National Insurance Company Limited

(A Govt. of India Undertaking)

CIN - U10200WB1906GOI001713 **IRDA Regn. No. - 58**

National MediclaimPlus Policy

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

Issuing Office

National Mediclaim Plus 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., (herein after called the company) for the insurance herein after set forth in respect of person(s) named in the schedule hereto (herein after called the insured person) and has paid premium as consideration for such insurance.

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

2.1Coverage
2.1.1 In-patient treatment
The company shall pay to the hospital or reimburse the insured in respect of the medical expenses for:
i. Room charges and intensive care unit charges (including diet charges, nursing care by qualified nurse, RMO charges, administration charges for IV fluids/blood transfusion/injection), subject to limit as mentioned in Section 2.1.1.1
ii. Medical practitioner(s)
iii. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances
iv. Medicines and drugs
v. Diagnostic procedures
vi. Prosthetics and other devices or equipment if implanted internally during a surgical procedure.

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

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

2.1.2 Pre hospitalisation
The company shall reimburse the insured in respect of the medical expenses incurred up to 30 (thirty) days immediately before the insured person is hospitalised, provided that:
i. such medical expenses are incurred for the same condition for which the insured person's hospitalisation was required, and
ii. the in-patient hospitalisation claim for such hospitalisation is admissible by the company
Pre hospitalisation shall be considered as part of hospitalisation claim.

2.1.3 Post hospitalisation
The company shall reimburse the insured in respect of the medical expenses incurred up to 60 (sixty) days immediately after the insured person is discharged from hospital, provided that:
i. such medical expenses are incurred for the same condition for which the insured person's hospitalisation was required, and
ii. the in-patient hospitalisation claim for such hospitalisation is admissible by the company
Post hospitalisation shall be considered as part of hospitalisation claim.

2.1.4 Daycare procedure
The company shall pay to the hospital in respect of the medical expenses or reimburse the insured in respect of the medical expenses and pre and post hospitalisation expenses, for day care procedures which require hospitalisation for less than 24 (twenty four) hours provided that
i. day care procedures/surgeries (as listed in Appendix -I) where such treatment is taken 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 24 (twenty four) hours and for which prior approval from company/TPA is mandatory.

2.1.5 Ayurveda and Homeopathy
The company shall pay to the hospital in respect of the medical expenses or reimburse the insured in respect of the medical expenses pre and post hospitalisation expenses, incurred for Ayurveda and Homeopathy treatment up to the limit as mentioned in the Table of Benefits provided treatment is taken in a government hospital or in an institute recognized by government and/or accredited by Quality Council of India/ National Accreditation Board for Health.

2.1.6 Organ donor's medical expenses
The company shall reimburse the insured in respect of expenses of hospitalisation of organ donor during the course of organ transplant of the insured person provided that
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. Organ donor's pre and post hospitalisation expenses, as per Section 2.1.2 and Section 2.1.3.

2.1.7 Maternity
The company shall pay to the hospital or reimburse the insured in respect of medical expenses, incurred as an in-patient, with respect to delivery or termination up to first two deliveries or terminations of pregnancy, after the policy has been continuously in force for 24 (twenty four) months, during the lifetime of the insured or the spouse of the insured, if covered under the policy, as described below, up to the limit mentioned in the Table of Benefits.
i. Medical expense for delivery (normal or caesarean).
ii. Medical expense for lawful medical termination of pregnancy.
iii. Medical expenses for pre natal medically necessary hospitalisation, up to 30 (thirty) days and post natal medically necessary hospitalisation, up to 60 (sixty) days, per delivery or lawful termination of pregnancy, if incurred as an in-patient.
iv. Medical expenses of the new born baby, including expenses with respect to vaccination (as listed in Appendix III). Hospitalisation is not required for vaccination of new born baby.

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. Delivery or termination within 2 (two) years of continuous coverage from the inception of the policy, or from the date of inclusion of insured person, whichever is later. However, this period can be waived only in the case of delivery, miscarriage or abortion induced by accident or other medical emergency.
2. More than one delivery or termination in a policy period.
3. Ectopic pregnancy. However, ectopic pregnancy is covered under Section 2.1.1 provided it may be established by medical reports.
4. Pre and post hospitalisation expenses as per Section 2.1.2 and Section 2.1.3, other than pre and post natal treatment.

2.1.8 Hospital cash
The company shall pay the insured a daily hospital cash allowance up to the limit mentioned in the Table of Benefits for a maximum of 5 (five) days, provided
i. hospitalisation exceeds 3 (three) days and starts within the policy period.
ii. a claim has been admitted under Section 2.1.1

2.1.9 Ambulance
The company shall reimburse the insured in respect of expenses incurred for transportation of the insured person to the hospital by ambulance up to the limit as mentioned in the Table of Benefits, provided a claim has been admitted under Section 2.1.1.

2.1.10 Air ambulance
The company shall reimburse the insured in respect of expenses incurred for medical evacuation of the insured person by air ambulance to the nearest hospital or from one hospital to another hospital following an emergency up to the limit mentioned in the Table of Benefits, provided prior intimation is given to the company/TPA, and a claim has been admitted under Section 2.1.1.

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

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

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

2.1.13 Vaccination for children
The company shall reimburse the insured, in respect of expenses incurred for vaccinations of children (up to 12 years), as listed in Appendix III, up to the limit mentioned in the Table of Benefits, provided the children are covered under the policy. Hospitalisation is not required for this benefit.

2.2 Medical Second Opinion
The company shall arrange for 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 as listed in Appendix II, during the policy period. The insured person can avail one Medical Second Opinion for each major illness (as listed in Appendix II to the policy) diagnosed during the policy period.
The insured person shall provide the medical records containing a diagnosis and a recommended course of treatment to the TPA. 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.

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 make 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 to which the Medical Second Opinion is put
iii. the company assume no 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.

Copayment
Claims under Section 2.1, except claims under Section 2.1.13 (Vaccination for children), shall be subject to a co payment of 20% (twenty percent) of the admissible claim amount if treatment is taken in a non-network provider. Co payment shall not apply to claims if treatment is undergone in a non-network provider in a place where the company/ TPA does not have tie-up with any hospital.

3 Good health incentives

3.1 Cumulative bonus (CB)
At the time of renewal, cumulative bonus allowed shall be an amount equal to 5% (five percent) of sum insured (excluding CB) of the expiring policy in respect of an insured person, provided no claims were reported under the expiring policy.
In the event of a claim being reported under the expiring policy the cumulative bonus with respect to the insured person shall be reduced by an amount equal to 5% (five percent) of sum insured (excluding CB) of the expiring policy. However, the reduction of CB will not impact sum insured (excluding CB).
Cumulative bonus shall be aggregated over the years and available, subject to maximum of 50% (fifty percent) of the sum insured (excluding CB) of the expiring policy.

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

4 Exclusions
The company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

4.1 Pre-existing diseases
All pre-existing diseases. Such diseases shall be covered after the policy has been continuously in force for 36 (thirty six) months. Any complication arising from pre-existing disease shall be considered as a part of the pre existing disease.
To illustrate if a person is suffering from either hypertension or diabetes or both at the time of taking the policy, then the policy shall be subject to following exclusions.

Diabetes	Hypertension	Diabetes and Hypertension
Diabetic Retinopathy	Coronary Artery Disease	Diabetic Retinopathy
Diabetic Nephropathy	Cerebro Vascular Accident	Diabetic Nephropathy

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

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

4.3 Specific waiting period
Following diseases/treatments are subject to a waiting period mentioned below.

i. **One year waiting period**
   a. Benign ENT disorders
   b. Tonsillectomy/Adenoidectomy/Mastoidectomy/Tympanoplasty

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

iii. **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**

4.4 HIV, AIDS, STD
Any condition directly or indirectly caused to or associated with HIV, AIDS, complications of AIDS and other sexually transmitted diseases (STD).

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

4.6 Sterility, infertility, assisted conception
Sterility, infertility/sub fertility, assisted conception procedures.

4.7 Pregnancy
Save as and to the extent provided for under Section 2.1.7, treatment arising from or traceable to pregnancy/childbirth including caesarean section, miscarriage, surrogate or vicarious pregnancy, abortion or complications thereof including changes in chronic conditions arising out of pregnancy

4.8 Refractive error
Surgery for correction of eye sight due to refractive error.

4.9 Obesity
Treatment for obesity or condition arising there from (including morbid obesity) and any other weight control and management program/services/supplies or treatment.

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

4.11 Genetic disorders, stem cell surgery.

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

4.13 Vaccination or inoculation
Save as and to the extent provided for under Section 2.1.7.iv and Section 2.1.13, vaccination or inoculation unless forming part of treatment and requires hospitalisation.

4.14 Cosmetic treatment, plastic surgery, sex change, hormone replacement
Cosmetic treatment or aesthetic treatment of any description, change of life or sex change operation, hormone replacement therapy. Expenses for plastic surgery other than as may be necessitated due to disease/ injury.

4.15 Massages, spa, steam bath, naturopathy, experimental treatment
Massages, spa, steam bath, shirodhara, udhwarthanam, abhyangam, kayasekham and similar treatment.
Expenses for naturopathy, experimental medicine/treatment, unproven procedure/treatment, alternative treatments (other than ayurveda and homeopathy), acupuncture, acupressure, magneto-therapy and similar treatment.

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

4.17 Vitamins, tonics
Vitamins and tonics unless forming part of treatment for disease/injury as certified by the attending medical practitioner.

4.18 Out-patient treatment
Any treatment taken as an out-patient.

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

4.20Treatment in convalescent home, nature clinic
Treatment in health hydro/nature care clinic rest home or convalescent home for the addicted, detoxification centre, sanatorium, home for the aged, mentally disturbed, remodeling clinic or similar institution.

4.21 Drug/alcohol abuse
Treatment arising out of disease/injury due to misuse or abuse of drugs/alcohol or use of intoxicating substances.

4.22 Stay in hospital which is not medically necessary.

4.23 Spectacles, contact lens, hearing aid, cochlear implants.

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

4.25 Expenses non related to the diagnosis and treatment of disease/ injury
Irrelevant investigations/treatment, drugs not supported by a prescription, private nursing charges, referral fee to family physician, outstation doctor/surgeon/consultants' fees and similar expenses (as listed in Appendix IV).

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

4.27 Service charge/ registration fee
Any kind of service charges including surcharges, admission fees, registration charges and similar charges (as listed in Appendix IV) levied by the hospital.

4.28 Home visit charges
Save as and to the extent provided for under Section 2.1.12, home visit charges during pre and post hospitalisation of doctor, attendant and nurse.

4.29 Treatment not related to disease
Treatment which the insured person was on before hospitalisation for the disease/ injury, different from the one for which claim for hospitalisation has been made.

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

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

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

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

5 Conditions

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

5.2 Condition precedent to admission of liability
The due observance and fulfillment of the terms and conditions of the policy, by the insured person, shall be a condition precedent to any liability of the company to make any payment under the policy.

5.3 Communication
i. All communication should be in writing.
ii. For claim serviced by TPA, ID card, PPN/network provider related issues to be communicated to the TPA at the address mentioned in the schedule. For claim serviced by the company, the policy related issues, change in address to be communicated to the policy issuing office at the address mentioned in the schedule.
iii. The company or TPA shall communicate to the insured person at the address mentioned in the schedule.

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

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

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

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

In case of a claim under Section 2.2, notification of claim is not required.

5.5.2 Procedure for Cashless claims
i. Cashless facility for treatment in network hospitals shall be available to insured if opted for claim processing by TPA.
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 reimbursement.

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

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

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

Type of claim	**Time limit for submission of documents to company/TPA**
Reimbursement of hospitalisation and pre hospitalisation expenses	Within 15 (fifteen) days of date of discharge from hospital
Reimbursement of post hospitalisation expenses	Within 15 (fifteen) days from completion of post hospitalisation treatment
Reimbursement of health checkup expenses (as per Section 3.2)	At least 45 (forty five) days before the expiry of the third policy period.
Vaccination for children	Within 15 (fifteen) days from date of vaccination

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

5.5.6 Services offered by TPA
The TPA shall render health care services covered under the policy like issuance of ID cards & guide book, hospitalization & pre-authorization services, call centre, acceptance of claim related documents, claim processing and other related services
The services offered by a TPA shall not include
i. Claim settlement and rejection with respect to the policy; However, TPA may handle claims admission and recommend to the company for the payment of the claim settlement
ii. Any services directly to the insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the company.

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

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

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

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

5.9 Subrogation
In the event of a claim paid under the policy, it is the right of the company to assume the rights of the insured person to recover expenses paid that may be recovered from any other source.

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

5.11 Cancellation
The company may at any time cancel the policy (on grounds of fraud, moral hazard, misrepresentation or noncooperation) by sending the insured person 30 (thirty) days notice by registered letter at insured person's last known address and in such event the company shall not allow any refund.
The insured person may at any time cancel the policy and in such an event the company shall allow refund of premium after charging premium at company's short period rate mentioned below provided no claim is reported up to the date of cancellation.

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

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

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

5.14 Disclaimer
If the company shall disclaim liability to the insured person for any claim hereunder and if the insured person shall not within 12 calendar months from the date of receipt of the notice of such disclaimer notify the company in writing that he does not accept such disclaimer and intends to recover his claim from the company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.15 Renewal of policy
The policy may be renewed by mutual consent. The company is not bound to give notice that it is due for renewal. Renewal of the policy cannot be denied other than on grounds of fraud, moral hazard, misrepresentation or noncooperation. In the event of break in the policy a grace period of 30 (thirty) days is allowed. Coverage is not available during the grace period.

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

5.18 Portability
In the event of the insured person porting to any other insurer, insured person must apply with details of the policy and claims to the insurer where the insured person wants to port, at least 45 (forty five) days before the date of expiry of the policy.
Portability shall be allowed in the following cases:
i. all individual health insurance policies issued by non-life insurance companies including family floater policies.
ii. individual members, including the family members covered under any group health insurance policy of a non-life insurance company shall have the right to migrate from such a group policy to an individual health insurance policy or a family floater policy with the same insurer. One year thereafter, the insured person shall be accorded the right to port to another non-life insurance company.

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

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

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

5.22 Free look period
The insured person is allowed a period of 15 (fifteen) days from date of receipt of policy to review the terms and conditions of the policy, and to return the same if not acceptable.
If the insured person has exercised the option of free look period and has not made any claim during the free look period, the insured person shall be entitled to-
i. a refund of the premium paid less any expenses incurred by the company on medical examination of the insured person and the stamp duty charges; or
ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period on cover
The free look provision is not applicable to renewal of the policy.

5.23 Nomination
The insured is mandatorily required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the insured.
Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made.
In case of any insured person other than the insured under the policy, for the purpose of payment of claims in the event of death, the default nominee would be the insured.
No assignment of the policy or the benefits there under shall be permitted.

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 45 (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 "modem medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

6.4 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.

6.5 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.

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

6.7 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.

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

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

i. **Internal congenital anomaly** means congenital anomaly which is not in the visible and accessible parts of the body
ii. **External congenital anomaly** means congenital anomaly which is in the visible and accessible parts of the body

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

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

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

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

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

i. undertaken under general or local anesthesia in a hospital/day care centre in less than 24 (twenty four) hrs because of technological advancement, and
ii. which would have otherwise required a hospitalisation of more than 24(twenty four) hours.

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

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

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

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

6.17 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 10 (ten) inpatient beds, in those towns having a population of less than 10,00,000 (10 lacs) and 15(fifteen) inpatient beds in all other places;
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.

6.18 Hospitalisationmeans admission in a hospital for a minimum period of 24 (twenty four) consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 (twenty four) consecutive hours.
Relaxation to 24(twenty four) hours minimum duration for hospitalisation is allowed in

i. day care procedures/surgeries (as listed in Appendix -I) where such treatment is taken 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 24(twenty four) hours and for which prior approval from company/TPA is mandatory.

6.19 I D card means the card issued to the insured person by the TPA for availing cashless facility in the network provider.

6.20 Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.

i. **Acute condition** means a disease, illness orinjury that is likely to respons quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
ii. **Chronic condition** means a disease, illness, or injury that has one or more of the following characteristics
    a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
    b) it needs ongoing or long-term control or relief 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.

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

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

6.23 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.

6.24 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.

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

6.26 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.

6.27 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.

6.28 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.

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

6.30 Newborn baby means baby born during the policy period and is aged between 1 (one) day and 90 (ninety) days, both days inclusive.

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

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

6.33 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.

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

6.35 Preferred provider network (PPN) means a network of hospitals which have agreed to a cashless packaged pricing for certain procedures for the insured person. The list is available with the company/TPA and subject to amendment from time to

time. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.

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

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

6.38 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.

6.39 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.

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

6.41 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.

6.42 Sum insured means the sum insured and the cumulative bonus accrued in respect of each insured person as mentioned in the schedule. The sum insured represents maximum liability for each insured person for any and all benefits claimed during the policy period, except any claim under the optional covers. Health check up expenses are payable over and above the sum insured, wherever applicable.

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

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

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

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

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

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

8 Optional covers

8.1 Critical illness

Subject otherwise to the terms, definitions, exclusions, and conditions of the policy and subject to the terms, definitions, exclusions, and conditions contained herein, it is hereby understood and agreed that the company shall pay the benefit amount, as stated in the schedule, provided that

i. the insured person is first diagnosed as suffering from a critical illness during the policy period, and
ii. the insured person survives at least 30 (thirty) days following such diagnosis
iii. diagnosis of critical illness is supported by clinical, radiological, histological and laboratory evidence acceptable to the company.

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

I Stroke resulting in permanent symptoms
Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 (three) months has to be produced.

The following are not covered
i. transient ischemic attacks (TIA)
ii. traumatic injury of the brain
iii. vascular disease affecting only the eye or optic nerve or vestibular functions.

II Cancer of specified severity
A malignant tumourcharacterised 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. alltumours of the prostate unless histologically classified as having a Gleason score greater than 6 (six) or having progressed to at least clinical TNM classification T2N0M0.
iv. papillary micro - carcinoma of the thyroid less than 1 (one) cm in diameter
v. chronic lymphocycticleukaemia less than RAI stage 3
vi. microcarcinoma of the bladder
vii. alltumours in the presence of HIV infection.

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

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

The following are not covered
i. other stem-cell transplants
ii. where only islets of langerhans are transplanted

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

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

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

The following are not covered
i. angioplasty and/or any other intra-arterial procedures

ii. any key-hole or laser surgery.

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

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

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

8.1.3 Condition
Claim amount
i. Any amount payable under the optional covers will not affect the sum insured applicable to Section 2.1.
ii. Copayment shall not apply to claims under optional covers.
iii. Any amount payable under the optional covers shall not affect the entitlement to cumulative bonus.

Notification of claim
In the event of a claim, the insured person/insured person's representative shall intimate the company in writing by letter, e-mail, fax providing all relevant information relating to the critical illness within 15 (fifteen) days of critical illness diagnosis

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

Documents
The claim is to be supported with the following original documents
i. Doctor's certificate confirming diagnosis of the critical illness along with date of diagnosis.
ii. Pathological/other diagnostic test reports confirming the diagnosis of the critical illness.
iii. Any other documents required by the company

Cessation of cover
1 This cover shall cease upon payment of the benefit amount on the occurrence of a critical illness and no further claim shall be paid for any other critical illness during the policy period.
2 On renewal, no claim shall be paid for any critical illness for which claim has already been made

Cancellation
In the event of cancellation of the policy by either insured or the company, the cover shall also be cancelled as per cancellation clause of the policy.

8.2 Out-patient treatment
Subject otherwise to the terms, definitions, conditions and Exclusions 4.14, 4.15, 4.21, 4.30, 4.31, 4.32 and 4.33, and subject to the terms, definitions, exclusions, and conditions contained herein, it is hereby understood and agreed that the company shall pay up to the limit, as stated in the schedule with respect of
i. Out-patient consultations by a medical practitioner
ii. Diagnostic tests prescribed by a medical practitioner
iii. Medicines/drugs prescribed by a medical practitioner
iv. Out patient dental treatment

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.

ii. Copayment shall not apply to claims under optional covers.
iii. Any amount payable under the optional covers shall not affect the entitlement to cumulative bonus.

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

Documents
The claim is to be supported with the following original documents
i. All bills, prescriptions from medical practitioner
ii. Diagnostic test bills, copy of reports
iii. Any other documents required by the company

Cancellation
In the event of cancellation of the policy by either insured or the company, the cover shall also be cancelled as per cancellation clause of the policy.

Insurance is the subject matter of solicitation
Please preserve the policy for all future reference.

Table of Benefits

Features	**Plans**		
	PLAN A	**PLAN B**	**PLAN C**
Sum insured	**INR 2/ 3 /4 / 5/ 6/ 7/ 8/ 9 /10 Lac**	**INR 15/ 20 /25 Lac**	**INR 30/ 40/ 50 Lac**
Coverage			
Hospitalisation, Pre (30days) and Post (60 days) Hospitalisation, Daycare procedure	Covered	Covered	Covered
Pre existing disease	Covered after 36 months of continuous coverage	Covered after 36 months of continuous coverage	Covered after 36 months of continuous coverage
Room/ ICU charges	Room - Up to 1% of SI per day ICU – Up to 2% of SI per day subject to max. of INR 15,000 per day	Up to INR 15,000 per day	Up to INR 20,000 per day
Limit for cataract surgery	For each eye – Up to 15% of sum insured or INR 60,000 whichever is lower	For each eye – Up to INR 80,000	For each eye – Up to INR 1,00,000
Ayurveda and Homeopathy	Up to sum insured	Up to sum insured	Up to sum insured
Organ donor's medical expenses	Covered	Covered	Covered
Maternity	Up to INR 30,000 for normal delivery and INR 50,000 for cesarean section	Up to INR 60,000 for normal delivery and INR 75,000 for cesarean section	Up to INR 80,000 for normal delivery and INR 100,000 for cesarean section
Hospital cash	INR 500 per day, max. of 5 days	INR 800 per day, max. of 5 days	INR 1,000 per day, max. of 5 days
Ambulance	Up to INR 2,500 in a policy period	Up to INR 4,000 in a policy period	Up to INR 5,000 in a policy period
Air ambulance	Not covered	Up to 5% of SI per policy period	Up to 5% of SI per policy period
Medical emergency reunion	Not covered	Up to INR 20,000 per policy period	Up to INR 20,000 per policy period
Doctor's home visit and nursing care during post hospitalisation	Not covered	INR 750 per day, max. of 10 days	INR 1,000 per day, max. of 10 days
Vaccination for children (up to 12 years)	Up to INR 1,000 in a policy period	Up to INR 1,000 in a policy period	Up to INR 1,000 in a policy period
Other benefits			
Medical Second Opinion (MSO)	One MSO for each new diagnosis of any of the major illnesses in Appendix II, in a policy period	One MSO for each new diagnosis of any of the major illnesses in Appendix II, in a policy period	One MSO for each new diagnosis of any of the major illnesses in Appendix II, in a policy period
Good Health Incentives			
Cumulative bonus	Increase in SI by 5% of SI (excluding CB) per year up to 50% of SI (excluding CB)	Increase in SI by 5% of SI (excluding CB) per year up to 50% of SI (excluding CB)	Increase in SI by 5% of SI (excluding CB) per year up to 50% of SI (excluding CB)
Health checkup	Every 2 yrs., up to INR 1,000	Every 2 yrs., up to INR 2,000	Every 2 yrs., up to INR 3,000
Copayment			
Copayment of 20% of admissible claim if treatment taken in non-network hospital (not applicable to optional covers)	Applicable	Applicable	Applicable
Optional covers			
Critical Illness	Benefit amountper individual - INR 2,00,000/ 3,00,000/ 5,00,000/ 10,00,000/ 15,00,000/ 20,00,000/ 25,00,000.		
Outpatient Treatment	Limit of cover per individual - INR 2,000/ 3,000/ 4,000/ 5,000/ 10,000.		

Day Care Procedure

Microsurgical operations on the middle ear

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

Other operations on the middle and internal ear

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

Operations on the nose and the nasal sinuses

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

Operations on the eyes

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

Operations on the skin and subcutaneous tissues

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

Operations on the tongue

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

Operations on the salivary glands and salivary ducts

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

Other operations on the mouth and face

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

Operations on the tonsils and adenoids

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

Trauma surgery and orthopaedics

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

Operations on the breast

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

Operations on the digestive tract

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

Operations on the female sexual organs

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

Operations on the prostate and seminal vesicles

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

Operations on the scrotum and tunica vaginalis testis

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

Operations on the testes

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

 Operations on the spermatic cord, epididymis and ductus deferens

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

 Operations on the penis

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

 Operations on the urinary system

135. Cystoscopical removal of stones

 Other Operations

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

Note:

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

Major Illness

Medical Second Opinion can be availed for the following illnesses

CATEGORY	MEDICAL CONDITION
Brain Disorders	Brain Tumor – Malignant and Benign
	Cerebral Aneurysms
	Severe Brain Damage
	Cerebral AV Malformations
Cancer Conditions	Adrenal cancer
	Bladder cancer
	Bone cancer – all forms
	Breast cancer
	Cervical cancer
	Colon cancer
	Colorectal cancer
	Duodenal cancer
	Endometrial cancer
	Esophageal cancer
	Eye cancer
	Follicular cancer
	Gallbladder cancer
	Gastric cancer
	Kidney cancer
	Intestinal cancer
	Laryngeal cancer
	Liver cancer
	Lung cancer
	Malignant Soft Tissue
	Medullary cancer
	Melanoma
	Metastatic Spine Tumor
	Multiple Myeloma
	Myelodysplastic Syndrome (Myelodysplasia)
	Neuroblastoma
	Oral Cavity cancer
	Ovarian cancer
	Pancreatic cancer
	Papillary cancer
	Parotid cancer
	Prostate cancer
	Rectal cancer
	Sarcomas
	Skin cancer, non-melanoma
	Stomach cancer
	Testicular cancer
	Thyroid cancer
	Uterine cancer
	Vaginal cancer
	Vocal cord cancer
	All malignant conditions
Cardiovascular Disorders	Abdominal Aortic Aneurysm
	Angina
	Aortic Aneurysm
	Cardiac Arrhythmia
	Cardiac Pacemaker (history of)
	Cardiomyopathy
	Congenital Heart Defect
	Congestive Heart Failure
	Coronary Artery Disease
	Coronary Bypass Surgery Evaluation
	Dilated Cardiomyopathy
	Heart Transplantation (evaluation for)
	Heart valve surgery
	Hypertensive Heart Disease
	Myocardial Infarction (MI)
	Pulmonary Arterial Hypertension
	ValvularHeart Disease
Colorectal Disorders	Colitis
	Crohn's Disease
	Ulcerative Colitis
Dermatological Disorders	Skin Ulcer
Endocrine Disorders	Aldocortisol Secreting Tumor
	Graves Disease
	M.E.N. (Multiple Endocrine Neoplasia Syndrome)
	Thyroiditis
Sensory Disorders	Age Related Macular Degeneration
	Blindness
	Diabetic Retinopathy
	Loss of Hearing
	Loss of Speech Macular Detachment
	Proliferative Vitreoretinopathy
	Retinal Detachment
Gastrointestinal Disorders	Chronic Relapsing Pancreatitis
	Cirrhosis
	Inflammatory Bowel Disease
	Hepatitis
	End state liver disease
	Liver failure
	Irritable Bowel Syndrome
	Large bowel disease
	Small bowel disease
Gynecological Disorders	Infertility (female)
Hematological Disorders	Aplastic Anemia
	Coagulopathies
	Hodgkin's disease (Pediatric)
	Leukemia (Adult & Pediatrics)
	Lymphoma (Adult & Pediatric)
	Non-Hodgkin's Lymphoma (Adult & Pediatric)
Neurologic Disorders	Amyotrophic Lateral Sclerosis
	Apallic Syndrome (Vegetative State)
	Coma
	Medullary Cystic Disease
	Motor Neuron Disease
	Multiple Sclerosis
	Muscular Dystrophy
	Myasthenia Gravis
	Parkinson’s Disease
	Primary lateral Sclerosis (PLS)
Orthopaedic Disorders (hip / knee)	Arthritis (Hip)
	Arthritis (Knee)
	Avascular Necrosis of Hip
	Avascular Necrosis of Knee
	Hip injury / disorders
	Loss of limbs
	Post-Traumatic Arthritis (knee)
	Severe Rheumatoid Arthritis
Orthopaedic Disorders (Tumors)	Benign / Malignant Bone Tumor
	Benign / Malignant Soft Tissue
Pulmonary Disorders	Asthma
	Bronchitis
	Chronic Obstructive Pulmonary Disease (COPD)
	Cystic Fibrosis
	Emphysema
	End stage lung disease
	Eosiniphilic Granuloma
	Histiocytosis X (lung)
	Chronic Pneumonia

	Pulmonary Fibrosis
	Pulmonary Hypertension
	Wegener's Granulomatosis
Shoulder Disorders	Arthritis
	Failed Surgery of the Shoulder
	Shoulder Fractures / Injuries
	Unstable shoulder
Spine Disorders (multiple)	Ankylosing Spondylitis
	Arthritis
	Herniated disc(s)
	Spinal Abscess
	Spinal Stenosis
	Spinal Tumor
	Vertebral Fracture
Urological Disorders	Kidney failure
	Renal Artery Disease
Vascular Disorders	Arteriosclerosis Obliterans
	Cerebrovascular Diseases
	Elephantiasis
	Embolism
	Lower Extremity (Leg) Problems – Arterial
	Lower Extremity (Leg) Problems - Venous
	Peripheral Vascular Disease
	Vena Cava Syndrome
	Venous Insufficiency
	Venous Thromboembolism
Systemic	Acquired Immunity Deficiency Disorder (AIDS/HIV)
	HIV infection
	Major Burns
	Paralysis
	Poliomyelitis
	Systemic Lupus Erythematosus
Major Organ Transplantation	Bone Marrow
	Cornea
	Heart
	Lung Kidney
	Liver
	Pancreas
	Skin Graft

Vaccinations for Children

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

Expenses Generally Excluded

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

SPUTUM CUP	**Payable under Investigation Charges, not as consumable**
BOYLES APPARATUS CHARGES	**Part of OT Charges, not separately**
BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	**Part of Cost of Blood, not payable**
ANTISEPTIC OR DISINFECTANT LOTIONS	**Not Payable-Part of Dressing Charges**
BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	**Not Payable - Part of Dressing charges**
COTTON	**Not Payable-Part of Dressing Charges**
COTTON BANDAGE	**Not Payable- Part of Dressing Charges**
MICROPORE/ SURGICAL TAPE	**Not Payable-Payable by the patient when prescribed, otherwise included as Dressing Charges**
BLADE	**Not Payable**
APRON	**Not Payable -Part of Hospital Services/ Disposable linen to be part of OT/ICU charges**
TORNIQUET	**Not Payable (service is charged by hospitals, consumables cannot be separately charged)**
ORTHOBUNDLE, GYNAEC BUNDLE	**Part of Dressing Charges**
URINE CONTAINER	**Not Payable**
ELEMENTS OF ROOM CHARGE	
LUXURY TAX	**Actual tax levied by government is payable. Part of room charge for sub limits**
HVAC	**Part of room charge not payable separately**
HOUSE KEEPING CHARGES	**Part of room charge not payable separately**
SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	**Part of room charge not payable separately**
TELEVISION & AIR CONDITIONER CHARGES	**Payable under room charges not if separately levied**
SURCHARGES	**Part of Room Charge, Not payable separately**
ATTENDANT CHARGES	**Not Payable - Part of Room Charges**
IM IV INJECTION CHARGES	**Part of room charge not payable separately**
CLEAN SHEET	**Part of Laundry/Housekeeping not payable separately**
EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	**Patient Diet provided by hospital is payable**
BLANKET/WARMER BLANKET	**Not Payable- part of room charges**
ADMINISTRATIVE OR NON-MEDICAL CHARGES	
ADMISSION KIT	**Not Payable**
BIRTH CERTIFICATE	**Not Payable**
BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	**Not Payable**
CERTIFICATE CHARGES	**Not Payable**
COURIER CHARGES	**Not Payable**
CONVENYANCE CHARGES	**Not Payable**
DIABETIC CHART CHARGES	**Not Payable**
DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	**Not Payable**
DISCHARGE PROCEDURE CHARGES	**Not Payable**
DAILY CHART CHARGES	**Not Payable**
ENTRANCE PASS / VISITORS PASS CHARGES	**Not Payable**
EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	**Payable under Post Hosp**
FILE OPENING CHARGES	**Not Payable**
INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	**Not Payable**
MEDICAL CERTIFICATE	**Not Payable**
MAINTAINANCE CHARGES	**Not Payable**
MEDICAL RECORDS	**Not Payable**
PREPARATION CHARGES	**Not Payable**
PHOTOCOPIES CHARGES	**Not Payable**
PATIENT IDENTIFICATION BAND / NAME TAG	**Not Payable**
WASHING CHARGES	**Not Payable**
MEDICINE BOX	**Not Payable**
MORTUARY CHARGES	**Payable up to 24 hrs, shifting charges not payable**
MEDICO LEGAL CASE CHARGES (MLC CHARGES)	**Not Payable**
EXTERNAL DURABLE DEVICES	
WALKING AIDS CHARGES	**Not Payable**
BIPAP MACHINE	**Not Payable**
COMMODE	**Not Payable**
CPAP/ CAPD EQUIPMENTS	**Device not payable**
INFUSION PUMP - COST	**Device not payable**
OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	**Not Payable**
PULSEOXYMETER CHARGES	**Device not payable**
SPACER	**Not Payable**
SPIROMETRE	**Device not payable**
SPO2 PROBE	**Not Payable**
NEBULIZER KIT	**Not Payable**
STEAM INHALER	**Not Payable**
THERMOMETER	**Not Payable**
CERVICAL COLLAR	**Not Payable**
SPLINT	**Not Payable**
DIABETIC FOOT WEAR	**Not Payable**
KNEE BRACES (LONG/ SHORT/ HINGED)	**Not Payable**
KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	**Not Payable**
LUMBO SACRAL BELT	**Payable for cases who have undergone surgery of lumbar spine.**
NIMBUS BED OR WATER OR AIR BED CHARGES	**Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at reasonable cost of approximately Rs 200/ day**
AMBULANCE COLLAR	**Not Payable**
AMBULANCE EQUIPMENT	**Not Payable**
MICROSHEILD	**Not Payable**
ABDOMINAL BINDER	**Payable for cases who have undergone surgery of lumbar spine.**
ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION	
BETADINE \ HYDROGEN PEROXIDE\SPIRIT\\DETTOL\SAVLON\ DISINFECTANTS ETC	**Payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital**
PRIVATE NURSES CHARGES-SPECIAL NURSING CHARGES	**Payable as per Section 2.1.12**
NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES	**Patient Diet provided by hospital is payable**
SUGAR FREE TABLETS	**Payable -Sugar free variants of admissible medicines are not excluded**
CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	**Payable when prescribed**
DIGESTION GELS	**Payable when prescribed**
ECG ELECTRODES	**Up to 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may**

	require a change and at least one set every second day is payable.
GLOVES	**Sterilized Gloves payable / unsterilized gloves not payable**
HIV KIT	**Payable - Pre operative screening**
LISTERINE/ ANTISEPTIC MOUTHWASH	**Payable when prescribed**
LOZENGES	**Payable when prescribed**
MOUTH PAINT	**Payable when prescribed**
NEBULISATION KIT	**Payable reasonably if used during hospitalisation**
NOVARAPID	**Payable when prescribed**
VOLINI GEL/ ANALGESIC GEL	**Payable when prescribed**
ZYTEE GEL	**Payable when prescribed**
VACCINATION CHARGES	**Routine Vaccination for children Payable as per Section 2.1.13/ Post Bite Vaccination Payable**
PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE	
AHD	**Not Payable - Part of Hospital's internal Cost**
ALCOHOL SWABES	**Not Payable - Part of Hospital's internal Cost**
SCRUB SOLUTION/STERILLIUM	**Not Payable - Part of Hospital's internal Cost**
OTHERS	
VACCINE CHARGES FOR BABY	**Payable under Section 2.1.7.iv for new born baby, and under 2.1.13 for children covered under the policy**

AESTHETIC TREATMENT / SURGERY	**Not Payable**
TPA CHARGES	**Not Payable**
VISCO BELT CHARGES	**Not Payable**
ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	**Not Payable**
EXAMINATION GLOVES	**Not payable**
KIDNEY TRAY	**Not Payable**
MASK	**Not Payable**
OUNCE GLASS	**Not Payable**
OUTSTATION CONSULTANT'S/ SURGEON'S FEES	**Not payable**
OXYGEN MASK	**Not Payable**
PAPER GLOVES	**Not Payable**
PELVIC TRACTION BELT	**Payable in case of PIVD requiring traction as this is generally not reused**
REFERAL DOCTOR'S FEES	**Not Payable**
ACCU CHECK (Glucometery/ Strips)	**Not payable pre hospitilasation or post hospitalisation / Reports and Charts required/ Device not payable**
PAN CAN	**Not Payable**
SOFNET	**Not Payable**
TROLLY COVER	**Not Payable**
UROMETER, URINE JUG	**Not Payable**
AMBULANCE	**Payable as per section 2.1.9 and 2.1.10**
TEGADERM / VASOFIX SAFETY	**Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs**
URINE BAG	**Payable where medically necessary till a reasonable cost - maximum 1 per 24 hrs**
SOFTOVAC	**Not Payable**
STOCKINGS	**Payable for case like CABG etc.**

The list is as per the standard list of excluded expenses stipulated by IRDA in Guidelines in Standardization in Health Insurance, dated 20.02.2013.