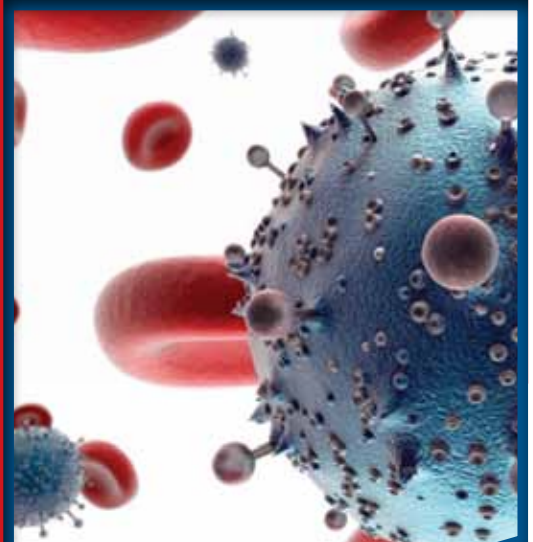




**Nampak**

SA Medical Scheme



# Member Guide 2012

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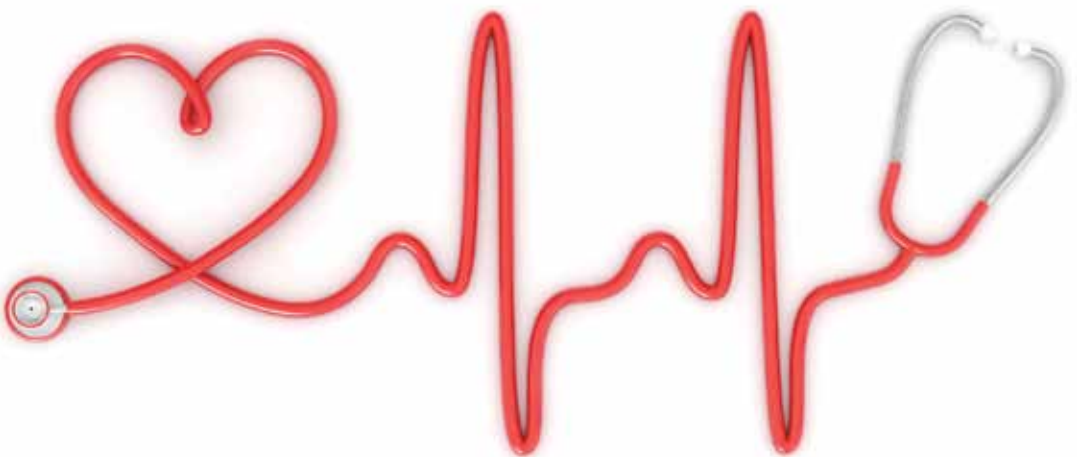
**... packaged for your benefit**

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.



# Membership

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

The Nampak Scheme does not apply “Underwriting” (refer to page 16 for details) 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 grandchild, the main member must legally adopt the grandchild 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 Designated Service Provider (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 "Scheme Rate" 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 (e.g. South African Medical Association – SAMA).

## **Cost**

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

## **MMAP: Maximum Medical Aid Price**

This is the maximum medical aid price paid by the Scheme for the cost of generic medication, where a generic alternative exists for branded or ethical medication. If no generic equivalent exists, the Scheme will cover the cost of the prescribed medication. 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 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.

## **Formulary**

A defined list of medicine used in the treatment of various diseases.

## **Specialist Network**

A specialist or group of specialists contracted to the Scheme to deliver quality healthcare services to its beneficiaries and to participate in the Scheme's managed healthcare process of beneficiaries.

## **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 fifth 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**

Medication prescribed and dispensed by the pharmacist (over the counter medication).

## **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**

Medication 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 medication 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/RPL) for Health care services published by the Council for Medical Schemes in 2006, plus an annual inflationary factor as indicated:

- 2007 - 4.9%
- 2008 - 5.4%
- 2009 - 10.7%
- 2010 - 7.9%
- 2011 - 5%
- 2012 - 5%

## **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 2012

## 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>



## Value Added Products for 2012



# e-Care

Members have free access to e-Care, an innovative online programme that offers a range of wellbeing services. e-Care covers every aspect of work, life and wellbeing in different formats: read it online, print it out, take a quiz or ask an expert. Members can receive the information in weekly emails.

In order to experience personalised wellness, members are required to answer questions about themselves. This information will remain confidential and only take a few minutes to complete.

e-Care is free for you and your family. It is completely confidential.

To enrol, members should visit <http://nampak.healthinsite.net>.

If already enrolled, members can profile themselves. Use the PROFILE button to receive the full benefit of this service.

Should members have any queries, they can contact us on **0861 06 66 66** or email us at [queries@healthinsite.net](mailto: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 service 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 and 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 **010 209 8911**.

### 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 10 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. This includes advice during pregnancy. Please dial **010 209 8911**.

## 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. For more information, please dial **082 911**.

## 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.

Please call **011 647 3654** for further information.

# Your Life 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 the Your Life HIV Management Programme.

**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 to join?** By joining the Your Life 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 their pregnancy, or are already aware of their HIV status when they fall pregnant, to inform us as soon as they are aware of their status. Mother-to-child transmission is very successfully prevented if the pregnant mother receives treatment with antiretrovirals.

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

**Will the member's condition remain confidential?** We do respect and salute members who have had the courage to disclose their condition and rise above all the stigma. **This 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 members qualify for?** 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 **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 Your Life on:**

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



# 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 their 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** during office hours.

### The Maternity Programme benefits are:

- 12 antenatal consultations up to the Scheme Rate;
- 2 routine antenatal ultrasound scans up to the Scheme Rate;
- 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; and
- Members may phone for advice during office hours.

## 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 **with histology results**, 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**.

### INDEPENDENT CLINICAL ONCOLOGY NETWORK (ICON) - Standard Option

ICON is an accredited Oncology Specialist Managed Care organisation. ICON was originally introduced to the healthcare industry to assist Medical Schemes to cope with the increased financial burden associated with the oncology risk of schemes. ICON meets all the criteria in terms of quality, geographic spread of oncologists and accredited facilities. Out of a potential 150 practicing Oncologists, 114 are on the ICON network, which represents almost 76% of all Oncologists in South Africa.

To register for the Oncology Programme, the member must visit an ICON Oncologist and be assessed by the treating Oncologist. The Oncologist will submit a treatment plan request, together with the histology results, to the Scheme. This information must be faxed to the Scheme's Oncology Department on **031 580 0446**. The Oncology Disease Manager of the Scheme will review the request in accordance with ICON's treatment guidelines and the Scheme Rules. The Oncology Disease Manager will liaise directly with the treating Oncologist regarding treatment. A current list of the ICON Oncologists can be accessed from the Scheme website, **www.nampakhealth.co.za** or Nampak's internal site, iN Sight. Alternatively, you can call the Scheme Contact Centre on **0860 10 10 47** and request a list. **If members on the Standard Option choose to obtain their oncology benefits from a non-ICON Oncologist, a 30% co-payment will apply.**

## Renal Management Programme

A chronic renal application form needs to be completed by the treating specialist and 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 specialist and in accordance with the relevant treatment protocols. Members are advised to negotiate preferred tariffs with their specialists should they wish to use a non-Network specialist. Please call **0860 10 10 47**.

# Medication

## Medipost Pharmacy (National Chronic Medication Management and Delivery)

Medipost offers members a range of benefits, such as more affordable prices, convenient delivery to an address of the member's choice and clinical advice about chronic medication usage. Medipost focuses on the patient's individual medication management needs in an environment of strict patient confidentiality. Qualified professional pharmacists are on call for personal consultations to assist with chronic medication matters, such as appropriate medication use. Medipost is committed to the highest ethical standards and take an uncompromising stance on issues such as compliance with the Scheme Rules and all laws regulating the pharmaceutical environment.

### What is chronic medication?

Chronic medication can be divided into two categories:  
CDL Chronic Medication and Non-CDL Chronic Medication.

**CDL Chronic Medication** is used for 26 life threatening conditions which a scheme has to cover according to legislation. Legislation also provides that a scheme is allowed to cover these conditions subject to formularies, pricing policies, designated service providers and managed health care rules. The medication for these conditions is subject to Nampak's authorisation criteria. This includes the application of MMAP, as well as the Scheme's medicine formulary as per the Scheme's Rules. This may result in a co-payment.

### Chronic Disease List (CDL)

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



**Non-CDL Chronic medication** is used for ongoing, disabling conditions that significantly affect productivity and quality of life, e.g. depression, gout, arthritis, etc. These conditions are also subject to the Scheme Rules, which include the application of MMAP and the Scheme's formulary which may result in a co-payment. Normally, these extra chronic conditions do not have unlimited funds and there is a possibility that you will have to pay for it in full later in the year.

Members on the Extended Option are advised to utilise Medipost, 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 apply and obtain your monthly chronic medication through Medipost:**

- You can phone the Medipost Call Centre on **012 426 4000** or email Medipost at **nampak@medipost.co.za**. Medipost will supply you with a Medipost patient information form.
- Once completed, the member is required to fax the information form, a six monthly repeat prescription and supporting documentation (if applicable) to **086 648 5777**.
- Medipost will arrange the chronic registration with the Scheme's Pharmaceutical Benefit Management Company.
- Medipost will initiate the member profile, follow up on products that require chronic authorisation, contact the member to make delivery arrangements and subsequently process and deliver the medication to the destination of choice.

### **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 medicine 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**

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 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/procedure 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, e.g. 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 guide)

- Surgical Prosthesis
- Organ Transplants
- Oxygen Supply
- Dentistry in Hospital
- Private Nursing and Hospice
- MRI, CT and PET Scans
- Mammograms
- Cancer Treatment
- 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 Scheme Rate up to the members dentistry limit. Please refer to the benefit guide in this book. Please contact **0860 10 10 47** to obtain your authorisation number.

## Nampak Specialist Arrangement

Nampak SA Medical Scheme is continually striving to enhance the healthcare experience for our members, as well as healthcare providers. We recognise the necessity for healthcare professionals to be reimbursed appropriately for healthcare services rendered, whilst at the same time guaranteeing you access to affordable healthcare.

We are working towards creating a hassle-free environment with increased financial benefits to both providers and our members by introducing direct payment to specialists who want to participate in this exciting 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.

To check if your specialist is on the above arrangement, please contact our Call Centre on **0860 10 10 47**.

## Patient Advocacy

Patient Advocacy is an enhancement to the current 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 the relevant information pertaining to an admission/procedure.

To ensure that the member is appropriately informed, it is 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 the provider. Providers receive their communication via email. The member is contacted and advised of benefits/limits and potential shortfalls.

The aim is to empower the member to make an informed choice/decision to either plan for the shortfall amount or to negotiate a lower fee/discount from the provider to avoid co-payments/out-of-pocket expenses. Patient Advocacy is a medium to create awareness at all levels to ensure that the member gets the best level of medical care at an appropriate cost.



## Accidents and Injuries (including motor vehicle accidents)

The Nampak SA Medical Scheme pays your medical costs at 100% of the Scheme Rate for all motor vehicle accidents, even if the member is involved as a third party (e.g. 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 the 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**.

### RAF Claims

For assistance with RAF claims and queries we suggest members contact the attorneys below:

#### Berkowitz Cohen Wartski

Contact Person : Mrs Fahreen Kader  
Telephone : **031 314 9300**  
Email : **fkader@berklaw.co.za**

## Tips to Cure the High Cost 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 the Scheme Rate;
- 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 – Scheme Rate

Claims for services supplied to practitioners who charge in line with the Scheme Rate, will be paid directly to the practitioner whilst claims for services provided by practitioners who charge in excess of the Scheme Rate, 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 by you for payment.

### Claims Excluded from Benefits

The Nampak SA Medical Scheme does not provide cover for the benefits listed below unless claimed as a PMB condition.

- Cosmetic treatment including treatment for obesity;
- Elective non-medically justifiable treatment;
- Medical costs that can be recovered from a third party;
- Participation in medical research;
- Insurance of physical fitness examinations;
- Travel costs other than an authorised ambulance;
- Holidays for recuperative purposes;
- Injuries due to dangerous sport activities (e.g. speed contest);
- Wilful, self-inflicted injury (unsuccessful suicide attempt);
- Injury caused by alcohol or drug abuse;
- Patent and proprietary drugs, bandages and aids, patent foods, preparations, domestic and biochemical remedies;
- Sunglasses;
- Medical costs in excess of defined limits;
- Letters or reports from doctors; and
- Any other medical costs referred to as exclusions by the Board of Trustees.



# Underwriting

Waiting periods and exclusions fall under the broader heading of “Underwriting” and are measures prescribed by 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).

Nampak SA Medical 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 carried forward to the new scheme.

## Choosing your Option

### The Nampak Scheme operates two options:

- Standard Option
- Extended Option with a Medical Savings Account

### The STANDARD Option

This option has an **overall annual healthcare benefit of R200 000 per family** for all claims excluding those services provided as PMB's. It is the preferred choice for persons who are looking for good medical cover at an affordable price.

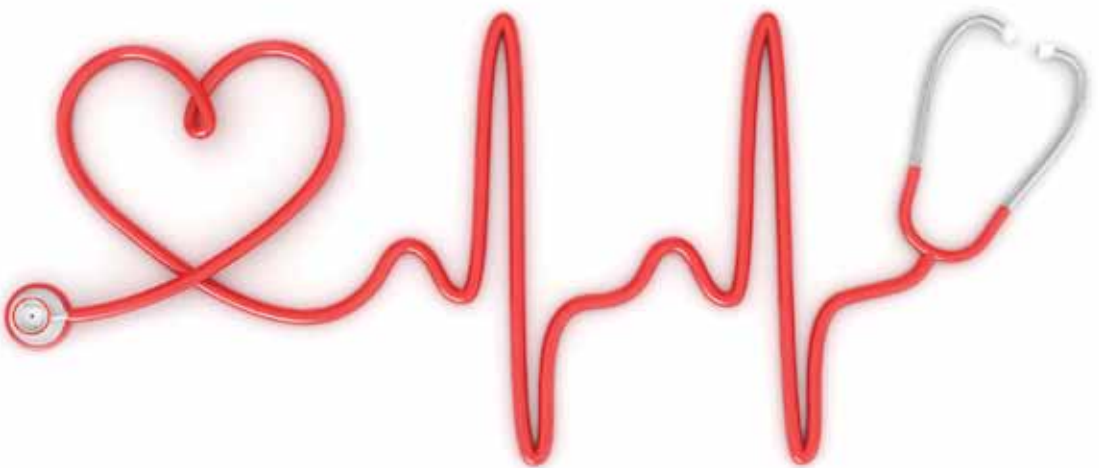
Members who select the Standard Option must ensure that they are familiar with the various benefit allocations within the particular treatment categories and budget their expenses accordingly. Where members anticipate high medical expenses, they should consider the Extended Option, which has higher benefit 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 R2 500 (routine/day to day benefit) for all out of hospital expenses **except a 30% co-payment on dentistry** once savings is exhausted.

The Extended Option savings account facilitates the 30% co-payment on dentistry as well as other day-to-day claims. Once the savings account is exhausted, further claims for these specific services will be paid for the rest of the benefit year from the R2 500 (routine/day to day benefit) apart from the diagnosis, treatment and management of any CDL's. Please refer to the benefits guide in this book 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 savings, (for which contributions have not yet been made) will have to pay the Scheme back the portion 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 such as glasses and contact lenses; and
- Alternative and auxilliary medical services.

Please note that claims falling into all categories are first paid from medical savings and the routine/day-to-day benefit thereafter **(except the 30% 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 15 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 (i.e. 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.

**Note**

This summary is for information purposes only and does not supersede the Rules of the Scheme. In the event of any discrepancy between the Rules and the summary, the Rules shall prevail. A copy of the Rules can be obtained from the Scheme.

The Board of Trustees has the right to change the Rules of the Scheme to comply with statutory requirements and the sound management of the Scheme, as it may deem necessary.

# Total Contributions 2012

## Standard Option

CURRENT TABLE		PREMIUM		
Category	Income Band	Principal Member	Spouse & Adult Dependant	Each Child Dependant
S1	R0 - R2 000	R 762	R 562	R 198
S2	R2 001 - R3 500	R1 033	R 769	R 268
S3	R3 501 - R5 000	R1 141	R 847	R 297
S4	R5 001 - R7 000	R1 253	R 928	R 326
S5	R7 001 - R9 000	R1 390	R1 027	R 361
S6	R9 001 - R11 000	R1 485	R1 100	R 386
S7	R11 001 +	R1 514	R1 122	R 393



## Extended Option

CURRENT TABLE		PREMIUM INCLUDING SAVINGS		
Category	Income Band	Principal Member	Spouse & Adult Dependant	Each Child Dependant
E1	R0 - R2 000	R1 531	R1 143	R 398
E2	R2 001 - R3 500	R1 952	R1 462	R 507
E3	R3 501 - R5 000	R2 169	R1 626	R 563
E4	R5 001 - R7 000	R2 320	R1 744	R 603
E5	R7 001 - R9 000	R2 385	R1 793	R 621
E6	R9 001 - R11 000	R2 468	R1 845	R 641
E7	R11 001 +	R2 520	R1 882	R 655

CURRENT TABLE		PREMIUM (15%)		
Category	Income Band	Principal Member	Spouse & Adult Dependant	Each Child Dependant
E1	R0 - R2 000	R 199	R 149	R 52
E2	R2 001 - R3 500	R 254	R 190	R 66
E3	R3 501 - R5 000	R 282	R 211	R 73
E4	R5 001 - R7 000	R 302	R 227	R 78
E5	R7 001 - R9 000	R 310	R 233	R 81
E6	R9 001 - R11 000	R 321	R 240	R 83
E7	R11 001 +	R 328	R 245	R 85

CURRENT TABLE		PREMIUM EXCLUDING SAVINGS		
Category	Income Band	Principal Member	Spouse & Adult Dependant	Each Child Dependant
E1	R0 - R2 000	R1 332	R 994	R 346
E2	R2 001 - R3 500	R1 698	R1 272	R 441
E3	R3 501 - R5 000	R1 887	R1 415	R 490
E4	R5 001 - R7 000	R2 018	R1 517	R 525
E5	R7 001 - R9 000	R2 075	R1 560	R 540
E6	R9 001 - R11 000	R2 147	R1 605	R 558
E7	R11 001 +	R2 192	R1 637	R 570

# BENEFIT GUIDE 2012

DEFINITIONS: SCHEME RATE: As defined on page 03 of the member guide. Scheme pays up to 150% of this rate 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.	STANDARD OPTION  OVERALL ANNUAL LIMIT (OAL) R200 000 PER FAMILY	EXTENDED OPTION  NO OVERALL ANNUAL LIMIT (OAL)
TREATMENT RECEIVED WHEN ADMITTED TO HOSPITAL:	PAYS	PAYS
	LIMITS	LIMITS
<b>PRE-AUTHORISATION NECESSARY IN ALL CASES</b> : 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. <b>Benefits will be provided in accordance with the Rules, Benefits, Clinical Protocols and Limits of the Scheme.</b>		
<b>HOSPITALISATION</b> Including ward and theatre fees, ICU & HCW, drugs, material, equipment, blood transfusions and transfer of blood. <b>Prescribed Minimum Benefits applicable in the event of Overall Annual Limit being exhausted.</b> <b>Excluding:</b> Costs of Dental Implants (see specified benefit), Accommodation in a private ward, Cosmetic procedures, Psychiatric treatment (see specified benefit), Organ transplants (see specified benefit), Costs relating to in-vitro fertilisation (see specified benefit) and To Take Out Drugs (see acute medicine benefit).	Private Hospitals Scheme Rate  Public Hospitals UPFS Rates	Subject to OAL  Private Hospitals Scheme Rate  Public Hospitals UPFS Rates
<b>SCOPES</b> All scopes performed in-hospital are subject to a R1 000 co-payment. <b>Subject to Prescribed Minimum Benefits (PMBs).</b>	Scheme Rate	None
<b>REHABILITATION TREATMENT - MEDICAL AND SURGICAL</b> <b>Subject to authorisation at approved institutions.</b>	Scheme Rate	None
<b>OUTPATIENT DEPARTMENTS AND EMERGENCY FACILITIES</b> <b>NOTE: This is not included as in-hospital benefit.</b>	Scheme Rate	Scheme Rate  Subject to MSA thereafter subject to day-to-day benefit of R2 500
<b>ACCIDENTS AND INJURIES - INCLUDING MOTOR VEHICLE ACCIDENTS (MVA's)</b> Including injuries relating to third party cases. <b>Accident report to be completed and submitted by member.</b>	Public Hospitals - UPFS rates  Private Hospitals Scheme Rate	Public Hospitals - UPFS rates  Private Hospitals Scheme Rate  None

<p><b>CONFINEMENTS (Membership of the maternity programme is compulsory)</b> Normal deliveries and Caesarean Sections in Private and Provincial Hospitals. <b>Registration is mandatory between 12 and 20 weeks of pregnancy.</b></p>	Scheme Rate	Subject to OAL	Scheme Rate	None
<p><b>DELIVERIES BY A REGISTERED NURSE/MIDWIFE</b> Benefit includes all costs relating to hospitalisation. <b>(Membership of the maternity programme is compulsory)</b></p>	Scheme Rate	Subject to OAL	Scheme Rate	None
<p><b>CONSULTATIONS AND SERVICES IN HOSPITAL BY SPECIALISTS</b> MRI, CT &amp; PET Scans are subject to a R500 co-payment. <b>(Pre-authorisation required)</b></p>	DSP Agreed Rate Non-DSP 100% of Scheme Rate	Subject to OAL	DSP Agreed Rate Non-DSP 150% of Scheme Rate	None
<p><b>CONSULTATIONS AND SERVICES IN HOSPITAL BY GENERAL PRACTITIONERS</b> <b>(Pre-authorisation required)</b></p>	Scheme Rate	Subject to OAL	150% of Scheme Rate	None
<p><b>EMERGENCY SERVICES</b> Road Ambulances, Emergency Services and General Advice Line. <b>SUBJECT TO CONFIRMATION OF RATES/SERVICE PROVIDER.</b> <b>(Pre-authorisation required - Contact Netcare 911 on 082 911)</b></p>	Scheme Rate	Through approved provider only	Scheme Rate	Through approved provider only
<p><b>SURGICAL PROSTHESIS</b> Including pacemakers and electronic devices plus coronary stents. <b>(Pre-authorisation required)</b></p>	Scheme Rate	R30 000 per beneficiary Subject to OAL	Scheme Rate	R40 470 per beneficiary
<p><b>KIDNEY AND HOME DIALYSIS</b> Including related drug therapy (through approved providers only). <b>All cases subject to full investigation, registration on the Renal Programme and pre-authorisation.</b></p>	Scheme Rate	Subject to OAL	Scheme Rate	R223 360 per beneficiary
<p><b>ORGAN TRANSPLANTS</b> Including organ harvesting and immunosuppressive drug therapy. <b>Subject to transplant motivation and pre-authorisation required.</b></p>	Scheme Rate	Subject to OAL	Scheme Rate	R220 600 per beneficiary
<p><b>DONOR COSTS</b> <b>Nampak Member Recipients ONLY</b> and limited to costs not covered by other Medical Schemes.</p>	Scheme Rate	R44 660 per donor Subject to OAL	Scheme Rate	R44 660 per donor
<p><b>PSYCHIATRY IN HOSPITAL</b> Hospitalisation conditions include anorexia nervosa, bulimia, alcoholism, treatment for substance abuse at SANCA approved facilities and all related accounts. <b>(Pre-authorisation required)</b></p>	Scheme Rate	R26 410 per beneficiary Subject to OAL	Scheme Rate	R26 410 per beneficiary

TREATMENT RECEIVED IN ROOMS WHEN NOT ADMITTED TO HOSPITAL:	PAYS	LIMITS	PAYS	LIMITS
<b>SPECIALISTS - ANAESTHETISTS, PHYSICIANS, NEUROLOGISTS, NEUROSURGEONS, SURGEONS, ORTHOPAEDIC SPECIALISTS, ORTORINOLARYNGOLOGISTS (ENT), RADIO THERAPISTS, THORACIC SURGEONS AND UROLOGISTS</b> Specialist conditions and treatment out of hospital. <b>(On referral by General Practitioners only)</b>	DSP Agreed Rate	None	DSP - Agreed Rate	None
<b>SPECIALISTS - DERMATOLOGISTS, GYNAECOLOGIST, OPHTHALMOLOGISTS, PAEDIATRICIANS, PLASTIC SURGEONS AND PHYSICAL MEDICINE (INCLUDING NEEDLES, SYRINGES AND STERILE TRAYS)</b> Out patients, out of hospital consultations, treatment in rooms and procedures.	Non-DSP 100% of Scheme Rate	M - R2 230 M1 - R3 070 M2 - R3 610 M3+ - R4 440  Subject to OAL	Scheme Rate	Scheme Rate
<b>GENERAL PRACTITIONERS</b> Out patients, out of hospital consultations, treatment in rooms and procedures.	Scheme Rate		Scheme Rate	None
<b>PSYCHIATRY, PSYCHOLOGY AND SOCIAL WORKERS</b> Consultations and treatment out of hospital.	Scheme Rate		Scheme Rate	None
<b>SCOPES</b> All scopes performed out of hospital are subject to a R500 co-payment. <b>Subject to Prescribed Minimum Benefits (PMBs)</b>	Scheme Rate	Subject to OAL	Scheme Rate	None
<b>DIAGNOSTIC RADIOLOGY, PATHOLOGY AND MEDICAL TECHNOLOGY</b> Including materials. <b>Referring doctors practice number to appear on all claims. (Pre-authorisation required for MRI, bone densitometry, mammograms and CT/PET Scans). A co-payment of R500 is applicable to MRI, CT and PET scans.</b>	Scheme Rate	2 scans per beneficiary	Scheme Rate	2 scans per beneficiary
<b>ONCOLOGY</b> Chemotherapy, Radiotherapy, Intravenous drugs and materials. <b>This benefit is subject to the submission and approval of a comprehensive treatment plan. To be sent to the Pre-Authorisation Department:</b> Fax: 031-5800472 or Address: P O Box 2338, Durban, 4000	DSP Rate	Subject to OAL	Scheme Rate	None
<b>MATERNITY BENEFIT</b> Antenatal Benefits and Scans	Scheme Rate	12 antenatal visits and 2 scans	Scheme Rate	12 antenatal visits and 2 scans

<p><b>CHRONIC PRESCRIBED MEDICATION</b> Medication prescribed or dispensed to patients registered on a chronic medication programme with the Scheme. (CDL - unlimited).</p>	<p>Subject to benefit pricing 100% of MIMAP and formulary at DSP</p> <p>Scheme Rate</p>	<p>R6 300 per family for non-CDL Subject to OAL</p>	<p>Subject to benefit pricing 100% of MIMAP and formulary</p>	<p>R6 300 per family for non-CDL</p>
<p><b>HIV/AIDS - ANTIRETROVIRAL TREATMENT (ART)</b> <b>Compulsory registration on the HIV Programme - 0860 10 97 93</b></p>	<p>Scheme Rate</p>	<p>R33 840 per beneficiary Subject to OAL</p>	<p>Scheme Rate</p>	<p>R33 840 per beneficiary</p>
<p><b>ACUTE MEDICATION</b> All medication including TTO's other than those obtained by members through the Chronic Medication programme. Medication prescribed and dispensed by pharmacists limited to R80 per script (PAT). Clinical and pharmacy dispensed vaccinations limited to R75 per script.</p>	<p>100% of MMAP</p>	<p>M - R3 060 M1 - R3 880 M2+ - R4 940 Subject to OAL</p>	<p>100% of Single Exit Price</p>	<p>Subject to MSA thereafter subject to day-to-day benefit of R2 500</p>
<p><b>PHYSIOTHERAPY/BIOKINETICS</b></p>	<p>Scheme Rate</p>	<p>R1 040 per family Subject to OAL</p>	<p>Scheme Rate</p>	<p>Subject to MSA thereafter subject to day-to-day benefit of R2 500</p>
<p><b>OPTICAL SERVICES</b> Optical tests</p>	<p>Scheme Rate</p>	<p>1 test per beneficiary per annum Subject to OAL</p>	<p>Scheme Rate</p>	<p>Subject to MSA thereafter subject to day-to-day benefit of R2 500</p>
<p>Spectacle lenses, frames and contact lenses</p>	<p>Scheme Rate</p>	<p>R1 150 per beneficiary every second year Subject to OAL</p>	<p>Scheme Rate</p>	<p>Subject to MSA thereafter subject to day-to-day benefit of R2 500</p>
<p><b>EXTERNAL APPLIANCES</b> Includes hearing aids, orthopaedic boots, surgical collars, nebulisers, wheelchairs, incontinence products and the hiring of equipment. Category limits: Hearing aids - R5 280 per beneficiary every two years; Wheelchairs - R5 280 per family; Nebulisers - R1 330 per family. <b>(Pre-authorisation required: Tel: 0860 10 10 47)</b></p>	<p>Scheme Rate</p>	<p>R8 000 per family with category limits Subject to OAL</p>	<p>Scheme Rate</p>	<p>R11 880 per family with category limits</p>
<p><b>ALL DENTISTRY IN AND OUT OF HOSPITAL</b> <b>(Hospitalisation subject to pre-authorisation)</b> Fillings, x-rays, extractions and prophylactics. Orthodontic, periodontic, crowns, bridge-work, dentures. Dental Maxillo-facial treatment, dental implants and related accounts.</p>	<p>70% of recommended Scheme Rate with 30% co-payment by member to supplier</p>	<p>M - R4 760 M1 - R8 980 M2 - R10 950 M3+ - R11 660 Subject to OAL</p>	<p>70% of recommended Scheme Rate with 30% co-payment by member to supplier</p>	<p>M - R5 570 M1 - R10 100 M2 - R12 880 M3+ - R13 220</p>

COMMUNITY CARE	PAYS	LIMITS	PAYS	LIMITS
<b>PRIVATE NURSING AND HOSPICES</b> In lieu of hospitalisation only. Nursing services and sub-acute facilities. <b>Subject to submission of doctor's comprehensive treatment plan and Scheme approval. (Pre-authorisation required).</b>	Scheme Rate	R5 110 per family Subject to OAL	Scheme Rate	R6 910 per family
<b>FRAILCARE</b> <b>Subject to doctor's letter of motivation and Scheme approval. (Pre-authorisation required)</b>	Scheme Rate	R5 110 per family Subject to OAL	Scheme Rate	R6 910 per family
<b>OXYGEN SUPPLY</b> <b>Supply through Preferred Provider only. Subject to submission and approval of a treatment plan. (Pre-authorisation required)</b>	Scheme Rate	Subject to OAL	Scheme Rate	None
<b>STOMATHERAPY MATERIALS</b> Bags, pouches and flanges <b>(Pre-authorisation required)</b>	Scheme Rate	Subject to OAL	Scheme Rate	None
<b>ALTERNATIVE SERVICES</b> Homeopaths and chiropractors. Including all services.	Scheme Rate	R1 040 per family Subject to OAL	Scheme Rate	Subject to MSA thereafter subject to day-to-day benefit of R2 500
<b>OTHER SERVICES</b> 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	R1 040 per family Subject to OAL	Scheme Rate	Subject to MSA thereafter subject to day-to-day benefit of R2 500

**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

DSP = Designated Service Provider

## CONTACT DETAILS

### Claims and Administration

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

### Regional Office

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

### Medipost

Tel: 012 426 4000  
Fax: 086 648 5777

Email: [nampak@medipost.co.za](mailto:nampak@medipost.co.za) or [nampakmgr@medipost.co.za](mailto:nampakmgr@medipost.co.za)

### Emergency Assistance and Ambulance

Netcare 911  
Tel: 082 911

### Your Life HIV Management 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](mailto:info@nampakhealth.co.za)

### Claims Email Address

[claims@nampakhealth.co.za](mailto:claims@nampakhealth.co.za)

