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National Insurance Company Limited

(A Govt. of India Undertaking)

CIN - U10200WB1906GOI001713

IRDAI Regn. No. - 58

National Super Top Up Mediclaim Policy

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

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National Super Top Up Mediclaim Policy



1 RECITAL CLAUSE

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.

2 OPERATIVE CLAUSE

The Company undertakes that during the policy period, if one or more insured person (s) shall suffer any illness or disease (hereinafter called illness) or sustain any bodily injury due to an accident (hereinafter called injury) requiring the insured person (s) to be hospitalised for treatment at any hospital/nursing home (hereinafter called hospital) or day care centre following the advice of a duly qualified medical practitioner the Company shall indemnify the hospital or insured the reasonable, customary and medically necessary expenses exceeding the threshold in such hospitalisation and any subsequent hospitalisation(s) towards the Coverage mentioned in Section 2.1 and Section 2.2 of the policy.

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

- the sum insured of that insured person covered in an individual plan or
- the floater sum insured in respect of one or more insured persons covered under a floater plan.

Important:

- 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 period exceeds the threshold and for all subsequent hospitalisation(s) during the policy period.
- Threshold shall be determined taking into account the Cumulative Medical Expenses incurred in one or more hospitalisation(s) during the policy period of this Policy for Coverage mentioned in Section 2.1 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 2.1 and Section 2.2 shall be payable.
- Maximum liability of the Company under the policy for all admissible claims during the policy period shall be the individual/floater sum insured opted.
- 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.**

2.1 Coverage

2.1.1 In-patient Treatment

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

- Room charges and intensive care unit charges (including diet charges, nursing care by qualified nurse, RMO charges, administration charges for IV fluids/blood transfusion/injection)
- Medical practitioner(s)
- Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances
- Medicines and drugs
- Diagnostic procedures
- Prosthetics and other devices or equipment if implanted internally during a surgical procedure.
- Dental treatment, necessitated due to an injury
- Plastic surgery, necessitated due to illness or injury
- Hormone replacement therapy, if medically necessary
- Vitamins and tonics, forming part of treatment for illness/injury as certified by the attending medical practitioner
- Circumcision, necessitated for treatment of an illness or injury

2.1.2 Pre Hospitalisation

The Company shall reimburse the insured the medical expenses incurred up to thirty days immediately before the insured person is hospitalised, provided that:

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

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

2.1.3 Post Hospitalisation

The Company shall reimburse the insured the medical expenses incurred up to sixty days immediately after the insured person is discharged from hospital, provided that:

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

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

2.1.4 Day Care Procedure

The Company shall pay to the hospital/ day care centre the medical expenses or reimburse the insured the medical expenses and pre and post hospitalisation expenses, 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)
- ii. any other surgeries/procedures (not listed in Appendix-I) which due to advancement of medical science require hospitalisation for less than twenty four hours and for which prior approval from the Company/TPA is mandatory.

2.1.5 Ayurveda and Homeopathy

The Company shall pay to the hospital the medical expenses or reimburse the insured the medical expenses and pre and post hospitalisation expenses, incurred for Ayurveda and Homeopathy treatment, provided the treatment is undergone in

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

2.1.6 Organ Donor's Medical Expenses

The Company shall pay to the hospital or reimburse the insured the medical expenses and pre and post hospitalisation expenses of the organ donor, during the course of organ transplant to the insured person, provided

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

Exclusions

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

1. Cost of the organ to be transplanted.
2. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

2.1.7 HIV Treatment

The Company shall pay to the hospital or reimburse the insured the medical expenses for treatment of HIV (Human Immunodeficiency Virus), AIDS (Acquired Immune Deficiency Syndrome), and complications of AIDS, after a waiting period of 3 months from the inception of the Policy. The stages of covered HIV infection are:

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

Exclusions

The Company shall not be liable to make any payment in respect of any expenses incurred in connection with or in respect of treatment of HIV/AIDS pre-existing at inception of the Policy.

2.1.8 Morbid Obesity Treatment

The Company shall pay to the hospital or reimburse the insured the medical expenses for bariatric surgery/surgical intervention required for the treatment of Morbid Obesity, after a waiting period of 36 months from the inception of the Policy.

Bariatric surgery for the purpose of this section shall mean any medical procedures performed on people who have morbid obesity (i.e., BMI>40).

Exclusions

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

1. Insured person less than 18 years of age
2. Infertility
3. Psychiatric disorder

2.1.9 Maternity

The Company shall pay to the hospital or reimburse the insured the medical expenses incurred for delivery or termination up to the first two deliveries or terminations of pregnancy during the lifetime of the insured or his spouse covered under the Policy, after a waiting period of 36 months from the date of inclusion of the insured person in the Policy. The benefits described below are up to the limit as shown in the Table of Benefits.

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

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

Exclusions

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

1. Insured and insured persons above forty five years of age.
2. More than one delivery or termination in a policy period.
3. Surrogacy
4. Pre and post hospitalisation expenses as per Section 2.1.2 and Section 2.1.3, other than pre and post natal treatment.

2.2 Additional Benefits

Following benefits shall be payable only for claims admissible under the policy

2.2.1 Hospital Cash

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

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

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

The Company shall reimburse the insured, for medically necessary expenses incurred for doctor's home visit, nursing care by qualified nurse, aya, attendant charges during post hospitalisation up to the limit as shown in the Table of Benefits., provided the related hospitalisation claim has been admitted under Section 2.1.1 and the physical mobility of the insured person outside residence is severely restricted due to the illness/ injury requiring hospitalization.

2.2.3 Ambulance Charges

The Company shall reimburse the insured the expenses incurred for actual emergency ambulance charges for transportation to the hospital, or from one hospital to another hospital, provided a claim has been admitted under Section 2.1.1. Ambulance charges will be paid once for any one illness for each insured person.

2.3 Migration to Policy without Threshold

The Company shall allow the insured persons to migrate to any indemnity health insurance product (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 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.
3. Insured person has to apply to the Policy issuing office for the migration at least 45 days prior to the renewal date.
4. On migration, terms and rates of the migrated policy shall apply.

3 GOOD HEALTH INCENTIVE

3.1 Cumulative Bonus (CB)

At the time of renewal, cumulative bonus allowed shall be an amount equal to 5% (five percent) of sum insured (excluding CB) of the expiring policy in respect of an insured person (for Policy issued on individual basis) or family (for Policy issued on floater basis), provided no claims were reported under the expiring policy.

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

Cumulative bonus shall be aggregated over the years and available, subject to maximum of 50% (fifty percent) of the sum insured (excluding CB) of the current 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

All pre-existing diseases. Any complication arising from pre-existing diseases shall be considered as a part of the pre-existing disease. Such diseases or complications thereof shall be covered after the Policy has been continuously in force for twelve months, 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

Illustration of pre-existing disease and related complication

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

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

4.2 First Thirty Days Waiting Period

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

4.3 Specific Waiting Period

Diseases/treatments listed below are subject to waiting periods as follows.

i. One year waiting period

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

ii. 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.

- Treatment for joint replacement unless arising from accident
- Osteoarthritis and osteoporosis

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

4.4 STD

Any condition directly or indirectly caused to or associated with sexually transmitted diseases (STD), except as and to the extent provided for under Section 2.1.7 (HIV Treatment).

4.5 General Debility, Congenital External Anomaly

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

4.6 Sterility, Infertility, Assisted Conception

Sterility, infertility/sub fertility, assisted conception procedures.

4.7 Pregnancy

Treatment arising from or traceable to pregnancy/childbirth including caesarean section, miscarriage, surrogate or vicarious pregnancy, abortion or complications thereof including changes in chronic conditions arising out of pregnancy other than ectopic pregnancy which may be established by medical reports), except as and to the extent provided for under Section 2.1.9 (Maternity).

4.8 Refractive Error

Surgery for correction of eye sight due to refractive error.

4.9 Obesity

Treatment for obesity and any other weight control and management programme/services/supplies or treatment), except as and to the extent provided for under Section 2.1.8 (Bariatric Surgery).

4.10 Psychiatric Disorder, Self Inflicted Injury

Treatment for all psychiatric and psychosomatic disorders/diseases, intentional self-inflicted injury, attempted suicide.

4.11 Stem Cell Surgery (except bone marrow transplant).

4.12 Circumcision

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

4.13 Vaccination or Inoculation

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

4.14 Cosmetic Treatment, Plastic Surgery, Sex Change, Hormone Replacement Therapy

Cosmetic treatment or aesthetic treatment of any description, change of life or sex change operation.

Expenses for plastic surgery, except as and to the extent provided for under Section 2.1.1.viii.

Expenses for hormone replacement therapy, except as and to the extent provided for under Section 2.1.1.ix.

4.15 Massages, Spa, Steam Bath, Naturopathy, Experimental Treatment

Massages, spa, steam bath, shirodhara, udhwarthanam, abhyangam, kayasekham and similar treatment.

Expenses for naturopathy, experimental medicine/treatment, unproven procedure/treatment, AYUSH treatments (other than ayurveda and homeopathy) acupuncture, acupressure, magneto-therapy and similar treatment.

4.16 Dental Treatment

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

4.17 Vitamins, Tonics

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

4.18 Out-patient Treatment

Any treatment undergone as an out-patient.

4.19 Hospitalisation for the Purpose of Diagnosis and Evaluation

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

4.20 Treatment in Convalescent Home, Nature Clinic

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

4.21 Drug/Alcohol Abuse

Treatment arising out of disease/ injury directly attributable to abuse of drugs/alcohol and intoxicating substances.

4.22 Stay in Hospital which is not Medically Necessary.

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

4.24 Equipments

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

4.25 Expenses not Related to the Diagnosis and Treatment of Disease/ Injury

Irrelevant investigations/treatment, drugs not supported by a prescription, private nursing charges, referral fee to family physician, outstation doctor/surgeon/consultants' fees and similar expenses (as listed in Appendix II).

4.26 Items of Personal Comfort

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

4.27 Service Charge/ Registration Fee

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

4.28 Home Visit Charges

Home visit charges during pre and post hospitalisation of doctor, attendant and nurse, except as and to the extent provided for under Section 2.2.2 (Doctor's Home Visit/ Aya/ Nurse/ Attendant charges during Post Hospitalisation).

4.29 Treatment not Related to Disease

Treatment which the insured person was on before hospitalisation for the disease/ injury, different from the one for which claim for hospitalisation has been made.

4.30 Risky Avocations

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

4.31 Breach of Law

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

4.32 War Group Perils

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

4.33 Radioactivity

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

5 CONDITIONS

5.1 Disclosure of Information

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

5.2 Condition Precedent to Admission of Liability

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

5.3 Communication

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

5.4 Physical examination

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

5.5 Claim Procedure

5.5.1 Condition Precedent to Claim

1. Claim shall be admissible for the hospitalisation during which the cumulative medical expenses as per Section 2.1 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 2.1 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 2.1 and Section 2.2 of the Policy.

5.5.2 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, 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, notification of claim shall be sent to the TPA mentioned in the schedule/ Company, immediately.

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

5.5.4 Procedure for Reimbursement of Claims

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

5.5.5 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 hospitalization, hospitalization and post hospitalization (if applicable)

- iv. Bills, receipt, investigation test reports etc. supported by prescription from attending medical practitioner for period of pre hospitalization, hospitalization and post hospitalization (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 (ii) to (viii) relating to previous hospitalisation(s) in the policy period along with claim settlement advice (if any), in original or certified copy.
- x. Any other document required by Company/TPA

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 documents listed under condition 5.5.5 duly certified by the said insurer along with claim settlement advice, 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	Within fifteen days from date of discharge from hospital
Reimbursement of post hospitalisation expenses	Within fifteen days from completion of post hospitalisation treatment

5.5.6 Claim Settlement

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

5.5.7 Services Offered by TPA

Servicing of claims under health insurance policies by way of pre-authorization 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.

Waiver

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

5.6 Payment of Claim

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

5.7 Territorial Limit

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

5.8 Multiple Policies

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

1. In all such cases the company who has issued the chosen policy 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.
2. Claims under other policy/ies may be made for the amount disallowed under the chosen policy irrespective of exhaustion of sum insured in the chosen policy

3. If the amount to be claimed exceeds the sum insured under a single policy after considering the threshold or co-pay, the insured shall have the right to choose companies from whom he/she wants to claim the balance amount.
4. Where an insured has policies from more than one company to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalisation costs in accordance with the terms and conditions of the chosen policy.

5.9 Fraud

The Company shall not be liable to make any payment under if the same is in any manner fraudulent or supported by any fraudulent means or device whether by the insured person or by any other person acting on his behalf.

5.10 Cancellation

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

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

5.11 Territorial Jurisdiction

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

5.12 Arbitration

- i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996, 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.

5.13 Disclaimer

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

5.14 Renewal of Policy

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

5.15 Enhancement of Sum Insured, Threshold

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

5.16 Adjustment of Premium for Overseas Travel Insurance Policy

If during the policy period any of the insured person is also covered by an Overseas Travel Insurance Policy of any 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.

5.17 Portability

In the event of the insured person porting to any other insurer, insured person must apply with details of the Policy and claims to the insurer where the insured person wants to port, at least forty five days before the date of expiry of the Policy.

Portability shall be allowed only to similar policies, in the following cases:

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

5.18 Withdrawal of Product

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

5.19 Revision of Terms of the Policy Including the Premium Rates

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

5.20 Free Look Period

The Free Look Period shall be applicable at the inception of the Policy.

The insured shall be allowed a period of fifteen days from date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

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

5.21 Nomination

The insured is mandatorily required at the inception of the Policy to make a nomination for the purpose of payment of claims by the Policy in the event of death of the insured. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of any insured person other than the insured, for the purpose of payment of claims, the default nominee would be the insured. The Policy or the benefits cannot be assigned.

Categorization policy conditions	Condition number
Conditions precedent to the contract	5.1, 5.2, 5.21
Conditions applicable during the contract	5.3, 5.7, 5.9, 5.10, 5.11, 5.20
Conditions when a claim arises	5.4, 5.5, 5.6, 5.8, 5.12, 5.13
Conditions for renewal of the contract	5.14, 5.15, 5.16, 5.17, 5.18, 5.19

6 DEFINITION

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

6.2 AIDS or Acquired Immune Deficiency Syndrome is a disease in which there is a severe loss of the body's cellular immunity, greatly lowering the resistance to infection and malignancy. AIDS is caused by infection with HIV (Human Immuno Deficiency Virus).

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

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

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

6.6 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/m², resulting from mass in kilograms and height in metres.

6.7 Cashless Facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.

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

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

6.10 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.

6.11 Cumulative Medical Expenses means the aggregate of medical expenses incurred during the policy period of this Policy towards one or more out of the Coverage mentioned in Section 2.1 of the Policy (i.e. under the heads of 2.1.1. In-patient Treatment, 2.1.2. Pre Hospitalisation, 2.1.3. Post Hospitalisation, 2.1.4. Day Care Procedure, 2.1.5. Ayurveda and Homeopathy, 2.1.6. Organ Donor's Medical Expenses, 2.1.7. HIV Treatment, 2.1.8. Morbid Obesity Treatment & 2.1.9. Maternity) in respect of,

a) Individual Plan

The insured person for one or more hospitalisation during the policy period

b) Floater Plan

One or more insured persons for one or more hospitalisation during the policy period.

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

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

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

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

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

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

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

6.16 Family Members means spouse, children and parents/ in laws of the insured, covered under the Policy.

6.17 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.

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

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

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

- 6.20 Hospitalisation** means admission in a hospital for a minimum period of twenty four (24) consecutive 'Inpatient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.
- 6.21 ID Card** means the card issued to the insured person by the TPA for availing cashless facility in the network provider.
- 6.22 Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.
- i. **Acute Condition** means a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
 - ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics
 - a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
 - b) it needs ongoing or long-term control or relief of symptoms
 - c) it requires rehabilitation for the patient or for the patient to be special trained to cope with it
 - d) it continues indefinitely
 - e) it recurs or is likely recur
- 6.23 In-Patient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
- 6.24 Insured/ Insured Person** means person(s) named in the schedule of the Policy.
- 6.25 Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
- 6.26 ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivists charges.
- 6.27 Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a medical practitioner.
- 6.28 Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.
- 6.29 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.
- 6.30 Medically Necessary** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which
- i. is required for the medical management of illness or injury suffered by the insured ;
 - ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
 - iii. must have been prescribed by a medical practitioner;
 - iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
- 6.31 Medical Practitioner** means a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of the licence.
- 6.32 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 weight.
- 6.33 Network Provider** means hospitals or health care providers enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.
- 6.34 Non- Network** means any hospital, day care centre or other provider that is not part of the network.
- 6.35 Notification of Claim** means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

6.36 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.

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

6.38 Pre-Existing Disease means any condition, ailment or injury or related condition(s) for which there were signs or symptoms and/or was diagnosed, and/or for which medical advice/ treatment was received within forty eight months (48) prior to the first policy issued by the insurer and renewed continuously thereafter.

6.39 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 Insurance Company.

6.40 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 inpatient hospitalisation claim for such hospitalisation is admissible by the Insurance Company.

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

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

6.43 Room Rent means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

6.44 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.

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

6.46 Sum insured means the 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 the policy period.

6.47 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.

6.48 Threshold means the amount of Cumulative Medical Expenses (as per Definition 6.11), as chosen by the insured and mentioned in the schedule, up to which no amount can be claimed under this Policy.

6.49 Third Party Administrator (TPA) means a company registered with the Authority, and engaged by an insurer, for a fee or remuneration, by whatever name called and as may be mentioned in the agreement, for providing health services.

Note: If opted for TPA service, TPA details are mentioned in the Policy Schedule.

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

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

7 REDRESSAL OF GRIEVANCE

Grievance Level 1 –In case of any grievance relating to servicing the Policy, the insured person may submit in writing to the Policy issuing office or regional office for redressal.

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

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

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

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

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

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

Name	National Super Top Up Mediclaim Policy			
Plan	Individual		Floater	
Threshold – Sum Insured	Threshold	Sum Insured	Threshold	Sum Insured
	2 Lakhs	3, 5 Lakhs	2 Lakhs	3, 5 Lakhs
	3 Lakhs	3, 5, 7 Lakhs	3 Lakhs	3, 5, 7 Lakhs
	5 Lakhs	5, 7, 10 Lakhs	5 Lakhs	5, 7, 10 Lakhs
	8 Lakhs	10, 15 Lakhs	8 Lakhs	10, 15 Lakhs
	10 Lakhs	15, 20 Lakhs	10 Lakhs	15, 20 Lakhs
Coverage*				
In patient Treatment	Up to Sum Insured No sub limits		Up to Sum Insured No sub limits	
System of Medicine	Allopathy, Ayurveda, Homeopathy		Allopathy, Ayurveda, Homeopathy	
Pre hospitalisation	30 days immediately before hospitalisation		30 days immediately before hospitalisation	
Post hospitalisation	60 days immediately after discharge		60 days immediately after discharge	
Day Care Procedures	140 day care procedures		140 day care procedures	
Ayurveda and Homeopathy	Up to Sum Insured		Up to Sum Insured	
Organ Donor's Medical Expenses	Medical expenses, Pre & Post Hospitalisation expenses up to Sum Insured		Medical expenses, Pre & Post Hospitalisation expenses up to Sum Insured	
AIDS Treatment	Medical Expenses for treatment of AIDS (any stage)		Medical Expenses for treatment of AIDS (any stage)	
Morbid obesity treatment	Bariatric surgery expenses (in case of life threatening condition)		Bariatric surgery expenses (in case of life threatening condition)	
Maternity Expenses	Actual expenses		Actual expenses	
Additional Benefits**				
Hospital Cash (in excess of initial 3 days)	<ul style="list-style-type: none"> Up to Sum Insured 10 Lakh, INR 1,000 per day for 5 days per individual Above Sum Insured 10 Lakh, INR 2,000 per day for 5 days per individual 		<ul style="list-style-type: none"> Up to Sum Insured 10 Lakh, INR 1,000 per day for 5 days per individual Above Sum Insured 10 Lakh, INR 2,000 per day for 5 days per individual 	
Doctor's Home Visit/ Aya/ Nurse/ Attendant Charges post hospitalisation	<ul style="list-style-type: none"> Up to Sum Insured Limit 10 Lakh, INR 1,000 per day for 10 days per individual Above Sum Insured Limit 10 Lakh, INR 2,000 per day for 10 days per individual 		<ul style="list-style-type: none"> Up to Sum Insured Limit 10 Lakh, INR 1,000 per day for 10 days per individual Above Sum Insured Limit 10 Lakh, INR 2,000 per day for 10 days per individual 	
Ambulance Charges	Actual charges		Actual charges	
Others				
Migration to Policy without Threshold	Option available		Option available	
Pre-existing Disease (PED) waiting period	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		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	
Renewal Benefit				
Cumulative Bonus (CB)	<ul style="list-style-type: none"> CB at 5% of Sum Insured Limit for each claim free year In case of claim, CB to be reduced at 5% per year 		<ul style="list-style-type: none"> CB at 5% of Sum Insured Limit for each claim free year In case of claim, CB to be reduced at 5% per year 	
Discounts				
Early Entry Discount	5% on individual premium		5% on individual premium	
Family Discount	5 % (in individual policy only)		NA	
Online/ Direct Discount	10% (for new and renewal, where no intermediary is involved)		10% (for new and renewal, where no intermediary is involved)	

* 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.

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)

□ Other operations on the middle and internal ear

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

□ Operations on the nose and the nasal sinuses

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

□ Operations on the eyes

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

□ Operations on the skin and subcutaneous tissues

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

□ Operations on the tongue

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

□ Operations on the salivary glands and salivary ducts

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

□ Other operations on the mouth and face

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

□ Operations on the tonsils and adenoids

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

□ Trauma surgery and orthopaedics

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

□ Operations on the breast

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

□ Operations on the digestive tract

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

□ Operations on the female sexual organs

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

□ Operations on the prostate and seminal vesicles

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

□ Operations on the scrotum and tunica vaginalis testis

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

□ Operations on the testes

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

122. Implantation, exchange and removal of a testicular prosthesis

123. Other operations on the testis

Operations on the spermatic cord, epididymis and ductus deferens

124. Surgical treatment of a varicocele and a hydrocele of the spermatic cord

125. Excision in the area of the epididymis

126. Epididymectomy

127. Reconstruction of the spermatic cord

128. Reconstruction of the ductus deferens and epididymis

129. Other operations on the spermatic cord, epididymis and ductus deferens

Operations on the penis

130. Operations on the foreskin

131. Local excision and destruction of diseased tissue of the penis

132. Amputation of the penis

133. Plastic reconstruction of the penis

134. Other operations on the penis

Operations on the urinary system

135. Cystoscopic removal of stones

Other Operations

136. Lithotripsy

137. Coronary angiography

138. Hemodialysis

139. Radiotherapy for Cancer

140. Cancer Chemotherapy

Note:

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

Expenses Generally Excluded

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

56.	HANSAPLAST/ ADHESIVE BANDAGES	Not Payable
57.	INFANT FOOD	Not Payable
58.	SLINGS	Reasonable costs for one sling in case of upper arm fractures is payable
	ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES	
59.	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Exclusion in Policy
60.	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Exclusion in Policy
61.	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Not payable
62.	HORMONE REPLACEMENT THERAPY	Payable
63.	HOME VISIT CHARGES	Payable in post hospitalisation
64.	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Exclusion in Policy
65.	OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	Payable as per Section 2.1.8
66.	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	Exclusion in Policy
67.	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Exclusion in Policy
68.	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Exclusion in Policy
69.	DONOR SCREENING CHARGES	Payable
70.	ADMISSION/REGISTRATION CHARGES	Exclusion in Policy
71.	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Exclusion in Policy
72.	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Exclusion in Policy
73.	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Payable as per Section 2.1.7
74.	STEM CELL IMPLANTATION/ SURGERY AND STORAGE	Not Payable except for Bone Marrow Transplantation
	ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS	
75.	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not payable separately
76.	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of Instruments not payable.
77.	MICROSCOPE COVER	Payable under OT Charges, not payable separately
78.	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT Charges, not payable separately
79.	SURGICAL DRILL	Payable under OT Charges, not payable separately
80.	EYE KIT	Payable under OT Charges, not payable separately
81.	EYE DRAPE	Payable under OT Charges, not payable separately

82.	X-RAY FILM	Payable under Radiology Charges, not as consumable
83.	SPUTUM CUP	Payable under Investigation Charges, not as consumable
84.	BOYLES APPARATUS CHARGES	Part of OT Charges, not separately
85.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
86.	ANTISEPTIC OR DISINFECTANT LOTIONS	Not Payable-Part of Dressing Charges
87.	BAND AIDS, BANDAGES, STERILE INJECTIONS, NEEDLES, SYRINGES	Not Payable - Part of Dressing charges
88.	COTTON	Not Payable-Part of Dressing Charges
89.	COTTON BANDAGE	Not Payable- Part of Dressing Charges
90.	MICROPORE/ SURGICAL TAPE	Not Payable-Payable by the patient when prescribed, otherwise included as Dressing Charges
91.	BLADE	Not Payable
92.	APRON	Not Payable -Part of Hospital Services/ Disposable linen to be part of OT/ICU charges
93.	TORNIQUET	Not Payable (service is charged by hospitals, consumables cannot be separately charged)
94.	ORTHOBUNDLE, GYNAEC BUNDLE	Part of Dressing Charges
95.	URINE CONTAINER	Not Payable
ELEMENTS OF ROOM CHARGE		
96.	LUXURY TAX	Actual tax levied by government is payable. Part of room charge for sub limits
97.	HVAC	Part of room charge not payable separately
98.	HOUSE KEEPING CHARGES	Part of room charge not payable separately
99.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
100.	TELEVISION & AIR CONDITIONER CHARGES	Payable under room charges not if separately levied
101.	SURCHARGES	Part of Room Charge, Not payable separately
102.	ATTENDANT CHARGES	Not Payable - Part of Room Charges
103.	IM IV INJECTION CHARGES	Part of room charge not payable separately
104.	CLEAN SHEET	Part of Laundry/Housekeeping not payable separately
105.	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
106.	BLANKET/WARMER BLANKET	Not Payable- part of room charges
ADMINISTRATIVE OR NON-MEDICAL CHARGES		
107.	ADMISSION KIT	Not Payable
108.	BIRTH CERTIFICATE	Not Payable
109.	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
110.	CERTIFICATE CHARGES	Not Payable
111.	COURIER CHARGES	Not Payable
112.	CONVENYANCE CHARGES	Not Payable
113.	DIABETIC CHART CHARGES	Not Payable

114.	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
115.	DISCHARGE PROCEDURE CHARGES	Not Payable
116.	DAILY CHART CHARGES	Not Payable
117.	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
118.	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	Payable under Post hospitalisation
119.	FILE OPENING CHARGES	Not Payable
120.	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
121.	MEDICAL CERTIFICATE	Not Payable
122.	MAINTAINANCE CHARGES	Not Payable
123.	MEDICAL RECORDS	Not Payable
124.	PREPARATION CHARGES	Not Payable
125.	PHOTOCOPIES CHARGES	Not Payable
126.	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
127.	WASHING CHARGES	Not Payable
128.	MEDICINE BOX	Not Payable
129.	MORTUARY CHARGES	Payable up to 24 hrs, shifting charges not payable
130.	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
EXTERNAL DURABLE DEVICES		
131.	WALKING AIDS CHARGES	Not Payable
132.	BIPAP MACHINE	Not Payable
133.	COMMUNE	Not Payable
134.	CPAP/ CAPD EQUIPMENTS	Device not payable
135.	INFUSION PUMP - COST	Device not payable
136.	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
137.	PULSEOXYMETER CHARGES	Device not payable
138.	SPACER	Not Payable
139.	SPIROMETRE	Device not payable
140.	SPO2 PROBE	Not Payable
141.	NEBULIZER KIT	Not Payable
142.	STEAM INHALER	Not Payable
143.	ARMSLING	Not Payable
144.	THERMOMETER	Not Payable
145.	CERVICAL COLLAR	Not Payable
146.	SPLINT	Not Payable
147.	DIABETIC FOOT WEAR	Not Payable
148.	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
149.	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
150.	LUMBO SACRAL BELT	Payable for cases who have undergone surgery of lumbar spine.
151.	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at reasonable cost of approximately Rs 200/ day
152.	AMBULANCE COLLAR	Not Payable
153.	AMBULANCE EQUIPMENT	Not Payable
154.	MICROSHEILD	Not Payable
155.	ABDOMINAL BINDER	Payable for cases who have undergone surgery of lumbar spine.
ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION		
156.	BETADINE \ HYDROGEN PEROXIDE\SPIRIT\DETTOL\SAVLON\ DISINFECTANTS ETC	Payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital
157.	PRIVATE NURSES CHARGES-SPECIAL NURSING CHARGES	Payable in post hospitalisation

158.	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES	Patient Diet provided by hospital is payable
159.	SUGAR FREE TABLETS	Payable -Sugar free variants of admissible medicines are not excluded
160.	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	Payable when prescribed
161.	DIGESTION GELS	Payable when prescribed
162.	ECG ELECTRODES	Up to 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day is payable.
163.	GLOVES	Sterilized Gloves payable / unsterilized gloves not payable
164.	HIV KIT	Payable - Pre operative screening
165.	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
166.	LOZENGES	Payable when prescribed
167.	MOUTH PAINT	Payable when prescribed
168.	NEBULISATION KIT	Payable reasonably if used during hospitalisation
169.	NOVARAPID	Payable when prescribed
170.	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
171.	ZYTEE GEL	Payable when prescribed
172.	VACCINATION CHARGES	Payable when prescribed
PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE		
173.	AHD	Not Payable - Part of Hospital's internal Cost
174.	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost

175.	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost
OTHERS		
176.	VACCINE CHARGES FOR BABY	Not Payable
177.	AESTHETIC TREATMENT / SURGERY	Not Payable
178.	TPA CHARGES	Not Payable
179.	VISCO BELT CHARGES	Not Payable
180.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
181.	EXAMINATION GLOVES	Not payable
182.	KIDNEY TRAY	Not Payable
183.	MASK	Not Payable
184.	OUNCE GLASS	Not Payable
185.	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable
186.	OXYGEN MASK	Not Payable
187.	PAPER GLOVES	Not Payable
188.	PELVIC TRACTION BELT	Payable in case of PIVD requiring traction as this is generally not reused
189.	REFERAL DOCTOR'S FEES	Not Payable
190.	ACCU CHECK (Glucometry/ Strips)	Not payable pre hospitalisation or post hospitalisation / Reports and Charts required/ Device not payable
191.	PAN CAN	Not Payable
192.	SOFNET	Not Payable
193.	TROLLY COVER	Not Payable
194.	UROMETER, URINE JUG	Not Payable
195.	AMBULANCE	Payable
196.	TEGADERM / VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs
197.	URINE BAG	Payable where medically necessary till a reasonable cost - maximum 1 per 24 hrs
198.	SOFTOVAC	Not Payable
199.	STOCKINGS	Payable for case like CABG etc.

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

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

Areas of Jurisdiction	Office of the Insurance Ombudsman		
Gujarat , UT of Dadra and Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@gbic.co.in		Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@gbic.co.in
Karnataka	Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@gbic.co.in	West Bengal, UT of Andaman and Nicobar Islands, Sikkim	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@gbic.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@gbic.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@gbic.co.in
Orissa	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 / 2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@gbic.co.in
Punjab , Haryana, Himachal Pradesh, Jammu and Kashmir , UT of Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@gbic.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshahr, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddha Nagar, U.P.-201301. Tel.: 0120-2514250 / 2514251 / 2514253 Email: bimalokpal.noida@gbic.co.in
Tamil Nadu, UT– Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@gbic.co.in	Bihar, Jharkhand.	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Email: bimalokpal.patna@gbic.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 32341320 Email: bimalokpal.pune@gbic.co.in
Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 (ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@gbic.co.in		
Andhra Pradesh, Telangana and UT of Yanam – a part of the UT of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@gbic.co.in		
Rajasthan	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.		