



BOI NATIONAL SWASTHYA BIMA POLICY

1 Recital clause

Whereas the insured person designated in the schedule hereto has by a proposal and declaration dated as stated in the schedule, which shall be the basis of this contract, and is deemed to be incorporated herein has applied to National Insurance Company Ltd. (hereinafter called the company) for the insurance hereinafter set forth in respect of account holders of Bank of India, and their eligible family members, named in the schedule hereto (hereinafter called, the insured person) and has paid premium as consideration for such insurance.

2 Operative clause

Now this policy witnesses that subject to the terms, definition, exclusions and conditions contained herein or endorsed, or otherwise expressed here on the company undertakes that if during the policy period stated in the schedule or during the continuance of this policy by renewal any insured person shall suffer from any illness or disease (hereinafter called disease) or sustain any bodily injury due to an accident (hereinafter called injury) and if such disease or injury shall require any such insured person, upon the advice of a duly qualified medical practitioner to be hospitalised for treatment at any nursing home/ hospital (hereinafter called hospital) in India, Nepal or Bhutan as an in-patient, the company shall pay to the hospital or reimburse the insured person the amount of such reasonable, customary and medically necessary expenses described below, incurred in respect thereof by or on behalf of such insured person but not exceeding the sum insured per family stated in the schedule hereto, in respect of all such claims, during the policy period.

Coverage

2.1 Room charges and Intensive care unit charges as provided by the hospital.

2.2 Nursing expenses by qualified nurse.

2.3 Surgeon, anaesthetist, medical practitioner, consultants, specialist's fees.

2.4 Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines & drugs, diagnostic materials and X-ray, dialysis, chemotherapy, radiotherapy cost of pacemaker, artificial limbs and similar expenses.

2.5 Ambulance charges not exceeding ₹1,000/- (Rupees one thousand only) per policy period.

2.6 In case of hospitalisation of children below 12 (twelve) years, a lump sum amount of ₹1,000/- (Rupees one thousand only) per policy period towards the out-of-pocket expenses. The payment will be made on the basis of a declaration from the parent without insisting on any supporting bill/cash memo.

2.7 Maternity and baby care expenses

Maternity & baby care expenses, subject to the conditions hereunder.

i. Cover is available up to a limit of 5% of sum insured.

ii. A waiting period of 9 (nine) months is applicable for payment of any claim relating to normal delivery or caesarean section or abdominal operation for extra uterine pregnancy. The waiting period may be relaxed only in case of delivery, miscarriage or abortion induced by accident or other medical emergency.

iii. Claim in respect of delivery for only first two children and/or operations associated therewith will be considered under the policy or any renewal thereof. Those insured persons who are already having two or more living children will not be eligible for this benefit.

iv. Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12 (twelve) weeks from the date of conception are not covered.

v. Pre-natal and post-natal expenses are not covered unless admitted in hospital and treatment is taken there.

2.8 In case of death in hospital, funeral expenses are reimbursed up to ₹1,000/- (Rupees one thousand only) over and above the sum insured subject to the hospitalisation claim being admissible under the policy.

2.9 Treatment of non resident Indians (NRIs) in hospital in India.

2.10 Treatment in hospitals in Nepal and Bhutan covered in Indian currency.

2.11 Good health incentive

2.11.1 Cost of health checkup

Expenses of health checkup will be reimbursed once at the end of a block of three continuous policy periods provided no claims are reported during the block and the policy has been continuously renewed with the company without a break. Expenses payable is a maximum of 1% of the average sum insured of the block.

3 Definition

3.1 Accident means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

3.2 Any one illness means continuous period of illness and it includes relapse within 45 (forty five) days from the date of last consultation with the hospital where treatment has been taken.

3.3 Break in policy occurs at the end of the existing policy period when the premium due on a given policy is not paid on or before the renewal date or within grace period.

3.4 Cashless facility means a facility extended to the insured person where the payment of the cost of treatment undergone by the insured person in accordance with the policy terms and conditions, is directly made to the network provider by the company to the extent of pre-authorization approval

3.5 Condition precedent means a policy term or condition upon which the company's liability under the policy is conditional upon.

3.6 Congenital anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

- i. **Internal congenital anomaly** means congenital anomaly which is not on the visible and accessible parts of the body
- ii. **External congenital anomaly** means congenital anomaly which is on the visible and accessible parts of the body

3.7 Contribution means the right of an company to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a ratable proportion.

3.8 Day care treatment means medical treatment, and/or surgical procedure which is:

- i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 (twenty four) hrs because of technological advancement, and
- ii. which would have otherwise required a hospitalisation of more than 24 (twenty four) hours.

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

3.9 Dental treatment means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

3.10 Family means the Bank of Baroda account holder, spouse and two dependant children.

3.11 Grace period means 30 days immediately following the premium due date during which a payment can be made to renew or continue the policy in force without loss of continuity benefits such as waiting period and coverage of pre-existing disease. Coverage is not available for the period for which no premium is received.

3.12 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:

- i. has qualified nursing staff under its employment round-the-clock;
- ii. has at least 10 (ten) in-patient beds in towns having a population of less than 10,00,000 (ten lacs) and at least 15 (fifteen) in-patient beds in all other places;
- iii. has qualified medical practitioner(s) in charge round-the-clock;
- iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
- v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

3.13 Hospitalisation means admission in a hospital as an in-patient for a minimum period of 24 (twenty four) consecutive hours.

However, this time limit is not applicable to

- i. dialysis, chemotherapy, radiotherapy, eye surgery, dental surgery, lithotripsy (kidney stone removal), dilatation and curettage (D&C), tonsillectomy
- ii. treatment that necessitates hospitalisation and the procedure involves specialized infrastructural facilities available in hospitals and due to technological advances hospitalisation is required for less than 24 (twenty four) hours only.

3.14 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.

- i. **Acute condition** means 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.
- ii. **Chronic condition** means a disease, illness, or injury that has one or more of the following characteristics
 - a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
 - b) it needs ongoing or long-term control or relief of symptoms
 - c) it requires your rehabilitation or for you to be specially trained to cope with it
 - d) it continues indefinitely
 - e) it comes back or is likely to come back.

3.15 In-patient means an insured person who is admitted in hospital upon the written advice of a duly qualified medical practitioner for more than 24 (twenty four) continuous hours, for the treatment of covered disease/ injury during the policy period.

3.16 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.

3.17 Medical advice means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

3.18 Medical expenses means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of disease/ injury 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 and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

3.19 Medical practitioner means 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 for 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 licence.

3.20 Network provider means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured person on payment by a cashless facility.

3.21 Non- network means any hospital, day care centre or other provider that is not part of the network.

3.22 Notification of claim means the process of notifying a claim to the company or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.

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

3.24 Policy period means period of one year as mentioned in the schedule for which the policy is issued.

3.25 Portability means transfer by an individual health insurance policy holder (including family cover) of the credit gained for pre-existing conditions and time bound exclusions if the policy holder chooses to switch from one insurer to another.

3.26 Preferred provider network (PPN) means a network of hospitals which have agreed to a cashless packaged pricing for certain procedures for the insured person. The list is available with the company/TPA and subject to amendment from time to time. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.

3.27 Pre hospitalisation means medical expenses incurred 30 (thirty) days immediately before the insured person is hospitalisation, provided that:

- i. such medical expenses are incurred for the same condition for which the insured person's hospitalisation was required, and
 - ii. the in-patient hospitalisation claim for such hospitalisation is admissible by the company
- Pre hospitalisation will be considered as part of hospitalisation claim.

3.28 Post hospitalisation means medical expenses incurred 60 (sixty) days immediately after the insured person is discharged from hospital, provided that:

- i. such medical expenses are incurred for the same condition for which the insured person's hospitalisation was required, and
 - ii. the in-patient hospitalisation claim for such hospitalisation is admissible by the company
- Post hospitalisation will be considered as part of hospitalisation claim.

3.29 Pre-existing disease means any condition, ailment or injury or related condition(s) for which the insured person had signs or symptoms and/or was diagnosed and/or received medical advice/ treatment within 48 (forty eight) months prior to the first policy issued by the company.

3.30 Reasonable and customary 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.

3.31 Room rent means the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

3.32 Sum insured means the floater sum insured as mentioned in the schedule. The sum insured represents maximum liability for the family, for any and all benefits claimed during the policy period.

3.33 Surgery 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.

3.34 TPA means any entity, licensed under the IRDA (Third Party Administrators - Health Services) Regulations, 2001 by the Authority, and is engaged, for a fee by the company for the purpose of providing health services.

3.35 Qualified nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

3.36 Waiting period means a period from the inception of the first policy during which specified diseases/treatment is not covered. On completion of the period, diseases/treatment will be covered provided the policy has been continuously renewed without any break.

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 Pre-existing diseases

All pre-existing diseases. Such diseases shall be covered after the policy has been continuously in force for 36 (thirty six) months. Any complication arising from pre-existing ailment/disease/injuries will be considered as a part of the pre existing health condition or disease.

4.2 First 30 days waiting period

Any disease contracted by the insured person during the first 30 (thirty) days of continuous coverage from the inception of the policy. This shall not apply in case the insured person is hospitalised for injuries, suffered in an accident which occurred after inception of the policy.

4.3 One year waiting period

Following diseases/treatment are subject to one year waiting period.

i	Cataract	vi	Internal congenital anomaly
ii	Benign prostatic hypertrophy	vii	Fistula in anus
iii	Hysterectomy for haemorrhage or fibromyoma	viii	Piles
iv	Hernia	ix	Sinusitis and related disorders
v	Hydrocele		

4.4 Circumcision unless necessary for treatment of a disease (if not excluded otherwise) or necessitated due to an accident.

4.5 Vaccination or inoculation.

4.6 Cosmetic, plastic surgery, sex change

Cosmetic or aesthetic treatment of any description, change of life or sex change operation. Expenses for plastic surgery other than as may be necessitated due to illness/ disease/ injury.

4.7 Spectacles, contact lens, hearing aid.

4.8 Dental treatment

Dental treatment or surgery of any kind unless requiring hospitalisation.

4.9 General debility, external congenital anomaly

Convalescence, general debility, run down condition or rest cure, external congenital anomaly.

4.10 Sterility, venereal disease, intentional self inflicted injury.

4.11 Drug/alcohol abuse

Treatment arising out of illness/disease/injury due to misuse or abuse of drugs/alcohol or use of intoxicating substances.

4.12 AIDS

All expenses arising out of any condition directly or indirectly caused to or associated with Human T-Cell Lymph tropic Virus Type-III (HTLV-III) or Lymphadenopathy Associated Virus (LAV) OR The Mutants Derivative or Variation Deficiency Syndrome or any syndrome or condition of similar kind commonly referred to as AIDS.

4.13 Hospitalisation for the purpose of diagnosis and evaluation, irrelevant investigations charges

All expenses incurred at Hospital primarily for diagnostic, x-ray or laboratory examinations or other diagnostic studies not consistent with nor incidental to the diagnosis and treatment of positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital.

4.14 Vitamins, tonics

Vitamins and tonics unless forming part of treatment for illness/disease/injury as certified by the attending medical practitioner.

4.15 Maternity

No expenses will be payable for any treatment arising from or traceable to voluntary termination of pregnancy.

4.15 Naturopathy treatment.

4.16 Domiciliary hospitalisation expenses

4.17 War group perils

Injury or disease directly or indirectly caused by or arising from or attributable to war invasion act of foreign enemy, warlike operations (whether war be declared or not) and injury or disease directly or indirectly caused by or contributed to by nuclear weapons/materials.

5 Conditions

5.1 Disclosure of information

The policy shall be void and all premium paid hereon shall be forfeited to the company, in the event of mis-representation, mis-description or non-disclosure of any material fact.

5.2 Condition precedent to admission of liability

The due observance and fulfillment of the terms and conditions of the policy, by the insured person, shall be a condition precedent to any liability of the company to make any payment under the policy.

5.3 Communication

- i. All communication should be in writing.
- ii. ID card, PPN/network provider related issues to be communicated to the TPA at the address mentioned in the schedule. The policy related issues, change in address to be communicated to the policy issuing office at the address mentioned in the schedule.
- iii. The company or TPA will communicate to the insured person at the address mentioned in the schedule.

5.4 Physical examination

Any medical practitioner authorised by the company shall be allowed to examine the insured person in case of any alleged injury or disease requiring hospitalisation when and as often as the same may reasonably be required on behalf of the company.

5.5 Payment of premium

The Policy shall commence either from (a) the date of Debit of Premium from the Insured's Bank account if the instrument with the proposal/renewal advice is dispatched to the company on the same date or (b) the actual date of dispatch of the instrument with proposal/renewal advice or (c) the date of deposit of premium to the company to comply to provisions of Section 64 VB of Insurance Act.

It is further understood and agreed that the premium has been remitted by the bank on collection of the same or by duly debiting the account of account holders with prior consent. On such policy of insurance being issued, the company shall not entertain any request for cancellation and consequent refund of premium therefore on any grounds whatsoever shall not arise.

5.6 Claim Procedure

5.6.1 Notification of claim

In case of a claim, the insured person/insured person's representative shall intimate the TPA in writing by letter, e-mail, fax providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit.

Claim notification in case of cashless facility	TPA must be informed:
In case of planned hospitalisation	At least 72 (seventy two) hours prior to the insured person's admission to network provider/PPN
In case of emergency hospitalisation	Within 24 (twenty four) hours of the insured person's admission to network provider/PPN

Claim notification in case of reimbursement	TPA must be informed:
In case of planned hospitalisation	At least 72 (seventy two) hours prior to the insured person's admission to hospital
In case of emergency hospitalisation	Within 24 (twenty four) hours of the insured person's admission to hospital

5.6.2 Procedure for cashless claims

- i. Treatment may be taken in a network provider/PPN and is subject to pre authorization by the TPA.
- ii. Cashless request form available with the network provider/PPN and TPA shall be completed and sent to the TPA for authorization.
- iii. The TPA upon getting cashless request form and related medical information from the insured person/ network provider/PPN will issue pre-authorization letter to the hospital after verification.
- iv. At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
- v. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
- vi. In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the TPA for reimbursement.

5.6.3 Procedure for reimbursement of claims

For reimbursement of claims the insured person may submit the necessary documents to TPA within the prescribed time limit.

5.6.4 Documents

The claim is to be supported with the following documents and submitted within the prescribed time limit.

- i. Completed claim form
- ii. Original bills, payment receipts, medical history of the patient recorded, discharge certificate/ summary from the hospital etc.
- iii. Original cash-memo from the hospital (s)/chemist (s) supported by proper prescription
- iv. Original payment receipt, investigation test reports etc. supported by the prescription from attending medical practitioner
- v. Attending medical practitioner's certificate regarding diagnosis and bill receipts etc.
- vi. Surgeon's original certificate stating diagnosis and nature of operation performed along with bills/receipts etc.
- vii. Any other document required by company/TPA

Note

In the event of a claim lodged as per clause 5.9 of the policy and the original documents having been submitted to the other insurer, the company may accept the documents listed under clause 5.6.4 of the policy and claim settlement advice duly certified by the other insurer subject to satisfaction of the company.

Type of claim	Time limit for submission of documents to TPA
Reimbursement of hospitalisation and pre hospitalisation expenses	Within 15 (fifteen) days of date of discharge from hospital
Reimbursement of post hospitalisation expenses	Within 15 (fifteen) days from completion of post hospitalisation treatment

5.6.5 Claim Settlement

- i. On receipt of the final document(s) or investigation report (if any), as the case may be, the company shall within a period of 30 days offer a settlement of the claim to the insured person.
- ii. If the company, for any reasons, decides to reject a claim under the policy, shall communicate to the insured person in writing and within a period of 30 (thirty) days from the receipt of the final document(s) or investigation report (if any), as the case may be.

- iii. Upon acceptance of an offer of settlement as stated above by the insured person, the payment of the amount due shall be made within 7 (seven) days from the date of acceptance of the offer by the company.
- iv. In the cases of delay in the payment, the company shall pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is paid.

5.6.6 Services offered by a TPA

The TPA shall render health care services covered under the policy like issuance of ID cards & guide book, hospitalization & pre-authorization services, call centre, acceptance of claim related documents, claim processing and other related services

The services offered by a TPA shall not include

- i. Claim settlement and rejection with respect to the policy; However, TPA may handle claims admission and recommend to the company for the payment of the claim settlement
- ii. Any services directly to the insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the company.

Waiver

Time limit for claim notification and submission of documents may be waived in cases where it is proved to the satisfaction of the company, that the circumstances under which insured person was placed, it was not possible to intimate the claim/submit the documents within the prescribed time limit.

5.7 Payment of claim

All claims under the policy shall be payable in Indian currency through NEFT/ RTGS only.

5.8 Territorial limit

All medical treatment for the purpose of this insurance will have to be taken in India, Nepal or Bhutan.

5.9 Contribution

In the case of a claim arising under the policy, there is in existence any other policy (other than cancer insurance policy in collaboration with Indian Cancer Society) effected by the insured person or on behalf of insured person which covers any claim in whole or in part made under the policy then the insured person has the option to select the policy under which the claim is to be settled. If the claimed amount, after considering the applicable co payment, exceeds the sum insured under any one policy then the company shall pay or contribute not more than its rateable proportion of the claim.

5.10 Medical expenses incurred under two policy periods

If the claim falls within two policy periods, the claims shall be paid taking into consideration the available sum insured in the two policy periods, including the deductibles for each policy period. Such eligible claim amount to be payable to the insured person shall be reduced to the extent of premium to be received for the renewal/due date of premium of health insurance policy, if not received earlier.

5.11 Fraud

The company shall not be liable to make any payment under the 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.

5.12 Cancellation

The company may at any time cancel the policy (on grounds of fraud, moral hazard, misrepresentation or noncooperation) by sending the insured person 30 (thirty) days notice by registered letter at insured person's last known address and in such event the company shall not allow any refund.

The insured person may at any time cancel the policy and in such an event the company shall allow refund of premium after charging premium at company's short period rate mentioned below provided no claim occurred up to the date of cancellation.

PERIOD OF RISK	RATE OF PREMIUM TO BE CHARGED
Up to one month	1/4th of the annual rate
Up to three months	1/2 of the annual rate
Up to six months	3/4th of the annual rate
Exceeding six months	Full annual rate

5.13 Disclaimer

If the Company/TPA shall disclaim liability to the insured for any claim hereunder and such claims shall not within 12 calendar months from the date of such disclaimer have been made the subject matter of a suit in court of law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.14 Territorial jurisdiction

All disputes or differences under or in relation to the policy shall be determined by the Indian court and according to Indian law.

5.15 Arbitration

If any dispute or difference shall arise as to the quantum to be paid under the policy (Liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties or if they cannot agree upon a single arbitrator within 30 (thirty) days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute / difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under/in accordance with the provisions of the Arbitration and Conciliation Act 1996.

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided if the company has disputed or not accepted liability under or in respect of this Policy. It is hereby expressly stipulated and declared that it shall be condition precedent to any right of action or suit upon this Policy that award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

5.16 Renewal

The policy may be renewed by mutual consent. The company is not bound to give notice that it is due for renewal. Renewal of the policy cannot be denied other than on grounds of fraud, moral hazard, misrepresentation or noncooperation. In the event of break in the policy a grace period of 30 (thirty) days is allowed.

5.17 The company shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealings with or relating to this policy but the receipt of the insured or his legal personal representative(s) shall in all cases be an effective discharge to the Company.

5.18 Portability

In the event of the insured person porting to any other insurer, insured person must apply with details of the policy and claims to the company where the insured person wants to port, at least 45 (forty five) days before the date of expiry of the policy.

Portability shall be allowed in the following cases:

- i. All individual health insurance policies issued by non-life insurance companies including family floater policies.
- ii. Individual members, including the family members covered under any group health insurance policy of a non-life insurance company shall have the right to migrate from such a group policy to an individual health insurance policy or a family floater policy with the same insurer. One year thereafter, the insured person shall be accorded the right to port to another non-life insurance company

5.19 Withdrawal of product

In case the policy is withdrawn in future, the company shall provide the option to the insured person to switch over to a similar policy at terms and premium applicable to the new policy.

5.20 Revision of terms of the policy including the premium rates

The company, in future, may revise or modify the terms of the policy including the premium rates based on experience. The insured person will be notified three months before the changes are effected.

5.21 Free look period

The insured person is allowed a period of 15 (fifteen) days from date of receipt of policy to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured person has exercised the option of free look period and has not made any claim during the free look period, the insured person shall be entitled to-

- i. a refund of the premium paid less any expenses incurred by the company on medical examination of the insured person and the stamp duty charges; or
- ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period on cover

The free look provision is not applicable to renewal of the policy.

5.22 Nomination

The insured is mandatorily required at the inception of the Policy to make a nomination for the purpose of payment of claims under the policy in the event of death.

Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made.

In case of any insured person other than the insured under the policy, for the purpose of payment of claims in the event of death, the default nominee would be the insured.

No assignment of this policy or the benefits there under shall be permitted.

6 Redressal of grievance

In case of any grievance relating to servicing the policy, the insured person may submit in writing to the policy issuing office or regional office for redressal. If the grievance remains unaddressed, insured person may contact Customer Relationship Management Dept., National Insurance company Limited, Chhabildas towers, 6A, Middleton Street, Kolkata - 700071.

If the insured person is not satisfied, the grievance may be referred to "Health Insurance Management Dept.", National Insurance company Limited, 3 Middleton Street, Kolkata - 700071.

The insured person may also approach the office of Insurance Ombudsman of the respective area/ region for redressal of grievance.

List of Expenses Generally Excluded

List of Expenses Generally Excluded ("Non-Medical") in Hospital Indemnity Policy -	
TOILETRIES/ COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS	
HAIR REMOVAL CREAM	Not Payable
BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
BABY FOOD	Not Payable
BABY UTILITES CHARGES	Not Payable
BABY SET	Not Payable
BABY BOTTLES	Not Payable
BRUSH	Not Payable
COSY TOWEL	Not Payable
HAND WASH	Not Payable
MOISTURISER PASTE BRUSH	Not Payable
POWDER	Not Payable
RAZOR	Payable
SHOE COVER	Not Payable
BEAUTY SERVICES	Not Payable
BELTS/ BRACES	Essential and should be paid at least specifically for cases who have undergone surgery of thoracic or lumbar spine
BUDS	Not Payable
BARBER CHARGES	Not Payable
CAPS	Not Payable
COLD PACK/HOT PACK	Not Payable
CARRY BAGS	Not Payable
CRADLE CHARGES	Not Payable
COMB	Not Payable
DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
EYE PAD	Not Payable
EYE SHEILD	Not Payable
EMAIL / INTERNET CHARGES	Not Payable
FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	Not Payable
FOOT COVER	Not Payable
GOWN	Not Payable
LEGGINGS	Essential in bariatric and varicose vein surgery and may be considered for at least these conditions where surgery itself is payable.
LAUNDRY CHARGES	Not Payable
MINERAL WATER	Not Payable
OIL CHARGES	Not Payable
SANITARY PAD	Not Payable
SLIPPERS	Not Payable
TELEPHONE CHARGES	Not Payable
TISSUE PAPER	Not Payable
TOOTH PASTE	Not Payable
TOOTH BRUSH	Not Payable
GUEST SERVICES	Not Payable
BED PAN	Not Payable
BED UNDER PAD CHARGES	Not Payable
CAMERA COVER	Not Payable
CLINIPLAST	Not Payable
CREPE BANDAGE	Not Payable/ Payable by the patient
CURAPORE	Not Payable
DIAPER OF ANY TYPE	Not Payable
DVD, CD CHARGES	Not Payable (However if CD is specifically sought by Insurer/TPA then payable)
EYELET COLLAR	Not Payable
FACE MASK	Not Payable

FLEXI MASK	Not Payable
GAUSE SOFT	Not Payable
GAUZE	Not Payable
HAND HOLDER	Not Payable
HANSAPLAST/ ADHESIVE BANDAGES	Not Payable
INFANT FOOD	Not Payable
SLINGS	Reasonable costs for one sling in case of upper arm fractures may be considered
ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES	
WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Exclusion in policy unless otherwise specified
COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Exclusion in policy unless otherwise specified
DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Exclusion in policy unless otherwise specified
HORMONE REPLACEMENT THERAPY	Exclusion in policy unless otherwise specified
HOME VISIT CHARGES	Exclusion in policy unless otherwise specified
INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Exclusion in policy unless otherwise specified
OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	Exclusion in policy unless otherwise specified
PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	Exclusion in policy unless otherwise specified
CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Exclusion in policy unless otherwise specified
TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Exclusion in policy unless otherwise specified
DONOR SCREENING CHARGES	Exclusion in policy unless otherwise specified
ADMISSION/REGISTRATION CHARGES	Exclusion in policy unless otherwise specified
HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Exclusion in policy unless otherwise specified
EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable - Exclusion in policy unless otherwise specified
ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Not payable as per HIV/AIDS exclusion
STEM CELL IMPLANTATION/ SURGERY AND STORAGE	Not Payable except Bone Marrow Transplantation where covered by policy
ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS	
WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not payable separately
ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of Instruments not payable.
MICROSCOPE COVER	Payable under OT Charges, not payable separately

SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT Charges, not payable separately
SURGICAL DRILL	Payable under OT Charges, not payable separately
EYE KIT	Payable under OT Charges, not payable separately
EYE DRAPE	Payable under OT Charges, not payable separately
X-RAY FILM	Payable under Radiology Charges, not as consumable
SPUTUM CUP	Payable under Investigation Charges, not as consumable
BOYLES APPARATUS CHARGES	Part of OT Charges, not separately
BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
ANTISEPTIC OR DISINFECTANT LOTIONS	Not Payable-Part of Dressing Charges
BAND AIDS, BANDAGES, STERILE INJECTIONS, NEEDLES, SYRINGES	Not Payable - Part of Dressing charges
COTTON	Not Payable-Part of Dressing Charges
COTTON BANDAGE	Not Payable- Part of Dressing Charges
MICROPORE/ SURGICAL TAPE	Not Payable-Payable by the patient when prescribed, otherwise included as Dressing Charges
BLADE	Not Payable
APRON	Not Payable -Part of Hospital Services/ Disposable linen to be part of OT/ICU charges
TORNIQUET	Not Payable (service is charged by hospitals, consumables cannot be separately charged)
ORTHOBUNDLE, GYNAEC BUNDLE	Part of Dressing Charges
URINE CONTAINER	Not Payable
ELEMENTS OF ROOM CHARGE	
LUXURY TAX	Actual tax levied by government is payable. Part of room charge for sub limits
HVAC	Part of room charge not payable separately
HOUSE KEEPING CHARGES	Part of room charge not payable separately
SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
TELEVISION & AIR CONDITIONER CHARGES	Payable under room charges not if separately levied
SURCHARGES	Part of Room Charge, Not payable separately
ATTENDANT CHARGES	Not Payable - Part of Room Charges
IM IV INJECTION CHARGES	Part of nursing charges, not payable
CLEAN SHEET	Part of Laundry/Housekeeping not payable separately
EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
BLANKET/WARMER BLANKET	Not Payable- part of room charges
ADMINISTRATIVE OR NON-MEDICAL CHARGES	
ADMISSION KIT	Not Payable
BIRTH CERTIFICATE	Not Payable
BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING	Not Payable

CHARGES	
CERTIFICATE CHARGES	Not Payable
COURIER CHARGES	Not Payable
CONVENYANCE CHARGES	Not Payable
DIABETIC CHART CHARGES	Not Payable
DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
DISCHARGE PROCEDURE CHARGES	Not Payable
DAILY CHART CHARGES	Not Payable
ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
FILE OPENING CHARGES	Not Payable
INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
MEDICAL CERTIFICATE	Not Payable
MAINTAINANCE CHARGES	Not Payable
MEDICAL RECORDS	Not Payable
PREPARATION CHARGES	Not Payable
PHOTOCOPIES CHARGES	Not Payable
PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
WASHING CHARGES	Not Payable
MEDICINE BOX	Not Payable
MORTUARY CHARGES	Payable upto 24 hrs, shifting charges not payable
MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
EXTERNAL DURABLE DEVICES	
WALKING AIDS CHARGES	Not Payable
BIPAP MACHINE	Not Payable
COMMODE	Not Payable
CPAP/ CAPD EQUIPMENTS	Device not payable
INFUSION PUMP - COST	Device not payable
OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
PULSEOXYMETER CHARGES	Device not payable
SPACER	Not Payable
SPIROMETRE	Device not payable
SPO2 PROBE	Not Payable
NEBULIZER KIT	Not Payable
STEAM INHALER	Not Payable
ARMSLING	Not Payable
THERMOMETER	Not Payable (paid by patient)
CERVICAL COLLAR	Not Payable
SPLINT	Not Payable
DIABETIC FOOT WEAR	Not Payable
KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
LUMBO SACRAL BELT	Essential and should be paid at least specifically for cases who have undergone surgery of lumbar spine.
NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at reasonable cost of approximately Rs 200/ day
AMBULANCE COLLAR	Not Payable
AMBULANCE EQUIPMENT	Not Payable
MICROSHEILD	Not Payable
ABDOMINAL BINDER	Essential and should be paid at least specifically for cases who have undergone surgery of lumbar spine.

ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION	
BETADINE \ HYDROGEN PEROXIDE\SPIRIT\DETTOL\SAVLON\ DISINFECTANTS ETC	May be payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital
PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Post Hospitalisation nursing charges not Payable
NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES	Patient Diet provided by hospital is payable
SUGAR FREE TABLETS	Payable -Sugar free variants of admissible medicines are not excluded
CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	Payable when prescribed
DIGESTION GELS	Payable when prescribed
ECG ELECTRODES	Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable.
GLOVES	Sterilized Gloves payable / unsterilized gloves not payable
HIV KIT	Payable - payable Pre operative screening
LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
LOZENGES	Payable when prescribed
MOUTH PAINT	Payable when prescribed
NEBULISATION KIT	If used during Hospitalisation is payable reasonably
NOVARAPID	Payable when prescribed
VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
ZYTEE GEL	Payable when prescribed
VACCINATION CHARGES	Routine Vaccination not Payable / Post Bite Vaccination Payable
PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE	
AHD	Not Payable - Part of

	Hospital's internal Cost
ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost
OTHERS	
VACCINE CHARGES FOR BABY	Not Payable
AESTHETIC TREATMENT / SURGERY	Not Payable
TPA CHARGES	Not Payable
VISCO BELT CHARGES	Not Payable
ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
EXAMINATION GLOVES	Not payable
KIDNEY TRAY	Not Payable
MASK	Not Payable
OUNCE GLASS	Not Payable
OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable, except for telemedicine consultations where covered by policy
OXYGEN MASK	Not Payable
PAPER GLOVES	Not Payable
PELVIC TRACTION BELT	Should be payable in case of PIVD requiring traction as this is generally not reused
REFERAL DOCTOR'S FEES	Not Payable
ACCU CHECK (Glucometry/ Strips)	Not payable pre hospitalisation or post hospitalisation / Reports and Charts required/ Device not payable
PAN CAN	Not Payable
SOFNET	Not Payable
TROLLY COVER	Not Payable
UROMETER, URINE JUG	Not Payable
AMBULANCE	Payable-Ambulance from home to hospital or interhospital shifts is payable/ RTA as specific requirement is payable
TEGADERM / VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs
URINE BAG	Payable where medically necessary till a reasonable cost - maximum 1 per 24 hrs
SOFTOVAC	Not Payable
STOCKINGS	Essential for case like CABG etc. where it should be paid.

The list is dynamic and as per the standard list of excluded expenses stipulated by IRDA.