



## RETAIL ALTH BENEFITS PLAN/PREMI

	SILVER RETAIL	GOLD RETAIL	DIAMOND RETAIL
INDIVIDUAL	55,013	84,854.00	112,200.00
FAMILY	275,065	424,270.00	561,000.00
HOSPITAL TIERS	BAND C	BAND B + C	BAND B + C
TOTAL ANNUAL LIMIT	1,000,000	2,500,000	4,000,000

### GENERAL MEDICAL SERVICES

General/non-specialist consultations and treatments (including prescribed medications)	COVERED	COVERED	COVERED
Accommodation for in-patient care	10 DAYS	15 DAYS	21 DAYS
Hospital Ward Care	GENERAL WARD	SEMI-PRIVATE WARD	SEMI-PRIVATE WARD
Feeding for enrollees on admission	NOT COVERED	COVERED	COVERED
Accommodation for parents whose infants are on admission		5 DAYS	7 DAYS

### ACCIDENT AND EMERGENCY CARE

Resuscitative care for accident and emergency cases	100,000 24 HOURS	200,000 24 HOURS	350,000 48 HOURS
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### HEAMATOLOGY

Hemoglobin (HB)	COVERED	COVERED	COVERED
Packed Cell Volume (PCV)	COVERED	COVERED	COVERED
Pregnancy test	COVERED	COVERED	COVERED
Full Blood Count and differentials (FBC)	COVERED	COVERED	COVERED
White Blood Cell count	COVERED	COVERED	COVERED
Red Blood Cell/Reticulocyte count	COVERED	COVERED	COVERED
Grouping and Cross Matching	COVERED	COVERED	COVERED
Genotype (on request by clinician)	COVERED	COVERED	COVERED
Blood group (on request by clinician)	COVERED	COVERED	COVERED

Erythrocyte Sedimentation Rate (ESR)	COVERED	COVERED	COVERED
Blood Pregnancy (Beta HCG) Test	COVERED	COVERED	COVERED
Blood Film	NOT COVERED	COVERED	COVERED

Subject to in and out  
patient limit

Subject to in and out  
patient limit

Subject to in and out  
patient limit

## MICROBIOLOGY/ PARASITOLOGY

Malaria Parasite (MP)	COVERED	COVERED	COVERED
Microscopy			
Stool/Urine	COVERED	COVERED	COVERED
Endocervical (ECS)/High Vaginal (HVS)/ Urethral Swab	COVERED	COVERED	COVERED
Throat/ Ear/ Wound/ Eye/ Sputum Swab	COVERED	COVERED	COVERED
VDRL (Venereal Disease Research Laboratory) test	COVERED	COVERED	COVERED
H.Pylori	COVERED	COVERED	COVERED
Mantoux/Heaf's Test	COVERED	COVERED	COVERED
Blood Culture	NOT COVERED	COVERED	COVERED
Stool Occult Blood	NOT COVERED	COVERED	COVERED

Subject to in and out  
patient limit

Subject to in and out  
patient limit

Subject to in and out  
patient limit

## CHEMISTRY INVESTIGATIONS

Fasting/Random Blood Sugar (FBS)/(RBS)	COVERED	COVERED	COVERED
2 Hours Post-prandial Blood Sugar	COVERED	COVERED	COVERED
Oral Glucose Tolerance Test (OGTT)	COVERED	COVERED	COVERED
Electrolytes, Urea and Creatinine (E/U/Cr)	COVERED	COVERED	COVERED
Serum Bicarbonate/Alkaline Phosphate/Acid Phosphate/Inorganic Phosphate	COVERED	COVERED	COVERED
Serum Bilirubin (Total and Direct)/Albumin	COVERED	COVERED	COVERED
Prothrombin time (PT/INR)	COVERED	COVERED	COVERED
Urine Pregnancy Test	COVERED	COVERED	COVERED
Lipid Profile (Cholesterol, HDL, LDL, Triglyceride Profile)	COVERED	COVERED	COVERED
Liver Function Test (LFT)	NOT COVERED	COVERED	COVERED

Subject to in and out  
patient limit

Subject to in and out  
patient limit

Subject to in and out  
patient limit

## BASIC DIAGNOSTIC IMAGING

X-Rays (All)	COVERED	COVERED	COVERED
Ultrasound Scans	COVERED	COVERED	COVERED

## HIV CARE/TREATMENT

Specialist Consultation	COVERED	COVERED	COVERED
Specialist Drug therapy	COVERED	COVERED	COVERED
Counselling Sessions	COVERED	COVERED	COVERED
Screening and Testings	COVERED	COVERED	COVERED

Subject to in and out patient limit to in and out patient limit to in and out patient limit

## OBSTETRICS/NEONATAL CARE

Family Planning	IUCD/INJECTIBLES/PILLS	IUCD/INJECTIBLES/PILLS	COVERED
Antenatal Care (SPECIALIST CARE AND ANC DRUGS)	COVERED	COVERED	COVERED
Delivery (SVD/NORMAL and COMPLICATED)	CARE LIMIT 150,000	CARE LIMIT 250,000	CARE LIMIT 500,000
CAESARIAN SECTION (C/S)			
Neonatal / Special Baby Care Unit	48 HOURS	5 DAYS	10 DAYS

## IMMUNIZATION

NPI	COVERED	COVERED	COVERED
Non-NPI	NOT COVERED	COVERED	COVERED
Adult immunization	NOT COVERED	NOT COVERED	COVERED

## INFERTILITY CARE

Fertility Specialist Consultation and Counselling	1 SESSION	2 SESSION	3 SESSIONS
Fertility Investigations	NOT COVERED	NOT COVERED	CARE LIMIT 200,000

## SPECIALIST MEDICAL SERVICES

General Consultations	COVERED	COVERED	COVERED
Specialist Consultations (Group 1) Family Medicine Obstetrics/Gynaecology	4 PER ANNUM	6 PER ANNUM	8 PER ANNUM

Cardiology Paediatrics General Surgery

## Specialist Consultations (Group 2)

Orthopedics	NOT COVERED	NOT COVERED	6 PER ANNUM
Endocrinology			
Haematology			
Maxillofacial Surgery			
Dermatology			
Neurology			
Urology			
ENT Surgery			

Gastroenterology			
Oncology			
Chronic Disease Management	Subject to In patient limit	Subject to In patient limit	Subject to In patient limit
<b>ADVANCED DIAGNOSTIC IMAGING</b>			
ECG (PRE AND POST EXERCISE)	COVERED	COVERED	COVERED
Colonoscopy/Endoscopy (Upper GI/Lower GI/ERCP)	NOT COVERED	1 PER ANNUM	1 PER ANNUM
Laryngoscopy/Bronchoscopy/Thoracoscopy	NOT COVERED	NOT COVERED	1 PER ANNUM
Hysteroscopy/Cystoscopy/Laparoscopy/Arthroscopy	NOT COVERED	NOT COVERED	1 PER ANNUM
Sigmoidoscopy/Enteroscopy/Gastroscopy	NOT COVERED	NOT COVERED	1 PER ANNUM
Doppler Ultrasound Scan	NOT COVERED	NOT COVERED	2 PER ANNUM
Echocardiography	NOT COVERED	1 PER ANNUM	2 PER ANNUM
CT Scan/MRI	NOT COVERED	1 PER ANNUM	2 PER ANNUM
<b>ADVANCED LABORATORY INVESTIGATION</b>			
Blood urea Nitrogen	COVERED	COVERED	COVERED
Hepatitis			
Hepatitis B Surface Antigen (HBsAg)	COVERED	COVERED	COVERED
Hepatitis C Screening	COVERED	COVERED	COVERED
Hepatitis B Screening	COVERED	COVERED	COVERED
Microscopy/Culture/Sensitivity (M/C/S)			
CSF Analysis	COVERED	COVERED	COVERED
Semen	COVERED	COVERED	COVERED
Thyroid Function Tests	COVERED	COVERED	COVERED
Serum Uric Acid	COVERED	COVERED	COVERED
24 Hour Creatinine Clearance	NOT COVERED	COVERED	COVERED
Pap Smear and Cytology	NOT COVERED	COVERED	COVERED
Prostate Specific Antigen	NOT COVERED	COVERED	COVERED
(HbA1C)	NOT COVERED	COVERED	COVERED
D-Dimer	NOT COVERED	COVERED	COVERED
G-6PD Screening	NOT COVERED	COVERED	COVERED
Creatinine phosphokinase	NOT COVERED	COVERED	COVERED
Serum Iron	NOT COVERED	COVERED	COVERED
Osmotic Fragility Test	NOT COVERED	COVERED	COVERED
Chlamydia Screening	NOT COVERED	COVERED	COVERED

Seminal Fluid Analysis (SFA)	NOT COVERED	NOT COVERED	COVERED
Syphilis Screening	NOT COVERED	NOT COVERED	COVERED
Protein Electrophoresis	NOT COVERED	NOT COVERED	COVERED
Coomb's Test (Indirect/Indirect)	NOT COVERED	NOT COVERED	COVERED
Serum immunoglobulins/Antibodies	NOT COVERED	NOT COVERED	NOT COVERED
Immunofluorescence assay	NOT COVERED	NOT COVERED	NOT COVERED

Subject to in and out  
patient limit

Subject to in and out  
patient limit

Subject to in and out  
patient limit

### PHYSIOTHERAPY CARE

Specialist Consultation	COVERED	COVERED	COVERED
Supportive Devices (i.e. Cervical Collar and Crutches)	NOT COVERED	NOT COVERED	NIGERIAN MADE
Walker	NOT COVERED	NOT COVERED	NOT COVERED
Number of Sessions Covered	5 Sessions per annum	10 Sessions per annum	15 Sessions per annum

### ENT ( OTOLARYNGOLOGICAL SERVICES)

Treatment of ENT diseases and removal of foreign bodies

COVERED

COVERED

COVERED

### SURGERIES

MINOR SURGERIES			
INTERMEDIATE SURGERIES	N250,000 PER ANNUM	N300,,000 PER ANNUM	N500,000 PER ANNUM
MAJOR SURGERIES			

### INTENSIVE CARE

ICU and ICU-related Care

COVERED (FOR 24 HOURS)

COVERED (FOR 24 HOURS)

COVERED (FOR 72  
HOURS)

### EYE/OPTICAL CARE

Specialist Ophthalmologist Consultation	COVERED	COVERED	COVERED
Basic ocular tests (Tonometry/Intra-Ocular Pressure, Refraction, Fundoscopy, Pachymetry, and Slit Lamp)	COVERED	COVERED	COVERED
Advanced Ocular tests (Central Visual Field, Indirect Ophthalmoscopy, Depth Perception Test, Shirmer's Tear Test, Amsler Test, Retina Photography, OCT Scan, A Scan, B Scan)	NOT COVERED	NOT COVERED	COVERED, 1 PER ANNUM
Lenses and Frames (Including Contact lenses)	UP TO 10, 000 ANNUAL LIMIT	UP TO 30, 000 ANNUAL LIMIT	UP TO 60, 000 ANNUAL LIMIT
Eye Surgery (Minor/Intermediate/Major)	NOT COVERED	NOT COVERED	SURGICAL LIMITS APPLIES

### DENTAL CARE

Specialist Consultation	ALL DENTAL CARE COVERED UP TO ANNUAL LIMIT OF 50,000 NAIRA	ALL DENTAL CARE COVERED UP TO ANNUAL LIMIT OF 150,000 NAIRA	ALL DENTAL CARE COVERED UP TO ANNUAL LIMIT OF 250,000 NAIRA
Routine dental examination			
Preventive dental care and counselling			
Dental pain therapy			
Access to prescribed drugs			
Surgical/Non-Surgical extraction			
Root Canal Therapy			
Scaling and Polishing			
Operculectomy			
Gingival Curettage			
Composite/Amalgam Filling			
Incision and Drainage			

### CANCER CARE

Oncologist/ Cancer Specialist visits	NOT COVERED	ALL CANCER CARE COVERED UP TO 100,000 NAIRA PER ANNUM	ALL CANCER CARE COVERED UP TO 200,,000 NAIRA PER ANNUM
Oncological investigations			
Cancer-related Radiological investigations			
Chemotherapy			
Surgical cancer care			

### RENAL CARE (DIALYSIS)

Dialysis and all related care	NOT COVERED	COVERED (3 SESSIONS PER YEAR)	COVERED (6 SESSIONS PER YEAR)
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### WELLNESS CHECKS

BMI Check	COVERED	COVERED	COVERED
General Physical Examination	COVERED	COVERED	COVERED
Blood Pressure Check (Hypertension Screening)	COVERED	COVERED	COVERED
Blood Sugar Check (Diabetes Screening)	COVERED	COVERED	COVERED
Blood Cholesterol Check	COVERED	COVERED	COVERED
Annual Visual Acuity Check (Using Snellen Chart)	COVERED	COVERED	COVERED
Urinalysis	COVERED	COVERED	COVERED
Chest X-ray	NOT COVERED	COVERED	COVERED

Pap Smear	NOT COVERED	COVERED	COVERED
PSA Check (For Men ≥ 40 years of age)	NOT COVERED	COVERED	COVERED
Mammography (For Women ≥ 40 years of age)	NOT COVERED	COVERED	COVERED
Liver Function Test	NOT COVERED	NOT COVERED	COVERED
Kidney Function Tests (E, U, and Cr)	NOT COVERED	NOT COVERED	COVERED

### MENTAL CARE

Mental illness care with certified psychiatrists	4 SESSIONS	6 SESSIONS	10 SESSIONS
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### AMBULANCE SERVICES

Movement of patients to and fro Hospital	COVERED	COVERED	COVERED
Movement of patients to and fro Home to Hospital	NOT COVERED	NOT COVERED	NOT COVERED

### ADDITIONAL BENEFITS

#### GYM

Access to gyms for regular exercise	DISCOUNTED ACCESS	1 SESSION PER WEEK	2 SESSION PER WEEK
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#### SPA

#### Facials

DISCOUNTED ACCESS	DISCOUNTED ACCESS	1 SESSION PER YEAR
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#### Massage

DISCOUNTED ACCESS	DISCOUNTED ACCESS	1 SESSION PER YEAR
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### DRUG DELIVERY / REFILLS

COVERED	COVERED	COVERED
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### TELEMEDICINE/ TELECONSULTATIONS

COVERED	COVERED	COVERED
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### HEMOCARE SERVICES

NOT COVERED	NOT COVERED	NOT COVERED
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### IN - PATIENT CARE

300,000	500,000	1,000,000
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### OUT - PATIENT CARE

150,000	250,000	500,000
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One year moratorium

### ANTENATAL, CARE DELIVERY AND POSTNATAL CARE

One year moratorium

One year moratorium

( 12 months moratorium applies)

One year moratorium on pre-existing conditions

One year moratorium on pre-existing conditions

One year moratorium on pre-existing conditions

	150,000	250,000	500,000
Dental Care ( Secondary Care)	20,000	60,000	80,000

**\*\*All tests must be Pre-authorised by CROWN  
JEWEL HMO**

### **GENERAL EXCLUSIONS**

The following exclusions are applicable to all the plans

- Cosmetic Surgery
- Dental Prosthesis
- Dental & Surgical Implants
- Domiciliary/Hospice Care
- Alternative /Unorthodox medicine

Neonatal care not listed under neonatal services

- Self-inflicted injuries

Congenital abnormalities for children not born on the plan

Injured by an act of war, an epidemic or Enrolee participating in a riot

Services primarily for weight reduction or treatment of obesity

- Treatment of substance abuse

Professional Sports and wilful exposure to needless danger

- School admission test

- Stem cell transplant or bone marrow transplant

- Laparoscopic surgery

- Epidural for normal delivery

Procedures, management and investigations not covered by the plan