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

VARISTHA Mediclaim for Senior Citizens Policy

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

Section I- Hospitalisation and Domiciliary Hospitalisation Cover

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

1.0 Coverage

Hospitalisation Benefits		**Limits**
1 A	Room charges subject to 1% of sum insured per day and Intensive care unit (ICU) charges subject to 2% of sum insured per day (including nursing care, RMO charges, IV fluids / blood transfusion / injection administration charges).	Maximum limit under Section 1 A - 25% of the sum insured per illness / injury
1 B	Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees	Maximum limit under Section 1 B - 25% of sum insured per illness / injury
1 C	Anesthesia, Blood, Oxygen, OT charges, Surgical appliances (any disposable surgical consumables), Medicines, drugs, Diagnostic material & X-Ray, Dialysis, Chemotherapy, Radiotherapy, cost of pacemaker, artificial limbs, Cost of Stent & Implants	Maximum limit under Section 1 C - 50% of sum insured per illness / injury

Sublimit

i. Company's liability in respect of claims arising due to **Cataract** is up to ₹10000/- (ten thousand) and that of **Benign prostatic hyperplasia** is up to ₹20,000/- (twenty thousand) only.
ii. Company's liability under Domiciliary Hospitalisation is limited to 20% of the sum insured under Section I.
iii. Hospitalisation expenses of person donating an organ during the course of organ transplant will also be payable subject to the sub limits under 1.C above applicable to the insured person within the sum insured of the insured person.
iv. Ambulance charges up to a maximum limit of ₹1000/- (one thousand) in a policy period shall be reimbursed, subject to the sub limits under 1.C above.
v. Sublimit mentioned in 1A, 1B and 1C shall not apply in case of Hospitalisation in a preferred provider network (PPN) for certain procedure/treatment.

Co-payment

Co-payment of 10% shall apply to all the admissible claims other than claims arising due to Cataract and Benign prostatic hyperplasia. Co-payment of 20% shall be considered wherever the insured person has opted.

Co-payment of 10% shall apply to all the admissible claims arising out of pre-existing diseases for which the insured person opted cover and paid additional premium. This copayment is in addition to the copayment stated herein above and applicable only for claims arising out of Pre-existing Diseases.

2 Good health incentives

2.1 Cumulative bonus (CB)

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 an insured person, provided no claims were 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.
Cumulative bonus shall be aggregated over the years and available, subject to maximum of 50% (fifty percent) of the sum insured (excluding CB) of the expiring policy.

Insured person has the option either to avail cumulative bonus or claim 5% discount in renewal premium in respect of each claim free year of insurance subject to maximum of 10 (ten) claim free years of insurance.

2.2 Health checkup
Expenses of health checkup will be reimbursed once at the end of a block of three continuous policy periods provided no claims are reported during the block and the policy has been continuously renewed with the company without a break. Expenses payable is a maximum of 2% of the average sum insured (excluding CB) of the block. Claim for health checkup benefits may be lodged at least 45 (forty five) days before the expiry of the fourth policy period.

3. Definitions

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

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

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

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

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

3.6 Congenital anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
i. **Internal congenital anomaly** means congenital anomaly which is not on the visible and accessible parts of the body
ii. **External congenital anomaly** means congenital anomaly which is on the visible and accessible parts of the body

3.7 Contract means prospectus, proposal, policy, policy schedule, constitute the contract of the policy. 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.

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

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

3.10 Cumulative bonus means any increase in the sum insured granted by the company without an associated increase in premium.

3.11 Day care treatment means medical treatment, and/or surgical procedure which is:
i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 (twenty four) hrs because of technological advancement, and
ii. which would have otherwise required a hospitalisation o f more than 24 (twenty four) hours.
Treatment normally taken on an out-patient basis is not included in the scope of this definition.

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

3.13 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:
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 shall not cover:
i. Treatment of less than 3 (three) days

ii. Expenses incurred for pre and post hospitalisation and
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) Diabetes mellitus and insipidus
   f) Epilepsy
   g) Hypertension
   h) Influenza, cough and cold
   i) All psychiatric or psychosomatic disorders
   j) Pyrexia of unknown origin for less than 10 (ten) days
   k) Tonsillitis and upper respiratory tract infection including laryngitis and pharingitis
   l) Arthritis, gout and rheumatism

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

3.15 Hospital means any institution established for in-patient care and day care treatment of illness and/ or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:
i. has qualified nursing staff under its employment round the clock;
ii. has at least 10 (ten) inpatient beds, in those towns having a population of less than 10,00,000 (ten lacs) and 15(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 Insurance Company's authorized personnel.

3.16 Hospitalisation means admission in a hospital as an in-patient for a minimum period of 24 (twenty four) consecutive hours. However, this time limit is not applied to specific treatments i.e. day care treatment for stitching of wound/s, close reduction/s and application of POP casts, dialysis, chemotherapy, radiotherapy, arthroscopy, eye surgery, ENT surgery, laparoscopic surgery, angiography, endoscopy, lithotripsy (kidney stone removal), dilatation and curettage (D&C), tonsillectomy taken in the hospital and the insured person is discharged on the same day. The treatment will be considered to be taken under hospitalisation benefit. This condition will also not apply in case of stay in hospital of less than 24 (twenty four) hours provided –

i. the treatment is such that it necessitates hospitalisation and the procedure involves specialized infra structural facilities available in hospitals.

And

ii. due to technological advances hospitalisation is required for less than 24 (twenty four) hours only.

3.17 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 orinjury that is likely to respons 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 o f symptoms
   c) it requires your rehabilitation or for you to be specially trained to cope with it
   d) it continues indefinitely
   e) it comes back or is likely to come back.

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

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

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

3.21 Medical practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence.

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

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

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

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

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

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

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

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

Pre hospitalisation will be considered as part of hospitalisation claim.

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

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

Post hospitalisation will be considered as part of hospitalisation claim.

3.30 Pre-existing disease means any condition, disease or injury or related conditions for which the insured person had signs or symptoms and/or was diagnosed and/or received medical advice/treatment within 48 (forty eight) months prior to the inception of the policy. Any complications arising from pre-existing disease/ injury shall be considered as pre-existing diseases.

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

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

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

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

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

3.36 Sum insured means the sum insured and the cumulative bonus accrued in respect of each insured person as mentioned in the schedule. The sum insured represents maximum liability for each insured person for any and all benefits claimed during the policy period. Health checkup expenses are payable over and above the sum insured, wherever applicable.

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

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

4 Exclusions (Applicable to Section I)
The company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any person in connection with or in respect of:

4.1 Pre existing disease
All pre-existing diseases. Such diseases shall be covered after the policy has been continuously in force for 12 months. Any complication arising from pre-existing disease shall be considered as a part of the pre existing disease.
Diabetes and/or Hypertension, if preexisting shall be covered from the inception of the policy, subject to exclusion 4.2 stated herein under, by charging additional premium. However, any ailment already manifested or being treated and attributable to diabetes and/or hypertension or consequences thereof at the time of inception of insurance will not be covered.

Cost of treatment towards dialysis, chemotherapy & radiotherapy for preexisting diseases is not payable even after 12 months.

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

4.3 One year waiting period

a. Cataract
b. Benign prostatic hypertrophy
c. Hernia
d. Hydrocele
e. Congenital internal disease
f. Fissure/Fistula in anus
g. Piles (Haemorrhoids)
h. Sinusitis
i. CSOM (Chronic Suppurative Otitis Media)
j. Pilonidal sinus
k. Calculus diseases
l. Benign lumps/growths in any part of the body
m. Surgical treatment of tonsils, adenoids and deviated nasal septum and related disorders
n. Hysterectomy for menorrhagia or fibromyoma
o. Joints replacements of any kind unless arising out of accident

If these diseases are pre-existing at the time of proposal, they will be covered only after one claim free year as mentioned in exclusion 4.1 above.

4.4 HIV, AIDS
Expenses arising out of any condition directly or indirectly caused to or associated with Human T-Cell Lymphotrophic Virus Type III (HTLV-III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or variations Deficiency Syndrome or any syndrome or condition of a similar kind commonly referred to as AIDS.

4.5 Convalescence, general debility 'Run Down' condition or rest cure.

4.6 Sterility, venereal disease.

4.7 Maternity
Treatment arising from or traceable to pregnancy childbirth including caesarean section.

4.8 Intentional self-injury, drug/alcohol abuse
Intentional self-injury and use of intoxicating drugs / alcohol, rehabilitation therapy in any form.

4.9 Congenital external disease or defects or anomalies.

4.10 Vaccination or inoculation.

4.11 Cosmetic, plastic surgery, change of life
Change of life or cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to as accident or as part of any illness.

4.12 Naturopathy treatment.

4.13 Dental treatment
Dental treatment unless arising due to an accident.

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

4.15 Hospitalisation for the purpose of diagnosis and evaluation
Expenses incurred at Hospital primarily for diagnostic, X-Ray or laboratory examinations or other diagnostic studies not consistent with nor incidental to the diagnosis and treatment of positive existence or presence of any ailment, sickness or injury for which confinement is required at a Hospital.

4.16 Spectacles and contact lenses, hearing aids.

4.17 Nuclear weapons/materials
Injury or disease directly or indirectly caused by or contributed to by nuclear weapons/materials.

4.18 War group perils
Injury or disease directly or indirectly caused by or arising from or attributable to War Invasion Act of Foreign Enemy Warlike operations (whether war be declared or not).

5 Conditions (Applicable to Section I)

5.1 Territorial Limit
All medical treatment for the purpose of this insurance will have to be taken in India only and all claims under the policy shall be payable in Indian currency only.

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

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

5.4 Claims Procedure
Section I - Hospitalisation and Domiciliary Hospitalisation Cover
Claims will be settled by the Third Party Administrators (TPA).

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

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

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

5.4.2 Procedure for Cashless claims
i. Treatment may be taken in a network provider/PPN and is subject to pre authorization by the TPA.

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

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

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

Type of claim	**Time limit for submission of documents to TPA**
Reimbursement of hospitalisation and pre hospitalisation expenses	Within 15 (fifteen) days of date of discharge from hospital
Reimbursement of post hospitalisation expenses	Within 15 (fifteen) days from completion of post hospitalisation treatment
Reimbursement of health checkup expenses (as per clause 2.2 of the policy)	At least 45 (forty five) days before the expiry of the fourth policy period.

Note
In the event of a claim lodged as per clause 5.3 of the policy and the original documents having been submitted to the other insurer, the company may accept the documents listed under clause 5.4.4 of the policy and claim settlement advice duly certified by the other insurer subject to satisfaction of the company.

5.4.5 Services offered by a TPA
The TPA shall render health care services covered under the policy like issuance of ID cards & guide book, hospitalization & pre-authorization services, call centre, acceptance of claim related documents, claim processing and other related services
The services offered by a TPA shall not include
i. Claim settlements and rejections with respect to the health insurance policies; However, TPA may handle claims admissions and recommend to the insurer for the payment of the claim settlement, provided a detailed guideline is prescribed by the insurer to the TPA for claims assessments & admissions in terms of capacity requirements, internal control requirements, claim assessment & admissions procedure requirements etc under the agreement
ii. Any services directly to the policyholder or 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 insurer.

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

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

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

Portability shall be allowed in the following cases:

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

Section II: Critical Illness Cover

Whereas the insured by a proposal and declaration, which shall be the basis of this contract and is deemed to be incorporated herein, has applied to the Company for the insurance herein after set forth and has paid the premium as consideration for such insurance in respect of the insured person as mentioned in the schedule.

The company shall pay to the insured person, the sum insured under this section as mentioned in the schedule, should an insured person be diagnosed, during the period of insurance set in the schedule, as suffering from a critical illness, symptoms (and/or the treatment) which were not present in such insured person at any time prior to inception of this policy.

1 Definitions

1.1 Critical illness means stroke resulting in permanent symptoms, cancer of specified severity, kidney failure requiring regular dialysis, major organ/ bone marrow transplant, multiple sclerosis with persisting symptoms and open chest CABG (Coronary Artery Bypass Graf) as mentioned in the policy.

Critical illness also includes permanent paralysis of limbs and blindness if mentioned in the schedule.

1.1.1 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 (three) months has to be produced.

The following are not covered

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

1.1.2 Cancer of specified severity

A malignant tumour 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 & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

The following are not covered

i. Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as premalignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
ii. Any skin cancer other than invasive malignant melanoma
iii. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 (six) or having progressed to at least clinical TNM classification T2N0M0.
iv. Papillary micro - carcinoma of the thyroid less than 1 (one) cm in diameter.
v. Chronic lymphocyctic leukaemia less than RAI stage 3 (three).
vi. Microcarcinoma of the bladder.
vii. All tumours in the presence of HIV infection.

1.1.3 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.

1.1.4 Major organ/ Bone marrow transplant

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

The following are not covered

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

1.1.5 Multiple Sclerosis with persisting symptoms
The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:
i. investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 (six) months, and
iii. well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with at least two clinically documented episodes at least one month apart.

The following are not covered
Other causes of neurological damage such as SLE (Systemic Lupus Erythematosus) and HIV (Human Immunodeficiency Virus)

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

The following are not covered
i. Angioplasty and/or any other intra-arterial procedures
ii. Any key-hole or laser surgery.

1.1.7 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 (three) months.

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

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

2 Exclusions (Applicable to section II)

2.1 Waiting period
No claim will be payable, if a critical illness as specified in the policy incepts or manifests during the first 90 (ninety) days of the inception of the policy.

2.2. Pre existing condition
The company will not be liable for a critical illness and/or its symptoms (and/or the treatment) of which were present in the insured person at any time before inception of the policy or the date on which cover was granted to such insured person, or which manifest themselves within a period of 90 (ninety) days from such date, whether or not the insured person had knowledge that the symptoms or treatment were related to such critical illness. In the event of any interruption in cover, the terms of this exclusion will apply as new from recommencement of cover.

2.3 Smoking
No claim will be payable if the insured person smokes 40 (forty) or more cigarettes / cigars or equivalent tobacco intake in a day.

2.4 The company shall not pay any benefit to any insured person who suffers a critical illness which arises or is caused by or associated with:

2.4.1 Non prescribed drug
The ingestion of drugs other than those prescribed by a practicing and duly qualified member of the medical profession.

2.4.2 Drug addiction
The ingestion of medicines, prescribed or not, for treatment of drug addiction and any treatment relating to drug addiction.

2.4.3 Suicide
Any attempt by the insured person at suicide or any, injury, which is self inflicted or in any manner willfully caused by or on behalf of the insured person.

2.4.4 AIDS, HIV
AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)**.** AIDS and HIV will be interpreted as broadly as possible so as to include all or any mutants, derivatives or variations thereof.

2.4.5 Radioactivity
Any illness or injury directly or indirectly caused by or contributed to by nuclear weapons/materials or contributed to by or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel.

2.4.6 War group perils
War, invasion, act of foreign enemy, hostilities, civil war, rebellion, revolution, insurrection, mutiny, military, or usurped power, seizure, capture, arrest, restraints and detainment of all kings, princes and people of whatever nation condition or quality whatsoever.

3. Conditions (Applicable to section II)

3.1 Medical examination
Each of the above illnesses mentioned in the policy, must be confirmed by a medical practitioner appointed by the company and must be supported by clinical, radiological, histological and laboratory evidence acceptable to the company and to be reconfirmed by a medical practitioner appointed by the company.

3.2 No. of claims in a policy period
The company shall pay to the insured person only once in respect of any particular critical illness in a policy period.

3.3 Cessation of cover
The cover under the policy will cease upon payment of the sum insured on the happening of a critical illness and no further payment will be made for any consequent disease or any dependent disease or any critical illness.

3.4 Survival period
The insured person needs to survive for 30 (thirty) days after the diagnosis of the critical illness in order to make a claim.

3.5 Multiple policies

3.5.1 An insured person shall not be covered under more than one Critical Illness Insurance policy issued by the company. In the event that an insured person is covered under more than one such insurance policy, the company will only pay under one insurance and will refund any duplicated premium, which may have been paid by or on behalf of the insured.

3.5.2 The insured person must give at least 30 (thirty) days' notice to the company of his intention to effect another policy (by any other name) covering the Critical Illness to be issued by another insurer before effecting such cover. Failure to give such notice shall render the policy liable to be cancelled or the benefits under the policy shall be forfeited.

3.6 Claims Procedure
Section II - Critical Illness Cover

3.6.1 Notification of claim:
Upon detection of any critical illness, which may give rise to a claim under this section, notice with full particulars shall be sent to the company within 15 (fifteen) days from the date of diagnosis of the disease.

3.6.2 Documents
Claim documents as mentioned hereunder must be submitted to the company after 30 (thirty) days from the date of diagnosis of the disease.

a. Discharge summary, Doctor's certificate confirming diagnosis of the critical illness along with date of diagnosis.
b. Pathological/ Radiological/other diagnostic test reports confirming the diagnosis of the critical illness.
c. Any other documents required by the company

3.7 Restricted cover

The amount payable for Open chest CABG shall be limited to 20% of the sum insured.

Conditions applicable to both Sections I & II

1 Disclosure of information

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

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.

3 Communication

i. All communication should be in writing.
ii. For claim 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, change in address to be communicated to the policy issuing office at the address mentioned in the schedule.
iii. The company or TPA will communicate to the insured person at the address mentioned in the schedule.

4 Claim documents

The insured person shall obtain and furnish the company with all original bills, receipts and other documents upon which a claim is based and shall also give the company such additional information and assistance as the company may require in dealing with the Claim.

5 Claim Settlement

i. On receipt of the final document(s) or investigation report (if any), as the case may be, the company shall within a period of 30 (thirty) days offer a settlement of the claim to the insured.
ii. If the company, for any reasons, decides to reject a claim under the policy, shall communicate to the insured person in writing and within a period of 30 (thirty) days from the receipt of the final document(s) or investigation report (if any), as the case may be.
iii. Upon acceptance of an offer of settlement as stated above by the insured, the payment of the amount due shall be made within 7 (seven) days from the date of acceptance of the offer by the company.
iv. In the cases of delay in the payment, the company shall pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is paid.

6 Payment of claim

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

7 Fraud

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

8 Cancellation

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

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

Period of risk	**Rate of premium to be charged**
Up to 1 month	¼ of the annual rate
Up to 3 months	½ of the annual rate
Up to 6 months	¾ of the annual rate
Exceeding 6 months	Full annual rate

9 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.

10 Arbitration

i. If any dispute or difference shall arise as to the quantum to be paid under the policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within 30 (thirty) days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.
ii. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the company has disputed or not accepted liability under or in respect of the policy.
iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

11 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 30 (thirty) days is allowed. Coverage is not available during the grace period.

12 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.

13 Withdrawal of product

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

14 Free look period

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

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

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

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

15 Nomination

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

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

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

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

16 Redressal of grievance

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

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

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

Appendix I

List of Expenses Generally Excluded

List of Expenses Generally Excluded ("Non-Medical") in Hospital Indemnity Policy -	
TOILETRIES/ COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS	
HAIR REMOVAL CREAM	**Not Payable**
BABY CHARGES (UNLESS SPECIFIED/INDICATED)	**Not Payable**
BABY FOOD	**Not Payable**
BABY UTILITES CHARGES	**Not Payable**
BABY SET	**Not Payable**
BABY BOTTLES	**Not Payable**
BRUSH	**Not Payable**
COSY TOWEL	**Not Payable**
HAND WASH	**Not Payable**
MOISTURISER PASTE BRUSH	**Not Payable**
POWDER	**Not Payable**
RAZOR	**Payable**
SHOE COVER	**Not Payable**
BEAUTY SERVICES	**Not Payable**
BELTS/ BRACES	**Essential and should be paid at least specifically for cases who have undergone surgery of thoracic or lumbar spine**
BUDS	**Not Payable**
BARBER CHARGES	**Not Payable**
CAPS	**Not Payable**
COLD PACK/HOT PACK	**Not Payable**
CARRY BAGS	**Not Payable**
CRADLE CHARGES	**Not Payable**
COMB	**Not Payable**
DISPOSABLES RAZORS CHARGES (for site preparations)	**Payable**
EAU-DE-COLOGNE / ROOM FRESHNERS	**Not Payable**
EYE PAD	**Not Payable**
EYE SHEILD	**Not Payable**
EMAIL / INTERNET CHARGES	**Not Payable**
FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	**Not Payable**
FOOT COVER	**Not Payable**
GOWN	**Not Payable**
LEGGINGS	**Essential in bariatric and varicose vein surgery and may be considered for at least these conditions where surgery itself is payable.**
LAUNDRY CHARGES	**Not Payable**
MINERAL WATER	**Not Payable**
OIL CHARGES	**Not Payable**
SANITARY PAD	**Not Payable**
SLIPPERS	**Not Payable**
TELEPHONE CHARGES	**Not Payable**
TISSUE PAPER	**Not Payable**
TOOTH PASTE	**Not Payable**
TOOTH BRUSH	**Not Payable**
GUEST SERVICES	**Not Payable**
BED PAN	**Not Payable**
BED UNDER PAD CHARGES	**Not Payable**
CAMERA COVER	**Not Payable**
CLINIPLAST	**Not Payable**
CREPE BANDAGE	**Not Payable/ Payable by the patient**
CURAPORE	**Not Payable**
DIAPER OF ANY TYPE	**Not Payable**
DVD, CD CHARGES	**Not Payable (However if CD is specifically sought by Insurer/TPA**
	then payable)
EYELET COLLAR	**Not Payable**
FACE MASK	**Not Payable**
FLEXI MASK	**Not Payable**
GAUSE SOFT	**Not Payable**
GAUZE	**Not Payable**
HAND HOLDER	**Not Payable**
HANSAPLAST/ ADHESIVE BANDAGES	**Not Payable**
INFANT FOOD	**Not Payable**
SLINGS	**Reasonable costs for one sling in case of upper arm fractures may be considered**
ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES	
WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	**Exclusion in policy unless otherwise specified**
COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	**Exclusion in policy unless otherwise specified**
DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	**Exclusion in policy unless otherwise specified**
HORMONE REPLACEMENT THERAPY	**Exclusion in policy unless otherwise specified**
HOME VISIT CHARGES	**Exclusion in policy unless otherwise specified**
INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	**Exclusion in policy unless otherwise specified**
OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	**Exclusion in policy unless otherwise specified**
PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	**Exclusion in policy unless otherwise specified**
CORRECTIVE SURGERY FOR REFRACTIVE ERROR	**Exclusion in policy unlessotherwise specified**
TREATMENT OF SEXUALLY TRANSMITTED DISEASES	**Exclusion in policy unless otherwise specified**
DONOR SCREENING CHARGES	**Exclusion in policy unless otherwise specified**
ADMISSION/REGISTRATION CHARGES	**Exclusion in policy unless otherwise specified**
HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	**Exclusion in policy unless otherwise specified**
EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	**Not Payable - Exclusion in policy unless otherwise specified**
ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	**Not payable as per HIV/AIDS exclusion**
STEM CELL IMPLANTATION/ SURGERY AND STORAGE	**Not Payable except Bone Marrow Transplantation where covered by policy**
ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS	
WARD AND THEATRE BOOKING CHARGES	**Payable under OT Charges, not payable separately**

ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	**Rental charged by the hospital payable. Purchase of Instruments not payable.**
MICROSCOPE COVER	**Payable under OT Charges, not payable separately**
SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	**Payable under OT Charges, not payable separately**
SURGICAL DRILL	**Payable under OT Charges, not payable separately**
EYE KIT	**Payable under OT Charges, not payable separately**
EYE DRAPE	**Payable under OT Charges, not payable separately**
X-RAY FILM	**Payable under Radiology Charges, not as consumable**
SPUTUM CUP	**Payable under Investigation Charges, not as consumable**
BOYLES APPARATUS CHARGES	**Part of OT Charges, not seperately**
BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	**Part of Cost of Blood, not payable**
ANTISEPTIC OR DISINFECTANT LOTIONS	**Not Payable-Part of Dressing Charges**
BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	**Not Payable - Part of Dressing charges**
COTTON	**Not Payable-Part of Dressing Charges**
COTTON BANDAGE	**Not Payable- Part of Dressing Charges**
MICROPORE/ SURGICAL TAPE	**Not Payable-Payable by the patient when prescribed, otherwise included as Dressing Charges**
BLADE	**Not Payable**
APRON	**Not Payable -Part of Hospital Services/ Disposable linen to be part of OT/ICU chatges**
TORNIQUET	**Not Payable (service is charged by hospitals, consumables cannot be separately charged)**
ORTHOBUNDLE, GYNAEC BUNDLE	**Part of Dressing Charges**
URINE CONTAINER	**Not Payable**
ELEMENTS OF ROOM CHARGE	
LUXURY TAX	**Actual tax levied by government is payable. Part of room charge for sub limits**
HVAC	**Part of room charge not payable separately**
HOUSE KEEPING CHARGES	**Part of room charge not payable separately**
SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	**Part of room charge not payable separately**
TELEVISION & AIR CONDITIONER CHARGES	**Payable under room charges not if separately levied**
SURCHARGES	**Part of Room Charge, Not payable separately**
ATTENDANT CHARGES	**Not Payable - Part of Room Charges**
IM IV INJECTION CHARGES	**Part of nursing charges, not payable**
CLEAN SHEET	**Part of**

	Laundry/Housekeeping not payable separately
EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	**Patient Diet provided by hospital is payable**
BLANKET/WARMER BLANKET	**Not Payable- part of room charges**
ADMINISTRATIVE OR NON-MEDICAL CHARGES	
ADMISSION KIT	**Not Payable**
BIRTH CERTIFICATE	**Not Payable**
BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	**Not Payable**
CERTIFICATE CHARGES	**Not Payable**
COURIER CHARGES	**Not Payable**
CONVENYANCE CHARGES	**Not Payable**
DIABETIC CHART CHARGES	**Not Payable**
DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	**Not Payable**
DISCHARGE PROCEDURE CHARGES	**Not Payable**
DAILY CHART CHARGES	**Not Payable**
ENTRANCE PASS / VISITORS PASS CHARGES	**Not Payable**
EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	**To be claimed by patient under Post Hosp where admissible**
FILE OPENING CHARGES	**Not Payable**
INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	**Not Payable**
MEDICAL CERTIFICATE	**Not Payable**
MAINTAINANCE CHARGES	**Not Payable**
MEDICAL RECORDS	**Not Payable**
PREPARATION CHARGES	**Not Payable**
PHOTOCOPIES CHARGES	**Not Payable**
PATIENT IDENTIFICATION BAND / NAME TAG	**Not Payable**
WASHING CHARGES	**Not Payable**
MEDICINE BOX	**Not Payable**
MORTUARY CHARGES	**Payable upto 24 hrs, shifting charges not payable**
MEDICO LEGAL CASE CHARGES (MLC CHARGES)	**Not Payable**
EXTERNAL DURABLE DEVICES	
WALKING AIDS CHARGES	**Not Payable**
BIPAP MACHINE	**Not Payable**
COMMODE	**Not Payable**
CPAP/ CAPD EQUIPMENTS	**Device not payable**
INFUSION PUMP - COST	**Device not payable**
OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	**Not Payable**
PULSEOXYMETER CHARGES	**Device not payable**
SPACER	**Not Payable**
SPIROMETRE	**Device not payable**
SPO2 PROBE	**Not Payable**
NEBULIZER KIT	**Not Payable**
STEAM INHALER	**Not Payable**
ARMSLING	**Not Payable**
THERMOMETER	**Not Payable (paid by patient)**
CERVICAL COLLAR	**Not Payable**
SPLINT	**Not Payable**
DIABETIC FOOT WEAR	**Not Payable**
KNEE BRACES (LONG/ SHORT/ HINGED)	**Not Payable**
KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	**Not Payable**
LUMBO SACRAL BELT	**Essential and should be paid at least specifically for cases who have undergone surgery of lumbar spine.**
NIMBUS BED OR WATER OR AIR BED CHARGES	**Payable for any ICU patient requiring more than 3 days in ICU, all**

	patients with paraplegia/quadriplegia for any reason and at reasonable cost of approximately Rs 200/ day
AMBULANCE COLLAR	**Not Payable**
AMBULANCE EQUIPMENT	**Not Payable**
MICROSHEILD	**Not Payable**
ABDOMINAL BINDER	**Essential and should be paid at least specifically for cases who have undergone surgery of lumbar spine.**
ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION	
BETADINE \ HYDROGEN PEROXIDE\SPIRIT\\DETTOL\SAVLON\ DISINFECTANTS ETC	**May be payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital**
PRIVATE NURSES CHARGES-SPECIAL NURSING CHARGES	**Post hospitalization nursing charges not Payable**
NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES	**Patient Diet provided by hospital is payable**
SUGAR FREE TABLETS	**Payable -Sugar free variants of admissible medicines are not excluded**
CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	**Payable when prescribed**
DIGESTION GELS	**Payable when prescribed**
ECG ELECTRODES	**Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable.**
GLOVES	**Sterilized Gloves payable / unsterilized gloves not payable**
HIV KIT	**Payable - payable Pre operative screening**
LISTERINE/ ANTISEPTIC MOUTHWASH	**Payable when prescribed**
LOZENGES	**Payable when prescribed**
MOUTH PAINT	**Payable when prescribed**
NEBULISATION KIT	**If used during hospitalization is payable reasonably**
NOVARAPID	**Payable when prescribed**
VOLINI GEL/ ANALGESIC GEL	**Payable when prescribed**
ZYTEE GEL	**Payable when prescribed**
VACCINATION CHARGES	**Routine Vaccination not Payable / Post Bite Vaccination Payable**
PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE	
AHD	**Not Payable - Part of Hospital's internal Cost**
ALCOHOL SWABES	**Not Payable - Part of Hospital's internal Cost**
SCRUB SOLUTION/STERILLIUM	**Not Payable - Part of Hospital's internal Cost**
OTHERS	
VACCINE CHARGES FOR BABY	**Not Payable**
AESTHETIC TREATMENT / SURGERY	**Not Payable**
TPA CHARGES	**Not Payable**
VISCO BELT CHARGES	**Not Payable**
ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	**Not Payable**
EXAMINATION GLOVES	**Not payable**
KIDNEY TRAY	**Not Payable**
MASK	**Not Payable**
OUNCE GLASS	**Not Payable**
OUTSTATION CONSULTANT'S/ SURGEON'S FEES	**Not payable, except for telemedicine consultations where covered by policy**
OXYGEN MASK	**Not Payable**
PAPER GLOVES	**Not Payable**
PELVIC TRACTION BELT	**Should be payable in case of PIVD requiring traction as this is generally not reused**
REFERAL DOCTOR'S FEES	**Not Payable**
ACCU CHECK (Glucometery/ Strips)	**Not payable pre hospitilasation or post hospitalisation / Reports and Charts required/ Device not payable**
PAN CAN	**Not Payable**
SOFNET	**Not Payable**
TROLLY COVER	**Not Payable**
UROMETER, URINE JUG	**Not Payable**
AMBULANCE	**Payable**
TEGADERM / VASOFIX SAFETY	**Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs**
URINE BAG	**Payable where medicaly necessary till a reasonable cost - maximum 1 per 24 hrs**
SOFTOVAC	**Not Payable**
STOCKINGS	**Essential for case like CABG etc. where it should be paid.**

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