National Super Top Up Mediclaim Policy

PROSPECTUS

1.1 Product

National Super Top Up Mediclaim Policy is a high threshold indemnity health insurance product, covering the members of a family under a single sum insured on floater basis or each member on individual sum insured basis. Claim under the Policy is payable provided the cumulative medical expenses for the insured (individual basis) or the family (floater basis) in a policy period exceeds the threshold. The Policy covers expenses in respect of inpatient treatment (allopathy, ayurveda and homeopathy) reasonably and customarily incurred for treatment of a disease or an injury contracted/sustained during the policy period. The Policy also covers pre hospitalisation and post hospitalisation expenses, 140+ day care procedures/surgeries, organ donor's medical expenses, hospital cash, doctor's home visit, nursing, aya and attendant charges, ambulance charges, HIV/ AIDS treatment, bariatric surgery and maternity.

Important:

1. Claim shall be admissible for the hospitalisation during which the cumulative medical expenses in respect of hospitalisation(s) of any insured person (individual plan) or one or more insured persons (floater plan) in a policy period exceeds the threshold and for all subsequent hospitalisation(s) during the policy period.
2. Threshold shall be determined taking into account the Cumulative Medical Expenses incurred in one or more hospitalisation(s) during the policy period of this Policy for Coverage mentioned in Section 1.2 only, irrespective of existence of any Base Policy covering the said hospitalisation(s).
3. For claims admissible under the Policy (after Cumulative Medical Expenses exceeds the Threshold) Coverage mentioned in both Section 1.2 and Section 1.3 shall be payable.
4. Maximum liability of the Company under the policy for all admissible claims during the policy period shall be the individual/ floater sum insured opted.
5. **The insured shall preserve and submit all original documents and/ or certified copies of documents related to all hospitalisation(s) during the policy period to enable the Company to calculate the cumulative medical expenses and threshold, for determining admissibility and payment of claims.**

1.2 Coverage

1.2.1 In-patient Treatment

The Company shall pay to the hospital or reimburse the insured, 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)
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.
vii. Dental treatment, necessitated due to an injury
viii. Plastic surgery, necessitated due to illness or injury
ix. Hormone replacement therapy, if medically necessary
x. Vitamins and tonics, forming part of treatment for illness/injury as certified by the attending medical practitioner
xi. Circumcision, necessitated for treatment of an illness or injury

1.2.1.1 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.**

1.2.2 Pre Hospitalisation

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

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

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

1.2.3 Post Hospitalisation

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

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

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

1.2.4 Day Care Procedure

The Company shall pay to the hospital/ day care centre the medical expenses or reimburse the insured the medical expenses and pre and post hospitalisation expenses, for day care procedures which require hospitalisation for less than twenty four hours, provided that

i. day care procedures/surgeries are undergone by an insured person in a hospital/day care centre (but not in the outpatient department of a hospital)
ii. any other surgeries/procedures which due to advancement of medical science require hospitalisation for less than twenty four hours and for which prior approval from the Company/TPA is mandatory.

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

1.2.6 Organ Donor's Medical Expenses
The Company shall pay to the hospital or reimburse the insured the medical expenses and pre and post hospitalisation expenses of the organ donor, during the course of organ transplant to the insured person, provided
i. the donation conforms to 'The Transplantation of Human Organs Act 1994' and the organ is for the use of the insured person
ii. the insured person has been medically advised to undergo an organ transplant,

Exclusions
The Company shall not be liable to make any payment in respect of any expenses incurred in connection with or in respect of
1. Cost of the organ to be transplanted.
2. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

1.2.7 HIV Treatment
The Company shall pay to the hospital or reimburse the insured the medical expenses for treatment of HIV (Human Immunodeficiency Virus), AIDS (Acquired Immune Deficiency Syndrome), and complications of AIDS, after a waiting period of 3 months from the inception of the Policy. The stages of covered HIV infection are:
1. Acute HIV infection – acute flu-like symptoms
2. Clinical latency – usually asymptomatic or mild symptoms
3. AIDS – full-blown disease; CD4 < 200

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

1.2.8 Morbid Obesity Treatment
The Company shall indemnify the Hospital or the Insured the Medical Expenses, including pre hospitalisation expenses and post hospitalisation expenses, incurred for surgical treatment of obesity that fulfils **all** the following conditions and subject to Waiting Period of thirty six (36) months:
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;
   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 Type 2 Diabetes

1.2.9 Maternity
The Company shall pay to the hospital or reimburse the insured the medical expenses incurred for delivery or termination up to the first two deliveries or terminations of pregnancy during the lifetime of the insured or his spouse covered under the Policy, after a waiting period of 36 months from the date of inclusion of the insured person in the Policy. The benefits described below are up to the limit as shown in the Table of Benefits.
i. Medical expense for delivery (normal or caesarean).
ii. Medical expense for lawful medical termination of pregnancy.
iii. Hospitalisation expenses, if medically necessary, up to a maximum of thirty days for pre-natal and sixty days for post-natal treatment.

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

Exclusions
The Company shall not be liable to make any payment in respect of any expenses incurred in connection with or in respect of
1. Insured and insured persons above forty five years of age.
2. More than one delivery or termination in a policy period.
3. Surrogacy
4. Pre and post hospitalisation expenses, other than pre and post natal treatment.

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

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

1.2.11 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 3.42) 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.

1.2.12 Correction of Refractive Error
The Company shall indemnify the Hospital or the Insured the Medical Expenses, including pre hospitalisation expenses and post hospitalisation expenses, incurred for expenses related to the treatment for correction of eye sight due to refractive error equal to or more than 7.5 dioptres, subject to Waiting Period of two (02) years as per Section 4.2.f.iii.

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

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

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

i. the hospitalisation exceeds three days.
ii. a claim has been admitted under Section 1.2.1.

Illustration
In case of hospitalisation of 3 days, threshold not exhausted – No Hospital Cash payable
In case of hospitalisation of 5 days, threshold not exhausted – No Hospital Cash payable
In case of hospitalisation of 5 days, threshold exhausted – Hospital Cash payable for 4^{th} and 5^{th} day only, i.e., 2 days
In case of hospitalisation of 10 days, threshold exhausted – Hospital Cash payable for 4^{th} to 8^{th} day, i.e., maximum 5 days
Hospitalisation of less than 24 hours shall not be considered for the purpose of payment of Hospital Cash

1.3.2 Doctor's Home Visit/ Aya/ Nurse/ Attendant Charges during Post Hospitalisation
The Company shall reimburse the insured, for medically necessary expenses incurred for doctor's home visit, nursing care by qualified nurse, aya, attendant charges during post hospitalisation up to the limit as shown in the Table of Benefits., provided the related hospitalisation claim has been admitted under Section 1.2.1 and the physical mobility of the insured person outside residence is severely restricted due to the illness/ injury requiring hospitalization.

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

1.4 Migration to Policy without Threshold
The Company shall allow the insured persons to migrate to any indemnity health insurance product (for same or lower sum insured without any threshold) of the Company with continuity coverage in terms of waiver of waiting periods to the extent of benefits covered under this Policy, provided the insured person has been covered under National Super Top Up Mediclaim Policy before attaining the age of 45 years and has continuously renewed the Policy for 5 years without interruption.

Conditions

1. Migration to any other indemnity health insurance product shall be subject to the Underwriting Guidelines of the said product, including Pre Policy Health Checkup (if applicable).
2. This option can be exercised by the Insured Person at the time of renewal only.
3. Insured person has to apply to the Policy issuing office for the migration at least 45 days prior to the renewal date.
4. On migration, terms and rates of the migrated policy shall apply.

1.5 Good Health Incentive

1.5.1 Cumulative Bonus (CB)

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

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

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

1.6 Hospitalisation Options

The Policy provides for cashless facility and/ or reimbursement of hospitalisation expenses for treatment of disease or injury.
Cashless facility is available only in network providers, if opted for TPA service, subject to prior approval by the TPA.

2.1 Eligibility

i. Policy can be opted on individual and floater basis. On floater basis, at least two family members, as defined below, shall be covered.
ii. Policy can be opted with or without a Base Policy (i.e., any Indemnity Based Health Insurance Product offered by any General Insurance Company covering the same members).
iii. Entry age of Proposer should be between eighteen years and sixty five years.
iv. Maximum entry age of any family member is sixty five years.
v. Children above the entry age of three months may be covered for the first time subject to maximum entry age as mentioned below, provided parent(s) is/are covered at the same time.
    a. Dependent male child up to twenty five (25) years of age or till the person is employed, whichever is earlier
    b. Dependent female child, till the person is employed or married
vi. Family members allowed under same policy.
    a. Proposer
    b. Spouse
    c. Dependent legitimate or legally adopted children
    d. Parents/ Parents-in law
vii. Renewal terms are as per Section 2.10 below.
viii. Midterm inclusion of family members at pro-rata premium is allowed only in case of
    a. newborn between the age of three months and six months
    b. spouse within sixty days of marriage

    (Members other than above may be included only at renewal. On inclusion of a new member, waiting period of 4.1, 4.2, 4.3 shall apply for the new member.)

2.2 Policy Period

The Policy can be issued for a period of one year.

2.3 Sum Insured (SI) and Threshold

i. The Policy is available with following combinations of Threshold and Sum Insured (in ₹)

Threshold	Sum Insured (above Threshold)
2L	3, 5L
3L	3, 5, 7L
5L	5, 7, 10L
8L	10, 15L
10L	15, 20L

ii. For Policy issued on individual basis, both Threshold and sum insured shall apply on individual basis on each insured person.
iii. For Policy issued on floater basis, both Threshold and sum insured shall apply on floater basis to all the insured persons.

2.3.1 Enhancement of Sum Insured, Threshold

i. Sum insured and/ or Threshold can be enhanced only at the time of renewal, to the next slab.
ii. 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.

2.4 Discounts

2.4.1 Early Entry Discount (EED)

In case where an insured person has entered the policy before the age 42 (completed years) and renewed the policy for a continuous period of 3 years, an EED of 5% on individual premium will be allowed starting from the fourth policy period and continue in subsequent renewals during the life time of the Policy.

Illustration

	Scenario I	**Scenario II**	**Scenario III**
Age at inception of Policy 1	41 yrs 6 months	25 yrs 2 months	43 yrs 0 months
Age at inception of Policy 2	42 yrs 6 months	26 yrs 2 months	44 yrs 0 months
Age at inception of Policy 3	43 yrs 6 months	27 yrs 2 months	45 yrs 0 months
Age at inception of Policy 4	44 yrs 6 months	28 yrs 2 months	46 yrs 0 months
EED from Policy 4	**Applicable**	**Applicable**	**Not applicable**

2.4.2 Family Discount (applicable only to Policy issued on individual basis)

In case one or more of the family members are covered along with the proposer - Discount of 5% shall be allowed on the total family premium for new and renewal policies.

2.4.3 Discount for Online, Direct

For Policy bought online, by walk in customer *(where no intermediary is involved)* - Discount of 10% shall be allowed on the final payable premium for new and renewal policies.

2.5 Tax Rebate

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

2.6 Buying the Policy

The Policy can be bought from the channels mentioned below.

i. online from portal, for policies where Pre Policy Checkup is not required.
ii. from our operating offices
iii. from our agents
iv. from self service kiosks
v. from Office on Wheels (office on mobile van)
vi. Any other channel introduced by the Regulator from time to time

2.7 Completion of Proposal Form

i. The proposal form is to be completed in all respects (including personal details, medical history of insured person) and to be submitted to the office or to the agent.
ii. Identity and address of the proposer must be supported by documentary proof.
iii. Details of Base Policy must be supported by documentary proof (for Policy issued with Base Policy)
iv. Person insured covered by any similar health insurance policy of any other general insurance Company and wishing to port (switch) to National Super Top Up Mediclaim Policy, will have to submit the proposal form and portability form to the office or to the agent.
v. If opting for Waiver of Threshold (Section 1.4), fresh Proposal Form applicable to new product shall be submitted.

2.8 Pre Policy Checkup

i. Pre Policy checkup is required for all individual family members aged fifty years and above
ii. The Company shall reimburse 50% of the expenses incurred for pre Policy checkup, if the proposal is accepted and the premium has been realized.
iii. No pre policy health check-up shall be required for existing policyholders of the Company, covered under any retail indemnity health insurance policy for a continuous period 3 years or more as on date of opting for National Super Top Up Mediclaim Policy.
iv. The Pre Policy checkup reports required are –
    a) Physical examination (report to be signed by the Doctor with minimum MD (Medicine) qualification)
    b) Blood sugar (fasting/ post prandial)
    c) Lipid profile
    d) Serum creatinine
    e) Urine routine and microscopic examination
    f) ECG
    g) Any other investigation required by the Company

Note: The date of medical reports should not exceed thirty days prior to the date of proposal.

2.9 Payment of Premium

i. For Policy issued on individual basis, premium depends on the SI opted and age of the member.
ii. For Policy issued on floater basis, premium depends SI opted, age of the senior most member and age of family members.
iii. The proposer has the option of claims being serviced by TPA (in which case cashless facility/reimbursement of expenses will be available) or the Company (in which case expenses will be reimbursed). If cashless facility is to be availed, the

premium payable is inclusive of TPA charges. If cashless facility is not required, the premium payable is without TPA charges.

iv. PAN details must be submitted to the Company.

v. In case PAN is not available, Form 60 or Form 61 as per Rule 114B of the Income-tax Rule,1962 must be submitted

2.10 Renewal of Policy

i. The Policy can be renewed throughout the lifetime of all the insured persons, except the following.
   - Dependent male child only up to twenty five years, shall be allowed renewal if not employed.
   - Dependent female child if not employed, shall only be allowed renewal till marriage.

ii. Insured Children have the option to port to similar health insurance product on completion of the specified exit age as mentioned in 2.10.i.

iii. The Policy may be renewed by mutual consent before the expiry of the Policy.

iv. The Company is not bound to send renewal notice.

v. Renewal of Policy can be denied on grounds of fraud, moral hazard, misrepresentation or noncooperation.

vi. In the event of break in the Policy a grace period of thirty days is allowed. Coverage is not available during the grace period.

vii. In case of non-continuance of the Policy by the insured (due to death or any other valid and acceptable reason)
   - The Policy may be renewed by any insured person above eighteen years of age, as the insured
   - Where only children (less than eighteen years of age) are covered, the Policy shall be allowed till the expiry of the policy period. The legal guardian may be allowed to renew the Policy as insured, covering the children.

viii. In case of death of the eldest insured person in a Policy issued on floater basis,
   - The premium to be charged shall be based on the age of the next eldest insured person.

ix. If during the policy period, the number of members covered in a floater policy reduces to a single member, then on renewal the Policy shall automatically be converted to individual basis.

3 Definitions

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

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

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

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

3.5 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

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

3.7 Body Mass Index (BMI) is defined as the body mass (weight) divided by the square of the height of an individual, and is universally expressed in units of kg/m2, resulting from mass in kilograms and height in metres.

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

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

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

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

a) Internal Congenital Anomaly

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

b) External Congenital Anomaly

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

3.12 Cumulative Medical Expenses means the aggregate of medical expenses incurred during the policy period of this Policy towards one or more out of the Coverage mentioned in Section 1.2 (i.e. under the heads of 1.2.1. In-patient Treatment, 1.2.2. Pre Hospitalisation, 1.2.3. Post Hospitalisation, 1.2.4. Day Care Procedure, 1.2.5. Ayurveda and Homeopathy, 1.2.6. Organ Donor's Medical Expenses, 1.2.7. HIV Treatment, 1.2.8. Morbid Obesity Treatment, 1.2.9. Maternity, 1.2.10 Modern Treatment, 1.2.11 Mental Illness Cover & 1.2.12 Correction of Refractive Error) in respect of,

a) Individual Plan

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

b) Floater Plan

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

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

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

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

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

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

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

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

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

3.18 Floater means the threshold/ sum insured, as mentioned in the Schedule, applicable to all the insured persons, for any and all claims made in aggregate during the policy period.

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

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

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

3.21 Hospitalisation means admission in a hospital for a minimum period of twenty four (24) consecutive 'Inpatient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.

3.22 ID Card means the card issued to the insured person by the TPA for availing cashless facility in the network provider.

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

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

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

3.24 In-Patient Care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

3.25 Insured/ Insured Person means person(s) named in the schedule of the Policy.

3.26 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.

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

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

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

3.30 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.

3.31 Medically Necessary means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which
i. is required for the medical management of illness or injury suffered by the insured ;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. must have been prescribed by a medical practitioner;
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

3.32 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.

3.33 Morbid Obesity is a medical term describing people who have a Body Mass Index (BMI) of at least 40 and with significant medical problems caused by or made worse by their weight.

3.34 Network Provider means hospitals or health care providers enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.

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

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

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

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

3.39 Pre Existing Disease means any condition, ailment, injury or disease
a) That is/are diagnosed by a physician within 48 months prior to the effective date of the Policy issued by the Company or its reinstatement or
b) For which Medical Advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Policy issued by the Company or its reinstatement.

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

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

3.41 Post-hospitalisation Medical Expenses means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and

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

3.42 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.

3.43 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.

3.44 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.

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

3.46 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.

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

3.48 Sum insured means the sum insured and the cumulative bonus (CB) accrued in respect of the insured person (for policies issued on individual basis)/ one or more insured persons (for policies issued on floater basis) as mentioned in the schedule. The sum insured represents maximum liability of the Company for any and all claims during the policy period.

3.49 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.

3.50 Threshold means the amount of Cumulative Medical Expenses (as per Definition 3.11), as chosen by the insured and mentioned in the schedule, up to which no amount can be claimed under this Policy.

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

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

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

3.53 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.

4 Exclusions

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

4.1. Pre-Existing Diseases (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 twelve (12) 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 twelve (12) months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us and as per the table given below.

Months from inception	Limit of claim
13-24 months	50% of the admissible claim
25-36 months	75% of the admissible claim
After 36 months	100% of the admissible claim

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

Above diseases/treatments under 4.2.f).i, ii shall be covered after the specified Waiting Period up to 100% of the admissible claim, provided they are not Pre Existing Diseases.

iii. **Two years waiting period**

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

a. Treatment for joint replacement unless arising from accident
b. Osteoarthritis and osteoporosis
c. Refractive error of the eye more than 7.5 dioptres.
d. Internal Congenital Anomaly
e. Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

After expiry of twenty four months any claim arising out of the above conditions or complications thereof will be paid as per the table given below

Months from inception	Limit of claim
25-36 months	75% of the admissible claim
After 36 months	100% of the admissible claim

4.3. 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.

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 (Excl 11)
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Company and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

4.12. Drug/Alcohol Abuse (Excl 12)
Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof (Excl 12)

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

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

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

4.16. Unproven Treatments (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

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.

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. Out Patient Department (OPD) or Domiciliary treatment
Any expenses incurred on OPD or Domiciliary 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.

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 and any medical equipment which could be used at home subsequently.

4.32. Items of personal comfort
Items of personal comfort and convenience 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 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 Section 1.3.2 (Doctor's Home Visit/ Aya/ Nurse/ Attendant charges during Post Hospitalisation)..

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)

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

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

5.5 Claim Procedure
5.5.1 Condition Precedent to Claim
1. Claim shall be admissible for the hospitalisation during which the cumulative medical expenses as per Section 1.2 in respect of hospitalisation(s) of any insured person (individual plan) or one or more insured person (floater plan)in a policy period exceeds the threshold as per Section 1.2 and for all subsequent hospitalisation(s) during the policy period.
2. Admissible claim amount for hospitalisation(s) mentioned above shall be calculated as per Section 1.2 and Section 1.3.

5.5.2 Notification of Claim
In order to lodge a claim under the Policy for any hospitalisation during the policy period, the insured person/insured person's representative shall notify the TPA (if claim is processed by TPA)/Company (if claim is processed by the Company) in writing by letter, e-mail, fax providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit.

Notification of claim for Cashless facility	**TPA must be informed:**
In the event of planned hospitalisation	At least seventy two hours prior to the insured person's admission to network provider
In the event of emergency hospitalisation	Within twenty four hours of the insured person's admission to network provider

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

Note:
i. In case of hospitalisation where the cumulative medical expenses are likely to exceed the threshold, notification of claim shall be sent to the TPA mentioned in the schedule/ Company.
ii. In case of hospitalisation where initially the cumulative medical expenses are not foreseen to exceed the threshold but subsequently exceeds, notification of claim shall be sent to the TPA mentioned in the schedule/ Company, immediately.

5.5.3 Procedure for Cashless Claims

i. **For the first claim under the Policy (i.e., the claim in which cumulative medical expenses exceeds the threshold) cashless facility shall be available provided all evidences and documents are produced prior to cashless authorization, to substantiate that the Cumulative Medical Expenses (CME) exceeds the Threshold. For all subsequent claims under the Policy cashless facility shall be available as usual, subject to sl. no ii to viii below.**
ii. Cashless facility for treatment in network hospitals can be availed, if TPA service is opted.
iii. Treatment may be taken in a network provider and is subject to pre authorization by the TPA. Booklet containing list of network provider shall be provided by the TPA. Updated list of network provider is available on website of the Company and the TPA mentioned in the schedule.
iv. Cashless request form available with the network provider and TPA shall be completed and sent to the TPA for authorization.
v. The TPA upon getting cashless request form and related medical information from the insured person/ network provider shall issue pre-authorization letter to the hospital after verification.
vi. At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
vii. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
viii. In case of denial of cashless access, the insured person may obtain the treatment as per treating medical practitioner's advice and submit the claim documents to the TPA for processing.

5.5.4 Procedure for Reimbursement of Claims

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

5.5.5 Documents

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

i. Completed claim form
ii. Medical practitioner's prescription advising admission for inpatient treatment.
iii. Bills, receipt from the hospital(s)/ chemist(s) supported by prescription from attending medical practitioner for period of pre hospitalization, hospitalization and post hospitalization (if applicable)
iv. Bills, receipt, investigation test reports etc. supported by prescription from attending medical practitioner for period of pre hospitalization, hospitalization and post hospitalization (if applicable)
v. Attending medical practitioner's certificate regarding diagnosis along with date of diagnosis and bill, receipts etc.
vi. Certificate from the surgeon regarding diagnosis and nature of operation and bills, receipts etc.
vii. Bills, receipt, Sticker of the Implants.
viii. Bills, payment receipts, medical history of the patient recorded, indoor case papers, discharge certificate/ summary, break up of final bill from the hospital etc.
ix. Documents as listed under Sl. No (ii) to (viii) relating to previous hospitalisation(s) in the policy period along with claim settlement advice (if any), in original or certified copy.
x. Any other document required by Company/TPA

Note

1. **The insured shall preserve and submit all original documents and/ or certified copies of documents related to all hospitalisation(s) during the policy period to enable the Company to calculate the cumulative medical expenses and threshold, for determining admissibility and payment of claims.**
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the documents listed under condition 5.5.5 duly certified by the said insurer along with claim settlement advice, subject to satisfaction of the Company. In all such cases, any amount payable under this Policy for any covered expense shall be reduced by any amount paid/ payable by the other insurer for the same expense during the same hospitalisation.

Type of claim	**Time limit for submission of documents to Company/TPA**
Reimbursement of hospitalisation, pre hospitalisation expenses and ambulance charges	Within fifteen days from date of discharge from hospital
Reimbursement of post hospitalisation expenses	Within fifteen days from completion of post hospitalisation treatment

5.5.6 Claim Settlement

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

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

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

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

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

5.5.7 Services Offered by TPA

Servicing of claims under health insurance policies by way of pre-authorization of cashless treatment or settlement of claims other than cashless claims or both, as per the underlying terms and conditions of the respective policy and within the framework of the guidelines issued by the insurers for settlement of claims.

The services offered by a TPA shall not include

i. Claim settlement and claim rejection; however, TPA may handle claims admission and recommend to the Company for settlement of the claim

ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

Waiver

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

5.6 Moratorium Period

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

5.7 Payment of Claim

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

5.8 Territorial limit

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

5.9 Multiple Policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

5.10 Fraud

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

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

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

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

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

5.11 Cancellation

i. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud

ii. The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

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

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

5.13 Arbitration
i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).
ii. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the Policy.
iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the Policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

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

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

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

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

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

5.19 Portability
The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

5.20 Withdrawal of Product

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

5.21 Revision of Terms of the Policy Including the Premium Rates

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

5.22Free Look Period

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

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

5.23 Nomination

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

6 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.

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

7 Disclaimer

The prospectus contains salient features of the Policy. For details reference is to be made to the Policy. In case of any difference between the prospectus and the Policy, the terms and conditions of the Policy shall prevail.

The prospectus and proposal form are part of the Policy. Hence please read the prospectus carefully and sign the same. The proposal form is to be completed in all respects for each insured person. Both the prospectus and the proposal form are to be submitted to the office or to the agent.

Place **Signature**

Date **Name**

Insurance is the subject matter of solicitation.
No loading shall apply on renewals based on individual claims experience

Table of Benefits

Name	**National Super Top Up Mediclaim Policy**	
Plan	**Individual**	**Floater**
Threshold – Sum Insured	**Threshold** / **Sum Insured**: 2 Lakhs / 3, 5 Lakhs; 3 Lakhs / 3, 5, 7 Lakhs; 5 Lakhs / 5, 7, 10 Lakhs; 8 Lakhs / 10, 15 Lakhs; 10 Lakhs / 15, 20 Lakhs	**Threshold** / **Sum Insured**: 2 Lakhs / 3, 5 Lakhs; 3 Lakhs / 3, 5, 7 Lakhs; 5 Lakhs / 5, 7, 10 Lakhs; 8 Lakhs / 10, 15 Lakhs; 10 Lakhs / 15, 20 Lakhs
Coverage*		
In patient Treatment	Up to Sum Insured No sub limits	Up to Sum Insured No sub limits
System of Medicine	Allopathy, Ayurveda, Homeopathy	Allopathy, Ayurveda, Homeopathy
Pre hospitalisation	30 days immediately before hospitalisation	30 days immediately before hospitalisation
Post hospitalisation	60 days immediately after discharge	60 days immediately after discharge
Day Care Procedures	140 day care procedures	140 day care procedures
Ayurveda and Homeopathy	Up to Sum Insured	Up to Sum Insured
Organ Donor's Medical Expenses	Medical expenses, Pre & Post Hospitalisation expenses up to Sum Insured	Medical expenses, Pre & Post Hospitalisation expenses up to Sum Insured
AIDS Treatment	Medical Expenses for treatment of AIDS (any stage)	Medical Expenses for treatment of AIDS (any stage)
Morbid obesity treatment	Bariatric surgery expenses (in case of life threatening condition)	Bariatric surgery expenses (in case of life threatening condition)
Maternity Expenses	Actual expenses	Actual expenses
Modern Treatment (12 nos)	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
Morbid Obesity	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
Additional Benefits**		
Hospital Cash (in excess of initial 3 days)	• Up to Sum Insured 10 Lakh, ₹ 1,000 per day for 5 days per individual • Above Sum Insured 10 Lakh, ₹ 2,000 per day for 5 days per individual	• Up to Sum Insured 10 Lakh, ₹ 1,000 per day for 5 days per individual • Above Sum Insured 10 Lakh, ₹ 2,000 per day for 5 days per individual
Doctor's Home Visit/ Aya/ Nurse/ Attendant Charges post hospitalisation	• Up to Sum Insured Limit 10 Lakh, ₹ 1,000 per day for 10 days per individual • Above Sum Insured Limit 10 Lakh, ₹ 2,000 per day for 10 days per individual	• Up to Sum Insured Limit 10 Lakh, ₹ 1,000 per day for 10 days per individual • Above Sum Insured Limit 10 Lakh, ₹ 2,000 per day for 10 days per individual
Ambulance Charges	Actual charges	Actual charges
Others		
Migration to Policy without Threshold	Option available	Option available
Pre-existing Disease (PED) waiting period (Only PEDs declared in the Proposal Form and accepted for coverage by the Company shall be covered)	12 months – PED claim not payable 13-24 months - 50% of PED claim 25-36 months - 75% of PED claim After 36 months - 100% of PED claim	12 months - PED claim not payable 13-24 months - 50% of PED claim 25-36 months - 75% of PED claim After 36 months - 100% of PED claim
Renewal Benefit		
Cumulative Bonus (CB)	• CB at 5% of Sum Insured Limit for each claim free year • In case of claim, CB to be reduced at 5% per year	• CB at 5% of Sum Insured Limit for each claim free year • In case of claim, CB to be reduced at 5% per year
Discounts		
Early Entry Discount	5% on individual premium	5% on individual premium
Family Discount	5 % (in individual policy only)	NA
Online/ Direct Discount	10% (for new and renewal, where no intermediary is involved)	10% (for new and renewal, where no intermediary is involved)

***** Aggregate of all the benefits under '*Coverage'* in a policy period are subject to the Threshold.

** Aggregate of all the benefits under '*Coverage'* and '*Additional Benefits'* for admissible claims in a policy period are subject to the Sum Insured opted.

Rate Chart (in ₹)

Premium (₹) per Individual (for ind policy)/ Senior most member (for floater policy)

Threshold	2 lakhs		3 lakhs			5 lakhs			8 lakhs		10 lakhs	
Sum Insured	3 lakhs	5 lakhs	3 lakhs	5 lakhs	7 lakhs	5 lakhs	7 lakhs	10 lakhs	10 lakhs	15 lakhs	15 lakhs	20 lakhs
Age Group												
0 – 5*	920	1,251	793	1,077	1,196	737	903	1,244	1,122	1,436	903	1,077
6 - 17*	920	1,251	793	1,077	1,196	737	903	1,244	1,122	1,436	903	1,077
18 - 25	1,955	2,463	1,444	1,870	2,046	1,090	1,336	1,838	1,658	2,122	1,334	1,591
26 - 35	2,014	2,525	1,472	1,898	2,073	1,090	1,336	1,839	1,658	2,122	1,334	1,591
36 - 40	2,540	3,190	1,864	2,408	2,632	1,391	1,705	2,348	2,117	2,710	1,703	2,032
41 - 45	2,540	3,190	1,864	2,408	2,632	1,391	1,705	2,348	2,117	2,710	1,703	2,032
46 - 50	3,997	5,137	3,077	4,039	4,438	2,473	3,032	4,174	3,765	4,819	3,029	3,614
51 - 55	4,900	6,365	3,855	5,097	5,612	3,196	3,918	5,394	4,867	6,229	3,916	4,671
56 - 60	5,187	6,871	4,246	5,684	6,282	3,711	4,550	6,264	5,653	7,235	4,548	5,425
61 - 65	8,117	10,858	6,775	9,124	10,103	6,068	7,440	10,244	9,245	11,831	7,437	8,872
66 - 70	10,215	13,736	8,615	11,638	12,898	7,814	9,580	13,190	11,905	15,236	9,577	11,425
71 - 75	13,420	18,093	11,375	15,390	17,064	10,380	12,726	17,522	15,815	20,239	12,722	15,177
76 - 80	13,695	18,466	11,612	15,712	17,421	10,600	12,996	17,893	16,150	20,668	12,992	15,499
81 - 85	13,695	18,466	11,612	15,712	17,421	10,600	12,996	17,893	16,150	20,668	12,992	15,499
>=86	13,695	18,466	11,612	15,712	17,421	10,600	12,996	17,893	16,150	20,668	12,992	15,499

GST extra

** 0-5 & 6-17 age groups not applicable in Floater option*

Premium (₹) for additional family member (for floater policy)

Threshold	2 lakhs		3 lakhs			5 lakhs			8 lakhs		10 lakhs	
Sum Insured	3 lakhs	5 lakhs	3 lakhs	5 lakhs	7 lakhs	5 lakhs	7 lakhs	10 lakhs	10 lakhs	15 lakhs	15 lakhs	20 lakhs
Age Group												
0 - 5	123	168	106	144	160	99	121	167	150	192	121	144
6 - 17	135	184	117	158	176	108	133	183	165	211	133	158
18 - 25	307	387	227	294	321	171	210	289	260	333	209	250
26 - 35	340	427	249	321	350	184	226	311	280	359	225	269
36 - 40	617	775	453	585	640	338	414	570	515	658	414	494
41 - 45	617	775	453	585	640	338	414	570	515	658	414	494
46 - 50	1,395	1,793	1,074	1,410	1,549	863	1,058	1,457	1,314	1,682	1,057	1,261
51 - 55	1,710	2,221	1,345	1,779	1,959	1,116	1,368	1,883	1,699	2,174	1,367	1,630
56 - 60	2,091	2,769	1,711	2,291	2,532	1,496	1,834	2,524	2,278	2,916	1,833	2,186
61 - 65	4,058	5,429	3,387	4,562	5,051	3,034	3,720	5,122	4,623	5,916	3,719	4,436
66 - 70	5,301	7,129	4,471	6,040	6,694	4,055	4,972	6,846	6,179	7,907	4,970	5,930
71 - 75	7,234	9,752	6,131	8,295	9,198	5,595	6,859	9,444	8,524	10,909	6,857	8,181
76 - 80	7,669	10,341	6,503	8,799	9,756	5,936	7,278	10,020	9,044	11,574	7,275	8,679
81 - 85	7,957	10,729	6,747	9,129	10,122	6,158	7,551	10,396	9,383	12,008	7,548	9,005
>=86	8,902	12,003	7,548	10,213	11,324	6,890	8,447	11,631	10,498	13,434	8,445	10,074

GST extra

The premiums rates given above are all inclusive of TPA charges.
For without TPA – 6% discount on the premiums tabulated above.

Discounts

Early Entry Discount (EED) – 5% on individual premium
Family Discount – 5% on total family premium
Online Discount – 10% on total payable premium

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