National Senior Citizen Mediclaim Policy

PROSPECTUS

1.1 PRODUCT

National Senior Citizen Mediclaim Policy is an indemnity health insurance policy for the aged. The Policy covers expenses in respect of inpatient treatment (allopathy and AYUSH), domiciliary hospitalisation, reasonably and customarily incurred for treatment of a disease or an injury contracted/sustained during the policy period. The Policy also covers pre hospitalisation and post hospitalisation expenses, day care procedures/surgeries, organ donor's medical expenses, hospital cash, ambulance charges, doctor's home visit, nursing, aya and attendant charges during post hospitalization, funeral expenses, reinstatement of SI due to Road Traffic Accident and regular medical consultation charges depending on the Plan opted.

Pre-existing Diabetes and/or Hypertension, Outpatient Treatment, Critical Illness and Personal Accident are available as Optional Covers on payment of additional premium

COVERAGE

1.2 BENEFITS AVAILABLE IN BOTH PLAN A & B

1.2.1 In-patient Treatment

The Company shall indemnify the Medical Expenses incurred for Hospitalization of the Insured Person during the Policy Period for:

i. Room charges and intensive care unit charges (including diet charges, nursing care by qualified nurse, RMO charges, administration charges for IV fluids/blood transfusion/injection)
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 illness or injury
ix. Hormone replacement therapy, if medically necessary
x. Vitamins and tonics, forming part of treatment for illness/injury as certified by the attending medical practitioner
xi. Circumcision, necessitated for treatment of an illness or injury

Sub limits

1.2.1.1 Limit for Room Charges and Intensive Care Unit Charges under Plan A

Room charges and intensive care unit charges per day shall be payable up to the limit as shown in the Table of Benefits. The limit shall not apply if the treatment is undergone as a package for a listed procedure in a Preferred Provider Network (PPN).

1.2.1.2 Limit for Cataract Surgery and Benign Prostatic Hyperplasia under Plan A

The Company's liability for Cataract Surgery and Benign Prostatic Hyperplasia shall be up to the limit as shown in the Table of Benefits, under Plan A only.

1.2.1.3 Treatment related to participation as a non-professional in hazardous or adventure sports

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

1.2.2 Pre Hospitalisation

The Company shall indemnify the medical expenses incurred 30 (thirty) days immediately before the insured person is hospitalised, provided that:

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

Pre hospitalisation shall be considered as part of hospitalisation claim.

1.2.3 Post Hospitalisation

The Company shall indemnify the medical expenses incurred 60 (sixty) days immediately after the insured person is discharged from hospital, provided that:

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

Post hospitalisation shall be considered as part of hospitalisation claim.

1.2.4 Domiciliary Hosptalisation

The Company shall indemnify the medical expenses incurred under domiciliary hospitalisation, including pre hospitalisation expenses and post hospitalisation expenses, up to the limit as shown in the Table of Benefits. Treating Medical Practitioner shall have to certify the commencement date of Domiciliary Hospitalisation, and the necessity following the circumstances mentioned below.

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 room in a hospital.

Domiciliary Hospitalisation beyond the first 7 days shall be treated as Post Hospitalisation and shall be covered for the period mentioned in Post Hospitalisation.

If the insured person is shifted to a Hospital as In-patient during the Domiciliary Hospitalisation for the same illness/ injury, the Post Hospitalisation period shall start from the date of discharge.

Exclusions

Domiciliary hospitalisation shall not cover:

i. Treatment of less than three days
ii. Expenses incurred prior to or after Domiciliary hospitalization, for the same treatment
iii. Expenses incurred for treatment other than Allopathy and AYUSH
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 mental illnesses, psychiatric or psychosomatic disorders
    h) Pyrexia of unknown origin for less than ten days
    i) Tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis
    j) Arthritis, gout and rheumatism
    k) HIV/ AIDS

1.2.5 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.

1.2.6 AYUSH Treatment

The Company shall indemnify the Medical Expenses for In-patient Care, Pre-Hospitalisation expenses and Post-Hospitalisation expenses, incurred for AYUSH treatment, provided the treatment is undergone in an AYUSH Hospital.

1.2.7 HIV/ AIDS Cover

The Company shall indemnify the medical expenses for in-patient care, pre hospitalisation expenses and post hospitalisation expenses, related to following stages of HIV infection:

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

Exclusions

1. Any treatment undertaken as Out Patient shall not be covered.
2. Any treatment undertaken as Domiciliary hospitalization shall not be covered.

1.2.8 Mental Illness Cover

The Company shall indemnify the medical expenses for in-patient care, pre hospitalisation expenses and post hospitalisation expenses, related to following mental illnesses:

1. Major Depressive Disorder- when the patient is aggressive or violent.
2. Acute psychotic conditions- aggressive/violent behaviour or hallucinations, incoherent talking or agitation.
3. Schizophrenia- esp. Psychotic episodes.
4. Bipolar disorder- manic phase.

The above covers are subject to the patient simultaneously exhibiting two or more of the following traits and requiring hospitalisation as per the treating psychiatrist's advice

- Suicidality
- Aggression
- Violent behaviour which are harmful to the patient and people around him
- Patients not responding to OPD drugs/treatments/therapy.

Condition

Treatment shall be undertaken at a Hospital categorized as Mental Health Establishment, under a Medical Practitioner qualified as Mental Health Professional.

Exclusions

1. Any treatment undertaken as Out Patient shall not be covered.
2. Any treatment undertaken as Domiciliary hospitalization shall not be covered.
3. Any kind of Psychological counselling, cognitive/ family/ group/ behavior/ palliative therapy or other kinds of psychotherapy for which hospitalisation is not necessary shall not be covered.

1.2.9 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 Section "In patient treatment" 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.

1.2.10 Ambulance Charges
The Company shall indemnify the expenses incurred for actual emergency ambulance charges for transportation to the hospital or from the hospital to another hospital or from the hospital to diagnostic center and return during the same hospitalization period, provided a claim has been admitted as Section In-patient Treatment. Ambulance charges will be subject to maximum INR 2,500 for Any One Illness for each insured person.

1.2.11 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

1.2.12 Morbid Obesity Treatment
The Company shall indemnify the Medical Expenses, including 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

1.2.13 Correction of Refractive Error
The Company shall indemnify the Medical Expenses, including 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

1.3 ADDITIONAL BENEFITS AVAILABLE IN PLAN B

1.3.1 Hospital Cash

The Company shall pay the insured a daily hospital cash allowance up to the limit as shown in the Table of Benefits for a maximum of five (05) days, provided

i. The hospitalisation exceeds three (03) days.
ii. A claim has been admitted as per Section In-patient Treatment.

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

Illustration

In case of hospitalisation of 3 days – No Hospital Cash payable
In case of hospitalisation of 5 days – Hospital Cash payable for 4th and 5th day only, i.e., 2 days
In case of hospitalisation of 10 days – Hospital Cash payable for 4th to 8th day, i.e., 5 days
For Reimbursement Claims, Hospital Cash shall be paid along with In-Patient Claim.
For Cashless Claims, Hospital Cash shall be paid along with Post Hospitalisation Claim/ separate benefit.

1.3.2 Doctor's Home Visit/ Aya/ Nurse/ Attendant/ Charges during Post Hospitalisation

The Company shall reimburse the insured, for medically necessary expenses incurred for doctor's home visit, nursing care by qualified nurse, aya, attendant charges during post hospitalisation up to the limit as shown in the Table of Benefits, provided the related hospitalisation claim has been admitted as per Section In-patient Treatment and the physical mobility of the insured person outside residence is severely restricted as advised in the discharge summary.

1.3.3Funeral Expenses

In the event of death of the insured person during hospitalisation, the Company shall pay funeral expenses subject to limit as mentioned in Table of Benefit provided hospitalisation claim is admitted as per Section In-patient Treatment.

1.3.4Reinstatement of Sum Insured if exhausted due to Road Traffic Accident

In the event of available sum insured in respect of the insured/ insured person being exhausted anytime during the policy period on account of hospitalisation/ domiciliary hospitalisation claims arising out of any injury due to a road traffic accident (RTA), the Company shall reinstate the sum insured (excluding Cumulative Bonus) to the extent as available prior to such RTA hospitalization, for any subsequent hospitalization(s) expenses that the insured/ insured person may incur due to any other disease/ injury during the balance policy period.

i. In a policy issued on individual basis, reinstatement of sum insured shall be available in respect of the insured person whose sum insured is exhausted as specified above. In a policy issued on floater basis, reinstatement shall be available to floater sum insured subject to exhaustion of sum insured as specified above by either or both of the insured persons.
ii. Reinstated sum insured shall be the amount of balance sum insured prior to the RTA, which is exhausted due to the RTA hospitalisation/ domiciliary hospitalisation claim.
iii. Reinstatement shall be allowed only once during the policy period
iv. Reinstated sum insured shall not be available for the Hospitalisation claim due to which the sum insured has exhausted, but shall be available only for subsequent hospitalization(s) due to any other disease/ injury (Subject to Definition 'Any One Illness').
v. Maximum liability of the Company under a single claim and any one illness shall not exceed the sum insured.
vi. Reinstated sum insured, if not exhausted, will not be carried forward to next policy period on renewal.

Illustration:

Case I: SI – INR 5L	**Case II: SI – INR 5L**
Claim 1 (hospitalization due to disease) – INR 2L Balance SI – INR 5L, Amount admissible – INR 2L SI exhausted – No, SI remaining – INR 3L SI reinstated – **No**	Claim 1 (hospitalization due to RTA) – INR 4L Balance SI – INR 5L, Amount admissible – INR 4L SI exhausted – No, SI remaining – INR 1L SI reinstated – **No**
Claim 2 (hospitalization due to RTA) – INR 4L Balance SI – INR 3L, Amount admissible – INR 3L SI exhausted – Yes, SI remaining – INR 0 SI reinstated – **Yes [INR 3L, i.e., balance SI prior to RTA]** ***(though SI is reinstated, it will be available in next claim)***	Claim 2 (hospitalization due to disease) – INR 2L Balance SI – INR 1L, Amount admissible – INR 1L SI exhausted – Yes, SI remaining – INR 0 SI reinstated – **No** ***(SI is not reinstated as not exhausted due to RTA)***
Claim 3 (hospitalization due to disease) – INR 1L Balance Reinstated SI – 3L Amount admissible – INR 1L SI remaining – INR 2L	Claim 3 (hospitalization due to disease/ RTA) – INR 1L Amount admissible – INR 0 ***(no amount available)***

1.4 GOOD HEALTH INCENTIVE

<u>For policies issued on individual basis</u>

At the time of renewal, Cumulative Bonus allowed shall be an amount equal to 5% (five percent) of Sum Insured (excluding CB) of the expiring policy in respect of the Insured Person provided no claim has been reported and admitted under the expiring policy.

In the event of claim(s) under the expiring policy, the cumulative bonus with respect to the Insured Person shall be reduced by an amount equal to 5% (five percent) of Sum Insured (excluding CB) of the expiring policy. However, the reduction of CB will not impact Sum Insured (excluding CB).
Cumulative bonus shall be accrued over the years, subject to maximum of 50% (fifty percent) of the Sum Insured (excluding CB) of the current policy.

For policies issued on floater basis

At the time of renewal, cumulative bonus allowed shall be an amount equal to 5% (five percent) of the floater Sum Insured (excluding CB) of the expiring policy provided no claim has been reported under the expiring policy by any Insured Person and admitted under the expiring policy.
In the event of claim(s) under the expiring policy the cumulative bonus with respect to the Insured family shall be reduced by an amount equal to 5% (five percent) of Sum Insured (excluding CB) of the expiring policy. However, the reduction of CB will not impact Sum Insured (excluding CB).
Cumulative bonus shall be accrued over the years, subject to maximum of 50% (fifty percent) of the Sum Insured (excluding CB) of the current policy.

Notes:

i. In case where the Policy is on Individual Basis, the CB shall be added and available individually to the Insured Person if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.
ii. In case where the Policy is on Floater Basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any Insured Person. CB shall reduce in case of claim from any of the Insured Persons.
iii. Any Cumulative Bonus that has accrued for a Policy Period will be credited at the end of that Period if the policy is renewed with the Company within Grace Period and will be available for any claims made in the subsequent Period.
iv. Merging of Policies or Migration from Individual to Floater Policy: If the Insured Persons in the expiring Policy are covered under Individual policy/policies and such expiring Policy has been Renewed with the Company on a Family Floater basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest percentage of Cumulative Bonus applicable on the lowest Sum Insured of the last Policy Period amongst all the expiring individual policies being merged.
v. 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.
vi. Revision in Sum Insured: If the 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.
vii. If a claim is made in the expiring Policy Year, and is notified to the Company after the acceptance of Renewal premium any awarded CB shall be withdrawn.

1.4.2 Preventive Health Check Up

1.4.2.1 Applicable to Plan A

Expenses of prescribed diagnostic tests only with respect to the Insured Person(s), shall be reimbursed at the end of a block of two continuous Policy Periods, provided the Policy has been continuously renewed with the Company without a break, claims are not reported during the block in respect of the Insured Person(s) and admitted by the Company, and the health checkup is conducted and documents submitted at least forty five (45) days before the expiry of the third Policy Period.
Expenses payable are subject to the limit as shown in the Table of Benefits.

1.4.2.2 Applicable to Plan B

Expenses of medical consultation incurred as Out Patient and prescribed diagnostic tests only (excluding cost of prescribed medicines) with respect to the Insured Person(s), up to the limit as mentioned in the Table of Benefit during a block of six months, shall be reimbursed provided no claims are reported during the block in respect of the Insured Person(s). Claim documents for both blocks of a policy period shall be submitted once, within 30 days from the end of the Policy.
For the purpose of this section, the block of first 6 months shall commence from the inception of the policy till end of 6 months from inception and block of second 6 months shall commence from 7th month of the policy period till expiry of the policy period.

Note: Benefit availed under Section Preventive Health Check Up shall not count as claims under the Policy, for the purpose of determining eligibility for subsequent claims under Section Preventive Health Check Up.

1.5 Hospitalisation Options

The Policy provides for cashless facility and/ or reimbursement of hospitalisation or domiciliary hospitalisation expenses for treatment of disease or injury.
Cashless facility is available, if opted for TPA service, subject to prior approval by the TPA.

2.1 Type of Policy

Policy can be issued, as opted by the Proposer, on

i. Individual Basis (i.e., separate Sum Insured shall apply on each insured person)
ii. Floater Basis (same Sum Insured shall apply to cover both insured person)

2.2 Proposer

Policy can be proposed by,

i. Any Senior Citizen (i.e., aged between 60 to 80 years).
ii. Son or Daughter for parents, where at least one parent is Senior Citizen (i.e., aged between 60 to 80 years)

No one else can be Proposer for this Policy.

2.3Eligibility

i. If Proposer is the Senior Citizen, Policy on **Individual Basis** can be availed for
    a. Self only aged between 60 to 80 years at inception.
    b. Self and Spouse, both aged between 60 to 80 years at inception.
ii. If Proposer is the Senior Citizen, Policy on **Floater Basis** can be availed for
    a. Self and Spouse together, where self is aged between 60 to 80 years and spouse is aged between 50 to 80 years at inception.
iii. If Son or Daughter is the Proposer, Policy on **Individual Basis** can be availed for
    a. Either Father or Mother, aged between 60 to 80 years at inception
    b. Father and Mother, both aged between 60 to 80 years at inception
iv. If Son or Daughter is the Proposer, Policy on **Floater Basis** can be availed for
    a. Father and Mother together, where at least one parent is aged between 60 to 80 years and the other aged between 50 to 80 years at inception.

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

2.4 Policy Period

The Policy can be issued for a period of one (01) year.

2.5 Plans

The Policy is available under two Plans, with varying covers.

i. Plan A
ii. Plan B

2.6 Sum Insured (SI)

i. The Policy is available with following SI under both Individual Basis and Floater Basis.
    Plan A – 10 slabs, INR 1,00,000 to INR 10,00,000 in multiple of INR 1,00,000
    Plan B – 10 slabs, INR 1,00,000 to INR 10,00,000 in multiple of INR 1,00,000

2.6.1 Enhancement of Sum Insured

i. Sum insured can be enhanced only at the time of renewal, subject to discretion of the Company.
ii. For the incremental portion of the SI, the waiting periods and conditions as mentioned in Exclusion 4.1, 4.2, 4.3 shall apply. Coverage on enhanced sum insured shall be available after the completion of waiting periods.
iii. Proposal for change of plan is allowed after four years of continuous coverage and only at the time of renewal, subject to discretion of the Company.

2.7 Discounts

2.7.1 Discount for Direct Sale

For Policy bought by walk in customer *(where no intermediary is involved)* - Discount of 10% shall be allowed on the final payable premium for new and subsequent renewals.
Above discount is not applicable to the premium for Optional Covers.

2.8Tax Rebate

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

2.9 Completion of Proposal Form

i. The proposal form is to be completed in all respects (including personal details, medical history of insured person) and to be submitted to the office or to the 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 Senior Citizen Mediclaim Policy**, the Portability Form and Proposal Form will have to be completed and submitted to the office or to the intermediary.

2.10 Pre Policy Checkup

i. Pre Policy Checkup is required for all individual irrespective of age, for fresh proposal.
ii. The Company shall reimburse 50% of the expenses incurred for Pre Policy Checkup, if the proposal is accepted and the premium has been realised.
iii. The Pre Policy Checkup reports required are –
    a) Physical examination (report to be signed by the Doctor with minimum MD (Medicine) qualification)
    b) HbA1c
    c) Lipid profile
    d) Serum creatinine
    e) Urine routine and microscopic examination
    f) ECG

g) Eye checkup (including retinoscopy)
h) Any other investigation required by the Company

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

2.11 Payment of Premium

i. Premium is based on the Zone opted by the proposer. Change of Zone shall not be allowed midterm.
ii. In case of Individual Policy, premium for each individual shall depend on the Zone, Plan, SI and age from the 'Premium Table for Individuals'.
iii. In case of Floater Policy, premium for senior most member shall depend on the Zone, Plan, SI and age from the 'Premium Table for Senior Most Member' and premium for spouse shall depend on age for same Plan and same SI from 'Premium Table for Spouse'.
iv. Base premium of the policy shall be total premium for both individual, calculated as mentioned above.
v. Premium for Optional cover depends upon the cover(s) opted.
vi. 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.
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 insured.
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 Terms

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 at Renewal.
iii. If the requisite premium is not paid within the Grace Period, the Break in Policy shall occur.
iv. Any change in the Policy, including Basic Sum Insured, Co-Payment, Insured Person(s), can only be incorporated at the time of Renewal.

3 DEFINITIONS

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

3.2 Age means completed years on last birthday as on Commencement Date.

3.3 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.

3.4 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.

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

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

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

3.7 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.

3.8 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.

3.9 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.

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

3.11 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.

3.12 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.

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

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

3.15 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.

3.16 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 hours because of technological advancement, and
ii. which would have otherwise required a Hospitalisation of more than twenty four hours.

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

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

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

3.19 Domiciliary Hospitalisation means medical treatment for an Illness/disease/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:

iii. the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
iv. the patient takes treatment at home on account of non-availability of room in a Hospital.

3.20 Floater Sum Insured means the Sum Insured mentioned in the Schedule, which is applicable to all the Insured Persons, for any and all claims made in aggregate during the Policy Period.

3.21 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.
Coverage shall not be available during the period for which no premium is received.

3.22 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.

3.23 Hospitalisation means admission in a Hospital or mental health establishment 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.

3.24 ID Card means the card issued to the Insured Person by the TPA for availing Cashless Facility.

3.25 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 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

3.26 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.

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

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

3.29 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.

3.30 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.

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

3.32 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.

3.33 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 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.

3.34 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.

3.35 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.

Mental Illness covered under the Policy shall be as specified in Section 3.1.8. Neurological disorders (Alzheimer's, Parkinsonism, Myasthenia Gravis, etc.), learning disabilities or mental retardation does not constitute Mental Illness.

3.36 Mental Health Establishment shall mean any health establishment meeting the criteria of Hospital, as defined in Definition 2.15, and includes AYUSH establishment, by whatever name called, meant for the care of persons with mental Illness.

3.37 Mental Health Professional means a Medical Practitioner, as defined in Definition 2.24 and practicing as
(i) a Psychiatrist, as defined in Definition 2.52; or
(ii) 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.

3.38 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.

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

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

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

3.42 Out-Patient Treatment means treatment in which the Insured 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.

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

3.44 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.

3.45 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 Insurance Company.

3.46 Pre Existing Disease means any condition, ailment, Injury or disease
a. that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
b. for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

3.47 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. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.

3.48 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 Insurance Company.

3.49 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.

3.50 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.

3.51 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.

3.52 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.

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

3.54 Senior Citizen means any person being a citizen of India, who has attained the age of sixty years or above.

3.55 Schedule means a document forming part of the Policy, containing details including name of the Insured Person, age, relation of the Insured Person, Sum Insured, premium paid and the Policy Period.

3.56 Sum Insured means the Sum Insured and the Cumulative Bonus (CB) accrued in respect of the Insured Person (s) as mentioned in the schedule. Health checkup expenses are payable over and above the Sum Insured, wherever applicable.

3.57 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.

3.58 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.

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

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

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 twenty four (24) 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 twenty four (24) months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

4.2. Specific 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. Hysterectomy, excluding malignancy
r. Refractive error of the eye more than 7.5 dioptres.
s. Congenital Internal Anomaly

iv. Three years waiting period

Following diseases shall be covered after **three** years of continuous cover from the inception of the Policy:

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 (4.2.f.iv), even if Pre-Existing Disease, shall be covered after the specified Waiting Period.

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

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

5.24. Out Patient Department (OPD) treatment
Any expenses incurred on OPD treatment, except as and to the extent provided for under Section Preventive Health Check Up - Applicable to Plan B.

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, 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, except as and to the extent provided for under Section Doctor's Home Visit/ Aya/ Nurse/ attendant Charges during Post Hospitalisation.

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

6 GENERAL TERMS AND CLAUSES

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 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)*

6.4 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.

6.5 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.

6.6 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 policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. The Insurer shall 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.

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.

6.7 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

6.8 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.

6.9 Renewal of Policy

i. A health insurance 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), the Policy may be renewed by the other Insured Person as the Insured.

6.10 Withdrawal of Policy

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.

6.11Moratorium 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.

6.12 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.

6.13 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, 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.
iv. 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.

6.14 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.

6.15Communication

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.

6.16 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.

6.17 Claim Procedure

6.17.1 Notification of Claim

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

Claim Intimation in case of 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

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

6.17.2 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 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 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/ network provider is unable to provide any required details related to the pre authorization request.
viii. 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.

6.17.3 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.

6.17.3.1 Procedure for Reimbursement of Claim under Domiciliary Hospitalisation

For reimbursement of claims under Domiciliary Hospitalisation, 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.

6.17.4 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, 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. For claim under Section Domiciliary Hospitalisation in addition to documents listed above (as applicable), medical certificate stating the circumstances requiring for Domiciliary Hospitalisation and fitness certificate/ medical certificate of state of patient from treating Medical Practitioner.
x. For claim under Section Funeral Expense certificate of death of Insured Person (original shall be returned following verification).
xi. 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.

6.17.5 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 30 days of date of discharge from Hospital
Reimbursement of post Hospitalisation expenses and doctor's home visit and nursing care during Post-Hospitalisation	Within 30 days from completion of Post-Hospitalisation treatment
Reimbursement of Domiciliary Hospitalisation expenses	Within 30 days from completion of issuance of fitness certificate/ medical certificate on state of patient
Reimbursement of preventive health check-up expenses under Plan A	Within 6 (six) months of the completion of a block of 2 Policy Period (to be submitted to the Policy issuing office only)
Reimbursement of preventive health check-up expenses under Plan B	Once every year, within 30 days from expiry of policy (to be submitted to the Policy issuing office only)

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.

6.17.6 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.

6.17.7 Classification of * Zone and Co-payment
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 two zones.*

Zone 1 - Gujarat, Delhi & NCR, Hyderabad, Mumbai & Mumbai Suburban, Thane and Navi Mumbai Nagpur, Pune
Zone 2 – Rest of India
Where treatment has been taken in a zone, other than the one for which ** premium has been paid, the claim shall be subject to Co-payment.
- Insured paying premium as per Zone 1 can avail treatment in Zone 1, Zone 2 without Co-payment
- Insured paying premium as per Zone 2 can avail treatment in Zone 2 without any Co-payment
    a. Availing treatment in Zone 1 will be subject to a Co-payment of 18.50%

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

6.17.8 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 25% discount in total premium.
- 10% Co-payment on each admissible claim under the Policy, with a 12.5% discount in total premium.

Above Co-payment shall not be applicable on Optional Covers.

6.18Payment of Claim
All claims under the Policy shall be payable in Indian currency and through NEFT/ RTGS only.

6.19Territorial Limit
All medical treatment for the purpose of this insurance will have to be taken in India only.

6.20 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.

6.21 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.

6.22 Disclaimer of Liability
If the Company shall disclaim liability to the Insured Person for any 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 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.

6.23 Enhancement of Sum Insured
Basic Sum insured can 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 Basic Sum Insured, the Waiting Periods and conditions as mentioned in Exclusion 4.1, 4.2, 4.3 shall apply afresh. Coverage on enhanced sum insured shall be available after the completion of Waiting Periods. Proposal for change of plan is allowed after four years of continuous coverage and only at the time of renewal, subject to discretion of the Company.

6.24 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 of any Non-Life Insurance Company, the Policy shall be inoperative in respect of the Insured Persons 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 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.

7 REDRESSAL OF GRIEVANCE
In case of any grievance related to the Policy, the insured person may submit in writing to the Policy Issuing Office or Grievance cell at Regional Office of the Company for redressal. If the grievance remains unaddressed, the insured person may contact Customer Relationship Management Dept., National Insurance Company Limited, Premises No. 18-0374, Plot no. CBD-81, Rajarhat, New Town, Kolkata - 700156, email: customer.relations@nic.co.in, griho@nic.co.in
For more information on grievance mechanism, and to download grievance form, visit our website https://nationalinsurance.nic.co.in
IRDAI Integrated Grievance Management System - https://irdai.gov.in/igms1
Insurance Ombudsman – The Insured person can also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The updated list of Office of Insurance Ombudsman are available on IRDAI website: https://irdai.gov.in/ and on the website of Council for Insurance Ombudsman: https://www.cioins.co.in/
Helpline Number: 18003450330
Dedicated Email ID for Senior Citizens: health.srcitizens@nic.co.in

8 OPTIONAL COVERS
Cover for Pre-existing Diabetes and/ or Hypertension, Outpatient Treatment, Critical Illness and Personal Accident are available as Optional Covers on payment of additional premium. The Optional Cover has to be opted on inception or renewal, and cannot be changed/ removed on mid-term of the policy.

8.1 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 since inception. On completion of the Waiting Period for Pre Existing Diseases (continuous twenty four months of coverage), the additional premium and co-payment shall not apply.

Limit of Cover
Sum Insured under the policy shall apply, on Individual Basis or Floater Basis as opted.

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

Renewal
This Optional Cover can be renewed annually till Exclusion 4.1 applies on diabetes and/or hypertension, with respect to the insured persons.

8.2 OUT-PATIENT TREATMENT
Subject otherwise to the terms, definitions, conditions, exclusions 5.9 (Drug/Alcohol Abuse), 5.7 (Breach of Law), 5.33 (War), 5.34 (Radioactivity) and on payment of additional premium, the Company shall pay up to the limit, as stated in the schedule with respect of

i. Out-patient consultations by a medical practitioner or psychiatrist
ii. Diagnostic tests prescribed by a medical practitioner or psychiatrist
iii. Medicines/drugs prescribed by a medical practitioner or psychiatrist
iv. Out-patient dental treatment

Limit of cover
Limit of cover, available under Outpatient Treatment are INR 2,000 / 4,000 / 5,000 / 7,500/ 10,000/ 15,000. The limit of cover may be utilized by one or all individuals covered under the policy irrespective of the type of Policy (as per Section 2.1).

Enhancement of limit of cover
i. Limit of cover can be enhanced only at the time of renewal.
ii. Limit of cover can be enhanced to the next slab subject to discretion of the Company.

8.2.1 Exclusions
The Company shall not make any payment under this Optional Cover in respect of

i. Treatment other than Allopathy/ Modern medicine, AYUSH
ii. * Cosmetic dental treatment to straighten, lighten, reshape, repair and replace teeth.

** Cosmetic dental treatments include veneers, bridges, tooth-coloured fillings, implants and tooth whitening.*

8.2.2 Condition
Claim amount
Any amount payable under this optional cover will be subject to the limit of cover mentioned in schedule, and not affect the sum insured applicable to the Policy or entitlement to Good Health Incentives. Co-payment shall not apply to claims under optional covers.

Claims Procedure
Documents supporting all out-patient treatments shall be submitted to the Company/ TPA once in a policy period either after the exhaustion of the limit or within 30 days from expiry of policy, whichever is earlier.

Documents
The claim is to be supported with the following original documents

i. All cash memos with supporting prescriptions from medical practitioner
ii. Diagnostic test bills and receipts, copy of reports with supporting prescriptions from medical practitioner
iii. Any other documents required by the Company/ TPA

Enhancement of Limit of Cover
i. Limit of Cover can be enhanced only at the time of renewal.
ii. Benefit amount can be enhanced only at the time of renewal subject to the availability of the higher slabs in the Policy with subject to discretion of the Company

8.3 CRITICAL ILLNESS
Subject otherwise to the terms, definitions, exclusions, conditions contained herein and on payment of additional premium, the Company shall pay the benefit amount, as stated in the schedule, provided that

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

Benefit amount
Benefit amount options available per individual insured person are INR 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 or the individual/ floater Sum Insured under the policy, whichever is lower.

Maximum Benefit amount each insured person can opt under Critical Illness cover shall be the individual/ floater Sum Insured under the policy.

Enhancement of benefit amount
i. Benefit amount can be enhanced only at the time of renewal.
ii. Benefit amount can be enhanced only at the time of renewal subject to the availability of the higher slabs in the Policy with subject to discretion of the Company, up to the individual/ floater Sum Insured under the Policy.

8.3.1 Definition

Critical illness means (i) Cancer of Specified Severity, (ii) Myocardial Infarction (First Heart Attack of Specified Severity), (iii) Open Chest Coronary Artery Bypass Graft Surgery, (iv) Open Heart Replacement or Repair of Heart Valves, (v) Coma of Specified Severity, (vi) Kidney Failure requiring Regular Dialysis, (vii) Stroke Resulting in Permanent Symptoms, (viii) Major Organ/Bone Marrow Transplant, (ix) Permanent Paralysis of Limbs, (x) Motor Neuron Disease with Permanent Symptoms and (xi) Multiple Sclerosis with Persisting Symptoms.

8.3.1.1 Cancer of Specified Severity

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

The following are excluded

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 & 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
vii. Non- invasive Papillary cancer of bladder histologically described as TaN0M0 (TNM Classification)or of a lesser classification;
viii. 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;

8.3.1.2 Myocardial Infarction (First Heart Attack of Specified Severity)

The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded

i. Other acute Coronary Syndromes.
ii. Any type of angina pectoris.
iii. A rise in cardiac biomarkers or Troponin T or I in absence of over ischemic heart disease OR following an intra-arterial cardiac procedure

8.3.1.3 Open Chest Coronary Artery Bypass Graft Surgery (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 sternotomy (cutting through 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 excluded

Angioplasty and/or any other intra-arterial procedures.

8.3.1.4 Open Heart Replacement or Repair of Heart Valve

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

The following are excluded

Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty are excluded.

8.3.1.5 Coma of Specified Severity

A state of unconsciousness with no reaction or response to external stimuli or internal needs.

This diagnosis must be supported by evidence of all of the following:

i. No response to external stimuli continuously for at least 96 hours;
ii. Life support measures are necessary to sustain life; and
iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The condition has to be confirmed by a specialist Medical Practitioner.

The following are excluded

Coma resulting directly from alcohol or drug abuse is excluded.

8.3.1.6 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.

8.3.1.7 Stroke Resulting in Permanent Symptoms
Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.
The following are excluded
i. Transient ischemic attacks (TIA)
ii. Traumatic injury of the brain
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8.3.1.8 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 excluded
i. Other stem-cell transplants
ii. Where only islets of langerhans are transplanted

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

8.3.1.10 Motor Neuron Disease with Permanent Symptoms
Motor Neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

8.3.1.11 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.

8.3.2 Exclusions
The Company shall not be liable to make any payment under the Policy for any critical illness 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. In the event of break in the Policy, the terms of this exclusion shall apply as new from the date of recommencement of cover

8.3.3 Condition
Claim Amount
Any amount payable under the optional covers will be subject to the benefit amount mentioned in schedule, and not affect the sum insured applicable to the Policy or entitlement to Good Health Incentives. Co-payment shall not apply to claims under optional covers.

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 below, supporting the diagnosis shall be submitted to the Company within sixty days (including survival period of thirty 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

i. Upon occurrence of a Critical Illness and payment of the benefit amount to the insured person, the cover shall cease in respect of the insured person for the remaining policy period.
ii. In case a claim has been paid to any insured person for a Critical Illness, in subsequent renewals no claim shall be paid to that insured person for the same critical illness or for any other Critical Illness induced by/arising out of that Critical Illness. However, claim for all other Critical Illnesses covered under the Policy shall be admitted, subject to terms and conditions of the Policy.

8.4 PERSONAL ACCIDENT

Subject otherwise to the terms, definitions, exclusions, conditions contained herein and on payment of additional premium, if during the policy period the insured person shall sustain any injury anywhere in the world due to an accident resulting to death or disability, the Company shall pay the amount specific to each section as herein after mentioned, subject to the capital sum insured (CSI) opted.

8.4.1 Coverage

The Company shall pay to the insured or his/her nominee the amount mentioned against the relevant section.

a) Death

If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of death of the insured, the CSI applicable to the insured person.

b) Loss by Physical Separation or Loss of Use of Two Limbs or Two Eyes or One Limb and One Eye

If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of the total and irrecoverable loss of

i. sight of both eyes or the actual loss by physical separation of the two hands or two feet or of one hand and one foot or loss of sight of one eye and loss of one hand or one foot, the CSI applicable to the insured person.
ii. use of two hands or two feet or one hand and one foot without physical separation or loss of sight of one eye and loss of use of one hand or one foot without physical separation, the CSI applicable to the insured person.

c) Loss by Physical Separation or Loss of Use of One Limb or One Eye

If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of the total and irrecoverable loss of

i. sight of one eye or the actual loss by physical separation of one hand or one foot, 50% of the CSI applicable to the insured person.
ii. use of a hand or a foot without physical separation, 50% of the CSI applicable to the insured person

d) Permanent Total Disablement

If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of permanently totally and absolutely disabling the insured from engaging in any employment or occupation of any description whatsoever, a lump sum equal to 100% of the CSI applicable to the insured person.

e) Permanent Partial Disablement

If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of the total and irrecoverable loss of use or of the actual loss by physical separation of the following, the percentage of the CSI indicated below:

Loss of part of body		**Percentage of Personal Accident Benefit Amount**
Loss of toes	All	20
	Great-both phalanges	5
	Great-one phalanx	2
	Other than great, if more than one toe lost each	1
Loss of hearing	both ears	50
	one ear	15
Loss of 4 fingers and thumb of 1 hand		40
Loss of 4 fingers of 1 hand		35
Loss of thumb	Both phalanges	25
	One phalange	10
Loss of Little finger	3 phalanges	4
	2 phalanges	3
	1 phalange	2
Loss of ring finger	3 phalanges	5
	2 phalanges	4
	1 phalange	2
Loss of middle finger	3 phalanges	6
	2 phalanges	4
	1 phalange	2
Loss of Index finger	3 phalanges	10

Loss of part of body		Percentage of Personal Accident Benefit Amount
	2 phalanges 1 phalange	8 4
Loss of metacarpal	1st or 2nd (additional) 3rd, 4th, or 5th (additional)	3 2
Any other permanent partial disablement	% as assessed by panel doctor of the Company	

Benefit amount

Capital Sum Insured (CSI) options available per individual insured person are INR 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 or the individual/ floater Sum Insured under the policy, whichever is lower.

Maximum Capital Sum Insured (CSI) each insured person can opt under Critical Illness cover shall be the individual/ floater Sum Insured under the policy.

Enhancement of CSI

i. CSI amount can be enhanced only at the time of renewal.
ii. Benefit amount can be enhanced only at the time of renewal subject to the availability of the higher slabs in the Policy with subject to discretion of the Company, up to the individual/ floater Sum Insured under the Policy.

8.4.2 Exclusions

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

8.4.2.1 Pre-existing Injury/ Disablement

Any disablement or death directly or indirectly arising out of or contributed to be or traceable to any disability or injury existing on the date of issue of this Policy.

8.4.2.2 Racing, Hunting, Mountaineering and Winter Sports

Any injury while racing on wheels or horseback, hunting, big game shooting, mountaineering or whilst engaged in winter sports-skiing and ice hockey.

8.4.2.3 Aviation or Ballooning

Any injury while the insured is engaged in aviation or ballooning

8.4.2.4 Non- fare Paying Passenger in Aircraft

Any injury while the insured is mounting into, dismounting from or travelling in any aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world

8.4.2.5 Payment of compensation in respect of death, injury or disablement of the insured –

i. from intentional self-injury, suicide or attempted suicide
ii. whilst under the influence of intoxication liquor or drug
iii. Directly or indirectly caused by venereal disease or insanity
iv. Arising or resulting from the insured committing any breach of the law with criminal intent.

8.4.3 Conditions

Limits of compensation

The Company shall not be liable to make any payment in respect of
i. More than one of the sub clauses of Section 8.4.1 (Coverage) in respect of the same period of disablement.
ii. Any claim after a claim under one of the clauses (8.4.1.a), (8.4.1.b) or (8.4.1.d) has been admitted and is payable.

8.4.3.1 Claim documents

Duly completed claim form
In addition, the following documents are to be submitted depending on the nature of the claim.

Death

i. Attending Medical Practitioner's report
ii. Original Policy for cancellation
iii. Original Death Certificate
iv. Original / attested post mortem / coroner's report, where applicable
v. Attested copy of FIR / Panchnama
vi. Police inquest report, where applicable
vii. Any other document required by the Company

Post mortem report if necessary, shall be furnished within fourteen days, after demanded in writing

Permanent Total Disablement/ Permanent Partial Disablement/ Temporary Total Disablement

i. Attending Medical Practitioner's report
ii. Original Policy for cancellation in case of Permanent Total Disablement
iii. Original Policy for reduction in CSI in case of Permanent Partial Disablement/ Temporary Total Disablement
iv. Disability certificate from Medical Practitioner, where applicable
v. Diagnostic reports like laboratory test, X- rays and/ or any other reports confirming injury
vi. Police inquest report, where applicable
vii. Any other document required by the Company

9 Disclaimer

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

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

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

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

Table of Benefits

Name of Product	**National Senior Citizen Mediclaim Policy**	
Plans	**Plan A (**Individual and Floater)	**Plan B (**Individual and Floater)
Sum Insured	INR 1L to 10L	INR 1L to 10L
Slab	In multiple of 1,00,000	In multiple of 1,00,000
Coverage		
In patient Treatment*	Room – 1% of SI per day subject to maximum of INR 5,000 per day ICU – 2% of SI per day subject to maximum of INR 10,000 per day	Room – 2% of SI per day subject to maximum of INR 10,000 per day ICU – 4% of SI per day subject to maximum of INR 20,000 per day
	Overall Limit A. Room/ ICU – 25% of SI per illness B. Medical Practitioner's fee - 25% of SI per illness C. Others – 50% of SI per illness	No overall limit
	Cataract Surgery - 15% of SI or INR 75,000 for each eye, whichever is lower **Benign Prostatic Hyperplasia** – 20% of SI	
System of Medicine	Allopathy, AYUSH	Allopathy, AYUSH
Pre hospitalisation	30 days immediately before hospitalisation	30 days immediately before hospitalisation
Post hospitalisation	60 days immediately after discharge	60 days immediately after discharge
Domiciliary Hospitalisation	Up to 20% of the Sum Insured	Up to 20% of the Sum Insured
Day Care Procedures	Day care procedures	Day care procedures
AYUSH Treatment	Up to Sum Insured	Up to Sum Insured
Organ Donor's Medical Expenses	Medical expenses, Pre & Post Hospitalisation expenses up to Sum Insured	Medical expenses, Pre & Post Hospitalisation expenses up to Sum Insured
Ambulance Charges	Up to INR 2,500 per illness	Up to INR 2,500 per illness
Modern Treatment (12 nos)	Up to 25% of SI for each treatment	Up to 25% of SI for each treatment
Treatment due to participation in hazardous or adventure sports (non-professionals)	Up to 25% of SI	Up to 25% of SI
Morbid Obesity	Covered after waiting period of 3 years	Covered after waiting period of 3 years
Refractive Error (min 7.5D)	Covered after waiting period of 2 years	Covered after waiting period of 2 years
Hospital cash (per individual)	x	INR 500/- per day for 5 days (in excess 3 days)
Aya, Doctor's home visit charges and nursing care during post hospitalisation (per individual)	x	INR 500/- per day for 7 days
Reinstatement of SI for road traffic accidents	x	Once during the policy period
Funeral expenses (per individual)	x	Up to INR 5,000
Others		
Pre Existing Disease	PEDs covered after 2 years	
Optional Cover (on payment of extra premium)		
Pre-existing Diabetes and/ or Hypertension	Up to the SI	
Outpatient Treatment	Limit of cover per family - 2,000 / 4,000 / 5,000 / 7,500/ 10,000/ 15,000	
Critical Illness **	Benefit amount per individual- INR 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	
Personal Accident **	Capital Sum Insured per individual – INR 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	
Good Health Incentives		
Cumulative Bonus	Increase by 5% of SI in respect of each claim free year of insurance Decrease by 5% of SI for each year with claim reported	
Preventive Health Check Up	Every **2** claim free years, prescribed diagnostics tests up to 2 % of the average SI (excluding CB) per insured person (individual basis) or family (floater basis), subject to maximum INR 4,000/- per insured person (individual basis) or per family (floater basis)	Every **6** claim free months, Regular medical consultation and prescribed diagnostics tests up to INR 1,000 per insured person (irrespective of individual basis or floater basis)
Discounts		
Direct Discount	10% discount (provided no intermediary is involved)	
Co-payment (optional)	If opted, policyholder may choose either of the two Co-payment options- • 20% Co-payment on each admissible claim, with a 25% discount in premium • 10% Co-payment on each admissible claim, with a 12.5% discount in premium	

***** The limits shall not apply if the treatment is undergone for a listed procedure in a Preferred Provider Network (PPN) as per eligible package.

****** Critical Illness benefit amount and Personal Accident Capital Sum Insured should not be more than the Sum Insured opted under the Policy

Rate Chart (in INR)

Zone 1 Plan A - Individual/ Eldest member in Floater										
Age	**100000**	**200000**	**300000**	**400000**	**500000**	**600000**	**700000**	**800000**	**900000**	**1000000**
60-65	9,233	14,431	17,921	20,589	24,705	29,507	34,860	38,345	39,930	41,128
66-70	13,851	21,647	26,882	30,881	37,057	44,261	52,290	57,518	59,895	61,693
71-75	15,958	24,938	30,969	35,576	42,693	50,990	60,240	66,264	69,002	71,071
76-80	18,250	28,523	35,420	40,692	48,830	58,320	68,898	75,788	78,920	81,289
81-85	22,453	35,084	43,570	50,050	60,062	71,734	84,793	93,271	97,125	100,039
86+	24,699	38,594	47,926	55,056	66,068	78,909	93,271	102,598	106,835	110,043
Zone 1 Plan A - Dependent in Floater										
Age	**100000**	**200000**	**300000**	**400000**	**500000**	**600000**	**700000**	**800000**	**900000**	**1000000**
50-55	2,122	3,316	4,118	4,731	5,677	6,781	8,011	8,812	9,176	9,452
56-60	3,543	5,538	6,877	7,901	9,480	11,323	13,378	14,715	15,323	15,783
61-65	5,343	8,351	10,371	11,915	14,297	17,076	20,174	22,190	23,108	23,801
66-70	8,302	12,974	16,112	18,509	22,210	26,528	31,340	34,474	35,898	36,976
71-75	9,915	15,495	19,242	22,104	26,526	31,682	37,429	41,172	42,873	44,159
76-80	11,760	18,379	22,824	26,220	31,465	37,579	44,396	48,835	50,854	52,380
81-85	14,469	22,608	28,076	32,252	38,704	46,226	54,640	60,104	62,587	64,465
86+	15,915	24,868	30,882	35,476	42,572	50,846	60,100	66,110	68,841	70,908
Zone 1 Plan B - Individual/ Eldest member in Floater										
Age	**100000**	**200000**	**300000**	**400000**	**500000**	**600000**	**700000**	**800000**	**900000**	**1000000**
60-65	12,004	18,760	23,297	26,765	32,115	38,360	45,318	49,848	51,908	53,466
66-70	18,007	28,141	34,946	40,146	48,174	57,539	67,977	74,773	77,863	80,200
71-75	20,745	32,419	40,261	46,250	55,501	66,288	78,311	86,142	89,703	92,393
76-80	23,725	37,079	46,047	52,899	63,479	75,815	89,568	98,525	102,596	105,675
81-85	29,190	45,610	56,640	65,066	78,079	93,255	110,230	121,252	126,262	130,050
86+	32,108	50,172	62,304	71,573	85,888	102,582	121,252	133,377	138,887	143,056
Zone 1 Plan B - Dependent in Floater										
Age	**100000**	**200000**	**300000**	**400000**	**500000**	**600000**	**700000**	**800000**	**900000**	**1000000**
50-55	2,758	4,311	5,355	6,151	7,381	8,815	10,415	11,456	11,929	12,288
56-60	4,607	7,198	8,940	10,272	12,325	14,721	17,391	19,128	19,920	20,518
61-65	6,946	10,856	13,483	15,490	18,585	22,199	26,227	28,848	30,040	30,942
66-70	10,793	16,866	20,944	24,062	28,873	34,487	40,743	44,816	46,667	48,068
71-75	12,891	20,143	25,015	28,736	34,483	41,187	48,657	53,523	55,735	57,405
76-80	15,289	23,893	29,671	34,087	40,904	48,854	57,715	63,486	66,110	68,094
81-85	18,810	29,391	36,500	41,929	50,314	60,093	71,032	78,135	81,363	83,805
86+	20,690	32,329	40,147	46,120	55,344	66,100	78,131	85,944	89,494	92,179
Zone 2 Plan A - Individual/ Eldest member in Floater										
Age	**100000**	**200000**	**300000**	**400000**	**500000**	**600000**	**700000**	**800000**	**900000**	**1000000**
60-65	7,802	12,194	15,143	17,397	20,876	24,933	29,457	32,401	33,741	34,753
66-70	11,704	18,291	22,715	26,095	31,313	37,400	44,185	48,603	50,611	52,130
71-75	13,484	21,073	26,169	30,062	36,075	43,087	50,903	55,993	58,307	60,055
76-80	15,422	24,102	29,930	34,385	41,261	49,280	58,219	64,041	66,688	68,689
81-85	18,973	29,646	36,816	42,292	50,752	60,616	71,650	78,814	82,071	84,533
86+	20,871	32,612	40,498	46,523	55,828	66,678	78,814	86,695	90,276	92,986
Zone 2 Plan A - Dependent in Floater										
Age	**100000**	**200000**	**300000**	**400000**	**500000**	**600000**	**700000**	**800000**	**900000**	**1000000**
50-55	1,793	2,802	3,480	3,998	4,797	5,729	6,769	7,445	7,753	7,986
56-60	2,994	4,679	5,811	6,676	8,011	9,568	11,304	12,434	12,948	13,336
61-65	4,515	7,056	8,763	10,067	12,080	14,428	17,046	18,749	19,525	20,111
66-70	7,015	10,963	13,614	15,640	18,767	22,416	26,482	29,130	30,334	31,244
71-75	8,379	13,094	16,261	18,679	22,416	26,773	31,629	34,792	36,230	37,316
76-80	9,937	15,531	19,287	22,157	26,588	31,755	37,515	41,267	42,972	44,262
81-85	12,225	19,103	23,723	27,251	32,702	39,058	46,168	50,784	52,883	54,470
86+	13,449	21,014	26,096	29,978	35,974	42,966	50,786	55,865	58,172	59,918
Zone 2 Plan B - Individual/ Eldest member in Floater										
Age	**100000**	**200000**	**300000**	**400000**	**500000**	**600000**	**700000**	**800000**	**900000**	**1000000**
60-65	10,142	15,852	19,686	22,617	27,138	32,413	38,294	42,122	43,863	45,179
66-70	15,214	23,779	29,529	33,922	40,706	48,620	57,441	63,183	65,794	67,770
71-75	17,530	27,393	34,020	39,081	46,898	56,013	66,174	72,791	75,798	78,072
76-80	20,048	31,333	38,909	44,700	53,639	64,064	75,685	83,253	86,694	89,295
81-85	24,664	38,539	47,861	54,980	65,977	78,800	93,144	102,457	106,692	109,893
86+	27,132	42,395	52,647	60,480	72,576	86,681	102,457	112,704	117,359	120,882
Zone 2 Plan B - Dependent in Floater										
Age	**100000**	**200000**	**300000**	**400000**	**500000**	**600000**	**700000**	**800000**	**900000**	**1000000**
50-55	2,332	3,643	4,523	5,197	6,236	7,449	8,800	9,680	10,079	10,382
56-60	3,892	6,083	7,555	8,679	10,414	12,437	14,695	16,163	16,831	17,337
61-65	5,869	9,173	11,392	13,087	15,704	18,756	22,160	24,374	25,383	26,144

66-70	9,120	14,253	17,699	20,331	24,398	29,141	34,427	37,869	39,435	40,617
71-75	10,892	17,022	21,138	24,284	29,141	34,806	41,119	45,230	47,099	48,511
76-80	12,918	20,191	25,072	28,805	34,564	41,282	48,770	53,647	55,865	57,540
81-85	15,893	24,834	30,840	35,427	42,513	50,776	60,019	66,019	68,748	70,810
86+	17,483	27,318	33,924	38,973	46,766	55,856	66,022	72,624	75,624	77,894

Note: Age band 50-55 and 56-60 shall only be available to spouse in floater policy

Zone	Zone definition
1	Gujarat, Delhi & NCR, Hyderabad, Mumbai & Mumbai Suburban, Thane and Navi Mumbai Nagpur, Pune
2	Rest of India

Premium Zone	2
Claim Zone	1
Zonal Co-payment	18.50%

TPA Charges and GST extra as applicable

Rate with TPA charge –3.5% loading on the premiums tabulated above.

Optional Covers

a) **Pre-existing diabetes/ hypertension**

Cover	Additional Premium with/ without TPA	Co-payment
Pre-existing diabetes or Hypertension	Additional Premium of 13.5% of individual premium	10% Co-payment on admissible claim amount for diabetes or hypertension claims
Pre-existing diabetes and Hypertension	Additional Premium of 30% of individual premium	25% Co-payment on admissible claim amount for diabetes or hypertension claims

b) Outpatient Treatment

Rate for Outpatient Treatment - GST extra as applicable						
Cover	**2000**	**4000**	**5000**	**7500**	**10000**	**15000**
Premium	1400	2800	3500	5250	7000	10500

c) Critical Illness

Ageband	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
50-55	1,359	2,718	4,077	5,436	6,795	8,153	9,512	10,871	12,230	13,589
56-59	2,536	5,071	7,607	10,143	12,679	15,214	17,750	20,286	22,822	25,357
60-65	3,639	7,278	10,917	14,556	18,196	21,835	25,474	29,113	32,752	36,391
66-70	7,804	15,607	23,411	31,214	39,018	46,822	54,625	62,429	70,232	78,036
71-75	13,074	26,148	39,222	52,296	65,371	78,445	91,519	104593	117667	130741
76-80	19,653	39,306	58,958	78,611	98,264	117917	137570	157222	176875	196528
81-85	21,618	43,236	64,854	86,472	108090	129708	151327	172945	194563	216181
86+	24,861	49,722	74,582	99,443	124304	149165	174025	198886	223747	248608

Note: Critical Illness Benefit Amount should not be more than the sum insured opted under the Policy
GST extra as applicable

d) Personal Accident

CSI	1L	2L	3L	4L	5L	6L	7L	8L	9L	10L
Premium	90	180	270	360	450	540	630	720	810	900

GST extra as applicable

Premium above is without GST and TPA charges. TPA charges of 3.5% of premium shall apply to avail TPA services.

Optional Co-payment

Option 1 Copay of 10% on all claims, with a discount of 12.5% on premium
Option 2 Copay of 20% on all claims, with a discount of 25% on premium

Instalment Premium

Half yearly:
1st instalment: 52.50% of annual premium
2nd instalment: 50% of annual premium
Quarterly:
1st instalment: 28.50% of annual premium
2nd, 3rd and 4th instalments: 25% of annual premium.

Discounts

Online discount (without intermediary) – 10%
Above discount will not apply on premium for Optional Covers
No loading shall apply on renewals based on individual claims experience
Insurance is the subject matter of solicitation