National Insurance Company Limited

CIN - U10200WB1906GOI001713 IRDAI Regn. No. – 58

New National Parivar Mediclaim Policy

PROSPECTUS

1.1 Product

National Parivar Mediclaim Policy is an indemnity floater health insurance, covering the members of a family under a single sum insured. The Policy covers expenses in respect of inpatient treatment (allopathy and AYUSH), domiciliary hospitalisaion, reasonably and customarily incurred for treatment of a disease or an injury contracted/sustained during the policy period. The Policy also covers pre hospitalization and post hospitalization expenses, 140+ day care procedures/surgeries, organ donor's medical expenses, hospital cash, ambulance charges, anti rabies vaccination, maternity expenses, infertility expenses and reinstatement of sum insured. Pre-existing Diabetes and/or Hypertension, Outpatient Treatment and Critical Illness are provided as Optional Covers.

Any amount admissible under the Policy in respect of claims shall be subject to the sub limits contained herein as well as shown in the Table of Benefits.

1.2 Coverage

1.2.1 In-patient Treatment

The Company shall indemnify the Medical Expenses incurred for all Hospitalisation(s) covered under the Policy, subject to the following Sub Limits applicable to broad heads as mentioned below:

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 per Table of Benefits.
ii. Medical practitioner(s)
iii. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances
iv. Medicines and drugs
v. Diagnostic procedures
vi. Prosthetics and other devices or equipment if implanted internally during a surgical procedure.
vii. Dental treatment, necessitated due to an injury
viii. Plastic surgery, necessitated due to disease or injury
ix. Hormone replacement therapy, if medically necessary
x. Vitamins and tonics, forming part of treatment for disease/injury as certified by the attending medical practitioner
xi. Circumcision, necessitated for treatment of a disease or injury

1.2.1.1 Limit for Room Charges and Intensive Care Unit Charges

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

1.2.1.2 Limit for Cataract

The Company's liability for treatment of cataract shall be up to the limit as shown in the Table of Benefits.

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.

Note:

1. 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 Procedures.
2. In case of admission to a Room at rates exceeding the aforesaid limits, the reimbursement/payment of Associated Medical Expenses incurred at the Hospital, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent charges. Proportionate deduction shall not apply if admitted to ICU.

Associated Medical Expenses shall include all related expenses except the following expenses,

a. Cost of pharmacy and consumables;
b. Cost of implants and medical devices
c. Cost of diagnostics

3. Sub limits as mentioned above, will not apply in case of treatment undergone as a package for a listed procedure in a Preferred Provider Network (PPN).
4. Listed procedures and Preferred Provider Network list are dynamic in nature, and will be updated in the Company's website from time to time

1.2.2 Pre Hospitalisation

The Company shall indemnify the Medical Expenses incurred up to forty five (45) days immediately before the insured person is hospitalised, provided that:

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

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

1.2.3 Post Hospitalisation

The Company shall indemnify the Medical Expenses incurred up to seventy five (75) days immediately after the insured person is discharged from hospital, provided that:

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

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

1.2.4 Domiciliary Hospitalisation

The Company shall indemnify the Medical Expenses incurred under Domiciliary Hospitalization, including pre hospitalisation expenses and post hospitalisation expenses, up to the limit as shown in the Table of Benefits.

Exclusions

Domiciliary hospitalisation shall not cover:

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

1.2.5 Day Care Procedure

The Company shall indemnify the Medical Expenses and pre and post hospitalisation expenses up to the sum insured, for day care procedures which require hospitalisation for less than twenty four hours provided that

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

1.2.6 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.

1.2.7 Organ Donor's Medical Expenses

The Company shall indemnify the Medical Expenses of the organ donor up to the sum insured, during the course of organ transplant to the Insured Person provided

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

Exclusions

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

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

1.2.8 Hospital Cash

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

i. the hospitalisation exceeds three days.
ii. a claim has been admitted under In-Patient Treatment

Hospital Cash shall be payable for each day from the 4th day of Hospitalisation up to the 8th day of Hospitalisation only.

1.2.9 Ambulance Charges

The Company shall indemnify the expenses incurred for transportation to the Hospital or from the Hospital to another Hospital or from the Hospital to diagnostic center and return to the Hospital during the same Hospitalisation, up to the limit as shown in the Table of Benefits, provided a claim has been admitted under In-Patient Treatment.

1.2.10 Anti Rabies Vaccination

The Company shall indemnify the Medically Necessary Expenses incurred for anti-rabies vaccination up to the limit as shown in the Table of Benefits. Hospitalisation is not required for vaccination.

1.2.11 Maternity

The Company shall indemnify Maternity Expenses of Insured or Spouse only, as described below and also Pre-Natal and Post-Natal Hospitalisation expenses per delivery, subject to the limit as shown in the Table of Benefits.

The New Born Baby shall be automatically covered under the available Maternity Benefit limit from birth, for up to 3 months including expenses for vaccination as listed below. Hospitalisation is not required for vaccination.

Type of vaccination	**Frequency**
BCG (From birth to 2 weeks)	1
OPV (0,6,10 weeks) OR OPV + IPV1 (6,10 weeks)	3 OR 4
DPT (6 & 10 week)	2
Hepatitis-B (0 & 6 week)	2
Hib (6 & 10 week)	2

Cover

Maternity Expenses means;

a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);

b) Expenses towards lawful medical termination of pregnancy during the Policy Period.

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

Exclusions

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

1. Insured and insured persons above forty five (45) years of age.
2. Delivery or termination within a Waiting Period of thirty six (36) months. However, the Waiting Period may be waived only in the case of delivery, miscarriage or abortion induced by accident.
3. Delivery or lawful medical termination of pregnancy limited to two deliveries or terminations or either during the lifetime of the Insured Person.
4. Insured Persons who are already having two or more living children
5. Surrogacy, unless claim is admitted under Infertility
6. Ectopic pregnancy
7. Pre and post hospitalisation expenses, other than pre and post natal treatment.

1.2.12 Infertility

The Company shall indemnify the medical expenses of the insured and his spouse, if covered by the Policy, for treatment undergone as an in-patient or as a day care treatment, for procedures and/ or treatment of infertility, provided the Policy has been continuously in force for thirty six (36) months from the inception of the Policy or from the date of inclusion of the insured person, whichever is later. The medical expenses for either or both the insured person shall be subject to the limit as shown in the Table of Benefits.

Exclusions

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

1. Insured and insured persons above forty five (45) years of age.
2. Diagnostic tests related to infertility
3. Reversing a tubal ligation or vasectomy
4. Preserving and storing sperms, eggs and embryos
5. An egg donor or sperm donor
6. Experimental treatments
7. Any disease/ injury, other than traceable to maternity, of the surrogate mother.

Conditions

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

Definitions for the purpose of the Section

1. **Donor** means an oocyte donor or sperm donor.
2. **Embryo** means a fertilized egg where cell division has commenced/ under the process and has completed the pre-embryonic stage.
3. **Gamete Intra-Fallopian Transfer (GIFT)** means a procedure where the sperm and egg are placed inside a catheter separated by an air bubble and then transferred to the fallopian tube. Fertilization takes place naturally.

4. **Infertility** means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. However the one year period may be waived, provided a medical practitioner determines existence of a medical condition rendering conception impossible through unprotected sexual intercourse, including but not limited to congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments.
5. **Intra-Cytoplasmic Sperm Injection (ICSI)** means an injection of sperm into an egg for fertilisation.
6. **In Vitro Fertilization (IVF)** means a process in which an egg and sperm are combined in a laboratory dish where fertilization occurs. The fertilized and dividing egg is transferred into the uterus of the woman.
7. **Surrogate** means a woman who carries a pregnancy for the insured person.
8. **Zygote Intra-Fallopian Transfer (ZIFT)** means a procedure where the egg is fertilized in vitro and transferred to the fallopian tube before dividing.

1.2.13 HIV/ AIDS Cover

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

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

1.2.14 Mental Illness Cover

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

Exclusions

1. 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.
2. Any treatment of the following Mental Illnesses shall be covered after Waiting Period of 2 years:
   i. Depression (ICD - F32; F33)
   ii. Schizophrenia (ICD - F20; F21; F25)

1.2.15 Modern Treatment

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

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

1.2.16 Morbid Obesity Treatment

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

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

1.2.17 Correction of Refractive Error
The Company shall indemnify the Medical Expenses for In-patient Care, Pre-Hospitalisation expenses and Post-Hospitalisation expenses, incurred for expenses related to the treatment for correction of eye sight due to refractive error equal to or more than 7.5 dioptres, subject to Waiting Period of two (02) years as per Section 4.2.f.iii.

Note: Aggregate of all the benefits above are subject to the Sum Insured.

1.3 OTHER BENEFITS
1.3.1 Reinstatement of Basic Sum Insured (available to Basic Sum Insured of ₹ 6L and above)
For Policies with Floater Basic Sum Insured of ₹ 6 lacs and above, in the event of available Sum Insured being exhausted anytime during the Policy Year on account of Hospitalisation claim(s), the Company shall reinstate the Basic Sum Insured (i.e., excluding any CB) to be utilized in any subsequent Hospitalisation(s), provided that
i. Reinstatement of Basic Sum Insured shall be effected only after the date of discharge from the Hospital, for the Hospitalisation claim which resulted in exhaustion of the Sum Insured.
ii. Any Illness/ Injury for which a claim has been admitted or paid under the Policy prior to such reinstatement, shall not be considered under the Reinstated Basic Sum Insured
iii. Reinstatement of Basic Sum Insured shall be available in respect of the covered Insured Persons.
iv. Reinstatement shall be allowed only once during the Policy Year of the Policy Period.
v. Reinstated Basic Sum Insured, if not exhausted, will not be carried forward to next Policy Year or Policy Period on Renewal

1.4 GOOD HEALTH INCENTIVES
1.4.1 Cumulative Bonus
For each claim free Policy Year (i.e., no claims are reported by any Insured Person), Cumulative Bonus allowed shall be an amount equal to 5% (five percent) of the Floater Basic Sum Insured (excluding CB) of the expiring Policy Period.
In case of claim(s) during a Policy Year in respect of any Insured Person, the accumulated CB (if any) will be reduced at the rate of 5% of Floater Basic Sum Insured (excluding CB) of the expiring Policy Period.
However, CB will be unchanged during the Policy Period and CB accrued/ reduced during a Policy Period shall be available on next Renewal. CB shall be accumulated over subsequent Policy Periods and the maximum CB shall not exceed 50% of the Floater Basic Sum Insured of the renewed Policy.
Wherever, due to reduction in Floater Basic Sum Insured on renewal, the accumulated CB exceeds 50% of the reduced Floater Basic Sum Insured, then CB shall be restricted to 50% of the reduced Floater Basic Sum Insured.

Example:
In case of 2 year policy 1 claim, CB allowed shall be + 5%

In case of 3 year policy, 1 claims
on Year 1, CB allowed shall be + 10%
on Year 2/ 3, CB allowed shall be + 5%

In case of 3 year policy, 2 claims
on Year 1 & 2, CB allowed shall be + 5%
on Year 1 & 3, CB allowed shall be 0%
on Year 2 & 3, CB allowed shall be 0%

1.4.2 Preventive Health Check Up
Expenses of preventive health check-up/ prescribed diagnostic tests will be reimbursed once at the end of a block of three (03) continuous years provided no claims are reported during the block and the policy has been continuously renewed with the Company without a Break in Policy. Expenses payable shall be as mentioned in the Table of Benefits. Claim for health check-up benefits may be lodged at least forty five (45) days before the expiry of the fourth Policy Period.

1.5 Optional Covers
Pre-existing diabetes/ hypertension, Outpatient Treatment and Critical Illness are optional covers.

1.5.1 Pre-existing Diabetes / Hypertension
The Company shall pay expenses for treatment of diabetes and/ or hypertension, if pre-existing, from the inception of the Policy. Waiting Period for any related complications to diabetes and/ or hypertension existing at the time of issuance of the Policy shall not be waived and not covered under this Optional Cover. On completion of continuous forty eight months of insurance, the additional premium and co-payment shall not apply.

Copayment
Claims shall be subject to a co payment on admissible claim amount as mentioned below
i. Insured opting for cover for pre existing diabetes, can avail treatment for diabetes, subject to a copayment of 10%
ii. Insured opting for cover for pre existing hypertension, can avail treatment for hypertension, subject to a copayment of 10%
iii. Insured opting for cover for pre existing diabetes and hypertension, can avail treatment for diabetes or hypertension, subject to a copayment of 25%

Claim Amount
Any amount payable shall be subject to the sum insured under the Policy, zonal copayment, optional copayment (if opted) and copayment mentioned above

1.5.2 Out-patient Treatment
Subject otherwise to the terms, definitions, conditions and Exclusions 4.7, 4.8, 4.9, 4.17, 4.10, 4.12, 4.16, 4.23, 4.34, 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

Type
The cover can be availed by all insured persons as a floater.

Limit of Cover
Limit of cover, available under Outpatient Treatment are INR 2,000/ 3,000/ 4,000/ 5,000/ 10,000, in addition to the sum insured opted.

Exclusions
The Company shall not make any payment under the cover in respect of
i. Treatment other than Allopathy/ Modern medicine and 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.*

Claim Amount
i. Any amount payable under the optional covers will not affect the Basic Sum Insured and entitlement to Cumulative Bonus and Preventive Health Check up.
ii. Any amount payable shall not be subject to copayment.

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

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

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

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

Benefit Amount
Benefit amount available per individual are INR 2,00,000/ 3,00,000/ 5,00,000/ 10,00,000, in addition to the sum insured opted.

Pre Policy checkup
Pre Policy checkup reports are required for individual opting for Critical illness cover between the age of eighteen years and sixty five years.

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

I Stroke Resulting in Permanent Symptoms
Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical

practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least three months has to be produced.

The following are not covered

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

II Cancer of Specified Severity

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

The following are not covered

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below; vi. Chronic lymphocytic leukaemia less than RAI stage 3
vi. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
vii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

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 unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
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.

The following are not covered

Other causes of neurological damage such as SLE (Systemic Lupus Erythematosus) are excluded.

VI Open Chest CABG

The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

The following are not covered

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

VII Permanent Paralysis of Limbs

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

VIII Blindness

Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.
The Blindness is evidenced by:
i. corrected visual acuity being 3/60 or less in both eyes or ;
ii. the field of vision being less than 10 degrees in both eyes.
The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

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

Claim Amount
i. Any amount payable under the optional covers will not affect the Basic Sum Insured and entitlement to Cumulative Bonus and Preventive Health Check up.
ii. Any amount payable shall not be subject to copayment.

Notification of Claim
In the event of a claim, the insured person/insured person's representative shall intimate the Company in writing by letter, e-mail, fax providing all relevant information relating to the critical illness within fifteen days of diagnosis of the critical illness.

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

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

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

1.6 Hospitalisation Options
The Policy provides for cashless facility and/ or reimbursement of hospitalisation expenses or reimbursement of domiciliary hospitalisation expenses for treatment of disease or injury.
Cashless facility is available only in network providers, if opted for TPA service, subject to prior approval by the TPA. Preferred Provider Network (PPN) is a hospital which has agreed to a cashless packaged pricing for listed procedures for the insured person. The list is available with the Company/TPA and subject to amendment from time to time.

2.1 Eligibility
i. Policy shall cover at least two family members, as defined below.
ii. Entry age of Proposer should be between eighteen (18) years and sixty five (65) years.
iii. Maximum entry age of any family member is sixty five (65) years.
iv. Un married Children over the age of three (03) months may be covered for the first time, provided parent(s) is/are covered at the same time.
v. Family members allowed under same policy
    a. Proposer
    b. Spouse
    c. Dependent natural or legally adopted children
    d. Parents
vi. Renewal terms are as per Section 2.10 below.
vii. Midterm inclusion of family members at pro-rata premium is allowed only in case of
    a. newborn between the age of three months and six months
    b. spouse within sixty days of marriage

    (Members other than above may be included only at renewal. On inclusion of a new member, waiting period of 4.1, 4.2, 4.3 shall apply)

No other relation even within the eligible age band can be covered under the Policy. Age in completed years.

2.2 Policy Period
The Policy can be issued for a period of one, two or three years, as opted by the proposer.
Installment Facility is available.
Long Term Discount is available in 2/ 3 years Policy

2.3 Basic Sum Insured (SI)

i. The Basic SI for each Policy Year ranges from ₹ 1,00,000 to ₹ 10,00,000, in multiple of ₹ 1,00,000.
ii. The SI is on Floater basis and applies to one or all the insured persons.

2.3.1 Enhancement of Sum Insured

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

2.4 Discounts

2.4.1 Long Term Discount

For a Policy issued for two policy years. - Discount of 2.25% shall be allowed on the total premium (including optional covers)
For a Policy issued for three policy years - Discount of 4.5% shall be allowed on the total premium (including optional covers)

2.4.2 Discount for Direct Sale

If the Policy is bought online or by walk-in/ direct customer *(where no intermediary is involved)*, a discount of 10% shall be allowed on the total premium for both new policy and subsequent renewals *(provided no intermediary is involved in Renewals)*.

2.4.3 Discount for Optional Co-payment

If the Proposer/ Insured opts for Optional Co-payment under the Policy, a discount shall be allowed on the total premium. Insured may opt from either of the two options:

- 16% discount in total premium, for 20% Co-payment on each admissible claim.
- 12% discount in total premium, for 15% Co-payment on each admissible claim.

The Co-payment percentage opted shall be applicable to claims from all Insured Persons under the Policy

2.5 Tax Rebate

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

2.6 Buying the Policy

The Policy can be bought from the channels mentioned below.

i. online, for policies where Pre Policy Checkup is not required.
ii. from our operating offices
iii. from our agents
iv. from self service kiosks
v. from Office on Wheels (office on mobile van)
vi. Any other channel introduced by the Regulator from time to time

2.7 Completion of Proposal Form

i. The proposal form is to be completed in all respects (including personal details, medical history of insured person) and to be submitted to the office or to the agent.
ii. Identity and address of the proposer must be supported by documentary proof.
iii. Person insured covered by any health insurance policy of any other non life insurance Company and wishing to port (switch) to **New National Parivar Mediclaim Policy**, will have to submit the proposal form and portability form to the office or to the agent.

2.8 Pre Policy Checkup

i. Pre Policy checkup is required for all individual family members
   a. sixty (60) years and above or
   b. between the age of eighteen (18) years and sixty five (65) years, opting for Critical Illness
ii. The Company shall reimburse 50% of the expenses incurred for pre Policy checkup, if the proposal is accepted and the premium has been realized.
iii. The Pre Policy checkup reports required are –
   a) Physical examination (report to be signed by the Doctor with minimum MD (Medicine) qualification)
   b) Blood sugar (fasting/ post prandial)
   c) Lipid profile
   d) Serum creatinine
   e) Urine routine and microscopic examination
   f) ECG
   g) Eye checkup (including retinoscopy)
   h) Any other investigation required by the Company

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

2.9 Payment of Premium

i. Premium is based on the zone opted by the proposer. Change of zone shall not be allowed midterm.
ii. **Base premium** depends on the zone and SI, age, and is the aggregate of the premium for each and every insured person for a year.
iii. **Premium for Optional cover premium** depends upon the cover opted.
iv. Copayment Discount and Direct discount are allowed on the base premium
v. For long term policy, total premium for 3 years to be calculated based on age at inception.
vi. Long Term Discount (if available) is allowed on the total premium.

vii. 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 be inclusive of TPA charges.
viii. PAN details must be submitted to the Company.
ix. In case PAN is not available, Form 60 or Form 61 as per Rule 114B of the Income-tax Rule,1962 must be submitted

2.10 Renewal of Policy

i. The Policy can be renewed without break throughout the lifetime of the Insured Persons except for the covered Children, who can renew till the Insured Person's marriage
ii. The Policy may be renewed by mutual consent, before the expiry of the Policy or a within a Grace Period of thirty (30) days after expiry of the Policy. Coverage is not available during the Grace Period.
iii. If the Policy is not renewed within the Grace Period, the Break in Policy shall occur.
iv. The Company is not bound to send renewal notice.
v. Renewal of Policy can be denied on grounds of fraud, moral hazard, misrepresentation or noncooperation.
vi. Any change in the Policy, including Basic Sum Insured, Co-Payment, Insured Person(s), can only be incorporated at the time of Renewal.
vii. In case of non continuance of the Policy by the insured (due to death or any other valid and acceptable reason)
    - The Policy may be renewed by any insured person above eighteen years of age, as the insured
    - Where only children (less than eighteen years of age) are covered, the Policy shall be allowed till the expiry of the policy period. The grandparents may be allowed to renew the Policy as insured, covering the grandchildren.
    - If the number of members covered reduces to a single member, then on expiry of the policy period, the insured person shall migrate to any individual health insurance product of the Company.
viii. In case of death of the eldest insured person
    - The base premium to be charged shall be based on the age of the next eldest insured person.

2.11 Instalment Facility

i. Premium for the Policy may be paid in instalments of **Quarterly** or **Half Yearly** as opted
ii. If policy period opted in the Proposal Form is more than 1 year (i.e., 2/ 3 years), total premium for entire Policy Period shall be payable in instalments during the first year of the policy only.
iii. Change of Premium Paying Frequency can be opted only at the time of renewal.
iv. Grace Period of **15 days** shall be allowed for payment of Installment Premium. If premium is not paid within Grace Period, the Policy shall be cancelled and no refund shall be allowed.

3 Policy Definition

Standard Definitions

3.1 Accident means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

3.2 Any One Illness means continuous period of illness and it includes relapse within forty five days from the date of last consultation with the hospital where treatment has been taken.

3.3 AYUSH Treatment refers to the medical and / or Hospitalisation treatments given Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.

3.4 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.

3.5 AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital or
b. Teaching hospital attached to AYUSH College recognized by the Central Government/ Central Council of Indian Medicine/ Central Council for Homeopathy; or
c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
    i. Having at least 5 in-patient beds;
    ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
    iii. Having dedicated AYUSH therapy sections as required;
    iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative

3.6 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 approved.

3.7 Condition Precedent means a Policy term or condition upon which the Company's liability by the Policy is conditional upon.

3.8 Congenital Anomaly refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

a) Internal Congenital Anomaly

Congenital anomaly which is not in the visible and accessible parts of the body.

b) External Congenital Anomaly

Congenital anomaly which is in the visible and accessible parts of the body.

3.9 Co-payment means a cost-sharing requirement by the Policy that provides that the insured shall bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

3.10 Cumulative Bonus means any increase or addition in the Sum Insured granted by the Company without an associated increase in premium.

3.11 Day Care Centre means any institution established for day care treatment of disease/ injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

i. has qualified nursing staff under its employment;
ii. has qualified medical practitioner (s) in charge;
iii. has a fully equipped operation theatre of its own where surgical procedures are carried out
iv. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

3.12 Day Care Treatment means medical treatment, and/or surgical procedure which is:

i. undertaken under general or local anesthesia in a hospital/day care centre in less than twenty four hrs because of technological advancement, and
ii. which would have otherwise required a hospitalisation of more than twenty four hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

3.13 Dental Treatment means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

3.14 Domiciliary Hospitalisation means medical treatment for an illness /injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances.

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

3.15 Grace Period means specified period of time 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.

3.16 Hospital means any institution established for in-patient care and day care treatment of disease/ 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 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 ten inpatient beds, in those towns having a population of less than ten lacs and fifteen inpatient 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 shall make these accessible to the Company's authorized personnel.

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

3.18 Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.

i. **Acute Condition** means a disease, illness or injury that is likely to response quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
ii. **Chronic Condition** means a disease, illness, or injury 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 or for you to be specially trained to cope with it
d) it continues indefinitely
e) it comes back or is likely to come back.

3.19 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.

3.20 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.

3.21 Injury means accidental physical bodily harm excluding disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a medical practitioner.

3.22 Medical Advice means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

3.23 Medical Expenses means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of disease/ injury 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.

3.24 Medically Necessary Treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which
i. is required for the medical management of the disease/ injuries 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.

3.25 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 the licence.

3.26 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.

3.27 Newborn Baby means baby born during the policy period and is aged upto 90 days.

3.28 Non- Network means any hospital, day care centre or other provider that is not part of the network.

3.29 Notification of Claim means the process of intimating a claim to the Company or TPA through any of the recognized modes of communication.

3.30 Out-Patient Treatment means treatment in 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.

3.31 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.

3.32 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.

3.33 Qualified Nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

3.34 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 disease/ injury involved.

3.35 Room Rent means the amount charged by a hospital towards Room and Boarding expenses and shall include associated medical expenses.

3.36 Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of a disease or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner.

3.37 Unproven/ Experimental Treatment means treatment, including drug therapy, which is not based on established medical practice in India, is experimental or unproven.

Specific Definitions

3.38 Alternative Treatment means forms of treatments other than "Allopathy" or "modem medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

3.39 Break in Policy occurs at the end of the existing policy period when the premium due on a given Policy is not paid on or before the renewal date or within grace period.

3.40 Contract means Prospectus, Proposal, Policy, and the policy schedule. Any alteration with the mutual consent of the insured person and the insurer can be made only by a duly signed and sealed endorsement on the Policy.

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

3.42 Family Members means spouse, children and parents of the insured, covered by the Policy.

3.43 I D card means the card issued to the insured person by the TPA for availing cashless facility in the network provider.

3.44 Insured/ Insured Person means person(s) named in the schedule of the Policy.

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

3.46 Policy Year means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule.

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

3.48 Psychiatrist means a medical practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognised by the University Grants Commission established under the University Grants Commission Act, 1956, or awarded or recognised by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognised 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.

3.49 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.

3.50 Sum Insured means the Basic Sum Insured and the Cumulative Bonus (CB) accrued and available to all the Insured Persons on Floater basis, and as mentioned in the Schedule. Preventive Health Checkup expenses are payable over and above the Sum Insured, wherever applicable.

1 Basic Sum Insured means the Sum Insured opted in respect of the insured person (s) as mentioned in the Schedule, without any Cumulative Bonus (CB) accrued.

2 Floater Basis means the Sum Insured, as mentioned in the Schedule, available to all the insured persons, for any and all claims made in the aggregate during each Policy Year.

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

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

3.52 Waiting Period means a period from the inception of this Policy during which specified diseases/treatment is not covered. On completion of the period, diseases/treatment shall be covered provided the Policy has been continuously renewed without any break.

4 Exclusions

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

4.1. Pre-Existing Diseases (Excl 01)

a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of forty eight (48) months of continuous coverage after the date of inception of the first policy with us.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of forty eight (48) months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

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

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

i. 90 Days Waiting Period (Life style conditions)

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

ii. **One year waiting period**

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

iii. **Two years waiting period**

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

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

iv. **Four years waiting period**

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

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

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

4.3. First 30 days waiting period (Excl 03)

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

4.4. Investigation & Evaluation (Excl 04)

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

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

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

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

4.6. Obesity/ Weight Control (Excl 06)

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

1) Surgery to be conducted is upon the advice of the Doctor

2) The surgery/Procedure conducted should be supported by clinical protocols

3) The member has to be 18 years of age or older and

4) Body Mass Index (BMI);

a. greater than or equal to 40 or

b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

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

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

4.8. Cosmetic or Plastic Surgery (Excl 08)

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

4.9. Hazardous or Adventure Sports (Excl 09)

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

4.10. Breach of Law (Excl 10)

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

4.11. Excluded Providers (Excl11)

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

4.12. Drug/Alcohol Abuse (Excl 12)

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

4.13. Non Medical Admissions (Excl 13)

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

4.14. Vitamins, Tonics (Excl 14)

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

4.15. Refractive Error (Excl 15)

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

4.16. Unproven Treatments (Excl16)

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

4.17. Hormone Replacement Therapy

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

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

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

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

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

4.22. Vaccination or Inoculation.
Vaccination or inoculation unless forming part of treatment and requires Hospitalisation, except as and to the extent provided for under Anti Rabies Vaccination and Maternity.

4.23. 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.

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

4.25. Out Patient Department (OPD)
Any expenses incurred on OPD, *except as payable under Out Patient Treatment Optional Cover, if opted*.

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

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

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

4.29. Treatment not Related to Disease for which Claim is Made
Treatment which the insured person was on before Hospitalisation for the Illness/Injury, different from the one for which claim for Hospitalisation has been made.

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

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

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

4.33. Home visit charges
Home visit charges during Pre and Post Hospitalisation of doctor, attendant and nurse.

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

4.35. Radioactivity
Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

4.36. Treatment taken outside the geographical limits of India

4.37. Permanently Excluded Diseases

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

5 Conditions

5.1 Disclosure of Information

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

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

5.2 Condition Precedent to Admission of Liability

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

5.3 Communication

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

5.4 Physical examination

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

5.5 Claim Procedure

5.5.1 Notification of Claim

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

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

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

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

5.5.2 Procedure for Cashless Claims

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

vii. In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the TPA for processing.

5.5.3 Procedure for Reimbursement of Claims

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

5.5.3.1 Procedure for Reimbursement of Claim under Domiciliary Hospitalisation

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

5.5.4 Documents

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

i. Completed claim form
ii. Bills, payment receipts, medical history of the patient recorded, discharge certificate/ summary from the hospital etc.
iii. Cash-memo from the hospital (s)/chemist(s) supported by proper prescription
iv. Payment receipt, investigation test reports etc. supported by the prescription from the attending medical practitioner
v. Attending medical practitioner's certificate regarding diagnosis along with date of diagnosis and bill receipts etc.
vi. Certificate from the surgeon stating diagnosis and nature of operation and bills/receipts etc.
vii. For claim under Domiciliary Hospitalisation, in addition to documents listed above (as applicable), medical certificate stating the circumstances requiring for Domiciliary hospitalisation and fitness certificate from treating medical practitioner.
viii. For claim under Maternity for surrogacy under Infertility in addition to documents listed above (as applicable), legal affidavit regarding intimation of surrogacy.
ix. Any other document required by Company/TPA

Note

In the event of a claim lodged as per condition 5.8 and the original documents having been submitted to the other insurer, the Company may accept the documents listed under above and claim settlement advice duly certified by the other insurer subject to satisfaction of the Company.

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

5.5.5 Claim Settlement

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

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

5.5.6 Services Offered by TPA

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

The services offered by a TPA shall not include

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

Waiver

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

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

** The country has been divided into four zones.*

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

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

- Insured paying premium as per Zone I can avail treatment in Zone I, Zone II, Zone III and Zone IV without copayment
- Insured paying premium as per Zone II
    a. Can avail treatment in Zone II, Zone III and Zone IV without any copayment
    b. Availing treatment in Zone I will be subject to a copayment of 4.5%
- Insured paying premium as per Zone III
    a. Can avail treatment in Zone III and Zone IV without any copayment
    b. Availing treatment in Zone I will be subject to a copayment of 11%
    c. Availing treatment in Zone II will be subject to a copayment of 7%
- Insured paying premium as per Zone IV
    a. Can avail treatment in Zone IV without any copayment
    b. Availing treatment in Zone I will be subject to a copayment of 30%
    c. Availing treatment in Zone II will be subject to a copayment of 27.5%
    d. Availing treatment in Zone III will be subject to a copayment of 20%

*** For premium rates please refer to the Prospectus/ Brochure*

5.5.8 Optional Co-payment
The Insured may opt for Optional Co-payment, with discount in premium. In such cases, each admissible claim under the Policy shall be subject to the same Co-payment percentage. Any change in Optional Co-payment may be done only during Renewal. Insured may choose either of the two Co-payment options:

- 20% Co-payment on each admissible claim under the Policy, with a 16% discount in total premium.
- 15% Co-payment on each admissible claim under the Policy, with a 12% discount in total premium.

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

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

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

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

5.9 Multiple Policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

5.10 Fraud

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

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

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

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

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

5.11 Cancellation

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

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

iii. For policies with a term exceeding one year, the insured may at any time cancel the Policy and in such an event, the Company shall allow pro-rata refund of premium for the unexpired policy period after retaining 10% of the pro-rata premium.

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.

5.12 Territorial Jurisdiction

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

5.13 Arbitration

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

5.14 Disclaimer

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

5.15 Renewal of Policy

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

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

v. No loading shall apply on renewals based on individual claims experience.

5.16 Enhancement of Sum Insured

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

5.17 Adjustment of Premium for Overseas Travel Insurance Policy

If during the Policy Period any of the Insured Person is also covered by an Overseas Travel Insurance Policy issued by the Company, the Policy shall be inoperative in respect of the Insured Person(s) for the number of days the Overseas Travel Insurance Policy is in force. Proportionate premium for such number of days shall be adjusted against the Renewal premium, provided the Insured has informed the Company in writing before leaving India, and submits an application, stating the details of visit(s) abroad, along with copies of the Overseas Travel Insurance Policy, within fifteen (15) days of return. The maximum premium refundable and adjusted on Renewal shall be limited to 80% of premium of the expiring Policy, in respect of the Insured Person(s) covered under Overseas Travel Insurance Policy.

5.18 Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

5.19 Portability

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

5.20 Withdrawal of Product

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

5.21 Revision of Terms of the Policy Including the Premium Rates

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

5.22 Free Look Period

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

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

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

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

5.23 Nomination

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

5.24 Premium Payment in Installments

If the Insured Person has opted for Payment of Premium on an installment basis i.e. Half Yearly or Quarterly, as mentioned in the Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

i. Grace Period of 15 days would be given to pay the installment premium due for the Policy.
ii. During such grace period, Coverage will not be available from the installment premium payment due date till the date of receipt of premium by Company.

iii. The Benefits provided under the Policy shall continue in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the installment premium is not paid on due date.
v. In case of installment premium due not received within the grace Period, the Policy will get cancelled.

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 Disclaimer

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

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

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

Table of Benefits

Features	Benefit
Sum insured (SI) (as Floater)	**INR 1/ 2/ 3/ 4/ /5/ 6/ 7/ 8/ /9 10 Lac**
Treatment	Allopathy and AYUSH
In built Covers (subject to the SI)	
In patient Treatment (as Floater)	Up to SI
Pre Hospitalisation	45 days
Post Hospitalisation	75 days
Pre-existing Disease (Only PEDs declared in the Proposal Form and accepted for coverage by the Company shall be covered)	Covered after 48 months
* Room/ ICU Charges (per day per insured person)	Room – Up to 1% of SI or actual, whichever is lower
	ICU – Up to 2% of SI or actual, whichever is lower
	Proportionate Deduction to apply, in case higher limit is opted
** Limit for Cataract Surgery (For each eye per insured person)	Up to 10% of SI or INR 40,000 whichever is lower
Domiciliary Hospitalisation (as Floater)	Up to 20% of SI, subject to maximum of INR 50,000
Day Care Procedures (as Floater)	Up to SI
AYUSH (as Floater)	Up to SI
Organ Donor's Medical Expenses (as Floater)	Hospitalisation, pre and post hospitalisation
Hospital Cash (per insured person, per day)	INR 300, max. of 5 days (For Basic SI 1-5 Lakhs) INR 500, max of 5 days (For Basic SI 6-10 Lakhs)
Ambulance (per insured person, in a policy year)	Up to INR 1,000/- per illness & INR 2,500/-
Anti rabies Vaccination (per insured person, in a policy year)	Up to INR 5,000
Maternity (including Baby from Birth Cover) (per insured person, in a policy year, waiting period of 3 years applies)	Up to 10% of SI subject to INR 30,000 in case of normal delivery and INR 50,000 in case of caesarean section
Infertility (per insured person, in a policy year, waiting period of 3 years applies)	Up to INR 50,000
Modern Treatment (12 nos)	Up to 25% of SI for each treatment
Treatment due to participation in hazardous or adventure sports (non-professionals)	Up to 25% of SI
Morbid Obesity	Covered after waiting period of 4 years
Refractive Error (min 7.5D)	Covered after waiting period of 2 years
Other benefits	
Reinstatement of SI	Once in a Policy Period, available to Policy with Basic SI ₹ 6L and above
Installment Premium	Quarterly, Half Yearly (only in case of policy period of 1 year)
Good Health Incentives	
Cumulative Bonus	CB to increase by 5% of Basic SI in respect of each claim free Policy Year CB to decrease by 5% of Basic SI for each year with claim reported Maximum accumulation, **50% of the Basic SI of the renewed Policy**
Health Check Up (as Floater)	Every 3 yrs, INR 3000 (For SI 1-5 Lakhs), INR 6000 (For SI 6-10 Lakhs)
Optional Cover	
Pre-existing Diabetes/Hypertension (as Floater)	Up to the SI
Out-patient Treatment (as Floater in a policy year)	Limit of cover per family - INR 2,000/ 3,000/ 4,000/ 5,000/ 10,000 in addition to the SI
***Critical Illness (per insured person in a policy year)	Benefit amount - INR 2,00,000/ 3,00,000/ 5,00,000/ 10,00,000 in addition to the SI

Note: *SI here means Floater Basic SI and Cumulative Bonus (CB), unless otherwise specified.*

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

Rate Chart (in ₹)

Zone 1 : Premium of senior-most member without TPA charges										
Age band	**100000**	**200000**	**300000**	**400000**	**500000**	**600000**	**700000**	**800000**	**900000**	**1000000**
18-25	4,566	6,228	7,580	8,462	9,248	9,919	10,795	11,556	12,194	12,885
26-30	4,880	6,309	7,644	9,104	10,099	11,251	12,233	13,204	14,117	14,927
31-35	5,245	6,569	7,737	9,130	10,211	11,306	12,313	13,605	14,866	15,708
36-40	6,062	8,428	10,462	11,545	13,077	14,159	15,352	16,491	17,668	19,455
41-45	6,555	9,142	11,270	13,111	14,852	16,643	17,971	19,387	20,590	22,674
46-50	8,648	13,060	14,808	16,974	19,021	20,969	23,687	25,227	26,614	28,106
51-55	9,511	13,938	16,563	19,651	21,685	23,697	26,768	28,508	30,076	31,761
56-60	11,490	16,719	20,837	23,059	24,541	26,097	29,500	30,376	31,910	34,173
61-65	13,149	20,925	24,279	28,351	31,430	34,706	37,962	39,405	44,170	45,329
66-70	15,046	24,090	28,595	33,962	38,249	42,469	45,164	47,753	50,891	54,613
71-75	17,402	29,449	38,805	46,842	52,740	59,098	66,115	70,165	73,701	76,667
76-80	18,674	32,011	42,713	51,018	59,498	67,049	76,344	84,655	91,186	98,385
81-85	20,383	35,003	49,331	58,826	68,893	78,020	91,061	1,02,636	1,18,346	1,25,544
86+	24,263	36,838	51,473	65,100	76,480	90,118	1,01,961	1,16,356	1,30,525	1,40,395

Zone 1: Premium of dependent without TPA charges										
Age band	**100000**	**200000**	**300000**	**400000**	**500000**	**600000**	**700000**	**800000**	**900000**	**1000000**
0-5	811	970	995	1,189	1,272	1,395	1,446	1,465	1,504	1,550
6-17	848	1,020	1,048	1,254	1,342	1,506	1,561	1,618	1,680	1,711
18-25	997	1,219	1,258	1,513	1,623	1,815	1,928	1,999	2,076	2,139
26-30	1,130	1,412	1,546	1,654	1,829	1,982	2,085	2,176	2,327	2,459
31-35	1,252	1,517	1,671	1,772	1,933	2,086	2,200	2,315	2,517	2,680
36-40	1,782	2,291	2,585	2,743	2,922	3,150	3,498	3,705	3,955	4,309
41-45	2,174	2,672	3,127	3,207	3,448	3,906	4,168	4,434	4,746	5,152
46-50	3,448	4,702	5,370	5,909	6,145	7,016	7,519	8,005	8,526	8,919
51-55	4,373	5,382	6,494	7,385	8,210	8,995	9,668	10,272	10,833	11,273
56-60	5,030	6,829	8,446	9,866	11,129	11,678	13,203	13,985	14,595	15,085
61-65	6,617	10,086	12,055	14,388	16,401	17,269	19,554	20,651	21,363	21,944
66-70	7,593	11,640	14,719	17,849	20,511	22,782	24,555	25,879	26,598	27,195
71-75	8,934	14,532	18,765	22,674	26,316	29,519	32,071	34,032	35,743	37,176
76-80	10,899	18,416	24,097	28,836	33,656	37,964	43,211	47,911	51,300	54,147
81-85	12,520	21,021	27,822	33,241	38,962	44,170	51,529	57,398	64,009	69,224
86+	13,749	21,826	29,047	36,769	43,236	50,956	57,659	65,833	71,697	77,413

Zone 2 : Premium of senior-most member without TPA charges										
Age band	**1 L**	**2 L**	**3 L**	**4 L**	**5 L**	**6 L**	**7 L**	**8 L**	**9 L**	**10 L**
18-25	4,384	5,979	7,277	8,123	8,878	9,523	10,363	11,094	11,706	12,370
26-30	4,685	6,057	7,338	8,739	9,695	10,801	11,743	12,675	13,552	14,330
31-35	5,035	6,306	7,427	8,765	9,802	10,854	11,821	13,061	14,272	15,080
36-40	5,819	8,091	10,044	11,083	12,554	13,593	14,738	15,832	16,961	18,677
41-45	6,293	8,776	10,819	12,586	14,258	15,977	17,252	18,612	19,767	21,767
46-50	8,302	12,538	14,216	16,295	18,260	20,130	22,739	24,218	25,550	26,982
51-55	9,131	13,380	15,901	18,865	20,818	22,750	25,697	27,368	28,873	30,491
56-60	11,031	16,050	20,003	22,137	23,559	25,053	28,320	29,161	30,633	32,806
61-65	12,623	20,088	23,308	27,217	30,173	33,317	36,443	37,829	42,403	43,516
66-70	14,444	23,127	27,452	32,604	36,719	40,770	43,358	45,843	48,855	52,428
71-75	16,706	28,271	37,253	44,968	50,630	56,734	63,471	67,358	70,753	73,600
76-80	17,927	30,731	41,005	48,978	57,119	64,367	73,290	81,269	87,538	94,450
81-85	19,568	33,602	47,358	56,473	66,137	74,899	87,418	98,530	1,13,612	1,20,522
86+	23,292	35,365	49,414	62,496	73,421	86,513	97,882	1,11,702	1,25,304	1,34,779

Zone 2: Premium of dependent without TPA charges										
Age band	**1 L**	**2 L**	**3 L**	**4 L**	**5 L**	**6 L**	**7 L**	**8 L**	**9 L**	**10 L**
0-5	779	931	955	1,141	1,221	1,339	1,388	1,407	1,444	1,488
6-17	814	979	1,006	1,203	1,289	1,446	1,498	1,553	1,612	1,642
18-25	957	1,171	1,208	1,452	1,558	1,743	1,851	1,919	1,993	2,053
26-30	1,085	1,355	1,484	1,587	1,755	1,903	2,001	2,089	2,234	2,361
31-35	1,201	1,456	1,604	1,701	1,855	2,002	2,112	2,222	2,416	2,573
36-40	1,711	2,200	2,482	2,633	2,806	3,024	3,359	3,557	3,797	4,136
41-45	2,087	2,565	3,002	3,078	3,310	3,750	4,002	4,257	4,556	4,946
46-50	3,310	4,514	5,155	5,672	5,899	6,735	7,218	7,684	8,185	8,562
51-55	4,198	5,167	6,234	7,089	7,882	8,635	9,281	9,861	10,400	10,822
56-60	4,829	6,556	8,108	9,471	10,684	11,211	12,675	13,425	14,011	14,482
61-65	6,352	9,683	11,573	13,812	15,745	16,578	18,772	19,825	20,509	21,067
66-70	7,290	11,175	14,130	17,135	19,690	21,871	23,572	24,844	25,534	26,108
71-75	8,577	13,951	18,014	21,767	25,264	28,338	30,788	32,671	34,313	35,689
76-80	10,463	17,679	23,134	27,683	32,309	36,446	41,483	45,995	49,248	51,981
81-85	12,019	20,180	26,709	31,911	37,404	42,403	49,468	55,102	61,449	66,455
86+	13,199	20,953	27,885	35,298	41,506	48,918	55,352	63,200	68,829	74,317

Zone 3 : Premium of senior-most member without TPA charges										
Age band	**1 L**	**2 L**	**3 L**	**4 L**	**5 L**	**6 L**	**7 L**	**8 L**	**9 L**	**10 L**
18-25	4,110	5,605	6,822	7,616	8,323	8,927	9,715	10,401	10,974	11,597
26-30	4,392	5,678	6,879	8,193	9,089	10,126	11,009	11,883	12,705	13,435
31-35	4,721	5,912	6,963	8,217	9,190	10,175	11,082	12,244	13,380	14,138
36-40	5,455	7,585	9,416	10,390	11,769	12,743	13,817	14,842	15,901	17,510
41-45	5,899	8,227	10,143	11,800	13,367	14,979	16,174	17,449	18,531	20,407
46-50	7,784	11,754	13,327	15,276	17,119	18,872	21,318	22,704	23,953	25,295
51-55	8,560	12,544	14,907	17,685	19,517	21,328	24,091	25,657	27,068	28,585
56-60	10,341	15,047	18,753	20,753	22,087	23,487	26,550	27,339	28,719	30,756
61-65	11,834	18,833	21,851	25,515	28,287	31,235	34,166	35,465	39,753	40,796
66-70	13,541	21,681	25,736	30,566	34,424	38,222	40,648	42,978	45,802	49,151
71-75	15,662	26,504	34,925	42,158	47,466	53,188	59,504	63,148	66,331	69,000
76-80	16,806	28,810	38,442	45,916	53,549	60,344	68,709	76,189	82,067	88,547
81-85	18,345	31,502	44,398	52,944	62,004	70,218	81,955	92,372	1,06,512	1,12,989
86+	21,837	33,154	46,326	58,590	68,832	81,106	91,765	1,04,720	1,17,473	1,26,356

Zone 3: Premium of dependent without TPA charges										
Age band	**1 L**	**2 L**	**3 L**	**4 L**	**5 L**	**6 L**	**7 L**	**8 L**	**9 L**	**10 L**
0-5	730	873	895	1,070	1,145	1,256	1,301	1,319	1,353	1,395
6-17	763	918	943	1,128	1,208	1,356	1,405	1,456	1,512	1,540
18-25	897	1,097	1,132	1,361	1,461	1,634	1,735	1,799	1,868	1,925
26-30	1,017	1,271	1,391	1,488	1,646	1,784	1,876	1,958	2,094	2,213
31-35	1,126	1,365	1,504	1,595	1,740	1,877	1,980	2,083	2,265	2,412
36-40	1,604	2,062	2,327	2,469	2,630	2,835	3,149	3,334	3,560	3,878
41-45	1,956	2,405	2,814	2,886	3,103	3,515	3,752	3,991	4,271	4,637
46-50	3,103	4,232	4,833	5,318	5,531	6,314	6,767	7,204	7,674	8,027
51-55	3,936	4,844	5,844	6,646	7,389	8,095	8,701	9,245	9,750	10,145
56-60	4,527	6,146	7,602	8,879	10,016	10,510	11,883	12,586	13,135	13,577
61-65	5,955	9,078	10,849	12,949	14,761	15,542	17,599	18,586	19,227	19,750
66-70	6,834	10,476	13,247	16,064	18,460	20,504	22,099	23,291	23,938	24,476
71-75	8,040	13,079	16,888	20,407	23,685	26,567	28,864	30,629	32,169	33,459
76-80	9,809	16,574	21,688	25,952	30,290	34,168	38,890	43,120	46,170	48,733
81-85	11,268	18,919	25,040	29,917	35,066	39,753	46,376	51,658	57,608	62,302
86+	12,374	19,643	26,142	33,092	38,912	45,861	51,893	59,250	64,527	69,672

Zone 4 : Premium of senior-most member without TPA charges										
Age band	**1 L**	**2 L**	**3 L**	**4 L**	**5 L**	**6 L**	**7 L**	**8 L**	**9 L**	**10 L**
18-25	3,425	4,671	5,685	6,346	6,936	7,440	8,096	8,667	9,145	9,664
26-30	3,660	4,732	5,733	6,828	7,574	8,438	9,174	9,903	10,588	11,195
31-35	3,934	4,927	5,803	6,848	7,658	8,479	9,235	10,204	11,150	11,781
36-40	4,546	6,321	7,847	8,659	9,808	10,619	11,514	12,368	13,251	14,591
41-45	4,916	6,856	8,453	9,833	11,139	12,482	13,478	14,540	15,443	17,006
46-50	6,486	9,795	11,106	12,730	14,266	15,727	17,765	18,920	19,961	21,079
51-55	7,134	10,453	12,422	14,738	16,264	17,773	20,076	21,381	22,557	23,821
56-60	8,618	12,539	15,628	17,294	18,406	19,572	22,125	22,782	23,932	25,630
61-65	9,862	15,694	18,209	21,263	23,573	26,029	28,471	29,554	33,127	33,997
66-70	11,285	18,068	21,446	25,472	28,686	31,851	33,873	35,815	38,168	40,960
71-75	13,052	22,087	29,104	35,131	39,555	44,323	49,587	52,623	55,276	57,500
76-80	14,005	24,009	32,035	38,264	44,624	50,287	57,258	63,491	68,389	73,789
81-85	15,287	26,252	36,998	44,120	51,670	58,515	68,295	76,977	88,760	94,158
86+	18,197	27,629	38,605	48,825	57,360	67,588	76,470	87,267	97,894	1,05,296

Zone 4: Premium of dependent without TPA charges										
Age band	**1 L**	**2 L**	**3 L**	**4 L**	**5 L**	**6 L**	**7 L**	**8 L**	**9 L**	**10 L**
0-5	608	727	746	892	954	1,046	1,085	1,099	1,128	1,163
6-17	636	765	786	940	1,007	1,130	1,171	1,214	1,260	1,283
18-25	748	915	944	1,135	1,217	1,362	1,446	1,500	1,557	1,604
26-30	848	1,059	1,159	1,240	1,371	1,487	1,564	1,632	1,745	1,844
31-35	939	1,138	1,253	1,329	1,450	1,564	1,650	1,736	1,888	2,010
36-40	1,336	1,718	1,939	2,057	2,192	2,363	2,624	2,779	2,967	3,231
41-45	1,630	2,004	2,345	2,405	2,586	2,929	3,126	3,326	3,559	3,864
46-50	2,586	3,526	4,027	4,431	4,609	5,262	5,639	6,003	6,395	6,689
51-55	3,280	4,037	4,870	5,538	6,158	6,746	7,251	7,704	8,125	8,454
56-60	3,773	5,122	6,335	7,399	8,347	8,758	9,902	10,489	10,946	11,314
61-65	4,963	7,565	9,041	10,791	12,301	12,952	14,665	15,489	16,022	16,458
66-70	5,695	8,730	11,039	13,387	15,383	17,087	18,416	19,409	19,949	20,397
71-75	6,700	10,899	14,074	17,006	19,737	22,139	24,053	25,524	26,807	27,882
76-80	8,174	13,812	18,073	21,627	25,242	28,473	32,408	35,933	38,475	40,610
81-85	9,390	15,766	20,867	24,931	29,222	33,128	38,647	43,049	48,007	51,918
86+	10,311	16,369	21,785	27,577	32,427	38,217	43,244	49,375	53,772	58,060

GST and TPA charges extra

Zone	Definition
1	Greater Mumbai Metropolitan area, entire state of Gujarat
2	Delhi, NCR, Chandigarh, Pune
3	Chennai, Hyderabad, Bangalore
4	Rest of India

Instalment Facility (all installments for 2/ 3 years policy to be payable during year 1 of the long term policy)

Instalment	Half Yearly	Quarterly
1st Instalment	52.00%	28.00%
Others	50.00%	25.00%

Long Term Discount (available to policies with 2/3 years duration)

Term	Discount
2 years	2.25%
3 years	4.50%

Online Discount 10% discount in premium (for new and Renewal, ONLY where no intermediary is involved)

Copayment

Treatment outside zone

- Insured paying premium as per Zone I can avail treatment in Zone I, Zone II, Zone III and Zone IV without copayment
- Insured paying premium as per Zone II
  a. Can avail treatment in Zone II, Zone III and Zone IV without any copayment
  b. Availing treatment in Zone I will be subject to a copayment of 4.5%
- Insured paying premium as per Zone III
  a. Can avail treatment in Zone III and Zone IV without any copayment
  b. Availing treatment in Zone I will be subject to a copayment of 11%
  c. Availing treatment in Zone II will be subject to a copayment of 7%
- Insured paying premium as per Zone IV
  a. Can avail treatment in Zone IV without any copayment
  b. Availing treatment in Zone I will be subject to a copayment of 30%
  c. Availing treatment in Zone II will be subject to a copayment of 27.5%
  d. Availing treatment in Zone III will be subject to a copayment of 20%

Optional Copayment

- 20% Co-payment on each admissible claim under the Policy, with a 16% discount in total premium.
- 15% Co-payment on each admissible claim under the Policy, with a 12% discount in total premium.

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

Rate for Critical Illness (Optional Cover)

Age/ SI	2,00,000	3,00,000	5,00,000	10,00,000
18-25	372	557	929	1,858
26-35	647	970	1,617	3,234
36-45	1,198	1,796	2,994	5,988
46-55	2,217	3,326	5,543	11,086
56-59	3,209	4,813	8,022	16,043
60-65	4,643	6,965	11,608	23,217
66-75	9,501	14,251	23,752	47,505
76-85	21,109	31,664	52,773	1,05,546
86+	47,155	70,733	1,17,889	2,35,777

Rate for Outpatient Treatment (Optional Cover)

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

Rate for Pre-existing diabetes / hypertension (Optional Cover)

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

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