ORACLE HEALTH
ESWATINI

# MEMBER GUIDE

2025

Protect what matters

ORACLE HEALTH
ESWATINI

# *Our Member Guide*

This guide is a summary of Oracle Health Eswatini Rules as of 2025. It's designed to help you understand how your Oracle Health Eswatini membership works and should be read together with the brochure you received when joining or changing your cover.

- Please read this guide and the brochure carefully and keep them for your reference.
- If you need further information about your cover or anything in this guide, please contact us.
- We'll send correspondence to your email address. It's important to let us know if your contact details change.
- It's also important to contact us if you, or anyone else on the membership, are going to need treatment, to check what services and treatments we pay benefits towards and what out-of-pocket expenses you may incur.

# *Oracle Health Eswatini Joining Statement*

## By joining Oracle Health Eswatini, you have agreed to...

- ...ensure that all information supplied to Oracle Health Eswatini is true and correct to the best of your knowledge and belief having made reasonable enquiries
- ...keep your membership information up to date and notify us of any changes as soon as possible.

Please contact us on **(+268) 2411 7500** or email **HealthInfo@oraclesz.com.**

For **Pre-Authorisation**, please contact **(+268) 3278 8000.**

- ...ensure that all members on the membership are aware of and abide by Oracle Health Eswatini Rules, and the information in this guide which summaries the Rules
- ...assume the authority to provide the personal information of other members on the membership
- ...ensure that you and all members on the membership are aware of Oracle Health Eswatini, including its Privacy Policy

## 1 YOUR WELCOME PACK

If you've just joined Oracle Health Eswatini, you'll receive a welcome pack which includes:

- This guide
- A brochure, which is a summary of the services and treatments you are covered for
- You'll also receive a membership card and/or a Health Wallet card,
  - Use your membership card to make a claim or arrange admission to a hospital.
  - Use your Health Wallet card to make payment for your day-to-day claims

Make sure you keep your card safe and advise us immediately if it's lost or stolen.

Oracle Health Eswatini won't accept liability for any loss to you resulting from the misuse of a lost or stolen membership card.

## 2 CHANGES TO THE TERMS AND CONDITIONS OF YOUR MEMBERSHIP

All members of Oracle Health Eswatini are subject to the Scheme Rules, which set out the terms and conditions of cover, as well as the services we pay benefits for.

We may change the Scheme Rules from time to time in a manner that is reasonable and consistent with the regulation of the Kingdom of Eswatini.

If there are any changes to the Scheme Rules that will or might have a detrimental effect on a member's entitlement to benefits under their cover, we'll provide the member with reasonable notice in writing about the changes (including any changes to premiums and an updated Brochure if required) a reasonable time before the changes are due to take effect unless the changes are required by law, in which case we will endeavor to provide notice as soon as reasonably practicable.

Any changes will apply regardless of whether premiums have been paid in advance and may include:

- *Termination of cover* – If we close a cover that you're on: – we may permit you to stay on the cover, but not make any changes to your membership (e.g. adding or removing a member or component of cover). If you want to make a change to your membership, you'll need to select a new cover; or– we may not permit you to stay on this cover and will move you to a cover with similar benefits.
- *Removing a service from the cover*.
- *Reducing or removing a benefit or benefits under a cover*. After you've been notified of a change, it will be assumed that you choose to continue your membership (under the new or changed cover), it will be assumed that you accept the change and will be bound by its terms and conditions. If you do not wish to continue under the new or changed cover, you have the option of transferring to a different cover or cancelling your membership by notifying us.

## 3 MANAGING YOUR PREMIUMS

You are required to pay your premium every month. Ensuring that your premiums are up to date means that you can enjoy cover. Failure to keep your premiums up to date will result in suspend and termination of cover.

### *Premium payment options.*

We offer a range of options for premium payments, including:

- Financial institution debit order
- Source deduction from employer
- Electronic Funds Transfers (EFT)
- Mobile money

## 4 PREMIUM REFUNDS

If you cancel your membership, you can apply for a refund of premiums paid in advance. Your refund will generally be calculated from the date of application. The refund will be paid into the account the funds were deducted from. Oracle Health Eswatini does not issue refunds to international bank accounts.

## 5 CHANGES TO YOUR MEMBERSHIP

As your circumstances change you may need to add or remove members to your cover. The following people can be on your Oracle Health Eswatini membership:

- *Partner* – Your spouse or partner who is not a member or a registered dependant of another medical scheme
- *Child* – A dependent child who is not a member or a registered dependant of another medical scheme
- *Adult* – an adult dependant blood relative (immediate family) of a member (parents, brothers and sisters) in respect of whom the member is liable
- *Special Dependent (Parents)* – these are parents of the principal member in a marital relationship. Cover is given to Parents at the discretion of the scheme.

### *How do I update or change my cover?*

- Members can change their product option, savings levels, Primary care plan and funeral cover once a year in November and December for the new calendar year.
- You are also allowed one savings level amendment in the calendar year
- You will be required to complete an amendment form and submit it to our offices for processing.

## 6 WHAT IS INPATIENT VS OUTPATIENT

Health care cover terminology can sometimes be difficult to understand, there is always confusion around inpatient VS outpatient. Here is a quick and easy summary to identify the differences

*Inpatient cover* is when someone stays in a hospital while they receive their treatment. Treatments include removing of tonsils, appendix, heart surgery, hip replacements etc

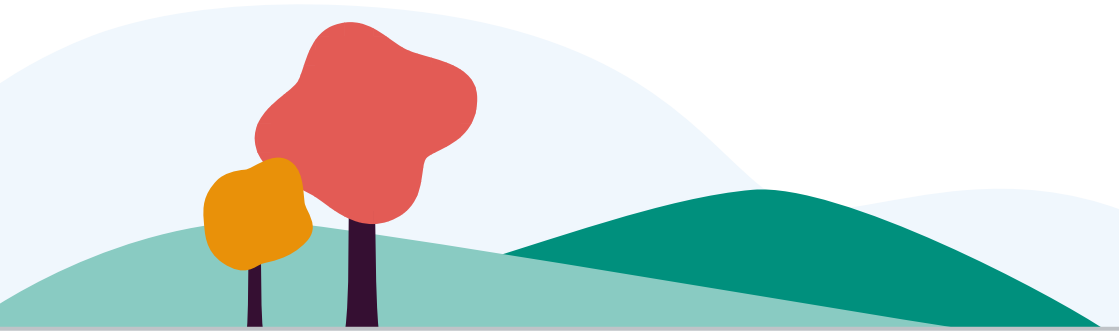
*Outpatient* is when a patient visits a health care facility for diagnosis or treatment without spending the night. Sometimes called a day patient. Treatments include, colds and flus, minor skin conditions such as eczema, general check-ups.

| DESCRIPTION | INPATIENT | OUTPATIENT |
|---|---|---|
| 1 hour Doctors visit | ✗ | ✓ |
| Medication from the pharmacy (Panado, cough mixture) | ✗ | ✓ |
| Chronic Medication | ✗ | ✓ |
| Sleeping in Hospital | ✓ | ✗ |
| Removing Tonsils | ✓ | ✗ |
| Visting the Dentist | ✗ | ✓ |

## 7 MEDICAL EXPENSES OUTSIDE ESWATINI

Should you travel outside of Eswatini to visit a service provider, where your doctor/s elects to charge more than the Oracle Health Eswatini rates, will be personally liable to pay the difference. To help you reduce or eliminate the gap, please contact Oracle Health Eswatini to find out what the tariffs are and ensure that you have adequate funds on your Health Wallet card to pay for any out-of-pocket expenses.

Please note that some service providers can charge up to 300 percent above tariff.



## 8 HOW TO CLAIM FOR MEDICAL CLAIMS I HAVE PAID FOR?

There are some instances where a service provider will insist on your paying cash for a doctor's visit. It is important to note that you can claim from Oracle Health Eswatini if such an event were to happen. The process to claim is as follows:

1. Submit your claim to **oracleclaims@mso.co.za**
2. Your claim must have the following.

   An invoice with:

   i. your membership number
   ii. the principal member's surname, initials and first name
   iii. the patient's surname, initials and first name
   iv. the treatment date
   v. the amount charged
   vi. the ICD–10 code,
   vii. tariff code and/or Nappi code
   viii. the service provider's name and practice number
   ix. proof of payment of the expense
3. The claim must be accompanied with confirmation of your banking details

***Please note:** Claim refunds are not carried for outpatient claims that have been put through the Health Wallet card.*

### *Oracle Health Eswatini rates*

These are fixed tariffs for the payment of relevant health services or benefits in accordance with the rules of the scheme. Health care providers are paid up to 100% of the Oracle Health Eswatini rates. These rates are reviewed annually. NB: If a health care provider bills above the OHER, the member shall be liable for the shortfall.

### PAYMENT OF CLAIMS

All claims submitted to Oracle Health Eswatini are processed in accordance with scheme and clinical protocols and Oracle Health Eswatini rates.

## 9 HOW TO AVOID CO-PAYMENTS

### *What is a co-payment?*

Co-payments are portions of the cost of procedures or medical services provided by doctors and/or pharmacies that members must pay from out of their pockets. The co-payment can be a certain amount or a percentage of the total bill. These are amounts over and above a set rate that Oracle Health Eswatini covers and usually apply to members who do not follow the Scheme Rules or managed care processes, or when benefits have been depleted for a service.

### *Use Designated Service Providers (DSPs)*

A DSP is a health care provider or group of providers chosen and contracted by Oracle Health Eswatini to provide members with medical condition diagnosis, treatment, and care. A co-payment may arise if you use a doctor who is outside the DSP. For example, if you receive chronic medicine from a pharmacy other than your designated DSP pharmacy. You may have to pay for the additional cost of that medication.

## 10 WAYS TO REDUCE CO-PAYMENTS

### *Maternity*

Give birth naturally if possible. An elective Caesarean section delivery (in other words, where Caesarean section is by choice, and not due to a medical condition or an emergency situation) will incur a co-payment.

In addition, if you opt to deliver out of Eswatini, you will be liable for the professional fees co-payment. To understand your co-payments, request a quote from the service provider and engage with the scheme for the scheme rates.

### *Chronic Formulary*

The Chronic Formulary is a list of cost-effective medicine which Oracle Health Eswatini pays in full according to Scheme Rules. If your doctor prescribes medicine that is not on the Oracle Health Eswatini Chronic Formulary (medicine list), you will have to pay the difference between the formulary price and the retail price the pharmacy has charged.

### *The Acute Formulary*

The Acute Formulary is a list of medicines and associated rules that will be applied to acute medicine claims on these options. It is important to ensure that your prescribing doctor refers to the acute formulary applicable to your option when prescribing acute medicine.

## 11 WHAT TO DO BEFORE GOING TO THE HOSPITAL

It's important to be aware that Hospital cover may not pay all of the costs associated with hospital treatment. You may still incur additional expenses above the benefits we pay.

To help understand your potential out of pocket expenses, you should contact us prior to any hospital admission. We encourage you to also speak to your doctors and hospital to confirm any out-of-pocket expenses you may incur.

***Before going to the hospital get pre-authorisation first!***

You need to get a pre-authorisation number (PAR) from Oracle Health Eswatini no later than 48 hours before you:

- are admitted to a private hospital;
- make an outpatient visit to a hospital (excluding emergencies and public hospitals); or
- have a CT scan, MRI scan or Radio-Isotope study.

*Please see **Page 8** on how to obtain pre-authorisation*

## 12 WHAT HAPPENS IN AN EMERGENCY IF I CANNOT PRE-AUTHORIZE A TREATMENT?

If you need emergency treatment or are admitted to hospital on a weekend, public holiday, or at night, you or a family member must contact Oracle Health Eswatini on the first working day following the incident. Failure to request authorization will result in Oracle Health Eswatini no granting the authorization, which the member must pay out of pocket, according to the Scheme Rules.

Discuss costs with the doctor obtaining pre-authorisation does not guarantee payment, nor does it imply that the event will be fully covered by the Scheme. The Scheme Rules will govern the payment of all benefits. For example, if the benefit is covered at 100% of the Scheme Rate but the doctor charges 200% of the Scheme Rate, you must pay the difference. Speak with your doctor to find out if they will be charging Scheme Rates and if any non-covered items will be used during your stay, procedure, or treatment. You can plan better and be aware of all payments that you may need to make out of your own pocket this way.

***Note:** It is your responsibility as a member/ beneficiary to check whether there will be charges above Scheme Rates, or procedures that are excluded or not covered.*

## 13 PRE-AUTHORISATION

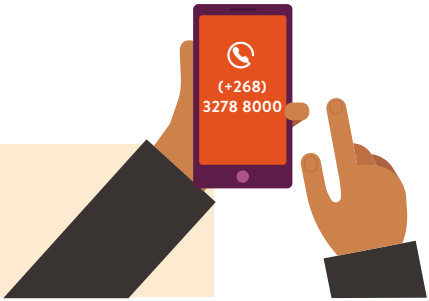
This is the process whereby you or the provider notify Oracle Health Eswatini that you are about to be hospitalised or that you want to access benefits for which pre-authorisation is required. Oracle Health Eswatini will confirm what benefits and amount of benefits are available.

### *What do I need pre-authorisation for?*

- ✔ Any hospital admission (including psychiatric hospitalisation)
- ✔ Procedures in doctor's rooms eg circumcision
- ✔ Rehabilitation
- ✔ Maternity benefits
- ✔ MRI/CT scan and radio isotope studies (inpatient cases)
- ✔ Bone density scans
- ✔ Interventional radiology and specialised radiology
- ✔ Angiography
- ✔ Dental surgery
- ✔ Chronic Medication

### *How is pre-authorisation obtained?*

Pre-authorisation is obtained by calling
**Local Tel: (+268) 3278 8000**
**SA Tel: (+27) 27 880 0208**
**email: oracleauths@mso.co.za**




### *Member Information*

Please have your membership card at hand. A pre-authorisation number will be issued for the specific event as listed above or indicated in the benefit structure. Pre-authorisation in an emergency event has to be obtained on the first working day following the hospital admission and/or emergency provider visit.

## 14 MEDICAL EXPENSES COVERED BY ORACLE HEALTH ESWATINI

### *Hospital and related expenses*

These are costs associated with medically necessary hospitalisation. Generally, these costs are not incurred often, however it may add up to a phenomenal amount typically not considered affordable by the average individual without the help of a health insurer.

### *Emergency medical conditions*

This is a sudden, unexpected life-threatening condition. It may include an emergency transfer to the nearest in country or cross border facility.

### *Preventative Assessment*

These are all benefits paid by the scheme up to a maximum amount per benefit. They are available at all our designated service provider outlets in Eswatini.


All claims submitted to Oracle Health Eswatini are processed in accordance with scheme and clinical protocols. In addition, it is subject to available benefits and Oracle Health Eswatini rates.

## 15 MATERNITY BENEFITS

### *What do I do when I fall pregnant?*

- Once your pregnancy is confirmed by your service provider you are required to register with the scheme to qualify for all maternity benefits.
- You must provide, how many weeks you are and when is the expected due date.
- Deliveries by a caesarean section require a clinical motivation.

### *Who is eligible to claim and how do I claim for the maternity benefits?*

A female main member or a female dependant are the only members entitled to the maternity benefits.

As the Starter, Growth and Lifestyle home births are cash benefits and you will be required to complete the necessary forms and submit them to our offices to be processed. Newborns are required to be registered within 30 days. Newborns registered after 30 days will be subject to underwriting.

### Maternity cash benefit: Starter, Growth and Lifestyle home births

- Clients have 30 days to notify the health plan of the delivery.
- All documentation must be submitted within 30 days for processing.

## 16 EMERGENCY/CASUALTY ROOM BENEFIT

### *What is an Emergency?*

A medical emergency is an acute injury or illness that poses an immediate risk to a person's life or long-term health and requires immediate medical attention. The occurrence of a medical emergency can happen at any time of the day.

**Examples of a medical emergency would be:**

- Bleeding that will not stop,
- Breathing problems,
- Choking,
- Vomiting blood,
- Fainting,
- Loss of consciousness,
- Suspected fractures,
- Cuts, and lacerations that will require suturing

If you experience a medical emergency proceed to the nearest medical facility that has the capacity to treat medical emergencies. For true medical emergencies the Provider can treat you immediately without having to obtain a pre-authorisation from the Scheme first. After the event the Provider must notify the Scheme of the occurrence so that an authorization number can be issued for the provider to claim against. Pre-authorisation must be done within 48 hours after the incident.

### *Major Disease Benefit (MDB)*

#### What is Major Disease Benefit?

It is an inpatient benefit that covers critical illness such as cancer and renal dialysis.

#### How do I access the benefit?

- Firstly, you would have to be diagnosed by your doctor with a critical illness
- Once diagnosed, the doctor will be required to share the details of your diagnosis and a proposed treatment plan with MSO international.
- Based on the condition and the available benefits, a pre-authorisation will be issued. Please see page 8 to on how to obtain pre-authorisation
- Once you begin treatment, your doctor will be required to provide regular updates on your progress and share any revised treatment plans.
- The clinical team will do regular check ins on how you feel and how you are progressing with treatment

It is important to Oracle Health Eswatini that you receive the necessary treatment to help improve your condition and quality of life.

## 17 OUTPATIENT (DAY TO DAY)

### HEALTH WALLET (MEDICAL SAVINGS ACCOUNT)


#### *What is a Medical Savings Account?*

It is an account which money is allocated to monthly for your outpatient needs. The funds are loaded on to your Health Wallet. The amount that is loaded is dependent on the savings option which you have selected at application stage.

Your Health Wallet is an excellent way of ensuring that you have enough money available to pay for your day-to-day medical needs. There are different Health Wallet savings levels a member may choose from: E500; E1 000; E1 500; E2 000; E2 500; E3 000 and E5 000. Starter has a savings cap of E1 500, Growth has a savings cap of E3 000 and E5 000 savings is limited to Lifestyle, Comprehensive and Comprehensive Plus.

#### *How does it work?*

- If you are not well and you need to visit a service provider, you will go through the normal process at the providers rooms but after the visit you are required to pay for the services rendered.
- The Health Wallet card works just like a debit card. You swipe and payment is done immediately.
- The card can be used in Eswatini and South Africa. The card only works at health care providers and is not usable with any other retailers.

#### *How do I view my balance?*

You can view your balance by visiting and logging into the Eswatini Bank Customer portal or simply downloading the Eswatini Bank App at

**https://portal.swazibank.co.sz/consumerSwaziBank/faces/consumer.xhtml.hat**

For easy access to the Eswatini Bank portal, scan the QR code using your cell phone.

### *Are remaining medical savings refunded to the member?*

At your request, medical savings may be paid out every year. A minimum balance that equals 3 months of your monthly savings premium must be held and the amount above this can be paid out. The remaining savings amount will be rolled over to the following year.

### *What happens to my savings account when I leave the scheme?*

Should the member leave the scheme, available medical savings are reimbursed at 100%.

### *How do I obtain a new PIN number?*

Call **(+268) 2411 7500** or Whatsapp us on **(+268) 7806 9118** for assistance or visit your nearest Eswatini Bank branch.

### *What happens when my Health Wallet card gets lost?*

The maximum number of Health Wallet cards is four, the first one is free and the other three cards come with an insurance fee/charge. If a card gets lost, call **(+268) 2411 7500** or **WhatsApp (+268) 7806 9118** for assistance and you will get a new card at an extra charge.

## 18 TRADITIONAL OUTPATIENT (DAY TO DAY)

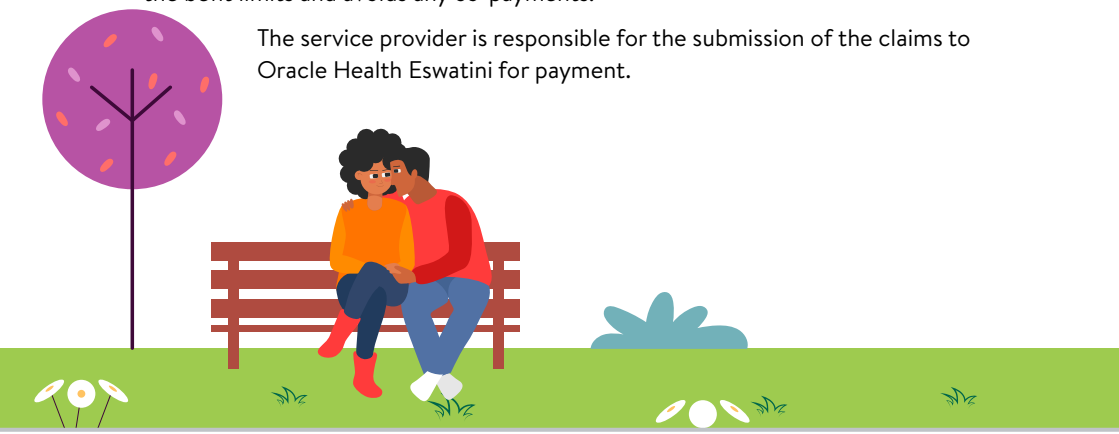
Plan 1, Plan 2, Plan 3, Comprehensive and Comprehensive Plus have a traditional outpatient benefit structure.

### *What does this mean?*

When visiting a service provider, you need to be mindful of the benefit limits and how much you have utilised.

When visiting a Provider, the service provider is required to verify your benefit limits before treatment. The purpose of this is to ensure that your treatment is done within the befit limits and avoids any co-payments.

The service provider is responsible for the submission of the claims to Oracle Health Eswatini for payment.



## 19 CHRONIC MEDICATION

### *What is a chronic condition?*

A disease or condition that usually lasts for 3 months or longer and may get worse over time. Chronic diseases tend to occur in older adults and can usually be controlled but not cured. The most common types of chronic disease are heart disease, stroke, diabetes, and arthritis.

### *Who qualifies for the programme?*

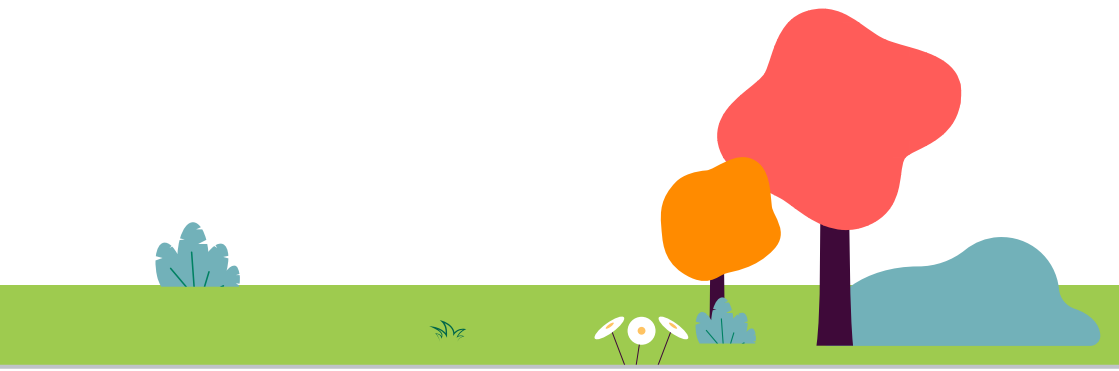
All members or beneficiaries who have a chronic (in other words, long-term) condition such as high blood pressure that requires medicine on an ongoing basis, qualify to join the Chronic Medicine Management (CMM) Programme. This is done by registering your chronic condition with Oracle Health Eswatini.

### *Find your chronic condition*

Below are the most common chronic conditions. Please kindly identify which conditions are covered under your plan.

### LISWATI PLANS AND COMBO PLANS

| CONDITION | PLAN 1 | PLAN 2 | PLAN 3 | STARTER + PLAN 2 | GROWTH + PLAN 2 | LIFESTYLE + PLAN 2 |
|---|---|---|---|---|---|---|
| Hypertension | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| Asthma | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| Diabetes I & II (Oral Medication) | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| Peptic Ulcers | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| Hyperlipidaemia | ✘ | ✔ | ✔ | ✔ | ✔ | ✔ |
| Epilepsy | ✘ | ✔ | ✔ | ✘ | ✘ | ✘ |
| HIV | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |



## COMPREHENSIVE AND COMPREHENSIVE PLUS

| CONDITION | COMPRE-HENSIVE | COMPRE-HENSIVE PLUS | STARTER SUBJECT TO MSA | GROWTH SUBJECT TO MSA | LIFESTYLE SUBJECT TO MSA |
|---|---|---|---|---|---|
| **Asthma** | ✔ | ✔ | ✔ | ✔ | ✔ |
| **Allergic Rhinitis** | ✔ | ✔ | ✔ | ✔ | ✔ |
| **Epilepsy** | ✔ | ✔ | ✔ | ✔ | ✔ |
| **GORD** | ✔ | ✔ | ✔ | ✔ | ✔ |
| **Hypertension** | ✔ | ✔ | ✔ | ✔ | ✔ |
| **Diabetes (Type 1& 2)** | ✔ | ✔ | ✔ | ✔ | ✔ |
| **Hyperlipidaemia** | ✔ | ✔ | ✔ | ✔ | ✔ |
| **HIV/ AIDS** | ✔ | ✔ | ✔ | ✔ | ✔ |

### *Additional chronic conditions*

Oracle Health Eswatini has additional chronic conditions which are covered by the scheme.

**The list is as follows:**

- Addison diseases,
- Bipolar Mood Disorder
- Cardiomyopathy
- Chronic Obstructive Pulmonary
- Chronic Obstructive Pulmonary
- Haemophilia, Hypothyroidism
- Parkinson disease
- Schizophrenia
- Cardiac Failure
- Chronic Renal Disease
- Coronary Artery Disease
- Dysrhythmias
- Glaucoma
- Multiple Sclerosis
- Rheumatoid Arthritis

Please contact MSO International for the full process on how to get registered for the additional conditions.

### *What are the 'terms and conditions' of the programme?*

To enable Oracle Health Eswatini to offer their members quality care for chronic conditions without jeopardising the quality of care, Oracle Health Eswatini has put in place procedures and protocols to limit what a member may claim for, in terms of chronic conditions. The purpose of these is to ensure that members can receive the right treatment and medication which allows them to enjoy a good quality of life.

## *How to join the Oracle Health Chronic Medicine Management Programme*

You have visited your physician and after numerous tests you have been diagnosed with a chronic condition.

**To ensure that you have access to the chronic Benefits you must do the following:**

1. Check if your chronic condition is covered by your plan
2. Obtain a copy of a valid prescription, detailing the doctor's details (name and practice number), the diagnosis or ICD-10 codes and the medicine details, such as name, strength, dosage form and directions for use.
3. Email MSO to register for your chronic medication @ **patientregistration@mso.co.za** or call **(+268) 7808 1026** or **(+268) 3278 8000**
4. **MSO will do the following:**
   - ✔ Verify your benefits
   - ✔ Advise you of the benefits
   - ✔ Register your script on the system
   - ✔ Advise you that your script has been successfully registered

## *Which pharmacy do I use to get my medication?*

Once you are registered on the CMM Programme, you will be required to collect your medication from any Clicks retailer country wide. Oracle Health Eswatini members receive a 20% discount for all medications at any Clicks retailer both in Eswatini and South Africa.

## *How to stretch your benefits and avoid co-payments*

### When and why would I run out of chronic benefits?

Depending on the chronic condition you have been registered for, and how you use your benefit, you may at some stage find that you have depleted your chronic medicine benefit and must now pay certain costs out of your own pocket.

Therefore, it is important to be mindful about how you use your benefits and how to ensure that they give you the benefits you need to enjoy life instead of being worried about the little things.

### So how do I stretch my benefit?

- ✔ Know and understand the benefit limits
- ✔ Have a conversation with your doctor about your condition and the difference types of medications
- ✔ Request your doctor to prescript generic medication which is cost effective
- ✔ Request the pharmacist for a generic medication that is within the Oracle formulary

## 20 THE BIG DEBATE: GENERIC VS BRAND NAME

### *What is generic medication?*

Generic medicine (also called a generic substitute) is a product that is similar to the original product in terms of active ingredients, strength, and form.

In Southern Africa, once pharmaceutical companies obtain approval from the Southern African Health Products Regulatory Authority to sell their newly developed medicines, they have patent protection that effectively lasts between 5 and 15 years. During this time, no other company can manufacture this specific medicine.

Once the patent period has expired, any other company may produce the same medicine under a different commercial name, using the same formulation (active ingredients). The company may sell their product, provided it has been registered with SAHPRA and its quality has been approved by the regulatory authority.

By using the generic alternatives, you can get more value from your benefit limit, as the benefit to cover your medication will last longer. This is because generic medicines are generally between 20% and 40% more cost-effective than original brand medicines.

Unfortunately, because generic medicines are cost effective compared to brand-name medicines, there is a general misconception that they are not as good as the original brand-name medicines. This misconception carries a cost, as members who continue using brand-name medicines are spending far more on medicines than is necessary. Not all medicines have a generic equivalent, but your pharmacist will advise on this

## *Tips to ensure Your chronic medication works effectively*

**To best control your chronic illness, take your medicine regularly and exactly as your doctor has instructed. This will help prevent your chronic condition from worsening and help prevent complications.**

- ✔ *Take the correct dosage* as prescribed by your doctor and indicated on your medicine labels. Do not change your dose because you feel better or because you think you need more, or less, medicine. Change the dose only if your doctor tells you to do so – this is especially important with chronic medicine, as it prevents you from becoming sicker or developing other, or more serious illnesses.
- ✔ *Take your medicine at the correct intervals* as prescribed by your doctor; for example, once, twice or three times a day. Make sure you understand exactly what these intervals mean and adhere to them. Twice a day usually means every 12 hours – or morning and night. It does not mean one tablet early in the morning and a second at lunchtime. If you are not sure what the dosing intervals mean, ask your pharmacist.
- ✔ *Take it at the correct time*. Should your doctor specify exact time(s), adhere to these to ensure that your medicine works properly.
- ✔ *Follow special instructions about food*. Should your doctor or pharmacist give instructions on when to take your medicine in relation to food, adhere to the instructions. If you are to take your medicine before or after food, ask your pharmacist how long before or after food.
- ✔ Most important of all, *take your medicine on an ongoing basis*. Chronic medicine is used to treat chronic conditions. Your condition will not get better on its own. You need to take your medicine for as long as your doctor says – usually for the rest of your life. Do not stop taking your medicine because you feel better, or because a friend suggests you stop.

Although most patients begin to feel well when taking chronic medicine, it does not mean that the illness is cured. It only means that it is being controlled by the medicine, so continue taking your medicine to keep feeling well. If you are not able to take your medicine because of side effects or because it does not fit in with your daily work or life schedule, discuss this with your doctor. Do not stop taking your medicine without discussing it with your doctor. If you do not take your medicine as you should, or if you skip doses or stop taking it, your chronic condition may no longer be controlled. Your symptoms may worsen, or you may even need to be hospitalised.

## 21 EXTRA BENEFITS

### PREVENTATIVE CARE BENEFIT

#### *What is a Preventative Care benefit?*

The purpose of the Preventative Care benefit is the early diagnoses of an underlying health conditions that you might not even be aware of. Doing a wellness check annually will tell you if there are any of the common risk factors that you need to concern yourself with or not. As we get older our own awareness around these chronic conditions need to increase.

The Scheme has therefore put together a wellness benefit for you taking into consideration your age and gender.

#### *How does the benefit work?*

To access the benefit, you will be required to contact our Pre-Authorisation department to obtain an authorisation number. The benefit is subject to the scheme rules and protocols.

| BENEFIT | MALE UNDER 40 | MALE OVER 40 | FEMALE UNDER 40 | FEMALE OVER 40 | HOW OFTEN? |
|---|---|---|---|---|---|
| **Primary Health Care Nurse Consultation** | ✔ | ✔ | ✔ | ✔ | Once a year |
| **Health assessment: Blood Pressure Test, cholesterol, and blood sugar tests (finger prick tests), BMI** | ✔ | ✔ | ✔ | ✔ | Once a year |
| **Flu Vaccine** | ✔ | ✔ | ✔ | ✔ | Once a year |
| **Pap Smear** | ✘ | ✘ | ✔ | ✔ | Every 2 years |
| **Mammogram** | ✘ | ✘ | ✔ | ✔ | Every 2 years |
| **Prostate Specific Antigen (Lancet test)** | ✘ | ✔ | ✘ | ✘ | Every 2 years |
| **General Physician (GP) consultation on referral from PHC Nurse** | ✔ | ✔ | ✔ | ✔ | Once a year |

***Please note** the preventative care benefit is subject to pre-authorisation.*
*Scheme rules and protocols apply.*

## 22 FUNERAL BENEFITS

### *How do I claim for the funeral benefit?*

Pay-out will only be for members who are on cover.

- In the event of your death while still a member of your scheme, your surviving spouse or next of kin can claim for the funeral benefit
- Surviving dependants need to inform Oracle Health Eswatini within 30 days of your death.
- Upon death of a dependant the funeral table limits will apply.
- All forms and documents must be completed and submitted to our offices for processing.

### *Funeral claim submissions:*

- Clients have 30 days to notify the health plan of the death of the principal member or dependants.
- Premiums must be up to date.
- All documentation must be submitted within 90 days for processing.

## 23 COMPLAINTS PROCEDURE

Oracle Health Eswatini is committed to ensuring that the interests of our members are protected at all times. This includes providing appropriate and adequate systems and processes to make sure we settle your claims timeously and provide a prompt response to any queries, complaints and disputes you may have.

*As the first point of call for a query, please contact us:*

- email us at **Xperience@oraclesz.com**
- send us a WhatsApp message
- or call us on (+268) **7602 7248/7806 2499**

If your query is not resolved satisfactorily, you may request that your query be escalated to the respective manager for intervention or resolution. If you are still not satisfied with the intervention or resolution, you may lodge a formal complaint or dispute in writing.

It is essential that you follow the complaints process as outlined above to ensure that your query is timeously and efficiently resolved by Oracle Health Eswatini. An aggrieved member does, however, have the right to lodge a complaint against a decision of Oracle Health Eswatini with the Ombudsman. The Ombudsman governs the Financial and Insurance industry and therefore your complaint should be related to your medical aid.

Any beneficiary who is aggrieved with the conduct of a medical scheme can submit a complaint. It is important to note that you should always first seek to resolve your complaints through the complaints processes in place at Oracle Health Eswatini, before approaching the Ombudsman for assistance. The Ombudsman protects and informs members and the public about their Health care rights and obligations, ensuring complaints raised are handled appropriately.


You can send your complaint in writing to the Ombudsman via email at **info@ombudsfs.org.sz**.

You can also call the Ombudsman of Financial Services on (+268) **2404 7653 / 4464** or visit **www.ombudsfs.org.sz** for more information and for the necessary forms that will need to be completed.

The OFS should send you written acknowledgement of your complaint within 14 working days of receiving it and will provide the reference number and contact details of the person who will be handling your complaint.

# Exclusions

General exclusions mentioned in this paragraph are not affected by any specific exclusion. Unless otherwise decided by the Scheme, expenses incurred in connection with any of the following will not be paid by Oracle Health Eswatini:

## BENEFITS EXCLUDED

1. All costs incurred during waiting periods and for conditions which existed at the date of application for membership of the Scheme but were not disclosed.
2. All costs that exceed the annual maximum allowed for the particular category for the benefit to which the beneficiary is entitled in terms of the Benefit Structure.
3. Injuries or conditions sustained during wilful participation in a riot, civil commotion, war, invasion, terrorist activity or rebellion.
4. Professional speed contests or professional speed trials (professional defined as where the beneficiary's main form of income is derived from partaking in these contests);
5. Illegal behaviour, negligence, or a breach of law;
6. Costs incurred as a result of failure to carry out the instructions of a medical doctor or dentist;
7. Health care provider not registered with the recognised professional body constituted in terms of an Act of parliament;
8. Holidays for recuperative purposes, whether deemed medically necessary or not, including headache and stress relief clinics;
9. All costs for treatment if the efficacy and safety of such treatment cannot be proved;
10. All costs for operations, medicine, treatments and procedures for cosmetic purposes or for personal reasons and not directly caused by or related to illness, accident or disease;
11. Obesity;
12. Costs for attempted suicide ;
13. Breast reduction and breast augmentation, gynaecomastia, otoplasty and blepharoplasty except where this is related to carcinoma, tumours or abscess.
14. Medication not registered by the Medicine Control Council;
15. Costs for services rendered by any institution, nursing home or similar institution not registered in terms of any law (except a State facility/hospital);
16. Gum guards and gold used in dentures;
17. Frail care;
18. Travelling expenses, excluding benefits covered by emergency rescue and international cover;
19. All costs, which in the opinion of the medical assessor are not medically necessary or appropriate to meet the health care needs of the patient;
20. Reversal of vasectomies or tubal ligation (sterilisation);
21. Injuries resulting from narcotism or alcohol abuse;
22. Examinations, tests and treatment for infertility and/or impotence.
23. The cost of injury and any other related costs as a result of scuba diving to depths below 40 metres and cave diving;
24. Voluntary termination of pregnancy;
25. Services rendered by social workers;
26. Injuries on duty.

# Glossary of terms

### *Annual limit*

An annual limit is the maximum amount of benefits we pay towards particular items or services, or a group of services and/or items within a calendar year (1 January to 31 December).

### *Sub-limit*

A sub-limit is the maximum number of benefits you can receive for a particular item or service within the overall annual limit. Sub-limits generally apply per calendar year.

### *Emergency medical condition*

The sudden, and at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy.

### *Oracle Health Eswatini rates*

These are fixed tariffs for the payment of relevant health services or benefits in accordance with the rules of the scheme. Health care providers are paid up to 100% of the Oracle Health Eswatini rates. These rates are reviewed annually. **NB: If a health care provider bills above the OHER, the member shall be liable for the shortfall.**

### *Pre-authorisation*

Pre-authorisation is when you call us to let us know that you are about to receive medical treatment. The Scheme will confirm whether you are covered for the expected treatment, and at what rate your option covers such treatment. You will receive a pre-authorisation number which you need to provide to the doctor. While pre-authorisation is not a guarantee that your treatment will be covered, it gives you the peace of mind that benefits will be paid in line with Scheme Rules, your option and membership status.

### *Pro-Rata*

The monthly apportioning of benefit limits according to member benefit year exposure to a particular option.

### *Cash Back Bonus*

If Oracle Health Eswatini receives no claims on inpatient benefits in a calendar year, 10% of your inpatient base premium (premium allocated to inpatient benefits) will be paid to the clients' savings. This will be accessible via your Health Wallet card and is paid every year in April for the previous year. Members who join in the middle of the year will not be entitled to the 10% cashback. Members who qualify must have been on cover for one calendar year from January to December and the cashback will be paid to the client's Health Wallet card.

# Notes

# Notes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ORACLE HEALTH
ESWATINI

**Pre-authorisation email:** oracleauths@mso.co.za

**Pre-authorisation:** Local Tel – (+268) 3278 8000
SA Tel – (+27) 27 880 0208

**Claims email:** oracleclaims@mso.co.za

**Website:** www.oraclesz.com