A NOTE ON GROUP MEDICLAIM POLICY ISSUED BY UNITED INDIA TO NEW INDIA ASSURANCE EMPLOYEES.

Policy No: 0210002820P100417623 (01-04-2020 to 31-03-2021)

The Policy has 5 chapters and 1 Annexure.
Chapter 1 deals with COVERAGE; Chapters 2 & 3 deal with DEFINITIONS;
Chapter 4 deals with EXCLUSIONS; Chapter 5 deals with CONDITIONS.
Clauses 6 to 13 deal with Miscellaneous matters like: Period of Insurance, Renewal of Policy, Product withdrawal, Liability restriction to Sum Insured, Authority to Obtain Records, Quality of Treatment, ID Cards and IRDA Regulation No: 5.

Now we shall discuss below the 5 chapters and Annexure.

CHAPTER 1 : COVERAGE

1.1 The Policy covers any (a) expenses relating to any disease or bodily injury that requires Hospitalisation as an Inpatient or (b) domiciliary treatment in India under Domiciliary Hospitalisation Benefit as herein defined the TPA / Company shall reimburse to the Hospital (if treatment taken in any Networked Hospital) or to the Insured person up to the limit of liability specified in the Policy but not exceeding the Sum Insured under the Policy for One or all the Family members stated in the Schedule of the Policy.

1.2 The following reasonable and necessary expenses, subject to Limits, are payable as under :

A	**HOSPITALISATION BENEFITS :**	
	BENEFIT	**LIMIT OF REIMBURSEMENT**
a.	Room, Boarding and Nursing Charges as provided by Hospital / Nursing Home.	1% of Sum Insured up to 10 Lacs + 0.5% of the Sum Insured above 10 Lacs in **"A" Class cities** subject to a Maximum of **Rs.15,000/- per day.** 0.75% of Sum Insured up to 10 Lacs + 0.5% of the Sum Insured beyond 10 Lacs in **all other places** subject to a limit of **Rs.12,500/- per day.**
b.	Intensive Care Unit (IC) expenses in Hospital / Nursing Home	Maximum reimbursement Limit is **Double the Room rent** limit per day if admitted in IC/CCU/ICCU/Critical Care.
	Number of days stay in both (a) and (b) above should not exceed the total stay in the Hospital. All related charges shall be as per entitled Category vis-a-vis Room rent except for Pharmact / Medicines bill and body Implants.	
c.	Surgeon, Anasthetist, Medical Practioner, Consultants' and Specialists fees.	As per the Limits of the Sum Insured.
d.	Anasthesia, Blood, Oxygen, OT charges, Surgical appliances, Medicines & Drugs, Diagnositc Material & X-ray, Dialysis, Chemo Therapy, Radio Therapy, Cost of Pacemaker, Artifical Limbs etc.,	As per the Limits of the Sum Insured.
e.	Ambulance Service Charges (refer 2.5)	Rs.5,000.- per Hospitalisation.

<table>
<tr><td>f.</td><td>Maternity Benefit</td><td>This benefit is for Hospitalisation of female employee / spouse of a male employee.<table><tr><td>Normal Delivery</td><td>A class cities : Rs.50,000/-
Other cities : Rs.40,000/-</td></tr><tr><td>Ceaserian Delivery</td><td>A class cities : Rs.1 Lacs
Other Cities : Rs.65,000/-</td></tr></table>This benefit is also extended to independent child or family member of dependent or independent Child provided such child or family member is covered under the policy for the last 3 years as on the date of Hospitalisation for Maternity Cover.</td></tr>
<tr><td>g.</td><td>Cover to Infant from day 1.</td><td>Eligible New Born baby of the employee stands covered from day 1 as a separate unit.
Premium to be collected when child completes age of 90 days from the 1st of the month on pro-rata basis.</td></tr>
<tr><td>h.</td><td>Medical Checkup facility.</td><td>Any member of the Family or Insured is entitled for this benefit after every 4 Claim Free years, in the 5th year till the end of the 5th year or any claim paid reported & paid under the Policy whichever shall first occur. The maximum amount reimbursable is Rs.5,000/- for the Family.</td></tr>
<tr><td>i.</td><td>Pre & Post Hospitalisation.</td><td>Medical expenses incurred 30 days prior to Hospitalisation and 60 days Post Hospitalisation covered</td></tr>
<tr><td>B</td><td colspan="2">DOMICILLIARY HOSPITALISATION (AS DEFINED HEREIN AFTER)</td></tr>
<tr><td>a.</td><td>Surgeon, Medical Practioner, Consultant, Specialists' Fees, Blood, Oxygen, Surgical Applicances, Medicines and Drugs, Diagnositc material and Peritoneal dialysis and Oral Chemotherapy and Nursing Charges.</td><td>Limited to 20% of Sum Insured, max of Rs.50,000/-.

For Peritoneal Dialysis and Oral Chemotherapy shall be 50% of S I, maximum of Rs.5,00,000/-.
The above expenses shall be on Floater basis during the Policy period.</td></tr>
<tr><td>b.</td><td>Treatment for Dog bite (or any other rabid animal like Monkey, cat etc.).</td><td>Reimbusement of reasonable expenses / medical costs actually incurred for immunisation based on merits of each case.
FOR THE PURPOSE OF THIS SECTION THE PRE REQUISITE CONDITIONS FOR DOMICILLIARY HOSPITALISATION CLAIM SHALL NOT APPLY.</td></tr>
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1.3 Hospitalisation / Nursing Home Charges, Surgery, Medicines and Drugs, Pathological tests, etc., incurred by the Donor during donating an organ to the Insured person during organ transplantation, is also reimbursable. **THE COST OF ORGAN IS NOT REIMBURSIBLE.**

1.4 The overall liability of the Insurer under 1.2 and 1.3 above is limited to Sum Insured under the Policy.

CHAPTER 2 & 3 : DEFINITIONS.

These two sections give definitions of various terms used in the Policy document. Totally there are 29 definitions. Only the important definitions are discussed here below. For other definitions Policy Document to be referred.

1. (2.5)AMBULANCE CHARGES: Actual ambulance charges paid to the max. of Rs.5,000/- will be reimbursable for shifting the Insured from Home to Hospital, from one hospital to another hospital, and from Hospital to to Home.
2. (2.6) MATERNITY EXPENSES: a) only for first 2 living children this benefit is payable. So if an insured has 2 living children, this benefit is not payable. b) These benefits are applicable only if insurred as in-patient in a Hospital or Nursing Home. c) A waiting period of 9 months is waived for Normal / Ceaserian Delivery or extra uterine pregnancy. d) Pre & Post Hospitalisation expenses are not admissible. e) Expenses incurred in respect of Voluntary Termination of Pregnancy after 12 weeks only are covered. f) Pre natal / Post natal expenses incurred are admissible only if taken as in patient in a Hospital / Nursing Home. g) New born child is covered from day one up to the age of 3 months and reimbused only if treatment is taken as in patient in a Hospital.
3. (3.13) CASHLESS FACILITY: It means a facility extended by the Insurer for payment of expenses, as per terms and conditions of the Policy directly to the Network Provider by the Insurer to the extent of Pre-Authorised amount.
4. (3.20) CONGENITAL ANAMOLY: Both Internal and External Congenital Defects / Diseases are covered.

CHATER 4 : EXCLUSIONS.

This section has total of 22 Exclusions, where Insurer is not liable to admit and pay the claim. Out of this 22 exclusions 5 exclusions are waived. Hence in effect there are only 17 exclusions. Let us examine these exclusions below :

4.1 Pre existing health Condition or desease or Injury/ailments.....**WAIVED.**
4.2 First 30 day Exclusion .....**.WAIVED.**
4.3 Time bound Exclusions .....**.WAIVED.**

IF continuity of Renewal is not maintained then the above WAIVED exclusions shall apply unless it is otherwise agreed to by the Company and suitable endorsement is passed.

4.4 Injury / disease directly or indirectly attributable to War or Warlike situation, whether war is declared or not.

4.5 Circumcision (unless necessitated for treatment of disease not excluded under the policy or as may be necessitated dur to accident), Vaccination, Inoculation, cosmetic or aesthetic treatment of any description or plastic surgery other than as may be necessitated by Accident or as a part of any illness.

4.6 a) Surgery for correction of eye sight excepting
(i) for keratotomy of Insured having more than -5 refractive error.
(ii) In case it is performed for therapeutic reasons like recurrent corneal erosions, nebular opacities and non-healing ulcers.
b) Cost of spectacles,
c) Contact lenses,
d) Hearing aids etc.

4.7 Any dental treatment or surgery, unless arising from injury, which requires hospitalisation, which is corrective, cosmetic or aesthetic in nature, filling or cavity, root canal, including treatment for wear or tear etc.,

4.8 Consvalescence, general debility, “run down” condition or rest cure. Sterility, any fertility or sub-fertility or assisted conception procedure, venereal disease, intentional self-injury, suicide, all psychiatric or psychosomatic disorders and diseases / Accident due to and / or use, misuse, abuse of drugs / alchohol or use of intoxicating substances etc.,

4.9 Any treatment received in Convalescent home / convalescent hospital / health hydro / nature cure or similar establishments.

4.10 All expenses arising out of directly or indirectly associated with HTLD – III, or LAV or which are commonly referred to as AIDS, HIV including STD.

4.11 Expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes which is not followed by active treatment.

4.12 Expenses incurred on Vitamins or Tonics unless forming part of treatment for Injury or Disease as certified by treating doctor.

4.13 Any treatment arising from or traceable to Pregnancy, Child birth, miscarriage, ceaserian section, abortions or complications arising out of these.....**WAIVED.**

4.14 Naturopathy treatment, or unproven procedure, experimental or alternative medicine and related treatment acupressure / acupuncture etc.,

4.15 Genetic disorders and stem cell implantation / injury.

4.16 Cost or any external and or durable Medical / Non-medical equipment of any kind used for diagnosis or treatment CPAP/CAPD/ INFUSION PUMP etc., Ambulatory devices.

4.17 Treatment of Obesity and condition arising there from.

4.18 Change of Treatment from one system to another, unless recommended by consultant under whom the treatment is taken.

4.19 Any treatment arising out of Insured's participation in any hazardous activity.

4.20 Out Patient – Diagnostic, Medical or Surgical Procedure or treatment, non-prescribed Drugs, medical supplies. Hormone therapy. Sex Change or treatment which results from in any way to such Sex Change.

4.21 Massages, Steam bathing, Shirodhara and like treatment under Ayurveda.

4.22 Any kind of Service Charges levied by the Hospital unless payable to Govt., WAIVED**.**

CHAPTER 5 : CONDITIONS.

This section contains 15 conditions of which the following are important ones.

5.4 NOTICE OF CLAIM: Within 48 hours of Admission / or Discharge whichever earlier, notice in writing should be given to the Company / TPA in writing giving full details.

5.5 CLAIM DOCUMENTS & TIME LIMIT : The Claim Documents to be submitted to the Company / TPA as under :

a) Hospitalisation and Pre-Hospitalisation Claims – Immediately after the Discharge from the Hospital and in any case not exceeding **THIRTY DAYS** from the date of Discharge.

b) Post Hospitalisation Claims – within **NINETY DAYS** from the Date of Discharge.

They shall be submitted along with Originals of Hospital Bills / Cash memos / Reports Claim form and list of documents listed below:

i) Original bills. Receipts and discharge Certificate / Card from the Hospital.

ii) Medical History of the patient recorded by the Hospital.

Iii) Original Cash Memos from the Hospital / Chemist with proper prescription.

iv) Original receipt. Pathological & other test reports from a Pathologist / Radiologist including film etc., supported by note etc., from attending Medical Practitioner / Surgeons demanding such Tests.

v) Attending Consultants' / Anasthetists' / Specialists' certificate regarding diagnosis and bills / receipts etc., in Original.

vi) Surgeons' original certificate stating diagnosis and nature of operation performed along with Bills / receipts etc.

vii) Any other information required by the TPA / Company.

ALL DOCUMENTS SHOULD BE DULY ATTESTED BY THE INSURED PERSON.

5.6 **PROCEDURE FOR AVAILING CASHLESS FACILITY :**

a) Available only in the Networked Hospitals / Nursing Homes.
b) The TPA after satisfying itself regarding the eligibility of the Insured person, shall issue a pre-authorised letter to the hospital or letter guaranteeing the payment to the Hospital.
c) The TPA / Insurer can deny the pre-authorised letter, incase the Hospital / Insured person fails to give the required information sought by the TPA/Insured. However, this is no bar for claiming the reimbursement subsequently.
d) Even after pre-authorised letter is issued the TPA / Insurer can withdraw the same if any doubt or investigation is required to be done by them. The withdrawal should be in any case before the discharge of the Partient.

5.7 Any Medical Practioner authorised by the TPA / Insured shall have deemed permission to examine the Patient as and when the TPA feels it necessary.

5.10 The Insurer has the right to Repudiate the claim, if not covered / not payable under the Policy. This should informed to the Insured in writing giving reason for Repudiation. The insured can approach the Grievience Redressal Cell of the company of the employee against the repudiation.

5.13 Any repudiation can be challenged within 12 months. If not done so then, the repudiation will be Final and cannot be recovered.

5.15 Mid term inclusion in to the Policy is allowed only for newly wed spouse and new born child.

This is only a gist of the MediClaim Policy issued by United India to the New India Employees for the year 2020-21. For any doubt or details the original Policy Document should be referred.

ANNUEXURE 1 : LIST OF PROCEDURES WHERE 24 HR HOSPITALISATION IS NOT REQUIRED.

Under this annexure, which forms part of the Policy Documents **121** Procedures are listed for which 24 hour Hospitalisation is not required for Claiming under MediClaim Policy of Public Sector GIC's Medi claim Policy.

Item No.122 states that any other Procedures / Surgeries agreed by the TPA and the Company which requires less than 24 hours of Hospitalisation and for which **prior approval of the TPA is required.**

The above note was originally prepared by Shri C T Joshi.
I have made some additions / alteration.
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