

1. NARAYANA ADITI: COMPREHENSIVE HOSPITALIZATION COVERAGE

Narayana Aditi provides a comprehensive hospitalization coverage and discretionary discounts for OPD services at our services.

Please note the following:

- a) The coverage outside Network Provider (Annexure 2) is limited basis the Plan opted at the time of purchase. It can **ONLY** be availed in the below scenarios, otherwise it is **NOT COVERED**.

- i. All cases of emergency. Emergency means a serious medical condition or symptom resulting from Illness or Injury which arises suddenly and unexpectedly and requires immediate care and treatment by a Medical Practitioner to prevent death or serious long-term impairment of the Insured Person's health.

Explanation: An unforeseen, sudden, and acute medical condition that arises without prior warning and requires immediate medical attention to prevent serious jeopardy to the insured person's life, significant impairment to bodily functions, or permanent dysfunction of any body organ or part.

The condition must be of such severity that a prudent layperson with average knowledge of health and medicine would reasonably expect that failure to seek immediate care could result in:

- Serious risk to life;
- Permanent disability; or
- Serious and irreversible harm to health.

Exclusions: Conditions not meeting the criteria for immediate and critical care, such as routine medical issues, elective procedures, or symptoms that are chronic, mild, or manageable through outpatient care, do not constitute an Emergency.

- ii. Treatment not available at Network Provider.
- iii. Insured Person travelling to a location where Network Provider is not accessible. In this scenario, Insured Person must submit a proof of travel and reason of travel with evidence which shall be accepted by Us.
- iv. Insured Person relocating to a location where Network Provider is not accessible. In this scenario, the Insured Person must submit the Proof of Address of the new relocated address within 2 months of relocation or at time of claim, whichever is lesser.
- b) Health check-up / examination plays a critical role in delivering the true sense of comprehensive coverage that the Plan offers. The Insured Persons (for both individual and family floater policies) aged 18 years and above can choose to undergo health check-up / examination either before Policy issuance or within 90 days of Policy Issuance. This choice will have an impact on applicable Waiting Periods, premium as well as discounts on renewal premium.
- c) There are 4 plans available for the Proposer (subject to availability for sales at several geographical locations) – Plan 1, Plan 2, Plus (Access to Preferred + Verified Provider Network) and Prime (Access to Preferred + Verified + Other Provider Network)

Premium Illustration is exhibited in Annexure 9. Please read the Prospectus carefully before you purchase the policy.

2. WHO CAN AVAIL BENEFITS OF THIS POLICY

Under this policy, following can be covered:

- a) A person and his/her family members including his/her spouse, upto 4 dependent children less than 25 years of age and both parents or parents-in-law.
- b) Residing in the serviceable location as determined and amended from time to time by the Company.
- c) The entry ages for the principal beneficiary of Certificate of Insurance is from 18 years (last birthday). The range of entry ages for dependent children are from 3 months to 25 years.
- d) Please note if any Insured Person who is a child and has completed 26 years at the time of Renewal, then such Insured Person will have to take a separate policy based on Our underwriting guidelines, as he/she will no longer be eligible to be covered under the Policy as a dependent child. In such cases, the credit of the Waiting Periods served under the issued Certificate of Insurance will be passed on to the separate Policy taken by such Insured Person.

Narayana Health Insurance Limited | CIN : U65120KA2023PLC174002 | IRDAI Reg. No. :166

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Product Name: Narayana Aditi | **UIN:** NHIHLIP26044V052526

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3. Base Benefits

The Benefits available under this Policy are described below.

- a. The Policy covers Reasonable and Customary Charges incurred towards medical treatment or consultation taken by the Insured Person during the Policy Period for an Illness, Injury or conditions as described in the sections below, provided such Illness, Injury or conditions contracted or sustained by an Insured Person during the Policy Period. The Benefits listed in the sections below will be payable subject to the terms, conditions and exclusions of this Policy and the availability of the Sum Insured and always subject to any sub-limits in respect of that Benefit as specified in the Policy Schedule for the Insured Person.
- b. All the Benefits (including Optional Covers and Value-Added Services) under the product have been summarized in the Policy Schedule as illustrated in Annexure 1.
- c. All claims for any benefits under the Policy must be made in accordance with the process defined under Section 11 (Claim Procedure).
- d. All claims paid under any benefit except for those paid under Section 3.7 (Health Checkup) shall reduce the Sum Insured for that Policy Year in which the claim has been incurred, unless otherwise specified in the respective section and only the balance Sum Insured after payment of claim amounts admitted shall be available for all future claims arising in that Policy Year.

3.1 Inpatient Care

We will indemnify the Medical Expenses incurred on the Insured Person's Hospitalization during the Policy Period following an Illness or Injury that occurs during the Policy Period, provided that:

- a. Hospitalization is Medically Necessary and advised by Medical Practitioner and the treatment follows Evidence Based Clinical Practices and Standard Treatment Guidelines.
- b. The Medical Expenses incurred are Reasonable and Customary Charges for one or more of the following:
 - i. Room Rent for General Ward unless selected otherwise as part of the Optional Cover "Room Category Modification Option" or the category of the room at respective Network Provider that is in-built with the Plan as illustrated in Annexure 1.
 - ii. Nursing charges for nursing services under Hospitalization through a qualified nursing staff as an Inpatient;
 - iii. Medical Practitioners' fees, excluding any charges or fees for Standby Services;
 - iv. Physiotherapy, investigation and diagnostics procedures directly related to the current event which lead to Hospitalization;
 - v. Medicines, drugs as prescribed by the treating Medical Practitioner related to the current event that lead to Hospitalization and not otherwise;
 - vi. Intravenous fluids, blood transfusion, injection administration charges, consumables and/or enteral feedings;
 - vii. Operation theatre charges;
 - viii. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery;
 - ix. Intensive / Critical Care Unit Charges;
 - x. Ancillary hospital charges;
 - xi. Implants as per hospital policy or clinical conditions.
- c. If the Insured Person chooses to get admitted in higher category room than General Ward, access to which is only permitted if the optional cover "Enhance Access to Provider Network" as described in Section 4.6, is opted or in-built with any Plan, We shall be liable to pay only a pro-rated portion of the total Associated Medical Expenses (including surcharges or taxes thereon) in the proportion of the difference between the Room Rent for eligible room category and the availed category of room.
- d. Proportionate deductions shall not be applicable for hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.
- e. We shall not be liable to pay the visiting fees or consultation charges for any Medical Practitioner visiting the Insured Person unless such:
 - i. Medical Practitioner's treatment or advice has been sought by the Hospital; and
 - ii. Visiting fees or consultation charges are included in the Hospital's bill

3.2 Pre-hospitalization Medical Expenses

We will indemnify the Insured Person's Pre-hospitalization Medical Expenses incurred following an Illness or Injury at Preferred Provider Network as listed in Annexure 2A and if optional cover "Enhance Access to Provider Network" is opted or in-built with any Plan, at Verified Provider Network and Other Provider Network listed in Annexure 2B and 2C respectively and at eligible and admissible cases at Out-of-Network as mentioned in Section 6 (a), (b), (c) and (d) and updated on our website from time to time, that occurs during the Policy Period provided that:

- a. We have accepted a claim for Inpatient Care under Section 3.1 (Inpatient Care) or Section 3.4 (Day Care Treatment) or Section 3.8 (Alternative Treatments) or Section 3.9 (Technological Advancements and Treatments) or Section 3.5 (Living Organ Donor Transplant) and Pre-hospitalization Medical Expenses are incurred for the same condition for which We have accepted the Inpatient Care or Day Care Treatment or Alternative Treatments or Technological Advancements & Treatments or Living Organ Donor Transplant claim.
- b. We will not be liable to pay Pre-hospitalization Medical Expenses for more than 60 days immediately preceding the Insured Person's admission for Inpatient Care/ Day Care Treatment/ Alternative Treatments/ Technological Advancement and Treatments/ Living Organ Donor Transplant or such expenses incurred prior to inception of the First Policy with Us.
- c. Pre-hospitalization Medical Expenses can be claimed under the Policy on a Reimbursement basis only.
- d. Pre-hospitalization Medical Expenses incurred on Physiotherapy will also be payable provided that such Physiotherapy is Medically Necessary and advised by the Medical Practitioner and such Physiotherapy is directly related to the current event that led to Hospitalization or Day Care Treatment.
- e. Sum Insured for the Policy Year in which In-patient Care/ Day Care Treatment/ Alternative Treatments/ Modern Treatments claim has been incurred shall be reduced.

3.3 Post-Hospitalization Medical Expenses

We will indemnify the Insured Person's Post-hospitalization Medical Expenses incurred following an Illness or Injury at Preferred Provider Network as listed in Annexure 2A and if optional cover "Enhance Access to Provider Network" is opted or in-built with any Plan, at Verified Provider Network and Other Provider Network listed in Annexure 2B and 2C respectively and at eligible and admissible cases at Out-of-Network as mentioned in Section 6 (a), (b), (c) and (d) and updated on our website from time to time, that occurs during the Policy Period provided that:

- a. We have accepted a claim for Inpatient Care under Section 3.1 (Inpatient Care) or Section 3.4 (Day Care Treatment) or Section 3.8 (Alternative Treatments) or Section 3.9 (Technological Advancements and Treatments) or Section 3.5 (Living Organ Donor Transplant) and Post-hospitalization Medical Expenses are incurred for the same condition for which We have accepted the Inpatient Care or Day Care Treatment or Alternative Treatments or Technological Advancements & Treatments claim or Living Organ Donor Transplant.
- b. We will not be liable to pay Post-hospitalization Medical Expenses for more than 90 days or 180 days (if the Optional Cover: Enhance Post-Hospitalization Medical Expenses has been opted / in-built with the Plan), if we have accepted the claim at Preferred Provider Network and Verified Provider Network listed in Annexure 2A and 2B respectively and Other Provider Network (if "Enhance Access to Provider Network" is opted or in-built with any Plan) listed in Annexure 2C, immediately post the Insured Person's discharge from the hospital for Inpatient Care/ Day Care Treatment/ Alternative Treatments/ Modern Treatments or such expenses incurred prior to inception of the First Policy with Us.
- c. Post-hospitalization Medical Expenses can be claimed under the Policy on a Reimbursement basis only.
- d. Post-hospitalization Medical Expenses incurred on Physiotherapy will also be payable provided that such Physiotherapy is Medically Necessary and advised by the Medical Practitioner and such Physiotherapy is directly related to current event that led to Hospitalization or Day Care Treatment.
- e. Sum Insured for the Policy Year in which In-patient Care/ Day Care Treatment/ Alternative Treatments/ Technological Advancements & Treatments/ Living Organ Donor Transplant claim has been incurred shall be reduced.

3.4 Day Care Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Day Care Treatment during the Policy Period following an Illness or Injury provided that:

- a. The Day Care Treatment is Medically Necessary and follows the written advice of a Medical Practitioner.
- b. The Medical Expenses incurred are Reasonable and Customary Charges for any procedure where such procedure is undertaken by an Insured Person as Day Care Treatment.
- c. We will not cover any OPD Treatment and Diagnostic Services under this Benefit.
- d. All Day Care Treatment as listed out in, but not limited to, Annexure 3 are covered under this benefit.
- e. Ancillary day care charges.

3.5 Living Organ Donor Transplant

We will indemnify the Medical Expenses incurred for a living organ donor's Inpatient treatment for the harvesting of the organ donated provided that:

- a. The donation conforms to The Transplantation of Human Organs Act 1994 and amendments thereafter from time to time, and the organ is for the use of the Insured Person.
- b. The recipient Insured Person has been Medically Advised to undergo an organ transplant.
- c. We have accepted the recipient Insured Person's claim under Section 3.1 (Inpatient Care).
- d. Medical Expenses incurred are Reasonable and Customary Charges.
- e. We shall not be liable to make any payment in respect of:
 - i. Stem cell donation whether or not Medically Necessary except for Bone Marrow Transplant.
 - ii. Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.
 - iii. Screening or any other Medical Expenses related to the organ donor which are not incurred during the duration of Insured Person's hospitalization for organ transplant.
 - iv. Transplant of any organ/tissue where the transplant is experimental or investigational.
 - v. Expenses related to organ transportation or preservation.
 - vi. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

3.6 Domestic Road Ambulance Charges

We will indemnify the Reasonable and Customary Charges for ambulance expenses incurred to transfer the Insured Person by surface transport provided that:

- a. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is injured or is ill to a Hospital where appropriate medical treatment can be obtained and / or from the existing Hospital to another Hospital with advanced facilities as advised by the treating Medical Practitioner for management of the current Hospitalization.
- b. The ambulance service is offered by a healthcare or ambulance Service Provider during case of emergency admission or in case treatment is not available at the Preferred Network Provider and Verified Network Provider listed in Annexure 2A and 2B respectively and Other Provider Network (if optional cover "Enhance Access to Provider Network" is opted or in-built with any Plan) listed in Annexure 2C.
- c. For all planned admissions that require the need for ambulance to commute from the insured's location to the Preferred Provider Network and Verified Provider Network listed in Annexure 2A and 2B respectively and Other Provider Network (if "Enhance Access to Provider Network" optional cover is opted or in-built with any Plan) listed in Annexure 2C, the ambulance services of the concerned Provider must be opted.

- d. We have accepted a claim under Section 3.1 (Inpatient Care) above.
- e. We will cover expenses up to the amount specified in the Policy Schedule.
- f. We will not make any payment under this Benefit if the Insured Person is transferred to any Hospital or diagnostic centre for evaluation purposes only.

3.7 Health Checkup

The Insured Person is eligible for an annual health checkup – defined package as detailed in Annexure 5, at our listed health checkup provider as on the website at no additional cost provided that:

- a. Health Checkup shall be requested by calling our customer support.
- b. The Insured Person is aged 18 years or above on the commencement of that Policy Year.
- c. Any unutilized Health checkup cannot be carried forward to the next Policy Year.
- d. The list of tests covered can be checked by calling our customer support.
- e. Insured Person is only eligible for one health checkup – “Base Package” - within that Policy Year.

3.8 Alternative Treatments

We will indemnify the Medical Expenses incurred on the Insured Person's Hospitalization for Inpatient Care during the Policy Period on treatment taken under Ayurveda, Unani, Sidha and Homeopathy. Conditions:

- a. The treatment should be taken in a recognized AYUSH Hospital.
- b. Exclusions as per Section 8.2.15 (other than for Yoga) shall not apply to the extent this benefit is applicable.

3.9 Technological Advancements and Treatment

- a. The following procedures / treatments will be covered either as Inpatient Care or as part of Day Care Treatment as per Section 3.1 or Section 3.4 respectively:
 - i. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
 - ii. Balloon Sinuplasty
 - iii. Deep Brain stimulation
 - iv. Oral chemotherapy
 - v. Immunotherapy- Monoclonal Antibody to be given as injection
 - vi. Intra vitreal injections
 - vii. Robotic surgeries - cost of consumables for Robotic surgeries are excluded
 - viii. Stereotactic radio surgeries
 - ix. Bronchial Thermoplasty
 - x. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
 - xi. IONM - (Intra Operative Neuro Monitoring)
 - xii. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered

For non-listed Technological Advancements & Treatments, coverage shall be as per conventional methods on Reasonable and Customary basis

- b. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with Sections 3.2 and Section 3.3 till the overall Sum Insured.

3.10 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 5, while coverage for List-I shall only be provided if the Optional Cover “Non-medical Expenses Cover”, as described in Section 4.8, is opted at select Provider Network or is in-built with any Plan.

3.11 Aggregate Deductible

The Insured Person shall bear an amount equal to the Aggregate Deductible specified on Policy Schedule for all admissible claims made by the Insured Person and assessed by the Company in a Policy Year. The liability of the Company to pay the admissible claim under that Policy Year will commence only once the specified Aggregate Deductible has been exhausted. This Cover shall be subject to the following conditions:

- a. This Cover is applicable on an annual aggregate basis and can be opted only at inception of the Policy or at subsequent Renewals. Aggregate Deductible can be increased at the time of Renewal.
- b. In case of Individual Policy, the entire amount of Aggregate Deductible must first be exhausted on per Insured Person basis, once in a Policy Year, before the Company pays for claims of that Insured Person in that Policy Year.
- c. In case of family floater Policy, the entire amount of Aggregate Deductible must first be exhausted by any one or more of the Insured Persons once in a Policy Year before the Company pays for claims of any Family Member covered under the Policy in that Policy Year.
- d. The Aggregate Deductible is not applicable to Section 3.7 (Health Checkup). Hence, coverage for Section 3.7 (Health Checkup) can be availed irrespective of whether the chosen Aggregate Deductible limit is breached or not, during the Policy Year.

4. Optional Cover

The Covers listed below are optional covers. An optional cover is applicable to an Insured Person only if it is specified in the Policy Schedule to be in force for that Insured Person, and such optional cover will be available in accordance with the procedures set out in this Policy and up to the Sub-limits mentioned in the Policy Schedule. Note: Please refer to 'Annexure 1' for details pertaining to optional covers available with your plan opted:

Key to read 'Annexure 1':

- 'Covered' means that particular benefit is an inbuilt feature in that particular plan and the premium of such benefits are included in the premium of the respective Plan.
- 'Not Covered' means that particular benefit is NOT available either as an inbuilt feature or as an optional feature in that particular plan.
- 'Optional' means that particular benefit is NOT an inbuilt feature BUT can be opted by the Proposer/Policyholder either at inception or at renewal.

4.1 Deferred Initial Health checkup / examination:

Option 1: Yes (Medical and Lifestyle Information and Declaration at pre-Policy Issuance with Health Checkup / Examination post Policy Issuance within 90 days from Policy Commencement Date).

If Insured Person opts for Option 1, following terms and conditions shall be applicable from the Policy Commencement Date:

- Excl01 (Pre-existing Disease) shall continue to prevail as described in Section 8.1.1
- Excl02 (Specific Disease / Procedure Waiting Period) shall continue to prevail as described in Section 8.1.2
- Excl03 (30-Day Waiting Period) shall continue to prevail as described in Section 8.1.3
- Loading of premium

However, if all the Insured Person aged 18 years and above undergo the required health checkup / examination at Health Checkup providers (as listed in Annexure 7) within 90 days from the Policy Commencement Date, the Insured Person shall be considered for modification in the following Waiting Periods, as determined by the Underwriting Policy:

- Pre-existing Disease (Excl-01) Waiting Period:

We will indemnify the Medical Expenses for Pre-existing Disease Treatment as per In-Patient Care benefit (Section 3.1) incurred on the Insured Person basis the risk as determined by the underwriting outcomes from the health checkup/ medical examination. The possibility of underwriting outcomes concerning coverage of the identified / declared Pre-existing Diseases may be any one of the following:

- If there are no self-declared or identified pre-existing diseases as an outcome of health checkup / examination post Policy Issuance, there shall be no exclusions concerning Pre-existing diseases for the Insured Person.
 - If there are certain self-declared or identified pre-existing diseases as an outcome of health checkup / examination post Policy Issuance, there may be exclusions concerning Pre-existing diseases for the Insured Person ranging from 0 year to a maximum of 3 years based on risk as determined by the Underwriting Policy.
- Specific Disease / Procedure Waiting Period (Excl-02) shall be subject to change from 24 months to 12 months or nil, or remain the same as 24 months, as an outcome of health checkup / examination post Policy Issuance as determined by the Underwriting Policy.
 - 30-Day Waiting Period (Excl-03) shall be subject to change from 30 days to nil, or remain the same as 30 days, as an outcome of health checkup / examination post Policy Issuance as determined by the Underwriting Policy.
 - We will provide additional discounts on Value Added Services (Section 9), for undergoing health check-up / examination within 90 days of post Policy Issuance.

Option 2: No (Health Checkup exists in Advance or Health Checkup/Examination to be done before Policy Issuance)

If Insured Person opts for Option 2, following terms and conditions shall be applicable from the Policy Commencement Date, as an

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outcome of health checkup / examination as determined by the Underwriting Policy.

- a. We will indemnify the Medical Expenses as per In-Patient Care benefit (Section 3.1) incurred on the Insured Person basis the risk as determined by the underwriting outcomes from the health checkup/ medical examination. The possibility of underwriting outcomes concerning coverage of the identified / declared Pre-existing Diseases may be any one of the following:
 - i. If there are no self-declared or identified pre-existing diseases as an outcome of pre-policy medical checkup and medical examination, there shall be no exclusions concerning Pre-existing diseases for the Insured Person.
 - ii. If there are certain self-declared or identified pre-existing diseases as an outcome of pre-policy medical checkup and medical examination, there may be exclusions concerning Pre-existing diseases for the Insured Person ranging from 0 year to a maximum of 3 years based on risk as determined by the Underwriting Policy.
- b. Specific Disease / Procedure Waiting Period (Excl-02) shall not be applicable for the Insured Person, and coverage on listed Specific Disease / Procedure shall begin from the Policy Commencement Date, unless it is mentioned in the Policy Schedule or identified as Pre-existing Disease.
- c. 30-Day Waiting Period (Excl-03) shall not be applicable for the Insured Person, unless it is mentioned in the Policy Schedule.

4.2 Global Health Cover (Emergency Treatment Only):

On availing this cover, In-patient Care (Section 3.1), Day Care Treatment (Section 3.4), Living Organ Donor Transplant (Section 3.5), Technological Advancements and Treatment (Section 3.9) shall be extended for Emergency Medical Expenses which are diagnosed and incurred outside India.

The following benefits remain excluded under this benefit:

- a. Alternative Treatment (Section 3.8)
- b. Pre-hospitalization Medical Expenses (Section 3.2)
- c. Post-hospitalization Medical Expenses (Section 3.3), if incurred outside India

4.2.1 Global Health Cover (Emergency Treatments Only) is applicable subject to the following terms and conditions:

- i. Our maximum liability in a Policy Year for claims under this cover shall not exceed the Sum Insured.
- ii. Section 3.11 (Aggregate Deductible) will not be applicable for any claim under this cover.
- iii. 10% co-payment shall be applicable for all admissible claims.
- iv. Claims shall normally be payable on Reimbursement basis only. Cashless facility may be arranged on case-to-case basis.
- v. The treatment should be taken in a registered Hospital, as per law, rules and/ or regulations applicable to the country, where the treatment is taken
- vi. The payment of any Claim under this Benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian Rupees for payment of Claims. If on the Insured Person's Date of Discharge, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.
- vii. We would not be liable to pay any claim wherein the medical treatment taken outside India has not commenced within the first 30 days of a trip.
Note: Each trip shall be deemed to start within the Policy Period and from the date Insured Person finally boards the flight (scheduled aircraft operated under a valid license for the transportation of fare paying passengers under a valid ticket) to leave from India.
- viii. There is no separate Sum Insured for this optional cover and any claim triggered under this benefit shall reduce the Sum Insured of the opted plan.

4.2.2 Specific Exclusions applicable to Global Health Cover (Emergency Treatments Only):

- i. Any Planned treatments

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- ii. In case we have paid a Hospitalization claim under this benefit, Pre-hospitalization Medical Expenses and/or Post-hospitalization Medical Expenses related to the claim whether incurred overseas or within India are not payable under this Policy.
- iii. Treatment or part of treatment for any condition which is not Life threatening in nature and can be safely postponed till the Insured Person returns to India.
- iv. Medical treatment taken outside India if that is the sole reason or one of the reasons for the journey.
- v. Any treatment of orthopaedic diseases or conditions except for fractures, dislocations and / or Injuries suffered during the Policy Period.
- vi. Oncological (Cancer) diseases
- vii. The Company may not be liable to make any payment under this Policy, wherein the Government of India has laid down territorial restriction.

4.3 AccumulatePlus:

On Renewal of this Policy with the Company without a break, Base Sum Insured as in the first Policy Year shall be increased by 25% or 50%, basis the option selected at the time of purchase, till 100% of the Base Sum Insured as in the first Policy Year, irrespective of any claims and shall be available under the Renewed Policy subject to the following conditions:

- i. This benefit is only applicable when the Base Sum Insured and the sub-limit for Non-Surgery or Non-Surgical Procedure is same, which means that there is no sub-limit in effect for Non-Surgery or Non-Surgical Procedure.
- ii. In case where the Policy is on individual basis as specified in the Policy Schedule, the AccumulatePlus shall be added and available individually to the Insured Person.
- iii. In case where the Policy is on floater basis, the AccumulatePlus shall be added and available to the family on floater basis.
- iv. AccumulatePlus shall be available only if the Policy is renewed/ premium paid within the Grace Period.
- v. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated AccumulatePlus for such Insured Persons under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the AccumulatePlus to be carried forward for credit in such Renewed Policy shall be the lowest one that is applicable among all the Insured Persons.
- vi. In case of floater policies where the Insured Persons Renew their expiring policy by splitting the Policy into two or more floater policies/individual policies or in cases where the Policy is split due to the child attaining the Age of 25 years, the AccumulatePlus of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Base Sum Insured of the Renewed Policy.
- vii. If the Base Sum Insured has been reduced at the time of Renewal, the applicable AccumulatePlus shall be reduced in the same proportion to the Sum Insured in current Policy.
- viii. If the Base Sum Insured under the Policy has been increased at the time of Renewal, the AccumulatePlus shall be calculated on the Sum Insured of the last completed Policy Year.
- ix. If the Policy Period is of two/three years, any AccumulatePlus that has accrued for the first/second Policy Year shall be credited post completion of each Policy Year.
- x. New Insured Person added to the Policy during subsequent Renewals will be eligible for AccumulatePlus as per their Renewal terms.
- xi. In plans where in AccumulatePlus is available as an optional cover, this benefit can be opted only at inception or at renewals and once opted the same can be opted out only at renewals. Upon opting out from this benefit, any accrued AccumulatePlus amount shall be carried forward to the renewed Policy and thereafter AccumulatePlus benefit shall cease to exist.
- xii. AccumulatePlus shall be available only if the Cover is specified to be applicable in the Policy Schedule.

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4.4 Revive:

In the event of complete or partial utilization of the Base Sum Insured due to any claim admitted during the Policy Year irrespective of the utilization of the AccumulatePlus, the Company shall restore the Sum Insured up to the Base Sum Insured (as applicable under the current Policy Year) for any subsequent claims, admissible under Section 3 (Base Benefits), subject to the following conditions:

- i. This benefit is only applicable when the Base Sum Insured and the sub-limit for Non-Surgery or Non-Surgical Procedure is same, which means that there is no sub-limit in effect for Non-Surgery or Non-Surgical Procedure.
- ii. This Revive can be triggered unlimited times during each Policy Year and any unutilized amount, in whole or in part, will not be carried forward to the subsequent Policy Year.
- iii. The restoration of Base Sum Insured under the Revive benefit would be triggered only upon complete or partial utilization of the Base Sum Insured by way of first claim admitted under the Policy and be available for subsequent claims thereafter in the Policy Year, for all Insured Persons.
- iv. In case of a family floater policy, the Revive will be available on floater basis for all Insured Persons covered under the Policy and will operate in accordance with the above conditions.
- v. A single claim in the Policy Year shall never exceed the cumulative addition of original/ Base Sum Insured and accrued AccumulatePlus benefit (if applicable and remaining during the Policy Year).

4.5 Waiver of aggregate deductible:

The Insured Person will have the option to either reduce or waive the applicable deductible only once in the lifetime of the Policy and at Renewal, subject to physical health checkup and underwriting and only if all the below mentioned conditions are fulfilled:

- i. Continuity benefits of waiting period accrued as per expiring Policy Year (with aggregate deductible) shall be offered even after availing this option.
- ii. This option shall apply to all Insured Person(s) once selected, without any individual selection.
- iii. Post availing 'Waiver of Aggregate Deductible' option, premium will be charged as per the modification made.

4.6 Enhance Access to Provider Network:

The Insured Person, by default, will have access to Preferred Provider Network listed out in Annexure 2A and Out-of-Network for eligible and admissible cases as per Section 6 (a), (b), (c) and (d). However, We will additionally provide cover to the Insured Person for Section 3.1 (Inpatient Care), Section 3.2 (Pre-Hospitalization Expenses), Section 3.3 (Post-Hospitalization Expenses), Section 3.4 (Day Care Treatment), Section 3.5 (Living Organ Donor Transplant), Section 3.6 (Domestic Road Ambulance Charges), Section 3.8 (Alternative Treatment), Section 3.9 (Technological Advancements and Treatments), Section 4.12, if opted, (In-patient Hospitalisation for Surrogate Mother) and Section 4.14, if opted, (In-patient Hospitalisation for Oocyte Donor) at below selected Provider Network, if this benefit is opted or is in-built in the Plan.

1. Verified Provider Network as listed in Annexure 2B
2. Other Provider Network as listed in Annexure 2C

4.7 Enhance Post- Hospitalization Expenses:

If this benefit is opted or in-built with any Plan, we will provide the Insured Person with increased no of days from 90 days as mentioned in Section 3.3 b (i) to 180 days for Post- Hospitalization Expenses (Section 3.3), at below sub-options available:

1. Preferred Provider Network
2. Verified Provider Network
3. Other Provider Network
4. Non-network Provider (for eligible and admissible cases as per Section 6 (a), (b), (c) and (d))

4.8 Non-Medical Expenses Cover:

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If this benefit is opted or in-built with any Plan, we will provide the Insured Person with coverage of expenses pertaining to List-I of Annexure 5 in case of admissible claims, which is otherwise not covered. This coverage can be opted at below sub-options available:

1. Preferred Provider Network
2. Verified Provider Network
3. Other Provider Network
4. Non-network Provider (for eligible and admissible cases as per Section 6 (a), (b), (c) and (d))

4.9 Daily Deductible:

If this benefit is opted or in-built with any Plan, the Daily Deductible shall be applicable from any of the below available options:

1. the Daily Deductible of INR 2,000 shall be applied on all admissible claims
2. the Daily Deductible of INR 2,000 shall be applied on all admissible claims for Non-Surgery or Non-Surgical Procedures

The Daily Deductible shall be applicable as below:

- i. For treatment as required in In-patient Care (Section 3.1), Alternative Treatment (Section 3.8), Living Organ Donor Transplant (Section 3.5), Technological Advancements & Treatments (Section 3.9), which must require hospitalization or a Day Care Treatment (Section 3.4) that are Surgery or Surgical Procedures, the following shall apply basis the plan selection by the Insured Person. For the purpose of clarification, the Day Care Treatment (Section 3.4) shall be deemed to constitute 1 Day of Hospitalization.
- ii. No Daily Deductible shall be applicable on any of the above-mentioned Plans for Day Care Treatment without Surgery or Surgical Procedure.
- iii. It is agreed that Our liability to make payment under the Policy in respect of any claim made in that Policy Year will only commence once the total deductible basis the number of hospitalization days has been exhausted.
- iv. Deductible will not apply to any claim under Domestic Road Ambulance charges (Section 3.6), Emergency Air Ambulance (Section 4.11), if opted and Health checkup (Section 3.7).

4.10 Domiciliary Hospitalization:

If this benefit is opted or in-built with the Plan, the Company shall indemnify the Medical Expenses incurred during the Policy Year on Domiciliary Hospitalization of the Insured Person prescribed in writing by treating Medical Practitioner at Preferred Provider Network only as listed in Annexure 2A, provided that:

- a. the condition of the Insured Person is such that he/she could not be removed/admitted to a Hospital. or,
- b. the Medically Necessary Treatment is taken at Home on account of non-availability of room in a Hospital.

Illnesses / Conditions as listed below shall be excluded under this benefit:

- i. Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;
- ii. Arthritis, gout and rheumatism;
- iii. Ailments of spine/disc;
- iv. Chronic nephritis and nephritic syndrome;
- v. Any liver disease;
- vi. Peptic ulcer;
- vii. Diarrhoea and all type of dysenteries, including gastroenteritis;
- viii. Diabetes mellitus and insipidus;
- ix. Epilepsy;
- x. Hypertension;
- xi. Pyrexia of any origin.

4.11 Emergency Air Ambulance:

If this benefit is opted or in-built with the Plan, The Company shall indemnify expenses incurred by the Insured Person during the Policy Year towards Ambulance transportation in an airplane or helicopter for Emergency Care which requires immediate and rapid Ambulance transportation that ground transportation cannot provide from the site of first occurrence of the Illness or Accident to any of the Preferred Provider Network and Verified Provider Network listed in Annexure 2A and 2B respectively and Other Provider Network (if "Enhance

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Access to Provider Network" optional cover is opted or in-built with any Plan) listed in Annexure 2C. The claim is subject to a maximum of Sum Insured as specified in the Policy Schedule against this Cover, and subject to the following conditions:

- a. The Air Ambulance transportation is advised in writing by a Medical Practitioner and verified by RMP at Preferred Provider Network and Verified Provider Network listed in Annexure 2A and 2B respectively and Other Provider Network (if "Enhance Access to Provider Network" optional cover is opted or in-built with any Plan) listed in Annexure 2C.
- b. Medically Necessary Treatment is not available within 100 kms of the location where the Insured Person is situated at the time of emergency.
- c. The Insured Person is in India and the treatment is taken in India at Preferred Provider Network and Verified Provider Network listed in Annexure 2A and 2B respectively and Other Provider Network (if "Enhance Access to Provider Network" optional cover is opted or in-built with any Plan) listed in Annexure 2C.
- d. No return transportation to the Insured Person's Home or elsewhere by the Air Ambulance will be covered under this Cover.
- e. A claim for the same Hospitalization is admissible under Section 3.1 (In-patient Care) or Section 3.9 (Technological Advancements and Treatment)
- f. The amount specified in the Policy Schedule against this benefit denotes the Company's maximum liability in respect to the benefit and shall reduce the Sum Insured of the policy.
- g. The claims under this benefit shall be payable on a reimbursement basis only.

4.12 In-patient Hospitalisation for Surrogate Mother

If this optional cover is opted or in-built with the Plan, We will cover the Medical Expenses incurred in respect of In-Patient Hospitalization of the Surrogate Mother appointed by the "Intending Couple"/ "Intending Woman" for complications arising out of pregnancy and post-partum delivery complications during the Policy Period, up to a maximum limit of INR 5 Lakhs and subject to the following conditions:

- a. Initial waiting period of 30 days will be applicable
- b. This benefit is applicable for all female Insured Persons who have opted for 3 years or more policy term.
- c. The maximum coverage available for a surrogate mother is a period of thirty-six (36) continuous months after the surrogacy procedure has been successful
- d. Any expenses incurred on delivery of the newborn (either via normal delivery or caesarean section) are excluded from the scope of this cover
- e. This coverage shall only be available if all the provisions as specified in The Surrogacy Regulation Act (2021), and all the rules and regulations made thereunder are fulfilled
- f. The terms and conditions of In-patient Care shall apply
- g. Expenses associated with automation machine for peritoneal dialysis shall not be payable

4.13 In-patient Hospitalisation for Oocyte Donor

If this optional cover is opted or in-built with the Plan, We will cover the Medical Expenses incurred in respect of Hospitalization of the Oocyte donor appointed by the "Intending Couple"/ "Intending Woman" for complications arising due to oocyte retrieval during the Policy Period, up to the annual sum insured subject to maximum limit of INR 5 Lakhs and subject to the following conditions:

- a. This cover shall be available only for a period of twelve months (12 months) after the oocyte retrieval procedure has been successful
- b. This benefit is applicable to all or any female insured person
- c. Any expenses incurred on delivery of the new born (either via normal delivery or caesarean section) are excluded from the scope of this cover
- d. This coverage shall only be available if all the provisions as specified in The Assisted Reproductive Technology (Regulation) Act, 2021, and all the rules and regulations made thereunder are fulfilled
- e. The terms and conditions of In-patient Care shall apply.
- f. Expenses associated with automation machine for peritoneal dialysis shall not be payable

4.14 Room Category Modification Option

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If this optional cover is opted or in-built with the Plan, the eligible Room Category shall be modified to the below available options of Room Category and Provider Network:

Room Category options:

- a. Semi Private Room
- b. Private Room
- c. At actuals

Provider Network Options:

- a. Preferred Provider Network
- b. Verified Provider Network
- c. Other Provider Network
- d. Out-of-Network (for eligible and admissible cases as per Section 6 (a), (b), (c) and (d))

4.15 Daily Deductible

If this optional cover is opted, the Daily Deductible of INR 2000 per day shall be applicable basis the below conditions:

- a. Daily Deductible will be applicable for below options available:
 - i. For all eligible and admissible cases of in-patient care
 - ii. For only Non-surgery or Non-surgical cases of in-patient care
- b. For treatment as required in In-patient Care (Section 3.1), Alternative Treatment (Section 3.8), Living Organ Donor Transplant (Section 3.5), Technological Advancements & Treatments (Section 3.9), which must require hospitalization or a Day Care Treatment (Section 3.4) that are Surgery or Surgical Procedures, the following shall apply basis the plan selection by the Insured Person. For the purpose of clarification, the Day Care Treatment (Section 3.4) shall be deemed to constitute 1 Day of Hospitalization.
- c. It is agreed that Our liability to make payment under the Policy in respect of any claim made in that Policy Year will only commence once the total deductible basis the number of hospitalization days has been exhausted.
- d. Daily Deductible will not apply to any claim under Domestic Road Ambulance charges (Section 3.6) and Health checkup (Section 3.7).

5. Other Optional Base Covers

5.1 Personal Accident Cover:

4.6.1 Accidental Death

If this sub-option under Personal Accident Cover is opted, We will pay in lumpsum the Base Sum Insured, as specified in the Policy Schedule against this benefit, if Insured Person sustains Injury during the Policy Period, which shall within twelve months of its occurrence be the sole and direct cause of Death of Insured Person.

a. Disappearance

We will pay in lumpsum the Base Sum Insured in the event if Insured Person's body cannot be located within 365 Days;

- i. after the forced landing, stranding, sinking or wrecking of a conveyance in which Insured Person was known to be a passenger during Policy Period or;
- ii. after and as a result of any Catastrophic Event during Policy Period

it shall be deemed, subject to all other terms and provisions of the Policy, that Insured Person shall have suffered Death due to Accident under the Coverage.

If at any time, after the payment of the Accidental death benefit, it is discovered that the Insured Person is still alive, claims settled shall be reimbursed in full to the Company.

Specific condition applicable to Accidental Death:

The Coverage under this Section terminates on admissibility of Claim equal to amount as specified in Policy Schedule.

4.6.2 Permanent Disablement

If this sub-option under Personal Accident Cover is opted and if Insured Person sustains Injury during the Policy Year, which shall within twelve (12) months of its occurrence be the sole and direct cause of Permanent Disablement (PD), We will pay in lumpsum, in accordance to any one of the chosen Benefit Tables (A, B, C and D) below upto maximum of amount as specified in Policy Schedule as stipulated against Permanent Disablement in the Policy Schedule/Policy Schedule provided such disablement is certified by the Medical Practitioner. The Sum Insured for this benefit shall be equal to the Base Sum Insured or INR 1 Crore, whichever is lesser.

Benefit Table A

Sno.	The Disablement	% of Sum Insured Payable
1	Permanent Total Disablement	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two Limbs (physical severance of Limbs)	100%
4	Permanent Total Loss of Sight in both eyes	100%
5	Permanent Total Loss of Sight of one eye and one Limb (physical severance of Limbs)	100%
6	Permanent Total Loss of Speech	100%
7	Complete removal of the lower jaw	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities essential to life without full time assistance	100%
10	Permanent Total Loss of Hearing in both ears	75%
11	Permanent Total Loss of one Limb (physical severance of Limbs)	50%
12	Permanent Total Loss of Sight of one eye	50%

Benefit Table B

Sno.	The Disablement	% of Sum Insured Payable
1	Permanent Total Disablement	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two Limbs (physical severance or the total and permanent loss of use of such Limb)	100%
4	Permanent Total Loss of Sight in both eyes	100%
5	Permanent Total Loss of Sight of one eye and one Limb (physical severance or the total and permanent loss of use of such Limb)	100%
6	Permanent Total Loss of Speech	100%
7	Complete removal of the lower jaw	100%
9	Permanent Total Loss of Mastication	100%
10	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any	75%

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	job and the inability to carry out Daily Activities essential to life without full time assistance	
11	Permanent Total Loss of Hearing in both ears	50%
12	Permanent Total Loss of one Limb (physical severance or the total and permanent loss of use of such Limb)	50%

Benefit Table C

Sno.	The Disablement	% of Sum Insured Payable
1	Permanent Total Disablement	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two Limbs (physical severance or the total and permanent loss of use)	100%
4	Permanent Total Loss of Sight in both eyes	100%
5	Permanent Total Loss of Sight of one eye and one Limb (physical severance or the total and permanent loss of use)	100%
6	Permanent Total Loss of Speech	100%
7	Complete removal of the lower jaw	100%
8	Permanent Total Loss of Mastication	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities essential to life without full time assistance	100%
10	Permanent Total Loss of Hearing in both ears	75%
11	Permanent Total Loss of one Limb (physical severance or the total and permanent loss of use)	50%
12	Permanent Total Loss of Sight of one eye	50%
13	Permanent Total Loss of Hearing in one ear	15%
14	Permanent Total Loss of the lens in one eye	25%
15	Permanent Total Loss of use of four fingers and thumb of either hand	40%
16	Permanent Total Loss of use of four fingers of either hand	20%
17	Permanent Total Loss of use of one thumb of either hand :	
a)	Both joints	20%
b)	One joint	10%
18	Permanent Total Loss of one finger of either hand :	
a)	Three joints	5%
b)	Two joints	4%
c)	One joint	2%
19	Permanent Total Loss of use of toes :	
a)	All -one foot	15%
b)	Big -both joints	5%

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c)	Big -one joint	2%
d)	Other than Big -each toe	2%
20	Established non -union of fractured leg or kneecap	10%
21	Shortening of leg by at least 5cms	8%
22	Ankylosis of the elbow, hip or knee	20%

Benefit Table D

Sno.	The Disablement	% of Sum Insured Payable
1	Permanent Total Disablement	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two Limbs (physical severance or the total and permanent loss of use)	100%
4	Permanent Total Loss of Sight in both eyes	100%
5	Permanent Total Loss of Sight of one eye and one Limb (physical severance or the total and permanent loss of use)	100%
6	Permanent Total Loss of Speech	100%
7	Complete removal of the lower jaw	100%
8	Permanent Total Loss of Mastication	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities essential to life without full time assistance	100%
10	Permanent Total Loss of Hearing in both ears	75%
11	Permanent Total Loss of one Limb (physical severance or the total and permanent loss of use)	50%
12	Permanent Total Loss of Sight of one eye	50%
13	Permanent Total Loss of Hearing in one ear	15%
14	Permanent Total Loss of the lens in one eye	25%
15	Permanent Total Loss of use of four fingers and thumb of either hand	40%
16	Permanent Total Loss of use of four fingers of either hand	20%
17	Permanent Total Loss of use of one thumb of either hand :	
a)	Both joints	20%
b)	One joint	10%
18	Permanent Total Loss of one finger of either hand :	
a)	Three joints	5%
b)	Two joints	4%
c)	One joint	2%
19	Permanent Total Loss of use of toes :	
a)	All -one foot	15%

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b)	Big -both joints	5%
c)	Big -one joint	2%
d)	Other than Big -each toe	2%
20	Established non -union of fractured leg or kneecap	10%
21	Shortening of leg by at least 5cms	8%
22	Ankylosis of the elbow, hip or knee	20%
23	Permanent disablement not otherwise provided for under Items 2-22 inclusive up to a maximum of	75%

5.1.2.1 Specific Conditions applicable to Permanent Disablement

- Ankylosis of the fingers (other than thumb and forefinger) and of the toes (other than the big toe) shall be limited to 50% of the Sum Insured payable for the loss of the said members
- Benefit under item 23 of Benefit Table D shall be determined by the independent Medical Practitioner who will certify the percentage of Sum Insured payable taking into consideration the nature of the Injury and disability in conjunction with the stated percentages Sum Insured for more specific injuries shown in the Table of Benefits.
- Any claim amount admissible/paid during a given Policy year will reduce the Sum Insured payable for the Cover in respect of subsequent claims that may arise in the remainder of the Policy Year.
- The total amount payable in respect of more than one disablement due to the same Injury is arrived at by adding together the various percentages of Sum Insured shown in the Table of Benefits.
- Only one Table out of Benefit Tables A, B, C, D stipulated above can be opted and the same shall be mentioned in the Policy Schedule.

5.1.2.2 Specific Conditions applicable to Permanent Accident Cover

- This cover is offered only on Individual Sum Insured basis
- In case Insured person opts for Personal Accident Cover, he would be eligible for both Accidental Death and Permanent Disablement
- The Sum Insured stipulated against Personal Accident section in the Policy Schedule is a common Sum Insured for Accidental Death and Permanent Disablement coverages
- In case we have paid a claim under Accidental Death, then the entire Personal Accident cover shall terminate for that Insured Person
- In case of Permanent Disablement claims, the Company's maximum liability in a particular Policy Year shall never exceed the Sum Insured stipulated against Personal Accident cover
- In case a claim is paid during the Policy Year under Permanent Disablement cover the Sum Insured for the same shall be replenished post completion of that Policy Year
- In case we have paid a claim for a particular Permanent Disablement, we shall not be liable to pay future PD claims pertaining to the exact same claim in the lifetime of the Policy
- In case we have paid a claim for Permanent Disablement during a Policy Year and the Insured person unfortunately succumbs to an Accidental Death in the same Policy Year, only the remaining portion of the Sum Insured (if any) stipulated against Personal Accident cover shall be payable as part of the Accidental Death cover.
- Geography of Personal Accident cover is worldwide
- No waiting periods whatsoever shall apply to this cover

5.1.2.3 Exclusions applicable specific to Accidental Death and Permanent Disablement only

- The abuse or the consequences of the abuse of tobacco, intoxicants or hallucinogenic substances including all forms of narcotic drugs and alcohol unless prescribed by Medical Practitioner
- War or any act of war (whether war be declared or not or caused during service in the armed forces of any country), invasion, act of foreign enemy, civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, Nuclear, Chemical, Biological attack or weapons/materials or radiation of any kind.

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- c. Whilst travelling in aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world.
- d. Death or Disability suffered by the Insured Person on account of his participation as the driver, co-driver or passenger during trial runs (excluding Test Drives) using a motorized vehicle or bicycle
- e. Death or Disability caused by or arising from or in consequence of or contributed to Nuclear, Chemical or Biological attack/weapons, material by or arising from or in consequence of or contributed to by ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel (including any self-sustaining process of nuclear fission).
- f. Any Insured Person committing or attempting to commit intentional self-Injury (except in an attempt to save human life) or suicide while mentally sound or suffering from Mental illness
- g. From engaging in or participation in naval, military or air force operation.
- h. Injury sustained whilst or as a result of participation as a professional in Hazardous or Adventure sports. Persons working in underground mines, explosives magazines, workers involved in electrical installation with high tension supply, Jockeys, Circus personnel, Persons engaged in activities like racing on wheels or horseback, big game hunting, Mountaineering, winter sports, skiing, ice hockey, hang gliding, river rafting, polo and persons engaged in occupations/activities of similar hazard are not covered.
- i. Breach of Law: Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
- j. Injury sustained whilst or as a result of active participation in any violent labour disturbance, riot or civil commotion or public disorder.
- k. Injury sustained whilst on service or on duty with or undergoing training with any military or police force, or militia or paramilitary organisation, notwithstanding that the Injury occurred whilst the Insured Person was on leave or not in uniform.

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5.2 Repatriation of Mortal Remains

If this benefit is opted, and if an Insured Person sustains Injury during the Policy Period and within twelve months of its occurrence this injury results in Accidental Death, we will pay the Sum Insured as specified in the Policy Schedule towards the return of Mortal Remains of the Insured Person from the place of Death to his home country or hometown or place of burial/cremation anywhere in the world.

5.3 Funeral Expenses

If this benefit is opted, We will pay an amount equal to the Sum Insured as specified in the Policy Schedule towards expenses incurred for last rites of the Insured Person if he sustains Injury due to Accident during the Period of Insurance, which shall within twelve months of its occurrence be the sole and direct cause of Death of Insured Person

5.4 Dependent Child Education Benefit

If this benefit is opted and if Insured Person sustains Injury due to an accident during the Policy Period, which shall within twelve months of its occurrence be the sole and direct cause of either death or a permanent disability of the Insured Person, we will pay the Sum Insured as mentioned in the Policy Schedule towards education of each Dependent Child aged less than 25 years.

Conditions applicable to this benefit:

- i. The Permanent Total Disablement must be as specified in Benefit Table B under Personal Accident and the same should be certified by the Medical Practitioner.
- ii. The Claim is admissible only with confirmatory diagnosis of Permanent Total Disablement while the Insured Person is alive (A claim would not be admitted if the diagnosis is made postmortem)
- iii. The Sum Insured mentioned in the Policy Schedule shall be provided on per child basis and for the number of children as stipulated in the Policy Schedule. The payable amount under this section shall be assessed basis the number of living children of the insured person who is below 25 years of age.

5.5 Hospital Daily Cash

On availing this option, if Insured Person contracts Illness or sustains Injury during Policy Year, which results in Medically Necessary:

- a. Hospitalization OR
- b. Domiciliary Hospitalization OR
- c. Hospitalization for Alternative Treatments of an Insured Person within India,

We will pay the per day cash benefit as specified in the Policy Schedule subject to maximum number of benefit days for each continuous and completed period of 24 hours of such Hospitalization:

Specific Conditions applicable to Hospital Daily Cash benefit:

- a. Claim payout shall be subject to the maximum number of days in a Policy Year as specified in the Schedule of Benefits on the Policy Schedule/Certificate of Insurance.
- b. All Waiting Periods as specified in the Policy Schedule/Certificate of Insurance against this cover shall apply. Timeframe for these waiting periods shall be as specified against this cover in the Certificate of Insurance / Policy Schedule. Terms, conditions and clauses for the applicable waiting periods are provided under Section 8.1.1, Section 8.1.2 and Section 8.1.3.
- c. The utilization of this benefit does not reduce the Base Sum Insured for hospitalization.
- d. Time Deductible (as defined in section 2.2.42) or Franchise Time Deductible (as defined in section 2.2.15) shall be applied on this benefit. We will pay the Insured Per day cash benefit upto the limit specified for a specified maximum number of benefit days with applicable Time Deductible or Franchise Time Deductible.

Exclusions applicable to Hospital Daily Cash

We shall not make any payment for claims that falls under the Standard Exclusions as listed in Section 8.1 and Specific Exclusions as listed in Section 8.2 for benefits under Section 5.5- Hospital Daily Cash, unless otherwise specified in the Policy Schedule.

6. Healthcare Provider

All In-patient Care Benefits (Section 3.1) under this policy shall be applicable for coverage only at Preferred Provider Network listed in Annexure 2A. The coverage will be extended to Verified Provider and/or Other Provider Network listed in Annexure 2C, only if the optional cover "Enhance Access to Provider Network" is opted or in-built with any Plan.

The coverage shall be extended to any Healthcare Provider beyond the list of Preferred Provider Network listed in Annexure 2A, Verified Provider Network as listed in Annexure 2B (if "Enhance Access to Provider Network –Verified Provider Network" is opted or in-built with the Plan), and Other Provider Network as listed in Annexure 2C (if "Enhance Access to Provider Network – Other Provider Network" is opted or in-built with the Plan), only in the below mentioned scenarios:

- All cases of emergency as defined in the above section.
- Treatment not available at the eligible networks (basis the plan selection), Preferred Provider Network, Verified Provider Network and Other Provider Network listed in Annexure 2A, 2B and 2C respectively
- Insured Person travelling to a location and incurs a case of emergency where Preferred Provider Network, Verified Provider Network and Other Provider Network listed in Annexure 2A, 2B and 2C respectively is not accessible. In this scenario, Insured Person must submit a proof of travel and reason of travel with evidence which shall be accepted by Us.
- Insured Person relocating to a location where eligible networks (basis the plan selection), Preferred Provider Network, Verified Provider Network and Other Provider Network listed in Annexure 2A, 2B and 2C respectively is not accessible. In this scenario, the Insured Person must submit the Proof of Address of the new relocated address within 2 months of relocation or at time of claim, whichever is earlier.

Below is the detailed illustration of eligibility to access Provider Network describing the above points:

Access to Provider Network - eligibility for planned admissions				
Plan Options	Preferred Provider Network	Verified Provider Network	Other Provider Network	Non-Network Provider (case of Section 6 (b) and 5 (d))
Plan 1	Yes	No	No	Yes
Plan 2	Yes	No	No	Yes
Plus	Yes	Yes	No	Yes
Prime	Yes	Yes	Yes	Yes

Access to Provider Network - eligibility for emergency admissions				
Plan Options	Preferred Provider Network	Verified Provider Network	Other Provider Network	Non-Network Provider (case of Section 6 (a) and 5 (c))
Plan 1	Yes	Yes	Yes	Yes
Plan 2	Yes	Yes	Yes	Yes
Plus	Yes	Yes	Yes	Yes
Prime	Yes	Yes	Yes	Yes

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7. Co-payment

Co-payment

Below is the illustration detailing out the applicability of non-intimation co-payment basis the in-built Plan (Annexure 1) at different category of Network Provider and Non-Network Provider.

Applicability of non-intimation co-payment for planned admissions				
Plan Options	Preferred Provider Network	Verified Provider Network	Other Provider Network	Non-Network Provider (case of Section 6 (b) and 5 (d))
Plan 1	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 48 hours prior to admission	10% non-intimation co-payment Intimation required 48 hours prior to admission	10% non-intimation co-payment Intimation required 48 hours prior to admission
Plan 2	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 48 hours prior to admission	10% non-intimation co-payment Intimation required 48 hours prior to admission	10% non-intimation co-payment Intimation required 48 hours prior to admission
Plus	Intimation not mandatory, but advised	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 48 hours prior to admission	10% non-intimation co-payment Intimation required 48 hours prior to admission
Prime	Intimation not mandatory, but advised	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 48 hours prior to admission	10% non-intimation co-payment Intimation required 48 hours prior to admission

Applicability of non-intimation co-payment for emergency admissions				
Plan Options	Preferred Provider Network	Verified Provider Network	Other Provider Network	Non-Network Provider (case of Section 6 (a) and 5 (c))
Plan 1	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 24 hours from the admission	10% non-intimation co-payment Intimation required 24 hours from the admission	10% non-intimation co-payment Intimation required 24 hours from the admission
Plan 2	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 24 hours from the admission	10% non-intimation co-payment Intimation required 24 hours from the admission	10% non-intimation co-payment Intimation required 24 hours from the admission
Plus	Intimation not mandatory, but advised	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 24 hours from the admission	10% non-intimation co-payment Intimation required 24 hours from the admission
Prime	Intimation not mandatory, but advised	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 24 hours from the admission	10% non-intimation co-payment Intimation required 24 hours from the admission

Utilization of Sum Insured:

The sequence of utilization of Sum Insured in this Policy will be as follows, subject to the covers being in force and amount utilized under each of the below sections during the Policy Year;;

- Aggregate Deductible (if opted and applicable)
- Base Sum Insured / Base Sub-limit for Non-surgery or Non-surgical Procedure
- AccumulatePlus (if opted and applicable and remaining during the Policy Year),
- Revive (if opted and applicable)

A single claim in the Policy Year shall never exceed the cumulative addition of

- Base Sum Insured / Base Sub-limit for Non-Surgery or Non-surgical Procedure
- AccumulatePlus (if opted and applicable and remaining during the Policy Year)

8. Exclusions

7.1 Standard Exclusions

7.1.1 Pre-existing Disease (Code-Excl01):

- Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.
- In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- 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.
- Coverage under the Policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

7.1.2 Specified Disease/Procedure waiting period (Code-Excl02):

- Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months 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.
- In case of enhancement of sum insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- 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.
- The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
- 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.
- List of specific diseases/procedures is provided below:

Illnesses

- Pancreatitis
- Diseases of gall bladder including cholecystitis
- All forms of Cirrhosis

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- iv. Cataract and other disorders of lens and Retina
- v. Perineal Abscesses
- vi. Osteoarthritis and osteoporosis
- vii. Fibroids (fibromyoma)
- viii. Non infective Arthritis
- ix. Calculus diseases of Urogenital system e.g. Kidney stone, Urinary Bladder Stone
- x. Ulcer and erosion of stomach and duodenum
- xi. Gastro Oesophageal Reflux Disorder (GERD)
- xii. Perianal Abscesses
- xiii. Fissure/fistula in anus, Haemorrhoids including Gout and rheumatism
- xiv. Benign Hyperplasia of Prostate
- xv. Pilonidal sinus
- xvi. Benign tumours, cysts, nodules, polyps including breast lumps
- xvii. Polycystic ovarian diseases
- xviii. Sinusitis, Rhinitis
- xix. Skin tumours
- xx. Tonsillitis

Surgical Procedures

- i. Adenoidectomy, tonsillectomy
- ii. Tympanoplasty, Mastoidectomy
- iii. Hernia
- iv. Dilatation and curettage (D&C)
- v. Nasal concha resection
- vi. Surgery for prolapsed inter vertebral disc
- vii. Myomectomy for fibroids
- viii. Surgery of Genito urinary system unless necessitated by Malignancy
- ix. Surgery for varicose veins and varicose ulcers
- x. Surgery on prostate

7.1.3 30-day waiting period (Code-Excl03):

- a. Expenses related to the treatment of any illness within 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 months.
- c. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

7.1.4 Investigation & Evaluation (Code-Excl04):

- 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.

7.1.5 Rest Cure, rehabilitation and respite care (Code-Excl05):

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

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

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7.1.6 Obesity/ Weight Control (Code-Excl06):

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

- a. Surgery to be conducted is upon the advice of the Doctor.
- b. The surgery/Procedure conducted should be supported by clinical protocols.
- c. The member has to be 18 years of age or older and;
- d. Body Mass Index (BMI);
 - i. greater than or equal to 40 or
 - ii. 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:
 - Obesity-related cardiomyopathy
 - Coronary heart disease
 - Severe Sleep Apnoea
 - Uncontrolled Type2 Diabetes

7.1.7 Change-of-Gender treatments (Code-Excl07):

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

7.1.8 Cosmetic or plastic Surgery (Code-Excl08):

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.

7.1.9 Hazardous or Adventure sports (Code-Excl09):

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.

7.1.10 Breach of law (Code-Excl10):

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

7.1.11 Excluded Providers (Code-Excl11):

Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our website / notified to the Policyholders are not admissible. However, in case of life-threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.

The complete list of excluded providers can be referred to on our website.

7.1.12 Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences there-of (Code-Excl12)

7.1.13 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. (Code-Excl13)

7.1.14 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 Practitioner as part of Hospitalization claim or Day Care procedure (Code-Excl14)

7.1.15 Refractive Error (Code-Excl15):

Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptries.

7.1.16 Unproven Treatments (Code-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.

7.1.17 Sterility and Infertility (Code-Excl17):

Expenses related to sterility and infertility. This includes:

- a. Any type of contraception, sterilization
- b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI.

Please note: This exclusion shall not apply to claims which are otherwise admissible under Base Benefits 3.14 "In-patient Hospitalisation for Oocyte Donor" which pertains to Medical Expenses incurred in respect of Hospitalization of the Oocyte donor for complications arising due to oocyte retrieval process"

- c. Gestational Surrogacy –

Please note: This exclusion shall not apply to claims which are otherwise admissible under Base Benefits 3.15 "In-patient Hospitalisation for Surrogate Mother" which pertains to Medical Expenses incurred in respect of Hospitalization of the Surrogate mother for complications arising out of pregnancy and postpartum delivery complications"

- d. Reversal of sterilization

7.1.18 Maternity (Code-Excl18):

- a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization) except ectopic pregnancy;
- b. Expenses towards miscarriage (unless due to an Accident) and lawful medical termination of pregnancy during the Policy Period.

Please note: In-Patient Hospitalization of the Surrogate Mother appointed by the "Intending Couple"/ "Intending Woman" for complications arising out of pregnancy and post-partum delivery complications during the Policy Period will continue to cover as per Section 4.12, if opted or in-built with the Plan.

7.2 Specific Exclusions

7.2.1 Charges related to treatment arising from or contributed or aggravated or accelerated by any of the following:

- a. Suicide or attempted suicide, while sane or insane, or due to use, misuse or abuse of narcotic or intoxicating drugs or alcohol or solvent
- b. Intentional self-injury

- c. Use or consumption of narcotic or intoxicating drugs or alcohol or solvent, or taking of drugs (except under the direction of a Medical Practitioner)

7.2.2 Charges related to a Hospital stay not expressly mentioned as being covered. This will include Resident Medical Officer (RMO) charges, surcharges and service charges levied by the Hospital.

7.2.3 Circumcision:

Circumcision unless necessary for the treatment of a disease or necessitated by an Accident.

7.2.4 Conflict & Disaster:

Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism.

7.2.5 External Congenital Anomaly: Screening, counseling or treatment related to external Congenital Anomaly.

7.2.6 Dental/oral treatment:

Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident.

7.2.7 Hormone Replacement Therapy:

Treatment for any condition / illness which requires hormone replacement therapy.

7.2.8 Multifocal Lens or any kind of eye wear for vision correction

7.2.9 Prosthetics and other Ambulatory devices such as walkers, crutches, splints, stockings of any kind and also any medical equipment which is subsequently used at home.

**7.2.10 Sexually transmitted Infections & diseases (other than HIV / AIDS)
Screening, prevention and treatment for sexually related infection or disease (other than HIV / AIDS).**

7.2.11 Sleep disorders:

Treatment for any conditions related to disturbance of normal sleep patterns or behaviours.

7.2.12 Any treatment or medical services received at Non-network Provider except for scenarios as defined in Section 6(a), 6(b), 6(c) and 6(d)

For treatment or medical services received at Non-network Provider, the clause of excluded provider (section 8.1.11) shall apply.

7.2.13 Unrecognized Physician or Hospital:

For treatment of those covered under the policy that are not available at the listed network healthcare provider and the Insured Person seeks the treatment beyond the listed network healthcare provider, the coverage will be denied if:

- a. Treatment or Medical Advice provided by a Medical Practitioner not recognized by the Medical Council of India or by Central Council of Indian Medicine or by Central council of Homeopathy.

- b. Treatment provided by anyone with the same residence as an Insured Person or who is a member of the Insured Person's immediate family or relatives.
- c. Treatment provided by Hospital or health facility that is not recognized by the relevant authorities in India.

7.2.14 Artificial life maintenance for the Insured Person who has been declared brain dead or in vegetative state as demonstrated by:

- a. Deep coma and unresponsiveness to all forms of stimulation; or
- b. Absent pupillary light reaction; or
- c. Absent oculovestibular and corneal reflexes; or
- d. Complete apnoea.

7.2.15 Alternative Treatment:

Any form of Alternative Treatments, except as mentioned under Section 3.8.

7.2.16 Treatment of injury or illness due to participation or involvement in naval, military or air force operation.

7.2.17 Personal comfort, cosmetics, convenience and hygiene related items and services.

7.2.18 Acupressure, acupuncture, magnetic and other therapies.

7.2.19 Any expenses incurred on Out Patient treatment.

7.2.20 Non-Medical expenses as listed in List-1 of Annexure 5. This exclusion is not applicable if the Optional Cover "Non-Medical Expenses" as described in Section 4.8, is opted at the Provider Network selected.

7.2.21 Aggregate Deductible - Claims/claim amount falling within Aggregate Deductible limit if opted and in force, as specified in the Policy Schedule.

7.2.22 Any treatment or part of a treatment that is not of a Reasonable and Customary Charge and not Medically Necessary including drugs or treatments which are not supported by a prescription.

7.2.23 Any Legal Liability due to any errors or omission or representation or consequences of any action taken on the part of any Hospital or Medical Practitioner.

9. Value Added Services

We may provide discretionary discounts to You on Out-patient expenses such as consultation, medicine, lab tests, diagnostic tests, etc. at our service providers listed on our website - www.narayanahealth.insurance.

10. Moratorium Period

After completion of sixty (60) continuous months under this policy no look back would be applied. This shall be applicable to ported policies as well subject to the condition that the coverage has been continuous. This period of 60 months is called the moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 60 continuous months would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of the Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy.

11. Claim Procedure

- 10.1 For treatment at Network Provider – Preferred Provider Network and Verified Provider Network (only applicable if "Enhance Access to Provider Network is opted"):**

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Cashless admission facility shall be extended to the Insured Person in case of admission at the listed Preferred and Verified Provider Network in Annexure 2 for the coverage as defined under the Benefits in this document.

Procedure for the Cashless Claim at Preferred Provider Network and Verified Provider Network listed in Annexure 2A and 2B respectively:

- a. While no intimation is required for pre-authorization of cashless admission for the coverage of benefits under In-Patient Care, Day Care Treatment, Alternate Treatment and Technological Advancement and Treatment, Living Organ Donor Transplant, it is recommended that the Insured Person intimates the Customer Support team in case of planned treatment to check the coverage applicability to avoid any confusion. A detailed description of the intimation process is available in the claims manual at the company website www.narayanahealth.insurance.
- b. Insured Person must produce the Digital Health Card or the Policy Copy or the Policy Number along with valid government Proof of Identity at the Insurance Desk of the Preferred Provider Network and Verified Provider Network to register for cashless processing, on the date of admission and before admission.
- c. We reserve the right to reject the cashless claim for planned admission if the treatment sought is beyond the coverage benefit of the policy.

10.2 For treatment at Network Provider – Other Provider Network (only applicable if “Enhance Access to Provider Network” optional cover is opted or in-built with any Plan):

Cashless admission facility shall be extended to the Insured Person in case of admission at the listed Other Provider Network (only applicable if “Enhance Access to Provider Network” optional cover is opted or in-built with any Plan) in Annexure 2 for the coverage as defined under the Benefits in this document.

Procedure for the Cashless Claim at Other Provider Network listed in Annexure 2C:

- a. 48-hours prior intimation for planned admissions and intimation within 24-hours for emergency admission is required for pre-authorization of cashless admission for the coverage of benefits under In-Patient Care, Day Care Treatment, Alternate Treatment, Technological Advancement and Treatment and Living Organ Donor Transplant. We reserve the right to apply non-intimation co-payment of 10% for planned admission and 10% for emergency admission for such cases and hence it is advised to the Insured Person that the intimation timelines are met to avoid non-intimation co-payment (Refer Section 7).
- b. Insured Person must produce the Digital Health Card or the Policy Copy or the Policy Number along with valid government Proof of Identity at the Insurance Desk of the Network Provider to register for cashless processing, on the date of admission and before admission.
- c. We reserve the right to reject the cashless claim for planned admission if the treatment sought is beyond the coverage benefit of the policy.

10.3 For treatment at Non-Network Provider (as defined in Section 2.1.35 of Policy Wording) except listed Excluded Providers pertaining to Section 6(b) & 6(d):

Cashless admission facility shall be extended to the Insured Person in case of planned admissions in such cases. The procedure for availing the cashless benefit in such cases are as below:

- a. Cashless request form available with the healthcare provider shall be completed and sent to Us for authorization.
- b. We, upon getting cashless request form and related medical information from the Insured Person/ network provider will issue pre-authorization letter to the hospital after verification.
- c. At the time of discharge, the Insured Person has to verify and sign the discharge papers, pay for inadmissible expenses and deductible as per the policy.
- d. Prior intimation of 48 hour is required for such cases of admission, failing which we reserve the right to apply 10% non-intimation co-payment and hence it is advised to the Insured Person that the intimation timelines are met to avoid non-intimation co-payment (Refer Section 7).
- e. We reserve the right to deny pre-authorization in case the Insured Person is unable to provide the relevant medical details.

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In case of denial of cashless access, the Insured Person may obtain the treatment as per treating doctor's advice and submit the claim documents to Us for reimbursement.

10.4 For Emergency admissions (Section 6(a) and 6(c)) at Non-network Provider, where admission at Network Provider was not reasonably possible

We shall extend the cashless facility in such cases subject to the concerned healthcare provider agreeing to such arrangements.

In case of denial of cashless admission by the concerned Healthcare Provider, the Insured Person may obtain the treatment as per treating doctor's advice and submit the claim documents to Us for reimbursement.

Intimation within 24 hours is required for such cases of admission, failing which we reserve the right to apply 10% non-intimation co-payment and hence it is advised to the Insured Person that the intimation timelines are met to avoid non-intimation co-payment (Refer Section 7).

Please note:

- Turnaround time for initial request for cashless authorization: Decide on the request for cashless authorization immediately but not more than one hour of receipt of request.
- Turnaround time for final approval of cashless claims: Final authorization within three hours of the receipt of discharge authorization request from the hospital
- Reimbursement option shall be availed for admissible Pre-hospitalization, Post-hospitalization expenses or for any expenses where cashless was not availed at the Healthcare Provider.
- Turnaround time for claim settlement via reimbursement – 15 days from the time the last required document has been received by Us.

10.5 Procedure for reimbursement of claim:

For reimbursement of claims, the Insured Person may submit the necessary documents at the earlier to Us and no later than the prescribed time limit as specified hereunder:

S No	Type of Claim	Prescribed Time limit for submission of necessary documents
1	Reimbursement of In-patient Care, Day Care Treatment, Pre-hospitalization expenses, Alternative Treatment, Technological Advancement and Treatment	Within 30 days of date of discharge from hospital
2	Reimbursement of post-hospitalization expenses	Within 15 days from completion of Post-hospitalization treatment

The claim will be processed within 15 days from the date of claim submission. Claim submission will be considered complete once all the necessary claim related documents are duly received

a. Notification of Claim:

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

- Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.
- At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

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b. Documents to be submitted:

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

- i. Duly Completed claim form
- ii. Photo Identity proof of the patient
- iii. Medical practitioner's prescription advising admission
- iv. Original bills with itemized break-up
- v. Payment receipts
- vi. Discharge summary including complete medical history of the patient along with other details.
- vii. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner
- viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgery/surgical procedure cases), wherever available
- ix. Sticker/Invoice of the Implants, wherever applicable
- x. MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, wherever applicable
- xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
- xii. KYC (Identity proof with Address) of the proposer
- xiii. Legal heir/succession certificate, wherever applicable
- xiv. Any other relevant document required by Company/TPA for assessment of the claim

We may specify the documents required in original and waive off any of above required as per their claim procedure

Note:

- a. We shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
- b. 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 and claim settlement advice, duly certified by the other insurer subject to satisfaction by Us
- c. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

Please note that the Claim forms are available at the website www.narayanahealth.insurance.

12. Claim Settlement (Provision for Penal Interest)

- 11.1 The Company shall settle or reject a claim, as the case may be, within 15 days from the date of claim submission. Claim submission will be considered complete once all the necessary claim related documents are duly received.
- 11.2 In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the concerned beneficiary from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- 11.3 However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such an 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 the claim within 45 days from the date of receipt of last necessary document.
- 11.4 In case of delay beyond stipulated 45 days the company shall be liable to pay interest to the concerned beneficiary at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

13. Payment of Claim

All claims under the policy shall be payable in Indian currency only.

14. General Terms and Conditions

13.1 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.

13.2 Condition Precedent to Admission of Liability

The due observance and fulfilment of the terms and conditions of the policy, by the Insured Person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the policy.

13.3 Loading of Premium

Based on Our discretion, upon the disclosure of the health status of the persons proposed for insurance and declarations made during the pre-policy medical checkup for underwriting purposes, We may apply a risk loading on the premium payable (excluding statutory levies and taxes) or Special Conditions on the Policy. The maximum risk loading applicable shall not exceed 50%. These loadings will be applied from inception date of the First Policy including subsequent Renewal(s) with Us.

13.4 Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

13.5 Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

13.6 Complete Discharge

Any payment to the Insured Person or his/ her nominees or his/ her legal heir/ representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall in all cases be a full, valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim

13.7 Notice & Communication

- Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
- Such communication shall be sent to the address of the Company or through any other electronic modes.
- The Company shall communicate with the Insured at the address or through any other electronic modes.

13.8 Territorial Limit

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

13.9 Multiple Policies

- a. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder 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 if chosen by the policy holder 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.
- b. Policyholder having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall independently settle the claim subject to the terms and conditions of this policy.
- c. If the amount to be claimed exceeds the sum insured under a single policy, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
- d. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

13.10 Fraud

If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support there-of, 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 shall be forfeited.

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the Policy Schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud", inter alia, means any of the following acts committed by the Insured Person or by his agent, 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

13.11 Cancellation

- a. Except in case any claim has been admitted or has been lodged or any benefit has been availed under the Policy, the Insured may cancel this Policy by giving 7 days' written notice and in such an event, the Company shall refund to the Insured a pro-rata premium for the unexpired Policy Period.

Note: For Policies where premium is paid by instalment: In case of admissible claim under the Policy, future instalment for the current Policy Year will be adjusted in the claim amount and no refund of any premium will be applicable during the Policy Year.

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 by the Insured Person under the Policy.

- b. The Company may cancel the Policy at any time on grounds of misrepresentation, non- disclosure of material facts, fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or established fraud.

13.12 Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate:

- a. In the case of his/her (Insured Person) demise. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other Insured Persons may also apply to renew the policy. In case the other Insured Person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardians appointed by court. All relevant particulars in respect of such a person (including his/her relationship with the Insured Person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the Insured Person. Pro-rata refund of premium of the deceased Insured Person for the balance period of the policy will be effective.
- b. Upon exhaustion of Sum Insured for the policy year.

However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

13.13 Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

13.14 Portability

The Insured Person will have the option to port the Policy to other insurers as per extant Guidelines related to 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 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

- a. The waiting periods specified in Pre-existing Diseases Excl01 (Section 8.1.1), Specific Disease Procedure Waiting Period Excl02 (Section 8.1.2) shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
- b. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

The extant Guidelines related to portability are as below:

- Portability means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained from one insurer to another insurer.
- By porting, the policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc. from the Existing Insurer to the Acquiring Insurer in the previous policy.
- The Acquiring and the Existing Insurers shall jointly, ensure that the entire underwriting details and claim history of the Policyholders are seamlessly transferred.
- The existing insurer shall provide the information sought by the Acquiring insurer immediately but not more than 72 hours of receipt of request through Insurance Information Bureau of India (IIB) <https://iib.gov.in/portal>
- The Acquiring insurer shall decide and communicate on the proposal at the earliest possible time but not more than 5 days of receipt of information from Existing insurer.
- A policyholder desirous of porting his/her policy to another insurer shall apply to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the due date for renewal. Insurers are free to consider proposal for portability even if the policyholder has approached within 15 days from the renewal date of the existing policy, but in all such cases acquiring insurer shall ensure that there is no break in policy.

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Product Name: Narayana Aditi | **UIN:** NHIHLIP26044V052526

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- No charges shall be levied on the policyholder for porting-in or porting-out

For Detailed Guidelines on Portability, please visit the weblink: <https://irdai.gov.in/document-detail?documentId=5625747>.

13.15 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the Insured Person. The Company is not bound to give notice that it is due for renewal.

- Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years.
- Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
- 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 available during the grace period.
- If not renewed within Grace Period after due renewal date, the Policy shall stand terminated with effect from the due date of renewal.

13.16 Multi-year Premium Payment

The Insured Person may choose to pay Premium for multi years for coverage upto a maximum of 3 Years. The Insured Person is eligible for discount on Premium basis the below slab, provided Insured has paid the premium in advance as a single premium.

No of years of coverage	Applicable Discount on premium (excl. taxes)
1 Year	0%
2 Years	7.5%
3 Years	7.5%

13.17 Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company may revise or modify the terms of the policy including the premium rates as per applicable IRDAI regulations. The Insured Person shall be notified three months before the changes are affected.

13.18 Free Look Period

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting the policy.

The insured shall be allowed a period of thirty days from the date of receipt of the Policy 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

- A refund of the premium paid; or
- Where the risk has already commenced and the option of return of the Policy is exercised by the insured, a deduction towards the proportionate risk premium for period of cover; or

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- c. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

13.19 Endorsements (Changes in Policy)

- a. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
- b. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir/immediate family members. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break. The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.

13.20 Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal subject to underwriting by the Company.

13.21 Terms and conditions of the Policy

The terms and conditions contained herein shall be deemed to form part of the Policy and shall be read together as one document.

13.22 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. For Claim settlement under reimbursement, the Company will pay the policyholder. In the event of death of the policyholder, the Company will pay the nominee (as named in the Policy Schedule / / 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. Nomination can be changed any time during the term of the policy.

13.23 Premium Payment in Instalments

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

- 1 Grace Period as mentioned in the table below would be given to pay the instalment premium due for the Policy

Options	Instalment Premium Option	Grace period applicable
Option 1	Multi-Year / Yearly	30 days
Option 2	Half-yearly	30 days
Option 3	Quarterly	30 days
Option 4	Monthly	15 days

- 2 If Premium is paid in instalments, then coverage will be available during the grace period.

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13.24 Redressal of Grievance

Step 1:

Call the Customer Support at +91 9821 034071
or email us at support@narayanahealth.insurance

Senior citizens may call at 1800-203-0234 or email us at seniorcitizencare@narayanahealth.insurance for priority assistance.

Step 2:

If the issue is not resolved in Step 1 and the customer wants to make a further suggestion or a complaint, they can email us at grievance@narayanahealth.insurance

Step 3:

If the customer for some reason feels that we have not been able to resolve the issue even in Step 2 and customer wishes to raise a concern, please write to Grievance Redressal Officer at gro@narayanahealth.insurance.

Step 4:

In case a complainant is not satisfied with the resolution from the above escalation authority, they may choose to log in their grievance at BIMA BHAROSA GRIEVANCE REDRESSAL PORTAL - bimabharosa.irdai.gov.in or they can approach the Insurance Ombudsman. The detailed addresses of all the Insurance Ombudsman can be found in the link below.

The contact details of the Insurance Ombudsman offices have been provided as Annexure 8.

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Customer Information Sheet

This document provides key information about your policy. You are also advised to go through your policy document.

Sno	Title	Description	Policy Clause No.
1	Name of Insurance Product / Policy	Narayana Aditi	NA
2	Policy Number	To be allotted at Policy Issuance	NA
3	Type of Insurance Product / Policy	Health Insurance Indemnity, Personal Accident Cover (Optional Base Cover) Repatriation of Mortal Remains (Optional Base Cover) Funeral Expenses (Optional Base Cover) Dependent Child Education Benefit (Optional Base Cover) Hospital Daily Cash (Optional Base Cover)	Section 3 and Section 4
4	Sum Insured (Basis) (Along with amount)	Base Sum Insured for Hospitalization Cover: INR 5 Lac / 10 Lac / 15 Lac / 20 Lac / 25 Lac / 50 Lac / 1 Crore Sub limit for Non-Surgery or Non-surgical Procedure – INR 5 Lac / 10 Lac / 15 Lac / 20 Lac / 25 Lac / 50 Lac / 1 Crore Individual / Multi-Individual/ Family floater basis with Sum Insured shared amongst all Eligibility for family floater - upto 4 adults + upto 4 children. <i>Note – Adult means individuals with 18 years of age and above. Children must be a dependent of the primary proposer and <25 years of age.</i>	Annexure-1
5	Policy Coverage (What the policy covers?) (Policy Clause Number/s)	Coverage available at Preferred Provider Network listed in Annexure 2A and at Verified and Other Provider Network (if "Enhance Access to Provider Network" optional cover is opted or in-built with any Plan) listed in Annexure 2B and 2C respectively in India. The coverage shall be extended to any Healthcare Provider beyond the eligible Healthcare Provider only in the below mentioned cases: - All cases of emergency as defined in Section 2.1.18. - Treatment not available at eligible provider network (Preferred Provider Network, Verified Provider Network and Other Provider Network listed in Annexure 2A, 2B and 2C respectively) basis the Plan selection - Insured Person travelling to a location and incurs a case of emergency where Preferred Provider Network, Verified Provider Network and Other Provider Network listed in Annexure 2A, 2B and 2C respectively is not accessible. In this scenario, Insured Person must submit a proof of travel and reason of travel with evidence which shall be accepted by Us. - Insured Person relocating to a location where Preferred Provider Network, Verified Provider Network and Other Provider Network listed in Annexure 2A, 2B and 2C respectively is not accessible. In this scenario, the Insured Person must submit the Proof of Address of the new relocated address within 2 months of relocation or at time of claim, whichever is earlier.	Section 3, Section 4, and Section 5

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		Base Hospitalization Cover: • In-patient Care (covered upto Base Sum Insured) – Hospitalization beyond continuous 24 hours of admission • Room rent and room type – ○ General Ward, or ○ Semi-Private Room / Private Room / at actuals basis the opted optional cover "Room Category Modification Option" or in-built with the Plan • Pre-hospitalization expenses (covered upto Base Sum Insured) – upto 60 days before the admission date • Post-hospitalization expenses (covered upto Base Sum Insured) • 90 days or 180 days (if Enhance Post-hospitalization expenses in opted or in-built with the Plan) • Day Care Treatment (covered upto Base Sum Insured) • Living Organ Donor Transplant (covered upto Base Sum Insured) • Domestic Road Ambulance Charges (covered upto Sum Insured) • Health Checkup – defined Health checkup package at empanelled Health Checkup provider. • Alternative Treatment (covered upto Sum Insured) • Technological Advancement and Treatment (covered upto Sum Insured) • 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 5, while coverage for List-I shall only be provided if the Optional Cover "Non-medical Expenses Cover", as described in Section 4.8, is opted at select Provider Network or is in-built with any Plan. • Aggregate Deductible – Nil / INR 25,000 / INR 50,000 / INR 1,00,000 / INR 2,00,000 / INR 3,00,000 / INR 4,00,000 / INR 5,00,000 Optional Cover: (HOSPITALIZATION) • Deferred Initial Health checkup / examination: Yes (Medical and Lifestyle Information and Declaration at pre Policy Issuance with Health Check-Up / Examination post Policy Issuance), ○ Pre-existing disease waiting period – 3 years ○ Specific Disease / Procedure waiting period – 2 years ○ 30-Day Waiting Period – 30 days ○ Loading of premium If Health checkup / examination is done within 90 days of post policy issuance, following outcomes are possible, basis underwriting policy: ○ Pre-existing disease waiting period – 3 / 2 / 1 / Nil year(s) ○ Specific Disease / Procedure waiting period – 2 / 1 / Nil year(s)	
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		○ 30-Day Waiting Period – 30 / Nil (days) ○ Discount on renewal premium OR No (Health Check-Up exists in Advance or Health Check-Up/Examination to be done before Policy Issuance). Following outcomes are expected basis underwriting policy ○ Pre-existing disease waiting period – 3 / 2 / 1 / Nil year(s) ○ Specific Disease / Procedure waiting period – Nil, unless specified in the Policy Schedule ○ 30-Day Waiting Period – Nil, unless specified in the Policy Schedule • Global Health Cover (Emergency Treatment Only): Upto Base Sum Insured or INR 1 Crore, whichever is lesser 10% co-payment applicable • Emergency Air Ambulance Charges (covered upto Sum Insured) • Domiciliary Hospitalization if prescribed in writing by treating Medical Practitioner at Preferred Provider Network only (covered upto Sum Insured) with exclusions of below conditions: ○ Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza; ○ Arthritis, gout and rheumatism; ○ Ailments of spine / disc; ○ Chronic nephritis and nephritic syndrome; ○ Any liver disease; ○ Peptic ulcer; ○ Diarrhoea and all type of dysenteries, including gastroenteritis; ○ Diabetes mellitus and insipidus; ○ Epilepsy; ○ Hypertension; ○ Pyrexia of any origin. • Accumulate Plus: Only applicable where there is no sublimit applicable for Non-Surgery or Non-Surgical Procedure. Additional Sum Insured in the subsequent Policy Year of 25% or 50%, basis option selected, upto 100% of the Base Sum Insured. • Revive: Only applicable where there is no sublimit applicable for Non-Surgery or Non-Surgical Procedure. Reinstatement of Base Sum Insured for subsequent claim in the same Policy Year upon complete or partial utilization of Base Sum Insured. • Waiver of Aggregate Deductible: Option to reduce or waive off Aggregate Deductible, subject to underwriting decisions • Enhance Access to Provider Network: Option to increase access of Healthcare Provider to Verified Provider Network and Other Provider Network • Enhance Post-Hospitalization Medical Expenses – Increase post-Hospitalization Medical Expenses for admissible planned admissions	
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		coverage limit of 90 days to 180 days at ○ Preferred Provider Network ○ Verified Provider Network ○ Other Provider Network • Non-Medical Expenses Cover at below sub-options ○ Preferred Provider Network ○ Verified Provider Network ○ Other Provider Network ○ Non-network Provider (for eligible and admissible cases as per Section 6 (a), (b), (c) and (d)) • Room Category Modification Options (OTHER BASE COVERS) • Personal Accident Cover: covered upto Base Sum Insured as mentioned in Policy Schedule Accidental Death + Permanent Disablement 1 option to choose from below Permanent Disablement Benefit Tables: ○ Benefit Table A ○ Benefit Table B ○ Benefit Table C ○ Benefit Table D • Repatriation of Mortal Remains – covered upto Sum Insured as mentioned in Policy Schedule • Funeral Expenses - covered upto Sum Insured as mentioned in Policy Schedule • Dependent Child Education Benefit – covered upto Sum Insured as specified in Policy Schedule for upto 2 dependent child each in case of Accidental Death or Total Permanent Disablement (Table B) • Hospital Daily Cash - Per day cash benefit as specified in the Policy Schedule subject to maximum number of benefit days for each continuous and completed period of 24 hours of such Hospitalization, with conditions of Time Deductible or Franchise Time Deductible, if applicable.	
6	Exclusions (What the policy does not cover?)	Standard Exclusions • Pre-existing Disease (Code-Excl01) • Specific Disease/Procedure waiting period (Code-Excl02) • 30-Day Waiting Period (Code-Excl03) • Investigation & Evaluation (Code-Excl04) • Rest Cure, rehabilitation, and respite care (Code-Excl05) • Obesity/ Weight Control (Code-Excl06): • Change-of-Gender treatments (Code-Excl07): • Cosmetic or Plastic Surgery (Code-Excl08) • Hazardous or Adventure sports (Code-Excl09) • Breach of law (Code-Excl10) • Excluded Providers (Code-Excl11) • Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences there-of (Code-Excl12)	Section 8.1, Section 8.2, Section 4.10, Section 5.1.2.3, Section 5.5

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		• 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. (Code-Excl13) • 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 Practitioner as part of Hospitalization claim or Day Care procedure (Code-Excl14) • Refractive Error (Code-Excl15): Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 diopters. • Unproven Treatments (Code-Excl16): • Sterility and Infertility (Code-Excl17) <i>Please note: This exclusion shall not apply to claims which are otherwise admissible under Base Benefits 3.14 and 3.15 "In-patient Hospitalisation for Oocyte Donor" and "In-patient Hospitalization for Surrogate Mother" which pertains to Medical Expenses incurred in respect of Hospitalization of the Oocyte donor for complications arising due to oocyte retrieval process and for complications arising out of pregnancy and postpartum delivery complications respectively.</i> • Maternity (Code-Excl18) <i>Please note: In-Patient Hospitalization of the Surrogate Mother appointed by the "Intending Couple"/ "Intending Woman" for complications arising out of pregnancy and post-partum delivery complications during the Policy Period will continue to cover as per Section 4.12</i> Specific Exclusions • Any treatment or medical services received outside the Preferred Provider Network and Verified Provider Network listed in Annexure 2A and 2B except for scenarios as defined in Section 6(a), 6(b), 6(c) and 6(d) • Charges related to treatment arising from or contributed or aggravated or accelerated by any of the following: ○ Suicide or attempted suicide, while sane or insane, or due to use, misuse or abuse of narcotic or intoxicating drugs or alcohol or solvent ○ Intentional self-injury ○ Use or consumption of narcotic or intoxicating drugs or alcohol or solvent, or taking of drugs (except under the direction of a Medical Practitioner) • Charges related to a Hospital stay not expressly mentioned as being covered. This will include Resident Medical Officer (RMO) charges, surcharges and service charges levied by the Hospital. • Circumcision • Conflict & Disaster • External Congenital Anomaly • Dental/oral treatment, unless due to accident • Hormone Replacement Therapy: • Multifocal Lens or any kind of eye wear for vision correction • Prosthetics and other Ambulatory devices • Sexually transmitted Infections & diseases (other than HIV / AIDS) • Sleep disorders: • Unrecognized Physician or Hospital • Artificial life maintenance for the Insured Person who has been declared brain dead or in vegetative state • Any form of Alternative Treatments, except as mentioned under Section 3.9	
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		• Treatment of injury or illness due to participation or involvement in naval, military or air force operation. • Acupressure, acupuncture, magnetic and other therapies • Any expenses incurred on Out Patient treatment, except Value Added Services (Section 8) • Non-Medical expenses as listed in List-1 of Annexure 5. This exclusion is not applicable if the Optional Cover "Non-Medical Expenses" as described in Section 4.8, is opted at the Provider Network selected. • Aggregate Deductible - Claims/claim amount falling within Aggregate Deductible limit if opted and in force, as specified in the Policy Schedule • Any treatment or part of a treatment that is not of a Reasonable and Customary Charge and not Medically Necessary including drugs or treatments which are not supported by a prescription. • Any Legal Liability due to any errors or omission or representation or consequences of any action taken on the part of any Hospital or Medical Practitioner. Exclusions for Domiciliary Hospitalization • Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza; • Arthritis, gout and rheumatism; • Ailments of spine/disc; • Chronic nephritis and nephritic syndrome; • Any liver disease; • Peptic ulcer; • Diarrhoea and all type of dysenteries, including gastroenteritis; • Diabetes mellitus and insipidus; • Epilepsy; • Hypertension; • Pyrexia of any origin. Specific Exclusions applicable to Global Health Cover (Emergency Treatments Only): • Any Planned treatments • In case we have paid a Hospitalization claim under this benefit, Pre-hospitalization Medical Expenses and/or Post-hospitalization Medical Expenses related to the claim whether incurred overseas or within India are not payable under this Policy. • Treatment or part of treatment for any condition which is not Life threatening in nature and can be safely postponed till the Insured Person returns to India. • Medical treatment taken outside India if that is the sole reason or one of the reasons for the journey. • Any treatment of orthopaedic diseases or conditions except for fractures, dislocations and / or Injuries suffered during the Policy Period. • Oncological (Cancer) diseases • The Company may not be liable to make any payment under this Policy, wherein the Government of India has laid down territorial restriction. Exclusions for Personal Accident Cover • The abuse or the consequences of the abuse of tobacco, intoxicants or hallucinogenic substances including all forms of narcotic drugs and alcohol unless prescribed by Medical Practitioner • War or any act of war (whether war be declared or not or caused during service in the armed forces of any country), invasion, act of foreign	
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Narayana Health Insurance Limited | CIN : U65120KA2023PLC174002 | IRDAI Reg. No. :166
Website: www.narayanahealth.insurance | **E-Mail:** support@narayanahealth.insurance | **Phone:** +91 9821034071
Product Name: Narayana Aditi | **UIN:** NHIHLIP26044V052526

Registered Office: No. 258/A, Bommasandra Industrial Area, Anekal Taluk, Bangalore - 560099, Karnataka, India
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		enemy, civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, Nuclear, Chemical, Biological attack or weapons/materials or radiation of any kind. • Whilst travelling in aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world. • Death or Disability suffered by the Insured Person on account of his participation as the driver, co-driver or passenger during trial runs (excluding Test Drives) using a motorized vehicle or bicycle • Death or Disability caused by or arising from or in consequence of or contributed to Nuclear, Chemical or Biological attack/weapons, material by or arising from or in consequence of or contributed to by ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel (including any self-sustaining process of nuclear fission). • Any Insured Person committing or attempting to commit intentional self-Injury (except in an attempt to save human life) or suicide while mentally sound or suffering from Mental illness • From engaging in or participation in naval, military or air force operation. • Injury sustained whilst or as a result of participation as a professional in Hazardous or Adventure sports. Persons working in underground mines, explosives magazines, workers involved in electrical installation with high tension supply, Jockeys, Circus personnel, Persons engaged in activities like racing on wheels or horseback, big game hunting, Mountaineering, winter sports, skiing, ice hockey, hang gliding, river rafting, polo and persons engaged in occupations/activities of similar hazard are not covered. • Breach of Law: Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent. • Injury sustained whilst or as a result of active participation in any violent labour disturbance, riot or civil commotion or public disorder. • Injury sustained whilst on service or on duty with or undergoing training with any military or police force, or militia or paramilitary organisation, notwithstanding that the Injury occurred whilst the Insured Person was on leave or not in uniform. Exclusions for Hospital Daily Cash • We shall not make any payment for claims that falls under the Standard Exclusions as listed in Section 8.1 and Specific Exclusions as listed in Section 8.2 for benefits under Section 5.5- Hospital Daily Cash, unless otherwise specified in the Policy Schedule.	
7	Waiting Period • Time period during which specified diseases/treatments	Waiting period depends on selection of Optional Cover "Deferred Initial Health checkup / examination" and underwriting outcomes as per Underwriting Policy. If Yes (Medical and Lifestyle Information and Declaration at pre Policy Issuance with Health Check-Up / Examination post Policy Issuance),	Section 4.1, Section 8.1.1, Section 8.1.2 and Section 8.1.3

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	are not covered It is counted from the beginning of the policy coverage.	- Pre-existing disease waiting period – 3 years - Specific Disease / Procedure waiting period – 2 years 30-Day Waiting Period – 30 days If Health checkup / examination is done within 90 days of post policy issuance, following outcomes are possible, basis underwriting policy: - Pre-existing disease waiting period – 3 / 2 / 1 / Nil year(s) - Specific Disease / Procedure waiting period – 2 / 1 / Nil year(s) 30-Day Waiting Period – 30 / Nil (days) OR If No (Health Check-Up exists in Advance or Health Check-Up/Examination to be done before Policy Issuance). Following outcomes are expected basis underwriting policy - Pre-existing disease waiting period – 3 / 2 / 1 / Nil year(s) - Specific Disease / Procedure waiting period – Nil unless specified in the Policy Schedule 30-Day Waiting Period – Nil unless specified in the Policy Schedule																															
8	Financial Limits of Coverage i. Sub-limit (It is a pre-defined limit and the insurance company will not pay any amount in excess of this limit) ii. Co-payment (It is a specified amount/percentage of the admissible claim amount to be paid by policyholder/insured). iii. Deductible (It is a specified amount: - up to which an insurance company will not pay any claim, and - which will be deducted from total claim amount (if claim amount is more than the specified amount) iv. Any other limit (as applicable)	Sub-limit - In-patient Hospitalization for Non-surgery or Non-surgical Procedure: INR 5 Lac / 10 Lac / 15 Lac / 20 Lac / 25 Lac / 50 Lac / 1 Crore - In-patient Hospitalization for Surrogate Mother: INR 5 Lac - In-patient Hospitalization for Oocyte Donor – INR 5 Lac Zero co-payment on all Base Benefits except for non-intimation copayment in the below scenario: <table><tr><th colspan="5">Applicability of non-intimation co-payment for planned admissions</th></tr><tr><th>Plan Options</th><th>Preferred Provider Network</th><th>Verified Provider Network</th><th>Other Provider Network</th><th>Non-Network Provider (case of Section 6 (b) and 5 (d))</th></tr><tr><td>Plan 1</td><td>Intimation not mandatory, but advised</td><td>10% non-intimation co-payment Intimation required 48 hours prior to admission</td><td>10% non-intimation co-payment Intimation required 48 hours prior to admission</td><td>10% non-intimation co-payment Intimation required 48 hours prior to admission</td></tr><tr><td>Plan 2</td><td>Intimation not mandatory, but advised</td><td>10% non-intimation co-payment Intimation required 48 hours prior to admission</td><td>10% non-intimation co-payment Intimation required 48 hours prior to admission</td><td>10% non-intimation co-payment Intimation required 48 hours prior to admission</td></tr><tr><td>Plus</td><td>Intimation not mandatory, but advised</td><td>Intimation not mandatory, but advised</td><td>10% non-intimation co-payment Intimation required 48 hours prior to admission</td><td>10% non-intimation co-payment Intimation required 48 hours prior to admission</td></tr><tr><td>Prime</td><td>Intimation not mandatory, but advised</td><td>Intimation not mandatory, but advised</td><td>10% non-intimation co-payment Intimation required 48 hours prior to admission</td><td>10% non-intimation co-payment Intimation required 48 hours prior to admission</td></tr></table>	Applicability of non-intimation co-payment for planned admissions					Plan Options	Preferred Provider Network	Verified Provider Network	Other Provider Network	Non-Network Provider (case of Section 6 (b) and 5 (d))	Plan 1	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 48 hours prior to admission	10% non-intimation co-payment Intimation required 48 hours prior to admission	10% non-intimation co-payment Intimation required 48 hours prior to admission	Plan 2	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 48 hours prior to admission	10% non-intimation co-payment Intimation required 48 hours prior to admission	10% non-intimation co-payment Intimation required 48 hours prior to admission	Plus	Intimation not mandatory, but advised	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 48 hours prior to admission	10% non-intimation co-payment Intimation required 48 hours prior to admission	Prime	Intimation not mandatory, but advised	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 48 hours prior to admission	10% non-intimation co-payment Intimation required 48 hours prior to admission	Section 4.12, Section 4.13, Section 3.11, Section 7
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9	Claims / Claims Procedure	For coverage within the Preferred Provider Network, and Verified Provider Network and Other Provider Network (if “Enhance Access to Provider Network” optional cover is opted or in-built with any Plan or in-built in the Plan) Cashless: - Intimation for planned and emergency admission may be required (refer Section 7) to avoid non-intimation co-payment - Hassle-free claim settlement process post discharge - TAT for claim settlement– 1 hour post discharge of the Insured Person by the healthcare provider Reimbursement: - For expenses pertaining to Pre-hospitalization, post-hospitalization which are covered by the policy or for expenses that have not been claimed for cashless settlement, reimbursement can be availed - TAT for claim settlement – TAT for claim settlement – 15 days from claim submission. Claim submission will be considered complete once all claim related documents are duly received For admission at Non-Network provider: You are requested to intimate the Claims team within 24 hours after hospitalisation for Emergency (Section 6(a) and 6(c)) and 48 hours before hospitalization for scenarios mentioned in Section 6(b) and 6(d) to avoid non-intimation copayment. Turn Around Time (TAT) for claims settlement at Non-Network provider: For Cashless Process: - TAT for pre-authorization of cashless facility: 1 hour from the time the last necessary document is received. - TAT for cashless final bill authorization: 3 hours from the time the last necessary document is received. (Note: In case of internal verification, the final stand will be confirmed within 24	Section 11																														

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		hours from the time the last necessary document is received by us) For Reimbursement Process: TAT for Claim settlement: 15 days from claim submission. Claim submission will be considered complete once all claim related documents are duly received. (Note: In case of internal verification, the final stand will be confirmed within 45 days from the time the last necessary document is received by us) We reserve the right to apply non-intimation co-pay as described in Row 8 of the Customer Information Sheet.	
10	Policy Servicing	Contact the customer support at +91 98210 34071 or support@narayanahealth.insurance for end-to-end policy servicing. Senior citizens may call at 1800 203 0234. For more details, visit us at: www.narayanahealth.insurance.	NA
11	Grievance / Complaints	Step 1: Call the Customer Support at +919821034071 or email us at support@narayanahealth.insurance. Senior citizens may call at 1800 203 0234 or email us at seniorcitizencare@narayanahealth.insurance for priority assistance. Step 2: If the issue is not resolved in Step 1 and the customer wants to make a further suggestion or a complaint, they can email us at grievance@narayanahealth.insurance Step 3: If the customer for some reason feels that we have not been able to resolve the issue even in Step 2 and customer wishes to raise a concern, please write to Grievance Redressal Officer at gro@narayanahealth.insurance Step 4: In case a complainant is not satisfied with the resolution from the above escalation authority, they may choose to log in their grievance at BIMA BHAROSA GRIEVANCE REDRESSAL PORTAL - bimabharosa.irdai.gov.in or they can approach the Insurance Ombudsman. The detailed addresses of all the Insurance Ombudsman can be found in the link below. The contact details of the Insurance Ombudsman offices have been provided as Annexure-5	Section 14.24
12	Things to Remember	Value Added Services: We may provide discretionary discounts to You on Out-patient expenses such as consultation, medicine, lab tests, diagnostic tests, etc. at our service providers listed on our website - www.narayanahealth.insurance. Free Look Cancellation: You may cancel the insurance policy if you do not want it, within 30 days from the beginning of the policy. Please contact the customer support at +91 98210 34071 or email us at support@narayanahealth.insurance for requesting Free Look Cancellation. Policy Renewal: Except on grounds of fraud, moral hazard or mis representation or non-co-operation, renewal of your policy shall not be denied, provided the policy is not withdrawn Migration and Portability: When your policy is due for renewal, you may migrate to another policy with us or port your policy to another insurer.	Section 9, Section 14.14, Section 14.15, Section 14.18, Section 14.20

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		Please contact the customer support at +91 98210 34071 or email us at support@narayanahealth.insurance for requesting Migration and Portability. For detailed guidelines on Portability, kindly refer the link https://irdai.gov.in/document-detail?documentId=5625747 Moratorium period: After completion of 60 continuous months under the policy no look back to be applied. This period of 60 months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. Change in Sum Insured: This policy has a single Sum Insured option. Hence, change of Sum Insured is not applicable. However, the Insured Person, may opt to change the sub-limit for Non-surgery or Non-surgical Procedures to options available in the Plan only during renewal.	
13	Your Obligations	Please disclose all pre-existing disease/s or condition/s or any other material information, as may be required, and fill in the complete details in the proposal form before buying a policy. Non-disclosure may affect the claim settlement.	NA

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Annexure 1– Schedule of Benefits

PRODUCT BENEFITS	Plan 1	Plan 2	Plus	Prime
Base Sum Insured (in INR) for hospitalization indemnity coverage	INR 5 Lac / 10 Lac / INR 1 Crore	INR 5 Lac / 1 Crore	INR 5 Lac / 10 Lac / 15 Lac / 20 Lac / 25 Lac / 50 Lac / 1 Crore	INR 5 Lac / 10 Lac / 15 Lac / 20 Lac / 25 Lac / 50 Lac / 1 Crore
Sub-limit for Non-Surgery or Non-surgical Procedure	INR 5 Lac / 10 Lac <i>This sub-limit option must be equal to or less than the Base Sum Insured</i>	INR 5 Lac	INR 5 Lac / 10 Lac / 15 Lac / 20 Lac / 25 Lac / 50 Lac / 1 Crore <i>This sub-limit option must be equal to or less than the Base Sum Insured</i>	INR 5 Lac / 10 Lac / 15 Lac / 20 Lac / 25 Lac / 50 Lac / 1 Crore <i>This sub-limit option must be equal to or less than the Base Sum Insured</i>
Policy Tenure	1 year / 2 years / 3 years (basis option selection)	1 year / 2 years / 3 years (basis option selection)	1 year / 2 years / 3 years (basis option selection)	1 year / 2 years / 3 years (basis option selection)
Geographical Coverage	India only, unless other specified otherwise for Specific Benefit(s)	India only, unless other specified otherwise for Specific Benefit(s)	India only, unless other specified otherwise for Specific Benefit(s)	India only, unless other specified otherwise for Specific Benefit(s)
Access to Provider Network	Preferred Provider Network+ Out of Network (only for admissible and eligible cases as per Section 6 of Policy Wording)	Preferred Provider Network+ Out of Network (only for admissible and eligible cases as per Section 6 of Policy Wording)	Preferred Provider Network + Verified Provider Network + Out of Network (only for admissible and eligible cases as per Section 6 of Policy Wording)	Preferred Provider Network+ Verified Provider Network + Other Provider Network + Out of Network (only for admissible and eligible cases as per Section 6 of Policy Wording)

BASE HOSPITALIZATION COVERAGE

PRODUCT BENEFITS	Plan 1	Plan 2	Plus	Prime
Room eligibility	General Ward	General Ward	Private Room: Covered At actuals: Optional for Preferred and Verified Provider Network	Private Room: Covered At actuals: Optional for Preferred and Verified Provider Network
Pre-hospitalization expenses	Covered for 60 days upto Sum Insured	Covered for 60 days upto Sum Insured	Covered for 60 days upto Sum Insured	Covered for 60 days upto Sum Insured
Post-hospitalization expenses	Covered for 90 days upto Sum Insured	Covered for 90 days upto Sum Insured	Covered for 180 days upto Sum Insured	Covered for 180 days upto Sum Insured
Day Care Treatment	Covered upto Sum Insured	Covered upto Sum Insured	Covered upto Sum Insured	Covered upto Sum Insured
Living Organ Donor Transplant	Covered upto Sum Insured	Covered upto Sum Insured	Covered upto Sum Insured	Covered upto Sum Insured

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Domestic Road Ambulance charges	Covered upto Sum Insured	Covered upto Sum Insured	Covered upto Sum Insured	Covered upto Sum Insured
Health check up	Covered upto Sum Insured	Covered upto Sum Insured	Covered upto Sum Insured	Covered upto Sum Insured
Alternative Treatment	Covered upto Sum Insured	Covered upto Sum Insured	Covered upto Sum Insured	Covered upto Sum Insured
Technological Advancements & Treatments	Covered upto Sum Insured	Covered upto Sum Insured	Covered upto Sum Insured	Covered upto Sum Insured
Aggregate Deductible	Nil / 25k / 50 k / 1 Lac	Nil	Nil / 25k / 50 k / 1L / 2L / 3L / 4L / 5L	Nil / 25k / 50 k / 1L / 2L / 3L / 4L / 5L

OPTIONAL COVERS (HOSPITALIZATION)

PRODUCT BENEFITS	Plan 1	Plan 2	Plus	Prime
Deferred Initial Health Check up	Covered Option 1: Yes (Medical and Lifestyle Information and Declaration at pre-Policy Issuance with Health Checkup / Examination post Policy Issuance within 90 days from Policy Commencement Date). Option 2: No (Health Checkup exists in Advance or Health Checkup/Examination to be done before Policy Issuance)	Covered Option 1: Yes (Medical and Lifestyle Information and Declaration at pre-Policy Issuance with Health Checkup / Examination post Policy Issuance within 90 days from Policy Commencement Date). Option 2: No (Health Checkup exists in Advance or Health Checkup/Examination to be done before Policy Issuance)	Covered Option 1: Yes (Medical and Lifestyle Information and Declaration at pre-Policy Issuance with Health Checkup / Examination post Policy Issuance within 90 days from Policy Commencement Date). Option 2: No (Health Checkup exists in Advance or Health Checkup/Examination to be done before Policy Issuance)	Covered Option 1: Yes (Medical and Lifestyle Information and Declaration at pre-Policy Issuance with Health Checkup / Examination post Policy Issuance within 90 days from Policy Commencement Date). Option 2: No (Health Checkup exists in Advance or Health Checkup/Examination to be done before Policy Issuance)
Domiciliary Hospitalization	Optional	Optional	Covered upto Sum Insured	Covered upto Sum Insured
Global Health Cover (Emergency Only)	Not covered	Not covered	Optional	Optional
Room Category Modification Option	Optional: Semi-Private Room, Private Room	Optional: Semi-Private Room, Private Room	Preferred & Verified Provider Network - Private room (Covered) Out of network - Private room (Covered) Preferred & Verified Provider Network -	Preferred, Verified Provider Network and Other Provider Network - Private room (Covered) Out of network - Private room (Covered) Preferred & Verified

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			(Optional for Modification to at actuals)	Provider Network - (Optional for Modification to at actuals)
Enhance Post-hospitalization expenses	Not covered	Not covered	Covered, upgrade from 90 days to 180 days	Covered, upgrade from 90 days to 180 days
Non-medical expenses cover	Covered at Preferred Provider Network and Out of Network (only for admissible cases) Optional to cover at Verified Provider Network and Other Provider Network, if optional cover "Enhance Access to Provider Network" is opted	Covered at Preferred Provider Network and Out of Network (only for admissible cases)	Covered at Preferred and Verified Provider Network and Out of Network (only for admissible cases)	Covered at Preferred and Verified Provider Network and Out of Network (only for admissible cases) Optional at Other Provider Network
Emergency Air Ambulance	Not covered	Not covered	Not covered	Covered
AccumulatePlus	Not covered	Not covered	Optional 25% / 50 % increment in Base Sum Insured at renewal till 100%	Optional 25% / 50 % increment in Base Sum Insured at renewal till 100%
Revive	Not covered	Not covered	Optional	Optional
Daily Deductible	Optional: Nil / INR 2000 per day for all cases of admission	Covered: INR 2000 per day for only Non-Surgery or Non-Surgical Cases	Not covered / Not applicable	Not covered / Not applicable
Enhance Access to Provider Network	Verified Provider Network – Optional Other Provider Network - Optional	Not covered	Verified Provider Network - Covered	Verified Provider Network – Covered Other Provider Network - Covered
In-patient hospitalization for Oocyte donor	Not covered	Not covered	Covered upto INR 5 Lacs	Covered upto INR 5 Lacs
In-patient hospitalization for Surrogate mother	Not covered	Not covered	Covered upto INR 5 Lacs	Covered upto INR 5 Lacs

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OPTIONAL BASE COVERS

PRODUCT BENEFITS	Plan 1	Plan 2	Plus	Prime
Personal Accident	Optional Covered upto Sum Insured: INR 5 / 10 / 15 / 20 Lacs Accidental Death (Yes / No) and Permanent Disablement (Yes / No), Options to select for Permanent Disablement: Benefit Table A / Benefit Table B / Benefit Table C / Benefit Table D	Optional Covered upto Sum Insured: INR 5 / 10 / 15 / 20 Lacs Accidental Death (Yes / No) and Permanent Disablement (Yes / No), Options to select for Permanent Disablement: Benefit Table A / Benefit Table B / Benefit Table C / Benefit Table D	Optional Covered upto Sum Insured: INR 5 / 10 / 15 / 20 Lacs Accidental Death (Yes / No) and Permanent Disablement (Yes / No), Options to select for Permanent Disablement: Benefit Table A / Benefit Table B / Benefit Table C / Benefit Table D	Optional Covered upto Sum Insured: INR 5 / 10 / 15 / 20 Lacs Accidental Death (Yes / No) and Permanent Disablement (Yes / No), Options to select for Permanent Disablement: Benefit Table A / Benefit Table B / Benefit Table C / Benefit Table D
Dependent Child Education Benefit	Optional: covered upto INR 1Lac for upto 2 dependent child each in case of Accidental Death or Total Permanent Disablement (Table B)	Optional: covered upto INR 1Lac for upto 2 dependent child each in case of Accidental Death or Total Permanent Disablement (Table B)	Optional: covered upto INR 1Lac for upto 2 dependent child each in case of Accidental Death or Total Permanent Disablement (Table B)	Optional: covered upto INR 1Lac for upto 2 dependent child each in case of Accidental Death or Total Permanent Disablement (Table B)
Repatriation of Mortal Remains	Optional: Covered upto Sum Insured INR 15,000	Optional: Covered upto Sum Insured INR 15,000	Optional: Covered upto Sum Insured INR 15,000	Optional: Covered upto Sum Insured INR 15,000
Hospital Daily Cash	Optional INR 500 / 1000 / 1500 / 2000 / 2500 / 5000 per day, for max of 7 / 10 / 15 / 30 / 60 / 180 days, with Time Deductible of 1 / 2 / 3 / 4 days, Franchise deductible of 1 / 2 / 3 / 4 days	Optional INR 500 / 1000 / 1500 / 2000 / 2500 / 5000 per day, for max of 7 / 10 / 15 / 30 / 60 / 180 days, with Time Deductible of 1 / 2 / 3 / 4 days, Franchise deductible of 1 / 2 / 3 / 4 days	Optional INR 500 / 1000 / 1500 / 2000 / 2500 / 5000 per day, for max of 7 / 10 / 15 / 30 / 60 / 180 days, with Time Deductible of 1 / 2 / 3 / 4 days, Franchise deductible of 1 / 2 / 3 / 4 days	Optional INR 500 / 1000 / 1500 / 2000 / 2500 / 5000 per day, for max of 7 / 10 / 15 / 30 / 60 / 180 days, with Time Deductible of 1 / 2 / 3 / 4 days, Franchise deductible of 1 / 2 / 3 / 4 days

NON-INTIMATION COPAYMENT STRUCTURE

Applicability of non-intimation co-payment for planned admissions				
Plan Options	Preferred Provider Network	Verified Provider Network	Other Provider Network	Non-Network Provider (case of Section 6 (b) and 5 (d))
Plan 1	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 48	10% non-intimation co-payment Intimation required 48	10% non-intimation co-payment Intimation required 48

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		hours prior to admission	hours prior to admission	hours prior to admission
Plan 2	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 48 hours prior to admission	10% non-intimation co-payment Intimation required 48 hours prior to admission	10% non-intimation co-payment Intimation required 48 hours prior to admission
Plus	Intimation not mandatory, but advised	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 48 hours prior to admission	10% non-intimation co-payment Intimation required 48 hours prior to admission
Prime	Intimation not mandatory, but advised	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 48 hours prior to admission	10% non-intimation co-payment Intimation required 48 hours prior to admission

Applicability of non-intimation co-payment for emergency admissions				
Plan Options	Preferred Provider Network	Verified Provider Network	Other Provider Network	Non-Network Provider (case of Section 6 (a) and 5 (c))
Plan 1	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 24 hours from the admission	10% non-intimation co-payment Intimation required 24 hours from the admission	10% non-intimation co-payment Intimation required 24 hours from the admission
Plan 2	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 24 hours from the admission	10% non-intimation co-payment Intimation required 24 hours from the admission	10% non-intimation co-payment Intimation required 24 hours from the admission
Plus	Intimation not mandatory, but advised	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 24 hours from the admission	10% non-intimation co-payment Intimation required 24 hours from the admission
Prime	Intimation not mandatory, but advised	Intimation not mandatory, but advised	10% non-intimation co-payment Intimation required 24 hours from the admission	10% non-intimation co-payment Intimation required 24 hours from the admission

VALUE ADDED SERVICES

Sn.	Services	Valid for all Plans
1	Value Added Services	We may provide discretionary discounts to You on Out-patient expenses such as consultation, medicine, lab tests, diagnostic tests, etc. at our service providers listed on our website - www.narayanahealth.insurance .

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Annexure 2A – List of Preferred Provider Network

PREFERRED PROVIDER NETWORK				
SN	Hospital Name	Hospital Address	Rohini ID	Location (City)
1	Narayana Multispeciality Hospital-Mysore	CAH/1, 3rd Phase, Devanur, 2nd Stage, R.S.Naidu Nagar, Mysuru, Karnataka 570019	8900080192119	MYSORE
2	Narayana Institute of Cardiac Sciences, Bangalore	#258/A, Narayana Hrudayalaya Health City, Bommasandra Industrial Area, Anekal Taluk	8900080190269	BANGALORE
3	Mazumdar Shaw Medical Centre, Bangalore	#258/A, Narayana Hrudayalaya Health City, Bommasandra Industrial Area, Anekal Taluk	8900080539952	BANGALORE
4	RL Jalappa Narayana Heart Centre, Kolar	SDUMC Campus, TAMAKA, KOLAR, KARNATAKA, INDIA - PIN - 563101	8900080191082	KOLAR
5	SDM Narayana Heart Centre, Dharwad	Sdm College of Medical Science & Hospital Manjushree Nagar, Sattur	8900080196834	DHARWAD
6	Sahyadri Narayana Multispeciality Hospital, Shimoga	Sahyadri Narayana Multispecialty Hospital, New Thirthahalli Road, Harakere, Shimoga - 577202	8900080344280	SHIMOGA
7	SS Narayana Heart Centre, Davangere	SS NARAYANA HEART CENTRE JNANASHANKAR, NH-4 BYPASS ROAD, DAVANGERE - 577055	8900080333604	DAVANGERE
8	Narayana Multispeciality Hospital, HSR Bangalore	Basanth Health Centre, No 1, 18th Main, Opposite HSR Club, Sector 3, HSR Layout, Bangalore	8900080327757	BANGALORE
9	Narayana Multispeciality Hospital, Ahmedabad	Opposite Rakhiyal Police Station, Rakhiyal Cross Road, Ahmedabad, Gujarat - 380023	8900080080003	AHMEDABAD
10	NH-Mumbai SRCC	SRCC CHILDREN'S HOSPITAL (Managed by Narayana Health.), 1-A HAJI ALI PARK, K KHADYE MARG, MAHALAXMI, MUMBAI - 400034	8900080368392	MUMBAI
11	NH-Jaipur Health City, Jaipur	Narayana Multispeciality Hospital, Sector - 28, Rana Sanga Marg, Kumbha Marg, Pratap Nagar, Sanganer, Jaipur, Rajasthan 302033	8900080062566	JAIPUR
12	NH-Narayana Superspeciality Hospital, Gurugram	Plot 3201, Block -V, DLF phase -3 , Sector 24	8900080388185	GURGAON
13	Rabindranath Tagore International Institute of Cardiac Sciences, Kolkata	Premises No: 1489, Mukundapur Main Road, 124, Eastern Metropolitan Bypass, Mukundapur, Kolkata, West Bengal 700099	8900080236394	KOLKATA
14	Brahmananda Narayana Multispeciality Hospital, Jamshedpur	Near Pardih Chowk, Tamolia, NH33, Jamshedpur 831012	8900080253421	JAMSHEDPUR
15	MMI Narayana Multispeciality Hospital, Raipur	Dhamtari Road, Lalpur, Raipur , PIN Code-492001	8900080188495	RAIPUR
16	Narayana Superspeciality Hospital, Guwahati	Tularam Bafna Civil Hospital Complex, Amingaon, Guwahati, Kamrup, Assam - 781031	8900080246737	GUWAHATI
17	Narayana Multispeciality Hospital, Barasat	78, Jessore Road (South), Barasat, 24 Pgs (N) - 700127	8900080236905	KOLKATA
18	Shri Mata Vaishno Devi Narayana Superspeciality Hospital, Jammu and Kashmir	Kakryal (Village & Post) Katra Tehsil Reasi District, Katra, Jammu and Kashmir 182320	8900080335080	JAMMU
19	Dharamshila Narayana Superspeciality Hospital, Delhi	Metro Station, Dharamshila marg, Vasundhara Enclave Near Ashok Nagar, Dallupura, New Delhi, Delhi 110096	8900080004702	DELHI
20	Narayana Superspeciality Hospital, Howrah	120, 1, Andul Rd, near Nabanna, Shibpur, Howrah, West Bengal 711103	8900080327269	HOWRAH

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21	Narayana Multispeciality Hospital, Howrah	Andul Rd, near Chunabati, Podara, Mourigram, Howrah, West Bengal 711109	8900080335332	HOWRAH
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Annexure 2B – List of Verified Provider Network

VERIFIED PROVIDER NETWORK				
SN	Hospital Name	Hospital Address	Rohini ID	Location (City)
1	Sparsh Hospital - Infantry Road	146,Prestige Opal, Infantry Road, Opp. Police Commissioner Office,Vasanth Nagar, Bengaluru, Karnataka 560001	8900080182080	BENGALURU
2	Sparsh Hospital - RR Nagar	8, Ideal Homes HBCS Layout, Javarandoddi, Rajarajeshwari Nagar, Bengaluru, Karnataka 560098	8900080449114	BENGALURU
3	Sparsh Hospital - Yelahanka	No. 1474/138 International Airport Road, Kogilu Cross, Yelahanka, Bengaluru, Karnataka 560064	8900080605039	BENGALURU
4	Sparsh Hospital - Yeshwanthpur	4/1, Tumkur Rd, Yeshwanthpur Industrial Area, Phase 1, Yeswanthpur, Bengaluru, Karnataka 560022	8900080347663	BENGALURU
5	Sparsh Hospital - Hennur	Chikkanna Layout, HBR Layout, Geddalhalli, Bengaluru Karnataka 560043	8900080691773	BENGALURU
6	Narayana Netralaya - Rajajinagar	121/C, Chord Rd, Near Iskcon Temple, 1st R Block, Rajajinagar, Bengaluru, Karnataka 560010	8900080183186	BENGALURU
7	Narayana Netralaya - Bommasandra	Narayana Health City, NarayanHrudayalaya Campus 258/A Bommasandra, Hosur Rd, Electronic City, Bengaluru, Karnataka 560099	8900080190276	BENGALURU
8	Narayana Netralaya - Indiranagar	#1/1, 1st main, Binnamangala, Defence Colony, 100 feet road, Indiranagar, Bangalore, Karnataka 560038	8900080184336	BENGALURU
9	Narayana Netralaya - Bennarghatta Road	No.63, Next to Royal Meenakshi Mall, Bannerghatta Road, Hulimavu, Bangalore, Karnataka 560 076	8900080337961	BENGALURU
10	Narayana Netralaya - WhiteField	Plot 3-C, Phase I, Doddenakkundi Industrial Area, Mahadevapura P.O., Next to Seetharamapalya metro station, Bengaluru, Karnataka 560048.	8900080684102	BENGALURU
11	Sakra World Hospital	Sy No 52/2 & 52/3,Devarabeesanahalli, Varthur Hobli, Opposite Intel, Outer Ring Road Bengaluru - 560103	8900080190443	BENGALURU
12	Gleneagles BGS Hospital	BGS Health & Education City, No.67, Uttarahalli Road, Kengeri Bangalore Rural , Karnataka	8900080187344	BENGALURU
13	Gleneagles Hospitals	5, 5, Richmond Rd, Shanthala Nagar, Ashok Nagar, Bengaluru, Karnataka 560025	8900080376625	BENGALURU
14	Fortis Hospital - BG Road	54, 9, Bannerghatta Rd, opposite IIM, Sahyadri Layout, Panduranga Nagar, Bengaluru, Karnataka 560076	8900080188587	BENGALURU
15	Fortis Hospital - Nagarbhavi	No 23, Building, 119, 80 Feet Main Road, Gurkrupa Layout, Stage 2, Naagarabhaavi, Bengaluru, Karnataka 560072	8900080354753	BENGALURU
16	Cloudnine Hospital - Jayanagar	Cloudnine, #1533, 9th Main, 3rd Block, Jayanagar, Bengaluru 560011	8900080345652	BENGALURU
17	Cloudnine Hospital - Old Airport Road	Cloudnine, #115, Kodihalli, Old Airport Road, Bengaluru - 560017	8900080181946	BENGALURU
18	Cloudnine Hospital - Malleshwaram	Cloudnine, # 47/1, 17th Cross, 11th Main, Malleshwaram, Bengaluru - 560055	8900080187047	BENGALURU
19	Cloudnine Hospital - Whitefield	Cloudnine, 2nd Floor, Plot # 11, Nagarjuna Sai Signet, Whitefield main road, Bengaluru - 560048	8900080333024	BENGALURU
20	Cloudnine Hospital - Bellandur	Cloudnine, No. 1/79/4, Bellandur Village, Varthur Hobli, Bengaluru East Taluk, Bengaluru 560103	8900080345645	BENGALURU
21	Cloudnine Hospital - HRBR Layout	Cloudnine, 636/1, Outer Ring Road, Horamavu Village, K.R.Puram Hobli, Bangalore 560043	8900080397392	BENGALURU

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22	Cloudnine Hospital - Kanakapura Road	Cloudnine # 776 and 767, Narayana Nagar, 1st Block, Doddakallasandra Village, Kanakapura Road, Bengaluru - 560062	8900080478312	BENGALURU
23	Cloudnine Hospital - Sahakarnagar	Cloudnine 2667/1/2501/1, Sahakarnagar Ward, 07, Kodigehalli Main Rd, Bengaluru, Karnataka 560092	8900080512795	BENGALURU
24	Cloudnine Hospital - Electronic City	Cloudnine No. 3, Opp. Puma Showroom, Doddathoguru Village Electronic City Phase 1, Neeladri Road, South, Taluk, Bengaluru, Karnataka 560100	8900080512825	BENGALURU
25	Even Hospitals	29/2, Race Course Rd, Madhava Nagar, Gandhi Nagar, Bengaluru, Karnataka 560001	8900080699236	BENGALURU
26	Vydehi Hospital	#82, Nallurahalli Main Rd, near BMTC 18th Depot, Vijayanagar, Nallurhalli, Whitefield, Bengaluru, Karnataka 560066	8900080187719	BENGALURU

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Annexure 2C – List of Other Provider Network

OTHER PROVIDER NETWORK

The Other Provider Network list is available on our website www.narayanahealth.insurance and updated from time-to-time.

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Annexure 3 – List of Day Care Treatments

SNO.	LIST OF DAY-CARE TREATMENTS
	ENT
1	STAPEDOTOMY
2	MYRINGOPLASTY (TYPE I TYMPANOPLASTY)
3	REVISION STAPEDECTOMY
4	LABYRINTHECTOMY FOR SEVERE VERTIGO
5	STAPEDECTOMY UNDER GA
6	OSSICULOPLASTY
7	MYRINGOTOMY WITH GROMMET INSERTION
8	TYMPANOPLASTY (TYPE III)
9	STAPEDECTOMY UNDER LA
10	REVISION OF THE FENESTRATION OF THE INNER EAR.
11	TYMPANOPLASTY (TYPE IV)
12	ENDOLYMPHATIC SAC SURGERY FOR MENIERE'S DISEASE
13	TURBINECTOMY
14	REMOVAL OF TYMPANIC DRAIN UNDER LA
15	ENDOSCOPIC STAPEDECTOMY
16	FENESTRATION OF THE INNER EAR
17	INCISION AND DRAINAGE OF PERICHONDritis
18	SEPTOPLASTY
19	VESTIBULAR NERVE SECTION
20	THYROPLASTY TYPE I
21	TYMPANOPLASTY (TYPE II)
22	REDUCTION OF FRACTURE OF NASAL BONE
23	EXCISION AND DESTRUCTION OF LINGUAL TONSILS
24	CONCHOPLASTY
25	THYROPLASTY TYPE II
26	TRACHEOSTOMY
27	EXCISION OF ANGIOMA SEPTUM
28	TURBINOPLASTY
29	INCISION & DRAINAGE OF RETRO PHARYNGEAL ABSCESS
30	UVULO PALATO PHARYNGO PLASTY
31	PALATOPLASTY
32	TONSILLECTOMY WITHOUT ADENOIDECTOMY
33	ADENOIDECTOMY WITH GROMMET INSERTION
34	ADENOIDECTOMY WITHOUT GROMMET INSERTION
35	VOCAL CORD LATERALISATION PROCEDURE
36	INCISION & DRAINAGE OF PARA PHARYNGEAL ABSCESS
37	TRANSORAL INCISION AND DRAINAGE OF A PHARYNGEAL ABSCESS
38	TONSILLECTOMY WITH ADENOIDECTOMY

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39	TRACHEOPLASTY
40	RECONSTRUCTION OF THE MIDDLE EAR
41	MASTOIDECTOMY
42	EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE NOSE
43	INCISION (OPENING) AND DESTRUCTION (ELIMINATION) OF THE INNER EAR
44	INCISION OF THE MASTOID PROCESS AND MIDDLE EAR
45	NASAL SINUS ASPIRATION
46	OTHER MICROSURGICAL OPERATIONS ON THE MIDDLE EAR
47	OTHER OPERATIONS ON THE AUDITORY OSSICLES
48	PLASTIC SURGERY TO THE FLOOR OF THE MOUTH
49	INCISION OF THE HARD AND SOFT PALATE
50	EXTERNAL INCISION AND DRAINAGE IN THE REGION OF THE MOUTH, JAW AND FACE
51	OTHER OPERATIONS ON THE SALIVARY GLANDS AND SALIVARY DUCTS
	OPHTHALMOLOGY
52	INCISION OF TEAR GLANDS
53	OTHER OPERATION ON THE TEAR DUCTS
54	INCISION OF DISEASED EYELIDS
55	EXCISION AND DESTRUCTION OF THE DISEASED TISSUE OF THE EYELID
56	REMOVAL OF FOREIGN BODY FROM THE LENS OF THE EYE.
57	CORRECTIVE SURGERY OF THE ENTROPION AND ECTROPION
58	OPERATIONS FOR PTERYGIUM
59	CORRECTIVE SURGERY OF BLEPHAROPTOSIS
60	REMOVAL OF FOREIGN BODY FROM CONJUNCTIVA
61	REMOVAL OF FOREIGN BODY FROM CORNEA
62	INCISION OF THE CORNEA
63	OTHER OPERATIONS ON THE CORNEA
64	OPERATION ON THE CANTHUS AND EPICANTHUS
65	REMOVAL OF FOREIGN BODY FROM THE ORBIT AND THE EYEBALL.
66	SURGERY FOR CATARACT
67	TREATMENT OF RETINAL LESION
68	REMOVAL OF FOREIGN BODY FROM THE POSTERIOR CHAMBER OF THE EYE
	ONCOLOGY
69	IV PUSH CHEMOTHERAPY
70	CONTINUOUS INFUSIONAL CHEMOTHERAPY
71	INFUSIONAL CHEMOTHERAPY
72	CCRT-CONCURRENT CHEMO + RT
73	SRS- STEREOTACTIC RADIOSURGERY
74	TBI- TOTAL BODY RADIOTHERAPY
75	ADJUVANT RADIOTHERAPY
76	RADICAL CHEMOTHERAPY
77	NEOADJUVANT RADIOTHERAPY

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78	PALLIATIVE RADIOTHERAPY
79	RADICAL RADIOTHERAPY
80	PALLIATIVE CHEMOTHERAPY
81	NEOADJUVANT CHEMOTHERAPY
82	ADJUVANT CHEMOTHERAPY
83	INDUCTION CHEMOTHERAPY
84	CONSOLIDATION CHEMOTHERAPY
85	MAINTENANCE CHEMOTHERAPY
	UROLOGY
86	AV FISTULA
87	URSL WITH STENTING
88	URSL WITH LITHOTRIPSY
89	ESWL
90	HAEMODIALYSIS
91	CYSTOSCOPY AND REMOVAL OF POLYP
92	EXCISION OF URETHRAL DIVERTICULUM
93	REMOVAL OF URETHRAL STONE
94	URETER ENDOSCOPY AND TREATMENT
95	SURGERY FOR PELVI-URETERIC JUNCTION OBSTRUCTION
96	INJURY PREPUCE- CIRCUMCISION
97	FRENULAR TEAR REPAIR
98	MEATOTOMY FOR MEATAL STENOSIS
99	SURGERY FOR FOURNIER'S GANGRENE SCROTUM
100	SURGERY FILARIAL SCROTUM
101	SURGERY FOR WATERING CAN PERINEUM
102	REPAIR OF PENILE TORSION
103	DRAINAGE OF PROSTATE ABSCESS
104	CYSTOSCOPY AND REMOVAL OF FB
105	TRANSURETHRAL EXCISION AND DESTRUCTION OF PROSTATE TISSUE
106	TRANSURETHRAL AND PERCUTANEOUS DESTRUCTION OF PROSTATE TISSUE
107	OPEN SURGICAL EXCISION AND DESTRUCTION OF PROSTATE TISSUE
108	RADICAL PROSTATOVESICULECTOMY
109	OTHER EXCISION AND DESTRUCTION OF PROSTATE TISSUE
110	INCISION OF THE PROSTATE
111	INCISION AND EXCISION OF PERIPROSTATIC TISSUE
112	OTHER OPERATIONS ON THE PROSTATE
	GYNAECOLOGY
113	HYSTEROSCOPIC REMOVAL OF MYOMA
114	D&C
115	HYSTEROSCOPIC RESECTION OF SEPTUM
116	HYSTEROSCOPIC ADHESIOLYSIS

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117	POLYPECTOMY ENDOMETRIUM
118	HYSTEROSCOPIC RESECTION OF FIBROID
119	LLETZ
120	CONIZATION
121	POLYPECTOMY CERVIX
122	HYSTEROSCOPIC RESECTION OF ENDOMETRIAL POLYP
123	VULVAL WART EXCISION
124	LAPAROSCOPIC PARAOVARIAN CYST EXCISION
125	UTERINE ARTERY EMBOLIZATION
126	BARTHOLIN CYST EXCISION
127	LAPAROSCOPIC CYSTECTOMY
128	ENDOMETRIAL ABLATION
129	VAGINAL WALL CYST EXCISION
130	VULVAL CYST EXCISION
131	LAPAROSCOPIC PARATUBAL CYST EXCISION
132	HYSTEROSCOPY, REMOVAL OF MYOMA
133	TURBT
134	LAPAROSCOPIC MYOMECTOMY
135	SURGERY FOR SUI
136	PELVIC FLOOR REPAIR (EXCLUDING FISTULA REPAIR)
137	LAPAROSCOPIC OOPHORECTOMY
138	INCISION OF THE OVARY
139	INSUFFLATION OF THE FALLOPIAN TUBES
140	DILATATION OF THE CERVICAL CANAL
141	CONISATION OF THE UTERINE CERVIX
142	HYSTEROTOMY
143	THERAPEUTIC CURETTAGE
144	CULDOTOMY
145	INCISION OF THE VAGINA
146	LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE VAGINA AND THE POUCH OF DOUGLAS
147	INCISION OF THE VULVA
	GENERAL SURGERY
148	INFECTED KELOID EXCISION
149	INCISION OF A PILONIDAL SINUS / ABSCESS
150	INFECTED SEBACEOUS CYST
151	INFECTED LIPOMA EXCISION
152	MAXIMAL ANAL DILATATION
153	SURGICAL TREATMENT OF HAEMORRHOIDS
154	LIVER ABSCESS- CATHETER DRAINAGE
155	FISSURE IN ANO- FISSURECTOMY
156	FIBROADENOMA BREAST EXCISION

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157	OESOPHAGEAL VARICES SCLEROTHERAPY
158	ERCP – PANCREATIC DUCT STONE REMOVAL
159	PERIANAL ABSCESS I&D
160	PERIANAL HEMATOMA EVACUATION
161	FISSURE IN ANO SPHINCTEROTOMY
162	UGI SCOPY AND POLYPECTOMY OESOPHAGUS
163	BREAST ABSCESS I& D
164	FEEDING GASTROSTOMY
165	ESOPHAGOSCOPY AND BIOPSY OF GROWTH OESOPHAGUS
166	ERCP – BILE DUCT STONE REMOVAL
167	ILEOSTOMY CLOSURE
168	POLYPECTOMY COLON
169	SPLenic ABSCESES LAPAROSCOPIC DRAINAGE
170	UGI SCOPY AND POLYPECTOMY STOMACH
171	RIGID ESOPHAGOSCOPY FOR FB REMOVAL
172	FEEDING JEJUNOSTOMY
173	COLOSTOMY
174	ILEOSTOMY
175	COLOSTOMY CLOSURE
176	SUBMANDIBULAR SALIVARY DUCT STONE REMOVAL
177	PANCREATIC PSEUDOCYSTS ENDOSCOPIC DRAINAGE
178	SUBCUTANEOUS MASTECTOMY
179	EXCISION OF RANULA UNDER GA
180	RIGID ESOPHAGOSCOPY FOR DILATION OF BENIGN STRICTURES
181	EVERSION OF SAC
182	1. A) UNILATERAL
183	B) BILATERAL
184	LORD'S PLICATION
185	JABOULAY'S PROCEDURE
186	SCROTOPLASTY
187	SURGICAL TREATMENT OF VARICOCELE
188	EPIDIDYMECTOMY
189	CIRCUMCISION FOR TRAUMA
190	MEATOPLASTY
191	INTERSPHINCTERIC ABSCESS INCISION AND DRAINAGE
192	PSOAS ABSCESS INCISION AND DRAINAGE
193	THYROID ABSCESS INCISION AND DRAINAGE
194	TIPS PROCEDURE FOR PORTAL HYPERTENSION
195	PAIR PROCEDURE OF HYDATID CYST LIVER
196	EXCISION OF CERVICAL RIB
197	SURGERY FOR FRACTURE PENIS

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198	PARASTOMAL HERNIA
199	REVISION COLOSTOMY
200	PROLAPSED COLOSTOMY- CORRECTION
201	LAPAROSCOPIC CARDIOMYOTOMY (HELLERS)
202	LAPAROSCOPIC PYLOROMYOTOMY (RAMSTEDT)
203	ORCHIECTOMY
204	INCISION OF THE BREAST
205	OPERATIONS ON THE NIPPLE
206	INCISION AND EXCISION OF TISSUE IN THE PERIANAL REGION
207	SURGICAL TREATMENT OF ANAL FISTULAS
208	DIVISION OF THE ANAL SPHINCTER (SPHINCTEROTOMY)
209	GLOSSECTOMY
210	RECONSTRUCTION OF THE TONGUE
211	INCISION, EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE TONGUE
212	OPERATIONS ON THE SEMINAL VESICLES
213	OTHER OPERATIONS ON THE SPERMATIC CORD, EPIDIDYMIS AND DUCTUS DEFERENS
214	LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE PENIS
215	OTHER OPERATIONS ON THE PENIS
216	OTHER EXCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
217	OTHER INCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
218	SIMPLE RESTORATION OF SURFACE CONTINUITY OF THE SKIN AND SUBCUTANEOUS TISSUES
219	FREE SKIN TRANSPLANTATION, DONOR SITE
220	FREE SKIN TRANSPLANTATION, RECIPIENT SITE
221	RECONSTRUCTION OF THE TESTIS
222	INCISION OF THE SCROTUM AND TUNICA VAGINALIS TESTIS
223	EXCISION IN THE AREA OF THE EPIDIDYMIS
224	REVISION OF SKIN PLASTY
225	OTHER RESTORATION AND RECONSTRUCTION OF THE SKIN AND SUBCUTANEOUS TISSUES
226	DESTRUCTION OF DISEASED TISSUE IN THE SKIN AND SUBCUTANEOUS TISSUES
	ORTHOPAEDICS
227	ARTHROSCOPIC REPAIR OF ACL TEAR KNEE
228	ARTHROSCOPIC REPAIR OF PCL TEAR KNEE
229	TENDON SHORTENING
230	ARTHROSCOPIC MENISCECTOMY – KNEE
231	TREATMENT OF CLAVICLE DISLOCATION
232	ARTHROSCOPIC MENISCUS REPAIR
233	HEMARTHROSIS KNEE- LAVAGE
234	ABSCESS KNEE JOINT DRAINAGE
235	REPAIR OF KNEE CAP TENDON
236	ORIF WITH K WIRE FIXATION- SMALL BONES
237	ORIF WITH PLATING- SMALL LONG BONES

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238	ARTHROTOMY HIP JOINT
239	SYME'S AMPUTATION
240	ARTHROPLASTY
241	PARTIAL REMOVAL OF RIB
242	TREATMENT OF SESAMOID BONE FRACTURE
243	AMPUTATION OF METACARPAL BONE
244	REPAIR / GRAFT OF FOOT TENDON
245	REVISION/REMOVAL OF KNEE CAP
246	REMOVE/GRAFT LEG BONE LESION
247	REPAIR/GRAFT ACHILLES TENDON
248	BIOPSY ELBOW JOINT LINING
249	BIOPSY FINGER JOINT LINING
250	TENDON LENGTHENING
251	SURGERY OF BUNION
252	TENDON TRANSFER PROCEDURE
253	REMOVAL OF KNEE CAP BURSA
254	TREATMENT OF FRACTURE OF ULNA
255	TREATMENT OF SCAPULA FRACTURE
256	REMOVAL OF TUMOR OF ARM/ ELBOW UNDER RA/GA
257	REPAIR OF RUPTURED TENDON
258	REVISION OF NECK MUSCLE (TORTICOLLIS RELEASE)
259	TREATMENT FRACTURE OF RADIUS & ULNA
260	INCISION ON BONE, SEPTIC AND ASEPTIC
261	CLOSED REDUCTION ON FRACTURE, LUXATION OR EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
262	REDUCTION OF DISLOCATION UNDER GA
	PAEDIATRIC SURGERY
263	VAGINOPLASTY
264	DILATATION OF ACCIDENTAL CAUSTIC STRICTURE OESOPHAGEAL
265	PRESACRAL TERATOMAS EXCISION
266	REMOVAL OF VESICAL STONE
267	EXCISION SIGMOID POLYP
268	STERNOMASTOID TENOTOMY
269	HIGH ORCHIDECTOMY FOR TESTIS TUMORS
270	EXCISION OF CERVICAL TERATOMA
271	RECTAL-MYOMECTOMY
272	RECTAL PROLAPSE (DELORME'S PROCEDURE)
273	ORCHIDOPEXY FOR UNDESCENDED TESTIS
274	DETORSION OF TORSION TESTIS
275	LAP. ABDOMINAL EXPLORATION IN CRYPTORCHIDISM
276	EUA + BIOPSY MULTIPLE FISTULA IN ANO
277	EXCISION OF FISTULA-IN-ANO

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	OTHERS
278	CORONARY ANGIOGRAPHY
279	ULTRASOUND GUIDED ASPIRATIONS
280	CHEMOSURGERY TO THE SKIN

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Annexure 4

LIST I – Non-Medical expenses that are not covered by the Policy, unless optional cover “Non-Medical Expenses Cover” is opted or in-built into the Plan offered at specified Network Provider.

S No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER

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37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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LIST II – Items that are to be subsumed into Room Charges

S No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMER CHARGES

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LIST III – Items that are to be subsumed into Procedure Charges

S No	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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LIST IV – Items that are to be subsumed into costs of treatment

S No	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER& STRIPS
18	URINE BAG

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Annexure 5 – Health checkup defined package

S No.	Test name
1	VITALS, BMI
2	CBC
3	ESR
4	RENAL PACKAGE
5	THYROID PROFILE (TSH, T4)
6	HBA1C
7	RANDOM BLOOD SUGAR
8	LIPID PROFILE INCLUDING SERUM APOLIPOPROTEIN A & B
9	ROUTINE URINE ANALYSIS
10	URINE MICRO ALBUMIN LEVELS
11	LIVER FUNCTION TESTS
12	ECG
13	ECHO
14	USG ABDOMEN PELVIS
15	CHEST X-RAY
16	PSA TEST (MALES > 45Y)
17	ORAL CAVITY CHECK-UP (FOR PRE-CANCEROUS LESIONS)
18	EYE CHECK-UP (LENS)
19	PHYSICIAN CONSULTATION

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Annexure 7 – Health checkup provider

The Health checkup provider list is available on our website www.narayanahealth.insurance and updated from time-to-time.

Annexure 8 – List of Insurance Ombudsman

AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in JURISDICTION: Gujarat, Dadra & Nagar Haveli, Daman and Diu.	BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in JURISDICTION: Karnataka.
BHOPAL Office of the Insurance Ombudsman, 1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in JURISDICTION: Madhya Pradesh, Chattisgarh.	BHUBANESWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in JURISDICTION: Odisha.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in JURISDICTION: Punjab, Haryana (excluding Gurugram, Faridabad, Sonapat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.	CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in JURISDICTION: Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in JURISDICTION: Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh.	ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in JURISDICTION: Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in JURISDICTION: Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in JURISDICTION: Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in JURISDICTION: Rajasthan.	KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, Kolkata - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.kolkata@cioins.co.in JURISDICTION: West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in JURISDICTION: Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorakhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in JURISDICTION: Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).

Narayana Health Insurance Limited | CIN : U65120KA2023PLC174002 | IRDAI Reg. No. :166

Website: www.narayanahealth.insurance | **E-Mail:** support@narayanahealth.insurance | **Phone:** +91 9821034071

Product Name: Narayana Aditi | **UIN:** NHIHLIP26044V052526

Registered Office: No. 258/A, Bommasandra Industrial Area, Anekal Taluk, Bangalore - 560099, Karnataka, India

Corporate Office: No. 261/A, Bommasandra Industrial Area, Anekal Taluk, Bangalore - 560099, Karnataka, India

Annexure 9 – Premium Illustration

Narayana Aditi - Prime Plan						
Policy Tenure - 1 Year						
Age of the Members	Coverage opted on individual/Multi individual basis covering each member of the family separately (at a single point in time)			Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)		
	Base Sum Insured of INR 1 Crore					
	Premium (INR)	GST @ 0% (INR)	Premium with GST (INR)	Premium (INR)	GST @ 0% (INR)	Premium with GST (INR)
45 (Male)	14,011	0	14,011	23,744	0	23,744
39 (Female)	9,492	0	9,492			
9 (Child 1)	5,763	0	5,763			
5 (Child 2)	5,763	0	5,763			
Total	35,028	0	35,028			
	Premium (with GST) for all members of the family is INR 35,028 when each member is covered separately for a Base Sum Insured of INR 1 Crore with sub-limit of INR 5 Lacs for Non-Surgery or Non-Surgical Procedures			Premium (with GST) when the whole family is covered on family floater basis is INR 23,744 for floater Sum Insured of INR 1 Crore with sub-limit of INR 5 Lacs for Non-Surgery or Non-Surgical Procedures		
Note:	Premiums shown are excluding stamp duty charges					

Narayana Aditi - Plus Plan							
Policy Tenure - 1 Year							
Age of the Members	Coverage opted on individual/Multi individual basis covering each member of the family separately (at a single point in time)			Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Base Sum Insured of INR 1 Crore With sub-limit of INR 5 Lacs for Non-Surgery or Non-Surgical Procedures						
	Premium (INR)	GST @ 0% (INR)	Premium with GST (INR)	Premium (INR)	GST @ 0% (INR)	Premium with GST (INR)	
	45 (Male)	12,627	0	12,627	21,414	0	21,414
	39 (Female)	8,571	0	8,571			
	9 (Child 1)	5,172	0	5,172			
	5 (Child 2)	5,172	0	5,172			
Total	31,543	0	31,543				
	Premium (with GST) for all members of the family is INR 31,543 when each member is covered separately for a Base Sum Insured of INR 1 Crore with sub-limit of INR 5 Lacs for Non-Surgery or Non-Surgical Procedures			Premium (with GST) when the whole family is covered on family floater basis is INR 21,414 for floater Sum Insured of INR 1 Crore with sub-limit of INR 5 Lacs for Non-Surgery or Non-Surgical Procedures			
Note:	Premiums shown are excluding stamp duty charges						

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NARAYANA ADITI PROSPECTUS

Version 5.0



Narayana Aditi - Plan 2						
Policy Tenure - 1 Year						
Age of the Members	Coverage opted on individual/Multi individual basis covering each member of the family separately (at a single point in time)			Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)		
	Base Sum Insured of INR 1 Crore With sub-limit of INR 5 Lacs for Non-Surgery or Non-Surgical Procedures					
	Premium (INR)	GST @ 0% (INR)	Premium with GST (INR)	Premium (INR)	GST @ 0% (INR)	Premium with GST (INR)
45	6,746	0	6,746	11,955	0	11,955
39	4,966	0	4,966			
9	2,999	0	2,999			
5	2,999	0	2,999			
Total	17,710	0	17,710			
	Premium (with GST) for all members of the family is INR 17,710 when each member is covered separately for a Base Sum Insured of INR 1 Crore with sub-limit of INR 5 Lacs for Non-Surgery or Non-Surgical Procedures			Premium (with GST) when the whole family is covered on family floater basis is INR 11,955 for floater Sum Insured of INR 1 Crore with sub-limit of INR 5 Lacs for Non-Surgery or Non-Surgical Procedures		
Note:	Premiums shown are excluding stamp duty charges					

Narayana Aditi - Plan 1						
Policy Tenure - 1 Year						
Age of the Members	Coverage opted on individual/Multi individual basis covering each member of the family separately (at a single point in time)			Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)		
	Base Sum Insured of INR 1 Crore With sub-limit of INR 5 Lacs for Non-Surgery or Non-Surgical Procedures					
	Premium (INR)	GST @ 0% (INR)	Premium with GST (INR)	Premium (INR)	GST @ 0% (INR)	Premium with GST (INR)
45	6,610	0	6,610	11,711	0	11,711
39	4,866	0	4,866			
9	2,929	0	2,929			
5	2,929	0	2,929			
Total	17,334	0	17,334			
	Premium (with GST) for all members of the family is INR 17,334 when each member is covered separately for a Base Sum Insured of INR 1 Crore with sub-limit of INR 5 Lacs for Non-Surgery or Non-Surgical Procedures			Premium (with GST) when the whole family is covered on family floater basis is INR 11,711 for floater Sum Insured of INR 1 Crore with sub-limit of INR 5 Lacs for Non-Surgery or Non-Surgical Procedures		
Note:	Premiums shown are excluding stamp duty charges					

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