

National Parivar Mediclaim Policy

PROSPECTUS

1.1 Product

National Parivar Mediclaim Policy is an indemnity 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 hospitalisation, reasonably and customarily incurred for treatment of a disease or an injury contracted/sustained during the policy period. The Policy also covers pre hospitalization and post hospitalization expenses, 140+ day care procedures/surgeries, organ donor's medical expenses, hospital cash, ambulance charges, anti rabies vaccination, maternity expenses, infertility expenses and medical second opinion. Pre-existing Diabetes and/or Hypertension, Outpatient Treatment and Critical Illness are provided as Optional Covers.

1.2 Coverage

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:

- 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
- Medical practitioner(s)
- Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances
- Medicines and drugs
- Diagnostic procedures
- Prosthetics and other devices or equipment if implanted internally during a surgical procedure.
- Dental treatment, necessitated due to an injury
- Plastic surgery, necessitated due to disease or injury
- Hormone replacement therapy, if medically necessary
- Vitamins and tonics, forming part of treatment for disease/injury as certified by the attending medical practitioner
- 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. The limit shall not apply if the treatment is undergone for a listed procedure in a Preferred Provider Network (PPN) as a package.

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. The limit shall not apply if the treatment is undergone for a listed procedure in a Preferred Provider Network (PPN) as a package.

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:

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

- such medical expenses are incurred for the same condition for which the insured person's hospitalisation was required, and
- the in-patient hospitalisation claim for such hospitalisation is admissible by 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 and post hospitalisation expenses, up to the limit mentioned in the Table of Benefits.

Exclusions

Domiciliary hospitalisation shall not cover:

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

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, 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. hospitalisation exceeds three days.
- ii. a claim has been admitted under In-patient Treatment

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 In-patient Treatment.

1.2.10 Anti Rabies Vaccination

The Company shall reimburse the insured the 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.

1.2.11 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 thirty six 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.

Baby from Birth Cover

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

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

Exclusions

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

1. Insured and insured persons above forty five years of age.
2. More than one delivery or termination in a policy year.
3. Surrogacy, unless claim is admitted under Infertility
4. Pre and post hospitalisation expenses, other than pre and post natal treatment.

1.2.12 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 thirty six 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 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 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.

1.2.13 HIV/ AIDS Cover

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

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

1.2.14 Mental Illness Cover

The Company shall indemnify the Hospital or the Insured the Medical Expenses for In-patient Care, Pre-Hospitalisation expenses and Post-Hospitalisation expenses, related to Mental Illnesses, provided the treatment shall be undertaken at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Psychiatrist 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.

1.2.15 Modern Treatment

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

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

1.2.16 Morbid Obesity Treatment

The Company shall indemnify the Hospital or the Insured the Medical Expenses for In-patient Care, Pre-Hospitalisation expenses and Post-Hospitalisation expenses, incurred for surgical treatment of obesity that fulfils **all** the following conditions and subject to Waiting Period of four (04) years as per Section 4.2.f.iv:

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

1.2.17 Correction of Refractive Error

The Company shall indemnify the Hospital or the Insured the Medical Expenses for In-patient Care, Pre-Hospitalisation expenses and Post-Hospitalisation expenses, incurred for expenses related to the treatment for correction of eye sight due to refractive error equal to or more than 7.5 dioptries, 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-I 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 1.2.17 are subject to the Sum Insured opted.

1.3 Medical Second Opinion

The Company shall arrange for a 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 period. One 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 does not assume 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.

1.4 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 with respect to the insured person(s), shall be reimbursed at the end of a block of four continuous policy years, provided claims are not reported during the block in respect of the insured person(s) and the Policy has been continuously renewed with the Company without a break. Expenses payable are subject to the limit as shown 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 at the same time.
- 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
- 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)

- i. The SI for each policy year ranges from ₹ 1,00,000 to ₹ 10,00,000, in multiple of ₹ 1,00,000.
- 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.

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. Person insured covered by any health insurance policy of any other non life insurance Company and wishing to port (switch) to National Parivar Mediclaim 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. fifty years and above or
 - b. 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 –

<ol style="list-style-type: none">a) Physical examination (report to be signed by the Doctor with minimum MD (Medicine) qualification)b) Blood sugar (fasting/ post prandial)c) Lipid profiled) Serum creatinine	<ol style="list-style-type: none">e) Urine routine and microscopic examinationf) ECGg) Eye checkup (including retinoscopy)h) Any other investigation required by the Company
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Note: 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 to the Company.
- 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)
 - o The Policy may be renewed by any insured person above eighteen years of age, as the insured
 - o Where 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
 - o The base premium to be charged shall be 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 Diagnosis means diagnosis by a medical practitioner, supported by clinical, radiological, histological and laboratory evidence, acceptable to the Company.

3.3 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.

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

3.5 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.

3.6 Hospitalisation means admission in a Hospital for a minimum period of twenty four consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four consecutive hours.

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

3.8 Outpatient 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 advice of a medical practitioner and the insured person is not admitted as a day care patient or in-patient.

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

3.10 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.

3.11 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.

3.12 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

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

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

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

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 forty eight (48) 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 forty eight (48) 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

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

iii. Two years waiting period

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

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.

Above diseases/treatments under 4.2.f).iv if pre-existing also, shall be covered after single Waiting Period of four (04) years only.

4.3. First 30 days waiting period (Excl 03)

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

4.4. Investigation & Evaluation (Excl 04)

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

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

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

- i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
- ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

4.6. Obesity/ Weight Control (Excl 06)

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

- 1) Surgery to be conducted is upon the advice of the Doctor
- 2) The surgery/Procedure conducted should be supported by clinical protocols
- 3) The member has to be 18 years of age or older and
- 4) Body Mass Index (BMI);
 - a. greater than or equal to 40 or
 - b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - i. Obesity-related cardiomyopathy
 - ii. Coronary heart disease
 - iii. Severe Sleep Apnea
 - iv. Uncontrolled Type2 Diabetes

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

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

4.8. Cosmetic or Plastic Surgery (Excl 08)

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

4.9. Hazardous or Adventure Sports (Excl 09)

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

4.10. Breach of Law (Excl 10)

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

4.11. Excluded Providers (Excl 11)

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

4.12. Drug/Alcohol Abuse (Excl 12)

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

4.13. Non Medical Admissions (Excl 13)

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

4.14. Vitamins, Tonics (Excl 14)

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

4.15. Refractive Error (Excl 15)

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.

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 Anti Rabies Vaccination and Maternity.

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 footwear, 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.

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.

5 Conditions

5.1 Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

5.2 Condition Precedent to Admission of Liability

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

5.3 Communication

- i. All communication should be made in writing.
- ii. For Policies serviced by TPA, ID card, 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.

5.4 Physical examination

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

5.5 Claim Procedure

5.5.1 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 hospitalisation	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 hospitalisation	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	At least twenty four hours prior to the vaccination

Note: For claim under Medical Second Opinion, notification of claim is not required.

5.5.2 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.

5.5.3 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.

5.5.3.1 Procedure for Reimbursement of Claim 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.

5.5.4 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 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 Maternity for surrogacy under Infertility in addition to documents listed above (as applicable), legal affidavit regarding intimation of surrogacy.
- ix. Any other document required by Company/TPA

Note

In the event of a claim lodged as per condition 5.9 and the original documents having been submitted to the other insurer, the Company may accept the documents listed under condition 5.5.4 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	Within fifteen days from date of discharge from hospital
Reimbursement of post hospitalisation expenses	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 and new born baby vaccination	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 fifth policy year.

5.5.5 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)

5.5.6 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.

5.5.7 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, Sonapat-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%

5.5.8 Treatment Outside Network

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.

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.

5.6 Moratorium Period

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

5.7 Payment of Claim

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

5.8 Territorial limit

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

5.9 Multiple Policies

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

- ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
- iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.
- iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

5.10 Fraud

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

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

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

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

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

5.11 Cancellation

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

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

- 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

5.12 Territorial Jurisdiction

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

5.13 Arbitration

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

5.14 Disclaimer

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

5.15 Renewal of Policy

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

- i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

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

5.16 Enhancement of Sum Insured

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

5.17 Adjustment of Premium for Overseas Travel Insurance Policy

If during the policy period any of the insured person is also covered by an Overseas Travel Insurance Policy of any 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.

5.18 Migration

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

5.19 Portability

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

5.20 Withdrawal of Product

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

5.21 Revision of Terms of the Policy Including the Premium Rates

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

5.22 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.

5.23 Nomination

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

6 Redressal of Grievance

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

Website: <https://nationalinsurance.nic.co.in/>

Toll free: 1800 345 0330

E-mail: customer.relations@nic.co.in

Phn : (033) 2283 1742

Post: National Insurance Co. Ltd.,

6A Middleton Street, 7th Floor,

CRM Dept.,

Kolkata - 700 071

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

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

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

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

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

7 Optional Covers

Pre-existing diabetes/ hypertension, Outpatient 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 forty eight months of insurance, the additional premium and co-payment shall not apply.

Copayment

Claims shall be subject to a co payment on admissible claim amount as mentioned below

- i. Insured opting for cover for pre existing diabetes, can avail treatment for diabetes, subject to a copayment of 10%
- ii. Insured opting for cover for pre existing hypertension, can avail treatment for hypertension, subject to a copayment of 10%
- iii. Insured opting for cover for pre existing diabetes and hypertension, can avail treatment for diabetes or hypertension, subject to a copayment of 25%

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 persons.

7.1.1 Condition

Claim Amount

Any amount payable shall be subject to the sum insured applicable to Section 1.2, copayment mentioned under Section 5.5.7 (Treatment outside Zone), Section 5.5.8 (Treatment outside Network) and copayment mentioned above

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 insured persons as a floater.

Limit of Cover

Limit of cover, available under Outpatient Treatment are INR 2,000/ 3,000/ 4,000/ 5,000/ 10,000, 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 Outpatient 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 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) and Health Check up (Section 1.5.2).
- 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 is to be supported with the following original documents

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

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 per individual are INR 2,00,000/ 3,00,000/ 5,00,000/ 10,00,000, 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 lymphocytic 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 6 months, and
- iii. well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with at least two clinically documented episodes at least one month apart.

The following are not covered

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

VI Open Chest CABG

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

The following are not covered

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

VII Permanent Paralysis of Limbs

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 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) and Health Check up (Section 1.5.2).
- 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 by letter, e-mail, fax providing all relevant information relating to the critical illness within fifteen days of diagnosis of the critical 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	Benefit
Sum insured (SI) (as Floater)	INR 1/ 2/ 3/ 4/ /5/ 6/ 7/ 8/ /9 10Lac
Treatment	Allopathy, Ayurveda and Homeopathy
In built Covers (subject to the SI)	
In patient Treatment (as Floater)	Up to SI
Pre Hospitalisation	30 days
Post Hospitalisation	60 days
Pre-existing Disease (Only PEDs declared in the Proposal Form and accepted for coverage by the Company shall be covered)	Covered after 48 months
* 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
** Limit for Cataract Surgery (For each eye per insured person)	Up to 10% of SI or INR 50,000 whichever is lower
Domiciliary Hospitalisation (as Floater)	Up to 20% of SI, subject to maximum of INR 50,000
Day Care Procedures (as Floater)	Up to SI
Ayurveda and Homeopathy (as Floater)	Up to SI
Organ Donor's Medical Expenses (as Floater)	Hospitalisation, pre and post hospitalisation
Hospital Cash (per insured person, per day)	INR 300, max. of 5 days
Ambulance (per insured person, in a policy year)	Up to INR 1,000/- per illness & INR 2,500/-
Anti rabies Vaccination (per insured person, in a policy year)	Up to INR 5,000
Maternity (including Baby from Birth Cover) (per insured person, in a policy year, waiting period of 3 years applies)	Up to 10% of SI subject to INR 30,000 in case of normal delivery and INR 50,000 in case of caesarean section
Infertility (per insured person, in a policy year, waiting period of 3 years applies)	Up to INR 50,000
Modern Treatment (12 nos)	Up to 25% of SI for each treatment
Treatment due to participation in hazardous or adventure sports (non-professionals)	Up to 25% of SI
Morbid Obesity	Covered after waiting period of 4 years
Refractive Error (min 7.5D)	Covered after waiting period of 2 years
Other benefits	
Medical Second Opinion (MSO) (for 88 major illness)	One MSO per family in a policy year
Good Health Incentives	
No Claim Discount	5% discount on base premium
Health Check Up (as Floater)	Every 4 yrs., up to INR 5,000
Optional Cover	
Pre-existing Diabetes/Hypertension (as Floater)	Up to the 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 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 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 family 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 +
1,00,000	Only dependents		3,618	3,966	4,920	7,250	9,240	10,306	11,870	13,798	14,577	15,902	20,311
2,00,000			4,859	5,005	6,863	11,043	14,023	16,420	20,052	22,899	24,992	27,584	29,144
3,00,000			5,885	6,062	8,461	12,626	16,538	18,932	22,338	30,984	34,843	38,849	41,444
4,00,000			6,608	7,091	9,842	14,980	17,967	22,051	26,492	38,512	44,086	49,660	53,491
5,00,000			7,257	7,932	11,147	16,783	19,026	24,577	29,957	46,220	52,811	60,080	65,243
6,00,000			7,852	8,778	12,489	18,338	20,311	27,579	33,020	52,911	61,031	70,085	76,672
7,00,000			8,470	9,654	13,484	20,713	22,954	29,572	35,433	57,918	68,238	79,122	87,213
8,00,000			9,067	10,580	14,546	22,058	23,542	30,949	37,430	61,186	75,281	92,257	1,01,727
9,00,000			9,571	11,575	15,448	23,270	25,050	35,024	40,236	63,903	81,955	1,06,377	1,17,329
10,00,000			10,053	12,177	17,011	24,572	26,924	37,354	43,261	66,093	88,421	1,21,575	1,32,878

GST extra

Rate for other 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 +
1,00,000	464	526	589	672	1,196	2,527	3,721	5,153	6,161	7,436	8,156	9,237	13,202
2,00,000	567	637	791	848	1,667	3,849	5,647	8,210	10,409	12,341	13,983	16,022	18,943
3,00,000	650	727	958	1,027	2,056	4,402	6,660	9,466	11,595	16,698	19,494	22,567	26,938
4,00,000	694	775	1,075	1,201	2,392	5,222	7,236	11,026	13,752	20,755	24,667	28,847	34,770
5,00,000	733	816	1,180	1,344	2,709	5,851	7,662	12,289	15,551	24,909	29,548	34,899	42,407
6,00,000	768	853	1,278	1,487	3,036	6,392	8,180	13,790	17,141	28,515	34,147	40,711	49,836
7,00,000	804	891	1,378	1,636	3,277	7,221	9,243	14,786	18,393	31,213	38,180	45,960	56,688
8,00,000	838	928	1,475	1,792	3,535	7,689	9,480	15,475	19,430	32,974	42,120	53,590	66,123
9,00,000	866	958	1,557	1,961	3,754	8,111	10,087	17,512	20,887	34,439	45,854	61,791	76,264
10,00,000	891	985	1,636	2,063	4,134	8,566	10,842	18,676	22,456	35,619	49,472	70,620	86,370

GST extra

Rate for senior most family 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 +
1,00,000	Only dependents		3,835	4,204	5,215	7,685	9,794	10,924	12,582	14,627	15,452	16,856	21,529
2,00,000			5,150	5,305	7,274	11,705	14,864	17,405	21,255	24,274	26,492	29,238	30,892
3,00,000			6,239	6,426	8,969	13,383	17,530	20,067	23,678	32,843	36,934	41,180	43,930
4,00,000			7,005	7,516	10,432	15,879	19,045	23,374	28,081	40,823	46,731	52,640	56,701
5,00,000			7,691	8,407	11,816	17,790	20,168	26,053	31,753	48,993	55,979	63,685	69,157
6,00,000			8,322	9,305	13,237	19,439	21,529	29,234	35,002	56,085	64,693	74,291	81,272
7,00,000			8,979	10,233	14,294	21,957	24,332	31,347	37,560	61,392	72,333	83,869	92,445
8,00,000			9,611	11,215	15,419	23,382	24,955	32,806	39,676	64,856	79,798	97,793	1,07,831
9,00,000			10,145	12,269	16,375	24,666	26,552	37,125	42,650	67,738	86,872	1,12,760	1,24,368
10,00,000			10,655	12,907	18,032	26,046	28,539	39,594	45,857	70,059	93,725	1,28,870	1,40,850

GST extra

Rate for other 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 +
1,00,000	492	558	624	712	1,267	2,679	3,944	5,462	6,531	7,882	8,646	9,791	13,994
2,00,000	602	676	838	899	1,768	4,080	5,986	8,702	11,033	13,082	14,822	16,984	20,080
3,00,000	689	771	1,015	1,089	2,180	4,665	7,059	10,034	12,291	17,700	20,664	23,920	28,555
4,00,000	736	821	1,139	1,274	2,536	5,536	7,669	11,688	14,577	22,001	26,146	30,577	36,855
5,00,000	777	865	1,252	1,425	2,872	6,201	8,122	13,026	16,483	26,403	31,320	36,993	44,953
6,00,000	814	904	1,355	1,576	3,217	6,776	8,670	14,617	18,169	30,225	36,196	43,153	52,827
7,00,000	852	945	1,461	1,734	3,473	7,653	9,799	15,673	19,496	33,086	40,470	48,717	60,089
8,00,000	888	984	1,563	1,901	3,747	8,151	10,050	16,403	20,596	34,952	44,647	56,805	70,090
9,00,000	918	1,015	1,651	2,079	3,980	8,598	10,692	18,563	22,139	36,505	48,606	65,499	80,840
10,00,000	945	1,044	1,734	2,187	4,382	9,079	11,492	19,798	23,804	37,756	52,440	74,857	91,553

GST 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, Sonapat-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
18-25	372	557	929	1,858
26-35	647	970	1,617	3,234
36-45	1,198	1,796	2,994	5,988
46-55	2,217	3,326	5,543	11,086
56-59	3,209	4,813	8,022	16,043
60-65	4,643	6,965	11,608	23,217
66-75	9,501	14,251	23,752	47,505
76-85	21,109	31,664	52,773	1,05,546
86+	47,155	70,733	1,17,889	2,35,777

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
Premium	1,200	1,800	2,400	3,000	6,000

Service Tax extra

Rate for Pre-existing diabetes / hypertension

Cover	Loading on base premium	Copayment
Pre-existing diabetes or Hypertension	13.5% loading on base premium	10% copayment on admissible claim amount for diabetes or hypertension claims
Pre-existing diabetes and Hypertension	30% loading on base premium	25% copayment on admissible claim amount for diabetes or hypertension claims

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

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%

Treatment outside network (10% for Policies with TPA Option)

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

Non-Cancerous Diseases			
1	AIDS/HIV	46	Poliomyelitis
2	Amyotrophic Lateral Sclerosis	47	Primary Lateral Sclerosis (PLS)
3	Angioplasty	48	Primary Pulmonary Arterial Hypertension
4	Aortic Aneurysm	49	Progressive Muscular Atrophy (PMA)
5	Apallic Syndrome (Vegetative State)	50	Progressive Scleroderma
6	Aplastic Anaemia	51	Pulmonary Arterial Hypertension
7	Benign Brain Tumor	52	Renal Failure = Kidney failure: see above
8	Blindness	53	(Severe) Asthma
9	Bone Marrow Transplantation	54	Severe Brain Damage
10	Cardiomyopathy	55	(Severe) Rheumatoid Arthritis
11	Cerebrovascular Diseases	56	Stroke
12	Chronic Obstructive Pulmonary Disease	57	Surgery to Aorta
13	Chronic Relapsing Pancreatitis	58	Systemic Lupus Erythematosus
14	Cirrhosis	59	Ulcerative Colitis
15	Coma		Cancerous Diseases
16	Congenital Heart Defect	60	Bladder Cancer
17	Coronary Artery Bypass Surgery	61	Bone Cancer
18	Coronary Artery Disease (CAD)	62	Brain Tumor
19	Creutzfeldt -Jacob Disease (CJD)	63	Breast Cancer
20	Cystic Fibrosis (CF)	64	Cervical Cancer
21	Elephantiasis	65	Colorectal Cancer
22	Emphysema	66	Esophageal Cancer
23	(End Stage) Liver Disease	67	Eye Cancer
24	(End Stage) Lung Disease	68	Gallbladder Cancer
25	(Fulminant) Viral Hepatitis	69	Kidney Cancer
26	Heart Valve Surgery	70	Leukemia
27	HIV Infection Due to Blood Transfusion	71	Liver Cancer
28	Kidney Failure	72	Lung Cancer
29	Liver Failure	73	Lymphoma
30	Valvular Heart Disease	74	Melanoma
31	Loss of Hearing	75	Multiple Myeloma
32	Loss of Limbs	76	Nasopharyngeal Cancer
33	Loss of Speech	77	Neuroblastoma
34	Major Burns	78	Non-Hodgkin's Lymphoma
35	Major Organ Transplantation	79	Oral Cavity Cancer
36	Medullary Cystic Disease	80	Ovarian Cancer
37	Motor Neuron Disease	81	Pancreatic Cancer
38	Multiple Sclerosis	82	Prostate Cancer
39	Muscular Dystrophy	83	Skin Cancer, non-Melanoma
40	Myasthenia Gravis	84	Stomach Cancer
41	Myelodysplastic Syndrome (Myelodysplasia)	85	Testicular Cancer
42	Myocardial Infarction (MI)	86	Thyroid Cancer
43	Necrotizing Fasciitis (Flesh Eating Disease)	87	Uterine Cancer
44	Paralysis	88	Vaginal Cancer
45	Parkinson's Disease (PD)		