THE NEW INDIA ASSURANCE COMPANY LIMITED
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GOODHEALTH GROUP MEDICLAIM POLICY

IRDA/NL-HLT/NIA/P-H/V.I/342/13-14

1. WHEREAS THE Proposer designated in the Certificate of Insurance forming part of the Schedule hereto, being a Card member or Account Holder or other customer of CITIBANK, has by a Proposal and declaration, in the mode specified in the Schedule, provided the information in such proposal which shall be the basis of this Contract and is deemed to be incorporated herein, has applied to **THE NEW INDIA ASSURANCE COMPANY LTD**. (hereinafter called the Company) **through the Group Good Health Policy purchased by CITIBANK**, for the insurance hereinafter set forth in respect of self and/or Family Members and/or domestic employees named in the Certificate of Insurance forming part of the Schedule hereto (hereinafter called the Insured Person) and has paid premium as consideration for such insurance.

1.1 NOW THIS POLICY WITNESSES that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, that if during the period stated in the Schedule or during the continuance of this policy by renewal any Insured Person shall contract any disease or suffer from any illness (hereinafter called Illness) or sustain any bodily injury through Accident (hereinafter called Injury) and if such Illness or Injury shall, require any such Insured Person, upon the advice of a duly Registered and qualified Physician/Medical Specialist/Medical Practitioner (hereinafter called Medical Practitioner) to incur Medically Necessary expenses for medical / surgical treatment at any Hospital in India as herein defined (hereinafter called Hospital) as an Inpatient during such period, this policy provides for payment to the Insured Person / to the hospital through the Third Party Administrator,

1.2 The Payment will be of the amount of such incurred expenses as are Reasonable, Customary and Medically Necessary thereof, in respect of such Insured Person, but not exceeding, in any one period of insurance, the limits indicated under the Table of Benefits subject to the Exclusions / Limits set out herein.

TABLE OF BENEFITS

S No	Hospitalisation Expenses	Limit Per Claim
(i)	ROOM RENT, Board & Nursing Expenses as provided by the hospital/nursing home.	Up to 1% of Sum Insured per day
(ii)	If admitted into INTENSIVE CARE UNIT	Up to 2% of Sum Insured per day
	All admissible claims under (i) and (ii) as capped during the policy period	Up to 30% of Sum Insured per claim
(iii)	Surgeon, Anaesthetist, MEDICAL PRACTITIONER, Consultants, Specialists Fees	Up to 30% of Sum Insured per claim
(iv)	Emergency Ambulance charges	up to Rs.1000/-
(v)	anaesthesia, Blood, Oxygen, Operation Theatre	Up to 40% of Sum Insured per

	Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs and any medical expenses incurred which is integral part of the operation/treatment	claim

NOTE:

a) PACKAGE CHARGES:
Hospitalization expenses incurred for treatment of any one Illness under agreed package charges will be restricted to 80% of the actual package charges or the sum insured whichever is less.

b) ORGAN TRANSPLANT-DONOR'S CLAIM:
Hospitalization expenses of a person donating an organ during the course of organ transplant will also be payable subject to the above sub limits applicable to the insured person within the overall sum insured of the insured person subject to the admissibility of the insured's claim under the Policy Terms & Conditions.

c) LIMIT PER CLAIM:
The limit per claim would apply to the overall total claim amount including pre and post-hospitalization claims and shall be subject to clause 2.3 pertaining to Any One Illness.

d) MAXIMUM LIABILITY:
Company's liability in respect of all claims admitted during the period of Insurance shall not exceed the Sum Insured for the insured person as mentioned in the Policy Certificate, issued to the insured.

e) NON- ALLOPATHIC / ALTERNATE TREATMENT:
The claims which are otherwise admissible under this Policy for in-patient treatment taken in a Hospital as defined herein below will be restricted to 20 % of the Sum Insured subject to maximum limit of Rs.25000/- per claim.

f) LIMITS FOR SPECIFIED AILMENTS:
In respect of following specified ailments, Company's liability in respect of each and every claim, as arrived at under the Table of Benefits given above and admitted during the period of insurance, subject to the policy terms, conditions and exclusions, shall not exceed the limits mentioned against the respective specified ailment OR the sum insured available for the insured person, whichever is less:

S No	Disease/Ailment/Treatment	Waiting period (Refer to 4.3 clause herein)	Limits per claim
1	Total Knee / Hip replacement (due to arthritis, rheumatism and other degenerative disorders)	3 years	50% of the sum insured
2	Cataract	3 years	20% of the Sum Insured, subject to maximum of Rs 40,000 per eye.
3	Benign Prostatic Hypertrophy	2 years	20% of the Sum

			Insured
4	Hysterectomy (Due to fibroids or Menorrhagia)	2 years	20% of the Sum Insured
5	Hernia	2 years	20% of the Sum Insured
6	Hydrocele	2 years	20% of the Sum Insured
7	Congenital Internal Disease / Defect	2 years	20% of the Sum Insured
8	Fistula in Anus and Piles	2 years	20% of the Sum Insured
9	Sinusitis & Related Disorders	2 years	20% of the Sum Insured

- All pre-existing Diseases are excluded for the first four policy years subject to Clause No. 4.1.
- In case of cataract and total knee or hip replacements, where two eyes or hips or knees are operated in a single procedure the limit per claim indicated as above will be reckoned at twice these limits.
- Cumulative Bonus allowed, if any, under the policy will also be considered for applying the "Limits" mentioned herein above.

2.0 DEFINITIONS:

2.1 ACCIDENT: An accident is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

2.2 ALTERNATE TREATMENT: Alternative treatments are forms of treatments other than "Allopathic" or "modern medicine" and include Ayurveda, Unani, Siddha and Homeopathy in the Indian Context.

2.3 ANY ONE ILLNESS, DISEASE OR INJURY: Any one illness means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/NursingHome where treatment may have been taken.

2.4 CANCELLATION: Cancellation defines the terms on which the policy contract can be terminated either by the insurer or the insured by giving sufficient notice to other which is not lower than a period of fifteen days.

2.5 CASHLESS FACILITY: "Cashless facility" means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.

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

2.7 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.

2.7.1 INTERNAL CONGENITAL ANAMOLY: Congenital anomaly which is not in the visible and accessible parts of the body.

2.7.2 EXTERNAL CONGENITAL ANAMOLY: Congenital anomaly which isin the visible and accessible parts of the body.

2.8 CONTRIBUTION: Contribution is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a rateable proportion of Sum Insured.

2.9 CUMULATIVE BONUS: Cumulative Bonus shall mean any increase in the sum insured granted by the insurer without an associated increase in premium.

2.10 DAY CARE TREATMENTS: Day care treatment refers to medical treatment, and/or *surgical procedure* which are:

i. undertaken under General or Local Anesthesia in A Hospital/Day Care Centre in less than 24 hrs because of technological advancement, and
ii. which would have otherwise required a hospitalization of more than 24 hours.

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

The following specific Day Care Treatments are covered Haemo-Dialysis, Parenteral Chemotherapy, Radiotherapy, Eye Surgery, Dental Surgery, Lithotripsy, (Kidney stone removal), D & C, Tonsillectomy.

The following additional Day Care Treatments are covered with a sublimit of 20% of the Sum Insured.

<table>
<tr><td>1) Adenoidectomy</td><td rowspan="2">15) Inguinal / ventral / umbilical / femoral hernia repair</td></tr>
<tr><td>2) Appendectomy</td></tr>
<tr><td>3) Anti Rabies Vaccination</td><td>16) Following Prostate Surgeries</td></tr>
<tr><td>4) Coronary Angiography</td><td rowspan="2">a) TUMT (Transurethral Microwave Thermotherapy</td></tr>
<tr><td>5) Coronary Angioplasty</td></tr>
<tr><td rowspan="2">6) ERCP (Endoscopic Retrograde Cholangiopancreatography)</td><td>b) TUNA (Transurethral Needle Ablation</td></tr>
<tr><td>c) TURP(Transurethral Resection of Prostate)</td></tr>
<tr><td>7) ESWL (Extracorporeal Shock Wave Lithotripsy)</td><td rowspan="2">d) TUEVAP (Transurethral Electro-vapourisation of the Prostate)</td></tr>
<tr><td>8)Excision of Cyst / Granuloma / Lump</td></tr>
<tr><td>9) FESS (Functional Endoscopic Sinus Surgery)</td><td>e) Laser Prostatectomy</td></tr>
<tr><td>10) Fissurectomy / Fistulectomy</td><td>17) Laparoscopic Cholecystectomy</td></tr>
<tr><td rowspan="2">11) Fracture / dislocation excluding hairline fracture</td><td>18) Liver Aspiration</td></tr>
<tr><td>19) Mastoidectomy</td></tr>
<tr><td rowspan="2">11) Fracture / dislocation excluding hairline fracture</td><td>20) Polypectomy</td></tr>
<tr><td>21) Sclerotherapy</td></tr>
<tr><td>12) Haemorrhoidectomy</td><td>22) Septoplasty</td></tr>
<tr><td>13) Hydrocelectomy</td><td>23) Surgery for Sinusitis</td></tr>
<tr><td>14) Hysterectomy</td><td>24) Varicose Vein Ligation</td></tr>
</table>

Or any other surgeries / procedures agreed by the TPA and the Company which require less than 24 hours Hospitalization and for which prior approval from TPA is mandatory.

Only those expenses which are directly relating to the treatment of the ILLNESS/ DISEASE/ INJURY for which the insured is hospitalized shall be considered and the expenses incurred for any other incidental treatment during the same period of hospitalization, shall not be considered under the claim.

2.11 DEDUCTIBLE: A deductible is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the insurer. A deductible does not reduce the sum insured.

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

2.13 DISCLOSURE OF INFORMATION NORM: The Policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, misdescription or non-disclosure of any material fact.

2.14 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.

2.15 HOSPITAL: 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 theenactments 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 10,00,000 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

2.16 HOSPITALIZATION: Admission in a Hospital for a minimum period of 24 in patient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours

2.16.1 DAY CARE 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 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 company's authorized personnel;

2.17 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.

2.18 INJURY: Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

2.19 INPATIENT CARE: Inpatient Care means treatment for which the insured person has to stay in a Hospital for more than 24 hours for a covered event.

2.20 INSURED PERSON means Citibank Credit Card members / Customers and/or their family members or domestic employees covered by this policy.

(PROPOSER means Citibank Credit Card members / Customers who have proposed for this insurance.)

2.21 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.

2.22 MATERNITY EXPENSES: Maternity expense shall include:

a. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalisation),
b. Expenses towards lawful medical termination of pregnancy during the Policy Period.

2.23 MEDICAL ADVICE: Any consultation or advice from a Medical Practitioner including the issueof any prescription or repeat prescription.

2.24 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 o f 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.

2.25 MEDICALLY NECESSARY: treatment is defined as any treatment, tests, medication, or stay in Hospital or part of a stay in 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.

2.26 MEDICAL PRACTITIONER: A 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 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.

It shall not include Insured Person and members of his/her family.

2.27 NETWORK HOSPITAL: "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 on payment by a cashless facility.

2.28 NON-NETWORK HOSPITAL: Any Hospital, Day Care centre or other provider that is not part of the Network.

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 a Medical Practitioner. The Insured is not admitted as a Day Care or Inpatient.

2.30 PERIOD OF INSURANCE means theperiod for which this Policy is taken as specified in the Schedule.

2.31 PRE-EXISTING DISEASES/CONDITONS: 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 within 48 months to prior to the first policy issued by theinsurer.

2.32 PRE-HOSPITALIZATION EXPENSES: Medical Expenses incurred 30 days immediately before the Insured Person is Hospitalised provided that:

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

2.33 POST-HOSPITALIZATION EXPENSES: Medical Expenses incurred 60 days immediately after the insured person is discharged from the hospital provided that:

i) Such Medical Expenses are incurred for the same condition for which the Insured Person's hospitalization was required and
ii) The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

2.34 PORTABILITY: Portability means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

2.35 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.

2.36 REASONABLE & CUSTOMARY CHARGES: Reasonable & 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.

2.37 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.

2.38 SUM INSURED is the maximum amount of coverage opted for each Insured Person and shown in the Schedule.

2.39 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.*

2.40 THIRD PARTY ADMINISTRATOR (TPA): Third Party Administrators or TPA means any person who is licensed under the IRDA (Third Party Administrators - Health Services) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

2.41 UNPROVEN EXPERIMENTAL TREATMENT: Treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

3.0 AGE LIMIT

3.1 This insurance is available to persons between ages of 18 yrs and 65 yrs.

3.2 Children between 3 months and 18 years of age can be covered provided one or both parents are covered simultaneously.

3.3 Persons between ages of 60 to 65 are enrolled only on submission of Medical Reports along with Medical Practitioners certificate. In case of acceptance of proposal 50% of reasonable cost towards the diagnostic tests and doctors' fees will be reimbursed by the Company (Subject to maximum of Rs 500 per Insured Person).

3.4 Persons above the age of 65 years can be considered for renewal only (no change in plan is allowed).

3.5 Change in Plan / Increase in Sum Insured

Person up to 60 years of age are allowed to change over to any Sum insured Band.

Persons between 60 to 65 years of age are allowed changing over to next Sum Insured Band at time of renewal.

Any increase in Sum insured shall attract clauses relating to waiting period and pre existing diseases.

NCB accrual will start from Zero for the increased SI.

3.6 The right to accept or reject coverage for any person proposed for this Mediclaim insurance on a fresh basis, shall rest solely with the Company.

4.0 EXCLUSIONS:

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

4.1 **PRE-EXISTING DISEASES**: Treatment of any Pre existing Condition/Disease, until 48 months of Continuous Coverage of such Insured Person have elapsed, from the Date of inception of his/her first Policy with Us as mentioned in the Schedule.

4.2 **30 DAYS EXCLUSION**: Any disease other than those stated in Clauses 1.2.(f) and 4.3, contracted by the Insured Person during the first 30 days from the commencement date of the policy is excluded. This exclusion will not apply if the policy is renewed under the Good Health Mediclaim Policy without any break. This exclusion shall not apply for accidental injuries sustained after the commencement date of the policy.

4.3 The expenses incurred on treatment of the specified diseases are payable only after completion of a continuous period of insurance under our Good Health Mediclaim Policy as specified against each disease, under the Para 1.2 (f) herein above

4.3.1 If those diseases are pre-existing, such claims will be dealt with in accordance with Clause No. 4.1 herein above. The claims, if admitted will be settled subject to the limits specified under the clause No. 1.2 (f) after completion of consecutive four policy periods.

4.4 **PERMANENT EXCLUSIONS**:

Any medical expenses incurred for or arising out of the following are not payable:

4.4.1 War, Invasion, Act of foreign enemy, War like operations, Nuclear weapons, Ionizing Radiations, contamination of Radioactive Material, Nuclear weapons or materials.

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

4.4.3 Vaccination/immunization and/or inoculation or change of life or cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.

4.4.4 The cost of spectacles and contact lenses, hearing aids including cochlear implants and durable medical equipments, walkers, crutches, wheel chairs and such other aids, cost of braces, equipment or external prosthetic devices, non-durable implants, sub cutaneous insulin pump, instrument used in treatment of Sleep Apnea Syndrome (CPAP) and Continuous Peritoneal Ambulatory Dialysis (CPAD) and Oxygen Concentrator for Bronchial Asthmatic condition.

4.4.5 All types of Dental Treatment of any kind unless necessitated due to accidental injuries and requiring hospitalization for such procedure to be performed in the operation theatre of a Hospital.

4.4.6 Convalescence, **All Health Checkup**, general debility, 'Run-down' condition or rest cure, Congenital External Diseases or Defects or Anomalies, sterility, infertility, venereal disease, genetic disorders and stem cell implantation / surgery, intentional self-injury and use of intoxicating drugs/alcohol, Obesity treatment, all psychiatric and psychosomatic disorders, participation in hazardous sports, participation in any criminal act.

4.4.7 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 Variations Deficiency Syndrome or any Syndrome or condition of a similar kind commonly referred to as AIDS and Sexually Transmitted Diseases.

4.4.8 Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-Ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any ailment, sickness or injury, for which confinement is required at Hospital.

4.4.9 Expenses on vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending Physician.

4.4.10 Maternity Expenses except treatment for extra uterine pregnancy (Ectopic Pregnancy subject to proof of Ultra Sonographic report and certification by the Treating Doctor).

4.4.11 Any Domiciliary Hospitalization/ treatment

4.4.12 Pre-existing Vision impairment requiring power correction and follow-up treatments arising out of implants done prior to inception of first policy.

4.4.13 Naturopathy treatment.

4.4.14 Hospital Record charges, special nursing charges, Transport charges, incidental and miscellaneous expenses, telephone charges, Attendant Charges and Non-medical expenses, Physiotherapist charges incurred at Home.

4.4.15 All treatments like Age Related Macular Degeneration (ARMD) AND/OR Choroidal Neo Vascular Membrane done by administration of Lucentis /Avastin /Macugen /Avastin and other related drugs as intra vitreal injection, Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Hyperberic Oxygen Therapy and unproven experimental treatment.

4.4.16 All the non-medical expenses mentioned in Annexure.

5.0 CLAIM PROCEDURE

5.1 Claims under this policy will be administered by Third Party Administrator (TPA) M/s MD India Health Care TPA Private Ltd.

5.2 This policy provides for Cashless Facility at Network Hospitals. If cashless access facility is availed, the TPA will directly settle the Hospital bills, subject to fulfillment of specified formalities by the insured and policy terms and conditions.

5.3 Where cashless access facility is not availed, the hospital bills will have to be first settled by the insured and thereafter reimbursement to be claimed from the TPA. The same procedure is applicable for Non-Network hospitals. Such claims will be processed by the TPA as per the policy terms and conditions. The claim for reimbursement of Pre & Post Hospitalization Expenses should be sent to the TPA which will also be processed by them as per policy terms and conditions.

5.4 **NOTIFICATION OF CLAIM** with particulars relating Good Health Certificate Number, name of insured person in respect of whom claim is made, nature of illness/injury and name and address of attending medical practitioner/hospital should be given by the card member to TPA within 7 days from the date of hospitalization, on receipt of which claim form will be sent by the TPA.

5.5 Final claim along with originals of all receipts, bills and cash memos, claim form and other documents as listed below, and the policy copies of current and earlier years, should be submitted to the TPA **within 30 days** from date of completion of treatment in the Hospital. Hospital/Diagnostic centers bills should be supported by proper serially numbered printed and revenue - stamped receipts.

a. Bill, Receipt and Discharge certificate / card from the Hospital.
b. Cash Memos from the Hospitals(s) / Chemists(s), supported by proper prescriptions.
c. Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests / pathological.
d. Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.
e. Attending Doctor's/ Consultant's/ Specialist's / Anesthetist's bill and receipt, and certificate regarding diagnosis.
f. Certificate from attending Medical Practitioner / Surgeon that the patient is fully cured.

5.6 No payments shall be made for any Hospitalization expenses incurred; unless they form part of the Hospital Bill (Hospital Bill should be supported by proper serially numbered printed and revenue stamped receipts). However the bills raised by Surgeon, Anesthetist directly and not included in the Hospital Bill shall be paid provided a numbered Bill giving details of cheque /cash payment is produced in support thereof. If payment is made in cash the maximum amount payable will be restricted to Rs 10,000.

5.7 For detailed claims procedure please refer to the "Guide Book" provided by the TPA. The guidebook, insured's identity cards and the list of Network Hospitals in the respective areas will be provided separately by the TPA.

5.8 The insurer shall settle the claim, including rejection, within thirty days of the receipt of the last necessary document.

On receipt of the duly completed documents either from the insured or Hospital the claim shall be processed as per the conditions of the policy. Upon acceptance of claim by the insured for settlement, the insurer or their representative (TPA) shall transfer the funds

within seven working days. In case of any extra ordinary delay, such claims shall be paid by the insurer or their representative (TPA) with a penal interest at a rate which is 2% above the bank rate at the beginning of the financial year in which the claim is reviewed.

5.9 Claim form can be downloaded from the website **www.mdindiaonline.com**

6.0 CONDITIONS

6.1 Any medical practitioner or other representative authorized by the Company / TPA shall be allowed to examine the Insured Person; in the event of any claim for Hospitalization being made when and so often as the same may reasonably be required on behalf of the Company/TPA

6.2 All medical/surgical treatment under this policy shall have to be taken in India. Admissible claims thereof shall be payable in Indian currency.

6.3 If the policy is to be renewed for enhanced sum insured, as a continuation of the earlier policy, the increased benefits are not applicable for those Illnesses / Injury contracted / suffered during the previous policy periods and in such cases, the claim if any arises for the said Illness / Injury, if admitted, shall be processed taking into account the sum insured prior to enhancement However the increased Sum insured shall become eligible after 48 months of continuous coverage.

6.4 MEDICAL EXPENSES INCURRED UNDER TWO POLICY PERIODS :
If the claim event 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 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.

7.0 CUMULATIVE BONUS
Cumulative Bonus will be available under this policy subject to the following conditions:

7.1 Sum Insured under the Policy shall be progressively increased by 5%, by way of cumulative bonus, in respect of each claim free year of insurance, subject to a maximum accumulation of 50%.

7.2 In case of any claim under this policy in respect of the insured person who has earned the cumulative bonus, the increased percentage will be reduced by 5% at the next renewal. However basic sum insured will be maintained and will not be reduced.

7.3 Cumulative bonus will be lost if policy is not renewed on the date of expiry.

7.4 The cumulative Bonus shown in the Policy is Provisional. It is subject to revision in the event of any claim under the earlier Policy being made after issuance of this policy.

7.5 Cumulative Bonus will start from zero for increased Sum Insured.

8.0 HOSPITAL CASH BENEFIT:
Hospital Cash Benefit Applicable for Table 2, Table 3 & Table 5

This benefit is extended to an insured person under Good Health Mediclaim Policy towards incidental expenses during hospitalization upon exercising the option for such a

coverage and appropriate premium for such cover having been received by the Company, subject to the limits specified against the insured person's names in the policy certificate.

If this Benefit is opted by payment of additional premium and confirmed in the Policy Certificate, the Company will pay Cash Benefit towards incidental expenses during Hospitalization at the rate and for the period stated below:

	Option for No. of Days			
Table	Table 2	Table -3	Table – 5 & Plan No.31-35	
No. of Days	15 Days	30 Days	200 Days	
	Age Upto 100 yrs	Age Upto 100 Yrs	Upto 70 Yrs at the commencement of Insurance	Age More than 70 Yrs and upto 100 Yrs on renewal if not opted otherwise
Cash Benefit Payable	@ 0.2% of Basic Sum Insured Per Day for Plan 15-22, Rs.1250/- for plan 93 and Rs.1500/- for plan 94	@ 0.2% of Basic Sum Insured Per Day for plan 23-30, Rs.1250/- for plan 95 and Rs.1500/- for plan 96.	@ Rs.1000 Per Day for Non-Accident Hospitalization However, if the insured person is **in ICU, during** such period benefit shall be paid @ Rs.2000 Per Day maximum of 15days during the policy year. 3) @ 2000 Per Day maximum of 15 days during the policy year for Hospitalisation due to **Accident.** **Convalescence Benefit** – Rs.15000 if confinement in hospital exceeds 21 consecutive days, payable once during the policy year.	@ 500/- Per Day for maximum of 30 days during the Period of Insurance irrespective of nature of Hospitalizations

The Benefit shall be payable

a) In addition to the Hospitalization Expenses covered by the Policy
b) Only in the event of claim for Hospitalization being admissible
c) In all, only for maximum number of days opted, in respect of any number of Hospitalizations/ claims that may occur during the Period of Insurance.
d) Under 200 days for age up to 70 yrs the benefits 2 & 3 starts on completion of first 24 hrs and only one benefit either 1,2 or 3 shall be payable at a time and not collectively.

8.1 CLAIMS PROCEDURE :

i) The benefit is admissible only if the claim under Good Health Mediclaim Policy is found admissible in accordance with the Terms and Conditions of the Policy.
ii) Hospital Cash Cover is not eligible for Day Care Procedures.

iii) The payment in respect of this benefit will be made directly to the insured by the Third Party Administrators after discharge from the hospital upon submission of proof of hospitalisation.

GENERAL CONDITIONS

1. PROPOSAL FOR INSURANCE

The Proposer shall make an application either in writing, in the prescribed application / proposal form, duly completed and signed, or by providing details and confirmations via telephonic mode along with the prescribed Medical Practitioner's Report and diagnostic test reports, wherever applicable, in respect of all the persons proposed for this Mediclaim insurance, so that the said details and confirmations are received prior to the last date specified for this purpose, to be eligible for consideration of his/her request for Good Health Mediclaim Policy cover.

2. ACCEPTANCE OF PROPOSALS

The proposals accepted by the Company for coverage shall be processed by Citibank for debiting the premium to the customers' card or bank account.

It is agreed and understood that acceptance of applications by Citibank will not constitute deemed acceptance of the persons proposed as eligible for insurance cover by the company.

3. PAYMENT OF PREMIUM

The Proposer authorizes Citibank to debit Good Health Policy premium to his Citibank Card/Account Holders for Good Health Mediclaim Policy benefits for self and/or family members and/or employees.

4. FREE LOOK PERIOD

The insured will be allowed a period of at least 45 days from the date of commencement of the policy to review the terms and conditions of the policy and to return the same if not acceptable at inception of policy and at each renewal if the same was done on a auto renewal basis without the consent of Insured.

In case insured opts to use the free look option then full premium charged will be refunded after deduction of Rs 100 as charges.

5. CANCELLATION: The Company may at any time cancel this policy certificate on grounds of misrepresentation, fraud, non-disclosure of material fact or non-cooperation by the insured by sending the insured 30 days notice by registered letter at the insured's last known address and in such event the Company shall refund to the insured a pro-rata premium for unexpired period of insurance. The Company shall however remain liable for any claim which arose prior to the date of cancellation.

In all other cases the insured may at any time cancel this policy and in such event the Company shall allow refund of premium at Company's short period rates only as indicated below, provided no claim has occurred up to the date of cancellation.

Period On Risk	Rate of premium to be retained
Up to 45 days	0% of the Annual Rate
Up to 3 months	50% of the Annual Rate
Up to 6 months	75% of the Annual Rate

Exceeding 6 months	Full Annual Rate

In the event of the insured requesting for cancellation of this policy and seeks refund of premium, any certificate issued to the insured for the purpose of claiming deduction under Section 80-D of the Income-Tax Act, 1961, shall also be deemed to be cancelled and the insured cannot claim any deduction for Income-Tax purposes, against the such policy or certificate.

Premium will be refunded to the insured by the Company provided no claim has occurred up to the date of cancellation. Citibank's confirmation of receipt of request for such cancellation will be binding upon the proposer/insured person.

Refund of premium can be done by Citibank directly to the proposer on behalf of the company under any of the above circumstances in respect of the insured person for whom the cover is sought to be cancelled..

Policy once cancelled shall not be reinstated under any circumstances and no claim shall be admissible under the Policy when once it is cancelled. If option for cancellation is notified to CITIBANK either in writing or over phone. Citibank's confirmation of receipt of request for such cancellation will be binding upon the insured.

The company does not undertake any responsibility to the insured and / or insured persons if Citibank arranges to have the insurance cover(s) withdrawn in case of delayed payment or non – payment of the dues in respect of this policy by the insured to Citibank.

6. RENEWAL OF POLICY

If the Proposer opts for non-renewal of this policy or for changes in renewal policy, he/she shall inform Citibank indicating his/her preference 20 days prior to the date of commencement of the policy. **Once the policy is renewed no request for alteration of policy choice will be entertained.**

The Company shall not be responsible or liable for non-renewal of the policy for any reason whatsoever arising out of any decision of Citibank in this regard.

The health policy shall ordinarily be renewed except on the grounds of fraud, moral hazard or misrepresentation or non-cooperation by the insured.

The company may at its discretion revise the premium rates and / or the Terms & conditions of the Policy every year upon renewal thereof.

Renewal of this Policy is Automatic, only if the premium due is paid by Citibank to the Company before the due date on behalf of the Card member or the accountholder as applicable.

If the company has discontinued issue of the Policy, in such event the Insured shall however has the option for renewal under any similar Policy being issued by the Company; provided however, benefits payable shall be subject to the terms contained in such other Policy.

7. The Company /TPA 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 or in the event of misrepresentation, misdescription or non- disclosure of any material particulars. The insured shall forfeit all benefits under this policy and the policy shall become void.

8. If the Company shall disclaim liability for any claim hereunder and such claim shall not within 12 calendar months from the date of the disclaimer have been made the subject matter of a suit in a Court of Law or of the appeal before the Insurance Ombudsman, then the claim shall for all practical purposes be deemed to have been abandoned and shall thereafter be not recoverable hereunder.

9. **FRAUD, MISREPRESENTATION, CONCEALMENT:** The policy shall be null and void and no benefits shall be payable in the event of misrepresentation, misdescription or nondisclosure of any material fact/particular 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/her behalf.

10. **CONTRIBUTION:** If two or more policies are taken by the Insured Person during a period from one or more insurers to indemnify treatment costs, the Company shall not apply the contribution clause, but the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his policies.

1. In all such cases the Company shall be obliged to settle the claim without insisting on the contribution clause as long as the claim is within the limits of and according to the terms of the policy.
2. If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the Insured Person shall have the right to choose insurers by whom the claim to be settled. In such cases, the insurer may settle the claim with contribution clause.
3. Except in benefit policies, in cases where an Insured Person has policies from more than one insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the Hospitalisation costs in accordance with the terms and conditions of the policy.

Note: The insured Person must disclose such other insurance at the time of making a claim under this Policy.

10. **PORTABILITY:** This policy is subject to portability guidelines issued by IRDA.

11. **PROTECTION OF POLICY HOLDERS' INTEREST:** Insured shall have all benefits as per Protection of Policy Holder's Interest Regulation 2002.

12. **GRIEVANCE REDRESSAL:** The insured may approach any of the following for redressal of grievances if any

1. Divisional Office	The New India Assurance Company Limited Customer Guidance Department, 260, Anna Salai, Chennai-600006
2. Regional Office	The New India Assurance Company Limited Customer Guidance Department, Dewas Towers,

	770-A, Anna Salai, Chennai- 600002
3. Head Office	The New India Assurance Company Limited Customer Guidance Department, No.87, M.G Road, Fort, Mumbai - 400 001
4. Insurance Ombudsman	Insurance Ombudsman 453 (Old No. 312), FathimaAkhtar Court, 4Th Floor, Teynampet, Chennai- 600018

** (Insured may contact Ins. Ombudsman Office constituted at various places in India)

For THE NEW INDIA ASSURANCE COMPANY LIMITED

DULY CONSTITUTED ATTORNEY

NOMINATION

FORMAT FOR DECLARATION OF NOMINATION

I/We the policy holder(s) under GOOD Health Policy with Certificate No.

Valid for the period from to and its subsequent renewals thereof do hereby assign the monies payable by The New India Assurance Co.Ltd., in the event of my/our death to the below mentioned person(s) and I/We further declare that the receipt given by the nominee(s) shall be sufficient discharge to the company. I/We shall furnish revised nomination form if there is any change in future.

S No	Name of the insured	Nominee's Name	DOB of Nominee	Relationship to the Insured Person	Signature of the Insured Person	Signature of Witness

Name and address of the witness

In case of Minor Nominee:

Name and address of Guardian and relationship with Minor
* (in case of Minor insured person guardian should sign)

Acknowledgement by New India Assurance

Signature / Date / Seal

Dear Customer,

Please Fill up your address here below before sending this Nomination form (in DUPLICATE)

(Original will be retained in the office and Duplicate copy duly acknowledged by the company will be returned to the Insured.) (This Nomination will be valid for the current Policy Period and its subsequent continuous Renewals, unless change in Nomination is made and duly acknowledged by the Company)

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…….PINCODE ……

ANNEXURE: LIST OF EXPENSES EXCLUDED ("NON-MEDICAL")

SNO	LIST OF EXPENSES EXCLUDED ("NON-MEDICAL")	SUGGESTIONS
TOILETRIES/COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS		
1	HAIR REMOVAL CREAM	Not Payable
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BRUSH	Not Payable
8	COSY TOWEL	Not Payable
9	HAND WASH	Not Payable
10	M01STUR1SER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable
15	BELTS/ BRACES	Essential and may be paid specifically for cases who have undergone surgery of thoracic or lumbar spine.
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable
18	CAPS	Not Payable
19	COLD PACK/HOT PACK	Not Payable
20	CARRY BAGS	Not Payable
21	CRADLE CHARGES	Not Payable
22	COMB	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25	EYE PAD	Not Payable
26	EYE SHEILD	Not Payable
27	EMAIL / INTERNET CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	Not Payable
29	FOOT COVER	Not Payable
30	GOWN	Not Payable
31	LEGGINGS	Essential in bariatric and varicose vein surgery and should be considered for these conditions where surgery itself is payable.
32	LAUNDRY CHARGES	Not Payable
33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SANITARY PAD	Not Payable
36	SLIPPERS	Not Payable
37	TELEPHONE CHARGES	Not Payable
38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Not Payable
40	TOOTH BRUSH	Not Payable
41	GUEST SERVICES	Not Payable
42	BED PAN	Not Payable

43	BED UNDER PAD CHARGES	Not Payable
44	CAMERA COVER	Not Payable
45	CLINIPLAST	Not Payable
46	CREPE BANDAGE	Not Payable/ Payable by the patient
47	CURAPORE	Not Payable
48	DIAPER OF ANY TYPE	Not Payable
49	DVD, CD CHARGES	Not Payable (However if CD is specifically sought by In surer/TPA then payable)
50	EYELET COLLAR	Not Payable
51	FACE MASK	Not Payable
52	FLEXI MASK	Not Payable
53	GAUSE SOFT	Not Payable
54	GAUZE	Not Payable
55	HAND HOLDER	Not Payable
56	HANSAPLAST/ADHESIVE BANDAGES	Not Payable
57	INFANT FOOD	Not Payable
58	SLINGS	Reasonable costs for one sling in case of upper arm fractures should be considered
ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES		
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Not Payable
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Not Payable
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Not Payable
62	HORMONE REPLACEMENT THERAPY	Not Payable
63	HOME VISIT CHARGES	Not Payable
64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Not Payable
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	Not Payable
66	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	Not Payable
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Not Payable
68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Not Payable
69	DONOR SCREENING CHARGES	Not Payable
70	ADMISSION/REGISTRATION CHARGES	Not Payable
71	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Not Payable
72	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable
73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Not Payable
74	STEM CELL IMPLANTATION/ SURGERY and storage	Not Payable
ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS		
75	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not separately
76	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the Hospital payable. Purchase of Instruments Not Payable.

77	MICROSCOPE COVER	Payable under OT Charges, not separately
78	SURGICAL BLADES, HARMONIC SCALPEL, SHAVER	Payable under OT Charges, not separately
79	SURGICAL DRILL	Payable under OT Charges, not separately
80	EYE KIT	Payable under OT Charges, not separately
81	EYE DRAPE	Payable under OT Charges, not separately
82	X-RAY FILM	Payable under Radiology Charges, not as consumable
83	SPUTUM CUP	Payable under Investigation Charges, not as consumable
84	BOYLES APPARATUS CHARGES	Part of OT Charges, not separately
85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
86	Antiseptic or disinfectant lotions	Not Payable - Part of Dressing Charges
87	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable - Part of Dressing charges
88	COTTON	Not Payable -Part of Dressing Charges
89	COTTON BANDAGE	Not Payable- Part of Dressing Charges
90	MICROPORE/ SURGICAL TAPE	Not Payable – Part of Dressing Charges
91	BLADE	Not Payable
92	APRON	Not Payable
93	TORNIQUET	Not Payable
94	ORTHOBUNDLE, GYNAEC BUNDLE	Not Payable, Part of Dressing Charges
95	URINE CONTAINER	Not Payable
ELEMENTS OF ROOM CHARGE		
96	LUXURY TAX	Actual tax levied by government is payable. Part of room charge for sub limits
97	HVAC	Part of room charge, Not Payable separately
98	HOUSE KEEPING CHARGES	Part of room charge, Not Payable separately
99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge, Not Payable separately
100	TELEVISION & AIR CONDITIONER CHARGES	Part of room charge, Not Payable separately
101	SURCHARGES	Part of room charge, Not Payable separately
102	ATTENDANT CHARGES	Part of room charge, Not Payable separately
103	IM IV INJECTION CHARGES	Part of nursing charge, Not Payable separately
104	CLEAN SHEET	Part of Laundry / Housekeeping, Not Payable separately

105	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by Hospital is payable
106	BLANKET/WARMER BLANKET	Part of room charge, Not Payable separately
ADMINISTRATIVE OR NON - MEDICAL CHARGES		
107	ADMISSION KIT	Not Payable
108	BIRTH CERTIFICATE	Not Payable
109	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
110	CERTIFICATE CHARGES	Not Payable
111	COURIER CHARGES	Not Payable
112	CONVENYANCE CHARGES	Not Payable
113	DIABETIC CHART CHARGES	Not Payable
114	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
115	DISCHARGE PROCEDURE CHARGES	Not Payable
116	DAILY CHART CHARGES	Not Payable
117	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
118	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	Payable under Post-Hospitalisation where admissible
119	FILE OPENING CHARGES	Not Payable
120	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
121	MEDICAL CERTIFICATE	Not Payable
122	MAINTENANCE CHARGES	Not Payable
123	MEDICAL RECORDS	Not Payable
124	PREPARATION CHARGES	Not Payable
125	PHOTOCOPIES CHARGES	Not Payable
126	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
127	WASHING CHARGES	Not Payable
128	MEDICINE BOX	Not Payable
129	MORTUARY CHARGES	Payable up to 24 hrs, shifting charges not payable
130	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
EXTERNAL DURABLE DEVICES		
131	WALKING AIDS CHARGES	Not Payable
132	BIPAP MACHINE	Not Payable
133	COMMODE	Not Payable
134	CPAP/ CAPD EQUIPMENTS	Device not payable
135	INFUSION PUMP – COST	Device not payable
136	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
137	PULSEOXYMETER CHARGES	Device not payable
138	SPACER	Not Payable
139	SPIROMETRE	Device not payable
140	SP02 PROBE	Not Payable
141	NEBULIZER KIT	Not Payable
142	STEAM INHALER	Not Payable
143	ARMSLING	Not Payable
144	THERMOMETER	Not Payable
145	CERVICAL COLLAR	Not Payable
146	SPLINT	Not Payable
147	DIABETIC FOOT WEAR	Not Payable
148	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
149	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
150	LUMBOSACRAL BELT	Payable for surgery of lumbar

		spine.
151	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
152	AMBULANCE COLLAR	Not Payable
153	AMBULANCE EQUIPMENT	Not Payable
154	MICROSHEILD	Not Payable
155	ABDOMINAL BINDER	Essential and should be paid in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.
ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION		
156	BETADINE / HYDROGEN PEROXIDE / SPIRIT / DISINFECTANTS ETC	Not Payable
157	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES Post hospitalization nursing charges	Not Payable
158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGESDIET CHARGES	Patient Diet provided by hospital is payable
159	SUGAR FREE Tablets	Payable -Sugar free variants of admissible medicines are not excluded
160	CREAMS POWDERS LOTIONS	Payable when prescribed (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
161	Digestion gels	Payable when prescribed
162	ECG ELECTRODES	One set every second day is Payable.
163	GLOVES Sterilized	Gloves payable / unsterilized gloves not payable
164	HIV KIT	payable Pre-operative screening
165	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
166	LOZENGES	Payable when prescribed
167	MOUTH PAINT	Payable when prescribed
168	NEBULISATION KIT	If used during Hospitalisation is Payable reasonably
169	NOVARAPID	Payable when prescribed
170	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
171	ZYTEE GEL	Payable when prescribed
172	VACCINATION CHARGES	Routine Vaccination not Payable / Post Bite Vaccination Payable
PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE		
173	AHD	Not Payable - Part of Hospital's internal Cost
174	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
175	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost

OTHERS		
176	VACCINE CHARGES FOR BABY	Not Payable
177	AESTHETIC TREATMENT / SURGERY	Not Payable
178	TPA CHARGES	Not Payable
179	VISCO BELT CHARGES	Not Payable
180	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
181	EXAMINATION GLOVES	Not payable
182	KIDNEY TRAY	Not Payable
183	MASK	Not Payable
184	OUNCE GLASS	Not Payable
185	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable
186	OXYGEN MASK	Not Payable
187	PAPER GLOVES	Not Payable
188	PELVIC TRACTION BELT	Payable in case of PIVD requiring traction
189	REFERAL DOCTOR'S FEES	Not Payable
190	ACCU CHECK (Glucometery/ Strips)	Not payable pre Hospitalisation or post Hospitalisation / Reports and Charts required / Device not payable
191	PAN CAN	Not Payable
192	SOFNET	Not Payable
193	TROLLY COVER	Not Payable
194	UROMETER, URINE JUG	Not Payable
195	AMBULANCE	Payable
196	TEGADERM / VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs
197	URINE BAG	Payable where Medically Necessary - maximum 1 per 24 hrs
198	SOFTOVAC	Not Payable
199	STOCKINGS	Payable for case like CABG etc.