

National Mediclaim Plus Policy

PROSPECTUS

1.1 Product

The policy covers expenses for inpatient treatment (cashless/reimbursement) reasonably and customarily incurred for treatment of illness/disease or injury contracted/sustained during the policy period. The policy covers medical expenses for 30 (thirty) days of pre hospitalisation, 60 (sixty) days of post hospitalization, 140+ day care procedures/surgeries, Ayush treatment, organ donor's medical expenses, maternity, hospital cash ambulance, air ambulance, medical emergency reunion, vaccination for children and medical second opinion.

The policy also provides optional covers for Critical Illness and Out-patient Treatment.

1.2 Coverage

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

1.2.1 In-patient Treatment

The company shall pay to the hospital or reimburse the insured, in respect of 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.

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 mentioned in the Table of Benefits. **The limit shall not apply if treatment is taken in a Preferred Provider Network (PPN) as a package.**

1.2.1.2 Limit for Cataract Surgery

Company's liability for cataract surgery shall be up to the limit mentioned in the Table of Benefits. **The limit shall not apply if treatment is taken in a Preferred Provider Network (PPN) as a package.**

1.2.1.3 Treatment related to Participation as a Non-Professional in Hazardous or Adventure Sports

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

1.2.2 Pre Hospitalisation

The company shall reimburse the insured in respect of the medical expenses incurred up to 30 (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 hospitalisation claim.

1.2.3 Post Hospitalisation

The company shall reimburse the insured in respect of the medical expenses incurred up to 60 (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 hospitalisation claim.

1.2.4 Day Care Procedure

The company shall pay to the hospital in respect of the medical expenses or reimburse the insured in respect of the medical expenses and pre and post hospitalisation expenses, for day care procedures which require hospitalisation for less than 24 (twenty four) hours provided that

- i. day care procedures/surgeries where such treatment is taken 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 24 (twenty four) hours and for which prior approval from company/TPA is mandatory.

1.2.5 AYUSH 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 the limit of Sum Insured as specified in the Policy Schedule in any AYUSH Hospital.

1.2.6 Organ Donor's Medical Expenses

The company shall reimburse the insured in respect of expenses of hospitalisation of organ donor during the course of organ transplant of the insured person provided that

- 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. Organ donor's pre and post hospitalisation expenses, as per Section 1.2.2 and Section 1.2.3.

1.2.7 Maternity

The company shall pay to the hospital or reimburse the insured in respect of medical expenses, incurred as an in-patient, with respect to delivery or termination up to first two deliveries or terminations of pregnancy, after the policy has been continuously in force for 24 (twenty four) months, during the lifetime of the insured or the spouse of the insured, if covered under the policy, as described below, up to the limit mentioned in the Table of Benefits.

- i. Medical expense for delivery (normal or caesarean).
- ii. Medical expense for lawful medical termination of pregnancy.
- iii. Medical expenses for pre natal medically necessary hospitalisation, up to 30 (thirty) days and post natal medically necessary hospitalisation, up to 60 (sixty) days, per delivery or lawful termination of pregnancy, if incurred as an in-patient.
- iv. Medical expenses of the new born baby, including expenses with respect to vaccination. Hospitalisation is not required for vaccination of new born baby.

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. Delivery or termination within 2 (two) years of continuous coverage from the inception of the policy, or from the date of inclusion of insured person, whichever is later. However, this period can be waived only in the case of delivery, miscarriage or abortion induced by accident or other medical emergency.
2. More than one delivery or termination in a policy period.
3. Ectopic pregnancy. However, ectopic pregnancy is covered under Section 1.2.1 provided it may be established by medical reports.
4. Pre and post hospitalisation expenses as per Section 1.2.2 and Section 1.2.3, other than pre and post natal treatment.

1.2.8 Hospital Cash

The company shall pay the insured a daily hospital cash allowance up to the limit mentioned in the Table of Benefits for a maximum of 5 (five) days, provided

- i. hospitalisation exceeds 3 (three) days and starts within the policy period.
- ii. a claim has been admitted under Section 1.2.1.

1.2.9 Ambulance

The company shall reimburse the insured in respect of expenses incurred for transportation of the insured person to the hospital by ambulance up to the limit as mentioned in the Table of Benefits, provided a claim has been admitted under Section 1.2.1.

1.2.10 Air Ambulance

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

1.2.11 Medical Emergency Reunion

In the event of the insured person being hospitalised in a place away from the place of residence for more than 5 (five) continuous days in an intensive care unit for any life threatening condition, the company after obtaining confirmation from the attending medical practitioner, of the need of a 'family member' to be present, shall reimburse the expenses of a round trip economy class air ticket, or first class railway ticket up to the limit mentioned in the Table of Benefits in a policy period to allow a family member.

For the purpose of the Section, 'family member' shall mean spouse, children and parents of the insured person.

1.2.12 Doctor's Home Visit and Nursing Care during Post Hospitalisation

The company shall reimburse the insured, medically necessary expenses incurred for doctor's home visit charges, nursing care by qualified nurse during post hospitalisation up to the limit mentioned in the Table of Benefits.

1.2.13 Vaccination for Children

The company shall reimburse the insured, in respect to expenses incurred for vaccinations of children (up to 12 years), up to the limit mentioned in the Table of Benefits, provided the children are covered under the policy. Hospitalisation is not required for this benefit.

1.2.14 HIV/ AIDS Cover

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

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

1.2.15 Mental Illness Cover

The Company shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) related to Mental Illnesses, provided the treatment shall be undertaken at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Psychiatrist or a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry.

Exclusions

Any kind of Psychological counselling, cognitive/ family/ group/ behavior/ palliative therapy or other kinds of psychotherapy for which Hospitalisation is not necessary shall not be covered.

1.2.16 Modern Treatment

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

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

1.2.17 Morbid Obesity Treatment

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

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

1.2.18 Correction of Refractive Error

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

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

1.3 Medical Second Opinion

The company shall arrange for Medical Second Opinion from a panel of World Leading Medical Centers (WLMC), at insured person's request if the insured person is diagnosed with one of the major illness, during the policy period. The insured person can avail one Medical Second Opinion for each major illness diagnosed during the policy period.

The insured person shall provide the medical records containing a diagnosis and a recommended course of treatment to the TPA. 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.

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 make 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 to which the Medical Second Opinion is put
- iii. the company assume no responsibility for and shall not be responsible for any actual or alleged errors, omissions or representations made by any medical practitioner or in any Medical Second Opinion or for any consequences of any action taken or not taken in reliance there on
- iv. Medical Second Opinion provided under this service shall not be valid for any medico-legal purposes
- v. Medical Second Opinion does not entitle the insured person to any consultations from or further opinions from that medical practitioner.

Copayment

Claims under Section 1.2, except claims under Section 1.2.13 (Vaccination for children), shall be subject to a co payment of 20% (twenty percent) of the admissible claim amount if treatment is taken in a non-network provider. Co payment shall not apply to claims if treatment is undergone in a non-network provider in a place where the company/ TPA does not have tie-up with any hospital.

1.4 Good Health Incentives

1.4.1 Cumulative Bonus (CB)

At the time of renewal, cumulative bonus allowed shall be an amount equal to 5% (five percent) of sum insured (excluding CB) of the expiring policy in respect of an insured person, provided no claims were reported under the expiring policy.

In the event of a claim being reported under the expiring policy the cumulative bonus with respect to the insured person shall be reduced by an amount equal to 5% (five percent) of sum insured (excluding CB) of the expiring policy. However, the reduction of CB will not impact sum insured (excluding CB).

Cumulative bonus shall be aggregated over the years and available, subject to maximum of 50% (fifty percent) of the sum insured (excluding CB) of the expiring policy.

1.4.2 Health Check Up

Expenses of health check up shall be reimbursed (irrespective of past claims) at the end of a block of two continuous policy period, provided the policy has been continuously renewed with the company without a break. Expenses payable is subject to the limit as stated in the Table of Benefits.

1.5 Hospitalisation Options

The policy provides for cashless facility and/ or reimbursement of 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 certain procedures for the insured person. The list is available with the company/TPA and subject to amendment from time to time.

2.1 Other Benefits

2.1.1 Family Discount

Discount of 10% (ten percent) is allowed in the premium for eligible family members if policy is bought for family, comprising the insured and any one or more of the family members as mentioned below

- i. Spouse
- ii. Dependent children
- iii. Dependent parents

2.1.2 Youth Discount

Discount of 10% (ten percent) is allowed in the premium for eligible members if either or both of the insured and spouse of the insured is aged between 18 (eighteen) to 25 (twenty five) years.

2.1.3 Online Discount

Discount of 5% (five percent) in the total premium is allowed if policy is bought online from <http://niconline.in/>.

Above discounts (as per Section 2.1.1, 2.1.2 and 2.1.3) are not applicable to the premium for optional covers.

2.1.4 Tax Rebate

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

2.2 Eligibility

- i. Policy can be issued to individuals on individual sum insured basis.
- ii. Entry age of proposer is between 18 (eighteen) years and 65(sixty five) years.

- iii. Maximum entry age of any individual is 65(sixty five) years.
- iv. Children between the age of 3 (three) months and 18 (eighteen) years may be covered, provided parent(s) is/are covered at the same time.
- v. Policy can be availed for self and the following family members
 - a. Spouse
 - b. Dependent legitimate or legally adopted children
 - Dependent child up to 18 (eighteen) years of age
 - Dependent male child above 18 (eighteen) years and up to 25 (twenty five) years, if a bona-fide student and not employed
 - Dependent female child if not employed, till marriage
 - c. Parents
- vi. Midterm inclusion of family members at pro-rata premium is allowed only in case of
 - a. newborn between the age of 3 (three) months and 6 (six) months
 - b. spouse within 60 (sixty) days of marriage
 (Family members other than above may be included only at renewal)
- vii. Dependent children have option to port to similar retail health insurance product of the company or of any other insurer at the end of the specified exit age as mentioned.

2.3 Sum Insured (SI)

- i. Plan A – 9 slabs, ₹ 2,00,000 to 10,00,000 in multiple of 1,00,000
Plan B – 3 slabs, ₹ 15,00,000/ 20,00,000/ 25,00,000
Plan C – 3 slabs, ₹ 30,00,000/ 40,00,000/ 50,00,000
- ii. The proposer has the option of selecting same SI for each family member or separate SI for different members.

2.4 Enhancement of Sum Insured

- i. Sum insured can be enhanced only at the time of renewal.
- ii. Sum insured can be enhanced to the next slab subject to discretion of the company.
- iii. For the incremental portion of the SI, 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.
- iv. Change of plan is allowed only at the time of renewal, subject to 4 (four) years of continuous coverage with the company and any insured person is not suffering from any chronic disease.
- v. For change of plan, medical reports as per Section 2.8.iii are required to be submitted with respect to each insured person aged 40 (forty) years and above.
- vi. For individual aged 70 (seventy) years and above, SI can be enhanced only in Plan A and change of plan is not allowed.

2.5 Policy Period

The policy and the optional covers are issued for a period of one year.

2.6 Buying the Policy

The policy can be bought

- i. online from portal
- ii. from our offices
- iii. from our agents
- iv. from self service kiosks
- v. from Office on Wheels (office on mobile van)

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 proofs.
- iii. If a person is insured under health insurance policy of any other non life insurance company and wants to port (switch) to National Mediclaim Plus Policy, the portability and proposal form will have to be completed and submitted to the office or to the agent.

2.8 Pre Policy Checkup

- i. Pre policy checkup is required for individual
 - a. 40 (forty) years and above or
 - b. opting for SI ₹ 6,00,000 and above, irrespective of age of the individual
 - c. opting for Critical Illness optional cover, between the age of 18 (eighteen) years and 65 (sixty five) years
- ii. The company shall reimburse 50% (fifty percent) of the expenses incurred for pre policy checkup, if the proposal is accepted and the premium has been realised.
- iii. The reports required are –

- | | |
|--|--|
| a) Physical examination (report to be signed by the Doctor with minimum MD (Medicine) qualification) | e) Urine routine and microscopic examination |
| b) HbA1c | f) ECG |
| c) Lipid profile | g) Eye checkup (including retinoscopy) |
| d) Serum creatinine | h) Any other investigation required by the company |

The date of medical reports should not exceed 30 (thirty) days prior to the date of proposal.

2.9 Payment of Premium

- i. Premium is based on age, SI, and optional covers opted.
- ii. 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.
- iii. Premium as per the premium table attached is to be paid in full before the commencement of the policy.
- iv. Premium can be paid online for both, new policy and renewals.
- v. No loadings shall apply on renewals based on individual claims experience.
- vi. PAN details must be submitted by the insured.
- vii. In case PAN is not available, Form 60 or Form 61 must be submitted

2.10 Renewal of Policy

- i. The policy can be renewed annually 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 30 (thirty) days is allowed. Coverage is not available during the grace period.

3 Policy Definition

3.1 Any One Illness means continuous period of illness and it includes relapse within 45 (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 Grace Period means 30 (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.

3.4 Hospitalisation means admission in a Hospital or mental health establishment for a minimum period of twenty four (24) consecutive 'Inpatient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.

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

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

3.7 Policy Period means period of one year as mentioned in the schedule for which the policy is issued.

3.8 Preferred Provider Network (PPN) means a network of hospitals which have agreed to a cashless packaged pricing for certain procedures for the insured person. The list is available with the company/TPA and subject to amendment from time to time. 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.

3.9 Pre-Existing Disease means any condition, ailment, injury or disease

- a) That is/are diagnosed by a physician within 48 months prior to the effective date of the Policy issued by the Company or its reinstatement or
- b) For which Medical Advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Policy issued by the Company or its reinstatement.

3.10 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

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

4 Exclusions

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

4.1. Pre-Existing Diseases (Excl 01)

- a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of thirty six (36) months of continuous coverage after the date of inception of the first policy with us.
- b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
- d) Coverage under the policy after the expiry of thirty six (36) months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

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

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

f) List of specific diseases/procedures

i. 90 Days Waiting Period (Life style conditions)

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

ii. One year waiting period

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

iii. Two years waiting period

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

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

iv. Four years waiting period

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

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

4.3. First 30 days waiting period (Excl 03)

- a) Expenses related to the treatment of any illness within thirty (30) days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
- b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve (12) months.

- c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4.4. Investigation & Evaluation (Excl 04)

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

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

- a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

4.6. Obesity/ Weight Control (Excl 06)

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

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

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

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

4.8. Cosmetic or Plastic Surgery (Excl 08)

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

4.9. Hazardous or Adventure Sports (Excl 09)

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

4.10. Breach of Law (Excl 10)

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

4.11. Excluded Providers (Excl 11)

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

4.12. Drug/Alcohol Abuse (Excl 12)

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

4.13. Non Medical Admissions (Excl 13)

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

4.14. Vitamins, Tonics (Excl 14)

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

4.15. Refractive Error (Excl 15)

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

4.16. Unproven Treatments (Excl16)

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

4.17. Birth control, Sterility and Infertility (Excl 17)

Expenses related to sterility and infertility. This includes:

- i. Any type of sterilization
- ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- iii. Gestational Surrogacy
- iv. Reversal of sterilization

4.18. Hormone Replacement Therapy

Expenses for hormone replacement therapy, unless part of Medically Necessary Treatment, except for Puberty and Menopause related Disorders

4.19. General Debility, Congenital External Anomaly

General debility, Congenital external anomaly.

4.20. Self Inflicted Injury

Treatment for intentional self-inflicted injury, attempted suicide.

4.21. Stem Cell Surgery

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

4.22. Circumcision

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

4.23. Vaccination or Inoculation.

Vaccination or inoculation unless forming part of treatment and requires Hospitalisation, except as and to the extent provided for under Section 1.2.7.iv and Section 1.2.13.

4.24. Massages, Steam Bath, Alternative Treatment (Other than AYUSH)

Massages, steam bath, expenses for alternative treatments (other than AYUSH), acupuncture, acupressure, magneto-therapy and similar treatment.

4.25. Dental treatment

Dental treatment, unless necessitated due to an Injury.

4.26. Domiciliary Hospitalization & Out Patient Department (OPD) treatment

Any expenses incurred on Domiciliary Hospitalization and OPD treatment.

4.27. Stay in Hospital which is not Medically Necessary.

Stay in hospital which is not medically necessary.

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

Spectacles, contact lens, hearing aid, cochlear implants.

4.29. Non Prescription Drug

Drugs not supported by a prescription, private nursing charges, referral fee to family physician, outstation doctor/surgeon/consultants' fees and similar expenses.

4.30. Treatment not Related to Disease for which Claim is Made

Treatment which the insured person was on before Hospitalisation for the Illness/Injury, different from the one for which claim for Hospitalisation has been made.

4.31. Equipments

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

4.32. Items of personal comfort

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

4.33. Service charge/ registration fee

Any kind of service charges including surcharges, admission fees, registration charges and similar charges levied by the hospital.

4.34. Home visit charges

Home visit charges during Pre and Post Hospitalisation of doctor, attendant and nurse, except as and to the extent provided for under 1.2.12.

4.35. War

War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

4.36. Radioactivity

Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

- a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
- b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
- c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

4.37. Treatment taken outside the geographical limits of India

4.38. Permanently Excluded Diseases

In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes (as listed in Appendix).

5 Policy conditions

5.1 Disclosure of information

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

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

5.2 Communication

- i. All communication should be in writing.
- ii. For claim 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, policy related issues, change in address to be communicated to the policy issuing office at the address mentioned in the schedule.
- iii. The company or TPA shall communicate to the insured person at the address mentioned in the schedule.

5.3 Claim Procedure

5.3.1 Notification of claim

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

| Notification of claim in case of Reimbursement | Company/TPA must be informed: |
|--|---|
| In the event of planned hospitalisation | At least 72 (seventy two) hours prior to the insured person's admission to hospital |
| In the event of emergency hospitalisation | Within 24 (twenty four) hours of the insured person's admission to hospital |

In case of a claim under Section 1.3, notification of claim is not required.

5.3.2 Procedure for Cashless claims

- i. Cashless facility for treatment in network hospitals shall be available to insured if opted for claim processing by TPA.
- ii. Treatment may be taken in a network provider/PPN and is subject to pre authorization 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 reimbursement.

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.

5.3.4 Documents

The claim is to be supported with the following original documents 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 attending medical practitioner
- v. Attending medical practitioner's certificate regarding diagnosis along with date of diagnosis and bill receipts etc.
- vi. Surgeon's original certificate stating diagnosis and nature of operation performed along with bills/receipts etc.
- vii. In the event of claim under Section 1.2.11, confirmation of the need of family member from attending medical practitioner
- viii. 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 hospitalisation and pre hospitalisation expenses | Within 15 (fifteen) days of date of discharge from hospital |
| Reimbursement of post hospitalisation expenses | Within 15 (fifteen) days from completion of post hospitalisation treatment |
| Reimbursement of health checkup expenses (as per Section 1.3.2) | At least 45 (forty five) days before the expiry of the third policy period. |
| Vaccination for children | Within 15 (fifteen) days from date of vaccination |

5.3.5 Claim Settlement

- i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

5.3.6 Services offered by TPA

The TPA shall render health care services covered under the policy like issuance of ID cards & guide book, hospitalization & 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 rejection with respect to the policy; However, TPA may handle claims admission and recommend to the company for the payment of the claim settlement
- ii. Any services directly to the 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.

5.4 Moratorium Period

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

5.5 Payment of claim

All medical treatments for the purpose of this insurance will have to be taken in India only. All claims under the policy shall be payable in Indian currency only.

5.6 Fraud

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

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

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

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

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

5.7 Cancellation

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

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

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 the Policy.

5.8 Migration

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

5.9 Portability

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

5.10 Revision of terms of the policy including the premium rates

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

5.11 Free look period

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

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

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

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

5.12 Nomination

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

6 Redressal of grievance

In case of any grievance 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/>

7 Optional covers

Critical Illness and Outpatient Treatment are optional covers.

7.1 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 30 (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 18 (eighteen) years and 65 (sixty five) years.

Benefit amount

Benefit amount available under Critical Illness cover shall be limited to the sum insured (excluding cumulative bonus) under the policy.

Benefit amount available per individual are INR 2,00,000/ 3,00,000/ 5,00,000/ 10,00,000/ 15,00,000/ 20,00,000/ 25,00,000.

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.

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 18 (eighteen) years and 65 (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.

7.1.1 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 3 (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 6 (six) or having progressed to at least clinical TNM classification T2N0M0.
- iv. papillary micro – carcinoma of the thyroid less than 1 (one) cm in diameter
- v. chronic lymphocytic leukaemia less than RAI stage 3
- vi. microcarcinoma of the bladder
- vii. all tumours in the presence of HIV infection.

III Kidney failure requiring regular dialysis

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

IV Major organ/ Bone marrow transplant

The actual undergoing of a transplant of:

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

The following are not covered

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

V Multiple sclerosis with persisting symptoms

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

- i. investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
- ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and
- iii. well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with at least two clinically documented episodes at least one month apart.

The following are not covered

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

VI Open chest CABG

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

The following are not covered

- i. angioplasty and/or any other intra-arterial procedures

- ii. any key-hole or laser surgery.

VII Permanent paralysis of limbs

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

VIII Blindness

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

7.1.2 Exclusions

The company shall not be liable to make any payment under the policy if:

- i. 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 90 (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
- ii. the insured person smokes 40 (forty) or more cigarettes / cigars or equivalent tobacco intake in a day

7.1.3 Condition

Claim amount

- i. Any amount payable under the optional covers will not affect the sum insured applicable to Section 1.2.
- ii. Copayment shall not apply to claims under optional covers.
- iii. Any amount payable under the optional covers shall not affect the entitlement to cumulative bonus.

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 15 (fifteen) days of critical illness diagnosis

Procedure for claims under critical illness

Claim documents supporting the diagnosis shall be submitted to the company after 30 (thirty) days and within 60 (sixty) days from the date of diagnosis of the disease.

Documents

The claim is to be supported with 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 This cover shall cease upon payment of the benefit amount on the occurrence of a critical illness and no further claim shall be paid for any other critical illness during the policy period.

2 On renewal, no claim shall be paid for any critical illness for which claim has already been made

Cancellation

In the event of cancellation of the policy by either insured or the company, the cover will also be cancelled as per cancellation clause of the policy.

7.2 Out-patient treatment

Subject to Exclusions 4.7, 4.8, 4.18, 4.16, 4.24, 4.12, 4.9, 4.10, 4.35 and 4.36, 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 individuals of any age band.

Limit of cover

Limit of cover available per individual are INR 2,000/ 3,000/ 4,000/ 5,000/ 10,000.

Enhancement of limit of cover

- i. Limit of cover 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.

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, AYUSH
- 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.
- ii. Copayment shall not apply to claims under optional covers.
- iii. Any amount payable under the optional covers shall not affect the entitlement to cumulative bonus.

Procedure for claims under outpatient treatment

Claim documents supporting all such outpatient treatments shall be submitted to the TPA/ company twice during the policy period, within 30 (thirty) days of completion of 6 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

Cancellation

In the event of cancellation of the policy by either insured or the company, the cover will also be cancelled as per cancellation clause of the policy.

8 Disclaimer

The prospectus contains salient features of the policy. For details reference is to be made to the Policy. In case of any difference between the prospectus and the policy, the terms and conditions of the policy shall prevail.

The prospectus and proposal form are part of the policy. Hence please read the prospectus carefully and sign the same. The proposal form is to be completed in all respects for each insured person. Both the prospectus and the proposal form are to be submitted to the office or to the agent.

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

Table of Benefits

| Features | Plans | | |
|--|---|---|---|
| | PLAN A | PLAN B | PLAN C |
| Sum insured | INR 2/ 3 /4 / 5/ 6/ 7/ 8/ 9 /10 Lac | INR 15/ 20 /25 Lac | INR 30/ 40/ 50 Lac |
| Coverage | | | |
| Hospitalisation, Pre (30days) and Post (60 days) Hospitalisation, Daycare procedure | Covered | Covered | Covered |
| Pre existing disease (Only PEDs declared in the Proposal Form and accepted for coverage by the Company shall be covered) | Covered after 36 months of continuous coverage | Covered after 36 months of continuous coverage | Covered after 36 months of continuous coverage |
| Room/ ICU charges | Room - Up to 1% of SI per day ICU – Up to 2% of SI per day subject to max. of INR 15,000 per day | Up to INR 15,000 per day | Up to INR 20,000 per day |
| Limit for cataract surgery | For each eye – Up to 15% of sum insured or INR 60,000 whichever is lower | For each eye – Up to INR 80,000 | For each eye – Up to INR 1,00,000 |
| AYUSH | Up to sum insured | Up to sum insured | Up to sum insured |
| Organ donor's medical expenses | Covered | Covered | Covered |
| Maternity | Up to INR 30,000 for normal delivery and INR 50,000 for caesarean section | Up to INR 60,000 for normal delivery and INR 75,000 for caesarean section | Up to INR 80,000 for normal delivery and INR 100,000 for caesarean section |
| Hospital cash | INR 500 per day, max. of 5 days | INR 800 per day, max. of 5 days | INR 1,000 per day, max. of 5 days |
| Ambulance | Up to INR 2,500 in a policy period | Up to INR 4,000 in a policy period | Up to INR 5,000 in a policy period |
| Air ambulance | Not covered | Up to 5% of SI per policy period | Up to 5% of SI per policy period |
| Medical emergency reunion | Not covered | Up to INR 20,000 per policy period | Up to INR 20,000 per policy period |
| Doctor's home visit and nursing care during post hospitalisation | Not covered | INR 750 per day, max. of 10 days | INR 1,000 per day, max. of 10 days |
| Vaccination for children (up to 12 years) | Up to INR 1,000 in a policy period | Up to INR 1,000 in a policy period | Up to INR 1,000 in a policy period |
| Modern Treatment (12 nos) | Up to 25% of SI for each treatment | Up to 25% of SI for each treatment | Up to 25% of SI for each treatment |
| Treatment due to participation in hazardous or adventure sports (non-professionals) | Up to 25% of SI | Up to 25% of SI | Up to 25% of SI |
| Morbid Obesity | Covered after waiting period of 4 years | Covered after waiting period of 4 years | Covered after waiting period of 4 years |
| Refractive Error (min 7.5D) | Covered after waiting period of 2 years | Covered after waiting period of 2 years | Covered after waiting period of 2 years |
| Other benefits | | | |
| Medical Second Opinion (MSO) | One MSO for each new diagnosis of any of the major illnesses, in a policy period | One MSO for each new diagnosis of any of the major illnesses, in a policy period | One MSO for each new diagnosis of any of the major illnesses, in a policy period |
| Good Health Incentives | | | |
| Cumulative bonus | Increase in SI by 5% of SI (excluding CB) per year up to 50% of SI (excluding CB) | Increase in SI by 5% of SI (excluding CB) per year up to 50% of SI (excluding CB) | Increase in SI by 5% of SI (excluding CB) per year up to 50% of SI (excluding CB) |
| Health checkup | Every 2 yrs., up to INR 1,000 | Every 2 yrs., up to INR 2,000 | Every 2 yrs., up to INR 3,000 |
| Copayment | | | |
| Copayment of 20% of admissible claim if treatment taken in non-network hospital (not applicable to optional covers) | Applicable | Applicable | Applicable |
| Optional covers | | | |
| Critical Illness | Benefit amount per individual - INR 2,00,000/ 3,00,000/ 5,00,000/ 10,00,000/ 15,00,000/ 20,00,000/ 25,00,000. | | |
| Outpatient Treatment | Limit of cover per individual - INR 2,000/ 3,000/ 4,000/ 5,000/ 10,000. | | |

Premium rate

Rate with TPA charges (in ₹)

| 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 + |
|-----------|--------|--------|---------|--------|--------|--------|----------|----------|----------|----------|----------|----------|----------|
| 2,00,000 | 5,303 | 5,356 | 5,951 | 6,070 | 6,192 | 8,533 | 12,344 | 16,064 | 23,304 | 27,103 | 28,586 | 29,833 | 31,009 |
| 3,00,000 | 6,918 | 6,918 | 7,687 | 7,841 | 7,841 | 11,344 | 16,543 | 21,324 | 31,356 | 35,820 | 38,967 | 40,992 | 42,519 |
| 4,00,000 | 8,381 | 8,382 | 9,314 | 9,499 | 9,499 | 13,913 | 20,392 | 26,096 | 38,732 | 43,681 | 48,573 | 51,387 | 53,218 |
| 5,00,000 | 9,743 | 9,743 | 10,826 | 11,042 | 11,043 | 16,314 | 24,000 | 30,536 | 45,645 | 50,964 | 57,643 | 61,251 | 63,285 |
| 6,00,000 | 10,852 | 10,852 | 12,057 | 12,299 | 12,300 | 18,592 | 27,428 | 34,730 | 52,208 | 57,817 | 65,726 | 70,106 | 73,039 |
| 7,00,000 | 11,901 | 11,902 | 13,224 | 13,488 | 13,489 | 20,596 | 30,536 | 38,565 | 58,332 | 64,169 | 73,674 | 78,903 | 82,260 |
| 8,00,000 | 12,902 | 12,903 | 14,338 | 14,624 | 14,624 | 22,518 | 33,528 | 42,242 | 64,230 | 70,245 | 81,347 | 87,302 | 91,173 |
| 9,00,000 | 13,865 | 13,865 | 15,407 | 15,714 | 16,365 | 24,375 | 36,420 | 45,784 | 69,936 | 76,091 | 88,660 | 95,446 | 99,820 |
| 10,00,000 | 14,792 | 14,793 | 16,437 | 16,765 | 18,201 | 26,173 | 39,229 | 49,212 | 75,477 | 81,739 | 95,752 | 1,03,367 | 1,08,237 |
| 15,00,000 | 19,952 | 19,953 | 29,474 | 33,076 | 33,407 | 66,663 | 52,460 | 61,655 | 80,547 | 87,132 | 1,07,210 | 1,25,964 | 1,32,586 |
| 20,00,000 | 23,806 | 23,807 | 31,806 | 46,836 | 47,305 | 47,777 | 63,596 | 72,329 | 87,633 | 90,500 | 1,19,378 | 1,46,718 | 1,55,270 |
| 25,00,000 | 27,358 | 27,359 | 34,314 | 49,016 | 49,506 | 53,523 | 73,732 | 80,878 | 90,644 | 93,994 | 1,26,742 | 1,62,657 | 1,72,917 |
| 30,00,000 | 31,217 | 31,219 | 37,515 | 51,819 | 53,158 | 62,159 | 83,223 | 88,196 | 91,285 | 98,102 | 1,31,041 | 1,75,246 | 1,86,618 |
| 40,00,000 | 37,389 | 37,392 | 43,547 | 56,662 | 61,703 | 77,050 | 98,473 | 98,478 | 99,351 | 1,05,769 | 1,31,384 | 1,90,674 | 2,04,536 |
| 50,00,000 | 42,950 | 42,952 | 50,148 | 61,024 | 70,992 | 91,358 | 1,11,388 | 1,11,395 | 1,11,400 | 1,14,035 | 1,31,391 | 1,97,469 | 2,13,206 |

Service Tax extra

Rate without TPA charges (in ₹)

| 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 + |
|-----------|--------|--------|---------|--------|--------|--------|----------|----------|----------|----------|----------|----------|----------|
| 2,00,000 | 5,003 | 5,053 | 5,614 | 5,727 | 5,841 | 8,050 | 11,645 | 15,155 | 21,984 | 25,569 | 26,968 | 28,144 | 29,253 |
| 3,00,000 | 6,527 | 6,527 | 7,252 | 7,397 | 7,397 | 10,703 | 15,607 | 20,117 | 29,581 | 33,792 | 36,761 | 38,672 | 40,112 |
| 4,00,000 | 7,907 | 7,908 | 8,786 | 8,962 | 8,962 | 13,125 | 19,237 | 24,619 | 36,540 | 41,208 | 45,823 | 48,479 | 50,206 |
| 5,00,000 | 9,191 | 9,192 | 10,212 | 10,417 | 10,417 | 15,391 | 22,641 | 28,808 | 43,061 | 48,078 | 54,380 | 57,784 | 59,702 |
| 6,00,000 | 10,238 | 10,238 | 11,375 | 11,603 | 11,604 | 17,539 | 25,875 | 32,764 | 49,253 | 54,544 | 62,006 | 66,138 | 68,904 |
| 7,00,000 | 11,228 | 11,228 | 12,475 | 12,725 | 12,726 | 19,429 | 28,808 | 36,383 | 55,031 | 60,537 | 69,504 | 74,438 | 77,603 |
| 8,00,000 | 12,173 | 12,173 | 13,526 | 13,796 | 13,797 | 21,244 | 31,630 | 39,851 | 60,593 | 66,269 | 76,742 | 82,361 | 86,012 |
| 9,00,000 | 13,080 | 13,081 | 14,534 | 14,825 | 15,439 | 22,995 | 34,359 | 43,193 | 65,977 | 71,784 | 83,641 | 90,044 | 94,170 |
| 10,00,000 | 13,956 | 13,956 | 15,506 | 15,817 | 17,171 | 24,692 | 37,008 | 46,427 | 71,206 | 77,113 | 90,332 | 97,516 | 1,02,110 |
| 15,00,000 | 18,822 | 18,823 | 27,805 | 31,204 | 31,516 | 34,588 | 49,491 | 58,165 | 75,987 | 82,200 | 1,01,142 | 1,18,835 | 1,25,080 |
| 20,00,000 | 22,457 | 22,458 | 30,006 | 44,185 | 44,627 | 45,073 | 59,996 | 68,235 | 82,673 | 85,378 | 1,12,620 | 1,38,412 | 1,46,480 |
| 25,00,000 | 25,809 | 25,810 | 32,373 | 46,242 | 46,704 | 50,493 | 69,558 | 76,300 | 85,513 | 88,674 | 1,19,569 | 1,53,449 | 1,63,129 |
| 30,00,000 | 29,450 | 29,451 | 35,392 | 48,886 | 50,149 | 58,640 | 78,513 | 83,204 | 86,118 | 92,549 | 1,23,623 | 1,65,327 | 1,76,055 |
| 40,00,000 | 35,273 | 35,275 | 41,082 | 53,454 | 58,211 | 72,688 | 92,899 | 92,904 | 93,727 | 99,782 | 1,23,947 | 1,79,881 | 1,92,959 |
| 50,00,000 | 40,520 | 40,521 | 47,310 | 57,570 | 66,973 | 86,187 | 1,05,084 | 1,05,089 | 1,05,095 | 1,07,580 | 1,23,954 | 1,86,291 | 2,01,137 |

Service Tax extra

Rate for Critical Illness (in ₹)

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

Service Tax extra

Rate for Outpatient Treatment (in ₹)

| Cover | 2,000 | 3,000 | 4,000 | 5,000 | 10,000 |
|---------|-------|-------|-------|-------|--------|
| Premium | 1,200 | 1,800 | 2,400 | 3,000 | 6,000 |

Service Tax extra

Discounts (not applicable to optional covers)

| | |
|-----------------|-----|
| Family discount | 10% |
| Youth discount | 10% |
| Online discount | 5% |

Insurance is the subject matter of solicitation

List of illnesses permanently excluded if existing at the time of taking the Policy

| SI | Existing Disease | ICD Code Excluded |
|----|---|---|
| 1 | Sarcoidosis | D86.0-D86.9 |
| 2 | Malignant Neoplasms | C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs • C40-C41 Malignant neoplasms of bone and articular cartilage • C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue • D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behaviour |
| 3 | Epilepsy | G40 Epilepsy |
| 4 | Heart Ailment Congenital heart disease and valvular heart disease | I49 Other cardiac arrhythmias, (I20-I25) Ischemic heart diseases, I50 Heart failure, I42 Cardiomyopathy; I05-I09 - Chronic rheumatic heart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system • Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0 Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1 to I34.9 - Valvular heart disease. |
| 5 | Cerebrovascular disease (Stroke) | I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases |
| 6 | Inflammatory Bowel Diseases | K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 - Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 - Other ulcerative colitis; K51.9 - Ulcerative colitis, unspecified. |
| 7 | Chronic Liver diseases | K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD) |
| 8 | Pancreatic diseases | K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis |
| 9 | Chronic Kidney disease | N17-N19 Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083 |
| 10 | Hepatitis B | B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 - Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 - Acute hepatitis B without delta-agent and without hepatic coma; B17.0 - Acute delta-(super) infection of hepatitis B carrier; B18.0 - Chronic viral hepatitis B with delta-agent; B18.1 - Chronic viral hepatitis B without delta-agent; |
| 11 | Alzheimer's Disease, Parkinson's Disease | G30.9 - Alzheimer's disease, unspecified; F00.9 - G30.9 Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease. |
| 12 | Demyelinating disease | G.35 to G 37 |
| 13 | HIV & AIDS | B20.0 - HIV disease resulting in mycobacterial infection; B20.1 - HIV disease resulting in other bacterial infections; B20.2 - HIV disease resulting in cytomegaloviral disease; B20.3 - HIV disease resulting in other viral infections; B20.4 - HIV disease resulting in candidiasis; B20.5 - HIV disease resulting in other mycoses; B20.6 - HIV disease resulting in Pneumocystis carinii pneumonia; B20.7 - HIV disease resulting in multiple infections; B20.8 - HIV disease resulting in other infectious and parasitic diseases; B20.9 - HIV disease resulting in unspecified infectious or parasitic disease; B23.0 - Acute HIV infection syndrome; B24 - Unspecified human immunodeficiency virus [HIV] disease |
| 14 | Loss of Hearing | H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified |
| 15 | Papulosquamous disorder of the skin | L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus |
| 16 | Avascular necrosis (osteonecrosis) | M 87 to M 87.9 |