National Insurance Company Limited

(A Govt. of India Undertaking)

CIN - U10200WB1906GOI001713 IRDA Regn. No. - 58

National Parivar Mediclaim Policy

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National Insurance Company Limited
Regd. Office 3, Middleton Street, Post Box 9229, Kolkata 700 071
CIN - U10200WB1906GOI001713 IRDA Regn. No. - 58

Issuing Office

National Parivar Mediclaim Policy

1 Recital Clause
Whereas the insured designated in the schedule hereto has by a proposal, 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 person(s)/ family members named in the schedule hereto (hereinafter called the insured persons) and has paid the premium as consideration for such insurance.

2 Operative Clause
The Company undertakes that if during the policy period or during the continuance of the Policy by renewal, any insured person shall suffer 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,
a. to be hospitalised for treatment at any hospital/nursing home (hereinafter called hospital),
b. to undergo treatment under Domiciliary Hospitalisation,
the Company shall pay to the hospital or reimburse the insured reasonable, customary and medically necessary expenses, incurred in India, as defined below, in respect thereof by, or on behalf of such insured person, but not exceeding the sum insured, being a floater, in respect of all such claims from one or all the insured persons during a policy year and subject to the terms, exclusions, conditions, definitions contained herein or endorsed or otherwise expressed hereon and limits as shown in the Table of Benefits.

2.1Coverage
2.1.1 In-patient Treatment
The Company shall pay to the hospital or reimburse the insured up to the sum insured, the medical expenses for:
i. Room charges and intensive care unit charges (including diet charges, nursing care by qualified nurse, RMO charges, administration charges for IV fluids/blood transfusion/injection), subject to limit as per Section 2.1.1.1
ii. Medical practitioner(s)
iii. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances
iv. Medicines and drugs
v. Diagnostic procedures
vi. Prosthetics and other devices or equipment if implanted internally during a surgical procedure.
vii. Dental treatment, necessitated due to an injury
viii. Plastic surgery, necessitated due to disease or injury
ix. Hormone replacement therapy, if medically necessary
x. Vitamins and tonics, forming part of treatment for disease/injury as certified by the attending medical practitioner
xi. Circumcision, necessitated for treatment of a disease or injury

2.1.1.1 Limit for Room Charges and Intensive Care Unit Charges
Room charges and intensive care unit charges per day shall be payable up to the limit as shown in the Table of Benefits. The limit shall not apply if the treatment is undergone for a listed procedure in a Preferred Provider Network (PPN) as a package.

Note:
Listed procedures and Preferred Provider Network list are dynamic in nature, and will be updated in the Company's website from time to time.

2.1.1.2 Limit for Cataract Surgery
The Company's liability for cataract surgery shall be up to the limit as shown in the Table of Benefits. The limit shall not apply if the treatment is undergone for a listed procedure in a Preferred Provider Network (PPN) as a package.

2.1.2 Pre Hospitalisation
The Company shall reimburse the insured the medical expenses incurred up to thirty 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 hospitalisation was required, and
ii. the in-patient hospitalisation claim for such hospitalisation is admissible by the Company
Pre hospitalisation shall be considered as part of the hospitalisation claim.

2.1.3 Post Hospitalisation
The Company shall reimburse the insured the medical expenses incurred up to 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 shall be considered as part of the hospitalisation claim.

2.1.4 Domiciliary Hospitalisation

The Company shall reimburse the insured the medical expenses incurred under domiciliary hospitalisation up to the limit as shown in the Table of Benefits.

Exclusions

Domiciliary hospitalisation shall not cover:

i. Treatment of less than three days
ii. Expenses incurred for pre and post hospitalisation
iii. Expenses incurred for alternative treatment
iv. Expenses incurred for maternity or infertility
v. Expenses incurred for any of the following diseases;
    a) Asthma
    b) Bronchitis
    c) Chronic nephritis and nephritic syndrome
    d) Diarrhoea and all type of dysenteries including gastroenteritis
    e) Epilepsy
    f) Influenza, cough and cold
    g) All psychiatric or psychosomatic disorders
    h) Pyrexia of unknown origin for less than ten days
    i) Tonsillitis and upper respiratory tract infection including laryngitis and pharingitis
    j) Arthritis, gout and rheumatism

2.1.5 Day Care Procedure

The Company shall pay to the hospital/ day care centre the medical expenses or reimburse the insured the medical expenses and pre and post hospitalisation expenses up to the sum insured, for day care procedures which require hospitalisation for less than twenty four hours provided that

i. day care procedures/surgeries (as listed in Appendix -I) are undergone by an insured person in a hospital/day care centre (but not the outpatient department of a hospital)
ii. any other surgeries/procedures (not listed in Appendix-I) which due to advancement of medical science require hospitalisation for less than twenty four hours and for which prior approval from the Company/TPA is mandatory.

2.1.6 Ayurveda and Homeopathy

The Company shall pay to the hospital the medical expenses or reimburse the insured the medical expenses pre and post hospitalisation expenses up to the sum insured, incurred for Ayurveda and Homeopathy treatment up to the sum insured, provided the treatment is undergone in a government hospital or in an institute recognized by the government and/or accredited by Quality Council of India/ National Accreditation Board for Health.

2.1.7 Organ Donor's Medical Expenses

The Company shall pay to the hospital or reimburse the insured the expenses of hospitalisation of the organ donor up to the sum insured, during the course of organ transplant to the insured person provided

i. the donation conforms to 'The Transplantation of Human Organs Act 1994' and the organ is for the use of the insured person
ii. the insured person has been medically advised to undergo an organ transplant,

Exclusions

The Company shall not be liable to make any payment in respect of any expenses incurred in connection with or in respect of

1. Cost of the organ to be transplanted
2. Pre and post hospitalisation expenses, as per Section 2.1.2 and Section 2.1.3, incurred by the organ donor unless the organ donor is an insured person.
3. Any other medical treatment or complication in respect of the donor, consequent to harvesting

2.1.8 Hospital Cash

The Company shall pay to the insured a daily hospital cash allowance up to the limit as shown in the Table of Benefits for a maximum of five days, provided

i. the hospitalisation exceeds three days.
ii. a claim has been admitted under Section 2.1.1

2.1.9 Ambulance

The Company shall reimburse the insured the expenses incurred for ambulance charges for transportation to the hospital, or from one hospital to another hospital, up to the limit as shown in the Table of Benefits, provided a claim has been admitted under Section 2.1.1.

2.1.10 Anti Rabies Vaccination
The Company shall reimburse the insured medically necessary expenses incurred for anti rabies vaccination up to the limit as shown in the Table of Benefits. Hospitalisation is not required for vaccination.

2.1.11 Maternity
The Company shall pay to the hospital or reimburse the insured the medical expenses, incurred as an in-patient, for delivery or termination up to the first two deliveries or terminations of pregnancy during the lifetime of the insured or his spouse, if covered by the Policy, provided the Policy has been continuously in force for thirty six months from the inception of the Policy or from the date of inclusion of the insured person by the Policy, whichever is later. The benefits described below are up to the limit as shown in the Table of Benefits.

i. Medical expense for delivery (normal or caesarean).
ii. Medical expense for lawful medical termination of pregnancy.
iii. Hospitalisation expenses, if medically necessary, up to a maximum of thirty days for pre-natal and sixty days for post-natal treatment.

Baby from Birth Cover

iv. Medical expenses of the new born baby/ new born babies (in the event of multiple birth in a delivery),, including expenses for vaccination (as listed in Appendix III). Hospitalisation is not required for vaccination.

Note: Ectopic pregnancy is covered under Section 2.1.1 'In-patient treatment', provided such pregnancy is established by medical reports.

Exclusions
The Company shall not be liable to make any payment in respect of any expenses incurred in connection with or in respect of
1. Insured and insured persons above forty five years of age.
2. More than one delivery or termination in a policy year.
3. Surrogacy, unless claim is admitted under Section 2.1.12 (Infertility)
4. Pre and post hospitalisation expenses as per Section 2.1.2 and Section 2.1.3, other than pre and post natal treatment.

2.1.12 Infertility
The Company shall pay to the hospital or reimburse the insured, in respect of the medical expenses of the insured and his spouse, if covered by the Policy, for treatment undergone as an in-patient or as a day care treatment, for procedures and/ or treatment of infertility, provided the Policy has been continuously in force for thirty six months from the inception of the Policy or from the date of inclusion of the insured person, whichever is later. The medical expenses for either or both the insured person shall be subject to the limit as shown in the Table of Benefits.

Exclusions
The Company shall not be liable to make any payment in respect of any expenses incurred in connection with or in respect of
1. Insured and insured persons above forty five years of age.
2. Diagnostic tests related to infertility
3. Reversing a tubal ligation or vasectomy
4. Preserving and storing sperms, eggs and embryos
5. An egg donor or sperm donor
6. Experimental treatments
7. Any disease/ injury, other than traceable to maternity, of the surrogate mother.

Conditions
1. Expenses advanced procedures, including IVF, GIFT, ZIFT or ICSI, shall be payable only if the Insured person has been unable to attain or sustain a successful pregnancy through reasonable, and medically necessary infertility treatment.
2. Maternity expenses of the surrogate mother shall be payable under Section 2.1.11 (Maternity). Legal affidavit regarding intimation of surrogacy shall be submitted to the Company.
3. Maximum of two claims shall be admissible by the Policy during the lifetime of the insured person if he has no living child and one claim if the insured has one living child.
4. Any one illness (Definition 6.2) limit shall not apply.

Definitions for the purpose of the Section
1. **Donor** means an oocyte donor or sperm donor.
2. **Embryo** means a fertilized egg where cell division has commenced/ under the process and has completed the pre-embryonic stage.
3. **Gamete Intra-Fallopian Transfer (GIFT)** means a procedure where the sperm and egg are placed inside a catheter separated by an air bubble and then transferred to the fallopian tube. Fertilization takes place naturally.
4. **Infertility** means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. However the one year period may be waived, provided a medical practitioner determines existence of a medical condition rendering conception impossible through unprotected sexual intercourse, including but not limited to

congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments.

5. **Intra-Cytoplasmic Sperm Injection (ICSI)** means an injection of sperm into an egg for fertilisation.
6. **In Vitro Fertilization (IVF)** means a process in which an egg and sperm are combined in a laboratory dish where fertilization occurs. The fertilized and dividing egg is transferred into the uterus of the woman.
7. **Surrogate** means a woman who carries a pregnancy for the insured person.
8. **Zygote Intra-Fallopian Transfer (ZIFT)** means a procedure where the egg is fertilized in vitro and transferred to the fallopian tube before dividing.

Note

Aggregate of all the benefits under 2.1.1 to 2.1.12 are subject to the Sum Insured opted.

2.2 Medical Second Opinion

The Company shall arrange for a Medical Second Opinion from a panel of World Leading Medical Centers (WLMC), at the insured person's request, if the insured person is diagnosed with one of the major illness listed in Appendix II, during the policy year. One Medical Second Opinion per family may be availed during a policy year, for any of the major illness (listed in Appendix II).

The insured person shall provide the medical records containing the diagnosis and recommended course of treatment to the service provider, through the TPA named in the schedule for servicing MSO (irrespective of claim being serviced by TPA or not). The Medical Second Opinion shall be based only on the information and documentation provided to the medical practitioner of WLMC by or on behalf of the insured person, and the second opinion and the recommended course of treatment shall be sent directly to the insured/ insured person. The TPA shall only be responsible for collecting the required documents from the insured person, and deliver them to the service provider.

In opting for this service and deciding to obtain a Medical Second Opinion, each insured person expressly notes and agrees that:

i. it is entirely for the insured person to choose whether or not to obtain a Medical Second Opinion from WLMC and if obtained under this service then whether or not to act on it
ii. the Company does not provide Medical Second Opinion or makes any representation as to the adequacy or accuracy of the same, the insured person's or any other person's reliance on the same, or the use of the Medical Second Opinion.
iii. the Company does not assume responsibility for and shall not be responsible for any actual or alleged errors, omissions or representations made by any medical practitioner or in any Medical Second Opinion or for any consequences of any action taken or not taken in reliance there on
iv. Medical Second Opinion provided under this service shall not be valid for any medico-legal purposes
v. Medical Second Opinion does not entitle the insured person to any consultations from or further opinions from that medical practitioner.

3 Good Health Incentives

3.1 No Claim Discount (NCD)

On renewal of policies with a term of one year, a NCD of flat 5% shall be allowed on the * base premium, provided claims are not reported in the expiring Policy.

On renewal of policies with a term exceeding one year, the NCD amount with respect to each claim free policy year shall be aggregated and allowed on renewal. Aggregate amount of NCD allowed shall not exceed flat 5% of the total base premium for the term of the policy.

* **Base premium** depends on the zone and sum insured and is the aggregate of the premium for senior most insured person and other insured persons for a year.

3.2 Health Check Up

Expenses of health check up with respect to the insured person(s), shall be reimbursed at the end of a block of four continuous policy years, provided claims are not reported during the block in respect of the insured person(s) and the Policy has been continuously renewed with the Company without a break. Expenses payable are subject to the limit as shown in the Table of Benefits.

4 Exclusions

The Company shall not be liable to make any payment by the Policy, in respect of any expenses incurred 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 forty eight months. Any complication arising from pre-existing diseases shall be considered as a part of the pre-existing disease.

For persons suffering from either hypertension or diabetes or both at the inception of the Policy, the following exclusions shall apply

Diabetes	Hypertension	Diabetes and Hypertension

Diabetic Retinopathy	Coronary Artery Disease	Diabetic Retinopathy
Diabetic Nephropathy	Cerebro Vascular Accident	Diabetic Nephropathy
Diabetic Foot/wound	Hypertensive Nephropathy	Diabetic Foot/wound
Diabetic Angiopathy	Internal Bleeding/ Haemorrhage	Diabetic Angiopathy
Diabetic Neuropathy		Diabetic Neuropathy
Hyper/Hypoglycemic shock		Hyper/Hypoglycemic shock
Coronary Artery Disease		Coronary Artery Disease
		Cerebro Vascular Accident
		Hypertensive Nephropathy
		Internal Bleeding/ Haemorrhage

4.2 First Thirty Days Waiting Period
Any disease contracted by the insured person during the first thirty days from the inception of the Policy. The waiting period shall not apply in case of renewal and if the insured person is hospitalised for injuries, sustained in an accident which occurred after the inception of the Policy.

4.3 Specific Waiting Period
Diseases/treatments listed below are subject to waiting periods as follows.

i. **One year waiting period**
   a. Benign ENT disorders
   b. Tonsillectomy
   c. Adenoidectomy
   d. Mastoidectomy
   e. Tympanoplasty

ii. **Two years waiting period**
   a. Cataract
   b. Benign prostatic hypertrophy
   c. Hernia
   d. Hydrocele
   e. Fissure/Fistula in anus
   f. Piles (Haemorrhoids)
   g. Sinusitis and related disorders
   h. Polycystic ovarian disease
   i. Non-infective arthritis
   j. Pilonidal sinus
   k. Gout and Rheumatism
   l. Hypertension and related complications as mentioned in 4.1
   m. Diabetes and related complications as mentioned in 4.1
   n. Calculus diseases
   o. Surgery of gall bladder and bile duct excluding malignancy
   p. Surgery of genito-urinary system excluding malignancy
   q. Surgery for prolapsed intervertebral disc unless arising from accident
   r. Surgery of varicose vein
   s. Hysterectomy

iii. **Four years waiting period**
   a. Treatment for joint replacement unless arising from accident
   b. Osteoarthritis and osteoporosis

4.4 HIV, AIDS, STD
Any condition directly or indirectly caused to or associated with HIV, AIDS, complications of AIDS and other sexually transmitted diseases (STD).

4.5 General Debility, Congenital External Anomaly
General debility, run down condition or rest cure, congenital external disease or defects or anomaly.

4.6 Sterility, Infertility, Assisted Conception
Sterility, infertility/sub fertility, assisted conception procedures, except as and to the extent provided for under Section 2.1.12 (Infertility).

4.7 Pregnancy
Treatment arising from or traceable to pregnancy/childbirth including caesarean section, miscarriage, surrogate or vicarious pregnancy, abortion or complications thereof including changes in chronic conditions arising out of pregnancy, except as and to the extent provided for under Section 2.1.11 (Maternity) and Section 2.1.12 (Infertility).

4.8 Refractive Error
Surgery for correction of eye sight due to refractive error.

4.9 Obesity
Treatment for obesity or a condition arising there from (including morbid obesity) and any other weight control and management programme/services/supplies or treatment.

4.10 Psychiatric Disorder, Self Inflicted Injury
Treatment for all psychiatric and psychosomatic disorders/diseases, intentional self-inflicted injury, attempted suicide.

4.11 Genetic Disorders, Stem Cell Surgery (except bone marrow transplant).

4.12 Circumcision
Circumcision, except as and to the extent provided for under Section 2.1.1.xi

4.13 Vaccination or Inoculation
Vaccination or inoculation unless forming part of treatment and requires hospitalisation, except as and to the extent provided for under Section 2.1.10 (Anti Rabies Vaccination) and Section 2.1.11.iv (Maternity).

4.14 Cosmetic Treatment, Plastic Surgery, Sex Change, Hormone Replacement Therapy
Cosmetic treatment or aesthetic treatment of any description, change of life or sex change operation.
Expenses for plastic surgery, except as and to the extent provided for under Section 2.1.1.viii.
Expenses for hormone replacement therapy, except as and to the extent provided for under Section 2.1.1.ix.

4.15 Massages, Spa, Steam Bath, Naturopathy, Experimental Treatment
Massages, spa, steam bath, shirodhara, udhwarthanam, abhyangam, kayasekham and similar treatment.
Expenses for naturopathy, experimental medicine/treatment, unproven procedure/treatment, alternative treatments (other than ayurveda and homeopathy), acupuncture, acupressure, magneto-therapy and similar treatment.

4.16 Dental Treatment
Dental treatment, except as and to the extent provided for under Section 2.1.1.vii.

4.17 Vitamins, Tonics
Vitamins and tonics, except as and to the extent provided for under Section 2.1.1.x.

4.18 Out-patient Treatment
Any treatment undergone as an out-patient.

4.19 Hospitalisation for the Purpose of Diagnosis and Evaluation
Diagnostic and evaluation purpose where such diagnosis and evaluation can be carried out as an outpatient procedure and the condition of the patient does not require hospitalisation.

4.20Treatment in Convalescent Home, Nature Clinic
Treatment in health hydro/nature care clinic rest home or convalescent home for the addicted, detoxification centre, sanatorium, home for the aged, mentally disturbed, remodeling clinic or similar institution.

4.21 Drug/Alcohol Abuse
Treatment arising out of disease/ injury directly attributable to use of drugs/alcohol and intoxicating substances.

4.22 Stay in Hospital which is not Medically Necessary.

4.23 Spectacles, Contact Lens, Hearing Aid, Cochlear Implants.

4.24 Equipments
External/durable medical/non-medical equipments/instruments of any kind used for diagnosis/ treatment including CPAP, CAPD, infusion pump, ambulatory devices such as walker, crutches, belts, collars, caps, splints, slings, braces, stockings, diabetic foot-wear, glucometer, thermometer and similar related items (as listed in Appendix IV) and any medical equipment which could be used at home subsequently.

4.25 Expenses not Related to the Diagnosis and Treatment of Disease/ Injury
Irrelevant investigations/treatment, drugs not supported by a prescription, private nursing charges, referral fee to family physician, outstation doctor/surgeon/consultants' fees and similar expenses (as listed in Appendix IV).

4.26 Items of Personal Comfort
Items of personal comfort and convenience (as listed in Appendix IV) including telephone, television, aya, barber, beauty services, baby food, cosmetics, napkins, toiletries, guest services.

4.27 Service Charge/ Registration Fee
Any kind of service charges including surcharges, admission fees, registration charges and similar charges (as listed in Appendix IV) levied by the hospital.

4.28 Home Visit Charges
Home visit charges during pre and post hospitalisation of doctor, attendant and nurse.

4.29 Treatment not Related to Disease
Treatment which the insured person was on before hospitalisation for the disease/ injury, different from the one for which claim for hospitalisation has been made.

4.30 Risky Avocations
Treatment for any disease/injury arising from scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing and similar activities.

4.31 Breach of Law
Any disease or injury as a result of committing or attempting to commit a breach of law with criminal intent.

4.32 War Group Perils
Any disease or injury directly or indirectly caused by or arising from or attributable to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.

4.33 Radioactivity
Any disease or injury directly or indirectly caused by or contributed by nuclear weapons/materials or arising from ionising radiation or contamination by any nuclear fuel or from any nuclear waste or combustion of nuclear fuel.

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, shall be a condition precedent to any liability of the Company to make any payment by the Policy.

5.3 Communication
i. All communication should be made in writing.
ii. For Policies serviced by TPA, ID card, PPN/network provider related issues to be communicated to the TPA at the address mentioned in the schedule. For claim serviced by the Company, the Policy related issues to be communicated to the Policy issuing office of the Company at the address mentioned in the schedule.
iii. Any change of address, state of health or any other change affecting any of the insured person, shall be communicated to the Policy issuing office of the Company at the address mentioned in the schedule
iv. The Company or TPA shall communicate to the insured 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 the event 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 Claim Procedure
5.5.1 Notification of Claim
In the event of hospitalisation/ domiciliary hospitalisation, the insured person/insured person's representative shall notify the TPA (if claim is processed by TPA)/Company (if claim is processed by the Company) 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.

Notification of claim for Cashless facility	**TPA must be informed:**
In the event of planned hospitalisation	At least seventy two hours prior to the insured person's admission to network provider/PPN
In the event of emergency hospitalisation	Within twenty four hours of the insured person's admission to network provider/PPN

Notification of claim for Reimbursement	**Company/TPA must be informed:**
In the event of planned hospitalisation/ domiciliary hospitalistion	At least seventy two hours prior to the insured person's admission to hospital/ inception of domiciliary hospitalisation
In the event of emergency hospitalisation/ domiciliary	Within twenty four hours of the insured person's admission to

hospitalistion	hospital/ inception of domiciliary hospitalisation

Notification of claim for vaccination	**Company/TPA must be informed:**
In the event of Anti Rabies Vaccination	At least twenty four hours prior to the vaccination

Note:
For claim under Section 2.2 (Medical Second Opinion), notification of claim is not required.

5.5.2 Procedure for Cashless Claims

i. Cashless facility for treatment in network hospitals can be availed, if TPA service is opted.
ii. Treatment may be taken in a network provider/PPN and is subject to pre authorization by the TPA. Booklet containing list of network provider/PPN shall be provided by the TPA. Updated list of network provider/PPN is available on website of the Company and the TPA mentioned in the schedule.
iii. Cashless request form available with the network provider/PPN and TPA shall be completed and sent to the TPA for authorization.
iv. The TPA upon getting cashless request form and related medical information from the insured person/ network provider/PPN shall issue pre-authorization letter to the hospital after verification.
v. At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
vi. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
vii. 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 processing.

5.5.3 Procedure for Reimbursement of Claims

For reimbursement of claims the insured person may submit the necessary documents to TPA (if claim is processed by TPA)/Company (if claim is processed by the Company) within the prescribed time limit.

5.5.3.1 Procedure for Reimbursement of Claim under Domiciliary Hospitalisation

For reimbursement of claims under domiciliary hospitalisation, the insured person may submit the necessary documents to TPA (if claim is processed by TPA)/Company (if claim is processed by the Company) within the prescribed time limit.

5.5.4 Documents

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

i. Completed claim form
ii. Bills, payment receipts, medical history of the patient recorded, discharge certificate/ summary from the hospital etc.
iii. Cash-memo from the hospital (s)/chemist(s) supported by proper prescription
iv. Payment receipt, investigation test reports etc. supported by the prescription from the attending medical practitioner
v. Attending medical practitioner's certificate regarding diagnosis along with date of diagnosis and bill receipts etc.
vi. Certificate from the surgeon stating diagnosis and nature of operation and bills/receipts etc.
vii. For claim under Section 2.1.4 (Domiciliary Hospitalisation) in addition to documents listed above (as applicable), medical certificate stating the circumstances requiring for Domiciliary hospitalisation and fitness certificate from treating medical practitioner.
viii. For claim under Section 2.1.11 (Maternity) for surrogacy under Section 2.1.12 (Infertility) in addition to documents listed above (as applicable), legal affidavit regarding intimation of surrogacy.
ix. Any other document required by Company/TPA

Note

In the event of a claim lodged as per condition 5.8 and the original documents having been submitted to the other insurer, the Company may accept the documents listed under condition 5.5.4 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 Company/TPA**
Reimbursement of hospitalization, pre hospitalisation expenses and ambulance charges	Within fifteen days from date of discharge from hospital
Reimbursement of post hospitalisation expenses	Within fifteen days from completion of post hospitalisation treatment
Reimbursement of domiciliary hospitalisation expenses	Within fifteen days from issuance of fitness certificate
Reimbursement of anti rabies vaccination and new born baby vaccination	Within fifteen days from date of vaccination
Reimbursement of expenses for infertility treatment	Within fifteen days of completion of treatment or fifteen days of expiry of policy period, whichever is earlier, once during the policy year

Reimbursement of health check up expenses (to be submitted to the office only)	Within six months of the fifth policy year.

5.5.5 Claim Settlement

i. On receipt of the final document(s) and investigation report (if required), the Company shall within a period of thirty days offer a settlement of the claim to the insured.
ii. If the Company, for any reasons, rejects a claim, it shall communicate to the insured in writing within a period of thirty days from the receipt of the document(s) and investigation report (if required).
iii. Upon the acceptance of an offer of settlement by the insured, the payment of the amount of claim shall be made within 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 2% above the bank rate prevalent at the beginning of the financial year in which the claim is paid.

5.5.6 Services Offered by TPA

The TPA shall render health care services covered by the Policy including issuance of ID cards & guide book, hospitalisation & 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 claim rejection; however, TPA may handle claims admission and recommend to the Company for settlement of the claim
ii. Any services directly to any 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 notification of claim and submission of documents may be waived in cases where it is proved to the satisfaction of the Company, that the physical circumstances under which insured person was placed, it was not possible to intimate the claim/submit the documents within the prescribed time limit.

5.5.7 Classification of * Zone and Copayment

The amount of claim admissible will depend upon the zone for which premium has been paid and the zone where treatment has been taken.

* The country has been divided into four zones.

Zone I - Greater Mumbai Metropolitan area, entire state of Gujarat
Zone II – National Capital Territory (NCT) Delhi and National Capital Region (# NCR), Chandigarh, Pune
Zone III - Chennai, Hyderabad, Bangalore, Kolkata
Zone IV - Rest of India
 # NCR includes Gurgaon-Manesar, Alwar-Bhiwadi, Faridabad-Ballabgarh, Ghaziabad-Loni, Noida, Greater Noida, Bahadurgarh, Sonepat-Kundli Charkhi Dadri, Bhiwani, Narnaul

Where treatment has been taken in a zone, other than the one for which ** premium has been paid, the claim shall be subject to copayment.

i. **Insured paying premium as per Zone I can avail treatment in Zone I, Zone II, Zone III and Zone IV without copayment**
ii. **Insured paying premium as per Zone II**
    a. **Can avail treatment in Zone II, Zone III and Zone IV without any copayment**
    b. **Availing treatment in Zone I will be subject to a copayment of 5%**
iii. **Insured paying premium as per Zone III**
    a. **Can avail treatment in Zone III and Zone IV without any copayment**
    b. **Availing treatment in Zone I will be subject to a copayment of 12.5%**
    c. **Availing treatment in Zone II will be subject to a copayment of 7.5%**
iv. **Insured paying premium as per Zone IV**
    a. **Can avail treatment in Zone IV without any copayment**
    b. **Availing treatment in Zone I will be subject to a copayment of 22.5%**
    c. **Availing treatment in Zone II will be subject to a copayment of 17.5%**
    d. **Availing treatment in Zone III will be subject to a copayment of 10%**

** For premium rates please refer to the Prospectus/ Brochure

5.5.8 Treatment Outside Network

Claims where treatment is undergone in a non-network provider shall be subject to co payment of 10%. If treatment is undergone in a non-network provider in a city/ town/ village where the Company/ TPA does not have tie-up with any hospital, copayment shall not apply.

Above copayments shall not be applicable on Critical illness & Outpatient treatment optional covers, but shall apply on Pre existing diabetes and/ or hypertension optional cover.

5.6 Payment of Claim
All claims by the Policy shall be payable in Indian currency and through NEFT/ RTGS only.

5.7 Territorial limit
All medical treatment for the purpose of this insurance will have to be taken in India only.

5.8 Contribution
In the event of a claim arising by 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 the insured person which covers any claim in whole or in part made by 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.

5.9 Fraud
The Company shall not be liable to make any payment under if the same is 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.

5.10 Cancellation
i. The Company may at any time cancel the Policy (on the grounds of fraud, moral hazard, misrepresentation or noncooperation) by sending the insured thirty days notice by registered letter at insured's last known address, and in such an event, the Company shall not allow any refund.
ii. For policies with a term of one year, the insured 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 claims are not reported up to the date of cancellation.

Period of risk	**Rate of premium to be charged**
Up to 1month	1/4 of the annual rate
Up to 3 months	1/2 of the annual rate
Up to 6 months	3/4 of the annual rate
Exceeding 6 months	Full annual rate

iii. For policies with a term exceeding one year, the insured may at any time cancel the Policy and in such an event, the Company shall allow pro-rata refund of premium for the unexpired policy period after retaining 10% of the pro-rata premium, provided claim are not reported up to the date of cancellation

5.11 Territorial Jurisdiction
All disputes or differences under or in relation to the Policy shall be determined by an Indian court in accordance to Indian law.

5.12 Arbitration
i. If any dispute or difference shall arise as to the quantum to be paid by 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 here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising 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 and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.
ii. 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 the Policy.
iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the Policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

5.13 Disclaimer
If the Company shall disclaim liability for a claim hereunder and if the insured person shall not within twelve calendar months from the date of receipt of the notice of such disclaimer notify the Company in writing that he/ she does not accept such disclaimer and intends to recover his/ her claim from the Company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.14 Renewal of Policy
The Policy may be renewed by mutual consent. The Company is not bound to give notice that the Policy 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 thirty days is allowed. Cover is not available during the grace period.

5.15 Enhancement of Sum Insured

Sum insured can be enhanced only at the time of renewal. Sum insured may be enhanced to the next slab subject to the discretion of the Company. For the incremental portion of the sum insured, the waiting periods and conditions as mentioned in exclusion 4.1, 4.2, 4.3 shall apply. Coverage on enhanced sum insured shall be available after the completion of waiting periods.

5.16 Adjustment of Premium for Overseas Travel Insurance Policy
If during the policy period any of the insured person is also covered by an Overseas Travel Insurance Policy of any non life insurance company, the Policy shall be inoperative in respect of the insured persons for the number of days the Overseas Travel Insurance Policy is in force and proportionate premium for such number of days shall be adjusted against the renewal premium. The insured person must inform the Company in writing before leaving India and may submit an application, stating the details of visit(s) abroad, along with copies of the Overseas Travel Insurance Policy, within seven days of return or expiry of the Policy, whichever is earlier.

5.17 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 insurer where the insured person wants to port, at least 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.

5.18 Medical Expenses Incurred under Two Policy Years
In case the claim falls within two policy years, the claims shall be paid taking into consideration the available sum insured in the two policy years, including the deductibles for each policy year. 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, if not received earlier.

5.19 Withdrawal of Product
In case the Policy is withdrawn in future, the Company shall provide options to the insured person to switch over to a similar Policy at terms and rates 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 shall be notified three months before the changes are effected.

5.21 Free Look Period
The Free Look Period shall be applicable at the inception of the Policy.
The insured shall be allowed a period of fifteen days from date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.
If the insured has not made any claim during the Free Look Period, the insured 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, a deduction towards the proportionate risk premium for period on cover

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 by the Policy in the event of death of the insured. 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 the event of death of any insured person other than the insured, for the purpose of payment of claims, the default nominee would be the insured. The Policy or the benefits cannot be assigned.

6 Definition

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

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

6.3 Alternative treatment means forms of treatments other than "Allopathy" or "modem medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

6.4 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.

6.5 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.

6.6. Condition precedent means a Policy term or condition upon which the Company's liability by the Policy is conditional upon.

6.7 Contract means prospectus, proposal, Policy, and the policy schedule. Any alteration with the mutual consent of the insured person and the insurer can be made only by a duly signed and sealed endorsement on the Policy.

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

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

i. which is not in the visible and accessible parts of the body is called **Internal congenital anomaly.**
ii. which is in the visible and accessible parts of the body is called **External congenital anomaly**

6.10 Co-payment means a cost-sharing requirement by the Policy that provides that the insured shall bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

6.11 Day care centre means any institution established for day care treatment of disease/ 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:

i. has qualified nursing staff under its employment;
ii. has qualified medical practitioner (s) in charge;
iii. has a fully equipped operation theatre of its own where surgical procedures are carried out
iv. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

6.12 Day care treatment means medical treatment, and/or surgical procedure (as listed in Annexure I) which is:

i. undertaken under general or local anesthesia in a hospital/day care centre in less than twenty four hrs because of technological advancement, and
ii. which would have otherwise required a hospitalisation of more than twenty four hours.

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

6.13 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.

6.14 Diagnosis means diagnosis by a medical practitioner, supported by clinical, radiological, histological and laboratory evidence, acceptable to the Company.

6.15 Domiciliary hospitalisation means medical treatment for an illness /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.

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

6.16 Family members means spouse, children and parents of the insured, covered by the Policy.

6.17 Floater means the sum insured, as mentioned in the Schedule, available to all the insured persons, for any and all claims made in the aggregate during each policy year.

6.18 Grace period means thirty 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.

6.19 Hospital means any institution established for in-patient care and day care treatment of disease/ 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 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 ten inpatient beds, in those towns having a population of less than ten lacs and fifteen inpatient 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 shall make these accessible to the Company's authorized personnel.

6.20 Hospitalisation means admission in a hospital for a minimum period of twenty four consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four consecutive hours.

6.21 I D card means the card issued to the insured person by the TPA for availing cashless facility in the network provider.

6.22 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 response 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.

6.23 In-patient care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

6.24 Insured/ Insured person means person(s) named in the schedule of the Policy.

6.25 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.

6.26 Injury means accidental physical bodily harm excluding disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a medical practitioner.

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

6.28 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.

6.29 Medically necessary means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

i. is required for the medical management of the disease/ injuries suffered by the insured person;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. must have been prescribed by a medical practitioner;
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

6.30 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 the licence.

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

6.32 Newborn baby means baby born during the policy period and is aged between one day and ninety days, both days inclusive.

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

6.34 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.

6.35 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 advise of a medical practitioner and the insured person is not admitted as a day care patient or in-patient.

6.36 Policy period means period of one policy year/ two policy years/ three policy years as mentioned in the schedule for which the Policy is issued.

6.37 Policy year means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule.

6.38 Preferred provider network (PPN) means a network of hospitals which have agreed to a cashless packaged pricing for listed procedures for the insured person. The list is available on the website of the Company/TPA and subject to amendment from time to time. For the updated list please visit the website of the Company/TPA. 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.

6.39 Pre-existing disease means any condition, disease or injury or related conditions for which the insured person had signs or symptoms and/or was diagnosed and/or received medical advice/treatment within forty eight months prior to the inception of the Policy.

6.40 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.

6.41 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.

6.42 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 disease/ injury involved.

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

6.44 Schedule means a document forming part of the Policy, containing details including name of the insured person, age, relation of the insured person, sum insured, premium paid and the policy period.

6.45 Service provider means an entity engaged by the Company to provide Medical Second Opinion.

6.46 Surgery means manual and / or operative procedure (s) required for treatment of a disease 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.

6.47 Third Party Administrator (TPA) means any entity, licenced 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.

6.48 Unproven/ Experimental treatment means treatment, including drug therapy, which is not based on established medical practice in India, is experimental or unproven.

6.49 Waiting period means a period from the inception of this Policy during which specified diseases/treatment is not covered. On completion of the period, diseases/treatment shall be covered provided the Policy has been continuously renewed without any break.

7 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. For more information on grievance mechanism, and to download grievance form, visit our website www.nationalinsuranceindia.com

The insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Appendix V.

8 Optional Covers

8.1 Pre-existing Diabetes / Hypertension

Subject otherwise to the terms, definitions, exclusions, and conditions of the Policy and on payment of additional premium, the Company shall pay expenses for treatment of diabetes and/ or hypertension, if pre-existing, from the inception of the Policy. On completion of continuous forty eight months of insurance, the additional premium and co-payment shall not apply.

Copayment
Claims shall be subject to a co payment on admissible claim amount as mentioned below

i. **Insured opting for cover for pre existing diabetes, can avail treatment for diabetes, subject to a copayment of 10%**
ii. **Insured opting for cover for pre existing hypertension, can avail treatment for hypertension, subject to a copayment of 10%**
iii. **Insured opting for cover for pre existing diabetes and hypertension, can avail treatment for diabetes or hypertension, subject to a copayment of 25%**

Eligibility
As per the Policy.

Limit of Cover
Sum Insured opted under the policy shall apply.

Policy period
The policy period for the Policy, and the cover should be identical, as mentioned in the schedule.

Tax rebate
The insured can avail tax benefits for the premium paid, under Section 80D of Income Tax Act 1961.

Renewal
The cover can be renewed annually till Exclusion 4.1 applies on diabetes and/or hypertension, with respect to the insured persons.

8.1.1 Condition
Claim Amount
Any amount payable shall be subject to the sum insured applicable to Section 2.1, copayment mentioned under Section 5.5.7 (Classification of Zone and Copayment), Section 5.5.8 (Treatment outside Network) and copayment mentioned above.

8.2 Out-patient Treatment
Subject otherwise to the terms, definitions, conditions and Exclusions 4.14, 4.15, 4.21, 4.30, 4.31, 4.32 and 4.33, the Company shall pay up to the limit, as stated in the schedule with respect of

i. Out-patient consultations by a medical practitioner
ii. Diagnostic tests prescribed by a medical practitioner
iii. Medicines/drugs prescribed by a medical practitioner
iv. Out patient dental treatment

Eligibility
The cover can be availed by all insured persons as a floater.

Limit of Cover
Limit of cover, available under Outpatient Treatment are INR 2,000/ 3,000/ 4,000/ 5,000/ 10,000, in addition to the sum insured opted.

Policy Period
The policy period for the Policy, and the cover should be identical, as mentioned in the schedule.

Tax Rebate
The insured person can avail tax benefits for the premium paid, under Section 80D of Income Tax Act 1961.

Renewal
The Outpatient Treatment cover can be renewed annually throughout the lifetime of the insured person.

8.2.1 Exclusions
The Company shall not make any payment under the cover in respect of

i. Treatment other than Allopathy/ Modern medicine, Ayurveda and Homeopathy
ii. * Cosmetic dental treatment to straighten lightens, reshape and repair teeth.

* Cosmetic treatments include veneers, crowns, bridges, tooth-coloured fillings, implants and tooth whitening).

8.2.2 Condition
Claim Amount

i. Any amount payable under the optional covers will not affect the sum insured applicable to Section 2.1 and entitlement to No Claim Discount (Section 3.1) and Health Check up (Section 3.2).
ii. Any amount payable shall not be subject to copayment.

Claims Procedure
Documents supporting all out-patient treatments shall be submitted to the TPA/ Company twice during the policy period, within thirty days of completion of six month period.

Documents
The claim has to be supported by the following original documents
i. All bills, prescriptions from medical practitioner
ii. Diagnostic test bills, copy of reports
iii. Any other documents required by the Company

Enhancement of Limit of Cover
Limit of cover can be enhanced only at the time of renewal.

8.3 Critical Illness
Subject otherwise to the terms, definitions, exclusions, and conditions of the Policy he Company shall pay the benefit amount, as stated in the schedule, provided that
i. the insured person is first diagnosed as suffering from a critical illness during the policy period, and
ii. the insured person survives at least thirty days following such diagnosis
iii. diagnosis of critical illness is supported by clinical, radiological, histological and laboratory evidence acceptable to the Company.

Eligibility (entry age)
The cover can be availed by persons between the age of eighteen years and sixty five years.

Benefit Amount
Benefit amount available per individual are INR 2,00,000/ 3,00,000/ 5,00,000/ 10,00,000, in addition to the sum insured opted.

Policy Period
The policy period for the Policy, and the cover should be identical, as mentioned in the schedule.

Pre Policy checkup
Pre Policy checkup reports (as per Section 2.8.iii) are required for individual opting for Critical illness cover between the age of eighteen years and sixty five years.

Tax Rebate
No tax benefit is allowed on the premium paid under Critical Illness cover (if opted)

Renewal
The Critical Illness cover can be renewed annually throughout the lifetime of the insured person.

8.3.1 Definition
Critical illness means stroke resulting in permanent symptoms, cancer of specified severity, kidney failure requiring regular dialysis, major organ/ bone marrow transplant, multiple sclerosis with persisting symptoms an open chest CABG (Coronary Artery Bypass Graft), permanent paralysis of limbs and blindness.

I Stroke Resulting in Permanent Symptoms
Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least three months has to be produced.

The following are not covered
i. transient ischemic attacks (TIA)
ii. traumatic injury of the brain
iii. vascular disease affecting only the eye or optic nerve or vestibular functions.

II Cancer of Specified Severity
A malignant tumour characterised by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy and confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

The following are not covered

i. tumours showing the malignant changes of carcinoma in situ and tumours which are histologically described as premalignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
ii. any skin cancer other than invasive malignant melanoma
iii. all tumours of the prostate unless histologically classified as having a Gleason score greater than six or having progressed to at least clinical TNM classification T2N0M0.
iv. papillary micro - carcinoma of the thyroid less than one cm in diameter
v. chronic lymphocyctic leukaemia less than RAI stage 3
vi. microcarcinoma of the bladder
vii. all tumours in the presence of HIV infection.

III Kidney Failure requiring Regular Dialysis

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

IV Major Organ/ Bone Marrow Transplant

The actual undergoing of a transplant of:

i. one of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
ii. human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are not covered

i. other stem-cell transplants
ii. where only islets of langerhans are transplanted

V Multiple Sclerosis with Persisting Symptoms

The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

i. investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and
iii. well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with at least two clinically documented episodes at least one month apart.

The following are not covered

Other causes of neurological damage such as SLE (Systemic Lupus Erythematosus) and HIV (Human Immunodeficiency Virus).

VI Open Chest CABG

The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

The following are not covered

i. angioplasty and/or any other intra-arterial procedures
ii. any key-hole or laser surgery.

VII Permanent Paralysis of Limbs

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than three months.

VIII Blindness

The total and permanent loss of all sight in both eyes.

8.3.2 Exclusions

The Company shall not be liable to make any payment by the Policy if any critical illness and/or its symptoms (and/or the treatment) which were present at any time before inception of the Policy, or which manifest within a period of ninety days from inception of the Policy, whether or not the insured person had knowledge that the symptoms or treatment were related to such critical illness. In the event of break in the Policy, the terms of this exclusion shall apply as new from recommencement of cover

8.3.3 Condition
Claim Amount

i. Any amount payable under the optional covers will not affect the sum insured applicable to Section 2.1 and entitlement to No Claim Discount (Section 3.1) and Health Check up (Section 3.2).
ii. Any amount payable shall not be subject to copayment.

Notification of Claim
In the event of a claim, the insured person/insured person's representative shall intimate the Company in writing by letter, e-mail, fax providing all relevant information relating to the critical illness within fifteen days of diagnosis of the critical illness.

Claims Procedure
Documents as mentioned above, supporting the diagnosis shall be submitted to the Company within sixty days from the date of diagnosis of the critical illness.

Documents
The claim has to be supported by the following original documents
i. Doctor's certificate confirming diagnosis of the critical illness along with date of diagnosis.
ii. Pathological/other diagnostic test reports confirming the diagnosis of the critical illness.
iii. Any other documents required by the Company

Cessation of Cover
1 upon payment of the benefit amount on the occurrence of a critical illness the cover shall cease and no further claim shall be paid for any other critical illness during the policy year.
2 On renewal, no claim shall be paid for a critical illness for which a claim has already been made

Enhancement of Benefit Amount
i. Benefit amount can be enhanced only at the time of renewal.
ii. Benefit amount can be enhanced to the next slab subject to discretion of the Company.

Insurance is the subject matter of solicitation
Please preserve the Policy for all future reference.

Table of Benefits

Features	**Benefit**
Sum insured (SI) (as Floater)	**INR 1/ 2/ 3/ 4/ /5/ 6/ 7/ 8/ /9 10Lac**
Treatment	Allopathy, Ayurveda and Homeopathy
In built Covers (subject to the SI)	
In patient Treatment (as Floater)	Up to SI
Pre Hospitalisation	30 days
Post Hospitalisation	60 days
Pre-existing Disease	Covered after 48 months
* Room/ ICU Charges (per day per insured person)	Room - Up to 1% of SI or actual, whichever is lower
	ICU – Up to 2% of SI or actual, whichever is lower
** Limit for Cataract Surgery (For each eye per insured person)	Up to 10% of SI or INR 50,000 whichever is lower
Domiciliary Hospitalisation (as Floater)	Up to 20% of SI, subject to maximum of INR 50,000
Day Care Procedures (as Floater)	Up to SI
Ayurveda and Homeopathy (as Floater)	Up to SI
Organ Donor's Medical Expenses (as Floater)	Hospitalisation, pre and post hospitalisation
Hospital Cash (per insured person, per day)	INR 300, max. of 5 days
Ambulance (per insured person, in a policy year)	Up to INR 1,000/- per illness & INR 2,500/-
Anti rabies Vaccination (per insured person, in a policy year)	Up to INR 5,000
Maternity (including Baby from Birth Cover) (per insured person, in a policy year, waiting period of 3 years applies)	Up to 10% of SI subject to INR 30,000 in case of normal delivery and INR 50,000 in case of caesarean section
Infertility (per insured person, in a policy year, waiting period of 3 years applies)	Up to INR 50,000
Other benefits	
Medical Second Opinion (MSO) (for 88 major illness)	One MSO per family in a policy year
Good Health Incentives	
No Claim Discount	5% discount on base premium
Health Check Up (as Floater)	Every 4 yrs., up to INR 5,000
Optional Cover	
Pre-existing Diabetes/Hypertension (as Floater)	Up to the SI
Out-patient Treatment (as Floater in a policy year)	Limit of cover per family - INR 2,000/ 3,000/ 4,000/ 5,000/ 10,000 in addition to the SI
***Critical Illness (per insured person in a policy year)	Benefit amount - INR 2,00,000/ 3,00,000/ 5,00,000/ 10,00,000 in addition to the SI

***** The limit shall not apply if the treatment is undergone for a listed procedure in a Preferred Provider Network (PPN) as a package.
****** The limit shall not apply if the treatment is undergone for a listed procedure in a Preferred Provider Network (PPN) as a package
*** Critical Illness benefit amount should not be more than the sum insured opted under the Policy

Appendix I

Day Care Procedure

Day care procedures will include following day care surgeries and day care treatment.

Microsurgical operations on the middle ear

1. Stapedotomy
2. Stapedectomy
3. Revision of a stapedectomy
4. Other operations on the auditory ossicles
5. Myringoplasty (Type -I Tympanoplasty)
6. Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles)
7. Revision of a tympanoplasty
8. Other microsurgical operations on the middle ear

Other operations on the middle and internal ear

9. Myringotomy
10. Removal of a tympanic drain
11. Incision of the mastoid process and middle ear
12. Mastoidectomy
13. Reconstruction of the middle ear
14. Other excisions of the middle and inner ear
15. Fenestration of the inner ear
16. Revision of a fenestration of the inner ear
17. Incision (opening) and destruction (elimination) of the inner ear
18. Other operations on the middle and inner ear

Operations on the nose and the nasal sinuses

19. Excision and destruction of diseased tissue of the nose
20. Operations on the turbinates (nasal concha)
21. Other operations on the nose
22. Nasal sinus aspiration

Operations on the eyes

23. Incision of tear glands
24. Other operations on the tear ducts
25. Incision of diseased eyelids
26. Excision and destruction of diseased tissue of the eyelid
27. Operations on the canthus and epicanthus
28. Corrective surgery for entropion and ectropion
29. Corrective surgery for blepharoptosis
30. Removal of a foreign body from the conjunctiva
31. Removal of a foreign body from the cornea
32. Incision of the cornea
33. Operations for pterygium
34. Other operations on the cornea
35. Removal of a foreign body from the lens of the eye
36. Removal of a foreign body from the posterior chamber of the eye
37. Removal of a foreign body from the orbit and eyeball
38. Operation of cataract

Operations on the skin and subcutaneous tissues

39. Incision of a pilonidal sinus
40. Other incisions of the skin and subcutaneous tissues
41. Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
42. Local excision of diseased tissue of the skin and subcutaneous tissues
43. Other excisions of the skin and subcutaneous tissues
44. Simple restoration of surface continuity of the skin and subcutaneous tissues
45. Free skin transplantation, donor site
46. Free skin transplantation, recipient site
47. Revision of skin plasty
48. Other restoration and reconstruction of the skin and subcutaneous tissues
49. Chemosurgery to the skin
50. Destruction of diseased tissue in the skin and subcutaneous tissues

Operations on the tongue

51. Incision, excision and destruction of diseased tissue of the tongue
52. Partial glossectomy
53. Glossectomy
54. Reconstruction of the tongue
55. Other operations on the tongue

Operations on the salivary glands and salivary ducts

56. Incision and lancing of a salivary gland and a salivary duct
57. Excision of diseased tissue of a salivary gland and a salivary duct
58. Resection of a salivary gland
59. Reconstruction of a salivary gland and a salivary duct
60. Other operations on the salivary glands and salivary ducts

Other operations on the mouth and face

61. External incision and drainage in the region of the mouth, jaw and face
62. Incision of the hard and soft palate
63. Excision and destruction of diseased hard and soft palate
64. Incision, excision and destruction in the mouth
65. Plastic surgery to the floor of the mouth
66. Palatoplasty
67. Other operations in the mouth

Operations on the tonsils and adenoids

68. Transoral incision and drainage of a pharyngeal abscess
69. Tonsillectomy without adenoidectomy
70. Tonsillectomy with adenoidectomy
71. Excision and destruction of a lingual tonsil
72. Other operations on the tonsils and adenoids

Trauma surgery and orthopaedics

73. Incision on bone, septic and aseptic
74. Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
75. Suture and other operations on tendons and tendon sheath
76. Reduction of dislocation under GA
77. Arthroscopic knee aspiration

Operations on the breast

78. Incision of the breast
79. Operations on the nipple

Operations on the digestive tract

80. Incision and excision of tissue in the perianal region
81. Surgical treatment of anal fistulas
82. Surgical treatment of haemorrhoids
83. Division of the anal sphincter (sphincterotomy)
84. Other operations on the anus
85. Ultrasound guided aspirations
86. Sclerotherapy etc.

Operations on the female sexual organs

87. Incision of the ovary
88. Insufflation of the Fallopian tubes
89. Other operations on the Fallopian tube
90. Dilatation of the cervical canal
91. Conisation of the uterine cervix
92. Other operations on the uterine cervix
93. Incision of the uterus (hysterotomy)
94. Therapeutic curettage
95. Culdotomy
96. Incision of the vagina
97. Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
98. Incision of the vulva
99. Operations on Bartholin's glands (cyst)

Operations on the prostate and seminal vesicles

100. Incision of the prostate
101. Transurethral excision and destruction of prostate tissue
102. Transurethral and percutaneous destruction of prostate tissue
103. Open surgical excision and destruction of prostate tissue
104. Radical prostatovesiculectomy
105. Other excision and destruction of prostate tissue
106. Operations on the seminal vesicles
107. Incision and excision of periprostatic tissue
108. Other operations on the prostate

Operations on the scrotum and tunica vaginalis testis

109. Incision of the scrotum and tunica vaginalis testis
110. Operation on a testicular hydrocele
111. Excision and destruction of diseased scrotal tissue
112. Plastic reconstruction of the scrotum and tunica vaginalis testis
113. Other operations on the scrotum and tunica vaginalis testis

Operations on the testes

114. Incision of the testes
115. Excision and destruction of diseased tissue of the testes
116. Unilateral orchidectomy
117. Bilateral orchidectomy
118. Orchidopexy
119. Abdominal exploration in cryptorchidism
120. Surgical repositioning of an abdominal testis
121. Reconstruction of the testis

122. Implantation, exchange and removal of a testicular prosthesis
123. Other operations on the testis

Operations on the spermatic cord, epididymis and ductus deferens

124. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
125. Excision in the area of the epididymis
126. Epididymectomy
127. Reconstruction of the spermatic cord
128. Reconstruction of the ductus deferens and epididymis
129. Other operations on the spermatic cord, epididymis and ductus deferens

Operations on the penis

130. Operations on the foreskin
131. Local excision and destruction of diseased tissue of the penis
132. Amputation of the penis
133. Plastic reconstruction of the penis
134. Other operations on the penis

Operations on the urinary system

135. Cystoscopical removal of stones

Other Operations

136. Lithotripsy
137. Coronary angiography
138.Hemodialysis
139. Radiotherapy for Cancer
140. Cancer Chemotherapy

Note:

i. Day care treatment will include above day care procedures
ii. Any surgery/procedure (not listed above) which due to advancement of medical science requires hospitalisation for less than 24 hours will require prior approval from Company/TPA.
iii. The standard exclusions and waiting periods are applicable to all of the above day care procedures / surgeries depending on the medical condition / disease under treatment. Only 24 hours hospitalisation is not mandatory.

Major Illness

Medical Second Opinion can be availed for the following illnesses

	Non-Cancerous Diseases
1	AIDS/HIV
2	Amyotrophic Lateral Sclerosis
3	Angioplasty
4	Aortic Aneurysm
5	Apallic Syndrome (Vegetative State)
6	Aplastic Anaemia
7	Benign Brain Tumor
8	Blindness
9	Bone Marrow Transplantation
10	Cardiomyopathy
11	Cerebrovascular Diseases
12	Chronic Obstructive Pulmonary Disease
13	Chronic Relapsing Pancreatitis
14	Cirrhosis
15	Coma
16	Congenital Heart Defect
17	Coronary Artery Bypass Surgery
18	Coronary Artery Disease (CAD)
19	Creutzfeld -Jacob Disease (CJD)
20	Cystic Fibrosis (CF)
21	Elephantiasis
22	Emphysema
23	(End Stage) Liver Disease
24	(End Stage) Lung Disease
25	(Fulminant) Viral Hepatitis
26	Heart Valve Surgery
27	HIV Infection Due to Blood Transfusion
28	Kidney Failure
29	Liver Failure
30	Valvular Heart Disease
31	Loss of Hearing
32	Loss of Limbs
33	Loss of Speech
34	Major Burns
35	Major Organ Transplantation
36	Medullary Cystic Disease
37	Motor Neuron Disease
38	Multiple Sclerosis
39	Muscular Dystrophy
40	Myasthenia Gravis
41	Myelodysplastic Syndrome (Myelodysplasia)
42	Myocardial Infarction (MI)
43	Necrotizing Fasciitis (Flesh Eating Disease)
44	Paralysis
45	Parkinson's Disease (PD)
46	Poliomyelitis
47	Primary Lateral Sclerosis (PLS)
48	Primary Pulmonary Arterial Hypertension
49	Progressive Muscular Atrophy (PMA)
50	Progressive Scleroderma
51	Pulmonary Arterial Hypertension
52	Renal Failure = Kidney failure: see above
53	(Severe) Asthma
54	Severe Brain Damage
55	(Severe) Rheumatoid Arthritis
56	Stroke
57	Surgery to Aorta
58	Systemic Lupus Erythematosus
59	Ulcerative Colitis
	Cancerous Diseases
60	Bladder Cancer
61	Bone Cancer
62	Brain Tumor
63	Breast Cancer
64	Cervical Cancer
65	Colorectal Cancer
66	Esophageal Cancer
67	Eye Cancer
68	Gallbladder Cancer
69	Kidney Cancer
70	Leukemia
71	Liver Cancer
72	Lung Cancer
73	Lymphoma
74	Melanoma
75	Multiple Myeloma
76	Nasopharyngeal Cancer
77	Neuroblastoma
78	Non-Hodgkin's Lymphoma
79	Oral Cavity Cancer
80	Ovarian Cancer
81	Pancreatic Cancer
82	Prostate Cancer
83	Skin Cancer, non-Melanoma
84	Stomach Cancer
85	Testicular Cancer
86	Thyroid Cancer
87	Uterine Cancer
88	Vaginal Cancer

Appendix III

Vaccinations for Children		
Time interval	**Type of vaccination**	**Frequency**
0-3 months	BCG (From birth to 2 weeks)	1
	OPV (0,6,10 weeks) OR OPV + IPV1 (6,10 weeks)	3 OR 4
	DPT (6 & 10 week)	2
	Hepatitis-B (0 & 6 week)	2
	Hib (6 & 10 week)	2

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	**Payable in case of varicose vein surgery**
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**
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 is payable**
ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES	
WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	**Exclusion in Policy**
COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	**Exclusion in Policy**
DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	**Not payable**
HORMONE REPLACEMENT THERAPY	**Payable as per Section 2.1.1.ix**
HOME VISIT CHARGES	**Exclusion in Policy**
INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	**Payable as per Section 2.1.12**
OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	**Exclusion in Policy**
PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	**Exclusion in Policy**
CORRECTIVE SURGERY FOR REFRACTIVE ERROR	**Exclusion in Policy**
TREATMENT OF SEXUALLY TRANSMITTED DISEASES	**Exclusion in Policy**
DONOR SCREENING CHARGES	**Payable**
ADMISSION/REGISTRATION CHARGES	**Exclusion in Policy**
HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	**Exclusion in Policy**
EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	**Exclusion in Policy**
ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	**Not payable**
STEM CELL IMPLANTATION/ SURGERY AND STORAGE	**Not Payable except for Bone Marrow Transplantation**
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, STERLILE 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 room charge not payable separately**
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 CHARGES	**Not Payable**
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	**Payable under Post Hosp**
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 up to 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**
THERMOMETER	**Not Payable**
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	**Payable 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	**Payable for cases who have undergone surgery of lumbar spine.**
ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION	
BETADINE \ HYDROGEN PEROXIDE\SPIRIT\\DETTOL\SAVLON\ DISINFECTANTS ETC	**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	**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	**Up to 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 is payable.
GLOVES	**Sterilized Gloves payable / unsterilized gloves not payable**
HIV KIT	**Payable - Pre operative screening**
LISTERINE/ ANTISEPTIC MOUTHWASH	**Payable when prescribed**
LOZENGES	**Payable when prescribed**
MOUTH PAINT	**Payable when prescribed**
NEBULISATION KIT	**Payable reasonably if used during hospitalisation**
NOVARAPID	**Payable when prescribed**
VOLINI GEL/ ANALGESIC GEL	**Payable when prescribed**
ZYTEE GEL	**Payable when prescribed**
VACCINATION CHARGES	**Anti rabies vaccination payable as per Section 2.1.10**
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	**Payable under Section 2.1.11.iv for new born baby**
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**
OXYGEN MASK	**Not Payable**
PAPER GLOVES	**Not Payable**
PELVIC TRACTION BELT	**Payable in case of PIVD requiring traction as this is generally not reused**
REFERAL DOCTOR'S FEES	**Not Payable**
ACCU CHECK (Glucometery/ Strips)	**Not payable pre hospitilasation 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 as per Section 2.1.9**
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	**Payable for case like CABG etc.**

The list is as per the standard list of excluded expenses stipulated by IRDA in Guidelines in Standardization in Health Insurance, dated 20.02.2013.

Appendix V

The contact details of the Insurance Ombudsman offices are as below-

Areas of Jurisdiction	**Insurance Ombudsman, Office of the Insurance Ombudsman**
Gujarat , UT of Dadra and Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@gbic.co.in
Karnataka	Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@gbic.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@gbic.co.in
Orissa	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.co.in
Punjab , Haryana, Himachal Pradesh, Jammu and Kashmir , UT of Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@gbic.co.in
Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@gbic.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.co.in
Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@gbic.co.in
Andhra Pradesh, Karnataka and UT of Yanam – a part of the UT of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@gbic.co.in
Rajasthan	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@gbic.co.in
Kerala , UT of (a) Lakshadweep, (b) Mahe – a part of UT of Pondicherry	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.

	Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@gbic.co.in
West Bengal, UT of Andaman and Nicobar Islands, Sikkim	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@gbic.co.in
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@gbic.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@gbic.co.in
State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	Office of the Insurance Ombudsman, Email: bimalokpal.noida@gbic.co.in
Bihar, Jharkhand.	Office of the Insurance Ombudsman, Email: bimalokpal.patna@gbic.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 32341320 Email: bimalokpal.pune@gbic.co.in