HEALTH INSURANCE FOR NRI CHARTERED ACCOUNTANTS
(MEMBERS OF THE INSTITUTE OF CHARTERED ACCOUNTANTS OF INDIA)

We welcome You as Our Customer. This document explains how the Group 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 19 years. Children between the age of 3 months and 19 years can be covered provided parents are covered simultaneously.

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 a discounted premium. There is also an option to cover the Proposer’s dependent Parents for a separate Sum Insured. PARENTS COVERAGE IS AVAILABLE ONLY FOR MEMBERS. The facilitation for insuring the parent could be done by our Dubai office. 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?**

100% direct billing facility for inpatient & outpatient treatment for our network hospital/clinics within UAE. Geographical limit is UAE, South East Asia and India. The members and their family in UAE with residence visa would be covered under family floater scheme for medical insurance in UAE/South East Asia/India. This Policy is designed to give your parents, protection against unforeseen Hospitalisation expenses in India.

4. **DOES IT COVER ALL CASES OF HOSPITALISATION?**

Yes. Except the following.

**Some of the exclusions are:**

- Pre-existing Diseases
- 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 and child birth
- War, Act of foreign enemy, ionising radiation and nuclear weapon.
- Naturopathy
- Experimental or unproven treatment
- All external equipments such as contact lenses, cochlear implants etc.
- Any kind of treatment for mental or emotional disturbances, hypnosis or psychotherapy.
- Infertility or related and birth control or related
- Birth defects or congenital diseases
- Circumcision.
- Routine medical examination.
- Orthodontic, bridges, crowns, gingivitis, periodontitis, root canaling any form of surgical dental treatment
- Hearing and Visual aids.
- Pharmaceuticals, bandages and medicines if not prescribed by the treating doctor.
- Sexually Transmitted Diseases, HIV and related.
- Rehabilitation.
- Nursing at home
- Sleep Apnea and Snoring
- Vocational Speech Therapy
- Eating disorders.
- Sex Change Operations.
- Varicose veins – (covered only if medically required)
• Complimentary therapies like Homeopathy and the like.
• Obesity and any treatment and related conditions.
• Deviated Nasal Septum – If medically required
• Skin disorders – Covered upon case to case basis
• Organ or tissue transplant – Recipient insured member only
• Hair and scalp treatment
• Work related problems
• Dental Treatment except when necessitated due to accidental injury

5. IS THERE A LIMIT TO WHAT THE COMPANY WILL PAY FOR TREATMENT?

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.

6. 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 generally valid for a period of one year from the date of beginning of insurance.

7. 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.

8. 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.
**9. 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.**

**10. 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.

**11. 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 treatments that come under the scope of Your policy. The TPA also settles reimbursement claims within the scope of the Policy.

**12. WHAT IS CASHLESS Treatment?**
Cashless treatment is service provided by the TPA on Our behalf whereby you are not required to settle the treatment expenses. 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 treated in 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.

13. 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.

14. 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. The amount payable is also governed by the Terms and Conditions of the Policy.

15. 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.

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