



NEWSLETTER

June 2021



TOPICS FOR DISCUSSION

1. 2022 AGM
2. Overaged Dependants
3. Benefit Information
4. Covid-19

The main purpose of the AGM meeting was to:

- Present and obtain member approval of the financial statements for 2021 Benefit year before submission to NAMFISA on 30 June 2022;
- Review the previous years' operations;
- Conduct Elections, but no Trustee elections were held this year;
- Ratify the appointment of auditors for 2022 benefit year;
- Discuss any motions, but no motions were submitted to be discussed at the meeting.

An open session was also hosted after the official AGM, and the following information was shared with members:

1. Benefit Accumulator - Purpose and benefits
2. Designated Service Providers (DSP) - Progress in setting-up
3. Initiatives to reduce co-payments/out-of-pocket expenses for members
4. Fraud, waste & abuse - update
5. FIM Act update - NAMFISA act to regulate financial sector and medical aids.

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1. ANNUAL GENERAL MEETING (AGM)

In terms of the Scheme rules and the Medical Aid Funds Act no.23 of 1995, each registered medical fund should hold an Annual General Meeting for its members before the 30th of June each year. The AGM for 2022 was held on Thursday 23rd June 2022 by way of a virtual online meeting and all members were informed by a notice of the AGM, which was distributed on the 31st May 2022 and well within the required 21 days as set in the Rules of the Scheme.

AGM - 2021 Benefit year - 1 January 2021 to 31 December 2021.

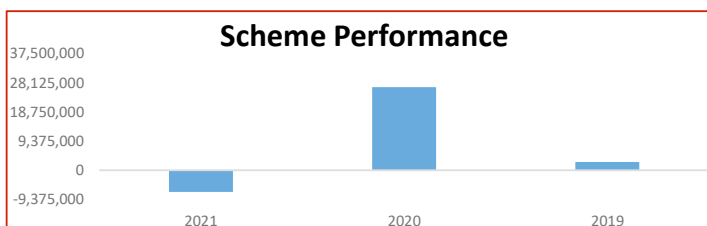
The AGM was legally constituted in terms of the Rules of the Scheme and the Medical Aid Fund Act and was hosted online via Zoom, with a total of 47 members in attendance and 92 represented by proxies. The Board of Trustees would like to extend their sincere gratitude to all members who made time out of their busy schedules to attend, and those that submitted proxies. The Board also appeals to members to support the Board of Trustees in managing the Scheme by attending the AGM and the members' roadshow sessions.

Some of the highlights from the Chairperson report included the following:

1.1. FUND PERFORMANCE OVERVIEW

For the year in review 2021, the Scheme focused on consolidating the Scheme's risk management tools and assisting members in taking due care of their chronic illness conditions through the implementation of disease management programs. These programs empower members with a better understanding of the Scheme benefits, and how to access their benefit profiles to address fraud, waste and abuse (FWA). The Scheme implemented these new initiatives to promote and provide quality affordable healthcare, and also to position the Scheme as a reliable and sustainable mutual fund within a rapidly evolving healthcare environment in Namibia

The Scheme reported a deficit of N\$ 6,960,7490. The performance is lower compared to the results of 2020, which was N\$ 26,746,0512. The good performance of 2020 was mainly attributed to the limited access to healthcare providers or facilities and postponement of elective medical procedures during the national lockdown in 2020.



1.2. DISCONTINUATION OF OPTION 2 EFFECTIVE 01 JANUARY 2023

In 2016, the Scheme in its effort to address a concern group of members for a lower priced option, introduced a second benefit option or Option 2. The number of members who joined the option since inception amounted to only 15 until 2018. The number of members on the option has since decreased and currently stand at ten (10) members in 2022.

With the promulgation of the Financial Intelligence Market Act (FIMA) in October 2021, the Registrar of Medical Aid Schemes (NAMFISA) is implementing the new Financial Intelligence Market Bill (FIM Bill), which includes a number of changes for medical aids under Chapter 7.

Taking into consideration the above-mentioned factors, the Board resolved to discontinue Option 2 effective 01 January 2023. All members on Option 2 will be transferred to Option 1. All members on Option 2 had been informed during 2021/2022 of the intent to discontinue the option effective 1 January 2023, to allow them time to prepare for the transfer to Option 1.

1.3. FIM ACT (FINANCIAL INSTITUTION MARKET ACT)

The much anticipated FIM Act was promulgated on the 30th of September 2021. The Financial Institutions and Market Act (FIMA) will replace the existing legislation for non-banking institutions regulated by the Namibia Financial Institutions Supervisory Authority (NAMFISA). The institutions that FIMA will govern include amongst others, medical aid funds, and their administrators, retirement funds, short- and long-term insurers and etc. FIMA was promulgated in 2021, but is not yet operational and it is expected to come into force on 1 October 2022.

1.4 SCHEME 2021 FINANCIALS

The AGM Pack provided an overview of the Scheme's results for the year ended 31 December 2021, as extracted from the 2021 financial statements. The Auditor expressed an unqualified opinion on the Consolidated Financial Statements with no audit findings or corrections.

The Scheme also issued an AGM pack, which was distributed to all members who registered to attend the meeting. The AGM pack covered topics such as summarized financials for the 2021 benefit year, chairpersons report, general Scheme activities, and other. The AGM pack is available on the Scheme website at www.gemhealthmedical.com.

1.5 BENEFIT ACCUMULATOR:



The Benefit Accumulator is a personal low-claim incentive allocated to members whose annual day-to-day claims are below the claims threshold. It is a scheme benefit that offers

members the option to accumulate funds to cater for healthcare costs. It is a reward offered to members as an incentive in recognition of their low claims during a benefit year.

2022 Update: Total allocations.

BENEFIT ACCUMULATOR WALLET BALANCES:

- 2021 rewards earned: N\$ 1.9 million
- Prior 2021 wallets carried over: N\$ 4.4 million
- Total Accumulator Wallet: N\$ 6.4 million



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BENEFIT UTILIZATION (MEMBER CLAIMS PAID FROM BENEFIT ACCUMULATOR)

The first Benefit Accumulator rewards were allocated to 922 members in 2019, and more members continue to qualify for the benefit since inception. Despite the increased communication from the Scheme to create awareness and promote utilization of the Benefit Accumulator to the members, its utilization remains low.

The total number of claims submitted on the Benefit Accumulator increased from 50 in 2020 to only 139 in 2021, which is a concern for the Board as it was introduced as an additional benefit for members. The Board has considered the current Scheme rules on the benefit accumulator, which requires members to pay upfront and claim for reimbursement, as a reason for the low utilization.

FUTURE SCHEME CHANGES ON THE BENEFIT ACCUMULATOR

In order to address the low utilization of the Benefit Accumulator, the Board resolved to amend the current rules with the 2023 benefit review and introduce an automatic payment process of levies, co-payments or benefits exceeded on chronic, acute and OTC medication benefits directly from the Benefit Accumulator. In other words, effective 01 January 2023, medication levies or co-payments due to the price difference or benefits exceeded payable at the pharmacies by members will be paid directly from the Benefit Accumulator.

The Board has tasked the Administrator to further investigate the process of automating direct payment on other benefits e.g Dental, Optical, etc.

2. OVER AGED DEPENDENTS

In terms of the rules of the Scheme, a registered dependent of a principal member over the age of 21 years is entitled to remain a member of the Scheme up to the age of 25 years, under the following conditions:

- A full-time student at a registered institution until the student reaches the maximum age of 25.
- A dependent of the member with mental or physical impairment may remain a member of the Scheme.

1. Documentation to be submitted as proof:

- Dependents aged 21 to 25 years – proof of full-time studies for 2022 at an accredited tertiary institution
- Dependent with Mental or Physical impairment: Doctor's motivating letter.

2. Scheme notification to Members

- All principal members with dependents in the stipulated age category of 21 till 25 have received sufficient communication from the Scheme & Human Resource Departments to submit the required proof before 31st March 2022.
- Members are hereby informed that effective 01 July, the Scheme will no longer accept proof of study for the 2022 calendar year.



3. Orthodontic Benefit

1. What is orthodontic treatment?

Orthodontics is a dentistry specialty that includes the diagnosis and correction of mal-positioned teeth and misaligned bite patterns. An orthodontist or dentist may carry out treatment to achieve any of the following:

- Align the tips of the teeth;
- Straighten misaligned teeth;
- Improve speech or chewing ability;
- Enhance the long-term health of gums and teeth;
- Prevent long-term excessive wear or trauma of the teeth;
- Treat an improper bite;
- Close the gap between the top and bottom front teeth; or
- Eliminate crowding of teeth.

2. How is orthodontic treatment covered by the Scheme?

The Scheme does not offer a separate benefit limit for orthodontic treatment; all claims are payable from the available dentistry limit and paid according to the Scheme tariffs. Members are advised to submit a treatment plan for approval and confirmation of benefits.

3. What you need to know about the Scheme payment?

When the Scheme approves the treatment plan, it does not guarantee that the Scheme will pay for the treatment. Claims are only paid from the available dental limit for the beneficiary at the time of processing the claim. The confirmed amount cannot be held in reserve.

Approval of the orthodontic treatment plan is not a guarantee of payment. The claims submitted to the Scheme will be paid according to available benefits at the time of claim processing.

The treatment plan submitted to the Scheme for approval will indicate the cost and the length of treatment. It is important to highlight that even though the treatment is done over a period of time, the Scheme will only confirm the benefit for the current financial year, in other words, if the treatment

plan is submitted in 2022, the Scheme will only confirm the benefits of 2022. Members are advised to confirm their dental benefits at the beginning of each year.

Once the Scheme approves the treatment plan, you will receive a confirmation quotation from the Scheme, which will indicate the total cost of the treatment, and available dental benefits at the time of issuing the quotation. Once they start with Orthodontic treatment, Members are advised to confirm benefits at the beginning of each year.

If the dental benefit is depleted, or if the Dentist/Orthodontist charges more than the Scheme tariffs, the member will be responsible for paying the difference.

PLAN AHEAD

Your Dentist / Orthodontist will plan regular appointments to monitor the movement and to ensure that everything is going according to plan. If you miss appointments, the treatment plan will be negatively affected leading to prolonged removal of retainers. Correction may occur, which means more time before the removal of the retainers.

Please ensure that you have enough personal funds available to continue orthodontic treatment and routine dental treatment when benefits become depleted.

Any possible available orthodontic benefit in the following year will only be used to pay for the remaining treatment in that benefit year.

For further information on the Orthodontic or Dental Benefits or to plan your treatment, please contact Prosperity Client Service at 0832832111

4. Covid-19

The Board is encouraged with the low number of members that are infected during the current fifth wave, and we wish to thank members for following the safety guidelines and to have you and your family vaccinated.

Likewise, we are also glad that the fifth wave is on the decline and that will soon be over. Take good care of your family's health, as Covid is not behind us as yet and the winter colds will also continue for the next few weeks. **Stay Safe!**