National Insurance Company Limited

CIN - U10200WB1906GOI001713 IRDAI Regn. No. - 58

National Super Top Up Mediclaim Policy

Issuing Office:

PREAMBLE

Whereas the insured designated in the schedule hereto has by a proposal together with declaration and reports (if any), 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 on individual or floater basis in respect of person(s)/ family members named in the schedule hereto (hereinafter called the Insured Persons) and has paid the premium as consideration for such insurance.

1. OPERATIVE CLAUSE

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 Injury requiring Hospitalisation of such Insured Person(s), for In-Patient Care at any Hospital or Day Care Centre, following the Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify the Hospital, Day Care Centre or Insured the Reasonable and Customary Charges incurred for Medically Necessary Treatment exceeding the Threshold (cumulatively) in such Hospitalisation and any subsequent Hospitalisation(s) towards the Coverage mentioned in Section 3.1 and Section 3.2 of the Policy.

Provided further that, the amount payable during each Policy Year of the Policy Period as stated in the schedule shall be subject to the terms, exclusions, conditions, definitions contained herein and limits as shown in the Table of Benefits, and shall not exceed:

(a) the Sum Insured of that Insured Person covered in an individual plan or
(b) the floater Sum Insured in respect of one or more Insured Persons covered under a floater plan.

Important:

1. Claim shall be admissible for the Hospitalisation during which the Cumulative Medical Expenses in respect of Hospitalisation(s) of any Insured Person (individual plan) or one or more Insured Persons (floater plan) in a Policy Year of the Policy Period exceeds the Threshold and for all subsequent Hospitalisation(s) during the Policy Year.
2. Maximum liability of the Company under the policy for all admissible claims during each Policy Year of the Policy Period shall be the individual / floater Sum Insured opted.
3. **The Insured shall preserve and submit all original documents and / or certified copies of documents related to all Hospitalisation(s) during the Policy Period to enable the Company to calculate the Cumulative Medical Expenses and Threshold, for determining admissibility and payment of claims.**

2. DEFINITIONS

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

2.2 Age / Aged means completed years on last birthday as on Commencement Date.

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

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

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 means any health care institution 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 recognised 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 recognised 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 criteria:

i. Having at least 5 in-patient beds;
ii. Having a qualified AYUSH Medical Practitioner in charge round the clock;
iii. Having dedicated AYUSH therapy sections as required; and
iv. Maintaining daily records of the patients and making them accessible to the Company's authorised representative.

2.7 AYUSH Treatment refers to the medical and / or Hospitalisation treatment given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

2.8 Body Mass Index (BMI) is defined as the body mass (weight) divided by the square of the height of an individual, and is universally expressed in units of kg/m^2, resulting from mass in kilograms and height in metres.

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

2.10 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.

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

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

a) Internal Congenital Anomaly
Congenital anomaly which is not in the visible and accessible parts of the body.

b) External Congenital Anomaly
Congenital anomaly which is in the visible and accessible parts of the body.

2.13 Contract means prospectus, proposal, Policy, and the policy schedule. Any alteration with the mutual consent of the Insured Person and the Company can be made only by a duly signed and sealed endorsement on the Policy.

2.14 Cumulative Bonus means any increase or addition in the Sum Insured granted by the Company without an associated increase in premium.

2.15 Cumulative Medical Expenses means the aggregate of Medical Expenses incurred during the Policy Year of the Policy Period of this Policy towards one or more out of the Coverage mentioned in Section 3.1 of the Policy (i.e. under the heads of 3.1.1. In-patient Treatment, 3.1.2. Pre-Hospitalisation, 3.1.3. Post-Hospitalisation, 3.1.4. Day Care Procedure, 3.1.5. AYUSH Treatment, 3.1.6. Organ Donor's Medical Expenses, 3.1.7. HIV Treatment, 3.1.8. Morbid Obesity Treatment, 3.1.9. Maternity, 3.1.10 Modern Treatment, 3.1.11 Mental Illness Cover & 3.1.12 Correction of Refractive Error) in respect of:

a) Individual Plan
The Insured Person for one or more Hospitalisation during the Policy Year of the Policy Period.

b) Floater Plan
One or more Insured Persons for one or more Hospitalisation during the Policy Year of the Policy Period.

2.16 Day Care Centre means any institution established for day care treatment of disease/ injuries or a medical setup within a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

i. has Qualified Nurses under its employment;
ii. has Medical Practitioner(s) in charge;
iii. has a fully equipped operation theatre of its own where surgical procedures are carried out; and
iv. maintains daily records of patients and shall make these accessible to the Company's authorised personnel.

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

i. undertaken under general or local anesthesia in a Hospital/ Day Care Centre in less than twenty four hours because of technological advancement, and
ii. which would have otherwise required a Hospitalisation of more than twenty four hours.

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

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

2.19 Diagnosis means diagnosis by a Medical Practitioner, supported by clinical, radiological, histological and laboratory evidence, acceptable to the Company.

2.20 Family Members means spouse, children and parents/ in-laws of the Insured, covered under the Policy.

2.21 Floater means the Threshold/ Sum Insured, as mentioned in the Schedule, applicable to all the Insured Persons, for any and all claims made in aggregate during the Policy Period.

2.22 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.
In case of Renewal, Coverage shall not be available during the period for which no premium is received.

2.23 Hospital means any institution including a nursing home established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:

i. has Qualified Nurses under its employment round the clock;
ii. has at least ten inpatient beds, in those towns having a population of less than ten lakh and fifteen inpatient beds in all other places;
iii. has Medical Practitioner(s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out; and
v. maintains daily records of patients and shall make these accessible to the Company's authorised personnel.

2.24 Hospitalisation means admission in a Hospital for a minimum period of twenty four (24) consecutive 'Inpatient care' hours except for procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.

2.25 ID Card means the card issued to the Insured Person by the TPA for availing cashless facility.

2.26 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 an Illness or Injury that is likely to response quickly to treatment which aims to return the person to his or her state of health immediately before suffering the Illness/ Injury which leads to full recovery.
ii. **Chronic Condition** means an Illness, or Injury that has one or more of the following characteristics:
   a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests,
   b) it needs ongoing or long-term control or relief of symptoms,
   c) it requires rehabilitation for the patient or for the patient to be specially trained to cope with it,
   d) it continues indefinitely, or
   e) it recurs or is likely recur.

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

2.28 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.

2.29 Insured/ Insured Person means person(s) named in the Schedule of the Policy.

2.30 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.

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

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

2.33 Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.

2.34 Medically Necessary means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

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

2.35 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 practise medicine within its jurisdiction; and is acting within the scope and jurisdiction of the licence.

2.36 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.

2.37 Morbid Obesity is a medical term describing people who have a Body Mass Index (BMI) of at least 40 and with significant medical problems caused by or made worse by their mass (weight).

2.38 Network Provider means Hospitals or Day Care Centers enlisted by the Company, TPA or jointly by the Company and TPA to provide medical services to an Insured by a Cashless Facility.

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

2.40 Notification of Claim means the process of intimating a claim to the Insurer or TPA through any of the recognised modes of communication.

2.41 Out-Patient Treatment means treatment in which the Insured visits a clinic / Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

2.42 Policy Period means period of one year, two years or three years as mentioned in the Schedule for which the Policy is issued.

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

2.44 Pre-Existing Disease means any condition, ailment, Injury or disease:

a) That is/are diagnosed by a physician within 36 months prior to the effective date of the Policy issued by the Company or its reinstatement or
b) For which Medical Advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the Policy issued by the Company or its reinstatement.

2.45 Pre-hospitalisation Medical Expenses means Medical Expenses incurred during predefined number of days preceding the Hospitalisation of the Insured Person, 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.

2.46 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.

2.47 Post-hospitalisation Medical Expenses means Medical Expenses incurred during predefined number of days immediately after the Insured Person is discharged from the Hospital provided that:

i. Such Medical Expenses are 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.

2.48 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.

2.49 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.

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

2.51 Room Rent means the amount charged by a Hospital towards room and boarding expenses and shall include the associated charges.

2.52 Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for Pre-existing diseases, time-bound exclusions and for all waiting periods.

2.53 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.

2.54 Sum Insured means the Basic Sum Insured and the Cumulative Bonus (CB) accrued in respect of the Insured Person (for policies issued on individual basis)/ one or more Insured Persons (for policies issued on floater basis) as mentioned in the schedule. The Sum Insured represents maximum liability of the Company for any and all claims during each Policy Year of the Policy Period.

2.55 Surgery or Surgical Procedure means manual and / or operative procedure(s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

2.56 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.

2.57 Threshold means the amount of Cumulative Medical Expenses (as per Definition 2.15 of the Policy), as chosen by the Insured and mentioned in the Schedule, up to which no amount can be claimed under this Policy.

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

2.59 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

Threshold shall be determined taking into account the Cumulative Medical Expenses incurred in one or more Hospitalisation(s) during each Policy Year of the Policy Period as stated in the Policy Schedule for Coverage mentioned in Section 3.1 only, irrespective of existence of any Base Policy covering the said Hospitalisation(s).
For claims admissible under the Policy after Cumulative Medical Expenses exceeds the Threshold, Coverage mentioned in both Section 3.1 and Section 3.2 shall be payable.

3.1 Coverage

3.1.1 In-patient Treatment

The Company shall indemnify the Medical Expenses incurred for all Hospitalisation(s):

i. Room Rent and Intensive Care Unit Charges (including diet charges, nursing care by qualified nurse, RMO charges, administration charges for IV fluids/ blood transfusion/ injection)
ii. Medical Practitioner(s) fees
iii. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances
iv. Medicines and drugs
v. Diagnostic procedures
vi. Prosthetics and other devices or equipment if implanted internally during a surgical procedure.
vii. Dental treatment, necessitated due to an Injury
viii. Plastic surgery, necessitated due to Illness or Injury
ix. Hormone replacement therapy, if Medically Necessary
x. Vitamins and tonics, forming part of treatment for Illness/ Injury as certified by the attending Medical Practitioner
xi. Circumcision, necessitated for treatment of an Illness or Injury

3.1.1.1 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 thirty days immediately before the Insured Person is hospitalised, provided that:

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

Pre-hospitalisation shall be considered as part of the Hospitalisation claim.

3.1.3 Post-Hospitalisation

The Company shall indemnify the Medical Expenses incurred up to sixty days immediately after the Insured Person is discharged from Hospital, provided that:

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

Post-hospitalisation shall be considered as part of the Hospitalisation claim.

3.1.4 Day Care Procedure

The Company shall indemnify the Medical Expenses and pre-hospitalisation and post-hospitalisation expenses, for day care procedures which require Hospitalisation for less than twenty four hours, provided that:

i. day care procedures / surgeries (as listed in Appendix -I) are undergone by an Insured Person in a Hospital / Day Care Centre (but not in the outpatient department of a Hospital), or
ii. any other surgeries / procedures (not listed in Appendix-I) which, due to advancement of medical science, require Hospitalisation for less than twenty four hours, and for which prior approval from the Company / TPA is mandatory.

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 Section **"In patient treatment"** 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 HIV/ AIDS Treatment

The Company shall indemnify the Medical Expenses for In-patient Care, Pre-Hospitalisation expenses and Post-Hospitalisation expenses, related to following stages of HIV infection:

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

3.1.8 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 thirty six (36) months:

1. Treatment that has been conducted is upon the advice of the Medical Practitioner, and
2. The surgery / procedure conducted must be supported by clinical protocols, and
3. The Insured Person is 18 years of age or older, and
4. 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

3.1.9 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 the 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 36 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.

Maternity Expenses means;

a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalisation);

b) Expenses towards lawful medical termination of pregnancy during the Policy Period.

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 any 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 thirty six (36) 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. **Ectopic pregnancy.**
6. **Pre and post hospitalisation expenses**, other than pre and post natal treatment.

3.1.10 Modern Treatment

The Company shall indemnify the Medical Expenses for In-Patient Treatment 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 prostrate	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

3.1.11 Mental Illness Cover

The Company shall indemnify the Medical Expenses (including pre-hospitalisation and post-hospitalisation expenses) related to mental Illnesses, provided that 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 or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post-graduate degree (Siddha) in Sirappu Maruthuvam.

Exclusions

1. Any kind of psychological counselling, cognitive/ family/ group/ behaviour/ palliative therapy or other kinds of psychotherapy for which Hospitalisation is not necessary shall not be covered.
2. Any treatment of the following mental Illnesses shall be covered after a Waiting Period of two (2) years:
   i. Depression (ICD - F32; F33).
   ii. Schizophrenia (ICD - F20; F21; F25).

3.1.12 Correction of Refractive Error

The Company shall indemnify the Medical Expenses for In-patient Treatment, including pre-hospitalisation expenses and post-hospitalisation expenses, incurred for expenses related to the treatment for correction of eyesight due to refractive error equal to or more than 7.5 dioptres, subject to Waiting Period of two (2) years as per Section 4.2.f.iii.

Note: The expenses that are not covered in this policy are placed under List-l of Appendix-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 Appendix-II of the Policy respectively.

3.2 Additional Benefits

The following benefits shall be payable only for claims admissible under the policy, after crossing of the Threshold.

3.2.1 Hospital Cash
The Company shall pay the Insured a daily Hospital cash allowance up to the limit as shown in the Table of Benefits for a maximum of five days, provided that:-
i. The Hospitalisation exceeds three days, and
ii. A claim has been admitted under Section 3.1.1.

3.2.2 Doctor's Home Visit/ Aya/ Nurse/ Attendant Charges during Post-Hospitalisation
The Company shall reimburse the Insured, for Medically Necessary expenses incurred for doctor's home visit, nursing care by qualified nurse, aya, attendant charges during post-hospitalisation up to the limit as shown in the Table of Benefits., provided that the related Hospitalisation claim has been admitted under Section 3.1.1 and the physical mobility of the Insured Person outside residence is severely restricted due to the Illness/ Injury requiring Hospitalisation.

3.2.3 Ambulance Charges
The Company shall reimburse the Insured the expenses incurred for actual emergency ambulance charges (by road only) for transportation to the Hospital, or from one Hospital to another Hospital, provided that a claim has been admitted under Section 3.1.1. Ambulance charges will be paid once for Any One Illness for each Insured Person.

3.3 Migration to Policy without Threshold
The Company shall allow the Insured Persons to migrate to any existing indemnity health insurance product of the Company (for same or lower Sum Insured without any Threshold) of the Company with continuity coverage in terms of waiver of Waiting Periods to the extent of benefits covered under this Policy, provided that the Insured Person has been covered under National Super Top Up Mediclaim Policy before attaining the age of 45 years and has continuously renewed the Policy for 5 years without interruption.

Conditions:
1. Migration to any other indemnity health insurance product shall be subject to the underwriting guidelines of the said product, including Pre-Policy Health Checkup (if applicable);
2. This option can be exercised by the Insured Person at the time of renewal only; and
3. On migration, the terms and rates of the migrated policy, i.e. later Policy shall apply.

3.4 Good Health Incentive

3.4.1 Cumulative Bonus (CB)
For each claim-free Policy Year (i.e. no claims are reported and admitted by the Company), Cumulative Bonus allowed shall be an amount equal to 5% of the Basic Sum Insured (excluding CB) of the expiring Policy Year.
If a claim is made in any particular Policy Year, the Cumulative Bonus accrued shall be reduced at the same rate at which it has accrued. However, Basic Sum Insured will be maintained and will not be reduced.
Cumulative Bonus shall be accumulated and available on renewal. Maximum Cumulative Bonus shall not exceed 50% of the Basic Sum Insured of the renewed Policy. Wherever, due to reduction in Basic Sum Insured on renewal, if the accumulated Cumulative Bonus exceeds 50% of the reduced Basic Sum Insured, then Cumulative Bonus shall be restricted to 50% of the reduced Basic Sum Insured.
In case there is no claim in a particular Policy Year, Cumulative Bonus shall be accumulated and available on renewal to the subsequent Policy Year, even in case of long term Policies for two/ three years, as opted by the Insured.

Notes:
i. In case where the Policy is on Individual Basis, the Cumulative Bonus shall be added and available individually to the Insured Person if no claim has been reported. Cumulative Bonus shall reduce only in case of claim from the same Insured Person.
ii. In case where the Policy is on floater Basis, the Cumulative Bonus shall be added and available to the family on floater basis, provided no claim has been reported from any Insured Person. Cumulative Bonus shall reduce in case of claim from any of the Insured Persons.
iii. Any Cumulative Bonus that has accrued for a Policy Year will be credited at the end of the Policy Period if the policy is renewed with the Company within Grace Period and will be available for any claims made in the subsequent Policy Period.
iv. If the Insured Persons in the expiring policy are covered on an Individual Basis as specified in the Policy Schedule and there is an accumulated Cumulative Bonus for each Insured Person under the expiring policy, and such expiring policy has been renewed on Floater Basis as specified in the Policy Schedule then the Cumulative Bonus to be carried forward for credit in such renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons.
v. In case of floater policies where Insured Persons renew their expiring policy by splitting the Sum Insured in to two or more floater Policies/ individual Policies, or in cases where the Policy is split due to the child attaining the age of 25 years, the Cumulative Bonus of the expiring Policy shall be apportioned to such renewed Policies in the proportion of the Sum Insured of each renewed Policy.
vi. If a claim is made in the expiring Policy Year, and is notified to the Company after the acceptance of Renewal premium any awarded Cumulative Bonus shall be withdrawn.
vii. **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.
viii. 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.

ix. **Splitting of policies or Migration from Floater to Individual Policy**: If the Insured Persons in the expiring Policy are covered on a Family Floater basis and such Insured Persons Renew their expiring Policy with the Company by splitting the Sum Insured in to two or more Family Floater/Individual policies then the Cumulative Bonus shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.

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 twelve (12) months of continuous coverage after the date of inception of the first Policy with the Company.
b) In case of enhancement of Sum Insured, the exclusion shall apply afresh to the extent of increase in the Sum Insured.
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 twelve (12) months for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by the Company and as per the table given below:

Months from inception	Limit of claim
13-24 months	50% of the admissible claim
25-36 months	75% of the admissible claim
After 36 months	100% of the admissible claim

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 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 increase in the Sum Insured.
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. Tympanoplasty
   f. Cataract
   g. Benign prostatic hypertrophy
   h. Hernia
   i. Hydrocele
   j. Fissure/Fistula in anus
   k. Piles (Haemorrhoids)
   l. Sinusitis and related disorders
   m. Polycystic ovarian disease
   n. Non-infective arthritis
   o. Pilonidal sinus
   p. Gout and Rheumatism
   q. Calculus diseases
   r. Surgery of gall bladder and bile duct excluding malignancy
   s. Surgery of genito-urinary system excluding malignancy
   t. Surgery for prolapsed intervertebral disc unless arising from accident
   u. Surgery of varicose vein
   v. Hysterectomy excluding malignancy

Above diseases/treatments under 4.2.f).i, ii shall be covered after the specified Waiting Period up to 100% of the admissible claim, provided they are not Pre Existing Diseases.

iii. **Two years waiting period**

Following diseases even if pre-existing shall be covered after two years of continuous cover from the inception of the Policy:
   a. Treatment for joint replacement unless arising from Accident
   b. Osteoarthritis and osteoporosis
   c. Refractive error of the eye more than 7.5 dioptres
   d. Internal congenital anomaly (not applicable for new born baby)
   e. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions

After expiry of twenty four months, any claim arising out of the above conditions or complications thereof will be paid as per the table given below:

Months from inception	Limit of claim
25-36 months	75% of the admissible claim
After 36 months	100% of the admissible claim

4.3. First 30 days waiting period (Excl 03)

a) Expenses related to the treatment of any Illness within thirty (30) days from the date of commencement of the first policy shall be excluded, except the claims arising due to an Accident, provided that the same are covered.
b) This exclusion shall not 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.

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)

a) 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 Qualified 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 Medical Practitioner,
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, or
      iv. Uncontrolled Type 2 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, gender.

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 as Medically Necessary, 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 (Excl 11)

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 stabilisation 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 Hospitalisation 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 dioptres.

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 sterilisation

5. GENERAL EXCLUSIONS
The Company shall not be liable to make any payment under the Policy in respect of any expenses incurred in connection with or in respect of:

5.1. Hormone Replacement Therapy
Expenses for hormone replacement therapy, unless part of Medically Necessary treatment, except for puberty and menopause related disorders.

5.2. General Debility, Congenital External Anomaly
General debility, congenital external anomaly.

5.3. Self-Inflicted Injury
Treatment for intentional self-inflicted injury, attempted suicide.

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

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

5.6. Vaccination or Inoculation.
Vaccination or inoculation unless forming part of treatment and requires Hospitalisation.

5.7. Massages, Steam Bath, Alternative Treatment (Other than AYUSH treatment)
Massages, steam bath, expenses for alternative treatments (other than AYUSH treatment), acupuncture, acupressure, magneto-therapy and similar treatment.

5.8. Dental treatment
Dental treatment, unless necessitated due to an Injury.

5.9. Out-Patient Department (OPD) or Domiciliary treatment
Any expenses incurred on OPD or Domiciliary treatment.

5.10. Stay in Hospital which is not Medically Necessary.
Stay in hospital which is not Medically Necessary.

5.11. Spectacles, Contact Lens, Hearing Aid, Cochlear Implants
Spectacles, contact lens, hearing aid, cochlear implants.

5.12. Non-Prescription Drugs
Drugs not supported by a prescription, private nursing charges, referral fee to family physician, outstation doctor/ surgeon/ consultants' fees and similar expenses (as listed in respective Appendix-II).

5.13. 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.

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

5.15. Items of personal comfort

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

5.16. Service charge/ registration fee

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

5.17. Home visit charges

Home visit charges during Pre and post-hospitalisation of Medical Practitioner, attendant and Qualified Nurse, except as and to the extent provided for under Section 3.2.2 (Medical Practitioner's Home Visit/ Aya/ Nurse/ Attendant charges during Post-Hospitalisation).

5.18. 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.

5.19. 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:
a) Nuclear attack or nuclear 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.
b) Chemical attack or chemical 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.
c) Biological attack or biological weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease-causing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesised toxins) which are capable of causing any Illness, incapacitating disablement or death.

5.20. Treatment taken outside the geographical limits of India

6. CONDITIONS:

General Terms and Conditions

6.1 Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of mis-representation, mis-description 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)*

6.2 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.

6.3 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 Insured from the date of receipt of last necessary document to the date of payment of claim at a rate of 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 Insured 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.)*

6.4 Multiple Policies

i. In case of multiple policies taken by an Insured Person during a period from more than one 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.
ii. 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 Company shall independently settle the claim subject to the terms and conditions of this Policy.
iii. 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.
iv. 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.

6.5 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 Company.

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/ Medical Practitioner/ any other party acting on behalf of the Insured Person, with intent to deceive the Company or to induce the Company to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
c) any other act fitted to deceive; and
d) 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 Company.

6.6 Cancellation

i. The Company may cancel the policy, on grounds of misrepresentation, non-disclosure of material facts by the insured person by giving 15 days' written notice. The Company may cancel the policy at any time on grounds of 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.
ii. 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.

6.7 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.

6.8 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.

6.9 Renewal of Policy

i. A health insurance 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 is not 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 Insured, covering the children.

6.10 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 that the Policy has been maintained without a break.

6.11 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.

6.12 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.

6.13 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 (30) 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.

6.14 Nomination

The Insured 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 Insured. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of the Insured, 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 Insured whose discharge shall be treated as full and final discharge of its liability under the Policy.

6.15 Communication

i. All communication must be made in writing.
ii. For Policies serviced by TPA, ID card, network provider related issues to be communicated to the TPA at the address mentioned in the Schedule. For claim serviced by the Company, the Policy related issues to be communicated to the Policy issuing office of the Company at the address mentioned in the Schedule.
iii. Any change of address, state of health or any other change affecting any of the Insured Person, shall be communicated to the Policy issuing office of the Company at the address mentioned in the Schedule.
iv. The Company or TPA shall communicate to the Insured at the address mentioned in the Schedule.

6.16 Physical examination

Any Medical Practitioner authorised by the Company shall be allowed to examine the Insured Person in the event of any alleged Injury requiring Hospitalisation when and as often as the same may reasonably be required on behalf of the Company.

6.17 Claim Procedure

6.17.1 Condition Precedent to Claim

1. Claim shall be admissible for the Hospitalisation during which the Cumulative Medical Expenses as per Section 3.1 of this Policy in respect of Hospitalisation(s) of any Insured Person (individual plan) or one or more Insured Person (floater plan) in a Policy Period exceeds the Threshold as per Section 3.1 of this Policy and for all subsequent Hospitalisation(s) during the Policy Period.
2. Admissible claim amount for Hospitalisation(s) mentioned above shall be calculated as per Section 3.1 and Section 3.2 of the Policy.

6.17.2 Notification of Claim

In order to lodge a claim under the Policy for any Hospitalisation during the Policy Period, 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 or fax providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit.

Notification of claim for Cashless facility	**TPA must be informed:**
In the event of planned Hospitalisation	At least seventy two hours prior to the Insured Person's admission to Network Provider
In the event of emergency Hospitalisation	Within twenty four hours of the Insured Person's admission to Network Provider

Notification of claim for Reimbursement	**Company/TPA must be informed:**
In the event of planned Hospitalisation	At least seventy two hours prior to the Insured Person's admission to Hospital
In the event of emergency Hospitalisation	Within twenty four hours of the Insured Person's admission to Hospital

Note:

i. In case of Hospitalisation where the Cumulative Medical Expenses are likely to exceed the Threshold, notification of claim shall be sent to the TPA mentioned in the Schedule/ Company.
ii. In case of Hospitalisation where initially the Cumulative Medical Expenses are not foreseen to exceed the Threshold but subsequently exceeds the Threshold, notification of claim shall be sent to the TPA mentioned in the Schedule/ Company, immediately.

6.17.3 Procedure for Cashless Claims

i. For the first claim under the Policy (i.e. the claim in which Cumulative Medical Expenses exceeds the Threshold) cashless facility shall be available provided that all evidences and documents are produced prior to cashless authorisation, to substantiate that the Cumulative Medical Expenses (CME) exceeds the Threshold. For all subsequent claims under the Policy, cashless facility shall be available as usual, subject to sl. no. 6.17.3 - ii to 6.17.3 - viii as below.
ii. Cashless facility for treatment can be availed, if TPA service is opted.
iii. Treatment may be taken in a Network Provider / PPN or any other provider and is subject to pre-authorisation by the TPA. Updated list of Network Providers is available on the website of the Company and the website of the TPA mentioned in the Schedule.
iv. Cashless request form available with the Network Provider and TPA shall be completed and sent to the TPA for authorisation.
v. Upon getting cashless request form and related medical information from the Insured Person/ Network Provider, the TPA shall issue pre-authorisation letter within an hour to the Hospital after verification.
vi. At the time of discharge, the Insured Person shall verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
vii. The TPA shall grant the final authorization within three hours of the receipt of discharge authorization request from the Hospital.
viii. The TPA reserves the right to deny pre-authorisation in case the Insured Person is unable to provide the relevant medical details.
ix. In case of denial of cashless access, the Insured Person may obtain the treatment as per treating Medical Practitioner's advice and submit the claim documents to the TPA for processing.

6.17.4 Procedure for Reimbursement of Claims

For reimbursement of claims, the Insured Person shall submit the necessary documents to TPA (if claim is processed by TPA)/ Company (if claim is processed by the Company) within the prescribed time limit.

6.17.5 Documents

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

i. Completed claim form
ii. Medical Practitioner's prescription advising admission for inpatient treatment.
iii. Bills, receipt from the Hospital(s)/ chemist(s) supported by prescription from attending Medical Practitioner for period of pre-Hospitalisation, Hospitalisation and post-Hospitalisation (if applicable)
iv. Bills, receipt, investigation test reports etc. supported by prescription from attending Medical Practitioner for period of pre-Hospitalisation, Hospitalisation and post-Hospitalisation (if applicable)
v. Attending Medical Practitioner's certificate regarding diagnosis along with date of diagnosis and bill, receipts etc.
vi. Certificate from the surgeon regarding diagnosis and nature of operation and bills, receipts etc.
vii. Bills, receipt, sticker of the implants.
viii. Bills, payment receipts, medical history of the patient recorded, indoor case papers, discharge certificate/ summary, break-up of final bill from the Hospital etc.
ix. Documents as listed under Sl. No 6.17.5 (ii) to 6.17.5 (viii) relating to previous Hospitalisation(s) in the Policy Year during the Policy Period along with claim settlement advice (if any), in original or certified copy.
x. Any other relevant document required by Company/TPA for assessment of the claim.

Note:

1. The Insured shall preserve and submit all original documents and/ or certified copies of documents related to all Hospitalisation(s) during the Policy Period to enable the Company to calculate the Cumulative Medical Expenses and Threshold, for determining admissibility and payment of claims.
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other Insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other Insurer subject to satisfaction of the Company. In all such cases, any amount payable under this Policy for any covered expense shall be reduced by any amount paid/ payable by the other insurer for the same expense during the same Hospitalisation.

Type of claim	**Time limit for submission of documents to Company/TPA**
Reimbursement of Hospitalisation, pre-Hospitalisation expenses and ambulance charges (by road only)	Within fifteen days from date of discharge from Hospital
Reimbursement of post-Hospitalisation expenses	Within fifteen days from completion of post-Hospitalisation treatment

6.17.6 Services Offered by TPA

Servicing of claims under health insurance policies by way of pre-authorisation of cashless treatment or settlement of claims other than cashless claims or both, as per the underlying terms and conditions of the respective Policy and within the framework of the guidelines issued by the insurers for settlement of claims.

The services offered by a TPA shall not include:

i. Claim settlement and claim rejection. However, TPA may handle claims admission and recommend to the Company for settlement of the claim.
ii. Any services directly to any Insured Person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

6.17.7 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 considering 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.

6.18 Payment of Claim

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

6.19 Territorial Limit

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

6.20 Territorial Jurisdiction

All disputes or differences under or in relation to the Policy shall be determined by an Indian Court in accordance to Indian law.

6.21 Disclaimer

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

6.22 Enhancement of Sum Insured, Threshold

Sum insured may be enhanced only at the time of renewal. Sum insured may be enhanced subject to availability of higher Sum Insured 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 the respective waiting periods.

6.23 Adjustment of Premium for Overseas Travel Insurance Policy

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

6.24 Arbitration

i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

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

7. 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 Appendix -IV. 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

Insurance is the subject matter of solicitation

Please preserve the Policy for all future reference.

No loading shall apply on renewals based on individual claims experience

Table of Benefits:

<table>
<tr><td>Name</td><td colspan="2">National Super Top Up Mediclaim Policy</td></tr>
<tr><td>Plan</td><td>Individual</td><td>Floater</td></tr>
<tr><td>Threshold – Sum Insured (in ₹)</td><td colspan="2"><table><tr><th>Threshold</th><th>Sum Insured</th></tr><tr><td>2 Lakhs</td><td>3,5,7 Lakhs</td></tr><tr><td>3 Lakhs</td><td>3,5,7,10 Lakhs</td></tr><tr><td>5 Lakhs</td><td>5,7,10,15 Lakhs</td></tr><tr><td>8 Lakhs</td><td>8,10,15,20 Lakhs</td></tr><tr><td>10 Lakhs</td><td>10,15,20,30 Lakhs</td></tr><tr><td>20 Lakhs</td><td>20,30,50,80 Lakhs</td></tr></table></td></tr>
<tr><td colspan="3">Coverage*</td></tr>
<tr><td>In patient Treatment</td><td colspan="2">Up to Sum Insured, No sub limits</td></tr>
<tr><td>System of Medicine</td><td colspan="2">Allopathy and AYUSH</td></tr>
<tr><td>Pre-hospitalisation</td><td colspan="2">30 days immediately before hospitalisation</td></tr>
<tr><td>Post-hospitalisation</td><td colspan="2">60 days immediately after discharge</td></tr>
<tr><td>Day Care Procedures</td><td colspan="2">140+ day care procedures</td></tr>
<tr><td>AYUSH Treatment</td><td colspan="2">Up to Sum Insured</td></tr>
<tr><td>Organ Donor’s Medical Expenses</td><td colspan="2">Medical expenses, Pre-hospitalisation & Post-hospitalisation expenses up to Sum Insured</td></tr>
<tr><td>AIDS Treatment</td><td colspan="2">Medical Expenses for treatment of AIDS (any stage)</td></tr>
<tr><td>Maternity Expenses</td><td colspan="2">Covered up to Sum Insured after waiting period of 3 years, No Sub Limit</td></tr>
<tr><td>Modern Treatment (12 nos)</td><td colspan="2">Up to 25% of SI for each Modern Treatment</td></tr>
<tr><td>Treatment due to participation in hazardous or adventure sports (non-professionals)</td><td colspan="2">Up to 25% of SI</td></tr>
<tr><td>Morbid Obesity</td><td colspan="2">Covered after waiting period of 3 years</td></tr>
<tr><td>Refractive Error (min 7.5D)</td><td colspan="2">Covered after waiting period of 2 years</td></tr>
<tr><td colspan="3">Additional Benefits**</td></tr>
<tr><td>Hospital Cash (in excess of initial 3 days)</td><td colspan="2">• Up to Sum Insured 10 Lakh, ₹ 1,000 per day for 5 days per individual
• Above Sum Insured 10 Lakh, ₹ 2,000 per day for 5 days per individual</td></tr>
<tr><td>Doctor's Home Visit/ Aya/ Nurse/ Attendant Charges post hospitalisation</td><td colspan="2">• Up to Sum Insured Limit 10 Lakh, ₹ 1,000 per day for 10 days per individual
• Above Sum Insured Limit 10 Lakh, ₹ 2,000 per day for 10 days per individual</td></tr>
<tr><td>Ambulance Charges (by road only)</td><td colspan="2">Actual charges</td></tr>
<tr><td colspan="3">Others</td></tr>
<tr><td>Migration to Policy without Threshold</td><td colspan="2">Option available</td></tr>
<tr><td>Pre-existing Disease (PED) waiting period (Only PEDs declared in the Proposal Form and accepted for coverage by the Company shall be covered)</td><td colspan="2">12 months – PED claim not payable
13-24 months - 50% of PED claim
25-36 months - 75% of PED claim
After 36 months - 100% of PED claim</td></tr>
<tr><td colspan="3">Renewal Benefit</td></tr>
<tr><td>Cumulative Bonus (CB)</td><td colspan="2">• CB at 5% of Sum Insured Limit for each claim free year
In case of claim, CB to be reduced at 5% per year</td></tr>
<tr><td colspan="3">Discounts</td></tr>
<tr><td>Early Entry Discount</td><td colspan="2">5% on individual premium (in case where an insured person has entered the policy before the age 42 (completed years) and renewed the policy for a continuous period of 3 years).</td></tr>
<tr><td>Family Discount</td><td>5 % (in individual policy only)</td><td>Not Applicable for Floater Policies</td></tr>
<tr><td>Online/ Direct Discount</td><td colspan="2">10% (for new and renewal, where no intermediary is involved)</td></tr>
<tr><td>Long Term Discount</td><td colspan="2">3% for a 2- year policy and 5% for a 3-year policy</td></tr>
</table>

* Aggregate of all the benefits under ‘*Coverage’* in a policy period are subject to the Threshold.
** Aggregate of all the benefits under ‘*Coverage’* and ‘*Additional Benefits’* for admissible claims in a policy period are subject to the Sum Insured opted.

Appendix I

Day Care Procedure - Day care procedures will include following day care surgeries and day care treatment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Operations on the testes
114. Incision of the testes
115. Excision and destruction of diseased tissue of the testes
116. Unilateral orchidectomy
117. Bilateral orchidectomy
118. Orchidopexy
119. Abdominal exploration in cryptorchidism
120. Surgical repositioning of an abdominal testis
121. Reconstruction of the testis
122. Implantation, exchange and removal of a testicular prosthesis
123. Other operations on the testis

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

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

Operations on the urinary system
135. Cystoscopical removal of stones

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

Note:

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

List I – List of coverage which 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 IMMOBILISER/SHOULDER IMMOBILISER
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	TROLLY 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	DISPOSABLE 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	TOURNIQUET
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 SWABS
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

Appendix III

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, 6th Floor, Tilak Marg, Relief Road, Ahmedabad-380001 Tel: 079 -25501201/ 02 Email: bimalokpal.ahmedabad@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, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in
Madhya Pradesh, Chhattisgarh	Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 / 2769203 Email: bimalokpal.bhopal@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
Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh	Office of the Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: bimalokpal.chandigarh@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
Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011- 46013992/ 23213504/ 23232481 Email: bimalokpal.delhi@cioins.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Pan Bazar, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 / 2631307 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.Hyundai Showroom, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325 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 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. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@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
Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@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
State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh 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 Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@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
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