SUMMARY OF GROUP MEDICLAIM POLICY 2019-20

1. About the Scheme

The Group Mediclaim Scheme provides pre-authorization for cashless/reimbursement of hospitalisation expenses to all classes of employees/retired employees of the Corporation and their dependents through a Group Mediclaim Policy. Policy is being serviced by **The New India Assurance Company Limited.** Scheme offers compulsory family floater sum insured of Rs**.5 Lakh, 6 Lakh** and **10 Lakh.** Employees have also availed benefit of optional increased Total Sum Insured (on floater basis) for **Rs.6 Lakh, 8 Lakh, 10 Lakh, 12 Lakh, 15 Lakh, 20 Lakh, 25 Lakh, 30 Lakh, 40 Lakh and 50 Lakh.**

2. The TPAs assigned to service various LIC zones for the policy period **01/04/2019** to **31/03/2020** are as following:

Western Zone (Incl. Central office, Foreign Posting, MDC, HFL, MF, other deputations) – MD India TPA

Central Zone - Health India TPA

Northern Zone – MD India TPA

North Central Zone - Raksha TPA

East Central Zone - Raksha TPA

Eastern Zone - Heritage TPA

South Central Zone - Medi Assist TPA

Southern Zone - Vidal TPA

3. Room Rent Limit:

Room, Boarding Expenses as provided by the hospital including Nursing charges, not exceeding 1.5% of Total Sum Insured (Basic + Additional) per day, subject to maximum amount of Rs. 7500/- (for Class A cities), Rs. 5000/-(for Class B cities) & Rs. 4000/- (for Other cities) per day are payable. **Members who are covered for total increased cover for Rs.40 and 50 Lakh are eligible for Room Rent Limit of Rs.9000/- per day in Class A cities.** The classification of Cities is given in policy document.

In case of admission to a Room Rent at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, drugs and implants, shall be effected as per eligible room category(reduced proportionately) in the Hospital.

Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses: There is NO Capping/Ceiling on ICU/ICCU expenses.

4. Pre and Post-Hospitalization limit:

Pre-Hospitalization medical expenses up to 30 days period and Post-Hospitalization medical

expenses up to 60 days period are covered. In case of Renal Failure and/or Organ Transplantation and/or Cancer related ailment/treatment the above condition of 30/60 days may be waived.

5. International Medical Second Opinion cover on treatment for critical conditions/diseases

6. Following expenses are NOT payable :

a) Hire Charges, Luxury tax, Escalation Charges, Miscellaneous Charges, File Charges, Departmental Charges, Ward Boy / Ayah Charges and any other similar charges levied by the hospital.
(Only Registration/Admission charges and GST/Surcharges are payable. Service charge, nursing charge if charged in hospital bill shall be payable within Room Rent Eligibility Limit)

b) Telephone charges , Television, Private Nursing/ Barber or Beauty Services, Diet Charges(other than patient diet), Baby Food, Cosmetics, Tissue Papers, Diapers, Toiletry Item, Baby Oil, Napkins, Sanitary Pad, Dettol, Savlon, Spirit, Razor, Blade, Dynaplast, Bandage, Towels, Bed-sheets, Plain Sheet, Cloth, One Touch Strips, Guest Services, Steam ,Electricity Water Charges and similar non medical items and incidental expenses.

c) Non-medical expenses including convenience items for personal comfort – External Durable Material / Non Medical Equipments of any kind used for Diagnosis / Treatment, Infusion Pump etc., **Ambulatory Devices** like Walker, Crutches, Belts, Collars, Caps, Splints, Slings, Braces, Stockings, Elastocrepe bandages, external orthopaedic pads, sub cutaneous insulin pump, Diabetic Footwear, Glucometer, Thermometer, alpha/water bed and similar related items etc. and also any medical equipments which is subsequently used at home.

The complete list of exclusions is given in Policy Document.

7. CASHLESS & REIMBURSEMENT FACILITY THROUGH TPA:

1. The insurer will provide cashless & reimbursement facility through TPA.

2. TPA will remain unchanged in case of inter zonal transfer of employee and/or if retired employee shifts his/ her residence from one place to another place. Original TPA will continue to provide services based on Pan India network of hospitals

8. Expenses relating to Diagnostic Tests without Hospitalization

Following Diagnostic Tests without hospitalization shall be covered subject to the following:

Diagnostic Tests	**Maximum charges payable.**
MRI charges	Rs.8,000/- each Insured
CT Scan charges	Rs.5,000/- each Insured
Sonography charges (Excluding maternity related)	Rs.2,000/- each Insured
Biopsy	Rs.4,000/- each Insured
Tread Mill Test	Rs.1200/- each Insured

Echo Test	Rs.1500/- each Insured
Gastroscopy	Rs.4000/- each Insured
Colonoscopy	Rs.6000-/ each Insured
EEG (Electroencephalogram)	Rs.1000/- each Insured
EMG (Electromyogram)	Rs.2000/- each Insured
Holter Monitor Test	Rs. 5000/- each insured
PAP SMEAR	Rs. 750/- each insured
PSA (Prostate Specific Antigen)	Rs. 750/- each insured
Mammography	Rs. 5000/- each insured
PET Scan	Rs.15000/-each insured

Reimbursement of expenses is allowed only for the above tests and no equivalent diagnostic test will be considered for this purpose. The maximum Reimbursable amount under this benefit shall be Rs. 75,000/- for the family, during the policy year. The above amounts shall be within the overall Sum Insured limit. For claiming reimbursement under this, the tests should have been recommended by an MD DOCTOR or A DOCTOR WITH EQUIVALENT QUALIFICATION and supported by documents and certification evidencing present complaints necessitating the tests to be carried out. However if the Test is recommended by prescription from a Govt. Hospital then the above condition can be waived.

These expenses incurred without hospitalization are payable only once for respective diagnostic tests during the policy period, per insured. However, for MRI, CT Scan, Sonography & Biopsy tests, the same are allowed twice during the policy period, per Insured person, if done for a different organ/body part.

9. SUB-LIMIT CLAUSE

1. Fees paid in cash will be reimbursed on submission of numbered bills upto a limit of:
   Surgeon/Consultant/Specialist: Rs. 30,000/-
   Assistant Surgeon : Rs 12,000/-
   Anesthetist: Rs 20,000/-.

2. Cataract shall be limited to Actual OR maximum of **Rs. 60,000/-** (inclusive of all charges, excluding service tax) for each eye, whichever is less.

3. Expenses incurred for Ayurvedic/Homeopathic/Unani Treatment are admissible provided the treatment for illness/disease and accidental injuries, is taken in a Government hospital or in any institute recognized by Government and/or accredited by Quality Council Of India / National Accreditation Board on Health, excluding centers for spas, massage and health rejuvenation procedures. Further, Steam Bath, Shirodhara, PANCHAKARMA and similar ayurvedic treatments are NOT payable. However the maximum reimbursement will be 25% of sum insured during the policy period.

4. Ambulance Charges: Actual or subject to maximum Rs.5000/- per hospitalization.

5. **Lasik Laser treatment:** The maximum amount payable is **Rs. 35,000/-** per eye for keratotomy of

Insured having more than **(-4)** refractive error, and for therapeutic reasons like recurrent corneal erosions, nebular opacities and non healing ulcers.

6. Age Related Macular Degeneration (ARMD) and/or treatment for retinal disease by intravitreal/intraocular injection/intervention admissible only upto Rs 40,000/- per member per eye per year.

10. Robotic surgery for Malignant Cancer/Cancer, Brain and Spine only are payable.

11. Cochlear Implant –Hospitalization expenses for cochlear implantation surgery (including cost of cochlear implant) is payable upto a sublimit of Rs 10,00,000/- per member with an excess of Rs 1,50,000/- to be borne by Insured member.

12. Maternity Expenses Benefit:

a. Normal Delivery: The maximum benefit allowable will be maximum upto Rs. 65,000/-

b. Caesarian Section Delivery: The maximum benefit allowable will be maximum upto Rs. 1,25,000/-.

13. Physiotherapy as a part of the Pre & Post hospitalization period is payable upto a limit of INR 40,000/- per person per year. Physiotherapy treatment taken at clinic or at specialized physiotherapy treatment centre is only payable. Treatment for Physiotherapy at home not payable. Physiotherapy treatment at home is payable only when the patient is permanently or temporarily disabled (Partial & Total). However such disability should be certified by the consultant doctor under whom patient is treated. Temporary Disability for Physiotherapy to be availed at home – Can be defined as: Impairment of mental or physical faculties that may impede the affected person from functioning normally only so far as he or she is under treatment; with a minimum of 15 days of treatment certified by the treating doctor. The pre & post hospitalization period limit of 30/60 days shall not be applicable for patients who are totally and permanently disabled/paralyzed.

14. Hospitalization less than 24 hrs.

Limitation of 24 hrs. hospitalization is NOT applicable for defined surgeries/procedures. Surgeries/Procedures not defined but agreed by Company/TPA which require less than 24 hours hospitalization due to advancement in Medical Technology are also covered.