ORACLE HEALTH
ESWATINI

BROCHURE

2024

ORACLE HEALTH
ESWATINI

Oracle Health Eswatini roots date back to 2008 and it is owned by Vunani Capital (JSE listed Asset Managers) and Eswatini Bank. Oracle Health's focus is giving members choice through various plans whilst making sure it gives back on claim free cashbacks, free preventative screenings, and discounts at Gyms and/or movies.

Oracle Health's administrative functions are performed by Oracle Insure Eswatini Ltd in partnership with Medical Services Organization (MSO, part of the Discovery group), a leading provider of integrated health care risk management and third-party administrative services and solutions to over a million beneficiaries throughout Africa. MSO provides a 24/7 call centre for members who require hospitalization. The local Eswatini call centre operates from Monday to Friday during office hours and afterhours calls are re-directed to MSO's international desk.

Oracle Health's products do not limit members to Eswatini health providers alone – we have agreements with all major South African hospitals (see page 26).

What is new in 2024:

1. Medical inflation (costs on medical procedures) in the SADC region is estimated to increase between 9 – 12% for the year. This has put pressure on medical aid providers concerning premium increments, but Oracle Health is happy to announce that we have kept the inflationary rate to the following:
   - Entry level offerings – 6% increase
   - Higher benefit limits – 8% increase
2. Benefit limits were reviewed as follows:
   - **The Comprehensive plan increased certain out-patient benefits** (see page 12) and members on this plan can add the debit card option to cater for day to day medical needs
   - **The Starter Plan increased its overall in-patient benefit limit** (see page 2) and added a new savings contribution option
   - **The Lifestyle Plan increased its overall in-patient benefit limit** (see page 2) and added a new savings contribution option
3. **A new plan called Comprehensive +** has been added. This is an In and Out-patient plan and was created for members who need higher benefit limits than our current plans offer (see pages 10-14).
4. **The funeral benefit has been amended.** As of 2024, all members will enjoy a built in Family Funeral benefit to a limit of E20 000. The cost for the E30 000 and E50 000 top up options has been reduced (see page 17).
5. A new and **more flexible outpatient option** has been also added (see page 5).

The Benefit Structure

Oracle Health's benefit structure is made up of five components

Major In-Patient Benefit

The Major In-Patient Benefit provides cover for hospitalisation and certain out-of-hospital procedures that can safely be performed in a doctor's room, registered day clinic or outpatient facility, provided treatment is clinically appropriate and has been pre-authorised.

Major Disease Benefit

This is a special benefit for oncology, organ transplant and chronic dialysis. Members should register on the programme to access benefits. Benefits are accessible in and out of hospital.

Medical Savings Account

Your MSA is an excellent way of ensuring that you have enough money available to pay for your day-to-day medical needs. There are different savings levels a member may choose from: E500; E1 000; E1 500; E2 000; E2 500, E3 000 and E5 000.

Health Assessment Benefit

This benefit is available to all Oracle Health members and is paid by the Scheme. Thus your medical savings benefits are not reduced. The Health Assessment encourages health awareness, enhances quality of life and gives a peace of mind through preventative care and early detection, health education and advice.

Rewards

This benefit provides members with a 10% no claims bonus if they do not claim their in-hospital benefits. It is paid in April for the previous year. Discounts in certain retail outlets such as the movies, restaurants, retail shops and more are given. The rewarder provides members with the option to top up their family funeral cover from E20 000 to E50 000.

Benefit Options – Inpatient

PRODUCT	STARTER 2024	GROWTH 2024	LIFESTYLE 2024
Overall limit in-patient (IP)	E400 000 per family per annum E200 000 per beneficiary per annum	E1 500 000 per family per annum	E4 000 000 per family per annum
Executive/private ward	Not covered	Not covered	E1 000 per day to a max of E5 000 per beneficiary per annum
High care and ICU	E50 000 per event	E50 000 per event	Subject to overall IP limit and clinical Protocals
Specialists and general practitioners	Subject to overall IP limit Paid at scheme rates	Subject to overall IP limit Paid at scheme rates	Subject to overall IP limit Paid at scheme rates
Ward and theatre medicines	Subject to overall IP limit	Subject to overall IP limit	Subject to overall IP limit
Major Disease Benefit (MDB)	E90 000 per family per annum	E180 000 per beneficiary per annum	E350 000 per family per annum
Oncology subject to MDB	Subject to MDB limit	Subject to MDB limit	Subject to MDB limit
Organ transplants subject to MDB	Subject to MDB limit	Subject to MDB limit	Subject to MDB limit
Organ transplants subject to donor and MDB	Subject to MDB limit	Subject to MDB limit	Subject to MDB limit
Renal dialysis subject to MDB	Subject to MDB limit	Subject to MDB limit	Subject to MDB limit
Motor vehicle accident	Subject to overall IP limit	Subject to overall IP limit	Subject to overall IP limit
Step-down/rehabilitation	E5 000 per family per annum	E10 000 per beneficiary per annum	E40 000 per beneficiary per annum
Medicines to take home	E920 per admission	E920 per admission	E920 per admission
Appliances	E5 000 per family per annum	E5 000 per beneficiary per annum	E25 000 per beneficiary per annum
Specialised radiology	Subject to radiology limit	Subject to radiology limit	Subject to radiology limit

PRODUCT	STARTER 2024	GROWTH 2024	LIFESTYLE 2024
Pathology	E10 000 per family per annum E5 000 per beneficiary per annum	E15 000 per beneficiary per annum	E40 000 per beneficiary per annum
Radiology	E10 000 per family per annum E5 000 per beneficiary per annum	E15 000 per beneficiary per annum	E25 000 per beneficiary per annum
Maxillofacial surgery	Not covered	Not covered	E90 000 per beneficiary per annum
Dental surgery (subject to conditions)	Not covered	Not covered	E25 000 per beneficiary per annum
Maternity	E8 000 payout into MSA after birth	E18 000 payout into MSA after birth	E45 000 per family including E3,990 benefit for scans
Home births	Not covered	Not covered	E25 000 per family
Neonatal, including neo-natal ICU and related costs	Not applicable	Not applicable	E200 000 per family
Internal and external prosthesis	Not covered	E25 000 per family	E70 000 per family per annum
Physiotherapy	E1 500 per family per annum	E6 000 per family per annum	E20 000 per family per annum
Psychiatric hospitalisations	E15 000 per family per annum	E20 000 per beneficiary per annum	E35 000 per beneficiary per annum
Addictive conditions and disorders	Subject to Psychiatric hospitalisations limit	Subject to Psychiatric hospitalisations limit	Subject to Psychiatric hospitalisations limit
Ambulance services (In-country only)	E5 720 per event	E5 720 per event	E10 000 per event
Air/cross borders evacuation	Not covered	E50 000 per beneficiary per annum	covered in full, according to fund protocols
Emergency/ Casualty Care Benefit	E2 000 per beneficiancy per annum	E2 000 per beneficiancy per annum	E3 000 per beneficiancy per annum

Benefit Options – Inpatient

SPECIAL BENEFITS	STARTER 2024	GROWTH 2024	LIFESTYLE 2024
Wellness Program	Limited to one GP consultation per beneficiary per annum. One GP consultation per beneficiary per annum covering: • GP consultation fee • Health Assessment (Blood pressure, Cholesterol, Blood glucose, BMI) • Pap smear for female beneficiaries • Prostate test for male beneficiaries • Osteoporosis screening • Mammogram for female beneficiaries • Flu vaccine • Pneumococcal vaccine		
Reward Program	Included	Included	Included
10% Cash Back if a family does not claim IP	Included	Included	Included
Funeral	Included	Included	Included

MONTHLY PREMIUM RATES			
M	528	1 228	1 959
M+1	862	1 691	2 732
M+2	991	1 897	3 059
M+3	1 421	2 025	3 360
M+4	1 511	2 064	3 465
M+5 +	2 243	2 243	3 714
Special Dependent	791	1 839	2 941

INTERNATIONAL STUDENT COVER

Oracle Health has partnered with South Africa's largest student medical provider, Momentum Ingwe South Africa.

Oracle Members who require assistance with student cover, please kindly contact our offices for more information.

Benefit Options – Outpatient Choices

We give you the freedom to structure and control your Outpatient

THIS IS HOW IT WORKS:

You can select a Medical Savings Account Level

This money is allocated monthly for your Outpatient needs that will be accessed via Mastercard prepaid card

NONE Savings | E500 Savings | E1 000 Savings | E1 500 Savings | E2 000 Savings | E2 500 Savings | E3 000 Savings | E5 000 Savings

You can also opt to select an Outpatient Plan (optional)

This is an outpatient benefit that provides a specific offering at a Designated Service Provider list.

Cover yourself and your family

PLAN 1

- Access to a primary care nurse
- Limited access to a GP
- Acute meds from a limited formulary
- Chronic meds from a limited formulary

PLAN 2

- Access to a primary care nurse and GPs
- Acute meds from a extended formulary
- Chronic meds from a extended formulary
- Visits to specialists
- Maternity benefits
- Basic radiology, dentist, and optometry benefits

CONTRIBUTIONS – 2024	PLAN 1	PLAN 2
M+0	171	525
M+1	314	882
M+2	424	1106
M+3	534	1 331
M+4	644	1 556
M+5	754	1 780

Medical Saving Account – Prepaid Card

What is a medical savings account?

- **Money is allocated monthly** for your outpatient needs.
- Choose **monthly savings** between **E500** to **E3 000**.
- Starter option savings are capped at **E1 500 per month**.
- Lifestyle option has the option to **save E5 000 per month.** This is limited to the lifestyle option.
- The **funds** are **loaded** on to your **prepaid card**.
- Pay for your **day-to-day medical needs**.

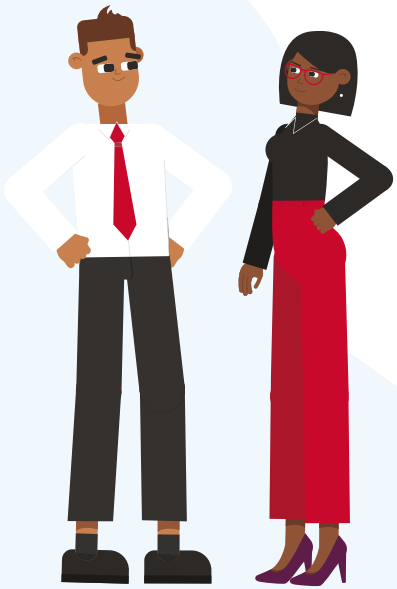
How does it work?

Use/swipe prepaid card for doctor's consultations and out of hospital medical expenses.

Payment is instant.

Can be used in eSwatini and South Africa.

The card only works at health care providers and is not usable with any other retailers.



You will receive discounted rates from providers in instances where settling is immediate.

How do I view my balance?

Download the Swazi Bank App, scan the QR code or WhatsApp **(+268) 7806 9118**

Are remaining medical savings refunded to the member?

Medical savings are paid at your request every year.

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

Medical savings are reimbursed at 100%.

LEARN MORE ON PAGE 21

Capitation (Additional Out-Patient Benefit)

Capitation is a quality, affordable living healthcare facility, which has been developed for the eSwatini market with the purpose of making limited private healthcare facilities accessible to a greater number of people in eSwatini. Oracle Health eSwatini has embedded a capitation benefit in its health product to provide more options to clients.

Product information

The option works as follows:

- You **choose a plan** that suites your lifestyle (1 or 2).
- You may **visit the provider** to access health care services as per your chosen option plan.
- You can only **access** the **Outpatient option by selecting** one of Oracle Health's **In-Patient products**.
- **6 months waiting period** on **optometry** and **dentistry** benefits
- **Cover ceases at 60 years of age** and the client will **move onto the medical savings plan**.

Process

Choose an Outpatient plan.

01 Complete the Oracle Health application form.

02 Choose a capitation plan.

03 All application forms are subject to underwriting.

MONTHLY PREMIUM RATES	PLAN 1 2024	PLAN 2 2024
M+0	171	525
M+1	314	882
M+2	424	1 106
M+3	534	1 331
M+4	644	1 556
M+5	754	1 780

How does it work?

When joining the health plan, you will select the capitation option that suits your needs.

- You will be given a **membership card** that will have your **plan option** and **service provider**.

- When visiting your service provider, you will **produce your membership card and ID** and will be attended to.

- You will **not be required to pay** for the services after your visit with the provider. This is subject to all procedures being done within the health plan protocols.

Pre-Authorisation

To access dentistry, optometry, or physiotherapy services, you will be required to contact our capitation office to **obtain pre-authorisation 48 hours in advance**:

Contact details are:

Email: oracleauths@mso.co.za

WhatsApp: (+268) 7844 0871

Pre-Authorisations Tel: (+268) 7808 1026

Inpatient benefits

INPATIENT BENEFITS	COMPREHENSIVE 2024	COMPREHENSIVE PLUS 2024
Overall Annual limit (OAL)	2 500 000 per beneficiary	Unlimited family per annum 2 500 000 per beneficiary per annum
Executive/Private Ward	Not covered	E1 000 per day to a max of E5 000 per beneficiary per annum
High Care and ICU	Subject to overall IP limit and Clinical Protocol	Subject to overall IP limit and Clinical Protocol
Specialists and General Practitioners	Hospitilisation subject to overall IP limit	Hospitilisation subject to overall IP limit
Ward and Theatre medicines	Paid at scheme rates subject to overall IP limit	Paid at scheme rates subject to overall IP limit
Major Disease Benefit (MDB)	E350 000 per family per annum	E400 000 per family per annum
Oncology subject to MDB	Subject to MDB limit	Subject to MDB limit
Organ Transplants subject to MDB	Subject to MDB limit	Subject to MDB limit
Organ Transplants subject to donor and MDB	Subject to MDB limit	Subject to MDB limit
Renal Dialysis subject to MDB	Subject to MDB limit	Subject to MDB limit
Motor Vehicle Accident	Subject to overall IP limit	Subject to overall IP limit
Step Down/Rehabilitation	E40 000 per family	E45 000 per family
Medicines to take home	E920 per admission	E920 per admission
Appliances	E12 230 per family	E15 000 per family
Pathology and Medical Technology (inpatient)	E41 600 per family	E50 000 per family
Radiology (inpatient)	E24 500 per family	E32 000 per family

INPATIENT BENEFITS	COMPREHENSIVE 2024	COMPREHENSIVE PLUS 2024
Specialised Radiology PET Scan and PET – CT scan Bone densitometry within Radiology limit	Pre-auth required 1 per family per annum	Pre-auth required 1 per family per annum
Maxillofacial Surgeon	E90 000 per beneficiary per annum	E100 000 per beneficiary per annum
Dental Surgery (subject to conditions)	E25 000 per beneficiary per annum	E30 000 per beneficiary per annum
Maternity	E40 000 per family	E45 000 per family
Home Births	Not covered	Not covered
Neonatal, including neonatal ICU and related costs	E200 000 per family	E250 000 per family
Internal and external prosthesis	E 57 200 per annum, per family	E 70 000 per annum per family
Physiotherapy	E6 820 per family	E 20 000 per annum per family
Mental Health (in and out of Hospital)	E22 800 per family	E33 000 per family
Ambulance Services (In Country Only)	E15 170 per family	E35 000 per family
Air/Cross Borders Evacuation	E50 000 per beneficiary per annum	Covered in full, according to fund protocols
Non-surgical procedures and tests	Up to 100% of the Oracle Health eSwatini rates	Up to 100% of the Oracle Health eSwatini rates
Emergency/Casualty Care Benefit	E3 000 per beneficiary per annum	E4 000 per beneficiary per annum

Outpatient benefits

OUTPATIENT BENEFITS	COMPREHENSIVE 2024	COMPREHENSIVE PLUS 2024
Consultations (General Practitioners and Specialists)	E6 350 M0 E7 240 M1 E8 450 M2+	E8 400 M0 E9 520 M1 E11 200 M2+
Basic/ Ordinary & Restorative (Including Plastic Dentures, Dental Technicians and Dental Therapist) Joint limit with Advanced Dentistry	E2 150 M0 E3 930 M1 E5 560 M2+ E2 150 per beneficiary	E3 024 M0 E5 600 M1 E7 280 M2+ E3 024 per beneficiary
Advanced Dentistry/Oral Surgery (Inlays, crowns, Bridges, Study models, Metal base, Oral medicines by: Orthodontists, Periodontists, Prosthodontists, and dental technicians)	E5 250 M0 E8 970 M1 E12 440 M2+ E5 250 per beneficiary Subject to Pre-Authorisation	E7 168 M0 E11 760 M1 E16 240 M2+ E7 168 per beneficiary Subject to Pre-Authorisation
Chronic Medication Only cover for: asthma, allergic rhinitis, epilepsy, GORD, Hypertension, Diabetes (Type 1 &2), hyperlipidaemia, HIV Subject to registration *Mediscory Standard Formulary*	E3 720 M0 E6 900 M1 E9 400 M2+	E5 040 M0 E8 736 M1 E10 640 M2+
Acute Medication *Subject to Mediscory Standard Formulary*	E4 620 M0 E9 030 M1 E12 750 M+2	E6 267 M0 E11 984 M1 E16 800 M2+
Pharmacy Advised Therapy (OTC) Within acute medicine limit Schedule 0,1,2 only *Mediscory Standard Formulary*	E1 150 E2 150 E3 090 E300 per script	E1 680 M0 E3 136 M1 E4 480 M2+ E300 per script
Contraceptives Within acute medication limit *Mediscory Standard Formulary*	E1 660 per family	E1 860 per family
Optometry Frames, Lenses, Readers One in 24 months claiming period.	3 880 M0 5 580 M1 6 400 M2+ 3 880 per beneficiary	5376 M0 7840 M1 8736 M2+ 5 376 per beneficiary
Eye Examination	One per beneficiary per year at scheme tariff	One per beneficiary per year at scheme tariff

OUTPATIENT BENEFITS	COMPREHENSIVE 2024	COMPREHENSIVE PLUS 2024
Refractive Surgery (Radial Keratotomy/Excimer Laser)	E2 940 per family	E4 256 per family
Pathology and Medical Technology (outpatient)	E6 140 family	E8 400 per family
Pregnancy/Confinement Services (Consultants, Visits & Scans) Ante-natal consults are from the consultation benefit and scans are from the radiology benefit and scans are limited to two	4 x post-natal midwife consultation per pregnancy	4 x post-natal midwife consultation per pregnancy
Radiology & Radiography Out of Hospital Within In-Hospital Radiology CT scan & MRI is subject to pre-auth	E3 990 per family	E4 470 per family
Alcoholism and drug dependency	E1 940 per family	E2 700 per family
Alternative health care Practitioners & Paramedical Services (audiology, biokinetics, chiropractors (including X-Rays), dieticians, Genetic Counselling, hearing aid acousticians, homeopathy, naturopathy (including medicines), occupational therapy, Orthoptic, physiotherapy, podiatry & speech therapy)	E5 460 per family	E10 528 per family
Wellness Program	Limited to 1 GP consultation per beneficiary per annum. 1 GP consultation per beneficiary per annum covering: • GP consultation fee • Blood pressure • Cholesterol • Blood glucose • Papsmear for female beneficiaries • Prostate test for male beneficiaries • BMI • Osteoporosis screening • Mammogram for female beneficiaries • Flu vaccine • Pneumococcal vaccine	

Outpatient benefits

MONTHLY PREMIUM RATES	COMPREHENSIVE 2024	COMPREHENSIVE PLUS 2024
M	E3 111	E3 623
M+1	E4 381	E5 102
M+2	E4 892	E5 695
M+3	E5 142	E5 988
M+4	E5 262	E6 129
M+5 +	E5 604	E6 523
Special Dependent	E3 111	E3 813

Private members:

MONTHLY PREMIUM RATES	<60 YEARS COMPREHENSIVE 2024	<60 YEARS COMPREHENSIVE PLUS 2024
Principal Member	E3 277	E3 897
Adult Dependant	E1 640	E1 950
Child Dependant	E821	E978
Parent	E4 096	E4 870

Comprehensive and Comprehensive Plus members now have the options of adding a prepaid card to the options.

Savings levels per month:

E500 Savings | E1 000 Savings | E1 500 Savings | E2 000 Savings | E2 500 Savings | E3 000 Savings | E5 000 Savings

Cash Back

Health Client approved cash back from 2017-2023

E3 127 002.17 CASH BACK

Join Oracle Health today to enjoy exclusive benefits

ORACLE rewarder YOU DESERVE IT

STARTER • GROWTH • LIFESTYLE

Get a 10% No Claims Bonus on your inpatient Premiums

Claim back as much as 75% of your excess funds on your prepaid card

COMPREHENSIVE

Gets a 30% rebate if a member has low claims

(T&Cs apply, see page 28 of this brochure)

Your health is vital

Why should I use the health assessments provided?

Health assessments encourage health awareness, enhances quality of life, and gives you peace of mind through preventative care and early detection, health education and advice

Clicks Assessment

Visit any Clicks clinic to access the benefit

Retha Harding's Assessment

Book an appoint with Retha Harding to access the benefit. **Contact (+268) 7684 4552**

Wellness Programme Assessment

This is done by your local GP.
Contact (+268) 7808 1045 to get pre-authorisation

Funeral Benefits

Funerals are least expected, and they can be very costly...

Extend your funeral benefit up to E50 000 for yourself and your dependants.

INTERESTED? Here is how you can extend your cover:

E10,000

Oracle Health eSwatini has a **built-in funeral benefit** amounting to **E20 000**.

TOP UP

You can **top up** your funeral benefit **by E30 000** and **E50 000** when you join the scheme.

Increase your family benefit to **E30 000** for only **E20 per month**

OR

Increase your family benefit to **E50 000** for only **E60 per month**

ITEM	E20 000 BUILT IN FUNERAL	E30 000 TOP-UP	E50 000 TOP-UP
Additional Premium	–	E20	E60
Main Member	E20 000	E30 000	E50 000
Spouse	E20 000	E30 000	E50 000
14 years and older	E20 000	E30 000	E50 000
6 years and older but younger than 14	E10 000	E15 000	E25 000
Younger than 6 years	E5 000	E7 500	E12 500
Stillborn after 28 weeks	E5 000	E7 500	E12 500

Learn more about **how to claim funeral benefits** and **funeral claim submissions** on **page 19**

ORACLE rewarder
YOU DESERVE IT

Oracle Health members are part of the Rewarder discount programme. You get discounts at various stores.

Some of the discounts are:

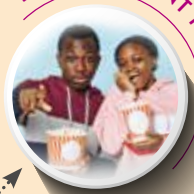
50%
off gym fees

Half price
movies
on a Monday and E10 off on any other day

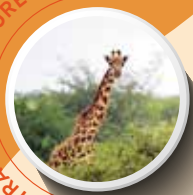
FASHION AND RETAIL PARTNERS

AUTOMOTIVE PARTNERS

ENTERTAINMENT PARTNERS



TRAVEL AND LEISURE



Produce the Oracle Health Membership card when paying and **get instant discounts.**

HEALTH AND BEAUTY PARTNERS

Visit www.oraclesz.com
To see the various discounts provided

1 JOINING ORACLE HEALTH ESWATINI

The benefit year for Oracle Health eSwatini runs from 1 January to 31 December. If your membership is effective from 1 January, the complete benefit as set out in the benefit structure will be granted.

If you join and your membership is effective after January, the benefits in the benefit structure will be pro-rated to reflect the number of months that you are enjoying benefits up to the end of the year.

All membership **Start Dates** are on the 1st of every month and all applications forms and documents must be submitted to our office by the 5th of every month cover for the month ahead.

2 DEPENDANTS

Who qualifies to be dependants?

- Your spouse or partner who is not a member or a registered dependant of another medical scheme;
- A dependent child who is not a member or a registered dependant of another medical scheme;
- Dependant blood relatives (immediate family) of a member (parents, brothers and sisters) in respect of whom the member is liable for family care and support and who has not yet reached the age of 60 years.

3 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 principle member or dependants.
- All documentation must be submitted within 6 months for processing.

4 GENERAL

- If you are an existing member of Oracle Health eSwatini you may retain your membership after retirement.
- New applicants aged 50 years and over will not be eligible for membership unless special approval for this has been granted by Oracle Health eSwatini. Such approval would need to be supported by medical reports provided by you and written approval by Oracle Health eSwatini. After an investigation of the doctor's report a general waiting period of six months, or a condition specific waiting period of 12 or 24 months can be applied if your application is accepted. Premium loading will apply. Your application may also be rejected.

Payment of Premiums

- If your premiums are not up to date, you are not entitled to any benefits and the health plan reserves the right suspend and terminate cover.
- Newly joined individual members are required to pay three months premium upfront.

AMENDMENTS TO MY COVER

How do I update or change my cover?

- Members can change their product option, savings levels, capitation 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.
- The deadline for amendments for the new calendar year is the 5th of January.

5 UNDERWRITING AND WAITING PERIODS

For individuals and groups less than 20 people, underwriting will apply.
New applicants joining an existing employer will be subject to underwriting.

In the light of the underwriting results the following waiting periods might apply:

- Six months general waiting period.
- Twelve month or twenty four months' condition specific waiting period.
- For all maternity benefits, a 12 month waiting period will apply.
- 12 – 24 months exclusion on admissions for undisclosed pre-existing conditions.
- Applicants that are 45 years and older are subject to submitting a medical report and premium loading may apply.
- Newborns are required to be registered within 30 days.
- Newborns registered after 30 days will be subject to underwriting.

6 MEDICAL SAVINGS ACCOUNT – PREPAID CARD

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 prepaid card. The amount that is loaded is dependant on the savings option which you have selected at application stage.

Your MSA is an excellent way of ensuring that you have enough money available to pay for your day-to-day medical needs. There are different 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 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 prepaid 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 Swazi Bank App at **https://portal.swazibank.co.sz/consumerSwaziBank/faces/consumer.xhtml**.

For easy access to the Swazi Bank portal, scan the QR code using your cellphone.

Are remaining medical savings refunded to 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** for assistance or visit your nearest Swazi Bank branch

What happens when my debit card gets lost?

The maximum number of debit cards is four, the first two are free and the other two cards come with an insurance fee/charge. If a card gets lost, call **(+268) 2411 7500** for assistance and you will get a new card at an extra charge.

7 PRE-AUTHORISATION

What is 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 (In-patient cases)
- Bone density scans
- Interventional radiology and specialised radiology
- Angiography
- Dental surgery

How is pre-authorisation obtained?

Pre-authorisation is obtained by calling:

Tel: **(+268) 7808 1045**
email: **oracleauths@mso.co.za**

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.

7 PRE-AUTHORISATION (continued)

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 normally not 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 emergency transfer to the nearest facility in-country and even outside the borders of eSwatini.

Health 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.

8 MATERNITY BENEFITS

What do I do when I fall pregnant?

- Once your pregnancy is confirmed by your service provider you are required to register at 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 6 months for processing.

9 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 what 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-authorization 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.

10 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.

10 PREVENTATIVE CARE BENEFIT (continued)

The table below sets out the Preventative Care benefit in detail:

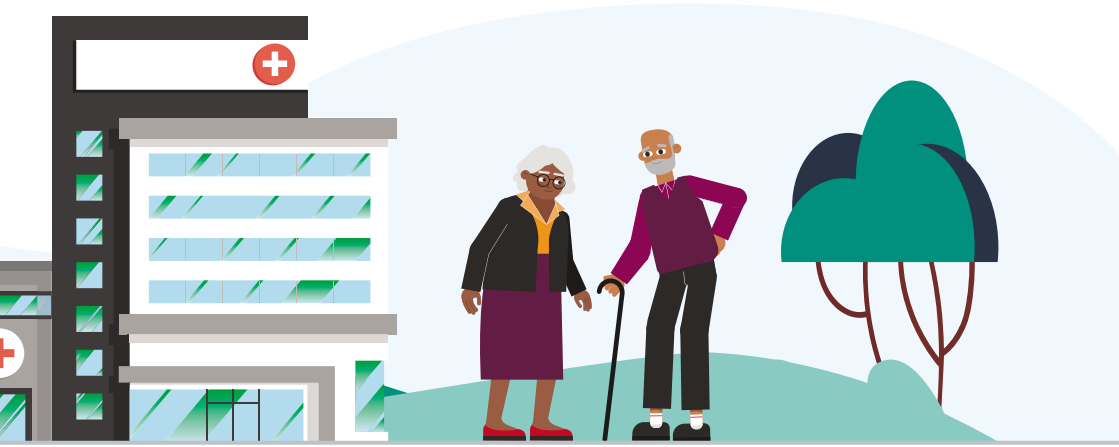
BENEFIT	WHO QUALIFIES?	HOW OFTEN?
1 GP consultation per beneficiary per annum		
General physical examination (GP consultation)	Beneficiaries 21 to 29	Once every 5 years
	Beneficiaries 30 to 59	Once every 3 years
	Beneficiaries 60 to 69	Once every 2 years
	Beneficiaries 70 and older	Once a year
Health assessment: Blood Pressure Test, cholesterol, and blood sugar tests (finger prick tests), BMI	All Principal members and adult beneficiaries	Once a year
Cholesterol test (pathologist) only covered if health assessment results indicate total cholesterol of 6mmol/L and above	All Principal members and adult beneficiaries	Once a year
Blood sugar (glucose) test (pathologist). Only covered if health assessment results indicate blood sugar levels of 11mmol/L and above	All Principal members and adult beneficiaries	Once a year
Pap smear (Pathologist) Consultation (GP or Gynaecologist)	Women 21 and older	Once every 2 years
Mammogram	Women 40 and older	Once every 2 years
Bone density scan	Beneficiaries 50 & older	Once every 3 years
Prostate specific antigen (pathologist)	Men 40 to 49	Once every 5 years
	Men 50 to 59	Once every 3 years
	Men 60 to 69	Once every 2 years
	Men 70 and older	Once a year
Flu vaccines	All beneficiaries older than 6 years old	Once a year
Pneumococcal vaccine	Beneficiaries 60 & older high-risk beneficiaries	Once a year

List of Hospitals

South African hospitals our members can access:

NETCARE	https://www.netcare.co.za/
MEDICLINIC	https://www.mediclinic.co.za
Life Healthcare	https://www.lifehealthcare.co.za/
NATIONAL HOSPITAL NETWORK	https://nhn.co.za/
JMH	https://www.jmh.co.za/
Clinix	https://www.clinix.co.za/

and many more...



Exclusions

BENEFITS EXCLUDED

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:

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.

Cash Benefits

No claim cash back bonus

Our no claims bonus is a bonus we pay to our members who have not claimed on their in-patient benefits. If you have not claimed in-patient benefits in a calendar year, we will pay you a 10% no claims bonus.

The process for the 10% no claims bonus is as follows:

01 The 10% no claims bonus will be **paid on the second week of April of every year.** The 10% no claims bonus will only be **paid or transferred to your debit card.**

02 EFT requests must be submitted by the **28th of February 2024.**

Medical savings refund

Cash back is the option we give our members once a year to withdraw surplus funds from their savings.

To claim your surplus funds from your savings account/debit card for that calendar year simply notify us by sending your request between the 5th of January and the 28th of January to the following email addresses:

@ **healthinfo@oraclesz.com** @ **eswatiniinfo@oraclesz.com**

Please make sure you send your request to both email addresses to avoid any inconveniences. It is vital that your request is seen by all email users.

Once all requests have been received, payments will be actioned from the 15th of February until the 5th of March. All balances must be verified after the last month of the health contribution year (December).

Note that You will have to have a minimum balance that equals 3 months of your monthly savings and the amount above the 3 months minimum balance can then be paid to you as surplus funds from savings/debit card.

No/Low Claim Bonus

What is a No/Low Claim Bonus?

A No/Low Claim bonus is a rebate that members are entitled to after the completion of Cover after a 12-month circle from January to December.

How does it work?

Members on the Comprehensive are entitled to a 30% No/Low Claim Bonus. Members must submit their request by the 31st of March 2024. Pay-out is from the 15th of July to the 31st of July 2024 after providers have submitted their claims for processing.

How is it calculated?

The Comprehensive option 30% rebate is calculated as follows:

- Total contributions for the Year (January to December) x 30% less Total claims paid for the Year.
- The bonus is the Surplus after the deduction of claims.

T&C's

- Premiums must be update date
- Members who have been on cover for one calendar year will qualify for Cash Benefits
- Cash benefit requests must be in writing or forms must be completed and submitted by the timelines stated
- Members who fail to bring their premiums up to date will forfeit the cash benefits

Glossary of Terms

1. *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.

2. *Oracle 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.

3. *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.

4. *Pro-Rata:*
   The monthly apportioning of benefit limits according to member benefit year exposure to a particular option.

5. *Cash Back Bonus:*
   If Oracle Health receives no claims on In-Patient benefits in a calendar year, 10% of your In-Patient base premium (premium allocated to In-Patient benefits) will be paid to the clients' savings. This will be accessible via your debit 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 debit card.

Notes

Protect what matters

ORACLE HEALTH
ESWATINI

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

Pre-authorisation: Tel (+268) 7808 1045

Claims email: oracleclaims@mso.co.za

Website: www.oracleinsurance.co

mso
medicalservicesorganisation
healthcare risk managers