National Insurance Company Limited

CIN - U10200WB1906GOI001713 IRDAI Regn. No. – 58

National Parivar Mediclaim Plus Policy

PROSPECTUS

1.1 Product

National Parivar Mediclaim Plus Policy is a floater health insurance, covering the members of a family under a single sum insured. The Policy covers expenses in respect of inpatient treatment (allopathy, ayurveda and homeopathy), domiciliary hospitalisaion, 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, ambulance charges, air ambulance charges, medical emergency reunion, doctor's home visit and nursing care during post hospitalisation, anti rabies vaccination, maternity expenses, infertility expenses, vaccination for children and medical second opinion. Pre-existing Diabetes and/or Hypertension, Outpatient Treatment and Critical Illness are provided as Optional Covers.

1.2 Coverage

The coverage depends on the plan opted as shown in the Table of Benefits.

1.2.1 In-patient Treatment

The Company shall pay to the hospital or reimburse the insured up to the sum 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), subject to limit as mentioned in Section 1.2.1.1
ii. Medical practitioner(s)
iii. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances
iv. Medicines and drugs
v. Diagnostic procedures
vi. Prosthetics and other devices or equipment if implanted internally during a surgical procedure.
vii. Dental treatment, necessitated due to an injury
viii. Plastic surgery, necessitated due to disease or injury
ix. Hormone replacement therapy, if medically necessary
x. Vitamins and tonics, forming part of treatment for disease/injury as certified by the attending medical practitioner
xi. Circumcision, necessitated for treatment of a disease or injury

1.2.1.1 Limit for Room Charges and Intensive Care Unit Charges

Room charges and intensive care unit charges payable shall be up to the limit as shown in the Table of Benefits, except for Plan B and Plan C. The limit shall not apply if the treatment is undergone for a listed procedure in a Preferred Provider Network (PPN) as a package, under Plan A

Note:

Listed procedures and Preferred Provider Network list are dynamic in nature, and will be updated in the Company's website from time to time.

1.2.1.2 Limit for cataract surgery

Company's liability for cataract surgery shall be up to the limit as shown in the Table of Benefits, except for Plan B and Plan C. The limit shall not apply if the treatment is undergone for a listed procedure in a Preferred Provider Network (PPN) as a package, under Plan A.

1.2.1.3 Treatment related to participation as a non-professional in hazardous or adventure sports

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

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 Domiciliary Hospitalisation

The Company shall reimburse the insured the medical expenses incurred under domiciliary hospitalization, including pre hospitalisation expenses (admissible as per Section 1.2.2) and post hospitalisation expenses (admissible as per Section 1.2.3), up to the limit mentioned in the Table of Benefits.

Exclusions

Domiciliary hospitalisation shall not cover:

i. Treatment of less than three days
ii. Expenses incurred for pre and post hospitalisation
iii. Expenses incurred for alternative treatment
iv. Expenses incurred for maternity or infertility
v. Expenses incurred for any of the following diseases;
   a) Asthma
   b) Bronchitis
   c) Chronic nephritis and nephritic syndrome
   d) Diarrhoea and all type of dysenteries including gastroenteritis
   e) Epilepsy
   f) Influenza, cough and cold
   g) All psychiatric or psychosomatic disorders
   h) Pyrexia of unknown origin for less than ten days
   i) Tonsillitis and upper respiratory tract infection including laryngitis and pharingitis
   j) Arthritis, gout and rheumatism

1.2.5 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 up to the sum insured, for day care procedures which require hospitalisation for less than twenty four hours provided that

i. day care procedures/surgeries where such treatment is undergone by an insured person in a hospital/day care centre (but not the out-patient 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.

1.2.6 Ayurveda and Homeopathy

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

1.2.7 Organ Donor's Medical Expenses

The Company shall pay to the hospital or reimburse the insured the expenses of hospitalisation of the organ donor up to the sum insured, 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. Pre and post hospitalisation expenses, as per Section 1.2.2 and Section 1.2.3, incurred by the organ donor unless the organ donor is an insured person.
3. Any other medical treatment or complication in respect of the donor, consequent to harvesting

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

1.2.9 Ambulance

The Company shall reimburse the insured the expenses incurred for ambulance charges for transportation to the hospital, or from one hospital to another hospital, up to the limit as shown in the Table of Benefits, provided a claim has been admitted under Section 1.2.1.

1.2.10 Air Ambulance

The Company shall reimburse the insured expenses incurred for medical evacuation of the insured person by air ambulance to the nearest hospital or from one hospital to another hospital following an emergency up to the limit as shown in theTable of Benefits, provided prior intimation is given to the Company/TPA, and a claim has been admitted under Section 1.2.1.

1.2.11 Medical Emergency Reunion
In the event of the insured person being hospitalised in a place away from the place of residence for more than five continuous days in an intensive care unit for any life threatening condition, the Company after obtaining confirmation from the attending medical practitioner, of the need of a 'family member' to be present, shall reimburse the expenses of a round trip economy class air ticket for Plan B and Plan C to allow a family member, provided a claim has been admitted under Section 1.2.1
For the purpose of the Section, 'family member' shall mean spouse, children and parents of the insured person.

1.2.12 Doctor's Home Visit and Nursing Care during Post Hospitalisation
The Company shall reimburse the insured, for medically necessary expenses incurred for doctor's home visit charges, nursing care by qualified nurse during post hospitalisation up to the limit as shown in the Table of Benefits.

2.1.13 Anti Rabies Vaccination
The Company shall reimburse the insured medically necessary expenses incurred for anti-rabies vaccination up to the limit as shown in the Table of Benefits. Hospitalisation is not required for vaccination.

1.2.14 Maternity
The Company shall pay to the hospital or reimburse the insured the medical expenses, incurred as an in-patient, for delivery or termination up to the first two deliveries or terminations of pregnancy during the lifetime of the insured or his spouse, if covered by the Policy, provided the Policy has been continuously in force for twenty four months from the inception of the Policy or from the date of inclusion of the insured person by the Policy, whichever is later. 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 within the sub limit for maternity.

Baby from Birth Cover

iv. Medical expenses of the new born baby/ new born babies (in the event of multiple birth in a delivery), including expenses with respect to vaccination. Hospitalisation is not required for vaccination.

Note: Ectopic pregnancy is covered under Section 1.2.1 '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 year.
3. Surrogacy, unless claim admitted under Section 1.2.15 (Infertility)
4. Pre and post hospitalisation expenses as per Section 1.2.2 and Section 1.2.3, other than pre and post natal treatment.

1.2.15 Infertility
The Company shall pay to the hospital or reimburse the insured, in respect of the medical expenses of the insured and his spouse, if covered by the Policy, for treatment undergone as an in-patient or as a day care treatment, for procedures and/ or treatment of infertility, provided the Policy has been continuously in force for twenty four months from the inception of the Policy or from the date of inclusion of the insured person, whichever is later. The medical expenses for either or both the insured person shall be subject to the limit as shown in the Table of Benefits.

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. Diagnostic tests related to infertility
3. Reversing a tubal ligation or vasectomy
4. Preserving and storing sperms, eggs and embryos
5. An egg donor or sperm donor
6. Experimental treatments
7. Any disease/ injury, other than traceable to maternity, of the surrogate mother.

Conditions

1. Expenses for advanced procedures, including IVF, GIFT, ZIFT or ICSI, shall be payable only if the Insured person has been unable to attain or sustain a successful pregnancy through reasonable, and medically necessary infertility treatment.
2. Maternity expenses of the surrogate mother shall be payable under Section 1.2.14 (Maternity). Legal affidavit regarding intimation of surrogacy shall be submitted to the Company.
3. Maximum of two claims shall be admissible by the Policy during the lifetime of the insured person if he has no living child and one claim if the insured has one living child.
4. Any one illness limit shall not apply.

Definitions for the purpose of the Section

1. **Donor** means an oocyte donor or sperm donor.
2. **Embryo** means a fertilized egg where cell division has commenced/ under the process and has completed the pre-embryonic stage.
3. **Gamete Intra-Fallopian Transfer (GIFT)** means a procedure where the sperm and egg are placed inside a catheter separated by an air bubble and then transferred to the fallopian tube. Fertilization takes place naturally.
4. **Infertility** means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. However the one year period may be waived, provided a medical practitioner determines existence of a medical condition rendering conception impossible through unprotected sexual intercourse, including but not limited to congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments.
5. **Intra-Cytoplasmic Sperm Injection (ICSI)** means an injection of sperm into an egg for fertilisation.
6. **In Vitro Fertilization (IVF)** means a process in which an egg and sperm are combined in a laboratory dish where fertilization occurs. The fertilized and dividing egg is transferred into the uterus of the woman.
7. **Surrogate** means a woman who carries a pregnancy for the insured person.
8. **Zygote Intra-Fallopian Transfer (ZIFT)** means a procedure where the egg is fertilized in vitro and transferred to the fallopian tube before dividing.

1.2.16 Vaccination for Children

The Company shall reimburse the insured, the expenses incurred for vaccinations of children (up to twelve years for male child and up to fourteen years for female child), up to the limit as shown in the Table of Benefits, provided the children are covered by the Policy. Hospitalisation is not required for this benefit.

1.2.17 HIV/ AIDS Cover

The Company shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) related to following stages of HIV infection:

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

1.2.18 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 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.

1.2.19 Modern Treatment

The Company shall pay to the hospital or reimburse the insured the medical expenses for In-Patient Care (admissible as per Section 1.2.1), Domiciliary Hosptalisation (admissible as per Section 1.2.4) or Day Care Procedure (admissible as per Section 1.2.5) along with pre hospitalisation expenses (admissible as per Section 1.2.2) and post hospitalisation expenses (admissible as per Section 1.2.3) incurred for following **Modern Treatments** (wherever medically indicated), subject to **Maximum amount admissible for any one Modern Treatment shall be 25% of Sum Insured**

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

1.2.20 Morbid Obesity Treatment

The Company shall indemnify the Hospital or the Insured the Medical Expenses, including pre hospitalisation expenses (admissible as per Section 1.2.2) and post hospitalisation expenses (admissible as per Section 1.2.3), incurred for surgical treatment of obesity that fulfils **all** the following conditions and subject to Waiting Period of four (04) years as per Section 4.2.f.iv:

1. Treatment has been conducted is upon the advice of the Medical Practitioner, and
2. The surgery/Procedure conducted should be supported by clinical protocols, and
3. The Insured Person is 18 years of age or older, and

4. Body Mass Index (BMI) is;
   b) greater than or equal to 40 or
   c) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type 2 Diabetes

1.2.21 Correction of Refractive Error
The Company shall indemnify the Hospital or the Insured the Medical Expenses, including pre hospitalisation expenses (admissible as per Section 1.2.2) and post hospitalisation expenses (admissible as per Section 1.2.3), incurred for expenses related to the treatment for correction of eye sight due to refractive error equal to or more than 7.5 dioptres, subject to Waiting Period of two (02) years as per Section 4.2.f.iii.

Note: The expenses that are not covered in this policy are placed under List-l of Appendix-IV of the Policy. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Appendix-IV of the Policy respectively

Note
Aggregate of all the benefits under 1.2.1 to 1.2.21 are subject to the Sum Insured opted.

1.3.1 Medical Second Opinion
The Company shall arrange for Medical Second Opinion from a panel of World Leading Medical Centers (WLMC), at the insured person's request if the insured person is diagnosed with one of the major listed illness, during the policy year. Up to two Medical Second Opinion per family can be availed during a policy year, for any of the major illness.
The insured person shall provide the medical records containing the diagnosis and recommended course of treatment to the service provider, through the TPA named in the schedule for servicing MSO (irrespective of claim being serviced by TPA or not). The Medical Second Opinion shall be based only on the information and documentation provided to the medical practitioner of WLMC by or on behalf of the insured person, and the second opinion and the recommended course of treatment shall be sent directly to the insured/ insured person. The TPA shall only be responsible for collecting the required documents from the insured person, and deliver them to the service provider.

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

1.3.2 Reinstatement of Sum Insured due to Road Traffic Accident
In the event of the sum insured being exhausted on account of claims arising out of any injury due to road traffic accident during a policy year, if the Insured and/or Insured Person (s) has to subsequently incur any expenses on hospitalisation due to any other disease/ injury, the Company shall reinstate the sum insured as mentioned in the schedule. Reinstatement shall be allowed only once during the policy year and the maximum amount payable under a single claim shall not exceed the sum insured as mentioned in the schedule.

1.4 Good Health Incentives
1.4.1 No Claim Discount (NCD)
On renewal of policies with a term of one year, a NCD of flat 5% shall be allowed on the * base premium, provided claims are not reported in the expiring Policy.
On renewal of policies with a term exceeding one year, the NCD amount with respect to each claim free policy year shall be aggregated and allowed on renewal. Aggregate amount of NCD allowed shall not exceed flat 5% of the total base premium for the term of the policy.
** **Base premium** depends on the zone and sum insured and is the aggregate of the premium for senior most insured person and other insured persons for a year.*

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

1.5 Hospitalisation Options

The Policy provides for cashless facility and/ or reimbursement of hospitalisation expenses or reimbursement of domiciliary 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. Preferred Provider Network (PPN) is a hospital which has agreed to a cashless packaged pricing for listed procedures for the insured person. The list is available with the Company/TPA and subject to amendment from time to time.

2.1 Eligibility

i. Policy shall cover at least two family members, as defined below.
ii. Proposer should be between eighteen years and sixty five years.
iii. Maximum entry age of any family member is sixty five years.
iv. Children between the age of three months and eighteen years may be covered, provided parent(s) is/are covered concurrently.
v. Family members
    a. Proposer
    b. Spouse
    c. Dependent legitimate or legally adopted children
        - Dependent child up to eighteen years of age
        - Dependent male child above eighteen years and up to twenty five years, if a bona-fide student and not employed
        - Dependent female child if not employed, till marriage
    d. Parents or Parents in law
vi. 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)
vii. Dependent children have the option to port to similar health insurance product of the Company or any other insurer on completion of the specified exit age as mentioned.
viii. If during the policy period, the number of members covered reduces to a single member, then on expiry of the policy period, the insured person shall port to similar health insurance product of the Company or of any other insurer.

2.2 Policy Period

The Policy can be issued for a period of one, two or three years, as opted by the proposer

2.3 Sum Insured (SI)

The SI for each policy year

i. Plan A – 5 slabs, ₹6,00,000 to ₹10,00,000 in multiple of ₹1,00,000
   Plan B – 3 slabs, ₹15,00,000/ ₹20,00,000/ ₹25,00,000
   Plan C – 3 slabs, ₹30,00,000/ ₹40,00,000/ ₹50,00,000
ii. The SI is on floater basis and applies to one or all the insured persons.

2.3.1 Enhancement of Sum Insured

i. Sum insured 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.
iii. Change of plan by enhancement of sum insured is allowed only at the time of renewal, subject to four years of continuous coverage with the Company and any insured person is not suffering from any disease.
iv. For change of plan, medical reports as per Section 2.8.iii are required to be submitted with respect to each insured person aged forty years and above.

2.4 Discounts

2.4.1 Long Term Discount

For a Policy issued for two policy years. - Discount of 4% shall be allowed on the total premium (including premium for optional covers)

For a Policy issued for three policy years. - Discount of 7.5% shall be allowed on the total premium (including premium for optional covers)

2.4.2 Online Discount

For policy bought online - Discount of 5% in the premium
For policy renewed online - Discount of 2.5% in the premium
Policy can be bought/ renewed online at http://niconline.in/

2.4.3 Discount in Lieu of no Maternity/ Infertility cover for individuals above forty five years

Discount of 3%, shall be allowed on individual premium, for Insured and his spouse above forty five years of age.

Discounts as per 2.4.2 and 2.4.3 shall not apply to optional covers and to mid term inclusion of family members.

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 http://niconline.in/, 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. Annual income statement to be submitted for the proposer opting for Critical Illness optional cover.
iv. Person insured covered by any health insurance policy of any other non life insurance Company and wishing to port (switch) to National Parivar Mediclaim Plus Policy, will have to submit the proposal form and portability form to the office or to the agent.

2.8 Pre Policy Checkup

i. Pre Policy Checkup is required for all individual family members
   a. forty years and above or
   b. irrespective of age, opting for Plan B or Plan C,
   c. between the age of eighteen years and sixty five years, opting for Critical Illness
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. The Pre Policy checkup reports required are –
   a) Physical examination (report to be signed by the Doctor with minimum MD (Medicine) qualification)
   b) HbA1c
   c) Lipid profile
   d) Serum creatinine
   e) Urine routine and microscopic examination
   f) ECG
   g) Eye checkup (including retinoscopy)
   h) Any other investigation required by the Company

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

2.9 Payment of Premium

i. Premium is based on the zone opted by the proposer. Change of zone shall not be allowed midterm
ii. **Base premium** depends on the zone and SI, age, and is the aggregate of the premium for each and every insured person for a year.
iii. **Premium for Optional cover premium** depends upon the cover opted.
iv. NCD and online discount are allowed on the base premium
v. Long term discount is allowed on the total premium (i.e, total of ii and iii above).
vi. 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.
vii. PAN details must be submitted by the insured.
viii. 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 the insured person.
ii. The Policy may be renewed by mutual consent before the expiry of the Policy.
iii. The Company is not bound to send renewal notice.
iv. Renewal of Policy can be denied on grounds of fraud, moral hazard, misrepresentation or noncooperation.
v. In the event of break in the Policy a grace period of thirty days is allowed. Coverage is not available during the grace period.
vi. 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
   - If only children (less than eighteen years of age) are covered, the Policy shall be allowed till the expiry of the policy period. The grandparents may be allowed to renew the Policy as insured, covering the grandchildren.
vii. In case of death of the eldest insured person
   - The base premium may be calculated based on the age of the next eldest insured person.

3 Policy Definition

3.1 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.

3.2 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

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

3.4 Domiciliary Hospitalisation means medical treatment for an illness /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.

i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
ii. the patient takes treatment at home on account of non availability of bed/ room in a hospital.

3.5 Floater means the sum insured, as mentioned in the Schedule, available to all the insured persons, for any and all claims made in aggregate during each policy year.

3.6 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 disease. Coverage is not available for the period for which no premium is received.

3.7 Hospitalisation means admission in a Hospital or mental health establishment 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.

3.8 Network Provider means hospitals or health care providers enlisted by the Company or jointly by the Company and a TPA to provide medical services to an insured person on payment by a cashless facility.

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

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

3.11 Preferred Provider Network (PPN) means a network of hospitals which have agreed to a cashless packaged pricing for listed procedures for the insured person. The list is available on the website of the Company/TPA and subject to amendment from time to time. For the updated list please visit the website of the Company/TPA. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.

3.12 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.

3.13 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

3.14 Service Provider means an entity engaged by the Company to provide Medical Second Opinion.

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

4 Exclusions

The Company shall not be liable to make any payment by 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 thirty six (36) months of continuous coverage after the date of inception of the first policy with us.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of thirty six (36) months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

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

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 90 days/ one year/ two year/ four years (as specified against specific disease/ procedure) of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing Diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f) List of specific diseases/procedures

i. 90 Days Waiting Period (Life style conditions)

a. Hypertension and related complications
b. Diabetes and related complications
c. Cardiac conditions

ii. **One year waiting period**

a. Benign ENT disorders
b. Tonsillectomy
c. Adenoidectomy
d. Mastoidectomy
e. Tympanoplasty

iii. **Two years waiting period**

a. Cataract
b. Benign prostatic hypertrophy
c. Hernia
d. Hydrocele
e. Fissure/Fistula in anus
f. Piles (Haemorrhoids)
g. Sinusitis and related disorders
h. Polycystic ovarian disease
i. Non-infective arthritis
j. Pilonidal sinus
k. Gout and Rheumatism
l. Calculus diseases
m. Surgery of gall bladder and bile duct excluding malignancy
n. Surgery of genito-urinary system excluding malignancy
o. Surgery for prolapsed intervertebral disc unless arising from accident
p. Surgery of varicose vein
q. Hysterectomy
r. Refractive error of the eye more than 7.5 dioptres
s. Congenital Internal Anomaly

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

iv. **Four years waiting period**

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

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

4.3. First 30 days waiting period (Excl 03)

a) Expenses related to the treatment of any illness within thirty (30) days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve (12) months.
c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4.4. Investigation & Evaluation (Excl 04)

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

4.5. Rest Cure, Rehabilitation and Respite Care (Excl 05)

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing,

dressing, moving around either by skilled nurses or assistant or non-skilled persons.
ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

4.6. Obesity/ Weight Control (Excl 06)
Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
a. greater than or equal to 40 or
b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
i. Obesity-related cardiomyopathy
ii. Coronary heart disease
iii. Severe Sleep Apnea
iv. Uncontrolled Type2 Diabetes

4.7. Change-of-Gender Treatments (Excl 07)
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

4.8. Cosmetic or Plastic Surgery (Excl 08)
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

4.9. Hazardous or Adventure Sports (Excl 09)
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

4.10. Breach of Law (Excl 10)
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

4.11. Excluded Providers (Excl11)
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Company and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

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

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

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

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

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

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

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

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

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

4.22. Vaccination or Inoculation.
Vaccination or inoculation unless forming part of treatment and requires Hospitalisation, except as and to the extent provided for under Section 1.2.13 (Anti Rabies Vaccination), Section 1.2.14.iv and Section 1.2.16 (Vaccination for Children).

4.23. 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.

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

4.25. Out Patient Department (OPD)
Any expenses incurred on OPD.

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

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

4.28. 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.

4.29. 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.

4.30. 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.

4.31. Items of personal comfort
Items of personal comfort and convenience including telephone, television, aya, barber, beauty services, baby food, cosmetics, napkins, toiletries, guest services.

4.32. Service charge/ registration fee
Any kind of service charges including surcharges, admission fees, registration charges and similar charges levied by the hospital.

4.33. 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 1.2.12 (Doctor's Home Visit and Nursing Care during Post Hospitalisation).

4.34. 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.

4.35. 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.

4.36. Treatment taken outside the geographical limits of India

4.37. 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 Communication

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

5.3 Claim Procedure

5.3.1 Notification of Claim

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

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

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

Notification of claim for vaccination	**Company/TPA must be informed:**
In the event of Anti Rabies Vaccination/ Vaccination for Children	At least twenty four hours prior to the vaccination

Note:

For claim under Section 1.3.1 (Medical Second Opinion), notification of claim is not required.

5.3.2 Procedure for Cashless Claims

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

5.3.3 Procedure for Reimbursement of Claims

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

5.3.3.1 Procedure for Reimbursement of Claims under Domiciliary Hospitalisation
For reimbursement of claims under domiciliary hospitalisation, 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.

5.3.4 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. Bills, payment receipts, medical history of the patient recorded, discharge certificate/ summary from the hospital etc.
iii. Cash-memo from the hospital (s)/chemist (s) supported by proper prescription
iv. Payment receipt, investigation test reports etc. supported by the prescription from the attending medical practitioner
v. Attending medical practitioner's certificate regarding diagnosis along with date of diagnosis and bill receipts etc.
vi. Certificate from the surgeon stating diagnosis and nature of operation and bills/receipts etc.
vii. For claim under Section 1.2.4 (Domiciliary Hospitalisation) in addition to documents listed above (as applicable), medical certificate stating the circumstances requiring for Domiciliary hospitalisation and fitness certificate from treating medical practitioner.
viii. For claim under Section 1.2.14 (Maternity) for surrogacy under Section 1.2.15 (Infertility) in addition to documents listed above (as applicable), legal affidavit regarding intimation of surrogacy.
ix. For claim under Section 1.2.11 (Medical Emergency Reunion) in addition to documents listed above (as applicable), confirmation of the need of family member from attending medical practitioner
x. For claim under Section 1.3.2 (Reinstatement of Sum Insured due to Road Traffic Accident) in addition to documents listed above (as applicable), police investigation report, confirming the road traffic accident.
xi. Any other document required by Company/TPA

Note
In the event of a claim lodged as per contribution clause of the Policy and the original documents having been submitted to the other insurer, the Company may accept the documents listed under condition 5.3.4 and claim settlement advice duly certified by the other insurer subject to satisfaction of the Company.

Type of claim	Time limit for submission of documents to Company/TPA
Reimbursement of hospitalization, pre hospitalisation expenses and ambulance charges, air ambulance charges and medical emergency reunion charges	Within fifteen days from date of discharge from hospital
Reimbursement of post hospitalisation expenses and doctor's home visit and nursing care during post hospitalisation	Within fifteen days from completion of post hospitalisation treatment
Reimbursement of domiciliary hospitalisation expenses	Within fifteen days from issuance of fitness certificate
Reimbursement of anti rabies vaccination, new born baby vaccination and vaccination of children	Within fifteen days from date of vaccination
Reimbursement of expenses for infertility treatment	Within fifteen days of completion of treatment or fifteen days of expiry of Policy period, whichever is earlier, once during the policy year
Reimbursement of health check up expenses (to be submitted to the office only)	Within six months of the third policy year.

5.3.5 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)*

5.3.6 Services Offered by TPA
The TPA shall render health care services covered by the Policy including issuance of ID cards & guide book, hospitalisation & pre-authorization services, call centre, acceptance of claim related documents, claim processing and other related services
The services offered by a TPA shall not include
i. Claim settlement and 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.

5.3.7 Classification of * Zone and Copayment
The amount of claim admissible will depend upon the zone for which premium has been paid and the zone where treatment has been taken.

* The country has been divided into four zones.

Zone I - Greater Mumbai Metropolitan area, entire state of Gujarat
Zone II – National Capital Territory (NCT) Delhi and National Capital Region (# NCR), Chandigarh, Pune
Zone III - Chennai, Hyderabad, Bangalore, Kolkata
Zone IV - Rest of India
 # NCR includes Gurgaon-Manesar, Alwar-Bhiwadi, Faridabad-Ballabgarh, Ghaziabad-Loni, Noida, Greater Noida, Bahadurgarh, Sonepat-Kundli Charkhi Dadri, Bhiwani, Narnaul

Where treatment has been taken in a zone, other than the one for which premium has been paid, the claim shall be subject to copayment.

a. Insured paying premium as per Zone I can avail treatment in Zone I, Zone II, Zone III and Zone IV without copayment
b. Insured paying premium as per Zone II
    a. Can avail treatment in Zone II, Zone III and Zone IV without any copayment
    b. Availing treatment in Zone I will be subject to a copayment of 5%
c. Insured paying premium as per Zone III
    a. Can avail treatment in Zone III and Zone IV without any copayment
    b. Availing treatment in Zone I will be subject to a copayment of 12.5%
    c. Availing treatment in Zone II will be subject to a copayment of 7.5%
d. Insured paying premium as per Zone IV
    a. Can avail treatment in Zone IV without any copayment
    b. Availing treatment in Zone I will be subject to a copayment of 22.5%
    c. Availing treatment in Zone II will be subject to a copayment of 17.5%
    d. Availing treatment in Zone III will be subject to a copayment of 10%

5.3.8 Treatment Outside Network
For policies under Plan A, claims where treatment is undergone in a non-network provider shall be subject to co payment of 10%. If treatment is undergone in a non-network provider in a city/ town/ village where the Company/ TPA does not have tie-up with any hospital, copayment shall not apply.
The copayment shall not apply to policies under Plan B and Plan C

Above copayments shall not be applicable on Critical illness & Outpatient treatment optional covers, but shall apply on Pre existing diabetes and/ or hypertension optional cover.

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

5.5 Payment of Claim
All medical treatments for the purpose of this insurance will have to be taken in India only. All claims by the Policy shall be payable in Indian currency and through NEFT/ RTGS only.

5.6 Fraud
If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.
Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.
For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:
a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent

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

5.7 Cancellation

i. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud
ii. The policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

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

iii. For policies with a term exceeding one year, the insured may at any time cancel the Policy and in such an event, the Company shall allow pro-rata refund of premium for the unexpired policy period after retaining 10% of the pro-rata premium, provided claim are not reported up to the date of cancellation

5.8 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 non life insurance company, the Policy shall be inoperative in respect of the insured persons for the number of days the Overseas Travel Insurance Policy is in force and proportionate premium for 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.

5.9 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.

5.10 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.

5.11 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.

5.12 Free Look Period

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

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

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

5.13 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 Optional Covers

Pre-existing diabetes/ hypertension, Out-patient Treatment and Critical Illness are optional covers.

7.1 Pre-existing Diabetes / Hypertension

The Company shall pay expenses for treatment of diabetes and/ or hypertension, if pre-existing, from the inception of the Policy. On completion of continuous thirty six months of insurance, the additional premium shall not apply

Eligibility

As per the Policy.

Limit of Cover

Sum Insured opted under the policy shall apply.

Policy Period

The policy period for the Policy, and the cover should be identical, as mentioned in the schedule.

Tax Rebate

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

Renewal

The cover can be renewed annually till Exclusion 4.1 applies on diabetes and/or hypertension, with respect to the insured person.

7.1.1 Condition

Claim Amount

Any amount payable shall be subject to the

i. Sum insured applicable to Section 1.2,
ii. Copayment mentioned under Section 5.3.7 (Treatment outside Zone), Section 5.3.8 (Treatment outside Network) and
iii. Sub limits mentioned below.

First year	Up to a maximum of 25% of sum insured
Second year	Up to a maximum of 50% of sum insured
Third year	Up to a maximum of 75% of sum insured

7.2 Out-patient Treatment

Subject to Exclusions 4.7, 4.8, 4.17, 4.16, 4.23, 4.12, 4.9, 4.10, 4.34 and 4.35, the Company shall pay up to the limit, as stated in the schedule with respect of

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

Eligibility

The cover can be availed by all family members as a floater.

Limit of Cover

Limit of cover, available under Out-patient Treatment are INR 2,000/ 3,000/ 4,000/ 5,000/ 10,000/ 15,000/ 20,000/ 25,000, in addition to the sum insured opted.

Policy Period

The policy period for the Policy, and the cover should be identical, as mentioned in the schedule.

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

Renewal
The Out-patient Treatment cover can be renewed annually throughout the lifetime of the insured person.

7.2.1 Exclusions
The Company shall not make any payment under the cover in respect of
i. Treatment other than Allopathy/ Modern medicine, Ayurveda and Homeopathy
ii. * Cosmetic dental treatment to straighten lightens, reshape and repair teeth.
* Cosmetic treatments include veneers, crowns, bridges, tooth-coloured fillings, implants and tooth whitening).

7.2.2 Condition
Claim Amount
i. Any amount payable will not affect the sum insured applicable to Section 1.2 and entitlement to No Claim Discount (Section 1.5.1).
ii. Any amount payable shall not be subject to copayment.

Claims Procedure
Documents supporting all out-patient treatments shall be submitted to the TPA/ Company twice during the policy period, within thirty days of completion of six month period.

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

Enhancement of Limit of Cover
Limit of cover can be enhanced only at the time of renewal.

7.3 Critical Illness
The Company shall pay the benefit amount, as stated in the schedule, provided that
i. the insured person is first diagnosed as suffering from a critical illness (as defined) during the policy period, and
ii. the insured person survives for at least thirty days following such diagnosis
iii. diagnosis of critical illness is supported by clinical, radiological, histological and laboratory evidence acceptable to the Company.

Eligibility (entry age)
The cover can be availed by persons between the age of eighteen years and sixty five years.

Benefit Amount
Benefit amount available under Critical Illness cover shall be limited to the 50% of the sum insured by the Policy.
Benefit amount available per individual are INR 2,00,000/ 3,00,000/ 5,00,000/ 10,00,000/ 15,00,000/ 20,00,000/ 25,00,000, in addition to the sum insured opted.

Policy Period
The policy period for the Policy, and the cover should be identical, as mentioned in the schedule.

Pre Policy Checkup
Pre Policy checkup reports (as per Section 2.8.iii) are required for individual opting for Critical illness cover between the age of eighteen years and sixty five years.

Tax Rebate
No tax benefit is allowed on the premium paid under Critical Illness cover (if opted)

Renewal
The Critical Illness cover can be renewed annually throughout the lifetime of the insured person.

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

I Stroke Resulting in Permanent Symptoms

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

The following are not covered

i. transient ischemic attacks (TIA)
ii. traumatic injury of the brain
iii. vascular disease affecting only the eye or optic nerve or vestibular functions.

II Cancer of Specified Severity

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

The following are not covered

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

III Kidney Failure Requiring Regular Dialysis

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

IV Major Organ/ Bone Marrow Transplant

The actual undergoing of a transplant of:

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

The following are not covered

i. other stem-cell transplants
ii. where only islets of langerhans are transplanted

V Multiple Sclerosis with Persisting Symptoms

The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

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

The following are not covered

Other causes of neurological damage such as SLE (Systemic Lupus Erythematosus) and HIV (Human Immunodeficiency Virus).

VI Open Chest CABG

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

The following are not covered

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

VII Permanent Paralysis of Limbs

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

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

7.3.2 Exclusions
The Company shall not be liable to make any payment by the Policy if, any critical illness and/or its symptoms (and/or the treatment) which were present at any time before inception of the first Policy, or which manifest within a period of ninety days from inception of the first Policy, whether or not the insured person had knowledge that the symptoms or treatment were related to such critical illness. In the event of break in the Policy, the terms of this exclusion shall apply as new from recommencement of cover

7.3.3 Condition
Claim Amount

i. Any amount payable under the optional covers will not affect the sum insured applicable to Section 1.2 and entitlement to No Claim Discount (Section 1.5.1).
ii. Any amount payable shall not be subject to copayment.

Notification of Claim
In the event of a claim, the insured person/insured person's representative shall intimate the Company in writing, providing all relevant information within fifteen days of diagnosis of the illness.

Claims Procedure
Documents as mentioned above, supporting the diagnosis shall be submitted to the Company within sixty days from the date of diagnosis of the critical illness.

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

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

Enhancement of Benefit Amount

i. Benefit amount can be enhanced only at the time of renewal.
ii. Benefit amount can be enhanced to the next slab subject to discretion of the Company.

8 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**

Table of Benefits

Features	Plans		
	PLAN A	**PLAN B**	**PLAN C**
Sum insured (SI) (as Floater)	**INR 6/ 7/ 8/ 9 /10 Lac**	**INR 15/ 20 /25 Lac**	**INR 30/ 40/ 50 Lac**
Treatment	Allopathy, Ayurveda and Homeopathy		
In built Covers (subject to the SI)			
In patient Treatment (as Floater)	Up to SI	Up to SI	Up to SI
Pre Hospitalisation	30 days	30 days	30 days
Post Hospitalisation	60 days	60 days	60 days
Pre-existing Disease (Only PEDs declared in the Proposal Form and accepted for coverage by the Company shall be covered)	Covered after 36 months of continuous coverage	Covered after 36 months of continuous coverage	Covered after 36 months of continuous coverage
* Room/ ICU Charges (per day per insured person)	Room - Up to 1% of SI or actual, whichever is lower ICU – Up to 2% of SI or actual, whichever is lower	Actual	Actual
** Limit for Cataract Surgery (For each eye per insured person)	Up to 15% of SI or INR 60,000 whichever is lower	Actual	Actual
Domiciliary Hospitalisation (as Floater)	Up to INR 1,00,000	Up to INR 2,00,000	Up to INR 2,00,000
Day Care Procedures (as Floater)	Up to SI	Up to SI	Up to SI
Ayurveda and Homeopathy (as Floater)	Up to SI	Up to SI	Up to SI
Organ Donor's Medical Expenses (as Floater)	Hospitalisation, pre and post hospitalisation	Hospitalisation, pre and post hospitalisation	Hospitalisation, pre and post hospitalisation
Hospital Cash (per insured person, per day)	INR 500, max. of 5 days	INR 1,000, max. of 5 days	INR 2,000, max. of 5 days
Ambulance (per insured person, in a policy year)	Up to INR 2,500	Up to INR 4,000	Up to INR 5,000
Air Ambulance (per insured person, in a policy year)	Not covered	Up to 5% of SI	Up to 5% of SI
Medical Emergency Reunion (per insured person, in a policy year)	Not covered	No sublimit	No sublimit
Doctor's Home Visit and Nursing Care during Post Hospitalisation (per insured person, in a policy year)	Not covered	INR 1,000 per day, max. of 10 days	INR 2,000 per day, max. of 10 days
Anti Rabies Vaccination (per insured person, in a policy year)	Up to INR 5,000	Up to INR 5,000	Up to INR 5,000
Maternity (including Baby from Birth Cover) (per insured person, in a policy year, waiting period of 2 years applies)	Up to INR 30,000 for normal delivery and INR 50,000 for caesarean section	Actual	Actual
Vaccination for New Born Baby	As part of Maternity	As part of Maternity	As part of Maternity
Infertility (per insured person, in a policy year, waiting period of 2 years applies)	Up to INR 50,000	Up to INR 1,00,000	Up to INR 1,00,000
Vaccination for Children, for male child up to 12 years and female child up to 14 years (per insured person, in a policy year, waiting period of 2 years applies)	Up to INR 1,000	Actual	Actual
Modern Treatment (12 nos)	Up to 25% of SI for each treatment	Up to 25% of SI for each treatment	Up to 25% of SI for each treatment
Treatment due to participation in hazardous or adventure sports (non-professionals)	Up to 25% of SI	Up to 25% of SI	Up to 25% of SI
Morbid Obesity	Covered after waiting period of 4 years	Covered after waiting period of 4 years	Covered after waiting period of 4 years
Refractive Error (min 7.5D)	Covered after waiting period of 2 years	Covered after waiting period of 2 years	Covered after waiting period of 2 years
Other benefits			
Medical Second Opinion (MSO) (for 160 major illness)	Up to two MSO per family for each new diagnosis of any of the major illnesses in Appendix II, in a policy year	Up to two MSO per family for each new diagnosis of any of the major illnesses in Appendix II, in a policy year	Up to two MSO per family for each new diagnosis of any of the major illnesses in Appendix II, in a policy year
Reinstatement of sum insured due to road traffic accident	Yes	Yes	Yes
Good Health Incentives			
No Claim Discount	5% discount on base premium,		
Health Check Up (as Floater)	Every 2 yrs., up to INR 5,000 irrespective of claims	Every 2 yrs., up to INR 7,500 irrespective of claims	Every 2 yrs., up to INR 10,000 irrespective of claims
Optional covers			
Pre-existing Diabetes/Hypertension (as Floater)	First year	Up to a maximum of 25% of SI	
	Second year	Up to a maximum of 50% of SI	
	Third year	Up to a maximum of 75% of SI	
Out-patient Treatment (as Floater in a policy year)	Limit of cover per family - INR 2,000/ 3,000/ 4,000/ 5,000/ 10,000/ 15,000/ 20,000/ 25,000 in addition to the SI		
***Critical Illness (per insured person in a policy year)	Benefit amount - INR 2,00,000/ 3,00,000/ 5,00,000/ 10,00,000/ 15,00,000/ 20,00,000/ 25,00,000 in addition to the SI		

***** The limit shall not apply if the treatment is undergone for a listed procedure in a Preferred Provider Network (PPN) as a package.
****** The limit shall not apply if the treatment is undergone for a listed procedure in a Preferred Provider Network (PPN) as a package
*** Critical Illness benefit amount should not be more than the sum insured opted under the Policy

Rate chart (in ₹)

Rate for senior most member (without TPA) for each policy year for Zone I (Greater Mumbai Metropolitan area, entire state of Gujarat**)**

SI	3m - 5	6 - 17	18 - 25	26-35	36-45	46-55	56-59	60-65	66-70	71-75	76-80	81-85	86 +
6,00,000	Only dependents		9,358	10,327	14,201	20,321	22,385	29,908	35,600	56,408	64,904	74,377	81,264
7,00,000			10,242	11,480	15,479	23,042	25,386	32,212	38,344	61,867	72,664	84,050	92,508
8,00,000			11,102	12,685	16,826	24,686	26,237	33,872	40,653	65,505	80,252	98,009	1,07,909
9,00,000			11,866	13,962	18,005	26,189	28,051	38,354	43,807	68,567	87,449	1,12,997	1,24,445
10,00,000			12,605	14,828	19,877	27,787	30,247	41,011	47,191	71,078	94,429	1,29,111	1,40,926
15,00,000			18,548	23,687	30,768	40,401	45,468	57,138	65,781	94,834	1,27,653	1,65,313	1,80,312
20,00,000			22,061	28,655	38,073	48,526	56,804	65,127	74,023	1,11,304	1,48,202	1,83,028	1,99,707
25,00,000			26,808	35,380	44,544	56,160	68,371	77,397	83,825	1,30,380	1,56,493	1,94,202	2,11,944
30,00,000			34,016	41,964	49,896	63,789	78,796	90,385	92,146	1,43,517	1,60,370	2,00,115	2,18,386
40,00,000			40,360	50,145	57,293	76,094	94,428	1,09,136	1,23,167	1,71,365	1,73,656	2,09,313	2,28,464
50,00,000			44,439	54,897	63,078	86,997	1,06,513	1,22,668	1,43,807	1,90,961	2,00,808	2,25,081	2,45,737

Service charge extra

Rate for family members (without TPA) for each policy year for Zone I (Greater Mumbai Metropolitan area, entire state of Gujarat**)**

SI	3m - 5	6 - 17	18 - 25	26-35	36-45	46-55	56-59	60-65	66-70	71-75	76-80	81-85	86 +
6,00,000	974	1,072	1,523	1,749	3,451	7,083	9,014	14,954	18,480	30,400	36,314	43,203	52,821
7,00,000	1,048	1,150	1,666	1,945	3,762	8,033	10,223	16,106	19,904	33,342	40,656	48,822	60,130
8,00,000	1,119	1,226	1,806	2,149	4,089	8,605	10,566	16,935	21,103	35,302	44,901	56,931	70,140
9,00,000	1,183	1,294	1,931	2,366	4,375	9,129	11,296	19,177	22,740	36,953	48,928	65,637	80,890
10,00,000	1,246	1,360	2,051	2,513	4,831	9,686	12,181	20,505	24,497	38,305	52,833	74,997	91,602
15,00,000	1,849	1,998	3,018	4,013	7,477	14,084	18,310	28,568	34,147	51,108	71,422	96,026	1,17,203
20,00,000	2,094	2,262	3,589	4,855	9,253	16,916	22,874	32,564	38,425	59,984	82,920	1,06,316	1,29,809
25,00,000	2,464	2,666	4,362	5,994	10,826	19,577	27,533	38,698	43,513	70,265	87,558	1,12,807	1,37,763
30,00,000	3,120	3,376	5,535	7,111	12,126	22,236	31,731	45,192	47,833	77,344	89,728	1,16,241	1,41,952
40,00,000	4,309	4,659	6,567	8,497	13,924	26,525	38,026	54,569	63,936	92,353	97,162	1,21,585	1,48,502
50,00,000	4,593	4,916	7,230	9,302	15,330	30,326	42,893	61,334	74,650	1,02,914	1,12,353	1,30,743	1,59,729

Service charge extra

Rate for senior most member (with TPA) for each policy year for Zone I (Greater Mumbai Metropolitan area, entire state of Gujarat**)**

SI	3m - 5	6 - 17	18 - 25	26-35	36-45	46-55	56-59	60-65	66-70	71-75	76-80	81-85	86 +
6,00,000	Only dependents		9,919	10,947	15,053	21,540	23,728	31,703	37,736	59,793	68,798	78,839	86,140
7,00,000			10,856	12,168	16,407	24,424	26,909	34,145	40,644	65,579	77,024	89,094	98,058
8,00,000			11,767	13,446	17,835	26,167	27,811	35,905	43,092	69,435	85,067	1,03,889	1,14,383
9,00,000			12,578	14,800	19,086	27,760	29,734	40,656	46,435	72,681	92,696	1,19,777	1,31,913
10,00,000			13,362	15,717	21,069	29,455	32,063	43,472	50,023	75,343	1,00,094	1,36,858	1,49,381
15,00,000			19,660	25,108	32,614	42,825	48,197	60,566	69,728	1,00,524	1,35,311	1,75,231	1,91,132
20,00,000			23,384	30,373	40,357	51,437	60,212	69,034	78,464	1,17,983	1,57,095	1,94,010	2,11,689
25,00,000			28,416	37,503	47,217	59,530	72,473	82,040	88,854	1,38,203	1,65,883	2,05,855	2,24,660
30,00,000			36,057	44,482	52,890	67,616	83,524	95,808	97,675	1,52,128	1,69,992	2,12,122	2,31,490
40,00,000			42,782	53,153	60,731	80,660	1,00,093	1,15,684	1,30,557	1,81,648	1,84,076	2,21,872	2,42,172
50,00,000			47,105	58,191	66,862	92,216	1,12,904	1,30,029	1,52,436	2,02,419	2,12,857	2,38,585	2,60,481

Service charge extra

Rate for family members (with TPA) for each policy year for Zone I (Greater Mumbai Metropolitan area, entire state of Gujarat**)**

SI	3m - 5	6 - 17	18 - 25	26-35	36-45	46-55	56-59	60-65	66-70	71-75	76-80	81-85	86 +
6,00,000	1,033	1,136	1,614	1,854	3,658	7,509	9,555	15,851	19,589	32,223	38,493	45,796	55,991
7,00,000	1,111	1,219	1,766	2,062	3,988	8,514	10,836	17,073	21,099	35,342	43,095	51,751	63,738
8,00,000	1,187	1,300	1,914	2,279	4,334	9,121	11,199	17,952	22,369	37,420	47,594	60,347	74,348
9,00,000	1,255	1,371	2,046	2,507	4,638	9,677	11,973	20,328	24,105	39,169	51,864	69,575	85,743
10,00,000	1,321	1,441	2,174	2,663	5,121	10,268	12,912	21,736	25,967	40,604	56,003	79,497	97,098
15,00,000	1,960	2,118	3,198	4,255	7,926	14,929	19,408	30,283	36,196	54,175	75,707	1,01,787	1,24,235
20,00,000	2,219	2,397	3,804	5,146	9,808	17,931	24,248	34,518	40,731	63,584	87,896	1,12,694	1,37,598
25,00,000	2,612	2,826	4,623	6,355	11,475	20,751	29,185	41,020	46,124	74,481	92,812	1,19,575	1,46,029
30,00,000	3,306	3,578	5,866	7,537	12,854	23,570	33,635	47,904	50,702	81,985	95,111	1,23,215	1,50,468
40,00,000	4,568	4,938	6,960	9,006	14,760	28,117	40,307	57,842	67,772	97,894	1,02,991	1,28,879	1,57,412
50,00,000	4,868	5,210	7,664	9,860	16,250	32,146	45,466	65,014	79,129	1,09,088	1,19,094	1,38,587	1,69,313

Service charge extra

Discount in premium for other zones

Zone	Region	Discount
II	National Capital Territory (NCT) Delhi and National Capital Region (# NCR), Chandigarh, Pune	4.44%
III	Chennai, Hyderabad, Bangalore, Kolkata	11.11%
IV	Rest of India	20.00%

 # NCR includes Gurgaon-Manesar, Alwar-Bhiwadi, Faridabad-Ballabgarh, Ghaziabad-Loni, Noida, Greater Noida, Bahadurgarh, Sonepat-Kundli Charkhi Dadri, Bhiwani, Narnaul

Optional cover

Rate for Critical Illness (rates per individual in ₹)

Age	2,00,000	3,00,000	5,00,000	10,00,000	15,00,000	20,00,000	25,00,000
18-25	372	557	929	1,858	2,786	3,715	4,644
26-35	647	970	1,617	3,234	4,851	6,468	8,085
36-45	1,198	1,796	2,994	5,988	8,981	11,975	14,969
46-55	2,217	3,326	5,543	11,086	16,629	22,172	27,715
56-59	3,209	4,813	8,022	16,043	24,065	32,086	40,108
60-65	4,643	6,965	11,608	23,217	34,825	46,434	58,042
66-75	9,501	14,251	23,752	47,505	71,257	95,009	1,18,762
76-85	21,109	31,664	52,773	1,05,546	1,58,319	2,11,093	2,63,866
86+	47,155	70,733	1,17,889	2,35,777	3,53,666	4,71,555	5,89,443

Service Tax extra Note: Critical Illness Benefit Amount should not be more than the sum insured opted under the Policy

Rate for Outpatient Treatment (rates per family in ₹)

Cover	2,000	3,000	4,000	5,000	10,000	15,000	20,000	25,000
Premium	1,200	1,800	2,400	3,000	6,000	9,000	12,000	15,000

Service Tax extra

Rate for Pre-existing diabetes / hypertension

Cover	Policy year	Claim payable (irrespective of Plan opted)	Loading on base premium (irrespective of Plan opted)
Pre-existing diabetes or Hypertension	Year one	Up to 25% of SI	6%
	Year two	Up to 50% of SI	12%
	Year three	Up to 75% of SI	18%
Pre-existing diabetes and Hypertension	Year one	Up to 25% of SI	14%
	Year two	Up to 50% of SI	28%
	Year three	Up to 75% of SI	42%

Service tax extra. Loading applicable on rates with/ without TPA, as opted by insured

Discounts

No Claim Discount – 5% on base premium for each claim free Policy Year (aggregated for each year and available on renewal)

Online discount 5% on base premium for new policy, 2.5% on base premium for renewal

Discount in Lieu of no Maternity/ Infertility cover for individuals above forty five years - 3% on individual premium

Above discounts will not apply on premium for Optional Covers

Long term discount

Policy with a term of two policy years - 4% on the total premium for two years (including premium for optional covers)

Policy with a term of three policy years- 7.5% on the total premium for three years (including premium for optional covers)

Copayment

Plan	A	B	C
Treatment outside zone **e. Insured paying premium as per Zone I can avail treatment in Zone I, Zone II, Zone III and Zone IV without copayment** **f. Insured paying premium as per Zone II** **a. Can avail treatment in Zone II, Zone III and Zone IV without any copayment** **b. Availing treatment in Zone I will be subject to a copayment of 5%** **g. Insured paying premium as per Zone III** **a. Can avail treatment in Zone III and Zone IV without any copayment** **b. Availing treatment in Zone I will be subject to a copayment of 12.5%** **c. Availing treatment in Zone II will be subject to a copayment of 7.5%** **h. Insured paying premium as per Zone IV** **a. Can avail treatment in Zone IV without any copayment** **b. Availing treatment in Zone I will be subject to a copayment of 22.5%** **c. Availing treatment in Zone II will be subject to a copayment of 17.5%** **d. Availing treatment in Zone III will be subject to a copayment of 10%**	**Copayment to apply**	**Copayment to apply**	**Copayment to apply**
Treatment outside network (10% for Policies with TPA Option)	**Copayment to apply**	**Copayment not to apply**	**Copayment not to apply**

Above copayments shall not be applicable on Critical illness & Outpatient treatment optional covers, but shall apply on Pre existing diabetes and/ or hypertension optional cover.

No loading shall apply on renewals based on individual claims experience

Insurance is the subject matter of solicitation

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

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

Appendix

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