AVURA CARES HMO PLANS

PLAN NAME & PRICING (PER ANNUM)	SAFEBUDDY
INDIVIDUAL	₦ 83,000.00
COUPLE (TWO INDIVIDUALS)	₦ 155,000.00
FAMILY (TWO ADULTS AND FOUR CHILDREN)	₦ 415,000.00
HOSPITAL TIER(S)	TIER 4
BENEFITS	
TOTAL BENEFIT LIMITS PER ENROLLEE (NAIRA); NOT TRANSFERABLE	2,000,000
GENERAL CONSULTATION	
Treatment of basic outpatient and in-patient cases	COVERED
MEDICATIONS	
Chronic disease medications	COVERED up to 300,000 out of outpatient limit
Non-chronic disease medications	COVERED up to 300,000 out of outpatient limit
SPECIALIST CONSULTATION	
Obstetrician	COVERED
Gynecologist	COVERED
Pediatrician	COVERED
General Surgeon	COVERED
Cardiothoracic Surgeon	COVERED
Neurosurgeon	COVERED
ENT Surgeon (Otorhinolaryngologist)	COVERED
Urologist	COVERED
Orthopedic Surgeon	COVERED
Gastroenterologist	COVERED
Cardiologist	COVERED
Neurologist	COVERED
Nephrologist	COVERED
Psychiatrist	COVERED
Neonatologist	COVERED
Dermatologist	COVERED
Dietician/Nutritionist	COVERED
Pulmonologist/Respiratory Physician	COVERED
Hematologist	COVERED
Oncologist	COVERED
Pathologist	COVERED
Endocrinologist	COVERED
Family Physician	COVERED
Oral and Maxillofacial Surgeon	COVERED
ACCESS TO FREE TELEMEDICINE APP	
Free chats with qualified and certified Doctors when in need of care during any medical emergency	COVERED
Free chats with qualified and certified Doctors when in need of any routine medical information	COVERED

Free drug Pick-up after concluding chats with qualified and certified Doctors at designated Pharmacies	COVERED
GPS-enabled access to hospital directories when hospital information is needed	COVERED
Free Telemedicine app with details of all covered benefits on the scheme	COVERED
ACCIDENT AND EMERGENCY CARE	
Resuscitative care for accident and emergency cases, including basic radiological and laboratory investigations needed to stabilize patient before being moved to the ICU if need be.	COVERED
BASIC DIAGNOSTIC IMAGING	**ALL OUTPATIENT BASIC & ADVANCED DIAGNOSTICS COVERED UP TO 300,000 OUTPATIENT LIMIT; INPATIENT TO CEILIING WITH PROOF OF MEDICAL NECESSITY**
Chest X-Rays	COVERED
Abdominal X-Rays	COVERED
Limbs (Hand, Forearm, Upper arm, Thigh and Leg) X-rays	COVERED
Neck X-rays	COVERED
Sinus X-rays	COVERED
Mastoid X-rays	COVERED
Cervical Spine X-rays	COVERED
Skull X-rays	COVERED
Pelvic X-rays	COVERED
Thoracic Inlet X-rays	COVERED
Thoraco-Lumbar X-rays	COVERED
Lumbosacral X-Rays	COVERED
Mandibles/Temporomandibular Joint X-Rays	COVERED
X-rays of All Body Joints	COVERED
Routine Ultrasound Scans (Obstetrics; Abdominal, Pelvic, Abdominopelvic, Breast, Testicular/Scrotal, Thyroid, Prostate, Bladder, and Brain Ultrasound Scans)	COVERED
ADVANCED DIAGNOSTIC IMAGING	**ALL OUTPATIENT BASIC & ADVANCED DIAGNOSTICS COVERED UP TO 300,000 OUTPATIENT LIMIT; INPATIENT TO CEILING WITH PROOF OF CRITICAL/LIFE THREATENING**
Doppler Ultrasound Scan	NOT COVERED
ECG (PRE AND POST EXERCISE)	COVERED
CT Scan	COVERED (1 SESSION PER ANNUM)
MRI	COVERED (1 SESSION PER ANNUM)
Echocardiography	NOT COVERED
Proctoscopy	NOT COVERED
Sigmoidoscopy	NOT COVERED
Upper GI Endoscopy	NOT COVERED
Endoscopic Ultrasound	NOT COVERED
Endoscopic retrograde cholangiopancreatography (ERCP)	NOT COVERED
Enterostomy	NOT COVERED
Gastroscopy	NOT COVERED
Colonoscopy	NOT COVERED
Laryngoscopy (Direct and Indirect)	NOT COVERED

Bronchoscopy	NOT COVERED
Thoracoscopy	NOT COVERED
Hysteroscopy	NOT COVERED
Cystoscopy	NOT COVERED
Laparoscopy	NOT COVERED
Arthroscopy	NOT COVERED
HEMATOLOGICAL TESTS	**ALL OUTPATIENT BASIC & ADVANCED DIAGNOSTICS COVERED UP TO 300,000 OUTPATIENT LIMIT; INPATIENT TO CEILIING WITH PROOF OF MEDICAL NECESSITY**
Hemoglobin (HB)	COVERED
Packed Cell Volume (PCV)	COVERED
White cell count (Total and Differential)	COVERED
Full Blood Count and differentials (FBC)	COVERED
White Blood Cell count	COVERED
Red Blood Cell/Reticulocyte count	COVERED
Grouping and Cross Matching	COVERED
Genotype (on request by clinician)	COVERED
Blood group (on request by clinician)	COVERED
Erythrocyte Sedimentation Rate (ESR)	COVERED
MCHC	COVERED
MCH	COVERED
MCV	COVERED
Blood Film	COVERED
Blood Pregnancy (Beta HCG) Test	COVERED
CHEMISTRY INVESTIGATIONS	**ALL OUTPATIENT BASIC & ADVANCED DIAGNOSTICS COVERED UP TO 300,000 OUTPATIENT LIMIT; INPATIENT TO CEILIING WITH PROOF OF MEDICAL NECESSITY**
Fasting Blood Sugar	COVERED
Random Blood Sugar	COVERED
2 Hours Post-prandial Blood Sugar	COVERED
Oral Glucose Tolerance Test (OGTT)	COVERED
Glucose Challenge Test	COVERED
Electrolytes, Urea and Creatinine	COVERED
Lipid Profile (Fasting) (Cholesterol, HDL, LDL, Triglyceride Profile)	COVERED
Liver Function Test (LFT)	COVERED
Serum Sodium	COVERED
Serum Calcium	COVERED
Serum Magnesium	COVERED
Serum Potasium	COVERED
Serum Lithium	COVERED
Serum Chloride	COVERED
Serum Bicarbonate	COVERED
Serum Alkaline Phosphate	COVERED
Serum Acid Phosphate	COVERED

Serum Inorganic Phosphate	COVERED
Serum Bilirubin (Total and Direct)	COVERED
Serum Albumin	COVERED
Serum Lactate Dehydrogenase	COVERED
Serum Gamma Glutamyl Transferase	COVERED
Prothrombin time (PT/INR)	COVERED
Urine Pregnancy Test	COVERED
MICROBIOLOGY AND PARASITOLOGY	**ALL OUTPATIENT BASIC & ADVANCED DIAGNOSTICS COVERED UP TO 300,000 OUTPATIENT LIMIT; INPATIENT TO CEILIING WITH PROOF OF MEDICAL NECESSITY**
Malaria Parasite (MP)	COVERED
Urine M/C/S	COVERED
Endocervical Swab (ECS) M/C/S	COVERED
High Vaginal Swab (HVS) M/C/S	COVERED
Urethral Swab M/C/S	COVERED
Throat Swab M/C/S	COVERED
Ear Swab M/C/S	COVERED
Wound Swab M/C/S	COVERED
Eye Swab M/C/S	COVERED
Sputum M/C/S	COVERED
Aspirates M/C/S	COVERED
Stool M/C/S	COVERED
VDRL (Veneral Disease Research Laboratory) Test	COVERED
H.Pylori	COVERED
Trypanosomes screening	COVERED
Toxoplasma Screening	COVERED
Skin Snip for Microfilaria	COVERED
Skin Scraping for Fungi	COVERED
Leishmania Screening	COVERED
Mantoux/Heaf's Test	COVERED
Blood Culture	COVERED
Stool Occult Blood	COVERED
ADVANCED LABORATORY INVESTIGATIONS/PATHOLOGY	**ALL OUTPATIENT BASIC & ADVANCED DIAGNOSTICS COVERED UP TO 300,000 OUTPATIENT LIMIT; INPATIENT TO CEILIING WITH PROOF OF CRITICAL/LIFE THREATENING**
Blood urea Nitrogen	COVERED
Hepatitis B Surface Antigen (HBSAg)	COVERED
(HBA1C)	NOT COVERED
Hepatitis C Screening	COVERED
Hepatitis B Screening	COVERED
HIV Screening	COVERED
HIV Confirmatory Test	COVERED
G-6PD Screening	NOT COVERED
Thyroid Function Tests	COVERED

Serum Uric Acid	COVERED
Creatinine phosphokinase	NOT COVERED
Syphilis Screening	NOT COVERED
Serum immunoglobulins/Antibodies	NOT COVERED
Immunofluorescence assay	NOT COVERED
QBC Malaria Concentration And Fluorescent Staining	COVERED
Pap Smear and Cytology	COVERED
Prostate Specific Antigen	COVERED
Protein Electrophoresis	NOT COVERED
CSF M/C/S (CSF Analysis)	COVERED
Semen M/C/S	COVERED
Serum Creatinine Phosphokinase	NOT COVERED
Serum Iron	NOT COVERED
24-Hour Creatinine Clearance	COVERED
Coomb's Test (Indirect)	NOT COVERED
Coomb's Test (Direct)	NOT COVERED
Osmotic Fragility Test	NOT COVERED
Chlamydia Screening	NOT COVERED
Seminal Fluid Analysis (SFA)	NOT COVERED
Clotting Time	COVERED
Bleeding Time	COVERED
D-Dimer	NOT COVERED
Sputum Acid Fast Bacilli (AFB) Test	COVERED
ADMISSIONS AND ACCOMMODATION	
Feeding for enrollees on admission	COVERED
Hospital Ward Care	COVERED (GENERAL WARD ONLY)
Skilled medical and paramedical services	COVERED
Supply of prescribed intravenous/intramuscular, oral and topical drugs	COVERED
Supply of all medical and surgical consumables	COVERED
Blood grouping, cross matching, and transfusion	COVERED
Accommodation for in-patient care	COVERED
Accommodation for parents/relatives of patients on admission (Excludes feeding for parents/relatives)	COVERED (FOR 24 HOURS; LIMITED TO ICU AND NEONATAL CARE ONLY
INTENSIVE CARE	
ICU and ICU-related Care	COVERED (FOR 24 HOURS)
EYE/OPTICAL CARE	
Specialist Ophthalmologist Consultation	COVERED
Basic ocular tests (Tonometry/Intra-Ocular Pressure, Refraction, Fundoscopy, Pachymetry, and Slit Lamp)	COVERED
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)	NOT COVERED
Lenses and Frames (Including Contact lenses)	COVERED (UP TO 10, 000 ANNUAL LIMIT)
Eye Surgeries (Treatment of glaucoma and Cataract extraction)	As a part of Overall limit on Surgical services
DENTAL CARE	
Specialist Consultation	

Routine dental examination	ALL DENTAL CARE COVERED UP TO ANNUAL LIMIT OF 15,000 NAIRA
Preventive dental care and counselling	
Dental pain therapy	
Pharmacological treatment of acute and chronic dental infections	
Access to prescribed drugs	
Surgical extraction & non-surgical extraction	
Root Canal Therapy, Composite Filling, Amalgam Filling, Operculectmy, Gingival Curettage, Incision & Drainage, Scaling & Polishing	
Orthodontic Treatment	NOT COVERED
Orthodontics, prosthetics, and oral/maxillofacial surgery	NOT COVERED
ENT	
Treatment of ENT diseases and removal of foreign bodies	COVERED
ENT Surgeries	As a part of Surgical services
PHYSIOTHERAPY CARE	
Specialist Consultation	COVERED
Routine fitness examination	COVERED
Preventive Counselling on referral	COVERED
Pain therapy	COVERED
Access to prescribed drugs	COVERED
Cervical Collar and Crutches	NOT COVERED
Walker	NOT COVERED
Number of Sessions Covered	7 Sessions per annum
SURGERIES	
MINOR SURGERIES	COVERED UP TO 200,000 NAIRA PER ANNUM
INTERMEDIATE SURGERIES	
MAJOR SURGERIES	
OBSTETRICS CARE	**(COVERED FOR INDIVIDUAL PLAN HOLDERS WITH COMPANY PRINCIPALS ≥ 30)**
Antenatal Care (INCLUDING ALL SPECIALIST CARE AND ANC DRUGS)	COVERED (FAMILY PLAN UP TO A LIMIT OF 300,000)
Delivery (SVD/NORMAL and COMPLICATED)	
Delivery (MULTIPLE)	
Assisted Delivery	
Therapeutic Abortion (Manual Vacuum Aspiration)	COVERED UNDER SURGERY LIMIT
Peri-Natal Obstetric Procedures (Cerclage, Amniocentesis, Fetal blood sampling, Extra cephalic Version)	
CAESARIAN SECTION	
INFERTILITY CARE	
Fertility Specialist Consultation and Counselling	NOT COVERED (TPA)
Fertility Investigations (USS, SFA, etc)	
Fertility Treatment	NOT COVERED
CARE FOR THE NEWBORN	
Care for babies actively on the plan	COVERED
Care for babies NOT actively on the plan (Expires after 6 weeks of life)	COVERED UP TO 30,000 NAIRA LIMIT

INCUBATOR CARE	
Neonatal / Special Baby Care Unit	COVERED (FOR 48 HOURS)
NPI IMMUNIZATION (0-5 YEARS)	
BCG	COVERED
Polio (OPV/IPV)	COVERED
Pentavalent	COVERED
Hepatitis B	COVERED
Diphtheria Pertussis Tetanus (DPT)	COVERED
Vitamin A	COVERED
Measles	COVERED
Yellow fever	COVERED
ADDITIONAL IMMUNIZATION (0-5 YEARS)	
Chicken Pox	COVERED
Meningitis	COVERED
MMR	COVERED
Varicella	COVERED
Cholera	NOT COVERED
Pneumococcal	NOT COVERED
Rotavirus	NOT COVERED
ADDITIONAL IMMUNIZATION (6 YEARS AND ABOVE)	
Hepatitis B	COVERED
Meningitis	COVERED
Varicella	COVERED
Hepatitis A	COVERED
TDAP (Adults)	COVERED
Yellow fever	COVERED
Typhoid	COVERED
HPV	NOT COVERED
Pneumococcal	NOT COVERED
FAMILY PLANNING	
Contraceptive pills	COVERED
Implants - Implanon, Norplant, Jadelle	COVERED
Copper T Intrauterine Device, Injectibles (Depo Provera,Noristerat)	COVERED
Tubal Ligation	COVERED UNDER SURGERY LIMIT
Vasectomy	COVERED UNDER SURGERY LIMIT
GYM	
Access to gyms for regular exercise	NOT COVERED
SPA	
Facials or Body Massage	NOT COVERED
CANCER CARE	
Oncologist/ Cancer Specialist visits	ALL CANCER CARE COVERED UP TO 250,000 NAIRA PER ANNUM
Oncological investigations	
Cancer-related Radiological investigations	
Surgical cancer care	

Chemotherapy	
RENAL CARE (DIALYSIS)	
Dialysis and all related care	COVERED (2 SESSIONS PER YEAR)
WELLNESS CHECKS	
BMI Check	COVERED
General Physical Examination	COVERED
Blood Pressure Check (Hypertension Screening)	COVERED
Blood Sugar Check (Diabetes Screening)	COVERED
Blood Cholesterol Check	COVERED
Annual Visual Acuity Check (Using Snellen Chart)	COVERED
Mammography (For Women ≥ 40 years of age every two years)	COVERED
Cervical Cancer Screening (every three years)	COVERED
Pap Smear	COVERED
PSA Check (For Men ≥ 40 years of age)	COVERED
Urinalysis	COVERED
Chest X-ray	COVERED
Liver Function Test	NOT COVERED
Kidney Function Tests (E, U, and Cr)	NOT COVERED
AMBULANCE SERVICES	
Movement of patients to and fro Hospital	COVERED (HOSPITAL TO HOSPITAL; ROADSIDE TO HOSPITAL)
PSYCHIATRY CARE	
Mental illness care with certified psychiatrists (Outpatient)	COVERED (6 SESSIONS PER YEAR)
HIV CARE AND TREATMENT	
Specialist Consulltation	COVERED
Specialist Drug therapy	COVERED
Counselling Sessions	COVERED
SEEKING SECOND OPINION	
Diagnosis confirmation from secondary and tertiary care centres	COVERED
Line of treatment confirmation from secondary and tertiary care centres	COVERED
Line of treatment confirmation from Internationally Certified Medical and Surgical Specialists Outside Africa	NOT COVERED
EXPANDED BENEFITS	
Employee Assistance Programme (EAP)	COVERED
After-demise compensation	COVERED (UP TO 25,000 NAIRA/ FAMILY)
Congenital disease (only on children born within the plan)	NOT COVERED
Inpatient psychiatry coverage	NOT COVERED
Child delivery reimbursement abroad, global emergency care refund limit.	NOT COVERED
Coverage within our Egypt/Senegal networks for surgery/cancer.	NOT COVERED
Personal health equipment for chronic conditionS	NOT COVERED
Doctor and vaccination home visits	NOT COVERED