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National Insurance Company Limited

CIN - U10200WB1906GOI001713 IRDAI Regn. No. - 58

Issuing Office

National Young India Mediclaim Policy

Whereas the proposer designated in the Schedule hereto has by a proposal together with declaration, which shall be the basis of this Contract and is deemed to be incorporated herein, has applied to National Insurance Company Ltd. (hereinafter called the Company), for the insurance hereinafter set forth, in respect of person(s) named in the Schedule hereto (hereinafter called the Insured Persons) and has paid the premium as consideration for such insurance.

1 PREAMBLE

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

Provided further that, the amount payable under the Policy in respect of all such claims during the Policy Year of the Policy Period shall be subject to the coverage, terms, exclusions, conditions, definitions and sub limits contained herein as well as shown in the Table of Benefits, and shall not exceed the Basic Sum Insured (Individual or Floater) opted, Cumulative Bonus (if any) and Reinstated Basic Sum Insured (if applicable as per terms).

2 DEFINITION

Standard Definitions

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

2.2 Any One Illness means continuous period of Illness and it includes relapse within forty five (45) days from the date of last consultation with the Hospital where treatment was taken.

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

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

2.4 Cashless Facility means a facility extended by the Company to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the Network Provider by the Company to the extent pre-authorization approved.

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

2.6 Congenital Anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

a) Internal Congenital Anomaly

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

b) External Congenital Anomaly

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

2.7 Co-Payment means a cost sharing requirement under a health insurance policy that provides that the Insured will bear a specified percentage of the admissible claims amount. A Co-Payment does not reduce the Sum Insured.

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

2.9 Day Care Centre means any Institution established for Day Care Treatment of Illness and/ or Injuries or a medical setup with 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.

2.10 Day Care Treatment means medical treatment, and/or Surgical Procedure (as listed in Appendix I) which is:

i. undertaken under general or local anesthesia in a Hospital/Day Care Centre in less than twenty four (24) hrs because of technological advancement, and
ii. which would have otherwise required a Hospitalisation of more than twenty four (24) hours.

Treatment normally taken on an Out-Patient basis is not included in the scope of this Definition.

2.11 Grace Period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as Waiting Periods and coverage of Pre-Existing Diseases. Coverage is not available for the period for which no premium is received.

2.12 Hospital means any Institution established for In-Patient Care and Day Care Treatment of Illness/ 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 (10)In-Patient beds, in those towns having a population of less than ten lacs and fifteen (15) 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.

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

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

2.15 Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

i. **Acute Condition** means a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics

a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
b) it needs ongoing or long-term control or relief of symptoms
c) it requires rehabilitation for the patient or for the patient to be special trained to cope with it
d) it continues indefinitely
e) it recurs or is likely to recur

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

2.17 In-Patient Care means treatment for which the Insured Person has to stay in a Hospital for more than twenty four (24) hours for a covered event.

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

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

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

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

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

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

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

2.24 Network Provider means hospitals enlisted by the Company, TPA or jointly by the Company and TPA to provide medical services to an Insured Person by a Cashless Facility.
In cities with Preferred Provider Network (Definition 2.48), PPN are the only Network Providers.

2.25 Non- Network Provider means any Hospital, Day Care Centre or other provider that is not part of the network.

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

2.27 OPD (Out-Patient) Treatment means the one in which the Insured Person visits a clinic / Hospital or associated facility like a consultation room for Diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a Day Care or In-Patient.

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

2.29 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.

2.30 Pre-hospitalisation Medical Expenses means Medical Expenses incurred during predefined number of days preceding the Hospitalisation of the Insured Person, provided that:

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

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

i. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The inpatient Hospitalisation claim for such Hospitalisation is admissible by the Company.

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

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

2.34 Renewal means the terms on which the Contract of Insurance can be renewed on mutual consent with a provision of Grace Period for treating the Renewal continuous for the purpose of gaining credit for Pre-Existing Diseases, time-bound Exclusions and for all Waiting Periods.

2.35 Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the Associated Medical Expenses.

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

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

Specific Definitions

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

2.39 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.

2.40 Contract means Prospectus, Proposal, Policy, and the Policy Schedule. Any alteration with the mutual consent of the Insured Person and the Company can be made only by a duly signed and sealed endorsement on the Policy.

2.41 Critical Illnesses means Cancer of Specified Severity, First Heart Attack of Specified Severity, Open Chest Coronary Artery Bypass Graft Surgery, Open Heart Replacement or Repair of Heart Valves, Coma of Specified Severity, Kidney Failure requiring Regular Dialysis, Stroke Resulting in Permanent Symptoms, Major Organ/Bone Marrow Transplant, Permanent Paralysis of Limbs, Motor Neurone Disease with Permanent Symptoms, Multiple Sclerosis with Persisting Symptoms.

a) Cancer of Specified Severity

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

The following are excluded

i. All tumours which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non- invasive, including but not limited to:
Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
ii. Any non- melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0;
v. All Thyroid cancers histologically classified as T1N0M0 (TNM classification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3
vii. Non- invasive Papillary cancer of bladder histologically described as TaN0M0 (TNM Classification) or of a lesser classification;
viii. All Gastro-intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

b) Myocardial Infarction (First Heart Attack of Specified Severity)

The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded

i. Other acute Coronary Syndromes.
ii. Any type of angina pectoris.
iii. A rise in cardiac biomarkers or Troponin T or I in absence of over ischemic heart disease OR following an intra-arterial cardiac procedure

c) Open Chest Coronary Artery Bypass Graft Surgery (CABG)

The actual undergoing of Heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via sternotomy (cutting through breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

The following are excluded

Angioplasty and/or any other intra-arterial procedures.

d) Open Heart Replacement or Repair of Heart Valve

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

The following are excluded
Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty are excluded.

e) Coma of Specified Severity
A state of unconsciousness with no reaction or response to external stimuli or internal needs.
This diagnosis must be supported by evidence of all of the following:
i. No response to external stimuli continuously for at least 96 hours;
ii. Life support measures are necessary to sustain life; and
iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
The condition has to be confirmed by a specialist Medical Practitioner.
The following are excluded
Coma resulting directly from alcohol or drug abuse is excluded.

f) 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.

g) 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 months has to be produced.
The following are excluded
i. Transient ischemic attacks (TIA)
ii. Traumatic injury of the brain
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

h) 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 excluded
i. Other stem-cell transplants
ii. Where only islets of langerhans are transplanted

i) 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 months.

j) Motor Neurone Disease with Permanent Symptoms
Motor neurone disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

k) Multiple Sclerosis with Persisting Symptoms
The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following
i. Investigations including typical MRI findings, which unequivocally confirm the diagnosis to be multiple sclerosis and
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
iii. Neurological damage due to SLE is excluded.

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

2.43 ID Card means the card issued to the Insured Person by the TPA for availing Cashless Facility in the Network Provider.

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

2.45 Mental Illness means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated

with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence.

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

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

2.48 Preferred Provider Network (PPN) means Network Providers in specific cities which have agreed to a cashless packaged pricing for specified planned procedures for the policyholders of the Company. The list of planned procedures is available with the Company/TPA and subject to amendment from time to time.

2.49 Proposer means an eligible person who proposes to enter into insurance Contract with the Company, to cover self and/ or any other eligible person(s), and pays the premium as consideration for such insurance.

2.50 Psychiatrist means a Medical Practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognised by the University Grants Commission established under the University Grants Commission Act, 1956, or awarded or recognised by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognised by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist.

2.51 Schedule means a document forming part of the Policy, containing details including name of the Insured Person(s), age, relation with the Proposer, Basic Sum Insured, Cumulative Bonus, premium and the Policy Period.

2.52 Sum Insured means the Basic Sum Insured specified in the Policy Schedule and the Cumulative Bonus (CB) accrued in respect of the Insured Person(s) as mentioned in the Schedule and represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year

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

2.54 Waiting Period means a period from the inception of this Policy during which specified Illness/treatments are not covered. On completion of the Waiting Period, Illness/treatments shall be covered provided the Policy has been continuously renewed without any break.

3 BENEFITS COVERED UNDER THE POLICY

3.1 COVERAGE

3.1.1 In-patient Treatment

The Company shall indemnify the Medical Expenses incurred for all Hospitalisation(s) covered under the Policy, subject to the Sub Limits applicable to broad heads as mentioned below:

i. Room Rent and Intensive Care Unit Charges (including diet charges, nursing care by qualified nurse, RMO charges, administration charges for IV fluids/blood transfusion/injection), subject to limit as per Section 3.1.1.1
ii. Medical Practitioner(s) fees
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.
vii. Dental Treatment, necessitated due to an injury
viii. Plastic surgery, necessitated due to disease or injury
ix. Hormone replacement therapy, if medically necessary
x. Vitamins and tonics, forming part of treatment for disease/injury as certified by the attending medical practitioner
xi. Circumcision, necessitated for treatment of a disease or injury

3.1.1.1 Limit for Room Rent and Intensive Care Unit Charges

Room Rent and Intensive Care Unit Charges per day shall be payable up to the limit as shown in the Table of Benefits.

3.1.1.2 Limit for Cataract

The Company's liability for treatment of cataract shall be up to the limit as shown in the Table of Benefits.

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

Note:
1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Procedures.
2. In case of admission to a room at rates exceeding the aforesaid limits, the reimbursement/payment of Associated Medical Expenses incurred at the Hospital, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent charges. Proportionate deduction shall not apply if admitted to ICU.
Associated Medical Expenses shall include all related expenses except the following expenses,
a. Cost of pharmacy and consumables;
b. Cost of implants and medical devices
c. Cost of diagnostics
3. Sub limits as mentioned above, will not apply in case of treatment undergone in a **Preferred Provider Network (PPN)** for a listed procedure as per eligible package.
4. Preferred Provider Network list is dynamic in nature, and will be updated in the Company's website from time to time

3.1.2 Pre Hospitalisation
The Company shall indemnify the Medical Expenses incurred up to forty five (45) days immediately before the Insured Person is hospitalised, provided that:
i. such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii. the In-Patient Hospitalisation claim for such Hospitalisation is admissible by the Company
Pre hospitalisation shall be considered as part of the Hospitalisation claim.

3.1.3 Post Hospitalisation
The Company shall indemnify the Medical Expenses incurred up to sixty (60) days immediately after the Insured Person is discharged from Hospital, provided that:
i. such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii. the In-Patient Hospitalisation claim for such Hospitalisation is admissible by the Company
Post hospitalisation shall be considered as part of the Hospitalisation claim.

3.1.4 Day Care Procedure
The Company shall indemnify the Medical Expenses and pre and post hospitalisation expenses up to the Sum Insured, for any Day Care Procedures which require Hospitalisation for less than twenty four hours provided that
i. day care procedures/surgeries 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 which due to advancement of medical science require Hospitalisation for less than twenty four hours and for which prior approval from the Company/TPA is mandatory.

3.1.5 Ayurveda and Homeopathy
The Company shall indemnify 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.

3.1.6 Ambulance Charges
The Company shall indemnify the expenses incurred for transportation to the Hospital or from the Hospital to another Hospital or from the Hospital to diagnostic center and return to the Hospital during the same Hospitalisation, up to the limit as shown in the Table of Benefits, provided a claim has been admitted under Section 3.1.1.

3.1.7 Maternity
The Company shall indemnify Maternity Expenses of Insured or Spouse only, as described below and also Pre-Natal and Post-Natal Hospitalisation expenses per delivery, subject to the limit as shown in the Table of Benefits. The New Born Baby shall be automatically covered under the available Maternity Benefit limit from birth, for up to 3 months including expenses for vaccination. Hospitalisation is not required for vaccination.

Maternity Expenses means;
a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization);
b) Expenses towards lawful medical termination of pregnancy during the Policy Period.
Note: Ectopic pregnancy is covered under Section 3.1.1 'In-patient Treatment', provided such pregnancy is established by medical reports.

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

1. Delivery or termination within a Waiting Period of twenty four (24) months. However, the Waiting Period may be waived only in the case of delivery, miscarriage or abortion induced by Accident.
2. Delivery or lawful medical termination of pregnancy after one admissible claim for delivery or termination during the lifetime of the Insured Person has been paid.
3. Insured Persons who are already having two or more living children
4. Surrogacy
5. Ectopic pregnancy
6. Pre and post hospitalisation expenses as per Section 3.1.2 and Section 3.1.3, other than pre and post natal treatment.

3.1.8 HIV/ AIDS Cover

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

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

3.1.9 Mental Illness Cover

The Company shall indemnify the Medical Expenses for In-patient Care, Pre-Hospitalisation expenses and Post-Hospitalisation expenses, related to Mental Illnesses, provided the treatment shall be undertaken at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Psychiatrist (as defined in Definition 2.50) or a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry.

Exclusions

1. 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. Any treatment of the following Mental Illnesses shall be covered after Waiting Period of 2 years:
   i. Depression (ICD - F32; F33)
   ii. Schizophrenia (ICD - F20; F21; F25)

3.1.10 Modern Treatment

The Company shall indemnify the Medical Expenses for In-Patient Care or Day Care Procedure along with pre hospitalisation expenses and post hospitalisation expenses incurred for following Modern Treatments (wherever medically indicated), subject to 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 prostrate (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.

3.1.11 Morbid Obesity Treatment

The Company shall indemnify the Medical Expenses for In-patient Care, Pre-Hospitalisation expenses and Post-Hospitalisation expenses, incurred for surgical treatment of obesity that fulfils **all** the following conditions and subject to Waiting Period of 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

3.1.12 Correction of Refractive Error

The Company shall indemnify the Medical Expenses for In-patient Care, Pre-Hospitalisation expenses and Post-Hospitalisation expenses, incurred for expenses related to the treatment for correction of eye sight due to refractive error equal to or more than 7.5 dioptres, 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-l of Appendix-I 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-I of the Policy respectively

Note: Aggregate of all the benefits under 3.1.1 to 3.1.12 are subject to the Sum Insured.

3.2 OTHER BENEFITS

3.2.1 Reinstatement of Basic Sum Insured (available to Basic Sum Insured of ₹ 5L and above)

For Policies with Basic Sum Insured of ₹ 5 lacs and above, in the event of available Sum Insured being exhausted anytime during the Policy Year on account of Hospitalisation claim(s), the Company shall reinstate the exhausted Basic Sum Insured (i.e., excluding any CB) to be utilized in any subsequent Hospitalisation(s) during the same Policy Year, provided that

i. Reinstatement of Basic Sum Insured shall be effected only after the date of discharge from the Hospital for the Hospitalisation claim which resulted in exhaustion of the Sum Insured.
ii. Any Illness/ Injury for which a claim has been admitted or paid under the Policy prior to such reinstatement, shall not be considered under the Reinstated Basic Sum Insured
iii. In a policy issued on Individual Basis, Reinstated Basic Sum Insured shall be available in respect of the Insured Person whose Sum Insured is exhausted as specified above by the Insured Person. In a policy issued on Floater Basis, Reinstated Basic Sum Insured shall be available to all Insured Person(s) subject to exhaustion of Sum Insured as specified above by any or multiple Insured Person(s).
iv. Reinstatement shall be allowed only once during the Policy Year of the Policy Period for each Insured Person (Individual Basis)/ each Policy (Floater Basis).
v. Reinstated Basic Sum Insured, if not exhausted, will not be carried forward to next Policy Year or Policy Period on Renewal.
vi. Reinstated Basic SI shall not be applicable to 11 defined **Critical Illnesses (CIs)**, i.e., Cancer of Specified Severity, First Heart Attack of Specified Severity, Open Chest Coronary Artery Bypass Graft Surgery, Open Heart Replacement or Repair of Heart Valves, Coma of Specified Severity, Kidney Failure requiring Regular Dialysis, Stroke Resulting in Permanent Symptoms, Major Organ/Bone Marrow Transplant, Permanent Paralysis of Limbs, Motor Neuron Disease with Permanent Symptoms, Multiple Sclerosis with Persisting Symptoms.

3.2.2 Personal Accident

The Company shall pay the specified benefit(s) on occurrence of the event(s) as mentioned below to the Insured Persons, in addition to any other pay out under Section 3.1.

In a Policy issued on Individual Basis, the Personal Accident benefit shall apply to each Insured Person individually with the maximum liability of the Company being the individual Sum Insured. In a Policy issued on Floater Basis, the Personal Accident benefit shall apply cumulatively on all Insured Persons with the maximum liability of the Company being the floater Sum Insured.

a) **Death**: 100% of Sum Insured shall be payable, on death of the Insured Person, due to an Injury sustained in an Accident during the Policy Period, provided that the Insured Person's death occurs within 12 months from the date of the Accident. Where claim payment has been made owing to disappearance of Insured Person following an Accident, if after the payment of accidental death claim, it is found that the Insured Person has survived the Accident, then the policyholder has to refund the payment back to the Company in consideration of the obligatory guarantee as provided during the claim.
b) **Permanent Total Disablement:** 100% of Sum Insured shall be payable, if an Insured Person suffers Permanent Total Disablement of the nature specified below, solely and directly due to an Accident during the Policy Period, provided that the Permanent Total Disablement occurs within 12 months from the date of the Accident:

a) Total and irrecoverable loss of sight of both eyes or
b) Physical separation or loss of use of both hands or feet or
c) Physical separation or loss of use of one hand and one foot or
d) loss of sight of one eye and Physical separation or loss of use of hand or foot
e) If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Insured Person from engaging in any employment or occupation of any description whatsoever.

c) **Permanent Partial Disablement:** Following percentage of Sum Insured shall be payable, if the Insured Person suffers Permanent Partial Disablement of the nature specified below solely and directly due to an Accident during the Policy Period provided that the Permanent Partial Disablement shall occur within 12 months of the date of the Accident.

	Loss Covered	**Percentage of Sum Insured**
1.	Loss of Use/ Physical Separation:	
	One entire hand	50%
	One entire foot	50%
	Loss of Sight of one eye	50%
	Loss of toes – all	20%
	Great both phalanges	5%
	Great – one phalanx	2%
	Other than great if more than one toe lost	1%
2.	Loss of Use of both ears	50%
3.	Loss of Use of one ear	20%
4.	Loss of four fingers and thumb of one hand	40%
5.	Loss of four fingers	35%

6.	Loss of thumb - both phalanges - one phalanx	 25% 10%
7.	Loss of Index finger - three phalanges two phalanges one phalanx	 10% 8% 4%
8.	Loss of middle finger – three phalanges two phalanges one phalanx	 6% 4% 2%
9.	Loss of ring finger - three phalanges two phalanges one phalanx	 5% 4% 2%
10.	Loss of little finger – three phalanges two phalanges one phalanx	 4% 3% 2%
11.	Loss of metacarpus - first or second (additional) third, fourth or fifth (additional)	 3% 2%
12.	Any other permanent partial disablement	Percentage as assessed by the independent Medical Practitioner

Maximum amount payable in respect of multiple nature of disablements shall be restricted to Sum Insured and Cumulative Bonus.

Note:

a) The Basic Sum Insured and Cumulative Bonus, if any, is applicable cumulatively for all the three covers specified under (a), (b) and (c) above i.e., there is a single Sum Insured for all the three covers namely, Accidental Death, Permanent Total Disability and Permanent Partial Disability.

b) If the Accident occurs during the Policy Period, benefits covered under (a), (b) and (c) above are payable, even if Death or Permanent Total Disablement or Permanent Partial Disablement or any combination thereof occurs after the completion of Policy Period, but within 12 months from the date of Accident.

3.3 OPTIONAL COVER

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

3.3.1 Waiting period waiver of pre-existing Diabetes and/or Hypertension – Optional 1

The Company shall indemnify Medical Expenses as per Section 3.1 incurred for treatment of pre-existing diabetes and/ or hypertension, from the inception of the Policy. Waiting Period for any related complications to diabetes and/ or hypertension existing at the time of issuance of the Policy shall not be waived and not covered under this Optional Cover.
On completion of the Waiting Period, the additional premium shall not apply.

3.3.2. Double SI for 11 Critical Illnesses – Optional 2

In the event of available Sum Insured being exhausted anytime during the Policy Year on account of Hospitalisation claim(s) and there being continued/ new Hospitalisation(s) for treatment of any one or more of the defined 11 Critical Illnesses (CIs) only, the Company shall indemnify the Medical Expenses up to the Basic SI (i.e, Double SI) incurred for such Hospitalisation(s) only, provided that

i. In a policy issued on Individual Basis, Double SI shall be available in respect of the Insured Person whose Sum Insured is exhausted as specified above by the Insured Person. In a policy issued on Floater Basis, Double SI shall be available to all Insured Person(s) subject to exhaustion of Sum Insured as specified above by any or multiple Insured Person(s).
ii. Double SI, if not exhausted, will not be carried forward to next Policy Year or Policy Period on Renewal.
iii. Double SI shall be allowed only once during the Policy Year of the Policy Period for each Insured Person (Individual Basis)/ each Policy (Floater Basis), irrespective of the occurrence of one or more critical illnesses.
iv. Double SI shall only be applicable to Hospitalisation for the treatment of 11 defined **Critical Illnesses (CIs)**, i.e., Cancer of Specified Severity, First Heart Attack of Specified Severity, Open Chest Coronary Artery Bypass Graft Surgery, Open Heart Replacement or Repair of Heart Valves, Coma of Specified Severity, Kidney Failure requiring Regular Dialysis, Stroke Resulting in Permanent Symptoms, Major Organ/Bone Marrow Transplant, Permanent Paralysis of Limbs, Motor Neuron Disease with Permanent Symptoms, Multiple Sclerosis with Persisting Symptoms, and not for any other Hospitalisation.
v. Occurrence of the CI shall be supported by documentary and clinical evidence specified under the respective Definition.

3.4 GOOD HEALTH INCENTIVES

3.4.1 Cumulative Bonus (CB)

For each claim free Policy Year (i.e., no claims are reported), Cumulative Bonus allowed shall be an amount equal to 5% of the Basic Sum Insured (excluding CB) of the expiring Policy Year.

If a claim is made in any particular Policy Year, the CB accrued shall be reduced at the same rate at which it has accrued. However, Basic Sum Insured will be maintained and will not be reduced.
CB shall be accumulated and available on renewal. Maximum CB shall not exceed 50% of the Basic Sum Insured of the renewed Policy. Wherever, due to reduction in Basic Sum Insured on renewal, if the accumulated CB exceeds 50% of the reduced Basic Sum Insured, then CB shall be restricted to 50% of the reduced Basic Sum Insured.

Notes:

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

4 EXCLUSIONS (Standard Exclusions)

The Company shall not be liable to make any payment under the Policy till the expiry of Waiting Period mentioned below, in respect of any expenses incurred in connection with or in respect of:

4.1. Pre-Existing Diseases (Excl 01)

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

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

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 90 days/ one year/ two year/ 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 and age related eye ailments
b. Refractive error of the eye more than 7.5 dioptres.
d. Benign prostatic hypertrophy
e. Hernia
f. Hydrocele
g. Fissure/Fistula in anus
h. Piles (Haemorrhoids)
i. Sinusitis and related disorders
j. Polycystic ovarian disease
k. Non-infective arthritis
l. Pilonidal sinus
m. Gout and Rheumatism
n. Calculus diseases
o. Surgery of gall bladder and bile duct excluding malignancy
p. Surgery of genito-urinary system excluding malignancy
q. Surgery for prolapsed intervertebral disc unless arising from accident
r. Surgery of varicose vein
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

a. Joint replacement unless necessitated due to an accident

b. Osteoarthritis and osteoporosis
c. 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 (Excl 11)

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

4.16. Unproven Treatments (Excl 16)
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

4.17. Birth control, Sterility and Infertility (Excl 17)
Expenses related to sterility and infertility. This includes:
i. Any type of sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

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

5.1. Hormone Replacement Therapy
Expenses for hormone replacement therapy, unless part of Medically Necessary Treatment, except for Puberty and Menopause related Disorders.

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

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

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

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

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

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

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

5.9. Domiciliary Hospitalization & Out Patient Department (OPD) treatment
Any expenses incurred on Domiciliary Hospitalization and OPD treatment

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

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

5.12. Non Prescription 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).

5.13. Treatment not Related to Disease for which Claim is Made
Treatment which the insured person was on before Hospitalisation for the Illness/Injury, different from the one for which claim for Hospitalisation has been made.

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

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

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

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

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

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

5.20. Treatment taken outside the geographical limits of India

5.21. 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.

6 GENERAL TERMS AND CLAUSES

Standard General Terms and Conditions

6.1 Disclosure of Information
The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.
*(**Explanation**: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)*

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

6.3 Claim Settlement
i. The Company shall settle or reject a claim, as the case may be, within 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)*

6.4 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.

6.5 Fraud

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

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

6.6 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 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

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

6.7 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.

6.8 Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 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.

6.9 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.

6.10 Withdrawal of Product

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

6.11Moratorium 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.

6.12 Revision of Terms of the Policy Including the Premium Rates

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

6.13 Free Look Period

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

The insured person shall be allowed free look period of 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.

6.14 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.

Specific General Terms and Conditions

6.15Communication

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.

6.16Physical Examination

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

6.17Claim Procedure

6.17.1 Notification of Claim

In order to lodge a claim under the Policy for any 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.

Claim Intimation in case of Cashless facility	**TPA must be informed:**
In the event of planned Hospitalisation	At least seventy two (72) hours prior to the Insured Person's admission to Network Provider

In the event of emergency Hospitalisation	Within twenty four (24) hours of the Insured Person's admission to Network Provider

Claim Intimation in case of Reimbursement	**Company/TPA must be informed:**
In the event of planned Hospitalisation	At least seventy two (72) hours prior to the Insured Person's admission to Hospital
In the event of emergency Hospitalisation	Within twenty four (24) hours of the Insured Person's admission to Hospital

6.17.2 Procedure for Cashless Claims

i. Cashless Facility for treatment in Network Providers can be availed, if TPA service is opted.
ii. Treatment may be taken in a Network Provider and is subject to pre authorization by the TPA. Booklet containing list of Network Provider shall be provided by the TPA. Updated list of Network Provider is available on website of the Company and the TPA mentioned in the Schedule.
iii. Cashless request form available with the Network Provider 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 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/ Network Provider is unable to provide any required details related to the pre authorization request.
vii. In case of denial of Cashless Facility, the Insured Person may obtain the treatment as per treating Medical Practitioner's advice and submit the necessary documents for reimbursement of claim.

6.17.3 Procedure for Reimbursement of Claims

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

6.17.4 Documents

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

i. Completed claim form
ii. Medical practitioner's prescription advising admission for inpatient treatment.
iii. Cash-memo from the hospital (s)/chemist (s) supported by proper prescription from attending medical practitioner for Pre Hospitalisation, Hospitalisation and Post Hospitalisation.
iv. Payment receipt, investigation test reports and associated plates/CDs in original, supported by the prescription from attending medical practitioner for Pre Hospitalisation, Hospitalisation and Post Hospitalisation.
v. Attending medical practitioner's certificate regarding Diagnosis along with date of Diagnosis and bill, receipts etc.
vi. Surgeon's certificate regarding Diagnosis and nature of operation performed along with bills, receipts etc.
vii. Bills, receipt, sticker of the Implants.
viii. Bills, payment receipts, medical history of the patient recorded, discharge certificate/ summary, break up of final bill from the hospital etc.
ix. Any other document required by Company/TPA.

Note: In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents listed under condition 6.17.4 and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company.

6.17.5 Time limit for submission of claim documents to the Company/ TPA

Type of claim	**Time limit**
Reimbursement of Hospitalisation, Pre Hospitalisation expenses and ambulance charges	Within thirty (30) days of date of discharge from Hospital
Reimbursement of post Hospitalisation expenses	Within thirty (30) days from completion of Post Hospitalisation treatment

Waiver

Time limit for claim intimation and submission of documents may be waived in cases where the Insured/ Insured Person or his/ her representative applies and explains to the satisfaction of the Company, that the circumstances under which Insured/ Insured Person was placed, it was not possible to intimate the claim/submit the documents within the prescribed time limit.

6.17.6 Services Offered by TPA

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the Policy.

The services offered by a TPA shall not include

i. Claim settlement and claim rejection;
ii. Any services directly to any Insured Person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

6.17.7 Classification of Zone and Copayment
Depending upon the zone for which premium has been paid and the zone where treatment has been taken, Copayment shall apply.

** The country has been divided into four zones.*
Zone I – Entire state of Gujarat
Zone II – Delhi, Delhi NCR, Maharashtra, Chennai, Hyderabad, Indore
Zone III – Rest of India

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 and Zone III without copayment
ii. Insured paying premium as per Zone II
    a. Can avail treatment in Zone II and Zone III without any copayment
    b. Availing treatment in Zone I will be subject to a copayment of 12.5%
iii. Insured paying premium as per Zone III
    a. Can avail treatment in Zone III without any copayment
    b. Availing treatment in Zone I will be subject to a copayment of 35%
    c. Availing treatment in Zone II will be subject to a copayment of 20%

6.18 Payment of Claim
All claims under the Policy shall be payable in Indian currency and through NEFT/ RTGS only.

6.19 Territorial Limit
All medical treatment for the purpose of this Policy will have to be taken in India only.

6.20 Territorial Jurisdiction
All disputes or differences under or in relation to the Policy shall be determined by the Indian court and according to Indian law.

6.21 Arbitration

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

6.22 Disclaimer
If the Company shall disclaim liability to the Insured Person for any claim hereunder and if the Insured Person shall not within twelve (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.

6.23 Enhancement of Basic Sum Insured
Basic Sum Insured can be enhanced only at the time of Renewal. Basic Sum Insured can be enhanced subject to discretion of the Company. For the incremental portion of the Basic Sum Insured, the Waiting Periods and conditions as mentioned in Exclusion 4.1, 4.2, 4.3 shall apply afresh.

6.24 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 issued by the Company, the Policy shall be inoperative in respect of the Insured Person(s) for the number of days the Overseas Travel Insurance Policy is in force. Proportionate premium for such number of days shall be adjusted against the Renewal premium, provided the Insured has informed the Company in writing before leaving India, and submits an application, stating the details of visit(s) abroad, along with copies of the Overseas Travel Insurance Policy, within fifteen (15) days of return. The maximum premium refundable and adjusted on Renewal shall be limited to 80% of premium of the expiring Policy, in respect of the Insured Person(s) covered under Overseas Travel Insurance Policy.

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

TABLE OF BENEFITS

Name	**National Young India Mediclaim Policy (NYIMP)**
Sum Insured	**₹ 3L, 5L, 10L (Basic SI)**
Policy Period	**1 year or 3 years**
Coverage	
Hospitalisation	**Room Rent** – Upto INR 5,000 per day for Basic SI 3L, 5L and upto INR 10,000 per day for Basic SI 10L **ICU Charges** – Upto INR 10,000 per day for Basic SI 3L, 5L and upto INR 20,000 per day for Basic SI 10L *Proportionate Deduction shall apply if opted for higher Room Rent* *Sub limit will not apply in case of Hospitalisation in a Preferred Provider Network (PPN) as per eligible package* **Cataract** - Up to 10% of Sum Insured, subject to maximum ₹ 50,000 per eye per year. Coverage for **Modern Treatment** (12 nos) – Up to 25% of SI for each treatment Expenses due to **hazardous or adventure sports (non-professionals) –** Up to 25% of SI
System of Medicine	**Allopathy, Ayurveda and Homeopathy** Covered up to SI
In Built Features	**Pre hospitalisation** - 45 days immediately before hospitalisation **Post hospitalisation** - 60 days immediately after discharge
	Day Care Procedures covered upto SI
	Ambulance Charges – Up to 1% of SI, subject to max of ₹ 2,000 per year
	Hospitalisation coverage for **HIV/AIDS** and **Genetic Disorders**
	Hospitalisation coverage for **Mental Illness**
	Maternity Cover (1 delivery/ termination, Waiting Period 2 years) – up to INR 30,000 (Basic SI 3L), INR 40,000 (Basic SI 5L), INR 50,000 (Basic SI 10L)
	Treatment of **Morbid Obesity** and **Refractive Error** of at least 7.5D, subject to Waiting Periods
	Reinstatement of SI – Base SI will be restored to its original amount upon exhaustion, available to Policy with Basic SI 5 and above. Not available for defined 11 CIs
	Personal Accident Cover - Up to SI, for death, permanent disability and permanent partial disability
Others	
Pre Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the Company shall be covered after **3 year Waiting Period**
Enhancement of SI	On Renewal
Optional Covers	
Waiting period waiver of PED Diabetes and/or Hypertension (Optional 1)	Option to waive waiting period of pre-existing Diabetes and/or Hypertension and covered since inception
Double SI for 11 critical Illnesses (Optional)	Upon exhaustion of the SI, the insured can claim up to another Base SI for the treatment of any/ all of the defined 11 CIs • Cancer of Specified Severity • Myocardial Infarction (First Heart Attack of Specified Severity) • Open Chest Coronary Artery Bypass Graft Surgery (CABG) • Open Heart Replacement or Repair of Heart Valves • Coma of Specified Severity • Kidney Failure requiring Regular Dialysis • Stroke Resulting in Permanent Symptoms • Major Organ/Bone Marrow Transplant • Permanent Paralysis of Limbs • Motor Neurone Disease with Permanent Symptoms • Multiple Sclerosis with Persisting Symptoms
Good Health Incentives	
Cumulative Bonus	CB to increase by 5% of Basic SI in respect of each claim free Policy Year CB to decrease by 5% of Basic SI for each year with claim reported Maximum accumulation, **50% of the Basic SI of the renewed Policy**

Note: *SI here means Basic SI and Cumulative Bonus (CB), unless otherwise specified.*

No loading shall apply on Renewals based on individual claims experience
Insurance is the subject matter of solicitation
Please preserve the policy for all future reference.

Appendix I

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

Appendix II

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

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat , UT of Dadra and Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka	Office of the Insurance Ombudsman, JeevanSoudhaBuilding,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@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
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
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
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@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. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
Kerala , UT of (a) Lakshadweep, (b) Mahe – a part of UT of Pondicherry	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@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
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@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
State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, 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
Bihar, Jharkhand.	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Email: bimalokpal.patna@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