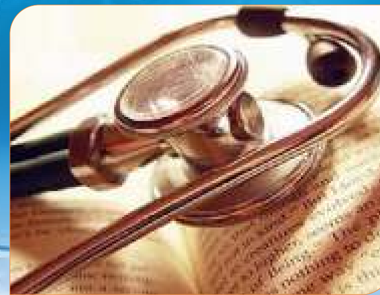
An Initiative of the Committee for Capacity Building of CA Firms and Small & Medium Practitioners, ICAI

Health Insurance Scheme

An Insurance Protection for Members & Students of ICAI

An Arrangement with New India Assurance Co. Ltd., Mumbai

FAQs on Health Insurance Scheme for Members & Students of ICAI



Committee for Capacity Building of CA Firms and Small & Medium Practitioners(CCBCAF & SMP),
The Institute of Chartered Accountants of India (ICAI), New Delhi
(Set up by an Act of Parliament)

FAQs

This document explains how the Health Insurance Scheme of ICAI could provide value to You. In the document the word 'You', 'Your' means you, the Insured under the Policy. 'We', 'Our', 'Us' means New India Assurance Co. Ltd. Though we have taken care to ensure that this document explains the scope of coverage under the Policy, if there is any conflict between this document and the Policy, then the provisions of the Policy would prevail over this document. We therefore advise You to read the terms and conditions of the Policy.

1. WHO CAN TAKE THIS POLICY?

This insurance is available to Registered Members of the Institute of Chartered Accountants of India , the Employees and Students of the Institute , not below the age of 18 years. Children between the age of 3 months and 18 years can be covered provided parents are covered simultaneously.

Students coverage is limited to Self and not available for the Dependants .

2. CAN I COVER MY FAMILY MEMBERS IN ONE POLICY?

Yes. You can cover Your family members in one policy. The members of the family who could be covered under the Policy under a single Sum Insured are:

a) Proposer

b) Proposer's Spouse

c) Proposer's two dependent Children

Additional dependent children may be covered by paying 10% loading on family premium .

There is also an option to cover the Proposer's dependent Parents for a separate Sum Insured equivalent to the Sum Insured of the Proposer's family .

The number of persons to be covered under the policy is to be declared at the inception of the policy **as a one-time option**. Inclusion of additional dependents would be allowed only in case of marriage of the Insured person , or birth of a child . No other inclusion would be permitted either during the coverage of the policy , or at the time of renewal .

3. WHAT DOES THE POLICY COVER?

This Policy is designed to give You, the Insured, protection against unforeseen Hospitalisation expenses.

4. DOES IT COVER ALL CASES OF HOSPITALISATION?

No. This Policy does NOT cover ALL cases of Hospitalisation. Hospitalisation expense relating to a Pre Existing Disease is payable upto the as extent specified below :

For members /employees/students without any previous continuous insurance, the coverage for pre-existing diseases would be subject to the following

First year of coverage	**25% of the admissible claim amount, subject to a maximum of 25% of the sum insured**
Second year of coverage	**50% of the admissible claim amount, subject to a maximum of 50% of the sum insured**
Third year of coverage	**75% of the admissible claim amount, subject to a maximum of 75% of the sum insured**
Fourth year of coverage	**100% of the admissible claim amount, subject to a maximum of 100% of the sum insured**

Similarly, Hospitalisation expenses for pregnancy is not covered under the Policy. There are other such instances, where the claim is not payable.

Some of the exclusions are:

- Diseases contracted within 30 days of insurance .However , this exclusion is not applicable for persons with previous continuous insurance coverage .
- Debility and General Run Down Conditions.
- Sexually transmitted diseases and HIV (AIDS)
- Circumcision, Cosmetic surgery, Plastic surgery unless required to treat injury or illness
- Vaccination and Inoculation
- Pregnancy, ailments related thereto and child birth
- War, Act of foreign enemy, ionising radiation and nuclear weapon.
- Treatment outside India
- Naturopathy
- Domiciliary Treatment
- Experimental or unproven treatment
- All external equipments s**uch as contact lenses, cochlear implants etc.**

Payments made to the Hospital like Service Charges, Surcharge, cost of external or durable medical equipments, non medical expenses, etc. are not payable.The exclusions stated above are not exhaustive. **The exclusions are mentioned in the Policy under the Section 4 " EXCLUSIONS".** You may go through the list of Exclusions to get to know what is NOT covered under the Policy.

5. WHAT IS A PRE EXISTING DISEASE?

The term Pre existing condition/disease is defined in the Policy. It is defined as:

"Any condition, ailment or injury or related condition(s) for which the Insured Person had signs or symptoms, and/or was diagnosed, and/or received medical advice/treatment, within 48 months prior to his/her first Policy with the Company." If You had:

a) Signs or symptoms, or

b) Been diagnosed or received Medical Advice,or

c)Been Treated for any condition or disease within forty eight months prior to the commencement of the first policy with us,

such a condition or disease shall be considered as Pre existing. Any hospitalisation arising out of such pre existing disease or condition is not covered under the Policy, only to the extent specified under Clause 4, for those without any Continuous Insurance, and for others as stated in Clause 6.

6. IS PRE EXISTING COVERED IF I HAD PREVIOUS INSURANCE WITH ANY OTHER INSURER?

YES. Our Policy gives credit for the years' of previous insurance with any other non life insurer, under a Hospitalisation Policy, provided You renew the Policy with Us, on the due date, or at the most within thirty days of the expiry of the Policy with the Previous Insurer. For instance, if you had Continuous Coverage with a previous Insurer for thirty six months, and renew the policy with us on or before expiry date of the previous policy, or within thirty days thereof, pre existing diseases would be fully covered. To put it shortly, this Policy treats your previous years' of insurance with any insurer, as if you had been insuring with us.

7. IS HOSPITALISATION ALWAYS NECESSARY TO GET A CLAIM?

Yes. Unless the Insured Person is Hospitalised for a condition warranting hospitalisation, no claim is payable under the Policy. The Policy does not cover outpatient treatments.

8. HOW LONG DOES THE INSURED PERSON NEED TO BE HOSPITALISED?

The Policy pays only where the Hospitalisation is for more than twenty four hours. But for certain treatments specified in the Policy, period of stay at the Hospital could be less than twenty four hours. Please refer to Clause 3.4 of the Policy for details.

9. WHAT DO I NEED TO DO AFTER I GET HOSPITALISED?

Immediately on Hospitalisation and a maximum of within seven days of such Hospitalisation, please intimate the TPA of this fact, with details of Your Policy Number, Name of the Hospital and treatment undertaken. This is an important condition of the Policy that you need to comply with.

10. IS PAYMENT AVAILABLE FOR EXPENSES INCURRED BEFORE HOSPITALISATION?

Yes. Relevant medical expenses incurred before hospitalization for a period of THIRTY days prior to the date of hospitalisation are payable. Relevant medical expenses means expenses related to the treatment of the disease for which the insured is hospitalised.

11. IS PAYMENT AVAILABLE FOR EXPENSES INCURRED AFTER HOSPITALISATION?

Yes. Relevant medical expenses incurred after Discharge from the Hospital for a period of SIXTY days after the date of discharge are payable. Relevant medical expenses means expenses related to the treatment of the disease for which the insured is hospitalised.

12. IS THERE A LIMIT TO WHAT THE COMPANY WILL PAY FOR HOSPITALISATION?

Yes. We will pay Hospitalisation expenses upto a limit, known as Sum Insured. This Sum Insured represents our total liability under the Policy for all admissible claims of all Insured members under the Policy . In cases where the Insured Person or other insured members were hospitalised , the total of all amounts paid

a) for all cases of Hospitalisation,

b) expenses paid for medical expenses prior to hospitalisation,

c) expenses paid for medical expenses after discharge from hospital, and

d) any other payment made under the Policy

shall not exceed the Sum Insured.

For each policy , the Sum Insured is on floater basis for all persons covered. In Floater basis , any payment made to one Insured Person would make the Sum Insured reduced for all Insured Persons. The total payments under this Policy for all Insured Persons for all claims during the Policy period shall not exceed the Sum Insured. However , since parents are covered under a separate floater Sum Insured , that separate Sum Insured would cover both the parents .

13. HOW LONG IS THE POLICY VALID?

The Policy is valid during the Period of Insurance stated in the Schedule attached to the Policy. It is usually valid for a period of one year from the date of beginning of insurance.

14. CAN THE POLICY BE RENEWED WHEN THE PRESENT POLICY EXPIRES?

Yes. You can and to get all Continuity benefits under the Policy, you should renew the Policy before the

expiry of the present policy. For instance, if Your Policy commences from 2nd March,2011 date of expiry is usually on 1st March, 2012. You should renew Your Policy by paying the Renewal Premium on or before 1st March 2012.

15. WHAT IS CONTINUITY BENEFIT?

There are certain treatments which are payable only after the Insured Person is continuously covered for a specified period. For example, any Pre-existing disease is covered only after four years of continuous insurance under a standard Mediclaim Policy . In the present Group Health Insurance Scheme of ICAI , however , Pre-existing illnesses are covered fully after continuous insurance for three years . Continuous insurance would mean insurance under a Hospitalization policy with any non-life insurer continuously without break . After such credit for previous continuous insurance , the amount payable for pre-existing illnesses would be :

If an Insured took a Policy in March 2012, does not renew it on time, and takes a Policy only in May 2013, and renewed it on time in May 2014, any claim for Pre-existing disease incurred in say, October 2014

First year of coverage	**25% of the admissible claim amount, subject to a maximum of 25% of the sum insured**
Second year of coverage	**50% of the admissible claim amount, subject to a maximum of 50% of the sum insured**
Third year of coverage	**75% of the admissible claim amount, subject to a maximum of 75% of the sum insured**
Fourth year of coverage	**100% of the admissible claim amount, subject to a maximum of 100% of the sum insured**

would become payable only upto the extent of 50% of Sum Insured, because the Insured person was not continuously covered for twenty four months. If, he had renewed the Policy in time in March 2013 and then in March 2014, then he would have been continuously covered for twenty four months and therefore his claim for would become payable upto 75% of the Sum Insured, in the example cited. Therefore, You should always ensure that you pay Your renewal Premium before Your Policy expires.

16. WHAT IS A NO CLAIM BONUS ?

Some of the Insurers , including Us, offer a Cumulative Bonus for years of claim free experience . This Cumulative Bonus represents an increase in Sum Insured available as a Bonus for claim free experience . For such persons with a Cumulative Bonus available in their Policy , we offer a Discount on Premium .

In the Group Health Scheme of ICAI , the Cumulative Bonus earned against any previous insurance policy of any insurer is protected by way of a discount on premium , the details of which are as below :

Cumulative Bonus of upto 10% - 5% discount in premium

Cumulative Bonus of 10-30% - 10% discount in premium

Cumulative Bonus of above 30% - 15% discount in premium

The average Cumulative Bonus available to the family would be considered for the purpose of allowing discount . This Discount is offered **as a one time measure,** offered in lieu of Cumulative Bonus offered by the Previous Insurer. This discount would continue to be extended as long as no claim is reported under the Policy . No additional discount would accrue for claim free years in this Group Policy.

17. WHAT WILL HAPPEN TO DISCOUNT AGAINST CB IF THERE IS A CLAIM?

If there is claim during the current year, next year, there will be no Discount against CB , and whatever

discount is allowed would stand withdrawn at the time of renewal . . Even if the claim is for a smaller amount and for only one person in the family , the No Claim Discount will be withdrawn in the next year.

18. CAN THE SUM INSURED BE INCREASED AT THE TIME OF RENEWAL?

No. You may choose the appropriate Sum Insured right at the time of enrolment into the Scheme.

19. WHAT IS HOSPITAL CASH ALLOWANCE ?

In case an Insured member is hospitalized for a period exceeding twenty four hours , we pay an additional benefit @0.10% of the Sum Insured . This benefit is known as Hospital Cash Allowance . This benefit is limited to a maximum of ten days of Hospitalization for any illness.

20. IS THERE AN AGE LIMIT UPTO WHICH THE POLICY WOULD BE RENEWED?

No. Your Policy can be renewed, as long as You pay the Renewal Premium before the date of expiry of the Policy. There is no age limit for renewal. However, if You do not renew Your Policy before the date of expiry or within THIRTY days of the date of expiry, the Policy may not be renewed. It is therefore in Your interest to ensure that Your Policy is renewed before expiry.

21. CAN THE INSURANCE COMPANY REFUSE TO RENEW THE POLICY?

We may refuse to renew the Policy only on rare occasions such as fraud, misrepresentation or suppression or non cooperation being committed by You or any one acting on Your behalf in obtaining insurance or subsequently in relation thereto. If We discontinue selling this Policy, it might not be possible to renew this Policy on the same terms and conditions. In such a case You shall however have the option for renewal under any similar Policy being issued by the Company, provided the benefits payable shall be subject to the terms contained in such other Policy.

22. CAN I MAKE A CLAIM IMMEDIATELY AFTER TAKING A POLICY?

Claims for Illnesses cannot be made during the first thirty days of a fresh Insurance policy. This condition would not apply to those persons who had insurance previously with any insurer, and renewing with us on time. Even for those who insure for the first time , claims for Hospitalisation due to accidents occurring during the first thirty days are payable.

23. WHAT IS THIRD PARTY ADMINISTRATOR (TPA)?

Third Party Administrator (TPA) is a service provider to facilitate service to You for providing Cashless facility for all hospitalizations that come under the scope of Your policy. The TPA also settles reimbursement claims within the scope of the Policy.

24. WHAT IS CASHLESS HOSPITALIZATION?

Cashless hospitalization is service provided by the TPA on Our behalf whereby you are not required to settle the hospitalization expenses at the time of discharge from hospital. The settlement is done directly by the TPA on Our behalf. However those expenses which are not admissible under the Policy would not be paid, and You would have to pay such inadmissible expenses to the Hospital.

Cashless facility is available only in Networked Hospitals. Prior approval is required from the TPA before the patient is admitted into the Networked Hospital. The list of Networked Hospitals can be obtained from the TPA or from their website. You will have full freedom to choose the hospitals from the Networked Hospitals and avail Cashless facility on production of proof of Insurance and Your identity, subject to the claim being admissible. The TPA might not agree to provide Cashless facility at a Hospital which is not a Network Hospital. In such cases You may avail treatment at any Hospital of Your choice and seek

reimbursement of the claim subject to the terms and conditions of the Policy. In cases where the admissibility of the claim could not be determined with the available documents, even if the treatment is at a Network Hospital, the TPA may refuse to provide Cashless facility. Such refusal may not necessarily mean denial of the claim. You may seek reimbursement of the expenses incurred by producing all relevant documents and the TPA may pay the claim, if it is admissible under the terms and conditions of the Policy.

25. CAN I CHANGE HOSPITALS DURING THE COURSE OF MY TREATMENT ?

Yes it is possible to shift to another hospital for reasons of requirement of better medical procedure. However, this will be evaluated by the TPA on the merits of the case and as per policy terms and conditions.

26. CAN I CHANGE FROM THIS GROUP POLICY TO AN INDIVIDUAL POLICY OF NEW INDIA AT THE TIME OF RENEWAL?

YES. You can. But thereafter, You would be covered by the terms of the Individual Policy, with suitable credit for the years of continuous insurance.

27. HOW TO GET REIMBURSEMENTS IN CASE OF TREATMENT IN NON- NETWORK HOSPITALS OR DENIAL OF CASHLESS FACILITY?

In case of treatment in a non-Network Hospital, TPA will reimburse You the amount of bills subject to the conditions of the Policy. You must ensure that the Hospital where treatment is taken fulfils the conditions of definition of Hospital in the Policy.Within twenty four hours of Hospitalisation the TPA should be intimated. The following documents in original should be submitted to the TPA within fifteen days from the date of Discharge from the Hospital:

- Claim Form duly filled and signed by the claimant
- Discharge Certificate from the hospital
- All documents pertaining to the illness starting from the date it was first detected i.e. Doctor's consultation reports/history
- Bills, Receipts, Cash Memos from hospital supported by proper prescription
- Receipt and diagnostic test report supported by a note from the attending medical practitioner/surgeon justifying such diagnostics.
- Surgeon's certificate stating the nature of the operation performed and surgeon's bill and receipt
- Attending doctor's / consultant's / specialist's / anesthetist's bill and receipt, and certificate regarding diagnosis
- Details of previous policies if the details are not already with TPA or any other information needed by the TPA for considering the claim.

28. HOW TO GET REIMBURSEMENT FOR PRE AND POST HOSPITALIZATION EXPENSES ?

The Policy allows reimbursement of medical expenses incurred before and after admissible Hospitalisation up to a certain number of days. For reimbursement, send all bills in original with supporting documents along with a copy of the discharge summary and a copy of the authorization letter to your TPA. The bills must be sent to the TPA within 7 days from the date of completion of treatment. You must also provide the TPA with additional information and assistance as may be required by the company/TPA in dealing with the claim.

29. WILL THE ENTIRE AMOUNT OF THE CLAIMED EXPENSES BE PAID?

The entire amount of the claim is payable, if it is within the Sum Insured and is related with the Hospitalisation as per Policy conditions and is supported by proper documents, except the expenses which are excluded. If the Policy is subject to Loading , then there would be a deduction towards copay.

30. CAN ANY CLAIM BE REJECTED OR REFUSED?

Yes, a claim, which is not covered under the Policy conditions, can be rejected. In case You are not satisfied by the reasons for rejection, you can represent to Us within 15 days of such denial. If You do receive a response to Your representation or if You are not satisfied with the response, You may write to our Grievance Cell, the details of which are provided at our website at http://newindia.co.in/public.asp. You may also call our Call Centre at on Toll free number 1800-209-1415, which is available 24x7. You also have the right to represent your case to the Insurance Ombudsman. The contact details of the office of the Insurance Ombudsman could be obtained from

http://www.irda.gov.in/ADMINCMS/cms/NormalData_Layout.aspx?page=PageNo234&mid=7.2

N.B. Please refer to the policy wording/document for further clarifications

For the details about the Health Insurance Scheme is available at :

http://www.icai.org/post.html?post_id=8061.

Members desirous to avail the benefits under this scheme may please contact directly to New India Assurance Co. Ltd. at the following address or the Committee Secretariat at ccbcaf@icai.org

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