

You Have Health Insurance. So Why Are You Still Paying Out of Pocket?



Temi found out she had fibroids on a Tuesday afternoon.

The doctor was matter-of-fact about it – and told her it was common, manageable, and not immediately dangerous. What she needed was a scan to determine the size, a follow-up consultation, and possibly a referral depending on what they found. Standard procedure.

Temi had health insurance. She had been paying into her company's HMO plan for two years, every month, without thinking much about it. It was one of those things that existed in the background of her employment – like pension contributions and tax deductions.

So when the doctor finished speaking, she did what most Nigerians do in that moment. She opened her wallet.

She paid for the scan herself. ₦35,000. She paid for the follow-up and she paid for the referral letter. By the time she had a full picture of her diagnosis, she had spent close to ₦80,000 – out of pocket, without ever asking whether her insurance would have covered any of it.

And it would have. In fact, almost all of it.

Temi's story is not unusual. It is, in fact, the norm.

Across Nigeria, millions of people are enrolled in health insurance plans — through their employers, through NHIA-backed schemes, through personal plans — and a significant number of them are still paying for healthcare the way they would if they had no coverage at all. Not because the insurance doesn't work, but there is a huge gap between having a plan and knowing how to use it.

The reasons are less about laziness and more about a system that was never explained clearly; a culture where asking questions at a hospital feels presumptuous; and a widespread belief that health insurance in Nigeria is designed to look good on a job offer and disappear when you actually need it.

That assumption is costing people money they don't have to spend.

The Coverage You Have But Don't Know About



Most HMO plans in Nigeria cover significantly more than their members realise. Outpatient consultations, laboratory investigations, prescribed medications, specialist referrals and preventive care — which includes screenings, immunisations, and routine checks that exist precisely to catch problems before they become expensive ones.

The first and most expensive misconception about health insurance in Nigeria is that it is primarily for emergencies and hospital admissions. It isn't. The most consistent value in a well-structured HMO plan is in the routine — the consultations, the investigations, and the prescriptions that quietly add up.

The Hospital Problem



The second reason people end up paying unnecessarily is simpler: they go to the wrong hospital.

Every HMO operates through a network of accredited providers — hospitals, clinics, and diagnostic centres that have agreed to accept the plan. Walk into an accredited provider, present your insurance card or ID, and the visit is processed through your plan. Walk into a hospital outside that network, and you are a private patient.

Most members know their HMO has a hospital list. Fewer have actually looked at it. Fewer still have saved it somewhere useful — in their phone, in their email, or somewhere they can access it at 11pm on a Sunday when something is wrong and they need to make a fast decision.

The result is predictable. Someone falls ill, needs care quickly, goes to the nearest familiar hospital — which may or may not be on the network — pays out of pocket, and

later discovers that three accredited hospitals were within the same radius. The insurance existed and the coverage was there, but the knowledge wasn't.

Checking your provider list before you need it is not a chore. It is, practically speaking, the difference between an ₦80,000 bill and a ₦0 bill.

What "Pre-existing Condition" Actually Means for You



This is the clause that has quietly eroded trust in Nigerian health insurance more than any other.

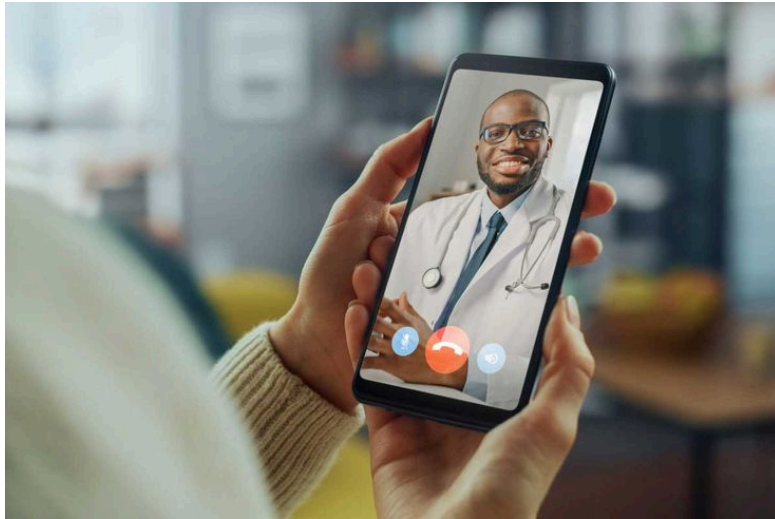
Pre-existing conditions — health issues that existed before your plan began — are handled differently across providers. Some plans exclude them entirely for an initial waiting period, typically three to six months, before coverage begins. Some cover them partially. Some cover them fully from day one depending on the plan tier.

What most members do is assume the worst: that any condition they had before the plan started is permanently excluded, forever, regardless of what the policy actually says. So they pay for the management of that condition themselves, indefinitely, even when their waiting period has long since passed and the coverage is sitting there unused.

Read your policy document. Specifically, find the section on pre-existing conditions and waiting periods. If the language is unclear — and it often is — call your HMO and ask

directly. What conditions are excluded? For how long? What documentation do you need to access coverage once the waiting period ends?

The Telemedicine Gap



One of the most underused benefits in modern HMO plans is also the most accessible: telemedicine. The ability to speak to a doctor from your phone, receive a diagnosis, get a prescription, and in many cases have that prescription processed through your plan — without leaving your house, without taking half a day off work, or sitting in a waiting room.

Most people enrolled in plans that include telemedicine have never used it. Some don't know it exists. Others assume it's for minor issues that don't really need a doctor. Others simply default to the familiar: show up, wait, see someone in person.

Telemedicine is particularly valuable for health concerns people tend to manage badly — the recurring issue they've been treating at the pharmacy for months, the symptom they've been meaning to get checked, or the prescription they need renewed. It is accessible, fast, covered and yet, largely unused.



Health insurance in Nigeria is imperfect. The networks have gaps. The claims process can be slow. The customer service is not always what it should be. None of that is nothing, and none of it should be dismissed.

But the gap between what people's plans actually cover and what they believe their plans cover is not a coverage problem. It is a knowledge problem. And unlike waiting periods and pre-authorisation requirements, knowledge is something you can close tonight.

Find your policy document. Look up your provider list. Try the telemedicine line once, just to know how it works. Ask your HR team the specific question you've been half-forming for months.

The insurance is already paid for. The only thing left is to use it.

Reliance HMO exists to make healthcare accessible, understandable, and actually useful for every Nigerian professional. Explore your plan benefits or find an accredited provider near you at getreliancehealth.com.