From	To
INDIAN OVERSEAS BANK Personnel Admn. Department **Welfare Section** **Central Office** **763, Anna Salai, Chennai 600 002.**	All Indian Branches / Regional Offices/ Zonal offices/Other offices

TRANSIENT SERIES (File :7 F) Circular No.57 of 2015-16 **Dated 06.11.2015**

STAFF- WELFARE

IMPLEMENTATION OF MEDICAL INSURANCE SCHEME FOR THE RETIRED/RESIGNED OFFICERS/ EMPLOYEES ETC.,IN LIEU OF EXISTING REMAS

As per the Xth bipartite settlement/joint note dated 25.05.2015, New Medical Insurance Scheme (Annexure II) has been framed for employees including retired/resigned officers/employees, etc and is being implemented by our Bank. The Retired Employees Medical Assistance Scheme (REMAS) will be replaced by the New Medical Insurance Scheme having tie-up with M/s United India Insurance Company Ltd and their Third Party Administrator is M/s MDIndia Health Services Pvt. Ltd.

The reimbursement from M/s Vidal Health care services and the Medical allowance of Rs.2000/- every year given to REMAS members will be withdrawn. However, the contribution towards REMAS will continue and the funds accumulated under the corpus will be utilized for bearing a portion of the premium of retirees by the Bank under the New Medical Insurance Scheme.

The salient features of the Scheme are briefly as under:

- **Family Definition :**

  Employee + Spouse

- **Room Eligibility :**

Room Rent Including boarding charges Rs.5000/- per day. ICU Charges Rs.7500/- per day. This is the only item for which maximum ceiling amount of reimbursement is fixed.

- **Pre- Post Hospitalization :**

Expense incurred during the Pre-hospitalization and Post-hospitalization period will be covered for 30 days prior to hospitalization and 90 days after discharge respectively.

- **Day Care Treatment :**

Expenses on Hospitalization for minimum period of a day are admissible. If the surgery is undertaken under General or Local Anaesthesia in a hospital / day care Centre in less than a day because of technological advancement and which would have otherwise required hospitalization of more than a day.

- **Change of Treatment:**

Change of treatment from one system of medicine to another is covered in the policy if recommended by treating doctor.

- **Pre-existing and other waivers :**
  1. Pre-existing diseases / Ailments are covered.
  2. All diseases and ailments are covered under the policy without any waiting period.

- **Domiciliary Cover:**

Medical expenses incurred for listed domiciliary ailments on out Patient basis are covered under the policy and shall be reimbursed to the extent of 100%.

- **Cashless Facility:**

The scheme also includes the benefit of cashless treatment facility in hospitals under a scheme worked by the Banks and the hospitals under a common insurance scheme.

- **PREMIUM DETAILS:**

The premium payable and the Insurance coverage available are as under:

RETIREES CADRE	SUM INSURED	PREMIUM	SERVICE TAX @ 14% (Rounded to next rupee)	Total Annual Premium
Officers	Rs.4.00 Lakhs	Rs.6573/-	Rs.921/-	Rs.7494/-
Clerical	Rs.3.00 Lakhs	Rs.4930/-	Rs.691/-	Rs.5621/-
Sub-Staff	Rs.3.00 Lakhs	Rs.4930/-	Rs.691/-	Rs.5621/-

The above mentioned amount is on family floater basis **covering Hospitalization expenses and also Domiciliary Treatment of member and spouse only.**

PREMIUM SHARING PATTERN:

Regarding the premium for the New Medical Insurance Scheme, member should pay as below:

1. Those who have retired earlier and not a member of REMAS will have to pay 50% of the insurance premium and an one time contribution fee to the corpus fund by choosing one of the options below (A or B):

   A. Pay 50% of the last drawn Basic pay inclusive of all components which form part of B.P. i.e., excluding DA, HRA,CCA

(OR)

   B. As per the schedule below:

S.No.	Cadre	Contribution Amount
1.	Scale VII	26000
2.	Scale VI	23400
3.	Scale V	20200
4.	Scale IV	18100
5.	Scale III	15750
6.	Scale II	14050
7.	Scale I	12850
8.	Clerical	9650
9.	Sub-staff	5675
10.	Part time Sweeper	2500

2. New retirees will have to pay 50% of the insurance premium and an one time contribution fee to the corpus fund as stated in para 1 above.

3. Those who have retired earlier and presently member of REMAS will have to pay 50% of the Insurance Premium for the new scheme.

4. Family pensioners will have to pay 50% of the insurance premium and an one time contribution fee to the corpus fund as stated below:

S.No.	Cadre of retired employee	Contribution amount
1.	Officers	Rs.7500/-
2.	Clerks	Rs.5000/-
3.	Sub-Staff	Rs.2500/-

Members who are not willing for payments as above, can pay full premium & join the new Medical Insurance Scheme.

GENERAL CONDITIONS:

1. The Insurance policy is aimed to cover the medical expenses of the retirees and his/her spouse only.

2. There is no upper age limit for coverage under this scheme.

3. The policy for retirees **commences on 01.11.2015 and will be effective from 01.12.2015 for our Bank this year. The policy period commences from November 1st of every year in future.**

4. **An one time option** is extended to the officers/ employees who have already retired / superannuated/ resigned etc. from the service of the Bank **to join the scheme.**

5. Members who are eligible and wish to join the Scheme, should submit willingness form (annexure I) for membership together with Demand Draft drawn in favour of **'INDIAN OVERSEAS BANK RETIRED EMPLOYEES MEDICAL ASSISTANCE SCHEME'** drawn on City Back Office, Chennai towards one time entry fee and send the same to **Chief Manager, Personnel Administration Department, Welfare Section, Central Office, Chennai .** The **annexure I** should **reach us on or before 28.11.2015** along with the DD where applicable.

6. **Those Ex-employees who do not opt now, would not be allowed to join later.**

7. The eligible ex-employees who join and subsequently opt out also will not be allowed to rejoin.

8. Bank will be debiting the required amount from the specified IOB account as and when due/ demanded without any prior intimation/ information to the member subject to availability of sufficient funds in the account. In case **sufficient balance is not maintained, the option would be treated as lapsed and the Bank shall not be responsible under any circumstances for non-inclusion of the concerned individual in the Insurance policy.**

9. Bank will continue to act as per the authorization letter unless the instructions otherwise is conveyed in writing atleast 45 days before the due date of premium.

10. **The annual premium payable is subject to change from time to time as fixed by the Insurance Company every year and the sharing pattern of the Bank will also be reviewed on a yearly basis.**

11. Bank shall act only as an intermediary in providing the data to the Insurance Company and is in no way responsible for reimbursement under the scheme except what is admissible/payable by the Insurance Company.

12. The terms, conditions & continuation of the scheme shall also be subject to Industry level decision and the clarification/ interpretation of various terms and conditions of the scheme shall be strictly as communicated by IBA and the Ex-employees shall be bound by the same.

PLEASE NOTE that Members who have retired/ are retiring on or after 01.10.2015 will have cover under serving employees scheme till 30.09.2016 and the reimbursement shall cover self, spouse and their dependents also. After that they have to pay one month premium on pro-rata basis for October 2016 for coverage under retirees' policy (definitions as per this circular) and then join the retirees' policy by paying the premium as mentioned above for coverage from 01.11.2016.

The existing members of REMAS should note to pay 50% of the premium for the new scheme, else they will not get coverage under REMAS or the new scheme.

The circular along with the authorisation form are made available in **IOB website "www.iob.in" ⟶ New Medical Insurance Scheme for retirees** and also in **IOB Online under Staff Corner ⟶ New Medical Insurance Scheme ⟶ Retirees.**

All branches/Offices are requested to bring the contents of the circular to the knowledge of all the pensioners and other ex-employees, so as to enable them to give their willingness to join this scheme. A copy of this circular should also be displayed in the notice board of all the branches. The information may be passed on to all the ex-employees on humanitarian grounds.

(INDIRA PADMINI)

GENERAL MANAGER

ANNEXURE I

To
The Chief Manager
Personnel Administration Dept.
Indian Overseas Bank
Central Office,
763, Annasalai,
Chennai- 600002.

Date:

Dear Sir,

Willingness/Consent/Authorisation letter to join the New Medical Insurance Scheme as per the circular no. 57 (file : 7F) of 2015-2016 dated 06.11.2015

LAST DATE FOR SUBMISSION-28.11.2015

I _____ retired etc., from the services of the Bank on_____(Date of retirement) as Officer/ Clerical/ Sub-staff, have gone through the terms and conditions of the Joint note dated 25.05.2015 on Medical Insurance Scheme and express my willingness to join the said scheme by paying the **agreed Insurance premium or full premium.**

I am maintaining the following SB/ CDCC account with our _____ Branch.

15 digit Account Number:

I hereby authorise you to recover the insurance premium to the debit of my above account and to pay the premium in future also. I will ensure that the sufficient balance is maintained in the account. In case, if sufficient balance is not maintained, my option/ renewal of policy would be treated as lapsed.

I also understand that Bank is facilitating the payment by obtaining this mandate and it will be my responsibility to ensure that annual premium is paid. I also understand and accept that the Bank shall act as an intermediary in providing the data to the Insurance Company and is in no way responsible for reimbursement of any amount under the scheme except what is admissible/payable by the Insurance Company.

I am furnishing the details of myself and my spouse hereunder:

Details	Name in Full	Date of Birth	Gender
Self			
Spouse			

Yours faithfully,

Place: _____

Date: _____

Signature _____

Name: _____

Roll No. _____

Address for Communication:

Address: **PINCODE:**	**Mobile :** **Tel. No:** **Email ID:**

ANNEXURE II

NEW MEDICAL INSURANCE SCHEME

(As per X Bi-partite Settlement/ Joint note for all employees)

To be read with our circulars

Transient series (File : 7F) Circular No. 57 of 2015-2016 dated 06.11.2015
Transient series (File : 7F) Circular No. 58 of 2015-2016 dated 07.11.2015

Having regard to the need to extend better coverage and reimbursement of hospitalization and medical expenses incurred by the officers / employees/dependent family members, the demand for full reimbursement of expenses connected with hospitalization and medical treatment including domiciliary hospitalization and domiciliary treatment was discussed by and between the parties and a new scheme for reimbursement of medical expenses has been formulated.

The salient features of the Scheme are as under:

The scheme shall cover expenses of the officers / employees and dependent family members in cases he/she shall contract any disease or suffer from any illness (hereinafter called DISEASE) or sustain any bodily injury through accident (hereinafter called INJURY) and if such disease or injury shall require any employee/ dependent family member, upon the advice of a duly qualified Physician/Medical Specialist/Medical practitioner (hereinafter called MEDICAL PRACTITIONER) or of a duly qualified Surgeon (hereinafter called SURGEON) to incur hospitalization/ domiciliary hospitalization and domiciliary treatment expenses as defined in the Scheme, for medical/surgical treatment at any Nursing Home/ Hospital / Clinic (for domiciliary treatment)/ Day care Centre which are registered with the local bodies in India as herein defined (hereinafter called HOSPITAL) as an inpatient or otherwise as specified as per the scheme.

The Scheme covers Employee + Spouse + Dependent Children + any two of the dependent Parents /Parents-in-law.

- No age limit for dependent children (including step children and legally adopted children).

- A child would be considered dependent if his/her monthly income does not exceed Rs.10,000/- per month;
- Widowed Daughter and dependent divorced / separated daughters, sisters including unmarried / divorced / abandoned or separated from husband/ widowed sisters and Crippled Child shall be considered shall be considered as dependent for the purpose of this policy.
- Physically challenged Brother / Sister with 40% or more disability shall also be covered as Dependent.
- No Age Limits for Dependent Parents. Any two, i.e. either dependent parents or parents-in-law will be covered as dependent.
- Parents would be considered dependent if their monthly income does not exceed Rs.10,000/- per month or as revised by Indian Banks' Association in due course, and wholly dependent on the employee as defined in this scheme.

All the existing permanent officers / employees of the Banks which are parties to this Settlement shall be covered by this Scheme from the date of introduction/implementation of this Scheme. All New Officers / employees shall be covered from the date of joining as per their appointment in the bank.

Till the new scheme is made effective and gets implemented, the existing provisions as per Bipartite Settlement/ Joint Note dated 27.4.2010 will continue to operate.

The new Scheme as applicable to the officers/ employees in service would be continued beyond their retirement/superannuation/resignation, etc. subject to payment of stipulated premium by them.

The new Scheme would also cover the existing retired officers/ employees of the Banks and dependent spouse subject to payment of stipulated premium by them.

In the event of any claim becoming admissible under this scheme, the Bank will reimburse the amount of such expenses as would fall under different heads mentioned below and as are reasonably and medically necessary incurred thereof by or on behalf of such employee.

Reimbursement shall cover Room and Boarding expenses as provided by the Hospital/Nursing Home not exceeding Rs.5000 per day or the actual amount whichever is less. Intensive Care Unit (ICU) expenses not

exceeding Rs.7500/- per day or actual amount whichever is less. Surgeon, team of surgeons, Assistant surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees, Nursing Charges, Service Charges, IV Administration Charges, Nebulization Charges, RMO charges, Anaesthetic, Blood, Oxygen, Operation Theatre Charges, surgical appliances, OT consumables, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like pacemaker, defibrillator, ventilator, orthopaedic implants, Cochlear Implant, any other implant, Intra-Occular Lenses, infra cardiac valve replacements, vascular stents, any other valve replacement, laboratory/ diagnostic tests, X-ray CT Scan, MRI, any other scan, scopies and such similar expenses that are medically necessary or incurred during hospitalization as per the advice of the attending doctor.

Hospitalization expenses (excluding cost of organ) incurred on donor in respect of organ transplant to officers/ employee/dependent would also be covered for reimbursement.

Pre and Post Hospitalization expenses payable in respect of each hospitalization shall be the actual expenses incurred subject to 30 days prior to hospitalization and 90 days after discharge.

Alternative systems of treatments other than treatment under Allopathy or modern medicine shall include Ayurveda, Unani, Siddha, Homeopathy and Naturopathy in the Indian context, for Hospitalization and Domiciliary treatment.

CASHLESS FACILITY: The scheme also includes the benefit of cashless treatment facility in hospitals under a scheme worked by the Banks and the hospitals under a common insurance scheme.

CONTRIBUTION: The officers / employees shall not be required to share the cost of such benefits under the new scheme. However, in the case of officers / employees retiring from the Banks after the scheme is introduced and those who are already retired from the services of the banks and who opt to avail the benefits of the scheme, the amount of contribution by such persons shall be decided at the respective Bank level.

Day care Treatments shall be covered under the scheme and would refer to medical treatment and or surgical procedure which is

(i) undertaken under general or local anaesthesia in a hospital/day care centre in less than a day because of technological advancement, and

(ii) which would have otherwise required hospitalisation of more than a day. Treatment normally taken on an out patient basis is not included in the scope of this definition.

DOMICILIARY HOSPITALIZATION: Domiciliary Hospitalization shall be covered under this scheme and would mean medical treatment for an illness/disease/injury which in the normal course would require care and

treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

(a) The condition of the patient is such that he/she is not in a condition to be removed to a hospital or

(b) the patient takes treatment at home on account of non-availability of room in a hospital.

DOMICILIARY TREATMENT shall also be covered under this scheme i.e. treatment taken for specified diseases which may or may not require hospitalization as mentioned herein below.

Domiciliary Hospitalization / Domiciliary Treatment : Medical expenses incurred in case of the following diseases which need Domiciliary Hospitalization /domiciliary treatment as may be certified by the recognized hospital authorities and bank's 'medical officer shall be deemed as hospitalization expenses and reimbursed to the extent of 100%.

Cancer, Leukemia, Thalassemia, Tuberculosis, Paralysis, Cardiac Ailments , Pleurisy , Leprosy, Kidney Ailment, All Seizure disorders, Parkinson's diseases, Psychiatric disorder including schizophrenia and psychotherapy, Diabetes and its complications, hypertension, Asthma, Hepatitis –B, Hepatitis - C, Hemophilia, My asthenia gravis, Wilson's disease, Ulcerative Colitis, Epidermolysis bullosa, Venous Thrombosis (not caused by smoking) Aplastic Anaemia, Psoriasis, Third Degree burns, Arthritis, Hypothyroidism, Hyperthyroidism, expenses incurred on radiotherapy and chemotherapy in the treatment of cancer and leukemia, Glaucoma, Tumor, Diphtheria, Malaria, Non-Alcoholic Cirrhosis of Liver, Purpura, Typhoid, Accidents of Serious Nature, Cerebral Palsy, Polio, all Strokes leading to Paralysis, Haemorrhages caused by accidents, all animal/reptile/insect bite or sting, chronic pancreatitis, Immuno suppressants, multiple sclerosis / motor neuron disease, status asthamaticus, sequalea of meningitis, osteoporosis, muscular dystrophies, sleep apnea syndrome(not related to obesity), any organ related (chronic) condition, sickle cell disease, systemic lupus erythematous (SLE), any connective tissue disorder, varicose veins, thrombo embolism venous thrombosis/ venous thrombo embolism (VTE), growth disorders, Graves' disease, Chronic Pulmonary Disease, Chronic Bronchitis, Physiotherapy and swine flu shall be considered for reimbursement under domiciliary treatment.
The cost of medicines, investigations, and consultations, etc.in respect of domiciliary treatment shall be reimbursed for the period stated by the specialist in Prescription. If no period stated, the prescription for the purpose of reimbursement shall be valid for a period not exceeding 90 days.

HOSPITAL / NURSING HOME: A Hospital under this scheme would mean any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a Hospital with the local authorities under the Clinical establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

- Has qualified nursing staff under its employment round the clock.
- Has at least 10 in-patient beds in towns having a population of less than 10 lacs and at least 15 in-patient beds in all other places;
- Has qualified medical practitioner(s) in charge, round the clock;
- Has a fully equipped Operation Theatre of its own where surgical procedures are carried out;
- Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

This clause will however be relaxed in areas where it is difficult to find such hospitals. The term ' Hospital / Nursing Home ' shall not include an establishment which is a place of rest, a place for the aged, a place for drug-addicts or place for alcoholics, a hotel or a similar place.

HOSPITALIZATION: Hospitalization would mean admission in a Hospital/ Nursing Home for a minimum period of 24 consecutive hours of inpatient care except for specified procedures/treatments, where such admission could be for a period of less than a day,

ID CARD: In terms of the scheme arrived at between the Banks and insurance companies, ID Cards would be issued to all the officers / employees/ dependent family members/retired officers / employees/their dependents for the purpose of availing cashless facility in network hospitals.

PRE-EXISTING DISEASE: Pre Existing Diseases would be covered for reimbursement under this scheme.

PRE–HOSPITALISATION MEDICAL EXPENSES : Medical expenses incurred immediately 30 days before the insured person is hospitalized will be considered as part of a claim provided that such medical expenses are incurred for the same condition for which the insured person's hospitalization was required.

POST HOSPITALISATION MEDICAL EXPENSES: Relevant medical expenses incurred immediately 90 days after the employee/ dependent/ retirement employee is discharged from the hospital provided that such medical expenses are incurred for the same condition for which the Insured Person's Hospitalization was required.

Additional Ex-Gratia for Critical Illness : In addition to the reimbursement covered under this scheme, officers / employees (only officers / employees and not their dependents or retired officers / employees) shall be provided additional ex gratia of Rs. 1,00,000/- . In case an employee contracts a Critical Illness as listed below, the sum of Rs.1,00,000/- shall be paid. This benefit shall be provided on first detection/diagnosis of the Critical Illness.

- Cancer including Leukemia
- Stroke
- Paralysis
- By Pass Surgery
- Major Organ Transplant/Bone marrow transplantation
- End Stage Liver Disease
- Heart Attack
- Kidney Failure
- Heart Valve Replacement Surgery

Hospitalization is not required to claim this benefit.
Expenses on Hospitalization for minimum period of a day are admissible.
However, this time limit shall not be applied to specific treatments, such as:

1	Adenoidectomy	19	Haemo dialysis
2	Appendectomy	20	Fissurectomy / Fistulectomy
3	Auroplasty not Cosmetic in nature	21	Mastoidectomy
4	Coronary angiography /Renal	22	Hydrocele
5	Coronary angioplasty	23	Hysterectomy
6	Dental surgery	24	Inguinal/ventral/umbilical/femoral hernia
7	D&C	25	Parenteral chemotherapy
8	Excision of cyst/granuloma/lump/tumor	26	Polypectomy
9	Eye surgery	27	Septoplasty

10	Fracture including hairline fracture/dislocation	28	Piles/ fistula
11	Radiotherapy	29	Prostate surgeries
12	Chemotherapy including parental chemotherapy	30	Sinusitis surgeries
13	Lithotripsy	31	Tonsillectomy
14	Incision and drainage of abscess	32	Liver aspiration
15	Varicocelectomy	33	Sclerotherapy
16	Wound suturing	34	Varicose Vein Ligation
17	FESS	35	All scopies along with biopsies
18	Operations/Micro surgical operations on the nose, middle ear/internal ear,tongue, mouth, face, tonsils & adenoids,salivary glands & salivary ducts, breast,skin & subcutaneous tissues, digestive tract, female/male sexual organs.	36	Lumbar puncture
		37	Ascitic Pleural tapping

This condition will also not apply in case of stay in hospital of less than a day provided the treatment is undertaken under General or Local Anesthesia in a hospital / day care centre in less than a day because of technological advancement and which would have otherwise required hospitalization of more than a day.

MATERNITY EXPENSES BENEFIT EXTENSION: Hospitalization expenses in respect of the new born child can be covered within the Mother's Maternity expenses. The maximum benefit allowable under this clause will be up to Rs. 50000/- for normal delivery and Rs. 75,000/- for Caesarean Section.

Baby Day one Cover: New born baby is covered from day one. All expenses incurred on the new born baby during maternity will be covered in addition to the maternity limit and up to Rs, 20,000/-.

Ambulance Charges: Ambulance charges are payable up to Rs 2500/- per trip to hospital and / or transfer to another hospital or transfer from hospital to home if medically advised. Taxi and Auto expenses in actual maximum up to Rs750/- per trip will also be reimbursable.

Ambulance charges actually incurred on transfer from one center to another center due to Non availability of medical services/ medical complication shall be payable in full.

Congenital Anomalies: Expenses for Treatment of Congenital Internal / External diseases, defects anomalies are covered under the scheme.

Psychiatric diseases: Expenses for treatment of psychiatric and psychosomatic diseases shall be payable with or without hospitalization.

Advanced Medical Treatment: All new kinds of approved advanced medical procedures for e.g. laser surgery, stem cell therapy for treatment of a disease is payable on hospitalization /day care surgery.

Treatment taken for Accidents can be payable even on OPD basis in Hospital.

Taxes and other Charges : All Taxes , Surcharges , Service Charges , Registration charges, Admission Charges , Nursing , and Administration charges to be payable.

Charges for diapers and sanitary pads are payable,if necessary, as part of the treatment.

Charges for Hiring a nurse / attendant during hospitalization will be payable only in case of recommendation from the treating doctor in case ICU / CCU, Neo natal nursing care or any other case where the patient is critical and requiring special care.

Treatment for Genetic Disorder and stem cell therapy shall be covered under the scheme.

Treatment for Age related Macular Degeneration (ARMD), treatment such as Rotational Field Quantum magnetic Resonance (RFQMR), Enhanced External Counter Pulsation (EECP), etc. are covered under the scheme. Treatment for all neurological/ macular degenerative disorders shall be covered under the scheme.

Rental Charges for External and or durable Medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Bi-PAP, Infusion pump etc. will be covered under the scheme. However purchase of the above equipment to be subsequently used at home in exceptional cases on medical advice shall be covered.

Ambulatory devices i.e., walker, crutches, Belts, Collars, Caps, Splints, Slings, Braces, Stockings, elastocrepe bandages, external orthopaedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer (including Glucose Test Strips)/ Nebulizer/ prosthetic devise/ Thermometer, alpha / water bed and similar related items etc., will be covered under the scheme.

Physiotherapy charges: Physiotherapy charges shall be covered for the period specified by the Medical Practitioner even if taken at home.

While reimbursement to the officers / employees shall be made by the Banks as hitherto, the Scheme shall be administered by the Banks through a scheme worked out between IBA/Banks and Insurance companies and officers / employees would in no way be directly bound by the terms and conditions of such scheme or arrangements.

However, for the purpose of clarity and information, the details of the Scheme worked out between IBA/Banks and insurance companies is appended herein as **Appendix I & II.**

The above stated scheme would not supersede the continuation of any bank-level arrangement or scheme providing for reimbursement of medical expenses, which is not covered herein, that may be in operation in any Bank.

Appendix I

Medical Scheme for the Officers/ Employees of IBA Member Banks, parties to the Bipartite Settlement/ Joint Note dated 25th May 2015 in lieu of the Existing Hospitalization Scheme

The scheme covers expenses of the officers / employees and dependent in cases he/she shall contract any disease or suffer from any illness (hereinafter called DISEASE) or sustain any bodily injury through accident (hereinafter called INJURY) and if such disease or injury shall require any such insured Person, upon the advice of a duly qualified Physician/Medical Specialist/Medical practitioner (hereinafter called MEDICAL PRACTITIONER) or of a duly qualified Surgeon (hereinafter called SURGEON) to incur hospitalization/domiciliary hospitalization and domiciliary treatment expenses as defined in the Scheme, for medical/surgical treatment at any Nursing Home/Hospital / Clinic (for domiciliary treatment)/ Day care Centre which are registered with the local bodies, in India as herein defined (hereinafter called HOSPITAL) as an inpatient or otherwise as specified as per the scheme, to the extent of the sum insured + Corporate buffer.

1.1 The Scheme Covers Employee + Spouse + Dependent Children + 2 dependent Parents /parents-in-law.

- No age limit for dependent children. (including step children and legally adopted children) A child would be considered dependent if their monthly income does not exceed Rs. 10,000/- per month; which is at present, or revised by Indian Banks' Association in due course. Widowed Daughter and dependant divorced / separated daughters, sisters including unmarried / divorced / abandoned or separated from husband/ widowed sisters and Crippled Child shall be considered as dependent for the purpose of this policy. Physically challenged Brother / Sister with 40% or more disability.
- No Age Limits for Dependent Parents. Either Dependent Parents or parents-In-law will be covered. Parents would be considered dependent if their monthly income does not exceed Rs. 10,000/- per month, which is at present, or revised by Indian Banks' Association in due course, and wholly dependent on the employee as defined in this scheme.

(The definition of family shall undergo a change as decided in due course in the negotiations)

1.2.1 All New Officers / employees to be covered from the date of joining as per their appointment letter. For additions /deletions during policy period, premium to be charged /refunded on pro rata basis.

1.2.2 Continuity benefits coverage to officers / employees on retirement and also to the Retired Officers / employees, who may be inducted in the Scheme.

1.3 Sum Insured: Hospitalization and Domiciliary Treatment coverage as defined in the scheme per annum

Officers	:Rs.400000
Clerical Staff	:Rs.300000
Substaff	:Rs.300000

Change in sum insured after commencement of policy to be considered in case of promotion of the employee or vice versa.

1.4 Corporate Buffer: Rs. 100,00,00,000/- Corporate buffer may be appropriated as per the premium of the bank. If the Corporate buffer of one bank is exhausted, the remaining amount can be claimed from the unutilized corporate buffer of the other banks. Corporate Buffer can be authorized by the Management, through an Authorized person / Committee as decided by IBA / Bank, and informed directly to the THIRD PARTY ADMINISTRATOR by keeping the insurance company in the loop.

1.5 In the event of any claim becoming admissible under this scheme, the company will pay through Third Party Administrator to the Hospital / Nursing Home or insured the amount of such expenses as would fall under different heads mentioned below and as are reasonably and medically necessary incurred thereof by or on behalf of such insured but not exceeding the Sum Insured in aggregate mentioned in the schedule hereto.

A. Room and Boarding expenses as provided by the Hospital/Nursing Home not exceeding Rs. 5000 per day or the actual amount whichever is less.
B. Intensive Care Unit (ICU) expenses not exceeding Rs. 7500 per day or actual amount whichever is less.
C. Surgeon, team of surgeons, Assistant surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees.
D. Nursing Charges , Service Charges, IV Administration Charges, Nebulization Charges, RMO charges, Anaesthetic, Blood, Oxygen, Operation Theatre Charges, surgical appliances, OT consumables, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like pacemaker, Defibrillator, Ventilator, orthopaedic implants, Cochlear Implant, any other implant, Intra-Occular Lenses, , infra cardiac valve replacements, vascular stents, any other valve replacement, laboratory/diagnostic tests, X-ray CT Scan, MRI, any other scan, scopies and such similar expenses that are medically necessary, or incurred during hospitalization as per the advice of the attending doctor.
E. Hospitalization expenses (excluding cost of organ) incurred on donor in respect of organ transplant to the insured.

1.6 Pre and Post Hospitalization expenses payable in respect of each hospitalization shall be the actual expenses incurred subject to 30 days prior to hospitalization and 90 days after discharge.

2. DEFINITIONS:

2.1 ACCIDENT: An accident is a sudden, unforeseen and involuntary event caused resulting in injury –

2.2 A."Acute condition" – Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.

B. "Chronic condition" – A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics –

- It needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests –
- It needs ongoing or long-term control or relief of symptoms
- It requires your rehabilitation or for you to be specially trained to cope with it
- It continues indefinitely
- It comes back or is likely to come back.

2.3 ALTERNATIVE TREATMENTS:

Alternative Treatments are forms of treatment other than treatment "Allopathy" or "modern medicine and includes Ayurveda, unani, siddha homeopathy and Naturopathy in the Indian Context, for Hospitalisation only and Domiciliary for treatment only under ailments mentioned under clause number 3.1
(Ref: 3.4 Alternative Therapy)

2.4 ANY ONE ILLNESS:

Any one illness will be deemed to mean continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital / Nursing Home where treatment has been taken. Occurrence of the same illness after a lapse of 45 days as stated above will be considered as fresh illness for the purpose of this policy.

2.5 CASHLESS FACILITY:

Cashless facility "means a facility extended by the insurer to the insured where the payments, of the cost of treatment undergone by the employee and the dependent family members of the insured in accordance with the policy terms and conditions, or directly made to the network provider by the insurer to the extent pre-authorization approved.

2.6 CONGENITAL ANOMALY:

Congenital Anomaly refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

(a) Internal Congenital Anomaly which is not in the visible and accessible parts of the body

(b) External Congenital Anomaly which is in the visible and accessible parts of the body

2.7 CONDITION PRECEDENT:

Condition Precedent shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

2.8 CONTRIBUTION:

The Officers / employees will not share the cost of an indemnity claim on a ratable proportion from their personal Insurance Policies.

2.9 DAYCARE CENTRE:

A day care centre means any institution established for day care treatment of illness and/ or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under;-

- has qualified nursing staff under its employment
- has all qualified medical practitioner(s) in charge
- has a fully equipped operation theatre of its own where surgical procedures are carried out.
- maintains daily records of patients and will make these accessible to the insurance companies authorised personnel.

2.10 DAY CARE TREATMENT:

Day care Treatment refers to medical treatment and or surgical procedure which is

I) undertaken under general or local anesthesia in a hospital/day care Centre in less than a day because of technological advancement, and

II) Which would have otherwise required a hospitalisation of more than a day.

Treatment normally taken on an out patient basis is not included in the scope of this definition.

2.11 DOMICILIARY HOSPITALIZATION:

Domiciliary Hospitalization means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

- The condition of the patient is such that he/she is not in a condition to be removed to a hospital or
- The patient takes treatment at home on account of non-availability of room in a hospital.

2.12 DOMICILIARY TREATMENT

Treatment taken for specified diseases which may or may not require hospitalization as mentioned in the Scheme under clause Number 3.1

2.13 HOSPITAL / NURSING HOME:

A Hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a Hospital with the local authorities under the Clinical establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under

- Has qualified nursing staff under its employment round the clock.
- Has at least 10 in-patient beds in towns having a population of less than 10 lacs and at least 15 in-patient beds in all other places;

- Has qualified medical practitioner(s) in charge round the clock;
- Has a fully equipped Operation Theatre of its own where surgical procedures are carried out;
- Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

The term ' Hospital / Nursing Home ' shall not include an establishment which is a place of rest, a place for the aged, a place for drug-addicts or place for alcoholics, a hotel or a similar place.

This clause will however be relaxed in areas where it is difficult to find such hospitals.

2.14 HOSPITALIZATION:
Hospitalization means admission in a Hospital/Nursing Home for a minimum period of 24 consecutive hours of inpatient care except for specified procedures/treatments, where such admission could be for a period of less than a day, as mentioned in clauses 2.9 and 2.10

2.15 ID CARD:
ID Card means the identity card issued to the insured person by the THIRD PARTY ADMINISTRATOR to avail cashless facility in network hospitals.

2.16 ILLNESS:
Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.

2.17 INJURY:
Injury means accidental physical bodily harm excluding illness or disease which is verified and certified by a medical practitioner.
However all types of Hospitalization is covered under the Scheme.

2.18 IN PATIENT CARE:
In Patient Care means treatment for which the insured person has to stay in a hospital for more than a day for a covered event.

2.19 INTENSIVE CARE UNIT:
Intensive Care Unit means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated medical practitioner(s) and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

2.20 MATERNITY EXPENSES:

Maternity expenses/treatment shall include:

(a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).

(b) Expenses towards medical termination of pregnancy during the policy period.

(c) Complications on Maternity would be covered up to the Sum Insured plus the Corporate Buffer.

2.21 MEDICAL ADVICE:

Any consultation or advice from a medical practitioner/doctor including the issue of any prescription or repeat prescription.

2.22 MEDICAL EXPENSES:

Medical Expenses means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of illness or accident on the advice of a medical practitioner, as long as these are no more than would have been payable if the insured person had not been insured.

2.23 MEDICALLY NECESSARY:

Medically necessary treatment is defined as any treatment, test, medication or stay in hospital or part of a stay in a hospital which

- is required for the medical management of the illness or injury suffered by the insured;
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
- must have been prescribed by a medical practitioner;
- must confirm to the professional standards widely accepted in international medical practice or by the medical community in India.

2.24 MEDICAL PRACTITIONER:

Medical Practitioner is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or the homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license. The term medical practitioner would include physician, specialist and surgeon.

(The Registered practitioner should not be the insured or close family members such as parents, parents-in-law, spouse and children.)

2.25 NETWORK PROVIDER:

Network Provider means hospitals or health care providers enlisted by an insurer or by a Third Party Administrator and insurer together to provide medical services to an insured on payment by a cashless facility.

The list of network hospitals is maintained by and available with the THIRD PARTY ADMINISTRATOR and the same is subject to amendment from time to time.

2.26 NEW BORN BABY:

A new born baby means baby born during the Policy Period aged between one day and 90 days, both days inclusive.

2.27 NON NETWORK :

Any hospital, day care Centre or other provider that is not part of the network.

2.28 NOTIFICATION OF CLAIM :

Notification of claim is the process of notifying a claim to the Bank, insurer or Third Party Administrator as well as the address/telephone number to which it should be notified.

2.29 OPD TREATMENT:

OPD Treatment is one in which the insured visits a clinic/hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of medical a practitioner. The insured is not admitted as a day care or in-patient.

2.30 PRE-EXISTING DISEASE:

Pre Existing Disease is any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and/or were diagnosed, and/or received medical advice/treatment, prior to the first policy issued by the insurer.

2.31 PRE – HOSPITALISATION MEDICAL EXPENSES:

Medical expenses incurred immediately 30 days before the insured person is hospitalized will be considered as part of a claim as mentioned under Item 1.2 above provided that;

(a) such medical expenses are incurred for the same condition for which the insured person's hospitalization was required and

(b) the inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

2.32 POST HOSPITALISATION MEDICAL EXPENSES:

Relevant medical expenses incurred immediately 90 days after the Insured person is discharged from the hospital provided that;

- Such Medical expenses are incurred for the same condition for which the Insured Person's Hospitalization was required; and
- The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

2.33 QUALIFIED NURSE:

Qualified Nurse is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India and/or who is employed on recommendation of the attending medical practitioner.

2.34 REASONABLE AND CUSTOMARY CHARGES:

Reasonable Charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/injury involved.

2.35 ROOM RENT:

Room Rent shall mean the amount charged by the hospital for the occupancy of a bed on per day basis.

2.36 SUBROGATION:

Subrogation shall mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source. It shall exclude the medical / accident policies obtained by the insured person separately.

2.37 SURGERY:

Surgery or surgical procedure means manual and/or operative procedure(s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or day care Centre by a medical practitioner.

2.38 Third Party Administrator

Third Party Administrator means a Third Party Administrator who holds a valid License from Insurance Regulatory and Development Authority to act as a THIRD PARTY ADMINISTRATOR and is engaged by the Company for the provision of health services as specified in the agreement between the Company and Third Party Administrator.

2.39 UNPROVEN/EXPERIMENTAL TREATMENT:

Unproven/Experimental treatment is treatment, including drug Experimental therapy, which is not based on established medical practice in India.

3. COVERAGES:

3.1 Domiciliary Hospitalization / Domiciliary Treatment : Medical expenses incurred in case of the following diseases which need Domiciliary Hospitalization /domiciliary treatment as may be certified by the attending medical practitioner and / or bank's 'medical officer shall be deemed as hospitalization expenses and reimbursed to the extent of 100%

Cancer , Leukemia, Thalassemia, Tuberculosis, Paralysis, Cardiac Ailments , Pleurisy , Leprosy, Kidney Ailment , All Seizure disorders, Parkinson's diseases, Psychiatric disorder including schizophrenia and psychotherapy , Diabetes and its complications, hypertension, Hepatitis –B , Hepatitis - C, Hemophilia, Myasthenia gravis, Wilson's disease, Ulcerative Colitis , Epidermolysis bullosa, Venous Thrombosis(not caused by smoking) Aplastic Anaemia, Psoriasis, Third Degree burns, Arthritis , Hypothyroidism , Hyperthyroidism expenses incurred on radiotherapy and chemotherapy in the treatment of cancer and leukemia, Glaucoma, Tumor, Diptheria, Malaria, Non-Alcoholic Cirrhosis of Liver, Purpura, Typhoid, Accidents of Serious Nature , Cerebral Palsy, , Polio, All Strokes Leading to Paralysis, Haemorrhages caused by accidents, All

animal/reptile/insect bite or sting , chronic pancreatitis, Immuno suppressants, multiple sclerosis / motorneuron disease, status asthamaticus, sequalea of meningitis, osteoporosis, muscular dystrophies, sleep apnea syndrome(not related to obesity), any organ related (chronic) condition, sickle cell disease, systemic lupus erythematous (SLE), any connective tissue disorder, varicose veins, thrombo embolism venous thrombosis/venous thrombo embolism (VTE)], growth disorders, Graves' disease, Chronic obstructive Pulmonary Disease, Chronic Bronchitis, Asthma, Physiotherapy and swine flu shall be considered for reimbursement under domiciliary treatment.

The cost of Medicines, Investigations, and consultations, etc.in respect of domiciliary treatment shall be reimbursed for the period stated by the specialist and / or the attending doctor and / or the bank's medical officer, in Prescription. If no period stated, the prescription for the purpose of reimbursement shall be valid for a period not exceeding 90 days.

3.2 Critical Illness : To be provided to the employee only subject to a sum insured of Rs. 1,00,000/- . Cover starts on inception of the policy. In case an employee contracts a Critical Illness as listed below, the total sum insured of Rs.1,00,000/- is paid, as a benefit. This benefit is provided on first detection/diagnosis of the Critical Illness.

- Cancer including Leukemia
- Stroke
- Paralysis
- By Pass Surgery
- Major Organ Transplant
- End Stage Liver Disease
- Heart Attack
- Kidney Failure
- Heart Valve Replacement Surgery

Hospitalization is not required to claim this benefit. Further the Employee can claim the cost of hospitalization on the same from the Group Mediclaim Policy as cashless / reimbursement of expenses for the treatment taken by him.

3.3 Expenses on Hospitalization for minimum period of a day are admissible. However, this time limit is not applied to specific treatments, such as

1	Adenoidectomy	20	Haemo dialysis
2	Appendectomy	21	Fissurectomy / Fistulectomy
3	Ascitic / Plueral tapping	22	Mastoidectomy
4	Auroplasty not Cosmetic in nature	23	Hydrocele
5	Coronary angiography /Renal	24	Hysterectomy
6	Coronary angioplasty	25	Inguinal/ ventral/ umbilica/ femoral hernia
7	Dental surgery	26	Parenteral chemotherapy
8	D&C	27	Polypectomy
9	Excision of cyst/ granuloma/lump/tumor	28	Septoplasty
10	Eye surgery	29	Piles/ fistula

11	Fracture including hairline fracture /dislocation	30	Prostate surgeries
12	Radiotherapy	31	Sinusitis surgeries
13	Chemotherapy including parental chemotherapy	32	Tonsillectomy
14	Lithotripsy	33	Liver aspiration
15	Incision and drainage of abscess	34	Sclerotherapy
16	Varicocelectomy	35	Varicose Vein Ligation
17	Wound suturing	36	All scopies along with biopsies
18	FESS	37	Lumbar puncture
19	Operations/Micro surgical operations on the nose, middle ear/internal ear, tongue, mouth, face, tonsils & adenoids, salivary glands & salivary ducts,breast, skin & subcutaneous tissues, digestive tract, female/male sexual organs.		

This condition will also not apply in case of stay in hospital of less than a day provided –

(a) The treatment is undertaken under General or Local Anesthesia in a hospital / day care Centre in less than a day because of technological advancement and

(b) Which would have otherwise required hospitalization of more than a day.

3.4 Alternative Therapy : Reimbursement of Expenses for hospitalization or domiciliary treatment (under clause 3.1) under the recognized system of medicines , viz, Ayurvedic ,Unani, Sidha, Homeopathy , Naturopathy , if such treatment is taken in a clinic /hospital registered, by the central and state government .

3.5 MATERNITY EXPENSES BENEFIT EXTENSION

The hospitalization expenses in respect of the new born child can be covered within the Mother's Maternity expenses. The maximum benefit allowable under this clause will be up to Rs. 50000/- for Normal Delivery and Rs. 75,000/- for Caesarean Section.

Special conditions applicable to Maternity expenses Benefit Extension:

(i) 9 months waiting period under maternity benefit will be waived from the policy.

(ii) Pre-natal & post natal charges in respect of maternity benefit are covered under the policy up to 30 days and 60 days only, unless the same requires hospitalization.

(iii) Missed Abortions , Miscarriage or abortions induced by accidents are covered under the limit of Maternity

(iv) Complications in Maternity including operations for extra uterine pregnancy ectopic pregnancy would be covered in the up to the Sum Insured + Corporate Buffer

(v) Expenses incurred for Medical Termination of Pregnancy

(vi) Claim in respect of delivery to be given irrespective of the number of children

3.6 Baby Day one Cover: New born baby is covered from day one. All expenses incurred on the new born baby during maternity will be covered in addition to the maternity limit up to Rs, 20000/-.

However if the baby contacts any illness the same shall be considered in the Sum Insured + Corporate buffer. Baby to be taken as an additional member within the normal family floater.

3.7 Ambulance Charges: Ambulance charges are payable up to Rs 2500/- per trip to hospital and / or transfer to another hospital or transfer from hospital to home if medically advised. Taxi and Auto expenses in actual maximum up to Rs750/- per trip.
Ambulance charges actually incurred on transfer from one center to another center due to Non availability of medical services/ medical complication shall be payable in full.

3.8 Pre- Existing Diseases / Ailments: Pre-existing diseases are covered under the scheme.

3.9 Congenital Anomalies: Expenses for Treatment of Congenital Internal / External diseases, defects anomalies are covered under the policy

3.10 Psychiatric diseases: Expenses for treatment of psychiatric and psychosomatic diseases be payable with or without hospitalization.

3.11 Advanced Medical Treatment: All new kinds of approved advanced medical procedures for e.g. laser surgery, stem cell therapy for treatment of a disease is payable on hospitalization /day care surgery.

3.12 Treatment taken for Accidents can be payable even on OPD basis in Hospital up to Sum Insured.

3.13 Taxes and other Charges : All Taxes , Surcharges , Service Charges , Registration charges , Admission Charges , Nursing , and Administration charges to be payable.

Charges for diapers and sanitary pads are payable if necessary as part of the treatment

Charges for Hiring a nurse / attendant during hospitalization will be payable only in case of recommendation from the treating doctor in case ICU / CCU, Neo natal nursing care or any other case where the patient is critical and requiring special care.

3.14 Treatment for Genetic Disorder and stem cell therapy is covered under the scheme.

3.15 Treatment for Age related Macular Degeneration (ARMD), treatment such as Rotational Field Quantum magnetic Resonance (RFQMR), Enhanced External Counter Pulsation (EECP), etc. are covered under the scheme. Treatment for all neurological/ macular degenerative disorders shall be covered under the scheme.

3.16 Rental Charges for External and or durable Medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Bi-PAP, Infusion pump etc. will be covered under the scheme. However purchase of the above equipment to be subsequently used at home in exceptional cases on medical advice shall be covered.

3.17 Ambulatory devices i.e., walker, crutches, Belts, Collars, Caps, Splints, Slings, Braces, Stockings, elastocrepe bandages, external orthopaedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer (including Glucose Test Strips)/ Nebulizer/ prosthetic devise/ Thermometer, alpha / water bed and similar related items etc., will be covered under the scheme.

3.18 Physiotherapy charges: Physiotherapy charges shall be covered for the period specified by the Medical Practitioner even if taken at home.
All claims admitted in respect of any/all insured person/s during the period of insurance shall not exceed the Sum Insured stated in the schedule and Corporate Buffer if allocated.

4. EXCLUSIONS:

The company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

4.1 Injury / disease directly or indirectly caused by or arising from or attributable to War, invasion, Act of Foreign enemy, War like operations (whether war be declared or not).

4.2 Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an accident.

(a) Vaccination or inoculation.

(b) Change of life or cosmetic or aesthetic treatment of any description is not covered.

(c) Plastic surgery other than as may be necessitated due to an accident or as part of any illness.

4.3 Cost of spectacles and contact lenses, hearing aids. Other than Intra-Ocular Lenses and Cochlear Implant.

4.4 Dental treatment or surgery of any kind which are done in a dental clinic and those that are cosmetic in nature.

4.5 Convalescence, rest cure, Obesity treatment and its complications including morbid obesity, , treatment relating disorders, Venereal disease, intentional self-injury and use of intoxication drugs / alcohol.

4.6 All expenses arising out of any condition directly or indirectly caused to or associated with Human T-Cell Lymphotropic Virus Type III (HTLB - III) or lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variation Deficiency Syndrome or any syndrome or condition of a similar kind commonly referred to as AIDS.

4.7 Charges incurred at Hospital or Nursing Home primarily for diagnosis x-ray or Laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of positive existence of presence of any ailment, sickness or injury, for which confinement is required at a Hospital / Nursing Home, unless recommended by the attending doctor.

4.8 Expenses on vitamins and tonics unless forming part of treatment for injury or diseases as certified by the attending physician

4.9 Injury or Disease directly or indirectly caused by or contributed to by nuclear weapon / materials.

4.10 All non-medical expenses including convenience items for personal comfort such as charges for telephone, television, /barber or beauty services, died t charges, baby food, cosmetics, tissue paper, diapers, sanitary pads, toiletry items and similar incidental expenses, unless and otherwise they are necessitated during the course of treatment.

5. CONDITIONS:

5.1 Contract: the proposal form, declaration, and the policy issued shall constitute the complete contract of insurance.

5.2 Every notice or communication regarding hospitalization or claim to be given or made under this Policy shall be communicated to the office of the Bank, dealing with Medical Claims, and/or the THIRD PARTY ADMINISTRATOR office as shown in the Schedule. Other matters relating to the policy may be communicated to the policy issuing office.

5.3 The premium payable under this Policy shall be paid in advance. No receipt for Premium shall be valid except on the official form of the company signed by a duly authorized official of the company. The due payment of premium and the observance and fulfillment of the terms, provisions, conditions and endorsements of this Policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be a condition precedent to any liability of the Company to make any payment under this Policy. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid unless made in writing and signed by an authorised official of the Company.

5.4 Notice of Communication: Upon the happening of any event which may give rise to a claim under this Policy notice with full particulars shall be sent to the Bank or Regional Office or THIRD PARTY ADMINISTRATOR named in the schedule at the earliest in case of emergency hospitalization within 7 days from the time of Hospitalisation/Domiciliary Hospitalisation .

5.5 All supporting documents relating to the claim must be filed with the office of the Bank dealing with the claims or THIRD PARTY ADMINISTRATOR within 30 days from the date of discharge from the hospital. In case of post-hospitalisation, treatment (limited to 90 days), (as mentioned in para 2.32) all claim documents should be submitted within 30 days after completion of such treatment.

Note: Waiver of these Conditions 5.4 and 5.5 may be considered in extreme cases of hardship where it is proved to the satisfaction of the Bank that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or deliberate or file claim within the prescribed time-limit. The same would be waived by the TPA without reference to the Insurance Company.

5.5.1 The Insured Person shall obtain and furnish to the office of the Bank dealing with the claims / THIRD PARTY ADMINISTRATOR with all original bills, receipts and other documents upon which a claim is based and shall also give such additional information and assistance as the Bank through the THIRD PARTY ADMINISTRATOR/Company may require in dealing with the claim.

5.5.2 Any medical practitioner authorised by the Bank / Third Party Administrator / shall be allowed to examine the Insured Person in case of any alleged injury or disease leading to Hospitalisation, if so required.

5.6 The Company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured Person or by any other person acting on his behalf.

5.7 DISCLOSURE TO INFORMATION NORM

The claim shall rejected in the event of misrepresentation, mis-description or non-disclosure of any material fact.

5.8 Claims will be managed through the same Office of the Bank from where it is managed at present. The Insurance Companies third party administrator will be setting up a help desk at that office and supporting the bank in clearing all the claims on real time basis.

5.9 In case of rejection of claims it would go through a Committee set up of the Bank, Third Party Administrator and United India Insurance Co Ltd. unless rejected by the committee in real time the claim should not be rejected.

5.10 There would be a continuity of this Scheme / benefits to the Retiring Officers / employees and their family and also to the Retired Officers / employees and their family.

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Appendix II

Mapping the underwriting, process, servicing and claims for the Medical Scheme of the Employees and their family members of Member Banks of Indian Banks' Association

1. The policy will be issued in the name of Indian Banks' Association Member Banks and the list of the member banks would be mentioned giving the data of the employees bifurcated into:-

a) Officers with the data of their dependent family members.
b) Clerical staff with the data of their dependent family members.
c) Sub staff with the data of their dependent family members.

The premium is decided by the number of employees uniformly but not based on the number of dependent family members. The collection of data of dependent family members at the initial stage may take long time. In such cases claims pertaining to dependent family members of employees pending collection of data may be settled on certification and recommendation of the appropriate authority of the respective bank.

2. The policy will commence on a uniform date for all the member banks to ensure they get the benefit of the large number of employees which has been instrumental in the procurement of the most competitive premium quote and would eventually also reflect in a positive claim ratio.
3. The member banks will submit their data and pay the premium to the lead Insurance Company viz. United India Insurance Co. Ltd., in proportion to their employee strength.
4. The insured name of Indian Banks' Association is used for getting the benefit of mass scale underwriting and a positive claim ratio that would benefit all the member Banks. All underwriting, process and claim servicing will be done by the member Banks' directly with United India Insurance Co. Ltd. and K. M. Dastur Reinsurance Brokers Pvt. Ltd.
5. The Corporate Buffer of all the member banks will be in proportion to the percentage of their premium contribution.
6. The allocation and use of this Corporate Buffer would rest with the individual management of the member bank. At the end of the year we would have a joint review on how many banks have totally utilized their Corporate Buffer and how many other member banks have not utilized their Corporate Buffer totally. The unutilized Corporate Buffer of the member banks would now be proportionately available to the member banks whose Corporate Buffer has been totally utilized. This would be one of the major benefits of the Group underwriting of all the member banks under one policy and at the same time individual underwriting of each member banks for data processing, servicing and claims.

7. The claim settlement of the member banks would be done in the same process as followed in the past, by each individual member banks.

8. The Third Party Administrator, appointed by the lead insure viz United India Insurance Co. Ltd. will station their representative at the banks regional/ nodal offices from where these banks have been settling medical claims of their employees.

9. The Third Party Administrator, would have a Dedicated Office, Server and a 24 X 7 Call Centre for the Member Banks of the Indian Banks' Association.

10. The employees would submit the claims to the same regional / nodal offices where they have been submitting in the past and the Third Party Administrator representative will be the backup support and ensure claim settlement is completed in thirty minutes.

11. (The Third Party Administrator should ensure placement of representative in all the regional/nodal offices of the member banks where the employees have been submitting their claims in the past)

12. No claims would be rejected by the insurance company/ Third Party Administrator unless the same is rejected by the committee comprising of the Bank management, Insurance Company, Third Party Administrator and K. M. Dastur Reinsurance Brokers Pvt Ltd.

13. All the employees and their family members would be issued ID cards by the Third Party Administrator, of the Insurance Company ie. United India Insurance Co. Ltd. In case the employee or his family member gets admitted in any of the preferred Provider Network of hospitals on production of ID card, the hospital authority in turn shall notify by fax / mail the details of hospitalisation along with ID card number and Name of the employee to the Third Party Administrator, who would again revert by fax / mail a confirmation to the hospital to proceed with the claim. This would even enable them to claim from anywhere in India and they would be able to admit themselves in hospitals anywhere in India by merely calling the dedicated call centres of the Third Party Administrator, which would be working on a 24x7 basis. The Third Party Administrator, would even be able to advise the employees on the nearest hospital available in their area. In case of an emergency admission to a hospital which is not in PP Network, the employees also have a benefit to get himself admitted on a cashless basis by intimating the Third Party Administrator, call centre number, mentioning his ID card No and name. The hospital authority would fax / mail the details of hospitalisation to the Third Party Administrator, who would again revert by fax / mail a confirmation to the hospital to proceed with the claim.

14. Most of the claims would be cashless; which would be paid directly to the hospital concerned.

15. The reimbursement claims of pre and post hospitalisation or in a few cases of actual hospitalisation would be paid to the employees through the banks regional/ nodal offices or directly credited to the employees account.

16. In case of reimbursement claim where the employee has not informed the banks Regional / Nodal offices; they may phone the 24 X 7 call centre of the Third Party Administrator giving the details of their card ID number and name. In such cases the reimbursement claim should be submitted on completion of hospitalisation and not later than 30 days of discharge from the hospital. In case of post-hospitalisation treatment, all claim documents should be submitted within 30 days after completion of such treatment. Wherever the hospitals are not in the approved list of Third Party Administrator, the Third Party Administrator should take necessary action for addition of those hospitals on their network hospital list in consultation with bank. In an emergency the claim payment would be paid to the hospital account and empanelment of the hospital would be considered.

17. All the addition and deletion of the employees and dependents of the various member banks would be done on a monthly basis. A newly recruited employee would automatically be admitted in the medical scheme from the date of his appointment letter. This has to be reflected in the addition / deletion statement to be sent to the Third Party Administrator/ K. M. Dastur Reinsurance Broker Pvt. Ltd., before the 10th of the beginning of every month.

18. ID cards will be prepared within 10 working days from the date of receipt of data. These cards can be couriered to the respective branch office in which the employee is located. The cards can be distributed by at the branch office by the bank's branch manager / any other person who is made responsible for the same. Corrections in cards, if any can be e-mailed to an exclusive id which will be exclusive for cards correction errors. This cards will be corrected and resent within 2 working days from the receipt of correction mail.

19. An adequate deposit premium have to be placed by the member banks for this addition, as this is a regulatory compliance under section 64 V B of the Insurance Act; wherein no insurance can be initiated without the payment of the premium.

20. At the same time refund premium of all deletions would be credited in the deposit account of the member banks.

21. All additions / deletions of employees and family members would be on prorata basis. In case, some member banks joined the scheme sometime after the main master policy has been incepted, they would also be joining on a prorate premium.
