National Insurance Company Limited

CIN - U10200WB1906GOI001713 IRDAI Regn. No. – 58

National Mediclaim Plus Policy

PROSPECTUS

1.1 Product

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

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

1.2 Coverage

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

1.2.1 In-patient Treatment

The company shall pay to the hospital or reimburse the insured, in respect of the medical expenses for:

i. Room charges and intensive care unit charges (including diet charges, nursing care by qualified nurse, RMO charges, administration charges for IV fluids/blood transfusion/injection), subject to limit as mentioned in Section 1.2.1.1
ii. Medical practitioner(s)
iii. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances
iv. Medicines and drugs
v. Diagnostic procedures
vi. Prosthetics and other devices or equipment if implanted internally during a surgical procedure.

1.2.1.1 Limit for Room Charges and Intensive Care Unit Charges

Room charges and intensive care unit charges payable shall be up to the limit mentioned in the Table of Benefits. **The limit shall not apply if treatment is taken in a Preferred Provider Network (PPN) as a package.**

1.2.1.2 Limit for Cataract Surgery

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

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

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

1.2.2 Pre Hospitalisation

The company shall reimburse the insured in respect of the medical expenses incurred up to 30 (thirty) days immediately before the insured person is hospitalised, provided that:

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

Pre hospitalisation shall be considered as part of hospitalisation claim.

1.2.3 Post Hospitalisation

The company shall reimburse the insured in respect of the medical expenses incurred up to 60 (sixty) days immediately after the insured person is discharged from hospital, provided that:

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

Post hospitalisation shall be considered as part of hospitalisation claim.

1.2.4 Day Care Procedure

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

i. day care procedures/surgeries where such treatment is taken by an insured person in a hospital/day care centre (but not the outpatient department of a hospital)
ii. any other surgeries/procedures which due to advancement of medical science require hospitalisation for less than 24 (twenty four) hours and for which prior approval from company/TPA is mandatory.

1.2.5 Ayurveda and Homeopathy

The company shall pay to the hospital in respect of the medical expenses or reimburse the insured in respect of the medical expenses pre and post hospitalisation expenses, incurred for Ayurveda and Homeopathy treatment up to the limit as mentioned in the Table of Benefits provided treatment is taken in an Ayush Hospital.

1.2.6 Organ Donor's Medical Expenses
The company shall reimburse the insured in respect of expenses of hospitalisation of organ donor during the course of organ transplant of the insured person provided that
i. the donation conforms to 'The Transplantation of Human Organs Act 1994' and the organ is for the use of the insured person
ii. the insured person has been medically advised to undergo an organ transplant.

Exclusions
The company shall not be liable to make any payment in respect of any expenses incurred in connection with or in respect of
1. Cost of the organ to be transplanted.
2. Organ donor's pre and post hospitalisation expenses, as per Section 1.2.2 and Section 1.2.3.

1.2.7 Maternity
The company shall pay to the hospital or reimburse the insured in respect of medical expenses, incurred as an in-patient, with respect to delivery or termination up to first two deliveries or terminations of pregnancy, after the policy has been continuously in force for 24 (twenty four) months, during the lifetime of the insured or the spouse of the insured, if covered under the policy, as described below, up to the limit mentioned in the Table of Benefits.
i. Medical expense for delivery (normal or caesarean).
ii. Medical expense for lawful medical termination of pregnancy.
iii. Medical expenses for pre natal medically necessary hospitalisation, up to 30 (thirty) days and post natal medically necessary hospitalisation, up to 60 (sixty) days, per delivery or lawful termination of pregnancy, if incurred as an in-patient.
iv. Medical expenses of the new born baby, including expenses with respect to vaccination. Hospitalisation is not required for vaccination of new born baby.

Exclusions
The company shall not be liable to make any payment in respect of any expenses incurred in connection with or in respect of
1. Delivery or termination within 2 (two) years of continuous coverage from the inception of the policy, or from the date of inclusion of insured person, whichever is later. However, this period can be waived only in the case of delivery, miscarriage or abortion induced by accident or other medical emergency.
2. More than one delivery or termination in a policy period.
3. Ectopic pregnancy. However, ectopic pregnancy is covered under Section 1.2.1 provided it may be established by medical reports.
4. Pre and post hospitalisation expenses as per Section 1.2.2 and Section 1.2.3, other than pre and post natal treatment.

1.2.8 Hospital Cash
The company shall pay the insured a daily hospital cash allowance up to the limit mentioned in the Table of Benefits for a maximum of 5 (five) days, provided
i. hospitalisation exceeds 3 (three) days and starts within the policy period.
ii. a claim has been admitted under Section 1.2.1.

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

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

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

1.2.12 Doctor's Home Visit and Nursing Care during Post Hospitalisation
The company shall reimburse the insured, medically necessary expenses incurred for doctor's home visit charges, nursing care by qualified nurse during post hospitalisation up to the limit mentioned in the Table of Benefits.

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

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

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

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

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

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

A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
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.

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

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

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

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

1.3 Medical Second Opinion
The company shall arrange for Medical Second Opinion from a panel of World Leading Medical Centers (WLMC), at insured person's request if the insured person is diagnosed with one of the major illness, during the policy period. The insured person can avail one Medical Second Opinion for each major illness diagnosed during the policy period.
The insured person shall provide the medical records containing a diagnosis and a recommended course of treatment to the TPA. The Medical Second Opinion shall be based only on the information and documentation provided to the medical practitioner of WLMC by or on behalf of the insured person, and the second opinion and the recommended course of treatment shall be sent directly to the insured/ insured person.

In opting for this service and deciding to obtain a Medical Second Opinion, each insured person expressly notes and agrees that:

i. it is entirely for the insured person to choose whether or not to obtain a Medical Second Opinion from WLMC and if obtained under this service then whether or not to act on it
ii. the company does not provide Medical Second Opinion or make any representation as to the adequacy or accuracy of the same, the insured person's or any other person's reliance on the same, or the use to which the Medical Second Opinion is put
iii. the company assume no responsibility for and shall not be responsible for any actual or alleged errors, omissions or representations made by any medical practitioner or in any Medical Second Opinion or for any consequences of any action taken or not taken in reliance there on
iv. Medical Second Opinion provided under this service shall not be valid for any medico-legal purposes
v. Medical Second Opinion does not entitle the insured person to any consultations from or further opinions from that medical practitioner.

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

1.4 Good Health Incentives

1.4.1 Cumulative Bonus (CB)
At the time of renewal, cumulative bonus allowed shall be an amount equal to 5% (five percent) of sum insured (excluding CB) of the expiring policy in respect of an insured person, provided no claims were reported under the expiring policy.
In the event of a claim being reported under the expiring policy the cumulative bonus with respect to the insured person shall be reduced by an amount equal to 5% (five percent) of sum insured (excluding CB) of the expiring policy. However, the reduction of CB will not impact sum insured (excluding CB).
Cumulative bonus shall be aggregated over the years and available, subject to maximum of 50% (fifty percent) of the sum insured (excluding CB) of the expiring policy.

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

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

2.1 Other Benefits
2.1.1 Family Discount
Discount of 10% (ten percent) is allowed in the premium for eligible family members if policy is bought for family, comprising the insured and any one or more of the family members as mentioned below
i. Spouse
ii. Dependent children
iii. Dependent parents

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

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

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

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

2.2 Eligibility
i. Policy can be issued to individuals on individual sum insured basis.
ii. Entry age of proposer is between 18 (eighteen) years and 65(sixty five) years.
iii. Maximum entry age of any individual is 65(sixty five) years.
iv. Children between the age of 3 (three) months and 18 (eighteen) years may be covered, provided parent(s) is/are covered at the same time.
v. Policy can be availed for self and the following family members
    a. Spouse

b. Dependent legitimate or legally adopted children
- Dependent child up to 18 (eighteen) years of age
- Dependent male child above 18 (eighteen) years and up to 25 (twenty five) years, if a bona-fide student and not employed
- Dependent female child if not employed, till marriage

c. Parents

vi. Midterm inclusion of family members at pro-rata premium is allowed only in case of
a. newborn between the age of 3 (three) months and 6 (six) months
b. spouse within 60 (sixty) days of marriage
(Family members other than above may be included only at renewal)

vii. Dependent children have option to port to similar retail health insurance product of the company or of any other insurer at the end of the specified exit age as mentioned.

2.3 Sum Insured (SI)

i. Plan A – 9 slabs, ₹ 2,00,000 to 10,00,000 in multiple of 1,00,000
Plan B – 3 slabs, ₹ 15,00,000/ 20,00,000/ 25,00,000
Plan C – 3 slabs, ₹ 30,00,000/ 40,00,000/ 50,00,000

ii. The proposer has the option of selecting same SI for each family member or separate SI for different members.

2.4 Enhancement of Sum Insured

i. Sum insured can be enhanced only at the time of renewal.
ii. Sum insured can be enhanced to the next slab subject to discretion of the company.
iii. For the incremental portion of the SI, the waiting periods and conditions as mentioned in exclusion 4.1, 4.2, 4.3 shall apply. Coverage on enhanced sum insured shall be available after the completion of waiting periods.
iv. Change of plan is allowed only at the time of renewal, subject to 4 (four) years of continuous coverage with the company and any insured person is not suffering from any chronic disease.
v. For change of plan, medical reports as per Section 2.8.iii are required to be submitted with respect to each insured person aged 40 (forty) years and above.
vi. For individual aged 70 (seventy) years and above, SI can be enhanced only in Plan A and change of plan is not allowed.

2.5 Policy Period

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

2.6 Buying the Policy

The policy can be bought

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

2.7 Completion of Proposal Form

i. The proposal form is to be completed in all respects (including personal details, medical history of insured person) and to be submitted to the office or to the agent.
ii. Identity and address of the proposer must be supported by documentary proofs.
iii. If a person is insured under health insurance policy of any other non life insurance company and wants to port (switch) to National Mediclaim Plus Policy, the portability and proposal form will have to be completed and submitted to the office or to the agent.

2.8 Pre Policy Checkup

i. Pre policy checkup is required for individual
a. 40 (forty) years and above or
b. opting for SI ₹ 6,00,000 and above, irrespective of age of the individual
c. opting for Critical Illness optional cover, between the age of 18 (eighteen) years and 65 (sixty five) years

ii. The company shall reimburse 50% (fifty percent) of the expenses incurred for pre policy checkup, if the proposal is accepted and the premium has been realised.

iii. The reports required are –
a) Physical examination (report to be signed by the Doctor with minimum MD (Medicine) qualification)
b) HbA1c
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

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

2.9 Payment of Premium

i. Premium is based on age, SI, and optional covers opted.
ii. The proposer has the option of claims being serviced by TPA (in which case cashless facility/reimbursement of expenses will be available) or the company (in which case expenses will be reimbursed). If cashless facility is to be availed, the premium payable is inclusive of TPA charges. If cashless facility is not required, the premium payable is without TPA charges.
iii. Premium as per the premium table attached is to be paid in full before the commencement of the policy.
iv. Premium can be paid online for both, new policy and renewals.
v. No loadings shall apply on renewals based on individual claims experience.
vi. PAN details must be submitted by the insured.
vii. In case PAN is not available, Form 60 or Form 61 must be submitted

2.10 Renewal of Policy

i. The policy can be renewed annually throughout the lifetime of the insured person.
ii. The policy may be renewed by mutual consent before the expiry of the policy.
iii. The company is not bound to send renewal notice.
iv. Renewal of policy can be denied on grounds of fraud, moral hazard, misrepresentation or noncooperation.
v. In the event of break in the policy a grace period of 30 (thirty) days is allowed. Coverage is not available during the grace period.

3 Policy Definition

3.1 Any One Illness means continuous period of illness and it includes relapse within 45 (forty five) days from the date of last consultation with the hospital where treatment has been taken.

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

3.3 Grace Period means 30 (thirty) days immediately following the premium due date during which a payment can be made to renew or continue the policy in force without loss of continuity benefits such as waiting period and coverage of pre-existing disease. Coverage is not available for the period for which no premium is received.

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

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

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

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

3.8 Preferred Provider Network (PPN) means a network of hospitals which have agreed to a cashless packaged pricing for certain procedures for the insured person. The list is available with the company/TPA and subject to amendment from time to time. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.

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

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

3.10 Schedule means a document forming part of the policy, containing details including name of the insured person, age, relation of the insured person, sum insured, premium paid and the policy period

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

4 Exclusions

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

4.1. Pre-Existing Diseases (Excl 01)

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

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

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

i. **90 Days Waiting Period (Life style conditions)**

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

ii. **One year waiting period**

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

iii. **Two years waiting period**

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

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

iv. **Four years waiting period**

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

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

4.3. First 30 days waiting period (Excl 03)

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

4.4. Investigation & Evaluation (Excl 04)

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

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

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

4.6. Obesity/ Weight Control (Excl 06)
Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
a. greater than or equal to 40 or
b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
i. Obesity-related cardiomyopathy
ii. Coronary heart disease
iii. Severe Sleep Apnea
iv. Uncontrolled Type2 Diabetes

4.7. Change-of-Gender Treatments (Excl 07)
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

4.8. Cosmetic or Plastic Surgery (Excl 08)
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

4.9. Hazardous or Adventure Sports (Excl 09)
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

4.10. Breach of Law (Excl 10)
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

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

4.12. Drug/Alcohol Abuse (Excl 12)
Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof (Excl 12)

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

4.14. Vitamins, Tonics (Excl 14)
Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioners part of hospitalization claim or day care procedure

4.15. Refractive Error (Excl 15)
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

4.16. Unproven Treatments (Excl16)
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

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

4.18. Hormone Replacement Therapy
Expenses for hormone replacement therapy, unless part of Medically Necessary Treatment, except for Puberty and Menopause related Disorders

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

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

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

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

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

4.24. Massages, Steam Bath, Alternative Treatment (Other than Ayurveda and Homeopathy)
Massages, steam bath, expenses for alternative or AYUSH treatments (other than Ayurveda and Homeopathy), acupuncture, acupressure, magneto-therapy and similar treatment.

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

4.26. Domiciliary Hospitalization & Out Patient Department (OPD) treatment
Any expenses incurred on Domiciliary Hospitalization and OPD treatment.

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

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

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

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

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

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

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

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

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

4.36. Radioactivity
Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing

any Illness, incapacitating disablement or death.
b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

4.37. Treatment taken outside the geographical limits of India

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

5 Policy conditions

5.1 Disclosure of information
The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.
*(**Explanation**: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)*

5.2 Communication
i. All communication should be in writing.
ii. For claim serviced by TPA, ID card, PPN/network provider related issues to be communicated to the TPA at the address mentioned in the schedule. For claim serviced by the company, policy related issues, change in address to be communicated to the policy issuing office at the address mentioned in the schedule.
iii. The company or TPA shall communicate to the insured person at the address mentioned in the schedule.

5.3 Claim Procedure

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

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

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

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

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

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

5.3.4 Documents

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

i. Completed claim form
ii. Bills, payment receipts, medical history of the patient recorded, discharge certificate/ summary from the hospital etc.
iii. Cash-memo from the hospital (s)/chemist (s) supported by proper prescription
iv. Payment receipt, investigation test reports etc. supported by the prescription from attending medical practitioner
v. Attending medical practitioner's certificate regarding diagnosis along with date of diagnosis and bill receipts etc.
vi. Surgeon's original certificate stating diagnosis and nature of operation performed along with bills/receipts etc.
vii. In the event of claim under Section 1.2.11, confirmation of the need of family member from attending medical practitioner
viii. Any other document required by company/TPA

Note

In the event of a claim lodged as per contribution clause of the policy and the original documents having been submitted to the other insurer, the company may accept the documents listed under condition 5.3.4 and claim settlement advice duly certified by the other insurer subject to satisfaction of the company.

Type of claim	**Time limit for submission of documents to company/TPA**
Reimbursement of hospitalisation and pre hospitalisation expenses	Within 15 (fifteen) days of date of discharge from hospital
Reimbursement of post hospitalisation expenses	Within 15 (fifteen) days from completion of post hospitalisation treatment
Reimbursement of health checkup expenses (as per Section 1.3.2)	At least 45 (forty five) days before the expiry of the third policy period.
Vaccination for children	Within 15 (fifteen) days from date of vaccination

5.3.5 Claim Settlement

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

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

5.3.6 Services offered by TPA

The TPA shall render health care services covered under the policy like issuance of ID cards & guide book, hospitalization & pre-authorization services, call centre, acceptance of claim related documents, claim processing and other related services

The services offered by a TPA shall not include

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

Waiver

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

5.4 Moratorium Period

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

5.5 Payment of claim

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

5.6 Fraud

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

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

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

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

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

5.7 Cancellation

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

Period of risk	**Rate of premium to be charged**
Up to 1month	¼ of the annual rate
Up to 3 months	½ of the annual rate
Up to 6 months	¾ of the annual rate
Exceeding 6 months	Full annual rate

5.8 Migration

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

5.9 Portability

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

5.10 Revision of terms of the policy including the premium rates

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

5.11 Free look period

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

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

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

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

5.12 Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and

such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

6 Redressal of grievance

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

Website: https://nationalinsurance.nic.co.in/
Toll free: 1800 345 0330
E-mail: customer.relations@nic.co.in
Phn : (033) 2283 1742

Post: National Insurance Co. Ltd.,
6A Middleton Street, 7th Floor,
CRM Dept.,
Kolkata - 700 071

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

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

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

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

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

7 Optional covers

Critical Illness and Outpatient Treatment are optional covers.

7.1 Critical illness

The company shall pay the benefit amount, as stated in the schedule, provided that

i. the insured person is first diagnosed as suffering from a critical illness (as defined) during the policy period, and
ii. the insured person survives for at least 30 (thirty) days following such diagnosis
iii. diagnosis of critical illness is supported by clinical, radiological, histological and laboratory evidence acceptable to the company.

Eligibility (entry age)

The cover can be availed by persons between the age of 18 (eighteen) years and 65 (sixty five) years.

Benefit amount

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

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

Enhancement of benefit amount

i. Benefit amount can be enhanced only at the time of renewal.
ii. Benefit amount can be enhanced to the next slab subject to discretion of the company.

Policy period

The policy period for the policy, and the cover should be identical, as mentioned in the schedule.

Pre policy checkup

Pre policy checkup reports (as per Section 2.8.iii) are required for individual opting for Critical illness cover between the age of 18 (eighteen) years and 65 (sixty five) years.

Tax rebate

No tax benefit is allowed on the premium paid under Critical Illness cover (if opted)

Renewal

The Critical Illness cover can be renewed annually throughout the lifetime of the insured person.

7.1.1 Definition

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

I Stroke resulting in permanent symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 (three) months has to be produced.

The following are not covered
i. transient ischemic attacks (TIA)
ii. traumatic injury of the brain
iii. vascular disease affecting only the eye or optic nerve or vestibular functions.

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

The following are not covered
i. tumours showing the malignant changes of carcinoma in situ and tumours which are histologically described as premalignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
ii. any skin cancer other than invasive malignant melanoma
iii. all tumours of the prostate unless histologically classified as having a Gleason score greater than 6 (six) or having progressed to at least clinical TNM classification T2N0M0.
iv. papillary micro – carcinoma of the thyroid less than 1 (one) cm in diameter
v. chronic lymphocyctic leukaemia less than RAI stage 3
vi. microcarcinoma of the bladder
vii. all tumours in the presence of HIV infection.

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

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

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

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

The following are not covered
Other causes of neurological damage such as SLE (Systemic Lupus Erythematosus) and HIV (Human Immunodeficiency Virus).

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

The following are not covered
i. angioplasty and/or any other intra-arterial procedures
ii. any key-hole or laser surgery.

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

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

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

i. any critical illness and/or its symptoms (and/or the treatment) which were present at any time before inception of the first policy, or which manifest within a period of 90 (ninety) days from inception of the first policy, whether or not the insured person had knowledge that the symptoms or treatment were related to such critical illness. In the event of break in the policy, the terms of this exclusion shall apply as new from recommencement of cover
ii. the insured person smokes 40 (forty) or more cigarettes / cigars or equivalent tobacco intake in a day

7.1.3 Condition

Claim amount

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

Notification of claim

In the event of a claim, the insured person/insured person's representative shall intimate the company in writing by letter, e-mail, fax providing all relevant information relating to the critical illness within 15 (fifteen) days of critical illness diagnosis

Procedure for claims under critical illness

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

Documents

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

Cessation of cover

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

Cancellation

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

7.2 Out-patient treatment

Subject to Exclusions 4.7, 4.8, 4.18, 4.16, 4.24, 4.12, 4.9, 4.10, 4.35 and 4.36, the company shall pay up to the limit, as stated in the schedule with respect of
i. Out-patient consultations by a medical practitioner
ii. Diagnostic tests prescribed by a medical practitioner
iii. Medicines/drugs prescribed by a medical practitioner
iv. Out-patient dental treatment

Eligibility

The cover can be availed by individuals of any age band.

Limit of cover

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

Enhancement of limit of cover

i. Limit of cover can be enhanced only at the time of renewal.
ii. Benefit amount can be enhanced to the next slab subject to discretion of the company.

Policy period

The policy period for the policy, and the cover should be identical, as mentioned in the schedule.

Tax rebate

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

Renewal

The Outpatient Treatment cover can be renewed annually throughout the lifetime of the insured person.

7.2.1 Exclusions

The company shall not make any payment under the cover in respect of
i. Treatment other than Allopathy/ Modern medicine, Ayurveda and Homeopathy
ii. Cosmetic dental treatment to straighten lightens, reshape and repair teeth. Cosmetic treatments include veneers, crowns, bridges, tooth-coloured fillings, implants and tooth whitening.

7.2.2 Condition

Claim amount

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

Procedure for claims under outpatient treatment

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

Documents

The claim is to be supported with the following original documents

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

Cancellation

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

8 Disclaimer

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

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

Place **Signature**

Date **Name**

Table of Benefits

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

Premium rate

Rate with TPA charges (in ₹)

SI	3m-5	6 - 17	18 - 25	26-35	36-45	46-55	56-59	60-65	66-70	71-75	76-80	81-85	86 +
2,00,000	5,303	5,356	5,951	6,070	6,192	8,533	12,344	16,064	23,304	27,103	28,586	29,833	31,009
3,00,000	6,918	6,918	7,687	7,841	7,841	11,344	16,543	21,324	31,356	35,820	38,967	40,992	42,519
4,00,000	8,381	8,382	9,314	9,499	9,499	13,913	20,392	26,096	38,732	43,681	48,573	51,387	53,218
5,00,000	9,743	9,743	10,826	11,042	11,043	16,314	24,000	30,536	45,645	50,964	57,643	61,251	63,285
6,00,000	10,852	10,852	12,057	12,299	12,300	18,592	27,428	34,730	52,208	57,817	65,726	70,106	73,039
7,00,000	11,901	11,902	13,224	13,488	13,489	20,596	30,536	38,565	58,332	64,169	73,674	78,903	82,260
8,00,000	12,902	12,903	14,338	14,624	14,624	22,518	33,528	42,242	64,230	70,245	81,347	87,302	91,173
9,00,000	13,865	13,865	15,407	15,714	16,365	24,375	36,420	45,784	69,936	76,091	88,660	95,446	99,820
10,00,000	14,792	14,793	16,437	16,765	18,201	26,173	39,229	49,212	75,477	81,739	95,752	1,03,367	1,08,237
15,00,000	19,952	19,953	29,474	33,076	33,407	36,663	52,460	61,655	80,547	87,132	1,07,210	1,25,964	1,32,586
20,00,000	23,806	23,807	31,806	46,836	47,305	47,777	63,596	72,329	87,633	90,500	1,19,378	1,46,718	1,55,270
25,00,000	27,358	27,359	34,314	49,016	49,506	53,523	73,732	80,878	90,644	93,994	1,26,742	1,62,657	1,72,917
30,00,000	31,217	31,219	37,515	51,819	53,158	62,159	83,223	88,196	91,285	98,102	1,31,041	1,75,246	1,86,618
40,00,000	37,389	37,392	43,547	56,662	61,703	77,050	98,473	98,478	99,351	1,05,769	1,31,384	1,90,674	2,04,536
50,00,000	42,950	42,952	50,148	61,024	70,992	91,358	1,11,388	1,11,395	1,11,400	1,14,035	1,31,391	1,97,469	2,13,206

Service Tax extra

Rate without TPA charges (in ₹)

SI	3m-5	6 - 17	18 - 25	26-35	36-45	46-55	56-59	60-65	66-70	71-75	76-80	81-85	86 +
2,00,000	5,003	5,053	5,614	5,727	5,841	8,050	11,645	15,155	21,984	25,569	26,968	28,144	29,253
3,00,000	6,527	6,527	7,252	7,397	7,397	10,703	15,607	20,117	29,581	33,792	36,761	38,672	40,112
4,00,000	7,907	7,908	8,786	8,962	8,962	13,125	19,237	24,619	36,540	41,208	45,823	48,479	50,206
5,00,000	9,191	9,192	10,212	10,417	10,417	15,391	22,641	28,808	43,061	48,078	54,380	57,784	59,702
6,00,000	10,238	10,238	11,375	11,603	11,604	17,539	25,875	32,764	49,253	54,544	62,006	66,138	68,904
7,00,000	11,228	11,228	12,475	12,725	12,726	19,429	28,808	36,383	55,031	60,537	69,504	74,438	77,603
8,00,000	12,173	12,173	13,526	13,796	13,797	21,244	31,630	39,851	60,593	66,269	76,742	82,361	86,012
9,00,000	13,080	13,081	14,534	14,825	15,439	22,995	34,359	43,193	65,977	71,784	83,641	90,044	94,170
10,00,000	13,956	13,956	15,506	15,817	17,171	24,692	37,008	46,427	71,206	77,113	90,332	97,516	1,02,110
15,00,000	18,822	18,823	27,805	31,204	31,516	34,588	49,491	58,165	75,987	82,200	1,01,142	1,18,835	1,25,080
20,00,000	22,457	22,458	30,006	44,185	44,627	45,073	59,996	68,235	82,673	85,378	1,12,620	1,38,412	1,46,480
25,00,000	25,809	25,810	32,373	46,242	46,704	50,493	69,558	76,300	85,513	88,674	1,19,569	1,53,449	1,63,129
30,00,000	29,450	29,451	35,392	48,886	50,149	58,640	78,513	83,204	86,118	92,549	1,23,623	1,65,327	1,76,055
40,00,000	35,273	35,275	41,082	53,454	58,211	72,688	92,899	92,904	93,727	99,782	1,23,947	1,79,881	1,92,959
50,00,000	40,520	40,521	47,310	57,570	66,973	86,187	1,05,084	1,05,089	1,05,095	1,07,580	1,23,954	1,86,291	2,01,137

Service Tax extra

Rate for Critical Illness (in ₹)

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

Service Tax extra

Rate for Outpatient Treatment (in ₹)

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

Service Tax extra

Discounts (not applicable to optional covers)
Family discount 10%
Youth discount 10%
Online discount 5%

Insurance is the subject matter of solicitation

Appendix

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

Sl	Existing Disease	ICD Code Excluded
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemiavera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behaviour
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I50 Heart failure, I42Cardiomyopathy; I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis,unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophagealvarices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 - Acute delta-(super) infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease	G30.9 - Alzheimer's disease, unspecified; F00.9 -G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	HIV & AIDS	B20.0 - HIV disease resulting in mycobacterial infection; B20.1 - HIV disease resulting in other bacterial infections; B20.2 - HIV disease resulting in cytomegaloviral disease; B20.3 - HIV disease resulting in other viral infections; B20.4 - HIV disease resulting in candidiasis; B20.5 - HIV disease resulting in other mycoses; B20.6 - HIV disease resulting in Pneumocystis carinii pneumonia; B20.7 - HIV disease resulting in multiple infections; B20.8 - HIV disease resulting in other infectious and parasitic diseases; B20.9 - HIV disease resulting in unspecified infectious or parasitic disease; B23.0 - Acute HIV infection syndrome; B24 - Unspecified human immunodeficiency virus [HIV] disease
14	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
15	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
16	Avascular necrosis (osteonecrosis)	M 87 to M 87.9