

# Sapphire Extra Plan



Plans	Sapphire Extra Plan
Individual Premium/Annum (₦)	₦9,000
Individual Premium/Month(₦)	₦1,500
Region of Cover	Local
Hospital Category	C-D
Inpatient Limit (₦)	150,000
Accidents & Emergencies: Resuscitative or lifesaving initial treatment	₦50,000
Accommodation (including feeding)	General Ward (3 Days/Annum)
Inpatient medication	√ (Up to Inpatient Limit)
Surgeries 1	₦75,000
Outpatient Limit(₦)	50,000
<b>Consultations</b>	
Hospital-based consultations with General practice doctors and medical officers	√ (Up to Outpatient Limit)
<b>Medications</b>	
Outpatient Prescription Medicine	₦20,000
<b>Diagnostics</b>	
Basic Diagnostic Tests	√ (Up to Outpatient Limit)
<b>Immunizations</b>	
NPI Immunizations for 0-5years	BCG, Measles, DPT, Oral polio, IPV, Vitamin A supplementation, Pentavalent vaccine

## NOTE

- 1 This benefit includes all surgical costs relating to day case procedures, minor, intermediate, major surgeries, Endoscopic Procedures (Therapeutic and Diagnostic)
- 2 This includes X-Rays, Ultrasounds, and Laboratory tests (WHO list of essential in-vitro diagnostics)

## SAPPHIRE EXTRA CARE (TELEHEALTH BENEFITS)

**Annual coverage limit**

₹50,000

**REGION OF COVER**

Africa + UAE + Asia + UK + US

Foreign consultation with General Practitioner or Follow-Up (Including 2nd opinions and diagnosis, prescriptions/ lab test/imaging test reviews)

Capped at 1 consultation per quarter

Local consultation with General Practitioner or Follow-Up (Including 2nd opinions and diagnosis, prescriptions/ lab test/imaging test reviews)

Capped at 4 consultations per quarter

Local Specialist Consultations or Follow-Up (Including 2nd opinions and diagnosis)

Capped at 1 consultations per quarter

One free Pap smear per annum (accessible after 3rd quarter)

Capped at 1 screening per annum

Prostate screening per annum (accessible after 3rd quarter)

Capped at 1 screening per annum

Personalized Message a provider feature

Covered

Digital access to electronic medical record (EMR)

Covered

## B. EXCLUSIONS:

The following are excluded from the plan:

1. Overseas treatment and transplant surgery
2. Plastic/cosmetic surgeries
3. Management of Chronic Diseases including but not limited to consultation, prescription drugs, and laboratory tests
4. Advanced and complex investigations including but not limited to CT Scan, MRI Scan, and Echocardiograph
5. Maternity services including but not limited to antenatal care, delivery services, postnatal care services
6. Investigations and treatment for problems relating to infertility e.g. hydrotubation, hysterosalpingogram, I.V.F, G.I.F.T and artificial insemination
7. Virility enhancing drugs
8. Herbal drugs, nonprescription drugs, experimental drugs, and treatment
9. Other laboratory investigations not listed in the schedule of covered services
10. Dental care not listed in the schedule of covered services
11. Homecare and domiciliary services
12. Intensive care treatment
13. Physiotherapy services
14. Interstate travel for services not available in the State
15. Joint replacements and prosthetic limbs
16. Family Planning Services
17. Renal Dialysis
18. Cancer Care
19. HIV/AIDS Care & Treatment
20. Psychiatric Treatment and illness
21. Comprehensive health screening/well persons' check
22. Pre-School Health examinations
23. Neonatal care services include but are not limited to male circumcision, ear piercing, treatment of mild or moderate neonatal sepsis, phototherapy, NICU, and SBCU services.
24. Self-inflicted injuries
25. Treatment of congenital abnormalities
26. Treatment of obesity
27. Covid-19 testing and treatment
28. Other advanced immunizations not specified in the plan benefits.
29. Other optical services not listed in covered services including but not limited to the treatment of chronic eye diseases, provisions of frames, lenses, and contact lenses.
30. Treatment of speech disorders
31. Room upgrades beyond that specified in the plan benefits
32. Management of severe burns (burns covering more than 10% of body surface area)
33. Learning difficulties, behavioral and developmental problems
34. Consultations with unrecognized consultants, hospitals, family doctors, therapists, dental practitioners, or complementary medicines practitioners
35. Any other treatment, service, procedure, or investigation not listed in the schedule of covered medical services

## C. NOTE

1. The maximum age limit on the Plan is 60 years.
2. There is a 14 (fourteen) day waiting period from date of registration to access of care by the enrollee. Therefore, a plan purchased becomes active 14 days after completion of registration.
3. The following benefits will not be covered or provided in the first year of the commencement of the scheme: Surgeries. This period otherwise known as waiting period shall commence on the date of entry to the date of renewal. On renewal, this benefit will be accessible provided the enrollee has been enrolled for one year with the HMO.

## A. TELEHEALTH Notes:

1. Benefits are restricted to outpatient services only. These are any service or treatment that doesn't require hospitalisation. And any appointment at a facility outside the hospital.
2. Free chat access available for medical emergencies and routine medical information.
3. Access loans to purchase medication, pay for your surgical procedures and cater to your well being within 24-48 hours. Pay back monthly at very low interest rates.  
Apply here: <https://diagnostar.com/services/?healthcare-financing-solutions>
4. \*\*Health screening includes Physical, BP, HIV, Cholesterol, Blood Sugar, PCV, Urinalysis, aLFT, E/u/Cr, ECG, Pap Smear, Physical Breast Examination, Mammogram, PSA Test.
5. Foreign consultation with general practitioner or follow-up activated after 2 months of consecutive subscription

**C. TELEHEALTH EXCLUSIONS: The following are excluded from all plans**

1. Advanced and complex investigations not stated in schedule of covered services
2. Other investigations and treatment for problems relating to infertility e.g. hydrotubation, hysterosalpingogram, I.V.F, G.I.F.T and artificial insemination
3. Virility enhancing drugs
4. Herbal drugs, non-prescription drugs, food supplements and experimental drugs and treatment
5. Other laboratory investigations not listed in the schedule of covered services
6. Dental care
7. Home care and domiciliary services
8. Joint replacements and prosthetic limbs
9. Long term psychiatric illness (Longer than 6 months)
10. Comprehensive health screening/well persons check outside the scope of the benefits covered by the health checks.
11. Pre – School Health examinations
12. Neonatal care and treatment for newborns
13. All Covid-19 Treatment
14. Speech disorders
15. Management of severe burns (Burns covering more than 10% body surface area)
16. Learning difficulties, behavioral and developmental problems
17. Consultations with unrecognized consultants, hospitals, family doctors, therapists, or complementary medicines practitioners
18. Any other treatment, service, procedure or investigation not listed in the schedule of covered medical services
19. Emergency services

