



HEALTH

CoopCare

Medical Cover

Affordable Health Insurance solution built for Cooperative Members



CIC GROUP

We keep our word



What is CoopCare?

This is a medical product tailor-made for Cooperative members and affiliates with a minimum membership of 4 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
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



PREMIUM RATES:

All benefits (Inpatient, Outpatient, Maternity, Dental, Optical and Last Expense)				
Plan	Cover Limits	Member Only	Member Plus upto 6 Dependants	Additional Dependants above 6
Option I	Inpatient: 100k Outpatient: 30k Maternity: 15k Dental: 5k Optical: 5k Last Expense: 50k	7,500	26,700	3,600
Option II	Inpatient: 200k Outpatient: 40k Maternity: 20k Dental: 5k Optical: 5k Last Expense: 50k	8,500	31,600	4,100
Option III	Inpatient: 300k Outpatient: 50k Maternity: 25k Dental: 7.5K Optical: 7.5K Last Expense: 50k	9,500	36,000	4,600

Inpatient only (Inpatient and Last Expense)				
Plan	Cover Limits	Member Only	Member Plus upto 6 Dependants	Additional Dependants above 6
Option I	Inpatient: 100k Last Expense: 50k	2,500	7,300	1,100
Option II	Inpatient: 200k Last Expense: 50k	3,200	10,800	1,400
Option III	Inpatient: 300k Last Expense: 50k	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.

Key Terms

Waiting periods

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

Eligibility

- Children from birth (born at full term of 37 weeks) to 21 years;
- Above 21 years up to 25 years are covered subject to proof of full time learning with proof from the learning institution.
- Principal member and spouse – up to 70 years.
- Lodger fees - covered for parent or dependant of child not exceeding 12 years.

Geographical limit

- Kenya.
- Road evacuation leading to admission covered.

Co- payment

- Kes 100 -outpatient visit.
- Kes 500 per day for Inpatient members without NHIF.

Access

- Strictly within the designated panel provided.
- Plastic cards are provided per member.
- Cost of card replacement for lost or damaged card is Kes 300 per card.

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.

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.

Sub limit Benefits

Condition	Inpatient Cover limit	Outpatient Cover limit
Maternity and 1st ever emergency caesarian section are mutually exclusive and cannot both be accessed in the same policy year. 1st ever Emergency CS up to Kes. 30,000		
Inpatient pre- existing / Chronic conditions	50% of Inpatient cover limit	Full outpatient limit.
Newly diagnosed conditions to be covered up to the full limit.		
Congenital and prematurity conditions	50,000 per family for Inpatient	Full outpatient limit.
Inpatient psychiatry	20% of the overall inpatient limit.	
Inpatient Non-accidental Dental Surgery	Ksh. 30,000 of overall inpatient cover	
Inpatient Non-accidental Ophthalmological Surgery	Ksh. 30,000 of overall inpatient limit.	
Post Hospitalization Benefit	Ksh. 20,000 on reimbursement basis up to 4 weeks post discharge.	
Covid 19	Covered up to full IP for Option 1. Covered up to Kes. 150,000 for Option 2. Covered up to Kes. 200,000 for Option 3.	Covered up to the full Outpatient limit. Tests capped at 6,000 per test within OP. Test must be prescribed by a doctor. Covid testing for travel purposes are excluded
Terrorism, Political war and Violence	Covered up to the full limit subject to the claimant not being an active participant.	

EXCLUSIONS - What is not covered

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. Dental 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. Diagnostic equipment (e.g. Glucometers, BP machines etc.) and hearing aids.
18. Experimental treatment.
19. Contamination by radio activity from nuclear fuel, waste or fission.
20. Laser correction of eye sight.
21. Pregnancy related treatment for dependants other than the spouse if covered on the benefit schedule.
22. Optical exclusions – Plano prescriptions, +/-0.25 prescriptions, photo chromatic lenses, antiglare coatings.
23. Bills incurred by doctors/hospitals outside the CIC designated panel.
24. Pandemic & Epidemic occurrence.
25. Air, evacuation, Outpatient ambulance services and health check-up.
26. Oversees Referral.

FAQs

1. Can I take the product for myself and family alone?

The product is an open ended policy and is distributed through Cooperative societies. One must belong to a cooperative. The minimum number of members to unlock a Cooperative is 4 principal members. Thereafter onboarding will be done on monthly basis and all members on boarded on the subsequent month will have one anniversary date. They must be in minimums of 4.

2. Does the policy allow me to cover my sister's children since my family size is below seven?

No. The policy only allows for nuclear family members which is spouse and biological children. However, adopted children and other differently abled children (physically disabled or mentally retarded) or adults under your care may be included as dependants subject to Proof of dependency. A letter may be obtained from the state department for social protection and senior citizen office nearest to you.

3. What happens to someone who has two spouses?

The policy only allows up to one spouse. Each additional spouse will have to take a separate cover. However, the Principal member can enjoy himself/herself one of the policies subject to maximum membership per family. Please note that the principal member cannot be in both policies at the same time.

4. What happens when I get a new dependant (spouse or child) within the policy?

If the principal member had purchased a M Only option, the additional dependant will be included at full premium for one year. This means that the member's policies will not be renewed at the same time.

5. Is there a maximum daily utilization amount per member or per family per visit?

No. Everything is subject to the full benefit or sublimit option.

6. Do Members need cards to access Medical services?

Yes, the policy provides for plastic cards for each member covered. No photos are required, just a copy of the National Identity card and a completion of the proposal form.

7. How do I know that a specific hospital on the list has my updated information to enable me access services from them?

Every time we onboard a new Cooperative, we share the details of the members with the hospitals. This includes the scheme name, start date and list of members. This is done continuously as we onboard new members.

8. What is a sublimit?

A sub limit is a ceiling set on the maximum amount of benefit one can spend within a certain category. It is mainly given for pre-existing and chronic conditions, maternity, congenital, psychiatry dental and optical conditions.

9. What are pre-existing and chronic conditions?

A pre-existing condition is a medical condition; which can be medically proven that a member had, or was known by the member to exist prior to the commencement date or prior to upgrading, whether or not treatment or advise or diagnosis was sought and received. It is any

condition diagnosed before expiry of 90days from the commencement date.

A chronic condition is a disease, illness or injury which has at least one of the following characteristics; has no cure, likely to recur, needs indefinite prolonged supervision and treatment by a specialist, permanent in nature and caused by changes in the body that cannot be reversed.

Examples are hypertension, high blood pressure, diabetes, cancer among others. The sub-limit for a chronic or pre-existing condition are defined in the policy based on the limit of cover taken.

10. If I am already expecting a baby, can I enjoy the maternity cover within the policy?

No the policy has a one year waiting period for maternity and maternity related conditions. The maternity sublimit are defined in the policy based on the limit of cover taken.

11. Can I appoint my own Doctor if I am going to the hospital for a procedure?

No. The Doctors are appointed by the Hospitals we have contracted.

12. Can I choose a hospital outside the list that CIC has provided?

No. The customers are only allowed to visit the hospitals within the provided list.

13. What happens if there is an emergency and the nearest appointed hospital is not within easy reach?

Please call the 24-hour emergency number on the card and the care team will advise you on the nearest hospitals you can access services. In the event that the nearest hospital on the panel is far away from where the customer is, or in the event that it is a medical emergency, the call center staff will give a pre authorization for the insured to be treated in the nearest facility. In such a case the insured will spend his/her own money and later claim reimbursement. Please note that self-authorized cases will not be reimbursed

14. Does the policy offer ambulance services?

Road rescue leading to admission is covered on reimbursement.

HEALTH

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