

Issuing Office

National Mediclaim Plus Policy

Whereas the proposer designated in the Schedule hereto has by a proposal together with declaration and medical reports (if applicable), 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.

1 PREAMBLE

The Company undertakes that if during the Policy Period stated in the Schedule, any 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 Hospitalisation of such Insured Person(s), for In-Patient Care at any hospital/nursing home (hereinafter called Hospital) or for Day Care Treatment at any Day Care Center, following the Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify the Hospital or the Insured, Reasonable and Customary Charges incurred for Medically Necessary Treatment towards the Coverage mentioned herein.

Provided further that, the amount payable under the Policy in respect of all such claims during the Policy Period shall be subject to the coverage, terms, exclusions, conditions, definitions and sub limits contained herein as well as shown in the Table of Benefits, and shall not exceed the Sum Insured (i.e., basic Sum Insured and Cumulative Bonus) of the Insured Person.

2 DEFINITION

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

2.2 Age/ Aged means completed years on last birthday as on Policy commencement date.

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

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

2.5 AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical / para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

- i. Having qualified registered AYUSH Medical Practitioner in charge round the clock;
- ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
- iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

2.6 AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

- a. Central or State Government AYUSH Hospital or
- b. Teaching hospital attached to AYUSH College recognized by the Central Government/ Central Council of Indian Medicine/ Central Council for Homeopathy; or
- c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
 - i. Having at least 5 in-patient beds;
 - ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
 - iii. Having dedicated AYUSH therapy sections as required;

Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative

2.7 Break in policy means the period of gap that occurs at the end of the existing Policy Period due date, when the premium due for renewal on a given policy due is not paid on or before the premium renewal date or Grace Period.

2.8 Cashless Facility means a facility extended by the Company 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 or a Non Network Provider to the extent pre-authorization approved.

- 2.9 Condition Precedent** means a policy term or condition upon which the company's liability under the policy is conditional upon.
- 2.10 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.
- 2.11 Congenital Anomaly** means 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.
- 2.12 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.
- 2.13 Cumulative Bonus** means any increase in the sum insured granted by the company without an associated increase in premium.
- 2.14 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:
- has qualified nursing staff under its employment;
 - has qualified medical practitioner (s) in charge;
 - has a fully equipped operation theatre of its own where surgical procedures are carried out
 - maintains daily records of patients and shall make these accessible to the company's authorized personnel.
- 2.15 Day Care Treatment** means medical treatment, and/or surgical procedure which is:
- undertaken under general or local anesthesia in a hospital/day care centre in less than twenty four hrs because of technological advancement, and
 - 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.
- 2.16 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.
- 2.17 Diagnosis** means diagnosis by a medical practitioner, supported by clinical, radiological, histological and laboratory evidence, acceptable to the company.
- 2.18 Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to Waiting Periods and coverage of Pre-Existing Diseases. The Grace Period for payment of the premium shall be thirty days. Coverage shall not be available during the period for which no premium is received.
- 2.19 Hospital** means any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:
- has qualified nursing staff under its employment round the clock;
 - has at least 10 (ten) inpatient beds, in those towns having a population of less than 10,00,000 (10 lacs) and 15(fifteen) inpatient beds in all other places;
 - has qualified medical practitioner (s) in charge round the clock;
 - has a fully equipped operation theatre of its own where surgical procedures are carried out
 - maintains daily records of patients and shall make these accessible to the company's authorized personnel.
- 2.20 Hospitalisation** means admission in a hospital for a minimum period of twenty four consecutive **Inpatient Care** hours except for procedures/ treatments, where such admission could be for a period of less than twenty four consecutive hours.
- 2.21 ID Card** means the card issued to the insured person by the TPA for availing cashless facility.
- 2.22 ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
- 2.23 Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.

- i. **Acute Condition** means a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
- ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics
 - a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
 - b) it needs ongoing or long-term control or relief of symptoms
 - c) it requires your rehabilitation or for you to be specially trained to cope with it
 - d) it continues indefinitely
 - e) it comes back or is likely to come back.

2.24 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.

2.25 Insured/ Insured Person means person(s) named in the schedule of the policy.

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

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

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

2.29 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.

2.30 Medically Necessary Treatment 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 Person;
- ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- iii. must have been prescribed by a Medical Practitioner;
- iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

2.31 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.

2.32 Migration means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

2.33 Network Provider means Hospitals or Day Care Centers enlisted by the Company or jointly by the Company and a TPA to provide medical services to an insured person on payment by a cashless facility.

2.34 Newborn Baby means baby born during the policy period and is aged upto 90 days

2.35 Non- Network Provider means any Hospital, Day Care Centre that is not part of the network.

2.36 Notification of Claim means the process of intimating a claim to the Company or TPA through any of the recognized modes of communication.

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

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

2.39 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.

2.40 Pre Existing Disease means any condition, ailment, injury or disease

- a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
- b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

2.41 Portability means a facility provided to the policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

2.42 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.

2.43 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.

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

2.45 Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated charges.

2.46 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.

2.47 Sum Insured means the basic 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, except any claim under the optional covers. Health check up expenses are payable over and above the sum insured, wherever applicable.

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

2.49 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.

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

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

3. BENEFITS COVERED UNDER THE POLICY

3.1 Coverage

3.1.1 In-patient Treatment

The company shall indemnify the Medical Expenses for:

- i. Room charges and intensive care unit charges (including diet charges, nursing care by qualified nurse, RMO charges, administration charges for IV fluids/blood transfusion/injection), subject to limit as mentioned in Section 3.1.1.1
- ii. Medical practitioner(s)
- iii. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances
- iv. Medicines and drugs
- v. Diagnostic procedures
- vi. Prosthetics and other devices or equipment if implanted internally during a surgical procedure.

3.1.1.1 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 mentioned in the Table of Benefits. **The limit shall not apply if treatment is taken in a Preferred Provider Network (PPN) as a package.**

3.1.1.2 Limit for Cataract Surgery

Company's liability for cataract surgery shall be up to the limit mentioned in the Table of Benefits. **The limit shall not apply if treatment is taken in a Preferred Provider Network (PPN) as a package.**

3.1.1.3 Treatment related to Participation as a Non-Professional in Hazardous or Adventure Sports

Expenses related to treatment necessitated due to participation as a **non-professional in hazardous or adventure sports, subject to Maximum amount admissible for Any One Illness shall be lower of 25% of Sum Insured.**

3.1.2 Pre Hospitalisation

The Company shall indemnify the Medical Expenses incurred up to 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 shall be considered as part of hospitalisation claim.

3.1.3 Post Hospitalisation

The Company shall indemnify the Medical Expenses incurred up to 60 (sixty) days immediately after the insured person is discharged from hospital, provided that:

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

Post hospitalisation shall be considered as part of hospitalisation claim.

3.1.4 Day Care Procedure

The Company shall indemnify the Medical Expenses (including Pre and Post Hospitalisation Expenses) for Day Care Treatments requiring Hospitalization as an In-Patient for less than 24 hours undergone by the Insured Person in a Hospital/ Day Care Centre, but not in the Outpatient department of a Hospital.

3.1.5 AYUSH Treatment:

The Company shall indemnify Medical Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Period up to the limit of Sum Insured as specified in the Policy Schedule in any AYUSH Hospital.

3.1.6 Organ Donor's Medical Expenses

The Company shall indemnify the Medical Expenses incurred in respect of an organ donor's Hospitalisation during the Policy Period for harvesting of the organ donated to an Insured Person, provided that:

- i. The organ donation confirms to the Transplantation of Human Organs Act 1994 (and its amendments from time to time)
- ii. The organ is used for an Insured Person and the Insured Person has been medically advised to undergo an organ transplant
- iii. The Medical Expenses shall be incurred in respect of the organ donor as an in-patient in a Hospital.
- iv. Claim has been admitted under In-patient treatment Section in respect of the Insured Person undergoing the organ transplant.

Exclusions

The Company shall not be liable to make payment for any claim under this Cover which arises for or in connection with any of the following:

- i. Pre-hospitalization Medical Expenses or Post- Hospitalization Medical Expenses of the organ donor.
- ii. Costs directly or indirectly associated with the acquisition of the donor's organ.
- iii. Medical Expenses where the organ transplant is experimental or investigational.
- iv. Any medical treatment or complication in respect of the donor, consequent to harvesting.
- v. Any expenses related to organ transportation or preservation.

3.1.7 Maternity

The Company shall indemnify Maternity Expenses as described below for any female Insured Person, and also Pre-Natal and Post-Natal Hospitalisation expenses per delivery, including expenses for necessary vaccination for New Born Baby, subject to the limit as shown in the Table of Benefits. The female Insured Person should have been continuously covered for at least 24 months before availing this benefit.

The **New Born Baby** shall be automatically covered from birth under the Sum Insured available to the mother during the corresponding Policy Period, for up to 3 months of age. On attaining 3 months of age, the **New Born Baby** shall be covered only if specifically included in the Policy **mid-term** and requisite premium paid to the Company.

Cover

Maternity Expenses means;

- a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
- b) Expenses towards lawful medical termination of pregnancy during the Policy Period.

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

Exclusions

The Company shall not be liable to make any payment under the cover in respect of **Maternity Expenses** incurred in connection with or in respect of:

1. Covered female Insured Person **below eighteen (18) years** and above forty-five (45) years of age.
2. Delivery or termination within a **Waiting Period of twenty-four (24) months**. However, the Waiting Period may be waived only in the case of delivery, miscarriage or abortion induced by accident.
3. Delivery or lawful medical termination of pregnancy limited to **two deliveries or terminations or either** has been paid under the Policy and its Renewals.
4. More than one delivery or lawful medical termination of pregnancy during a single Policy Period.
5. **Maternity Expenses of Surrogate Mother**, unless claim is admitted under **Section 3.1.12 (Infertility)**
6. **Ectopic pregnancy**
7. **Pre and post hospitalisation expenses**, other than pre and post natal treatment.

3.1.8 Hospital Cash

The Company shall pay the insured a daily hospital cash allowance up to the limit mentioned in the Table of Benefits for a maximum of 5 (five) days, provided

- i. hospitalisation exceeds 3 (three) days and starts within the policy period.
- ii. a claim has been admitted under In-patient treatment Section.

Hospital Cash shall be payable for each day from the 4th day of Hospitalisation up to the 8th day of Hospitalisation only. Hospitalisation of less than 24 hours shall not be considered for the purpose of payment of Hospital Cash

3.1.9 Ambulance

The Company shall reimburse the insured in respect of expenses incurred for transportation of the insured person to the hospital by ambulance up to the limit as mentioned in the Table of Benefits, provided a claim has been admitted under In-patient treatment Section.

3.1.10 Air Ambulance

The Company shall reimburse the insured in respect of expenses incurred for medical evacuation of the insured person by air ambulance to the nearest hospital or from one hospital to another hospital following an emergency up to the limit mentioned in the Table of Benefits, provided prior intimation is given to the company/TPA, and a claim has been admitted under In-patient treatment Section.

3.1.11 Medical Emergency Reunion

In the event of the insured person being hospitalised in a place away from the place of residence for more than 5 (five) continuous days in an intensive care unit for any life threatening condition, the Company after obtaining confirmation from the attending medical practitioner, of the need of a 'family member' to be present, shall reimburse the expenses of a round trip economy class air ticket, or first class railway ticket up to the limit mentioned in the Table of Benefits to allow a family member.

For the purpose of the Section, 'family member' shall mean spouse, children and parents of the insured person.

3.1.12 Doctor's Home Visit and Nursing Care during Post Hospitalisation

The Company shall reimburse the insured, medically necessary expenses incurred for doctor's home visit charges, nursing care by qualified nurse during post hospitalisation up to the limit mentioned in the Table of Benefits.

3.1.13 Vaccination for Children

The Company shall reimburse the Insured, in respect of expenses incurred for vaccinations of children (up to 12 years), as listed in Annexure I, up to the limit mentioned in the Table of Benefits, provided the children are covered under the policy. Hospitalisation is not required for this benefit.

3.1.14 HIV/ AIDS Cover

The Company shall indemnify the Medical Expenses (including Pre and Post Hospitalisation Expenses) related to following stages of HIV infection:

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

3.1.15 Mental Illness Cover

The Company shall indemnify the Medical Expenses (including Pre and Post Hospitalisation Expenses) related to Mental Illnesses, provided the treatment shall be undertaken at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Psychiatrist or a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry.

Exclusions

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.

3.1.16 Modern Treatment

The Company shall indemnify the Medical Expenses for In-Patient Care or Day Care Procedure along with pre hospitalisation expenses and post hospitalisation expenses incurred for following Modern Treatments (wherever medically indicated), subject to the limit of 25% of the Sum Insured for the related modern procedure/ component/ medicine of each Modern Treatment during the Policy Period.

Modern Treatment	Coverage
UAE & HIFU	Limit is for Procedure cost only
Balloon Sinuplasty	Limit is for Balloon cost only
Deep Brain Stimulation	Limit is for implants including batteries only
Oral Chemotherapy	Only cost of medicines payable under this limit, other incidental charges like investigations and consultation charges not payable.
Immunotherapy	Limit is for cost of injections only.
Intravitreal injections	Limit is for complete treatment, including Pre & Post Hospitalization
Robotic Surgery	Limit is for robotic component only.
Stereotactic Radio surgeries	Limit is for radiation procedure.
Bronchial Thermoplasty	Limit is for complete treatment, including Pre & Post Hospitalization
Vaporization of the prostate	Limit is for LASER component only.
IONM	Limit is for IONM procedure only.
Stem cell therapy	Limit is for complete treatment, including Pre & Post Hospitalization

3.1.17 Morbid Obesity Treatment

The Company shall indemnify the Medical Expenses for In-Patient Treatment, Pre-Hospitalisation expenses and Post-Hospitalisation expenses, incurred for surgical treatment of obesity that fulfils **all** the following conditions and subject to Waiting Period of **three (03)** years as per Section 4.2.f.iv:

Treatment has been conducted is upon the advice of the Medical Practitioner, and

1. The surgery/Procedure conducted should be supported by clinical protocols, and
2. The Insured Person is 18 years of age or older, and
3. Body Mass Index (BMI) is;
 - a) greater than or equal to 40 or
 - b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - i. Obesity-related cardiomyopathy
 - ii. Coronary heart disease
 - iii. Severe Sleep Apnea
 - iv. Uncontrolled Type 2 Diabetes

3.1.18 Correction of Refractive Error

The Company shall indemnify the Medical Expenses, including Pre Hospitalisation expenses and Post Hospitalisation expenses, incurred for expenses related to the treatment for correction of eye sight due to refractive error equal to or more than 7.5 dioptries, subject to Waiting Period of two (02) years as per Section 4.2.f.iii.

Note: The expenses that are not covered in this policy are placed under List-I of Annexure-II of the Policy. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-II of the Policy respectively

3.2 GOOD HEALTH INCENTIVES

3.2.1 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 and admitted 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 aggregated over the years and available, subject to maximum of 50% (fifty percent) of the sum insured (excluding CB) of the expiring policy.

Note:

- a) No Cumulative Bonus will be added if the Policy is not renewed with the Company by the end of the Grace Period.
- b) The Cumulative Bonus will not be accumulated in excess of 50% of the Basic Sum Insured under the current Policy with the Company under any circumstances.
- c) Any Cumulative Bonus that has accrued for a Policy Period will be credited at the end of that Period if the policy is renewed with the Company within Grace Period and will be available for any claims made in the subsequent Period.
- d) **Merging of Policies or Migration from Individual to Floater Policy:** If the Insured Persons in the expiring Policy are covered under Individual policy/policies and such expiring Policy has been Renewed with the Company on a Family Floater basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest percentage of Cumulative Bonus applicable on the lowest Sum Insured of the last Policy Period amongst all the expiring individual policies being merged.
- e) **Revision in Sum Insured:** If the Basic Sum Insured under the Policy has been increased/decreased at the time of Renewal, the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Period.

3.2.2 Health Check Up

Expenses of health check up shall be reimbursed (irrespective of past claims) at the end of a block of two continuous policy period, provided the policy has been continuously renewed with the company without a break. Expenses payable is subject to the limit as stated in the Table of Benefits.

4 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:

4.1. Pre-Existing Diseases (Excl 01)

- a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of thirty six (36) months of continuous coverage after the date of inception of the first policy with us.
- b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
- d) Coverage under the policy after the expiry of thirty six (36) months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

4.2. Specified Disease/Procedure Waiting Period (Excl 02)

- a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 90 days/ one year/ two year/ three years (as specified against specific disease/ procedure) of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident
- b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c) If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing Diseases, then the longer of the two waiting periods shall apply.
- d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
- f) List of specific diseases/procedures
 - i. **90 Days Waiting Period (Life style conditions)**
 - a. Hypertension and related complications
 - b. Diabetes and related complications
 - c. Cardiac conditions
 - ii. **One year waiting period**
 - a. Benign ENT disorders
 - b. Tonsillectomy
 - c. Adenoidectomy
 - d. Mastoidectomy
 - e. Tympanoplast
 - iii. **Two years waiting period**
 - a. Cataract
 - b. Benign prostatic hypertrophy
 - c. Hernia
 - d. Hydrocele
 - e. Congenital internal anomaly (not applicable for New Born Baby)
 - f. Fissure/Fistula in anus
 - g. Piles (Haemorrhoids)
 - h. Sinusitis and related disorders
 - i. Polycystic ovarian disease
 - j. Non-infective arthritis
 - k. Pilonidal sinus
 - l. Gout and Rheumatism
 - m. Calculus diseases
 - n. Surgery of gall bladder and bile duct excluding malignancy
 - o. Surgery of genito-urinary system excluding malignancy
 - p. Surgery for prolapsed intervertebral disc unless arising from accident
 - q. Surgery of varicose vein
 - r. Hysterectomy
 - s. Refractive error of the eye more than 7.5 dioptries

Above diseases/treatments under 4.2.f).i, ii, iii shall be covered after the specified Waiting Period, provided they are not Pre Existing Diseases.

iv. Three years waiting period

Following diseases shall be covered after **three** years of continuous cover from the inception of the Policy.

- a. Treatment for joint replacement unless arising from accident
- b. Osteoarthritis and osteoporosis
- c. Morbid Obesity and its complications
- d. Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

4.3. First 30 days Waiting Period (Excl 03)

- a) Expenses related to the treatment of any illness within thirty (30) days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
- b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve (12) months.
- c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4.4. Investigation & Evaluation (Excl 04)

- a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
- b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

4.5. Rest Cure, Rehabilitation and Respite Care (Excl 05)

Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

- i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
- ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

4.6. Obesity/ Weight Control (Excl 06)

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

- 1) Surgery to be conducted is upon the advice of the Doctor
- 2) The surgery/Procedure conducted should be supported by clinical protocols
- 3) The member has to be 18 years of age or older and
- 4) Body Mass Index (BMI);
 - a. greater than or equal to 40 or
 - b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - i. Obesity-related cardiomyopathy
 - ii. Coronary heart disease
 - iii. Severe Sleep Apnea
 - iv. Uncontrolled Type2 Diabetes

4.7. Change-of-Gender Treatments (Excl 07)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

4.8. Cosmetic or Plastic Surgery (Excl 08)

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

4.9. Hazardous or Adventure Sports (Excl 09)

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

4.10. Breach of Law (Excl 10)

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

4.11. Excluded Providers (Excl11)

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Company and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

4.12. Drug/Alcohol Abuse (Excl 12)

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof (Excl 12)

4.13. Non Medical Admissions (Excl 13)

Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons (Excl 13)

4.14. Vitamins, Tonics (Excl 14)

Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioners part of hospitalization claim or day care procedure

4.15. Refractive Error (Excl 15)

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.

4.16. Unproven Treatments (Excl16)

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

4.17. Birth control, Sterility and Infertility (Excl 17)

Expenses related to sterility and infertility. This includes:

- i. Any type of sterilization
- ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- iii. Gestational Surrogacy
- iv. Reversal of sterilization

4.18. Hormone Replacement Therapy

Expenses for hormone replacement therapy, unless part of Medically Necessary Treatment, except for Puberty and Menopause related Disorders

4.19. General Debility, Congenital External Anomaly

General debility, Congenital external anomaly.

4.20. Self Inflicted Injury

Treatment for intentional self-inflicted injury, attempted suicide.

4.21. Stem Cell Surgery

Stem Cell Surgery (except Hematopoietic stem cells for bone marrow transplant for haematological conditions).

4.22. Circumcision

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

4.23. Vaccination or Inoculation.

Vaccination or inoculation unless forming part of treatment and requires Hospitalisation, except as and to the extent provided for under Maternity Section and Vaccination for Children Section.

4.24. Massages, Steam Bath, Alternative Treatment (Other than AYUSH)

Massages, steam bath, expenses for alternative treatments (other than AYUSH), acupuncture, acupressure, magneto-therapy and similar treatment.

4.25. Dental treatment

Dental treatment, unless necessitated due to an Injury.

4.26. Domiciliary Hospitalization & Out Patient Department (OPD) treatment

Any expenses incurred on Domiciliary Hospitalization and OPD treatment.

4.27. Stay in Hospital which is not Medically Necessary.

Stay in hospital which is not medically necessary.

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

Spectacles, contact lens, hearing aid, cochlear implants.

4.29. Non Prescription Drug

Drugs not supported by a prescription, private nursing charges, referral fee to family physician, outstation doctor/surgeon/consultants' fees and similar expenses.

4.30. Treatment not Related to Disease for which Claim is Made

Treatment which the insured person was on before Hospitalisation for the Illness/Injury, different from the one for which claim for Hospitalisation has been made.

4.31. Equipments

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

4.32. Items of personal comfort

Items of personal comfort and convenience including telephone, television, aya, barber, beauty services, baby food, cosmetics, napkins, toiletries, guest services.

4.33. Service charge/ registration fees

Any kind of service charges including surcharges, admission fees, registration charges and similar charges levied by the hospital.

4.34. Home visit charges

Home visit charges during Pre and Post Hospitalisation of doctor, attendant and nurse, except as and to the extent provided for under Doctor's Home Visit and Nursing Care during Post Hospitalisation Section.

4.35. War

War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

4.36. Radioactivity

Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

- Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
- Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
- Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

4.37. Treatment taken outside the geographical limits of India

5 CONDITIONS

5.1 Disclosure of information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, misdescription or non-disclosure of any material fact by the policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

5.2 Condition precedent to admission of liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

5.3 Communication

- All communication should be in writing.
- 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.
- The company or TPA shall communicate to the insured person at the address mentioned in the schedule.

5.4 Physical examination

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

5.5 Claim Procedure

5.5.1 Notification of claim

In the event of a hospitalisation claim, the insured person/insured person's representative shall notify the TPA (if claim is processed by TPA)/company (if claim is processed by the company) in writing by letter, e-mail, fax providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit.

Notification of claim in case of Cashless facility	TPA must be informed:
In the event of planned hospitalisation	At least 72 (seventy two) hours prior to the insured person's admission
In the event of emergency hospitalisation	Within 24 (twenty four) hours of the insured person's admission

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

5.5.2 Procedure for Cashless claims

- Cashless Facility for treatment can be availed, if TPA service is opted.
- Treatment may be taken in a network provider / PPN or Non Network Provider and is subject to pre-authorisation by the TPA. Updated list of network provider/PPN is available on the website of the Company and the TPA mentioned in the schedule.
- Cashless request form available with the Network Provider and TPA shall be completed and sent to the TPA for authorization.
- The TPA upon getting cashless request form and related medical information from the Insured Person/ Network Provider shall issue a pre-authorization letter **within an hour** 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 shall grant the final authorization **within three hours of the receipt** of discharge authorization request from the Hospital.
- vii. 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.
- viii. 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 to the Company or the TPA for reimbursement of claim.

5.5.3 Procedure for reimbursement of claims

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

5.5.4 Documents

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

- i. Completed claim form
- ii. Bills, payment receipts, medical history of the patient recorded, discharge certificate/ summary from the hospital etc.
- iii. Cash-memo from the hospital (s)/chemist (s) supported by proper prescription
- iv. Payment receipt, investigation test reports etc. supported by the prescription from attending medical practitioner
- v. Attending medical practitioner's certificate regarding diagnosis along with date of diagnosis and bill receipts etc.
- vi. Surgeon's original certificate stating diagnosis and nature of operation performed along with bills/receipts etc.
- vii. In the event of claim under Section 2.1.11, confirmation of the need of family member from attending medical practitioner
- viii. Any other document required by company/TPA

Note

In the event of a claim lodged as per condition 5.8 and the original documents having been submitted to the other insurer, the company may accept the documents listed under condition 5.5.4 and claim settlement advice duly certified by the other insurer subject to satisfaction of the company.

Type of claim	Time limit for submission of documents to company/TPA
Reimbursement of 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 Section 3.2)	At least 45 (forty five) days before the expiry of the third policy period.
Vaccination for children	Within 15 (fifteen) days from date of vaccination

5.5.5 Claim Settlement

- i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.
- ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- iii. 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 any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

5.5.6 Services offered by TPA

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

The services offered by a TPA shall not include

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

5.5.7 Optional Co-payment

The Insured may opt for Optional Co-payment, with discount in premium. In such cases, each admissible claim under the Policy shall be subject to the same Co-payment percentage. Any change in Optional Co-payment may be done only during Renewal. Insured may choose either of the two Co-payment options:

- 20% Co-payment on each admissible claim under the Policy, with a 25% discount in total premium.

- 10% Co-payment on each admissible claim under the Policy, with a 12.5% discount in total premium.

Waiver

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

5.6 Moratorium Period

After completion of sixty continuous months of coverage (including Portability and Migration), no claim shall be contestable by the Company on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as Moratorium Period. The moratorium would be applicable for the Basic Sums Insured of the first policy. Wherever, the Basic Sum Insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of Basic Sums Insured only on the enhanced limits.

5.7 Payment of claim

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

5.8 Territorial limit

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

5.9 Multiple Policies

- In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person 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 insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
- Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
- If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.
- Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.
- On occurrence of an insured event under specified critical illnesses, the policyholders can claim from all Insurers under all policies.

5.10 Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

- the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
- the active concealment of a fact by the insured person having knowledge or belief of the fact;
- any other act fitted to deceive; and
- any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

5.11 Cancellation

- The Company may cancel the policy at any time, on grounds of misrepresentation, non-disclosure of material facts or established fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.
- The policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. The Company shall refund proportionate premium for unexpired policy period, if there is no claim(s) made during the policy period.

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed under the Policy.

5.12 Territorial jurisdiction

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

5.13 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 for arbitration as per Arbitration and Conciliation Act 1996, as amended from time to time.
- ii. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the Policy.
- iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the Policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

5.14 Disclaimer

If the company shall disclaim liability to the insured person for any claim hereunder and if the insured person shall not within 12 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.

5.15 Renewal of policy

- i. The policy shall be renewable provided the product is not withdrawn, except in case of established fraud or non-disclosure or misrepresentation by the Insured. If the product is withdrawn, the policyholder shall be provided with suitable options to migrate to other similar health insurance products/plans offered by the Company.
- ii. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- iii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- iv. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- v. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage shall not be available during the grace period.
- vi. No loading shall apply on renewals based on individual claims experience.
- vii. In case of non-continuance of the Policy by the Insured (due to death or any other valid and acceptable reason):
 - The Policy may be renewed by any Insured Person above eighteen (18) years of age, as the Insured.
 - Where only children (less than eighteen years of age) are covered, the Policy shall be allowed till the expiry of the Policy period. The legal guardian may be allowed to renew the Policy as Proposer, covering the children.

5.16 Enhancement of sum insured

Sum insured may be enhanced only at the time of renewal subject to the availability of the higher slabs in the Policy and at the discretion of the Company. For the incremental portion of the sum insured, the waiting periods and conditions as mentioned in exclusion 4.1, 4.2, 4.3 shall apply. Coverage on enhanced sum insured shall be available after the completion of waiting periods. Change of plan is allowed only at the time of renewal, subject to 4 (four) years of continuous coverage with the company and any insured person is not suffering from any chronic disease.

5.17 Adjustment of premium for Overseas Travel Insurance Policy

If during the policy period the insured person is also covered under an Overseas Travel Insurance Policy of any non life insurance company, the policy shall be inoperative in respect of the insured persons for the number of days the Overseas Travel Insurance Policy is in force and proportionate premium for the number of days the Overseas Travel Insurance Policy was in force shall be adjusted in the renewal premium. The insured person must inform the company in writing before leaving India and may submit an application, stating the details of visit(s) abroad, along with copies of the Overseas Travel Insurance Policy, within 7 (seven) days of return from abroad or expiry of the policy, whichever is earlier.

5.18 Migration

The Insured Person will have the option to migrate the Policy to an alternative health insurance product offered by the Company by applying for Migration of the policy at least 30 days before the policy renewal date as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under this Policy offered by the Company,

- i. The Insured Person will get all the accrued continuity benefits for credits gained to the extent of the specific waiting periods, waiting period for pre-existing diseases and Moratorium period of the Insured Person.
- ii. Migration benefit will be offered to the extent of Sum Insured and accrued Cumulative Bonus (as part of the sum insured) of the previous policy. Migration benefit shall not apply to any other additional increased Sum Insured.

The Proposal may be subject to fresh Underwriting as per terms of conditions of the migrated product, if the insured is not continuously covered for at least 36 months under the previous product.

5.19 Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at least **15** days before, but not earlier than **60 days** from the policy renewal date, as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under this Policy offered by the Company,

- i. The proposed Insured Person will get all the accrued continuity benefits for specific waiting periods, waiting period for pre-existing diseases and Moratorium period of the Insured Person under the previous health insurance Policy.
- ii. Portability benefit will be offered to the extent of Sum Insured and accrued Cumulative Bonus (as part of the sum insured) of the previous policy. Portability benefit shall not apply to any other additional increased Sum Insured.

5.20 Withdrawal of product

- i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
- ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

5.21 Revision of terms of the policy including the premium rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified before the changes are effected.

5.22 Free look period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of **thirty** days from date of receipt of the policy document to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy. This option is available in case of policies with a term of one year or more.

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 person, a deduction towards the proportionate risk premium for period of cover or
- iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

5.23 Nomination

The policyholder is 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 of the policyholder. 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 the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

6 Redressal of Grievance

In case of any grievance related to the Policy, the insured person may submit in writing to the Policy Issuing Office or Grievance cell at Regional Office of the Company for redressal. If the grievance remains unaddressed, the insured person may contact: Customer Relationship Management Dept., National Insurance Company Limited, Premises No. 18-0374, Plot no. CBD-81, New Town, Kolkata - 700156, email: customer.relations@nic.co.in, griho@nic.co.in

For more information on grievance mechanism, and to download grievance form, visit our website <https://nationalinsurance.nic.co.in>

Bima Bharosa (an Integrated Grievance Management System earlier known as IGMS) - <https://bimabharosa.irdai.gov.in/>

Insurance Ombudsman – The Insured person can also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as listed in Annexure -III. The updated list of Office of Insurance Ombudsman are available on IRDAI website: <https://irdai.gov.in/> and on the website of Council for Insurance Ombudsman: <https://www.cioins.co.in/>

Helpline Number: 1800 345 0330

Dedicated Email ID for Senior Citizens: health.srcitizens@nic.co.in

7 OPTIONAL COVERS

At the option of the Insured and on payment of additional premium the following covers shall be available to the Insured Persons during the Policy Period, provided the same is mentioned in the Policy Schedule.

7.1 Critical illness

Subject otherwise to the terms, definitions, exclusions, and conditions of the policy and subject to the terms, definitions, exclusions, and conditions contained herein, it is hereby understood and agreed that 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 **as a first incidence**, and
- ii. the insured person survives at least 30 (thirty) days following such diagnosis
- iii. diagnosis of critical illness is supported by clinical, radiological, histological and laboratory evidence acceptable to the company.

7.1.1 Definition

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

I Stroke resulting in permanent symptoms

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

II Cancer of specified severity

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

The following are not covered

- i. tumours showing the malignant changes of carcinoma in situ and tumours which are histologically described as premalignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
- ii. any skin cancer other than invasive malignant melanoma
- iii. all tumours of the prostate unless histologically classified as having a Gleason score greater than 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 lymphocytic leukaemia less than RAI stage 3
- vi. microcarcinoma of the bladder
- vii. all tumours in the presence of HIV infection.

III Kidney failure requiring regular dialysis

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

IV Major organ/ Bone marrow transplant

The actual undergoing of a transplant of:

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

The following are not covered

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

V Multiple sclerosis with persisting symptoms

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

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

The following are not covered:

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

VI Open chest CABG

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

The following are not covered

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

VII Permanent paralysis of limbs

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 (three) months.

VIII Blindness

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

7.1.2 Exclusions

The company shall not be liable to make any payment under the policy if:

- i. any critical illness and/or its symptoms (and/or the treatment) which were present at any time before inception of the policy, or which manifest within a period of 90 (ninety) days from inception of the policy, whether or not the insured person had knowledge that the symptoms or treatment were related to such critical illness. In the event of break in the policy, the terms of this exclusion shall apply as new from recommencement of cover
- ii. the insured person smokes 40 (forty) or more cigarettes / cigars or equivalent tobacco intake in a day

7.1.3 Condition

Claim amount

- i. Any amount payable under the optional covers will not affect the sum insured applicable to Section 3.1.
- ii. Co-payment shall not apply to claims under optional covers.
- iii. Any amount payable under the optional covers shall not affect the entitlement to cumulative bonus.

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 15 (fifteen) days of critical illness diagnosis

Procedure for claims under critical illness

Claim documents supporting the diagnosis shall be submitted to the company after 30 (thirty) days and within 60 (sixty) days from the date of diagnosis of the disease.

Documents

The claim is to be supported with the following original documents

- i. Doctor's certificate confirming diagnosis of the critical illness along with date of diagnosis.
- ii. Pathological/other diagnostic test reports confirming the diagnosis of the critical illness.
- iii. Any other documents required by the company

Cessation of cover

1 This cover shall cease upon payment of the benefit amount on the occurrence of a critical illness and no further claim shall be paid for any other critical illness during the policy period.

2 On renewal, no claim shall be paid for any critical illness for which claim has already been made

Cancellation

In the event of cancellation of the policy, the cover shall also be cancelled as per Cancellation clause of the policy.

7.2 Out-patient treatment

Subject otherwise to the terms, definitions, conditions and Exclusions 4.7, 4.8, 4.18, 4.16, 4.24, 4.12, 4.9, 4.10, 4.35 and 4.36, and subject to the terms, definitions, exclusions, and conditions contained herein, it is hereby understood and agreed that the company shall pay up to the limit, as stated in the schedule with respect of

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

7.2.1 Exclusions

The company shall not make any payment under the cover in respect of:

- i. Treatment other than Allopathy/ Modern medicine, AYUSH
- ii. Cosmetic dental treatment to straighten lightens, reshape and repair teeth. Cosmetic treatments include veneers, crowns, bridges, tooth-coloured fillings, implants and tooth whitening.

7.2.2 Condition

Claim amount

- i. Any amount payable under the optional covers will not affect the sum insured applicable to Section 3.1.
- ii. Co-payment shall not apply to claims under optional covers.
- iii. Any amount payable under the optional covers shall not affect the entitlement to cumulative bonus.

Procedure for claims under outpatient treatment

Claim documents supporting all such outpatient treatments shall be submitted to the TPA/ company twice during the policy period, within 30 (thirty) days of completion of 6 month period.

Documents

The claim is to be supported with the following original documents

- i. All bills, prescriptions from medical practitioner
- ii. Diagnostic test bills, copy of reports
- iii. Any other documents required by the company

Cancellation

In the event of cancellation of the policy, the cover shall also be cancelled as per Cancellation clause of the policy.

Insurance is the subject matter of solicitation

Please preserve the policy for all future reference.

Table of Benefits

Features	PLAN A	PLAN B	PLAN C
Sum insured	INR 2/ 3 /4 / 5/ 6/ 7/ 8/ 9/10 Lac	INR 15/ 20 /25 Lac	INR 30/ 40/ 50 Lac
Coverage			
Hospitalisation, Pre (30 days) and Post (60 days) Hospitalisation, Day Care Treatment	Covered	Covered	Covered
Pre Existing Disease	Covered after 36 months of continuous coverage	Covered after 36 months of continuous coverage	Covered after 36 months of continuous coverage
Room/ ICU charges	Room - Up to 1% of SI per day ICU – Up to 2% of SI per day subject to max. of INR 15,000 per day	Up to INR 15,000 per day	Up to INR 20,000 per day
Limit for Cataract Surgery	For each eye – Up to 15% of sum insured or INR 60,000 whichever is lower	For each eye – Up to INR 80,000	For each eye – Up to INR 1,00,000
AYUSH	Up to Sum Insured	Up to Sum Insured	Up to Sum Insured
Organ Donor's Medical Expenses	Covered	Covered	Covered
Maternity (Covered after waiting period of 2 years)	Up to INR 30,000 for normal delivery and INR 50,000 for caesarean section	Up to INR 60,000 for normal delivery and INR 75,000 for caesarean section	Up to INR 80,000 for normal delivery and INR 100,000 for caesarean section
Hospital Cash	INR 500 per day, max. of 5 days	INR 800 per day, max. of 5 days	INR 1,000 per day, max. of 5 days
Ambulance	Up to INR 2,500 in a policy period	Up to INR 4,000 in a policy period	Up to INR 5,000 in a policy period
Air Ambulance	Not covered	Up to 5% of SI per policy period	Up to 5% of SI per policy period
Medical Emergency Reunion	Not covered	Up to INR 20,000 per policy period	Up to INR 20,000 per policy period
Doctor's Home Visit and Nursing Care during Post Hospitalisation	Not covered	INR 750 per day, max. of 10 days	INR 1,000 per day, max. of 10 days
Vaccination for Children (up to 12 years)	Up to INR 1,000 in a policy period	Up to INR 1,000 in a policy period	Up to INR 1,000 in a policy period
Modern Treatment (12 nos)	Up to 25% of SI for the related modern procedure/ component/ medicine	Up to 25% of SI for the related modern procedure/ component/ medicine	Up to 25% of SI for the related modern procedure/ component/ medicine
Treatment due to Participation in Hazardous or Adventure Sports (Non-Professionals)	Up to 25% of SI	Up to 25% of SI	Up to 25% of SI
Morbid Obesity	Covered after waiting period of 3 years	Covered after waiting period of 3 years	Covered after waiting period of 3 years
Refractive Error (min 7.5D)	Covered after waiting period of 2 years	Covered after waiting period of 2 years	Covered after waiting period of 2 years
Other benefits			
Enhancement of Basic SI	On Renewal Change in Plan allowed after 4 yrs of coverage	On Renewal Change in Plan allowed after 4 yrs of coverage	On Renewal Change in Plan allowed after 4 yrs of coverage
Good Health Incentives			
Cumulative Bonus	Increase in SI by 5% of SI (excluding CB) per year up to 50% of SI (excluding CB)	Increase in SI by 5% of SI (excluding CB) per year up to 50% of SI (excluding CB)	Increase in SI by 5% of SI (excluding CB) per year up to 50% of SI (excluding CB)
Health Checkup	Every 2 yrs., up to INR 1,000	Every 2 yrs., up to INR 2,000	Every 2 yrs., up to INR 3,000
Optional covers			
Critical Illness	Benefit amount per individual - INR 2,00,000/ 3,00,000/ 5,00,000/ 10,00,000/ 15,00,000/ 20,00,000/ 25,00,000.		
Outpatient Treatment	Limit of cover per individual - INR 2,000/ 3,000/ 4,000/ 5,000/ 10,000.		
Optional Co-payment	If opted, policyholder may choose either of the two co-payment options: 20% Co-payment on each admissible claim, with a 25% discount in premium 10% Co-payment on each admissible claim, with a 12.5% discount in premium		
Add-on Covers			
Home Care	INR 10,000/ 15,000/ 20,000/ 25,000/ 30,000/ 35,000/ 40,000/ 45,000/ 50,000, subject to 10% of Basic SI under base Policy		
Non Medical Expenses (available to SI 5 lacs & above)	Up to 10% of Basic Sum Insured (excluding Cumulative Bonus, if any) of base Policy and shall be part of the base Policy Basic Sum Insured (excluding Cumulative Bonus, if any).		

Annexure I

Vaccinations for Children

Time interval	Type of vaccination	Frequency
Vaccination for new born		
0-3 months	BCG (From birth to 2 weeks)	1
	OPV (0,6,10 weeks) OR OPV + IPV1 (6,10 weeks)	3 OR 4
	DPT (6 & 10 week)	2
	Hepatitis-B (0 & 6 week)	2
	Hib (6 & 10 week)	2
Vaccination for first year		
3-6 months	OPV (14 week) OR OPV + IPV2	1 OR 2
	DPT (14 week)	1
	Hepatitis-B (14 week)	1
	Hib (14 week)	1
9 months	Measles (+9 months)	1
12 months	Chicken Pox (12 months)	1
Vaccinations for age 1 to 12 years		
1-2 years	OPV (15 & 18 months) OR OPV + IPV3	1 OR 2
	DPT (15-18 months)	1
	Hib (15-18 months)	1
	MMR (15- 18 months)	1
	Meningococcal vaccine (24 months)	1
2-3 years	Typhoid (+2 years)	1
10-12 years	TT	1

List I – List of which coverage is not available in the policy	
Sl	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLEY COVER
66	UROMETER, URINE JUG
67	VASOFIX SAFETY
List II – Items that are to be subsumed into Room Charges	
Sl	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH

14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES
List III – Items that are to be subsumed into Procedure Charges	
Sl	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE
List IV – Items that are to be subsumed into costs of treatment	
Sl	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE/SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION\STERILLIUM
17	Glucometer & Strips
18	URINE BAG

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

Areas of Jurisdiction	Office of the Insurance Ombudsman		
Gujarat, Dadra & Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6 th Floor, Tilak Marg, Relief Road, Ahmedabad-380001 Tel: 079 -25501201/ 02/ 05/ 06 Email: bimalokpal.ahmedabad@cioins.co.in		Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in
Karnataka	Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in
Madhya Pradesh, Chhattisgarh	Office of the Insurance Ombudsman, 1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareilly, 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 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 / 2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane)	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in
Punjab, Haryana (excluding Gurugram, Faridabad, Sonapat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & 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 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshahr, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddha nagar, 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 Buddha Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in
Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Bihar, Jharkhand	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in
Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Maharashtra, Areas 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.: 020-24471175 Email: bimalokpal.pune@cioins.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in		
Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry	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 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in		
Rajasthan	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363/2740798 Email: Bimalokpal.jaipur@cioins.co.in		
Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry	Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College, M.G. Road, Kochi - 682 011.		