

EMERALD BENEFITS PLAN				
COVERED SERVICES	EMERALD			
medical emmergency services	COVERED			
outpatient services	General + Specialist consultation (10)			
inpatient medical services	semi private ward (20 days cumulative)			
malaria	COVERED			
- Typhoid	COVERED			
- ENDOCRINE / METABOLIC DISORDERS	COVERED			
- ALLERGIES	COVERED			
- MEASLES	COVERED			
- CHICKEN POX	COVERED			
- URINARY TRACT INFECTION	COVERED			
. Uncomplicated urinary tract infection	COVERED			
- PEPTIC ULCER DISEASE	COVERED			
. Acute exacerbation of peptic ulcer disease	COVERED			
- INDIGESTION	COVERED			
- UPPER AND LOWER RESPIRATORY TRACT INFECTION	COVERED			
. Pneumonia	COVERED			
. Bronchitis	COVERED			
. Influenza	COVERED			
. Viral Croup	COVERED			
. Bronchiolitis	COVERED			
. Tonsillitis	COVERED			
- ASTHMA	COVERED			
Catarrh and cold	COVERED			
HIV/AIDS investigation for confirmation	COVERED			
INVESTIGATIONS				
. PCV	COVERED			
. MP	COVERED			
. WIDAL	COVERED			
. FBC + DIFF	COVERED			
. SERUM PREGNANCY TEST(BLOOD)	COVERED			
. URINE PREGNANCY TEST (URINE)	COVERED			
. ESR	COVERED			
. RBS/FBS	COVERED			
. URINALYSIS	COVERED			
. M/C/S (URINE, SPUTUM, CSF, WOUND SWAB)	COVERED			
. E/U/CR	COVERED			
. BLOOD GROUP AND GENOTYPE	COVERED			
. HBSAg	COVERED			
. HBV / HCV	COVERED			
. H. PYLORI	COVERED			
. COOMB'S TEST	COVERED			
. BLOOD CULTURE	COVERED			
. PERIPHERIAL BLOOD FILM	COVERED			
. CLOTING PROFILE	COVERED			
. BLEEDING TIME	COVERED			
. INR	COVERED			
. D- DIMER	COVERED			
. FECAL OCCULT BLOOD	COVERED			
. FERRITIN LEVELS	COVERED			
. HbA1c	COVERED			
. LFT	COVERED			
. KFT	COVERED			
MATERNITY AND CHILD SERVICES				
Confirmation of pregnancy	COVERED			
Antenatal Care (from 12weeks)	COVERED			
Management of labor and delivery	COVERED			
Surgical intervention	COVERED			
Postnatal care	COVERED			
Febrile convulsions	COVERED			
Routine immunization services	COVERED			
ICU/SCBU (1 st 24Hrs and monetary limit 50,000)	COVERED			
SURGICAL SERVICES				
Minor Procedures	COVERED			
Intermediate procedures	COVERED			
Major procedures	Surgical limit = 200,000 for individual			
EYE SERVICES				
Basic eye examination (only)	COVERED			
. Stye	COVERED			
. Conjunctivitis	COVERED			
. ocular allergies	COVERED			
. keratitis	COVERED			
Optical Lens Limit (Biennial)	15,000			
Eye surgeries (minor)	COVERED			
Eye surgery (intermediate)	COVERED			
Eye surgeries (Major)	NOT COVERED			
DENTAL CARE				
TREATMENT OF MINOR AILMENTS	COVERED			
. Gingivitis	COVERED			
. Scurvy	COVERED			
. Tooth pain	COVERED			
Simple Extraction	COVERED			
Routine pain management	COVERED			
Amalgam filling	COVERED			
Scaling and polishing	COVERED			
Denture and bridges	50% COVERED			
RCT	COVERED			
Surgical extraction	15,000			
RADIOLOGICAL SERVICES				
X-rays and Ultrasound	COVERED			
CT Scan & MRI (50% co-payment)	EMERGENCY + ONCE			
Echocardiography	COVERED			
Electrocardiography	NOT COVERED			
Doppler scan	30% COVERED			
PHYSIOTHERAPY				
Sessions	5			
MEDICAL CHECK UP				
Annual Medical Examination	45% copayment on investigations			
PRESCRIBE MEDICATION	Generic			
ADDED BENEFITS				
Family planning services	COVERED			
Renal dialysis (Monetary limit of 30,000)	NOT COVERED			
Infertility consultation, investigation and non-hormonal drug management	COVERED			
Blood pressure, diabetes and sickle cell anemia can be managed based on plan of choice.	COVERED			
PREMIUM PER ANNUM				
SINGLE INDIVIDUAL	N55,000.00			
FAMILY (MAXIMUM OF 4)	N300,000.00			
ADDITIONAL DEPENDANT EACH	N55,000.00			
ADDITIONAL BENEFITS				
	COVERED			
Feeding (N1500.00 Per day)				
Gym services	Once a week			
Ambulance services	Hospital, accident scene			
Mortuary services	Ten days			