National Insurance Company Limited

CIN - U10200WB1906GOI001713 IRDAI Regn. No. – 58

Issuing Office

National Mediclaim Plus Policy

Whereas the insured designated in the schedule hereto has by a proposal, dated as stated in the schedule, which shall be the basis of this contract and is deemed to be incorporated herein, has applied to National Insurance Company Ltd., (herein after called the company) for the insurance herein after set forth in respect of person(s) named in the schedule hereto (herein after called the insured person) and has paid premium as consideration for such insurance.

1 PREAMBLE

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

2 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 2.46), PPN are the only Network Providers.

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

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

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

2.28 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.

2.29 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.

2.30 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.

2.31 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.

2.32 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.

2.33 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.

2.34 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.

2.35 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.

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

2.37 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.

2.38 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

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

2.40 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.

2.41 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.

2.42 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 (01) year as mentioned in the Schedule for which the Policy is issued.

2.47 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.

2.48 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.

2.49 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.

2.50 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.

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

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

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 diseases/treatment is not covered. On completion of the period, diseases/treatment shall be covered provided the policy has been continuously renewed without any break.

3 BENEFITS COVERED UNDER THE POLICY

3.1 Coverage

3.1.1 In-patient Treatment

The company shall pay to the hospital or reimburse the insured in respect of the medical expenses for:

i. Room charges and intensive care unit charges (including diet charges, nursing care by qualified nurse, RMO charges, administration charges for IV fluids/blood transfusion/injection), subject to limit as mentioned in Section 3.1.1.1
ii. Medical practitioner(s)
iii. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances
iv. Medicines and drugs
v. Diagnostic procedures
vi. Prosthetics and other devices or equipment if implanted internally during a surgical procedure.

3.1.1.1 Limit for Room Charges and Intensive Care Unit Charges

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

3.1.1.2 Limit for Cataract Surgery

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

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.**

3.1.2 Pre Hospitalisation

The company shall reimburse the insured in respect of the medical expenses incurred up to 30 (thirty) days immediately before the insured person is hospitalised, provided that:

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

Pre hospitalisation shall be considered as part of hospitalisation claim.

3.1.3 Post Hospitalisation

The company shall reimburse the insured in respect of the medical expenses incurred up to 60 (sixty) days immediately after the insured person is discharged from hospital, provided that:

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

Post hospitalisation shall be considered as part of hospitalisation claim.

3.1.4 Day Care Procedure

The company shall pay to the hospital in respect of the medical expenses or reimburse the insured in respect of the medical expenses and pre and post hospitalisation expenses, for day care procedures which require hospitalisation for less than 24 (twenty four) hours provided that

i. day care procedures/surgeries (as listed in Appendix -I) where such treatment is taken by an insured person in a hospital/day care centre (but not the outpatient department of a hospital)
ii. any other surgeries/procedures (not listed in Appendix-I) which due to advancement of medical science require hospitalisation for less than 24 (twenty four) hours and for which prior approval from company/TPA is mandatory.

3.1.5 Ayurveda and Homeopathy

The company shall pay to the hospital in respect of the medical expenses or reimburse the insured in respect of the medical expenses pre and post hospitalisation expenses, incurred for Ayurveda and Homeopathy treatment up to the limit as mentioned in the Table of Benefits provided treatment is taken in an Ayush Hospital.

3.1.6 Organ Donor's Medical Expenses

The company shall reimburse the insured in respect of expenses of hospitalisation of organ donor during the course of organ transplant of the insured person provided that

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

Exclusions

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

1. Cost of the organ to be transplanted
2. Organ donor's pre and post hospitalisation expenses, as per Section 3.1.2 and Section 3.1.3.

3.1.7 Maternity

The company shall pay to the hospital or reimburse the insured in respect of medical expenses, incurred as an in-patient, with respect to delivery or termination up to first two deliveries or terminations of pregnancy, after the policy has been continuously in

force for 24 (twenty four) months, during the lifetime of the insured or the spouse of the insured, if covered under the policy, as described below, up to the limit mentioned in the Table of Benefits.

i. Medical expense for delivery (normal or caesarean).
ii. Medical expense for lawful medical termination of pregnancy.
iii. Medical expenses for pre natal medically necessary hospitalisation, up to 30 (thirty) days and post natal medically necessary hospitalisation, up to 60 (sixty) days, per delivery or lawful termination of pregnancy, if incurred as an in-patient.
iv. Medical expenses of the new born baby, including expenses with respect to vaccination (as listed in Appendix III). Hospitalisation is not required for vaccination of new born baby.

Exclusions

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

1. Delivery or termination within 2 (two) years of continuous coverage from the inception of the policy, or from the date of inclusion of insured person, whichever is later. However, this period can be waived only in the case of delivery, miscarriage or abortion induced by accident or other medical emergency.
2. More than one delivery or termination in a policy period.
3. Ectopic pregnancy. However, ectopic pregnancy is covered under Section 3.1.1 provided it may be established by medical reports.
4. 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 Hospital Cash

The company shall pay the insured a daily hospital cash allowance up to the limit mentioned in the Table of Benefits for a maximum of 5 (five) days, provided

i. hospitalisation exceeds 3 (three) days and starts within the policy period.
ii. a claim has been admitted under Section 3.1.1

3.1.9 Ambulance

The company shall reimburse the insured in respect of expenses incurred for transportation of the insured person to the hospital by ambulance up to the limit as mentioned in the Table of Benefits, provided a claim has been admitted under Section 3.1.1.

3.1.10 Air Ambulance

The company shall reimburse the insured in respect of expenses incurred for medical evacuation of the insured person by air ambulance to the nearest hospital or from one hospital to another hospital following an emergency up to the limit mentioned in the Table of Benefits, provided prior intimation is given to the company/TPA, and a claim has been admitted under Section 3.1.1.

3.1.11 Medical Emergency Reunion

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

3.1.12 Doctor's Home Visit and Nursing Care during Post Hospitalisation

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

3.1.13 Vaccination for Children

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

3.1.14 HIV/ AIDS Cover

The Company shall indemnify the Hospital or the Insured the Medical Expenses (including Pre 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

3.1.15 Mental Illness Cover

The Company shall indemnify the Hospital or the Insured the Medical Expenses (including Pre 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 2.49) or a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry.

Exclusions

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

3.1.16 Modern Treatment

The Company shall pay to the hospital or reimburse the insured the medical expenses for In-Patient Care (admissible as per Section 3.1.1) or Day Care Procedure (admissible as per Section 3.1.4) along with pre hospitalisation expenses (admissible as per Section 3.1.2) and post hospitalisation expenses (admissible as per Section 3.1.3) incurred for following **Modern Treatments** (wherever medically indicated), subject to **Maximum amount admissible for any one Modern Treatment shall be 25% of Sum Insured.**

A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
B. Balloon Sinuplasty
C. Deep Brain stimulation
D. Oral chemotherapy
E. Immunotherapy- Monoclonal Antibody to be given as injection
F. Intra vitreal injections
G. Robotic surgeries
H. Stereotactic radio surgeries
I. Bronchical Thermoplasty
J. Vaporisation of the 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.

3.1.17 Morbid Obesity Treatment

The Company shall indemnify the Hospital or the Insured the Medical Expenses, including pre hospitalisation expenses (admissible as per Section 3.1.2) and post hospitalisation expenses (admissible as per Section 3.1.3), incurred for surgical treatment of obesity that fulfils **all** the following conditions and subject to Waiting Period of four (04) years as per Section 4.2.f.iv:

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

3.1.18 Correction of Refractive Error

The Company shall indemnify the Hospital or the Insured the Medical Expenses, including pre hospitalisation expenses (admissible as per Section 3.1.2) and post hospitalisation expenses (admissible as per Section 3.1.3), incurred for expenses related to the treatment for correction of eye sight due to refractive error equal to or more than 7.5 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-IV of the Policy. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Appendix-IV of the Policy respectively

3.2 Medical Second Opinion

The company shall arrange for Medical Second Opinion from a panel of World Leading Medical Centers (WLMC), at the insured person's request if the insured person is diagnosed with one of the major illness as listed in Appendix II, during the policy period. The insured person can avail one Medical Second Opinion for each major illness (as listed in Appendix II to the policy) diagnosed during the policy period.

The insured person shall provide the medical records containing a diagnosis and a recommended course of treatment to the TPA. The Medical Second Opinion shall be based only on the information and documentation provided to the medical practitioner of WLMC by or on behalf of the insured person, and the second opinion and the recommended course of treatment shall be sent directly to the insured/ insured person.

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

i. it is entirely for the insured person to choose whether or not to obtain a Medical Second Opinion from WLMC and if obtained under this service then whether or not to act on it
ii. the company does not provide Medical Second Opinion or make any representation as to the adequacy or accuracy of the same, the insured person's or any other person's reliance on the same, or the use to which the Medical Second Opinion is put
iii. the company assume no responsibility for and shall not be responsible for any actual or alleged errors, omissions or representations made by any medical practitioner or in any Medical Second Opinion or for any consequences of any action taken or not taken in reliance there on
iv. Medical Second Opinion provided under this service shall not be valid for any medico-legal purposes
v. Medical Second Opinion does not entitle the insured person to any consultations from or further opinions from that medical practitioner.

Copayment
Claims under Section 3.1, except claims under Section 3.1.13 (Vaccination for children), shall be subject to a co payment of 20% (twenty percent) of the admissible claim amount if treatment is taken in a non-network provider. Co payment shall not apply to claims if treatment is undergone in a non-network provider in a place where the company/ TPA does not have tie-up with any hospital.

3.3 Good Health Incentives

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

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

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

Standard Exclusions

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

r. Hysterectomy
s. Refractive error of the eye more than 7.5 dioptres

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

iv. **Four years waiting period**

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

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

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)

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

4.6. Obesity/ Weight Control (Excl 06)

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
a. greater than or equal to 40 or
b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
i. Obesity-related cardiomyopathy
ii. Coronary heart disease
iii. Severe Sleep Apnea
iv. Uncontrolled Type2 Diabetes

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

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

4.8. Cosmetic or Plastic Surgery (Excl 08)

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

4.9. Hazardous or Adventure Sports (Excl 09)

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

4.10. Breach of Law (Excl 10)

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

4.11. Excluded Providers (Excl11)

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

4.12. Drug/Alcohol Abuse (Excl 12)

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

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

4.14. Vitamins, Tonics (Excl 14)
Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioners part of hospitalization claim or day care procedure

4.15. Refractive Error (Excl 15)
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

4.16. Unproven Treatments (Excl16)
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

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

Specific Exclusions

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

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

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

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

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

4.23. Vaccination or Inoculation.
Vaccination or inoculation unless forming part of treatment and requires Hospitalisation, except as and to the extent provided for under Section 3.1.7.iv and Section 3.1.13.

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

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

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

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

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

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

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

4.31. 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.

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

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

4.34. Home visit charges
Home visit charges during Pre and Post Hospitalisation of doctor, attendant and nurse, except as and to the extent provided for under 3.1.12.

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

4.36. Radioactivity
Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

4.37. Treatment taken outside the geographical limits of India

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

5 GENERAL TERMS AND CLAUSES

Standard General Terms and Conditions

5.1. Disclosure of information
The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, 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)*

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

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

iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

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

5.4. Moratorium Period

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

5.5. Multiple Policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.
iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

5.6. Fraud

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

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

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

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

5.7. 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

5.8. Migration

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

5.9. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date

as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

5.10. Renewal of policy

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

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
v. No loading shall apply on renewals based on individual claims experience.

5.11. Withdrawal of product

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

5.12. 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.

5.13. 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.

5.14. 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

5.15. Communication

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

5.16. Physical examination

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

5.17. Claim Procedure

5.17.1 Notification of claim

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

Notification of claim in case of Cashless facility	**TPA must be informed:**
In the event of planned hospitalisation	At least 72 (seventy two) hours prior to the insured person's

	admission to network provider/PPN
In the event of emergency hospitalisation	Within 24 (twenty four) hours of the insured person's admission to network provider/PPN

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

In case of a claim under Section 3.2, notification of claim is not required.

5.17.2 Procedure for Cashless claims

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

5.17.3 Procedure for reimbursement of claims

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

5.17.4 Documents

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

i. Completed claim form
ii. Bills, payment receipts, medical history of the patient recorded, discharge certificate/ summary from the hospital etc.
iii. Cash-memo from the hospital (s)/chemist (s) supported by proper prescription
iv. Payment receipt, investigation test reports etc. supported by the prescription from attending medical practitioner
v. Attending medical practitioner's certificate regarding diagnosis along with date of diagnosis and bill receipts etc.
vi. Surgeon's original certificate stating diagnosis and nature of operation performed along with bills/receipts etc.
vii. In the event of claim under Section 3.1.11, confirmation of the need of family member from attending medical practitioner
viii. Any other document required by company/TPA

Note

In the event of a claim lodged as per Condition 5.5 and the original documents having been submitted to the other insurer, the company may accept the documents listed under Condition 5.17.4 and claim settlement advice duly certified by the other insurer subject to satisfaction of the company.

Type of claim	**Time limit for submission of documents to company/TPA**
Reimbursement of hospitalisation and pre hospitalisation expenses	Within 15 (fifteen) days of date of discharge from hospital
Reimbursement of post hospitalisation expenses	Within 15 (fifteen) days from completion of post hospitalisation treatment
Reimbursement of health checkup expenses (as per Section 3.3.2)	At least 45 (forty five) days before the expiry of the third policy period.
Vaccination for children	Within 15 (fifteen) days from date of vaccination

5.17.5 Services offered by TPA

The TPA shall render health care services covered under the policy like issuance of ID cards & guide book, hospitalization & pre-authorization services, call centre, acceptance of claim related documents, claim processing and other related services

The services offered by a TPA shall not include

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

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

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

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

5.20. 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.

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

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

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

5.24. Adjustment of premium for Overseas Travel Insurance Policy
If during the policy period the insured person is also covered under an Overseas Travel Insurance Policy of any non life insurance company, the policy shall be inoperative in respect of the insured persons for the number of days the Overseas Travel Insurance Policy is in force and proportionate premium for the number of days the Overseas Travel Insurance Policy was in force shall be adjusted in the renewal premium. The insured person must inform the company in writing before leaving India and may submit an application, stating the details of visit(s) abroad, along with copies of the Overseas Travel Insurance Policy, within 7 (seven) days of return from abroad or expiry of the policy, whichever is earlier.

6 REDRESSAL OF GRIEVANCE
In case of any grievance the insured person may contact the company through

Website: https://nationalinsurance.nic.co.in/
Toll free: 1800 345 0330
E-mail: customer.relations@nic.co.in
Phn : (033) 2283 1742

Post: National Insurance Co. Ltd.,
6A Middleton Street, 7th Floor,
CRM Dept.,
Kolkata - 700 071

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.
If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer (Office in-Charge) at that location.
For updated details of grievance officer, kindly refer the link: https://nationalinsurance.nic.co.in/
If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017 (Annexure VI).
Grievance may also be lodged at IRDAI Integrated Grievance Management System -https://igms.irda.gov.in/

7 OTHER TERMS AND CONDITIONS - OPTIONAL COVERS
7.1 Critical illness
Subject otherwise to the terms, definitions, exclusions, and conditions of the policy and subject to the terms, definitions, exclusions, and conditions contained herein, it is hereby understood and agreed that the company shall pay the benefit amount, as stated in the schedule, provided that

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

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

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

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

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

The following are not covered
i. tumours showing the malignant changes of carcinoma in situ and tumours which are histologically described as premalignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
ii. any skin cancer other than invasive malignant melanoma
iii. alltumours of the prostate unless histologically classified as having a Gleason score greater than 6 (six) or having progressed to at least clinical TNM classification T2N0M0.
iv. papillary micro - carcinoma of the thyroid less than 1 (one) cm in diameter
v. chronic lymphocycticleukaemia less than RAI stage 3
vi. microcarcinoma of the bladder
vii. alltumours in the presence of HIV infection.

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

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

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

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

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

VI Open chest CABG

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

The following are not covered

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

VII Permanent paralysis of limbs

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

VIII Blindness

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

7.1.2 Exclusions

The company shall not be liable to make any payment under the policy if:

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

7.1.3 Condition

Claim amount

i. Any amount payable under the optional covers will not affect the sum insured applicable to Section 3.1.
ii. Copayment shall not apply to claims under optional covers.
iii. Any amount payable under the optional covers shall not affect the entitlement to cumulative bonus.

Notification of claim

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

Procedure for claims under critical illness

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

Documents

The claim is to be supported with the following original documents

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

Cessation of cover

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

Cancellation

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

7.2 Out-patient treatment

Subject otherwise to the terms, definitions, conditions and Exclusions 4.7, 4.8, 4.18, 4.16, 4.24, 4.12, 4.9, 4.10, 4.35 and 4.36, and subject to the terms, definitions, exclusions, and conditions contained herein, it is hereby understood and agreed that the company shall pay up to the limit, as stated in the schedule with respect of

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

7.2.1 Exclusions

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

i. Treatment other than Allopathy/ Modern medicine, Ayurveda and Homeopathy

ii. Cosmetic dental treatment to straighten lightens, reshape and repair teeth. Cosmetic treatments include veneers, crowns, bridges, tooth-coloured fillings, implants and tooth whitening.

7.2.2 Condition
Claim amount

i. Any amount payable under the optional covers will not affect the sum insured applicable to Section 3.1.
ii. Copayment shall not apply to claims under optional covers.
iii. Any amount payable under the optional covers shall not affect the entitlement to cumulative bonus.

Procedure for claims under outpatient treatment

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

Documents

The claim is to be supported with the following original documents

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

Cancellation

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

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

Table of Benefits

Features	**Plans**		
	PLAN A	**PLAN B**	**PLAN C**
Sum insured	**INR 2/ 3 /4 / 5/ 6/ 7/ 8/ 9 /10 Lac**	**INR 15/ 20 /25 Lac**	**INR 30/ 40/ 50 Lac**
Coverage			
Hospitalisation, Pre (30days) and Post (60 days) Hospitalisation, Daycare procedure	Covered	Covered	Covered
Pre existing disease (Only PEDs declared in the Proposal Form and accepted for coverage by the Company shall be covered)	Covered after 36 months of continuous coverage	Covered after 36 months of continuous coverage	Covered after 36 months of continuous coverage
Room/ ICU charges	Room - Up to 1% of SI per day ICU – Up to 2% of SI per day subject to max. of INR 15,000 per day	Up to INR 15,000 per day	Up to INR 20,000 per day
Limit for cataract surgery	For each eye – Up to 15% of sum insured or INR 60,000 whichever is lower	For each eye – Up to INR 80,000	For each eye – Up to INR 1,00,000
Ayurveda and Homeopathy	Up to sum insured	Up to sum insured	Up to sum insured
Organ donor's medical expenses	Covered	Covered	Covered
Maternity	Up to INR 30,000 for normal delivery and INR 50,000 for caesarean section	Up to INR 60,000 for normal delivery and INR 75,000 for caesarean section	Up to INR 80,000 for normal delivery and INR 100,000 for caesarean section
Hospital cash	INR 500 per day, max. of 5 days	INR 800 per day, max. of 5 days	INR 1,000 per day, max. of 5 days
Ambulance	Up to INR 2,500 in a policy period	Up to INR 4,000 in a policy period	Up to INR 5,000 in a policy period
Air ambulance	Not covered	Up to 5% of SI per policy period	Up to 5% of SI per policy period
Medical emergency reunion	Not covered	Up to INR 20,000 per policy period	Up to INR 20,000 per policy period
Doctor's home visit and nursing careduring post hospitalisation	Not covered	INR 750 per day,max. of 10 days	INR 1,000 per day,max. of 10 days
Vaccination for children (up to 12 years)	Up to INR 1,000 in a policy period	Up to INR 1,000 in a policy period	Up to INR 1,000 in a policy period
Modern Treatment (12 nos)	Up to 25% of SI for each treatment	Up to 25% of SI for each treatment	Up to 25% of SI for each treatment
Treatment due to participation in hazardous or adventure sports (non-professionals)	Up to 25% of SI	Up to 25% of SI	Up to 25% of SI
Morbid Obesity	Covered after waiting period of 4 years	Covered after waiting period of 4 years	Covered after waiting period of 4 years
Refractive Error (min 7.5D)	Covered after waiting period of 2 years	Covered after waiting period of 2 years	Covered after waiting period of 2 years
Other benefits			
Medical Second Opinion (MSO)	One MSO for each new diagnosis of any of the major illnesses in Appendix II, in a policy period	One MSO for each new diagnosis of any of the major illnesses in Appendix II, in a policy period	One MSO for each new diagnosis of any of the major illnesses in Appendix II, in a policy period
Good Health Incentives			
Cumulative bonus	Increase in SI by 5% of SI (excluding CB) per year up to 50% of SI (excluding CB)	Increase in SI by 5% of SI (excluding CB) per year up to 50% of SI (excluding CB)	Increase in SI by 5% of SI (excluding CB) per year up to 50% of SI (excluding CB)
Health checkup	Every 2 yrs., up to INR 1,000	Every 2 yrs., up to INR 2,000	Every 2 yrs., up to INR 3,000
Copayment			
Copayment of 20% of admissible claim if treatment taken in non-network hospital (not applicable to optional covers)	Applicable	Applicable	Applicable
Optional covers			
Critical Illness	Benefit amount per individual - INR 2,00,000/ 3,00,000/ 5,00,000/ 10,00,000/ 15,00,000/ 20,00,000/ 25,00,000.		
Outpatient Treatment	Limit of cover per individual - INR 2,000/ 3,000/ 4,000/ 5,000/ 10,000.		

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

• Microsurgical operations on the middle ear
1. Stapedotomy
2. Stapedectomy
3. Revision of a stapedectomy
4. Other operations on the auditory ossicles
5. Myringoplasty (Type -I Tympanoplasty)
6. Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles)
7. Revision of a tympanoplasty
8. Other microsurgical operations on the middle ear
• Other operations on the middle and internal ear
9. Myringotomy
10. Removal of a tympanic drain
11. Incision of the mastoid process and middle ear
12. Mastoidectomy
13. Reconstruction of the middle ear
14. Other excisions of the middle and inner ear
15. Fenestration of the inner ear
16. Revision of a fenestration of the inner ear
17. Incision (opening) and destruction (elimination) of the inner ear
18. Other operations on the middle and inner ear
• Operations on the nose and the nasal sinuses
19. Excision and destruction of diseased tissue of the nose
20. Operations on the turbinates (nasal concha)
21. Other operations on the nose
22. Nasal sinus aspiration
• Operations on the eyes
23. Incision of tear glands
24. Other operations on the tear ducts
25. Incision of diseased eyelids
26. Excision and destruction of diseased tissue of the eyelid
27. Operations on the canthus and epicanthus
28. Corrective surgery for entropion and ectropion
29. Corrective surgery for blepharoptosis
30. Removal of a foreign body from the conjunctiva
31. Removal of a foreign body from the cornea
32. Incision of the cornea
33. Operations for pterygium
34. Other operations on the cornea
35. Removal of a foreign body from the lens of the eye
36. Removal of a foreign body from the posterior chamber of the eye
37. Removal of a foreign body from the orbit and eyeball
38. Operation of cataract
• Operations on the skin and subcutaneous tissues
39. Incision of a pilonidal sinus
40. Other incisions of the skin and subcutaneous tissues
41. Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
42. Local excision of diseased tissue of the skin and subcutaneous tissues
43. Other excisions of the skin and subcutaneous tissues
44. Simple restoration of surface continuity of the skin and subcutaneous tissues
45. Free skin transplantation, donor site
46. Free skin transplantation, recipient site
47. Revision of skin plasty
48. Other restoration and reconstruction of the skin and subcutaneous tissues
49. Chemosurgery to the skin
50. Destruction of diseased tissue in the skin and subcutaneous tissues
• Operations on the tongue
51. Incision, excision and destruction of diseased tissue of the tongue
52. Partial glossectomy
53. Glossectomy
54. Reconstruction of the tongue
55. Other operations on the tongue
• Operations on the salivary glands and salivary ducts
56. Incision and lancing of a salivary gland and a salivary duct
57. Excision of diseased tissue of a salivary gland and a salivary duct
58. Resection of a salivary gland
59. Reconstruction of a salivary gland and a salivary duct
60. Other operations on the salivary glands and salivary ducts
• Other operations on the mouth and face
61. External incision and drainage in the region of the mouth, jaw and face
62. Incision of the hard and soft palate
63. Excision and destruction of diseased hard and soft palate
64. Incision, excision and destruction in the mouth
65. Plastic surgery to the floor of the mouth
66. Palatoplasty
67. Other operations in the mouth
• Operations on the tonsils and adenoids
68. Transoral incision and drainage of a pharyngeal abscess
69. Tonsillectomy without adenoidectomy
70. Tonsillectomy with adenoidectomy
71. Excision and destruction of a lingual tonsil
72. Other operations on the tonsils and adenoids
• Trauma surgery and orthopaedics
73. Incision on bone, septic and aseptic
74. Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
75. Suture and other operations on tendons and tendon sheath
76. Reduction of dislocation under GA
77. Arthroscopic knee aspiration
• Operations on the breast
78. Incision of the breast
79. Operations on the nipple
• Operations on the digestive tract
80. Incision and excision of tissue in the perianal region
81. Surgical treatment of anal fistulas
82. Surgical treatment of haemorrhoids
83. Division of the anal sphincter (sphincterotomy)
84. Other operations on the anus
85. Ultrasound guided aspirations
86. Sclerotherapy etc.
• Operations on the female sexual organs
87. Incision of the ovary
88. Insufflation of the Fallopian tubes
89. Other operations on the Fallopian tube
90. Dilatation of the cervical canal
91. Conisation of the uterine cervix
92. Other operations on the uterine cervix
93. Incision of the uterus (hysterotomy)
94. Therapeutic curettage
95. Culdotomy
96. Incision of the vagina
97. Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
98. Incision of the vulva
99. Operations on Bartholin's glands (cyst)
• Operations on the prostate and seminal vesicles
100. Incision of the prostate
101. Transurethral excision and destruction of prostate tissue
102. Transurethral and percutaneous destruction of prostate tissue
103. Open surgical excision and destruction of prostate tissue
104. Radical prostatovesiculectomy
105. Other excision and destruction of prostate tissue
106. Operations on the seminal vesicles
107. Incision and excision of periprostatic tissue
108. Other operations on the prostate
• Operations on the scrotum and tunica vaginalis testis
109. Incision of the scrotum and tunica vaginalis testis
110. Operation on a testicular hydrocele
111. Excision and destruction of diseased scrotal tissue
112. Plastic reconstruction of the scrotum and tunica vaginalis testis
113. Other operations on the scrotum and tunica vaginalis testis
• Operations on the testes
114. Incision of the testes
115. Excision and destruction of diseased tissue of the testes
116. Unilateral orchidectomy
117. Bilateral orchidectomy
118. Orchidopexy
119. Abdominal exploration in cryptorchidism
120. Surgical repositioning of an abdominal testis
121. Reconstruction of the testis
122. Implantation, exchange and removal of a testicular prosthesis
123. Other operations on the testis
• Operations on the spermatic cord, epididymis and ductus deferens
124. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
125. Excision in the area of the epididymis
126. Epididymectomy
127. Reconstruction of the spermatic cord
128. Reconstruction of the ductus deferens and epididymis
129. Other operations on the spermatic cord, epididymis and ductus deferens
• Operations on the penis
130. Operations on the foreskin
131. Local excision and destruction of diseased tissue of the penis
132. Amputation of the penis
133. Plastic reconstruction of the penis
134. Other operations on the penis
• Operations on the urinary system
135. Cystoscopical removal of stones
• Other Operations
136. Lithotripsy
137. Coronary angiography
138.Hemodialysis
139. Radiotherapy for Cancer
140. Cancer Chemotherapy

Note:

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

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

	MEDICAL CONDITION
Brain Disorders	Brain Tumor – Malignant and Benign
	Cerebral Aneurysms
	Severe Brain Damage
	Cerebral AV Malformations
Cancer Conditions	Adrenal cancer
	Bladder cancer
	Bone cancer – all forms
	Breast cancer
	Cervical cancer
	Colon cancer
	Colorectal cancer
	Duodenal cancer
	Endometrial cancer
	Esophageal cancer
	Eye cancer
	Follicular cancer
	Gallbladder cancer
	Gastric cancer
	Kidney cancer
	Intestinal cancer
	Laryngeal cancer
	Liver cancer
	Lung cancer
	Malignant Soft Tissue
	Medullary cancer
	Melanoma
	Metastatic Spine Tumor
	Multiple Myeloma
	Myelodysplastic Syndrome (Myelodysplasia)
	Neuroblastoma
	Oral Cavity cancer
	Ovarian cancer
	Pancreatic cancer
	Papillary cancer
	Parotid cancer
	Prostate cancer
	Rectal cancer
	Sarcomas
	Skin cancer, non-melanoma
	Stomach cancer
	Testicular cancer
	Thyroid cancer
	Uterine cancer
	Vaginal cancer
	Vocal cord cancer
	All malignant conditions
Cardiovascular Disorders	Abdominal Aortic Aneurysm
	Angina
	Aortic Aneurysm
	Cardiac Arrhythmia
	Cardiac Pacemaker (history of)
	Cardiomyopathy
	Congenital Heart Defect
	Congestive Heart Failure
	Coronary Artery Disease
	Coronary Bypass Surgery Evaluation
	Dilated Cardiomyopathy
	Heart Transplantation (evaluation for)
	Heart valve surgery
	Hypertensive Heart Disease
	Myocardial Infarction (MI)
	Pulmonary Arterial Hypertension ValvularHeart Disease
Colorectal Disorders	Colitis
	Crohn's Disease
	Ulcerative Colitis
Dermatological Disorders	Skin Ulcer
Endocrine Disorders	Aldocortisol Secreting Tumor
	Graves Disease
	M.E.N. (Multiple Endocrine Neoplasia Syndrome)
	Thyroiditis
Sensory Disorders	Age Related Macular Degeneration
	Blindness
	Diabetic Retinopathy
	Loss of Hearing
	Loss of Speech Macular Detachment
	Proliferative Vitreoretinopathy
	Retinal Detachment
Gastrointestinal Disorders	Chronic Relapsing Pancreatitis
	Cirrhosis
	Inflammatory Bowel Disease
	Hepatitis
	End state liver disease
	Liver failure
	Irritable Bowel Syndrome
	Large bowel disease
	Small bowel disease
Gynecological Disorders	Infertility (female)
Hematological Disorders	Aplastic Anemia
	Coagulopathies
	Hodgkin's disease (Pediatric)
	Leukemia (Adult & Pediatrics)
	Lymphoma (Adult & Pediatric)
	Non-Hodgkin's Lymphoma (Adult & Pediatric)
Neurologic Disorders	Amyotrophic Lateral Sclerosis
	Apallic Syndrome (Vegetative State)
	Coma
	Medullary Cystic Disease
	Motor Neuron Disease
	Multiple Sclerosis
	Muscular Dystrophy
	Myasthenia Gravis
	Parkinson's Disease
	Primary lateral Sclerosis (PLS)
Orthopaedic Disorders (hip / knee)	Arthritis (Hip)
	Arthritis (Knee)
	Avascular Necrosis of Hip
	Avascular Necrosis of Knee
	Hip injury / disorders
	Loss of limbs
	Post-Traumatic Arthritis (knee)
	Severe Rheumatoid Arthritis
Orthopaedic Disorders (Tumors)	Benign / Malignant Bone Tumor
	Benign / Malignant Soft Tissue
Pulmonary Disorders	Asthma
	Bronchitis
	Chronic Obstructive Pulmonary Disease (COPD)
	Cystic Fibrosis
	Emphysema
	End stage lung disease
	Eosiniphilic Granuloma
	Histiocytosis X (lung)
	Chronic Pneumonia
	Pulmonary Fibrosis
	Pulmonary Hypertension
	Wegener's Granulomatosis
Shoulder Disorders	Arthritis
	Failed Surgery of the Shoulder
	Shoulder Fractures / Injuries
	Unstable shoulder
Spine Disorders (multiple)	Ankylosing Spondylitis
	Arthritis
	Herniated disc(s)
	Spinal Abscess
	Spinal Stenosis
	Spinal Tumor
	Vertebral Fracture
Urological Disorders	Kidney failure
	Renal Artery Disease
Vascular Disorders	Arteriosclerosis Obliterans
	Cerebrovascular Diseases
	Elephantiasis
	Embolism
	Lower Extremity (Leg) Problems – Arterial
	Lower Extremity (Leg) Problems - Venous
	Peripheral Vascular Disease
	Vena Cava Syndrome
	Venous Insufficiency
	Venous Thromboembolism
Systemic	Acquired Immunity Deficiency Disorder (AIDS/HIV)
	HIV infection
	Major Burns
	Paralysis
	Poliomyelitis
	Systemic Lupus Erythematosus
Major Organ Transplantation	Bone Marrow
	Cornea
	Heart
	Lung Kidney
	Liver
	Pancreas
	Skin Graft

Vaccinations for Children

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

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 V

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

Sl	Existing Disease	ICD Code Excluded
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemiavera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behaviour
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I50 Heart failure, I42Cardiomyopathy; I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis,unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophagealvarices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 – Acute hepatitis B without delta-agent and without hepatic coma; B17.0 - Acute delta-(super) infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease	G30.9 - Alzheimer's disease, unspecified; F00.9 -G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	HIV & AIDS	B20.0 - HIV disease resulting in mycobacterial infection; B20.1 - HIV disease resulting in other bacterial infections; B20.2 - HIV disease resulting in cytomegaloviral disease; B20.3 - HIV disease resulting in other viral infections; B20.4 - HIV disease resulting in candidiasis; B20.5 - HIV disease resulting in other mycoses; B20.6 - HIV disease resulting in Pneumocystis carinii pneumonia; B20.7 - HIV disease resulting in multiple infections; B20.8 - HIV disease resulting in other infectious and parasitic diseases; B20.9 - HIV disease resulting in unspecified infectious or parasitic disease; B23.0 - Acute HIV infection syndrome; B24 - Unspecified human immunodeficiency virus [HIV] disease
14	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
15	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
16	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

Appendix VI

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

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat , UT of Dadra and Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th Floor, Tilak Marg, Relief Road, Ahmedabad-380001 Tel: 079 -25501201/ 02/ 05/ 06 Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka	Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in
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 - 23232481 / 23213504 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, Jeevan Bhawan, 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. Tel: 0612-2680952 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