ORACLE HEALTH
ESWATINI

ESWATINI BROCHURE

2022

No matter how much wealth you have, it is difficult to enjoy quality of life if you are not in good health. Oracle Health eSwatini helps you to safeguard and even improve your health, while also preserving and growing your wealth. From offering free preventative screenings, flexible savings accounts, discounted gym memberships and other rewards to a strong claim paying ability, and a philosophy that underpins the popularity of Oracle Health.

Oracle Heath eSwatini's roots date back to 2008 and it is owned by Vunani Capital (JSE listed Asset Managers) and Eswatini Bank. Its goal has always been to provide essential affordable health care to more people in eSwatini. It is truly an eSwatini registered company with accumulated funds and reserves being reinvested in eSwatini.

Vunani Capital is a leading BEE rated asset management company in South Africa with a presence in five African countries.

THE BENEFIT STRUCTURE

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

01

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.

02

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.

ORACLE HEALTH ESWATINI

Oracle Health has partnered with Medical Services Organisation (MSO, part of the Discovery Group), a leading provider of integrated health care risk management and third-party administration services and solutions to over a million beneficiaries throughout Africa.

MSO provides a 24/7 call centre for members who require hospitalisation.

The local call centre in eSwatini operates from Monday to Friday, 08h00 to 16h30 and all afterhours calls are re-directed to the International help desk.

Oracle Health eSwatini has secured agreements with all hospital groups in South Africa and eSwatini and this provides our members with direct access to those facilities.

These agreements include preferential discounted rates and agreed claims submission procedures.

03
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.

04
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.

05
REWARDS

This benefit provides members with a 10% no claims bonus in the event that 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 E10 000 to E50 000.

BENEFIT OPTIONS

PRODUCT	STARTER 2022	GROWTH 2022	LIFESTYLE 2022
Overall limit in-patient (IP)	E300 000 per family per annum E150 000 per beneficiary per annum	E1 000 000 per family per annum	E3 000 000 per family per annum
Executive/private ward	Not covered	Not covered	E1000 per day to a max of E5,000 per beneficiary per annum
High care and ICU	Subject to overall IP limit	Subject to overall IP limit	Subject to overall IP limit
Specialists and general practitioners	Subject to overall IP limit	Subject to overall IP limit	Subject to overall IP limit
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	7 days supply	7 days supply	7 days supply
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
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

PRODUCT	STARTER 2022	GROWTH 2022	LIFESTYLE 2022
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	E40,000 per family including E3,990 benefit for scans
Home Births	Not covered	Not covered	E25,000 payout into the MSA after the birth
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 per annum	Internal E50,000 per family per annum External prosthesis E30,000 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
Non-surgical procedures and tests	Up to 100% of the Oracle Health eSwatini rates	Up to 100% of the Oracle Health eSwatini rates	Up to 100% of the Oracle Health eSwatini rates
Air/cross border evacuation	Not covered	E50,000 per beneficiary per annum	Covered in full, according to fund protocols
Emergency/ Casualty Care Benefit	E2 000 per beneficiary per annum	E2 000 per beneficiary per annum	E3 000 per beneficiary per annum

BENEFIT OPTIONS

SPECIAL BENEFITS	STARTER 2022	GROWTH 2022	LIFESTYLE 2022
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 • Bone Density Screen • 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

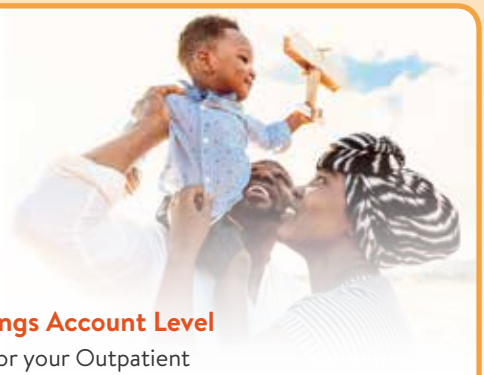
MONTHLY PREMIUM RATES			
M	473	1 103	1 726
M+1	774	1 519	2 408
M+2	889	1 703	2 696
M+3	1 276	1 819	2 962
M+4	1 357	1 853	3 054
M+5 +	2 015	2 015	3 274
Special Dependent	710	1 651	2 592

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.

We give you the freedom to structure and control your Outpatient



This is how it works:

01 **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
- E1000 Savings
- E1500 Savings
- E2000 Savings
- E2500 Savings
- E3000 Savings

02 **You can also opt to select a Capitation Plan (optional)**

This is an outpatient benefit that provides a specific offering at a dedicated provider

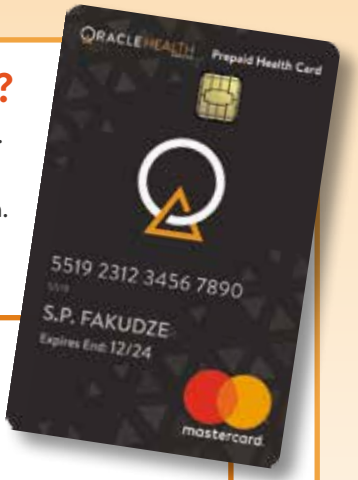
Cover yourself and your family

CAPITATION PLAN A	CAPITATION PLAN B
■ Unlimited access to a nurse ■ Limited access to a GP ■ Acute meds from a limited formulary ■ Chronic meds from a limited formulary	■ Unlimited access to a nurse and GP's ■ Acute meds from an extended formulary ■ Chronic meds from an extended formulary ■ 6 visits to specialists ■ Maternity benefits ■ Basic radiology, dentist, and optometry benefits

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 **E1000 per month**.
- 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 16

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 (A or B).
- You **choose a Designated Service Provider** (DSP).
- You may **visit the provider** to access health care services as per your chosen option plan.
- You can only **access** the **capitation 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

The process applies as follows:

01 Complete the Oracle Health application form.

02 Choose a capitation plan.

03 Choose a Designated Service Provider.

04 All application forms are subject to underwriting.

MONTHLY PREMIUM RATES	CAPITATION PLAN A 2022	CAPITATION PLAN B 2022
M	148	473
M+1	273	796
M+2	368	998
M+3	461	1200
M+4	555	1401
M+5	650	1603

CAPITATION BENEFIT SCHEDULE

SERVICE PROVIDERS

Current service providers that offer Capitation are as follows:

- Mbabane Clinic
- Matsapha Health Care
- Manzini Clinic

BENEFIT SCHEDULE	PLAN A	PLAN B
Primary care nurse practitioners	Full access to primary care nurse practitioners at the care centres	Full access to primary care nurse practitioners at the care centres
General practitioners	Limited access on referral by the nurse practitioners only to general practitioners at care centres	Full access to general practitioners at care centres and other contracted practices
Acute medicines	Medicines from Plan A Care Formulary	Medicines from Care Formulary
Chronic medicines	Medication for the treatment of high blood pressure, diabetes and asthma from the Plan A Care Formulary	Medication for the treatment of high blood pressure, diabetes and asthma from the Care Formulary
Specialists	None	Contracted specialists in eSwatini on referral from care centres or contracted practices and on approval of the medical director for consultations only. Six visits / annum
Maternity	None	Outpatient benefits only. Limited to three prenatal scans and four specialist visits per event.
Pathology	Basic room tests only. Urine dipsticks, blood glucose and haemoglobin	Basic room tests only. Urine dipsticks, blood glucose and haemoglobin
Radiology	None	Basic black and white radiology
Dentist	None	Scaling, extractions & uncomplicated fillings (6 months waiting period)
Contracted Optometrists	None	Eye examinations / spectacles single vision lenses (basic frames) once every 2 years per beneficiary
HIV treatment	Basic treatment, counselling and management	Basic treatment, counselling and management
Physiotherapy	None	On referral
Other ancillary services	None	None

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-authorization 48 hours in advance**:

Contact details are:

Email: capitationservices@clinicgrp.co.sz
Tel: (+268) 2404 7500
WhatsApp: (+268) 7808 6075

Get Cash Back

Get a 10% No Claims Bonus on your inpatient Premiums

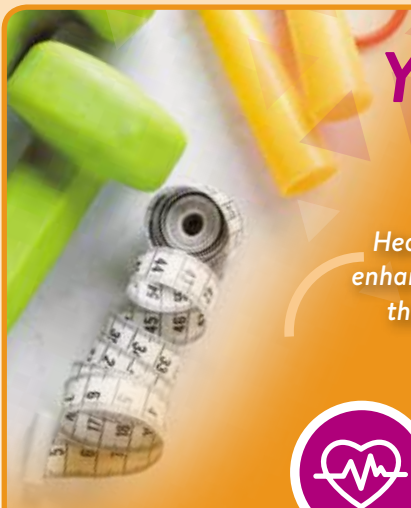
Claim back as much as 75% of your excess funds on your prepaid card

(T&Cs apply, see page 24 of this brochure)

Join Oracle Health today to enjoy exclusive benefits

rewarder
YOU DESERVE IT

LEARN MORE ON PAGE 24



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

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 **E10 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 **E60 per month**

OR

Increase your family benefit to **E50,000** for only **E120 per month**

ITEM	BUILT- IN FUNERAL	E30 000 TOP-UP	E50 000 TOP-UP
Additional monthly premium	–	60.00	120.00
Main member	10 000	30 000	50 000
Spouse	10 000	30 000	50 000
16 years and older	10 000	30 000	50 000
6 years and older but younger than 16	5 000	15 000	25 000
Children 1 - 5	2 500	7 500	12 500
Children 0 - 11 months	2 500	7 500	12 500
Stillborn after 28 weeks	2 500	7 500	12 500

LEARN MORE ABOUT **HOW TO CLAIM FUNERAL BENEFITS** AND **FUNERAL CLAIM SUBMISSIONS** ON **PAGE 14**

rewarder
YOU DESERVE IT

Oracle Insure Rewarder rewards you for being a member of Oracle Health.

As a member you get discounts at over 20 partner outlets including:

TRAVEL AND LEISURE

AUTOMOTIVE PARTNERS

FASHION AND RETAIL PARTNERS

ENTERTAINMENT PARTNERS

HEALTH AND BEAUTY PARTNERS

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

Visit www.oracleinsurance.co
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 three months, or a condition specific waiting period of 12 or 24 months can be applied if your application is accepted. 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.

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 14 people, underwriting will apply.

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.
- Applicates that are 45 years and older are subject to submitting a medical report.

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. Starter has a savings cap of E1 000.

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) 2404 1369** 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) 2404 1369** 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:

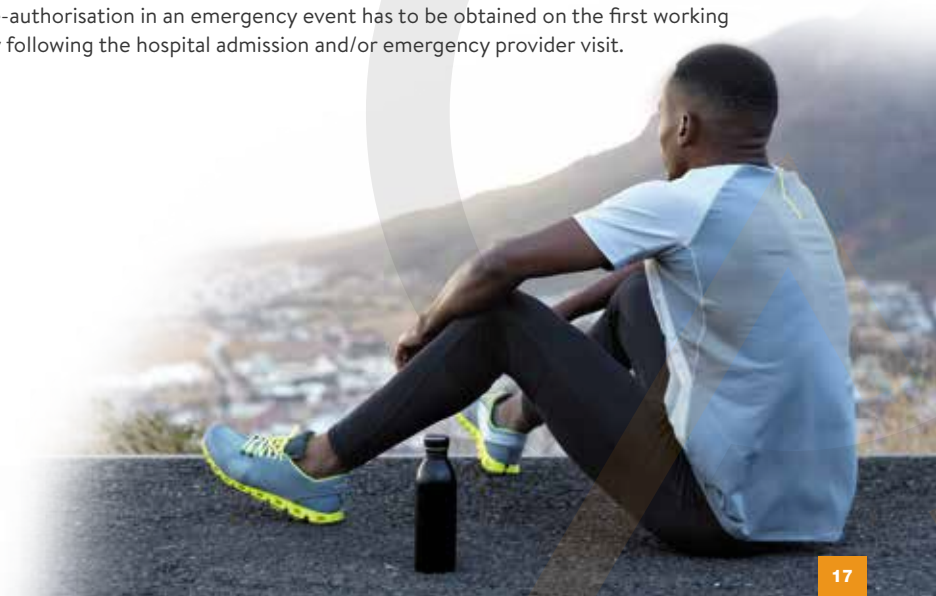
Tel: **(+268) 7808 1045** or **(+27) 11 259 5403** for after hours or

email: **eswatiniauths@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 notify the health scheme.
- You must provide, how many weeks you are and when is the expected due date.

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. The pay-out is subject to the new-born baby being added to the main member's medical aid.

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.

10 WELLNESS BENEFIT

What is a Wellness benefit?

The purpose of the wellness 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 WELLNESS BENEFIT (continued)

The table below sets out the wellness 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 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. This includes the costs of treatment or surgery related to transsexual procedures;
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;

GLOSSARY OF TERMS

1. *Emergency medical condition* means 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.

NO CLAIM CASH BACK BONUS

(10% No Claims 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 Members who have been **on cover for 1 calendar year** will qualify for the **10% cashback**

NB: The no claims bonus will only be processed for members whose premiums are up to date.

MEDICAL SAVINGS REFUND

(Medical Savings)

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

To claim your surplus funds from your savings account/debit card for that particular 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. The reason is that we need to verify the balances on the cards in January 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.

NB: the cashback will only be processed for members whose premiums are up to date.

Building up your balance in your savings account/debit card is important to make sure you have enough funds for your daily out-patient needs.

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