral Surgery benefit.
- All benefits are subject to availability of pooled Day-to-Day benefits.
- Intra ocular lenses included in Appliances and prosthesis surgical benefit - limited to N$ 7 000 per lens. Refer to 3.7.
- Blood pressure monitor: N$ 635 per beneficiary.
- Consultations or visits: Out-of-hospital: When day-to-day benefit has been depleted, 1 additional GP visit per beneficiary. Subject to registration on the Chronic Care Programme.
- Auxiliary services - 15 consultations inclusive of 5 virtual consultations per listed specialities. Subject to available benefits.
- A Smart Saver benefit is added to a family's Accumulated Roll-Over benefit on completion of: (1) A Health Risk assessment by the principal member or an adult dependant at any of the Fund's Wellness Days or at a qualifying pharmacy. (2) Any of the preventative care benefits offered by the Fund by a qualifying beneficiary.

Roll-over benefit	
For diligent management of your healthcare expenditure	
Principal	4 250
Adult/Spec dep	880
Child	880
Example of Roll-Over benefit (Principal member + spouse + 2 children) per year	= 6 890

Spec dep = Special dependant
VC = Virtual Consultations

Silver contribution tables							
Employer group rates				Individual rates			
Age	Principal	Adult/spec dep	Child dep	Age	Principal	Adult/spec dep	Child dep
0 - 25	2 524	1 559	834	0 - 25	2 782	1 876	1 004
26 - 30	2 719	1 835	834	26 - 30	3 061	2 178	1 004
31 - 35	3 001	1 912	834	31 - 35	3 438	2 548	1 004
36 - 40	3 274	2 102	834	36 - 40	3 845	2 844	1 004
41 - 45	3 615	2 376	834	41 - 45	4 182	3 214	1 004
46 - 50	3 849	2 548	834	46 - 50	4 482	3 457	1 004
51 - 55	4 059	2 865	834	51 - 55	4 690	3 678	1 004
56 - 60	4 408	3 050	834	56 - 60	5 200	3 979	1 004
61 - 65	4 728	3 697	834	61 - 65	5 498	4 338	1 004
66+	5 263	3 883	834	66+	5 900	4 507	1 004

Bronze

Major medical benefits: Expense limit per category		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Overall Annual Limit (OAL)			570 000		930 000	
1.	**Healthcare provider or medical specialists**					**SPA**
1.1	Consultations or visits: In-hospital	150%				
1.2	Procedures: In-hospital	150%				
2.	**Chronic medicine**		**4 460**		**7 090**	
2.1	Chronic medicine approved: Min levy of N$ 30 - subject to prior registration on Chronic Care programme	80%				No benefit without registration
3.	**Hospital services**					**SPA**
3.1	Accommodation and theatre	100%				
3.2	Blood transfusions	100%				
3.3	Dialysis	No benefit				
3.4	Medication	100%				
3.5	Accommodation: Private wards	100%	6 360		12 700	
3.6	Accommodation other than a recognised hospital or medical institution: SA only	100%			875 per day	
3.7	Appliances and prosthesis: Surgical	100%	24 200		48 700	
3.8	Refractive surgery: Full procedure - a waiting period of 12 months will apply	No benefit				
3.9	Organ transplants: Full procedure	100%			90 700	
3.10	Private nursing	100%			13 300	
3.11	Oncology	No benefit				
4.	**Radiology**					**SPA**
4.1	Radiology: Specialised MRI and CT scans - In-and-out of hospital combined	100%			19 200	
4.2	Basic Radiology: In-hospital	100%				
5.	**Pathology**					
5.1	Pathology: In-hospital	100%				
6.	**Dentistry**					**SPA**
6.1	Oral surgery: Full procedure	100%			42 200	
6.2	Maxillo facial surgery: Non-elective only	100%				
6.3	Dental Implants					
6.3.1	Hospitalisation	No benefit				
6.3.2	Implant: Consultation, procedure and cost	No benefit				
7.	**Psychiatric treatment**		**17 700**		**31 800**	**SPA**
7.1	Hospitalisation or institutionalisation	100%				
7.2	Rehabilitation of alcohol and drug addiction or abuse	100%				
8.	**Maternity**					
8.1	Confinement: Full procedure - subject to pre-authorisation	100%				SPA
8.2	Antenatal consultations	100%			12 Visits	OAL
8.3	Sonar scans: 2D	100%			2 Scans	OAL
8.4	Amniocentesis	100%				SPA
8.5	Panorama Prenatal test	100%				SPA
9.	**Preventative care**					**OAL**
9.1	Preventative care benefit: As per list	100%				
10.	**Specified illness conditions**			**31 900**	**64 700**	**OAL**
10.1	HIV/AIDS: Including the cost of pathology tests	100%				SPA
10.2	Sexually transmitted diseases	100%			1 640	SPA
11.	**Ambulance services: Only for medical or trauma emergencies**					**SPA**
11.1	Emergency evacuation: Air	100%				
11.2	Ambulance services	100%				
11.3	Ambulance services: Inter-hospital transfer	100%	5 140	5 140		
11.4	Other transportation	80%				
12.	**Artificial limbs or eyes**					**SPA**
12.1	Artificial limbs	100%	Subject to Auxiliary services - Day-to-Day			
12.2	Artificial eyes	100%				
13.	**Heart surgery: Rehabilitation**	**100%**	**Subject to Auxiliary services - Day-to-Day**			
14.	**Insertion Mirena Device: All Inclusive - every 3 years**	**100%**		**7 400**		**OAL/SPA**
15.	**Stoma Care products**	**100%**			**34 700**	**OAL/SPA**
16.	**Back and Neck Rehabilitation Programme**	**100%**	**Subject to DBC protocol**			**OAL/SPA**

OAL = Overall Annual Limit SPA = Subject to pre-authorisation DBC = Document Based Care

Bronze

Day-to-Day benefits: Expense limit per category		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Out-of-hospital: Sub-limit			7 200	2 400		OAL
1.	**Healthcare provider or medical specialists**					
1.1	Consultations or visits: Out-of-hospital	100%				
1.1.1	Virtual GP consultations	100%	5	5		
1.2	Procedures: Out-of-hospital services	100%				
1.3	Pathology or Radiology: Out-of-hospital	100%				
1.4	Chronic Lifestyle disease extender benefit	No benefit				
2.	**Medicine and injections**					
2.1	Acute medicine					
2.1.1	Acute medicine: Pharmacy dispensed - min levy of N$ 30	80%				
2.1.2	Acute medicine: Doctors dispensed - min levy of N$ 30	80%				
2.1.3	Self medication: Over-the-counter - no levy. Subject to acute medicine limit.	100%	960	165		255 per claim
2.1.4	Vitamins, homeopathic and phytotherapy medicines - min levy of N$ 30 - subject to acute medicine limit	80%	430	135		255 per claim
3.	**Dentistry**		**2 260**		**4 620**	
3.1	Basic dentistry: Subject to sub-limit	100%				
3.2	Dental technicians	100%				
3.3	Advanced dentistry					
3.3.1	Orthodontics	50%				
3.3.2	Dental implants: Full procedure	No benefit				
4.	**Optical**		**2 490**	**615**		
4.1	Eye tests	100%				Frame limited to 1 230
4.2	Spectacles or lenses: Frames every 2nd year	100%				
4.3	Orthoptics	100%				
5.	**Auxiliary services**					
5.1	Chiropody	100%		15 Visits		5 VC
5.2	Clinical psychology	100%		15 Visits		5 VC
5.3	Dietician	100%		15 Visits		5 VC
5.4	Homeopathy: Consultation only	100%		15 Visits		5 VC
5.5	Occupational therapy	100%		15 Visits		5 VC
5.6	Social workers	100%		15 Visits		5 VC
5.7	Appliances: Non-surgical	100%				SPA
5.8	Physiotherapy	100%		15 Visits		5 VC
5.9	Biokinetics	100%		15 Visits		5 VC
5.10	Audiology or speech therapy	100%		15 Visits		5 VC
5.11	Chiropractic	100%		15 Visits		5 VC
5.12	Podiatry	100%		15 Visits		5 VC
6.	**Smart Saver benefit**					
6.1	Health Risk Assessment	100%			525	
6.2	Preventative Care Incentives	100%	80	80		
7.	**Roll-Over Benefit**	**100%**	**2 200**	**450**	**450**	

- Flu vaccines are covered as part of the Preventative Care benefit.
- 1 COVID-19 vaccine regimen per year is covered as part of the Preventative Care benefit for all beneficiaries older than 16 years.
- Vitamins under specific conditions to be authorised from the Chronic Medication benefit.
- Limited benefit for vitamins available under 2.1.4. above, without a prescription.
- NHP pays for contraceptives (oral and injections) limited to N$ 255 per claim.
- Sunblock may be purchased at pharmacies under the Self-medication benefit.
- Pre-authorised travelling costs for specialist referrals in Namibia partly covered if residing more than 150km from Windhoek - accommodation included, limited to N$ 875 per night, maximum of 2 nights per family per annum.
- No basic dentistry will be covered under the Oral surgery benefit.
- All benefits are subject to availability of pooled Day-to-Day benefits.
- Intra ocular lenses included in Appliances and prosthesis surgical benefit - limited to N$ 7 000 per lens. Refer to 3.7.
- Blood pressure monitor: N$ 635 per beneficiary.
- Consultations or visits: Out-of-hospital: When day-to-day benefit has been depleted, 1 additional GP visit per beneficiary. Subject to registration on the Chronic Care Programme.
- Auxiliary services - 15 consultations inclusive of 5 virtual consultations per listed specialities. Subject to available benefits.
- A Smart Saver benefit is added to a family's Accumulated Roll-Over benefit on completion of: (1) A Health Risk assessment by the principal member or an adult dependant at any of the Fund's Wellness Days or at a qualifying pharmacy. (2) Any of the preventative care benefits offered by the Fund by a qualifying beneficiary.

Roll-over benefit

For diligent management of your healthcare expenditure	
Principal	2 200
Adult/Spec dep	450
Child	450
Example of Roll-Over benefit (Principal member + spouse + 2 children) per year	= 3 550

Spec dep = Special dependant
VC = Virtual Consultations

Bronze contribution tables

Employer group rates				Individual rates			
Age	Principal	Adult/spec dep	Child dep	Age	Principal	Adult/spec dep	Child dep
0 - 25	1 843	1 109	642	0 - 25	1 981	1 207	707
26 - 30	1 927	1 216	642	26 - 30	2 092	1 332	707
31 - 35	2 005	1 297	642	31 - 35	2 200	1 495	707
36 - 40	2 088	1 406	642	36 - 40	2 304	1 652	707
41 - 45	2 276	1 478	642	41 - 45	2 518	1 786	707
46 - 50	2 309	1 520	642	46 - 50	2 543	1 862	707
51 - 55	2 426	1 629	642	51 - 55	2 680	1 996	707
56 - 60	2 532	1 718	642	56 - 60	2 836	2 032	707
61 - 65	3 082	1 898	642	61 - 65	3 498	2 239	707
66+	3 404	1 974	642	66+	4 006	2 438	707

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NHP has a dedicated toddler's health advice line called Babyline. Babyline is available 24/7, 365 days of the year.

All you need to do is have your membership number ready before you call the toll-free number 0800 255 255 and a paediatric trained registered nurse will be available on the phone to assist with any health related concerns.

Just give us a ring and we'll be happy to help. We're about you!

tel 061 285 5400
website www.nhp.com.na

Hospital benefit option

Hospital

Comprehensive hospital cover

The Hospital benefit option gives members comprehensive cover for private hospitalisation should an illness or accident occur.

Peace of mind

For members who are medium income earners, the Hospital benefit option is their peace of mind that they are covered should they need to be hospitalised.

Recommended

For healthy families that take responsibility for their own health and know that prevention is better than cure.

No Day-to-Day Medical Expenses

The Hospital benefit option offers no benefits in respect of Day-to-Day Medical Expenses.

Hospital

Major medical benefits: Expense limit per category		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Overall Annual Limit (OAL)			1 270 000		2 830 000	
1.	**Healthcare provider or medical specialists**					**SPA**
1.1	Consultations or visits: In-hospital	150%				
1.2	Procedures: In-hospital	150%				
2.	**Chronic medicine**					
2.1	Chronic medicine approved: Min levy of N$ 30 - subject to prior registration on Chronic Care programme	No benefit				
3.	**Hospital services**					**SPA**
3.1	Accommodation and theatre	100%				
3.2	Blood transfusions	100%				
3.3	Dialysis	100%				
3.4	Medication	100%				
3.5	Accommodation: Private wards	100%	13 300		26 400	
3.6	Accommodation other than a recognised hospital or medical institution: SA only	100%			875 per day	
3.7	Appliances and prosthesis: Surgical	100%	28 800		58 300	
3.8	Refractive surgery: Full procedure - a waiting period of 12 months will apply	100%	7 430		9 670	
3.9	Organ transplants: Full procedure	100%			121 000	
3.10	Private nursing	100%	24 300		24 300	
3.11	Oncology	100%			679 000	
4.	**Radiology**					**SPA**
4.1	Radiology: Specialised MRI and CT scans - In-and-out of hospital combined	100%			23 300	
4.2	Basic Radiology: In-hospital	100%				
5.	**Pathology**					
5.1	Pathology: In-hospital	100%				
6.	**Dentistry**					**SPA**
6.1	Oral surgery: Full procedure	100%			56 000	
6.2	Maxillo facial surgery: Non-elective only	100%				
6.3	Dental Implants					
6.3.1	Hospitalisation	No benefit				
6.3.2	Implant: Consultation, procedure and cost	No benefit				
7.	**Psychiatric treatment**		**24 800**		**45 900**	**SPA**
7.1	Hospitalisation or institutionalisation	100%				
7.2	Rehabilitation of alcohol and drug addiction or abuse	100%				
8.	**Maternity**					
8.1	Confinement: Full procedure - subject to pre-authorisation	100%				SPA
8.2	Antenatal consultations	100%			12 Visits	OAL
8.3	Sonar scans: 2D	100%			2 Scans	OAL
8.4	Amniocentesis	100%				SPA
8.5	Panorama Prenatal test	100%				SPA
9.	**Preventative care**					**OAL**
9.1	Vaccinations: As per list	No benefit				
10.	**Specified illness conditions**			**22 700**		**OAL**
10.1	HIV/AIDS: Including the cost of pathology tests	100%				SPA
10.2	Sexually transmitted diseases	100%	3 700		4 890	SPA
11.	**Ambulance services: Only for medical or trauma emergencies**					**SPA**
11.1	Emergency evacuation: Air	100%				
11.2	Ambulance services	100%				
11.3	Ambulance services: Inter-hospital transfer	100%	5 140	5 140		
11.4	Other transportation	80%				
12.	**Artificial limbs or eyes**					
12.1	Artificial limbs	No benefit				
12.2	Artificial eyes	No benefit				
13.	**Heart surgery: Rehabilitation**	**100%**			**18 000**	**OAL/SPA**
14.	**Insertion Mirena Device: All Inclusive - every 3 years**	**100%**		**7 400**		**OAL/SPA**
15.	**Stoma Care products**	**100%**			**34 700**	**OAL/SPA**
16.	**Back and Neck Rehabilitation Programme**	**100%**	**Subject to DBC protocol**			**OAL/SPA**

OAL = Overall Annual Limit SPA = Subject to pre-authorisation DBC = Document Based Care

Hospital

Day-to-Day benefits: Expense limit per category		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Out-of-hospital: Sub-limit						
1.	**Healthcare provider or medical specialists**					
1.1	Consultations or visits: Out-of-hospital	No benefit				
1.1.1	Virtual GP Consultations	No benefit				
1.2	Procedures: Out-of-hospital services	No benefit				
1.3	Pathology or Radiology: Out-of-hospital	No benefit				
1.4	Chronic Lifestyle Disease Extender benefit	No benefit				
2.	**Medicine and injections**					
2.1	Acute medicine					
2.1.1	Acute medicine: Pharmacy dispensed - min levy of N$ 30	No benefit				
2.1.2	Acute medicine: Doctors dispensed - min levy of N$ 30	No benefit				
2.1.3	Self medication: Over-the-counter - no levy Subject to acute medicine limit	No benefit				
2.1.4	Vitamins, homeopathic and phytotherapy medicines: min levy of N$ 30- subject to acute medicine limit"	No benefit				
3.	**Dentistry**					
3.1	Basic dentistry: Subject to sub-limit	No benefit				
3.2	Dental technicians	No benefit				
3.3	Advanced dentistry					
3.3.1	Orthodontics	No benefit				
3.3.2	Dental implants: Full procedure	No benefit				
4.	**Optical**					
4.1	Eye tests	No benefit				
4.2	Spectacles or lenses: Frames every 2nd year	No benefit				
4.3	Orthoptics	No benefit				
5.	**Auxiliary services**					
5.1	Chiropody	No benefit				
5.2	Clinical psychology	No benefit				
5.3	Dietician	No benefit				
5.4	Homeopathy: Consultation only	No benefit				
5.5	Occupational therapy	No benefit				
5.6	Social workers	No benefit				
5.7	Appliances: Non-surgical	No benefit				
5.8	Physiotherapy	No benefit				
5.9	Biokinetics	No benefit				
5.10	Audiology or speech therapy	No benefit				
5.11	Chiropractic	No benefit				
5.12	Podiatry	No benefit				
6.	**Smart Saver benefit**					
6.1	Health Risk Assessment	100%			525	
7.	**Roll-Over benefit**	**No benefit**				

- No Day-to-Day benefits are available.
- 1 COVID-19 vaccine regimen per year is covered as part of the Preventative Care benefit for all beneficiaries older than 16 years.
- No Roll-Over benefit apart from a Smart Saver benefit that is added to a family's Accumulated Roll-Over benefit on completion of a health risk assessment by the principal member or an adult dependent at any of the Fund's Wellness Days or at a qualifying pharmacy.
- Pre-authorised travelling costs for specialist referrals in Namibia partly covered if residing more than 150km from Windhoek - accommodation included, limited to N$ 875 per night, maximum of 2 nights per family per annum.
- Intra ocular lenses included in Appliances and Prosthesis Surgical benefit - limited to N$ 7 000 per lens, refer to 3.7.

Hospital Plus contribution tables

Employer group rates				Indivudual rates			
Age	Principal	Adult/spec dep	Child dep	Age	Principal	Adult/spec dep	Child dep
0 - 25	1 620	711	437	0 - 25	1 653	756	483
26 - 30	1 768	819	437	26 - 30	1 798	960	483
31 - 35	1 937	999	437	31 - 35	2 005	1 110	483
36 - 40	2 098	1 194	437	36 - 40	2 182	1 322	483
41 - 45	2 237	1 379	437	41 - 45	2 339	1 513	483
46 - 50	2 375	1 486	437	46 - 50	2 510	1 623	483
51 - 55	2 469	1 567	437	51 - 55	2 651	1 740	483
56 - 60	2 611	1 736	437	56 - 60	2 787	1 918	483
61 - 65	2 750	1 874	437	61 - 65	2 985	2 104	483
66+	3 059	1 934	437	66+	3 403	2 192	483

Spec dep = Special dependant
VC = Virtual Consultations

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Primary Healthcare benefit options

Blue Diamond | Litunga

Two benefit options

Our Primary healthcare benefit options are Blue Diamond and Litunga.

Peace of mind

Ideal for individuals who cannot afford full medical cover but still want peace of mind concerning primary healthcare services.

Designated service providers

Provides members and families with basic Day-to-Day benefits at affordable prices through a network of contracted designated service providers and registered nurses.

Day-to-Day Expenses

Comprehensive cover for Day-to-Day primary healthcare services subject to the use of contracted designated service providers.

Major Medical Expenses

Only Blue Diamond members are covered for certain Major Medical Expenses.

Blue Diamond

Major medical benefits: Expense limit per category - DSP only		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Overall Annual Limit (OAL)					Unlimited	
1.	**Doctors and specialists**					**SPA**
1.1	Consultations and visits: In-hospital	100%				
1.2	Procedures: In-hospital	100%				
2.	**Hospital services**					**SPA**
2.1	You can be admitted into the state hospital facility (private wing) but it has to first be approved by NHP - subject to pre-authorisation	100%				
2.2	Selected private hospitals: Limited access benefit for treatment	100%				
2.2.1	Ward fees	60%				
2.3	Routine and scheduled surgical and hospitalisation events	100%				
3.	**Ambulance services: Only for medical or trauma emergencies**					**SPA**
3.1	Air evacuation	100%				
3.2	In an emergency you are covered for ambulance services but only in Namibia	100%				
3.3	You are covered for transport between 2 hospitals	100%	5 140	5 140		
3.4	Other transportation	No benefit				
4.	**Maternity**					**SPA**
4.1	When you are pregnant, you can go visit certain doctors 12 times per pregnancy - subject to pre-authorisation	100%			12 Visits	
4.2	2D Sonar scans	100%			2 Scans	
5.	**Back and Neck Rehabilitation Programme**	**100%**	**Subject to DBC protocol**			**OAL**
6.	**Preventative care**					**OAL**
6.1	Vaccinations: COVID-19	100%				

OAL = Overall Annual Limit SPA = Subject to pre-authorisation DBC = Document Based Care DSP = Designated service providers

Blue Diamond contribution tables

Employer group rates				Individual rates			
Age	Principal	Adult/spec dep	Child dep	Age	Principal	Adult/spec dep	Child dep
0 - 25	670	561	268	0 - 25	756	628	306
26 - 30	700	577	268	26 - 30	784	661	306
31 - 35	745	599	268	31 - 35	848	682	306
36 - 40	777	642	268	36 - 40	880	716	306
41 - 45	806	664	268	41 - 45	923	762	306
46 - 50	836	672	268	46 - 50	962	793	306
51 - 55	863	704	268	51 - 55	1 004	836	306
56 - 60	880	760	268	56 - 60	1 014	895	306
61 - 65	946	806	268	61 - 65	1 100	946	306
66+	1 022	861	268	66+	1 178	1 044	306

Spec dep = Special dependant
VC = Virtual Consultations

Blue Diamond

Day-to-Day benefits: Expense limit per category		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Out-of-hospital: Sub-limit					Unlimited	
1.	**Doctors and specialists**					**DSP**
1.1	Consultations and visits: Obtained from certain doctors, during normal working hours - N$ 15 per visit	100%				
1.1.1	Virtual GP consultations		5	5		
1.1.2	Nurse: N$ 15 per visit - new conditions		Limited to 2 visits p/m and 12 p/a	Limited to 2 visits p/m and 12 p/a		
1.1.3	General practitioner: N$ 15 per visit - new conditions				425 per visit	
1.1.4	Medical specialist: Upon referral from doctor - N$ 15 per visit	100%				
1.1.5	Medical specialist: Travel assistance benefit - Windhoek or Swakopmund	100%			765 per visit	
1.2	Out-of-hospital services	100%				
1.3	Limited to 2 after-hour consultations at certain doctors: Per family per year	100%				
2.	**Medicine and injections**				**Unlimited**	**DSP**
2.1	Acute medicine					
2.1.1	As dispensed or prescribed by certain doctors and pharmacies	100%	Limited to 2 scripts p/m and 12 p/a	Limited to 2 scripts p/m and 12 p/a		240 per script
2.1.2	Self medication: Over-the-counter	100%			860	245 per claim
2.2	Chronic medicine					
2.2.1	Chronic medicine: Dispensed - as per chronic medicine formulary - subject to prior registration on Chronic Care programme	100%			3 950	No benefit without registration
2.3	Antiretroviral therapy: Dispensed - patient needs to enrol in the AfA Programme	100%				
3.	**Primary care dentistry: N$15 per visit - new conditions**		**1 840**		**3 670**	**DSP**
3.1	Subject to the use of certain dentists: According to a list of approved dental codes	100%				
3.1.1	Consultations, primary extractions, fillings level 1 to 3, fluoride treatment, instructions on oral hygiene scaling and polishing					
3.1.2	Plastic dentures: Limited to 1 set per family per 24 months					
3.1.3	Surgical removal of teeth, root canal treatment and dentures: Subject to pre-authorisation					
3.2	Specialised dentistry	No benefit				
4.	**Radiology**				**Unlimited**	**DSP**
4.1	Black and white x-rays as requested by certain doctors: According to a list of approved radiology codes	100%				
5.	**Pathology**				**Unlimited**	**DSP**
5.1	Basic blood tests as requested by certain doctors: According to a list of approved pathology codes	100%				
6.	**Optical: N$15 per visit - new conditions**				**1 075**	**DSP**
6.1	Optical test	100%				Limited to 110
6.2	Spectacles and lenses: Limited to 1 pair of glasses per family per 24 months - when joining NHP, you cannot claim for glasses for the first 6 months	100%				Claim limited to 965
7.	**Mother and child healthcare services**					**DSP**
7.1	Family planning, immunisation, pre- and post- antenatal care	100%				
8.	**Counselling and health education**					**DSP**
8.1	Instruction of prevention of certain illnesses, oral hygiene, poisons, HIV/AIDS, etc.	100%				
9.	**Specified illness conditions**					**DSP**
9.1	HIV/AIDS: Aids and HIV Positivity, Pathology, HIV councelling and testing, Prophylactic medicine for prevention of HIV, transmission in the case of needle-prick, rape or infection of mother (mother-to-child prevention)	100%			Unlimited	
9.2	Sexually transmitted diseases	100%			1 580	
10.	**Rehabilitation: Alcohol and drug addiction or abuse**	**100%**			**1 580**	**DSP**

- Travel assistance for specialist visits in Namibia only, limited to 2 per family per year.
- 1 COVID-19 vaccine regimen per year is covered as part of the Preventative Care benefit for all beneficiaries older than 16 years.
- International Travel benefit.
- NHP pays for contraceptives (oral and injections) limited to N$ 245 per claim.
- Immunisations are only available from designated service providers, subject to the formulary.
- No Roll-Over benefit.
- No Preventative Care benefit, including Cervarix, apart from the COVID-19 vaccine and a health risk assessment at any of the Fund's Wellness Days or at a qualifying pharmacy.
- No Mirena benefit available.
- No contact lenses benefit available.
- Acute medication script limit is N$ 240.
- The Out-of-Hospital (OOH) benefit in respect of consultations with doctor's/specialists and nurses will be limited to 2 per beneficiary per month (p.b.p.m) up to a maximum of 12 per beneficiary per annum (p.b.p.a), and scripts for medicines and injection materials also limited to 2 per beneficiary per month (p.b.p.m) up to a maximum of 12 per beneficiary per annum (p.b.p.a).

Litunga

Major medical benefits: Expense limit per category - DSP only		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Overall Annual Limit (OAL)					Unlimited	
1.	**Doctors and specialists**					**SPA**
1.1	Consultations and visits: In-hospital	No benefit				
1.2	Procedures: In-hospital	No benefit				
2.	**Hospital services**					**SPA**
2.1	You can be admitted into the state hospital facility (private wing) but it has to first be approved by NHP - subject to pre-authorisation	No benefit				
2.2	Selected private hospitals: Limited access benefit for treatment	No benefit				
2.2.1	Ward fees	No benefit				
2.3	Routine and scheduled surgical and hospitalisation events	No benefit				
3.	**Ambulance services: Only for medical or trauma emergencies**					**SPA**
3.1	Air evacuation	No benefit				
3.2	In an emergency you are covered for ambulance services but only in Namibia	No benefit				
3.3	You are covered for transport between 2 hospitals	No benefit				
3.4	Other transportation	No benefit				
4.	**Maternity**					**SPA**
4.1	When you are pregnant, you can go visit certain doctors 12 times per pregnancy - subject to pre-authorisation	No benefit				
4.2	2D Sonar scans	No benefit				
5.	**Back and Neck Rehabilitation Programme**	**100%**	**Subject to DBC protocol**			**OAL**
6.	**Preventative Care**					**OAL**
6.1	Vaccinations: COVID-19	100%				

OAL = Overall Annual Limit SPA = Subject to pre-authorisation DBC = Document Based Care DSP = Designated service providers

Litunga Contribution tables

Employer group rates				Individual rates			
Age	Principal	Adult/spec dep	Child dep	Age	Principal	Adult/spec dep	Child dep
0 - 25	279	236	114	0 - 25	321	268	130
26 - 30	296	245	114	26 - 30	329	280	130
31 - 35	313	254	114	31 - 35	356	287	130
36 - 40	327	271	114	36 - 40	373	301	130
41 - 45	340	276	114	41 - 45	389	321	130
46 - 50	356	285	114	46 - 50	409	335	130
51 - 55	366	297	114	51 - 55	423	353	130
56 - 60	372	321	114	56 - 60	429	377	130
61 - 65	399	340	114	61 - 65	464	398	130
66+	431	364	114	66+	494	438	130

Spec dep = Special dependant
VC = Virtual Consultations

Litunga

Day-to-Day benefits: Expense limit per category		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Out-of-hospital: Sub-limit					Unlimited	
1.	**Doctors and specialists**					**DSP**
1.1	Consultations and visits: Obtained from certain doctors, during normal working hours - N$ 15 per visit	100%				
1.1.1	Virtual GP consultations		5	5		
1.1.2	Nurse: N$ 15 per visit - new conditions		Limited to 2 visits p/m and 12 p/a	Limited to 2 visits p/m and 12 p/a		
1.1.3	General Practitioner: N$ 15 per visit: New conditions				425 per visit	
1.1.4	Medical specialist: Upon referral from doctor - N$15 per visit	No benefit				
1.1.5	Medical specialist: Travel assistance benefit - Windhoek or Swakopmund	No benefit				
1.2	Out-of-hospital services	100%				
1.3	Limited to 2 after-hour consultations at certain doctors: Per family per year	No benefit				
2.	**Medicine and injections**				**Unlimited**	**DSP**
2.1	Acute medicine					
2.1.1	As dispensed or prescribed by certain doctors and pharmacies	100%				240 per script
2.1.2	Self medication: Over-the-counter	No benefit				
2.2	Chronic medicine					
2.2.1	Chronic medicine: Dispensed - as per chronic medicine formulary - subject to prior registration on Chronic Care programme	100%			3 160	No benefit without registration
2.3	Antiretroviral therapy: Dispensed - patient needs to enrol in the AfA Programme	100%				
3.	**Primary care dentistry: N$15 per visit - New conditions**		**1 840**		**3 670**	**DSP**
3.1	Subject to the use of certain dentists: According to a list of approved dental codes	100%				
3.1.1	Consultations, primary extractions, fillings level 1 to 3, fluoride treatment, instructions on oral hygiene scaling and polishing					
3.1.2	Plastic dentures: Limited to 1 set per family per 24 months					
3.1.3	Surgical removal of teeth, root canal treatment and dentures: Subject to pre-authorisation					
3.2	Specialised dentistry	No benefit				
4.	**Radiology**				**Unlimited**	**DSP**
4.1	Black and white x-rays as requested by certain doctors: According to a list of approved radiology codes	100%				
5.	**Pathology**				**Unlimited**	**DSP**
5.1	Basic blood tests as requested by certain doctors: According to a list of approved pathology codes	100%				
6.	**Optical: N$15 per visit - New conditions**				**1 075**	**DSP**
6.1	Optical test	100%				Limited to 110
6.2	Spectacles and lenses: Limited to 1 pair of glasses per family per 24 months - when joining NHP, you cannot claim for glasses for the first 6 months	100%				Claim limited to 965
7.	**Mother and child healthcare services**					**DSP**
7.1	Family planning, immunisation, pre- and post- antenatal care	100%				
8.	**Counselling and health education**					**DSP**
8.1	Instruction of prevention of certain illnesses, oral hygiene, poisons, HIV/AIDS, etc.	100%				
9.	**Specified illness conditions**					**DSP**
9.1	HIV/AIDS: Aids and HIV Positivity, Pathology, HIV councelling and testing, Prophylactic medicine for prevention of HIV, transmission in the case of needle-prick, rape or infection of mother (mother-to-child prevention)	100%			Unlimited	
9.2	Sexually transmitted diseases	100%			1 580	
10.	**Rehabilitation: Alcohol and drug addiction or abuse**	**100%**			**1 580**	**DSP**

- International Travel benefit.
- 1 COVID-19 vaccine regimen per year is covered as part of the preventative care benefit for all beneficiaries older than 16 years.
- Immunisations are only available from designated service providers, subject to the formulary.
- Members do not qualify for the Lifestyle programme.
- No Roll-Over benefit.
- No Preventative Care benefit, including Cervarix, apart from the COVID-19 vaccine and a health risk assessment at any of the Fund's Wellness Days or at a qualifying pharmacy.
- The Out-of-Hospital (OOH) benefit in respect of consultations with doctor's/specialists and nurses will be limited to 2 per beneficiary per month (p.b.p.m) up to a maximum of 12 per beneficiary per annum (p.b.p.a), and scripts for medicines and injection materials also limited to 2 per beneficiary per month (p.b.p.m) up to a maximum of 12 per beneficiary per annum (p.b.p.a).

How to make the most of NHP

- Contact us well in advance before you have to go into hospital.

- Look after yourself, eat well, exercise and have all the medical tests and vaccinations that your doctor recommends, e.g. women aged 50 to 74 years should have a mammogram every 2 years.

- Ask your doctor to prescribe the most cost effective medicine possible.

- Submit your claims within 4 months from the treatment date.

Contribution

A “contribution” is the amount that members pay the Fund each month. Your contribution received is utilised to pay for medical expenses. By pooling everyone’s money together, NHP helps to make healthcare cover accessible for everyone who can afford to pay his/her monthly contributions.

You must discuss your treatment with us in detail, so that we can help you to understand what we will pay for and what we will not pay for. We might not cover the costs if we have not agreed to the treatment plan for you.

Waiting periods - new members

Individual members:

- A general waiting period of 6 months will apply for the optical benefit on the Blue Diamond and Litunga benefit options.
- A general waiting period of 3 months for all Day-to-Day and Major Medical Expense claims will apply in respect of aged parents joining the Fund as a dependant, in addition to a 12 month condition specific waiting period for pre-existing conditions.
- A condition specific waiting period of 12 months will apply to Day-to-Day and Major Medical Expense claims relating to maternity.

Employer group members:

- All new employer group members joining the Fund will normally be exempt from condition specific exclusions, unless the member/dependants joins the Fund 3 months after becoming eligible for membership.
- A 12 month condition specific period for maternity related claims will apply if the member does not apply for membership within 3 months after qualifying.
- All dependants of employer group members joining as from the 4th month after the principal member or 3 months after becoming eligible to qualify as a dependant will be subjected to a 12 month condition specific waiting period.

Condition-specific:

- If a principal member and/or dependant suffers from a specific illness, the Fund has the right to exclude benefits for this specific condition for a period of up to 12 months.
- A condition-specific waiting period will apply if the previous medical aid fund had imposed such waiting period and it had not expired at the time of termination.

Non-disclosure consequences:

- If found that, during the 120 day review period, false information has been submitted or that any relevant information has deliberately been omitted on an application, the Fund may correct this in terms of its rules, which may include re-underwriting or termination of membership.

Refractive surgery:

- A 12 month waiting period will apply on all members across all benefit options where the benefit is available, including members previously covered by other medical aid funds.

Maternity:

- All new employer group members joining the Fund will be exempt from maternity related exclusions unless the member/dependants join the Fund 3 months after becoming eligible for membership.
- A condition-specific waiting period of 12 months will apply to new individual members and to a member who joins NHP already pregnant, until and including delivery.
  All maternity related treatment falls under the 12 month waiting period. This also applies to members previously covered by other medical aid funds.

Newborn:

- The principal member is required to register a newborn as a child dependant within 30 days from the date of birth, in order to qualify for immediate benefits.
- If a member applies to register a baby older than 30 days or newly adopted child as a dependant after 3 months following the date of birth or adoption of the child, the Fund may subject the child dependant to a condition specific waiting period. A medical declaration completed by a doctor will be required for the child dependant.

Changing benefit options

Members can submit requests to change benefit options up to the end of January for the new benefit year. Members will need approval from their employer if membership falls under an employer group.

Under normal circumstances members will not be allowed to buy-up or buy-down from one benefit option to another during the course of a benefit year. In the case of a member requiring a mid-year upgrade, a request should be addressed in writing to the Fund for consideration. In the event of the Fund approving such a request, the change will be made, backdated to 1 January with additional payments being requested to cover the difference in monthly contributions. Therefore, members need to ensure that they are adequately insured for any potential major medical expenses.

Members will receive new membership cards, with the new benefit option selected, whilst the membership number remains the same.

Keeping NHP updated with changes to membership

It is very important to notify NHP of any changes in personal and dependant(s) details. Not informing NHP timeously of changes can for example, affect the payment of refunds if the banking details are incorrect or the deduction of contributions if there is an addition or termination of dependant(s). In addition, in order to keep members informed of critical and membership information, we need to be able to reach them.

Please let us know if any of the following membership details change:

- Address, telephone/cell number or other contact details.
- Banking details.
- Marital status.
- Addition or termination of dependants.
- Passing away of the principal member or any registered dependant(s).

Members must notify the Fund of any change of address, including email address as well as cellphone details immediately and without delay. The Fund will not be held liable if a member's rights are prejudiced or forfeited as a result of neglect to comply with the requirements of this rule. The Fund will not be held liable for any information not delivered to the member due to the member's failure to furnish and update his/her latest contact details, inclusive of banking details.

Sending claims to NHP

A claim is an invoice for medical treatment submitted to the Fund for payment or reimbursement. Most healthcare providers have the ability to send claims electronically, ensuring a shorter processing time. Alternatively, members or healthcare providers must submit claims in hard copy format.

If the member's healthcare provider claims electronically and members receive a copy of the invoice (for members information), it is not necessary to send a copy to NHP. However it remains the members responsibility to ensure that all accounts are submitted within 4 months from the service date.

Checklist to make sure the correct information is submitted to avoid payment delays:

- Is it a detailed account bearing the practice name?
- Does it clearly state the facility practice number?
- Does it include the facility address?
- Does it specify the consulting healthcare provider's name?
- Are the admission and discharge dates correct?
- Is the diagnosis stated (ICD 10 code)?
- What are the relevant NAPPI codes at primary and secondary level?
- Does it state the treatment provided (ICD 10 code)?
- Please confirm that membership details are correct:
  - Principal member's name and surname
  - Patient's name and surname
  - Membership number clearly stated and
  - Dependant code
  - ID number or date of birth
- Are the patient's details the same as those stated on the NHP membership card?

Submission of claims for medical treatment within 4 months after the treatment date.

It is important for members to understand that it is their obligation to follow-up and ensure all claims are submitted within the required 4 month period. All claims submitted after this period will be stale and will not qualify for payment. Members remain liable to the doctor for treatment and the full balance of the invoice, irrespective of whether such claim was paid.

If members pay the doctor upfront, they must attach proof of payment to the claim before submitting the claim for processing. Members should make copies for their own records.

Members and/or doctors have 60 days to resubmit any rejected claim following the date of rejection. The Fund will not accept any amended claim after the given 60 days. The claim run-off period for treatment up to 31 December will extend to 30 April of the following year.

The same principle to process and pay for claims will apply for authorization updates, motivations and any other additional information requested in accordance with the rules of the Fund.

It is thus the member's responsibility to ensure and check that accounts submitted the first time are complete.

Stale claims

A stale claim is an invoice not submitted in its entirety, returned for correction but not resubmitted and is older than 4 months from the date of treatment. The Fund shall inform the member why the claim is rejected giving the member a certain amount of time to correct and resubmit such claim.

It is the member's responsibility to ensure and check that accounts submitted the first time are complete.

Members MUST have pre-authorisation

Members must get pre-authorisation before their Major Medical Expense benefit will cover any claim, e.g. a planned or emergency hospital admission, specialised radiology, or selected procedures. If in doubt, members are to contact NHP to find out if they require pre-authorisation. Members must also obtain pre-authorisation for any in-room procedures.

The member is responsible for obtaining a detailed quote prior to the procedure from the provider/practitioner and to obtain a benefit confirmation.

Pre-authorisation for in-hospital admissions

Hospital pre-authorisation is a process where a member applies to the Fund, before hospital admission, for pre-authorisation of any procedure or treatment in hospital. The pre-authorisation process assesses the medical necessity and appropriateness of the planned procedure or treatment according to clinical protocols and guidelines prior to hospital admission.

Obtaining hospital pre-authorisation remains the member's responsibility. Members must obtain pre-authorisation at least 72 hours before hospital admission. In the case of an emergency requiring hospital admission, authorisation is mandatory within 48 hours after hospital admission. Should a member fail to obtain pre-authorisation, the Fund will pay only at 90% of the NAMAF benchmark tariff for any claims related to the hospital admission.

Important:

- Pre-authorisation does not guarantee payment for other associated costs.
- Benefits, according to what is permitted in terms of the clinical protocols and guidelines, are covered.
- Treatment must commence within 30 days of pre-authorisation, subject to available benefits.
- Pre-authorisation for treatment in hospital is only valid and restricted to conditions for which pre-authorisation has been requested for and subsequently granted.
- Certain in-hospital expenses incurred as part of the planned procedure might be an exclusion from the member's in-hospital benefit.
- Certain procedures, medication and new technology used in hospital may require a separate pre-authorisation. Members must clarify with their healthcare provider prior to applying for pre-authorisation before hospital admission.

Any treatment falling outside of the scope of such pre-authorised treatment will require an update and further pre-authorisation.

Why is it important to pre-authorise?

- The members' hospital stay will be subject to the specific procedures and services that were pre-authorised by the Managed Care department. Any additional days in hospital, multiple procedures, or additional services will require further pre-authorisation or motivation.
- No further benefits will be covered or paid unless a longer stay or revised requirements are authorised by the Fund.
- There might be requirements for additional information.

Why are certain pre-authorisations for hospital admissions or specific procedures declined?

- The requested procedure excludes cover under the members specific benefit option.
- The procedure does not qualify for funding from the in-hospital benefit, instead is funded from the out-of-hospital benefit.
- The procedure is not appropriate at the specific time.
- It is a combination procedure.
- Benefits are depleted (if applicable).
- Requested procedure falls under an exclusion.
- Members may have a waiting period or exclusion(s) imposed when joining the Fund.

Members must contact NHP in the event of a postponement of admission or procedure, or if being re-admitted with the same condition, re-applying for pre-authorisation with the revised details.

Important details about pre-authorisation numbers:

- The pre-authorisation number only applies to the specific hospital or practice, specified on pre-authorisation request. If there are any changes to details, members must notify the Fund.
- Contact NHP for any benefit related services out of hospital, e.g. if physiotherapy is required after discharge from hospital.
- The Fund has the right to cancel a pre-authorised procedure, if the actual information or procedure differs from what was pre-authorised.

Ask your healthcare provider questions and get information before agreeing to a procedure or treatment:

- Discuss the procedure in detail prior to the hospital admission.
- Ask about the advantages and disadvantages of undergoing such a procedure or treatment.
- Ask about the cost of the procedure/treatment. If possible ask to get a quote indicating the NAMAF benchmark tariff codes to be used for that specific procedure or treatment and contact NHP to assess if this will be covered by your available benefit limits and how much will the co-payment be after GAP cover.
- Where multiple procedures during the same procedure are performed these could be covered at different percentages as set out in the guidelines.
- Ask for alternatives before opting for surgery.
- Ask if the healthcare provider charges according to the NAMAF benchmark tariffs.
- Ask who the anaesthetist is and ask if he/she bills at medical aid fund rates.

The Managed Care department must be contacted on the first working day following any after hour emergency related procedures.

Benefits excluded, unless proven medically necessary: (Please refer to page 32 in the User Guide for the extended list)

- Breast reduction and enlargement.
- Hyperbaric oxygen treatment.
- Bariatric surgery.
- Bilateral split osteotomy.
- Attempted suicide, wilfully self-inflicted injuries, or sickness conditions/costs incurred in respect of treatment associated with drug abuse or overdosing, including Alkogen treatment.
- Costs incurred for treatment arising out of an injury or disablement resulting from war, invasion or civil war.
- Treatment of ailments, which were specifically excluded at the commencement of membership.
- Treatment of an illness or injury sustained where such illness or injury is directly attributable to failure to carry out the instructions of a healthcare provider or to negligence on the part of the member/dependant.
- Treatments that are in excess of OAL or applicable sub-limits, to which a member is entitled to in terms of the rules of the Fund.
- The cost of treatment for complications that resulted from a procedure specifically excluded by the rules of the Fund.
- Ambulance services not authorised, unless provided in circumstances of emergency medical condition as determined by the Fund, or ambulance services not registered as an emergency medical service provider.
- Ambulance services requested by a hospital for the purpose of transporting a patient to and from an x-ray facility, unless provided in circumstances of emergency medical condition as determined by the Fund.

Mandatory pre-authorisation for non-emergency specialised radiology and scopes

A pre-authorisation reference number (PAR) is required before services in respect of hospitalisation and specialised Radiology qualify for benefits, even in the event of non-emergency specialised radiology and scopes.

Non specialised radiology includes medical x-rays and radiography. Medical x-rays are used to generate images of tissues and structures inside the body. Radiography is the imaging of parts of the body using x-rays (high-energy electromagnetic radiation) or sound navigation (sonar).

Specialised radiology is the medical discipline that uses medical imaging to diagnose diseases and guide treatment within the human body. Specialised radiology refers to all imaging modalities, including computed tomography (CT), fluoroscopy, and nuclear medicine, including positron emission tomography.
Interventional radiology is the performance of usually minimalistic invasive procedures with the guidance of imaging technologies such as those mentioned above.

Implementation of ICD-10 coding structure from 2024 onwards

The Namibian medical aid funds industry in association with NAMAF is embarking on the introduction and compulsory utilisation of ICD-10 codes, as a compulsory measure for all claims in order to be paid, as from 1 January 2025. It is important for members to be aware of the introduction of the ICD-10 codes as from 2024.

It is primarily the medical practice's responsibility to issue the medical statement containing the correct breakdown of ICD-10 treatment codes, services and tariffs.

However, members must be aware that they are ultimately responsible for settling the account to any healthcare practitioner. If an account in the members name is not settled and paid due to incorrect or incomplete information received then the member will still be held accountable for settling that account irrespective whether the medical aid fund has paid or not.

In order to avoid any future disappointment or unhappiness, members must be aware that it remains their responsibility to ensure that all claims for medical treatment are submitted on time and in the correct format with the correct information.

Claims without ICD-10 codes will not be rejected for the period 1 January 2024 – 31 December 2024, and shall only be identified with a system claims processing error code.

Any claim submitted without the appropriate ICD-10 codes as from 1 January 2025, shall be rejected and only reimbursed once the claim with the correct codes has been resubmitted. Rejected claims shall be identified with a system claims processing error code.

Remember that it is very important to pre-authorise and we suggest that members obtain a time line from their healthcare provider. Pre-authorisations can be obtained from the Managed Care department at tel 061 285 5400 or send an email to cases@nhp.com.na.

Roll-Over benefit

If members claim less than a certain threshold amount included in their Day-to-Day benefits, they can build up a Roll-Over benefit that they can use to pay for healthcare treatment and medical costs. Claims paid in accordance to the Day-to-Day benefits of each benefit option, taking into account the threshold level, will first be debited against the Roll-Over benefit where after the normal Day-to-Day benefits will be utilised.

At the end of April, in the following benefit year, if the previous year's Day-to-Day benefit claims, excluding costs for chronic medication are less than the Roll-Over benefit threshold amount, the remaining balance will be transferred into the members accumulated Roll-Over benefit account.

- Members Roll-Over benefit accumulates in their name for as long as they are members of NHP.
- A Roll-Over benefit instruction claims form for manual Roll-Over refunds must be completed and be sent via mail to claims@nhp.com.na.
- If members select the automated claims process, the completed form can be sent via e-mail to members@nhp.com.na.

Whilst being a member of NHP, any positive balance accumulated in their Roll-Over benefit account can pay for:

- Routine medical costs.
- Outstanding member's portions.
- Medical treatment normally excluded from benefits.
- Medical expenses with a valid chargeable Tariff or Nappi Code which are usually excluded by the Fund. These medical services must be provided by a registered healthcare provider.
- The difference between the actual medical costs and the NAMAF tariff for medical services covered by the Rules.
- Medical aid contributions.
- Claims in respect of benefits for sickness conditions, medical procedures or medicines excluded (including exclusions from the Optical and Dental benefits) may be paid from a positive balance on the accumulated Roll-Over benefit.
- Medical expenses in respect of new dependants where a waiting period may apply.

Claims not eligible for payment from the Roll-Over benefit:

- Non-medical expenses without a valid chargeable tariff code and Nappi code which is not rendered by a registered medical service provider.
- Any medical or non-medical expenses claimed for beneficiaries not actively registered as dependants of the main member.
- Green Cross shoes.
- Sunglasses, whether or not prescribed by a registered optomotrist or ophthalmologist.

Upon resignation from an employer group, the member may elect to continue membership with the Fund, either as an individual or as a member of another employer group, in which case the accumulated Roll-Over benefit transfers to the new membership without forfeiture of the accumulated benefit.

Chronic medication benefit

Chronic medication is medicine needed to treat a long-term illness, which is taken on a regular basis (usually daily). This is an additional benefit over and above any Day-to-Day benefits allowed for by the choice of benefit option.

This benefit relates to medicine only and does not include the provider's consultations. It should be noted that a 20% levy applies to all chronic medicine prescribed, irrespective of whether it is dispensed by a pharmacy or any other registered healthcare provider. A minimum co-payment of N$ 30 in respect of any prescribed medicine applies.

The Chronic medication benefit is also available on Blue Diamond and Litunga options.

Members with chronic conditions must inform the Fund of their condition as soon as a healthcare provider has diagnosed and provided a prescription for on-going medicine to ensure appropriate funding. Chronic medicine is subject to the available benefits as indicated under each benefit option.

When benefits are depleted, the available acute medication benefit is then utilised. To ensure payment, medication must be prescribed by a registered healthcare provider for a period of 3 months or longer.

Members must renew their chronic medication authorisation annually.

Eligibility requirements for accessing Chronic Medication benefits

During 2024, the Fund will be introducing a significant change to the way that members will access their chronic medicine benefit.

To qualify for the chronic medicine benefits, it will now become a mandatory requirement for members to enroll onto the Chronic Care Programme before the person/s chronic benefits can be accessed.

The reason for this mandatory registration is to allow the Fund to better you, the member through improved adherence and provision of adequate benefits to ensure optimal control of chronic illness and reduced hospitalisation.

Enrolment and registration on the chronic care programme will commence as from 1 January 2024 with mandatory enforcement as from 1 July 2024. This will provide existing members a 6 month window period during which they can register. We appeal to members not to wait until the last moment in order to avoid bottle necks with registration which may result in unnecessary delays with the approval process.

Once the member has successfully registered onto the Chronic Care Programme it will not be necessary to re-register on an annual basis unless there is a new chronic illness condition. In exceptional circumstances, there may be a need to register for a specific medicine or dose of a medicine.

As from 1 July 2024 enrolment onto the chronic care programme will be mandatory to access chronic medicine benefits, failing which chronic medicines will be claimed against the acute medicine benefit.

Once the member has successfully enrolled onto the programme, the member will qualify for one additional GP consultation.

The claims processing system will identify the chronic products by applying the following rules:

- If the product appears on the basket of chronic approved conditions, it is a chronic product, otherwise the product is an acute or pharmacy advised therapy product.
- Chronic authorisations are obtained according to the registration requirements for any product that is identified as a chronic product.
- The member will have to complete a chronic medication form providing the diagnosis, the number of repeat scripts, as well as the type of medication prescribed.
- Once registered for a chronic condition there is no need for annual registration. In exceptional circumstances, there may be a need to register for a specific medicine or dose of a medicine.

Benefits include:

- Chronic medication, if registered, will pay from the correct benefit without requiring members to request pre-authorisation.
- Improved adherence to prescribed chronic medication thereby reducing the member's health risk through increased compliance.
- Provision of adequate benefits to ensure optimal control of chronic illness.
- Reduced hospitalisation through greater adherence and better control of chronic illness conditions.
- Clinical and Fund Rules apply automatically, if registered.

Chronic Lifestyle Disease Extender benefit

The Chronic Lifestyle Disease Extender benefit is only available to members on the Gold, Platinum and Titanium benefit options. High risk members on the Silver benefit option, subject to approval and furthermore registration on the Beneficiary Risk Management Programme, may apply for this benefit. Members on the Bronze, Hospital, Blue Diamond and Litunga benefit options do not have access to this benefit.

This benefit is limited to specific ambulatory healthcare services for beneficiaries diagnosed with one or more of the following medical conditions:

- Hypertension
- Hypercholesterolemia
- Diabetes Mellitus

The intention is to assist high risk chronic members to remain under treatment for the period of cover in terms of each benefit year subject to being on a qualifying benefit option and being

registered on the programme. Where a member may be diagnosed with more than one of the above conditions, the allowable services for multiple conditions shall be determined by combining the services for each disease. The quantity limits will however remain as the number approved for each individual disease.

The treatment covered by this benefit includes:

- Additional consultation(s) by healthcare providers restricted to the prescribed frequency of treatment codes.
- Chronic Medicines, inclusive of diabetic disposables such as syringes, needles, strips and lancets for registered patients, excluding insulin pumps and consumables.
- Additional pathology and radiology tests.

The Chronic Lifestyle Disease Extender benefit will only be activated once all other acute- and chronic medication benefits as well as any available Accumulated Roll-Over benefits have been depleted.

Diabetic devices benefit

Globally there is a significant increase in the number of people living with diabetes and it is expected that this trend will continue into the future. This trend of increasing prevalence of diabetes can also be seen for NHP. It is therefore of great importance to ensure that Diabetic patients receive the correct treatment and that their condition is well controlled.

Advances in medical technology has seen the launch of insulin pumps and glucose monitors aimed at aiding diabetics to manage their glucose control. However, it should be noted that the devices are costly and should be reserved for those diabetics who find it challenging to control their glucose levels. Furthermore, the use of these devices require dedication and compliance to ensure that the benefits are realised.

Currently all diabetics on NHP, irrespective of option, have access to consultations, pathology and medicines. Since there is no cure for diabetes, the critical form of management of this condition relates to the monitoring of blood glucose levels, compliance to medicine treatment and impactful lifestyle changes.

The Fund introduced a Diabetic Devices benefits for diabetics on the Gold, Platinum and Titanium Options for Diabetic patients who are deemed to be at risk due to uncontrollable sugar levels. In an effort to provide better targeted assistance to diabetic patients, members on these options are able to access cover for insulin pumps and glucose monitoring systems.

Benefits will be subject to application and clinical criteria will be applied when accessing these authorisations. It is crucial that diabetics considering using an insulin pump or continuous glucose monitoring device understand the requirements for using these devices. Research indicates that these devices, whilst providing benefit, can also provide hindrances e.g. some glucose monitors uses apps to share glucose readings and therefore require data and integration with smartphones.

Diabetic devices benefit (D-t-D)

Gold Option

- Per family = N$ 46 300 – covered at 80% of NAMAF benchmark tariff and further limited to a 4 year cycle i.e. 2024 to 2027.
- Diabetic related consumables = N$ 44 400.

Platinum Option

- Per family = N$ 43 600 – covered at 80% of NAMAF benchmark tariff and further limited to a 4 year cycle i.e. 2024 to 2027.
- Diabetic related consumables = N$ 41 800.

Titanium Option

- Per family = N$ 38 100 – covered at 80% of NAMAF benchmark tariff and further limited to a 4 year cycle i.e. 2024 to 2027.
- Diabetic related consumables = N$ 39 200.

The following conditions will apply:

- Enhancement of Diabetes related consumables for Insulin Pumps / Glucose monitoring systems and Glucose readers will be covered at 80% of NAMAF benchmark tariff and limited to the amounts above per beneficiary.
- Access to the benefit is subject to pre-authorisation and will require a detailed motivation from a specialist.
- The benefit is subject to the Overall Annual Limit (OAL) and NAMAF benchmark tariffs and further subject to limits, co-payments and a frequency as per the 4 year cycle depicted above.

Diabetics on the other options, can apply for Ex-Gratia benefits to access these devices. Note that Ex-Gratia applications are not guaranteed and devices will not be funded in full.

The following is a short summary of some of the diabetic technologies available:

Glucose Monitoring Devices

- Self-monitoring of blood glucose (SMBG)
  Also known as a finger-stick or finger-prick test. This involves testing blood glucose levels using a lancing device to obtain a small drop of blood from the fingertip, applying the blood drop to a test strip and inserting it into a blood glucose meter (glucometer). The frequency of testing depends upon the diabetes type (Type 1 or 2) and treatments used (oral medications, insulin, lifestyle modifications). Glucometers are currently funded from the Appliances Benefits and will continue to be funded from this benefit.
- Continuous Glucose Monitoring (CGM)
  Continuous glucose monitoring systems use a glucose sensor to measure the level of glucose in the fluid under the skin. The sensor is attached to a transmitter which wirelessly transmits results to a recording device/reader or a smartphone, or directly to an insulin pump. Glucose levels are measured either in real-time or every 5 to 15 minutes, 24 hours a day. Results are downloadable to track the glucose readings and share with the doctor. Because of reliability issues and the need to calibrate some of the devices, CGM does not eliminate the need for at least occasional finger-stick tests.

Insulin Pumps

- Continuous subcutaneous insulin infusion (CSII) pumps
  Insulin pumps, also known as continuous subcutaneous insulin infusion (CSII) pumps, are devices filled with insulin which delivers insulin continuously under the skin via a small plastic tube.

Acute medication benefit

Acute medication is medicine prescribed once off for less than a month by a healthcare provider, or medicine for conditions not listed or recognised as chronic conditions by the Fund, e.g. antibiotics prescribed for tonsillitis. Immunisations not covered under the Preventative Care benefit will be payable from the acute medication benefit.

A 20% levy applies to all prescribed acute medication. A minimum co-payment of N$ 30 in respect of any prescribed acute medication applies.

Oral and parenteral contraceptives are limited to N$ 255 per claim, subject to the acute medication benefit.

Self-medication benefit

Self-medication referred to as over-the-counter (OTC) medication, is medicine bought from a pharmacy without a prescription. Only medication that a pharmacist legally dispenses without a prescription from a healthcare provider qualifies under this benefit. This includes all schedule 0, 1 and 2 medication and includes the typical cold and flu medicine, such as cough medicine and decongestants, including vitamins with a NAPPI code.

Claims in respect of self-medication vary per benefit option.

Members are able to use their self-medication benefit at pharmacies without having to pay first and claim later, instead the pharmacist can claim electronically from the Fund. No levy will be applied in respect of self-medication, subject to the claim being within the per claim limit.

Claims for over-the-counter medicine are subject to the availability of the Acute medication benefit.

Benefits included:

- This benefit includes sun block with a NAPPI code purchased at a pharmacy.
- Members on the Blue Diamond benefit option may obtain legally dispensed medication by a pharmacist without a prescription from a healthcare provider up to a maximum of N$ 860 per family per year. This includes all schedule 0, 1, and 2 medication. Claims in respect of self-medication will be limited to N$ 245 per claim.

Benefits excluded:

- Consultations charged by a pharmacist
- Medication acquired off the shelf in supermarkets

Consultations and script limits for Blue Diamond and Litunga Options

The Out-of-Hospital (OOH) benefit in respect of consultations with doctor's/specialists and nurses will be limited to 2 per beneficiary per month (p.b.p.m) up to a maximum of 12 per beneficiary per annum (p.b.p.a) and scripts for medicines and injection materials also limited to 2 per beneficiary per month (p.b.p.m) up to a maximum of 12 per beneficiary per annum (p.b.p.a).

Preventative Care benefit

Gold, Platinum, Titanium, Silver, Bronze, subject to OAL

This benefit is now also linked to the Preventative Care incentive.

Designed to cover high risk conditions in almost every life-stage the preventative care benefit pays for expenses normally covered from the Day-to-Day benefit.

The intention is to shift the focus from curative, to preventative healthcare. There is a need to introduce broader evidence based preventative care benefits in an affordable manner in order to address the burden of disease amongst members of the Fund.

If diagnosed early and managed, the outcome could change significantly for the better.

Women's health

Breast and cervical cancer screening:

- Mammograms: Breast cancer screenings for females aged 50 to 74 years. The Fund will pay for 1 mammogram every 2 years.
- Pap smears: For cervical cancer, tests for females aged 21 to 65 years. The Fund will pay for 1 pap smear every 3 years.
- Cervical vaccination is available.

The Fund will pay for immunisations against the HP virus e.g. Cervarix, Gardasil on the following conditions:

- Subject to 80% of the NMPL up to a maximum amount of N$ 883 per script, claimed from the preventative care benefit.
- No age motivation will be required for NHP members.
- The Fund will pay for a maximum of 3 injections per female dependant.

Children's health

Immunisations/Vaccinations:

- The Preventative Care benefit will cover child immunisations for child beneficiaries up to the age of 10 years, resulting in a considerable amount of Day-to-Day benefit savings. Depending on the healthcare provider, a co-payment may be required, which NHP will not fund. Please note that various limits apply.

The following childhood immunisations will be paid for children 10 years and younger:

- Polio
- Diphtheria
- Pertussis
- Tetanus
- Haemophilus influenza type B
- Measles
- Mumps
- Rubella
- Varicella (chickenpox)
- Pneumococcal disease
- Rotavirus
- Hepatitis A and B
- Meningococcal disease

Men's health

Prostate-Specific Antigen (PSA) testing:

- Test for the likelihood of prostate cancer. The Fund will pay for 1 test every 2 years for male beneficiaries aged from 50 years and older.

Senior health

Bone densitometry:

- For females aged from 65 years and males aged from 70 years. The Fund will pay for 1 osteoporosis screening per beneficiary every 2 years.

Colorectal cancer screening:

- For all beneficiaries aged from 50 to 75 years, limited to 1 faecal occult blood test every year, 1 flexible sigmoidoscopy screening every 5 years and 1 colonoscopy screening every 10 years.

Cardiac health

Cholesterol screening - Full lipogram:

- The Fund will pay for 1 lipogram every 4 years for beneficiaries 20 years and older.

Sexual health

HIV:

- The Fund will pay for 1 HIV test per beneficiary per year.

Other vaccinations

Flu vaccine:

- Members of all ages will qualify for flu vaccines at a rate of 1 flu vaccination per beneficiary per year.

Employer groups hosting flu vaccine campaigns for their employees must note that the Fund will not be responsible for the cost of the enrolled registered nurse(s) if offered on-site. Employer groups must contact the Fund in this regard before embarking on a flu vaccine campaign directed at their employees. For more details contact: wellness@nhp.com.na.

This benefit excludes:

- More than 1 flu vaccination per beneficiary per year.
- Childhood vaccinations for children older than 10 years.
- Other vaccinations not listed above are payable from the acute medication benefit.

COVID-19 vaccine:

- Members older than 16 years qualify for 1 COVID-19 vaccine regimen per beneficiary per year.

Pneumococcal vaccine:

- Only for ages 65 years and above and for beneficiaries with respiratory problems, 1 vaccination per beneficiary per lifetime.

International travel benefit

This benefit provides cover for up to N$ 10 000 000 per beneficiary for medical emergencies whilst travelling outside Namibia and overseas. Cover includes costs related to medical and related expenses, emergency medical assistance, medical evacuation and repatriation, return of dependant's children and emergency medical assistance.

In order to qualify for the International Travel benefit, members must register themselves and their dependants accompanying them before leaving Namibia.

The International travel benefit is for leisure and business travel only, planned medical treatment will not be covered. Benefits are limited to a maximum travel period of 90 days and 30 days and N$ 600 000 per case if there is a pre-existing condition. Cover is only available to members and registered dependants between the ages of 3 months to 80 years.

Upon receipt of the above mentioned information, the Fund will issue a letter to the principal member involved, confirming the terms and conditions of medical cover during the intended overseas visit or visit to South Africa and neighbouring countries.

During the overseas visit, the member will be liable for all expenses related to normal medical treatment.

Failure of members to give full disclosure in respect of any pre-existing illnesses prior to departure may result in treatment of a possible illness or injury being rejected by the insurer.

Pre-existing acute conditions defined as any condition giving rise to a claim for which the insured, within the 12 consecutive calendar months prior to the trip, has:

- Consulted a medical practitioner or specialist.
- Received medical treatment or advice.
- Manifested with symptoms, which would have caused a reasonable person to seek medical advice.

Any liability in respect of loss, injury or damage sustained directly or indirectly caused by or arising from the following, will be excluded:

- Any cardiac or cardiovascular or cerebrovascular disease or conditions thereof or complication that can reasonably be related thereto, if the insured person is over the age of 69 years or

has received medical advice or treatment for hypertension 12 months prior to the commencement of the insured journey.
- Expenses for medical treatment incurred for continuing treatment, including any medication commenced prior to the commencement date of the insured journey.
- Expenses for medical treatment incurred for fillings, crowns, or precious metals.
- Expenses for medical treatment incurred for any procedures relating to dental or oral hygiene.
- Expenses for medical treatment incurred for specialist medical treatment without referral from a healthcare provider.
- Any elective/planned procedure performed outside of Namibia.
- Travel for the sole purpose to receive medical treatment.
- Medication or condition related to a terminal prognosis known to the insured person prior to the effective date of coverage.
- Employment in manual labour.
- Undertaking employment on a permanent or contract basis, which is not casual.
- Participating in a sport as a professional sport player.
- Excludes injuries whilst doing technical training abroad.
- Any hazardous pursuits.
- The insured person's intention to emigrate.
- War, invasion, hostilities, civil war, rebellion, labour disturbances, riot, strike, or lockout.
- Deliberate violation of criminal law.
- Non-adherence or travelling against medical advice.
- Pregnancy or childbirth of the insured person and sexually transmitted diseases.

Prerequisites

1. Complete the application for international travel assistance, submitting copies of all passport(s) and flight tickets for all persons travelling. Members can apply online at www.nhp.com.na.
2. Registration of the principal member and all dependants, including children, must be finalised prior to leaving Namibia.
3. Obtain a cover letter and a copy of the policy document from NHP, which shows the policy number and emergency contact details as well as the conditions of cover.
4. Obtain an embassy letter for extended travel.

How to claim

1. To apply visit the NHP website at www.nhp.com.na.
2. Always obtain a reference number if in a medical emergency or need to claim.
3. Obtain a comprehensive medical report with diagnosis from the treating healthcare provider.
4. Keep all invoices and submit all proof of the medical costs paid for and a copy of the airline ticket(s).
5. When members return, they should complete and submit a claim form attaching all supporting documents.
6. Submit a report from the local healthcare provider stating treatment received 12 months prior to the effective date of insurance in respect of any pre-existing medical condition.

The risk of this product is fully underwritten by a registered insurer as required by the Medical Aid and Insurance Acts.

Repatriation benefit

Should something unexpected happen to a member or dependant member, (usually a medical emergency a long distance from where they live) the Fund will cover the costs of transporting a member or dependant member back home. The Fund will either pay the transport costs in cash or through an agreement with a preferred transport company.

For all repatriation enquiries, please contact the NHP Call Centre.

The repatriation benefit will cover the cost of repatriation in case of:
- Emergency transportation within South Africa and Namibia whether by means of bus transport or commercial flight, where a patient is still alive after an emergency treatment.
- Emergency transportation within South Africa and Namibia where the patient passed away and the mortal remains are repatriated to the town of residence in Namibia.
- Mortal remains repatriation inclusive from the place of death in Namibia to the mortuary or nearest town within Namibian borders will be paid to a maximum of N$ 15 000 per event.
- The Fund will pay one commercial flight ticket or refund any fuel costs for repatriation in South Africa and Namibia after a medical emergency evacuation per annum.
- Repatriation of mortal remains in Namibia or South Africa is covered if a member or a dependant receives pre-authorised treatment but subsequently passes away.

The benefit payment is subject to provision of the following documentation:
- Valid claim form to be completed.
- Certified copy of the death certificate of the insured.

Premium Waiver

The NHP Premium Waiver is an inclusive benefit that ensures dependants retain membership for 3 months after the passing of the principal member.

To qualify for benefits, the remaining dependant(s) must:
- Download and complete the required claim form by visiting NHP's website www.nhp.com.na and fax it to 061 230 465 or email to members@nhp.com.na.
- Submit a death certificate in respect of the deceased.
- Submit proof of paid up membership with the Fund.

Emergency Evacuation benefit

Definition of a medical emergency:
An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's life in serious jeopardy.

The Fund may make use of the services of any accredited locally registered emergency service provider with the appropriate infrastructure in place to provide adequate cover and peace of mind.

Please see inside back cover for medical emergency service providers.

International EMS Cover

Outside Namibian borders

NHP members will enjoy cover for medical emergencies, both by road and air evacuation, in Namibia, Botswana, Kenya, Lesotho, Malawi, Mozambique, South Africa, eSwatini, Tanzania, Zambia, Zimbabwe and Angola. In addition, members will also be covered for emergency medical evacuation in the event of a motor vehicle accident.

Members requiring emergency medical assistance should provide the following information at the time of requesting such assistance:

- Membership number
- Personal particulars
- The place and telephone number where the patient or his/her representative can be reached.
- A brief description of the emergency.
- The nature of the assistance required.

Non-emergency transfers must be pre-authorised by the Fund's medical service provider call centre prior to the transfer of the patient. An authorisation number will be allocated to the case and issued to the healthcare provider at the time of the request for transportation. Authorisation numbers will not be issued for cases where the member has already been transferred.

Transfer from the hospital to home qualifies as a non-emergency.

For further enquiries, please contact NHP Call Centre.

Funeral benefit - Optional

Underwritten by Sanlam Namibia

The last thing a member should worry about are the funeral expenses following a sudden illness. NHP members have the option to obtain funeral cover at a very competitive rate. The funeral cover is not part of the normal medical aid fund benefits.

The risk of this product is fully underwritten by a registered insurer as required by the Medical Aid and Insurance Acts.

Members must indicate whether funeral cover should apply just for them or include their dependant(s). The Funeral Cover monthly contribution will be additional to the normal monthly contributions.

Contact NHP offices to enquire about the available options.

Oncology Programme

Gold, Platinum, Titanium, Silver, Hospital

It will be to the members' advantage to contact the Managed Care department before starting any treatment, once diagnosed with cancer. Members will be required to submit the treatment plan, blood tests, x-ray report and histology report to the clinical team as all oncology treatment is subject to pre-authorisation and case management.

The Oncology Programme will not only help a member to manage the high costs associated with treatment, but members will receive help, support and education on their condition from the Oncology Case Manager.

By enrolling on the programme, members will qualify for the annual Oncology benefit limit. It will also ensure that healthcare services related to Oncology, such as the doctor's consultations, general and specialised radiology and pathology during follow-up visits to the doctor will be deducted from the member's Oncology benefit. By obtaining authorisation, members are also ensuring that their treatment is effectively managed within their available benefits.

In most cases, this limit will be sufficient to cover well-managed costs. If a treatment plan is rejected, the member will not have access to the oncology benefit limit, and all cancer-related claims, will be covered from the members' Day-to-Day benefit, if available.

The Oncology Case Manager will address any concerns with the treating oncologist.

Aid for AIDS (AfA) Programme

Acquired Immunodeficiency Syndrome (AIDS) is a chronic, potentially life-threatening condition caused by the Human Immunodeficiency Virus (HIV). By affecting the immune system, this virus interferes with the body's ability to fight organisms that cause infection and other diseases.

There is currently no cure for HIV/AIDS, but there is medicine available that can dramatically slow down the progression of the disease.

The AfA Programme is available to all members at no additional cost. All interaction between the members and the AfA Programme is kept strictly confidential in order to reassure the member that his/her status will remain confidential. The AfA Programme provides comprehensive benefits for the treatment of HIV/AIDS.

Registration

A member or dependent must register on the AfA Programme in order to qualify for benefits. A member must forward a clinical summary to the Fund. This summary must contain the relevant history, clinical findings, results of the HIV/AIDS diagnostic test as well as all the CD4 and viral load test results. Members must submit any additional test results that have a bearing on the clinical picture that impact the disease, e.g. tests including full blood counts, liver function tests and specimens sent for microscopy.

When on the AfA Programme, members can be assured that they are being looked after by a team that value and respect ones privacy.

Contact details

Tel: 061 285 5423
Email: info@afa.com.na
Postal: PO Box 5948, Ausspannplatz, Windhoek

An application form can be downloaded from the website www.nhp.com.na. The healthcare provider can also contact us directly on behalf of the member.

Beneficiary Risk Management (BRM) Programme

NHP has an effective BRM Programme in place, which offers its members active management of their health related conditions. The aim of this programme is to identify members who may be at possible risk due to lifestyle diseases and has as its sole purpose to assist our members in managing their health status and risks through the creation of greater awareness and possible lifestyle changes.

Many medical conditions can lead to life threatening complications that can be avoided with the appropriate treatment and advice, for example high cholesterol levels, which can lead to a number of cardiac related problems that can pose a serious health risk. By providing information and advice relating to nutrition, exercise and the importance of sticking to treatment guidelines and medication, the programme helps to manage these conditions effectively.

A team of qualified medical staff are available to discuss possible challenges and provide relevant information on medical conditions.

There is no need for members to apply for participation in the programme, as NHP will automatically identify members who fall within the specific risk parameters set by the Fund and contact them, as they would benefit from this support.

This programme is made available free of charge to all members. Member participation is voluntary and the member is under no obligation to participate. It would however be advantageous to decide to provide consent. Once the member gives his/her consent, members are provided with information regarding their condition and NHP will engage telephonically in order to schedule possible intervention.

Wellness Programme

NHP is uniquely positioned and well experienced in hosting and managing a customised Wellness Programme for the benefit of its members. The Wellness Programme consists of a team reaching out and hosting physical wellness events at various locations. In addition the Beneficiary Risk Management Programme is focused on identifying and engaging with high risk, high claiming chronically ill members with identified chronic lifestyle diseases in an effort to ensure greater adherence to treatment guidelines whilst reducing long terms risk exposure and costs for the Fund.

NHP will be responsible for initiating wellness events at employer groups. Members that participate at such events will be provided with a personalised feedback report. Various methods are used to encourage participation at such events. Members are provided with various levels of preventative healthcare communications and education with regards to prevention of preventable disease and conditions. Detailed depersonalised feedback and wellness reports are also provided to the employer.

Health Risk Assessments (HRA) provide an “early warning” for disease management while empowering the member to take responsibility for their health.

Health Risk Assessment (HRA) Incentive

Members on the Gold, Platinum, Titanium, Silver, Bronze and Hospital options may now qualify for the Health Risk Assessment (HRA) incentive through participation at any of the Fund’s wellness days or at a network pharmacy for an HRA to be done.

This benefit is limited to one (1) incentive per family per annum and will not be granted on a per beneficiary basis.

The maximum amount for which a member may qualify, in respect of the successful completion of a number of HRA’s per family, may not be more than the family benefit quoted below:

Option	Smart Saver benefit per family
Gold	N$ 1 050
Platinum	N$ 1 050
Titanium	N$ 785
Silver	N$ 785
Bronze	N$ 525
Hospital	N$ 525
Blue Diamond	No benefit
Litunga	No benefit

Effectiveness is ensured as follows:

- All HRA data is submitted to Medscheme's Electronic Health Record providing the member with a report on their health risks and recommended actions to be taken. It also provides a view of the health risks associated with the member and their willingness to change.
- Any individual identified as "at risk" during the screening process (HRA) is contacted, provided with information on how to access the appropriate Fund programmes (e.g. register on the chronic medicine programme) and is referred to their family practitioner. Where specific risks (e.g. obesity, cardiac risks) are identified (a clinical algorithm forms part of the HRA) the member may also be referred to a biokineticist for a targeted lifestyle intervention (subject to available benefits). All data collected is used in profiling in the ongoing risk stratification process.NHP's approach towards preventative care is to proactively manage the health of its members by increasing access to comprehensive health risk assessments (HRA's) that focus on physical screening components, providing personalised health education and providing on-site wellness interventions.

The Administrator, Medscheme Namibia facilitates on-site wellness days that include logistical requirements; coordinate pre-planning meetings; ensure the deployment of sufficient suitably trained healthcare professionals (qualified nurses); co-ordinate the delivery of consumables; setting up of clinical screening stations at the agreed venue.

Medscheme Namibia contracts a nursing agency to provide clinical staff to administer the clinical screening tests i.e. blood pressure, glucose, cholesterol and body mass index and to educate "at-risk" employees on applicable health topics thereby empowering them to manage their health. Educational material on the management and the prevention of chronic disease is available to all participants.

Using evidence-based algorithms, at risk beneficiaries are identified using results from the health risks assessments. These individuals, who have multiple and complex co-morbidities are managed through the Beneficiary Risk Management programme where a care manager (registered nurse) carefully coordinates best medical care.

The objectives of these health risk assessments are:

- To make the member aware of the importance of early identification of common risk factors that could be managed through lifestyle intervention or improved through therapy.
- The long-term reduction in end-stage organ damage and morbidities.

Contact the Wellness team at 061 285 5437 or wellness@nhp.com.na for more information.

Back and Neck Rehabilitation Programme

This benefit is applicable to members on all benefit options (including the Blue Diamond and Litunga benefit options) and further subject to application and pre-authorisation. The benefit is intended to fund the cost of Document Based Care (DBC) conservative treatment for chronic back and neck ailments.

Access to this benefit is limited to the identification processes below:

- Referral by the treating general practitioner or specialist of eligible members who would benefit from the DBC Back and Neck Programme, as opposed to surgery in the first instance and post-surgical rehabilitation.
- Pre-emptive identification of eligible beneficiaries.
- Pre-emptive identification through requests for hospital authorisation relating to surgery.
- Identification of eligible employee as part of Wellness Day screenings, with subsequent referral to the DBC Programme.

The benefit makes provision for consultations by the General Practitioner and treatment by the Physiotherapist and Biokineticist.

The treatment protocol includes:

- Initial assessment
- 1st Cycle of treatment sessions and interim assessment by a medical doctor.
- 2nd Cycle of treatment sessions and re-assessment by a medical doctor.
- Bi-monthly maintenance sessions, if approved.

This conservative treatment is funded from the Major Medical Expense risk benefit and not from Day-to-Day benefits, since this programme offers conservative treatment for back and neck related conditions.

We're about you

Emergency numbers

EVACUATION/AMBULANCE PROVIDERS NAMIBIA

Main area of coverage	Emergency evacuation provider	Contact number/s
All major centres & air ambulance evacuation countrywide	Lifelink Emergency Services Medical Rescue Africa (MRA)	999 (from any landline) / 064 500 346 Nationally: 912 Internationally: +264 8333 900 33 / +264 81 129 4973
All major centres countrywide	E-Med Rescue 24	081 924 / 083 924 061 411 600 / Toll Free 924
Coast (Arandis, Walvis Bay, Swakopund & Henties Bay)	St. Gabriel Community Ambulance Trust Code Red Medical Services	085 955 / 081 124 5999 085 9900 / 085 705 8940 (from cell)
Eenhana	Intensive Therapy Unit Ambulance Services	081 444 7807
Grootfontein	Ohangwena Private Ambulance Services	081 9797 / 081 571 2695 / 067 241 091
International travel only	International SOS Namibia	081 129 3137
Katima Mulilo	Ohangwena Private Ambulance Services Enkehaus Private Hospital - Ambulance Service	081 9797 / 081 571 2695 / 067 241 091 061 302 931 / 085 718 3525
Long distance countrywide	Intensive Therapy Unit Ambulance Services Crisis Respone	081 444 7807 081 881 8181 / 061 303 395 / 083 3912
Mercy flights countrywide	MR 24/7 Crisis Response	085 956 / 061 255 676 / 081 257 1810 081 881 8181 / 061 303 395 / 083 3912
Okahandja	Emergency Assist 991 Lifeline Medical Rescue Cc	Toll Free 987 081 222 9810
Okahandja and surrounding areas	Okahandja Paramedical Services	987
Ondangwa & countrywide	Ondangwa Ambulance Services	081 902 00 / 081 237 5437
Otjiwarongo	MR 24/7	085 956 / 061 255 676 / 081 257 1810
Outapi, Oshakati & surrounding areas	Outapi Ambulance	065 251 022 / 061 251 800
Outapi, Ongwediva, Ondangwa	Namibia Private Ambulance Services	081 9696
Rehoboth	Elite Emergency Rescue Services	081 450 9333
Rosh Pinah	Roshcare Clinic Ambulance Services Life Employee Health Solution Namibia / Sidadi Clinic	063 274 911 / 063 274 918 / 081 161 8734
Rundu	Namibia Private Ambulance Services	081 9696
Tsumeb	MR 24/7 Ohangwena Private Ambulance Services	085 956 / 061 255 676 / 081 257 1810 081 9797 / 081 571 2695 / 067 241 091
Windhoek & surrounding areas	AEMS Ambulance Services City of Windhoek Emergency Services Crisis Response MR 24/7 Ohangwena Private Ambulance Services	081 963 / 061 300 118 061 211 111 081 881 8181 / 061 303 395 / 083 3912 085 956 / 061 255 676 / 081 257 1810 081 9797 / 081 571 2695 / 067 241 091

Contact details

GET IN TOUCH

Head office: Windhoek
Tel: 061 285 5400
Website: www.nhp.com.na
Walk-in assistance: Unit 2, Demushuwa Suites,
C/o Grove and Ombika Streets, Kleine Kuppe
Postal: PO Box 23064, Windhoek
Operating hours: Monday to Friday 07:45 - 17:00

Fraud hotline - Confidential
Tel: 0800 647 000
Email: fraud@medscheme.com.na

NHP emergency numbers
(Monday to Sunday until 22:00)
After hours: 081 372 9910
In-hospital: 081 145 8580

BRANCHES

Swakopmund
Tel: 064 405 714
Email: swakop@nhp.com.na
Walk-in assistance: Office number 2,1st floor,
Food Lovers Market, 50 Moses Garoeb Street
Postal: PO Box 2081, Swakopmund

Walvis Bay
Tel: 064 205 534
Email: walvis@nhp.com.na
Walk-in assistance: Office No. 7, Welwitschia Hospital Centre
Postal: PO Box 653, Walvis Bay

Ongwediva
Tel: 065 238 950
Email: oshakati@nhp.com.na
Walk-in assistance: Unit 1, Central Park (opposite Medipark),
Auguste Tanyaanda Street
Postal: PO Box 23064, Windhoek

Keetmanshoop
Tel: 063 225 141
Email: keetmans@nhp.com.na
Walk-in assistance: Unit 12, No. 17, Hampie Plichta Street,
Desert Plaza
Postal: PO Box 1541, Keetmanshoop

DEDICATED

Aid for AIDS (AfA) Programme
Tel: 061 285 5423
Email: info@afa.com.na

DEDICATED

Oncology Disease Management Programme
Tel: 061 285 5422
Email: oncology@nhp.com.na

Wellness
Tel: 061 285 5437
Email: wellness@nhp.com.na

CLINICAL RISK

Chronic Medicine Management
Tel: 061 285 5417
Email: chronicapp@nhp.com.na

Beneficiary Risk Management
Tel: 061 285 5417
Email: nhpbrm@nhp.com.na

SUPPORT

Membership
(Applications, contributions and amendments)
Tel: 061 285 5400
Email: members@nhp.com.na

Ex-Gratia
Email: exgratia@nhp.com.na

Optical
Email: optics@nhp.com.na

Claims
Tel: 061 285 5400
Email: claims@nhp.com.na

Hospital pre-authorisation
Tel: 061 285 5400
Email: cases@nhp.com.na

International Travel Insurance
Tel: 061 285 5400
Email: nhptravel@nhp.com.na

New business
Tel: 061 285 5407
Email: newbusiness@nhp.com.na

Healthcare providers
Tel: 061 285 5444
Email: providers@nhp.com.na