National Mediclaim Policy
PROSPECTUS

1.1 PRODUCT
National Mediclaim Policy is an indemnity health insurance policy. The Policy covers expenses incurred due to Hospitalisation for In-Patient Care (allopathy, ayurveda and homeopathy) or Day Care Treatment Reasonably and Customarily incurred for treatment of an Illness contracted/Injury sustained during the Policy Period. The Policy provides for Pre Hospitalisation (45 days) and Post Hospitalisation (60 days) expenses, 140+ Day Care Procedures, organ donor's medical expenses, ambulance charges, Morbid Obesity Treatment, Correction of Refractive Error and provides for Reinstatement of Basic Sum Insured (above SI of 6L), if applicable as per terms.
Any amount admissible under the Policy in respect of claims shall be subject to the sub limits contained herein as well as shown in the Table of Benefits.

1.2 Coverage – Sub Limits
The Company shall indemnify the expenses incurred for all Hospitalisation(s) covered under the Policy, subject to the following Sub Limits applicable to broad heads as mentioned below.

1.2.a	**Room Charges** Room Rent, Intensive Care Unit charges and associated charges (including diet charges, nursing care by Qualified Nurse, RMO charges, administration charges for IV fluids/blood transfusion/injection) i. Room Rent per day shall be payable up to 1% of Sum Insured subject to max of ₹ 10,000 per day ii. ICU Charges per day shall be payable up to 2% of Sum Insured subject to max of ₹ 20,000 per day	**Maximum amount admissible under Room Charges for Any One Illness shall be 25% of Sum Insured (i.e., Basic Sum Insured and Cumulative Bonus) as mentioned in the Schedule.**
1.2.b	**Medical Practitioner's Fees** Fees for Medical Practitioners, including treating Medical Practitioners, Surgeons, Anaesthetists, Consultants, Specialists whose services has been utilized during the Hospitalisation	**Maximum amount admissible under Medical Practitioner's Fees for Any One Illness shall be 25% of Sum Insured (i.e., Basic Sum Insured and Cumulative Bonus) as mentioned in the Schedule.**
1.2.c	**Other Expenses** All other expenses related to the Hospitalisation: i. Anaesthesia, blood, oxygen, operation theatre charges and surgical appliances ii. Medicines and drugs iii. Diagnostic procedures iv. Prosthetics and other devices or equipment if implanted internally during a surgical procedure. v. Hemodialysis vi. Chemotherapy vii. Radiotherapy viii. Ambulance Charges, as per Section 1.3.6	**Maximum amount admissible under Other Expenses for Any One Illness shall be 50% of Sum Insured (i.e., Basic Sum Insured and Cumulative Bonus) as mentioned in the Schedule.**
1.2.d	Expenses for the following procedures inclusive of above sub limits (i.e., Section 1.2.a, 1.2.b, 1.2.c) i. **Hemodialysis** ii. **Chemotherapy** iii. **Radiotherapy**	**Maximum amount admissible for Any One Illness shall be lower of 50% of Sum Insured (i.e., Basic Sum Insured and Cumulative Bonus) or the PPN Package Rate.**
1.2.e	Following **Modern Treatments** will be covered (wherever medically indicated) either as In patient or as part of Day Care Treatment in a Hospital, inclusive of above sub limits (i.e., Section 1.2.a, 1.2.b, 1.2.c): A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound) B. Balloon Sinuplasty C. Deep Brain stimulation D. Oral chemotherapy E. Immunotherapy- Monoclonal Antibody to be given as injection F. Intra vitreal injections G. Robotic surgeries H. Stereotactic radio surgeries I. Bronchical Thermoplasty J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment) K. IONM - (Intra Operative Neuro Monitoring) L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.	**Maximum amount admissible for any one Modern Treatment shall be 25% of Sum Insured (i.e., Basic Sum Insured and Cumulative Bonus)**

1.2.f	Expenses related to treatment necessitated due to participation as a **non-professional in hazardous or adventure sports,** inclusive of above sub limits (i.e., Section 1.2.a, 1.2.b, 1.2.c)	**Maximum amount admissible for Any One Illness shall be lower of 25% of Sum Insured (i.e., Basic Sum Insured and Cumulative Bonus)**
1.2.g	**Pre Hospitalisation** Medical expenses incurred before Hospitalsation.	Up to **forty five (45) days** immediately before the Insured Person is Hospitalised
1.2.h	**Post Hospitalisation** Medical expenses incurred after discharge from Hospital.	Up to **sixty (60) days** immediately after the Insured Person is discharged

Note: Sub limits as mentioned in Section 1.2.a, 1.2.b and 1.2.c above, will not apply in case of treatment undergone in a **Preferred Provider Network (PPN)** for a listed procedure as per eligible package.

1.3 Terms specific to Day Care Procedure, Ayurveda and Homeopathy, HIV/ AIDS Cover, Mental Illness Cover, Organ Donor's Medical Expenses and Ambulance Charges, Morbid Obesity Treatment and Correction of Refractive Error

In addition to the applicable Sub Limits (mentioned above), Hospitalisation due to any of the following shall be subject to the terms mentioned against each.

1.3.1 Day Care Procedure

The Company shall indemnify the Hospital/ Day Care Centre or the insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) for Day Care Treatment of procedures/surgeries, provided that Day Care Treatment is undergone by the Insured Person in a Hospital/ Day Care Centre, but not in the Outpatient department of a Hospital.

In case of any other surgeries/ procedures which would have otherwise required a Hospitalisation of more than twenty four (24) hours, but due to advancement of medical science require Hospitalisation for less than twenty four (24) hours, shall be covered subject to prior approval of the Company/TPA.

1.3.2 Ayurveda and Homeopathy

The Company shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) incurred for Ayurveda and Homeopathy treatment, provided the treatment is undergone in an Ayush Hospital.

1.3.3 HIV/ AIDS Cover

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

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

1.3.4 Mental Illness Cover

The Company shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) related to Mental Illnesses, provided the treatment shall be undertaken at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Psychiatrist (as defined in Definition 3.42) or a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry.

Exclusions

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

1.3.5 Organ Donor's Medical Expenses

The Company shall indemnify the Hospital or the Insured, the Medical Expenses (excluding Pre and Post Hospitalisation Expenses) incurred for organ donor's treatment during the course of organ transplant to any Insured Person.

Provided that,

i. the donation conforms to 'The Transplantation of Human Organs Act 1994'
ii. the Insured Person has been Medically Advised to undergo an organ transplant, or the Insured Person has been certified by a qualified Medical Practitioner to be suitable for organ donation.

Exclusions

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

1. Cost of the organ to be transplanted.
2. Any other medical treatment or complication in respect of the organ donor (other than Insured Person), consequent to harvesting.

1.3.6 Ambulance Charges

The Company shall reimburse the Insured the expenses incurred for emergency ambulance charges, up to 1% of Sum Insured subject to maximum ₹ 2,000/- in a Policy Period for each Insured Person, for transportation to the Hospital or from the Hospital to another Hospital or from the Hospital to diagnostic center and return during the same Hospitalisation.

Ambulance charges shall be admissible provided a Hospitalisation claim has been admitted under the Policy.

1.3.7 Morbid Obesity Treatment

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

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

1.3.8 Correction of Refractive Error

The Company shall indemnify the Hospital or the Insured, the Medical Expenses (including Pre 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 Appendix-II of the Policy. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Appendix-II of the Policy respectively

1.4 OTHER BENEFITS

1.4.1 Reinstatement of Basic Sum Insured (available to Basic Sum Insured of ₹ 6L and above)

For Insured Persons with Basic Sum Insured of ₹ 6 lacs and above, in the event of available Sum Insured being exhausted anytime during the Policy Period 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 whose claim 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 only in respect of the Insured Person whose Sum Insured is exhausted as specified above.
iv. Reinstatement shall be allowed only once during the Policy Period for each eligible Insured Person.
v. Reinstated Basic Sum Insured, if not exhausted, will not be carried forward to next Policy Period on Renewal

Illustration: ***SI means SI including CB, Basic SI means SI excluding CB***

Case I: Basic SI – ₹ 6L, CB – ₹ 1L	**Case II: Basic SI – ₹ 6L, CB – ₹ 1L**
Claim 1 (hospitalization due to disease) – ₹ 3L Balance SI – ₹ 7L (i.e., 6+1), Amount admissible – ₹ 3L Payable – ₹ 3L, SI exhausted – No, SI remaining – ₹ 4L Basic SI reinstated – **No** Claim 2 (hospitalization due to RTA) – ₹ 5L SI remaining – ₹ 4L, Amount admissible – ₹ 5L Payable – ₹ 4L, SI exhausted – Yes, SI remaining – ₹ 0 Basic SI reinstated – **Yes [₹ 6L, i.e., Basic SI only]** ***(Reinstated SI will be available from next claim)*** Claim 3 (hospitalization due to disease) – ₹ 2L Balance Reinstated SI – 6L Amount admissible – ₹ 2L Reinstated SI remaining – ₹ 4L	Claim 1 (hospitalization due to RTA) – ₹ 10L Balance SI – ₹ 7L (i.e., 6+1), Amount admissible – ₹ 10L Payable – ₹ 7L, SI exhausted – Yes, SI remaining – ₹ 0 Basic SI reinstated – **Yes [₹ 6L, i.e., Basic SI only]** ***(Reinstated SI will be available from next claim)*** Claim 2 (hospitalization due to disease) – ₹ 8L Balance Reinstated SI – ₹ 6L, Amount admissible – ₹ 8L Payable – ₹ 6L, Reinstated SI remaining – ₹ 0 SI reinstated – **No** ***(Basic SI is reinstated only once during the Policy Period)***

1.5 GOOD HEALTH INCENTIVE

1.5.1 Cumulative Bonus

For each claim free Policy Period (i.e., no claims are reported) provided the policy is continuously renewed with the Company without a Break in Policy, each Insured Person will be eligible to get a Cumulative Bonus (CB) at the rate of 5% of the Basic Sum Insured of the expiring Policy. CB accrued for a claim free Policy Period shall be available on next Renewal. CB shall be accumulated for each subsequent claim free Policy Periods and the maximum CB shall not exceed 50% of the Basic Sum Insured of the renewed Policy. Wherever, due to reduction in Basic Sum Insured on renewal, the accumulated CB exceeds 50% of the reduced Basic Sum Insured, then CB shall be restricted to 50% of the reduced Basic Sum Insured.

In case of claim(s) during a Policy Period in respect of an Insured Person, who has accumulated CB for earlier claim free Policy Periods, the accumulated CB will be reduced on the next Renewal at the rate of 5% of Basic Sum Insured of the expiring policy. However, Basic Sum Insured will be maintained and not be reduced.

1.5.2 Preventive Health Check Up

Expenses of preventive health check-up/ prescribed diagnostic tests will be reimbursed once at the end of a **block of four (04) continuous Policy Periods** provided **no claims are reported** during the block and the policy has been continuously renewed with the Company without a Break in Policy. Expenses payable shall be up to **1% of the average Basic Sum Insured** of the block, subject to a maximum of ₹ 5,000 per Insured Person. Claim for health check-up benefits may be lodged at least forty five (45) days before the expiry of the fifth Policy Period

Note: Claims under Section 1.5.2 shall not be counted as a claim under the Policy.

1.6 Hospitalisation Options

The Policy provides for Cashless Facility and/ or reimbursement of Hospitalisation expenses for treatment of Illness or Injury. Cashless Facility is available only in Network Providers if TPA service is opted in the Policy.

2.1 Type of Policy

Policy can be issued on Individual Basis (i.e., separate Basic Sum Insured and Cumulative Bonus shall apply on each Insured Person).

2.2 Eligibility

i. Entry age of Proposer should be between eighteen (18) years and sixty five (65) years.
ii. Maximum entry age of any family member is sixty five (65) years.
iii. Un married Children over the age of three (03) months may be covered for the first time, provided parent(s) is/are covered at the same time.
iv. Family members allowed under same policy.
    a. Proposer
    b. Spouse
    c. Dependent natural or legally adopted children
    d. Parents
    e. Brother, till marriage
    f. Sister, till marriage
    g. Parent-in-laws
v. Renewal terms are as per Section 2.10 below.
vi. Midterm inclusion of family members at pro-rata premium is allowed only in case of
    a. newborn between the age of three (03) months and six (06) months
    b. spouse within sixty (60) days of marriage

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

No other relation even within the eligible age band can be covered under the Policy.

2.3 Policy Period

The Policy can only be issued for a period of one (01) year (i.e., 12 calendar months).

2.4 Basic Sum Insured (Basic SI)

The Policy is available with options of Basic SI of ₹ **1/ 2/ 3/ 4/ 5/ 6/ 7/ 8/ 9/ 10 L.**

Proposer has the option of selecting same Basic SI for each family member or separate Basic SI for different members.

2.4.1 Enhancement of Basic Sum Insured

i. Basic Sum Insured can be enhanced only at the time of Renewal.
ii. For the incremental portion of the Basic SI, the Waiting Periods as mentioned in Exclusion 4.1, 4.2, 4.3 shall apply. Coverage on enhanced Basic SI shall be available after the completion of Waiting Periods.

2.5 Discounts

2.5.1 Discount for Optional Co-payment

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

- 15% discount in total premium, for 20% Co-payment on each admissible claim.
- 10% discount in total premium, for 15% Co-payment on each admissible claim.

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

2.5.2 Discount for Direct Sale

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

2.5.3 Covid-19 Vaccination Discount

Discount of 5% is allowed on individual premium if the Insured Person has received 2 doses of COVID-19 vaccine. Children (Insured Persons less than 18 years) may be allowed discount provided both parents are vaccinated.

2.6 Tax Rebate

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

2.7 Completion of Proposal Form

i. The Proposal Form is to be completed in all respects (including personal details, medical history of Insured Person) and to be submitted to the Company's office or to Company's intermediary.
ii. Identity and address of the Proposer must be supported by documentary proofs, as detailed in Proposal Form Annexure C.
iii. If a person is insured under health insurance policy of any other Non-Life Insurance Company and wants to port (switch) to **National Mediclaim Policy**, the Portability Form and Proposal Form will have to be completed and submitted to the Company's office or to Company's intermediary.

2.8 Pre Policy Checkup

i. Pre policy checkup is required for persons aged **fifty (50) years and above**, and availing the Policy for the first time with the Company.
ii. The Company shall reimburse 50% of the expenses incurred for pre policy checkup, if the proposal is accepted.
iii. The Pre Policy checkup reports required are –
   a) Physical examination (report to be signed by the Doctor with minimum MD (Medicine) qualification)
   b) Blood sugar: fasting/ post prandial (till Basic SI of ₹ 5L)/ HBA1C (Basic SI of ₹ 6 L and above)
   c) Lipid profile
   d) Serum creatinine
   e) Urine routine and microscopic examination
   f) ECG
   g) Eye checkup (including retinoscopy)
   h) Any other investigation required by the Company

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

2.9 Payment of Premium

i. Premium for each individual shall depend on the Basic SI and completed age, as provided in the 'Rate Chart'.
ii. The proposer has the option of claims being serviced by TPA (in which case both Cashless Facility and Reimbursement Facility will be available) or the Company (in which case Cashless Facility shall not be available). If Cashless Facility is to be availed, the premium payable is inclusive of TPA charges. If Cashless Facility is required, the premium shall be selected from Rate Chart with TPA Charges, otherwise to be selected from Rate Chart without TPA charges.
iii. Base premium of the policy shall be total premium for all individuals, calculated as mentioned above.
iv. Discounts, if any, shall apply on the Individual/ total Base Premium (as specified).
v. As opted in the Proposal Form, Insured have the option to either pay the premium annually, or in half yearly or quarterly instalment as per factors provided in Rate Chart.
vi. Full premium/ first instalment of premium shall be paid in full before the commencement of the Policy.
vii. Premium can be paid online for Renewals without break, provided there is no material change in the Policy.
viii. PAN details must be submitted by the Proposer.
ix. In case PAN is not available, Form 60 or Form 61 as per Rule 114B of the Income-tax Rule,1962 must be submitted

2.10 Renewal of Policy

i. The Policy can be renewed without break throughout the lifetime of the Insured Persons except for the covered Children or siblings, who can renew till the Insured Person's marriage
ii. The Policy may be renewed by mutual consent, before the expiry of the Policy or a within a Grace Period of thirty (30) days after expiry of the Policy. Coverage is not available during the Grace Period.
iii. Grace Period of **15 days** shall be allowed for payment of Installment Premium. If premium is not paid within Grace Period, the Policy shall be cancelled and no refund shall be allowed.
iv. If the Policy is not renewed within the Grace Period, the Break in Policy shall occur.
v. The Company is not bound to send Renewal Notice.
vi. Renewal of Policy can be denied on grounds of fraud, moral hazard, misrepresentation or noncooperation.
vii. Any change in the Policy, including Basic Sum Insured, Co-Payment, Insured Person(s), can only be incorporated at the time of Renewal.
viii. In case of non-continuance of the Policy by the Insured (due to death or any other valid and acceptable reason)
   - The Policy may be renewed by any Insured Person above eighteen (18) years of age, as the Insured
   - Where only children (less than eighteen years of age) are covered, the Policy shall be allowed till the expiry of the Policy period. The legal guardian may be allowed to renew the Policy as Insured, covering the children.

3 DEFINITIONS

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

3.2 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.

3.3 Any One Illness means continuous period of Illness and it includes relapse within forty five (45) days from the date of last consultation with the Hospital where treatment was taken.

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

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

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

3.6 **Break in Policy** occurs at the end of the existing Policy Period when the premium due on a given Policy is not paid on or before the Renewal date or within Grace Period.

3.7 **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 by the Company to the extent pre-authorization approved.

3.8 **Condition Precedent** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

3.9 **Contract** means prospectus, proposal, Policy, and the policy Schedule. Any alteration with the mutual consent of the Insured Person and the Company can be made only by a duly signed and sealed endorsement on the Policy.

3.10 **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

a) Internal Congenital Anomaly
Congenital Anomaly which is not in the visible and accessible parts of the body.

b) External Congenital Anomaly
Congenital Anomaly which is in the visible and accessible parts of the body.

3.11 **Co-Payment** means a cost sharing requirement under a health insurance policy that provides that the Insured will bear a specified percentage of the admissible claims amount. A Co-Payment does not reduce the Sum Insured.

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

3.13 **Day Care Centre** means any Institution established for Day Care Treatment of Illness and/ or Injuries or a medical setup with a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:

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

3.14 **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 (24) hrs because of technological advancement, and
ii. which would have otherwise required a Hospitalisation of more than twenty four (24) hours.

Treatment normally taken on an Out-Patient basis is not included in the scope of this Definition.

3.15 **Dental Treatment** means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.

3.16 **Diagnosis** means diagnosis by a Medical Practitioner, supported by clinical, radiological, histological and laboratory evidence, acceptable to the Company.

3.17 **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as Waiting Periods and coverage of Pre-Existing Diseases. Coverage is not available for the period for which no premium is received.

3.18 Hospital means any Institution established for In-Patient Care and Day Care Treatment of Illness/ 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 (10) In-Patient beds, in those towns having a population of less than ten lacs and fifteen (15) inpatient beds in all other places;
iii. has qualified Medical Practitioner (s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out
v. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

3.19 Hospitalisation means admission in a Hospital for a minimum period of twenty four (24) consecutive 'In-Patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.

3.20 ID Card means the card issued to the Insured Person by the TPA for availing Cashless Facility in the Network Provider.

3.21 Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

i. **Acute Condition** means a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ 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 rehabilitation for the patient or for the patient to be special trained to cope with it
d) it continues indefinitely
e) it recurs or is likely to recur

3.22 Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

3.23 In-Patient Care means treatment for which the Insured Person has to stay in a Hospital for more than twenty four (24) hours for a covered event.

3.24 Insured/ Insured Person means person(s) named in the Schedule of the Policy.

3.25 Intensive Care Unit means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

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

3.27 Medical Advice means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

3.28 Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.

3.29 Medical Practitioner means a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of the licence.

3.30 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 Illness or Injury suffered by the Insured Person;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. must have been prescribed by a Medical Practitioner;
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

3.31 Mental Illness means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence.

3.32 Network Provider means hospitals enlisted by the Company, TPA or jointly by the Company and TPA to provide medical services to an Insured Person by a Cashless Facility.
In cities with Preferred Provider Network (Definition 3.38), PPN are the only Network Providers.

3.33 Non- Network Provider means any Hospital, Day Care Centre or other provider that is not part of the network.

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

3.35 OPD (Out-Patient) Treatment means the one in which the Insured Person visits a clinic / Hospital or associated facility like a consultation room for Diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a Day Care or In-Patient.

3.36 Policy Period means period of one (01) year as mentioned in the Schedule for which the Policy is issued.

3.37 Pre Existing Disease means any condition, ailment, injury or disease
a) That is/are diagnosed by a physician within 48 months prior to the effective date of the Policy issued by the Company or its reinstatement or
b) For which Medical Advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Policy issued by the Company or its reinstatement.

3.38 Preferred Provider Network (PPN) means Network Providers in specific cities which have agreed to a cashless packaged pricing for specified planned procedures for the policyholders of the Company. The list of planned procedures is available with the Company/TPA and subject to amendment from time to time.

3.39 Pre-hospitalisation Medical Expenses means Medical Expenses incurred during predefined number of days preceding the Hospitalisation of the Insured Person, 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.

3.40 Proposer means an eligible person who proposes to enter into insurance Contract with the Company, to cover self and/ or any other eligible person(s), and pays the premium as consideration for such insurance.

3.41 Post-hospitalisation Medical Expenses means Medical Expenses incurred during predefined number of days immediately after the Insured Person is discharged from the Hospital provided that:
i. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The inpatient hospitalisation claim for such hospitalisation is admissible by the Company.

3.42 Psychiatrist means a Medical Practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognised by the University Grants Commission established under the University Grants Commission Act, 1956, or awarded or recognised by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognised by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist.

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

3.44 Reasonable and Customary Charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness/ Injury involved.

3.45 Renewal means the terms on which the Contract of Insurance can be renewed on mutual consent with a provision of Grace Period for treating the Renewal continuous for the purpose of gaining credit for Pre-Existing Diseases, time-bound Exclusions and for all Waiting Periods.

3.46 Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated Medical Expenses.

3.47 Schedule means a document forming part of the Policy, containing details including name of the Insured Person(s), age, relation with the Proposer, Basic Sum Insured, Cumulative Bonus, premium and the Policy Period.

3.48 Sum Insured means the Basic Sum Insured and the Cumulative Bonus (CB) accrued in respect of the Insured Person(s) as mentioned in the Schedule. Preventive Health Checkup expenses are payable over and above the Sum Insured, wherever applicable.

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

3.49 Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

3.50 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.

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

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

4 WAITING PERIOD - EXCLUSIONS

The Company shall not be liable to make any payment under the Policy till the expiry of Waiting Period mentioned below, in respect of any expenses incurred in connection with or in respect of:

4.1. Pre-Existing Diseases (Excl 01)

a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of forty eight (48) months of continuous coverage after the date of inception of the first policy with us.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the policy after the expiry of forty eight (48) months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

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

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 90 days/ one year/ two year/ four years (as specified against specific disease/ procedure) of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing Diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases/procedures

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

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

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

iv. Four years Waiting Period
a. Joint replacement unless necessitated due to an accident
b. Osteoarthritis and osteoporosis
c. Morbid Obesity and its complications
d. Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.
Above diseases/treatments under 4.2.f).iv if pre-existing also, shall be covered after single Waiting Period of four (04) years only.

4.3. First 30 days waiting period (Excl 03)

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

5 PERMANENT EXCLUSIONS

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

5.1. 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.

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

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

5.3. 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

5.4. 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.

5.5. 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.

5.6. 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.

5.7. Breach of Law (Excl 10)

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

5.8. Excluded Providers (Excl 11)

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

5.9. Drug/Alcohol Abuse (Excl 12)

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

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

5.11. 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

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

5.13. 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.

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

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

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

5.17. General Debility, Congenital External Anomaly
General debility, congenital external anomaly.

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

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

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

5.21. Vaccination or Inoculation.
Vaccination or inoculation unless forming part of treatment and requires Hospitalisation.

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

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

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

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

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

5.27. 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.

5.28. 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.

5.29. 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.

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

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

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

5.33. 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.

5.34. 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.

5.35. Treatment taken outside the geographical limits of India

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

6 CONDITIONS

6.1 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)*

6.2 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.

6.3 Communication
i. All communication should be made in writing.
ii. For Policies serviced by TPA, ID card, PPN/Network Provider related issues to be communicated to the TPA at the address mentioned in the Schedule. For claim serviced by the Company, the Policy related issues to be communicated to the Policy issuing office of the Company at the address mentioned in the Schedule.
iii. Any change of address, state of health or any other change affecting any of the Insured Person, shall be communicated to the Policy issuing office of the Company at the address mentioned in the Schedule
iv. The Company or TPA shall communicate to the Insured at the address mentioned in the Schedule.

6.4 Physical Examination
Any Medical Practitioner authorised by the Company shall be allowed to examine the Insured Person in the event of any alleged Illness/Injury requiring Hospitalisation when and as often as the same may reasonably be required on behalf of the Company.

6.5 Claim Procedure

6.5.1 Notification of Claim

In order to lodge a claim under the Policy for any 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.

Claim Intimation in case of Cashless facility	**TPA must be informed:**
In the event of planned Hospitalisation	At least seventy two (72) hours prior to the Insured Person's admission to Network Provider
In the event of emergency Hospitalisation	Within twenty four (24) hours of the Insured Person's admission to Network Provider

Claim Intimation in case of Reimbursement	**Company/TPA must be informed:**
In the event of planned Hospitalisation	At least seventy two (72) hours prior to the Insured Person's admission to Hospital
In the event of emergency Hospitalisation	Within twenty four (24) hours of the Insured Person's admission to Hospital

6.5.2 Procedure for Cashless Claims

i. Cashless Facility for treatment in Network Providers can be availed, if TPA service is opted.
ii. Treatment may be taken in a Network Provider and is subject to pre authorization by the TPA. Booklet containing list of Network Provider shall be provided by the TPA. Updated list of Network Provider is available on website of the Company and the TPA mentioned in the Schedule.
iii. Cashless request form available with the Network Provider 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 shall issue pre-authorization letter to the Hospital after verification.
v. At the time of discharge, the Insured Person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
vi. The TPA reserves the right to deny pre-authorization in case the Insured Person/ Network Provider is unable to provide any required details related to the pre authorization request.
vii. In case of denial of Cashless Facility, the Insured Person may obtain the treatment as per treating Medical Practitioner's advice and submit the necessary documents for reimbursement of claim.

6.5.3 Procedure for Reimbursement of Claims

For reimbursement of claims the Insured Person shall 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.

6.5.4 Documents

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

i. Completed claim form
ii. Medical practitioner's prescription advising admission for inpatient treatment.
iii. Cash-memo from the hospital (s)/chemist (s) supported by proper prescription from attending medical practitioner for Pre Hospitalisation, Hospitalisation and Post Hospitalisation.
iv. Payment receipt, investigation test reports and associated plates/ CDs in original, supported by the prescription from attending medical practitioner for Pre Hospitalisation, Hospitalisation and Post Hospitalisation.
v. Attending medical practitioner's certificate regarding Diagnosis along with date of Diagnosis and bill, receipts etc.
vi. Surgeon's certificate regarding Diagnosis and nature of operation performed along with bills, receipts etc.
vii. Bills, receipt, sticker of the Implants.
viii. Bills, payment receipts, medical history of the patient recorded, discharge certificate/ summary, break up of final bill from the hospital etc.
ix. Any other document required by Company/TPA.

Note

In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents listed under condition 6.5.4 and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company.

6.5.5 Time limit for submission of claim documents to the Company/ TPA

Type of claim	**Time limit**
Reimbursement of Hospitalisation, Pre Hospitalisation expenses and ambulance charges	Within thirty (30) days of date of discharge from Hospital
Reimbursement of post Hospitalisation expenses	Within thirty (30) days from completion of Post Hospitalisation treatment
Reimbursement of Preventive Health Check-Up expenses	At least forty five (45) days before the expiry of the fifth Policy Period

Waiver

Time limit for claim intimation and submission of documents may be waived in cases where the Insured/ Insured Person or his/ her representative applies and explains to the satisfaction of the Company, that the circumstances under which Insured/ Insured Person was placed, it was not possible to intimate the claim/submit the documents within the prescribed time limit.

6.5.6 Claim Settlement

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

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

6.5.7 Services Offered by TPA

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

i. Claim settlement and claim rejection;
ii. Any services directly to any Insured Person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

6.5.8 Optional Co-payment

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

- 20% Co-payment on each admissible claim under the Policy, with a 15% discount in total premium.
- 15% Co-payment on each admissible claim under the Policy, with a 10% discount in total premium.

6.6 Moratorium Period

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

6.7 Payment of Claim

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

6.8 Territorial Limit

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

6.9 Multiple Policies

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

6.10Fraud

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.

6.11 Cancellation

i. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud

ii. The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

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

6.12 Territorial Jurisdiction

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

6.13 Arbitration

i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred 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.

6.14 Disclaimer

If the Company shall disclaim liability to the Insured Person for any claim hereunder and if the Insured Person shall not within twelve (12) calendar months from the date of receipt of the notice of such disclaimer notify the Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

6.15 Renewal of Policy

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

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the Grace Period.

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

6.16 Enhancement of Basic Sum Insured

Basic Sum Insured can be enhanced only at the time of Renewal. Basic Sum Insured can be enhanced subject to discretion of the Company. For the incremental portion of the Basic Sum Insured, the Waiting Periods and conditions as mentioned in Exclusion 4.1, 4.2, 4.3 shall apply afresh.

6.17 Adjustment of Premium for Overseas Travel Insurance Policy

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

6.18 Migration

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

6.19 Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per

IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

6.20 Withdrawal of Product

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

6.21 Revision of Terms of the Policy Including the Premium Rates

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

6.22 Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.
The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.
If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

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

6.23 Nomination

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

7 REDRESSAL OF GRIEVANCE

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

Website: https://nationalinsurance.nic.co.in/	Post: National Insurance Co. Ltd.,
Toll free: 1800 345 0330	6A Middleton Street, 7th Floor,
E-mail: customer.relations@nic.co.in	CRM Dept.,
Phn : (033) 2283 1742	Kolkata - 700 071

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.
If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer (Office in-Charge) at that location.
For updated details of grievance officer, kindly refer the link: https://nationalinsurance.nic.co.in/
If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.
Grievance may also be lodged at IRDAI Integrated Grievance Management System -https://igms.irda.gov.in/

8 DISCLAIMER

The Prospectus contains salient features of the Policy. For details reference is to be made to the Policy. In case of any difference between the Prospectus and the Policy, the terms and conditions of the Policy shall prevail.
The Prospectus and Proposal form are part of the Policy. Hence please read the Prospectus carefully and sign the same. The Proposal form is to be completed in all respects for each Insured Person. Both the Prospectus and the Proposal Form are to be submitted to the Company's office or to the Company's agent.

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

TABLE OF BENEFITS

Name	**National Mediclaim Policy**
Basic SI (excluding CB)	**₹ 1L – 10 L**
Slabs	**₹ 1/ 2/ 3/ 4/ 5/ 6/ 7/ 8/ 9/ 10 L**
Coverage	
Hospitalisation	**Sub limits** **A. Room Charges** – Up to25% of SI for Any One Illness **Room Rent** – Up to 1% of SI per day subject to max of ₹ 10,000 **ICU Charges** – Up to 2% of SI per day subject to max of ₹ 20,000 **B. Medical Practitioner's fee** – Up to 25% for Any One Illness **C. Others** – Up to 50% of SI for Any One Illness *Sub limit will not apply in case of Hospitalisation in a Preferred Provider Network (PPN) as per eligible package* **D. Hemodialysis, Chemotherapy, Radiotherapy** Restricted to 50% of Sum Insured or the PPN Package Rate, whichever is lower (inclusive of above sub limits) **E.** Coverage for **Modern Treatment** (12 nos) – Up to 25% of SI for each treatment **F.** Expenses due to **hazardous or adventure sports (non-professionals)–** Up to 25% of SI
System of Medicine	**Allopathy, Ayurveda, Homeopathy** Covered up to SI
In Built Features	**Pre hospitalisation -** 45 days immediately before hospitalisation **Post hospitalisation -** 60 days immediately after discharge
	Organ Donor's hospitalisation expenses only
	Ambulance Charges – 1% of SI subject to maximum of ₹ 2,000 in a Policy Period
	Hospitalisation coverage for **HIV/ AIDS** and **Mental Illness**
	Treatment of **Morbid Obesity** and **Refractive Error** of at least 7.5D, subject to Waiting Periods
	Reinstatement of Basic SI – Once in a Policy Period, available to Policy with Basic SI ₹ 6L and above
Others	
Pre Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the Company shall be covered after **4 year Waiting Period**
Enhancement of Basic SI	**On Renewal** No limit
Good Health Incentives	
Cumulative Bonus	Increase by 5% of Basic SI in respect of each claim free Policy Period Decrease by 5% of Basic SI for each year with claim reported Maximum accumulation, **50% of the Basic SI of the renewed Policy**
Preventive Health check up	Every **4** claim free years, prescribed diagnostics tests up to 1% of the average Basic SI per insured person, subject to maximum ₹ 5,000/-
Discounts	
Copayment (optional)	If opted, policyholder may choose either of the two copayment options- • 20% Co-payment on each admissible claim, with a 15% discount in premium • 15% Co-payment on each admissible claim, with a 10% discount in premium
Online Discount	10% discount in premium (for new and Renewal, ONLY where no intermediary is involved)
Covid-19 Vaccination Discount	Discount of 5% is allowed on individual premium if the Insured Person has received 2 doses of COVID-19 vaccine. Children (Insured Persons less than 18 years) may be allowed discount provided both parents are vaccinated.

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

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

Rate Chart (in ₹ per Individual, without TPA Charges)

Age band / SI	1,00,000	2,00,000	3,00,000	4,00,000	5,00,000	6,00,000	7,00,000	8,00,000	9,00,000	10,00,000
3m-5y	2,392	3,386	4,350	4,974	5,674	6,347	6,810	7,273	7,739	8,206
6-17	2,124	3,180	3,836	4,578	5,152	5,758	6,174	6,589	7,007	7,425
18-25	2,411	3,315	4,263	5,429	5,620	6,080	6,564	6,988	7,416	7,844
26-30	2,718	3,390	4,550	6,033	6,486	7,021	7,583	8,077	8,574	9,072
31-35	2,901	3,507	4,993	6,535	6,569	7,179	7,678	8,178	8,764	9,272
36-40	3,295	4,139	5,834	6,561	7,278	7,880	8,432	9,069	9,629	10,189
41-45	3,509	5,367	5,971	6,714	7,422	8,035	8,597	9,158	9,723	10,287
46-50	4,779	7,294	9,757	10,307	10,508	11,496	12,309	13,121	13,943	14,764
51-55	6,015	10,011	12,932	14,987	16,872	18,477	19,798	21,119	22,675	24,027
56-60	8,111	13,701	16,503	21,121	23,277	25,479	27,293	29,386	31,261	33,136
61-65	10,700	17,457	21,129	28,384	31,289	34,274	36,738	39,577	42,137	44,698
66-70	14,251	21,959	28,092	33,621	38,513	42,232	45,308	48,383	52,012	55,174
71-75	15,676	24,154	30,059	36,983	42,364	46,456	49,841	53,226	57,218	60,698
76-80	17,244	26,570	32,163	40,286	44,482	48,311	52,334	55,888	60,081	63,736
81-85	18,968	29,227	34,414	42,715	46,706	50,727	54,952	58,685	63,087	66,926
86+	20,865	32,149	36,823	44,415	51,377	55,801	60,450	64,557	68,741	73,625

GST extra

Rate with TPA charge – 6% loading on the premiums tabulated above.

Instalment Premium
Half yearly:
1st instalment: 52% of annual premium
2nd instalment: 50% of annual premium
Quarterly:
1st instalment: 28% of annual premium
2nd, 3rd and 4th instalments: 25% of annual premium.

Discounts
Discount for Optional Co-payment – 15% discount on policy premium (if opted for 20% Co-payment) or 10% discount on policy premium (if opted for 15% Co-payment)
Discount for Direct Sale – 10% on total premium
Covid-19 Vaccination Discount – 5% on individual premium