



Member Guide 2010



Nampak

SA Medical Scheme



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The Nampak SA Medical Scheme is managed by a Board of Trustees, with the primary objective to look after the interests of the members.

The Scheme continues to be well managed and it is pleasing to note that we continue to achieve the stringent criteria and solvency levels set by the Registrar of Medical Schemes.

We are committed to provide members with access to appropriate and quality healthcare benefits at competitive rates in a managed healthcare environment, supported by efficient administration.

Our Scheme is open to Nampak employees only and we believe that our valued members utilise their benefits in an honest and responsible manner and are conscious of the importance of good health.



... packaged for your benefit



MEMBERSHIP

Nampak SA Medical Scheme is a restricted scheme which is open to Nampak Employees **only**.

The Nampak Scheme does not apply “Underwriting” to new employees provided they join within the first three months (window period) of commencing employment with Nampak. This will also apply to their registered dependants subject to the rules. Should a member marry or have a baby after joining, they are required to add this dependant within 30 days of the event in order to avoid possible “Underwriting”.

- In respect of an adopted child, step child, common law spouse’s child and foster child, a certified copy of the High Court Adoption Certificate is required by the Scheme. In respect of a grand child, the main member must legally adopt the grand child and a certified copy of the High Court Adoption Certificate is required by the Scheme.
- In the event of a common law spouse, full underwriting and a late joiners penalty will apply. Proof of cohabitation (for not less than one year) in the form of an affidavit is required by the Scheme.
- In the event of a dependant being handicapped, the child rate will apply up until the age of 26. Thereafter, the adult rate will apply.
- In the event of the parents of a main member joining the Scheme, full underwriting and a late joiners penalty will apply. Proof of total financial dependence in the form of an affidavit is required by the Scheme.
- In the event of a divorce, the main member’s ex-spouse will be terminated.

Child Dependant (21 years up until the age of 26)

- **Full Time Student**
Child rate will apply provided proof of full time study from the relevant Educational Institution is submitted to the Scheme.
- **Unemployed Child**
Adult rate will apply and the child will be terminated upon reaching the age of 26.
- No children over the age of 26 are allowed on the scheme.



TERMS FOR EASY REFERENCE

PMB: Prescribed Minimum Benefits (PMB's)

In accordance with the Medical Schemes Act, all medical schemes are required to make provision for the payment of PMB's. These PMB's are defined according to a list of specified conditions and the Scheme will pay for the treatment of these conditions in accordance with the regulations. These treatments will be obtained at the Schemes' appointed DSP as applicable to the chosen option.

DSP: Designated Service Provider

This is the network of providers that the Scheme has selected/negotiated with as the preferred providers to their members. If the member chooses to use another provider, he/she may be required to co-pay the difference between the "NHRPL" amount and the "Cost". If the member chooses to use another provider, he/she will be required to co-pay at the point of service.

Private Rates/"Contracted Out" Rates

The maximum fee in respect of services as determined by the various Private Provider Associations (eg: South African Medical Association – SAMA).

Cost

Represents the actual amount charged by a provider (could be in excess of Nampak Negotiated Rates).

TTO: To Take Out

Medication supplied by the hospital when the member and/or dependants are discharged. These are often more expensive than when obtained from a discount chemist.

NHRPL: National Health Reference Price List

This is the baseline against which medical schemes/associations can determine reimbursement levels and from which providers can individually determine fees charged.

MMAP: Maximum Medical Aid Price

This is the maximum medical aid price paid by the Scheme on the Standard Option for the cost of generic medicine, where a generic alternative exists for branded or ethical medicine. If no generic equivalent exists, the Scheme will cover the cost of the prescribed medicine. However, if a generic alternative exists and a brand product is selected, the member will be liable to pay the difference between the generic and branded product.

Generic Medication

This is the medication that contains exactly the same active ingredients as branded/ethical products. Generic medication is manufactured once the patent on the branded product has expired. As a result, the price of generics is usually lower than branded medication.

Reference Price

This is the maximum benefit price a scheme will pay for a therapeutic class of drugs/medication. The member will be liable for the shortfall between the benefit price and the actual price of the prescribed drug.

Condition Specific Waiting Period

A period (normally 12 months) during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received prior to an application for membership.

Pre-Authorisation

The confirmation received from the call centre when a member requires access to specific treatment/procedures. Pre-authorisation does not guarantee payment of claims but is merely a pre-notification mechanism whereby the Scheme is advised of a pending procedure/treatment and providers confirmation that the member may have access to benefits.

ICD-10: International Classification Of Disease Version 10

These codes allow provision for details of the actual disease consulted for (eg: instead of a doctor's account just reflecting "consultation", there is now provision to say "Respiratory Tract Infection" etc). Since 1st January 2006, it has been mandatory for doctors to have an ICD-10 code with the 5th digit on the account in order to claim for it. All providers are required to provide the ICD-10 codes with five digits for PMB's/CDL's. Failure to include these may result in the benefits for these conditions being paid from normal scheme benefits.

PAT: Pharmacy Advised Therapy

Medicines prescribed and dispensed by the pharmacist (over the counter medicines).

Child Dependant

A member's natural child or legally adopted child who is under the age of 21, who is not in receipt of a regular remuneration of more than the maximum social pension per month or a members child who, due to a mental or physical disability, is dependent upon the member.

General Waiting Period

A period in which a beneficiary is not entitled to claim any benefits (normally three months).

Acute Medication

Medicine that a doctor normally prescribes to alleviate the symptoms of an acute illness such as a common cold. This includes all medication including TTO's and PAT. Vaccinations that are clinically indicated and pharmacy dispensed are covered under this benefit up to the Nampak SA Medical Scheme limit.

Chronic Medication

Usually life-sustaining medicines prescribed or dispensed to patients registered with the Scheme on the Chronic Medication Programme, Chronicare Network (CCN) and as described on the list of chronic medicine. The patient is required to take this medication for at least three months or a longer period.

Oncology

Cancer treatment, which includes chemotherapy, radiotherapy, intravenous drugs and materials.

Scheme Rate

100% of the National Health Reference Price List (NHRPL) published by the Department of Health.

Uniform Patient Fee Schedule (UPFS)

This is a fee charged at Provincial Hospitals.

Medical Savings Account (MSA)

The Extended Option operates a Savings Account and members on this option allocate 15% of their monthly contribution to a Medical Savings Account.

VALUE ADDED PRODUCTS FOR 2010

Internet Access - Nampak Health Website

Members can apply to register on the Administrator's Website. They will be given their own password and the ability to do the following:

Membership

- Access Contact details.
- Check and update telephone/cell phone numbers, postal and residential addresses.

Statements

- View past monthly statements.

New Card

- Apply for a new member card.

Claims

- Claims information.
- Check claims for the last six months, including claimed amounts, paid amounts, surcharges and payment dates.

In order to log on, go to the following address in your browser:

<http://www.nampakhealth.co.za>





Are you in good health?

Do you have boundless energy?

Do you understand your doctor?

What does wellbeing really mean for YOU?

HealthInSite is a primary source for all your wellness needs, providing an innovative website called e-Care which is accessible to all Nampak SA Medical Scheme members. Our e-Care programme can help with many wellness queries, creating a one stop wellness centre at your fingertips.

This uniquely personalised online programme will allow you to create your own unique profile to describe your own wellness, health, interests and more. e-Care will then deliver a programme tailored for YOU specifically so that you get the resources, information, and advice you need and want (and not all the spam you do not want). You'll get weekly emails, newsletters, ask-the-doctor, ask-the-dietician, health campaigns, health assessments, and much more!

e-Care brings you, and your family, the very best in online health and wellbeing services.

- It's free for all members
- It's completely confidential
- It's an investment in your present and your future

To make sure you are enrolled just visit <http://nampak.healthinsite.net>

If you're already enrolled please be sure to profile yourself (just look for the PROFILE button) so you get the full benefit of this service.

Should you have any queries, please don't hesitate to contact us on **0861 06 66 66** or email us at queries@healthinsite.net



NETCARE 911 EMERGENCY SERVICES

Netcare 911 is a contracted service provider for all ambulance services by air and road in emergency situations. Members are covered throughout South Africa, Swaziland and Lesotho.

In the event of a medical emergency, dial **082 911** from a landline or cellular phone.

Emergency services benefits include:

- Emergency telephonic medical advice and information;
- Emergency medical response by road or air (where clinically appropriate) to the scene of the medical emergency;
- Transfer by road or air to the closest, most appropriate, medical facility;
- Repatriation of patient where medical intervention is required; and
- Specialised travel advice.

The procedure you should follow is:

- Only dial **082 911** in a medical emergency;
- Give your name and the telephone/cellular phone number that you are calling from;
- Provide a brief description of what has happened and how serious the situation is;
- Provide the address or location of the incident to assist paramedics to get there;
- Do not cut the call until the person on the other side has disconnected.

Important Points to Remember:

- Please ensure that all of your registered dependants are aware of this service.
- Ensure that you have the EMERGENCY SERVICES identification stickers on your vehicle(s).
- Inform your child's/children's school that he/she is a member of the Nampak SA Medical Scheme. Make sure your child/children and all members know the emergency number.

Ambulance Pre-Authorisation procedure for inter-facility (inter-hospital) transfers:

When you or a registered dependant are admitted to hospital, you must inform the hospital that you are a Nampak SA Medical Scheme member and that any transfers must be authorised by calling **(010) 205 9000**.

Emergency

In all instances, members must phone **082 911**. In all cases where a member is transported by another service provider involuntarily (other than Netcare 911), the member must ensure that the service provider submits an invoice to Netcare 911 within ten days of the service date to facilitate payment of this account.

Medical Advice

Members have access to 24-hour medical advice administered by clinical sisters at Netcare 911. Please dial **(010) 205 9000**.

TRAVEL ADVICE

Members can now get free advice on health issues when travelling to other countries. This is provided via our link with Netcare and SAA Travel Clinics. **Tel: (011) 647 3654**.

HIV MANAGEMENT PROGRAMME

Members and beneficiaries of the Nampak SA Medical Scheme have access to benefits for the treatment and management of HIV/AIDS. These benefits can be accessed by joining Momentum Medical Scheme Administrator's HIV Programme.

We care about your quality of life

People with HIV are entitled to live normal, productive lives, free from discrimination or misunderstanding. With advances in medical research, HIV infection and AIDS need no longer be considered as a death sentence, but rather a chronic manageable infectious disease. Every person needs to take care of his/her body and health. For people who are HIV positive, this is more important because their immune systems are unable to fight off diseases or minor ailments.

When should I join?

Join us today!! By joining the HIV programme, you will benefit even if you are at a stage before you and/or your beneficiaries get ill or require treatment with antiretrovirals. Over the years of running this programme, we have achieved wonderful outcomes with members who have had the courage to join the programme. We encourage all members and/or beneficiaries who test HIV-positive to join the programme as soon as the diagnosis is made. It is very important that pregnant females who test HIV-positive during the pregnancy, or are already aware of their HIV status when they fall pregnant, to inform us as soon as they are aware of the status. Mother-to-child transmission is very successfully prevented if the pregnant mother receives treatment with antiretrovirals.

How do I register?

The registration process is easy and confidential. Please call our **confidential** telephone line on **0860 10 97 93** to start the process.

Will my condition remain confidential?

We do respect and salute members who have had the courage to disclose their condition and rise above all the stigma. **The programme is a confidential programme.** Please be assured that confidentiality will be respected by all staff managing your condition. Our nursing sisters and the doctor who will be responsible to treat your condition form part of a dynamic team. A confidential clause ensures that all registered members details are treated with the strictest of confidence. Your status will under no circumstances be disclosed to anyone, including your employer.

What benefits do I qualify for?

Your benefits are focussed on your total wellness and not just the virus. We have experienced that AIDS may not be the same in everybody and that each member has special needs. On registration, you are allocated a dedicated individual who will manage your condition within an allocated budget.

Benefits for Post Exposure Treatment

Please call our share call line on **0860 10 97 93** or the after hours mobile line, which is **082 821 0994**. This will enable members to get access to recommended treatment with antiretrovirals specific for the prevention of infection by the virus after accidental exposure. It is important to do this within at least two to six hours after the possibility of having come into contact with the virus in order to meet the optimal treatment guidelines.

We understand that this diagnosis brings with it added social burdens and emotions. Our experienced staff are there to assist you to overcome your fears, and most of all teach you to live a positive and healthy life.

Should you require further information or support, please do not hesitate to contact the HIV Programme on:

Tel : **0860 10 97 93**
Mobile : 082 821 0994
Fax : 012 675 3848

RAPE CRISIS CENTRES

Our members will have access to specialised Rape Crisis Centres where accredited protocols ensure that rape victims and their families receive the most appropriate treatment in a safe caring environment. **Tel: 082 911.**



MANAGEMENT PROGRAMMES

Maternity Programme

The Maternity Care Programme affords members on the Scheme who are pregnant, additional benefits during their pregnancy at no extra costs to the member. The programme is managed by qualified midwives, who are available to answer questions relating to the member's confinement, post natal care as well as any questions regarding the newborn baby. Registration is compulsory when the member is 12 weeks pregnant and **no later than 20 weeks pregnant**. Please call **0860 10 10 47**.

The Maternity Programme benefits are:

- 12 antenatal consultations up to NHRPL;
- 2 routine antenatal ultrasound scans up to NHRPL;
- A benefit is afforded for antenatal classes;
- Prescribed prenatal vitamins and iron supplements may be claimed from your day-to-day benefit during your pregnancy;
- Members will receive the Tina Otte Pregnancy and Birth Book on joining the programme as well as a "Baby on Board" sticker;
- Members may phone for advice; and
- Members will be contacted during pregnancy and after birth.

Oncology Management Programme

Registration on the Oncology Management Programme is compulsory for all cancer patients wanting to access oncology benefits. Your treating oncologist must provide a detailed treatment plan, outlining all chemotherapy, radiotherapy, drugs required for side-effects, radiology and pathology that is required.

All applications are assessed in accordance with the treatment protocols and benefits are provided in accordance with your relevant option choice. Please negotiate with your oncologist to charge you the preferred tariff. Please call **0860 10 10 47**.

Renal Management Programme

A detailed written request outlining details of the renal treatment must be submitted to your scheme administrator for registration on the Renal Management Programme. Benefits for renal dialysis and renal transplants are based on the details provided by the treating doctor and in accordance with the relevant treatment protocols. Members are advised to negotiate preferred tariffs with their doctors. Please call **0860 10 10 47**.

MEDICATION

Chronic Medication

Chronic medication relates to those medicines prescribed for a period of three months or longer for the treatment of chronic conditions that are usually recognised as life-threatening.

These medicines need to be authorised by the Scheme's Chronicare Management (CCM) and, in order to ensure that these chronic medicines are paid from the appropriate benefit, namely Chronic Prescribed Medication benefit, members are required to register with CCM, who are responsible for the management of chronic medication benefits. **An effectively managed chronic illness will result in fewer acute or long-term medical complications and side effects.**

The CCM staff, which will include registered pharmacists and clinicians, use set guidelines and protocols to assess each chronic benefit application and they check that the medication prescribed is appropriate, cost-effective and in the correct therapeutic dosages. CCM guidelines are maintained in conjunction with the medical specialists as well as local and international treatment protocols.

How to register

The process to apply for chronic medication is a paperless telephonic process. Any members who require approval for chronic benefits or wish to update their existing authorisation can contact the Scheme on **0860 10 10 47** where our team of pharmacists and assistants will assist members. If members arrange for the doctor or pharmacist to contact the Scheme directly on **0860 10 10 47** the authorisation will be **processed online**. Authorisations for certain medicines expire after six months and it is the responsibility of the member to obtain a new authorisation for their medicine.

Chronic Disease List (CDL)

The current list of 270 Prescribed Minimum Benefits (PMB's) has been extended to include 25 CDL's. Schemes are required to cover the diagnosis, treatment and medical management of these CDL's according to the Scheme's Algorithms and DSP's (please refer to the list below).

PMB/CDL

- Addison's Disease
- Asthma
- Bipolar Mood Disorder
- Bronchiectasis
- Cardiac Failure
- Cardiomyopathy
- Chronic Renal Disease
- COPD
- Coronary Artery Disease
- Crohns Disease
- Diabetes Insipidus
- Diabetes Mellitus 1 and 2
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple Sclerosis
- Parkinson's Disease
- Rheumatoid Arthritis
- Schizophrenia
- Systemic Lupus Erythematosus
- Ulcerative Colitis



Chronicare Medicine - Designated Service Provider

One of the leading courier Pharmacies, Chronicare Medicines (Chronicare) has been appointed at the Schemes' Designated Service Provider (DSP) to dispense chronic medication at a significantly discounted dispensing fee.

The chronic medication will be couriered to the member's place of employment or in the case of our pensioner/continuation members, to their home address.

It is compulsory for members on the Standard Option to obtain their chronic medicine through Chronicare and no benefit will be accessible through any other service provider.

Members on the Extended Option are advised to utilise Chronicare, however, should they decide to make use of another service provider, any difference in the dispensing fee, will be the members responsibility and will be treated as a co-payment. **Members on the Extended Option will not be able to claim the difference in the dispensing fee from positive savings.**

How to obtain your monthly chronic medication from Chronicare Medicines Courier Pharmacy:

- Complete a Chronicare Medicines Information form.
- Return the completed Chronicare Information form, together with your original/copy of the doctor's hand-written prescription to Chronicare.
- Chronicare will contact you, the patient, to confirm receipt of the completed form and script, if required Chronicare will provide assistance in obtaining authorisation, or a prescription from your doctor.
- Chronicare will confirm the exact medication required by you.
- Chronicare will confirm your delivery address, delivery date and personal details. Confirmation of delivery date will rule out any unnecessary delivery and the return of medication.
- Medication can be delivered within 48 hours after receipt of details and prescription, if so requested, or alternatively, on the date confirmed with Chronicare.
- Chronicare will send educational material related to your specific disease and/or medication.

Chronicare Contact Details:

Tel : **(011) 660 4005 or 0860 10 23 04**
Fax : 086 688 0070
email : info@chronicare.co.za

Acute Medication

Members are advised to shop around to secure the best discount from a pharmacy for their acute medication requirements. Reduced costs will enable members to purchase more within their benefit limits. The price difference between the DSP and the cost of the script, if not obtained through the DSP, will be for payment by the member.

Generic Medication

Generic medicines can help you save money

Did you know that it is no longer necessary for the pharmacist to consult with the doctor prior to making a generic substitution? The decision to substitute now rests with the patient, following the advice of the pharmacist.

What are generic medicines?

Generic medicines are the equivalent to the brand-name medicines. They contain the same active ingredient, strength and dosage form as the original product. It is, however, important to purchase your medication from a reputable and trusted source.

Why are brand-name medicines more expensive than generic medicines?

Once the brand-name medicine has undergone research and development, which is very costly and time consuming, the pharmaceutical manufacturer receives a license or a patent. This patent gives the pharmaceutical manufacturer exclusive rights to market the product to the public for a certain length of time. When the patent expires, other pharmaceutical manufacturers may produce the same medicine under a generic name. The generic medicine is less costly because it does not have to undergo the same expensive research and development.

Are generic medicines as safe as the original product?

The Medicines Control Council (MCC) of South Africa requires that all medicines, whether brand-name or generics, meet the standards of safety, strength, purity and effectiveness. For a medicine to be marketed under a generic label, the manufacturer must comply with the MCC standards. The MCC sets up the guidelines and requires strict testing in order to ensure that generic medicines are the same as the original product.

PRE-AUTHORISATION FOR HOSPITALISATION

Members who are advised that they need to be hospitalised are required to obtain **prior** approval for hospital procedures and treatment by contacting the Scheme on telephone number **0860 10 10 47**.

When members contact the Scheme for hospital authorisation, they are required to have the following information on hand:

- Membership number;
- Name and address of admitting doctor;
- Date of admission into hospital;
- Name of hospital or clinic;
- Medical condition;
- Diagnosis;
- ICD-10 code;
- Type of procedure/operation (where applicable); and
- Expected length of stay.

Once hospitalisation has been pre-approved, the member will be supplied with an authorisation number, which is valid for 30 days from issue. Members are required to provide their doctor and the relevant hospital or clinic with the authorisation number. (Provided the member's contributions are up to date, the authorisation number confirms that benefits are available and guarantee's the member's admission, however, it is not a guarantee of payment).

Failure to obtain hospital pre-authorisation will result in the member being liable for the full cost of hospitalisation and any related expenses.

Hospitalisation authorisation does **NOT** include external appliances required as part of the hospital procedure, eg: backbraces, guards, etc, and members must ensure that additional authorisation is obtained prior to admission to hospital.

Emergency Admission

In the event of **emergency hospitalisation**, where the member is unable to obtain pre-authorisation, the member's spouse or family member is required to inform the Scheme on **0860 10 10 47** within 48 hours (two days) of admission. This will enable the Scheme to ensure that the patient receives quality care and that the account is processed correctly.

Other Treatment where Pre-Authorisation is required

Please refer to benefit schedule:

- Surgical Prosthesis
- Organ Transplants
- Oxygen Supply
- Dentistry in Hospital
- Private Nursing and Hospice
- MRI, CT and PET Scans
- Mammograms
- Cancer Treatment
- Laser Refractive Eye Surgery
- Rehabilitation
- Dialysis
- Psychiatric Hospitalisation
- Stomatherapy
- Bone Densitometry Scans
- Emergency Services: Netcare 911
- External Appliances

Specialised Dental Treatment in Hospital

If members or their dependants need to be hospitalised for specialised dental treatment, they are required to submit a quotation from the specialist to the Scheme, detailing the total cost as well as the expected duration of the treatment. All treatment will be paid at NHRPL up to the members dentistry limit. Please refer to the benefit schedule in this booklet. Contact **0860 10 10 47** to obtain your authorisation number.

ACCIDENTS AND INJURIES (INCLUDING MOTOR VEHICLE ACCIDENTS)

The Nampak SA Medical Scheme pays your medical costs at 100% of NHRPL for all motor vehicle accidents, even if the member is involved as a third party (eg: a pedestrian). Members are required to submit claims to the Road Accident Fund (RAF). Any amounts recovered for medical expenses already paid by the Scheme are immediately refundable to the Scheme.

The following documents should be submitted for your claim to be considered:

- An accident injury report (obtainable from the member's Human Resources Manager or Contact Centre: **0860 10 10 47**);
- A police/accident report; and
- A signed legal undertaking.

Benefits are paid in accordance with the member's option choice.

REPORTS ON INJURIES

A member who suffers even a minor injury will be required to submit a report/doctor's letter detailing the cause of the injury. Where injury is severe, the member will be required to complete and submit an accident/injury report before any claims will be considered for payment. Please contact **0860 10 10 47**.



TIPS TO CURE THE HIGH COSTS OF HEALTHCARE

Remember, this is your Scheme and it is your responsibility to manage it effectively in order to maximise your benefits.

The following suggestions could help reduce costs and curb high annual increases:

- Please ask for a copy of your account even if the doctor/pharmacist submits the account directly;
- Check all accounts carefully;
- Ensure that your doctor prescribes sufficient, and not surplus medication;
- Enquire about equivalent substitute medication (generic as opposed to patented medication);
- Determine, before treatment, if you will be charged at NHRPL;
- When you visit a specialist, please ensure that the results of all pathological and radiological tests (including x-rays and blood tests) are handed to the specialist. Your Scheme will not pay for duplication of tests; and
- Keep a record of all claims submitted.



THE CORRECT CLAIMS PROCEDURE

You must submit your claim directly to the Scheme at:

Nampak SA Medical Scheme
P O Box 2338
Durban
4000

Members are no longer required to complete a claim form, however, original invoices and prescriptions have to be submitted before payment will be considered.

Members are encouraged to submit their claims promptly as all claims expire at the end of the fourth month after date of treatment and will NOT be paid as a result. **Approved** claims will be paid within 30 days of receipt by the Scheme.

Members must ensure that all invoices and prescriptions are endorsed with the following:

- The Schemes' registered name - Nampak SA Medical Scheme;
- The main member's name and the name of the patient (dependant) as registered and indicated on the membership card;
- The correct medical aid reference number;
- Member's signature and date;
- Proof of payment, signed by the member and indicated as "PAID" (where applicable).

Copies of all submitted claims should be retained by the member. The onus rests on the member to check his/her statement to ensure that payment has been made. It is also the responsibility of the member to inform the service provider (doctor, pharmacist, etc) of the correct name and address of the Scheme as well as the medical reference number.

It should be noted that all dentist laboratory accounts have to be submitted together with the dentist account.

Payment of Claims - NHRPL

Claims for services supplied to practitioners who charge in line with the NHRPL, will be paid directly to the practitioner whilst claims for services provided by practitioners who charge in excess of the NHRPL, will be paid to the member. In this instance, it is the member's responsibility to settle the practitioner's account in full.

Members who pay cash to a service provider for treatment/medication are required to attach a signed receipt to their claim as proof that payment has been made. The word "PAID" should be clearly reflected on the claim in order to prevent the Scheme from inadvertently paying the service provider instead of the member.

remember the ICD-10 codes

All service providers are required, by law, to indicate ICD-10 codes on all accounts and next to each medicine item on a prescription. Even if you submit a claim after having paid for the services yourself, a valid applicable ICD-10 code should be indicated on the account.

If items on a prescription are used for the treatment of more than one sickness condition, the correct and applicable ICD-10 code should be indicated next to each medicine item and not only once on the prescription. You should, therefore, confirm with your doctor that he/she has indicated the correct ICD-10 codes on all prescriptions and accounts. Also check your statements regularly to ensure that claims have been paid. A claim on which the ICD-10 codes are missing or the incorrect ICD-10 codes have been indicated, will be rejected and a modified account reflecting the correct ICD-10 codes will have to be submitted for payment.

ICD-10

UNDERWRITING

Waiting periods and exclusions fall under the broader heading of “Underwriting” and are measures prescribed in law. The Medical Schemes Act allows schemes to protect their financial viability by applying certain “Underwriting” policies to new members.

It is not seen as fair to allow members who have not been members of a scheme previously and having not contributed to the fund reserve, to be able to claim and benefit from the reserves that existing members have built over a period. In this case, it would be appropriate to impose a waiting period on the membership.

The policies also prevent what is known as “Scheme Hopping” where members who have exhausted their benefits in one scheme, resign to join another scheme in order to access more benefits. The rules state that any person who joins a scheme for reasons other than changing employment, will not be able to claim from that scheme for the first three months of membership (general waiting period). In addition, the scheme will not entertain any claims arising in the first 12 months for any condition that “pre-existed” prior to the member joining the scheme (condition specific waiting period).

The Nampak Scheme does not apply “Underwriting” to new employees provided they join within the first three months (window period) of commencing employment with Nampak. This will also apply to their registered dependants subject to the rules. Should a member marry or have a baby after joining, they are required to add this dependant within 30 days of the event in order to avoid possible “Underwriting”.

Late Joiner Penalties (LJP's)

Another penalty has been added that is applied to members over the age of 35 who join a medical scheme for the first time (having not belonged to a medical scheme previously). This is referred to as LJP's.

A percentage penalty is charged in addition to the members' monthly contribution and applied for as long as the member remains on a registered medical scheme. The penalty can be as high as 75% depending on the age and creditable cover if any. Should the member join another scheme, the penalty will be applied there as well.

TOTAL CONTRIBUTIONS

STANDARD OPTION

CURRENT TABLE		PREMIUM		
Category	Income Band	Principal Member	Spouse & Adult Dependant	Each Child Dependant
S1	R0 - R2 000	R 663	R 489	R 172
S2	R2 001 - R3 500	R 899	R 668	R 234
S3	R3 501 - R5 000	R 993	R 736	R 258
S4	R5 001 - R7 000	R1 090	R 807	R 283
S5	R7 001 - R9 000	R1 209	R 894	R 314
S6	R9 001 - R11 000	R1 292	R 957	R 336
S7	R11 001 +	R1 317	R 976	R 342



TOTAL CONTRIBUTIONS continued

EXTENDED OPTION

CURRENT TABLE		PREMIUM INCLUDING SAVINGS		
Category	Income Band	Principal Member	Spouse & Adult Dependant	Each Child Dependant
E1	R0 - R2 000	R1 323	R 987	R 344
E2	R2 001 - R3 500	R1 685	R1 263	R 438
E3	R3 501 - R5 000	R1 872	R1 404	R 487
E4	R5 001 - R7 000	R2 002	R1 505	R 521
E5	R7 001 - R9 000	R2 059	R1 547	R 535
E6	R9 001 - R11 000	R2 131	R1 593	R 554
E7	R11 001 +	R2 175	R1 625	R 565

CURRENT TABLE		SAVINGS (15%)		
Category	Income Band	Principal Member	Spouse & Adult Dependant	Each Child Dependant
E1	R0 - R2 000	R 173	R 129	R 45
E2	R2 001 - R3 500	R 220	R 165	R 57
E3	R3 501 - R5 000	R 244	R 183	R 64
E4	R5 001 - R7 000	R 261	R 196	R 68
E5	R7 001 - R9 000	R 268	R 202	R 70
E6	R9 001 - R11 000	R 278	R 208	R 72
E7	R11 001 +	R 284	R 212	R 74

CURRENT TABLE		PREMIUM EXCLUDING SAVINGS		
Category	Income Band	Principal Member	Spouse & Adult Dependant	Each Child Dependant
E1	R0 - R2 000	R1 150	R 858	R 299
E2	R2 001 - R3 500	R1 465	R1 098	R 381
E3	R3 501 - R5 000	R1 628	R1 221	R 423
E4	R5 001 - R7 000	R1 741	R1 309	R 453
E5	R7 001 - R9 000	R1 791	R1 345	R 465
E6	R9 001 - R11 000	R1 853	R1 385	R 482
E7	R11 001 +	R1 891	R1 413	R 491

Benefit Guide 2010

DEFINITIONS:

SCHEME RATE represents 100% of NHRPL published by the Department of Health and pays up to 200% of NHRPL for certain professional services in hospital on the Extended option. SCHEME RATE when admitted to hospital: Claims are paid according to rates negotiated with each hospital group.

OVERALL ANNUAL LIMIT (OAL)

STANDARD OPTION

R200 000 PER FAMILY

EXTENDED OPTION

NONE

TREATMENT RECEIVED WHEN ADMITTED TO HOSPITAL

PAYS

LIMITS

PAYS

LIMITS

PRE-AUTHORISATION NECESSARY IN ALL CASES

Emergencies must be authorised within 48 hours of being admitted. Failure to pre-authorise will result in the member being liable for the full cost of hospitalisation and related expenses.

Benefits will be provided in accordance with the Rules, Benefits, Clinical Protocols and Limits of the Scheme.

HOSPITALISATION

Including ward and theatre fees, ICU & HCW, drugs, material, equipment, blood transfusions and transfer of blood.

Prescribed Minimum Benefits applicable in the event of Overall Annual Limit being exhausted.

Excluding:

- a. Cost of Dental Implants (See specified benefit)
- b. Accommodation in a private ward
- c. Cosmetic procedures
- d. Refractive surgery (For Laser Keratectomy, (see specified benefit)
- e. Psychiatric treatment (See specified benefit)
- f. Organ transplants (See specified benefit)
- g. Cost relating to in-vitro fertilisation (See specified benefit)
- h. To Take Out Drugs (See acute medicine benefit)

Public Hospitals
UPFS rates

Private Hospitals
Scheme Rate

Subject to OAL

Public Hospitals
UPFS rates

Private Hospitals
Scheme Rate

None

REHABILITATION TREATMENT - MEDICAL AND SURGICAL

(Subject to authorisation at approved institutions)

Scheme Rate

Subject to OAL

Scheme Rate

None

OUTPATIENT DEPARTMENTS AND EMERGENCY FACILITIES

(Note this is not included as in-hospital benefit)

Scheme Rate

Subject to Consultation
Limits

Scheme Rate

Subject to Day-to-day
benefit of R2 500 thereafter
subject to MSA

<p>ACCIDENTS AND INJURIES, INCLUDING MOTOR VEHICLE ACCIDENTS (MVA's) Including injuries relating to third party cases. Accident report to be completed and submitted by member.</p>	<p>Public Hospitals UPFS rates</p> <p>Private Hospitals Scheme Rate</p>	<p>Subject to OAL</p>	<p>Public Hospitals UPFS rates</p> <p>Private Hospitals Scheme Rate</p>	<p>None</p>
<p>CONFINEMENTS Normal deliveries and Caesarean Sections in Private and Provincial Hospitals. Registration is mandatory between 12 and 20 weeks of pregnancy. (Membership of the maternity programme is compulsory)</p>	<p>Scheme Rate</p>	<p>Subject to OAL</p>	<p>Scheme Rate</p>	<p>None</p>
<p>DELIVERIES BY A REGISTERED NURSE/MIDWIFE Benefit includes all costs relating to hospitalisation. (Membership of the maternity programme is compulsory)</p>	<p>Scheme Rate</p>	<p>Subject to OAL</p>	<p>Scheme Rate</p>	<p>None</p>
<p>CONSULTATIONS AND SERVICES IN HOSPITAL Treatment and Consultations in hospital by Specialist and General Practitioners. (Pre-authorization required)</p>	<p>Scheme Rate</p>	<p>Subject to OAL</p>	<p>Scheme Rate</p>	<p>None</p>
<p>EMERGENCY SERVICES Road Ambulances, Emergency Services and General Advice Line. SUBJECT TO CONFIRMATION OF RATES/SERVICE PROVIDER. (Pre-authorization required - Contact Netcare 911 on 082 911)</p>	<p>Scheme Rate</p>	<p>Through approved provider only</p>	<p>Scheme Rate</p>	<p>Through approved provider only</p>
<p>SURGICAL PROSTHESIS Including pacemakers and electronic devices plus coronary stents. (Pre-authorization required)</p>	<p>Scheme Rate</p>	<p>R36 700 per beneficiary Subject to OAL</p>	<p>Scheme Rate</p>	<p>R36 700 per beneficiary</p>
<p>KIDNEY AND HOME DIALYSIS Including related drug therapy (through approved providers only). All cases subject to full investigation, registration on the Renal Programme and pre-authorization.</p>	<p>Scheme Rate</p>	<p>Subject to OAL</p>	<p>Scheme Rate</p>	<p>R202 590 per beneficiary</p>
<p>ORGAN TRANSPLANTS Including organ harvesting and immunosuppressive drug therapy. Subject to transplant motivation and pre-authorization required.</p>	<p>Scheme Rate</p>	<p>Subject to OAL</p>	<p>Scheme Rate</p>	<p>R200 080 per beneficiary</p>
<p>DONOR COSTS Nampak Member Recipients ONLY and limited to costs not covered by other Medical Schemes.</p>	<p>Scheme Rate</p>	<p>R37 850 per Donor Subject to OAL</p>	<p>Scheme Rate</p>	<p>R40 500 per Donor</p>
<p>PSYCHIATRY IN HOSPITAL Hospitalisation conditions include anorexia nervosa, bulimia, alcoholism, treatment for substance abuse at SANCA approved facilities and all related accounts. (Pre-authorization required)</p>	<p>Scheme Rate</p>	<p>R23 950 per beneficiary Subject to OAL</p>	<p>Scheme Rate</p>	<p>R23 950 per beneficiary</p>

TREATMENT RECEIVED IN ROOMS WHEN NOT ADMITTED TO HOSPITAL:	PAYS	LIMITS	PAYS	LIMITS
<p>SPECIALISTS Specialist conditions and treatment out of hospital by anaesthetists, physicians, neurologists, neurosurgeons, surgeons, orthopaedic specialists, otorhinolaryncologists (ENT), radiotherapists, thoracic surgeons and urologists. (On referral by General Practitioners only)</p>	Scheme Rate	M - R2 010 M1 - R2 780 M2 - R3 260 M3+ - R4 010 Subject to OAL	Scheme Rate	None
<p>GENERAL PRACTITIONERS & CERTAIN SPECIALISTS Out patients, out of hospital consultations, treatment in rooms and procedures. Dermatologists, gynaecologist, ophthalmologists, paediatricians, plastic surgeons and physical medicine (including needles, syringes and sterile trays).</p>				Subject to Day-to-day benefit of R2 500 thereafter subject to MSA
<p>PSYCHIATRY, PSYCHOLOGY & SOCIAL WORKERS Consultations and treatment out of hospital.</p>				
<p>DIAGNOSTIC RADIOLOGY, PATHOLOGY AND MEDICAL TECHNOLOGY Including materials. Referring doctors practice number to appear on all claims. (Pre-authorisation required for MRI, bone densitometry, mammograms and CT/PET Scans).</p>	Scheme Rate	Subject to OAL	Scheme Rate	None
<p>ONCOLOGY Chemotherapy, Radiotherapy, Intravenous drugs and materials. This benefit is subject to the submission and approval of a comprehensive treatment plan. To be sent to the Pre-Authorisation Department: Fax: 031-5800472 or Address: P O Box 2338, Durban, 4000</p>	Scheme Rate	Subject to OAL	Scheme Rate	None
<p>MATERNITY BENEFIT - Antenatal Benefits and Scans</p>	Scheme Rate	12 antenatal visits and 2 scans	Scheme Rate	12 antenatal visits and 2 scans
<p>CHRONIC PRESCRIBED MEDICATION Medicines prescribed or dispensed to patients registered on a chronic medication programme with the Scheme. (CDL - unlimited).</p>	Subject to benefit pricing 100% of MMAP at DSP	R2 720 per beneficiary Subject to OAL	100% of Single Exit Price	None
<p>HIV/AIDS Antiretroviral Treatment (ART). Compulsory registration on HIV Programme - 0860 109 793</p>	Scheme Rate	R30 680 per beneficiary Subject to OAL	Scheme Rate	R30 680 per beneficiary
<p>ACUTE MEDICATION All medication including TTO's other than those obtained by members through the Chronic Medication programme. Medicines prescribed and dispensed by pharmacists limited to R80 per script.(PAT) Clinical and pharmacy dispensed vaccinations limited to R75 per script.</p>	100% of MMAP	M - R2 770 M1 - R3 510 M2+ - R4 470 Subject to OAL	100% of Single Exit Price	Subject to Day-to-day benefit of R2 500 thereafter subject to MSA
<p>PHYSIOTHERAPY/BIOKINETICS</p>	Scheme Rate	R940 per family Subject to OAL	Scheme Rate	Subject to Day-to-day benefit of R2 500 thereafter subject to MSA

OPTICAL SERVICES Optical tests.	Scheme Rate	1 test per beneficiary per annum Subject to OAL	Scheme Rate	Subject to Day-to-day benefit of R2 500 thereafter subject to MSA
Spectacle lenses, frames and contact lenses.	Scheme Rate	R1 030 per beneficiary every second year Subject to OAL	Scheme Rate	Subject to Day-to-day benefit of R2 500 thereafter subject to MSA
Laser Keratectomy/Excimer laser only. Only one treatment per lifetime per beneficiary permitted inclusive of facility and equipment fee. (Pre-authorisation and quotation required).	Scheme Rate	R3 860 per eye Subject to OAL	Scheme Rate	R3 860 per eye
EXTERNAL APPLIANCES Includes hearing aids, orthopaedic boots, surgical collars, nebulisers, wheelchairs, incontinence products and the hiring of equipment. Category limits: Hearing aids - R4 780 per beneficiary every two years; Wheelchairs - R4 780 per family; Nebulisers - R1 200 per family. (Pre-authorisation required: Tel: 0860 10 10 47)	Scheme Rate	R10 770 per family with category limits Subject to OAL	Scheme Rate	R10 770 per family with category limits
ALL DENTISTRY IN AND OUT OF HOSPITAL (Hospitalisation subject to pre-authorisation) Fillings, x-rays, extractions and prophylactics. Orthodontic, periodontic, crowns, bridgework, dentures. Dental Maxillo-facial treatment, dental implants and related accounts.	80% of recommended Scheme Rate with 20% co-payment by member to supplier	M - R4 310 M1 - R8 140 M2 - R9 920 M3+ - R10 570 Subject to OAL	80% of recommended Scheme Rate with 20% co-payment by member to supplier	M - R5 040 M1 - R9 150 M2 - R11 670 M3+ - R11 990
COMMUNITY CARE	PAYS	LIMITS	PAYS	LIMITS
PRIVATE NURSING AND HOSPICES In lieu of hospitalisation only. Nursing services and sub-acute facilities. Subject to submission of doctor's comprehensive treatment plan and Scheme approval. (Pre-authorisation required).	Scheme Rate	R4 620 per family Subject to OAL	Scheme Rate	R6 260 per family
FRAILCARE Subject to doctor's letter of motivation and Scheme approval. (Pre-authorisation required)	Scheme Rate	R4 620 per family Subject to OAL	Scheme Rate	R6 260 per family
OXYGEN SUPPLY Supply through Preferred Provider only. Subject to submission and approval of a treatment plan. (Pre-authorisation required)	Scheme Rate	Subject to OAL	Scheme Rate	None
STOMATHERAPY MATERIALS Bags, pouches and flanges. (Pre-authorisation required)	Scheme Rate	Subject to OAL	Scheme Rate	None
ALTERNATIVE SERVICES Homeopaths and chiropractors. Including all services.	Scheme Rate	R940 per family Subject to OAL	Scheme Rate	Subject to Day-to-day benefit of R2 500 thereafter subject to MSA

OTHER SERVICES

Speech therapy, audiology, occupational therapy, podiatry and dieticians, infertility examinations, treatment and medication, including in-vitro fertilisation.
(Hospital accommodation forms part of benefit)

Scheme Rate

R940 per family
Subject to OAL

Scheme Rate

Subject to Day-to-day
benefit of R2 500 thereafter
subject to MSA

FOR THE STANDARD OPTION: All individual benefit limits are subject to and fall within the Overall Annual Limit.

ABBREVIATIONS:

MSA = Medical Savings Account
MMAP = Maximum Medical Aid Price
OAL = Overall Annual Limit



CHOOSING YOUR OPTION

The Nampak Scheme operates two options:

- Standard Option
- Extended Option with a MSA

The STANDARD Option

This option has an **overall annual healthcare benefit of R200 000** per family for all claims excluding those services provided in a Provincial Hospital as PMB's.

It is the preferred choice for persons who are looking for good medical cover at an affordable price.

Members who select the Standard Option must ensure that they are familiar with the various benefit allocations within the particular treatment categories and budget their expenses accordingly. Where members anticipate high medical expenses, they should consider the Extended Option, which has higher benefit levels.

The EXTENDED Option

The Extended Option consists of a risk pool account that pays claims incurred in hospital, claims for chronic medication and certain other costs like blood tests, radiology (x-rays) and cancer treatment.

In addition, this risk pool pays the first R2 500 (routine/day to day benefit) for all out of hospital expenses **except a 20% co-payment on dentistry**.

The Extended Option also consists of a savings account that facilitates the 20% co-payment on dentistry. Members who exceed their routine/day to day benefit may request payment of further claims from their **positive brought forward** savings. In this case, a Request to Pay from Positive Savings form has to be completed and submitted to the Scheme. Once the savings account is exhausted, no further claims for these specific services will be paid for the rest of the benefit year apart from the diagnosis, treatment and management of any CDL's. Please refer to the benefits schedule in this guide for further details on the Extended Option.

It should be noted that members who resign from Nampak during the year and have used their full year's entitlement of benefits, (for which contributions have not yet been made) will have to pay the Scheme the portion of contributions that is still outstanding.

The benefits covered by your medical savings account are:

- Outpatient department and emergency facilities at a private hospital;
- General practitioner visits and consultations;
- Some specialist consultations and treatment outside a hospital;
- Acute medication;
- Physiotherapy and biokinetics;
- Optical services like glasses and contact lenses; and
- Alternative and auxiliary medical services.

Please note that claims falling into all categories are first paid from the Routine/Day-to-day Benefit. **(Except the 20% co-payment for dentistry, which will still be paid from the Medical Savings Account.)**

Important Notes on Medical Savings Account

The MSA facility applies only to members on the Extended Option and 15% of the monthly contribution is allocated to their MSA.

Members have an overdraft facility up to the value of their total annual savings balance for the current year, which is available from the first day of the year. If a member's employment terminates during the year, he/she will be liable to repay any outstanding savings as advanced. Should a member join another scheme with a savings account facility, the member is required to transfer accumulated savings to the new scheme.

Positive savings balances are carried over to the following year and may be used to cover benefits in subsequent years. The Medical Schemes Act prohibits cash payment of MSA balances back to members unless they resign from the Scheme.

Members on the Standard option who were previously on Extended and who carried over positive savings, may use these savings to pay benefits exceeded on the Standard Option.

Changing Options

You may change your option once per calendar year only. Your application to change your option must reach Group Salaries before 16 November of the current year and the change will come into effect on 1 January the following year.

Pro-Rata Apportionment

If you join the medical aid scheme as a new member in the middle of the year (ie. after the month of January), your benefits and limits are calculated pro rata on a monthly basis from your joining date to 31 December. Your membership card will indicate your starting date.



CONTACT DETAILS

Claims and Administration

Postal address for claims & correspondence:
Nampak SA Medical Scheme
PO Box 2338 - Durban - 4000

Regional Office Durban

1-3 Canegate Road - La Lucia Ridge - 4019

OTHER IMPORTANT NUMBERS

Customer Care

Contact Centre
Tel: 0860 10 10 47
Fax: (031) 580 0480

Hospital and Pre-Authorisation

Tel: 0860 10 10 47

Chronic Medication Registration and Queries

Chronicare Management (CCM)
Tel: 0860 10 10 47
Fax: (031) 580 0471

Chronicare Medicine DSP

Tel: (011) 660 4005 / 0860 10 23 04
Fax: 086 688 0070
email: info@chronicare.co.za

Emergency Assistance and Ambulance

Netcare 911
Tel: 082 911

HIV Programme

Tel: 0860 10 97 93

Maternity Programme

Maternity Care Focus
Tel: 0860 10 10 47

Multiply

Tel: 0861 10 07 89

Nampak Health Website

<http://www.nampakhealth.co.za>

Health-In-Site Website

<http://nampak.healthinsite.net>

Contact Centre Email Address

info@nampakhealth.co.za