



Dear Member

In this edition of our newsletter, we will be focussing on the Specialist Network Arrangement for 2012 and Patient Advocacy. We will also provide you with a summary of the other changes you can expect for the New Year.

We welcome any suggestions that you may have on the types of articles/topics or member benefits that you would like published in future newsletters. Please email suggestions to Lallie Govender – lallie.govender@momentum.co.za or fax number **031 580 0455**.

Yours in good health

Nampak SA Medical Scheme Specialist Arrangement

Increasing Specialist costs form a large component of claims paid by the Scheme. In addition to this, the payment of Prescribed Minimum Benefit (PMB) claims at cost has increased the financial burden on Medical Schemes. In an effort to minimize the risk that this poses, Nampak SA Medical Scheme has decided to implement a Specialist Network for its members as a Designated Service Provider (DSP) from 1 January 2012 on both the Standard and Extended Options. The Scheme has contracted with a group of Specialists to deliver quality healthcare services to its beneficiaries and to participate in the Scheme's managed healthcare process of beneficiaries.

We have negotiated with these Specialists, who have agreed to charge all Nampak SA Medical Scheme members a specified rate. This will apply to PMB related accounts as well. Members are encouraged to utilise these Network Specialists both in and out of hospital as this will ensure that members with available benefits do not incur huge co-payments. We have also arranged for direct payment to these specialists on a weekly basis so members will not be inconvenienced as in the past.

Should members opt to use specialists outside of the Network, they will be liable for any amounts charged above the Scheme rate. It is also important to note that the Scheme is not liable to pay for PMB accounts at cost if a non-Network specialist is used and this could result in unnecessary member co-payments. In addition to this, accounts from these non-Network specialists will be refunded to members if they are charged above the Scheme Rate.

Nampak SA Medical Scheme is striving towards creating a hassle-free environment with increased financial benefits to both providers and our members by introducing this exciting Specialist

Network arrangement. Our members who utilise the services of any of our specialists on the above arrangement will enjoy the benefits of having full cover for appropriate services provided by these specialists.

The list of all Network Specialists will be finalised by the first week of December. To check if your specialist is on the above arrangement, please call our Call Centre on **0860 10 10 47** thereafter.



Patient Advocacy is an enhancement to the pre-authorisation service. Patient Advocacy is done at the point of pre-authorisation whereby the agent will provide the member or the provider with all relevant information to an admission/procedure.

To ensure that the member is appropriately informed, it is very important for the member to request a quotation from the Doctor/Specialist with the relevant tariff codes for the hospital admission/procedure.

At the point of call, the member will be made aware of the following:

- The reimbursement rate on the member's plan option.
- The Doctor's / Specialist's billing behaviour, i.e. does the provider charge Scheme Rates or in excess of the Scheme Rate.
- All event / benefit limits, e.g. surgical prosthesis, implants, etc.
- Managed Care Guidelines and Clinical Policies / Protocols.

The above details will allow the member to negotiate with the provider where necessary. Once the pre-authorisation process is complete, the member will receive confirmation via SMS or email.

The above pre-authorisation process is also followed when the provider calls on behalf of the member. Once the authorisation is approved, the Scheme will send electronic communication to both the member and provider. Providers get their communications via email. The member is contacted and advised of benefits/limits and potential shortfalls.

Patient Advocacy is a medium to create awareness at all levels to ensure that members get the best level of medical care are an appropriate cost.

Summary of Changes for 2012

DESCRIPTION OF CHANGE
Day-to-day benefit on the Extended Option will be paid from your 2012 savings and, thereafter, from your R2 500 routine benefit.
A limit will be implemented on non-CDL (Chronic Disease List) medication on both options.
A standard formulary with Maximum Medical Aid Price (MMAP) will be implemented on chronic medication on both options.
The dentistry co-payment has been increased on both options.
A co-payment on scopes performed in and out of hospital will be implemented.
A limit and co-payment on MRI and CT/PET scans performed in and out of hospital will be implemented.
The External Appliance and Surgical Prosthesis limit on the Standard Option has been changed.
Certain benefits on both options have been increased by 5%.
The contributions on the Standard Option have been increased by 6.9%.
The contributions on the Extended Option have increased by 7.8%.

Please note that the complete Member Guide for 2012 will be posted to all members by mid-November 2011.

Discontinuation of GP Network for 2012

As you may remember the Scheme introduced a GP network on 01 June 2011 on a voluntary basis and we advised that this would be reviewed for 2012.

The Scheme has reviewed the impact this had on both the Scheme and its members and have taken a decision to cancel the GP Network for 2012.

