National Insurance Company Limited
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CIN - U10200WB1906GOI001713 IRDA Regn. No. - 58

National Parivar Mediclaim Policy

PROSPECTUS

1.1 Product

National Parivar Mediclaim Policy is a floater health insurance, covering the members of a family under a single sum insured. The Policy covers expenses in respect of inpatient treatment (allopathy, ayurveda and homeopathy), domiciliary hospitalisaion, reasonably and customarily incurred for treatment of a disease or an injury contracted/sustained during the policy period. The Policy also covers pre 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:

i. Room charges and intensive care unit charges (including diet charges, nursing care by qualified nurse, RMO charges, administration charges for IV fluids/blood transfusion/injection), subject to limit as mentioned in Section 1.2.1.1
ii. Medical practitioner(s)
iii. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances
iv. Medicines and drugs
v. Diagnostic procedures
vi. Prosthetics and other devices or equipment if implanted internally during a surgical procedure.
vii. Dental treatment, necessitated due to an injury
viii. Plastic surgery, necessitated due to disease or injury
ix. Hormone replacement therapy, if medically necessary
x. Vitamins and tonics, forming part of treatment for disease/injury as certified by the attending medical practitioner
xi. Circumcision, necessitated for treatment of a disease or injury

1.2.1.1 Limit for Room Charges and Intensive Care Unit Charges

Room charges and intensive care unit charges payable shall be up to the limit as shown in the Table of Benefits. 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.

1.2.2 Pre Hospitalisation

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

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

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

1.2.3 Post Hospitalisation

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

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

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

1.2.4 Domiciliary Hospitalisation

The Company shall reimburse the insured the medical expenses incurred under domiciliary hospitalisation up to the limit mentioned in the Table of Benefits.

Exclusions
Domiciliary hospitalisation shall not cover:

i. Treatment of less than three days
ii. Expenses incurred for pre and post hospitalisation
iii. Expenses incurred for alternative treatment
iv. Expenses incurred for maternity or infertility

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

1.2.5 Day Care Procedure

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

i. day care procedures/surgeries 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 a government hospital or in an institute recognized by the government and/or accredited by Quality Council of India/ National Accreditation Board for Health.

1.2.7 Organ Donor's Medical Expenses

The Company shall pay to the hospital or reimburse the insured the expenses of hospitalisation of the organ donor up to the sum insured, during the course of organ transplant to the insured person provided

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

Exclusions

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

1. Cost of the organ to be transplanted.
2. Pre and post hospitalisation expenses, as per Section 1.2.2 and Section 1.2.3, incurred by the organ donor unless the organ donor is an insured person.
3. Any other medical treatment or complication in respect of the donor, consequent to harvesting

1.2.8 Hospital Cash

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

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

Illustration

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

1.2.9 Ambulance

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

1.2.10 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 (as listed in Appendix III). Hospitalisation is not required for vaccination.

Note: Ectopic pregnancy is covered under Section 1.2.1 'In-patient treatment', provided such pregnancy is established by medical reports.

Exclusions

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

1. Insured and insured persons above forty five years of age.
2. More than one delivery or termination in a policy year.
3. Surrogacy, unless claim is admitted under Section 1.2.12 (Infertility)
4. Pre and post hospitalisation expenses as per Section 1.2.2 and Section 1.2.3, other than pre and post natal treatment.

1.2.12 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 Section 1.2.11 (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.

Note

Aggregate of all the benefits under 1.2.1 to 1.2.12 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 INR1,00,000 to INR10,00,000, in multiple of INR1,00,000.
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 –
   a) Physical examination (report to be signed by the Doctor with minimum MD (Medicine) qualification)
   b) Blood sugar (fasting/ post prandial)
   c) Lipid profile
   d) Serum creatinine
   e) Urine routine and microscopic examination
   f) ECG
   g) Eye checkup (including retinoscopy)
   h) Any other investigation required by the Company

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

2.9 Payment of Premium

i. 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)
    - The Policy may be renewed by any insured person above eighteen years of age, as the insured
    - Where only children (less than eighteen years of age) are covered, the Policy shall be allowed till the expiry of the policy period. The grandparents may be allowed to renew the Policy as insured, covering the grandchildren.
vii. In case of death of the eldest insured person
    - The base premium 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 advise 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, disease or injury or related conditions for which the insured person had signs or symptoms and/or was diagnosed and/or received medical advice/treatment within forty eight months prior to the Policy.

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

4 Exclusions

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

4.1 Pre-existing Diseases

All pre-existing diseases. Such diseases shall be covered after the Policy has been continuously in force for forty eight months. Any complication arising from pre-existing diseases shall be considered as a part of the pre-existing disease.

For persons suffering from either hypertension or diabetes or both at the inception of the Policy, the following exclusions shall apply

Diabetes	Hypertension	Diabetes and Hypertension
Diabetic Retinopathy	Coronary Artery Disease	Diabetic Retinopathy
Diabetic Nephropathy	Cerebro Vascular Accident	Diabetic Nephropathy
Diabetic Foot/wound	Hypertensive Nephropathy	Diabetic Foot/wound
Diabetic Angiopathy	Internal Bleeding/ Haemorrhage	Diabetic Angiopathy
Diabetic Neuropathy		Diabetic Neuropathy
Hyper/Hypoglycemic shock		Hyper/Hypoglycemic shock
Coronary Artery Disease		Coronary Artery Disease
		Cerebro Vascular Accident
		Hypertensive Nephropathy
		Internal Bleeding/ Haemorrhage

4.2 First Thirty Days Waiting Period

Any disease contracted by the insured person during the first thirty days from the inception of the Policy. The waiting period shall not apply in case of renewal and if the insured person is hospitalised for injuries, sustained in an accident which occurred after the inception of the Policy.

4.3 Specific Waiting Period

Diseases/treatments listed below are subject to waiting periods as follows.

i. **One year waiting period**
   a. Benign ENT disorders
   b. Tonsillectomy
   c. Adenoidectomy
   d. Mastoidectomy
   e. Tympanoplasty

ii. **Two years waiting period**
   a. Cataract
   b. Benign prostatic hypertrophy
   c. Hernia
   d. Hydrocele
   e. Fissure/Fistula in anus
   f. Piles (Haemorrhoids)
   g. Sinusitis and related disorders
   h. Polycystic ovarian disease
   i. Non-infective arthritis
   j. Pilonidal sinus
   k. Gout and Rheumatism
   l. Hypertension and related complications as mentioned in 4.1
   m. Diabetes and related complications as mentioned in 4.1
   n. Calculus diseases
   o. Surgery of gall bladder and bile duct excluding malignancy
   p. Surgery of genito-urinary system excluding malignancy
   q. Surgery for prolapsed intervertebral disc unless arising from accident
   r. Surgery of varicose vein
   s. Hysterectomy

iii. **Four years waiting period**
   a. Treatment for joint replacement unless arising from accident
   b. Osteoarthritis and osteoporosis

4.4 HIV, AIDS, STD

Any condition directly or indirectly caused to or associated with HIV, AIDS, complications of AIDS and other sexually transmitted diseases (STD).

4.5 General Debility, Congenital External Anomaly

General debility, run down condition or rest cure, congenital external disease or defects or anomaly.

4.6 Sterility, Infertility, Assisted Conception

Sterility, infertility/sub fertility, assisted conception procedures, except as and to the extent provided for under Section 1.2.12 (Infertility).

4.7 Pregnancy
Treatment arising from or traceable to pregnancy/childbirth including caesarean section, miscarriage, surrogate or vicarious pregnancy, abortion or complications thereof including changes in chronic conditions arising out of pregnancy, except as and to the extent provided for under Section 1.2.11 (Maternity) and Section 1.2.12 (Infertility).

4.8 Refractive Error
Surgery for correction of eye sight due to refractive error.

4.9 Obesity
Treatment for obesity or a condition arising there from (including morbid obesity) and any other weight control and management programme/services/supplies or treatment.

4.10 Psychiatric Disorder, Self Inflicted Injury
Treatment for all psychiatric and psychosomatic disorders/diseases, intentional self-inflicted injury, attempted suicide.

4.11 Genetic Disorders, Stem Cell Surgery (except bone marrow transplant).

4.12 Circumcision
Circumcision, except as and to the extent provided for under Section 1.2.1.xi

4.13 Vaccination or Inoculation
Vaccination or inoculation unless forming part of treatment and requires hospitalisation, except as and to the extent provided for under Section 1.2.10 (Anti Rabies Vaccination) and Section 1.2.11.iv (Maternity).

4.14 Cosmetic Treatment, Plastic Surgery, Sex Change, Hormone Replacement Therapy
Cosmetic treatment or aesthetic treatment of any description, change of life or sex change operation.
Expenses for plastic surgery, except as and to the extent provided for under Section 1.2.1.viii.
Expenses for hormone replacement therapy, except as and to the extent provided for under Section 1.2.1.ix.

4.15 Massages, Spa, Steam Bath, Naturopathy, Experimental Treatment
Massages, spa, steam bath, shirodhara, udhwarthanam, abhyangam, kayasekham and similar treatment.
Expenses for naturopathy, experimental medicine/treatment, unproven procedure/treatment, alternative treatments (other than ayurveda and homeopathy), acupuncture, acupressure, magneto-therapy and similar treatment.

4.16 Dental Treatment
Dental treatment, except as and to the extent provided for under Section 1.2.1.vii.

4.17 Vitamins, Tonics
Vitamins and tonics, except as and to the extent provided for under Section 1.2.1.x.

4.18 Out-patient Treatment
Any treatment undergone as an out-patient.

4.19 Hospitalisation for the Purpose of Diagnosis and Evaluation
Diagnostic and evaluation purpose where such diagnosis and evaluation can be carried out as an outpatient procedure and the condition of the patient does not require hospitalisation.

4.20 Treatment in Convalescent Home, Nature Clinic
Treatment in health hydro/nature care clinic rest home or convalescent home for the addicted, detoxification centre, sanatorium, home for the aged, mentally disturbed, remodeling clinic or similar institution.

4.21 Drug/Alcohol Abuse
Treatment arising out of disease/ injury directly attributable to use of drugs/alcohol and intoxicating substances.

4.22 Stay in Hospital which is not Medically Necessary.

4.23 Spectacles, Contact Lens, Hearing Aid, Cochlear Implants.

4.24 Equipments
External/durable medical/non-medical equipments/instruments of any kind used for diagnosis/ treatment including CPAP, CAPD, infusion pump, ambulatory devices such as walker, crutches, belts, collars, caps, splints, slings, braces, stockings, diabetic foot-wear, glucometer, thermometer and similar related items (as listed in Appendix IV) and any medical equipment which could be used at home subsequently.

4.25 Expenses not Related to the Diagnosis and Treatment of Disease/ Injury
Irrelevant investigations/treatment, drugs not supported by a prescription, private nursing charges, referral fee to family physician, outstation doctor/surgeon/consultants' fees and similar expenses.

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

4.27 Service Charge/ Registration Fee
Any kind of service charges including surcharges, admission fees, registration charges and similar charges levied by the hospital.

4.28 Home Visit Charges
Home visit charges during pre and post hospitalisation of doctor, attendant and nurse.

4.29 Treatment not Related to Disease
Treatment which the insured person was on before hospitalisation for the disease/ injury, different from the one for which claim for hospitalisation has been made.

4.30 Risky Avocations
Treatment for any disease/injury arising from scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing and similar activities.

4.31 Breach of Law
Any disease or injury as a result of committing or attempting to commit a breach of law with criminal intent.

4.32 War Group Perils
Any disease or injury directly or indirectly caused by or arising from or attributable to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.

4.33 Radioactivity
Any disease or injury directly or indirectly caused by or contributed by nuclear weapons/materials or arising from ionising radiation or contamination by any nuclear fuel or from any nuclear waste or combustion of nuclear fuel.

5 Policy Conditions

5.1 Disclosure of Information
The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of mis-representation, mis-description or non-disclosure of any material fact.

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

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

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

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

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

Note:

For claim under Section 1.3 (Medical Second Opinion), notification of claim is not required.

5.3.2 Procedure for Cashless Claims

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

5.3.3 Procedure for Reimbursement of Claims

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

5.3.3.1 Procedure for Reimbursement of 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.

5.3.4 Documents

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

i. Completed claim form
ii. Bills, payment receipts, medical history of the patient recorded, discharge certificate/ summary from the hospital etc.
iii. Cash-memo from the hospital (s)/chemist(s) supported by proper prescription
iv. Payment receipt, investigation test reports etc. supported by the prescription from the attending medical practitioner
v. Attending medical practitioner's certificate regarding diagnosis along with date of diagnosis and bill receipts etc.
vi. Certificate from the surgeon stating diagnosis and nature of operation and bills/receipts etc.
vii. For claim under Section 1.2.4 (Domiciliary Hospitalisation) in addition to documents listed above (as applicable), medical certificate stating the circumstances requiring for Domiciliary hospitalisation and fitness certificate from treating medical practitioner.
viii. For claim under Section 1.2.11 (Maternity) for surrogacy under Section 1.2.12 (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 contribution clause of the Policy and the original documents having been submitted to the other insurer, the Company may accept the documents listed under Condition 5.3.4 and claim settlement advice duly certified by the other insurer subject to satisfaction of the Company.

Type of claim	**Time limit for submission of documents to Company/TPA**
Reimbursement of hospitalization, pre hospitalisation expenses and ambulance charges	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.

5.3.5 Claim Settlement

i. On receipt of the final document(s) and investigation report (if required), the Company shall within a period of thirty days offer a settlement of the claim to the insured.
ii. If the Company, for any reasons, rejects a claim, it shall communicate to the insured in writing within a period of thirty days from the receipt of the document(s) and investigation report (if required).
iii. Upon the acceptance of an offer of settlement by the insured, the payment of the amount of claim shall be made within seven days from the date of acceptance of the offer by the Company.

iv. In the cases of delay in the payment, the Company shall pay interest at a rate 2% above the bank rate prevalent at the beginning of the financial year in which the claim is paid.

5.3.6 Services Offered by TPA

The TPA shall render health care services covered by the Policy including issuance of ID cards & guide book, hospitalisation & pre-authorization services, call centre, acceptance of claim related documents, claim processing and other related services

The services offered by a TPA shall not include

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

Waiver

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

5.3.7 Classification of * Zone and Copayment

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

* The country has been divided into four zones.

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

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

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

5.3.8 Treatment Outside Network

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.

5.4 Payment of Claim

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

5.5 Fraud

The Company shall not be liable to make any payment under if the same is in any manner fraudulent or supported by any fraudulent means or device whether by the insured person or by any other person acting on his behalf.

5.6 Cancellation

i. The Company may at any time cancel the Policy (on the grounds of fraud, moral hazard, misrepresentation or noncooperation) by sending the insured thirty days notice by registered letter at insured's last known address, and in such an event, the Company shall not allow any refund.

ii. For policies with a term of one year, the insured may at any time cancel the Policy and in such an event, the Company shall allow refund of premium after charging premium at Company's short period rate mentioned below, provided claims are not reported up to the date of cancellation.

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

5.7 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.

5.8 Portability

In the event of the insured person porting to any other insurer, insured person must apply with details of the Policy and claims to the insurer where the insured person wants to port, at least forty five days before the date of expiry of the Policy.

Portability shall be allowed in the following cases:

i. All individual health insurance policies issued by non-life insurance companies including family floater policies.
ii. Individual members, including the family members covered under any group health insurance policy of a non-life insurance Company shall have the right to migrate from such a group policy to an individual health insurance policy or a family floater policy with the same insurer. One year thereafter, the insured person shall be accorded the right to port to another non-life insurance Company.

5.9 Revision of Terms of the Policy Including the Premium Rates

The Company, in future, may revise or modify the terms of the Policy including the premium rates based on experience. The insured person shall be notified three months before the changes are effected.

5.10 Free Look Period

The Free Look Period shall be applicable at the inception of the Policy.

The insured shall be allowed a period of fifteen days from date of receipt of the Policy 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, a deduction towards the proportionate risk premium for period on cover

5.11 Nomination

The insured is mandatorily required at the inception of the Policy to make a nomination for the purpose of payment of claims by the Policy in the event of death of the insured. 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 any insured person other than the insured, for the purpose of payment of claims, the default nominee would be the insured. The Policy or the benefits cannot be assigned.

6 Redressal of Grievance

In case of any grievance relating to the servicing the Policy, the insured person may approach the Grievance cell of the Company set up at divisional offices, regional offices and head office. For more information on grievance mechanism, and to download grievance form, visit our website www.nationalinsuranceindia.com.

The insured person may also approach the office of Insurance Ombudsman of the respective area/ region for redressal of grievance.

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 5.3.7 (Treatment outside Zone), Section 5.3.8 (Treatment outside Network) and copayment mentioned above

7.2 Out-patient Treatment
Subject to Exclusions 4.14, 4.15, 4.21, 4.30, 4.31, 4.32 and 4.33, 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 lymphocyctic leukaemia less than RAI stage 3
vi. microcarcinoma of the bladder
vii. all tumours in the presence of HIV infection.

III Kidney Failure requiring Regular Dialysis

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

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

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

V Multiple Sclerosis with Persisting Symptoms
The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:
i. investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 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	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
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 INR)

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		3,446	3,777	4,686	6,905	8,800	9,815	11,305	13,141	13,883	15,145	19,344
2,00,000			4,628	4,767	6,536	10,517	13,355	15,638	19,097	21,809	23,802	26,270	27,756
3,00,000			5,605	5,773	8,058	12,025	15,750	18,030	21,274	29,509	33,184	36,999	39,470
4,00,000			6,293	6,753	9,373	14,267	17,111	21,001	25,230	36,678	41,987	47,295	50,944
5,00,000			6,911	7,554	10,616	15,984	18,120	23,407	28,530	44,019	50,296	57,219	62,136
6,00,000			7,478	8,360	11,894	17,465	19,344	26,266	31,448	50,391	58,125	66,748	73,021
7,00,000			8,067	9,194	12,842	19,727	21,861	28,164	33,746	55,160	64,989	75,354	83,060
8,00,000			8,635	10,076	13,853	21,008	22,421	29,475	35,648	58,272	71,696	87,864	96,883
9,00,000			9,115	11,024	14,712	22,162	23,857	33,356	38,320	60,860	78,052	1,01,311	1,11,742
10,00,000			9,574	11,597	16,201	23,402	25,642	35,575	41,201	62,946	84,210	1,15,786	1,26,550

Service charge 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	442	501	561	640	1,139	2,407	3,544	4,908	5,868	7,082	7,768	8,797	12,573
2,00,000	540	607	753	808	1,588	3,666	5,378	7,819	9,913	11,753	13,317	15,259	18,041
3,00,000	619	692	912	978	1,958	4,192	6,343	9,015	11,043	15,903	18,566	21,492	25,655
4,00,000	661	738	1,024	1,144	2,278	4,973	6,891	10,501	13,097	19,767	23,492	27,473	33,114
5,00,000	698	777	1,124	1,280	2,580	5,572	7,297	11,704	14,810	23,723	28,141	33,237	40,388
6,00,000	731	812	1,217	1,416	2,891	6,088	7,790	13,133	16,325	27,157	32,521	38,772	47,463
7,00,000	766	849	1,312	1,558	3,121	6,877	8,803	14,082	17,517	29,727	36,362	43,771	53,989
8,00,000	798	884	1,405	1,707	3,367	7,323	9,029	14,738	18,505	31,404	40,114	51,038	62,974
9,00,000	825	912	1,483	1,868	3,575	7,725	9,607	16,678	19,892	32,799	43,670	58,849	72,632
10,00,000	849	938	1,558	1,965	3,937	8,158	10,326	17,787	21,387	33,923	47,116	67,257	82,257

Service charge 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		3,652	4,004	4,967	7,319	9,328	10,404	11,983	13,930	14,716	16,053	20,504
2,00,000			4,905	5,052	6,928	11,148	14,156	16,576	20,243	23,118	25,230	27,846	29,421
3,00,000			5,942	6,120	8,542	12,746	16,695	19,111	22,550	31,279	35,175	39,219	41,838
4,00,000			6,671	7,158	9,935	15,123	18,138	22,261	26,744	38,879	44,506	50,133	54,001
5,00,000			7,325	8,007	11,253	16,943	19,208	24,812	30,241	46,660	53,313	60,652	65,864
6,00,000			7,926	8,862	12,607	18,513	20,504	27,842	33,335	53,414	61,612	70,753	77,402
7,00,000			8,551	9,746	13,613	20,911	23,173	29,854	35,771	58,469	68,889	79,875	88,043
8,00,000			9,153	10,681	14,685	22,269	23,767	31,244	37,787	61,768	75,998	93,136	1,02,696
9,00,000			9,662	11,685	15,595	23,491	25,288	35,357	40,619	64,512	82,735	1,07,390	1,18,446
10,00,000			10,148	12,292	17,173	24,806	27,180	37,709	43,673	66,723	89,262	1,22,733	1,34,143

Service charge 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	469	531	594	678	1,207	2,551	3,756	5,202	6,220	7,507	8,234	9,325	13,328
2,00,000	573	644	798	856	1,684	3,886	5,701	8,288	10,508	12,459	14,116	16,175	19,124
3,00,000	656	734	967	1,037	2,076	4,443	6,723	9,556	11,706	16,857	19,680	22,781	27,195
4,00,000	701	782	1,085	1,213	2,415	5,272	7,304	11,131	13,883	20,953	24,901	29,121	35,100
5,00,000	740	824	1,192	1,357	2,735	5,906	7,735	12,406	15,698	25,146	29,829	35,231	42,812
6,00,000	775	861	1,290	1,501	3,064	6,453	8,257	13,921	17,304	28,786	34,472	41,098	50,311
7,00,000	811	900	1,391	1,651	3,308	7,289	9,332	14,927	18,568	31,510	38,543	46,397	57,228
8,00,000	846	937	1,489	1,810	3,569	7,763	9,571	15,622	19,615	33,288	42,521	54,100	66,752
9,00,000	874	967	1,572	1,980	3,790	8,189	10,183	17,679	21,085	34,767	46,291	62,380	76,990
10,00,000	900	994	1,651	2,083	4,173	8,647	10,945	18,855	22,670	35,958	49,943	71,292	87,193

Service charge extra

Discount in premium for other zones

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

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

Optional cover

Rate for Critical Illness (rates per individual in INR)

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 INR)

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

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%**

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