Mitera HMO SME Plans

miterahealth®

Accredited by the National Health Insurance Authority (NHIA)

MITERA HMO CORPORATE PLANS	MI LITE	MI CLASSIC	MI GOLD	MI GOLD PLUS	MI DIAMOND
Coverage for one person (annual payment)	**103,000**	**151,800**	**251,900**	**379,100**	**730,700**
Coverage for a family (annual payment)	**412,000**	**607,200**	**1,007,600**	**1,516,400**	**2,922,800**
Hospital access level (quality of facility available)	BAND D	BAND C AND D	BAND B,C,D	BAND A,B,C,D	BAND A,B,C,D
MAXIMUM YEARLY BENEFIT Each person can use up to this limit yearly (not shareable)	**2,000,000 NGN**	**3,500,000 NGN**	**5,000,000 NGN**	**7,000,000 NGN**	**10,000,000**
VISITS TO PRIMARY CARE DOCTORS	Covered	Covered	Covered	Covered	Covered
Consultation with a general practitioner (GP)	✓	✓	✓	✓	✓
Registration fees and general examination	✓	✓	✓	✓	✓
Medical certifications and occupational examinations	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
SPECIALIST CONSULTATIONS	Covered	Covered	Covered	Covered	Covered
Allergist / Immunologist	✓	✓	✓	✓	✓
Anesthesiologist	✓	✓	✓	✓	✓
Benign Hematologist	✓	✓	✓	✓	✓
Cardiologist	✓	✓	✓	✓	✓
Dermatologist	✓	✓	✓	✓	✓
Endocrinologist	✓	✓	✓	✓	✓
Family Medicine Physician	✓	✓	✓	✓	✓
Gastroenterologist	✓	✓	✓	✓	✓
General Surgeon	✓	✓	✓	✓	✓
Gynaecologist / Obstetrician	✓	✓	✓	✓	✓
Neurologist	✓	✓	✓	✓	✓
Nephrologist	✓	✓	✓	✓	✓
Oncologist	✓	✓	✓	✓	✓
Ophthalmologist	✓	✓	✓	✓	✓
Orthopedic Surgeon	✓	✓	✓	✓	✓
Otolaryngologist (ENT Specialist)	✓	✓	✓	✓	✓
Pediatrician and non-surgical pediatric specialists	✓	✓	✓	✓	✓
Psychiatrist	✓	✓	✓	✓	✓
Pulmonologist	✓	✓	✓	✓	✓
Radiologist	✓	✓	✓	✓	✓
Rheumatologist	✓	✓	✓	✓	✓
Urologist	✓	✓	✓	✓	✓

PRESCRIBED MEDICATIONS (ACUTE AND OTC MEDICATIONS)	One session per year	Two session per year	Covered	Covered	Covered
Antibiotics (for infections, excluding recurrent or prophylactic use)	✓	✓	✓	✓	✓
Antihistamines (for acute allergic reactions; not for chronic urticaria or allergic rhinitis)	✓	✓	✓	✓	✓
Antidiarrheal agents (short-term use in acute diarrheal illness)	✓	✓	✓	✓	✓
Anthelmintic medications (e.g., for deworming or parasitic infections)	✓	✓	✓	✓	✓
Non-steroidal anti-inflammatory drugs (NSAIDs) and Paracetamol (for pain, fever, or inflammation)	✓	✓	✓	✓	✓
Vitamins and minerals (e.g., Vitamin C, B-complex, Calcium, Iron, Potassium, Zinc) only when there is documented evidence of acute medical necessity (e.g., acute deficiency, postoperative support)	✓	✓	✓	✓	✓
Antimalarials (e.g., for confirmed or suspected malaria treatment)	✓	✓	✓	✓	✓
Antacid and acid-suppressing medications (e.g., for gastritis, dyspepsia—not long-term GERD management)	✓	✓	✓	✓	✓
Antifungal agents (topical or systemic, for acute infections)	✓	✓	✓	✓	✓
Antispasmodic medications (e.g., for gastrointestinal or urogenital spasm)	✓	✓	✓	✓	✓
Oral benzodiazepines (for short-term management of acute anxiety, seizures, or procedural sedation)	✓	✓	✓	✓	✓
Antiemetic medications (for nausea and vomiting, including during acute illness or chemotherapy)	✓	✓	✓	✓	✓
Opioid pain medications (for acute, severe pain episodes; not for chronic pain management)	✓	✓	✓	✓	✓
Muscle relaxants (e.g., for acute musculoskeletal spasm or injury)	✓	✓	✓	✓	✓
Antiviral medications (e.g., for influenza, herpes simplex, or other acute viral infections)	✓	✓	✓	✓	✓
Nebulized treatments for acute reactive airway conditions	✓	✓	✓	✓	✓

PRESCRIBED MEDICATIONS FOR CHRONIC ILLNESSES	300,000NGN LIMIT	750,000NGN LIMIT	1,000,000 NGN LIMIT	1,500,000 NGN LIMIT	2,500,000 NGN LIMIT
Antihypertensive medications (diuretics, beta blockers, calcium channel blockers, ACE inhibitors)	✓	✓	✓	✓	✓
Antidiabetic (antiglycemic) medications (biguanides, sulfonylureas, meglintindes, TZDs and gliptins)	✓	✓	✓	✓	✓
Insulin and supplies (e.g., insulin preparations, syringes, pen needles)	✓	✓	✓	✓	✓
COX-2 inhibitors and selective NSAIDs	✓	✓	✓	✓	✓
Proton pump inhibitors (PPIs)	✓	✓	✓	✓	✓
Antidepressants (e.g., SSRIs, SNRIs, tricyclic antidepressants) and other chronic psychiatric drugs	✓	✓	✓	✓	✓

Asthma maintenance medications	✓	✓	✓	✓	✓
Statins and other lipid-lowering agents	✓	✓	✓	✓	✓
Platelet inhibitors and anticoagulants	✓	✓	✓	✓	✓
Diuretics	✓	✓	✓	✓	✓
Antiepileptic medications	✓	✓	✓	✓	✓
Neuropathic pain treatments	✓	✓	✓	✓	✓
Alpha blockers	✓	✓	✓	✓	✓
Thyroid hormone treatments	✓	✓	✓	✓	✓
Hydroxyurea	✓	✓	✓	✓	✓
Migraine prophylaxis and maintenance treatments	✓	✓	✓	✓	✓
Recurring prescriptions for acute medications longer than 3 months.	✓	✓	✓	✓	✓
TELEMEDICINE CONSULTATIONS	Covered	Covered	Covered	Covered	Covered
Teleconsulation with qualified and certified Doctors on Mapp	✓	✓	✓	✓	✓
ACCIDENT AND EMERGENCY CARE	Covered	Covered	Covered	Covered	Covered
Resuscitative Care for Accident and Emergency Cases	✓	✓	✓	✓	✓
Road Ambulance Transportation Movement of patients to and from a hospital, including: Roadside to Hospital, Home to Hospital, Hospital to Hospital transfers, transport from accident scene to the hospital.	✓	✓	✓	✓	✓
AIR Movement of patients to and from Hospital	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
INTENSIVE CARE UNIT	500,000 NGN Limit	1,000,000 NGN Limit	1,500,000 NGN Limit	2,500,000 NGN Limit	3,000,000 NGN Limit
ICU Room fees, service charges and ICU-related Monitoring and Care	Covered	Covered	Covered	Covered	Covered
Resuscitation Procedure	✓	✓	✓	✓	✓
Arterial Blood Gases	✓	✓	✓	✓	✓
Endotrachael intubation, positive airway pressure and ventilator management	✓	✓	✓	✓	✓
Pressors, paralytics and inotropes infusions	✓	✓	✓	✓	✓
IN-PATIENT SERVICES	20 DAY LIMIT	25 DAY LIMIT	30 DAY LIMIT	COVERED	COVERED
Admissions	Covered (General Ward)	Covered (Semi-Private Ward)	Covered (Private Ward)	Covered (Private Ward)	Covered (Private Ward)
Skilled medical and paramedical services FEES	✓	✓	✓	✓	✓
Fluids intravenous/intramuscular administration	✓	✓	✓	✓	✓
Supply of all medical and surgical consumables for inpatient and outpatient care outside of OR	✓	✓	✓	✓	✓
Blood transfusion	✓	✓	✓	✓	✓

Oxygen administration	✓	✓	✓	✓	✓
Accommodation for parents whose infants are on admission	2 Days Limit	3 Days Limit	4 Days Limit	5 Days Limit	7 Days Limit
BASIC LAB TESTS (HAEMATOLOGY, CHEMISTRY AND MICROBIOLOGY	Covered	Covered	Covered	Covered	Covered
Hemoglobin (HB)	✓	✓	✓	✓	✓
Packed Cell Volume (PCV)	✓	✓	✓	✓	✓
White cell count (Total and Differential)	✓	✓	✓	✓	✓
Full Blood Count and differentials (FBC)	✓	✓	✓	✓	✓
White Blood Cell count	✓	✓	✓	✓	✓
Red Blood Cell/Reticulocyte count	✓	✓	✓	✓	✓
Grouping and Cross Matching (on request by clinician)	✓	✓	✓	✓	✓
Genotype (on request by clinician)	✓	✓	✓	✓	✓
Erythrocyte Sedimentation Rate (ESR)	✓	✓	✓	✓	✓
Osmotic Fragility Test	✓	✓	✓	✓	✓
MCHC	✓	✓	✓	✓	✓
MCH	✓	✓	✓	✓	✓
MCV	✓	✓	✓	✓	✓
Blood Film	✓	✓	✓	✓	✓
Urine and Blood Pregnancy (Beta HCG) Test	✓	✓	✓	✓	✓
Blood Sugar Tests (fasting, random, post-prandial)	✓	✓	✓	✓	✓
Glucose Challenge Test	✓	✓	✓	✓	✓
Electrolytes, Urea and Creatinine	✓	✓	✓	✓	✓
Vitamin Level Measurement	✓	✓	✓	✓	✓
Lipid Profile (Fasting) (Cholesterol, HDL, LDL, Triglyceride Profile	✓	✓	✓	✓	✓
Amylase/ Lipase measurement	✓	✓	✓	✓	✓
Liver Function Test (LFT)	✓	✓	✓	✓	✓
Serum Sodium	✓	✓	✓	✓	✓
Serum Calcium	✓	✓	✓	✓	✓
Serum Magnesium	✓	✓	✓	✓	✓
Serum Potasium	✓	✓	✓	✓	✓
Serum Lithium	✓	✓	✓	✓	✓
Serum Chloride	✓	✓	✓	✓	✓
Serum Bicarbonate	✓	✓	✓	✓	✓
Serum Alkaline Phosphate	✓	✓	✓	✓	✓
Serum Acid Phosphate	✓	✓	✓	✓	✓

Serum Bilirubin (Total and Direct)	✓	✓	✓	✓	✓
Serum Albumin or protein	✓	✓	✓	✓	✓
Serum Lactate Dehydrogenase	✓	✓	✓	✓	✓
Serum Gamma Glutamyl Transferase	✓	✓	✓	✓	✓
Prothrombin time (PT/INR)	✓	✓	✓	✓	✓
Urinalysis and urine chemistries	✓	✓	✓	✓	✓
Malaria Parasite (MP)	✓	✓	✓	✓	✓
Urine M/C/S	✓	✓	✓	✓	✓
Endocervical Swab (ECS) M/C/S	✓	✓	✓	✓	✓
High Vaginal Swab (HVS) M/C/S	✓	✓	✓	✓	✓
Urethral Swab M/C/S	✓	✓	✓	✓	✓
Throat Swab M/C/S	✓	✓	✓	✓	✓
Ear Swab M/C/S	✓	✓	✓	✓	✓
Wound Swab M/C/S	✓	✓	✓	✓	✓
Eye Swab M/C/S	✓	✓	✓	✓	✓
Sputum M/C/S	✓	✓	✓	✓	✓
Aspirates M/C/S	✓	✓	✓	✓	✓
Stool M/C/S	✓	✓	✓	✓	✓
VDRL (Veneral Disease Research Laboratory) Test	✓	✓	✓	✓	✓
H.Pylori (serum antigen or antibody)	✓	✓	✓	✓	✓
Trypanosomes screening	✓	✓	✓	✓	✓
Toxoplasma Screening	✓	✓	✓	✓	✓
Skin Snip for Microfilaria	✓	✓	✓	✓	✓
Skin Scraping for Fungi	✓	✓	✓	✓	✓
Leishmania Screening	✓	✓	✓	✓	✓
Mantoux/Heaf's Test	✓	✓	✓	✓	✓
Blood Culture	✓	✓	✓	✓	✓
Stool Occult Blood	✓	✓	✓	✓	✓
Stool and Urine Microscopy	✓	✓	✓	✓	✓
Hepatitis B and C Screening Tests (Hep B surface antigen, antibody, core antigen	✓	✓	✓	✓	✓
HIV Screening	✓	✓	✓	✓	✓
Widal and other outdated or low-value investigations (e.g., Weil-Felix, non-specific urine/stool microscopy, unconfirmed rapid tests, unsupported tumor markers	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

BASIC DIAGNOSTIC IMAGING AND PROCEDURES	Covered	Covered	Covered	Covered	Covered
Chest X-Rays	✓	✓	✓	✓	✓
Abdominal X-Rays	✓	✓	✓	✓	✓
Limbs (Hand,Forearm,Upper arm, Thigh and Leg) X-rays	✓	✓	✓	✓	✓
Neck X-rays	✓	✓	✓	✓	✓
Sinus X-rays	✓	✓	✓	✓	✓
Cervical Spine X-rays	✓	✓	✓	✓	✓
Skull X-rays	✓	✓	✓	✓	✓
Pelvic X-rays	✓	✓	✓	✓	✓
Thoracic Inlet X-rays	✓	✓	✓	✓	✓
Thoraco-Lumbar X-rays	✓	✓	✓	✓	✓
Lumbosacral X-Rays	✓	✓	✓	✓	✓
X-rays of All Body Joints	✓	✓	✓	✓	✓
Routine Ultrasound Scans (Obstetrics; Abdominal, Pelvic, Abdominopelvic, Breast, Testicular/ Scrotal, Thyroid, Prostate, Bladder, Transvaginal and Brain Ultrasound Scans)	✓	✓	✓	✓	✓
12 Lead Electrocardiogram (ECG)	✓	✓	✓	✓	✓

ADVANCED LABORATORY INVESTIGATIONS	500,000 NGN LIMIT	750,000 NGN LIMIT	1,000,000 NGN LIMIT	1,500,000 NGN LIMIT	2,500,000 NGN LIMIT
Blood Urea Nitrogen (BUN)	✓	✓	✓	✓	✓
Glycated Hemoglobin (HbA1c)	✓	✓	✓	✓	✓
HIV Confirmatory Test	✓	✓	✓	✓	✓
Hepatitis B/C Confirmatory Tests	✓	✓	✓	✓	✓
C-Reactive Protein (CRP)	✓	✓	✓	✓	✓
G6PD Deficiency Screening	✓	✓	✓	✓	✓
Thyroid Function Tests (TSH, Free T4 ± Free T3)	✓	✓	✓	✓	✓
Uric Acid	✓	✓	✓	✓	✓
Creatine Kinase (CK/CPK)	✓	✓	✓	✓	✓
Syphilis Screening (RPR/VDRL)	✓	✓	✓	✓	✓
Malaria QBC Concentration (Fluorescent Stain)	✓	✓	✓	✓	✓
Body Fluid Microscopy/Culture/ Sensitivity (M/C/S)	✓	✓	✓	✓	✓
Iron Studies (Serum Iron, TIBC, Transferrin, Ferritin)	✓	✓	✓	✓	✓
24-Hour Creatinine Clearance	✓	✓	✓	✓	✓
Chlamydia/Gonorrhea Testing (NAAT)	✓	✓	✓	✓	✓

Clotting Time (CT)	✓	✓	✓	✓	✓
Bleeding Time (BT)	✓	✓	✓	✓	✓
D-Dimer	✓	✓	✓	✓	✓
Sputum AFB Smear/Microscopy	✓	✓	✓	✓	✓
H. pylori Test (Stool Antigen or Urea Breath Test)	✓	✓	✓	✓	✓
Cardiac Biomarkers Panel (Troponin, CK-MB, BNP, NT-proBNP, hs-CRP, ApoB/ ApoA1)	✓	✓	✓	✓	✓
Drugs of abuse screen	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
ADVANCED DIAGNOSTIC IMAGING AND PROCEDURES	One session per year	Two session per year	Three sessions per year	Covered	Covered
Doppler Ultrasound Scan	✓	✓	✓	✓	✓
CT Scan	✓	✓	✓	✓	✓
MRI	✓	✓	✓	✓	✓
Echocardiography	✓	✓	✓	✓	✓
Proctoscopy	✓	✓	✓	✓	✓
Sigmoidoscopy	✓	✓	✓	✓	✓
Upper GI Endoscopy	✓	✓	✓	✓	✓
Endoscopic Ultrasound	✓	✓	✓	✓	✓
Enteroscopy	✓	✓	✓	✓	✓
Gastroscopy	✓	✓	✓	✓	✓
Colonoscopy	✓	✓	✓	✓	✓
Laryngoscopy (Direct and Indirect)	✓	✓	✓	✓	✓
Bronchoscopy	✓	✓	✓	✓	✓
Thoracoscopy	✓	✓	✓	✓	✓
Hysteroscopy	✓	✓	✓	✓	✓
Cystoscopy	✓	✓	✓	✓	✓
Arthroscopy	✓	✓	✓	✓	✓
Mammogram	✓	✓	✓	✓	✓
Nuclear Stress Test (myocardial perfusion imaging)	✓	✓	✓	✓	✓
Urodynamic Testing	✓	✓	✓	✓	✓
Hysterosalpingography (HSG)	✓	✓	✓	✓	✓
Dual-Energy X-Ray Absorptiometry (DEXA)	✓	✓	✓	✓	✓
Holter and Ambulatory Electrocardiogram	✓	✓	✓	✓	✓
Audiology assements (i.e. Pure tone audiometry, tympanometry, otoacoustic emissions)	✓	✓	✓	✓	✓

SURGICAL SERVICES	150,000 NGN LIMIT	200,000 NGN LIMIT	400,000 NGN LIMIT	700,000 NGN LIMIT	1,000,000 NGN LIMIT
General Surgery Consultation	✓	✓	✓	✓	✓
Anesthesiology Consultation	✓	✓	✓	✓	✓
Cardiothoracic Surgery Consultation	✓	✓	✓	✓	✓
ENT (Otorhinolaryngology) Consultation	✓	✓	✓	✓	✓
Urology Consultation	✓	✓	✓	✓	✓
Orthopedic Surgeon Consultation	✓	✓	✓	✓	✓
Interventional Cardiology Consultation	✓	✓	✓	✓	✓
Interventional Radiology Consultation	✓	✓	✓	✓	✓
Wound care (suture insertion/removal, dressing)	✓	✓	✓	✓	✓
Foreign body removal (skin, soft tissue, or superficial sites)	✓	✓	✓	✓	✓
Incision and drainage of abscesses	✓	✓	✓	✓	✓
Arthrocentesis and intra-articular injections	✓	✓	✓	✓	✓
Simple biopsies (needle, excisional, FNAC, bone marrow)	✓	✓	✓	✓	✓
Debridement, irrigation, or marsupialization of minor lesions	✓	✓	✓	✓	✓
General Surgery Procedures (appendedctomy, hernia repair, cholestectomy, lysis of adhesions, gastric lavage)	✓	✓	✓	✓	✓
Urologic Procedures (Catheterization (placement, change, removal), Urethral dilatation, Hydrocelectomy, orchidopexy and varicocelectomy, Vasectomy) or Laser lithotripsy (for stones >20 mm))	✓	✓	✓	✓	✓
Gynecologic Procedures (myometctomy, hysterectomy, tubal ligation)	✓	✓	✓	✓	✓
Anesthesia - local, regional and global	✓	✓	✓	✓	✓
OR consumables associated with covered surgery and procedure	✓	✓	✓	✓	✓
Operating Room or Theatre Fees	✓	✓	✓	✓	✓
ENT procedures (Ear Syringing, adenoidectomy)	✓	✓	✓	✓	✓
Amputation	✓	✓	✓	✓	✓
POP Casting and Immbolization, REMOVAL	✓	✓	✓	✓	✓
Thyroidectomy	✓	✓	✓	✓	✓
Open and Close Reduction of Fractures or Dislocations	✓	✓	✓	✓	✓
Endoscopic retrograde cholangiopancreatography (ERCP)	✓	✓	✓	✓	✓
Orchidopexy	✓	✓	✓	✓	✓
Neurosurgeon Consultation	✓	✓	✓	✓	✓

Plastic Surgery Consultations	NOT COVERED				
Cardiac and Cardiothoracic Surgeries (including CABG, valve repair and replacement, electrophysiology procedures and pericardial window)					
Foetal Surgery including intrauterine procedures					
Liver procedures including resections, shunts and hepatobiliary surgeries for trauma.					
Interventional Radiology procedures (Image guided including endoscopic, fluroscopic, ultrasound guidance procedures)					
Neurosurgeries including craniotomy, aneurysms, spinal surgies, shunts and implants.					
Organ transplant including heart, lung, liver, kidney, pancreas, bone marrow/HSCT and corneal procedures.					
Shunt procedures including VP, LP, biliary and dialysis related.					
Joint replacements and spinal fusion					
Plastic surgery procedures including resections, grafts, reconstructions and repairs					
Bariatric Surgery					
Vascular Surgeries including Bypass					
Keloid excision and intralesional steroid injection					

OPTICAL CARE					
Specialist Opthalmologist Consultation	✓	✓	✓	✓	✓
Basic ocular tests (Tonometry/Intra-Ocular Pressure, Refraction, Fundoscopy, Pachymetry, and Slit Lamp)	✓	✓	✓	✓	✓
Advanced Ocular tests (Central Visual Field, Indirect Opthalmoscopy, Depth Perception Test, Shirmer's Tear Test, Amsler Test, Retina Photography, OCT Scan, A Scan, B Scan)	✓	✓	✓	✓	✓
Eye drops and optical medications	✓	✓	✓	✓	✓
Lenses and Frames (ONCE EVERY 2 YEARS)	10,000	15,000	30,000	40,000	60,000
Eye Surgeries (Treatment of glaucoma and Cataract extraction, corneal grafts, retinal detachment, pterygium excision, foreign body)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

DENTAL CARE	25,000 NGN Limit	40,000 NGN Limit	100,000 NGN Limit	150,000 NGN Limit	200,000 NGN Limit
Dental Consultation and routine examination	✓	✓	✓	✓	✓
Preventive dental care and counselling	✓	✓	✓	✓	✓
Dental pain therapy, nerve blocks	✓	✓	✓	✓	✓
Surgical & Non-surgical extraction	✓	✓	✓	✓	✓
Root Canal Therapy, Composite Filling, Amalgam Filling, Operculectmy, Gingival Curettage, Incision & Drainage, Scaling & Polishing	✓	✓	✓	✓	✓
Oral and Maxillofacial Surgeon	✓	✓	✓	✓	✓
Mandibles/Temporomandibular Joint X-Rays or other dental imaging	✓	✓	✓	✓	✓
Cosmetic Consultations and Procedures	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Orthodontic Treatment	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Prosthetics, and bone grafting	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

ENT SERVICES					
Treatment for ENT diseases	✓	✓	✓	✓	✓
ENT surgery (Subject to overall surgical limit)	✓	✓	✓	✓	✓

MENTAL HEALTH MANAGEMENT					
Mental illness care with certified psychiatrists (Outpatient)	Covered (6 Sessions Per Year)	Covered (8 Sessions Per Year)	Covered (12 Sessions Per Year)	Covered (12 Sessions Per Year)	Covered (15 Sessions Per Year)
Inpatient psychiatry treatment	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Employee Assistance Programme (EAP)	Covered	Covered	Covered	Covered	Covered

LIFESTYLE MANAGEMENT					
Access to gyms for regular exercise	Not Covered	1 Sessions Per Year	1 Sessions Per Year	1 Sessions Per Year	1 Sessions Per Year
SPA (Facials OR Body Massage)	Not Covered	1 Sessions Per Year	1 Sessions Per Year	1 Sessions Per Year	1 Sessions Per Year
Access to ifitness gyms	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Dietician/Nutritionist	Not Covered	Covered	Covered	Covered	Covered

OBSTETRICS AND GYNAECOLOGY	150,000 NGN LIMIT	200,000 NGN LIMIT	250,000 NGN LIMIT	300,000 NGN LIMIT	500,000 NGN LIMIT
Antenatal Care Registration	✓	✓	✓	✓	✓
Oral Glucose Tolerance Test (OGTT)	✓	✓	✓	✓	✓
Delivery – Spontaneous Vaginal Delivery (Normal and Complicated)	✓	✓	✓	✓	✓
Delivery (MULTIPLE)	✓	✓	✓	✓	✓
Assisted Delivery	✓	✓	✓	✓	✓
Therapeutic Abortion (Manual Vacuum Aspiration, Diletation and Curretage)	✓	✓	✓	✓	✓
Peri-Natal Obstetric Procedures (Cerclage, Amniocentesis, Fetal blood sampling, Extra cephalic Version, episiotomy repair)	✓	✓	✓	✓	✓
CAESARIAN SECTION	✓	✓	✓	✓	✓
Obstetrician Consultation	✓	✓	✓	✓	✓
Oxytocin Administration	✓	✓	✓	✓	✓
Foetal Surgery including intrauterine procedures	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

POST NATAL CARE 6 WEEKS (ONLY ON PLANS WITH ANTENATAL CARE AND DELIVERY COVERAGE)	25,000 NGN LIMIT	35,000 NGN LIMIT	50,000 NGN LIMIT	70,000 NGN LIMIT	100,000 NGN LIMIT
Routine Neonatal Care (First 6 Weeks)	✓	✓	✓	✓	✓
Essential Neonatal Immunizations (OPV, Hepatitis B, BCG)	✓	✓	✓	✓	✓
Incubator Support	✓	✓	✓	✓	✓
Phototherapy for Neonatal Jaundice	✓	✓	✓	✓	✓
Infant Circumcision (Medically Indicated)	✓	✓	✓	✓	✓
Bilirubin Level Assessment	✓	✓	✓	✓	✓

NEONATAL INTENSIVE CARE AND INCUBATORS (ONLY ON PLANS WITH ANTENATAL CARE AND DELIVERY COVERAGE)	500,000 NGN LIMIT	1,000,000 NGN LIMIT	2,500,000 NGN LIMIT	3,500,000 NGN LIMIT	5,000,000 NGN LIMIT
Neonatologist	✓	✓	✓	✓	✓
NICU Room fees, service charges and NICU-related Monitoring and Care	✓	✓	✓	✓	✓
Resuscitation Procedure	✓	✓	✓	✓	✓
Arterial Blood Gases	✓	✓	✓	✓	✓
Endotrachael intubation, positive airway pressure and ventilator management	✓	✓	✓	✓	✓
Pressors, paralytics and inotropes infusions	✓	✓	✓	✓	✓
Congenital anomaly treatment (for children born on the plan)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

INFERTILITY MANAGEMENT	Not Covered	100,000 NGN Limit	150,000 NGN Limit	200,000 NGN Limit	250,000 NGN Limit
Fertility Specialist Consultation and Counselling	Not Covered	Covered	Covered	Covered	Covered
Fertility Investigations (USS, SFA, etc)	Not Covered	Covered	Covered	Covered	Covered
Seminal Fluid Analysis (SFA)	Not Covered	Covered	Covered	Covered	Covered
Female reproductive hormone profile (FSH, LH, E2, Progesterone, Prolactin, AMH, Testosterone, DHEA)	Not Covered	Covered	Covered	Covered	Covered
Male Reproductive Hormone Profile (FSH, LH, Testosterone, Prolactin, SHBG, E2)	Not Covered	Covered	Covered	Covered	Covered
Reproductive Hormone replacement therapies	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Fertility Treatment	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

BASIC IMMUNIZATIONS	Covered	Covered	Covered	Covered	Covered
Bacillus Calmette-Guérin (BCG)	✓	✓	✓	✓	✓
Oral Polio Vaccine (OPV)	✓	✓	✓	✓	✓
Inactivated Polio Vaccine (IPV)	✓	✓	✓	✓	✓
Pentavalent Vaccine (DPT-HepB-Hib)	✓	✓	✓	✓	✓
Haemophilus influenzae type B (Hib)	✓	✓	✓	✓	✓
Hepatitis B	✓	✓	✓	✓	✓
Diphtheria, Pertussis, Tetanus (DPT) Booster	✓	✓	✓	✓	✓
Measles	✓	✓	✓	✓	✓
Yellow Fever	✓	✓	✓	✓	✓
Meningitis A (MenA)	✓	✓	✓	✓	✓
Vitamin A Supplementation	✓	✓	✓	✓	✓
Tetanus, Diphtheria (Td) Booster	✓	✓	✓	✓	✓
Tetanus, Diphtheria, and Pertussis (Tdap) Booster	✓	✓	✓	✓	✓

SECONDARY IMMUNIZATIONS	ONE SESSION PER YEAR	TWO SESSIONS PER YEAR	THREE SESSIONS PER YEAR	FOUR SESSIONS PER YEAR	FIVE SESSIONS PER YEAR
Pneumococcal Conjugate Vaccine (PCV 10/13)	✓	✓	✓	✓	✓
Rotavirus Vaccine	✓	✓	✓	✓	✓
Human Papillomavirus (HPV) Vaccine	✓	✓	✓	✓	✓
Influenza (Flu) Vaccine	✓	✓	✓	✓	✓
Measles, Mumps, Rubella (MMR)	✓	✓	✓	✓	✓
Varicella (Chickenpox) Vaccine	✓	✓	✓	✓	✓
Meningitis ACWY	✓	✓	✓	✓	✓
Typhoid Vaccine	✓	✓	✓	✓	✓
Cholera Vaccine	✓	✓	✓	✓	✓
Rabies Vaccine	✓	✓	✓	✓	✓

FAMILY PLANNING					
Contraceptive pills	Not Covered	Covered	Covered	Covered	Covered
Implants - Implanon, Norplant, Jadelle	Not Covered	Covered	Covered	Covered	Covered
Copper T Intrauterine Device, Injectibles (Depo Provera,Noristerat)	Not Covered	Covered	Covered	Covered	Covered

WELLNESS CHECK(Principal & Spouse)					
BMI Check	✓	✓	✓	✓	✓
General Physical Examination	✓	✓	✓	✓	✓
Blood Pressure Check (Hypertension Screening)	✓	✓	✓	✓	✓
Blood Sugar Check (Diabetes Screening)	✓	✓	✓	✓	✓
Blood Cholesterol Check	✓	✓	✓	✓	✓
Annual Visual Acuity Check (Using Snellen Chart)	✓	✓	✓	✓	✓
Urinalysis	✓	✓	✓	✓	✓
Chest X-ray	✓	✓	✓	✓	✓
Mammography every 2 years (For Women ≥ 40 years of age)	Not Covered	Covered	Covered	Covered	Covered
Pap smear every 2 years for females >35 years	Not Covered	Covered	Covered	Covered	Covered
PSA Check (For Men ≥ 40 years of age)	Not Covered	Covered	Covered	Covered	Covered
Liver Function Test	Not Covered	Not Covered	Covered	Covered	Covered
Kidney Function Tests (E, U, and Cr)	Not Covered	Not Covered	Covered	Covered	Covered

PHYSIOTHERAPY SERVICESS	6 Sessions Per Year	12 Sessions Per Year	18 Sessions Per Year	24 Sessions Per Year	30 Sessions Per Year
Physiotherapy Consultation	✓	✓	✓	✓	✓
Routine fitness examination	✓	✓	✓	✓	✓
Preventive Counselling on referral	✓	✓	✓	✓	✓
Pain therapy	✓	✓	✓	✓	✓

DURABLE MEDICAL EQUIPMENT	30,000 NGN Limit	75,000 NGN Limit	150,000 NGN Limit	300,000 NGN Limit	500,000 NGN Limit
Cervical Collar and Crutches	Covered	Covered	Covered	Covered	Covered
Brace, splint, support device	✓	✓	✓	✓	✓
Glucometer	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Sphygmomanometer/BP machine	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Compression stockings	Covered	Covered	Covered	Covered	Covered
Hearing Aids	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Prosthetic limbs and Orthothic Devices	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

CANCER CARE	100,000 NGN Per Year	150,000 NGN Per Year	300,000 NGN Per Year	500,000 NGN Per Year	750,000 NGN Per Year
Oncology Specialist Consultations (Medical & Surgical Oncology)	✓	✓	✓	✓	✓
Advanced Tumor Marker Panel	✓	✓	✓	✓	✓
Oncology Molecular & Genetic Diagnostics	✓	✓	✓	✓	✓
Oncology Imaging & Radiological Studies (PET-CT/PET-MRI, Bone Scan, Nuclear Medicine)	✓	✓	✓	✓	✓
Surgical Oncology Procedures	✓	✓	✓	✓	✓
Chemotherapy & Oncology Pharmacotherapy	✓	✓	✓	✓	✓
RENAL CARE (DIALYSIS)					
Dialysis and all related care for Late Stage Kidney Disease	2 Sessions Per Year	4 Sessions Per Year	6 Sessions Per Year	8 Sessions Per Year	10 Sessions Per Year
MORTUARY SERVICES	Not Covered	50,000 NGN Per FAMILY	100,000 NGN Per FAMILY	100,000 NGN Per FAMILY	100,000 NGN Per FAMILY
After-demise compensation/ Mortuary Fees	Not Covered	✓	✓	✓	✓

SCHEDULE B – POLICY EXCLUSIONS (NON-COVERED SERVICES)

Exclusions and limits apply to all costs associated with benefits, diagnoses, or services that are not covered under this policy. Services include all drugs, equipment, devices, treatments, therapeutic procedures, and diagnostic procedures required to treat the excluded or limited benefit category or diagnosis.

If a benefit category, service, or diagnosis is not covered, all related services necessary for its treatment will also be excluded, even if those services would otherwise be covered under different circumstances. Non-covered services can still be accessed through our approved providers via our TPA (Third-Party Administrator) service platform.

Except otherwise specifically stated, any services or benefits not listed in (Schedule A) are automatically excluded from coverage under this policy in addition to the following:

Medical examinations, services and supplies.	The following medical examinations services and supplies are excluded from coverage under this policy unless otherwise stated in schedule A, including but Not limited to: Educational or Licensing Examinations Employment-Related Examinations Medical examinations conducted for the purposes of obtaining, maintaining, or certifying fitness for employment, including any tests, screenings, or related procedures required by employers or potential employers. Medical examinations required as part of admission into schools, compliance with school obligations, or as a condition for obtaining professional licenses, certifications, or insurance coverage.
Non-Covered DME	Non-Covered Durable Medical Equipment Preventive and Non-Essential Services: Services unrelated to medical improvement or patient care. Provision, rental, or repair of durable medical equipment, prosthetics, orthotics, hearing aids, or similar devices unless explicitly listed as Covered under Schedule A of this policy.
Advanced surgeries	The following advanced surgical procedures and any associated costs are excluded from coverage under this policy unless otherwise stated in Schedule A, including but Not limited to: Cardiac and Cardiothoracic Surgeries: Surgical interventions involving the heart, major blood vessels, or chest cavity. Foetal Surgeries: Any surgical procedures performed on a foetus in utero. Liver Surgeries: Surgical procedures involving the liver, including but Not limited to resections and other complex interventions. Neurosurgeries: Surgical procedures involving the brain, spinal cord, or peripheral nerves. Organ Transplants: Transplantation of organs or tissues, including but Not limited to heart, liver, kidney, lung, pancreas, and bone marrow transplants. Shunt Operations: Procedures involving the placement, adjustment, or removal of shunts, including those for cerebrospinal fluid drainage. Subspecialist Surgeries and Procedures: Surgeries or medical procedures performed by surgical subspecialists This is including but Not limited to joint replacements and other similar high-risk procedures which may require tertiary, critical care or otherwise specialized postoperative care. The following cosmetic services and any associated costs are excluded from coverage under this policy unless otherwise stated in Schedule A, including but Not limited to: Artificial Limbs: Provision, replacement, or maintenance of prosthetic limbs, except where explicitly listed as Covered under this policy. Cosmetic Surgery: Surgical procedures performed primarily to enhance or alter physical appearance without medical necessity. Medical necessity is defined as procedures required to treat a condition or illness that directly improves medical outcomes, such as survival, or preservation of functionality, of vital organs.
Cosmetic Care	Dental Aesthetics: Procedures such as the provision of dentures, advanced conservative restorations, orthodontic treatments, or any associated cosmetic dental services. Hair Treatments: Services for alopecia, baldness, or wigs. Orthodontic and Related Treatments: Any dental or maxillofacial treatments primarily for aesthetic purposes.
Custodial care	Personal Comfort Items: Non-essential items that may be claimed as part of care provision including Television or entertainment, beauty services, etc. The following types of care and associated costs are excluded from coverage under this policy unless otherwise stated in Schedule A: Custodial Care: Non-medical care provided to assist with activities of daily living (ADLs), such as bathing, dressing, toileting, mobility, or other personal care tasks, regardless of whether such care is provided by licensed personnel or family members. This includes care that does Not require the supervision of medical professionals or is Not intended to treat or improve a specific medical condition. Home Care: Care provided at home primarily for convenience, comfort, or maintenance, including but Not limited to homemaker services, companionship, or general supervision. This exclusion applies regardless of whether such care is recommended by a healthcare provider or involves periodic visits by medical personnel.

Cosmetic Dental care	The following cosmetic dental services and any associated costs are excluded from coverage under this policy unless otherwise stated in Schedule A, including but Not limited to: Associated Supplies and Procedures: Any materials, tools, or follow-up treatments related to cosmetic dental enhancements. Cosmetic Dental Surgeries: Surgical procedures performed to enhance the appearance of teeth, gums, or jawline, including but Not limited to gum contouring, tooth reshaping, or other non-medically necessary interventions. Dental Appliances: Provision, replacement, or repair of dental appliances used primarily for cosmetic purposes, such as veneers, crowns, or bridges Not required for medical necessity. Dental Implants: Placement, maintenance, or replacement of dental implants or any associated supplies and procedures conducted for aesthetic enhancement.
Experimental, unorthodox or trado-medical care	The following types of care and associated costs are excluded from coverage under this policy: Alternative Medicine: Including but Not limited to acupuncture, aromatherapy, homeopathy, and herbal remedies. Experimental or Unproven Treatments: Any medical, surgical, or therapeutic procedures, devices or drugs that are Not scientifically validated or officially recognized by the relevant regulatory or professional medical bodies as effective and standard care. Traditional Bone-Setting: Treatment of bone fractures or musculoskeletal conditions in traditional bone-setting facilities or by practitioners Not recognized within the framework of orthodox medicine. Trado-Medical Practices: Treatments, remedies, or procedures rooted in traditional, cultural, or herbal medicine that lack endorsement or recognition within orthodox medical practice. The following eye care services and any associated costs are excluded from coverage under this policy: Cosmetic or Convenience Treatments: Procedures performed primarily for cosmetic or convenience purposes, including but Not limited to laser vision correction (e.g., LASIK, PRK) or other refractive surgeries that are Not medically necessary to treat an underlying eye disease or condition. Non-Covered Treatments: Any eye care treatments, procedures, or associated costs Not explicitly listed as Covered in Schedule A of this policy, which describes the specific benefits included under this plan. Non-Covered Treatments: Any ear-related treatments, procedures, or associated costs Not specifically mentioned in Schedule A of this policy, which outlines the Covered benefits.
Force majeure	The following conditions and associated costs are excluded from coverage under this policy due to force majeure events, including but Not limited to: Epidemics and Pandemics: Events arising from outbreaks of infectious diseases, including epidemics, pestilence and pandemics, that impact the general population. Natural Disasters: Injuries caused by earthquakes and, weather related fire, drought, flooding, heatwaves, landslides etc. Other Force Majeure Events: Any other unforeseeable events beyond the control of the parties involved, such as natural disasters, terrorism, or governmental actions, which disrupt normal operations and services. War, Terrorism and Civil Strife: Injuries or damages sustained because of participation in acts of war, riots, terrorism, strikes, civil unrest, or any form of civil strife.
Professional and Amateur Sports and High-Risk Recreational Activities	The following bodily injuries and associated costs are excluded from coverage under this policy: Professional and Amateur Sports: Injuries arising from participation in professional or amateur sports, or any sports where the individual is compensated for their involvement or where participation is for competitive purposes. High-Risk Activities: Bodily injuries resulting from participation in high-risk recreational activities, including but Not limited to mountaineering, aviation, hand gliding and parachuting, horse racing, motor racing.
Injuries related to intoxication or fights and physical brawls.	The following injuries and associated costs are excluded from coverage under this policy: Drug Addiction: Treatment for drug addiction or rehabilitation services for substance abuse disorders. Fights and Physical Brawls: Injuries sustained while engaging in or as a result of participation in fights, physical brawls, or violent altercations. Injuries Resulting from Criminal Activities: Injuries or disabilities caused while engaging in or attempting to engage in illegal activities, including but Not limited to theft, assault, or any criminal action. Intoxication: Injuries or disablement caused wholly or partly by the influence of intoxicating liquor, illegal drugs, or other substances (excluding those prescribed by a licensed medical practitioner). Self-Inflicted Injuries: Injuries resulting from attempted suicide, self-harm, or other willfully inflicted injuries.
Obstetrics	The following obstetric services and associated costs are excluded from coverage under this policy unless otherwise indicated in Schedule A: Excessive Pregnancies: Ante-natal care and delivery services for pregnancies in excess of allowable number of plan dependents, whether the offspring are born under the scheme or Not. This applies once the insurance quota of allowed dependent quota has been reached. Any additional dependent will attract an additional premium to be charged by Mitera HMO prior to coverage. Fetal Anomaly Scans: Any costs related to fetal anomaly scans, including screenings or diagnostics, are excluded. Molecular Diagnostics and In-Utero Testing: All costs related to molecular diagnostics of parent or foetus or genetic testing performed in utero are excluded. Newborns coverage: Mitera HMO shall Not cover or pay for any treatment incurred by or for any new-born that is Not registered after 6weeks of birth. Non-Covered Individuals: Antenatal and delivery services for individuals other than the principal insured or Covered legal spouse of the principal insured. Mitera HMO shall Not cover or pay for any treatment incurred by or for any new-born in the first 6 weeks of life delivered to persons who are Not Covered or enrolled under this policy. We only provide automatic cover for specified services, as listed in the benefit schedule, to new-borns in the first 6 weeks of life delivered to Principal Enrollees or Spouses Covered by this policy.

Mental Health Management	The following mental health services and associated costs are excluded from coverage under this policy unless explicitly specified in Schedule A: Inpatient Mental Health Treatment: Inpatient care or hospitalization for mental health conditions is excluded unless specifically Covered under the policy. Suicide or Self-Inflicted Injuries: Medical treatment for injuries sustained from attempted suicide, deliberate self-harm, or other wilfully inflicted injuries. Treatment for Addiction and Intoxication: Services related to the treatment of substance abuse disorders, including addiction to drugs or alcohol. Treatment for injuries or conditions resulting from intoxication or substance use is also excluded.
Experimental, unorthodox or trado-medical care	The following conditions and associated costs are excluded from coverage under this policy unless otherwise stated in Schedule A, including but Not limited to: Age-Related Conditions: Excludes conditions primarily caused by aging, including but Not limited to Alzheimer's disease and cognitive impairments. Autoimmune Diseases: Exclusions include but are Not limited to conditions such as lupus, rheumatoid arthritis, and celiac disease. Congenital Abnormalities: Treatment for congenital abnormalities or birth defects is excluded, except for life-threatening cases. Gender-Affirmation and Sterility Treatments: Consultations, Surgeries, treatments, or medications related to gender affirmation or gender transition. Growth Hormone Therapy: Treatments or medications for growth hormone deficiencies or hormonal therapies unless otherwise specified. Illnesses of Unknown Cause: Coverage is excluded for illnesses without a conclusive diagnosis or determined cause. Newborn Treatment: Excludes treatment for newborns of non-Covered mothers. No coverage is provided for newborns Not registered within six (6) weeks of birth. Obesity Treatments: Surgical and non-surgical treatments for obesity (including morbid obesity) and weight control programs are excluded. Specifically, the use of GLP-1 agonist drugs for weight management or obesity treatment is excluded unless explicitly Covered under Schedule A. Sexual Dysfunction and Virility Enhancing Drugs: Consultations, treatments, and medications related to sexual dysfunction or performance enhancement. Smoking Cessation Programs: Treatments, supplies, and therapies aimed at quitting smoking or nicotine addiction. Diseases of Unknown Cause: Any illnesses, diseases, or medical conditions where the underlying cause is undetermined or unknown, and no conclusive diagnosis can be made based on available medical evidence. Treatments for sterility, infertility, or related conditions, including sexual dysfunction, are Not Covered unless otherwise stated in Schedule A. Work-Related Accidents: Injuries or conditions arising from workplace accidents are excluded as per applicable laws.
Overseas treatment	All medical expenses incurred for treatments, procedures, or services provided outside the country of Nigeria, except as otherwise outlined and Covered in Schedule A.
Treatment, service or supplies considered not to be medically necessary.	The following services, treatments, or supplies are excluded from coverage under this policy, even if prescribed, recommended, or approved by the attending physician or dentist: Unproven Treatments: Not validated by regulatory bodies. Alternative Medicine: Including acupuncture, homeopathy, and herbal remedies. Experimental Devices and Drugs. For a treatment, service, or supply to be considered Medically Necessary, it must meet the following criteria: Effectiveness: The service or supply must be likely to produce a significant positive outcome, and no more likely to produce a negative outcome than any alternative service or supply, both in relation to the specific sickness or injury and the person's overall health condition. Diagnostic Procedures: A diagnostic procedure must be indicated by the person's health status and should be likely to provide information that could influence the course of treatment, and no more likely to result in a negative outcome than any alternative diagnostic procedure. Cost Considerations: The diagnosis, care, and treatment must Not be more costly (considering all related health expenses) than any alternative service or supply that meets the above criteria. In determining whether a service or supply is appropriate under the circumstances, Mitera HMO will consider: Information relating to the affected person's health status; Reports from peer-reviewed medical literature; Guidelines published by nationally recognized healthcare organizations that include supporting scientific data; Opinions from health professionals in the relevant medical specialty; and Any other relevant information brought to Mitera HMO's attention. The following services or supplies will never be considered Medically Necessary: Non-Technical Services: Services that do Not require the technical skills of a medical, mental health, or dental professional. Personal Comfort or Convenience: Services provided mainly for the personal comfort or convenience of the individual, their caregivers, family members, healthcare providers, or healthcare facilities. Inpatient Services Not Required: Services provided solely because the person is an inpatient on any day when their sickness or injury could safely and adequately be diagnosed or treated while Not confined to a healthcare facility. Inappropriate Setting: Services furnished solely because of the setting (e.g., inpatient care) when the service could safely and adequately be furnished in a physician's or dentist's office, or in a less costly setting.

Miscellaneous Exclusions	The following services and associated costs are excluded from coverage under this policy unless explicitly stated otherwise in Schedule A: Excluded Populations: Coverage is Not provided for adults over the age of 65 or dependent children above the age of 24, unless explicitly stated as Covered under the policy agreement in Schedule A. Injuries Sustained During Criminal Actions: Coverage is excluded for injuries resulting from participation in or as a consequence of criminal actions by the insured individual. Molecular Diagnostics: Molecular diagnostics, including genetic, genomic, and other molecular testing unless otherwise stated in schedule A, is excluded from coverage under this plan. New Staff: Staff joining the company mid-scheme year will Not be Covered until a pro-rated premium based on the remaining months until the current plan's expiration is paid. A full premium will be required for such staff at the start of the new scheme year. Search and Rescue Operations: Expenses related to search and rescue activities for individuals lost in remote areas are excluded. Solicitation of Specific Treatments or Drugs: Any treatment or medication specifically requested by the enrollee but Not deemed medically necessary or appropriate by the attending physician is excluded. Unapproved Inpatient Treatment: Inpatient care obtained without documented prior authorization from Mitera HMO is excluded. Queries and concessions must be granted prior to care delivery for coverage. Unlisted Benefits: Any benefit or service Not explicitly included in the list of Covered services is excluded.

C. CONDITIONS

1. AGE LIMIT: Assigned enrollees must be under age 75 at the time of plan purchase or reactivation.

2. WAITING PERIODS: Waiting periods are reset when payment is interrupted and plans are allowed to expire.

3. plan doees not reimburse for any care carried out outside of the territory of Nigeria.

4.Replacement/Exchange/Swap of covered enrollee during a policy is not allowed under any circumstances

5. All life threatening conditions must be established by a certified medical doctor, additional documentation may be required to established medical need

Important Information – Please Read

Life-threatening conditions must be diagnosed by a certified medical doctor. Additional documents may be required to confirm medical necessity.

2-week waiting period for inpatient admissions, accidents, and emergencies from policy start date.

3-month waiting period for surgeries, durable medical equipment, wellness screenings, and critical care services.

After death, compensation and certain diagnoses have a 1-year waiting period, including:

Chronic/end-stage kidney disease

Review all plan limits and exclusions carefully.

Member replacement, exchange, or swap is not allowed during the policy period.

No reimbursement for care received outside Nigeria.

Coverage interruptions due to unpaid premiums attract penalties and reset waiting periods.

Additional fees may apply for changes to plan level or coverage during the year.