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## **National Insurance Company Limited**

**(A Govt. of India Undertaking)**

CIN - U10200WB1906GOI001713

IRDA Regn. No. - 58

### **National Senior Citizen Mediclaim Policy**

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*\* Contact the policy issuing office at address mentioned in Schedule, for any assistance. If unanswered for over 30 days, then contact Head Office.*

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Issuing Office

## National Senior Citizen Mediclaim Policy

### 1 RECITAL CLAUSE

Whereas the insured designated in the schedule hereto has by a proposal together with declaration and reports, 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) 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 during the policy period, if one or more insured person (s) shall suffer any illness or disease (hereinafter called illness) or sustain any bodily injury due to an accident (hereinafter called injury) requiring the insured person(s) to be either

a) hospitalised for treatment at any hospital/nursing home (hereinafter called hospital) or day care center, or

b) undergo treatment under Domiciliary Hospitalisation (as defined),

following the advice of a duly qualified medical practitioner, the Company shall indemnify the hospital or the insured reasonable, customary and medically necessary expenses towards the Coverage mentioned in Section 2.1 (Plan A and B) and Section 2.2 of the policy (Plan B only), depending on the Plan opted.

Provided further that, the amount payable under the policy in respect of all such claims during the policy period shall be subject to the terms, exclusions, conditions, definitions contained herein and limits as shown in the Table of Benefits, and shall not exceed:

- the sum insured of that insured person, if covered on individual basis or
- the floater sum insured in respect of the insured and spouse, if covered on floater basis.

**Note:** Subject to applicability of Section 2.2.4 the maximum liability of the Company in a policy period shall be the sum insured and reinstated sum insured.

### 2.1 COVERAGE

#### 2.1.1 In-patient Treatment

The Company shall pay to the hospital or reimburse the insured, medical expenses for:

- 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)
- Medical practitioner(s)
- Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances
- Medicines and drugs
- Diagnostic procedures
- Prosthetics and other devices or equipment if implanted internally during a surgical procedure.
- Dental treatment, necessitated due to an injury
- Plastic surgery, necessitated due to illness or injury
- Hormone replacement therapy, if medically necessary
- Vitamins and tonics, forming part of treatment for illness/injury as certified by the attending medical practitioner
- Circumcision, necessitated for treatment of an illness 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 as a package for a listed procedure in a Preferred Provider Network (PPN).

#### 2.1.1.2 Limit for Cataract Surgery and Benign Prostatic Hyperplasia

The Company's liability for cataract surgery and Benign Prostatic Hyperplasia shall be up to the limit as shown in the Table of Benefits, under Plan A only.

#### 2.1.2 Pre Hospitalisation

The Company shall reimburse the insured in respect of the medical expenses incurred 30 (thirty) days immediately before the insured person is hospitalised, provided that:

- such medical expenses are incurred for the same condition for which the insured person's hospitalisation was required, and
- the in-patient hospitalisation claim for such hospitalisation is admissible by the Company

Pre hospitalisation shall be considered as part of hospitalisation claim.

#### 2.1.3 Post Hospitalisation

The Company shall reimburse the insured in respect of the medical expenses incurred 60 (sixty) days immediately after the insured person is discharged from hospital, provided that:

- such medical expenses are incurred for the same condition for which the insured person's hospitalisation was required, and
- the in-patient hospitalisation claim for such hospitalisation is admissible by the Company

Post hospitalisation shall be considered as part of 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. Treating Medical Practitioner shall have to certify the commencement date of Domiciliary Hospitalisation, and the necessity following the circumstances mentioned below (also mentioned in Definition 7.14).

- 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 room in a hospital.

Domiciliary Hospitalisation beyond the first 7 days shall be treated as Post Hospitalisation and shall be covered for the period mentioned in Section 2.1.3 (Post Hospitalisation).

If the insured person is shifted to a Hospital as In-patient during the Domiciliary Hospitalisation for the same illness/ injury, the Post Hospitalisation period shall start from the date of discharge.

#### Exclusions

Domiciliary hospitalisation shall not cover:

- i. Treatment of less than three days
- ii. Expenses incurred for AYUSH Treatment
- iii. 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 mental illnesses, psychiatric or psychosomatic disorders
  - h) Pyrexia of unknown origin for less than ten days
  - i) Tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis
  - j) Arthritis, gout and rheumatism
  - k) HIV/ AIDS

#### 2.1.5 Daycare Procedure

The Company shall pay to the hospital/ day care centre or reimburse the insured the medical expenses and pre and post hospitalisation expenses, for day care treatment of procedures/surgeries (as listed in Appendix -I), provided that day care treatment is undergone by the insured person in a hospital/ day care centre, but not the outpatient department of a hospital.

In case of any other surgeries/procedures (not listed in Appendix-I) which would have otherwise required a hospitalization of more than 24 hours, but due to advancement of medical science require hospitalisation for less than 24 hours, shall be covered subject to prior approval of the Company/TPA.

#### 2.1.6 Ayurveda and Homeopathy

The Company shall pay to the hospital or reimburse the insured the medical expenses for in-patient care (admissible as per Section 2.1.1), pre hospitalisation expenses (admissible as per Section 2.1.2) and post hospitalisation expenses (admissible as per Section 2.1.3), incurred for Ayurveda and Homeopathy treatment, provided the treatment is undergone in

- i. a government hospital, or
- ii. an institute recognized by the government and/or accredited by Quality Council of India/ National Accreditation Board for Health, or
- iii. Teaching Hospitals of AYUSH Colleges recognized by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH), or
- iv. AYUSH Hospitals having registration with a Government Authority under appropriate Act in the State/ UT and complies with the following as minimum criteria:
  - a. Has at least fifteen in-patient beds;
  - b. Has minimum five qualified and registered AYUSH doctors;
  - c. Has qualified paramedical staff under its employment round the clock
  - d. Has dedicated AYUSH therapy sections
  - e. maintains daily records of patients and makes these accessible to the Company's authorized personnel

#### 2.1.7 HIV/ AIDS Cover

The Company shall pay to the hospital or reimburse the insured the medical expenses for in-patient care (admissible as per Section 2.1.1), pre hospitalisation expenses (admissible as per Section 2.1.2) and post hospitalisation expenses (admissible as per Section 2.1.3)) related to following stages of HIV infection:

1. Acute HIV infection – acute flu-like symptoms
2. Clinical latency – usually asymptomatic or mild symptoms
3. AIDS – full-blown disease; CD4 < 200

#### Exclusions

1. Any treatment undertaken as Out Patient shall not be covered.
2. Any treatment undertaken as Domiciliary hospitalization shall not be covered.

### **2.1.8 Mental Illness Cover**

The Company shall pay to the hospital or reimburse the insured the medical expenses for in-patient care (admissible as per Section 2.1.1), pre hospitalisation expenses (admissible as per Section 2.1.2) and post hospitalisation expenses (admissible as per Section 2.1.3)), related to following mental illnesses:

1. Major Depressive Disorder- when the patient is aggressive or violent.
2. Acute psychotic conditions- aggressive/violent behaviour or hallucinations, incoherent talking or agitation.
3. Schizophrenia- esp. Psychotic episodes.
4. Bipolar disorder- manic phase.

The above covers are subject to the patient simultaneously exhibiting two or more of the following traits and requiring hospitalisation as per the treating psychiatrist's advice

- Suicidality
- Aggression
- Violent behaviour which are harmful to the patient and people around him
- Patients not responding to OPD drugs/treatments/therapy.

### **Condition**

Treatment shall be undertaken at a Hospital categorized as Mental Health Establishment, under a Medical Practitioner qualified as Mental Health Professional.

### **Exclusions**

1. Any treatment undertaken as Out Patient shall not be covered.
2. Any treatment undertaken as Domiciliary hospitalization shall not be covered.
3. Any kind of Psychological counselling, cognitive/ family/ group/ behavior/ palliative therapy or other kinds of psychotherapy for which hospitalisation is not necessary shall not be covered.

### **2.1.9 Organ Donor's Medical Expenses**

The Company shall pay to the hospital or reimburse the insured the medical expenses for in-patient care (admissible as per Section 2.1.1), pre hospitalisation expenses (admissible as per Section 2.1.2) and post hospitalisation expenses (admissible as per Section 2.1.3)) of the organ donor, 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. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

### **2.1.10 Ambulance Charges**

The Company shall reimburse the insured the expenses incurred for actual emergency ambulance charges for transportation to the hospital or from the hospital to another hospital or from the hospital to diagnostic center and return during the same hospitalization period, provided a claim has been admitted as per Section 2.1.1 (In-patient Treatment). Ambulance charges will be subject to maximum INR 2,500 for Any One Illness for each insured person.

## **2.2 ADDITIONAL BENEFITS AVAILABLE IN PLAN B**

### **2.2.1 Hospital Cash**

The Company shall pay 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 as per Section 2.1.1 (In-patient Treatment).

Hospital Cash shall be payable for each day from the 4<sup>th</sup> day of Hospitalisation up to the 8<sup>th</sup> day of Hospitalisation only.

### **2.2.2 Doctor's Home Visit/ Aya/ Nurse/ Attendant Charges during Post Hospitalisation**

The Company shall reimburse the insured, for medically necessary expenses incurred for doctor's home visit, nursing care by qualified nurse, aya, attendant charges during post hospitalisation up to the limit as shown in the Table of Benefits., provided the related hospitalisation claim has been admitted as per Section 2.1.1 (In-patient Treatment) and the physical mobility of the insured person outside residence is severely restricted as advised in the discharge summary.

### **2.2.3 Funeral Expenses**

In the event of death of the insured person during hospitalisation, the Company shall pay funeral expenses subject to limit as mentioned in Table of Benefit provided hospitalisation claim is admitted as per Section 2.1.1 (In-patient Treatment) of the policy.

### **2.2.4 Reinstatement of Sum Insured if exhausted due to Road Traffic Accident**

In the event of available sum insured in respect of the insured/ insured person being exhausted anytime during the policy period on account of hospitalisation/ domiciliary hospitalisation claims arising out of any injury due to a road traffic accident (RTA), the Company shall reinstate the sum insured (excluding Cumulative Bonus) to the extent as available prior to such RTA hospitalization, for any subsequent hospitalization(s) expenses that the insured/ insured person may incur due to any other disease/ injury during the balance policy period.

- i. In a policy issued on individual basis, reinstatement of sum insured shall be available in respect of the insured person whose sum insured is exhausted as specified above. In a policy issued on floater basis, reinstatement shall be available to floater sum insured subject to exhaustion of sum insured as specified above by either or both of the insured persons.
- ii. Reinstated sum insured shall be the amount of balance sum insured prior to the RTA, which is exhausted due to the RTA hospitalisation/ domiciliary hospitalisation claim.
- iii. Reinstatement shall be allowed only once during the policy period
- iv. Reinstated sum insured shall not be available for the hospitalisation claim due to which the sum insured has exhausted, but shall be available only for subsequent hospitalization(s) due to any other disease/ injury (Subject to Definition 7.2 Any One Illness).
- v. Maximum liability of the Company under a single claim and any one illness shall not exceed the sum insured.
- vi. Reinstated sum insured, if not exhausted, will not be carried forward to next policy period on renewal.

**Illustration:**

<b>Case I: SI – INR 5L</b>	<b>Case II: SI – INR 5L</b>
<p>Claim 1 (hospitalization due to disease) – INR 2L            Balance SI – INR 5L, Amount admissible – INR 2L            SI exhausted – No, SI remaining – INR 3L            SI reinstated – No</p> <p>Claim 2 (hospitalization due to RTA) – INR 4L            Balance SI – INR 3L, Amount admissible – INR 3L            SI exhausted – Yes, SI remaining – INR 0            SI reinstated – <b>Yes [INR 3L, i.e., balance SI prior to RTA]</b>  <i>(though SI is reinstated, it will be available in next claim)</i></p> <p>Claim 3 (hospitalization due to disease) – INR 1L            Balance Reinstated SI – 3L Amount admissible – INR 1L            SI remaining – INR 2L</p>	<p>Claim 1 (hospitalization due to RTA) – INR 4L            Balance SI – INR 5L, Amount admissible – INR 4L            SI exhausted – No, SI remaining – INR 1L            SI reinstated – No</p> <p>Claim 2 (hospitalization due to disease) – INR 2L            Balance SI – INR 1L, Amount admissible – INR 1L            SI exhausted – Yes, SI remaining – INR 0            SI reinstated – No  <i>(SI is not reinstated as not exhausted due to RTA)</i></p> <p>Claim 3 (hospitalization due to disease/ RTA) – INR 1L            Amount admissible – INR 0  <i>(no amount available)</i></p>

**3 GOOD HEALTH INCENTIVE**

**3.1 Cumulative Bonus (CB)**

**For policies issued on individual basis**

At the time of renewal, cumulative bonus allowed shall be an amount equal to 5% (five percent) of sum insured (excluding CB) of the expiring policy in respect of the insured person provided no claim has been reported under the expiring policy.

In the event of a claim being reported under the expiring policy the cumulative bonus with respect to the insured person shall be reduced by an amount equal to 5% (five percent) of sum insured (excluding CB) of the expiring policy. However, the reduction of CB will not impact sum insured (excluding CB).

Cumulative bonus shall be accrued over the years, subject to maximum of 50% (fifty percent) of the sum insured (excluding CB) of the current policy.

**For policies issued on floater basis**

At the time of renewal, cumulative bonus allowed shall be an amount equal to 5% (five percent) of the floater sum insured (excluding CB) of the expiring policy provided no claim has been reported under the expiring policy by any insured person.

In the event of a claim being reported under the expiring policy the cumulative bonus with respect to the insured family shall be reduced by an amount equal to 5% (five percent) of sum insured (excluding CB) of the expiring policy. However, the reduction of CB will not impact sum insured (excluding CB).

Cumulative bonus shall be accrued over the years, subject to maximum of 50% (fifty percent) of the sum insured (excluding CB) of the current policy.

**3.2 Preventive Health Check Up**

**3.2.1. Applicable to Plan A**

Expenses of prescribed diagnostic tests only with respect to the insured person(s), shall be reimbursed at the end of a block of two continuous policy periods, provided the Policy has been continuously renewed with the Company without a break, claims are not reported during the block in respect of the insured person(s) and the health checkup is conducted within a period of 6 months after expiry of the block of two continuous policy periods (i.e., in the third policy period).

Expenses payable are subject to the limit as shown in the Table of Benefits.

**3.2.2. Applicable to Plan B**

Expenses of medical consultation incurred as Out Patient and prescribed diagnostic tests only (excluding cost of prescribed medicines) with respect to the insured person(s), up to the limit as mentioned in the Table of Benefit during a block of six months, shall be reimbursed provided no claims are reported during the block in respect of the insured person(s). Claim for both blocks shall be submitted once, after the end of the policy as specified in Section 6.5.5.

For the purpose of this section, the block of first 6 months shall commence from the inception of the policy till end of 6 months from inception and block of second 6 months shall commence from 7<sup>th</sup> month of the policy period till expiry of the policy period.

**Note:** Claims under Section 3.2 shall not count as claims under the Policy, for the purpose of determining eligibility for subsequent claims under Section 3.2.

**4 WAITING PERIOD - EXCLUSIONS**

The Company shall not be liable to make any payment under the policy till the expiry of waiting period mentioned below, in respect of any expenses incurred in connection with or in respect of:

**4.1 Pre-Existing Diseases**

All pre-existing diseases and any complication arising from pre-existing diseases (including Genetic Disorders/ HIV/ AIDS/ Mental Illness), till expiry of a waiting period of twenty four months. After expiry of the waiting period, this exclusion shall not apply.

**Illustration of pre-existing disease and related complication**

For persons suffering from either hypertension or diabetes or both at the inception of the Policy, related complications as per the following table shall be considered as pre-existing diseases.

<b>Diabetes</b>	<b>Hypertension</b>	<b>Diabetes and Hypertension</b>
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 waiting period of first thirty days. The waiting period shall not apply in case of renewal policies 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

Above diseases/treatments under 4.3.i shall be covered after the specified waiting period, provided they are not pre existing disease.

**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. Joint replacement unless necessitated due to an accident
- b. Osteoarthritis and osteoporosis

Above diseases/treatments under 4.3.iii, even if pre-existing shall be covered after waiting period four years, including the waiting period for pre-existing disease.

**5 PERMANENT EXCLUSIONS**

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

### **5.1 STD**

Any condition directly or indirectly caused to or associated with any sexually transmitted diseases (STD), other than HIV/ AIDS.

### **5.2 General Debility, Congenital External Anomaly**

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

### **5.3 Sterility, Infertility, Assisted Conception**

Sterility, infertility/sub fertility, assisted conception procedures.

### **5.4 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.

### **5.5 Refractive Error**

Surgery for correction of eye sight due to refractive error.

### **5.6 Obesity**

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

### **5.7 Self Inflicted Injury**

Treatment for intentional self-inflicted injury, attempted suicide.

### **5.8 Stem Cell Surgery (except bone marrow transplant).**

### **5.9 Circumcision**

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

### **5.10 Vaccination or Inoculation**

Vaccination or inoculation unless forming part of treatment and requires hospitalisation.

### **5.11 Cosmetic, Plastic Surgery, Sex Change, Hormone Replacement**

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.

### **5.12 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, AYUSH treatments (other than ayurveda and homeopathy), acupuncture, acupressure, magneto-therapy and similar treatment.

### **5.13 Dental Treatment**

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

### **5.14 Vitamins, Tonics**

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

### **5.15 Out-Patient Treatment**

Any treatment taken as an out-patient, except as and to the extent provided for under Section 3.2.2.

### **5.16 Hospitalisation for the Purpose of Diagnosis and Evaluation**

Diagnostic and evaluation purpose where such diagnosis and evaluation can be carried out as outpatient procedure and the condition of the patient does not require hospitalisation.

### **5.17 Treatment 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.

### **5.18 Drug/Alcohol Abuse**

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

### **5.19 Stay in Hospital which is not Medically Necessary.**

### **5.20 Spectacles, Contact Lens, Hearing Aid, Cochlear Implants.**



### **5.21 Equipments**

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

### **5.22 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 II).

### **5.23 Items of Personal Comfort**

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

### **5.24 Service Charge/ Registration Fee**

Any kind of service charges including surcharges, admission fees, registration charges and similar charges (as listed in Appendix II) levied by the hospital.

### **5.25 Home Visit Charges**

Home visit charges during pre and post hospitalisation of doctor, aya, attendant and nurse, except as and to the extent provided for under Section 2.2.2.

### **5.26 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.

### **5.27 Risky Avocations**

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

### **5.28 Breach of Law**

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

### **5.29 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.

### **5.30 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.

## **6 CONDITIONS**

### **6.1 Disclosure of Information**

In the event of misrepresentation, mis-description or non-disclosure of any material fact, the policy shall be void and all premium paid hereon shall be forfeited to the Company.

### **6.2 Condition Precedent to Admission of Liability**

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

### **6.3 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.

### **6.4 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.

## 6.5 Claim Procedure

### 6.5.1 Notification of Claim

In order to lodge a claim under the Policy for any 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.

<b>Claim Intimation in case of Cashless facility</b>	<b>TPA must be informed:</b>
In the event of planned hospitalisation	At least seventy two hours prior to the insured person's admission to network provider
In the event of emergency hospitalization	Within twenty four hours of the insured person's admission to network provider

<b>Claim Intimation in case of Reimbursement</b>	<b>Company/TPA must be informed:</b>
In the event of planned hospitalization or domiciliary hospitalisation	At least seventy two hours prior to the insured person's admission to hospital/ commencement of Domiciliary Hospitalisation
In the event of emergency hospitalization or domiciliary hospitalisation	Within twenty four hours of the insured person's admission to hospital/ commencement of Domiciliary Hospitalisation

### 6.5.2 Procedure for Cashless Claims

- i. Cashless facility for treatment in network providers can be availed, if TPA service is opted.
- ii. Treatment may be taken in a network provider and is subject to pre authorization by the TPA. Booklet containing list of network provider shall be provided by the TPA. Updated list of network provider is available on website of the Company and the TPA mentioned in the schedule.
- iii. Cashless request form available with the network provider 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 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/ network provider is unable to provide any required details related to the pre authorization request.
- vii. In case of denial of cashless facility, the insured person may obtain the treatment as per treating medical practitioner's advice and submit the necessary documents for reimbursement of claim.

### 6.5.3 Procedure for Reimbursement of Claims

For reimbursement of claims the insured person shall 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.

#### 6.5.3.1 Procedure for Reimbursement of Claim under Domiciliary Hospitalisation

For reimbursement of claims under domiciliary hospitalisation, the insured person shall 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.

### 6.5.4 Documents

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

- i. Completed claim form
- ii. Medical practitioner's prescription advising admission for inpatient treatment.
- iii. Cash-memo from the hospital (s)/chemist (s) supported by proper prescription from attending medical practitioner for pre hospitalization, hospitalization and post hospitalization.
- iv. Payment receipt, investigation test reports, supported by the prescription from attending medical practitioner for pre hospitalization, hospitalization and post hospitalization.
- v. Attending medical practitioner's certificate regarding diagnosis along with date of diagnosis and bill, receipts etc.
- vi. Surgeon's certificate regarding diagnosis and nature of operation performed along with bills, receipts etc.
- vii. Bills, receipt, Sticker of the Implants.
- viii. Bills, payment receipts, medical history of the patient recorded, discharge certificate/ summary, break up of final bill from the hospital etc.
- ix. 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/ medical certificate of state of patient from treating medical practitioner.
- x. For claim under Section 2.2.3 (Funeral expense), certificate of death of insured person (original shall be returned following verification).
- xi. Any other document required by Company/TPA.

**Note**

In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents listed under condition 6.5.4 and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company.

**6.5.5 Time limit for submission of claim documents to the Company/ TPA**

Type of claim	Time limit
Reimbursement of hospitalisation, pre hospitalisation expenses and ambulance charges	Within 30 days of date of discharge from hospital
Reimbursement of post hospitalisation expenses and doctor's home visit and nursing care during post hospitalisation	Within 30 days from completion of post hospitalisation treatment
Reimbursement of domiciliary hospitalisation expenses	Within 30 days from completion of issuance of fitness certificate/ medical certificate on state of patient
Reimbursement of preventive health check-up expenses under Plan A	Within 6 (six) months of the completion of a block of 2 policy period (to be submitted to the policy issuing office only)
Reimbursement of preventive health check-up expenses under Plan B	Once every year, within 30 days from expiry of policy (to be submitted to the policy issuing office only)

**Waiver**

Time limit for claim intimation and submission of documents may be waived in cases where the insured/ insured person or his/ her representative applies and explains to the satisfaction of the Company, that the circumstances under which insured/ insured person was placed, it was not possible to intimate the claim/submit the documents within the prescribed time limit.

**6.5.6 Claim Settlement**

- The Company shall settle or reject a claim, as may be the case, within 30 days from the date of receipt of last necessary document.
- In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest. In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document.
- In case of delay beyond stipulated 45 days the Insurer shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

**6.5.7 Services Offered by TPA**

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include

- Claim settlement and claim rejection;
- 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.

**6.5.8 Treatment in Non-Network Provider**

Claims where treatment is undergone in a non-network provider in PPN cities shall be restricted to the PPN rates for same procedure in similar hospital in the city. 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, the condition shall not apply.

**6.6 Payment of Claim**

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

**6.7 Territorial Limit**

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

**6.8 Option of Insured if covered under Multiple Policies**

If two or more Policies/ Optional Covers are taken by an insured during a period from one or more insurers to indemnify treatment costs, the insured shall have the right to require a settlement of his/her claim in terms of any of his/her policies.

- In all such cases the Company shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of this Policy.
- Any amount disallowed under any other chosen policy, irrespective of exhaustion of sum insured of that policy, may also be claimed under this Policy. Such claims shall be admissible in accordance with the terms and conditions of this Policy.

If two or more Policies/ Optional Covers are taken by an insured during a period from one or more insurers to provide fixed benefits (e.g., Critical Illness, Personal Accident), on the occurrence of the insured event in accordance with the terms and conditions of the policies, the Company shall make the claim payments independent of payments received under other similar policies.

**Note:** The Insured must disclose such other Policies at the time of making a claim under this Policy.

### 6.9 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.

### 6.10 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. 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

### 6.11 Territorial Jurisdiction

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

### 6.12 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, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).
- 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.

### 6.13 Disclaimer

If the Company shall disclaim liability to the insured person for any 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 does not accept such disclaimer and intends to recover his claim from the Company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

### 6.14 Renewal of Policy

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

### 6.15 Enhancement of Sum Insured

Sum insured can be enhanced only at the time of renewal. Sum insured can be enhanced to the next higher slab subject to 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 afresh.

### 6.16 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. Proportionate premium for such number of days shall be adjusted against the renewal premium, provided the insured has informed the Company in writing before leaving India, and submits an application, stating the details of visit(s) abroad, along with copies of the Overseas Travel Insurance Policy, within fifteen days of return. The maximum premium refundable and adjusted on renewal shall be limited to 80% of premium of the expiring Policy, in respect of the insured person(s) covered under Overseas Travel Insurance Policy.

### 6.17 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 all individual health insurance policies issued by Non-Life Insurance Companies including family floater policies.

### 6.18 Withdrawal of Product

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

### 6.19 Revision of Terms of the Policy Including the Premium Rates

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

### 6.20 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 of cover

### 6.21 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.

### 6.22 Categorization policy conditions

Categories	Condition number
Conditions precedent to the contract	6.1, 6.2, 6.21
Conditions applicable during the contract	6.3, 6.7, 6.9, 6.10, 6.11, 6.20
Conditions when a claim arises	6.4, 6.5, 6.6, 6.8, 6.12, 6.13
Conditions for renewal of the contract	6.14, 6.15, 6.16, 6.17, 6.18, 6.19

## 7 DEFINITIONS

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

**7.2 AIDS** means Acquired Immune Deficiency Syndrome, a condition characterised by a combination of signs and symptoms, caused by Human Immunodeficiency Virus (HIV), which attacks and weakens the body's immune system making the HIV-positive person susceptible to life threatening conditions or other conditions, as may be specified from time to time.

**7.3 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.

**7.4 AYUSH Treatment** refers to the medical and / or hospitalisation treatments given Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.

**7.5 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.

**7.6 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.

**7.7 Condition Precedent** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

**7.8 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.

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

**a) Internal Congenital Anomaly**

Congenital anomaly which is not in the visible and accessible parts of the body.

**b) External Congenital Anomaly**

Congenital anomaly which is in the visible and accessible parts of the body.

**7.10 Co-payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

**7.11 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.

**7.12 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.

**7.13 Dental Treatment** means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.

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

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

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

**7.16 Floater Sum Insured** means the sum insured mentioned in the Schedule, which is applicable to all the insured persons, for any and all claims made in aggregate during the policy period.

**7.17 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 diseases. Coverage is not available for the period for which no premium is received.

**7.18 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.

**7.19 Hospitalisation** means admission in a hospital or mental health establishment for a minimum period of twenty four (24) consecutive 'Inpatient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.

**7.20 ID Card** means the card issued to the insured person by the TPA for availing cashless facility in the network provider.

**7.21 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 rehabilitation for the patient or for the patient to be special trained to cope with it
- d) it continues indefinitely
- e) it recurs or is likely to recur

**7.22 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.

**7.23 Insured/ Insured Person** means person(s) named in the schedule of the Policy.

**7.24 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.

**7.25 ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivists charges.

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

**7.27 Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

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

**7.29 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 illness or injury suffered by the insured ;
- 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.

**7.30 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.

**7.31 Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence.

Mental Illness covered under the Policy shall be as specified in Section 2.1.8. Neurological disorders (Alzheimer's, Parkinsonism, Myasthenia Gravis, etc.), learning disabilities or mental retardation does not constitute Mental Illness.

**7.32 Mental Health Establishment** shall mean any health establishment meeting the criteria of Hospital, as defined in Definition 7.18, and includes Ayurveda and Homoeopathy establishment, by whatever name called, meant for the care of persons with mental illness.

**7.33 Mental Health Professional** means a medical practitioner, as defined in Definition 7.30 and practicing as

- (i) a Psychiatrist, as defined in Definition 7.43; or
- (ii) a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry.

**7.34 Network Provider** means hospitals enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility. In cities with Preferred Provider Network (Definition 7.36), PPN are the only Network Providers.

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

- 7.36 Notification of Claim** means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.
- 7.37 Out-Patient Treatment** means treatment in which the insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a medical practitioner. The insured is not admitted as a day care or in-patient.
- 7.38 Policy Period** means period of one year as mentioned in the schedule for which the Policy is issued.
- 7.39 Pre-Existing Disease** means any condition ailment or injury or related condition(s) for which there were signs or symptoms and/or was diagnosed, and/or for which medical advice/ treatment was received within forty eight months (48) prior to the first policy issued by the insurer and renewed continuously thereafter.
- 7.40 Preferred provider network (PPN)** means network providers in specific cities which have agreed to a cashless packaged pricing for specified planned procedures for the policyholders of the Company. The list of planned procedures is available with the Company/TPA and subject to amendment from time to time. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.
- 7.41 Pre-hospitalisation Medical Expenses** means medical expenses incurred during predefined number of days preceding the hospitalisation of the Insured Person, provided that:
- Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
  - The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.
- 7.42 Post-hospitalisation Medical Expenses** means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:
- Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and
  - The inpatient hospitalisation claim for such hospitalisation is admissible by the Insurance Company.
- 7.43 Psychiatrist** means a medical practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognised by the University Grants Commission established under the University Grants Commission Act, 1956, or awarded or recognised by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognised by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist.
- 7.44 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.
- 7.45 Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/ injury involved.
- 7.46 Room Rent** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.
- 7.47 Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.
- 7.48 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.
- 7.49 Sum insured** means the sum insured and the cumulative bonus (CB) accrued in respect of the insured person (s) as mentioned in the schedule. Health checkup expenses are payable over and above the sum insured, wherever applicable.
- 7.50 Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.
- 7.51 Third Party Administrator (TPA)** means a Company registered with the Authority, and engaged by an insurer, for a fee or remuneration, by whatever name called and as may be mentioned in the agreement, for providing health services.
- 7.52 Unproven/ Experimental Treatment** means treatment, including drug experimental therapy, which is not based on established medical practice in India, is experimental or unproven.



**7.53 Waiting Period** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

## 8 REDRESSAL OF GRIEVANCE

**Grievance Level 1** – 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.

**Grievance Level 2** – If the grievance remains unaddressed, insured person may contact Customer Relationship Management Dept., National Insurance Company Limited, Chhabildas Towers, 6A, Middleton Street, Kolkata - 700071.

**Grievance Level 3** – 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](http://www.nationalinsuranceindia.com).

**IRDAI Integrated Grievance Management System** - <https://igms.irda.gov.in/>

**Insurance Ombudsman** – 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 III.

## 9 OPTIONAL COVERS

Cover for Pre-existing Diabetes and/ or Hypertension, Outpatient Treatment, Critical Illness and Personal Accident are available as optional covers on payment of additional premium. The Optional Cover has to be opted on inception or renewal, and cannot be changed/ removed on mid-term of the policy.

### 9.1 PRE-EXISTING DIABETES AND/ OR HYPERTENSION

Subject otherwise to the terms, definitions, exclusions, and conditions of the Policy and on payment of additional premium, the Company shall waive Exclusion 4.1 in respect of pre-existing diabetes and/ or hypertension only and pay for expenses for such treatment from inception of the policy, subject to the Co-payment, for the first twenty four months of insurance. On completion of continuous twenty four months of insurance, the additional premium and co-payment shall not apply.

#### Co-payment

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

- i. Insured opting for cover for pre-existing diabetes for the first two policy periods, can avail treatment for diabetes, subject to a co-payment of 10%
- ii. Insured opting for cover for pre-existing hypertension for the first two policy periods, can avail treatment for hypertension, subject to a co-payment of 10%
- iii. Insured opting for cover for pre-existing diabetes and hypertension for the first two policy periods, can avail treatment for diabetes or hypertension, subject to a co-payment of 25%

#### Renewal

This Optional Cover can be renewed annually till Exclusion 4.1 applies on diabetes and/or hypertension, with respect to the insured persons.

### 9.2 OUT-PATIENT TREATMENT

Subject otherwise to the terms, definitions, conditions, exclusions 5.18 (Drug/Alcohol Abuse), 5.28 (Breach of Law), 5.29 (War Group Perils), 5.30 (Radioactivity) and on payment of additional premium, the Company shall pay up to the limit, as stated in the schedule with respect of

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

#### 9.2.1 Exclusions

The Company shall not make any payment under this Optional Cover in respect of

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

\* *Cosmetic dental treatments include veneers, bridges, tooth-coloured fillings, implants and tooth whitening.*

#### 9.2.2 Condition

##### Claim Amount

Any amount payable under this optional cover will be subject to the limit of cover mentioned in schedule, and not affect the sum insured applicable to Section 2.1 or entitlement to Good Health Incentives (Section 3).

#### Claims Procedure

Documents supporting all out-patient treatments shall be submitted to the Company/ TPA once in a policy period either after the exhaustion of the limit or within 30 days from expiry of policy, whichever is earlier.

### **Documents**

The claim has to be supported by the following original documents

- i. All cash memos with supporting prescriptions from medical practitioner
- ii. Diagnostic test bills and receipts, copy of reports with supporting prescriptions from medical practitioner
- iii. Any other documents required by the Company/ TPA

### **Enhancement of Limit of Cover**

- i. Limit of cover can be enhanced only at the time of renewal.
- ii. Limit of cover can be enhanced to the next slab subject to discretion of the Company.

### **9.3 CRITICAL ILLNESS**

Subject otherwise to the terms, definitions, exclusions, conditions contained herein and on payment of additional premium, the 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.

#### **9.3.1 Definition**

**Critical illness** means (i) Cancer of Specified Severity, (ii) Myocardial Infarction (First Heart Attack of Specified Severity), (iii) Open Chest Coronary Artery Bypass Graft Surgery, (iv) Open Heart Replacement or Repair of Heart Valves, (v) Coma of Specified Severity, (vi) Kidney Failure requiring Regular Dialysis, (vii) Stroke Resulting in Permanent Symptoms, (viii) Major Organ/Bone Marrow Transplant, (ix) Permanent Paralysis of Limbs, (x) Motor Neuron Disease with Permanent Symptoms and (xi) Multiple Sclerosis with Persisting Symptoms.

##### **9.3.1.1 Cancer of Specified Severity**

A malignant tumor characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

#### **The following are excluded**

- i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non- invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
- ii. Any non- melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- iii. Malignant melanoma that has not caused invasion beyond the epidermis;
- iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0;
- v. All Thyroid cancers histologically classified as T1N0M0 (TNM classification) or below;
- vi. Chronic lymphocytic leukaemia less than RAI stage 3
- vii. Non- invasive Papillary cancer of bladder histologically described as TaN0M0 (TNM Classification) or of a lesser classification;
- viii. All Gastro-intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
- ix. All tumors in the presence of HIV infection.

##### **9.3.1.2 Myocardial Infarction (First Heart Attack of Specified Severity)**

The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

- i. A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
- ii. New characteristic electrocardiogram changes
- iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

#### **The following are excluded**

- i. Other acute Coronary Syndromes.
- ii. Any type of angina pectoris.
- iii. A rise in cardiac biomarkers or Troponin T or I in absence of over ischemic heart disease OR following an intra-arterial cardiac procedure

##### **9.3.1.3 Open Chest Coronary Artery Bypass Graft Surgery (CABG)**

The actual undergoing of Heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via sternotomy (cutting through breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

**The following are excluded**

Angioplasty and/or any other intra-arterial procedures.

**9.3.1.4 Open Heart Replacement or Repair of Heart Valve**

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

**The following are excluded**

Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty are excluded.

**9.3.1.5 Coma of Specified Severity**

A state of unconsciousness with no reaction or response to external stimuli or internal needs.

This diagnosis must be supported by evidence of all of the following:

- i. No response to external stimuli continuously for at least 96 hours;
- ii. Life support measures are necessary to sustain life; and
- iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The condition has to be confirmed by a specialist Medical Practitioner.

**The following are excluded**

Coma resulting directly from alcohol or drug abuse is excluded.

**9.3.1.6 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.

**9.3.1.7 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 3 months has to be produced.

**The following are excluded**

- i. Transient ischemic attacks (TIA)
- ii. Traumatic injury of the brain
- iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

**9.3.1.8 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 excluded**

- i. Other stem-cell transplants
- ii. Where only islets of langerhans are transplanted

**9.3.1.9 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 3 months.

**9.3.1.10 Motor Neuron Disease with Permanent Symptoms**

Motor Neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

**9.3.1.11 Multiple Sclerosis with Persisting Symptoms**

The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following

- i. Investigations including typical MRI findings, which unequivocally confirm the diagnosis to be multiple sclerosis and
- 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

**The following are excluded**

Other causes of neurological damage such as SLE and HIV.

**9.3.2 Exclusions**

The Company shall not be liable to make any payment under the Policy for any critical illness 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. In the event of break in the Policy, the terms of this exclusion shall apply as new from the date of recommencement of cover

**9.3.3 Condition**

**Claim Amount**

Any amount payable under the optional covers will be subject to the benefit amount mentioned in schedule, and not affect the sum insured applicable to Section 2.1 or entitlement to Good Health Incentives (Section 3).

**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 below, supporting the diagnosis shall be submitted to the Company within sixty days (including survival period of thirty 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**

- i. Upon occurrence of a Critical Illness and payment of the benefit amount to the insured person, the cover shall cease in respect of the insured person for the remaining policy period.
- ii. In case a claim has been paid to any insured person for a Critical Illness, in subsequent renewals no claim shall be paid to that insured person for the same critical illness or for any other Critical Illness induced by/arising out of that Critical Illness. However, claim for all other Critical Illnesses covered under the Policy shall be admitted, subject to terms and conditions of the Policy.

**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, up to the individual/ floater Sum Insured under the policy

**9.4 PERSONAL ACCIDENT**

Subject otherwise to the terms, definitions, exclusions, conditions contained herein and on payment of additional premium, if during the policy period the insured person shall sustain any injury anywhere in the world due to an accident resulting to death or disability, the Company shall pay the amount specific to each section as herein after mentioned, subject to the capital sum insured (CSI) opted.

**9.4.1 Coverage**

The Company shall pay to the insured or his/her nominee the amount mentioned against the relevant section.

**a) Death**

If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of death of the insured, the CSI applicable to the insured person.

**b) Loss by Physical Separation or Loss of Use of Two Limbs or Two Eyes or One Limb and One Eye**

If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of the total and irrecoverable loss of

- i. sight of both eyes or the actual loss by physical separation of the two hands or two feet or of one hand and one foot or loss of sight of one eye and loss of one hand or one foot, the CSI applicable to the insured person.
- ii. use of two hands or two feet or one hand and one foot without physical separation or loss of sight of one eye and loss of use of one hand or one foot without physical separation, the CSI applicable to the insured person.

**c) Loss by Physical Separation or Loss of Use of One Limb or One Eye**

If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of the total and irrecoverable loss of

- i. sight of one eye or the actual loss by physical separation of one hand or one foot, 50% of the CSI applicable to the insured person.
- ii. use of a hand or a foot without physical separation, 50% of the CSI applicable to the insured person

**d) Permanent Total Disablement**

If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of permanently totally and absolutely disabling the insured from engaging in any employment or occupation of any description whatsoever, a lump sum equal to 100% of the CSI applicable to the insured person.

**e) Permanent Partial Disablement**

If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of the total and irrecoverable loss of use or of the actual loss by physical separation of the following, the percentage of the CSI indicated below:

Loss of part of body		Percentage of Personal Accident Benefit Amount
Loss of toes	all	20
	Great-both phalanges	5
	Great-one phalanx	2
	Other than great, if more than one toe lost each	1
Loss of hearing	both ears	50
	one ear	15
Loss of 4 fingers and thumb of 1 hand		40
Loss of 4 fingers of 1 hand		35
Loss of thumb	Both phalanges	25
	One phalange	10
Loss of Little finger	3 phalanges	4
	2 phalanges	3
	1 phalange	2
Loss of ring finger	3 phalanges	5
	2 phalanges	4
	1 phalange	2
Loss of middle finger	3 phalanges	6
	2 phalanges	4
	1 phalange	2
Loss of Index finger	3 phalanges	10
	2 phalanges	8
	1 phalange	4
Loss of metacarpal	1st or 2nd (additional)	3
	3rd, 4th, or 5th (additional)	2
Any other permanent partial disablement	% as assessed by Board of Doctors of a Government hospital	

**9.4.2 Exclusions**

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

**9.4.2.1 Pre-existing Injury/ Disablement**

Any disablement or death directly or indirectly arising out of or contributed to be or traceable to any disability or injury existing on the date of issue of this Policy.

**9.4.2.2 Racing, Hunting, Mountaineering and Winter Sports**

Any injury while racing on wheels or horseback, hunting, big game shooting, mountaineering or whilst engaged in winter sports- skiing and ice hockey.

**9.4.2.3 Aviation or Ballooning**

Any injury while the insured is engaged in aviation or ballooning

**9.4.2.4 Non- fare Paying Passenger in Aircraft**

Any injury while the insured is mounting into, dismounting from or travelling in any aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world

**9.4.2.5 Payment of compensation in respect of death, injury or disablement of the insured –**

- i. from intentional self-injury, suicide or attempted suicide
- ii. whilst under the influence of intoxication liquor or drug
- iii. Directly or indirectly caused by venereal disease or insanity
- iv. Arising or resulting from the insured committing any breach of the law with criminal intent.

### **9.4.3 Conditions**

#### **Limits of compensation**

The Company shall not be liable to make any payment in respect of

- i. More than one of the sub clauses of Section 9.4.1 (Coverage) in respect of the same period of disablement.
- ii. Any claim after a claim under one of the clauses (9.4.1.a), (9.4.1.b) or (9.4.1.d) has been admitted and is payable.

#### **9.4.3.1 Claim documents**

Duly completed claim form

In addition, the following documents are to be submitted depending on the nature of the claim.

#### **Death**

- i. Attending Medical Practitioner's report
- ii. Original Policy for cancellation
- iii. Original Death Certificate
- iv. Original / attested post mortem / coroner's report, where applicable
- v. Attested copy of FIR / Panchnama
- vi. Police inquest report, where applicable
- vii. Any other document required by the Company

Post mortem report if necessary, shall be furnished within fourteen days, after demanded in writing

#### **Permanent Total Disablement/ Permanent Partial Disablement/ Temporary Total Disablement**

- i. Attending Medical Practitioner's report
- ii. Original Policy for cancellation in case of Permanent Total Disablement
- iii. Original Policy for reduction in CSI in case of Permanent Partial Disablement/ Temporary Total Disablement
- iv. Disability certificate from Medical Practitioner, where applicable
- v. Diagnostic reports like laboratory test, X- rays and/ or any other reports confirming injury
- vi. Police inquest report, where applicable
- vii. Any other document required by the Company

#### **9.4.3.2 Enhancement of CSI**

- i. CSI amount can be enhanced only at the time of renewal.
- ii. CSI amount can be enhanced to the next slab subject to discretion of the Company, up to the individual/ floater Sum Insured under the policy.

**No loading shall apply on renewals based on individual claims experience**

**Insurance is the subject matter of solicitation**

**Please preserve the policy for all future reference.**

**Table of Benefits**

<b>National Senior Citizen Mediclaim Policy</b>		
<b>Name of Product</b>	<b>National Senior Citizen Mediclaim Policy</b>	
<b>Plans</b>	<b>Plan A (Individual and Floater)</b>	<b>Plan B (Individual and Floater)</b>
<b>Sum Insured</b>	INR 1L to 10L	INR 1L to 10L
<b>Slab</b>	In multiple of 1,00,000	In multiple of 1,00,000
<b>Coverage</b>		
<b>In patient Treatment*</b>	Room – 1% of SI per day subject to maximum of INR 5,000 per day ICU – 2% of SI per day subject to maximum of INR 10,000 per day	Room – 2% of SI per day subject to maximum of INR 10,000 per day ICU – 4% of SI per day subject to maximum of INR 20,000 per day
	Overall Limit A. Room/ ICU – 25% of SI per illness (Section 2.1.1.i) B. Medical Practitioner’s fee - 25% of SI per illness (Section 2.1.1.ii) C. Others – 50% of SI per illness (All other Sections)	No overall limit
	<b>Cataract</b> - 15% of SI or INR 75,000 for each eye, whichever is lower <b>Benign Prostatic Hyperplasia</b> – 20% of SI	<b>Cataract</b> - Actual <b>Benign Prostatic Hyperplasia</b> – Actual
<b>System of Medicine</b>	Allopathy, Ayurveda, Homeopathy	Allopathy, Ayurveda, Homeopathy
<b>Pre hospitalisation</b>	30 days immediately before hospitalisation	30 days immediately before hospitalisation
<b>Post hospitalisation</b>	60 days immediately after discharge	60 days immediately after discharge
<b>Domiciliary Hospitalisation</b>	Up to 20% of the Sum Insured	Up to 20% of the Sum Insured
<b>Day Care Procedures</b>	140 day care procedures	140 day care procedures
<b>Ayurveda and Homeopathy</b>	Up to Sum Insured	Up to Sum Insured
<b>Organ Donor’s Medical Expenses</b>	Medical expenses, Pre & Post Hospitalisation expenses up to Sum Insured	Medical expenses, Pre & Post Hospitalisation expenses up to Sum Insured
<b>Ambulance Charges</b>	Up to INR 2,500 per illness	Up to INR 2,500 per illness
<b>Hospital cash (per individual)</b>	x	INR 500/- per day for 5 days (in excess 3 days)
<b>Aya, Doctor's home visit charges and nursing care during post hospitalisation (per individual)</b>	x	INR 500/- per day for 7 days
<b>Reinstatement of SI for road traffic accidents</b>	x	Once during the policy period
<b>Funeral expenses (per individual)</b>	x	Up to INR 5,000
<b>Others</b>		
<b>Pre Existing Disease</b>	Covered after 2 year	Covered after 2 year
<b>Optional Cover (on payment of extra premium)</b>		
<b>Pre-existing Diabetes and/ or Hypertension</b>	Up to the SI	
<b>Outpatient Treatment</b>	Limit of cover per family - 2,000 / 4,000 / 5,000 / 7,500/ 10,000/ 15,000	
<b>Critical Illness **</b>	Benefit amount per individual- INR 1,00,000/ 2,00,000/ 3,00,000/ 4,00,000/ 5,00,000/ 6,00,000/ 7,00,000/ 8,00,000/ 9,00,000/ 10,00,000	
<b>Personal Accident **</b>	Capital Sum Insured per individual – INR 1,00,000/ 2,00,000/ 3,00,000/ 4,00,000/ 5,00,000/ 6,00,000/ 7,00,000/ 8,00,000/ 9,00,000/ 10,00,000	
<b>Good Health Incentives</b>		
<b>Cumulative Bonus</b>	Increase by 5% of SI in respect of each claim free year of insurance Decrease by 5% of SI for each year with claim reported	Increase by 5% of SI in respect of each claim free year of insurance Decrease by 5% of SI for each year with claim reported
<b>Preventive Health Check Up</b>	Every 2 claim free years, prescribed diagnostics tests up to 2 % of the average SI (excluding CB) per insured person (individual basis) or family (floater basis), subject to maximum INR 4,000/- per insured person (individual basis) or per family (floater basis)	Every 6 claim free months, Regular medical consultation and prescribed diagnostics tests up to INR 1,000 per insured person (irrespective of individual basis or floater basis)
<b>Discounts</b>		
<b>Direct Discount</b>	10% discount (provided no intermediary is involved)	

\* The limits 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 and Personal Accident Capital Sum Insured should not be more than the sum insured opted under the Policy

## 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. Cystoscopic 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.

## Expenses Generally Excluded

S. No.	List of Expenses Generally Excluded ("Non-Medical") in Hospital Indemnity Policy -	
	<b>TOILETRIES/ COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS</b>	
1.	HAIR REMOVAL CREAM	Not Payable
2.	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3.	BABY FOOD	Not Payable
4.	BABY UTILITES CHARGES	Not Payable
5.	BABY SET	Not Payable
6.	BABY BOTTLES	Not Payable
7.	BRUSH	Not Payable
8.	COSY TOWEL	Not Payable
9.	HAND WASH	Not Payable
10.	MOISTURISER PASTE BRUSH	Not Payable
11.	POWDER	Not Payable
12.	RAZOR	Payable
13.	SHOE COVER	Not Payable
14.	BEAUTY SERVICES	Not Payable
15.	BELTS/ BRACES	Essential and should be paid at least specifically for cases who have undergone surgery of thoracic or lumbar spine
16.	BUDS	Not Payable
17.	BARBER CHARGES	Not Payable
18.	CAPS	Not Payable
19.	COLD PACK/HOT PACK	Not Payable
20.	CARRY BAGS	Not Payable
21.	CRADLE CHARGES	Not Payable
22.	COMB	Not Payable
23.	DISPOSABLES RAZORS CHARGES ( for site preparations)	Payable
24.	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25.	EYE PAD	Not Payable
26.	EYE SHEILD	Not Payable
27.	EMAIL / INTERNET CHARGES	Not Payable
28.	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	Not Payable
29.	FOOT COVER	Not Payable
30.	GOWN	Not Payable
31.	LEGGINGS	Payable in case of varicose vein surgery
32.	LAUNDRY CHARGES	Not Payable
33.	MINERAL WATER	Not Payable
34.	OIL CHARGES	Not Payable
35.	SANITARY PAD	Not Payable
36.	SLIPPERS	Not Payable
37.	TELEPHONE CHARGES	Not Payable
38.	TISSUE PAPER	Not Payable
39.	TOOTH PASTE	Not Payable
40.	TOOTH BRUSH	Not Payable
41.	GUEST SERVICES	Not Payable
42.	BED PAN	Not Payable
43.	BED UNDER PAD CHARGES	Not Payable
44.	CAMERA COVER	Not Payable
45.	CLINIPLAST	Not Payable
46.	CREPE BANDAGE	Not Payable
47.	CURAPORE	Not Payable
48.	DIAPER OF ANY TYPE	Not Payable
49.	DVD, CD CHARGES	Not Payable (However if CD is specifically sought by Insurer/TPA then payable)
50.	EYELET COLLAR	Not Payable
51.	FACE MASK	Not Payable
52.	FLEXI MASK	Not Payable
53.	GAUSE SOFT	Not Payable
54.	GAUZE	Not Payable
55.	HAND HOLDER	Not Payable
56.	HANSAPLAST/ ADHESIVE BANDAGES	Not Payable

57.	INFANT FOOD	Not Payable
58.	SLINGS	Reasonable costs for one sling in case of upper arm fractures is payable
	<b>ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES</b>	
59.	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Exclusion in Policy
60.	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Exclusion in Policy
61.	HOME VISIT CHARGES	Payable in post hospitalisation
62.	DONOR SCREENING CHARGES	Payable
63.	ADMISSION/REGISTRATION CHARGES	Exclusion in Policy
64.	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Exclusion in Policy
65.	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Exclusion in Policy
	<b>ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS</b>	
66.	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not payable separately
67.	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of Instruments not payable.
68.	MICROSCOPE COVER	Payable under OT Charges, not payable separately
69.	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT Charges, not payable separately
70.	SURGICAL DRILL	Payable under OT Charges, not payable separately
71.	EYE KIT	Payable under OT Charges, not payable separately
72.	EYE DRAPE	Payable under OT Charges, not payable separately
73.	X-RAY FILM	Payable under Radiology Charges, not as consumable
74.	SPUTUM CUP	Payable under Investigation Charges, not as consumable
75.	BOYLES APPARATUS CHARGES	Part of OT Charges, not separately
76.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
77.	ANTISEPTIC OR DISINFECTANT LOTIONS	Not Payable-Part of Dressing Charges
78.	BAND AIDS, BANDAGES, STERILE INJECTIONS, NEEDLES, SYRINGES	Not Payable - Part of Dressing charges
79.	COTTON	Not Payable-Part of Dressing Charges
80.	COTTON BANDAGE	Not Payable- Part of Dressing Charges
81.	MICROPORE/ SURGICAL TAPE	Not Payable-Payable by the patient when prescribed, otherwise included as Dressing Charges
82.	BLADE	Not Payable
83.	APRON	Not Payable -Part of Hospital Services/

		Disposable linen to be part of OT/ICU charges
84.	TORNIQUET	Not Payable (service is charged by hospitals, consumables cannot be separately charged)
85.	ORTHOBUNDLE, GYNAEC BUNDLE	Part of Dressing Charges
86.	URINE CONTAINER	Not Payable
<b>ELEMENTS OF ROOM CHARGE</b>		
87.	LUXURY TAX	Actual tax levied by government is payable. Part of room charge for sub limits
88.	HVAC	Part of room charge not payable separately
89.	HOUSE KEEPING CHARGES	Part of room charge not payable separately
90.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
91.	TELEVISION & AIR CONDITIONER CHARGES	Payable under room charges not if separately levied
92.	SURCHARGES	Part of Room Charge, Not payable separately
93.	ATTENDANT CHARGES	Not Payable - Part of Room Charges
94.	IM IV INJECTION CHARGES	Part of room charge not payable separately
95.	CLEAN SHEET	Part of Laundry/Housekeeping not payable separately
96.	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
97.	BLANKET/WARMER BLANKET	Not Payable- part of room charges
<b>ADMINISTRATIVE OR NON-MEDICAL CHARGES</b>		
98.	ADMISSION KIT	Not Payable
99.	BIRTH CERTIFICATE	Not Payable
100.	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
101.	CERTIFICATE CHARGES	Not Payable
102.	COURIER CHARGES	Not Payable
103.	CONVENYANCE CHARGES	Not Payable
104.	DIABETIC CHART CHARGES	Not Payable
105.	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
106.	DISCHARGE PROCEDURE CHARGES	Not Payable
107.	DAILY CHART CHARGES	Not Payable
108.	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
109.	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	Payable under Post Hosp
110.	FILE OPENING CHARGES	Not Payable
111.	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
112.	MEDICAL CERTIFICATE	Not Payable
113.	MAINTAINANCE CHARGES	Not Payable
114.	MEDICAL RECORDS	Not Payable
115.	PREPARATION CHARGES	Not Payable
116.	PHOTOCOPIES CHARGES	Not Payable
117.	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
118.	WASHING CHARGES	Not Payable
119.	MEDICINE BOX	Not Payable
120.	MORTUARY CHARGES	Payable up to 24 hrs, shifting charges not payable

121.	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
<b>EXTERNAL DURABLE DEVICES</b>		
122.	WALKING AIDS CHARGES	Not Payable
123.	BIPAP MACHINE	Not Payable
124.	COMMODE	Not Payable
125.	CPAP/ CAPD EQUIPMENTS	Device not payable
126.	INFUSION PUMP - COST	Device not payable
127.	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
128.	PULSEOXYMETER CHARGES	Device not payable
129.	SPACER	Not Payable
130.	SPIROMETRE	Device not payable
131.	SPO2 PROBE	Not Payable
132.	NEBULIZER KIT	Not Payable
133.	STEAM INHALER	Not Payable
134.	ARMSLING	Not Payable
135.	THERMOMETER	Not Payable
136.	CERVICAL COLLAR	Not Payable
137.	SPLINT	Not Payable
138.	DIABETIC FOOT WEAR	Not Payable
139.	KNEE BRACES ( LONG/ SHORT/ HINGED)	Not Payable
140.	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
141.	LUMBO SACRAL BELT	Payable for cases who have undergone surgery of lumbar spine.
142.	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadruplegia for any reason and at reasonable cost of approximately Rs 200/ day
143.	AMBULANCE COLLAR	Not Payable
144.	AMBULANCE EQUIPMENT	Not Payable
145.	MICROSHEILD	Not Payable
146.	ABDOMINAL BINDER	Payable for cases who have undergone surgery of lumbar spine.
<b>ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION</b>		
147.	BETADINE \ HYDROGEN PEROXIDE\SPIRIT\DETTOL\SAV LON\ DISINFECTANTS ETC	Payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital
148.	PRIVATE NURSES CHARGES-SPECIAL NURSING CHARGES	Payable in post hospitalisation
149.	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES	Patient Diet provided by hospital is payable
150.	SUGAR FREE TABLETS	Payable -Sugar free variants of admissible medicines are not excluded
151.	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	Payable when prescribed
152.	DIGESTION GELS	Payable when prescribed
153.	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.
154.	GLOVES	Sterilized Gloves payable / unsterilized gloves not payable
155.	HIV KIT	Payable - Pre operative screening

156.	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
157.	LOZENGES	Payable when prescribed
158.	MOUTH PAINT	Payable when prescribed
159.	NEBULISATION KIT	Payable reasonably if used during hospitalisation
160.	NOVARAPID	Payable when prescribed
161.	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
162.	ZYTEE GEL	Payable when prescribed
163.	VACCINATION CHARGES	Payable when prescribed
<b>PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE</b>		
164.	AHD	Not Payable - Part of Hospital's internal Cost
165.	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
166.	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost
<b>OTHERS</b>		
167.	VACCINE CHARGES FOR BABY	Not Payable
168.	TPA CHARGES	Not Payable
169.	VISCO BELT CHARGES	Not Payable
170.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable

171.	EXAMINATION GLOVES	Not payable
172.	KIDNEY TRAY	Not Payable
173.	MASK	Not Payable
174.	OUNCE GLASS	Not Payable
175.	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable
176.	OXYGEN MASK	Not Payable
177.	PAPER GLOVES	Not Payable
178.	PELVIC TRACTION BELT	Payable in case of PIVD requiring traction as this is generally not reused
179.	REFERAL DOCTOR'S FEES	Not Payable
180.	ACCU CHECK ( Glucometry/ Strips)	Not payable pre hospitalisation or post hospitalisation / Reports and Charts required/ Device not payable
181.	PAN CAN	Not Payable
182.	SOFNET	Not Payable
183.	TROLLY COVER	Not Payable
184.	UROMETER, URINE JUG	Not Payable
185.	AMBULANCE	Payable
186.	TEGADERM / VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs
187.	URINE BAG	Payable where medically necessary till a reasonable cost - maximum 1 per 24 hrs
188.	SOFTOVAC	Not Payable
189.	STOCKINGS	Payable for case like CABG etc.

The list is as per the list of optional expenses stipulated by IRDAI in Guidelines in Standardization in Health Insurance, 2016.

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

Areas of Jurisdiction	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: <a href="mailto:bimalokpal.ahmedabad@gbic.co.in">bimalokpal.ahmedabad@gbic.co.in</a>
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: <a href="mailto:bimalokpal.bengaluru@gbic.co.in">bimalokpal.bengaluru@gbic.co.in</a>
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: <a href="mailto:bimalokpal.bhopal@gbic.co.in">bimalokpal.bhopal@gbic.co.in</a>
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 / 2596455 Fax: 0674 - 2596429 Email: <a href="mailto:bimalokpal.bhubaneswar@gbic.co.in">bimalokpal.bhubaneswar@gbic.co.in</a>
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: <a href="mailto:bimalokpal.chandigarh@gbic.co.in">bimalokpal.chandigarh@gbic.co.in</a>
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: <a href="mailto:bimalokpal.chennai@gbic.co.in">bimalokpal.chennai@gbic.co.in</a>
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: <a href="mailto:bimalokpal.delhi@gbic.co.in">bimalokpal.delhi@gbic.co.in</a>
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: <a href="mailto:bimalokpal.guwahati@gbic.co.in">bimalokpal.guwahati@gbic.co.in</a>
Andhra Pradesh, Telangana 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: <a href="mailto:bimalokpal.hyderabad@gbic.co.in">bimalokpal.hyderabad@gbic.co.in</a>
Rajasthan	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor,

	Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: <a href="mailto:Bimalokpal.jaipur@gbic.co.in">Bimalokpal.jaipur@gbic.co.in</a>
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: <a href="mailto:bimalokpal.ernakulam@gbic.co.in">bimalokpal.ernakulam@gbic.co.in</a>
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: <a href="mailto:bimalokpal.kolkata@gbic.co.in">bimalokpal.kolkata@gbic.co.in</a>
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, 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: <a href="mailto:bimalokpal.lucknow@gbic.co.in">bimalokpal.lucknow@gbic.co.in</a>
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: <a href="mailto:bimalokpal.mumbai@gbic.co.in">bimalokpal.mumbai@gbic.co.in</a>
State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshahr, 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, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514251 / 2514253 Email: <a href="mailto:bimalokpal.noida@gbic.co.in">bimalokpal.noida@gbic.co.in</a>
Bihar, Jharkhand.	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Email: <a href="mailto:bimalokpal.patna@gbic.co.in">bimalokpal.patna@gbic.co.in</a>
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: <a href="mailto:bimalokpal.pune@gbic.co.in">bimalokpal.pune@gbic.co.in</a>