USER GUIDE 2026

nhp™

We're about you

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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 2026, 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 2026 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.

FUND OVERVIEW:

FUND OVERVIEW

NHP is governed by a Board of Trustees elected by our members and appointed by the Board, ensuring accountability and member representation. The Board operates within the framework of the Medical Aid Funds Act, 1995 (Act 23 of 1995) and the Fund Rules. Strategic leadership is provided by the Principal Officer, who oversees the implementation of Board decisions and the day-to-day execution of the Fund's objectives.

Our Promise to You

As we continue this journey of excellence, NHP remains committed to setting the standard in Namibia's medical aid landscape. We extend our deepest gratitude to our members, employer groups, healthcare providers, and partners for their continued trust and support.

Together, we are building a healthier Namibia—one member at a time.

Management of the Fund

The NHP Board of Trustees, elected by Fund members and appointed by the Board, oversees all Fund operations in line with the Medical Aid Funds Act, 1995 (Act 23 of 1995) and the Fund Rules. The Board is responsible for developing and implementing a forward-looking strategy that aligns with NHP's mission, while the Principal Officer, as the Fund's Executive Officer, is tasked with executing this strategy.

We thank our members and corporate employer groups for their continued trust and support and look forward to serving you with passion and dedication well into the future. NHP is proud to set the standard in Namibia's medical aid industry.

NHP Board of Trustees

Ms. Sabrina Jacobs (Chairperson)
Ms. Taimi lileka-Amupanda (Vice-Chairperson)
Mr. Wilko Duvel
Mr. Jacques Van Zyl
Ms. Lilian Esme Botes
Ms. Anna Kamkuemah
Ms. Amuhe-Tangeni Mungoba
Ms. Magreth Mengo
Mr. Bradley Neumbo
Mr. Johan Maass
Dr. Nils Kock
Ms. Nyanyukweni Auala

Principal Officer (PO)
Ms. Dantago Garosas

What role does NAMFISA and NAMAF play in the medical aid industry?

The Fund is a member of the Namibian Association of Medical Aid Funds (NAMAF), the controlling body for medical aid funds in Namibia. Private medical aid funds must register with the Registrar of Medical Aid Funds in Namibia. NAMFISA is the registrar of non-banking financial institutions and is responsible for the supervision of these institutions in terms of the NAMFISA Act, 2001 (Act 3 of 2001).

On an annual basis, NAMAF publishes benchmark tariffs for specific healthcare treatment, services and procedures performed in or out of hospital. These NAMAF benchmark tariffs are only a guideline for any healthcare provider e.g. general practitioners, specialists and anaesthetists, to follow when they consider billing the portion for which the Fund will be accountable in respect of treatment provided.

The function of NAMAF is to protect members of medical aid funds against abuse from both medical aid funds and providers of healthcare services and to serve as an advocate between medical aid funds and their members.

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. 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. This User Guide is a summary of the latest Fund Rules. All members have access to the latest version of the User Guide and Benefit Guide on the Fund's website.
www.nhp.com.na.

The annual Summary of Changes 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 document for future reference.

Management of Risk

The application of risk management techniques ensures good value for money regarding the fit between membership contributions and the need for comprehensive benefits.

All monthly contributions are determined following a comprehensive actuarial risk assessment of the inherent risk arising from the demographic and claims profile of the Fund.

In an effort to manage the risk of the Fund, a Roll-Over benefit is available to encourage members to take control of their own medical expenditure and to motivate them to claim prudently.

About Medscheme Namibia

Medscheme Namibia is a privately owned company with private equity status whereas NHP is a medical aid fund. NHP is a non-profit organisation and does not declare any dividends. Any surplus remains within NHP, accumulating over time and is reflected as reserves of the Fund.

The Fund contracts with Medscheme Namibia, the Administrator, to perform specific job requirements on behalf of the member.

Medscheme Namibia has consistently delivered innovative medical aid administration and health risk management solutions to NHP for over two decades.

Medscheme Namibia delivers comprehensive, integrated healthcare management solutions, which recognise that flexibility and differentiation are crucial to remain competitive in the highly dynamic medical aid industry.

Therefore their priority is to meet medical aid needs through service excellence, quality and differentiation and personalised solutions.

Delivered through:

- A unique, client-centred business philosophy.
- Highly skilled, experienced managers and staff.
- State-of-the-art technology.
- Constant monitoring of quality and efficiency.
- Expertise and excellence in corporate governance.

Responsibilities

The relationship managed between Medscheme Namibia and NHP is by means of a Service Level Agreement and in terms of which the fee for the services rendered is predetermined.

Responsibilities towards the Fund:

- Claims management
- Membership and contributions management
- Client services management
- Financial management
- Information technology management
- Marketing management
- All operational procedures
- Fraud, waste and abuse

FRAUD, WASTE AND ABUSE AGAINST THE FUND

NHP adopts a zero tolerance to fraud

NHP's objective is to curb incidences of fraud and other inappropriate behaviour while building member awareness.

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.

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, and

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, waste 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, waste 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?

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.
- Pay attention to the amounts claimed and determine whether the charges are unusually high 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.
- Only the member knows what services were received.
- If members notice a discrepancy in any document, they are encouraged to contact the Fund for clarification.

Members should note that the Fund reserves the right to implement the following procedures against members and healthcare providers guilty of fraudulent, wasteful 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 provider 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.

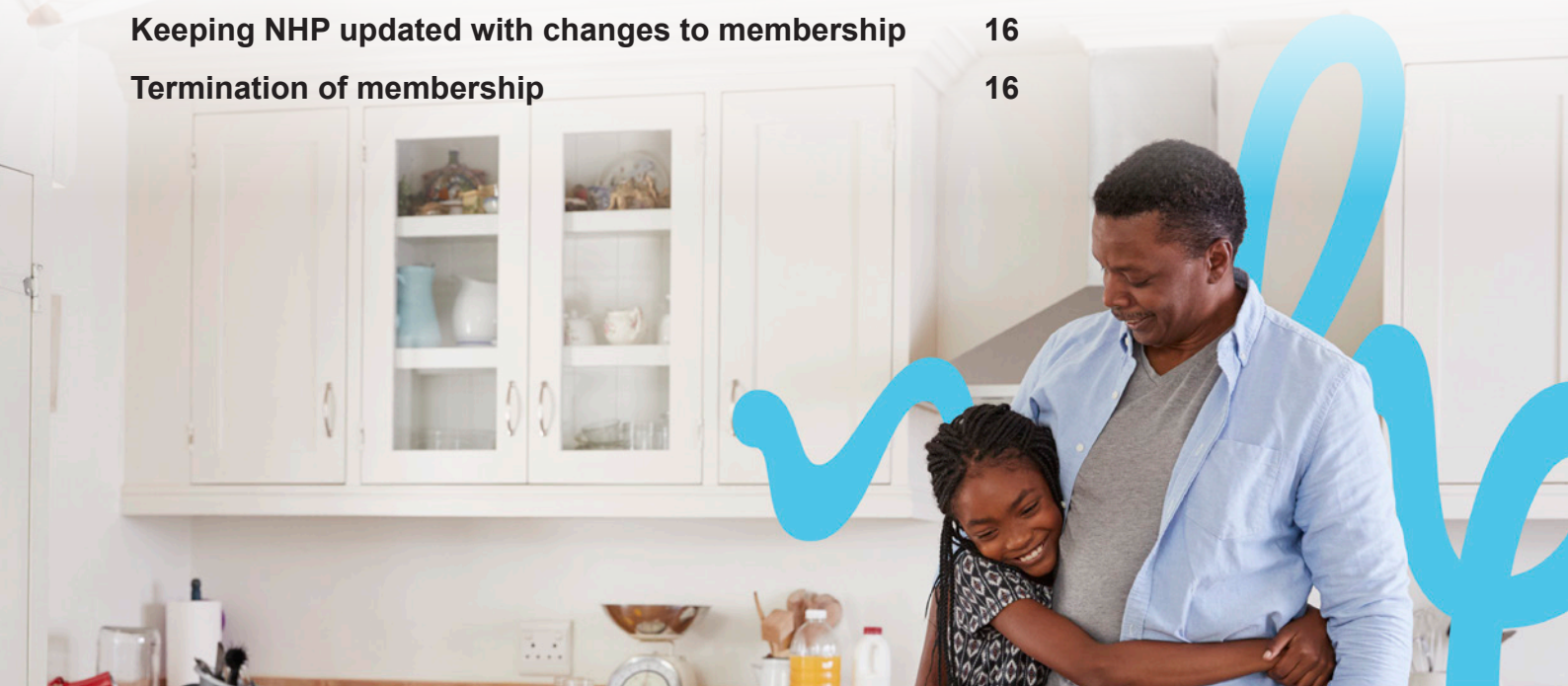
Save your benefits for a better tomorrow!

Report any suspicious activity to our Whistle-blower Hotline.

Fraud Hotline: 0800 647 000
Email: medschemenamibia@whistleblowing.co.za

WHISTLE BLOWERS

MEMBERSHIP:



MEMBERSHIP

Membership to NHP is open to anyone who wishes to join, whether as an individual or as part of an employer group. NHP has certain rules, regulations and conditions that govern access to membership of the Fund.

APPLICATION

New applicants must complete and submit a membership application form to the Fund. This membership application form, once accepted by the Fund, is a contract of agreement. Any false declaration by the applicant may render the agreement "null and void" and may result in immediate cancellation of membership. If a membership is cancelled or terminated, such member will be responsible to the Fund for any benefit payments in excess of contributions received during the period of membership.

Employees and/or their dependants, who have not applied for membership with the Fund within the stipulated 3 month period after accepting full-time employment with an employer group, must also have the declaration of health completed by a healthcare provider.

The Fund reserves the right to impose exclusions on pre- existing conditions for employees who join after the 3 month window period has expired. As part of the underwriting process, the Fund reserves the right to request additional information regarding the medical history and a doctor's certificate, relating to the member's health and family medical history from either the member or healthcare provider.

Pro-rata Day-to-Day benefits will apply as from the date of joining, unless the joining date is 1 January of any given year.

Supplementary documentation required when applying for membership (principal member and adult/child dependant):

- A medical certificate showing the healthcare provider's practice stamp, as per requirement.
- Copies of ID/Passport documents for all applicants applying for membership.
- Copies of full birth certificate(s).
- Copy of the marriage certificate (if applicable).
- A declaration under oath must be submitted in the case of a common-law spouse or same sex partner who has been living with the principal member as a couple continuously for more than 12 months subject to the approval of the Fund.
- A copy of previous medical aid fund membership certificate (if applicable).
- Proof of children legally adopted (if applicable).
- Proof of legal guardianship (if applicable).
- Supporting document with banking details e.g. letter from bank or bank statement with bank stamp.

Note: The proposed effective date of membership, will be placed on hold until all supporting documents in respect of marriage certificate(s), birth certificate(s), or medical declaration or certificate(s) have been submitted.

General membership terms and conditions:

- No person, whether a member or dependant, may be a dependant of more than one medical aid fund registered in terms of the Medical Aid Funds Act, 1995 (Act 23 of 1995) or any medical aid arrangement offered by the Government of Namibia (PSEMAS) at the same time.
- Should a member of NHP be found to be a member of another medical aid fund or PSEMAS, they and their dependant(s) will immediately cease to be members of the Fund and all claims paid during this dual membership period will be immediately reimbursable to the Fund.
- Members may not cede (give away), transfer, pledge (promise) or give over to any third party any benefit, claim or part thereof.
- The relationship between NHP and its members is at all times one of trust and good faith. Upon acceptance, a member acknowledges and agrees to give NHP all and any information that may affect a decision that concerns him/ her, dependant(s) or claim(s).
- Whether benefits are used or not, members are obligated to pay for their monthly contributions to the Fund.
- Pro-rata benefits will occur upon joining or terminating membership during a benefit year. The benefit year runs from 1 January to 31 December.

MONTHLY CONTRIBUTIONS

Monthly contributions for employer groups, pensioners and private members are set out in the contribution tables of the Fund. All monthly contributions are determined following a comprehensive actuarial risk assessment of the inherent risks associated and arising from the demographic and claims profile of the Fund or an employer group.

Monthly membership contributions to the Fund are based on the age of the principal member. The age of the principal member in January of each financial year will determine the age category and therefore the monthly contributions for the remainder of that financial year. Monthly contributions are not increased in accordance with the principal members birthday during the course of the year.

Monthly contributions are payable in advance before or on the 7th day of each calendar month. The first payment needs to be made by electronic funds transfer (EFT). Debit orders will only be processed as from the 2nd calendar month of membership.

The employer bears the responsibility to ensure that all monthly contributions deducted and collected from members' salaries are paid over to the Fund no later than the 7th day of each calendar month in which monthly contributions are due in terms of the agreement.

New employer groups will only be provided with a system generated invoice once payment in respect of new members has been received and all members are loaded onto the system. Proof of membership will only be provided once the 1st monthly contributions have been paid over. In cases where the Administrator has not received payment by the 7th day of the calendar month, the Fund will have the right to suspend benefits or withdraw or refuse payment of benefits.

Where claims accounts have been paid, to either the healthcare provider or the principal member, during any period for which monthly contributions have not been received, the principal member will be held liable for the full claim's amount paid to the healthcare provider or the principal member, proportionate to the unpaid monthly contributions. Alternatively, should the principal member concerned settle his/her arrear debt to the Fund, he/she will be entitled to benefits for services rendered during the period of suspension.

PRE-EXISTING CONDITIONS

The Fund reserves the right to impose exclusions or restrictive conditions on pre-existing medical conditions as from the date of joining the Fund and for a period not exceeding 12 months as part of its underwriting criteria. The Fund will not impose exclusions on pre-existing conditions in the event of employees or individual members joining the medical aid fund within 3 months after having resigned from a previous medical aid fund due to employement changes.

In the event of a member with a pre-existing medical condition applying for membership the Fund may impose exclusions.

This is subject to the following conditions:

- In the event of an individual member applying for membership, such pre-existing conditions and subsequent medical treatment thereof, may be excluded from cover, if such application is not based on change of employement.
- In the event of a new employee with an existing employer group opting not to take up membership with the Fund within 3 months after being employed, such pre-existing conditions are regarded as anti-selective behaviour and may be excluded.
- In respect of a new employer group that has never subscribed to the Fund, the Fund reserves the right to impose exclusions in respect of pre-existing conditions as part of the underwriting criteria for a period of 12 months after the initial date of joining. If the new employer group does not agree to the Fund Rules, the Fund may decline the application request if the risk to the Fund is deemed to be too high.

Note: Exclusions on pre-existing conditions expire after a 12 month period.

GENERAL UNDERWRITING CONDITIONS

Underwriting is the process applied by the Fund to assess the risk profile of individuals or groups applying for membership. On completion of the application for membership a medical declaration will be compulsory for all members, irrespective of whether or not they have previously belonged to another medical aid fund.

Any failure to disclose any conditions, whether intentionally or unintentionally, which manifested or originated from the causes prior to admission as a member, or within 120 days from the date of such admission ("the underwriting review period"), will at the sole discretion of the NHP, be met with the following consequences:

- If NHP, in its sole discretion, believes any condition for which benefits claimed during the underwriting period may have existed or originated before commencement of membership, benefits will be put on hold until submission of such proof to confirm otherwise.
- If the member cannot prove beyond reasonable doubt that such medical condition was not present at the time of commencement of membership, then NHP, at its sole discretion, reserves the right to withhold benefits relating to the treatment required.
- NHP may exclude or limit any benefits in respect of the undisclosed condition and/or NHP may unilaterally terminate membership.

Medical declaration requirements for employer groups:

- Upon joining NHP, it will not be necessary for a new employer group to submit medical certificates for any of its employees, if all employees join the Fund within 3 months after becoming eligible for such membership.
- In respect of existing employer groups, it is not required to submit a medical certificate when enrolling a new employee, if such an employee joins the Fund within 3 months after becoming eligible for such membership.
- All employees joining the Fund must complete the medical declaration.
- The Fund reserves the right to return any incomplete membership application form before the employee is accepted onto the Fund.
- In order to manage the Fund's risk and to enforce the request for full disclosure, the Administrator will continue to monitor new members for a period of 120 days after they have joined and manage potential cases of non-disclosure for possible exclusions.

- Submission of a medical certificate is compulsory for employees not having exercised his/her right to become a member of the Fund within 3 months after becoming eligible for membership. The Fund reserves the right to impose exclusions in respect of any pre-existing conditions identified at that stage.
- The submission of a medical certificate is compulsory in the event of a member not having registered all his/her dependants within 3 months after becoming eligible for membership of the Fund. The Fund reserves the right to impose exclusions in respect of any pre-existing conditions identified at that stage.
- A medical certificate will be compulsory for any member wishing to enrol their aged parents as special dependants onto the Fund, either immediately upon joining the Fund or at a later stage.

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. The Fund will not impose a waiting period on a pregnancy and birth of the child in the event of an individual female joining the Fund within 3 months after having resigned from a previous medical aid fund due to employment changes.

Dependants:

- Members must apply to the Administrator for the registration of all dependants on date of admission, and must inform the Fund, through the Administrator, 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 join 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 during the 120 day review period that 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.
- The Fund will not impose exclusions on a pregnancy and birth of the child in the event of an employer group or individual female joining the Fund within 3 months after having resigned from a previous medical aid fund due to employment changes.

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.
- 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.

PRO-RATA ANNUAL BENEFITS

If a member joins NHP after 1 January in any benefit year, the member will receive benefits on a pro-rata basis. NHP calculates benefits for a period of 12 months from 1 January to 31 December. Pro-rata annual benefits apply for all Day- to-Day benefits and chronic

medication. This means that the Fund will reduce the annual benefit limits in proportion to the number of months remaining in the benefit year.

If a member registers a dependant during the course of a benefit year, the Fund will calculate benefits according to the number of months remaining for that benefit year. On joining the Fund a member will have the option of paying back-dated monthly contributions to the start of the benefit year in order to increase his/her benefits to the full overall annual limit.

Pro-rata annual benefits are applicable when joining the Fund in the course of the benefit year, but also on termination of membership during the course of the benefit year.

If a member terminates his/her membership from the Fund before the last day of the benefit year, he/she will be deemed to have terminated membership with the Fund on the last day of the calendar month in which his/her membership actually terminates. In such event, the provisions of the previous paragraph shall apply mutatis mutandis.

The Fund may recoup from the member or from his/her deceased estate, as the case may be, any sum disbursed by the Fund on behalf of such member or his/her dependants that exceeds the pro-rated portion of the annual benefits applicable to such member's membership at the date of termination of membership.

A FINANCIAL OR BENEFIT YEAR

The Fund's financial and benefit year runs concurrently from 1 January to 31 December. The Fund announces annually its new monthly contributions and benefits structure that will apply for the following year.

The Fund reserves the right to adjust monthly contributions with a one month written notice period in the event of unforeseen market changes.

The Roll-Over benefit is a low claims incentive through which unused Day-to-Day benefits below the threshold value will transfer from one year to another. At the beginning of the year, new NAMAF benchmark tariffs and benefits structures allocated to members in accordance with the benefit structure will apply for that particular benefit year.

BENEFIT OPTIONS

All benefit options cater for the medical needs of its members as well as affordability. The range of benefit options are developed in conjunction with consulting actuaries who specialise in healthcare financing, in order to create a flexible range of legislatively compliant, sustainable, actuarially sound and cost-effective benefit options.

OVERALL ANNUAL LIMIT (OAL)

The OAL is a specific amount allocated and defined either by an individual member or by a family. The OAL is the maximum amount the individual member or family may claim. Different sub-limits apply in respect of Major Medical Expenses and Day-to-Day benefits.

FAMILY FOCUSED BENEFITS

As the health status differs within a family, so do the requirements for medical services. In order to allow for greater flexibility in the utilisation of benefits, these are calculated on a "per family" benefit and can be added together and allocated to a single family member within a family, should this be required. A "per family" benefit applies wherein any registered dependant of the family may access any portion of the OAL and Day-to-Day qualifying benefit per sub-limit as may be determined based on the size of a family.

In principle, the Fund recognises that even within the same family the health risks and needs vary from person to person. The Fund enables members and their families to decide on how to best utilise their available benefits.

VALUE FOR MONEY CONTRIBUTION TABLES

The Fund's age-based contribution tables offer value for money by ensuring that the Fund's risk is properly distributed and that the monthly contributions charged are fair towards all members. It is important for members to understand the relationship that exists between the level of benefits provided relative to the monthly contributions that are charged and how these two variables influence each other.

CHOOSING THE RIGHT BENEFIT OPTION

NHP offers various benefit options and members have a choice between Traditional, New Generation, Hospital or Primary Care options.

Traditional benefit options

Gold, Platinum, Titanium

Covers almost all medical expenses offering various sub-limits in respect of benefits for in-hospital, Day-to-Day benefits and chronic medication, subject to the rules of the Fund. These benefit options are for individuals or families who are in need of comprehensive cover.

New Generation benefit options

Silver, Bronze

Have a pooled Day-to-Day medical component and benefits for almost all medical expenses and include benefits for in-hospital, Day-to-Day Expenses and chronic medication, subject to the rules of the Fund.

The Silver and Bronze benefit options are ideal for single persons and families who require comprehensive cover if they need to go to hospital in case of an emergency or a planned procedure wanting to enjoy the flexibility of pooled benefits for those Day-to-Day Expenses.

Hospital benefit option

Hospital

Covers accounts submitted for treatment by healthcare providers for in-hospital expenses only. Members are responsible for their own Day-to-Day Expenses, including emergency ward treatment.

The Hospital benefit option costs considerably less than Traditional and New Generation benefit options.

First determine the difference between the monthly contributions of the Hospital benefit option and that of a more comprehensive benefit option before making a decision.

The Hospital benefit option is for healthy members and families.

It is important to be aware that some procedures are not covered.

Primary Care benefit options

Blue Diamond and Litunga

Provides members and families with basic Day-to-Day benefits at affordable prices at a network of contracted healthcare providers and registered nurses. It might also be a good option for someone who cannot really afford full medical cover but still wants some peace of mind concerning treatment.

Designated Service Providers (DSP) refer to a healthcare provider or a group of healthcare providers and registered nurses contracted by the Fund to provide its members the diagnosis, treatment and care needed.

Blue Diamond and Litunga benefit option members are obligated to obtain their healthcare services from the DSP listed on the website, **www.nhp.com.na.** To ensure the quality of healthcare provided, the Fund assumes direct responsibility for the DSP network. These benefit options provide comprehensive cover for Day-to-Day primary care services as long as members and dependants use the DSP facilities.

Blue Diamond and Litunga benefits are not pro-rated with the exception of the optical, dental, self-medication and chronic medication benefits, where sub-limits are applicable.

Members should evaluate their benefit option

If a member notices that he/she has used up all their benefits at the beginning of the year and are having to pay for all other Day-to-Day expenses out of pocket, it would be worthwhile to reconsider the choice of benefit option. Compare the benefits offered and monthly contributions with a more comprehensive benefit option.

If a member's benefits run out, the member will have to pay for any further Day-to-Day expenses out of pocket. Take note of co-payments on certain procedures.

Some procedures might not be covered and if they are covered, the NAMAF benchmark amount should first be confirmed. If the specialist and anaesthetist charge more than what the medical aid fund is prepared to pay, members will be personally responsible for the cost.

Answers to the following questions will help make the final choice regarding the best benefit option:

1. Would I be limited to a network of hospitals?
2. What rate of hospital reimbursement is applicable?
3. Do I need additional chronic medication cover?
4. To what extent do I need Day-to-Day cover?
5. What contribution can I afford?
6. What is my family composition?
7. Are there any future planned procedures?
8. What are the current and past health conditions of the family?

INDIVIDUAL MEMBERS

Any person who is self-employed or financially independent and who is neither an employee nor a continuation member of a participating employer group may apply to become a member of the Fund. Members should be 60 years or younger at the date of applying for membership.

EMPLOYER/UMBRELLA GROUPS

Employees obtain membership with NHP by virtue of their employment with a particular employer group. Membership status will become effective on the first day of the calendar month, following the date on which approval was obtained from the Fund.

A member qualifies as a member of an employer group if his/ her membership derives from the participation in the Fund of an employer who employs at least 10 employees, who are members of the Fund.

An employer group, upon written application, may obtain membership for its employees if at least 10 of its employees, who qualify for membership, join NHP. An employer group will be classified as a compulsory group if all employees of the group who are eligible for membership, join the Fund. An employer group classifies as a voluntary group if the employer provides employees with the opportunity to choose from more than one medical aid fund which to join.

Should the number of members employed by the employer group decrease to less than 10 and not increase again to at least 10 at the beginning of each benefit year, the members of such employer group will be reclassified as individuals and be liable for the monthly contributions payable by an individual member. Should the employer group again employ at least 10 employees who are members, then such employer will be reclassified as an employer group and be liable for monthly contributions payable by members of an employer group.

The establishment of umbrella groups is aimed at providing recognised business and professional body member employers' an opportunity to join the Fund under employer group contribution rates.

Employers registered with any umbrella body or accredited broker/consultant body, may apply to join the Fund as an employer group. The condition for continued employer group status as part of an umbrella body is that companies or members should renew their

membership on an annual basis and provide proof of such updated subscription to NHP.

The underwriting conditions applied will be the same as for individual members, whilst qualifying for the reduced monthly contributions under the NHP employer group structure. Employer groups with fewer than 10 employees and not forming part of any other umbrella body may also apply to join the Fund but will not be eligible for the reduced monthly contributions.

Employees of a new employer group joining NHP from another medical aid fund with 10 or more employees are entitled to join the Fund. Such members have a window period of 3 months to apply for membership. Thereafter, the normal rules of the Fund as defined shall apply.

The provision of a medical history applies to any person who wishes to become a member of the Fund, even if he/ she does join the Fund within the defined 3 month period. A special application to waive this condition may, however, be made to the Fund in writing.

Members and dependants transferring from another medical aid fund will enjoy benefits from day one, with the same terms and conditions (state of health) as accepted by the previous medical aid fund, provided that such member and dependants were members of the previous medical aid fund for a minimum period of 2 years and were not without any form of medical aid fund cover for a period exceeding 3 months.

The Fund reserves the right to place exclusions on pre- existing conditions should a person not apply for membership within 3 months of becoming eligible for membership with the Fund. The Fund reserves the right to impose exclusions, in respect of pre-existing conditions, for a 12 month period after the initial date of joining.

STUDENT MEMBERS

Students who are not regarded as dependants on their parents medical aid fund, but apply for membership with the Fund, are required to pay their monthly contributions in advance for the benefit year (1 January to 31 December), once accepted.

Requirements for medical aid cover at tertiary institutions in South Africa:

South African universities and other tertiary institutions require Namibian students to obtain membership with any of the South African registered medical aid funds.

This requirement is enforced by means of the Amended Immigration Act, 2004 (Act 19 of 2004), which requires that all international students must submit proof of membership of a medical aid fund registered in terms of the 1998 Act on Medical Aid Funds in order to register. Failure to submit proof of paid up membership may result in the study permit being revoked.
It is important that parents whose children are studying in South Africa or intend to study in South Africa, enquire with the relevant authorities at the particular university or tertiary institution about the enrolment requirements concerning medical aid cover.

CONTINUATION OF MEMBERSHIP

Applies in 3 instances:

- Retirement of the principal member from active employment.
- Upon the death of the principal member.
- When a student child dependant turns 28 years old.

Retirees

A principal member may retain his/her membership with NHP as a continuation member together with his/her registered dependants.

In the event of retiring on pension from the service of his/ her employer or employment being terminated by his/her employer on account of age, ill-health or other physical/ mental disability, provided the employer's conditions of employment allows for such continuation of membership, then the member may continue as a pensioner member of that particular employer group, enjoying the full benefit of the employer group rates.

However, it may also be that the employer does not provide for pensioners to remain on the medical aid fund once they go on retirement. If the person has been a member of the Fund prior to retirement, the member will be entitled to transition from employer group status to individual membership status without new underwriting requirements applied, provided that such application is submitted within 3 months from the date of retirement.

This will still require that the member fills out a new application form as the basis of the contract between him/ her and the medical aid fund. Thus, in short, members who have been members of the medical aid fund prior to going on retirement, have the right to remain on the Fund if they comply with the requirements of the Fund.

Unless such member informs NHP in writing of his/ her desire to terminate their membership, they shall continue to be a member. NHP will be entitled to collect all contributions in terms of his/her membership in terms of their current benefit option.
A principal member, who receives a subsidy from an employer, needs to confirm whether the subsidy will continue after retirement. If not, the member will be responsible for the full contribution amount.

The principal member will remain on his/her current benefit option until the end of that financial year, where after he/she may elect to change benefit options in accordance with the rules of the Fund.

Upon the death of the principal member

The dependants of a deceased principal member must notify and provide a copy of the death certificate to the Fund as soon as possible.

The dependants of a deceased member, who are registered with NHP as his/her dependants at the time of such member's death, shall be entitled to retain membership with the Fund as continuation members without any new restrictions, limitations or waiting periods, provided that the contributions are paid up to date.

If a child dependant(s) is the sole survivor, the eldest child is deemed to be the principal member, as well as any younger siblings as child dependant(s), provided the monthly contributions are up to date.

The dependants of a deceased member have 30 days from the date of the deceased member's death to inform NHP in writing of their intention to resign from membership. The Fund should be notified within this period, that they shall continue as the principal member and the Fund will be entitled to collect all contributions in terms of their membership from the first day of the month following the principal member's death, irrespective of age.

For continuation of membership, the surviving dependant must, within 3 months after the death of the principal member, fill in a new membership application form submitting a copy of the death certificate.

If a surviving dependant chooses to be a member of another medical aid fund by virtue of employment, remarriage or otherwise, membership with the Fund will cease upon written confirmation of the intent to resign from the Fund within one month of such notice served.

In the terms of the rules of the Fund, if a surviving dependant no longer regards himself/herself as a child dependant, then that dependant shall cease to be a member/dependant of the Fund. Any remaining dependants regarded as children in terms of the rules of the Fund may assume the role of principal member. Any person, who no longer qualifies for membership as a dependant, is eligible for individual membership.

DEPENDANTS

To register a dependant, a dependant registration form must be completed and submitted to the Fund along with the required documentation such as copies of birth certificates when registering children, affidavits and marriage certificates for spouses and partners, proof of study and/or affidavits proving dependency for dependants over the age of 21 years.

The dependant registration form makes provision for the disclosure of pre-existing conditions that prospective dependants might have. Depending on the severity of the condition(s), the Fund may consider certain waiting periods before dependants can claim benefits.

Failure to disclose all pre-existing conditions could limit or exclude a member from claiming benefits. In such event, he/ she may be required by the Fund to refund any sum which, but for his/her abuse of the benefits or privileges of the Fund would not have been disbursed on his/her behalf.

Adult and "special adult" dependants

Adult dependants are older than 21 years and can be a spouse or life partner. Spouses who are registered within 30 days of marriage will qualify for benefits immediately. A marriage certificate or affidavit must be submitted with the dependant registration form.

A life partner is the person with whom the principal member has a sustained committed, serious relationship akin to a marriage based on objective criteria of mutual dependency and a shared and common household continuously for 12 months, irrespective of the gender of either party and may be registered as the member's adult dependant provided that he/she is not a member or entitled to membership of another medical aid fund. The registration is subject to the approval of the Fund.

Only one first dependant may be registered as a beneficiary in the event that a divorced person decides to remarry or add a person as a common law spouse. An ex-partner may not remain as a dependant if another spouse or partner is added.

Children over the age of 21 years, suffering from any mental/ physical disability who are not spouses or life partners, but solely dependent on the principal member for healthcare and financial support can register as a special adult dependant. An affidavit proving this dependency is required.

Acceptance of a child born to a child dependant as a registered special dependant is subject to the approval of the Fund.

Should your contributions be subsidised by your employer, you will have to confirm whether such an arrangement can be accommodated.

Aged dependants

A principal member can apply to register an aged parent who is older than 60 years, solely and totally dependent on the principal member for healthcare and financial support, submitting proof of dependency and a direct biological relationship. Proof of financial hardship will be required.

Principal members are limited to registering two aged dependants. Approval of the application to enrol aged parents onto the medical aid fund is subject to the discretion and approval of the Fund. The decision of the Fund will be final and cannot be appealed.

A 3 month general waiting period applies in respect of aged parents, in addition to a 12 month specific waiting period for pre-existing conditions.

Child dependants

- Biological and legally adopted or custodian unmarried, unemployed children under the age of 21 years, who are totally dependent on the principal member.
- To register a child dependant, a full birth certificate, identity document, or affidavit (where the child's surname is not the same as the principal member's) is required.
- A medical report and declaration of dependency must be submitted for child dependants who are mentally/ physically disabled.
- Children under the age of 21 years, both of whose parents have passed away and who are financially dependent on the appointed guardian. A copy of the death certificate of such parents as well as proof of guardianship must be submitted.

Student dependants

- Biological and legally adopted or custodian unmarried, unemployed children enrolled as full-time students at a registered and accredited academic institution may remain on the principal member's medical aid up to the age of 27 years, provided they are financially dependent on the main member and continue paying child dependants' contribution rates.
- Proof of study must be submitted for child dependants who are students.

Once they turn 28 years of age, they are no longer allowed to stay on their parents' medical aid as a child dependant, and can continue as a private individual member on their own medical aid, should they choose to.

Students that complete their studies and start working, can no longer stay on their parents' medical aid as child dependants, and can continue as a private individual member on the medical aid, should they choose to.

No waiting periods or exclusions will apply should they take up membership with the medical aid within 3 months after being terminated on their parents' medical aid. They will be loaded as continuation members.

Should they apply for membership with the medical aid fund, 3 months after being terminated on their parents' medical aid, underwriting rules will apply.

Birth of a child

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.

The following conditions will apply:

- If the mother or father is registered as a member / adult dependant on the Fund, then the newborn will be registered as a dependant from the date of birth.
- A newborn child may be registered as a dependant on the existing membership of a parent, guardian, or adoptant with effect from the date of birth and without underwriting, provided the registration with the Fund occurs within thirty (30) days of birth. Contributions for the newborn shall commence from the first day of the month following the birth.
- Where an application for registration of a newborn is submitted more than thirty (30) days after the date of birth, the Fund may apply underwriting to such registration. In such cases, contributions shall be due from the first month following birth.
- No restriction for congenital ailments and conditions will be imposed by the Fund on a newly born child, if registered in accordance to the Rules of the Fund.
- 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.

PAYING FOR MEDICAL AID

Members must use their membership number or employer group number as reference when making payment.

Banking details:

Account name:	**NHP**
Bank name:	**Bank Windhoek**
Account number:	**108 228 9601**
Branch name:	**Windhoek**
Branch number:	**481 972**

MEMBERSHIP CARD

Upon acceptance, members will receive one membership card. Members can request for an additional membership card.

A membership card is proof that the holder is a registered NHP member. Upon termination of membership, members must destroy their membership cards.

To prevent possible fraud, always keep membership cards in a safe place. A membership card must never be used by anyone other than the principal member or his/ her registered dependants.

1NUMBER4LIFE

Members are able to retain their original membership number from the date of joining to the date of termination of membership, irrespective of whether the member has changed benefit options during his/her period of membership with the Fund.

FOREIGN ACCOUNTS

The Fund covers for available benefits within the borders of Namibia and South Africa. The Board of Trustees may, in its absolute discretion, pay for benefits for medical treatment obtained in Botswana, Zimbabwe, eSwatini, Lesotho, Mozambique, Angola and Zambia, provided all accounts are printed in Standard English with appropriate medical terminology and breakdown of treatment.

Members intending to travel outside the borders of Namibia must register and apply for the international travel benefit prior to departure.

The Fund shall not be obligated to make special arrangements to obtain foreign services or medicines for special conditions.This includes harvesting and transportation of organs and tissue for transplants and any medicines or medical services of any kind that are available only outside of Namibia or South Africa.

NOTIFICATION FOR CLAIMS SUBMITTED FOR PAYMENT

Through the Nexus Administration System, the Fund communicates with its members via email and SMS regarding his/her utilisation of benefits as well as changes regarding membership status. Members are required to give their correct cellphone number. If a member does not have an email address, the Fund will post their monthly remittance statement.

Typical events include notification of the following:

- Claims acknowledgement – Captured
- Claims payment - Next pay run
- New member – Captured
- New member – Active
- Card generation
- Change of membership/dependant details
- Change of bank account details
- Membership suspension/reinstatement
- Membership termination
- Voice of Customer (VOC) emails

This tool serves as a method for creating greater awareness of claims submitted on behalf of the member, thereby reducing abuse and fraud against the Fund.

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 beneficiary 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).

A termination of membership form must be completed and sent via fax 061 230 465 or emailed to members@nhp.com.na.

In addition, in order to keep members informed of critical healthcare 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.

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.

TERMINATION OF MEMBERSHIP

Members can resign from the Fund at any time during the benefit year by submitting a one calendar month's written notice, starting on the first day of any calendar month.

A member serving a notice period is still entitled to receive available benefits until the last day of the notice period.

Once a member's or dependant's membership has been terminated with the Fund, such a member or dependant will only be allowed to re-join the Fund at the beginning of a new financial year, unless this membership is through a participating employer group or is due to a change in employment. Change of employment by the individual member must be proven.

Resignation:

- Upon resignation, the member forfeits to the Fund, any accumulated positive balance from their Roll-Over benefit account.
- If a member resigns during the course of a benefit year, the liability of the member will be limited to the amount of unpaid monthly contributions, together with any benefits incorrectly disbursed by the Fund. In the event of a member having outstanding amounts owing, members must pay all monies upon resignation.
- The member remains liable for payment of contributions to NHP irrespective of whether he/she receives financial assistance from an employer. An employer subsidy remains a matter between the member and the employer.

Termination of an employer group's membership:

An employer group wishing to terminate its contract with the Fund must provide the Fund with one calendar months' written notice, per registered mail and /or email of such intention. Failing this, the employer group will be held liable for one months' contributions calculated as the average monthly contributions over the preceding six months.

Proportional annual benefits will apply to a membership period shorter than twelve (12) months (one calendar year).

Termination of a principal member's membership:

- On resignation of the principal member from an employer, where membership was a condition of service and the principal member did not opt to retain it.
- Upon the death of the principal member.
- When the member submits a one calendar month's written notice of termination to the Fund.
- When a principal member no longer qualifies for membership in terms of any other stipulation as contained in the latest Fund Rules.
- If the Fund finds that, a principal member and/or dependant(s) have misused their benefits.

Termination of a dependant's membership:

- When the principal member's membership is terminated.
- When the principal member terminates his/her dependants membership, giving a minimum of one calendar month's written notice.
- If the Fund finds that a principal member and or dependant(s) have misrepresented or committed fraud relating to his/her benefits.

Certificate of membership:

- Upon termination of membership, the Fund will provide a certificate of membership upon request. Certificates are also available for download under the NHP Login Portal on the Funds website www.nhp.com.na, or on the NHP mobile app.

Reinstatement of membership:

- A member may apply for reinstatement of membership within 30 days from the date of notification of termination, if all outstanding debts are settled.
- Suspension of membership in the case of contributions being in arrears does not imply that membership will be terminated.
- Whilst suspended, payments for any outstanding claims will be rejected until any outstanding monies are paid and membership has been reinstated.

NHP will terminate membership on the following conditions:

- Non-disclosure of material information such as if a member fails to inform the Fund about a certain medical condition.
- Failure to pay contributions by due date, as stated in the rules of the Fund.
- The Board of Trustees may exclude from benefits or terminate the membership of a member or dependant whom the Board finds guilty of defrauding, abusing the privileges of or otherwise acting in a manner prejudicial to the interests of the Fund. The member will be invited to respond to such allegation, which will be considered in the Board's review. If upheld, the Board may require the member to refund the Fund any sum, which, but for the abuse of the privileges of the Fund, would not have been disbursed on their behalf.

Termination of membership within three months of joining:

- The membership of individual members or their dependants who terminate their membership within three months from date of inception onto the Fund will have that membership declared null and void de novo, with all contributions and benefit payments proportionately returned to the member or the Fund respectively.
- The member will be responsible to the Fund for any benefit payments in excess of contributions received. Beyond the initial three months from inception, routine termination processes will be required with one months' prior written notice to the Fund.

BENEFITS:

BENEFITS

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 can be emailed to **claims@nhp.com.na.**
- If members select the automated claims process, the completed form can be emailed 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 benchmark tariff for medical services covered by the rules of the Fund.
- 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 code and Nappi code which is not rendered by a registered healthcare 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.

TRAVEL ASSISTANCE BENEFIT

Travelling costs for specialist treatment in Namibia

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

Members living in remote and outlying regions of Namibia, in need of specialist treatment referred by their local healthcare provider, provided the particular treatment is not available in their town of residence and thus need to travel in Namibia for treatment, may apply to the Fund for assistance in defraying some of the transportation costs to and from their town of residence.

The following conditions will apply:

- No referrals within a radius of 150km outside of home town shall qualify for consideration.
- Transportation costs for specialist treatment, required in Namibia.
- 80% of the transportation cost for the first and all subsequent visits for the same medical condition will be paid.
- All claims for reimbursement are subject to pre-authorisation.
- The Fund will not pay for claims submitted, if there is no pre-authorisation number.
- Members travelling in their own vehicle must submit a detailed log sheet and attach all supporting fuel slips.
- Members must submit a referral letter from a healthcare provider to a specialist when services are not available in their town of residence.
- The Fund will only cover for one fill-up in the town of residence on arrival.

- Members must attach a confirmation of the appointment with the specialist to the travelling claim.
- No fill-up will be refunded on departure from town of residence.
- Benefits exclude orthodontic treatment. Only the travelling cost for the first consultation will be paid.
- All travelling costs for auxiliary services are excluded.

Note: Travelling costs for specialist treatment in Namibia for Blue Diamond benefit option is limited to 2 visits per family per year, with a limit of N$ 883 per visit.

Travelling cost for specialist medical treatment within South Africa

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

In the event of a member being in need of a specific medical treatment or a procedure not available within Namibia and on application, the Fund may assist in defraying some of the transportation costs only to and from South Africa, provided that the treatment is not subject to specific exclusions.

The following conditions will apply:

- Members travelling with their own vehicle must submit a detailed log sheet and attach supporting fuel slips.
- Members must submit a bona fide referral letter from a specialist in Namibia.
- The Fund will only cover for one fill-up in the town of residence on arrival.
- Members must submit a confirmation of an appointment with a specialist in South Africa.
- No fill-up will be refunded on departure from town of residence.

Benefits include:

- 80% of transportation costs in respect of the first and any subsequent visit.
- Commercial flights or approved flights will be organised by the Fund with a registered service provider.
- 80% of transportation costs in respect of the guardian accompanying the child dependant. A guardian must accompany a child dependant if the child is a minor,18 years and younger when travelling to South Africa.

Benefits exclude:

- Transportation costs to and from the airport.
- First and business class and any chartered flight.
- Failure to obtain pre-authorisation will result in the Fund not accepting any liability in respect of such costs, unless in the case of a medical emergency.
- Transportation costs to and from South Africa if the services are available within Namibia, unless a specific exemption has been approved by the Fund.
- Accommodation for the accompanying guardian.

Accommodation other than a recognised hospital or medical institution in Namibia

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

In the event of a member living more than 150km outside of an urban center being referred to a specialist in Namibia for treatment, the Fund will contribute towards the cost of accommodation at a recognised and accredited accommodation establishment such as a guest house or bed and breakfast.

The following rates will apply:

- N$ 953 per night, maximum of 2 nights per family per benefit year.
- This benefit excludes members on the Blue Diamond and Litunga benefit options.
- No claim will be considered if the member did not receive pre-authorisation to claim such expenses from the Fund.

Benefits exclude:

- Any form of accommodation or lodging fees in a medical recovery facility or old age home, frail care facility, institutions for the physically/mentally disabled or similar.
- Any form of accommodation or treatment in spas and resorts for health, slimming, chiropractic, homeopathic or similar purposes and home nursing.
- Accommodation in a private room of a hospital, except when clinically motivated by a healthcare provider and pre- authorised by the Fund.
- The cost of holidays for recuperative purposes, whether deemed medically necessary or not.
- Accomodation for insurance and physical examinations related to examinations for purpose of employment, fitness tests, school camps, visa, insurance cover or similar purposes.

Accommodation other than a recognised hospital or medical institution within South Africa

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

This benefit provides cover for a patient's accommodation according to a specific amount per day for accommodation other than a recognised hospital or medical institution. This benefit excludes an accompanying spouse/partner or guardian unless the patient is a minor 18 years and younger, whilst the patient is in hospital.

This benefit is aimed solely at members who are not hospitalised but are required to attend treatment, consultations or examinations in-and-out of hospital while referred to South Africa for treatment.

This benefit will only apply to treatment received in South Africa on special referral and is subject to pre-authorisation at a rate of N$ 953 per day, per family.

MATERNITY BENEFIT

The Maternity benefit covers Day-to-Day and in-hospital expenses for expectant mothers and newborns. Pre-notification and pre- authorisation is essential in order to qualify for Maternity benefits.

A female who is not registered as a member or dependant at the time she falls pregnant will not be eligible for any maternity related benefits in terms of the rules for the entire pregnancy and the birth of the child.

The Fund will not impose exclusions on a pregnancy and birth of the child in the event of an employer group or individual female joining the Fund within 3 months after having resigned from a previous medical aid fund due to employment changes.

In the event of a new employee with an existing employer group opting not to take up membership with the Fund for either him/ herself or any dependants within 3 months after becoming eligible for membership and if such employee finds herself or a dependant of the principal member to be pregnant and would like to join the Fund after the 3 month period has expired, then an exclusion will be imposed with respect to the pregnancy as well as the childbirth. The Fund will impose a condition specific waiting period of 12 months on maternity benefits.

The Fund will cover the costs of confinement in hospital for a period of up to 3 days for normal vaginal deliveries and up to 5 days for caesarean sections. The mother must provide the Fund with a motivation letter from her doctor should the need arise for a longer period of stay. The Fund will cover lodger fees for breast- feeding mothers of newborn babies if motivated by the attending doctor.

It is important for expecting mothers to obtain hospital pre-authorisation. In case of an emergency, pre-authorisation can be obtained on the day or the day after the birth.

Remember that it is very important to pre-authorise and we suggest that members obtain a time line from their doctor and pre-authorise before the special day. Pre-authorisations can be obtained from Managed Care department or via email: cases@nhp.com.na.

Remember that newborn babies should be registered as a child dependant within 30 days after the date of birth. NHP does not automatically register the baby as a child dependant. It is extremely important to register the baby as soon after the birth as possible to ensure that any related medical costs are covered. A copy of the full birth certificate is required. The Fund will not impose any restriction for congenital ailments and conditions on a newly born child, if registered in accordance to the rules of the Fund.

If a member applies to register a newborn or newly adopted child as a dependant after 3 months of the date of birth or adoption of the child, the Fund may subject the child dependant to a condition specific exclusion. A condition specific exclusion medical declaration will be required for the child dependant.

Benefits exclude:

- Appointments not kept.
- Breast-feeding instructions.
- Mother-craft.
- Pre-and-post antenatal exercise classes, including hydrotherapy by physiotherapist.

In respect of infertility, the following services are excluded:

- The treatment and diagnosis of infertility and any related expenses.
- Artificial insemination of a person as defined in the Human Tissue Act 1993.
- Reversal of vasectomy.
- Reversal of sterilisation.

INTRA UTERINE DEVICES

- The Fund will pay for the insertion of intra uterine devices (IUD) and contraceptive implants, up to a maximum amount of N$ 8 057 per female dependant every 3 years.
- This benefit excludes Blue Diamond and Litunga.
- Members who have claimed for the device will not be able to claim for oral contraceptive medicine during the 3 year period.
- Pre-authorisation is required.
- The Fund will pay for IUD devices, in or out of hospital, subject to the available benefits, for all services included.

DENTISTRY BENEFIT

Dentistry: In-hospital

The dentistry in-hospital benefit is subject to pre-authorisation providing cover for the following treatments:

- Maxillo facial surgery: Not planned, involving the case of an accident, surgical removal of tumours and neoplasm's, trauma, congenital birth defects and other major surgery.
- Oral surgery: A planned surgery benefit for all services regarding a doctor, anaesthetist, hospitalisation and medication, involving impacted wisdom teeth, surgical removal of apicectomy and other surgery. There is no oral surgery benefit for basic dentistry.
- Jaw related surgery and facial surgery: As a direct result of trauma, e.g. a motor vehicle accident.

Benefits granted for general anaesthetics, conscious analgosedation and hospitalisation for dental work are only in the event of children under the age of 10 years and younger.

Dental implants for the Gold and Platinum benefit options:

- Members qualify for a separate dental implant benefit under the OAL. For all other benefit options, if available, this is included under the normal Day-to-Day advanced dentistry benefit.

- The benefit provides a set benefit for treatment in hospital for surgery and a separate benefit for consultations, procedures and the cost of the implant(s).
- Dental implants are subject to pre-authorisation referring to applicable sub-limits.

Dentistry: Out-of-hospital

The dentistry benefit includes conservative dental treatment, orthodontic treatment and dental implants under the Day-to-Day benefit unless indicated to the contrary.

Orthodontics

Any treatment plan for orthodontic treatment must be pre- authorised before any treatment may commence. The treatment plan must clearly state right from the outset whether orthognathic surgery for the correction of malocclusions and split osteotomy are required at the end of the treatment.

Pre-authorisation against a treatment plan is required in order to protect the member against any nasty surprises if, at the end of treatment, orthognathic surgery for instance is required but not pre-authorised.

The following rules apply for orthodontic treatment and especially orthognathic surgery in the case of correction of malocclusions and split-osteotomy:

- Orthodontic treatment, not fully disclosed upon joining the medical aid fund, may be excluded for a period of 12 months after joining if it is found that no proper disclosure took place when the member submitted his/her membership application form.
- Orthodontic treatment falls within the provision made for under Day-to-Day benefits and as provided for in the rules of the Fund.
- Orthodontic treatment in general forms part of the normal Day-to-Day benefits with sub-limits that may apply.
- Orthodontic treatment normally takes place in a dental practice and treatment may extend over a period of 18 to 36 months depending on the extent of treatment required.
- All orthodontic treatment needs to be pre-authorised prior to the actual treatment commencing. Members therefore need to submit a comprehensive treatment plan. In return, the member will receive an authorisation number and treatment may proceed.

Members must submit the following information with their first account:

- A treatment plan indicating the total cost that will be charged by the orthodontist for the treatment, the duration of the treatment, the initial fee and the monthly fee payable, which will be levied on the member.
- Applicable to NAMAF benchmark tariff codes.

Orthognathic surgery

Orthognathic surgery if required, needs to be motivated by the treating specialist especially if it does not relate to trauma, cancer, a congenital deformity, reconstructive surgery or other extenuating circumstances, which may require such treatment.

There is no benefit for orthognathic surgery provided under the dentistry in-hospital benefit. If a member requires such surgery, the Fund advises members to submit their applications to the Ex-Gratia Committee for consideration. Orthognathic surgery excludes procedures elective and cosmetic in nature.

Health tip: Based on best practice advice, it is the opinion of the medical advisory board that orthodontic treatment is considered most effective if it takes place before the age of 18 years.

Dental implants

Dental implants are subject to pre-authorisation. A set benefit for the full procedure will apply, e.g. metal implant, doctor, hospital and anaesthetist. The Gold and Platinum benefit options cover for dental implants as per the benefit sub-limit. Please refer to the dental Day-to-Day sub-limit applicable to the Titanium and Silver benefit options.

Benefits exclude:

- Labial (maxiliary) frenectomies in respect of beneficiaries under the age of 11 years.
- Lingual frenectomies in respect of beneficiaries over the age of 8 years.
- Periodontal plastic procedures for cosmetic reasons.
- Bleaching of teeth.
- Mouth protectors, gold inlays, devices and materials such as floss, toothbrushes and toothpaste.
- Any dental procedures recommended for cosmetic purposes.
- General anaesthetics, conscious analgo sedation, and hospitalisation for dental work, except in the case of patients 10 years and younger or bony impaction of the third molars.
- All general anaesthetics and conscious analgo sedation in the practitioner's rooms, unless pre-authorised.

OPTICAL BENEFIT

The Fund's benefit year runs from 1 January to 31 December, with the exception of the frame benefit under the optical benefit that runs for a period of 2 years.The optical benefit covers for healthcare services related to the health of the eyes.The Fund pays for frames, lenses, and contact lenses, subject to the sub- limit applicable to each benefit option.

It is possible for one dependant to use the full family benefit, but each claim is limited as specified. Members are limited to one set of frames with a monetary limit per registered dependant, every 2 years.

A frame can only be claimed when the invoice states that the old lenses are transferred or re- edged, and must be accompanied by an eye test consultation. Members may replace their lenses more frequently as prescription changes.

These claims are limited, applicable to the optical sub-limit as well as the per frame limit. Cover for refractive surgery is under the refractive surgery benefit.

The optical benefit for a set of spectacles for Blue Diamond and Litunga members runs for every 2 years.

Benefits exclude:

- Contact lens solutions
- Colour contact lenses
- Scripts less than 0.50 dioptre
- Spectacle cases
- Spectacle repairs
- Tints higher than 35%
- All types of sunglasses, whether or not prescribed by an optometrist or ophthalmologist.
- The fee associated with the fitting and adjustment of contact lenses.

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 healthcare provider's consultations. It should be noted that a 0% levy applies to all chronic medicine prescribed, irrespective of whether it is dispensed by a pharmacy or any other registered healthcare provider on condition that the member is registered on the Chronic Care Programme.

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

Once you have registered onto the Chronic Care programme, there will be no need to register annually, unless there is a new diagnosed condition, change in medication and/or dosages.

Eligibility requirements for accessing Chronic Medication benefits:

To qualify for the chronic medicine benefits, it is 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 requirement 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 patiens 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 diabetic patients on the Gold, Platinum and Titanium options 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 devices 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)

- The benefit, “Diabetic Devices benefit” has been created in order to provide partial funding for the costs associated with Insulin pumps, Glucose monitoring devices and Glucose readers.
- Funding of the Diabetic Devices benefit for members on these options can only be accessed if referred and approved on Ex- Gratia basis - subject to application and pre-authorisation.
- Access to this benefit is limited to a 4-year cycle.

Gold Option

- Per family = N$ 50 414 – covered at 80% of NAMAF benchmark tariff and further limited to a 4 year cycle i.e. 2026 to 2029.
- Diabetic related consumables = N$ 62 220.

Platinum Option

- Per family = N$ 47 474 – covered at 80% of NAMAF benchmark tariff and further limited to a 4 year cycle i.e. 2026 to 2029.
- Diabetic related consumables = N$ 57 035.

Titanium Option

- Per family = N$ 41 485 – covered at 80% of NAMAF benchmark tariff and further limited to a 4 year cycle i.e. 2026 to 2029.
- Diabetic related consumables = N$ 51 850.

The following conditions will apply:

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.

Diabetes related consumables:

- Enhancement of diabetes related consumables for diabetic devices on Gold, Platinum and Titanium.
- Consumables (e.g. Insulin, needles, syringes, lancets) for Insulin pumps, Glucose monitor systems and Glucose readers will be funded in accordance with clinical protocols – Annual benefit.

OPTION	2026 BENEFIT
Gold	N$ 62 220
Platinum	N$ 57 035
Titanium	N$ 51 850

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 funded from the Appliances Benefits.

- 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 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.

Depending on benefit option, a 20% or 10% 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$ 278 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$ 993 per family per year. This includes all schedule 0, 1, and 2 medication. Claims in respect of self-medication will be limited to N$ 283 per claim including oral contraceptives and injections on Blue Diamond.

Benefits exclude:

- 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) benefits in respect of consultations with doctors/specialists/nurses, and related scripts for medicines and injection materials, will be limited to the benefit amounts indicated in the specific option schedules.

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.

SMART SAVER BENEFIT

Preventative Care Incentives

- The member is incentivised to utilise the Fund's available preventative care benefits.
- This benefit is granted on a per beneficiary basis i.e. if two members in the same family go for the same test then both beneficiaries may be rewarded/incentivised (e.g. 2 x N$ 169 for Bone Density testing for a pensioner couple).

- The rules pertaining to Preventative Care benefits will apply and be taken into consideration when quantifying the amount applicable and to be transferred to the member's Accumulated Roll-Over Account.

The benefits will be applied on each option and for each preventative care benefit as follows:

WOMEN'S HEALTH

Breast cancer screening:

- Mammograms: Breast cancer screenings for females aged 40 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$ 961 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:

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.

Before employer groups embark on hosting a flu vaccine campaign they should contact the Fund in this regard. Contact wellness@nhp.com.na for more details.

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.

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

EX-GRATIA APPLICATIONS FOR ADDITIONAL BENEFITS

Should the need for an Ex-Gratia request for financial assistance arise, members are advised to contact NHP for assistance in completing and submitting the relevant forms. The Fund is under no obligation to grant anything in respect of an application if it is of the opinion that the application does not meet its qualifying criteria.

The overarching principles applied to evaluate ex-gratia applications are:

- clinical necessity;
- financial hardship of the member and;
- cost benefit to the member and the Fund.

Members must provide full disclosure of their financial status when completing a form for Ex-Gratia assistance. Withholding of critical financial information may result in the Ex-Gratia Committee or Board of Trustees not being able to obtain a truthful reflection of the members level of financial hardship and may result in an application being declined or delayed.

INTERNATIONAL TRAVEL BENEFIT

This benefit provides cover for up to N$ 10 000 000 per beneficiary for medical emergencies whilst travelling outside of 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 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 any further enquiries in this regard, please contact NHP Call Centre.

FUNERAL BENEFIT - OPTIONAL

Contact the Administrator, Medscheme Namibia for further details.

EXCLUDED MEDICAL BENEFITS

With due regard to applicable legislation and the registered rules and benefit guide of Namibia Health Plan (the 'Fund'), expenses in connection with any of the following shall not be paid by the Fund:

Medicines

1.1 Medicines or chemotherapeutic agents not approved by the Namibia Medicines Regulatory Council (NMRC) unless approval is obtained and pre-authorised by the relevant Managed Healthcare Programme.

1.2 Anabolic steroids and immunostimulants and remedies for body building purposes or exercise and sport specific enhancers.

1.3 Growth hormones, unless pre-authorised.

1.4 Immunoglobulins and immune stimulants, oral and parenteral, unless pre-authorised.

1.5 Erythropoietin, unless pre-authorised.

1.6 Slimming preparations for obesity.

1.7 Treatment for loss of libido.

1.8 Injection and infusion material, except for out-patient parenteral treatment and diabetes as prescribed by a registered medical practitioner.

1.9 The following medicines, unless they are authorised by the relevant Managed Healthcare Programme:

a. Liposomal Ampthotericin B for fungal infections;

b. Protein C inhibitors such as Xigris, for septic shock and septicaemia;

c. Cancer treatment outside managed care protocols;

d. Herceptin (Trastuzumab) for the treatment of HER2-positive early breast cancer that exceeds the dose and duration of the 9 week regimen as used in the FinHer protocol;

e. Any specialised drugs not included in the applicable Managed Healthcare protocols for that option that have not convincingly demonstrated a median overall survival advantage of more than 3 (three) months in advanced or metastatic solid organ malignant tumours, unless deemed cost effective for the specific setting, compared to standard therapy (excluding specialised drugs) as defined in established and generally accepted treatment protocols.

1.10 Erectile dysfunction medical treatment.

1.11 Biological drugs for non-oncology treatment, unless pre-authorised.

1.12 Medicines not included in a prescription from a registered medical practitioner or other healthcare provider who is legally entitled to prescribe such medicines, except for schedule 0, 1 and 2 medicines supplied by a registered pharmacist.

1.13 Medicines not authorised or defined as exclusions by the relevant Managed Healthcare Programme.

1.14 New medicines or those with additional registered indications, that have not been reviewed by the relevant Managed Healthcare Programme.

1.15 Cosmetic preparations, emollients, moisturisers, medicated or otherwise, soaps, scrubs and other cleansers, sun-tanning preparations, medicated shampoos and conditioners, except for the treatment of lice, scabies and other microbial infections and coal tar products for the treatment of psoriasis.

1.16 Patent medicines, household remedies and proprietary preparations and preparations not otherwise classified.

1.17 Traditional and Indigenous Medicines, except Chinese medicines as prescribed by a registered Chinese Medicine Practitioner.

1.18 Anti-habit-forming drugs and medicines for alcohol or drug addiction.

1.19 Medication and clinical services as advertised directly to the public.

Appliances

2.1 Appliances, devices and procedures not scientifically proven or appropriate.

2.2 Continuous Glucose Monitoring Systems unless provided for in the option benefit guide and pre-authorised.

2.3 Cardiac assist devices, e.g. Berlin heart.

2.4 Custom made compression garments.

2.5 Diagnostic kits, agents and appliances unless otherwise stated, except for diabetic accessories.

2.6 Pain relieving machines, e.g. TENS and APS.

2.7 Repair of hearing aids, spectacle frames or lenses and medical apparatus beyond available benefits.

2.8 Breast pumps and baby/apnoea monitors.

2.9 Orthopaedic shoes and boots, unless specifically authorised.

2.10 Pulse oximeters.

2.11 The hire or purchase of oxygen apparatus or gases, unless authorised.

Expenses for the following

3.1 Services not considered appropriate in terms of Managed Healthcare Principles, or that are not lifesaving, life sustaining or life supporting. The Fund reserves the right to determine such instances in general or for specific instances at any time, at its discretion;

3.2 All costs which are not:

a. medically necessary and appropriate to meet the health care needs of the beneficiary;

b. consistent with the diagnosis or condition;

c. rendered in a cost-effective manner and type of setting appropriate to the supply of the service required for purposes other than comfort or convenience;

d. appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition at an affordable level of service and cost.

3.3 All costs for treatment, if its efficacy and safety cannot be proved to the satisfaction of the Fund or have not been published in scientific peer-reviewed journals or in standard medical texts.

3.4 Compensation for pain and suffering, loss of income, funeral expenses or claims for damages.

3.5 Services rendered by any person not registered under his/her applicable statutory body, either in Namibia or South Africa.

3.6 All services for which a beneficiary was specifically excluded for the first 12-months' of membership.

3.7 The cost of services related to complications resulting from a procedure or condition specifically excluded by the Rules of the Fund.

3.8 Services in excess of the annual maximum benefits or applicable sub-limits in terms of the Rules of the Fund.

3.9 Treatment of an illness or injury sustained by a member or a dependant of a member where such illness or injury is directly attributable to failure to carry out the instructions of a healthcare provider or to negligence on the part of the member or dependant.

3.10 Accommodation in convalescent, old age homes, frail care or similar institutions, and assistance in the home environment unless provided for in a benefit option, and holidays for recuperative purposes.

3.11 All benefits for clinical trials/research, or such ongoing treatment thereafter.

3.12 Operations, medicines and treatments of a cosmetic nature, which shall be determined by the Fund at its discretion.

3.13 The treatment of obesity, including surgical treatment (unless specifically authorised) and gastric balloons.

3.14 Platelet-rich plasma.

3.15 Hyperbaric oxygen treatment.

3.16 Robotic Assisted surgery, unless specifically authorised.

3.17 Erectile dysfunction surgical procedures.

3.18 Gender re-alignment and Gender re-assignment treatment and surgery.

3.19 Vaginoplasty.

3.20 Surgical procedures and appliances for snoring.

3.21 All services for infertility and any related expenses including artificial insemination of a person as defined in the Human Tissue Act, 1993, and all services for surrogacy.

3.22 Bandages and dressings, except for medicated dressings or bandages applied after a procedure in a medical facility.

3.23 Pilates, and other exercise programmes unless prescribed and approved for treatment or rehabilitation.

3.24 Back rests, chair seats and pillows, bed and mattresses and other household appliances, e.g. toilet seat raisers, shower and bath rails, humidifiers, ionisers and air purifiers, electric tooth brushes, etc.

3.25 Diagnostic agents, unless pre-authorised.

3.26 Food and nutritional supplements including baby food and special milk preparations unless prescribed for malabsorptive disorders and if registered on the relevant Managed Healthcare Programme or for mother to child HIV transmission, prophylaxis, if registered on the relevant Managed Healthcare Programme.

3.27 Tonics, evening primrose oil, fish liver oils, patented food or medicines, special foods, and injections for the treatment of obesity, and nutritional supplements (including baby foods). This exclusion does not apply to registered products that include haematinics or to products used for:

a. Supplementation to pregnant mothers and infants during lactation;

b. Vitamins and multi-vitamins, where these are:

i. For children under 5 years of age;

ii. For adults over 50 years of age;

iii. For use during pregnancy, as provided for in the benefit guide;

iv. Prescribed by a person legally entitled to prescribe for a special diagnosis registered and authorised by the Fund, or;

v. Claimed as self-mdication.

3.28 Assessment for children or tests to determine school readiness, except for clinical diagnostic tests used for the identification of developmental delays.

3.29 The following counselling and therapy services: family, marital and social support, sex therapy, stress management, study tips, life and business coaching, career guidance, employee assistance programmes, dietetics therapy, mental health group and directive therapy, sleep therapy, music therapy, child kinetics, hypnotherapy, reflexology, etc.

3.30 Insurance and physical examinations related to examinations for purposes of employment, insurance policies, school activities, visa requirements, emigration or immigration, admission to schools or universities, court reports, fitness examinations and tests, or similar.

3.31 Stethoscopes or other medical equipment designed for professional use.

3.32 All types of sunglasses, whether prescribed by an optometrist or ophthalmologist.

3.33 Low Vision Training Sessions and Low Vision Aid Appliances e.g. ORCAM, C-pens.

3.34 Genetic tests, unless authorised.

3.35 Telephonic consultation for Dentistry and Optometric Services.

3.36 Appointments for a healthcare provider which are not kept.

3.37 Forensics.

ALTERNATIVE HEALTHCARE TREATMENT

The following alternative healthcare treatments are excluded from benefits, unless provided for in a benefit schedule, including but not limited to:

4.1 Acupuncture – except as provided by a registered Chinese Medicine Practitioner;

4.2 Aromatherapy;

4.3 Ayurvedics;

4.4 Herbalists;

4.5 Iridology;

4.6 Osteopathy;

4.7 Reflexology;

4.8 Therapeutic massage therapy (masseurs), including massage or relaxation therapy for the relief of general, chronic and acute muscular discomforts or stress relief;

4.9 Traditional / indigenous healing therapies and medicines except Chinese medicines as prescribed by a registered Chinese Medicine Practitioner;

4.10 Any other alternative healthcare service which is not specifically included in the benefit guide;

4.11 Pathology tests requested by beneficiaries, Physiotherapists or other alternative medicine providers.

TRAVELLING ASSISTANCE

5.1 Transport costs to and from South Africa if the services are available in Namibia, unless specific exemption has been received from the Managed Care department.

5.2 International medical expenses and air ambulance repatriation costs outside the borders of Namibia and South Africa, unless pre-authorised.

5.3 Travelling costs within Namibia, if such travelling is done without a valid referral letter to a specialist or specialist service and no approval received from the Managed Care department.

5.4 Ambulance services not authorised, unless provided in circumstances of emergency medical condition as determined by the Fund, or ambulance services not registered as a accredited medical transport service provider.

5.5 Ambulance services requested by a hospital for the purpose of transporting a patient to and from an x-ray facility, unless provided in circumstances of emergency medical condition as determined by the Fund.

IMPORTANT:

IMPORTANT

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
  - 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

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

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

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.

Members and/or healthcare providers 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 updates, motivations and any other additional information requested in accordance with the rules of the Fund.

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, guidelines prior to hospital admission.

The member will be required to present his/her membership card on arrival at the hospital.

The member and/or hospital must contact the Administrator to obtain pre-authorisation for admission. A guarantee of payment of the member's account, at NAMAF recommended tariffs, will be issued, subject to the member's benefit entitlement. Should pre-authorisation not be obtained in non-emergency cases, the fund may decline to settle all or part of the claim.

Obtaining hospital pre-authorisation remains the member's responsibility. Apart from non-emergency cases, Members must obtain pre-authorisation at least 72 hours before hospital admission.

If not pre-authorised, no benefits will be paid, except in the case of emergency hospital admissions and emergencies after hours, weekends and public holidays.

Pre-authorisation for treatment in hospital is only valid and restricted to conditions for which such pre-authorisation has been requested for and subsequently granted. Any treatment falling outside of the scope of such pre-authorised treatment will require an update and further authorization from the Fund and its administrator.

If, however, a member is hospitalised in a private hospital or private ward, the rates charged could be above the NAMAF benchmark tariff. On discharge, the member becomes liable for the Excess of Tariff - the difference between the NAMAF benchmark tariff rate and the rate charged by the hospital.

Important:

- Pre-authorisation does not guarantee payment for other associated costs.
- Benefits according to what are permitted in terms of clinical protocols and guidelines of the rules of the Fund 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.

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.

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

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.

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

Important details about pre-authorisation numbers:

- The pre-authorisation number only applies to the specific hos- pital 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 dischargefrom 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 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 as- sess if this will be covered by your available benefit limits and how much will the co-payment be after AHB cover.
- Where multiple procedures during the same procedure are performed these could be covered at different percentages as set out in the guidelines.
- Ask for alternatives before opting for surgery.
- Ask if the healthcare provider charges according to the NAMAF benchmark tariffs.
- Ask who the anaesthetist is and ask if he/she bills at medical aid fund rates.
- You have the right to a second opinion or contact managed care for a clinical review.

Managed Care is to be contacted for authorisation on the first working day following any after hour emergency related procedures.

Benefits excluded, unless proven medically necessary:

- Breast reduction and enlargement.
- Hyperbaric oxygen treatment.
- Bariatric surgery.
- Bilateral split osteotomy.
- Attempted suicide, wilfully self-inflicted injuries, or sickness conditions/costs incurred in respect of treatment associated with drug abuse or overdosing, including Alkogen treatment.
- Costs incurred for treatment arising out of an injury or disable- ment resulting from war, invasion or civil war.
- Treatment of ailments, which were specifically excluded at the commencement of membership.
- Treatment of an illness or injury sustained where such illness or injury is directly attributable to failure to carry out the instruc- tions of a healthcare provider or to negligence on the part of the member/dependant.
- Treatments that are in excess of OAL or applicable sub-limits, to which a member is entitled to in terms of the rules of the Fund.
- The cost of treatment for complications that resulted from a procedure specifically excluded by the rules of the Fund.

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

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 specialized 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.

CASE MANAGEMENT

Case management ensures that members receive the best and most cost-effective treatment. This includes liaising with the medical personnel in respect of the patient's progress, investigating alternative healthcare and the validation of membership.

The Fund reserves the right to suggest an alternative treatment facility, if there is such a facility available and without compromising on the quality of healthcare provided. In the case of the Fund being able to source an alternative treatment facility which is to the financial benefit of both the member and the Fund, the Fund reserves the right to impose a co-payment onto the member should the member decide not to make use of such a recommended facility.

AUXILIARY SERVICES

Members are limited to the sub-limit value per year for all listed disciplines.

Artificial limbs and eyes under the Bronze benefit option are subject to auxiliary services under Day-to-Day benefits.

Non-surgical appliances, excluding artificial limbs and artificial eyes, are one of the many subcategories of benefits that fall under the auxiliary services benefit limit. As such, the non-surgical appliances benefit is now split from auxiliary services and becomes a standalone benefit payable from OAL on the Gold, Platinum, Titanium and Silver options only.

Benefits include:

- Medical appliances and devices are payable from the annual appliances benefit, sub-limited under the benefit for auxiliary services. Pre-authorisation with the Fund is required.
- Blood pressure monitors: Limited to N$ 881 per family every 3 years. Subject to registration of the funds Chronic Care programme.
- Disease management disposables, syringes and needles for diabetes are payable from the chronic medication benefit if a member has requested it to be registered under the chronic medication benefit, or the annual appliances benefit which is sub-limited under the benefit for auxiliary services.
- Oxygen: Payable from the annual appliances benefit, sub-limited under the benefit for auxiliary services.
- Pre-authorisation with the Fund is required.

Benefits exclude:

- All transportation costs for auxiliary services including appliances.

MAJOR MEDICAL EXPENSES

Major Medical Expenses are the various types of treatments rendered while the beneficiary is hospitalised or requires a period of stay in a hospital for medical treatment. In the case of Major Medical Expenses, benefits will be allocated on either a per principal member basis or alternatively on a per family basis.

The Fund is to be contacted on the first working day following a member requiring medical treatment or a surgical procedure in a hospital if occurring over a weekend or on a public holiday.

DAY-TO-DAY EXPENSES

Healthcare does not begin and end with hospitals. At NHP, we understand that people get sick daily and need treatment from healthcare providers and access to medication.

On joining the Fund, the principal members' chosen benefit option becomes accessible and in the event of there being one or more dependants, an additional amount per dependant is available. The amount granted per dependant is added to the amount initially allocated to the principal member.

The "per family" benefit structure means that any of the registered dependants of the family unit may use any amount of the allocated Day-to-Day benefit.

A further advantage is that homeopathic, phytotherapeutic and naturopathic medicines, as well as vitamins with a valid NAPPI code are covered, subject to available acute medicine benefit where applicable.
A 3 month general waiting period in respect of Day-to-Day benefits may apply for aged dependants.

ADDITIONAL HOSPITAL BENEFIT (AHB) COVER

The Fund offers its members an AHB that provides additional cover up to 50% on top of the NAMAF benchmark tariff, depending on the benefit option chosen, for services provided in-hospital by healthcare providers. AHB cover is over and above the normal benefits and is applied automatically.

Benefits apply to the following in-hospital services:

- Medical or dental practitioners.
- Medical or dental specialists.
- Physiotherapy, biokinetics, dieticians, occupational therapy, speech therapy, audiology and psychology whilst the patient is in the hospital.
- Radiology.
- Pathology.

The Gold, Platinum, Titanium, Silver, Bronze and Hospital benefit options cover up to 150% of the NAMAF benchmark tariff for services provided in-hospital by aforementioned healthcare providers.

No additional hospital benefit cover is available for the Blue Diamond benefit option.

Benefits exclude:

- HIV/AIDS
- National epidemics
- Organ transplants
- Post-hospitalisation and rehabilitation medication.
- Refractive surgery
- Breast surgery
- Bariatric surgery
- Surgical prosthesis
- Dental surgery, but for children 10 years and under and maxilo facial surgery.
- Dental implants
- Oral surgery
- Orthognathic surgery and
- In-hospital lung function tests

In order to qualify for AHB cover, members must ensure that all relevant invoices are submitted within 4 months after the date of medical treatment. Members who have reached their benefit limit in respect of surgical prostheses will not qualify for AHB cover.

No additional hospital benefit cover will be granted in respect of any set limits, e.g. in the case of oral surgery or organ transplant where a benefit for the full procedure has been granted.

The Fund reserves the right to reimburse any claim.

PAYMENT OF CLAIMS

Despite anything to the contrary contained in any other rule, the Fund may deduct from any benefit paid to a member or a supplier of health services any amount of money which has been paid bona fide in accordance with the provisions of a member's benefits and the NAMAF benchmark tariffs to which that member or the supplier of health services is not entitled.

The Fund may take proceedings in a court against a member or supplier of health services for the repayment of any amount referred to above, which it has not been able to recover through a deduction referred to.

CHRONIC CARE PROGRAMME REGISTRATION

DO YOU HAVE A CHRONIC CONDITION?

ARE YOU ON CHRONIC MEDICATION?

HAS YOUR DOSAGE OR MEDICATION CHANGED?

If your answer is **'YES'** on any of the above questions, complete the user friendly **Chronic Care Registration form** online (with your Doctor's assistance), and email the form to **chroniccare@nhp.com.na.**

- Submitting the form to NHP is mandatory. Members can find the **Chronic Care Registration form** on our website.
- You are required to complete and submit the form.
- Once you have successfully registered onto the Chronic Care Programme it will not be necessary to reregister on an annual basis unless there is a new chronic illness condition or change in medicine dosages.

SCAN THE QR CODE TO DOWNLOAD THE FORM

PROGRAMMES:

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 and/or 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 healthcare provider's consultations, general and specialised radiology and pathology during follow-up visits to the healthcare provider will come 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 purpose of the programme is to:

- Co-ordinate and manage the healthcare of the patient throughout the course of the treatment.
- Ensure that patients are placed on a treatment plan.
- Ensure that the treatment plan is managed in relation to the benefits available in consultation with the oncologist or treating physician.
- Involve the patient during the treatment period.
- Promote optimal wellbeing.

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

How to register?

It is important that, after the diagnosis of cancer, members are registered with the Oncology Programme and that their treatment plan is forwarded to the Managed Care department of the Fund without delay. The oncology treatment is subject to pre-authorisation and case management. If pre-authorisation is not obtained, the member might be liable for the account or might need to pay a penalty for late authorisation as per the Fund Rules.

Once the Managed Care department has received the treatment plan, blood tests, x-ray report and histology report, the member's details in addition to the disease information and proposed treatment plan are captured.

The Oncology Programme is supported and guided by a set of cancer guidelines and protocols based on international best practice standards which are used during the pre-authorisation process. The oncology guidelines focus on maintaining quality of care and standards, efficacy of care and efficiency of care delivered to patients whilst ensuring sustainability, using affordable methods.

The focus is on providing the patient with the best possible therapy which allows for the fact that the most cost effective treatment with the same outcome should always be used. The guidelines are focused on results and outcomes. The guidelines are not branded, i.e. linked or incentivised through any pharmaceutical or commercial interest. The guidelines are flexible in terms of the treatment prescribed but at the same time remove the perverse incentives from the type and brand of medication prescribed. A set of cancer guidelines and protocols are used during the pre-authorisation process.

Treatment plans, progress reports, updates and changes in medication

Once the treatment plan has been submitted it is then reviewed and, if required, a member of the clinical team will contact the treating healthcare provider to discuss appropriate or cost effective treatment alternatives. After the treatment plan has been assessed and approved, an authorisation code will be sent to the member's treating healthcare provider. The member will also be issued with an authorisation letter.

It is important that the Oncology Disease Management team is informed of any changes made to the member's treatment, as their authorisation will need to be reassessed and updated.

Any specialised drugs that have not convincingly demonstrated a median overall survival advantage of more than 3 months in advanced or metastatic solid organ malignant tumours, unless deemed cost effective for the specific setting, compared to standard therapy (excluding specialised drugs) as defined in established and generally accepted treatment protocols, for example Nexavar (Sorafenib) for hepatocellular carcinoma, Avastin (Bevacizumab) for colorectal and metastatic breast cancer will be excluded from benefits.

In the event of any of the above-mentioned drugs being prescribed, the proposed treatment plan will be reviewed by a panel of multi-disciplinary oncologists against international best practice standards and subject to all the required blood tests and histology reports having been submitted by the treating specialist.

The final treatment decision is up to the healthcare providers discretion and expertise allowing for flexibility. It is important that the Oncology Disease Management team is informed of any changes made to the member's treatment, as their authorisation will need to be reassessed

and updated. Should treatment proceed without the required authorisation then the member may be held liable for such treatment not covered by the Fund.

Active treatment

In accordance with the Fund's protocols, the active treatment period is defined as the period from the date on which the patient first receives treatment with chemotherapy and/or radiotherapy and continues up to 90 days after the last date of active therapy.

While a patient is receiving active treatment, the following treatments and procedures will come from the oncology benefit, provided a valid pre-authorisation number is obtained and claims are submitted with the correct NAMAF benchmark tariff codes to match the pre-authorisation:

- Chemotherapy
- Radiotherapy
- Hospitalisation
- Oncology related pathology
- Medication, directly associated with the treatment of cancer
- General oncology related radiology
- Consultations by the treating oncologist (in-and-out of hospital)

Specialised radiology e.g. MRI's, scans, angiography, radioiso- topes, require a separate pre-authorisation.

Prior to commencement on active treatment, please contact NHP. A trained and qualified advisor will explain the benefits available as well as the fact that a treatment plan is required from an oncologist. The treatment plan must be emailed to: oncology@nhp.com.na.

Positron-Emission Tomography (PET) scans are used to detect cancer and to examine the effects of cancer therapy by characterising biochemical changes in cancer.

PET scans are paid strictly in accordance with the Funds protocols. PET scans are available only during active treatment, subject to pre-authorisation.

Members must renew their authorisation annually.

Post-active treatment and medication

Due to the emotional impact of cancer and requirement for continuous follow-up monitoring, patients continue to do annual blood tests and scans to determine their status. The current post active treatment period extends over a lifetime post recovery.

In the event of a patient no longer requiring active treatment (such as the removal of a tumour) it may still be required that the patient undergoes follow-up visits to the specialist. The specialist consultations, pathology tests and radiology treatment will also be paid from the oncology benefit and not from the out- of-hospital benefit, subject to pre-authorisation.

A cancer patient admitted for hospitalisation needs to obtain pre-authorisation. The case will be assigned to a case manager who will follow up on the patient's progress in hospital.

A member needs to obtain pre-authorisation from the Managed Care department before claiming for any stoma therapy. A benefit of N$ 37 783 is available per family, per annum for Stoma products.

Related costs, such as the cost of wigs and external breast prostheses, will be paid from the member's annual appliance benefit, subject to pre-authorisation.

A private nursing benefit covers for accommodation in a hospice for the care of patients in a terminal stage of cancer, where available, subject to pre-authorisation.

Medication and procedures not directly related to the oncology treatment, e.g. high blood pressure medication and anti-depressants, pays from the chronic medication or Day-to-Day benefit.

There are separate authorisation numbers issued for chemo- therapy, radiotherapy, specialised radiology and hospitalisation. Members must obtain an authorisation number for each proce- dure. Blood tests are authorised together with the concomitant chemotherapy or radiotherapy.

For pre-authorisation in respect of hospitalisation, radiotherapy and chemotherapy in a healthcare provider's rooms, during hospitalisation and on an outpatient basis at the hospital, as well as radiotherapy, MRI, CT and PET scans, call NHP.

Oncology claims

The Fund will pay for claims in accordance with the NAMAF benchmark tariff structure if there is a valid authorisation and benefits available. Oncology patients with a specific claim query need to get in contact with NHP for further assistance. When members' active treatment period is complete, any post treatment scans and tests come from the Oncology benefit.

The Oncology Programme does not handle the account claims process and any claims query. These queries must go directly to NHP Client Services, tel 061 285 5400.

Benefits Excluded:

- Medicines defined as exclusions by the Fund.
- Medicines or chemotherapeutic agents not approved by the Medicine Control Council unless approval is pre-authorised.
- Medicines not authorised.
- New medicine not approved by the Medicine Control Council.

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.

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.

The AfA Programme offers both members and registered dependants:

- Medication to treat HIV, including drugs to prevent mother-to-child transmission and infection after sexual assault or needle-stick injury, at the most appropriate time.
- Treatment to prevent opportunistic infections such as certain serious forms of pneumonia and TB.
- Regular monitoring of disease progression and response to therapy through regular tests to pick up possible side-effects of treatment, subject to benefits available.
- On-going patient support via a nurse-line.
- Clinical guidelines and telephonic support for healthcare providers.
- Help in finding a registered counsellor to give emotional support.

If any member suspects that he/she has been exposed to the HIV/AIDS virus through sexual assault or needle-stick injury, he/she should urgently request his/her healthcare provider to contact the AfA Programme to authorise special antiretroviral dicine, to help prevent possible HIV/AIDS infection.

This medicine must be taken as soon as possible (ideally within 6 hours) after exposure. If the incident has occurred over the weekend, members should ensure that they get the necessary medication on time. A member or his/her healthcare provider can contact the AfA Programme on the first working day following the incident in order to arrange authorisation for payment by the Fund.

Confidentiality

We really do understand how sensitive an issue HIV/AIDS can be. That is why we do everything we can to build long-term, trusting relationships with members living with the infection. We empathise with the individuals faced with its challenges and treat their status, treatment and personal details with the utmost discretion and confidentiality.

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/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 or the impact the disease, e.g. tests including full blood counts, liver function tests and specimens sent for microscopy.
After the member has received the application form, his/her healthcare provider must complete the form and return it to the AfA Programme, using the confidential fax line number or email on the form. A highly qualified medical team will examine the member's details and, if necessary, discuss cost-effective and appropriate treatment with the member's healthcare provider.

Once treatment has been agreed upon, the member and his/her healthcare provider will receive a detailed treatment plan which explains the approved medication as well as the regular tests that need to be done to ensure that medication is working correctly and safely.

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 healthcare 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.

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

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 diseases 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$ 1 144
Platinum	N$ 1 144
Titanium	N$ 854
Silver	N$ 854
Bronze	N$ 571
Hospital	N$ 571
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 Scheme 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; and 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 program where a care manager (registered nurse) carefully coordinates best medical care.

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

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.

ROLL-OVER BENEFIT

If a member claims less than a certain threshold amount included in their Day-to -Day benefits, they can build up a Roll-Over benefit that can be used to pay for healthcare treatment and medical costs.

ROLL-OVER BENEFITS CAN BE USED FOR:

- Routine medical costs;
- Outstanding member's portions;
- Treatment normally excluded from your benefits;
- Medical treatments with valid chargeable Nappi codes which are usually excluded by the Fund. These medical treatments must be provided by a registered healthcare provider;
- The difference between the actual medical costs and the NAMAF benchmark tariff for medical services covered by the Rules; and
- Medical aid contributions.

Your Roll-Over benefit accumulates in your name for as long as you are a member of the Fund.

Use the Smart Saver benefit to increase your Roll-Over benefit.

GENERAL:

GENERAL

PRICE FILE

Price file refers to the maximum payment for medicine. This reference pricing system does not restrict the choice of medicines, it controls the cost of medication. The price list only applies to medications for which generic equivalents are available.

Reducing the cost of medication

There is always medicine available that will not require a co-payment. It will help if a healthcare provider prescribes the active ingredient rather than the trade name, or states on the script a generic substitution. Make sure to discuss options with a healthcare provider or pharmacy.

Price file groups are:

- For items that are the generic equivalent, i.e. same ingredients, same strength or same formulation.
- For products, which are generically similar and contain the same active ingredients, at the same effective strength, but the formulation may differ, e.g. tablets vs. capsules.

In the healthcare environment, there is an increase in costly chronic diseases and medical aid membership contributions are rising faster than general inflation. For this reason, the implementation of a price management tool plays a major role in managing medicine prices within available benefit options.

Members should remember to ask the pharmacist for the generic equivalent in order to minimise co-payments.

What is generic medicine?

Generics are medicines that contain exactly the same active ingredients, strength and formulation as the ethical products. The same or another company manufactures these medicines once the patent on the branded product has expired. As a result, the price of generic medicine is usually considerably lower.

The Medicines Control Council analyses each medicine for safety and efficacy before it is registered.

What are patented or branded medicines?

Pharmaceutical companies incur high research and development (R&D) costs before going into production. The pharmaceutical company is therefore given the patent right to be the only manufacturer of that specific medicine (brand) for a number of years, in order to recover R&D costs.

Why use a generic medicine?

Generics are more cost-effective, providing optimum value in respect of the medicine benefit limit. As a result cheaper generic alternatives will result in lower levies payable per prescription. The use of generic medicines therefore helps to limit total medicine expenditure, which in turn limits annual contribution increases.

In Namibia, generic medicines are subject to the same stringent quality control measures as all other medicines.

IMPLEMENTATION OF ICD CODING STRUCTURE FROM 2026 ONWARDS

The Namibian medical aid funds industry in association with NAMAF is embarking on the introduction and compulsory utilization of ICD codes.

It is important for members to be aware of the introduction of the ICD codes as from 2026.

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.

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.

UNDERSTANDING NAMAF BENCHMARK TARIFFS

What does '100%, 150%, 80% and 50%' of the NAMAF benchmark tariff mean?

The reference to NAMAF benchmark tariffs does not limit or restrict the healthcare provider from charging more than what the NAMAF benchmark tariff states. To the same extent, a healthcare provider is not limited or restricted to charge less than the NAMAF benchmark tariff. The NAMAF benchmark tariff is a guideline tariff used by the Fund indicating the maximum rate at which the Fund is willing and able to reimburse for the services charged.

Reference, within the Fund's benefit option structure, to services covered at 100%, 150%, 80% and 50% of the NAMAF benchmark tariff, indicates the intent to reimburse specific claims only up to these limits as per the percentage stated. As noted above, it does not limit or restrict a healthcare provider to charge more or less than the NAMAF benchmark tariff as stated in our Benefit

guide. 100% of the NAMAF benchmark tariff does not necessarily mean 100% of the cost of medical treatment billed by the healthcare provider.

If the healthcare provider charges more than the stated NAMAF benchmark tariff any amount over and above, will be for the members' account.

SPLIT BILLING

Split billing is an instance where a healthcare provider collects a certain amount from the member in cash and then bills the balance of the account at the Fund's benchmark tariff. There is no reflection on the members claim for cash payments received.

This implies that the value of the medical treatment received is undervalued. Whilst the Fund is not incurring any loss by paying out the same or claimed amount, the transaction is undervalued and thus distorts the Fund's data used for actuarial projections. NHP does not regard split billing as an acceptable way of billing.

The Fund does not allow split billing.

In the event of the healthcare provider charging more than the NAMAF benchmark tariff an invoice must be provided to the member clearly indicating the amount charged in respect of the NAMAF benchmark tariff and the amount to be charged to the member in respect of his/her member's portion.

It is important for members to insist that all invoices provided contain the split in monetary amounts per NAMAF benchmark tariff used.

Should the healthcare provider insist on an upfront payment, where he/she charges in excess of the NAMAF benchmark tariff, without clearly specifying the payment received under the member's portion, then such account is commonly referred to as a split bill as explained above. Split billing is an undesirable practice for tax avoidance purposes. Furthermore, the practice of split billing creates a false impression with the Fund on submission of the claim that the healthcare provider is actually charging in line with the NAMAF benchmark tariff whilst in reality the actual cost of treatment is much more.

Members are encouraged to report any instances of split billing to NHP who in turn will report it to NAMAF for onward reporting to the Health Professions Council of Namibia (HPCNA), alternatively, members may also lay a complaint directly.

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 medical 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.

ACTIVE REGISTERED HEALTHCARE PROVIDERS

In order for any healthcare provider to claim from any medical aid fund both the facility and the individual provider must be registered with NAMAF. NAMAF's registration of such and/or individual service provider is subject to the facility having been declared fit for use by the Ministry of Health and Social Services (MoHSS), the individual practitioner has been accredited with and registered by the Health Professions Council of Namibia (HPCNA) as well as having received a certificate of Good Standing from the Ministry of Inland Revenue.

Once such criteria has been complied with, NAMAF may issue such health facility or healthcare provider with a registration and associated practice number which will allow that provider to make use of the NAMAF Tariff codes as well as submit claims with the medical aid fund for claiming purposes.

In order to remain a registered practitioner, healthcare providers need to ensure that their practice remains in good standing with the Receiver of Revenue, comply with operating requirements as determined by the MoHSS, remain in good standing with the HPCNA and lastly renew their annual registration with NAMAF.

Failure to adhere to any of the above may result in NAMAF resorting to a temporary suspension of practice numbers in terms of the Act on Medical Aid Funds (Act. 23 of 1995) until such time that all registration requirements have been met.

Members are at risk to the extent that should they have used the services of any healthcare practitioners with a suspended practice number during such time, then such services are deemed not to be eligible for processing against a person's medical aid benefits.

Foreign Healthcare Providers, including visiting specialists from South Africa, who treat and/or provide a service within the borders of Namibia to Namibian registered Medical Aid Fund members without a NAMAF issued practice number should be registered with NAMAF and be in possession of a NAMAF issued practice number. Although not yet legislated the possibility exists that in future Medical Aid Funds will not honour such claims rendered in Namibia by an unregistered provider and will not pre-authorise hospital admissions where the consulting/referring doctors are visiting non-registered services providers without a valid NAMAF Practice Number.

Claims for members visiting South Africa or receiving treatment in South Africa by a registered practitioner will be honoured as in the past.

MOTOR VEHICLE ACCIDENT FUND (MVA FUND)

The MVA Fund assumes responsibility for the recovery and stabilisation of injured people from the scene of a motor vehicle accident as well as the evacuation to the nearest appropriate state facility.

Call emergency services immediately if you need help. Use the MVA Fund accident response number (9682) to report tar/gravel road accidents anywhere in the country.

Be ready with the following information:

- Location of the accident
- Number of vehicles involved
- Number of people injured
- Where possible, types of injuries
- Upon receipt of a call, the MVA Fund Call Centre will immediately dispatch an ambulance to the accident scene and all injured people will be stabilised and transported to the nearest medical facility.

The MVA Fund only pays for such transfers at the state rate. After examination, the treating healthcare provider may authorise a transfer of the injured person to a private hospital depending on the seriousness of the injuries sustained. The MVA Fund case manager attends to injured persons in the hospital and ensures members understand the benefits and claim procedures.

A treating specialist/healthcare provider will decide whether the patient(s) needs to be transferred to a private hospital for more complicated treatment and procedures.

Members will still qualify for treatment in private hospital facilities if their benefits provide for it.

It is important for members to remember the following:

- All MVA cases must first be reported to the Namibian Police and then to the Fund.
- A copy of the police accident report (Pol 66 form) must be submitted to the Fund within 2 months following the accident.
- As part of the requirements, the police report is an essential document as it proves that the road accident actually did take place.

For more information on the MVA Fund, members can contact the MVA Fund Call Centre, tel 9682.

RIGHT OF RECOVERY OF THIRD PARTY CLAIMS

In the instance that the member or his/her dependant(s) has/have received compensation for past and/or future medical expenses in terms of any legal action or claim against a third party, the Fund shall have the right:

- To recover from the member or his/her dependant(s) an amount, which shall not exceed the amount so remitted by the Fund in respect of the medical expenses incurred by the member or his/her dependant(s) and for which he/she or his/ her dependants has/have received the said compensation.
- To repudiate any claim for medical expenses incurred by the member or his/her dependant(s) and for which he/she or his/ her dependant(s) has/have received the said compensation.
- The amount so recovered/reimbursed by the Fund shall not exceed the amount actually paid to the member or his/her dependants in terms of any legal action or claim in connection with the members'/dependants' past medical expenses.
- Such amounts received by the Fund from any third party will be reinstated against the members'/dependants benefits within the benefit year in which the claims/loss occurred.

INJURIES ON DUTY

The Fund covers members who are injured on duty. Only people earning less than N$ 81,300 per annum qualify for financial assistance relating to medical treatment from the Workmen's Compensation Act (WCA).

The Social Security Commission (SSC) is not supportive of entertaining medical claims submitted by a medical aid fund for reimbursement. Therefore, members should institute any claims against the SSC in their personal capacity.

In order to submit a valid claim the employee and employer are required to fill out and submit documentation to the WCA.

Upon treatment for an injury at work, the member is required to submit a copy of the WCA form and injury report to the Fund.

The Fund reserves the right to reclaim any amount paid in respect of medical treatment on behalf of the member from the SSC.

For more information regarding injuries on duty, members can contact the SSC, tel 061 280 7999

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
Karasburg	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

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