

Issuing Office

National Parivar Mediclaim Policy

1 RECITAL CLAUSE

Whereas the insured designated in the schedule hereto has by a proposal, dated as stated in the schedule, which shall be the basis of this contract and is deemed to be incorporated herein, has applied to National Insurance Company Ltd. (hereinafter called the Company), for the insurance hereinafter set forth, 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 if during the policy period or during the continuance of the Policy by renewal, any insured person shall suffer any illness or disease (hereinafter called disease) or sustain any bodily injury due to an accident (hereinafter called injury) and if such disease or injury shall require any such insured person, upon the advice of a duly qualified medical practitioner,

- to be hospitalised for treatment at any hospital/nursing home (hereinafter called hospital),
- to undergo treatment under Domiciliary Hospitalisation,

the Company shall pay to the hospital or reimburse the insured reasonable, customary and medically necessary expenses, incurred in India, as defined below, in respect thereof by, or on behalf of such insured person, but not exceeding the sum insured, being a floater, in respect of all such claims from one or all the insured persons during a policy year and subject to the terms, exclusions, conditions, definitions contained herein or endorsed or otherwise expressed hereon and limits as shown in the Table of Benefits.

2.1 COVERAGE

2.1.1 In-patient Treatment

The Company shall pay to the hospital or reimburse the insured up to the sum 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), subject to limit as per Section 2.1.1.1
- 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 disease or injury
- Hormone replacement therapy, if medically necessary
- Vitamins and tonics, forming part of treatment for disease/injury as certified by the attending medical practitioner
- Circumcision, necessitated for treatment of a disease or injury

2.1.1.1 Limit for Room Charges and Intensive Care Unit Charges

Room charges and intensive care unit charges per day shall be payable up to the limit as shown in the Table of Benefits. The limit shall not apply if the treatment is undergone for a listed procedure in a Preferred Provider Network (PPN) as a package.

Note: Listed procedures and Preferred Provider Network list are dynamic in nature, and will be updated in the Company's website from time to time.

2.1.1.2 Limit for Cataract Surgery

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

2.1.1.3 Treatment related to participation as a non-professional in hazardous or adventure sports

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

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 Domiciliary Hospitalisation

The Company shall reimburse the insured the medical expenses incurred under domiciliary hospitalization, including pre hospitalisation expenses (admissible as per Section 2.1.2) and post hospitalisation expenses (admissible as per Section 2.1.3), up to the limit as shown in the Table of Benefits.

Exclusions

Domiciliary hospitalisation shall not cover:

- i. Treatment of less than three days
- ii. Expenses incurred for pre and post hospitalisation
- iii. Expenses incurred for alternative treatment
- iv. Expenses incurred for maternity or infertility
- v. Expenses incurred for any of the following diseases;
 - a) Asthma
 - b) Bronchitis
 - c) Chronic nephritis and nephritic syndrome
 - d) Diarrhoea and all type of dysenteries including gastroenteritis
 - e) Epilepsy
 - f) Influenza, cough and cold
 - g) All psychiatric or psychosomatic disorders
 - h) Pyrexia of unknown origin for less than ten days
 - i) Tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis
 - j) Arthritis, gout and rheumatism

2.1.5 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 up to the sum insured, 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 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.

2.1.6 Ayurveda and Homeopathy

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

2.1.7 Organ Donor's Medical Expenses

The Company shall pay to the hospital or reimburse the insured the expenses of hospitalisation of the organ donor up to the sum insured, 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. Pre and post hospitalisation expenses, as per Section 2.1.2 and Section 2.1.3, incurred by the organ donor unless the organ donor is an insured person.
3. Any other medical treatment or complication in respect of the donor, consequent to harvesting

2.1.8 Hospital Cash

The Company shall pay to 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

2.1.9 Ambulance

The Company shall reimburse the insured the expenses incurred for ambulance charges for transportation to the hospital, or from one hospital to another hospital, up to the limit as shown in the Table of Benefits, provided a claim has been admitted under Section 2.1.1.

2.1.10 Anti Rabies Vaccination

The Company shall reimburse the insured medically necessary expenses incurred for anti-rabies vaccination up to the limit as shown in the Table of Benefits. Hospitalisation is not required for vaccination.

2.1.11 Maternity

The Company shall pay to the hospital or reimburse the insured the medical expenses, incurred as an in-patient, for delivery or termination up to the first two deliveries or terminations of pregnancy during the lifetime of the insured or his spouse, if covered by the Policy, provided the Policy has been continuously in force for thirty six (36) months from the inception of the Policy or from the date of inclusion of the insured person by the Policy, whichever is later. 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.

Baby from Birth Cover

- iv. Medical expenses of the new born baby/ new born babies (in the event of multiple birth in a delivery), including expenses for vaccination (as listed in Appendix III). Hospitalisation is not required for vaccination.

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 (45) years of age.
2. More than one delivery or termination in a policy year.
3. Surrogacy, unless claim is admitted under Section 2.1.12 (Infertility)
4. Pre and post hospitalisation expenses as per Section 2.1.2 and Section 2.1.3, other than pre and post natal treatment.

2.1.12 Infertility

The Company shall pay to the hospital or reimburse the insured, in respect of the medical expenses of the insured and his spouse, if covered by the Policy, for treatment undergone as an in-patient or as a day care treatment, for procedures and/ or treatment of infertility, provided the Policy has been continuously in force for thirty six (36) months from the inception of the Policy or from the date of inclusion of the insured person, whichever is later. The medical expenses for either or both the insured person shall be subject to the limit as shown in the Table of Benefits.

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 (45) years of age.
2. Diagnostic tests related to infertility
3. Reversing a tubal ligation or vasectomy
4. Preserving and storing sperms, eggs and embryos
5. An egg donor or sperm donor
6. Experimental treatments
7. Any disease/ injury, other than traceable to maternity, of the surrogate mother.

Conditions

1. Expenses advanced procedures, including IVF, GIFT, ZIFT or ICSI, shall be payable only if the Insured person has been unable to attain or sustain a successful pregnancy through reasonable, and medically necessary infertility treatment.
2. Maternity expenses of the surrogate mother shall be payable under Section 2.1.11 (Maternity). Legal affidavit regarding intimation of surrogacy shall be submitted to the Company.
3. Maximum of two claims shall be admissible by the Policy during the lifetime of the insured person if he has no living child and one claim if the insured has one living child.
4. Any one illness (Definition 6.2) limit shall not apply.

Definitions for the purpose of the Section

1. **Donor** means an oocyte donor or sperm donor.
2. **Embryo** means a fertilized egg where cell division has commenced/ under the process and has completed the pre-embryonic stage.
3. **Gamete Intra-Fallopian Transfer (GIFT)** means a procedure where the sperm and egg are placed inside a catheter separated by an air bubble and then transferred to the fallopian tube. Fertilization takes place naturally.
4. **Infertility** means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. However the one year period may be waived, provided a medical practitioner determines existence of a medical condition rendering conception impossible through unprotected sexual intercourse, including but not limited to congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments.
5. **Intra-Cytoplasmic Sperm Injection (ICSI)** means an injection of sperm into an egg for fertilisation.
6. **In Vitro Fertilization (IVF)** means a process in which an egg and sperm are combined in a laboratory dish where fertilization occurs. The fertilized and dividing egg is transferred into the uterus of the woman.
7. **Surrogate** means a woman who carries a pregnancy for the insured person.

8. **Zygote Intra-Fallopian Transfer (ZIFT)** means a procedure where the egg is fertilized in vitro and transferred to the fallopian tube before dividing.

2.1.13 HIV/ AIDS Cover

The Company shall indemnify the Hospital or the Insured the Medical Expenses for In-patient Care (admissible as per Section 2.1.1), Pre-Hospitalisation expenses (admissible as per Section 2.1.2) and Post-Hospitalisation expenses (admissible as per Section 2.1.3), related to following stages of HIV infection:

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

2.1.14 Mental Illness Cover

The Company shall indemnify the Hospital or the Insured the Medical Expenses for In-patient Care (admissible as per Section 2.1.1), Pre-Hospitalisation expenses (admissible as per Section 2.1.2) and Post-Hospitalisation expenses (admissible as per Section 2.1.3), related to Mental Illnesses, provided the treatment shall be undertaken at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Psychiatrist (as defined in Definition 6.41) or a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry.

Exclusions

Any kind of Psychological counselling, cognitive/ family/ group/ behavior/ palliative therapy or other kinds of psychotherapy for which Hospitalisation is not necessary shall not be covered.

2.1.15 Modern Treatment

The Company shall pay to the hospital or reimburse the insured the Medical Expenses for In-Patient Care (admissible as per Section 2.1.1), Domiciliary Hospitalisation (admissible as per Section 2.1.4) or Day Care Procedure (admissible as per Section 2.1.5) along with pre hospitalisation expenses (admissible as per Section 2.1.2) and post hospitalisation expenses (admissible as per Section 2.1.3) incurred for following **Modern Treatments** (wherever medically indicated), subject to **Maximum amount admissible for any one Modern Treatment shall be 25% of Sum Insured**

- A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
- B. Balloon Sinuplasty
- C. Deep Brain stimulation
- D. Oral chemotherapy
- E. Immunotherapy- Monoclonal Antibody to be given as injection
- F. Intra vitreal injections
- G. Robotic surgeries
- H. Stereotactic radio surgeries
- I. Bronchical Thermoplasty
- J. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
- K. IONM - (Intra Operative Neuro Monitoring)
- L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

2.1.16 Morbid Obesity Treatment

The Company shall indemnify the Hospital or the Insured the Medical Expenses for In-patient Care (admissible as per Section 2.1.1), Pre-Hospitalisation expenses (admissible as per Section 2.1.2) and Post-Hospitalisation expenses (admissible as per Section 2.1.3), incurred for surgical treatment of obesity that fulfils **all** the following conditions and subject to Waiting Period of four (04) years as per Section 4.2.f.iv:

1. Treatment has been conducted is upon the advice of the Medical Practitioner, and
2. The surgery/Procedure conducted should be supported by clinical protocols, and
3. The Insured Person is 18 years of age or older, and
4. Body Mass Index (BMI) is;
 - b) greater than or equal to 40 or
 - c) 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

2.1.17 Correction of Refractive Error

The Company shall indemnify the Hospital or the Insured the Medical Expenses for In-patient Care (admissible as per Section 2.1.1), Pre-Hospitalisation expenses (admissible as per Section 2.1.2) and Post-Hospitalisation expenses (admissible as per Section 2.1.3), incurred for expenses related to the treatment for correction of eye sight due to refractive error equal to or more than 7.5 diopres, subject to Waiting Period of two (02) years as per Section 4.2.f.iii.

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

Note: Aggregate of all the benefits under 2.1.1 to 2.1.17 are subject to the Sum Insured opted.

2.2 Medical Second Opinion

The Company shall arrange for a Medical Second Opinion from a panel of World Leading Medical Centers (WLMC), at the insured person's request, if the insured person is diagnosed with one of the major illness listed in Appendix II, during the policy year. One Medical Second Opinion per family may be availed during a policy year, for any of the major illness (listed in Appendix II).

The insured person shall provide the medical records containing the diagnosis and recommended course of treatment to the service provider, through the TPA named in the schedule for servicing MSO (irrespective of claim being serviced by TPA or not). The Medical Second Opinion shall be based only on the information and documentation provided to the medical practitioner of WLMC by or on behalf of the insured person, and the second opinion and the recommended course of treatment shall be sent directly to the insured/ insured person. The TPA shall only be responsible for collecting the required documents from the insured person, and deliver them to the service provider.

In opting for this service and deciding to obtain a Medical Second Opinion, each insured person expressly notes and agrees that:

- i. it is entirely for the insured person to choose whether or not to obtain a Medical Second Opinion from WLMC and if obtained under this service then whether or not to act on it
- ii. the Company does not provide Medical Second Opinion or makes any representation as to the adequacy or accuracy of the same, the insured person's or any other person's reliance on the same, or the use of the Medical Second Opinion.
- iii. the Company does not assume responsibility for and shall not be responsible for any actual or alleged errors, omissions or representations made by any medical practitioner or in any Medical Second Opinion or for any consequences of any action taken or not taken in reliance there on
- iv. Medical Second Opinion provided under this service shall not be valid for any medico-legal purposes
- v. Medical Second Opinion does not entitle the insured person to any consultations from or further opinions from that medical practitioner.

3 GOOD HEALTH INCENTIVES

3.1 No Claim Discount (NCD)

On renewal of policies with a term of one year, a NCD of flat 5% shall be allowed on the * base premium, provided claims are not reported in the expiring Policy.

On renewal of policies with a term exceeding one year, the NCD amount with respect to each claim free policy year shall be aggregated and allowed on renewal. Aggregate amount of NCD allowed shall not exceed flat 5% of the total base premium for the term of the policy.

* **Base premium** depends on the zone and sum insured and is the aggregate of the premium for senior most insured person and other insured persons for a year.

3.2 Health Check Up

Expenses of health check up with respect to the insured person(s), shall be reimbursed at the end of a block of four continuous policy years, provided claims are not reported during the block in respect of the insured person(s) and the Policy has been continuously renewed with the Company without a break. Expenses payable are subject to the limit as shown in the Table of Benefits.

4 EXCLUSIONS

The Company shall not be liable to make any payment by 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 forty eight (48) months of continuous coverage after the date of inception of the first policy with us.
- b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
- d) Coverage under the policy after the expiry of forty eight (48) months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

4.2. Specified disease/procedure waiting period (Excl 02)

- a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 90 days/ one year/ two year/ four years (as specified against specific disease/ procedure) of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident
- b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c) If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing Diseases, then the longer of the two waiting periods shall apply.

- d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
- f) List of specific diseases/procedures

i. 90 Days Waiting Period (Life style conditions)

- a. Hypertension and related complications
- b. Diabetes and related complications
- c. Cardiac conditions

ii. One year waiting period

- a. Benign ENT disorders
- b. Tonsillectomy
- c. Adenoidectomy
- d. Mastoidectomy
- e. Tympanoplasty

iii. Two years waiting period

- a. Cataract
- b. Benign prostatic hypertrophy
- c. Hernia
- d. Hydrocele
- e. Fissure/Fistula in anus
- f. Piles (Haemorrhoids)
- g. Sinusitis and related disorders
- h. Polycystic ovarian disease
- i. Non-infective arthritis
- j. Pilonidal sinus
- k. Gout and Rheumatism
- l. Calculus diseases
- m. Surgery of gall bladder and bile duct excluding malignancy
- n. Surgery of genito-urinary system excluding malignancy
- o. Surgery for prolapsed intervertebral disc unless arising from accident
- p. Surgery of varicose vein
- q. Hysterectomy
- r. Refractive error of the eye more than 7.5 dioptries
- s. Congenital Internal Anomaly

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

iv. Four years waiting period

Following diseases even if pre-existing shall be covered after four years of continuous cover from the inception of the Policy.

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

Above diseases/treatments under 4.2.f).iv if pre-existing also, shall be covered after single Waiting Period of four (04) years only.

4.3. First 30 days waiting period (Excl 03)

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

4.4. Investigation & Evaluation (Excl 04)

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

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

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

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

4.6. Obesity/ Weight Control (Excl 06)

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

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

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

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

4.8. Cosmetic or Plastic Surgery (Excl 08)

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

4.9. Hazardous or Adventure Sports (Excl 09)

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

4.10. Breach of Law (Excl 10)

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

4.11. Excluded Providers (Excl11)

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

4.12. Drug/Alcohol Abuse (Excl 12)

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

4.13. Non Medical Admissions (Excl 13)

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

4.14. Vitamins, Tonics (Excl 14)

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

4.15. Refractive Error (Excl 15)

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

4.16. Unproven Treatments (Excl16)

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

4.17. Hormone Replacement Therapy

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

4.18. General Debility, Congenital External Anomaly

General debility, Congenital external anomaly.

4.19. Self Inflicted Injury

Treatment for intentional self-inflicted injury, attempted suicide.

4.20. Stem Cell Surgery

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

4.21. Circumcision

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

4.22. Vaccination or Inoculation.

Vaccination or inoculation unless forming part of treatment and requires Hospitalisation, except as and to the extent provided for under Section 2.1.10 (Anti Rabies Vaccination) and Section 2.1.11.iv (Maternity).

4.23. Massages, Steam Bath, Alternative Treatment (Other than Ayurveda and Homeopathy)

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

4.24. Dental treatment

Dental treatment, unless necessitated due to an Injury.

4.25. Out Patient Department (OPD)

Any expenses incurred on OPD.

4.26. Stay in Hospital which is not Medically Necessary.

Stay in hospital which is not medically necessary.

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

Spectacles, contact lens, hearing aid, cochlear implants.

4.28. Non Prescription Drug

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

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

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

4.30. 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 respective Appendix-II) and any medical equipment which could be used at home subsequently.

4.31. Items of personal comfort

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

4.32. 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.

4.33. Home visit charges

Home visit charges during Pre and Post Hospitalisation of doctor, attendant and nurse.

4.34. War

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

4.35. 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 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 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 weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

4.36. Treatment taken outside the geographical limits of India

4.37. Permanently Excluded Diseases

In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes (as listed in Appendix-V)

5 CONDITIONS

5.1 Disclosure of Information

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

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

5.2 Condition Precedent to Admission of Liability

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

5.3 Communication

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

5.4 Physical Examination

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

5.5 Claim Procedure

5.5.1 Notification of Claim

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

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/PPN
In the event of emergency hospitalisation	Within twenty four hours of the insured person's admission to network provider/PPN

Notification of claim for Reimbursement	Company/TPA must be informed:
In the event of planned hospitalisation/ domiciliary hospitalisation	At least seventy two hours prior to the insured person's admission to hospital/ inception of domiciliary hospitalisation
In the event of emergency hospitalisation/ domiciliary hospitalisation	Within twenty four hours of the insured person's admission to hospital/ inception of domiciliary hospitalisation

Notification of claim for vaccination	Company/TPA must be informed:
In the event of Anti Rabies Vaccination	At least twenty four hours prior to the vaccination

Note: For claim under Section 2.2 (Medical Second Opinion), notification of claim is not required.

5.5.2 Procedure for Cashless Claims

- i. Cashless facility for treatment in network hospitals can be availed, if TPA service is opted.
- ii. Treatment may be taken in a network provider/PPN and is subject to pre authorization by the TPA. Booklet containing list of network provider/PPN shall be provided by the TPA. Updated list of network provider/PPN is available on website of the Company and the TPA mentioned in the schedule.
- iii. Cashless request form available with the network provider/PPN and TPA shall be completed and sent to the TPA for authorization.
- iv. The TPA upon getting cashless request form and related medical information from the insured person/ network provider/PPN shall issue pre-authorization letter to the hospital after verification.
- v. At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
- vi. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
- vii. In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the TPA for processing.

5.5.3 Procedure for Reimbursement of Claims

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

5.5.3.1 Procedure for Reimbursement of Claim under Domiciliary Hospitalisation

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

5.5.4 Documents

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

- i. Completed claim form
- ii. Bills, payment receipts, medical history of the patient recorded, discharge certificate/ summary from the hospital etc.
- iii. Cash-memo from the hospital (s)/chemist(s) supported by proper prescription
- iv. Payment receipt, investigation test reports etc. supported by the prescription from the attending medical practitioner
- v. Attending medical practitioner's certificate regarding diagnosis along with date of diagnosis and bill receipts etc.
- vi. Certificate from the surgeon stating diagnosis and nature of operation and bills/receipts etc.
- vii. For claim under Section 2.1.4 (Domiciliary Hospitalisation) in addition to documents listed above (as applicable), medical certificate stating the circumstances requiring for Domiciliary hospitalisation and fitness certificate from treating medical practitioner.
- viii. For claim under Section 2.1.11 (Maternity) for surrogacy under Section 2.1.12 (Infertility) in addition to documents listed above (as applicable), legal affidavit regarding intimation of surrogacy.
- ix. Any other document required by Company/TPA

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

Type of claim	Time limit for submission of documents to Company/TPA
Reimbursement of hospitalization, 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
Reimbursement of domiciliary hospitalisation expenses	Within fifteen days from issuance of fitness certificate
Reimbursement of anti rabies vaccination and new born baby vaccination	Within fifteen days from date of vaccination
Reimbursement of expenses for infertility treatment	Within fifteen days of completion of treatment or fifteen days of expiry of policy period, whichever is earlier, once during the policy year
Reimbursement of health check up expenses (to be submitted to the office only)	Within six months of the fifth policy year.

5.5.5 Claim Settlement

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

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

5.5.6 Services Offered by TPA

The TPA shall render health care services covered by the Policy including issuance of ID cards & guide book, hospitalisation & pre-authorization services, call centre, acceptance of claim related documents, claim processing and other related services. The services offered by a TPA shall not include

- i. Claim settlement and 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.

5.5.7 Classification of * Zone and Copayment

The amount of claim admissible will depend upon the zone for which premium has been paid and the zone where treatment has been taken.

* The country has been divided into four zones.

Zone I - Greater Mumbai Metropolitan area, entire state of Gujarat

Zone II – National Capital Territory (NCT) Delhi and National Capital Region (# NCR), Chandigarh, Pune

Zone III - Chennai, Hyderabad, Bangalore, Kolkata

Zone IV - Rest of India

NCR includes Gurgaon-Manesar, Alwar-Bhiwadi, Faridabad-Ballabgarh, Ghaziabad-Loni, Noida, Greater Noida, Bahadurgarh, Sonapat-Kundli Charkhi Dadri, Bhiwani, Narnaul

Where treatment has been taken in a zone, other than the one for which ** premium has been paid, the claim shall be subject to copayment.

- i. Insured paying premium as per Zone I can avail treatment in Zone I, Zone II, Zone III and Zone IV without copayment
- ii. Insured paying premium as per Zone II
 - a. Can avail treatment in Zone II, Zone III and Zone IV without any copayment
 - b. Availing treatment in Zone I will be subject to a copayment of 5%
- iii. Insured paying premium as per Zone III
 - a. Can avail treatment in Zone III and Zone IV without any copayment
 - b. Availing treatment in Zone I will be subject to a copayment of 12.5%
 - c. Availing treatment in Zone II will be subject to a copayment of 7.5%
- iv. Insured paying premium as per Zone IV
 - a. Can avail treatment in Zone IV without any copayment
 - b. Availing treatment in Zone I will be subject to a copayment of 22.5%
 - c. Availing treatment in Zone II will be subject to a copayment of 17.5%
 - d. Availing treatment in Zone III will be subject to a copayment of 10%

** For premium rates please refer to the Prospectus/ Brochure

5.5.8 Treatment Outside Network

Claims where treatment is undergone in a non-network provider shall be subject to co payment of 10%. If treatment is undergone in a non-network provider in a city/ town/ village where the Company/ TPA does not have tie-up with any hospital, copayment shall not apply.

Above copayments shall not be applicable on Critical illness & Outpatient treatment optional covers, but shall apply on Pre existing diabetes and/ or hypertension optional cover.

5.6 Moratorium Period

After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy.

5.7 Payment of Claim

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

5.8 Territorial limit

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

5.9 Multiple Policies

- i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
- 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 even if the sum insured is not exhausted. Then the insurer 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.

5.10 Fraud

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

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

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

- 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 insurer.

5.11 Cancellation

- i. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, 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 this policy by giving 15 days’ written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Period of risk	Rate of premium to be charged
Up to 1 month	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

- iii. For policies with a term exceeding one year, the insured may at any time cancel the Policy and in such an event, the Company shall allow pro-rata refund of premium for the unexpired policy period after retaining 10% of the pro-rata premium, provided claim are not reported up to the date of cancellation

5.12 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.

5.13 Arbitration

- i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred 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.
- ii. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the Policy.
- iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the Policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

5.14 Disclaimer

If the Company shall disclaim liability 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.

5.15 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

- i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- iv. 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.
- v. No loading shall apply on renewals based on individual claims experience.

5.16 Enhancement of Sum Insured

Sum insured 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.

5.17 Adjustment of Premium for Overseas Travel Insurance Policy

If during the policy period any of the insured person is also covered by an Overseas Travel Insurance Policy of any non life insurance company, the Policy shall be inoperative in respect of the insured persons for the number of days the Overseas Travel Insurance Policy is in force 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.

5.18 Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

5.19 Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 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 any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

5.20 Withdrawal of Product

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

5.21 Revision of Terms of the Policy Including the Premium Rates

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

5.22 Free Look Period

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

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document 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 person, a deduction towards the proportionate risk premium for period of cover or
- iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

5.23 Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

6 DEFINITION

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

6.2 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.

6.3 Alternative Treatment means forms of treatments other than "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

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

- a. Central or State Government AYUSH Hospital or
- b. Teaching hospital attached to AYUSH College recognized by the Central Government/ Central Council of Indian Medicine/ Central Council for Homeopathy; or

- c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
- Having at least 5 in-patient beds;
 - Having qualified AYUSH Medical Practitioner in charge round the clock;
 - Having dedicated AYUSH therapy sections as required;
 - Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative

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

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

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

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

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

a) Internal Congenital Anomaly

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

b) External Congenital Anomaly

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

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

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

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

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

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

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

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

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

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

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

6.16 Family Members means spouse, children and parents of the insured, covered by the Policy.

6.17 Floater means the sum insured, as mentioned in the Schedule, available to all the insured persons, for any and all claims made in the aggregate during each policy year.

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

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

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

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

6.29 Medically Necessary means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

- i. is required for the medical management of the disease/ injuries suffered by the insured person;
- ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- iii. must have been prescribed by a medical practitioner;
- iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

6.31 Network Provider means hospitals or health care providers enlisted by the Company or jointly by the Company and a TPA to provide medical services to an insured person on payment by a cashless facility.

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

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

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

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

6.36 Policy Period means period of one policy year/ two policy years/ three policy years as mentioned in the schedule for which the Policy is issued.

6.37 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.

6.38 Preferred Provider Network (PPN) means a network of hospitals which have agreed to a cashless packaged pricing for listed procedures for the insured person. The list is available on the website of the Company/TPA and subject to amendment from time to time. For the updated list please visit the website of the Company/TPA. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.

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

- a) That is/are diagnosed by a physician within 48 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 48 months prior to the effective date of the Policy issued by the Company or its reinstatement.

6.40 Portability means the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

6.41 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.

6.42 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.

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

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

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 Service Provider means an entity engaged by the Company to provide Medical Second Opinion.

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

6.48 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.

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

6.50 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

In case of any grievance the insured person may contact the company through

Website: <https://nationalinsurance.nic.co.in/>

Toll free: 1800 345 0330

E-mail: customer.relations@nic.co.in

Phn : (033) 2283 1742

Post: National Insurance Co. Ltd.,

6A Middleton Street, 7th Floor,

CRM Dept.,

Kolkata - 700 071

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer (Office in-Charge) at that location.

For updated details of grievance officer, kindly refer the link: <https://nationalinsurance.nic.co.in/>

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017 (Annexure VI).

Grievance may also be lodged at IRDAI Integrated Grievance Management System - <https://igms.irda.gov.in/>

8 OPTIONAL COVERS

8.1 Pre-existing Diabetes / Hypertension

Subject otherwise to the terms, definitions, exclusions, and conditions of the Policy and on payment of additional premium, the Company shall pay expenses for treatment of diabetes and/ or hypertension, if pre-existing, from the inception of the Policy. On completion of continuous forty eight months of insurance, the additional premium and co-payment shall not apply.

Copayment

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

- i. Insured opting for cover for pre existing diabetes, can avail treatment for diabetes, subject to a copayment of 10%
- ii. Insured opting for cover for pre existing hypertension, can avail treatment for hypertension, subject to a copayment of 10%
- iii. Insured opting for cover for pre existing diabetes and hypertension, can avail treatment for diabetes or hypertension, subject to a copayment of 25%

Eligibility

As per the Policy.

Limit of Cover

Sum Insured opted under the policy shall apply.

Policy period

The policy period for the Policy, and the cover should be identical, as mentioned in the schedule.

Tax rebate

The insured can avail tax benefits for the premium paid, under Section 80D of Income Tax Act 1961.

Renewal

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

8.1.1 Condition

Claim Amount

Any amount payable shall be subject to the sum insured applicable to Section 2.1, copayment mentioned under Section 5.5.7 (Classification of Zone and Copayment), Section 5.5.8 (Treatment outside Network) and copayment mentioned above.

8.2 Out-patient Treatment

Subject otherwise to the terms, definitions, conditions and Exclusions 4.7, 4.8, 4.17, 4.16, 4.23, 4.12, 4.9, 4.10, 4.34 and 4.35, the Company shall pay up to the limit, as stated in the schedule with respect of

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

Eligibility

The cover can be availed by all insured persons as a floater.

Limit of Cover

Limit of cover, available under Outpatient Treatment are INR 2,000/ 3,000/ 4,000/ 5,000/ 10,000, in addition to the sum insured opted.

Policy Period

The policy period for the Policy, and the cover should be identical, as mentioned in the schedule.

Tax Rebate

The insured person can avail tax benefits for the premium paid, under Section 80D of Income Tax Act 1961.

Renewal

The Outpatient Treatment cover can be renewed annually throughout the lifetime of the insured person.

8.2.1 Exclusions

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

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

8.2.2 Condition

Claim Amount

- i. Any amount payable under the optional covers will not affect the sum insured applicable to Section 2.1 and entitlement to No Claim Discount (Section 3.1) and Health Check up (Section 3.2).
- ii. Any amount payable shall not be subject to copayment.

Claims Procedure

Documents supporting all out-patient treatments shall be submitted to the TPA/ Company twice during the policy period, within thirty days of completion of six month period.

Documents

The claim has to be supported by the following original documents

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

Enhancement of Limit of Cover

Limit of cover can be enhanced only at the time of renewal.

8.3 Critical Illness

Subject otherwise to the terms, definitions, exclusions, and conditions of the Policy the Company shall pay the benefit amount, as stated in the schedule, provided that

- i. the insured person is first diagnosed as suffering from a critical illness during the policy period, and
- ii. the insured person survives at least thirty days following such diagnosis
- iii. diagnosis of critical illness is supported by clinical, radiological, histological and laboratory evidence acceptable to the Company.

Eligibility (entry age)

The cover can be availed by persons between the age of eighteen years and sixty five years.

Benefit Amount

Benefit amount available per individual are INR 2,00,000/ 3,00,000/ 5,00,000/ 10,00,000, in addition to the sum insured opted.

Policy Period

The policy period for the Policy, and the cover should be identical, as mentioned in the schedule.

Pre Policy checkup

Pre Policy checkup reports are required for individual opting for Critical illness cover between the age of eighteen years and sixty five years.

Tax Rebate

No tax benefit is allowed on the premium paid under Critical Illness cover (if opted)

Renewal

The Critical Illness cover can be renewed annually throughout the lifetime of the insured person.

8.3.1 Definition

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

I Stroke Resulting in Permanent Symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist

medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least three months has to be produced.

The following are not covered

- i. transient ischemic attacks (TIA)
- ii. traumatic injury of the brain
- iii. vascular disease affecting only the eye or optic nerve or vestibular functions.

II Cancer of Specified Severity

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

The following are not covered

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

III Kidney Failure requiring Regular Dialysis

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

IV Major Organ/ Bone Marrow Transplant

The actual undergoing of a transplant of:

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

The following are not covered

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

V Multiple Sclerosis with Persisting Symptoms

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

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

The following are not covered

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

VI Open Chest CABG

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

The following are not covered

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

VII Permanent Paralysis of Limbs

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

VIII Blindness

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

8.3.2 Exclusions

The Company shall not be liable to make any payment by the Policy if any critical illness and/or its symptoms (and/or the treatment) which were present at any time before inception of the Policy, or which manifest within a period of ninety days from inception of the Policy, whether or not the insured person had knowledge that the symptoms or treatment were related to such critical illness. In the event of break in the Policy, the terms of this exclusion shall apply as new from recommencement of cover

8.3.3 Condition

Claim Amount

- i. Any amount payable under the optional covers will not affect the sum insured applicable to Section 2.1 and entitlement to No Claim Discount (Section 3.1) and Health Check up (Section 3.2).
- ii. Any amount payable shall not be subject to copayment.

Notification of Claim

In the event of a claim, the insured person/insured person's representative shall intimate the Company in writing by letter, e-mail, fax providing all relevant information relating to the critical illness within fifteen days of diagnosis of the critical illness.

Claims Procedure

Documents as mentioned above, supporting the diagnosis shall be submitted to the Company within sixty days from the date of diagnosis of the critical illness.

Documents

The claim has to be supported by the following original documents

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

Cessation of Cover

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

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

Enhancement of Benefit Amount

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

Insurance is the subject matter of solicitation

Please preserve the Policy for all future reference.

Table of Benefits

Features	Benefit
Sum insured (SI) (as Floater)	INR 1/ 2/ 3/ 4/ /5/ 6/ 7/ 8/ /9 10Lac
Treatment	Allopathy, Ayurveda and Homeopathy
In built Covers (subject to the SI)	
In patient Treatment (as Floater)	Up to SI
Pre Hospitalisation	30 days
Post Hospitalisation	60 days
Pre-existing Disease (Only PEDs declared in the Proposal Form and accepted for coverage by the Company shall be covered)	Covered after 48 months
* Room/ ICU Charges (per day per insured person)	Room - Up to 1% of SI or actual, whichever is lower ICU – Up to 2% of SI or actual, whichever is lower
** Limit for Cataract Surgery (For each eye per insured person)	Up to 10% of SI or INR 50,000 whichever is lower
Domiciliary Hospitalisation (as Floater)	Up to 20% of SI, subject to maximum of INR 50,000
Day Care Procedures (as Floater)	Up to SI
Ayurveda and Homeopathy (as Floater)	Up to SI
Organ Donor's Medical Expenses (as Floater)	Hospitalisation, pre and post hospitalisation
Hospital Cash (per insured person, per day)	INR 300, max. of 5 days
Ambulance (per insured person, in a policy year)	Up to INR 1,000/- per illness & INR 2,500/-
Anti rabies Vaccination (per insured person, in a policy year)	Up to INR 5,000
Maternity (including Baby from Birth Cover) (per insured person, in a policy year, waiting period of 3 years applies)	Up to 10% of SI subject to INR 30,000 in case of normal delivery and INR 50,000 in case of caesarean section
Infertility (per insured person, in a policy year, waiting period of 3 years applies)	Up to INR 50,000
Modern Treatment (12 nos)	Up to 25% of SI for each treatment
Treatment due to participation in hazardous or adventure sports (non-professionals)	Up to 25% of SI
Morbid Obesity	Covered after waiting period of 4 years
Refractive Error (min 7.5D)	Covered after waiting period of 2 years
Other benefits	
Medical Second Opinion (MSO) (for 88 major illness)	One MSO per family in a policy year
Good Health Incentives	
No Claim Discount	5% discount on base premium
Health Check Up (as Floater)	Every 4 yrs., up to INR 5,000
Optional Cover	
Pre-existing Diabetes/Hypertension (as Floater)	Up to the SI
Out-patient Treatment (as Floater in a policy year)	Limit of cover per family - INR 2,000/ 3,000/ 4,000/ 5,000/ 10,000 in addition to the SI
***Critical Illness (per insured person in a policy year)	Benefit amount - INR 2,00,000/ 3,00,000/ 5,00,000/ 10,00,000 in addition to the SI

* The limit shall not apply if the treatment is undergone for a listed procedure in a Preferred Provider Network (PPN) as a package.

** The limit shall not apply if the treatment is undergone for a listed procedure in a Preferred Provider Network (PPN) as a package

*** Critical Illness benefit amount should not be more than the sum insured opted under the Policy

Day Care Procedure

Day care procedures will include following day care surgeries and day care treatment.

Microsurgical operations on the middle ear

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

Other operations on the middle and internal ear

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

Operations on the nose and the nasal sinuses

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

Operations on the eyes

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

Operations on the skin and subcutaneous tissues

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

Operations on the tongue

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

Operations on the salivary glands and salivary ducts

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

Other operations on the mouth and face

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

Operations on the tonsils and adenoids

68. Transoral incision and drainage of a pharyngeal abscess
69. Tonsillectomy without adenoidectomy
70. Tonsillectomy with adenoidectomy

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.

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
80. Incision and excision of tissue in the perianal region

Operations on the digestive tract

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

Major Illness**Medical Second Opinion can be availed for the following illnesses**

Non-Cancerous Diseases		Cancerous Diseases	
1	AIDS/HIV	60	Bladder Cancer
2	Amyotrophic Lateral Sclerosis	61	Bone Cancer
3	Angioplasty	62	Brain Tumor
4	Aortic Aneurysm	63	Breast Cancer
5	Apallic Syndrome (Vegetative State)	64	Cervical Cancer
6	Aplastic Anaemia	65	Colorectal Cancer
7	Benign Brain Tumor	66	Esophageal Cancer
8	Blindness	67	Eye Cancer
9	Bone Marrow Transplantation	68	Gallbladder Cancer
10	Cardiomyopathy	69	Kidney Cancer
11	Cerebrovascular Diseases	70	Leukemia
12	Chronic Obstructive Pulmonary Disease	71	Liver Cancer
13	Chronic Relapsing Pancreatitis	72	Lung Cancer
14	Cirrhosis	73	Lymphoma
15	Coma	74	Melanoma
16	Congenital Heart Defect	75	Multiple Myeloma
17	Coronary Artery Bypass Surgery	76	Nasopharyngeal Cancer
18	Coronary Artery Disease (CAD)	77	Neuroblastoma
19	Creutzfeldt -Jacob Disease (CJD)	78	Non-Hodgkin's Lymphoma
20	Cystic Fibrosis (CF)	79	Oral Cavity Cancer
21	Elephantiasis	80	Ovarian Cancer
22	Emphysema	81	Pancreatic Cancer
23	(End Stage) Liver Disease	82	Prostate Cancer
24	(End Stage) Lung Disease	83	Skin Cancer, non-Melanoma
25	(Fulminant) Viral Hepatitis	84	Stomach Cancer
26	Heart Valve Surgery	85	Testicular Cancer
27	HIV Infection Due to Blood Transfusion	86	Thyroid Cancer
28	Kidney Failure	87	Uterine Cancer
29	Liver Failure	88	Vaginal Cancer
30	Valvular Heart Disease		
31	Loss of Hearing		
32	Loss of Limbs		
33	Loss of Speech		
34	Major Burns		
35	Major Organ Transplantation		
36	Medullary Cystic Disease		
37	Motor Neuron Disease		
38	Multiple Sclerosis		
39	Muscular Dystrophy		
40	Myasthenia Gravis		
41	Myelodysplastic Syndrome (Myelodysplasia)		
42	Myocardial Infarction (MI)		
43	Necrotizing Fasciitis (Flesh Eating Disease)		
44	Paralysis		
45	Parkinson's Disease (PD)		
46	Poliomyelitis		
47	Primary Lateral Sclerosis (PLS)		
48	Primary Pulmonary Arterial Hypertension		
49	Progressive Muscular Atrophy (PMA)		
50	Progressive Scleroderma		
51	Pulmonary Arterial Hypertension		
52	Renal Failure = Kidney failure: see above		
53	(Severe) Asthma		
54	Severe Brain Damage		
55	(Severe) Rheumatoid Arthritis		
56	Stroke		
57	Surgery to Aorta		
58	Systemic Lupus Erythematosus		
59	Ulcerative Colitis		

Vaccinations for Children		
Time interval	Type of vaccination	Frequency
0-3 months	BCG (From birth to 2 weeks)	1
	OPV (0,6,10 weeks) OR OPV + IPV1 (6,10 weeks)	3 OR 4
	DPT (6 & 10 week)	2
	Hepatitis-B (0 & 6 week)	2
	Hib (6 & 10 week)	2

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

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

List of illnesses permanently excluded if existing at the time of taking the Policy

Sl	Existing Disease	ICD Code Excluded
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs • C40-C41 Malignant neoplasms of bone and articular cartilage • C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue • D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behaviour
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25) Ischemic heart diseases, I50 Heart failure, I42 Cardiomyopathy; I05-I09 - Chronic rheumatic heart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system • Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0 Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1 to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 - Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 - Other ulcerative colitis; K51.9 - Ulcerative colitis, unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 – Acute hepatitis B without delta-agent and without hepatic coma; B17.0 - Acute delta-(super) infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease	G30.9 - Alzheimer's disease, unspecified; F00.9 -G30.9 Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	HIV & AIDS	B20.0 - HIV disease resulting in mycobacterial infection; B20.1 - HIV disease resulting in other bacterial infections; B20.2 - HIV disease resulting in cytomegaloviral disease; B20.3 - HIV disease resulting in other viral infections; B20.4 - HIV disease resulting in candidiasis; B20.5 - HIV disease resulting in other mycoses; B20.6 - HIV disease resulting in Pneumocystis carinii pneumonia; B20.7 - HIV disease resulting in multiple infections; B20.8 - HIV disease resulting in other infectious and parasitic diseases; B20.9 - HIV disease resulting in unspecified infectious or parasitic disease; B23.0 - Acute HIV infection syndrome; B24 - Unspecified human immunodeficiency virus [HIV] disease
14	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
15	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
16	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

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, Jeevan Prakash Building, 6 th Floor, Tilak Marg, Relief Road, Ahmedabad-380001 Tel: 079 -25501201/ 02/ 05/ 06 Email: bimalokpal.ahmedabad@ecoi.co.in		Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
Karnataka	Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.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@ecoi.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.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@ecoi.co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 / 2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, JeevanSevaAnnexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.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@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshihar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautambuddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514251 / 2514253 Email: bimalokpal.noida@ecoi.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@ecoi.co.in	Bihar, Jharkhand.	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481 / 23213504 Email: bimalokpal.delhi@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	Office of the Insurance Ombudsman, JeevanDarshan 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@ecoi.co.in
Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, JeevanNivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@ecoi.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@ecoi.co.in		
Rajasthan	Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.		