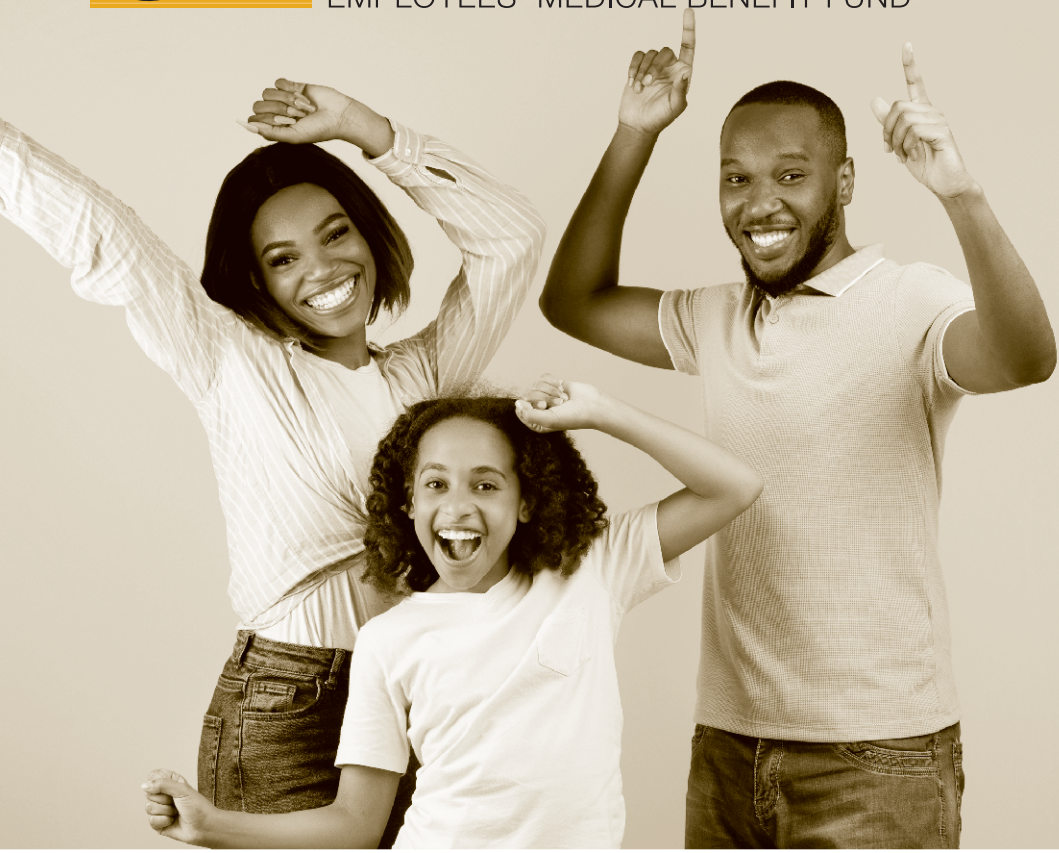
GOLDEN ARROW
EMPLOYEES' MEDICAL BENEFIT FUND



MEMBER **HANDBOOK**

contents

welcome to
Golden Arrow Employees' Medical Benefit Fund

INTRODUCTION

Golden Arrow Employees' Medical Benefit Fund (also referred to as the Fund) is dedicated to providing affordable healthcare through a comprehensive range of benefits to the employees and pensioners of Golden Arrow Bus Services.

OBJECTS

The Fund is committed to providing affordable healthcare to its members and to cover the medical expenses of all beneficiaries in return for a monthly contribution.

The Fund is managed by the Board of Trustees, who is responsible for ensuring that the Fund operates effectively and remains financially stable. The Board of Trustees consists of six Trustees, three of whom are elected by members and three who represent the employer – Golden Arrow Bus Services.

THE FUND'S HEALTHCARE ADMINISTRATOR

Momentum Health Solutions is the Administrator of the Fund and is responsible for managing its day-to-day operation, which includes the collection of contributions and the payment of claims.

THE FUND'S SERVICE PROVIDERS

- Momentum Health Solutions is the Fund's managed healthcare provider and is responsible for managing various managed care programmes.
- Mediscor is responsible for validating pharmacy claims submitted online.
- Netcare 911 is the Fund's ambulance service provider and is responsible for providing ambulance services to the Fund, 24 hours a day, seven days a week.

The Fund is committed to providing affordable healthcare to its members

membership

GENERAL

All employees of Golden Arrow Bus Services who earn a wage or salary must join the Fund, as it is a condition of employment, unless you are a registered dependant on your spouse's medical scheme.

If the latter is the case, kindly forward a membership certificate to the Fund as proof that you are a registered dependant on your spouse's medical scheme. Annual proof of dependancy must be provided to your employer.

BENEFIT ENTITLEMENT

The membership of all employees who join the Fund will be subject to underwriting criteria, such as a three-month general and/or 12-month condition-specific waiting period, depending on previous medical aid cover. Please refer to page 4, which confirms the process an employee should follow when applying for membership of the Fund.

DEPENDANT

In terms of the Fund's rules, the following persons may be registered as your dependants, provided they are not members or registered dependants of a member of another medical scheme:

- **Spouse**
  You may register your spouse, to whom you are married in terms of any law or custom, as your dependant.

- **Child dependants under the age of 21**
  You may register your natural child, stepchild, legally adopted child, a child you are in the process of legally adopting or a child who has been placed in your or your spouse's custody.

  The child dependant contribution rate must be paid for all child dependants under the age of 21. In the case of an adopted child dependant, kindly forward the adoption documents to the Fund as proof that you have legally adopted your child dependant.

- **Child dependants over the age of 21**
  You may register your dependent child who is between the ages of 21 and 26 and who is a student at a recognised learning institution. Written proof of registration is required on an annual basis.

  You will pay the adult dependant contribution rate for a child over the age of 21.

- **Child dependants who are physically or mentally disabled**
  You may register your child dependant who, due to physical or mental disability, is dependent on you for family care and support.

Kindly forward a medical report to the Fund as proof of disability.

PLEASE NOTE:

The total contribution for an additional adult dependant is your responsibility, as the company does not contribute towards such dependants.

HOW DO I JOIN THE FUND?

All new members must complete the membership application form in full, attach the necessary supporting documents to it and return it to the Fund.

Please make sure that the following sections of your application are completed:

- the 'State of your health' section for you and your dependants;
- the 'Authorisation' section, allowing the Fund to deduct contributions from your wage, salary or bank account;
- a copy of your identification document;
- proof of prior membership of any other medical scheme; and
- any other information that the Board of Trustees may request.

Please make sure that you attach the required documents. **No dependants will be registered if the required documents, e.g. marriage certificate, birth certificate, etc., are not provided.**

For a copy of the membership application form, please visit the medical office at the Montana depot, contact the client service department (see contact details on page 21) or visit www.goldenarrowmed.co.za.

PLEASE NOTE:

It is important that the membership application form be completed in full, that all the required details are provided and that all supporting documentation is included. You or your dependant will not be covered for any medical costs until such time as the Fund receives a valid and complete membership application form.

WHAT HAPPENS WHEN I REGISTER A NEW DEPENDANT?

Registration of a dependant newborn or newly adopted child
If a member applies to register a newborn or newly adopted child within 30 days of the date of birth or adoption of the child, the increased contribution will be payable from the start of the new month. The dependant's benefits will be effective from the date of birth or adoption.

New spouse
If a member applies to register his/her spouse within 30 days of the date of marriage, the increased contribution will be payable from the start of the new month. The spouse's benefits will be effective from the date of marriage.

PLEASE NOTE:

No dependant will qualify for benefits until the principal member qualifies for benefits.

MEMBERSHIP CERTIFICATES AND CARDS

For a membership certificate or membership card, visit the medical office

at the Montana depot or, alternatively, contact the client service department (please see contact details on page 21).

WHAT HAPPENS WHEN I RESIGN?

The following applies to **employees who are paid a weekly wage:**

- If your employment with the company ends on a Monday, Tuesday or Wednesday, no contribution will be deducted from your wages.
- If your employment with the company ends on a Thursday, Friday, Saturday or Sunday, the full week's contribution will be deducted from your wages.

The following applies to **employees who are paid a monthly salary:**

- If your employment with the company ends on or before the 15th day of a month, no contribution will be deducted from your salary.
- If your employment with the company ends after the 15th day of a month, the full month's contribution will be deducted from your salary.

PLEASE NOTE:

Your last day of service at the employer will be your last day of cover on the Fund.

WHAT HAPPENS WHEN I RESIGN A DEPENDANT?

Please notify the Fund within 30 days of the resignation of your dependant. The change in your contribution rate will take effect at the start of the new month.

PLEASE NOTE:

A change in your or any of your dependants' current membership status may affect your contribution.

WHAT HAPPENS WHEN I RETIRE?

Please notify the Fund within 30 days of your intention to remain a member of the Fund.

The following persons are eligible for continued membership and may elect to remain members of the Fund:

- members who retire from service; and
- dependants of deceased members who are registered at the time of death of the principal member.

CHANGES IN MEMBERSHIP STATUS

Please notify the Fund within 30 days of any of the following changes to your membership status:

- marriage;
- divorce;
- birth or adoption of children;
- death of a dependant;
- change of address and contact details;
- children who no longer qualify for child dependant status; and
- retirement.

contributions

GENERAL

All members of medical schemes are required to pay monthly fees to the Fund to cover their monthly medical expenses. These fees are called contributions.

As a member of Golden Arrow Employees' Medical Benefit Fund, your contribution is payable monthly in arrears. In the case of all active employees, your employer will collect your contributions either weekly or monthly. Pensioner member contributions will be collected via debit order or from your monthly pension.

The number of dependants you have registered on the Fund determines your monthly contribution.

WHEN ARE CONTRIBUTIONS DUE?

The following applies to **employees who are paid a weekly wage:**

- If your employment with the company starts on a Monday, Tuesday or Wednesday, a full week's contribution will be deducted from your wages.
- If your employment with the company starts on a Thursday or Friday, the deduction will be made at the start of the new week.

The following applies to **employees who are paid a monthly salary:**

- If your employment with the company starts on or before the 15th day of a month, a full month's contribution will be deducted from your salary.
- If your employment with the company starts after the 15th day of a month, the deduction will be made at the start of the new month.

CHANGES THAT MAY AFFECT YOUR CONTRIBUTION

As any one of the following events could affect your contributions, please notify the Fund of the following changes to your membership status as soon as possible:

- marriage;
- divorce;
- birth or adoption of children;
- death of a dependant;
- children who no longer qualify for child dependant status; and
- retirement.

claiming

GENERAL

After each consultation and irrespective of what type of service provider the patient consulted, you will be issued with a claims statement setting out the details of the transaction and the amount payable.

The bulk of claims received from most service providers are submitted directly to the Fund. However, in cases where claims are not submitted directly to the Fund, it remains the member's responsibility to ensure that the claim is received within the stipulated claiming period, i.e. within four months of the date of service.

In terms of the rules of the Fund, all claims received from a network service provider will be paid at the agreed rate, i.e. the negotiated tariff fee payable to various service providers, including those listed on the network. Claims received from non-network service providers that have been approved by the Fund will be paid at the Scheme rate.

HOW TO SUBMIT A CLAIM TO THE FUND

Please send all claims to:
Golden Arrow Employees'
Medical Benefit Fund
PO Box 15729
Vlaeberg
8018.

Alternatively, you may hand your claim in at the medical office at the Montana depot.

FAXING ACCOUNTS

The Fund will only accept original claims sent by post or submitted electronically by your service providers.

Unfortunately, we may not accept faxed accounts. Faxes are often unclear and difficult to read. If you fax us a service provider's account, it may cause delays in the payment of your claims.

DETAILS ON THE ACCOUNT

Ask your service provider to provide you with a copy of your account so that you may check it thoroughly to make sure the following details appear on it:

- your membership number;
- your surname and initials;
- the patient's first name, surname and initials;
- the name of the Fund, i.e. Golden Arrow Employees' Medical Benefit Fund;
- the name and practice number of the service provider;
- the date the patient received the service;
- the nature and cost of the treatment;
- the referring doctor's practice number (on specialist's accounts);
- the referring doctor's practice number on pathology and radiology accounts;

- the tariff code for the service the patient received; and
- the ICD-10 diagnostic code for the service the patient received.

If you paid the account directly to the service provider, please ensure that you attach the receipt to the account.

SENDING CLAIMS IN ON TIME

It is your **responsibility** to ensure that all claims are sent to the Fund **within four months of the date of service.** If claims are received after the four-month claiming period, you will be liable for payment of the account directly to the service provider.

PAYMENT OF ACCOUNTS

Claims are paid to service providers twice a month and to members at the end of each month. If you wish to know when the next claims payment will take place, please contact our client service department.

CHECK YOUR CLAIMS STATEMENT

Your claims statement is one of the most important documents you will receive from the Fund. This document serves as proof that your claim has been paid. Please check your claims statements regularly to ensure that your claims have been settled.

CLAIMS STATEMENTS

If the Fund has processed a claim sent in by either you or your service provider, we will send you and your service provider a claims statement, which sets out the benefit paid and the reason why claims were not paid.

It is in your best interest to ensure that all the information on the statement is correct. Please check your statement to ensure that:

- the claims reflected on the statement are for services that you or one of your dependants received;
- the Fund has processed all the claims that you have submitted; and
- the correct dependant code and name of the patient is reflected next to each claim that has been settled.

Contact the client service department should you have a query with regard to your claims statement.

MAKING USE OF NETWORK SERVICE PROVIDERS

In terms of the rules of the Fund, members may consult network or non-network service providers for day-to-day benefits, where applicable.

If you have made use of a non-network provider, a co-payment equal to the difference between the network and non-network provider rate may apply.

Please contact the client service department to confirm if a network is applicable and/or if a service provider is a network or non-network service provider.

day-to-day benefits

GENERAL

The Fund offers three benefit options to members. On joining the Fund, you have to select one of the available options. Your dependants will automatically belong to the option you have selected.

THE THREE OPTIONS

1. PRIMARY OPTION (CLOSED OPTION)

This option only covers out-of-hospital services, i.e. services rendered out of hospital and services provided at State facilities.

2. STANDARD OPTION

This option covers out-of-hospital services, plus limited private hospital cover.

3. ADVANCED OPTION

This option covers out-of-hospital services, plus private hospital cover.

CHANGING OPTIONS

You may change your option on 1 January of each year. All members will receive an option amendment form during November of each year that will notify you of your right to change your current option.

If you wish to change your current option, complete the option amendment form and return it to the Fund before 15 December each year.

BENEFIT YEAR

This is the period that your benefits are available to you. The benefit year runs from 1 January to 31 December of each year. There are exceptions to this rule, which are explained in your benefit schedule.

SPECIALISTS

In terms of the rules of the Fund, all visits to specialists must be approved by the managed care provider.

A general practitioner must refer you and your dependants to a specialist (a network or non-network specialist may be used). You must ensure that an authorisation number is obtained before you consult a specialist.

ACUTE MEDICATION

Any general practitioner may be used. This benefit will be subject to a 'per beneficiary per day' limit and subject to your available day-to-day benefit limit.

OVER-THE-COUNTER (OTC) MEDICATION

This benefit covers all medication classified as schedule 1 and 2 at a pharmacy. This benefit includes homeopathic, herbal and natural medication. The Fund's exclusion categories will be applicable to all OTC medication.

EMERGENCY MEDICAL CONDITIONS AND TRAUMA UNITS

The following definitions are applicable to the emergency benefit:

Emergency medical condition
An emergency medical condition is classified as the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide such treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place a beneficiary's life in serious jeopardy.

Trauma centre/unit
A trauma centre/unit is a hospital or facility equipped as a casualty receiving station for the provision of emergency medical services by providing the best possible medical and surgical care for traumatic injuries 24 hours a day, 365 days a year.

Emergency room (ER)/casualty department
An emergency room is a hospital unit or primary care facility that provides initial treatment to patients with a broad spectrum of acute illnesses or injuries, some of which may be life threatening and which may require immediate attention. These accounts will be covered by your day-to-day benefits.

Consultations and medication dispensed
This applies to all primary care consultations, including those requiring basic nursing input, e.g. blood pressure monitoring, urine testing, application of simple bandages and administration of injections, and the administering of acute medication, e.g. to treat earache, headache and fever. Claims for these services will be paid for from your available overall annual day-to-day benefit. This benefit excludes the facility fee, which you will be responsible for.

Consultations, medication dispensed and materials required for minor procedures
This applies to all minor emergency procedures that, in addition to a consultation and acute medication, require the use of a procedure room and nursing attention, e.g. the application of plaster of Paris, stitching of wounds or intravenous therapy. These claims will be paid for from your available overall annual day-to-day benefit. This benefit excludes the facility fee, which you will be responsible for.

Consultation and resuscitation of patient
This applies to all cases where the patient needs to be resuscitated and incubated in a trauma unit accredited and approved by the Board of Healthcare Funders. These claims will be paid for from the member's available annual in-hospital benefit.

PLEASE NOTE:

If you are admitted to hospital following treatment in a trauma/24-hour emergency room, all the associated facility costs will be covered from the available annual in-hospital benefit.

chronic medicine benefit

GENERAL

This benefit covers medication for certain specified conditions, as approved by the Fund. These conditions are often life threatening and require medication for a period of more than six months.

You may purchase your chronic medicine from either your pharmacy or dispensing network doctor. Please remember that you need your prescription when your medication is dispensed and that your prescription is only valid for six months.

You need to renew your prescription at your treating doctor.

Chronic medication application forms are available on request from the client service department.

APPROVED CHRONIC CONDITION LIST

The full list of chronic conditions covered by the Fund is as follows:

TABLE 1: CHRONIC DISEASE LIST (CDL) CONDITIONS (excluding HIV/AIDS)			
1.	Addison's disease	14.	Epilepsy
2.	Asthma	15.	Glaucoma
3.	Bipolar mood disorder	16.	Haemophilia
4.	Bronchiectasis	17.	Hyperlipidaemia
5.	Cardiac failure	18.	Hypertension
6.	Cardiomyopathy	19.	Hypothyroidism
7.	Chronic renal disease	20.	Multiple sclerosis
8.	Coronary artery disease	21.	Parkinson's disease
9.	Chronic obstructive pulmonary disorder	22.	Rheumatoid arthritis
10.	Crohn's disease	23.	Schizophrenia
11.	Diabetes insipidus	24.	Systemic lupus erythematosis
12.	Diabetes mellitus, types 1 and 2	25.	Ulcerative colitis
13.	Dysrhythmias		

TABLE 2: OTHER CHRONIC CONDITIONS			
1.	Allergic rhinitis – only in patients with asthma	8.	Menopausal hormone dysfunction
2.	Benign prostate hypertrophy	9.	Motor neuron disease
3.	Conditions that require long-term oxygen therapy	10.	Osteoporosis
4.	Cystic fibrosis	11.	Peripheral vascular disease
5.	Deep vein thrombosis	12.	Pituitary adenoma/hyperfunction of pituitary gland
6.	Gout	13.	Severe/chronic eczema and psoriasis
7.	Major depressive disorder	14.	Systemic connective tissue disorders

APPLICATION FOR CHRONIC MEDICINE

To qualify for chronic condition cover, you and your doctor must complete a Medicine Risk Management application form, which can be obtained from the Fund's client service department (please see contact details on page 21) or at www.goldenarrowmed.co.za and send it, together with a copy of your prescription, to:

Post: Medicine Risk Management,
PO Box 15079, Vlaeberg 8018
Email: chronic@goldenarrowmed.co.za.
Fax: 021 480 2755

Alternatively, send it to the Fund's client service department.

For **telephonic authorisation**, your **doctor or pharmacy** may call the client service department and follow the voice prompts.

All applications will be processed according to clinical guidelines. You will be notified in writing of whether or not the application has been successful. Details will be supplied if the medication you applied for has not been approved as chronic.

If your application is successful, the cost of the approved medication will be paid for from the annual chronic medication benefit to the maximum allowed per beneficiary per year for the period that the authorisation is valid.

CHANGES TO AUTHORISED MEDICINE

Should your doctor wish to change your medication, its strength or dosage during the authorised period and to prevent any delays in obtaining a new prescription, he or she may complete a Medicine Risk Management application form. Please see 'Application for chronic medication' for details on returning the form.

Alternatively, your **doctor or pharmacy** may call the client service department and follow the voice prompts.

GENERIC MEDICINE

A generic medicine is medicine in which the active ingredients are identical to those of the original brand-name medicine. There may be differences in shape, size, packaging or colour, but the ingredients that make the medicine work are exactly the same.

hospital benefit

PRE-AUTHORISATION FOR HOSPITALISATION

All hospital admissions must be authorised by calling your managed care provider on 0861 888 118 during office hours. Pre-authorisation must be obtained at least 48 hours before you go to hospital or, in the case of an emergency, within 24 hours of the admission, or on the next working day after you were admitted.

When you need to obtain pre-authorisation, please ask your doctor for as much assistance as possible. It remains your responsibility to ensure that an authorisation number is obtained. Should this not be done, you will be liable for payment of the full account.

The following information is required from you when you call:

- name, surname and date of birth of the patient;
- main member's ID number;
- name of the Fund, i.e. Golden Arrow Employees' Medical Benefit Fund;
- your membership number;
- name of treating doctor and, if possible, the practice number;
- hospital you will be admitted to;
- proposed length of stay at the hospital;
- date and time of admission;
- procedure (remember to ask your doctor for the CPT-4 code); and
- diagnosis (remember to ask your doctor for the ICD-10 code).

YOUR BENEFITS WHILE IN HOSPITAL (STANDARD AND ADVANCED OPTIONS)

Patients who are admitted to hospital under the care of a general practitioner must be referred to a specialist within 24 hours of admission.

The Fund covers the following, subject to the annual hospital benefit limit:

- all costs in hospital, including general ward, high care, ICU, theatre fees, medicines and consumables;
- all professional fees directly associated with each admission (surgeons, anaesthetists, pathology, radiology, etc.);
- home nursing services instead of hospitalisation;
- MRI and CT scans;
- confinements; and
- diagnostic tests and procedures (e.g. gastroscopies, colonoscopies, etc.).

The following procedures have certain restrictions under the hospital benefit:

- Maxillo-facial/oral surgery is covered for trauma patients only.
- Patients may be required to undergo lifestyle changes, e.g. to stop smoking or lose weight, before authorisation is given for surgery where such risk factors may negatively affect the outcome of planned surgery.
- Psychiatric care and substance abuse rehabilitation is covered only in contracted facilities.
- Private hospital admissions for a chronic illness will only be covered if the treatment conforms with the patient's recommended chronic therapy, e.g. a diabetic patient who fails to take his/her insulin would be disqualified from private hospital cover if he or she should go into a coma due to this.
- Chemotherapy, transplants, cardiothoracic surgery, neurosurgery and renal dialysis are only covered at State facilities.

PLEASE NOTE:

If the hospital costs are likely to be more than the annual hospital limit, you will be directed to a State facility.

LIST OF CONTRACTED FACILITIES

NAME	AREA	PRIVATE/ STATE
Akeso Kenilworth Clinic	Kenilworth	Private
Cape Eye Institute	Bellville	Private
Christiaan Barnard Memorial Hospital	Cape Town	Private
Crescent Mental Health Services	Claremont	Private
Netcare Kuils River Hospital	Kuils River	Private
Ramot Centre for Alcohol and Drug Abuse	Parow East	Private
Rondebosch Medical Centre	Mowbray	Private
Toevlug Rehabilitation Centre	Worcester	Private
UCT Private Hospital (no trauma unit)	Observatory	Private
West Coast Private Hospital	Vredenburg	Private
Booth Memorial Hospital	Oranjezicht	State
Groote Schuur Hospital	Observatory	State
Karl Bremer Hospital	Parow	State
Mowbray Maternity Hospital	Mowbray	State
Red Cross Children's Hospital	Rondebosch	State
Somerset Hospital	Greenpoint	State
Tygerberg Hospital	Parow	State

MATERNITY BENEFIT

If you join the maternity programme before you are 16 weeks pregnant, you will receive the following benefits:

- free access to all services offered by the maternity programme, including advice, information and ongoing education;
- advice on the number of days of hospital accommodation that will be covered by the Fund during confinement;
- referral to an appropriate professional to prepare you for birth and motherhood;
- the monitoring of your hospital account to prevent overcharging;
- your case manager will be there to support you and your baby until your post-natal check-up;
- specialist visits and ultrasounds when needed and on referral from a midwife or general practitioner (day-to-day benefit);
- delivery of baby by private midwife in a private network hospital (in-hospital benefit);
- payment of all claims is subject to pre-authorisation from your managed care provider and payment at Scheme rates;
- if the patient wishes to terminate her pregnancy, this procedure must be performed at facilities authorised by your managed care provider; and
- multiple pregnancies are covered at facilities authorised by your managed care provider.

PLEASE NOTE:

All high-risk pregnancies will be referred to a State facility. There is no benefit for neonatal intensive care units in private hospitals. All premature babies are to be admitted to a State facility only.

ambulance services

The Fund pays 100% of the cost of ambulance services, provided that you make use of Netcare 911. Please call **Netcare 911** on **082 911** if you need an ambulance.

Please keep the following in mind when you call:

- Medical support will be provided to the patient at the scene of the accident.
- Accounts will not be paid if you have made use of another rescue service when Netcare 911 was available.

PLEASE NOTE:

Should either you or any of your dependants use the services of any ambulance service other than Netcare 911, kindly contact Netcare 911 within 24 hours for an authorisation number.

Service provider claims will not be considered for any other ambulance if the member does not obtain an authorisation number.

The Fund covers the following services offered by Netcare 911:

- **private ambulance services for routine transfers to and from hospital; and**
- **inter-hospital and emergency transportation services.**

For voluntary use of any other emergency service provider, members will be liable for a 20% co-payment.

exclusions
(conditions, products and procedures not covered by the fund)

The Fund is governed by a set of registered rules, which sets out its benefits, contributions and exclusions.

The following exclusions apply to all members of the Fund and will not be paid for:

- laser surgery;
- frail care nursing services;
- selective admission for specialised or advanced dentistry;
- self-inflicted injuries and suicide;
- treatment of obesity;
- cosmetic treatment;
- treatment for infertility;
- patent remedies;
- vitamins and minerals for voluntary dietary supplementation;
- injuries due to participation in professional sport; and
- cancelled appointments.

PLEASE NOTE:

For a full list of the Fund's exclusions, kindly contact the client service department.

This handbook does not replace the registered rules. However, it serves as a summary of information. You may obtain a full set of benefits and rules from the client service department. The rules of the Fund are subject to change in accordance with legislation.

complaints process

According to the Fund's rules, members can lodge a complaint with the Fund in the following ways:

Phone: 0860 104 122
Email: enquiries@goldenarrowmed.co.za
Post: PO Box 15729, Vlaeberg 8018

When you lodge a complaint, the Fund will respond within seven working days from the time the complaint was received. There are, however, complaints that need clinical input and investigation and these would reasonably take longer to resolve. Members will always be informed of the status of their complaint and the Fund will work tirelessly to make sure that the complaint is resolved quickly and efficiently.

THE DISPUTES COMMITTEE

Should you not be satisfied with the response from the Fund, you can request in writing that your complaint be lodged with the Fund`s Disputes Committee (you can send your request to the same contact details listed above). The Committee comprises independent professionals who have medical and legal expertise.

If you are still not satisfied with the outcome, you can lodge a complaint with the Registrar of the Council for Medical Schemes for a ruling. You are encouraged to make use of the internal procedures available to lodge your complaints, as you are guaranteed a speedy resolution.

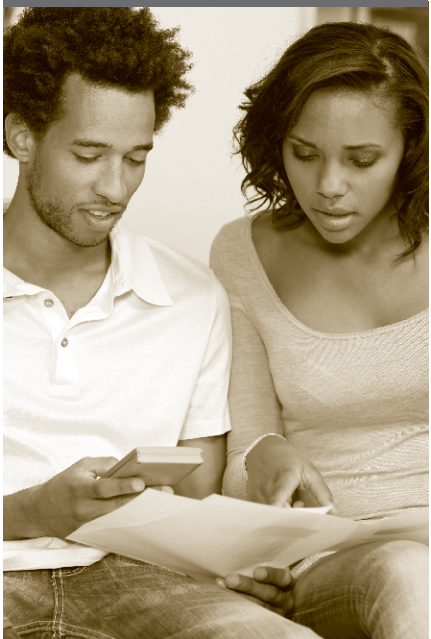
COUNCIL FOR MEDICAL SCHEMES

The Council for Medical Schemes is a statutory body established by the Medical Schemes Act (131 of 1998) to provide regulatory supervision of private health financing through medical funds.

CONTACT DETAILS:

Council for Medical Schemes
Private Bag X34
Hatfield
0028

Tel: 0861 123 267
Fax: 086 206 8260
Email: complaints@medicalschemes.co.za
Website: www.medicalschemes.co.za



glossary of terms

MANAGED CARE PROGRAMMES
These programmes are aimed at managing costs related to hospitalisation, medicine and treatment, while ensuring that you get the most appropriate care for your illness.

BENEFIT YEAR
This is the period for which benefits and contributions apply, i.e. 1 January to 31 December. If you join the Fund during a benefit year, you are only entitled to a pro rata portion of the benefits and limits for that year. Each year you will have the opportunity to change your option, which will be effective the following year.

CASE MANAGERS
The case managers are a team of experienced, registered nursing sisters who monitor your progress and provide ongoing advice for hospitalisation, disease management and throughout pregnancy and after confinement.

CHRONIC MEDICATION
This is medication for a chronic disease, i.e. a condition that requires ongoing medication.

DAY-TO-DAY BENEFIT
This benefit typically covers the medical treatment that you receive out of hospital or as an outpatient at a hospital, e.g. consultations and medication.

ICD-10 CODE
ICD-10 stands for International Classification of Diseases – version 10, as regulated by the Registrar of Medical Schemes. This international system represents and identifies the disease according to a specific category. All claims submitted for payment to the Fund require an ICD-10 code.

IN-HOSPITAL BENEFIT
This benefit typically covers the medical treatment that you receive in hospital, such as hospitalisation, cancer treatment and maternity.

THE FUND'S ADMINISTRATOR
The Administrator was appointed by the Fund and its responsibilities include, among others, the collection of contributions, processing claims and to ensure that member data is kept up to date.

NETWORK
This is a healthcare provider or group of providers selected by the Fund as the preferred provider of defined health services.

useful contact details

ACUTE MEDICINE
Acute medication is prescribed by a registered healthcare provider for a short period of time, often to combat a temporary illness; for instance diarrhoea, flu or sinus infection.

PRACTICE NUMBER
The Board of Healthcare Funders allocates practice numbers to qualified service providers. Legislation requires the practice number to be indicated on all claims before they may be settled. The first two numbers of a practice number (prefix) indicate the discipline of the service provider.

AGREED RATE
A negotiated tariff payable to any designated service provider, including those listed on the network.

TARIFF CODE
This code appears on your account or claim and specifies the treatment you received for a particular condition.

UPFS
The uniform patient fee structure is the fee structure applied by the State.

WAITING PERIOD
This period may apply upon late registration.

AMBULANCE SERVICES
Netcare 911: 082 911

CLAIMS SUBMISSION
POSTAL ADDRESS
Golden Arrow Employees' Medical Benefit Fund
PO Box 15729
Vlaeberg
8018

PHYSICAL ADDRESS – CAPE TOWN OFFICE
Parc du Cap
7 Mispel Road
Bellville
7530

PHYSICAL ADDRESS – MONTANA OFFICE
Palotti Road
Montana Estate
Cape Town
8001

CLIENT SERVICE DEPARTMENT
Telephone: 0860 104 122
Fax: 0860 104 124
Email: enquiries@goldenarrowmed.co.za

HOSPITAL ADMISSION AND SPECIALIST AUTHORISATION PROGRAMMES
Telephone: 0861 888 118
Fax: 0861 888 311

WEBSITE
www.goldenarrowmed.co.za