National Insurance Company Limited

CIN - U10200WB1906GOI001713 IRDAI Regn. No. – 58

Issuing Office

New National Parivar Mediclaim Policy

Whereas the Proposer designated in the schedule hereto has by a Proposal together with Declaration, which shall be the basis of this contract and is deemed to be incorporated herein, has applied to National Insurance Company Ltd. (hereinafter called the Company), for the insurance hereinafter set forth, in respect of person(s)/ family members named in the schedule hereto (hereinafter called the Insured Persons) and has paid the premium as consideration for such insurance.

1 PREAMBLE

The Company undertakes that if during the Policy Period, any Insured Person shall suffer any illness or disease (hereinafter called Illness) or sustain any bodily injury due to an Accident (hereinafter called Injury) requiring Hospitalisation of such Insured Person(s) for In-Patient Care at any hospital/nursing home (hereinafter called Hospital) or for Day Care Treatment at any Day Care Center or to undergo treatment under Domiciliary Hospitalisation, following the Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify the Hospital or the Insured, Reasonable and Customary Charges incurred for Medically Necessary Treatment towards the Coverage mentioned herein.

Provided further that, the amount payable under the Policy in respect of all such claims during each Policy Year of the Policy Period shall be subject to the Definitions, Terms, Exclusions, Conditions contained herein and limits as shown in the Table of Benefits, and shall not exceed the Sum Insured on Floater Basis in respect of the Insured family.

2 DEFINITION

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

2.2 Age / Aged means completed years on last birthday as on Commencement Date.

2.3 AIDS means Acquired Immune Deficiency Syndrome, a condition characterised by a combination of signs and symptoms, caused by Human Immunodeficiency Virus (HIV), which attacks and weakens the body's immune system making the HIV-positive person susceptible to life threatening conditions or other conditions, as may be specified from time to time.

2.4 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.

2.5 AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical / para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner in charge round the clock;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

2.6 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

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

2.8 Break in policy means the period of gap that occurs at the end of the existing Policy Period / Instalment Premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or Grace Period.

2.9 Cashless Facility means a facility extended by the Company 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 or a Non Network Provider to the extent pre-authorization approved.

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

2.11 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.

2.12 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.

2.13 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.

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

2.15 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.

2.16 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.

2.17 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.

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

2.19 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.

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

2.21 Grace Period means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to Waiting Periods and coverage of Pre-Existing Diseases. The Grace Period for payment of the premium shall be thirty days.

In case of Premium payment in instalments, if the due instalment premium is paid within Grace Period, coverage shall be available during the Grace Period.

In case of Renewal, Coverage shall not be available during the period for which no premium is received.

2.22 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.

2.23 Hospitalisation means admission in a Hospital for a minimum period of twenty four (24) consecutive **Inpatient Care** hours except for procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.

2.24 I D card means the card issued to the Insured person by the TPA for availing Cashless Facility.

2.25 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.

2.26 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.

2.27 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.

2.28 ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

2.29 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.

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

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

2.32 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.

2.33 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.

2.34 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.

2.35 Migration means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

2.36 Network Provider means Hospitals or Day Care Centers enlisted by the Company, TPA or jointly by the Company and TPA to provide medical services to an Insured Person by a Cashless Facility.

2.37 New Born Baby means baby born during the policy period and is aged upto 90 days.

2.38 Non- Network Provider means any Hospital, Day Care Centre that is not part of the network.

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

2.40 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.

2.41 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.

2.42 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.

2.43 Pre Existing Disease means any condition, ailment, injury or disease:

a) That is/are diagnosed by a physician within 36 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 36 months prior to the effective date of the Policy issued by the Company or its reinstatement.

2.44 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.

2.45 Portability means a facility provided to the policyholders (including all members under family cover), to transfer the credits gained for, Pre-Existing Diseases and Specific Waiting Periods from one insurer to another insurer.

2.46 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.

2.47 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.

2.48 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.

2.49 Room Rent means the amount charged by a Hospital towards Room and boarding expenses and shall include the associated charges.

2.50 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.

2.51 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.

2.52 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.

i. **Basic Sum Insured** means the Sum Insured opted and as mentioned in the Schedule, without any Cumulative Bonus (CB) accrued.

ii. **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.

2.53 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.

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

2.55 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.

3 BENEFITS COVERED UNDER THE POLICY

3.1 COVERAGE

3.1.1 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 Section 3.1.1.1
ii. Medical practitioner(s)
iii. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances
iv. Medicines and drugs
v. Diagnostic procedures
vi. Prosthetics and other devices or equipment if implanted internally during a surgical procedure.
vii. Dental treatment, necessitated due to an injury
viii. Plastic surgery, necessitated due to disease or injury
ix. Hormone replacement therapy, if medically necessary
x. Vitamins and tonics, forming part of treatment for disease/injury as certified by the attending medical practitioner
xi. Circumcision, necessitated for treatment of a disease or injury

3.1.1.1 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.

3.1.1.2 Limit for Cataract

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

3.1.1.3 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

3.1.2 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.

3.1.3 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.

3.1.4 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 treatment other than Allopathy and AYUSH
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

3.1.5 Day Care Procedure

The Company shall indemnify the Medical Expenses (including Pre and Post Hospitalisation Expenses) for Day Care Treatments requiring Hospitalization as an In-Patient for less than 24 hours undergone by the Insured Person in a Hospital/ Day Care Centre, but not in the Outpatient department of a Hospital.

3.1.6 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.

3.1.7 Organ Donor's Medical Expenses

The Company shall indemnify the Medical Expenses incurred in respect of an organ donor's Hospitalisation during the Policy Period for harvesting of the organ donated to an Insured Person, provided that:

i. The organ donation confirms to the Transplantation of Human Organs Act 1994 (and its amendments from time to time)
ii. The organ is used for an Insured Person and the Insured Person has been medically advised to undergo an organ transplant
iii. The Medical Expenses shall be incurred in respect of the organ donor as an in-patient in a Hospital.
iv. Claim has been admitted under In-patient Treatment Section in respect of the Insured Person undergoing the organ transplant

Exclusions

The Company shall not be liable to make payment for any claim under this Cover which arises for or in connection with any of the following:

i. Pre-hospitalization Medical Expenses or Post- Hospitalization Medical Expenses of the organ donor.
ii. Costs directly or indirectly associated with the acquisition of the donor's organ.
iii. Medical Expenses where the organ transplant is experimental or investigational.
iv. Any medical treatment or complication in respect of the donor, consequent to harvesting.
v. Any expenses related to organ transportation or preservation.

3.1.8 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 Section

Hospital Cash shall be payable for each day from the 4th day of Hospitalisation up to the 8th day of Hospitalisation only. Hospitalisation of less than 24 hours shall not be considered for the purpose of payment of Hospital Cash

3.1.9 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 Section.

3.1.10 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.

3.1.11 Maternity

The Company shall indemnify Maternity Expenses as described below for any female Insured Person, and also Pre-Natal and Post-Natal Hospitalisation expenses per delivery, including expenses for necessary vaccination for the New Born Baby, subject to the limit as shown in the Table of Benefits. The female Insured Person should have been continuously covered for at least 36 months before availing this benefit.

The New Born Baby shall be automatically covered from birth under the Sum Insured available to the mother during the corresponding Policy Period, for up to 3 months of age. On attaining 3 months of age, the New Born Baby shall be covered only if specifically included in the Policy mid-term and requisite premium paid to the Company.

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 Section, 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. Covered female Insured Person below eighteen (18) years and 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 has been paid under the Policy and its Renewals.
4. More than one delivery or lawful medical termination of pregnancy during a single Policy Period.
5. Maternity Expenses of Surrogate Mother, unless claim is admitted under Section 3.1.12 (Infertility)
6. Ectopic pregnancy
7. Pre and post hospitalisation expenses, other than pre and post natal treatment.

3.1.12 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 Section 3.1.11 (Maternity). Legal affidavit regarding intimation of surrogacy shall be submitted to the Company.
3. Maximum of two claims shall be admissible by the Policy during the lifetime of the insured person if he has no living child and one claim if the insured has one living child.
4. Any One Illness limit shall not apply.

Definitions for the purpose of the Section

1. **Donor** means an oocyte donor or sperm donor.
2. **Embryo** means a fertilized egg where cell division has commenced/ under the process and has completed the pre-embryonic stage.
3. **Gamete Intra-Fallopian Transfer (GIFT)** means a procedure where the sperm and egg are placed inside a catheter separated by an air bubble and then transferred to the fallopian tube. Fertilization takes place naturally.
4. **Infertility** means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. However the one year period may be waived, provided a medical practitioner determines existence of a medical condition rendering conception impossible through unprotected sexual intercourse, including but not limited to congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments.
5. **Intra-Cytoplasmic Sperm Injection (ICSI)** means an injection of sperm into an egg for fertilisation.
6. **In Vitro Fertilization (IVF)** means a process in which an egg and sperm are combined in a laboratory dish where fertilization occurs. The fertilized and dividing egg is transferred into the uterus of the woman.
7. **Surrogate** means a woman who carries a pregnancy for the insured person.
8. **Zygote Intra-Fallopian Transfer (ZIFT)** means a procedure where the egg is fertilized in vitro and transferred to the fallopian tube before dividing.

3.1.13 HIV/ AIDS Cover

The Company shall indemnify the Medical Expenses for In-patient Treatment, 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

3.1.14 Mental Illness Cover

The Company shall indemnify the Medical Expenses for In-patient Treatment, 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 or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post-graduate degree (Siddha) in Sirappu Maruthuvam.

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)

3.1.15 Modern Treatment

The Company shall indemnify the Medical Expenses for In-Patient Treatment 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 the limit of 25% of the Sum Insured for the related modern procedure/ component/ medicine of each Modern Treatment during the Policy Period**:**

Modern Treatment	**Coverage**
UAE & HIFU	Limit is for Procedure cost only
Balloon Sinuplasty	Limit is for Balloon cost only
Deep Brain Stimulation	Limit is for implants including batteries only
Oral Chemotherapy	Only cost of medicines payable under this limit, other incidental charges like investigations and consultation charges not payable.
Immunotherapy	Limit is for cost of injections only.
Intravitreal injections	Limit is for complete treatment, including Pre & Post Hospitalization
Robotic Surgery	Limit is for robotic component only.
Stereotactic Radio surgeries	Limit is for radiation procedure.
Bronchial Thermoplasty	Limit is for complete treatment, including Pre & Post Hospitalization
Vaporization of the prostrate	Limit is for LASER component only.
IONM	Limit is for IONM procedure only.
Stem cell therapy	Limit is for complete treatment, including Pre & Post Hospitalization

3.1.16 Morbid Obesity Treatment

The Company shall indemnify the Medical Expenses for In-patient Treatment, 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 three (03) 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;
   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 Type 2 Diabetes

3.1.17 Correction of Refractive Error

The Company shall indemnify the Medical Expenses for In-patient Treatment, 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: The expenses that are not covered in this policy are placed under List-l of Annexure-I 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 Annexure-I of the Policy respectively

Aggregate of all the benefits under 3.1.1 to 3.1.17 are subject to the Sum Insured.

3.2 OTHER BENEFITS

3.2.1 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

3.3 GOOD HEALTH INCENTIVES

3.3.1 Cumulative Bonus

For each claim free Policy Year (i.e., no claims are reported by any Insured Person and admitted by the Company), 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.

Note:

a) No Cumulative Bonus will be added if the Policy is not renewed with the Company by the end of the Grace Period.

b) The Cumulative Bonus will not be accumulated in excess of 50% of the Basic Sum Insured under the current Policy with the Company under any circumstances.

c) Any Cumulative Bonus that has accrued for a Policy Year will be credited at the end of the Policy Period if the policy is renewed with the Company within Grace Period and will be available for any claims made in the subsequent Policy Period.

d) **Splitting of policies or Migration from Floater to Individual Policy**: If the Insured Persons in the expiring Policy are covered on a Family Floater basis and such Insured Persons Renew their expiring Policy with the Company by splitting the Sum Insured in to two or more Family Floater/Individual policies then the Cumulative Bonus shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.

e) **Revision in Sum Insured**: If the Basic Sum Insured under the Policy has been increased/decreased at the time of Renewal, the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Period.

3.3.2 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 and admitted 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.

3.4 OPTIONAL COVERS

At the option of the Insured and on payment of additional premium the following covers shall be available to the Insured Persons during the Policy Period, provided the same is mentioned in the Policy Schedule.

3.4.1 Pre-existing Diabetes / Hypertension

Subject otherwise to the terms, definitions, exclusions, and conditions of the Policy and on payment of additional premium, 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 thirty six 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

3.4.2 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

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 has to be supported by 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

3.4.3 Critical Illness
Subject otherwise to the terms, definitions, exclusions, and conditions of the Policy, 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 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.

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 an 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
iii. Neurological damage due to SLE is 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 Policy, or which manifest within a period of ninety days from inception of the 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

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 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/ three 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 (not applicable for new born baby

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. **Three years waiting period**
Following diseases even if pre-existing shall be covered after three 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)

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.

4.10Breach 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.

4.11Excluded 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.

4.12Drug/Alcohol Abuse (Excl 12)

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

4.13Non 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 Section 3.1.10 (Anti Rabies Vaccination) and Section 3.1.11.iv (Maternity).

4.23 Massages, Steam Bath, Alternative Treatment (Other than AYUSH treatment)
Massages, steam bath, expenses for alternative treatments (other than AYUSH treatment), 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

5 GENERAL TERMS AND CLAUSES

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 Claim Settlement
i. The Company shall settle or reject a claim, as the case may be, within 15 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)*

5.4 Moratorium Period
After completion of sixty continuous months of coverage (including Portability and Migration), no claim shall be contestable by the Company on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as Moratorium Period. The moratorium would be applicable for the Basic Sums Insured of the first policy. Wherever, the Basic Sum Insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of Basic Sums Insured only on the enhanced limits.

5.5 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. 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.
v. On occurrence of an insured event under specified critical illnesses, the policyholders may claim under all policies.

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 or established fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.
ii. The Insured may cancel the Policy at any time during the term, by giving 7 days notice in writing. The Company shall,
    a) refund proportionate premium for unexpired policy period, if the term of policy upto one year and there is no claim (s) made during the policy period.
    b) refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced and refund proportionate premium for unexpired policy period for the current policy year

There shall be no refund for the completed policy year elapsed.

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

5.8 Renewal of Policy

i. The policy shall be renewable provided the product is not withdrawn, except in case of established fraud or non-disclosure or misrepresentation by the Insured. If the product is withdrawn, the policyholder shall be provided with suitable options to migrate to other similar health insurance products/plans offered by the Company.
ii. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
iii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iv. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
v. 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.
vi. No loading shall apply on renewals based on individual claims experience.
vii. In case of non continuance of the Policy by the insured (due to death or any other valid and acceptable reason)
    a. The Policy may be renewed by any insured person above eighteen years of age, as the insured
    b. 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 Proposer, covering the grandchildren.
    c. 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
    a. The base premium to be charged shall be based on the age of the next eldest insured person.

5.9 Migration

The Insured Person will have the option to migrate the Policy to an alternative health insurance product offered by the Company by applying for Migration of the policy at least 30 days before the policy renewal date as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under this Policy offered by the Company,

i. The Insured Person will get all the accrued continuity benefits for credits gained to the extent of the specific waiting periods, waiting period for pre-existing diseases and Moratorium period of the Insured Person.
ii. Migration benefit will be offered to the extent of Sum Insured and accrued Cumulative Bonus (as part of the sum insured) of the previous policy. Migration benefit shall not apply to any other additional increased Sum Insured.

The Proposal may be subject to fresh Underwriting as per terms of conditions of the migrated product, if the insured is not continuously covered for at least 36 months under the previous product

5.10 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 **15** 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 this Policy offered by the Company,

i. The proposed Insured Person will get all the accrued continuity benefits for specific waiting periods, waiting period for pre-existing diseases and Moratorium period of the Insured Person under the previous health insurance Policy.

ii. Portability benefit will be offered to the extent of Sum Insured and accrued Cumulative Bonus (as part of the sum insured) of the previous policy. Portability benefit shall not apply to any other additional increased Sum Insured.

5.11 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.

5.12 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 before the changes are effected.

5.13 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 **thirty** days from date of receipt of the policy document to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy. This option is available in case of policies with a term of one year or more.

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.

5.14 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.

5.15 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.

5.16 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.

5.17 Claim Procedure

5.17.1 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
In the event of emergency hospitalisation	Within twenty four hours of the insured person's admission

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	Within twenty four hours of vaccination.

5.17.2 Procedure for Cashless Claims

i. Cashless Facility can be availed, if TPA service is opted.
ii. Treatment may be taken in a Network Provider / PPN or Non Network Provider and is subject to pre-authorisation by the TPA. Updated list of network provider/PPN is available on the 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 **within an hour** 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 shall grant the final authorization **within three hours of the receipt** of discharge authorization request from the Hospital.
vii. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
viii. 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.

5.17.3 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.

5.17.3.1 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.

5.17.4 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 5.5 and the original documents having been submitted to the other insurer, the Company may accept the documents listed 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)	At least forty five (45) days before the expiry of the third Policy Year.

5.17.5 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.

5.17.6 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 three zones.*

Zone I - Greater Mumbai Metropolitan area, entire state of Gujarat, Delhi, NCR, Chandigarh, Pune

Zone II – Chennai, Hyderabad, Bangalore

Zone III - 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.

i. Insured paying premium as per Zone I can avail treatment in Zone I, Zone II and Zone III without copayment
ii. Insured paying premium as per Zone II
    a. Can avail treatment in Zone II and Zone III without any copayment
    b. Availing treatment in Zone I will be subject to a copayment of 13%
iii. Insured paying premium as per Zone III
    a. Can avail treatment in Zone III without any copayment
    b. Availing treatment in Zone I will be subject to a copayment of 28%
    c. Availing treatment in Zone II will be subject to a copayment of 13.5%

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

5.17.7 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 25% discount in total premium.
- 10% Co-payment on each admissible claim under the Policy, with a 12.5% 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.

5.18 Payment of Claim

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

5.19 Territorial limit

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

5.20 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.

5.21 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 for arbitration as per Arbitration and Conciliation Act 1996, as amended from time to time.
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.

5.22 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.

5.23Enhancement of Sum Insured

Basic Sum insured may be enhanced only at the time of renewal subject to the availability of the higher slabs in the Policy**.** Basic Sum Insured can be enhanced subject to 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.

5.24Adjustment 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.

5.25Premium 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 (as defined) would be given to pay the instalment premium due for the policy.
ii. If Installment Premium is not paid within Grace Period, the Policy shall be cancelled and no refund shall be allowed. However, if the installment premium is paid in instalments within the Grace Period, coverage shall be available during the Grace Period.
iii. In case of a claim being admissible under the Policy, all the remaining installments for the Policy Period shall become due and payable immediately.
iv. Change of Premium Paying Frequency can be opted only at the time of renewal.

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, 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

Bima Bharosa (an Integrated Grievance Management System earlier known as IGMS) - https://bimabharosa.irdai.gov.in/

Insurance Ombudsman – The Insured person can also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as listed in Annexure -II. 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/

Helpline Number: 1800 345 0330

Dedicated Email ID for Senior Citizens: health.srcitizens@nic.co.in

Table of Benefits

Features	Benefit
Sum insured (SI) (as Floater)	**INR 1/ 2/ 3/ 4/ /5/ 6/ 7/ 8/ /9 10 Lac**
Treatment	Allopathy, 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 36 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 (In PPN hospital PPN package shall apply) *Proportionate Deduction to apply, in case higher limit is opted*
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 Treatment (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 **3** 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 (Copayment applicable)
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
Discounts	
Copayment (optional)	If opted, policyholder may choose either of the two copayment options- • 25% discount in total premium, for 20% Co-payment on each admissible claim. • 12.5% discount in total premium, for 10% Co-payment on each admissible claim.
Online Discount	10% discount in premium (for new and Renewal, ONLY where no intermediary is involved)
Long Term Discount	Discount of 2.25% for 2 years Policy and Discount of 4.5% for 3 years Policy
Add-ons (cover available on payment of additional premium)	
National Home Care Treatment Add-On	INR 10,000/ 15,000/ 20,000/ 25,000/ 30,000/ 35,000/ 40,000/ 45,000/ 50,000, subject to 10% of Basic SI under base Policy.
National Non-Medical Expenses Add-on (available to SI 5 lacs & above)	Up to 10% of Basic Sum Insured (excluding Cumulative Bonus, if any) of base Policy and shall be part of the base Policy Basic Sum Insured (excluding Cumulative Bonus, if any).

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

No loading shall apply on Renewals based on individual claims experience
Insurance is the subject matter of solicitation
Please preserve the policy for all future reference.

Annexure I

List I – List of which coverage is not available in the policy	
Sl	**Item**
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	VASOFIX SAFETY
List II – Items that are to be subsumed into Room Charges	
Sl	**Item**
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES
List III – Items that are to be subsumed into Procedure Charges	
Sl	**Item**
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE
List IV – Items that are to be subsumed into costs of treatment	
Sl	**Item**
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer & Strips
18	URINE BAG

Annexure II

The contact details of the Insurance Ombudsman offices are as below-

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th Floor, Tilak Marg, Relief Road, Ahmedabad-380001 Tel: 079 -25501201/ 02/ 05/ 06 Email: bimalokpal.ahmedabad@cioins.co.in
Karnataka	Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in
Madhya Pradesh, Chhattisgarh	Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in
Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in
Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in
Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in
Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in
Rajasthan	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363/2740798 Email: Bimalokpal.jaipur@cioins.co.in
Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry	Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College, M.G. Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in
Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in
Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane)	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in
State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in
Bihar, Jharkhand	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in
Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region)	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in