HUMAN RESOURCES DEPARTMENT
EMPLOYEE BENEFITS DIVISION

239, Vidhan Bhavan Marg, Nariman Point, Mumbai 400 021

STAFF CIRCULAR NO. 7348 January 27, 2021

To: **All Branches/Offices**,

Major Highlights

- **Guidelines issued for Addition of members (Para 6; Sub-para 6.9 of the policy)**
- **No change in Room rent ceiling: Ceiling Rs.5000/- per day**
- **No change in ceiling for ICU: Ceiling Rs.7500/- per day**
- **No change in the list of ailments covered under 'Domiciliary Treatment' (Para 3 - Additional Coverage)**
- **Claim Intimation: TPA must be informed within 48 hours of the Insured person's admission to hospital in case of reimbursement claim {for both planned & emergency admissions}**
- **Claim submission: No change in the time limit for submission of documents in case of reimbursement. Reimbursement Claim pertaining to hospitalization & pre-hospitalization expenses must be submitted within 30 days of date of discharge from the hospital. Reimbursement claim pertaining to post hospitalization expenses must be submitted within 30 days from completion of post hospitalization treatment.**
- **Valid pre-printed GST number mandatory on bills.**

Subject - **Medical Insurance Policy for Existing Employees**
Policy Tenure 01.10.2020 to 30.09.2021

1. Attention is invited to Staff Circular No. 7074 dated 05-12-2019 providing the details of Medical Insurance Policy for existing employees for the period of 01.10.2019 to 30.09.2020. The policy for existing employees has been renewed for a further period of one year i.e. from 01-10-2020 up to 30-09-2021. Consequent to the amalgamation of Andhra Bank and Corporation Bank into Union Bank of India with effect from 01.04.2020, the said policy, which commenced from 01.10.2020, is the first Medical Insurance Policy of the amalgamated entity.

2. The initial information on 'renewal of the policy' for existing employees was circulated vide Staff Circular 7254 dated 06-10-2020. All employees and their dependents (as per Union Parivar; subject to para 3) existing on Bank's payroll as on 01.10.2020 are covered under this policy of Medical Insurance from **01.10.2020 to 30.09.2021**. The policy number is **251100502010000250**. The policy document received from 'National Insurance Company' is provided herewith as **Annexure I**.

3. **Dependent Data in Union Parivar:**

   Attention is hereby drawn to Staff Circular 7240 dated 05-09-2020, vide which the below mentioned information/ communication received from Insurance Company was circulated:

   - E-card of dependent, where date of birth is not updated in Union Parivar, will not be displayed on the TPA's website as the data will not be uploaded at all and no cashless/ reimbursement facility will be available without proper updation of data.

   - Any discrepancy in name, surname, age of dependent, etc. between Union Parivar data and submitted KYC documents {Preferably Aadhaar Card} will lead to rejection of cashless/ reimbursement claim.

4. **Dependent Data: Additions/ Deletions – Group Mediclaim Policy**

   The 'National Insurance Company Ltd has provided fresh guidelines for 'Addition of members' in the policy year 2020-21, the guidelines issued by the Insurance Co are reproduced below 'verbatim' for ready reference and necessary information of all concerned:

   "Midterm additions are allowed only for natural additions subject to intimation received within 30 days, i.e. new joinees, newly married spouses and new born children. Any additions for new employee, spouse/ children would be allowed within 30 days of date of joining, marriage/ birth respectively"

5. **No piece-meal updation of Dependent Data:**

   In terms of the minutes issued in respect of the 10th Bipartite Settlement/ Joint Note dated 25.05.2015 the Insurance Company has informed that, '**the dependent data addition/ modification will be accepted only through monthly Annexure and no piece-meal updation will be carried out in the dependents data**'.

   All are required to go through their respective bio-data in Union Parivar for the purpose of checking and updation of dependent details to avoid any kind of inconvenience during medical exigencies.

6. **Employee contact details**: As per information received from NIC, the mobile number and email address of all employees should be updated in their database. All

employees to ensure that their mobile number and email address is mentioned positively on the claim form while submission of domiciliary/ reimbursement claim forms.

7. **Employee Account Number and IFSC Code**: Salary account numbers and related IFSC codes in respect of account numbers pertaining to all the covered employees have already been shared with National Insurance Company.

8. **Aadhaar & PAN number**: As per IRDAI letter no IRDAI/SDD/MISC/CIR/248/11/2017 dated 08th Nov 2017, linkage of Aadhaar and PAN to Medical Insurance Policy has been made mandatory under the prevention of Money- laundering (Maintenance of Records) Second Amendment Rules, 2017. All employees would be required to submit a copy of Aadhaar card of the self/ dependent with their claim form in case of both cashless and reimbursement cases. Also, all employees would be required to submit copy of their PAN cards with claim reimbursement forms. **Annexure II**

9. To ensure quick settlement of claims, a checklist for proper claim submission, is produced herewith as **Annexure III**. For the benefit of all employees, domiciliary and hospitalization claim forms, already circulated previously vide SC 7254 are attached to this circular.

    - Domiciliary Claim Form. **Annexure IV**
    - Reimbursement Claim Form. Both Part A and B to be filled in. **Annexure V**

10. **Medicards**: The details of all existing employees along with their dependents have been shared with NIC and medi-cards are available on Paramount TPA's website, the path to generate Medi-card is as follows:

    www.paramounttpa.com → View E-card → Select Insurance Company- National Insurance Company → Employee ID → Group Code – Ubank → Mobile Number for OTP → Submit.

11. **Claim intimation & Claim submission**: Attention is hereby invited to Staff Circular No. 7074 dated 05.12.2019 vide which details pertaining to Medical Insurance Policy for existing employees, for the policy period of 01.10.2019 to 30.09.2020, were circulated. Information shared vide Staff Circular 7074 dated: 05.12.2019, on the details pertaining to '**claim intimation & claim submission**', holding relevance in the policy year 2020-21 also, is provided below :-

    - **TPA must be intimated/ notified within 48 hours of the Insured person's admission to hospital in case of reimbursement claims {for both planned & emergency admissions}.**

    - **Notification of claim within prescribed time limit is mandatory in all hospitalization/ IPD cases.**

    - As per Clause no. 5 of Medical Insurance Policy for Existing Employees, following time limits are to be mandatorily complied with:

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

Notification of claim in case of Reimbursement	**TPA must be informed :**
In event of planned hospitalization	Within 48 (forty eight) hours of the insured person's admission to the network provider/ PPN Hospital
In event of emergency hospitalization	Within 48 (forty eight) hours of the insured person's admission to the network provider/ PPN Hospital

- **Various methods of "claim intimation" are mentioned below:-**

  a) **Email** - Claim intimation can be done by sending a detailed mail on claim.intimation@paramounttpa.com. The mail must contain details like Employee No., employee name, patient name, relationship with the employee, hospital name, treating doctor name, hospital address, date of admission in hospital, estimated expense etc.
  b) **Phone Call** - Claim intimation can also be done by calling on TPA's Helpline no. **022-66620808 or 1800-266-7008**.
  c) **Paramount TPA Mobile App (mW!se)** - Claim intimation can also be done through Mobile App, **mW!se**.
  d) **Paramount TPA website** - Claim intimation can also be done through Paramount TPA website, www.paramounttpa.com.

- Upon intimation, a 'claim intimation number' is generated/ provided to the insured. For all the reimbursement hospitalization/ IPD claims, this claim intimation no. is to be mandatorily mentioned on the claim form.

- In case the insured person/ insured person's representative fails to intimate/ notify the claim to the TPA or fails to submit/ file the claim within the prescribed time limit, 'delay intimation &/ or submission condonation letter' is to be submitted to the respective Regional Office. Detailed procedure has been circulated vide Staff Circular 7288 dated 10.11.2020.

- The 'delay intimation &/ or submission condonation letter' already circulated vide Staff Circular 7254 dated 06.10.2020 & SC 7288 dated 10.11.2020 is attached herewith again as **Annexure VI**. Kindly note that **the claim intimation number, for hospitalization/ IPD claims, should be mandatorily mentioned in the given field on the letter**.

- **Submission of claim documents**: In case of reimbursement claim, all claim documents should be submitted **within 30 days** of date of treatment/ discharge to the TPA, **in original**.

- For reimbursement of post hospitalization claims, the claim documents must be submitted to TPA, within 30 days of completion of post hospitalization treatment.

- The point elucidated in policy in respect of 'delayed intimation/ submission' & already circulated vide Staff Circular 7288 dated 10.11.2020 is, reproduced as verbatim:

  Note: Waiver of this condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.

12. **Pre & Post Hospitalisation Medical Expenses**: Medical expenses incurred immediately 30 days before the insured person is hospitalized will be considered as part of a claim. Relevant medical expenses incurred immediately 90 days after the Insured person is discharged from the hospital provided that;

    - Such Medical expenses are incurred for the same condition for which the Insured Person's Hospitalization was required; and

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

13. **Maternity Expenses Benefit Extension: for maternity cases, refer para 3; sub-para 3.5 of the policy**.

14. **Additional Coverages - Domiciliary Treatment**:

    a) The list of domiciliary ailments covered under this policy is given as para 3; sub-para 3.1 of the policy document. The listed diseases/ ailments, which need domiciliary treatment as may be certified by a medical practitioner and/ or bank's medical officer shall be deemed as hospitalization expenses and reimbursed to the extent of 100%, subject to overall limit of Sum Insured under the policy.

b) The cost of Medicines, Investigations and consultations, etc. in respect of listed domiciliary treatment shall be reimbursed for the period, stated by the specialist and/ or the attending doctor and/ or the bank's medical officer, in prescription duly supported by relevant investigation reports wherever necessary.

c) If no period stated, the prescription for the purpose of reimbursement shall be valid for a period not exceeding 90 days.

d) **Prescriptions with the time limit of more than 180 days shall require to be re-validated after 180 days by the attending doctor**.

Documents to be submitted for Domiciliary claim:

- Domiciliary claim form.
- Original prescription for the first month. Attested Xerox copy of prescription for next two months. Again original prescription will be required in the fourth month and the process will continue in the same fashion.
- All original paid bills of medicine pertaining to the ailment. **Pre-printed & valid GST number** of the retailer is **mandatory** on the bills for further processing.
- Original investigation reports, if any.
- The field of mobile number and email address is mandatory and must be filled in every time the form is submitted.

15. **Claim closure**: It is to be noted that in terms of the communication received from Insurance Company, any claim in respect of which deficiency has been generated would remain open for a period of 45 days only from the date of generation of 'first deficiency letter' and it is to be ensured that any deficiency/ deficiencies raised in respect of the claim is/ are addressed within this timeline of 45 days. Subsequent to the completion of the 45 days period the claim would be **closed**. **Claim once closed would not be opened by the Insurance Company**.

16. **Corporate Buffer**: An amount of Rs.12,90,81,790/-(Twelve Crores Ninety Lacs Eighty One Thousand Seven Hundred and Ninety Rupees Only) has been allotted to the Bank as funds under Corporate Buffer (Medical Assistance). Corporate Buffer policy for the year 2020-21 has been circulated vide Staff Circular 7315 dated 15-12-2020.

    - Employees with coverage under Super Top-Up will be eligible for benefit of Corporate Buffer only after full utilization of both Basic & Super Top-Up facility, i.e. Rs.9 lacs for officers and Rs.7 lacs for award staff.

17. **Super Top-Up Tax Benefit**: Employees who have opted for/ chosen Super Top-Up facility/ benefit are eligible for tax benefit against the premium paid towards the same. Tax-benefit certificate against the premium paid towards Super-top up would

be issued in due course of time and a separate circular would be issued vide which the requisite information on the certificate would be circulated.

18. **Online Consent/ Withdrawal by Retiring Employees**: It is evident that employees retiring during the tenure of the policy, i.e. retiring between the months of Oct2020 and Sep 2021, will be covered under the policy for existing employee till 30.09.2021, subject to their submitting the consent to continue in the policy. Kindly refer to Staff Circular 7256 dated 06th October, 2020 for details. At the cost of repetition, it is hereby again informed that, **"In case no option is received from the employee, it will be considered as exit from the policy and the retiring employee will be shifted out of the policy coverage with immediate effect. It is to be noted that, for employees exiting the policy, there is no option to re-join"**. [Para 16 of SC 7256 dated 06.10.2020]

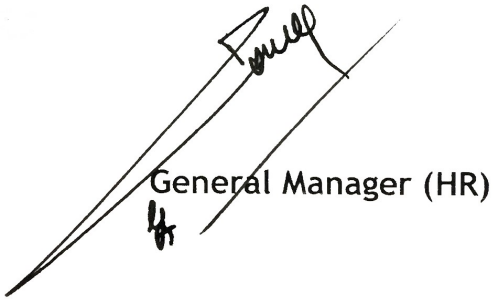
    - Pro-rate premium once deducted will not be refunded**.**

19. **In case any payment has been carried out by the insured during a cashless hospitalization, the insured is required to submit the original receipts along with claim form to TPA, for reimbursement, within 07 days post discharge**.

    At the cost of repetition, please note that all such claims must be invariably submitted to the TPA within 07 days of discharge, **failing which the same will not be considered for further processing.**

    This condition is **not applicable** for amount deposited to hospital as **security money and non payable items.**

20. All concerned are requested to take a careful note of the above.



Annexure I to SC 7348

Forming Part of Policy No. 251100502010000250

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National Insurance
Trusted Since 1906

Part – II

1 RECITAL CLAUSE

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

1.2 OPERATIVE CLAUSE

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

Provided further that, the amount payable under the Policy in respect of all such claims during the Policy Period shall be subject to the coverage, terms, exclusions, conditions, definitions and sub limits contained herein as well as shown in the Table of Benefits, and shall not exceed the Sum Insured of the Insured Person as mentioned in the Schedule.

1.3 BASIC COVER:

1.3.1 In the event of any claim becoming admissible under this scheme, the company will pay to the Hospital/Nursing Home or Insured Person the amount of such expenses as would fall under different heads mentioned below and as are reasonably and medically necessary incurred thereof by or on behalf of such insured person but not exceeding the Sum Insured in aggregate mentioned in the Schedule hereto.

A) Room and boarding expenses as provided by the Hospital/Nursing Home not exceeding per day limit as mentioned in the Schedule or the actual amount whichever is less.

B) Intensive care Unit (ICU) expenses not exceeding per day limit as mentioned in the Schedule or actual amount whichever is less.

C) Surgeon, team of surgeons, Assistant surgeon, Anaesthetist, Medical Practitioner Consultants, Specialists Fees.

D)Nursing Charges, Service Charges, IV Administration Charges, Nebulization Charges, RMO Charges, Aesthetic , Oxygen, Blood, Operation Theatre Charges, surgical appliances, OT Consumables, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Cost of Artificial Limbs, Cost of Prosthetic devices implanted during surgical procedure like pacemaker, Defibrillator Ventilator, Orthopaedic implants, Cochlear Implant, any other implant, Intra-Ocular Lenses, infra cardiac valve
replacements, vascular stents, any other valve replacement, Laboratory/Diagnostic tests, X-ray CT Scan, MRI, any other scan and such similar expenses that are medically necessary, or incurred during hospitalization as per the advice of the attending doctor.

E) Hospitalization expenses (excluding cost of organ) incurred on donor in respect of organ transplant to the insured.

1.3.2 **Pre-Hospitalization and Post- Hospitalization Expenses** – Medical Expenses relevant to the same condition for which the hospitalization is required incurred during the period up to 30 days prior to hospitalization and during the period up to 90 days after the discharge from the hospital. These expenses are admissible only if the primary hospitalization claim is admissible under the policy.

2. Definitions:

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

2.2 ALTERNATIVE TREATMENTS- Alternative treatments are forms of treatment other than treatment "Allopathic" or "Modern medicine" and includes Ayurveda, Unani, Siddha, Naturopathy and Homeopathy in the Indian context.

2.3 ANY ONE ILLNESS will be deemed to mean continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment has been taken.

2.4 CANCELLATION defines the terms on which the policy contract can be terminated either by the insurer or the insured person by giving sufficient notice to other which is not lower than a period of fifteen days.

2.5 CASHLESS FACILITY means a facility extended by the insurer to the insured where the payment 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.

2.6 CONGENITAL ANOMALY refers to a condition(s) which is present since birth and which is abnormal with reference to form, structure or position.

1 Internal Congenital Anomaly

Which is not in the visible and accessible parts of the body.

2 External Congenital Anomaly

Which is in the visible and accessible parts of the body.

2.7 CONDITION PRECEDENT shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional.

2.8 CONTINUOUS COVERAGE means uninterrupted coverage of the insured person under our Individual Health Insurance Policies or Family Floater policy from the time the coverage incepted under the policy, provided a break in the insurance period not exceeding thirty days being grace period shall not be reckoned as an interruption in coverage for the purposes of this clause. In case of change in Sum Insured during such uninterrupted coverage, the lowestsum insured would be reckoned for determining continuous coverage.

However, the benefit of Continuous Coverage getting carried over from other policies will not be available for HIV/AIDS coverage.

2.9 DAY CARE CENTRE means any institution established for day care treatment of illness and /or injuries or a medical set – up 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:

a. Has qualified nursing staff under its employment.
b. Has qualified Medical practitioner(s) in charge
c. Has a fully equipped operation theatre of its own where surgical procedures are carried out.
d. Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

2.10 DAY CARE TREATMENT-Day Care Treatment means the medical treatment and / or surgical procedure which is -

i) Undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hours because of technological advancement and

ii) Which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an outpatient basis is not included in the scope of this definition.

2.11 DEDUCTIBLE is a cost sharing requirement under a Health Insurance Policy that provides that the Insurer will not be liable for a specified rupee amount in case of Indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the sum insured.

2.12 DENTAL TREATMENT means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

2.13 DISCLOSURE TO INFORMATION NORM: 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.

2.14 EMERGENCY CARE means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

2.15 EMERGENCY DENTAL TREATMENT means the services or supplies provided by a Licensed dentist, Hospital or other provider that are medically and immediately necessary to treat dental problems resulting from injury. However, this definition shall not include any treatment taken for a pre-existing condition.

2.16 EMERGENCY MEDICAL TREATMENT means the services or supplies provided by a Physician, Hospital or Licensed provider that are medically necessary to treat any illness or other covered condition that is acute (onset is sudden and unexpected),considered life threatening and one which if left untreated, could deteriorate resulting in serious and irreparable harm.

2.17 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.

2.18 HOSPITAL/NURSING HOME means any institution established for in -patient care and day care treatment of illness and/or 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 the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under

- Has qualified nursing staff under its employment round the clock.
- Has at least 10 in-patient beds in towns having a population of less than 10 Lacs and at least 15 in - patient beds in all other places.
- Has a qualified medical Practitioner(s) in charge round the clock.
- Has a fully equipped Operation Theatre of its own where surgical procedures are carried out.
- Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

The term 'Hospital/Nursing Home' shall not include an establishment which is a place of rest ,a place for the aged, a place for drug-addicts or place for alcoholics, a hotel or a similar place.
For Ayurveda, Unani, Siddha, Naturopathy and Homeopathy treatment, hospitalisation expenses are admissible only when the treatment has been undergone in a hospital as defined in clause 3.3 below.

2.19 HOSPITALISATION

Means admission in a Hospital/Nursing Home for a minimum period of 24 In-patient care consecutive "In-patient care" hours except for the specified day care procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.
For the list of these specified day care procedures/treatments, please see3.4.
Note: Procedures/treatments usually done in outpatient department are not payable under the policy even if admitted/converted as an in-patient in the hospital for more than 24hours.

2.20 ID CARD means the identity card issued to the insured person by the TPA to avail cashless facility in network provider.

2.21 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.

(a) Acute Condition-Acute condition is 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

(b)Chronic Condition-A chronic Condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

- It needs ongoing or long term monitoring through consultations, examinations, check-ups, and/or tests.
- It needs ongoing or long term control or relief of symptoms.
- It requires rehabilitation for the patient or for the patient to be specially trained to cope with it.
- It continues indefinitely.
- It recurs or is likely to recur.

2.22 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.

2.23 IN-PATIENT CARE means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

2.24 INSURED PERSON means the employee of the bank and each of the other family members who are covered under this policy as shown in the Schedule.

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

2.26 INTENSIVE CARE (ICU) 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.

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

2.28 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.

2.29 MEDICALLY NECESSARY TREATMENT is defined as any treatment ,tests, medication, or stay in hospital or part of a stay in a hospital which

- Is required for the medical management of the illness or injury suffered by the insured;
- Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope duration or intensity.
- Must have been prescribed by a Medical Practitioner.
- Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

2.30 MEDICAL PRACTITIONER: A Medical Practitioner is a person who holds a valid registration from the Medical Council of any State of India 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 practise medicine within its jurisdiction, and is acting within the scope and jurisdiction of license.

The term Medical Practitioner would include Physician, Specialist and Surgeon. The registered Medical Practitioner should not be the insured or any member of his family including parents and in-laws.

2.31 NETWORK PROVIDER means the hospital/nursing home or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility. The list of Network Hospitals is maintained by and available with the TPA and the same is subject to amendment from time to time.

PPN-PREFERRED PROVIDER NETWORK means a network of hospitals which have agreed to a cashless packaged pricing for specified planned procedures for the insured person. Updated list of network provider/PPN is available on website of the company (https://nationalinsurance.co.in/tpa PPN network hospital)and website of the TPA mentioned in the schedule and is subject to amendment from time to time.

2.32 NEW BORN BABY: A new born baby means a baby born during the Policy Period aged between one day and 90 days, both days inclusive.

2.33 NON -NETWORK HOSPITALS means any hospital, day care centre or other provider that is not part of the network.

2.34 NOTIFICATION OF CLAIM is the process of notifying a claim to the insurer or TPA within specified timelines through any of the recognized modes of communication.

2.35 OPD (Out-patient) TREATMENT means the one 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.

2.36 PERIOD OF INSURANCE means the period for which this policy is taken and is in force as specified in the Schedule.

2.37 PORTABILITY means transfer by an Individual Health Insurance Policyholder (including family cover) of the credit gained for pre-existing conditions and time bound exclusions if he/she chooses to switch from one insurer to another.

2.38 PRE-EXISTING DISEASE means any condition, ailment or injury or related condition(s) for which insured person had signs or symptoms, and/or were diagnosed, and/or received medical advice/treatment within 48 months prior to the first policy issued by the insurer. Any complication arising from pre-existing disease shall be considered as a part of the pre -existing disease.

2.39 PRE-HOSPITALISATION MEDICAL EXPENSES

Relevant medical expenses incurred immediately 30 days before the Insured person is hospitalised provided that

- Such medical expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required: and
- The In-patient Hospitalisation claim for such Hospitalisation is admissible by us.

2.40 POST HOSPITALISATION MEDICAL EXPENSES

Relevant medical expenses incurred immediately 90 days after the insured person is discharged from the hospital provided that:

- Such Medical expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required; and
- The In-patient Hospitalisation claim for such Hospitalisation is admissible by us.

2.41 PSYCHIATRIC DISORDER means clinically significant Psychological or behavioural syndrome that causes significant distress, disability or loss of freedom (and which is not merely a socially deviant behaviour or an expected response to a stressful life event) as certified by a Medical Practitioner specialized in the field of Psychiatry after physical examination of the insured person in respect of whom a claim is lodged.

2.42 PSYCHOSOMATIC DISORDER means one or more psychological or behavioural problems that adversely and significantly affect the course and outcome of general medical condition or that significantly increase a person's risk of an adverse outcome as certified by a Medical Practitioner specialized in the field of Psychiatry after Physical examination of the insured person in respect of whom a claim is lodged.

2.43 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.

2.44 REASONABLE AND CUSTOMARY CHARGES

Reasonable and Customary charges mean 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 illness/injury involved.

2.45 RENEWAL defines 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 all waiting periods.

2.46 ROOM RENT shall mean the amount charged by a hospital for the Occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

2.47 SUM INSURED is the maximum amount of coverage under this policy opted for all insured persons shown in the schedule.

2.48 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 or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

2.49 THIRD PARTY ADMINISTRATOR (TPA) means any person who is registered under the IRDAI (Third Party Administrators-Health Services) Regulations 2016 notified by the Authority, and is engaged for a fee or remuneration by an insurance company, for the purposes of providing health services as defined in those.

2.50 UNPROVEN/EXPERIMENTAL TREATMENT means any treatment including drug experimental therapy which is not based on established medical practise in India.

2.51 WE/OUR/US/COMPANY means NATIONAL INSURANCE COMPANY LIMITED

3 ADDITIONAL COVERAGES:

3.1 DOMICILIARY TREATMENT:

Medical expenses incurred in case of the following diseases which need domiciliary treatment as may be certified by the attending medical practitioner and /or bank's medical officer shall be deemed as hospitalization expenses and reimbursed to the extent of 100% subject to the overall limit of Sum Insured under the policy:

1 Accidents of Serious Nature
2 Addison's Disease
3 All Animal/reptile/insect bite or sting
4 All Seizure disorders
5 Any organ related (chronic) condition
6 Aplastic Anemia
7 Arthritis
8 Autoimmune Myositis
9 Autoimmune vasculitis
10 Cancer
11 Cardiac Ailments
12 Celiac Disease
13 Cerebral Palsy
14 Chronic obstructive Pulmonary Disease, Chronic Bronchitis, Asthma
15 Chronic Pancreatitis
16 Connective tissue disorder
17 Diabetes and its complications (including Type 1Diabetes)
18 Diphtheria
19 Epidermolysis bullosa
20Glaucoma
21 Grave's Disease
22 Growth disorders
23 Haemorrhages caused by accidents
24 Hashimoyo's Thyroiditis
25 Haemophilia
26 Hepatitis -B, Hepatitis-C
27 Hypertension
28 Hypothyroidism,hyperthyroidism expenses incurred on radiotherapy and chemotherapy in the treatment of cancer and leukaemia
29 Inflammatory Bowel Disease
30Kidney Ailment
31 Leprosy
32 Leukemia
33 Malaria
34 Multiple Sclerosis/Motor Neuron Disease
35 Muscular dystrophies
36 Myasthenia gravis
37 Non – Alcoholic Cirrhosis of Liver
38 Osteoporosis

39 Paralysis
40 Parkinsons's Diseases
41Pernicious Anemia
42 Physiotherapy
43 Pleurisy
44 Polio
45 Psoriasis/Psoriatic Arthritis
46 Psychiatric disorder including Schizophrenia and Psychotherapy
47 Purpura
48 Rheumatoid Arthritis (RA)
49 Sickle cell disease ,systemic lupus erythematous (SLE)
50 Sjogrens's Syndrome
51. Sleep apnea syndrome (not related to obesity)
52. Status asthamaticus , sequalea of neningitis
53. Swine flu
54. System Lupus Erythematous
55. Thalassemia
56. Third Degree burns
57. Thrombo embolism venous thrombosis/venous thrombo embolism (VTE)
58. Tuberculosis
59. Tumor
60. Typhoid
61. Ulcerative Colitis
62. Varicose veins
63. Venous Thrombosis (not caused by smoking)
64. Wilson's disease
65. All strokes leading to paralysis.

The cost of medicines, investigations, and consultations etc. In respect of domiciliary treatment shall be reimbursed for the period stated by the specialist and/or the attending doctor and/or the bank's medical officer, in Prescription duly supported by relevant investigation reports wherever necessary.
If no period stated, the prescription for the purpose of reimbursement shall be valid for a period not exceeding 90 days.

3.2Domiciliary Hospitalisation means medical treatment for a period exceeding 3 days for such an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

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

3.3 Alternative Treatment- Subject to the condition that the hospitalisation expenses are admissible only when the treatment has been undergone in:

i. A Government hospital or in any institute recognised by the Government and/or accredited by Quality Council of India/National Accreditation Board on Health.
ii. Teaching hospitals of Ayurveda , Unani, Siddha, Naturopathy and Homeopathy colleges recognized by Central Council of Indian Medicine (CCIM)

iii. Ayurveda, Unani, Siddha, Naturopathy and Homeopathy Hospitals having registration with a Government authority under appropriate Act in the state/UT and complies with the following as minimum criteria:

a) Has at least 15 in-patient beds;
b) Has minimum 5 qualified and registered Ayurveda , Unani, Siddha, Naturopathy and Homeopathy doctors;
c) Has qualified paramedical staff under its employment round the clock
d) Has dedicated Ayurveda, Unani, Siddha, Naturopthy and Homeopathy therapy sections;
e) Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

Company's Liability for all claims admitted in respect of any/ill insured person/s during the period of insurance shall not exceed the Sum Insured stated in the schedule.

3.4 Expenses on Hospitalization for minimum period of a day are admissible. However, this time limit is not applied to specific treatments, such as

1	Adenoidectomy	20	Haemo dialysis
2	Appendectomy	21	Fissurectomy/Fistulectomy
3	Ascitic/Pleural tapping	22	Mastoidectomy
4	Auroplasty not Cosmetic in nature	23	Hydrocele Surgeries
5	Coronary/Renal Angiography	24	Hysterectomy
6	Coronary angioplasty	25	Inguinal/ventral/mbilical/femoral hernia surgeries
7	Dental Surgery	26	Parental Chemotherapy
8	D&C	27	Polypectomy
9	Excision of cyst/granuloma/lump/tumor	28	Septoplasty
10	Eye Surgery	29	Piles/Fistula Surgeries
11	Fracture including hairline fracture/dislocation	30	Prostate surgeries
12	Radiotherapy	31	Sinusitis surgeries
13	Chemotherapy	32	Tonsillectomy
14	Lithotripsy	33	Liver aspiration
15	Incision and drainage of abscess	34	Sclerotherapy
16	Varicocelectomy	35	Varicose Vein Ligation
17	Wound Suturing	36	All scopies along with biospies
18	FESS	37	Lumbar punture
19	Operations/Micro Surgical operations on the nose, mouth, middle ear/internal ear, tongue, face, tonsils & adenoids , salivary ducts, breast, skin & subcutaneous tissues, digestive tract, female/male sexual organs.		

This condition will also apply in case of stay in hospital of less than a day provided –

A) The treatment is undertaken under General or Local Anesthesia in a hospital/day care Centre in less than a day because of technological advancement and

B) Which would have otherwise required hospitalisation of more than a day

3.5MATERNITY EXPENSES BENEFIT EXTENSION

We will pay the Maternity Expenses for the delivery of a child and/or Maternity Expenses related to a Medically Necessary Treatment and lawful medical termination of pregnancy during the Policy Year. The maximum benefit available allowable under this clause will be upto Rs. 50,000/- for Normal Delivery and Rs. 75000/- for Caesarean Section- The hospitalization expenses in respect of the new born child will be covered within the Mother's Maternity expenses.

Special conditions applicable to Maternity Expenses Benefit Extension:

I. No waiting period for 9 months under Maternity benefit.

II. Pre-natal and Post-natal charged in respect of Maternity benefit are covered up to 30 days and 60 days respectively unless the same requires hospitalisation.

III. Missed Abortions, Miscarriage, Medical Termination of pregnancy or abortions induced by accidents are covered under the limit of maternity expenses.

IV. Complications in Maternity including operations for extra uterine/ectopic pregnancy would be covered up to Sum Insured + Corporate buffer.

V. Maternity Expenses Benefit Extension is allowable irrespective of the number of living children.

3.6BABY DAY ONE COVER

New born baby is covered from day one. All expenses incurred on the new born baby during maternity will be covered up to Rs. 20,000/- per child, in addition to the Maternity limit.

However, if the baby contracts any illness the same shall be considered in the Sum Insured + Corporate Buffer. Baby to be taken as an additional member within the normal family floater.

3.7AMBULANCE CHARGES

Ambulance charges are payable up to Rs. 2500 per trip to hospital and/or transfer to another hospital or transfer from hospital to home if medically advised. Taxi and Auto expenses in actual maximum up to Rs. 750 per hospitalisation.

Ambulance charges actually incurred on transfer from one centre to another centre due to non-availability to medical service/medical complication shall be payable in full.

3.8PRE EXISTING DISEASES/AILMENTS

Pre-existing diseases are covered under the scheme from day one.

3.9 CONGENITAL ANOMALIES

Expenses for treatment of congenital internal/external diseases, defects anomalies are covered under the policy

3.10 PSYCHIATRIC DISEASES

Expenses for treatment of psychiatric and psychosomatic diseases will be payable with or without hospitalisation up to the sum insured.

3.11 ADVANCED MEDICAL TREATMENT

New advanced medical procedures approved by the appropriate authority eg. Laser surgery, stem cell therapy for treatment of a disease is payable on hospitalisation/day care surgery.

3.12 Treatments taken for accidents can be payable even on OPD basis in a hospital up to Sum Insured

3.13 TAXES AND OTHER CHARGES

All Taxes, Surcharges, Service charges, Registration charges, Admission Charges, Nursing, and Administration charges to be payable.

Charges for diapers and sanitary pads are payable if necessary as part of treatment. Charges for hiring a nurse/attendant during hospitalisation will be payable only in case of recommendation from treating doctor in case ICU/CCU, Neo natal nursing care or any other case where the patient is critical and requiring special care.

3.14 Treatment for Genetic disorder and stem cell therapy is covered under the scheme.

3.15 Treatment for Age related Mascular Degeneration (ARMD), treatment such as Rotational Field Quantum Magnetic Resonance (RFQMR), Enhanced External Counter Pulsation (EECP) and related treatments are covered under the scheme. Treatment for all neurological/macular degenerative disorders shall be covered under the scheme.

3.16 Rental charges for external and/or durable medical equipment used for diagnosis and/or treatment including CPAP, CAPD, Bi-PAP, Infusion pump and related equipment will be covered under the scheme.However, purchase of the above equipment to be subsequently used at home in exceptional cases on medical advice shall be covered.

3.17 Ambulatory devices i.e walker, crutches, belts, collars, caps, splints, braces, stockings, elastocrepe bandages, external orthopaedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer (including glucose test strips)/Nebulizer/prosthetic device/Thermometer, alpha/water bed and similar items will be covered under the scheme.

3.18 PHYSIOTHERAPY CHARGES: Physiotherapy charges shall be covered for the period specified by the medical practitioner even if taken at home.

All claims admitted in respect of any/all insured person/s during the period of insurance shall not exceed the sum insured stated in the schedule and Corporate Buffer if allocated.

4. EXCLUSIONS:

The company shall not be liable to make any payment under the policy in respect of any expenses whatsoever incurred by the insured person in connection with or in respect of:

4.1. Investigation& Evaluation

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.

4.2. Rest Cure, Rehabilitation and Respite Care
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.

4.3. Change-of-Gender Treatments
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

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

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

4.6. Birth control, Sterility and Infertility
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

4.7. Refractive Error
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

4.8. Unproven Treatments
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.

4.9. Drug/Alcohol Abuse
Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof

4.10. 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 Annexure-I).

4.11. Home Visit Charges
Home visit charges during Pre and Post Hospitalisation of doctor, aya, attendant and nurse.

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

4.13 Injury/disease directly or indirectly caused by or attributable to war, invasion, Act of Foreign Enemy, War like operations (whether war be declared or not); Nuclear radiation/weapon/materials.

4.14

a. Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an accident.
b. Vaccination or Inoculation
c. Change of life or cosmetic or aesthetic treatment of any description is not covered.
d. Plastic surgery other than as may be necessitated due to an accident or as part of any illness.

4.15 Cost of spectacles and contact lenses, hearing aids, other than Intra-Ocular Lenses and Cochlear Implant.

4.16 Dental treatment or surgery of any kind which are done in a dental clinic and those that are cosmetic in nature.

4.17 Convalescence , rest cure, obesity treatment and its complications including morbid obesity , Venereal disease and use of intoxication drugs/alcohol.

4.18 All expenses arising out of any condition directly or indirectly caused to or associated with Human T Cell Lymphotropic Virus Type III (HTLB – III) or Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variation Deficiency Syndrome or any syndrome of a similar kind commonly referred to as AIDS.

4.19 Charges incurred at hospital/nursing home primarily for diagnosis x ray or laboratory examinations or other diagnostic studies not consistent with diagnosis and treatment of positive existence of any ailment, sickness or injury for which confinement is required at a Hospital/Nursing Home unless recommended by the attending doctor.

4.20 Expenses on vitamins and tonics unless forming part of treatment for injury or diseases as certified the attending physician.

4.21 All non-medical expenses including convenience items for personal comfort such as charges for telephone, television, barber or beauty devices, diet charges, baby food, cosmetics, tissue paper, diapers, sanitary pads, toiletry items and similar incidental expenses unless and otherwise necessitated during the course of treatment.

4.22 Critical illness diagnosed before the commencement of the policy are not covered.

4.23 Expenses on purchase of medicine not supported by bills/receipts/cash memos with valid GST No of the issuer of such bills/receipts/cash memos.

5. Claims Procedure

A. Claims Administration and Process

It shall be the condition precedent to admission of our Liability under this policy that the terms and conditions of making payment of premium on full or in time insofar as they relate to anything to be done or complied with by you or any Insured Person, are fulfilled including complying with the following in relation to claims ;

1. On the occurrence or discovery of any illness or injury that may give rise to a claim under this policy, the claims procedure set out below shall be followed.

2. The treatment should be taken as per the advice, directions and guidance of the treating medical practitioner. Any failure to follow such advice, directions and guidance will prejudice the claim.
3. The insured person must submit to medical examination by our medical practitioner in case requested by us and at our cost, as often as we consider reasonable and necessary and we/our representatives must be permitted to inspect the medical and hospitalisation records pertaining to the insured person's treatment and to investigate the circumstances pertaining to the claim.
4. We and our representatives must be given all reasonable cooperation in investigating the claim in order to assess our liability and quantum in respect of the claim.

Notification of Claim

Upon the happening of any event which may give rise to any claim under this policy, the insured or insured's representative shall notify the TPA in writing by letter, email, fax providing all relevant information relating to claim including plan of treatment, policy number etc. within prescribed time limit.

Notification of Claim in case of Cashless facility	**TPA must be informed:**
In the event of planned hospitalisation	At least 72 hours prior to the insured person's admission to network provider/ PPN hospital
In the event of emergency hospitalisation	Within 24 hours of the insured person's admission to network provider/PPN hospital.

Notification of Claim in case of Reimbursement	**TPA must be informed:**
In the event of planned hospitalisation	Within 48 hours of the insured person's admission to network provider/non network/ PPN hospital
In the event of emergency hospitalisation	Within 48 hours of the insured person's admission to network provider/ non network /PPN hospital.

B. Procedure for cashless claims

1. Cashless facility for treatment shall be available to insured in network hospitals only.
2. Treatment may be taken in a network provider/PPN and is subject to pre authorization by the TPA. Booklet containing list of network providers/PPN hospitals shall be provided by the TPA. Updated list of network provider/PPN is available on website of the company (https://nationalinsurance.nic.co.in/en/health-insurance/city-wise-list-ppn-hospitals) and the TPA mentioned in the schedule

3. Call the TPA's toll free phone number provided on the health ID card for intimation of claim and related assistance. Inform the ID number for easy reference.

4. On admission in the network provider/PPN, produce the ID card issued by the TPA at the hospital helpdesk. Cashless request form available with the network provider/PPN and TPA shall be completed and sent to TPA for authorization. Each request for pre authorization must be through duly completed standard pre-authorization format including the following details:
   i. The health card which the insurer or the associated TPA has issued to the insured person supported with KYC documents;
   ii. The Policy Number;
   iii. Name of the Policy Number/Employer;
   iv. Name and address of insured person/Employee/member in respect of whom the request is being made;
   v. Nature of the illness/injury and the treatment/surgery required;
   vi. Name and address of the attending Medical Practitioner;
   vii. Hospital where the treatment/surgery is proposed to be taken;
   viii. Proposed date of admission;
5. If these details are not provided in full or sufficient or are insufficient for the associated TPA to consider the request, the associated TPA will request additional information or documentation in respect of that request.
6. When the associated TPA has obtained sufficient details to access the request, the associated TPA will issue the authorisation letter specifying the specified amount, any specific limitation on the claim, applicable deductibles, and non-payable items if applicable, or We may reject the request for pre-authorisation specifying reason for the rejection.
7. The TPA upon getting cashless request form and related medical information from the insured person/network hospital/PPN shall issue pre-authorisation letter to the hospital afterverification.
8. Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorisation date at a Network Provider and pre-authorisation shall be valid only if all the details of the authorised treatment, including dates, hospitals and locations match with the details of the actual treatment received. For Hospitalisation where Cashless Facility is pre-authorised by the associated TPA, the associated TPA will make the payment of the amounts assessed to be due directly to the Network Provider.
9. In the event that the cost of hospitalisation exceeds the authorised limits as mentioned in the authorisation letter :
   a. The network provider shall request us for an enhancement of authorisation limit as described under section 5.B including details of the specific circumstances which have led to the need for increase in the previously authorised limit. We will verify the eligibility and evaluate the request for enhancement on the availability of further limits.
   b. We shall accept or decline such request for enhancement of pre-authorised limit for enhancement. In the event of any change in the diagnosis, plan of Treatment, cost of Treatment during Hospitalisation to the insured person, the network provider shall obtain a fresh authorisation letter from Us in accordance with the process described under 5.B above.
10. At the time of discharge, the insured person shall verify and sign the discharge papers and pay for non-medical and inadmissible expenses.

11. At the time of discharge:
    a. The Network Provider may forward a final request for authorisation for any residual amount to the TPA along with the discharges summary and the detailed bill break up in accordance with the process described at 5.B above.
    b. Upon receipt of the final authorisation letter from TPA, the insured person may be discharged by the Network Provider.

Note: (Applicable to 5 B): Cashless facility for hospitalisation expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Provider/PPN hospital for Illness or Injury/Accident/Critical Illness as the case which may be which are covered under the policy. For all cashless authorisations, the insured person, will in any event be required to settle all non-admissible expenses, expenses above specified Sub Limits (if applicable), Co-Payments and/or opted Deductible (Per Claim/Aggregate/Corporate) (if applicable), directly with the hospital.

12. The TPA reserves the right to deny pre-authorisationin case the insured person is unable to provide the relevant medical details. Denial of a pre-authorisation request is in no way to be construed as denial of treatment or denial of coverage. The insured person may get the treatment as per treating doctor's advice and submit the claim documents to the TPA for possible reimbursement.
13. Claims for pre hospitalisation and post hospitalisation will be settled on a reimbursement basis on production of cash receipts.

C. Procedure for reimbursement of claims

In non-network hospitals payment must be made upfront and for reimbursement of claims the insured person may submit the necessary documents to TPA (if claim is processed by TPA)/the bank's office authorised to deal with Health Claims within the prescribed time limit.

For all claims for which Cashless Facilities have not been pre-authorised or for which treatment has not been taken at a Network Provider, We shall be given written notice of the claim along with the following details within the timelines as mentioned for reimbursement claims in B above:

i. The Policy Number;
ii. Name of the Policy Number/Employer;
iii. Name and address of Insured person/Employee/member in respect of whom the request is being made;
iv. Health Card, photo ID, KYC documents;
v. Nature of illness or injury and the treatment/Surgery taken;
vi. Name and address of the attending medical practitioner;
vii. Hospital where treatment/surgery was taken;
viii. Date of Admission and Date of Discharge;
ix. Any other information that may be relevant to the Illness/Injury/Hospitalisation;
x. Duly completed claim form

D. Documents

1. The claim is to be supported with the following original documents and submitted within the prescribed time limit.
    i. Duly completed claim form
    ii. Photo ID and Age Proof

iii. Health Card, Policy copy, Photo ID and KYC documents

iv. Attending medical practitioner's/surgeon's certificate regarding diagnosis/nature of operation performed along with date of diagnosis, investigation test reports etc supported by the prescription from attending medical practitioner

v. Original discharge card/day care summary/transfer summary

vi. Original final hospital bill with all original deposit and final payment receipt

vii. Original invoice with payment receipt and implant stickers for all implants used during surgeries i.e lens sticker and invoice in cataract surgery, stent invoice and sticker in Angioplasty surgery

viii. All previous consultation papers indicating history and treatment details for current ailment

ix. All original diagnostic reports (including imaging and laboratory)along with medical practitioner's prescription and bill/invoice with receipt from diagnostic centre.

x. All original medicine/pharmacy bills along with medical practitioner's prescription;

xi. MLC /FIR copy- in Accidental case only;

xii. Copy of death summary and copy of death certificate (in death claims only);

xiii. Pre and post-operative imaging reports-in Accidental cases only;

xiv. Copy of indoor case papers with nursing sheet detailing medical history of the Insured Person, treatment details and the Insured Person's progress;

Note

In the event of a claim lodged as per Settlement under multiple policies clause and the original documents having been submitted to the other insurer, the company may accept the duly certified documents listed under condition 5.C. & 5.D. And claim settlement advice duly certified by the other insurer subject to satisfaction of the company.

2. Time limit for submission of documents

Type of claim	Time limit for submission of documents to company/TPA
Where Cashless Facility has been authorised	Immediately after discharge.
Reimbursement of hospitalisation and per hospitalisation expenses (limited to 30 days)	Within 30 (Thirty) days of date of discharge from hospital
Reimbursement of post hospitalisation expenses (limited to 90 days)	Within 30 (thirty) days from completion of post hospitalisation treatment.

Note: Waiver of this condition may be considered in extreme case of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him of any other person to give such notice or file claim within the prescribed time-limit.

3. The insured Person shall also give the TPA/Company such additional information and assistance as the TPA/Company may require in dealing with the claim including an authorisation to obtain Medical and other records from the hospital, lab, etc.

4. All the documents submitted to TPA shall be electronically collected by us for settlement and denial of the claims by the appropriate authority.

E. Scrutiny of Claim Documents

a. The TPA shall scrutinize the claim form and the accompanying documents. Any deficiency in the documents shall be intimated to the Insured Person/Network Provider as the case may be within 7 working days of submission of documents.If the deficiency in the necessary claim documents is not met or are partially met in 10 working days, The TPA will send a maximum of 3 (three) reminders. We may, at our sole discretion, decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if we observe that such a claim is otherwise valid under the Policy.

b. In case a reimbursement claim is received when a pre-authorization letter has been issued, before approving such a claim, a check will be made with the Network Provider whether the pre-authorization has been utilized as well as whether the Insured Person has settled all the dues with the Network Provider. Once such check and declaration is received from the Network Provider, the case will be processed.

c. The Pre-Hospitalization Medical Expenses Cover claim and Post-Hospitalization Medical Expenses Cover claim shall be processed only after decision of the main Hospitalization claim.

F.Claim Assessment

Insurer will pay the fixed or indemnity amount as specified in the applicable Base of Optional Cover in accordance with the terms of the Policy.

Insurer will assess all admissible claims under the Policy in the following progressive order:

I. If any Sub Limit on Medical Expenses are applicable as specified in the Policy Schedule/Certificate of Insurance, our liability to make payment shall be limited to the extent of the applicable Sub Limit for that Medical Expense.

II. Opted Deductible (Pre Claim/ Aggregate/ Corporate), if any, shall be applicable on the amount payable by Us after applying (I), and (ii) above.

III. Co-Payments if any, shall be applicable on the amount payable by us after applying (i), and (ii).

The Claim amount assessed under Section 5 F (i), (ii) and (iii) will be deducted from the following amounts in the following progressive order after applying Sub Limit.

a. Sum Insured
b. Corporate Buffer

G. Claim Settlement

1. On receipt of the final document(s), the company shall within a period of 24 (Twenty Four) days offer a settlement of the claim to the insured person.
2. In the cases of delay in the payment, the company shall pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate that is 2%(Two percent) above the bank rate prevalent at the beginning of the financial year in which the claim is paid.
3. 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 the 30 days from the date of receipt of last necessary document. In such cases, Insurer shall settle the claim within 45 days from the date of receipt of last necessary document.

4. In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate prevalent at the beginning of the financial year in which the claim is paid, from the date of receipt of last necessary document to the date of payment of claim.
5. The payment of the amount due shall be made by the company, upon acceptance of an offer of settlement as stated above by the insured person, within 7(Seven) days from the date of acceptance of the offer.
6. A claim, which is not covered under the policy cover and conditions, can be rejected.

H. Rejection/ Repudiation of Claim

a. If the company, for any reasons, decides to reject/repudiate –a claim under the policy, we shall communicate to the insured person in writing explicitly mentioning the grounds for rejection/repudiation and within a period of 30 (thirty) days from the receipt of the final document(s) of investigation report (if any), as the case may be. Where a rejection is communicated by the Company, the Insured Person may, is so desired, within 15 days from the date of receipt of the claims decision represent to the Company for reconsideration of the decision.

b. In case of rejection of claims, it would go through a committee set up of the Bank, Third Party Administrator and National Insurance Co. Ltd. unless rejected by the committee in real time the claim should not be rejected.

I. Claim Payment Terms

I. We shall have no liability to make payment of a claim under the Policy in respect of an Insured Person once the Sum Insured for that Insured Person is exhausted.

II. All claims will be payable in India and in Indian rupees.

III. We are not obligated to make payment for any claim or that part of any claim that could have been avoided of reduced if the Insured Person could have reasonable minimized the costs incurred, or that is brought about or contributed to by the Insured Person by failing to follow the directions, Medical Advice of guidance provided by a Medical Practitioner.

IV. The Sum insured opted under the Policy shall be reduced by the amount payable/ paid under the Policy terms and conditions and any optional covers applicable under the Policy and only the balance shall be available as the Sum Insured for the unexpired Policy Period.

V. If the Insured Person suffers a relapse within 45 days from the date of discharge from the Hospital for which a claim has been made, then such relapse shall be deemed to be part of the same claim and all the limits for "Any one illness" under this Policy shall be applied as if they were under a single claim.

VI. For Cashless claims, the payment shall be made to the Network Provider whose discharge would be complete and final.

VII. For Reimbursement claims, the payment shall be made to the Insured person. In the unfortunate event of the Insured person's death, we will pay the Nominee (as named in the Policy Schedule/ Certificate of Insurance) and in case of no Nominee, to the legal heir who holds a succession certificate of indemnity bond to that effect, whichever is available and whose discharge shall be treated as full and final discharge of Our liability under the Policy.

J. Claims will be managed through the same Office of the Bank from where it is managed at Present. The Third Party Administrator will be setting up a help desk at that office and supporting the bank in clearing all the claims on real time basis.

6 CONDITIONS

6.1 Disclosure of Information

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

6.2 Condition Precedent to Admission of Liability

The terms and conditions of the Policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the Policy.

6.3Communication

i. All communication should be made in writing.

ii. For Policies serviced by TPA, ID card, PPN/Network Provider related issues to be communicated to the TPA at the address mentioned in the Schedule. For claim serviced by the Company, the Policy related issues to be communicated to the Policy issuing office of the Company at the address mentioned in the Schedule.

iii. Any change of address, state of health or any other change affecting any of the Insured Person, shall be communicated to the Policy issuing office of the Company at the address mentioned in the Schedule.

iv. The Company or TPA shall communicate to the Proposer/ Insured Person at the address mentioned in the Schedule.

6.4Physical Examination

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

6.5 Fraud

If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this Policy, all benefits under this Policy and the premium paid shall be forfeited. Any amount already paid against claims made under this Policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the Company. 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 Company or to induce the Company 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 Company.

6.6 Territorial Limit

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

6.7 Renewal of Policy

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

i. The company shall endeavour 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. After the end of the policy period, the policy can be renewed within the Grace Period of 30 days to maintain continuity benefits without break in policy. Coverage is not available during the grace period.
v. No Loading shall apply on renewals based on individual claims experience.

6.8 Enhancement of Sum Insured:

Change in Sum Insured after commencement of policy to be considered in case of promotion of the employee of vice versa.

6.9 Guideline for Addition of members: -

Midterm additions are allowed only for natural additions subject to intimation received within 30 days, i.e. new joinees, newly married spouses and new born children. Any additions for new employee, spouse / children would be allowed within 30 days of date of joining marriage / birth respectively. **Mid- term additions are allowed for Parents/ Parent in laws only if they become dependent on Employee due to changed circumstances during policy period.**

6.10 Cancellation:

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

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

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

6.10 Territorial Jurisdiction

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

6.11 Maintenance Of member Records

The Insured shall throughout the period of insurance keep and maintain a proper record of register containing the names of all the Insured persons and other relevant details as are normally kept in any institution/ Organisation. The Insured shall declare to the company any additions in the number of Insured persons as and when arising during the period of
Insurance and shall pay the additional premium as agreed.
It is hereby agreed and understood that, this insurance being a Group Policy availed by the Insured covering Members, the benefit thereof would not be available to member who cease to be part of the group for any reason whatsoever.

6.12Low Claim Ratio Discount (Bonus)

Low Claim Ratio Discount at the following scale will be allowed on the total premium at renewal only depending upon the incurred claim ration for the entire group Insured under the Group Mediclaim Insurance Policy for the preceding 3 completed years excluding the year immediately preceding the date of renewal where the Group Mediclaim Insurance Policy has not been in force for 3 completed years, such shorter period of completed years excluding the year immediately preceding the date of renewal will be taken in to account.

Incurred Claim Ratio under the Policy	Discount
Above 70%	Nil
66-70%	2.50%
61-65%	5%
56-60%	10%
51-55%	15%
41-50%	25%
31-40%	35%
21-30%	40%
Not exceeding 20%	50%

6.13 Arbitration

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 or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shell 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.

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 this policy.

It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this policy that award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

6.14Disclaimer

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

6.15IRDA Regulations

This policy is subject to Provisions of Insurance Act, 1938, IRDAI (health Insurance) Regulations 2016 and IRDA (protection of policyholder's interest) Regulations 2017 as amended from time to time.

6.16 Grievance Redressal

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

Website: https://nationalinsurance.nic.co.in/ Post: National Insurance Co. Ltd.,
Toll free: 1800 345 0330 6A Middleton Street, 7th Floor,
CRM Dept.,
E-mail: customer.relations@nic.co.in Kolkata - 700 071
Phn : (033) 2283 1742

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

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

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

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

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

6.17Revision of Terms of the Policy Including the Premium Rates

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

6.18 Withdrawal of Policy

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.

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 waiver of Waiting Period as per IRDAI guidelines, provided the policy has been maintained without a break.

PART-III

Critical Illness Benefit Cover

For the purpose of this Section, "Critical Illness" means any illness, medical event of surgical procedure as specifically defined whose signs or symptoms first commence since the commencement of the policy year. The benefits under this cover (as set out below) will be over and above the base sum insured.

The cover is applicable provided that the critical illness, which the insured person is suffering from, occurs or first manifests itself during the policy year as a first incidence.

Critical illness is to be provided to the employee subject to a sum insured of Rs. 1,00,000/-. The cover starts on inception of the policy. In case an employee contracts a critical illness as listed below, the total sum insured of Rs. 1, 00,000/- is paid, as a benefit. This benefit is provided on first detection/diagnosis of the critical illness.

A. List of Critical Illnesses cover under this Benefit:

I. Cancer of Specified Severity (Including Leukemia)

A malignant tumor characterized 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. The terms cancer includes leukemia, lymphoma and sarcoma.

The following are excluded-

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, of non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1,CIN-2, and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

a. Malignant melanoma that has not caused invasion beyond the epidermis;
b. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
c. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below.
d. Chronic lymphocytic leukemia less than RAI stage 3.
e. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification.

f. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs.
g. All tumours in the presence of HIV infection.

II. Stroke Resulting in Permanent Symptoms

Any cerebrovascular incident producing permanent neurological sequela. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extra cranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

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

III. Permanent Paralysis of Limbs

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

IV. Open Chest CABG

The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
The following are excluded:
Angioplasty and/or any other intra-arterial procedures.

V. Myocardial Infarction (First Heart Attack of Specific severity)

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

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
ii. New characteristic electrocardiogram changes.
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers. The following are excluded.

iv. Other acute Coronary Syndromes.
v. Any type of angina pectoris.
vi. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an inter-arterial cardiac procedure.

VI. Open heart Replacement or Repair of Heart valves

The actual undergoing of open-heart valve surgery is to replace or repair one of more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty are excluded.

VII. Major organ/Bone Marrow Transplant

i. The actual undergoing of a transplant of:
a. One of the following human organs: heart, lung, liver, kidney, pancreas that resulted from irreversible end-stage failure of the relevant organ.
b. Human bone marrow using hematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.
ii. The following are excluded:
a. Other stem-cell transplants.
b. Where only islets of Langerhans are transplanted.

VIII. 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 (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

IX. End Stage Liver Failure

Permanent and irreversible failure of liver function that has resulted in all three of the following:

i. Permanent jaundice.
ii. Ascites.
iii. Hepatic encephalopathy.
iv. Liver failure secondary to alcohol or drug abuse is excluded

B. Cover

If an insured person is diagnosed to be suffering from any of the Critical Illnesses of the nature specified above during the policy year, then we will pay a Critical Illness Sum Insured specified in the policy schedule/certificate of insurance provided that:

a. Under this policy there would be no waiting period for the payment of the claim on the inception of the policy, nor any survival period for the payment of the claim on the individual contracting any of the above mentioned Critical Illness.
b. Upon our admission of the first claim under this benefit in respect of an insured person in any policy year, the cover under this benefit shall automatically terminate in respect of that insured person.
c. Our total and cumulative liability in respect of an insured person under this benefit will be limited to the Critical Illness Sum Insured of **Rs. 1,00,000/- only.**
d. This benefit is paid as a lump sum amount and is over and above the base Sum Insured.

Hospitalization is not required to claim this benefit. Further the employee can claim the cost of hospitalization on the same from the Group Mediclaim Policy as cashless/reimbursement of expenses for the treatment taken by him.

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For any information please contact the Policy Issuing Office or visit our website at www.nationalinsuranceindia.com

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