Benefit Guide 2025

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pmr .africa

Diamond Arrow Award

Highest rated medical aid in Namibia 2010 - 2024

Administered by

Medscheme Namibia

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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 2025, 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 2025 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 15th consecutive year (2010 to 2024).

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 39 338 principal members providing healthcare benefits to over 80 943 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 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 medschemenamibia@whistleblowing.co.za

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!

WHISTLE BLOWERS
Fraud Hotline: 0800 647 000 or
email medschemenamibia@whistleblowing.co.za

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.

- Flu vaccines are covered as part of the preventative care benefit.
- 1 COVID-19 vaccine regimen per year are 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$268 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$919 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$7 350 per lens. Refer to 3.7.
- Blood pressure monitor: N$850 per family every 3 years. Subject to registration on the Fund's 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:
  - 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;
  - Any of the preventative care benefits offered by the Fund by a qualifying beneficiary.
- Contribution tables on page 11.

Gold

Major Medical Expenses: **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 chronic care programme	80%				Subject to registration on Chronic Care programme
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	Accomodation: Private wards	100%	30 240		61 215	
3.6	Accomodation other than a recognised hospital or medical institution: SA only	100%			919 per day	
3.7	Appliances and prosthesis: Surgical	100%	84 315		136 500	
3.8	Refractive surgery: Full procedure - A waiting period of 12 months will apply	100%	36 120		44 625	
3.9	Organ transplants: Full procedure	100%			761 250	
3.10	Private nursing	100%	81 795		81 795	
3.11	Oncology	100%			1 000 000	
4.	**Radiology**					**SPA**
4.1	Radiology: Specialised MRI and CT scans - In-and-out of hospital combined	100%			47 775	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%			73 815	
6.2	Maxillo facial surgery: Non-elective only	100%				
6.3	Dental Implants					OAL
6.3.1	Hospitalisation	100%			21 420	
6.3.2	Implant: Consultation, Procedure and cost	100%			23 100	4 630 per implant
7.	**Psychiatric treatment**		**42 000**		**72 240**	**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**			**60 165**		**OAL**
10.1	HIV/AIDS: Including the cost of pathology tests	100%				SPA
10.2	Sexually transmitted diseases	100%	7 550		10 143	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%	5 397	5 397		
11.4	Other transportation	80%				
12.	**Artificial limbs or eyes**					**SPA**
12.1	Artificial limbs	100%		78 015		
12.2	Artificial eyes	100%		31 185		
13.	**Heart surgery: Rehabilitation**	100%			**26 040**	**OAL**
14.	**Insertion Mirena Device: All Inclusive - Every 3 years**	100%		**7 770**		**OAL**
15.	**Stoma Care products**	100%			**36 435**	**OAL**
16.	**Back and Neck Rehabilitation Programme**	100%	**Subject to DBC protocol**			**OAL**

Gold

Day-to-Day Expenses: **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**		**20 055**	**5 460**		
1.1	Consultations or visits: Out-of-hospital	100%	Unlimited: 5 VC	Unlimited: 5 VC		
1.1.1	Consultations or visits: Out-of-hospital: When healthcare provider or medical specialists benefit has been depleted	100%		1		Subject to registration on Chronic Care programme
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		11 655	6 773		
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 actute medicine limit	100%	2 153	536		268 per claim
2.1.4	Vitamins, homeopathic, chinese medicine and phytotherapy medicines - Min levy of N$30 Subject to acute medicine limit	80%	1 155	315		268 per claim
3.	**Dentistry**		**24 045**		**47 670**	
3.1	Basic dentistry: Subject to sub-limit	100%	13 545	4 641		
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**		**7 266**	**2 709**		
4.1	Eye tests	100%				
4.2	Spectacles or lenses: Frames every 2nd year	100%				Frame limited to 2 625
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; 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	Physiotherapy	100%		15 Visits		5 VC
5.8	Biokinetics	100%		15 Visits		5 VC
5.9	Audiology or speech therapy	100%		15 Visits		5 VC
5.10	Chiropractic	100%		15 Visits		5 VC
5.11	Podiatry	100%		15 Visits		5 VC
5.12	Chinese medicine and acupuncture visits	100%		15 Visits		5 VC
6.	**Appliances: Non-surgical**	**100%**		**OAL**		**SPA**
6.1	Wheelchair - every 3 years		22 000		33 000	
6.2	Hearing aid - every 3 years		45 000		67 500	22 500 per ear
6.3	Other external appliances		15 000		22 500	
7.	**Diabetic Devices Benefit**					**OAL**
7.1	Insulin Pumps / Glucose Monitoring System / Glucose Reader	80%			48 615	
7.2	Diabetes related Consumables for Insulin Pumps / Glucose Monitoring System / Glucose Reader	80%	60 000	60 000		
8.	**Smart Saver benefit**					
8.1	Health Risk Assessment	100%			1 103	
8.2	Preventative Care Incentives	100%	163	163		
9.	**Roll-Over Benefit**	**100%**	**8 770**	**2 240**	**2 240**	

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

Platinum

Major Medical Expenses: **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%				Subject to registration on Chronic Care programme
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	Accomodation: Private wards	100%	19 110		38 535	
3.6	Accomodation other than a recognised hospital or medical institution: SA only	100%			919 per day	
3.7	Appliances and prosthesis: Surgical	100%	75 915		90 720	
3.8	Refractive surgery: Full procedure - A waiting period of 12 months will apply	100%	27 405		36 120	
3.9	Organ transplants: Full procedure	100%			376 950	
3.10	Private nursing	100%	56 805		56 805	
3.11	Oncology	100%			800 000	
4.	**Radiology**					**SPA**
4.1	Radiology: Specialised MRI and CT scans - In-and-out of hospital combined	100%			41 475	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%			66 255	
6.2	Maxillo facial surgery: Non-elective only	100%				
6.3	Dental Implants					OAL
6.3.1	Hospitalisation	100%			15 645	
6.3.2	Implant: Consultation, Procedure and cost	100%			17 745	4 630 per implant
7.	**Psychiatric treatment**		**34 500**		**57 750**	**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**			**60 165**		**OAL**
10.1	HIV/AIDS: Including the cost of pathology tests	100%				SPA
10.2	Sexually transmitted diseases	100%	5 660		7 550	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%	5 397	5 397		
11.4	Other transportation	80%				
12.	**Artificial limbs or eyes**					**SPA**
12.1	Artificial limbs	100%		54 600		
12.2	Artificial eyes	100%		27 405		
13.	**Heart surgery: Rehabilitation**	**100%**			**21 840**	**OAL**
14.	**Insertion Mirena Device: All Inclusive - Every 3 years**	**100%**		**7 770**		**OAL**
15.	**Stoma Care products**	**100%**			**36 435**	**OAL**
16.	**Back and Neck Rehabilitation Programme**	**100%**	**Subject to DBC protocol**			**OAL**

Platinum

Day-to-Day Expenses: **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**		**16 905**	**3 518**		
1.1	Consultations or visits: Out-of-hospital	100%	Unlimited: 5 VC	Unlimited: 5 VC		
1.1.1	Consultations or visits: Out-of-hospital: When healthcare provider or medical specialists benefit has been depleted	100%		1		Subject to registration on Chronic Care programme
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 actute medicine limit	100%	1 790	300		268 per claim
2.1.4	Vitamins, homeopathic, chinese medicine and phytotherapy medicines - Min levy of N$30 Subject to acute medicine limit	80%	855	250		268 per claim
3.	**Dentistry**		**17 430**		**31 710**	
3.1	Basic dentistry: Subject to sub-limit	100%	9 503	2 184		
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**		**6 384**	**1 596**		
4.1	Eye tests	100%				
4.2	Spectacles or lenses: Frames every 2nd year	100%				Frame limited to 2 268
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; 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	Physiotherapy	100%		15 Visits		5 VC
5.8	Biokinetics	100%		15 Visits		5 VC
5.9	Audiology or speech therapy	100%		15 Visits		5 VC
5.10	Chiropractic	100%		15 Visits		5 VC
5.11	Podiatry	100%		15 Visits		5 VC
5.12	Chinese medicine and acupuncture visits	100%		15 Visits		5 VC
6.	**Appliances: Non-surgical**	**100%**	**OAL**		**OAL**	**SPA**
6.1	Wheelchair - every 3 years		18 000		27 000	
6.2	Hearing aid - every 3 years		37 500		56 250	18 750 per ear
6.3	Other external appliances		10 000		15 000	
7.	**Diabetic Devices Benefit**					**OAL**
7.1	Insulin Pumps / Glucose Monitoring System / Glucose Reader	80%			45 780	
7.2	Diabetes related Consumables for Insulin Pumps / Glucose Monitoring System / Glucose Reader	80%	55 000	55 000		
8.	**Smart Saver benefit**					
8.1	Health Risk Assessment	100%			1 103	
8.2	Preventative Care Incentives	100%	163	163		
9.	**Roll-Over Benefit**	**100%**	**6 630**	**1 700**	**1 700**	

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

Titanium

Major Medical Expenses: **Limit per category**		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Overall Annual Limit (OAL)			**1 701 000**		**2 541 000**	
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%				Subject to registration on Chronic Care programme
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	Accomodation: Private wards	100%	13 230		25 935	
3.6	Accomodation other than a recognised hospital or medical institution: SA only	100%			919 per day	
3.7	Appliances and prosthesis: Surgical	100%	58 905		68 040	
3.8	Refractive surgery: Full procedure - A waiting period of 12 months will apply	100%	12 000		14 500	
3.9	Organ transplants: Full procedure	100%			127 050	
3.10	Private nursing	100%	30 870		30 870	
3.11	Oncology	100%			676 200	
4.	**Radiology**					**SPA**
4.1	Radiology: Specialised MRI and CT scans - In-and-out of hospital combined	100%			24 465	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%			58 800	
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**		**29 500**		**48 195**	**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**			**44 940**		**OAL**
10.1	HIV/AIDS: Including the cost of pathology tests	100%				SPA
10.2	Sexually transmitted diseases	100%	3 885		5 135	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%	5 397	5 397		
11.4	Other transportation	80%				
12.	**Artificial limbs or eyes**					**SPA**
12.1	Artificial limbs	100%		31 185		
12.2	Artificial eyes	100%		15 645		
13.	**Heart surgery: Rehabilitation**	**100%**			**18 900**	**OAL**
14.	**Insertion Mirena Device: All Inclusive - Every 3 years**	**100%**		**7 770**		**OAL**
15.	**Stoma Care products**	**100%**			**36 435**	**OAL**
16.	**Back and Neck Rehabilitation Programme**	**100%**	**Subject to DBC protocol**			**OAL**

Titanium

Day-to-Day Expenses: **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**		**10 206**	**2 216**		
1.1	Consultations or visits: Out-of-hospital	100%	Unlimited: 5 VC	Unlimited: 5 VC		
1.1.1	Consultations or visits: Out-of-hospital: When healthcare provider or medical specialists benefit has been depleted	100%		1		Subject to registration on Chronic Care programme
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 actute medicine limit	100%	1 220	240		268 per claim
2.1.4	Vitamins, homeopathic, chinese medicine and phytotherapy medicines - Min levy of N$30 Subject to acute medicine limit	80%	675	220		268 per claim
3.	**Dentistry**		**12 180**		**21 945**	
3.1	Basic dentistry: Subject to sub-limit	100%	6 930	1 733		
3.2	Dental technicians	100%				
3.3	Advanced dentistry					
3.3.1	Orthodontics	100%				
3.3.2	Dental implants: Full procedure	100%				
4.	**Optical**		**4 242**	**1 271**		
4.1	Eye tests	100%				
4.2	Spectacles or lenses: Frames every 2nd year	100%				Frame limited to 1 533
4.3	Orthoptics	100%				
5.	**Auxiliary services**		**13 755**	**767**		
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	Physiotherapy	100%		15 Visits		5 VC
5.8	Biokinetics	100%		15 Visits		5 VC
5.9	Audiology or speech therapy	100%		15 Visits		5 VC
5.10	Chiropractic	100%		15 Visits		5 VC
5.11	Podiatry	100%		15 Visits		5 VC
5.12	Chinese medicine and acupuncture visits	100%		15 Visits		5 VC
6.	**Appliances: Non-surgical**	**100%**	**OAL**		**OAL**	**SPA**
6.1	Wheelchair - every 3 years		10 500		15 750	
6.2	Hearing aid- every 3 years		30 000		45 000	15 000 per ear
6.3	Other external appliances		7 500		11 250	
7.	**Diabetic Devices Benefit**					**OAL**
7.1	Insulin Pumps / Glucose Monitoring System / Glucose Reader	80%			40 005	
7.2	Diabetes related Consumables for Insulin Pumps / Glucose Monitoring System / Glucose Reader	80%	50 000	50 000		
8.	**Smart Saver benefit**					
8.1	Health Risk Assessment	100%			824	
8.2	Preventative Care Incentives	100%	110	110		
9.	**Roll-Over Benefit**	**100%**	**4 460**	**920**	**920**	

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

Roll-Over benefit	
For diligent management of your healthcare expenditure	
Principal	8 770
Adult/Spec dep	2 240
Child	2 240
Example of Roll-Over benefit (Principal member + spouse + 2 children) per year	= 15 490

Spec dep = Special dependant

GOLD

Group Rates				Individual Rates			
Age	**Principal**	**Adult/ spec dep**	**Child dep**	**Age**	**Principal**	**Adult/ spec dep**	**Child dep**
0 - 25	4 159	3 109	1 728	0 - 25	5 060	3 929	2 057
26 - 30	4 729	3 816	1 728	26 - 30	5 683	4 776	2 057
31 - 35	5 177	4 247	1 728	31 - 35	6 365	5 239	2 057
36 - 40	6 012	5 100	1 728	36 - 40	7 416	6 532	2 057
41 - 45	6 516	5 741	1 728	41 - 45	7 913	7 134	2 057
46 - 50	6 868	5 967	1 728	46 - 50	8 536	7 452	2 057
51 - 55	7 104	6 299	1 728	51 - 55	8 830	7 867	2 057
56 - 60	7 467	6 548	1 728	56 - 60	9 252	8 299	2 057
61 - 65	8 309	7 082	1 728	61 - 65	10 486	9 051	2 057
66+	8 637	7 289	1 728	66+	10 961	9 401	2 057

Roll-Over benefit	
For diligent management of your healthcare expenditure	
Principal	6 630
Adult/Spec dep	1 700
Child	1 700
Example of Roll-Over benefit (Principal member + spouse + 2 children) per year	= 11 730

Spec dep = Special dependant

PLATINUM

Group Rates				Individual Rates			
Age	**Principal**	**Adult/ spec dep**	**Child dep**	**Age**	**Principal**	**Adult/ spec dep**	**Child dep**
0 - 25	3 500	2 585	1 315	0 - 25	3 963	3 221	1 705
26 - 30	3 847	2 818	1 315	26 - 30	4 453	3 717	1 705
31 - 35	4 144	2 997	1 315	31 - 35	5 046	4 531	1 705
36 - 40	4 666	3 443	1 315	36 - 40	5 581	4 937	1 705
41 - 45	5 121	3 964	1 315	41 - 45	6 211	5 479	1 705
46 - 50	5 566	4 185	1 315	46 - 50	6 753	5 846	1 705
51 - 55	5 924	4 757	1 315	51 - 55	7 392	6 356	1 705
56 - 60	6 393	5 436	1 315	56 - 60	7 888	6 603	1 705
61 - 65	6 653	5 850	1 315	61 - 65	8 370	7 055	1 705
66+	7 192	6 142	1 315	66+	9 327	8 049	1 705

Roll-Over benefit	
For diligent management of your healthcare expenditure	
Principal	4 460
Adult/Spec dep	920
Child	920
Example of Roll-Over benefit (Principal member + spouse + 2 children) per year	= 7 220

Spec dep = Special dependant

TITANIUM

Group Rates				Individual Rates			
Age	**Principal**	**Adult/ spec dep**	**Child dep**	**Age**	**Principal**	**Adult/ spec dep**	**Child dep**
0 - 25	2 990	1 844	984	0 - 25	3 290	2 222	1 189
26 - 30	3 217	2 175	984	26 - 30	3 616	2 578	1 189
31 - 35	3 552	2 259	984	31 - 35	4 066	3 013	1 189
36 - 40	3 876	2 491	984	36 - 40	4 548	3 366	1 189
41 - 45	4 279	2 814	984	41 - 45	4 942	3 801	1 189
46 - 50	4 557	3 015	984	46 - 50	5 300	4 089	1 189
51 - 55	4 800	3 393	984	51 - 55	5 546	4 349	1 189
56 - 60	5 215	3 613	984	56 - 60	6 150	4 703	1 189
61 - 65	5 595	4 376	984	61 - 65	6 501	5 131	1 189
66+	6 228	4 595	984	66+	6 979	5 331	1 189

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.

- Flu vaccines are covered as part of the preventative care benefit.
- 1 COVID-19 vaccine regimen per year are 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$268 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$919 per night, maximum of 2 nights per family per annum.
- No basic dentistry will be covered under the oral surgery benefit.
- All day-to-day benefits are subject to availability of pooled Day-to-Day Expenses.
- Intra ocular lenses included in Appliances and prosthesis surgical benefit - limited to N$7 350 per lens. Refer to 3.7.
- Blood pressure monitor: N$850 per family every 3 years. Subject to registration on the Fund's 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:
  - 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;
  - Any of the preventative care benefits offered by the Fund by a qualifying beneficiary.
- Contribution tables on page 17.

Silver

Major Medical Expenses: Limit per category		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Overall Annual Limit (OAL)			**1 500 000**		**2 131 500**	
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%				Subject to registration on Chronic Care programme
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	Accomodation: Private wards	100%	13 230		25 935	
3.6	Accomodation other than a recognised hospital or medical institution: SA only	100%			919 per day	
3.7	Appliances and prosthesis: Surgical	100%	58 905		68 040	
3.8	Refractive surgery: Full procedure - A waiting period of 12 months will apply	100%	12 000		14 500	
3.9	Organ transplants: Full procedure	100%			127 050	
3.10	Private nursing	100%	30 870		30 870	
3.11	Oncology	100%			676 200	
4.	**Radiology**					**SPA**
4.1	Radiology: Specialised MRI and CT scans - In-and-out of hospital combined	100%			24 465	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%			58 800	
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**		**29 500**		**48 195**	**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**			**44 940**		**OAL**
10.1	HIV/AIDS: Including the cost of pathology tests	100%				SPA
10.2	Sexually transmitted diseases	100%	3 885		5 135	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%	5 397	5 397		
11.4	Other transportation	80%				
12.	**Artificial limbs or eyes**					**SPA**
12.1	Artificial limbs	100%		31 185		
12.2	Artificial eyes	100%		15 645		
13.	**Heart surgery: Rehabilitation**	**100%**			**18 900**	**OAL**
14.	**Insertion Mirena Device: All Inclusive - Every 3 years**	**100%**		**7 770**		**OAL**
15.	**Stoma Care products**	**100%**			**36 435**	**OAL**
16.	**Back and Neck Rehabilitation Programme**	**100%**	**Subject to DBC protocol**			**OAL**

Silver

Day-to-Day Expenses: **Limit per category**		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Out-of-hospital: Sub-limit			**19 740**	**4 095**		**OAL**
1.	**Healthcare provider or medical specialists**					
1.1	Consultations or visits: Out-of-hospital	100%	5 VC	5 VC		
1.1.1	Consultations or visits: Out-of-hospital: When day-to-day benefit has been depleted	100%		1		Subject to registration on Chronic Care programme
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 actute medicine limit	100%	1 271	252		268 per claim
2.1.4	Vitamins, homeopathic, chinese medicine and phytotherapy medicines - Min levy of N$30 Subject to acute medicine limit	80%	625	221		268 per claim
3.	**Dentistry**		**10 920**		**21 630**	
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**		**3 749**	**940**		
4.1	Eye tests	100%				
4.2	Spectacles or lenses: Frames every 2nd year	100%				Frame limited to 1 439
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	Physiotherapy	100%		15 Visits		5 VC
5.8	Biokinetics	100%		15 Visits		5 VC
5.9	Audiology or speech therapy	100%		15 Visits		5 VC
5.10	Chiropractic	100%		15 Visits		5 VC
5.11	Podiatry	100%		15 Visits		5 VC
5.12	Chinese medicine and acupuncture visits	100%		15 Visits		5 VC
6.	**Appliances: Non-surgical**	**100%**	**OAL**		**OAL**	**SPA**
6.1	Wheelchair - every 3 years		6 000		9 000	
6.2	Hearing aid - every 3 years		27 500		41 250	13 750 per ear
6.3	Other external appliances		5 000		7 500	
7.	**Smart Saver benefit**					
7.1	Health Risk Assessment	100%			824	
7.2	Preventative Care Incentives	100%	110	110		
8.	**Roll-Over Benefit**	**100%**	**4 460**	**920**	**920**	

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

Bronze

Major Medical Expenses: Limit per category		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Overall Annual Limit (OAL)			**750 000**		**1 100 000**	
1.	**Healthcare provider or medical specialists**					**SPA**
1.1	Consultations or visits: In-hospital	150%				
1.2	Procedures: In-hospital	150%				
2.	**Chronic medicine**		**4 683**		**7 445**	
2.1	Chronic medicine approved - Min levy of N$ 30: Subject to prior registration on chronic care programme	80%				Subject to registration on Chronic Care programme
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	Accomodation: Private wards	100%	6 678		13 335	
3.6	Accomodation other than a recognised hospital or medical institution: SA only	100%			919 per day	
3.7	Appliances and prosthesis: Surgical	100%	25 410		51 135	
3.8	Refractive surgery: Full procedure - A waiting period of 12 months will apply	No benefit				
3.9	Organ transplants: Full procedure	100%			95 235	
3.10	Private nursing	100%			13 965	
3.11	Oncology	No benefit				
4.	**Radiology**					**SPA**
4.1	Radiology: Specialised MRI and CT scans - In-and-out of hospital combined	100%			20 160	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%			44 310	
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**		**21 000**		**33 390**	**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**			**33 495**	**67 935**	**OAL**
10.1	HIV/AIDS: Including the cost of pathology tests	100%				SPA
10.2	Sexually transmitted diseases	100%			1 722	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%	5 397	5 397		
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%**		**7 770**		**OAL**
15.	**Stoma Care products**	**100%**			**36 435**	**OAL**
16.	**Back and Neck Rehabilitation Programme**	**100%**	**Subject to DBC protocol**			**OAL**

Bronze

Day-to-Day Expenses: **Limit per category**		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Out-of-hospital: Sub-limit			**7 560**	**2 520**		**OAL**
1.	**Healthcare provider or medical specialists**					
1.1	Consultations or visits: Out-of-hospital	100%	5 VC	5 VC		
1.1.1	Consultations or visits: Out-of-hospital: When day-to-day benefit has been depleted	100%		1		Subject to registration on Chronic Care programme
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 actute medicine limit	100%	1 008	173		268 per claim
2.1.4	Vitamins, homeopathic, chinese medicine and phytotherapy medicines - Min levy of N$30 Subject to acute medicine limit	80%	452	142		268 per claim
3.	**Dentistry**		**3 500**		**6 500**	
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**		**2 615**	**646**		
4.1	Eye tests	100%				
4.2	Spectacles or lenses: Frames every 2nd year	100%				Frame limited to 1 292
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
5.13	Chinese medicine and acupuncture visits	100%		15 Visits		5 VC
6.	**Smart Saver benefit**					
6.1	Health Risk Assessment	100%			551	
6.2	Preventative Care Incentives	100%	84	84		
7.	**Roll-Over Benefit**	**100%**	**2 310**	**470**	**470**	

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

Roll-Over benefit	
For diligent management of your healthcare expenditure	
Principal	4 460
Adult/Spec dep	920
Child	920
Example of Roll-Over benefit (Principal member + spouse + 2 children) per year	= 7 220

Spec dep = Special dependant

SILVER

Group Rates				Individual Rates			
Age	**Principal**	**Adult/ spec dep**	**Child dep**	**Age**	**Principal**	**Adult/ spec dep**	**Child dep**
0 - 25	2 673	1 651	883	0 - 25	2 946	1 987	1 063
26 - 30	2 879	1 943	883	26 - 30	3 242	2 307	1 063
31 - 35	3 178	2 025	883	31 - 35	3 641	2 698	1 063
36 - 40	3 467	2 226	883	36 - 40	4 072	3 012	1 063
41 - 45	3 828	2 516	883	41 - 45	4 429	3 404	1 063
46 - 50	4 076	2 698	883	46 - 50	4 746	3 661	1 063
51 - 55	4 298	3 034	883	51 - 55	4 967	3 895	1 063
56 - 60	4 668	3 230	883	56 - 60	5 507	4 214	1 063
61 - 65	5 007	3 915	883	61 - 65	5 822	4 594	1 063
66+	5 574	4 112	883	66+	6 248	4 773	1 063

Roll-Over benefit	
For diligent management of your healthcare expenditure	
Principal	2 310
Adult/Spec dep	470
Child	470
Example of Roll-Over benefit (Principal member + spouse + 2 children) per year	= 3 720

Spec dep = Special dependant

BRONZE

Group Rates				Individual Rates			
Age	**Principal**	**Adult/ spec dep**	**Child dep**	**Age**	**Principal**	**Adult/ spec dep**	**Child dep**
0 - 25	1 952	1 174	680	0 - 25	2 098	1 278	749
26 - 30	2 041	1 288	680	26 - 30	2 215	1 411	749
31 - 35	2 123	1 374	680	31 - 35	2 330	1 583	749
36 - 40	2 211	1 489	680	36 - 40	2 440	1 749	749
41 - 45	2 410	1 565	680	41 - 45	2 667	1 891	749
46 - 50	2 445	1 610	680	46 - 50	2 693	1 972	749
51 - 55	2 569	1 725	680	51 - 55	2 838	2 114	749
56 - 60	2 681	1 819	680	56 - 60	3 003	2 152	749
61 - 65	3 264	2 010	680	61 - 65	3 704	2 371	749
66+	3 605	2 090	680	66+	4 242	2 582	749

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.

- No Day-to-Day Expenses are available.
- 1 COVID-19 vaccine regimen per year are 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 dependant 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$ 919 per night, maximum of 2 nights per family per annum.
- Intra ocular lenses included in Appliances and prosthesis surgical benefit - limited to N$7 350 per lens. Refer to 3.7.
- Contribution tables on page 20.

Hospital

Major Medical Expenses: Limit per category		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Overall Annual Limit (OAL)			**1 800 000**		**2 971 500**	
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	Accomodation: Private wards	100%	13 965		27 720	
3.6	Accomodation other than a recognised hospital or medical institution: SA only	100%			919 per day	
3.7	Appliances and prosthesis: Surgical	100%	30 240		61 215	
3.8	Refractive surgery: Full procedure - A waiting period of 12 months will apply	100%	12 000		14 500	
3.9	Organ transplants: Full procedure	100%			127 050	
3.10	Private nursing	100%	25 515		25 515	
3.11	Oncology	100%			712 950	
4.	**Radiology**					**SPA**
4.1	Radiology: Specialised MRI and CT scans - In-and-out of hospital combined	100%			24 465	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%			58 800	
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**		**29 500**		**48 195**	**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: COVID-19	100%				
9.2	Health Risk Assessment	100%				
10.	**Specified illness conditions**			**23 835**		**OAL**
10.1	HIV/AIDS: Including the cost of pathology tests	100%				SPA
10.2	Sexually transmitted diseases	100%	3 885		5 135	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%	5 397	5 397		
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%**			**18 900**	
14.	**Insertion Mirena Device: All Inclusive - Every 3 years**	**100%**		**7 770**		**OAL**
15.	**Stoma Care products**	**100%**			**36 435**	**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 VC = Virtual Consultations

Hospital

Day-to-Day Expenses: **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				
1.2	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 actute medicine limit	No benefit				
2.1.4	Vitamins, homeopathic, chinese medicine 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				
5.13	Chinese medicine and acupuncture visits	No benefit				
6.	**Smart Saver benefit**					
6.1	Health Risk Assessment	100%			551	
7.	**Roll-Over Benefit**	**No benefit**				

HOSPITAL

Group Rates				Individual Rates			
Age	**Principal**	**Adult/ spec dep**	**Child dep**	**Age**	**Principal**	**Adult/ spec dep**	**Child dep**
0 - 25	1 716	753	463	0 - 25	1 751	801	511
26 - 30	1 872	867	463	26 - 30	1 904	1 017	511
31 - 35	2 051	1 058	463	31 - 35	2 123	1 175	511
36 - 40	2 222	1 264	463	36 - 40	2 311	1 400	511
41 - 45	2 369	1 460	463	41 - 45	2 477	1 602	511
46 - 50	2 515	1 574	463	46 - 50	2 658	1 719	511
51 - 55	2 615	1 659	463	51 - 55	2 807	1 843	511
56 - 60	2 765	1 838	463	56 - 60	2 951	2 031	511
61 - 65	2 912	1 985	463	61 - 65	3 161	2 228	511
66+	3 239	2 048	463	66+	3 604	2 321	511

Spec dep = Special dependant

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.

- 1 COVID-19 vaccine regimen per year are covered as part of the preventative care benefit for all beneficiaries older than 16 years.
- Travel assistance for specialist visits in Namibia only, limited to 2 per family per year. (Blue Diamond) - Limited to N$ 803.00 per visit.
- No travel assistance (Litunga).
- International travel benefit.
- NHP pays for contraceptives (oral and injections) limited to N$257 per claim on Blue Diamond.
- 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.

Blue Diamond

Major Medical Expenses: **Limit per category**		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%	5 397	5 397		
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%				
6.2	Health Risk Assessment	No benefit				

BLUE DIAMOND

Group Rates				Individual Rates			
Age	**Principal**	**Adult/ spec dep**	**Child dep**	**Age**	**Principal**	**Adult/ spec dep**	**Child dep**
0 - 25	710	594	284	0 - 25	801	665	324
26 - 30	741	611	284	26 - 30	830	700	324
31 - 35	789	634	284	31 - 35	898	722	324
36 - 40	823	680	284	36 - 40	932	758	324
41 - 45	854	703	284	41 - 45	977	807	324
46 - 50	885	712	284	46 - 50	1 019	840	324
51 - 55	914	746	284	51 - 55	1 063	885	324
56 - 60	932	805	284	56 - 60	1 074	948	324
61 - 65	1 002	854	284	61 - 65	1 165	1 002	324
66+	1 082	912	284	66+	1 248	1 106	324

Spec dep = Special dependant

Blue Diamond

Day-to-Day Expenses: **Limit per category - DSP only**		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Out-of-hospital: Sub-limit						
1.	**Doctors and specialists**					**DSP**
1.1	Consultations and visits: Obtained from certain doctors, during normal working hours - N$15 per visit	100%	5 VC	5 VC		
1.1.1	Nurse: N$15 per visit: New conditions		5 352		13 380	446 per visit
1.1.2	General practitioner: N$15 per visit: New conditions					
1.1.3	Medical specialist - Upon referral from doctor: N$15 per visit					
1.1.4	Medical specialist: Travel assistance benefit - Windhoek or Swakopmund	100%			803 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**					**DSP**
2.1	Acute medicine					
2.1.1	As dispensed or prescribed by certain doctors and pharmacies	100%	3 024		7 560	252 per script
2.1.2	Self medication: Over-the-counter	100%			903	257 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%			4 148	Subject to registration on Chronic Care programme
2.3	Antiretroviral therapy: Dispensed - Patient needs to enrol in the AfA Programme	100%				
3.	**Primary care dentistry: N$15 per visit - New conditions**		**1 932**		**3 854**	**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 teatment, 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**				**1 134**	**DSP**
6.1	Optical test	100%				Limited to 115
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 1 013
7.	**Mother and child healthcare services**					**DSP**
7.1	Family planning, immunisation, pre- and post- antenatal care					
8.	**Counselling and health education**					**DSP**
8.1	Instruction of prevention of certain illnesses, oral hygiene, poisons, HIV/AIDS, etc.					
9.	**Specified illness conditions**					**DSP**
9.1	HIV/AIDS: Aids and HIV Positivity, Pathology, HIV councelling and testing, Prophylactic medicine for prevention of HIV virus, transmission in the case of needle-prick, rape or infection of mother (mother-to-child prevention)	100%			Unlimited	
9.2	Sexually transmitted diseases				1 659	
10.	**Rehabilitation: Alcohol and drug addiction or abuse**	**100%**			**1 659**	**DSP**

OAL = Overall Annual Limit SPA = Subject to pre-authorisation DBC = Document Based Care
VC = Virtual Consultations DSP = Designated Service Provider

Litunga

Major Medical Expenses: **Limit per category**		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					
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%				
6.2	Health Risk Assessment	No benefit				

LITUNGA

Group Rates				Individual Rates			
Age	**Principal**	**Adult/ spec dep**	**Child dep**	**Age**	**Principal**	**Adult/ spec dep**	**Child dep**
0 - 25	295	250	121	0 - 25	340	284	138
26 - 30	313	259	121	26 - 30	348	297	138
31 - 35	331	269	121	31 - 35	377	304	138
36 - 40	346	287	121	36 - 40	395	319	138
41 - 45	360	292	121	41 - 45	412	340	138
46 - 50	377	302	121	46 - 50	433	355	138
51 - 55	388	315	121	51 - 55	448	374	138
56 - 60	394	340	121	56 - 60	454	399	138
61 - 65	423	360	121	61 - 65	491	421	138
66+	456	385	121	66+	523	464	138

Spec dep = Special dependant

Litunga

Day-to-Day Expenses: **Limit per category - DSP only**		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Out-of-hospital: Sub-limit						
1.	**Doctors and specialists**					**DSP**
1.1	Consultations and visits: Obtained from certain doctors, during normal working hours - N$15 per visit	100%	5 VC	5 VC		
1.1.1	Nurse: N$15 per visit: New conditions		5 352		13 380	446 per visit
1.1.2	General practitioner: N$15 per visit: New conditions					
1.1.3	Medical specialist - Upon referral from doctor: N$15 per visit	No benefit				
1.1.4	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**					**DSP**
2.1	Acute medicine					
2.1.1	As dispensed or prescribed by certain doctors and pharmacies	100%	3 024		7 560	252 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%			3 318	Subject to registration on Chronic Care programme
2.3	Antiretroviral therapy: Dispensed - Patient needs to enrol in the AfA Programme	100%				
3.	**Primary care dentistry: N$15 per visit - New conditions**		**1 932**		**3 854**	**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 teatment, 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**				**1 134**	**DSP**
6.1	Optical test	100%				Limited to 115
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 1 013
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 virus, transmission in the case of needle-prick, rape or infection of mother (mother-to-child prevention)	100%			Unlimited	
9.2	Sexually transmitted diseases	100%			1 659	
10.	**Rehabilitation: Alcohol and drug addiction or abuse**	**100%**			**1 659**	**DSP**

OAL = Overall Annual Limit SPA = Subject to pre-authorisation DBC = Document Based Care
VC = Virtual Consultations DSP = Designated Service Provider

PharmacyCare

Major Medical Expenses: **Limit per category**		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Overall Annual Limit (OAL)						
1.	**Doctors and specialists**					
1.1	Consultations and visits: In-hospital	No benefit				
1.2	Procedures: In-hospital	No benefit				
2.	**Hospital services**					
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**					
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**					
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**	**No benefit**				
6.	**Preventative care**					
6.1	Vaccinations: COVID-19	No benefit				

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

PharmacyCare

Day-to-Day Expenses: **Limit per category - DSP only**		NAMAF tariff or % thereof	Principal member	Per additional beneficiary	Per family	Condition
Out-of-hospital: Sub-limit						
1.	**Doctors**					**DSP**
1.1	Consultations: Only when advised by pharmacist	100% Virtual benefit only			2 VC	
2.	**Medicine and injections**					**DSP**
2.1	Acute medicine					
2.1.1	As dispensed or prescribed by certain doctors and pharmacies	100%				158 per script
2.1.2	Pharmacy Initiated Care	100%			1 386	
2.2	Chronic medicine	No benefit				
2.3	Antiretroviral therapy: Dispensed - Patient needs to enrol in the AfA Programme	No benefit				
3.	**Primary care dentistry**	**No benefit**				
4.	**Radiology**	**No benefit**				
5.	**Pathology**	**No benefit**				
6.	**Optical: N$15 per visit - New conditions**	**No benefit**				
7.	**Mother and child healthcare services**	**No benefit**				
8.	**Counselling and health education**	**No benefit**				
9.	**Specified illness conditions**	**No benefit**				
10.	**Rehabilitation: Alcohol and drug addiction or abuse**	**No benefit**				

- No Roll-Over benefit.
- No preventative care benefits.
- Limited to 4 individuals.

PHARMACYCARE			
Group / Individual Rates			
Age	**Principal**	**Adult/spec dep**	**Child dep**
All members	211	0	0

Spec dep = Special dependant

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.

Dependants:

- Members must apply to the Administrator's for the registration of all dependants on date of admission, and must inform the Fund, through the Administrator's, of the occurrence of any event which results in additional dependants, or if any one of the dependants no longer satisfies the conditions under which a dependant may be registered.
- From the time a dependant ceases to be eligible for registration as a dependant, such dependant will no longer be deemed as being registered, and all rights to benefits will cease.

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 applies, 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.
- Members must notify the Administrator within thirty (30) days of the birth of an infant, in order to permit registration of the infant as a dependant. Increase of contributions for this dependant will be due as from the first day of the month following the birth.

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 code)?
- What are the relevant NAPPI codes at primary and secondary level?
- Does it state the treatment provided (ICD 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 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.

Pre-authorisation does not guarentee payment if benefit limit is exceeded.

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 clinically 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. 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.
- 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.
- You have the right to a second opinion or contact Managed Care for a clinical review.

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

Benefit exclusions:
(Please refer to page 32 in the User Guide to view all exclusions)

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 coding structure from 2025 onwards

The Namibian medical aid funds industry in association with NAMAF is embarking on the introduction and compulsory utilisation of ICD codes, the date of enforcement will be communicated once recieved from the regulator.

It is primarily the medical practice's responsibility to issue the medical statement containing the correct breakdown of ICD 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 codes will not be rejected and shall only be identified with a system claims processing error code.

Members and service providers will be informed of when ICD codes will be made compulsary.

Pre-authorisation is very important prior to undergoing a procedure or treatment. Ensure pre-authorisation is done well in advance. Consult your healthcare provider to ensure adequate and timely pre-authorisation.

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 register on the Chronic Care programme.

Eligibility requirements for accessing Chronic Medication benefits

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 support members through improved adherence and provision of adequate benefits to ensure optimal control of chronic illness and reduced hospitalisation.

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.

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 care 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 benefit 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 (Day-to-Day)

Gold Option
- Per family = N$ 48 615 – covered at 80% of NAMAF benchmark tariff and further limited to a 4 year cycle i.e. 2025 to 2028.
- Diabetic related consumables = N$ 60 000.

Platinum Option
- Per family = N$ 45 780 – covered at 80% of NAMAF benchmark tariff and further limited to a 4 year cycle i.e. 2025 to 2028.
- Diabetic related consumables = N$ 55 000.

Titanium Option
- Per family = N$ 40 005 – covered at 80% of NAMAF benchmark tariff and further limited to a 4 year cycle i.e. 2025 to 2028.
- Diabetic related consumables = N$ 50 000.

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.

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$ 268 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$ 903 per family per year. This includes all schedule 0, 1, and 2 medication. Claims in respect of self-medication will be limited to N$ 257 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 N$ 5 352 per principal member - N$ 13 380 per family. Scripts for medicines and injection materials limited to N$ 3 024 per principal member - N$7 560 per family.

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$ 927 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

Contact the administrator Medscheme Namibia for further details.

Programmes

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.

HIV/AIDS is a sexually transmitted infection. It also can spread by contact with infected blood or from mother to child during pregnancy, childbirth or breast-feeding. Without medicine, it may take years before HIV weakens the immune system to the point of having full-blown AIDS.

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.

The AfA Programme is in full compliance with the guidelines provided by the Ministry of Health and Social Services. The AfA Programme is advised by a team of experts who are acknowledged leaders in the field of HIV medicine in Sub-Saharan Africa.

The AfA Programme ensures confidentiality whilst managing the significant healthcare costs associated with the disease. Benefits include education, counselling, vaccinations, medication including antiretroviral therapy, hospitalisation, regular consultations and tests. The AfA Programme also provides for the monitoring of clinical outcomes and the measurement of patient compliance to treatment.

Registration

A member or dependant 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.

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 Assessment (HRA) Incentive

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

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$ 1 103
Platinum	N$ 1 103
Titanium	N$ 824
Silver	N$ 824
Bronze	N$ 551
Hospital	N$ 551
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. It is 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 pre- or post-surgical rehabilitation.
- Pre-emptive identification of eligible beneficiaries.
- Pre-emptive identification through requests for specialised radiology/hospital authorisation for spinal procedures.
- Identification of eligible employee as part of Wellness Day screenings, with subsequent referral to the DBC Programme.

The benefit makes provision for interdisciplinary active rehabilitation and functional restoration treatments at the DBC Centers, including the consultations by the General Practitioner and treatment by the Physiotherapist and Biokineticist on the specialized DBC equipment.

Emergency numbers

Main area of coverage	Emergency evacuation provider	Contact number/s
All major centres & air ambulance evacuation countrywide	Lifelink Emergency Services Medical Rescue Africa (MRA) Namibian Marshall Rangers Emergency Rescue Services CC	999 (from any landline) / 064 500 346 Nationally: 912 Internationally: +264 8333 900 33 / +264 81 129 4973 +264 (081) 2962297
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
Kasarburg	Mosmed 24 Paramedic Services	081 263 9886
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	Toll Free 987
Okahandja and surrounding areas	Okahandja Paramedical Services	987
Ondangwa & countrywide	Ondangwa Ambulance Services	081 902 00 / 081 237 5437
Oranjemund	Namdeb Private Hospital Ambulance	063 238 046
Otjiwarongo	MR 24/7	085 956 / 061 255 676 / 081 257 1810
Outapi, Oshakati & surrounding areas	Outapi Ambulance MedCare 24 Ambulance	065 251 022 / 061 251 800 081 3916689
Outapi, Ongwediva, Ondangwa	Namibia Private Ambulance Services Northern Ambulance Services	081 9696 065 250688
Rehoboth	Elite Emergency Rescue Services	081 450 9333
Rosh Pinah	Roshcare Clinic Ambulance Services Life Employee Health Solution Namibia / Sidadi Clinic	063 274 918 / 081 161 8734 063 274 911
Rundu	Namibia Private Ambulance Services Medstar Ambulance Services cc Aqua Ambulance Services	081 9696 066 256 969 085 589 0000
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 Desert Ambulance Rescue Training Services CC Guardian Angels Emergency Services Medical Rescue 911 NEMC Delta Emergency Rescue Shili Ambulance and Med Evacuation cc Emergency Medical Assistance Three Sixty Emergency Service	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 / 067 241 091 081 3816340 085 3008 911 085 668 2661 081 566 3635 081 295 2268 085 800 1832 061 302 931 081 750 0001

Contact details

GET IN TOUCH

Head office: Windhoek
Walk-in assistance: Erf 1319 Grove Street, Kleine Kuppe
Tel: 061 285 5400
Website: www.nhp.com.na
Postal: PO Box 23064, Windhoek
Operating hours: Monday to Friday 07:45 - 17:00

Fraud hotline - Confidential
Tel: 0800 647 000
Email: medschemenamibia@whistleblowing.co.za

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: chroniccare@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