TOPAZ BENFITS PLAN

COVERED SERVICES	TOPAZ
medical emmergency services	COVERED
outpatient services	General consultation +one specialist
inpatient medical services	General ward (10)
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	NOT COVERED
. HBV / HCV	NOT COVERED
. H. PYLORI	NOT COVERED
. COOMB'S TEST	NOT COVERED
. BLOOD CULTURE	NOT COVERED
. PERIPHERIAL BLOOD FILM	NOT COVERED
. CLOTING PROFILE	NOT COVERED
. BLEEDING TIME	NOT COVERED
. INR	NOT COVERED
. D- DIMER	NOT COVERED
. FECAL OCCULT BLOOD	NOT COVERED
. FERRITIN LEVELS	NOT COVERED
. HbA1c	NOT COVERED
. LFT	NOT COVERED
. KFT	NOT COVERED
MATERNITY AND CHILD SERVICES	
Confirmation of pregnancy	COVERED
Antenatal Care (from 12weeks)	COVERED
Management of labor and delivery	NOT COVERED
Surgical intervention	NOT COVERED
Postnatal care	NOT COVERED
Febrile convulsions	COVERED
Routine immunization services	COVERED
ICU/SCBU (1st 24Hrs and monetary limit 50,000)	NOT COVERED
SURGICAL SERVICES	
Minor Procedures	COVERED
Intermediate procedures	NOT COVERED
Major procedures	NOT COVERED
EYE SERVICES	
Basic eye examination (only)	COVERED
. Stye	COVERED
. Conjunctivitis	COVERED
. ocular allergies	COVERED
. keratitis	COVERED
Optical Lens Limit (Biennial)	5,000
Eye surgeries (minor)	NOT COVERED
Eye surgery (intermediate)	NOT 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	NOT COVERED
Scaling and polishing	NOT COVERED
Denture and bridges	NOT COVERED
RCT	NOT COVERED
Surgical extraction	5000
RADIOLOGICAL SERVICES	
X-rays and Ultrasound	COVERED
CT Scan & MRI (50% co-payment)	NOT COVERED
Echocardiography	NOT COVERED
Electrocardiography	NOT COVERED
Doppler scan	NOT COVERED
PHYSIOTHERAPHY	
Sessions	0
MEDICAL CHECK UP	
Annual Medical Examination	NOT COVERED
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	NOT COVERED
Blood pressure, diabetes and sickle cell anemia can be managed based on plan of choice.	NOT COVERED
PREMIUM PER ANNUM	
SINGLE INDIVIDUAL	N40,500.00
FAMILY (MAXIMUM OF 4)	N150,000.00
ADDITIONAL DEPENDANT EACH	N20,000.00
ADDITIONAL BENEFITS	
	COVERED
Feeding (N1500.00 Per day)	
Gym services	NOT COVERED
Ambulance services	NOT COVERED
Mortuary services	NOT COVERED