National Insurance Company Limited

CIN - U10200WB1906GOI001713 IRDAI Regn. No. - 58

Divyangjan Sanjeevani Policy - National

PROSPECTUS

1.1 PRODUCT

Divyangjan Sanjeevani Policy - National is a specially designed indemnity health insurance policy for persons falling under the following categories, who shall be the Insured Persons under the Policy.

A) Covering Persons with Disability as per The Rights of Persons with Disabilities Act, 2016 and The Mental Healthcare Act, 2017. The cover under this policy is available for persons with the following disability/disabilities as defined under the Rights of Persons with Disabilities Act, 2016 and any subsequent additions / modifications to the list in the Act.

1. Blindness	2. Muscular Dystrophy
3. Low vision	4. Chronic Neurological conditions
5. Leprosy Cured persons	6. Specific Learning Disabilities
7. Hearing Impairment (deaf and hard of hearing)	8. Multiple Sclerosis
9. Locomotor Disability	10. Speech and Language disability
11. Dwarfism	12. Thalassemia
13. Intellectual Disability	14. Haemophilia
15. Mental Illness	16. Sickle Cell disease
17. Autism spectrum disorder	18. Multiple Disabilities including deaf/ blindness
19. Cerebral Palsy	20. Acid Attack victim
21. Parkinson's disease	

a) It is Condition Precedent that this cover can be availed only on mandatory submission self-attested copy of Disability certificate issued by the Medical Board appointed by the government for certifying Disability.

b) Disability for the purpose of this policy means a person with not less than forty percent of a specified disability as per the Act, where, specified disability has not been defined in measurable terms and includes an Insured Person with disability where specified disability has been defined in measurable terms, as Certified by the Medical Board appointed by the government for certifying Disability.

or / and

B) Individuals with HIV/AIDS as defined under the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017.

1.2 COVERAGE

1.2.1 Inpatient Care:

The Company shall indemnify Medical Expenses incurred for Hospitalization of the Insured Person, up to the Sum insured as specified in the Policy Schedule (other than any sub-limits, co-pay as specified in the policy) for:

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to maximum of 1% of the Sum Insured per day.
ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to maximum of 2% of Sum Insured per day.
iii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating Medical Practitioner/ surgeon or to the Hospital
iv. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

Other expenses

i. Expenses incurred on treatment of **Cataract Surgery** subject to the sub limits, as mentioned in the Table of Benefits.
ii. **Dental Treatment** necessitated due to Disease or Injury (for Inpatient Care only).
iii. **Plastic Surgery** necessitated due to Disease or Injury.
iv. All **Day Care Treatments**

Note:

Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment.

1.2.2AYUSH Treatment:

The Company shall indemnify Medical Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Period up to 100% of Sum Insured as specified in the Policy Schedule in any AYUSH Hospital.

1.2.3 Pre-Hospitalization Medical Expenses:

The Company shall indemnify Pre-Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient Care, for a fixed period of 30 days prior to the date of admissible Hospitalization covered under the Policy during the Policy Period.

Conditions:

i. The claim is accepted under Section Inpatient Care or Section AYUSH Treatment or Section Modern Treatments in respect of that Insured Person.
ii. Pre-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

1.2.4Post-Hospitalization Medical Expenses:

The Company shall indemnify Post Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient Care, for a fixed period of 60 days from the date of discharge from the Hospital, following an admissible hospitalization covered under the Policy during the Policy Period.

Conditions:

i. The claim is accepted under Section Inpatient Care or Section AYUSH Treatment or Section Modern Treatments in respect of that Insured Person.
ii. Post-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

1.2.5 Emergency Ground Ambulance

The Company will reimburse Reasonable and Customary Charges for expenses incurred towards Ambulance charges for transportation of an Insured Person, per Hospitalization as per the limit mentioned in Table of Benefits.

Specific Conditions:

The Company will reimburse payments under this Benefit provided that.

i. The medical condition of the Insured Person requires immediate Ambulance services from the place where the Insured Person is Injured or is suffering from an Illness to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital as advised by the treating Medical Practitioner in writing for management of the current Hospitalization.
ii. Expenses incurred on road Ambulance subject to a maximum of Rs.2,000/- per hospitalisation subject to maximum Rs. 7,000 in a Policy Period.
iii. The Ambulance service is offered by a healthcare or Registered Ambulance Service Provider.
iv. The original Ambulance bills and payment receipt is submitted to the Company.
v. The Company has accepted a claim under Section Inpatient Care above in respect of the same period of Hospitalization or Section AYUSH Treatment or Section Modern Treatments.
vi. Any payment under this Benefit will be excluded if the Insured Person is transferred to any Hospital or Diagnostic Center for evaluation purposes only.

1.2.6 Cataract Treatment

The Company shall indemnify Medical Expenses incurred for treatment of Cataract, subject to a limit of Rs.40,000/-, per each eye in one Policy Period. Above Sub Limit for Medical Expenses in Cataract Treatment shall include claim under Section Inpatient Care, Section Pre-Hospitalization Medical Expenses and Section Post-Hospitalization Medical Expenses.

1.2.7Modern Treatment:

The following procedures will be covered (wherever medically indicated) either as In patient or as part of Day Care Treatment in a Hospital up to 50% of Sum Insured, specified in the Policy Schedule, during the Policy Period.

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. Bronchial Thermoplasty
j. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
k. IONM- (lntra Operative Neuro Monitoring)
l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

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

2 SALIENT FEATURES

2.1Hospitalisation Options

The Policy provides for cashless facility and/ or reimbursement of hospitalisation or 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.

2.2 Type of Policy
Policy can be issued, as opted by the Proposer on Individual Basis (i.e., separate Sum Insured shall apply on each Insured Person)

2.3 Proposer
Policy can be proposed by,
i. Any eligible person as defined in Section 1.1 above.
ii. Parent or Legal Guardian of eligible person as defined above.

2.4 Eligibility
Policy can be availed for eligible persons on **Individual Basis**
- Age eligibility for adults: 18 years to 65 years
- Age eligibility for Children: Newborn to 18 years

2.5 Policy Period
The Policy can be issued for a period of one (01) year.

2.6 Sum Insured (SI)
The Policy is available with SI options of Rs. 4 lacs and Rs. 5 lacs on Individual Basis.

2.6.1 Enhancement of Sum Insured
i. Sum insured can be enhanced only at the time of renewal, to the next available slab subject to discretion of the Company.
ii. For the incremental portion of the SI, the Waiting Periods shall apply. Coverage on enhanced sum insured shall be available after the completion of Waiting Periods.

2.7 Discounts
2.7.1 Discount for Direct Sale
For Policy bought by walk in customer *(where no intermediary is involved)* - Discount of 10% shall be allowed on the final payable premium for new and subsequent renewals.

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

2.9 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 intermediary.
ii. Identity and address of the proposer must be supported by documentary proofs, as detailed in Proposal Form Annexure C.
iii. If a person is insured under health insurance policy of any other Non-Life Insurance Company and wants to port (switch) to **Divyangjan Sanjeevani Policy - National**, the Portability Form and Proposal Form will have to be completed and submitted to the office or to the intermediary.

2.11 Payment of Premium
i. Premium for each individual shall depend on the category of disability, SI and age from the 'Premium Table'.
ii. In case of multiple eligible disabilities or disease, category of disability shall be Category 1.
iii. The proposer has the option of claims being serviced by TPA (in which case cashless facility/reimbursement of expenses will be available) or the Company (in which case expenses will be reimbursed). If cashless facility is to be availed, the premium payable shall include TPA charges also.
iv. Premium as per the premium table attached is to be paid in full before the commencement of the policy.
v. Premium can be paid online for renewals without break, provided there is no material change in the policy.
vi. PAN details must be submitted by the insured.
vii. In case PAN is not available, Form 60 or Form 61 as per Rule 114B of the Income-tax Rule,1962 must be submitted

2.12 Renewal of Policy
i. The Policy can be renewed without break 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.

3 DEFINITIONS
The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and other gender and references to any statutory enactment includes subsequent changes to the same.

3.1 <u>Standard Definitions</u>
1. Accident means sudden, unforeseen, and involuntary event caused by external, visible, and violent means.

2. **Any one Illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital / Nursing Home where treatment was taken.
3. **AYUSH Treatment** refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
4. **AYUSH Hospital** means an AYUSH Hospital is a healthcare facility wherein medical / surgical / para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   i. Central or State Government AYUSH Hospital; or
   ii. Teaching hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/ Central Council for Homeopathy; or
   iii. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      a) Having at least 5 in-patient beds.
      b) Having qualified AYUSH Medical Practitioner in charge round the clock;
      c) Having dedicated AYUSH therapy sections as required and / or has equipped operation theatre where surgical procedures are to be carried out;
      d) Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
5. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical / para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:
   i. Having qualified registered AYUSH Medical Practitioner in charge round the clock;
   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
   iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
6. **Break in Policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof
7. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the Network Provider by the insurer to the extent pre-authorization is approved.
8. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
9. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure, or position.
   i. Internal Congenital Anomaly– Congenital Anomaly which is not in the visible and accessible parts of the body.
   ii. External Congenital Anomaly– Congenital Anomaly which is in the visible and accessible parts of the body
10. **Co-payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
11. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner and must comply with all minimum criterion as under:
   i. has qualified nursing staff under its employment.
   ii. has qualified medical practitioner/s in charge.
   iii. has fully equipped operation theatre of its own where surgical procedures are carried out
   iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
12. **Day Care Treatment** means medical treatment, and/or surgical procedure which is
   i. Undertaken under General or Local Anesthesia in a hospital/day care center in less than 24 hours because of technological advancement, and
   ii. which would have otherwise required hospitalization of more than 24 hours.

   Treatment normally taken on an out-patient basis is not included in the scope of this definition.
13. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions, and surgery.
14. **Disclosure of information norm** means the policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
15. **Emergency Care** means management for an Illness which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the insured person's health.
16. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre –existing diseases. Coverage is not available for the period for which no premium is received.
17. **Hospital** means any institution established for In-patient Care and Day Care Treatment of diseases, injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act or complies with all minimum criteria as under:

i. has qualified nursing staff under its employment round the clock,
ii. has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and 15 in-patient beds in all other places,
iii. has qualified Medical Practitioner(s) in charge round the clock,
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out,
v. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

18. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.
19. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible, and evident means which is verified and certified by a Medical Practitioner.
20. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    i. Acute condition - Acute condition is a disease, Illness that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ Illness which leads to full recovery
    ii. Chronic condition - A chronic condition is defined as a disease, Illness that has one or more of the following characteristics:
        a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
        b. it needs ongoing or long-term control or relief of symptoms
        c. it requires your rehabilitation for the patient or for the patient to be specially trained to cope with it
        d. it continues indefinitely.
        e. it recurs or is likely to recur.
21. **In-patient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.
22. **Insured Person** means person(s) named in the schedule of the Policy.
23. **Intensive Care Unit** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
24. **ICU Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
25. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow up prescription.
26. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
27. **Medical Necessary Treatment** means any treatment, tests, medication, or stay in Hospital or part of stay in Hospital which:
    i. is required for the medical management of the illness or injury suffered by the Insured Person.
    ii. must not exceed the level of care necessary to provide safe, adequate, and appropriate medical care in scope, duration, or intensity.
    iii. must have been prescribed by a medical practitioner.
    iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
28. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.
29. **Migration** means the right accorded to health insurance policyholders (including all members under Family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.
30. **Network Provider** means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a Cashless facility.
31. **New born Baby** means baby born during the Policy Period and is aged up to 90 days.
32. **Non-Network Provider** means any Hospital, Day Care Centre or other provider that is not part of the Network.
33. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
34. **OPD Treatment** means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.
35. **Pre-Hospitalization Medical Expenses** means medical expenses incurred during pre- defined number of days preceding the hospitalization of the Insured Person, provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
36. **Pre-Existing Disease (PED)** means any condition, ailment, injury, or disease.
    i. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or

ii. 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 insurer or its reinstatement.

37. **Post-Hospitalization Medical Expenses** means medical expenses incurred during pre- defined number of days immediately after the insured person is discharged from the hospital provided that:
    i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
    ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.
38. **Portability** means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.
39. **Qualified Nurse** is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India.
40. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of Grace Period for treating the Renewal continuous for the purpose of gaining credit for Pre-Existing Diseases, time-bound exclusions and for all waiting periods.
41. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.
42. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
43. **Surgery or Surgical Procedures** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a Medical Practitioner.
44. **Unproven/Experimental Treatment** is a treatment including drug experimental therapy, which is based on established medical practice in India, is a treatment experimental or unproven.

3.2 <u>Specific Definitions</u>

1. **Adventurous/Hazardous Sports** means any sport or activity involving physical exertion and skill in which an Insured Person participates or competes for entertainment or as part of his profession whether he/ she is trained or not.
2. **Age** means completed years on last birthday as on Commencement Date.
3. **Ambulance** means a motor vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
4. **Antiretroviral Therapy (ART)** is treatment of people infected with human immunodeficiency virus (HIV) using anti-HIV drugs.
5. **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.
6. **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.
7. **Claims** means a demand made by the Policyholder/Insured Person or on his behalf, for payment of Medical Expenses under any Benefit, as covered under the Policy.
8. **Commencement Date** means the date of inception of first policy with the Company.
9. **CD4** cells are a type of white blood cells, also called as CD4 T lymphocytes or 'helper T cells' which serve as primary receptor for HIV.
10. **Diagnostic Centre** means a place where diagnostic tests and exploratory or therapeutic procedures required for the detection, identification and treatment of a medical condition are done.
11. **Person with Disability/Disability/Disabled** means a person with long term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others.
12. **HIV** means Human Immunodeficiency Virus.
13. **Insured Person** means the person named in the Policy Schedule who is insured under the Policy and is **Citizen of India**, in respect of whom the applicable premium has been received by the Company.
14. **Life-threatening Emergency** shall mean a serious medical condition or symptom, which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long-term impairment of the Insured Person's health, until stabilization at which time this medical condition or symptom is not considered an Emergency anymore.
15. **Material Facts** means 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.
16. **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence.
17. **Medical Practitioner for treatment of Mental Illnesses** means a Medical Practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognized by the University Grants Commission established under the University Grants Commission Act, 1956, or awarded or recognized by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognized by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist for the purposes of this Act;
18. **Mental Health Establishment** means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and

Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with Mental Illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person, where persons with mental Illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general Hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person; but does not include a family residential place where a person with mental Illness resides with his relatives or friends;

19. **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof, as amended from time to time, and shall be read together. The Policy contains details of the extent of cover available to the Insured Person, applicable exclusions, and the terms & conditions applicable under the Policy.
20. **Policy Period** means the period between the Commencement Date and either the Expiry Date specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier.
21. **Policy Holder** means the entity or person named as such in the Schedule.
22. **Policy Schedule** means the Policy Schedule attached to and forming part of this Policy specifying the details of the Insured Persons, the Sum Insured, the Policy Period and the Sub-limits to which benefits under the Policy are subject to, including any annexures and/ or endorsements, made to or on it from time to time, and if more than one, then the latest in time.
23. **Proposal Form** means a form to be filled in by the Proposer in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.
24. **Sub-limit** means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit. The Sub- limit as applicable under the Policy is specified in the Policy Schedule against the relevant Cover in force under the Policy.
25. **Sum Insured** means the pre-defined limit specified in the Policy Schedule and represents the maximum, total and cumulative liability for any and all claims made under the Policy in respect of each insured person as mentioned in the Policy Schedule.
26. **Waiting Period** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the Waiting Period, diseases/ treatments shall be covered provided the Policy has been continuously renewed without any break.

4 WAITING PERIOD

The Company is not liable to make any payment under the Policy in connection with or in respect of the following expenses till the expiry of the waiting period and any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or any way attributable to any of the following unless expressly stated to the contrary in this Policy.

1. Pre-Existing Diseases (Code- 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 24months for pre-existing disability/ 48 months for all pre-existing conditions other than HIV/AIDS and Disability(as mentioned in Policy Schedule) of continuous coverage after the date of inception of the first policy with insurer.
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 number of months (as mentioned in Policy Schedule) for any pre-existing disease is subject to the same being declared at the time of application and accepted by the Company.

2. First 30 days waiting period- Code- Excl 03

a) Expenses related to the treatment of any illness within 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 months.
c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

3. Specified disease/procedure waiting period- Code- Excl 02

a) Expenses related to the treatment of the listed Conditions; surgeries/treatments shall be excluded until the expiry of 24monthsas (mentioned in Policy Schedule)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.

Waiting Period of 24 Months

1. Benign ENT disorders
2. Tonsillectomy

3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumors, cysts, polyps of any kind, including benign breast lumps.
8. Benign prostate hypertrophy
9. Cataract and age-related eye ailments
10. Gastric/ Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele
14. Non-Infective Arthritis
15. Piles, Fissures and Fistula in anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident.
18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers

5 SPECIFIC CONDITIONS APPLICABLE FOR PERSONS WITH DISABILITY

The Company will indemnify reasonable and customary charges for Medical Expenses incurred towards Inpatient Hospitalisation arising due to the pre-existing disability covered, or condition as listed under The Rights of Persons with Disabilities Act, 2016 subject to the terms and limits mentioned below.

i. Any treatment for the pre-existing disability covered, will have a Waiting Period of 24 months from the first policy inception date.

ii. Any reconstructive / cosmetic / prosthesis / external or internal device implanted/ used at home for the purpose of treatment of existing disability or used for activities of daily living are/is excluded from the policy.

6 SPECIFIC CONDITION APPLICABLE FOR PERSONS WITH HIV-AIDS

The Company will indemnify the Reasonable and Customary Charges for any Medical Condition which requires Inpatient Hospitalization of the Insured Person, up to the Sum Insured opted as mentioned in the Policy Schedule.

Condition

This cover will exclude cost for any Anti-Retroviral Treatment.

7 EXCLUSIONS

7.1 <u>Standard Exclusions</u>

1. Investigation & Evaluation- Code- 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.

2. Rest Cure, rehabilitation, and respite care- Code- 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.

3. Obesity/ Weight Control: Code- 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 must 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 Apnoea
      iv. Uncontrolled Type2 Diabetes

4. Change-of-Gender treatments: Code- Excl 07

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

5. Cosmetic or plastic Surgery: Code- 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.

6. Hazardous or Adventure sports: Code- 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.

7. Breach of law: Code- 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.

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

9. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code- Excl 12**

10. Treatments received in heath 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. **Code- Excl 13**

11. 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 practitioner as part of hospitalization claim or day care procedure. **Code- Excl 14**

12. Refractive Error: Code- Excl 15
Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

13. Unproven Treatments: **Code- Excl 16**
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.

14. Sterility and Infertility: Code- Excl 17
Expenses related to sterility and infertility. This includes:
(i) Any type of contraception, sterilization
(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
(iii) Gestational Surrogacy
(iv) Reversal of sterilization

15. Maternity: Code Excl 18
i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy.
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

7.2 Specific Exclusions

1. Any medical treatment taken outside India.

2. Hospitalization for donation of any body organs by an Insured including complications arising from the donation of organs.

3. Nuclear damage caused by, contributed to, by or arising from ionising radiation or contamination by radioactivity from:
a. any nuclear fuel or from any nuclear waste; or
b. from the combustion of nuclear fuel (including any self-sustaining process of nuclear fission);
c. nuclear weapons material.
d. nuclear equipment or any part of that equipment.

4. 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.

5. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or as may be necessitated due to an accident.

6. Alternative Treatment (Other than AYUSH), experimental or any other treatment such as acupuncture, acupressure, magnetic, osteopath, chiropractic, reflexology and aromatherapy.

7. Suicide**,** Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) and any violation of law or participation in an event/activity that is against law with a criminal intent.

8. Vaccination or inoculation except as post bite treatment for animal bite.

9. Convalescence, general debility, "Run-down" condition, rest cure, Congenital External Illness/Disease/Defect.

10. Outpatient diagnostic, medical and surgical procedures or treatments, non-prescribed drugs and medical supplies, hormone replacement therapy and expenses related to Domiciliary Hospitalization shall not be covered.

11. Dental Treatment or Surgery of any kind unless requiring Hospitalisation as a result of accidental Bodily Injury.

12. Venereal/ Sexually Transmitted disease

13. Stem cell storage.

14. Any kind of service charge, surcharge levied by the hospital.

15. Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.

16. Non-Payable items: The expenses that are not covered in this Policy are placed under List-I of Annexure-II

17. Any medical procedure or treatment, which is not Medically Necessary or not performed by a Medical Practitioner.

8 GENERAL TERMS AND CONDITIONS

8.1 Standard terms & Conditions

1. Disclosure of Information

The Policy shall be void and all premiums paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description, or non-disclosure of any Material Fact by the Insured Person.

2. Condition Precedent to Admission of Liability

The Due observance and fulfillment of the terms and conditions of the Policy, by the Insured Person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the Policy.

3. Claim Settlement (provision for Penal interest)

i. The Company shall settle or reject a claim as the case may be, 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.

4. Complete Discharge

Any payment to the Insured Person or his/her nominees or his/her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim

5. Multiple Policies

i. In case of multiple policies taken by an Insured person during a period from the same or 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 Beneficiary 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.
v. Under this product, no insured can take more than one policy from any or all insurers.
vi. In case of this product, the maximum liability of all policies put together from all insurers cannot exceed the maximum sum insured under this product.

6. Fraud

If any claim made by the Insured Person, is any respect of 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.

7. Cancellation

The Insured may cancel this Policy by giving 15days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

Refund of Premium (basis Policy Period)	
Timing of Cancellation	**Refund %**
Up to to 30 days	75.00%
31 to 90 days	50.00%
91 days to 180 days	25.00%
181 days to 365 days	0.00%

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed under this Policy.
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.

8. Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to 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, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:
i. The waiting periods specified in Section 5 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
ii. Migration benefit will be offered to the extent of sum of previous insured and accrued bonus (as part of the sum insured), migration benefit shall not apply to any other additional increased Sum Insured.
iii. Migration under this product shall be allowed only due to withdrawal of the product subject to IRDAI Regulations
For Detailed Guidelines on Migration, kindly refer the link -
https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

9. Portability

The Insured Person will have the option to port the Policy to same product of other insurers as per extant Guidelines related to portability, If such person is presently covered and has been continuously covered without any lapses under this health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:
i. The waiting periods specified in Section 5 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the sum insured), portability benefit shall not apply to any other additional increased Sum Insured.
For Detailed Guidelines on Portability, kindly refer the link -
https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

10. Renewal of Policy:

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. The Company is not bound to give notice that it is due for renewal.
i. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years.
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
iii. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.
iv. If not renewed within Grace Period after due renewal date, the Policy shall terminate.

11. Moratorium Period

After completion of eight continuous years under the policy no look back to 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 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of

Moratorium Period no health insurance claim 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, deductibles as per the policy contract.

12. Possibility of 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 (3) months before the changes are affected.

13. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals of 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.

lf 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.

14. Nomination

The policy holder 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 policy holder. 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. ln the event of death of the Insured Person, the Company will pay the nominee (as named in the Policy Schedule/endorsement (if any)) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Insured Person whose discharge shall be treated as full and final discharge of its liability under the Policy.

8.2 <u>Specific Conditions</u>

1. Arbitration clause

i. If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independent of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties thereto, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, onetobeappointedbyeachofthepartiestothedispute/differenceandthethirdarbitratortobeappointedbysuch two Arbitrators who shall act as the presiding arbitrator and Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996) as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).
ii. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration, as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of this Policy.
iii. It is here by expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/ arbitrators of the amount of expenses shall be first obtained.

2. Change of Sum Insured

Sum Insured can be changed (increase / decrease) only at the time of Renewal or at any time, subject to underwriting by the Company. For any increase in Sum Insured, the Waiting Period shall start afresh only for the enhance portion of the Sum Insured.

3. Material Change

The Insured Person shall notify the Company in writing of any material change in the risk in relation to the declaration made in the Proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

4. Notice and Communication

i. Any notice, direction, instruction, or any other communication related to the Policy should be made in writing.
ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule/certificate of insurance.

5. Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

6. Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

7. Eligibility Criteria

All Persons with Disability who have at least one of the disabilities as defined under Specified Disability under The Rights of Persons with Disabilities Act, 2016 with valid disability certificate and Individuals with HIV/AIDS as defined under the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 are eligible to enroll under this product.

8. Alterations in the Policy

The Proposal Form, Policy Schedule constitute the complete contract of insurance. This Policy constitutes the complete contract of insurance between the Policyholder and the Company. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement, signed, and stamped by Company. All endorsement requests will be made by the Insured Person only. This Policy cannot be changed by anyone (including an insurance agent or broker) except the Company.

9. Revision and Modification of the Policy Product-

i. Any revision or modification will be done with the approval of the Authority. We shall notify about revision /modification in the Policy including premium payable thereunder. Such information shall be given at least ninety (90) days prior to the effective date of modification or revision coming into effect.
ii. Existing Policy will continue to remain in force till its expiry, and revision will be applicable only from the date of next renewal. Credit of continuity/waiting periods for all the previous policy years would be extended in the new policy on Renewal.

10. Terms and conditions of the Policy

The terms and conditions contained herein and in the Policy Schedule be deemed to form part of the Policy and shall be read together as one document.

9 CLAIM PROCEDURE

9.1 Procedure for Cashless claims:

i. Treatment may be taken in a network provider and is subject to preauthorization by the Company or its authorized TPA,
ii. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.
iii. The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification.
iv. At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
v. The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details,
vi. 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 Company / TPA for reimbursement.

9.2 Procedure for reimbursement of claims:

For reimbursement of claims the insured person may submit the necessary documents to Company within the prescribed time limit as specified hereunder.

S. No	Type of Claim	Prescribed Time limit
1.	Reimbursement of hospitalization, day care and pre hospitalization expenses	Within 30 days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within 30 days from completion of post hospitalization treatment

9.3 Notification of Claim

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

i. Within 24 hours from the date of Emergency Hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.
ii. At least 72 hours prior to admission in Hospital in case of a planned Hospitalization.

9.4 Documents to be submitted

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

i. Duly Completed claim form.
ii. Photo Identity proof of the patient
iii. Medical Practitioner's prescription advising admission.
iv. Original bills with itemized break-up
v. Payment receipts
vi. Discharge summary including complete medical history of the patient along with other details.
vii. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner
viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
ix. Sticker/invoices of the Implants, wherever applicable.
x. MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, wherever applicable.
xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque.
xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines
xiii. Legal heir/succession certificate, wherever applicable
xiv. Any other relevant document required by Company/TPA for assessment of the claim.

Note

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person
4. The Company shall assess the admissibility of claim as per Policy terms and conditions. Upon satisfactory completion of assessment and admission of claim, the Company will make the payment of benefit as per the Policy. In case if the claim is repudiated the Company will inform the Insured about the same in writing with reason for repudiation.

9.5 Co-payment

Each and every claim under the Policy shall be subject to a Co-payment of 20% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.
This co-payment can be waived off by paying an additional premium (optional).

9.6 Services Offered by TPA

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of preauthorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.
The services offered by a TPA shall not include:

i. Claim settlement and claim rejection.
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.

9.7 Payment of Claim

All claims under the Policy shall be payable in Indian currency only.

10 REDRESSAL OF GRIEVANCE

In case of any grievance related to the Policy, the insured person may submit in writing to the Policy Issuing Office or Grievance cell at Regional Office of the Company for redressal. If the grievance remains unaddressed, the insured person may contact Customer Relationship Management Dept., National Insurance Company Limited, Premises No. 18-0374, Plot no. CBD-81, Rajarhat, New Town, Kolkata - 700156, email: customer.relations@nic.co.in, griho@nic.co.in

For more information on grievance mechanism, and to download grievance form, visit our website https://nationalinsurance.nic.co.in

IRDAI Integrated Grievance Management System - https://irdai.gov.in/igms1

Insurance Ombudsman – The Insured person can also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The updated list of Office of Insurance Ombudsman are available on IRDAI website: https://irdai.gov.in/ and on the website of Council for Insurance Ombudsman: https://www.cioins.co.in/

11 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 Company's office or to the Company's agent.

Place	**Signature**
Date	**Name**

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

TABLE OF BENEFITS

Product Name	**Divyangjan Sanjeevani Policy - National**
Product Type	Indemnity based
Sum insured (in INR)	4 lacs and 5 lacs, Individual basis only
Policy Period	1 Year
Product Eligibility	Persons with existing Disability or / and persons with HIV/AIDS
Age band	Age eligibility for adults: 18 years to 65 years Age eligibility for Children: Newborn to 18 years
Grace Period	Fixed period of 30 days is to be allowed as Grace Period
Hospitalisation Expenses	Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible.
Day Care Procedure	Time limit of 24 hrs shall not apply in respect of Day Care Treatment
Pre-Hospitalisation	For 30 days prior to the date of hospitalization
Post Hospitalisation	For 60 days from the date of discharge from the hospital
Sublimit for Room/ Medical Practitioner`s fee	1. Room Rent, Boarding, Nursing Expenses, all inclusive as provided by the Hospital/Nursing Home up to maximum of 1% of the sum insured per day. 2. Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges, all inclusive as provided by the Hospital / Nursing Home up to maximum of 2% of the sum insured per day.
Cataract Treatment	Up to Rs.40,000/-, for each eye during policy period (waiting period of 24 months)
Modern Treatment	Covered for listed procedures up to 50% of sum insured available for Inpatient Hospitalisation Care
Emergency Ground Ambulance	Expenses covered up to Rs. 2000 per hospitalisation, subject to max 7000 in a policy period
AYUSH	Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered up to 100% of sum insured, during Policy period
Pre-Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the company shall be covered.
Initial Waiting period	30 days for all claims except resulting from Accident
PED waiting period	48 months (For any pre-existing diseases other than pre-existing Disability and HIV/AIDS)
Specific Disease/ illness waiting period	24 months Waiting Period
Waiting Period and specific Sublimit for HIV AIDS Cover	Initial waiting period of 30 days
Waiting Period and specific Sublimit for Disability Cover	24 months initial waiting period is applicable for the pre-existing Disability covered under the policy.
Co-pay	20% on all claims made under the policy Co-pay can be waived with additional premium

No loading shall apply on Renewals based on individual claims experience
Please preserve the policy for all future reference.

Rate Chart (in INR)

Note: This policy is specially designed for persons with Disability or / and persons with HIV/AIDS. Premium shall depend on existing Disability/ Illness and age of the Insured, and sum insured opted.

Disability/ Illness Category	Existing Disability/ Illness of the Insured	Disability/ Illness Category	Existing Disability/ Illness of the Insured
1	Cerebral Palsy	4	Low vision
	Chronic Neurological conditions		Autism spectrum disorder
	HIV		Haemophilia
	Mental illness		Hearing impairment (deaf and hard of hearing)
	Multiple disabilities including deaf/blindness		Intellectual disability
	Multiple sclerosis		Specific Learning disabilities
2	Acid attack victim		Speech and language disability
	Leprosy cured persons	5	Blindness
	Muscular Dystrophy		Dwarfism
3	Parkinson's disease		Locomotor disability
	Thalassemia		Sickle cell disease

Age band (yrs)/ Disability/ Illness Category	SI – INR 4,00,000					SI – INR 5,00,000				
	1	2	3	4	5	1	2	3	4	5
0-5	20861	12671	8607	7771	7431	26068	14620	10171	9103	8288
6-17	20430	12409	8428	7610	7278	25255	14164	9853	8819	8029
18-25	23401	14214	9654	8717	8336	29663	16636	11573	10358	9431
26-30	26382	16024	10884	9827	9398	35187	19734	13728	12287	11187
31-35	28643	17398	11817	10670	10204	37650	21116	14689	13147	11970
36-40	31547	19162	13015	11751	11238	40167	22527	15671	14026	12770
41-45	37956	23055	15659	14139	13521	49208	27597	19198	17183	15644
46-50	49278	29932	20330	18356	17554	66363	37219	25892	23173	21098
51-55	67891	41237	28009	25290	24184	88332	49540	34463	30845	28083
56-60	91540	55602	37765	34099	32609	121829	68326	47532	42542	38733
61-65	122599	74467	50579	45669	43673	163912	91928	63950	57236	52112
66-70	161393	98031	66584	60120	57492	208712	117053	81429	72880	66355
71-75	181660	110341	74945	67669	64712	219148	135675	94383	84475	76911
76+	206037	125148	85002	76749	73396	230105	154989	107819	96500	87860

Premium above is without GST and TPA charges. TPA charges of 3.5% shall apply to avail TPA services.

Waiver of 20% Co-payment **16% loading on premium**

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