

MEMBER ENGAGEMENT SESSION: RESPONSE TO QUESTIONS



11 MAY 2026 - 14:30 - 16:00

WINDHOEK, NAMIBIA (ZOOM AND MICROSOFT TEAMS)

INTRODUCTION

This document contains formal responses to each substantive question raised by our members during the recent member engagement on the Managed Care Transition. Questions appear verbatim as submitted.

1. Payment Provider Transition and Claims

Q.1 When will NHP commit to having all services restored to their pre-transition standard, including clearing all outstanding claim backlogs?

NHP recognises the importance of restoring all services to their pre transition standard, including the full clearance of the outstanding claims backlog. A structured remediation programme is currently being implemented, with defined milestones specifically targeting backlog reduction, claims turnaround times, system stability and overall service performance.

Claims processing capacity has been enhanced, and prioritisation protocols are in place for aged and high-impact claims, which are being monitored daily. Subject to the successful implementation of these measures and continued cooperation from service providers, NHP expects to restore all services to normal levels..

Q.2 What is the status of unpaid claims? Many members have been waiting since late March/April 2026 with no resolution. Why is reimbursement taking up to 15 working days, and can this be shortened significantly?

NHP acknowledges that certain members have been asked to pay cash by their doctors and we sincerely regret the impact this has had on affected members.

All outstanding claims have been categorised by age and complexity, with the oldest and most urgent claims

prioritised for processing first. The extended timeframes currently experienced are a temporary consequence of the clearance process and the need to ensure payment accuracy.

As backlog volumes reduce and system performance normalises, turnaround times will shorten progressively. Our target is to return to standard processing timelines as soon as possible and members will be notified once normal turnaround times have been fully reinstated.

We ask that member claims be submitted to memberrefunds@care.nhp.com.na with the subject line "Member Refund", including the invoice and proof of payment, so we can trace it and expedite investigation and payment where the claim is valid and complete.

2. Dental, Orthodontic and Specialist Services

Q.3 When will NHP restore its relationship with dental practitioners so that members are no longer required to pay cash upfront?

NHP acknowledges the concerns raised by our valued members regarding upfront payments at dental practitioners, and we sincerely understand the financial pressure this places on you and your families.

We want to assure you that your dental benefits have not changed and you remain fully entitled to all your dental cover as per your benefit option. We are continuously and

actively engaging with dental practices to strengthen our relationship and ensure that our members receive the care they deserve without the burden of upfront payments.

Furthermore, we have engaged directly with the specific practices requiring upfront cash in question on a one-on-one basis to address specific concerns relating to outstanding claims. A direct communication channel has been established with all practices, and any remaining operational concerns are being addressed on an ongoing basis.

We appreciate your patience and loyalty, and we remain fully committed to keeping you informed as we make further progress.

Q.4 Which dental, orthodontic, and other specialist practitioners have formally agreed to assist NHP members without requiring upfront payment?

NHP is actively engaging with dental, orthodontic and other specialist practitioners to discourage upfront payment requirements and to support a return to standard claim submission and reimbursement arrangements.

Members are encouraged to contact NHP for assistance where upfront payment is requested, so that the matter may be addressed directly with the provider on a case by case basis.

Q.5 Members with active orthodontic treatment plans are now being asked to pay out-of-pocket. Who bears responsibility for disrupted treatment plans and the resulting financial consequences?

NHP understands the seriousness of disrupted orthodontic treatment, and we sincerely apologise for the distress this has caused affected members and their families.

To be clear, NHP has not changed any Fund Rules or benefits mid-year. Where members are being asked to pay out-of-pocket, this is an administrative disruption that we are committed to resolving, and we will address each affected case individually.

All claims and refunds will be processed in full accordance with Fund Rules and your approved benefits. If you or a family member is affected, please contact us urgently with the following details:

- Full name and membership number

- Patient details
- Orthodontic or dental practice name and practice number (if available)

This will allow us to intervene as quickly as possible on your behalf. Call us on 061 242 821 for urgent assistance.

Q.6 Physiotherapists and psychologists are also requesting upfront cash payments from NHP members due to non-payment of claims since April 2026. When will this be resolved?

NHP is aware that some physiotherapists and psychologists have requested upfront cash payments from members. This is being addressed as a priority.

NHP is engaging continuously, on a one on one basis, with individual physiotherapy and psychology practices, as well as with the relevant healthcare provider associations, to resolve and address any practice specific concerns.

3. Benefit Changes and Fund Rules

Q.7 Why have NHP Fund Rules changed mid-financial year without prior member engagement or communication? (e.g., braces now restricted to members under 18; dental cleanings limited to once per year.)

NHP's Fund Rules have not changed, and there have been no mid financial year amendments to benefit rules or limits. Members' benefits remain unchanged.

During the recent system migration, some administrative or system disruptions may have caused incorrect benefit displays or limitations to appear on certain dental claims. These were system issues, not rule changes, and are being actively corrected.

Members who experience any incorrect benefit application are encouraged to contact NHP so the matter can be investigated and rectified urgently. Please have the following information available:

- Your full name
- Your NHP membership number
- The name of the dental practice (and practice number, if available)

Members may contact NHP for immediate assistance.

Q.8 Why are existing treatment authorisations being rejected with the reason “no pre-auth” when these were previously approved?

Pre existing treatment authorisations have not been withdrawn or invalidated. All authorisations issued prior to 1 April 2026 remain valid under the Fund Rules.

During the transition period, some previously approved authorisations were not immediately visible or correctly linked in the new administration system. This arose from data handover and system integration issues, not from any rule or policy change.

These cases must be escalated for correction, and dedicated teams are reviewing and reinstating affected authorisations, particularly for dental, orthodontic, physiotherapy and other continuity of care treatments.

Members or providers who receive a “no pre auth” rejection despite prior approval are requested to contact NHP so the authorisation can be verified and rectified without delay.

Q.9 Why, since 1 April 2026, have some chronic medication claims being deducted from acute benefits/rollover savings and attracting co-payments instead of being processed under the chronic benefit?

All existing chronic medicine authorisations were migrated to the new system to ensure continuity of cover following the transition on 1 April 2026.

In a limited number of cases, chronic medicine claims may currently be paying from the acute benefit (and, in some instances, rollover). These are system related linking issues, not benefit changes.

NHP is actively reviewing and correcting affected authorisations so that eligible chronic medicines are funded from the correct chronic benefit going forward. Members who previously had approved chronic medication that is now paying from the acute benefit are asked to contact NHP so the matter can be investigated and resolved urgently.

Please note that any new chronic condition or medication still requires a new chronic authorisation application to be funded from the chronic benefit.

Furthermore, on the co payments, claims continue to be assessed in line with the NHP Fund Rules, including the application of reference pricing on medicine benefits. NHP applies a Namibian specific reference pricing model to ensure consistent and appropriate claims assessment.

Q.10 Why are compounded Novocy pharmacy products no longer being covered, particularly when the prescribed alternatives are not available in Namibia?

Novocy pharmacy products are compounded medicines and therefore require pre authorisation in terms of the NHP Fund Rules. All valid compounded medicine authorisations that were in place prior to 1 April 2026 were carried over to ensure continuity of treatment following the transition. Where such authorisations exist, cover remains in place.

Any new compounded items, changes to formulations, or newly prescribed compounded medicines require a new pre authorisation request before claims can be processed.

Members or prescribers experiencing difficulties with access to authorised compounded medicines, particularly where alternatives are not readily available in Namibia, are encouraged to contact NHP so the matter can be reviewed and addressed appropriately.

Q.11 Why has the mammogram screening frequency been reduced to every two years?

Mammogram screening intervals are designed to balance the benefits of early cancer detection with the risks and downsides of over screening, while still ensuring clinically meaningful cancers are detected timeously. For women at average risk, most clinical guidelines allow for, or recommend, biennial (every two years) screening.

The current mammogram screening frequency reflects a risk based, evidence aligned approach for average risk members. This change was not implemented during the April 2026 transition, but formed part of the benefit enhancements and rule changes approved in late 2025, which were duly approved by NAMFISA.

Q.12 A prescription co-payment of N\$30 has been introduced – why, and was this communicated to members?

The prescription co payment of N\$30 is applied in accordance with the NHP Fund Rules for 2026. This is not a new or ad hoc charge linked to the April 2026 transition. The applicable co payment depends on the type of medication being claimed and is applied consistently in line with the approved benefit structure. These rules formed part of the registered 2026 Fund Rules and were therefore already in effect for the current benefit year.

4. Universal Care Selection and Governance

Q.13 What was the procurement and due diligence process followed to appoint Universal as the new administrator? Why was a South African-based company selected?

Universal was appointed as a Managed Care service provider, not the Fund’s administrator. Medscheme Namibia remains the administrator. The appointment of Universal followed NHP’s formal governance processes, under the oversight of the Board of Trustees and within the Fund’s legal and regulatory framework. A structured procurement process was conducted, including due diligence and evaluation against defined operational and technical requirements, with the primary objective of securing the most suitable capability to protect member interests, service continuity, and the long-term sustainability of the Fund.

The selection was based on service capability and delivery requirements including system functionality, operational capacity, and the ability to support care management effectively rather than the geography of the parent organisation. Importantly, the Managed Care provider operates through local presence and capacity in Namibia and NHP remains accountable for ensuring compliance, oversight, and member protection.

Q.14 Why was this decision not discussed at the AGM, and why were members not consulted before the transition was executed?

In terms of how the Fund is governed, decisions such as appointing a Managed Care provider are made by the Board of Trustees, who are elected to represent members and are legally required to act in members’ best interests and protect the Fund’s long-term sustainability.

These decisions are therefore taken through structured governance processes, with appropriate oversight. What we want to assure members is that this governance model exists precisely to protect you to ensure decisions are made responsibly, based on due diligence, and with continuity of cover in mind.

Q.15 If the transition has been planned since 2023, why was Universal not operationally ready at the time of go-live?

The Fund did not begin planning the transition in 2023. In 2023, NHP started a process of assessing and reviewing the Managed Care function as part of its ongoing service optimisation and sustainability work. The detailed planning for the actual transition only commenced later, once the review process progressed and the required governance steps were concluded.

NHP’s intention was for the transition to be seamless. However, the reality is that some issues only surface at scale once a system goes live nationally across thousands of real-time provider interactions particularly around telephone routing, portal access and switching integrations. What is important is that NHP did not “walk away” from the transition. A dedicated stabilisation plan is active with daily oversight.

Q.16 How many Namibian employees does Universal employ, and how does this align with local employment obligations?

Universal is a contracted service provider to the Fund and localisation formed part of the contractual requirements. The Fund required appropriate local operational presence and capacity in Namibia. Recruitment to strengthen this local capacity is ongoing, consistent with NHP’s commitment to supporting national employment objectives and prioritising suitably qualified Namibian talent.

Q.17 Who is actually processing claims – Namibian staff or South African staff – and are members being charged international call rates when contacting Universal?

Claims assessing is performed by teams based in both Namibia and South Africa. Members are not charged international call rates: incoming calls are received via our Namibian local number on 061 285 5400.

Q.18 Is it legally permissible under FIMA for NHP to outsource the assessment of claims to Universal? The Act appears to require the fund to administer claims itself.

NHP operates within the applicable regulatory framework and remains subject to NAMFISA's ongoing supervision and compliance requirements. FIMA became effective on 1 May 2026, and the Fund has a 12-month transition period to complete full alignment. NAMFISA is the regulatory authority for medical aid funds and exercises supervisory oversight over all registered funds, including NHP.

Q.19 What was the stated reason for terminating the relationship with Medscheme? What specific failures or shortcomings led to this decision?

NHP has not terminated its relationship with Medscheme Namibia as the Fund's administrator. Medscheme remains the administrator, and that relationship continues. The only change implemented is the transition of Managed Care and claims assessing functions to a new service provider. This decision was not driven by a single incident or "failure," but by a strategic review of service capability and the Fund's long-term sustainability objectives. As part of normal governance, the Board periodically assesses how key functions are delivered to ensure the Fund continues to improve efficiency, strengthen care management, and protect member value over time.

Q.20 What early termination costs were incurred when ending the Medscheme contract, and how does NHP justify using member funds to cover penalties?

No termination costs were incurred by the Fund.

5. Member Portal and Communication

Q.21 When will the member portal (SOBIT) be fully functional, including access to claims history and benefit information? Members were told it would be live within a week – that was over three weeks ago.

The member portal is now live and can be accessed at: <https://nhp.universal.co.za/picsites/PHP/frameset.mp?frs=58>

Once logged in, members can view their profile information, including the relevant benefit and claims information. To log in, members will need their membership number; a one-time PIN (OTP) is then sent to the email address held on our system.

If your email address has changed, please contact members@nhp.com.na so that we can update your details.

Q.22 Can NHP share the direct link to the updated benefits guide on the website, and confirm whether it reflects the current (post-transition) benefits?

You can view the 2026 NHP Benefit Guide here: <https://nhp.com.na/uploads/documents/Benefit%20Guide%202026-041225-085241.pdf>.

This guide has not been updated and it reflects the current 2026 benefits and Fund Rules. The Managed Care transition is an operational service-provider change and does not change member benefits, benefit options, limits, or contributions.

Q.23 Why are NHP's Fund Rules not published on the NHP website, when other funds such as NMC make theirs publicly available? Members are currently required to obtain them from NAMFISA.

The Fund Rules are available to all members upon request. For ease of access, we will also publish the Rules on our website and members will be notified once they are available online. In the meantime, members are welcome to request a copy through our official channels.

Q.24 Will NHP commit to proactive and direct communication to all members before any future benefit, rule, or administrator changes are made?

Yes. NHP is committed to proactive, direct communication with members ahead of any future changes that materially affect benefits, Fund Rules, contributions, or member-facing administration. Where a change requires formal governance and/or regulatory processes, we will communicate at the appropriate stages through direct member channels (email/SMS where available), supported by website notices, FAQ, and member engagement sessions. We are also strengthening our communications approach to ensure messages are clearer, earlier and reach more members consistently.

6. Managed Care – Clarity for Members

Q.25 What exactly does "managed care" mean in practice for NHP members? Please explain in plain language how it differs from the previous arrangement.

Managed care is the part of your medical aid that helps coordinate and approve certain healthcare services so that your benefits are applied correctly and you can access care smoothly. In practice, it includes things like pre-authorisations

for hospital procedures, registration and management of chronic medication, and clinical support for more complex cases.

What has changed is not your benefits or Fund Rules, but who provides this managed care service. Previously, managed care was handled under the former arrangement. Now, Universal provides the managed care function for NHP. Your cover remains the same. The transition relates to the backend process of how approvals and related assessments are managed.

Q.26 Will managed care require members to use specific doctors, hospitals, or pharmacies? If so, which current providers may no longer be approved?

Only members on the Blue Diamond and Litunga options are subject to networks for general practitioners (GPs) and dentists. Members on these options must therefore use a network GP or dentist.

For hospitalisation, Blue Diamond and Litunga members have access to state facilities. There are no network restrictions for members on the other NHP options.

Q.27 Which treatments or procedures will now require pre-authorisation that previously did not? When will a comprehensive list be distributed to members?

Pre-authorisations are managed in accordance with the NHP Fund Rules. Members are encouraged to refer to their 2026 Benefit Guide, which indicates all benefits that are subject to pre-authorisation.

Q.28 Will NHP deny claims for chronic conditions (e.g., high blood pressure, diabetes, asthma) if a member does not participate in a managed care programme?

No. Claims will be processed against the available benefits on the member's selected option. For chronic medication to be funded from the Chronic Medicine Benefit, the member must be registered on the Chronic Care Programme, in line with the rules of the selected benefit option. Members are encouraged to ensure that their chronic condition and related treatment are registered and approved before claiming chronic benefits.

Q.29 Does NHP's adoption of managed care affect hospital admission rights? Are members still covered at hospitals as before, or are they now treated as private patients?

A member's hospital admission rights are not affected by the application of managed care. Admissions will continue to be funded in accordance with the NHP Fund Rules.

Q.30 Can Universal provide a demonstrably better managed care service than Medscheme? What specific improvements have members seen?

The objective of appointing a new Managed Care provider is to strengthen managed care capability and improve operational efficiency.

7. Accountability and Trust

Q.31 The member satisfaction survey cited an 81% approval rating. Was this survey conducted before or after the transition to Universal? If before, does it still reflect the current reality?

The 81% satisfaction rating is before the Managed Care transition as we conduct Member Surveys every two years. The 2026 Member Survey will be released to our members in September - October 2026.

Q.32 What concrete accountability measures are in place for the Board of Trustees and management regarding this transition?

Accountability is in place through Board oversight and management reporting. The Board receives regular updates on performance, risks, and corrective actions, while management tracks clear service metrics (authorisations, claims turnaround, and access issues) and escalates urgent cases through defined channels until stability is restored.

Q.33 Will the Board of Trustees provide a formal written commitment to members outlining timelines and resolution milestones?

NHP can commit to providing members with formal updates that outline the key stabilisation actions underway, measurable progress and the milestones we are working toward. These updates will be issued through official NHP channels (website, email/SMS where available and our WhatsApp channel).

8. Chronic Medication and Co-payments

Q.34 Universal appears to be applying the South African price file for chronic medication, resulting in higher co-payments for Namibian members. When will the correct Namibian pricing be applied?

The correct pricing is being applied in line with the transition arrangements. Where any misalignment is identified, it will be corrected promptly.

Q.35 The 18-year age limit on orthodontic treatment was never communicated to members. When was this rule introduced, and why were members not informed?

At the start of the take-on process, an annexure was issued based on a rule that the Fund had intended to implement. This rule was subsequently not approved by NAMFISA, and the Fund has since clarified this with Universal Care. We have reviewed all orthodontic requests that were previously declined for patients over the age of 18. Where applicable, these have now been authorised, and the affected claims have been identified for reprocessing.

Q.36 Radiology service providers are also treating NHP members as private patients. When will this be resolved?

We are engaging continuously, on a one-on-one basis, with individual radiology practices to resolve outstanding claims, payment expectations and any practice-specific concerns.

9. Hospitalisation, Pre-authorisation and Emergency Care

Q.37 Why is a full specialist motivation and radiology results required for a procedure such as a hysterectomy, given NHP's assurance that nothing would change?

In general, a full specialist motivation and radiology results are not required for routine authorisation requests of this nature. However, as previously in place, in certain out-of-the-ordinary cases, additional clinical information may be requested to support proper assessment of the request in line with the NHP Fund Rules and clinical guidelines.

NHP's commitment that benefits and access would not change remains in place. Any request for additional information is not intended to create a new barrier to care, but rather to confirm clinical details where further clarity is needed. Where additional documentation has been requested, members and providers are encouraged to submit this so that the authorisation can be finalised as quickly as possible.

Q.38 In the case of an emergency operation or hospitalisation (e.g., an accident), how does the pre-authorisation process apply when a member cannot follow the process beforehand?

If you or one of your dependants experiences a serious medical emergency and requires immediate hospital care, please go to the nearest hospital or emergency unit without delay.

In an emergency, your health and safety come first. The hospital, the doctor or the member should still contact our emergency or pre-authorisation support line as soon as possible so that the case can be registered. However, if you cannot reach us immediately, please do not delay emergency care. NHP has arrangements in place with hospitals to treat emergencies that require immediate medical attention. The pre-authorisation line is available 24 hours a day, and emergency numbers are available to members.

For planned or elective hospital admissions, pre-authorisation must be obtained before admission. This includes planned treatment in hospitals or other approved care facilities. Please contact NHP in advance for any planned admission so that pre-authorisation can be arranged.

Please note that pre-authorisation means that the treatment has been approved based on your benefit option, available benefits and the NHP Fund Rules. Related costs will be covered in accordance with the benefits and rules that apply to your option.

Contact details:

- Main support line: 061 285 5400
- Emergency: +264 61 285 5400
- Emergency: +264 81 769 6962
- Emergency: +264 81 769 6941

Q.39 Are there claims submitted prior to 1 April 2026 that are still outstanding? If so, when will these be settled?

All claims received by Universal including claims with service dates prior to 1 April 2026 will be processed in line with our standard claims process. All valid and fully complete claims received during the week are captured and paid out the following week. Where a claim is received late in the week and is not processed on the day, it will enter the following week's payment run.

Q.40 When will members be able to submit claims paid at a doctor's office directly via the NHP website? This functionality was available previously.

This functionality is currently under development and once it has gone live, it shall be communicated. In the absence thereof, members should submit their claims/refunds to memberrefunds@care.nhp.com.na with the subject line "Member Refund", including the invoice and proof of payment.

10. Universal Care – Local Approach and Member Benefits

Q.41 What will happen to Namibian employees who lose their jobs as a result of Medscheme having to reduce its workforce? Many of these individuals are also NHP members.

Medscheme Namibia is a contracted service provider to the Fund. As such NHP does not direct the employment arrangements of its service providers.

11. Managed Care – Savings and Approach

Q.42 If managed care is intended to reduce costs, how exactly will this be achieved? Will Universal evaluate and screen claims to prevent wastage – and is this not something that already happened under the previous arrangement?

Managed care reduces costs by preventing avoidable high-cost events and reducing waste, not by "blocking" care. In practice, it does this through better chronic disease and case management (fewer complications and hospital admissions) and utilisation controls like clinical protocols and prior authorisation for selected services to ensure care is appropriate and benefits are applied correctly. These approaches are widely used to support long-term sustainability in medical schemes.

Yes, claims screening and authorisation checks already existed under the previous arrangement. What changes now is the service provider executing the function, the systems used, and the performance standards/turnaround targets applied.

12. Communication and Member Access

Q.43 Not all members can access the NHP WhatsApp channel via the link shared. Please provide the WhatsApp number directly so members can save and use it.

The WhatsApp channel does not operate with a number. It is a public platform whereby one can join using the following link: <https://whatsapp.com/channel/0029VbCKW1g8PgHS10zjS2J>

Q.44 Can NHP commit to improved, proactive communication to pharmacies and service providers – particularly regarding co-payments?

Yes. Online sessions for healthcare providers were initiated during the second week of April 2026. We have also engaged extensively with pharmacies and other provider associations, and we continue to provide daily support to pharmacies and providers experiencing issues. This support will continue until all matters are resolved. We acknowledge the need for improved and more proactive communication, and we are committed to strengthening this going forward.