PROCEDURE FOR GROUP MEDICAL INSURANCE POLICY

FOR THE REGULAR EMPLOYEES AND PENSIONERS OF

INDIAN INSTITUE OF SCIENCE AND

THEIR DEPENDENT FAMILY MEMBERS

This is the procedure for the group Medical Insurance Policy and a part of the Institute Contributory Health Service Scheme:

1. **CONTRIBUTION:** The rate of contribution is 0.075% of the Basic Pay and DA in 7th CPC. In case of pensioners/family pensioners the contribution will be 0.075% of the Basic Pay and DA in 7th CPC that he/she would have drawn (at the time of retirement) by him/her had he/she continued in service now but for his/her retirement/death. This contribution covers both the inpatient (including group medical insurance) and outpatient services.
2. **BENEFICIARIES:** The regular employees and pensioners of the Institute with their dependents. The Insurance coverage is restricted to Bangalore City only. However in case of inpatient treatment availed outside Bangalore city while on duty, the claim for reimbursement will be considered on case to case basis.

Note: The members are requested to verify the list of insured kept in Unit IA /Unit IB/Health Centre for inclusion of all entitled family members.

3. DEFINITION OF FAMILY:

A.'Family' in respect of employees -

(a) Husband/Wife

(b) Parents or parents-in-law. A female employee has a choice to include either her parents or her Parents-in-law. Option exercised can be changed only once during the service period.

(c) Children including legally adopted children, stepchildren and children taken as wards subject to the following conditions:

Unmarried Son: Till he starts earning or attains the age of 25 years, whichever is earlier.

Daughter: Till she starts earning or gets married, whichever is earlier, irrespective of the age limit.

B. 'Family' in respect of pensioners: –

(a) In case of regular pensioners – Spouse only. If Pensioner has dependents with a permanent disability (Physical/Mental) as per Govt. of India rules, they will also be covered.

(b) In case of family pensioners (after the death of the pensioner) – only self

(c) In case of family pensioners (death while in service) - till the date of normal retirement of the employee– self and dependent children. Beyond that date, self only.

C. The coverage under the policy would be without any upper age limit.

D. Dependency

The income limit for dependency of the family members (other than spouse) is Rs. 3,500/- per month plus the Dearness Relief admissible on Rs. 3,500/- on the date of consideration of the claim.

NOTE: The definition of dependent shall be governed as per guidelines issued by the Central Government from time to time.

E. Addition & Deletion of Family Members during the Running Policy

(a) Addition to the family is allowed in following contingencies during the policy:

(1) Marriage of the beneficiary (requiring inclusion of spouse's name)

(2) New born Baby from day one.

(b) Deletion from Family is applicable in following contingencies:

- Death of beneficiary.
- Divorce of the spouse.
- Member becoming ineligible (on condition of dependency).

F. New Employees:

As regards to the new incumbents, the coverage in the group insurance scheme starts from date of submission of the family declaration and subsequent intimation to the Insurance Company. The family declaration should be submitted within 15 days from

the date of joining the Institute.

4. IDENTIFICATION OF BENEFICIARIES:

Beneficiaries shall be identified by a "Identity Card" issued by the Institute/Insurance company. Cards issued last year may be utilized since they are not having any validity date. If cards are not available may contact council section for getting new cards.

5. SUM INSURED AND BUFFER/CORPORATE SUM INSURED:

(a) **Sum Insured** : The Scheme shall provide coverage for meeting all expenses relating to hospitalization of beneficiary members up to Rs. 5,00,000/- per family per year in any of the registered Hospital/Nursing Home/Day Care Unit. The benefit shall be available to each and every member of the family on floater basis i.e. the total reimbursement of Rs. 5,00,000/- (Rupees Five Lakh only) can be availed either by one individual or collectively by all members of the family.

If the employee/pensioner has also opted for the additional insurance, then the insurance coverage for the member plus family will be basic insurance of Rs. 5,00,000 + additional insurance.

(b) Buffer/Corporate Sum Insured: An additional Sum Insured of Rs. 35 lakhs shall be provided by the Insurance company as Buffer/Corporate Floater. In case hospitalization expenses of a family exceed the original sum insured of Rs. 5,00,000/- plus the additional sum insured if any, the beneficiary is required to inform the IISc Authority with the details. On case to case basis, the IISc., Authority will decide the distribution and disbursement of the buffer amount. The maximum buffer amount would be Rs.5,00,000/- in case of **Cancer**, **Kidney** and **Cardiac Ailments** and in all other cases it would be limited to Rs. 50,000/- only. The buffer amount can be authorized only along with the basic coverage and exclusive buffer authorization is not admissible.

(c) **Limitations**:

(i) Room Rent Limit: 2% of the Sum Insured i.e. including Top-up (subject to a maximum of Rs. 7,500/- per day) for hospitalization and no cap for ICU.

(ii) The cost of maternity procedure is limited to Rs. 50,000/- for both normal and Cesarean.

(iii) Cataract surgery is limited to Rs. 25,000/- per eye.

6.INSURANCE COVERAGE:

(A) **In-patient benefits** – The insurance scheme shall pay expenses (subject to policy limitations) incurred in course of medical treatment availed of by the beneficiaries in a registered Hospitals/Nursing Homes within Bangalore, arising out of either illness/disease/injury and/or sickness. **The treatment must require at least 24-hours hospitalization (excluding day care procedures).** A list of empanelled hospitals/nursing homes are in Annexure I. Any addition/deletion of Hospitals will be notified.

(B) **Coverage of pre-existing diseases** – Pre-existing diseases, if any, shall be covered from day one under this insurance scheme.

(C) **Post hospitalization benefit** – All expenses (subject to sum insured and expenses not covered and policy exclusions) during the post-hospitalization period of up to 60 days required due to the treatment of the sickness for which hospitalization was done would be covered in this scheme limited to Rs. 5,000/- maximum.

(D) Day Care procedures-

The scheme would also provide for day care facilities (which require less than 24 hours hospitalization) for identified procedures. List of such procedures are in Annexure II.

(E) MATERNITY AND NEWBORN BENEFITS

A. Maternity Benefit

(a) Maternity benefit is without 9 months waiting period.

(b) Includes maternity related procedure/treatments arising from childbirth (including both normal delivery/Caesarean section, including miscarriage or abortion induced by accident or other medical emergency)

This **benefit would be limited to only first two living children** in respect of Dependent Spouse/Female Employee

The **new born baby** will be covered by the insurance policy **from the day one** without any waiting period.

The parents/guardians of the baby must report the birth of the child to appropriate IISc authority at the earliest.

The **cost of maternity** procedure is limited to **Rs. 50,000/-**

(c) **Treatment for infer**tility – covered up to maternity limit.

(d) **Internal Congenital Diseases** – Covered, External is also covered in case of life threatening.

B. <u>Newborn Benefit</u>

Newborn child **(single/twins**) to an insured mother would be covered under the scheme from day one for the expenses limited to Rs.5000/- incurred for treatment taken in registered Hospitals/Nursing Homes/Day Care Clinics as an in-patient.

If, in first pregnancy, twins are born then the benefit stand ceases for second pregnancy. However, if in second pregnancy twins are born then both the children will be covered.

7. <u>PROCEDURE FOR AVAILING CASHLESS SERVICES IN NETWORK HOSPITAL/ NURSING HOME</u>:

1. Claims in respect of Cashless Services will be through the list of the network/empanelled Hospitals/Nursing Homes.

2. Cashless services for all planned medical treatment are subject to pre-admission authorization (referral letter) from the Health Centre.

3. In case of emergency, the Insurance Company should be contacted immediately after admission preferably through the hospital/ nursing home. The Insurance Company will send the authorization directly to the Hospital after obtaining referral letter from the Health Centre.

4. A panel of 30 Hospitals/Nursing Homes selected by the IISc Authority is available where admission will be processed without any deposit (cashless in absolute term). However, the employee has to pay for charges related to non-medical/non-admissible items.

5. Claims for hospitalization in non-network or non-empanelled hospital will be reimbursed by the Insurance Company after submitting the claim documents.

6. The Insurance company shall pay the hospital expenses up to the sum insured (including basic coverage + additional insurance + buffer authorized, if any) and the employee/pensioner himself has to pay the balance amount to the hospital. The Institute will not take any responsibility in payment of the balance amount to the Hospital. For reimbursement of the amount paid by the beneficiary exceeding the sum insured, additional insurance and buffer if any authorized, the beneficiary may submit to the Institute a claim which will be processed as per CHSS norms i.e., at St. John's Hospital rates.

8. Claim Documents for non-Cashless Services:

Claim documents in original as per details below should be submitted to the Health Centre **within 30 days from the date of discharge** from the Hospital to enable the Institute to forward the same to Insurance company for reimbursement. However, for Post-hospitalization treatment it shall be within 30 days from the date of completion of Post-hospitalization treatment.

Hospital Main Bills
Hospital Detailed
Bills Prescriptions
Cash Bills
Discharge
Summary
Investigation
Reports
X-ray and Scan
reports Cash Paid
Vouchers

Note: All in Original

9 (a) EXPENSES NOT COVERED UNDER THE POLICY

- Admission/Registration Charges
- Telephone Charges
- Attendant's Changes
- Home Visit/Nursing Charge – at residence after discharge
- Assistant fee/Follow up Charges in advance
- Thermometer Charges
- Container for Specimen/Disposable Bag Charges
- Admission Kit
- Insurance Processing Charges
- External Surgical Aids: Lumbo-Sacral/Collar belt/ Knee cap/Knee brace/Walker/Hot water bag/Baby kit/Urine pot/Traction kit/Folding commode etc.
- Inhaler/Nebulizer

- Diet Charges
- Special/Protein diet/Health drinks unless prescribed by the doctor
- Documentation/Folder/Stationery/In Patient chart charges

Non Medical/ Non Admissible

01.	Documentation Charges
02.	Blade
03.	Pulse Oxymeter
04.	Monitor
05.	S Cover
06.	Cautery
07.	N S T
08.	Gloves
09.	GRBS
10.	M S Solution
11.	Portable Scan
12.	Sanitary Pads
13.	Dietician Fee
14.	H I V
15.	HBSAG
16.	Leads
17.	Plaster
18.	Cotton Gauze
19.	Medico Legal Charge
20.	Skin Preparation
21.	Hand Sanitizer
22.	Enema
23.	Catheterization
24.	Biopsy Container
25.	GRBS(Needle)
26.	Dis. Cautry leads
27.	CARM Charge
28.	Luxury Tax

The above list is only an indicative one and may change from time to time.

Note: Insurance processing charges are covered.

(b) PERMANENT POLICY EXCLUSIONS

- Injuries or diseases caused by war and war like operations. Circumcision, Vaccination, Inoculation, Cosmetic treatment, Plastic surgery (other than as may be necessitated due to an accident or as a part of illness)
- Spectacles, Contact lenses, Hearing Aids, Crutches, wheel chairs, walking stick & collar

- Convalescence, General weakness, Congenital disease, Sterility, Venereal disease, Alcohol use, Self injury
- Diagnostic expenses not followed by active treatment for the ailment
- Vitamins and Tonics unrelated to treatment
- Injuries or diseases caused by nuclear weapons
- Abortion/voluntary termination during first three months of pregnancy
- Naturopathy Homeopathy, Ayurvedic and Unani treatments.
- Injuries sustained due as a result of active participation in any hazardous sports
- Diagnostics, X-Ray or Laboratory examination not consistent with or

incidental to diagnosis of positive existence and treatment of any ailment,

sickness or injury for which confinement is required at Hospital/Nursing

Home

- Instrument used in treatment of Sleep Apnea Syndrome and Continuous

Peritoneal Ambulatory Dialysis and Oxygen Concentrator for Bronchial

Asthmatic Condition

- Genetic disorders and stem cell implantation/surgery
- Experimental and unproven treatment

All non medical expenses including convenience items for personal comfort such as telephone, television, Ayah, Private Nursing/Barber or beauty services, Diet Charges, Baby Food, Cosmetics, Tissue Papers, Diapers, Sanitary Pads, Toiletry items etc.

All expenses arising out of any condition directly or indirectly caused by or associated with Human T-Cell Lymphotrophic Virus type III (HTLD-III) or Lymphdanopathy associated virus(LAV) or the mutant derivative or variations deficiency syndrome or any syndrome or condition of similar kind commonly referred to as AIDS.

Domiciliary hospitalization

Dental treatment except in case of accident

Name of the Insurance Company:

M/s Star Health & Allied Insurance Co., Ltd.,,

Help Desk: Mr. K Dinesh 89718 99445 email. kdinesh@futurisk.in

For any further clarification, Contact:

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