



HEALTH

CoopCare

Medical Cover

Affordable Health Insurance solution built for Cooperative Members



We keep our word



What is CoopCare?

This is a medical product tailor-made for Cooperative members and affiliates with a minimum membership of 10 principal members. The product allows members of a cooperative to enjoy a group cover on fairly priced group terms. The product covers Inpatient, Outpatient, Maternity, Dental, Optical and Last Expense benefits. One may choose to purchase Inpatient only or Inpatient and Outpatient benefits.

Affordability is at the center of this product with a carefully selected low cost provider panel mainly encompassing mission hospitals and low cost private hospitals. The maximum joining age is 70 years and the product is available either as a family package allowing up to 6 dependants (M+6) or as Member only (M+0). Any family beyond M+6 will attract a minimal additional premium to cover the extra dependants.

Benefits Summary

Benefit	Inpatient	Outpatient	Maternity	Dental	Optical	Last Expense	Accommodation (Net of NHIF)
Family/ Person	Family	Family	Family	Family	Family	Family	Bed Type
Option 1	100,000	30,000	15,000	5,000	5,000	50,000	Ward Bed
Option 2	200,000	40,000	20,000	5,000	5,000	50,000	Ward Bed
Option 3	300,000	50,000	25,000	7,500	7,500	50,000	Ward Bed



Benefit cover Summary	Limit of Cover	Sublimit/Stand Alone
Inpatient overall cover limit	As per table above.	Stand alone
Outpatient	As per table above.	Stand alone
Outpatient Dental	As per table above.	Sublimit of Outpatient
Outpatient Optical	As per table above.	Sublimit of Outpatient
Maternity Inpatient maternity complications	As per table above. Maternity and 1st ever emergency caesarian section are mutually exclusive and cannot both be accessed in the same policy year.	Sublimit of inpatient
1st Ever Emergency Caesarian	Up to Kes. 30,000	Sublimit of inpatient
Antenatal and postnatal	Covered within the outpatient up to the full limit	Sub limit of inpatient
Inpatient pre-existing Conditions/pre-existing Chronic conditions	Up to 50% of the Inpatient cover limit Newly diagnosed to be covered up to the full limit.	Sub limit of inpatient
Congenital and prematurity conditions	Up to Kes. 50,000 per family	Sub limit of inpatient
Accommodation/Bed Capacity	As per table above net of NHIF Where a member does does not have NHIF, the member shall be required to copay Kes 500 for every day of admission.	Sub limit of inpatient
Last Expense	As per table above.	Stand alone

Benefit cover Summary	Limit of Cover	Sublimit/Stand Alone
Inpatient psychiatry	Kes. 20% of overall inpatient cover	Sublimit of inpatient
Inpatient Non-accidental Dental Surgery	Kes. 30,000 of overall inpatient cover	Sublimit of inpatient
Inpatient Non-accidental Ophthalmological Surgery	Kes. 30,000 of overall inpatient cover	Sublimit of inpatient
Posthospitalization	Covered up to Kes 20,000 within Inpatient on reimbursement basis up to 4 weeks post discharge.	Sublimit of inpatient
Terrorism, Political war and Violence	Covered up to the full limit subject to the claimant not being an active participant.	Sublimit of both inpatient and outpatient.
Vaccines	KEPI vaccines.	Sub limit of outpatient
Outpatient Chronic conditions	Covered within the outpatient up to the full limit.	Sublimit of outpatient
Outpatient congenital conditions	Covered within the outpatient up to the full limit.	Sublimit of outpatient
Outpatient HIV/AIDS and related conditions	Covered within the outpatient up to the full limit.	Sublimit of outpatient
Lodger fees	Payable up to 12 years	Inpatient
Road evacuation leading to admission	Covered within Inpatient	Sublimit of inpatient
ICU and HDU cover	Covered within the applicable benefit limit	Sublimit of inpatient
External aids including corsets, walking frames, wheelchairs	Covered within Inpatient up to Kes 30,000	Sublimit of inpatient

Benefit cover Summary	Limit of Cover	Sublimit/Stand Alone
Air evacuation	Not covered	N/A
Outpatient Ambulance services	Not covered	N/A
Health Check-up	Not covered	N/A
Joining age	37 weeks subject to discharge	N/A
Overseas referral	Not covered	N/A
Covid - 19	<p>Covered up to full Inpatient for Option 1 Covered up to Kes 150,000 for Option 2 within Inpatient Covered up to Kes 200,000 for Option 3 within Inpatient</p> <p>Outpatient treatment is covered up to full Outpatient limit. Outpatient tests are capped at Kes 6,000 per test within Outpatient. The test must be prescribed by a doctor. Covid testing for purposes of travel is excluded.</p>	Inpatient and Outpatient as applicable

SPECIAL TERMS

1. Waiting periods

- No waiting period for accident related admissions
- 1 year for pre existing & chronic conditions treatment.
- 10 months waiting period for Maternity and maternity related treatment.

2. Eligible age for Children from birth (born at full term of 37 weeks) to 18 years; 21 years up to 25 years subject to proof of full time learning with proof from the learning institution.

3. Eligible age for Principle member and spouse – up to 70 years.

4. Geographical limit is Kenya only.

5. Lodging facilities for parent accompanying a child below 12 years being admitted

6. Copay of Kes 100 applies to every outpatient visit.

7. Members without NHIF shall be required to copay Kes 500 for every day of admission..

8. Access is strictly within the designated panel provided.

9. Members will access services through Photo cards. Cost of card replacement for lost or damaged card is Kes 300 per card.

10. Dental benefits which covers;

- Cost of fillings
- Root canal
- X-rays
- Polishing and scaling necessitated by a prevailing medical conditions and authorized by a doctor.
- Tooth extractions including surgical extraction together with anesthetics fees
- Decay
- Accidental dental injury.
- Consultation.

11. Optical benefits which covers;

- Expenses relating to eye treatment
- Accidental eye injury.
- Consultation.
- Eye testing
- Treatment arising from injury to the eyes caused solely and directly by accident external and visible means or arising from a disease affecting the eye or optical nerve.
- The supply of Lenses
The prescribed spectacles will be acquired from an approved optician limited to one pair every two years.

EXCLUSIONS

1. Cosmetic surgery unless caused by accident
2. Weight management treatments and drugs.
3. Hazardous sports e.g., bungee jumping, paragliding
4. Family planning/infertility related treatment
5. Treatment other than by registered medical practitioner
6. Self-referred or self-prescribed treatment.
7. Scaling, crowns, bridges, orthodontics, and dentures.
8. Nutritional supplements unless prescribed as part of medical treatment.
9. Specialists Fees.
10. Alternative treatment - Chiropractors, Acupuncturist, Herbalist.
11. Drunkenness, drug addiction, Intentional self-injury, attempted suicide.
12. War and Kindred risks (whether war be declared or not).
13. Participation in Riot, Strike and Civil commotion.
14. Naval, Military or Air force operations.
15. Expenses recoverable under any other insurance e.g. NHIF, GPA, WIBA.
16. Beauty treatment in nature cures clinics or health hydro's.
17. External surgical appliances - unless benefit has been provided for.
18. Diagnostic equipment (e.g. Glucometers, BP machines etc.) and hearing aids.
19. Experimental treatment.
20. Contamination by radio activity from nuclear fuel, waste or fission.
21. Laser correction of eye sight.
22. Pregnancy related treatment for dependants other than the spouse if covered on the benefit schedule.
23. Optical exclusions – Plano prescriptions, +/-0.25 prescriptions, photo chromatic lenses, antiglare coatings.
24. Bills incurred by doctors/hospitals outside the CIC designated panel.
25. Pandemic & Epidemic occurrence.

PREMIUM RATES:

All benefits (Inpatient, Outpatient, Maternity, Dental, Optical and Last Expense)			
Plan	Member Only	Member Plus upto 6 Dependants	Additional Dependants above 6
Option I	7,500	26,700	3,600
Option II	8,500	31,600	4,100
Option III	9,500	36,000	4,600

Inpatient only (Inpatient, Maternity and Last Expense)			
Plan	Member Only	Member Plus upto 6 Dependants	Additional Dependants above 6
Option I	2,500	7,300	1,100
Option II	3,200	10,800	1,400
Option III	3,800	12,700	1,700

Notes

1. Add taxes to get the gross premium as follows: Training Levy (0.2%); PHCF (0.25%); Stamp Duty (KES 40/-).
2. Outpatient, Maternity Dental and Optical Plan options chosen must correspond with the selected Inpatient Plan. One cannot select a higher or lower Outpatient plan from the Inpatient selected plan.

HEALTH

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