National Young India Mediclaim Plus Policy

PROSPECTUS

1.1 PRODUCT

National Young India Mediclaim Plus Policy is an Indemnity Health Insurance Policy and can be issued on Individual or Floater basis. The Policy covers expenses incurred due to Hospitalisation for In-Patient Care (allopathy and AYUSH) or Day Care Treatment which has been Reasonably and Customarily incurred for treatment of an Illness contracted/Injury sustained during the Policy Period. The Policy provides for Pre Hospitalisation (45 days) and Post Hospitalisation (60 days) expenses, any Day Care Procedures, Ambulance Charges, Morbid Obesity Treatment, Correction of Refractive Error, Maternity and Infertility Cover, Reinstatement of Basic Sum Insured and Domestic Travel, if applicable as per terms. Additionally Optional Cover is also available.
Any amount admissible under the Policy in respect of claims shall be subject to the sub limits contained herein as well as shown in the Table of Benefits.

1.2 COVERAGE

1.2.1 In-patient Treatment

The Company shall indemnify the Medical Expenses incurred for all Hospitalisation(s) covered under the Policy, subject to the Sub Limits applicable to broad heads as mentioned below:

i. Room Rent and Intensive Care Unit Charges (including diet charges, nursing care by qualified nurse, RMO charges, administration charges for IV fluids/blood transfusion/injection), subject to limits
ii. Medical Practitioner(s) fees
iii. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances
iv. Medicines and drugs
v. Diagnostic procedures
vi. Prosthetics and other devices or equipment if implanted internally during a surgical procedure.
vii. Dental Treatment, necessitated due to an injury
viii. Plastic surgery, necessitated due to disease or injury
ix. Hormone replacement therapy, if medically necessary
x. Vitamins and tonics, forming part of treatment for disease/injury as certified by the attending medical practitioner
xi. Circumcision, necessitated for treatment of a disease or injury

1.2.1.1 Limit for Room Charges and Intensive Care Unit Charges

Room Rent for base category single occupancy air-conditioned room available in the Hospital, shall be payable.
Intensive Care Unit Charges per day shall be payable up to the limit as shown in the Table of Benefits.

1.2.1.2 Limit for Cataract

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

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

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

Note:

1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Procedures.
2. In case of admission to a room of category higher than the aforesaid limit, the reimbursement/payment of Associated Medical Expenses incurred at the Hospital, shall be effected in the same proportion as the admissible Room Rent per day bears to the actual Room Rent per day. Proportionate deduction shall not apply if admitted to ICU.

Associated Medical Expenses shall include all related expenses except the following expenses,

a. Cost of pharmacy and consumables;
b. Cost of implants and medical devices
c. Cost of diagnostics

3. Sub limits as mentioned above, will not apply in case of treatment undergone in a **Preferred Provider Network (PPN)** for a listed procedure as per eligible package.
4. Preferred Provider Network list is dynamic in nature, and will be updated in the Company's website from time to time

1.2.2 Pre Hospitalisation

The Company shall indemnify the Medical Expenses incurred up to forty five (45) days immediately before the Insured Person is hospitalised, provided that:

i. such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii. the In-Patient Hospitalisation claim for such Hospitalisation is admissible by the Company

Pre hospitalisation shall be considered as part of the Hospitalisation claim.

1.2.3 Post Hospitalisation

The Company shall indemnify the Medical Expenses incurred up to sixty (60) days immediately after the Insured Person is discharged from Hospital, provided that:

i. such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii. the In-Patient Hospitalisation claim for such Hospitalisation is admissible by the Company

Post hospitalisation shall be considered as part of the Hospitalisation claim.

1.2.4 Day Care Procedure

The Company shall indemnify the Medical Expenses and pre and post hospitalisation expenses up to the Sum Insured, for any Day Care Procedures which require Hospitalisation for less than twenty four hours provided that

i. day care procedures/surgeries are undergone by an Insured Person in a Hospital/Day Care Centre (but not the outpatient department of a Hospital)
ii. any other surgeries/procedures which due to advancement of medical science require Hospitalisation for less than twenty four hours and for which prior approval from the Company/TPA is mandatory.

1.2.5 AYUSH Treatment

The Company shall indemnify Medical Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Period up to the limit of Sum Insured as specified in the Policy Schedule in any AYUSH Hospital.

1.2.6 Ambulance Charges

The Company shall indemnify the expenses incurred for transportation to the Hospital or from the Hospital to another Hospital or from the Hospital to diagnostic center and return to the Hospital during the same Hospitalisation, up to the limit as shown in the Table of Benefits, provided an In-patient Care claim has been admitted.

Air Ambulance Charges, shall also be payable up to the limit as shown in the Table of Benefits, provided requirement of an Air Ambulance has been prescribed by a Medical Practitioner and an In-patient Care claim has been admitted.

1.2.7 Maternity

The Company shall indemnify Maternity Expenses of Insured or Spouse only, as described below, and also Pre-Natal and Post-Natal Hospitalisation expenses per delivery, subject to the limit as shown in the Table of Benefits.

The New Born Baby shall be automatically covered from birth up to the Sum Inured available to the mother during the corresponding policy period, for up to 3 months including expenses for vaccination. Hospitalisation shall not be required for vaccination. On attaining 3 months of age, the New Born Baby shall be covered if specifically included in the policy mid-term and requisite premium paid to the Company.

Maternity Expenses of Surrogate Mother (as per Surrogacy Act 2021 and subsequent amendments) shall also be covered under the Maternity limit, provided the Insured or Spouse are not having any living children and have been diagnosed with Infertility.

Maternity Expenses means;

a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);

b) Expenses towards lawful medical termination of pregnancy during the Policy Period.

Note: Ectopic pregnancy is covered under 'In-patient Treatment', provided such pregnancy is established by medical reports.

Exclusions

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

1. Delivery or termination within a Waiting Period of twenty four (24) months. However, the Waiting Period may be waived only in the case of delivery, miscarriage or abortion induced by Accident.
2. Delivery or lawful medical termination of pregnancy after one admissible claim for delivery or termination during the lifetime of the Insured Person has been paid under the Policy
3. Insured Persons who are already having two or more living children
4. Ectopic pregnancy
5. Pre and post hospitalisation expenses, other than pre and post natal treatment.
6. Any Medical Expenses, other than traceable to Maternity, of the Surrogate Mother.

1.2.8 Infertility

The Company shall indemnify the Medical Expenses of the Insured and his spouse, if covered by the Policy, for treatment undergone as an In-Patient or as a Day Care Treatment, for procedures and/ or treatment of infertility, provided the Policy has been continuously in force for twenty four (24) months from the inception of the Policy or from the date of inclusion of the Insured Person, whichever is later. The Medical Expenses for either or both the Insured Person shall be subject to the limit as shown in the Table of Benefits.

Exclusions

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

1. Insured and insured persons above forty five (45) years of age and having at least one living child.
2. Diagnostic tests related to infertility
3. Reversing a tubal ligation or vasectomy
4. Preserving and storing sperms, eggs and embryos
5. Experimental infertility treatments

Conditions

1. Expenses for Assisted Reproductive Technology as per ART Act 2021 and subsequent amendments, shall be payable only if the Insured person has been unable to attain or sustain a successful pregnancy through reasonable, and medically necessary infertility treatment. No expenses of the Donor shall be payable under this Policy.
2. Maternity expenses of the Surrogate Mother, shall be payable under Maternity Section. Surrogacy related expenses (e.g. Fertilization, insemination etc.) shall also be covered under this Section under the available limit.
3. Maximum of one claim shall be admissible by the Policy during the lifetime of the Insured Person.
4. Any One Illness limit shall not apply.

Definitions for the purpose of the Section

1. **Donor** means an oocyte donor or sperm donor.
2. **Assisted Reproductive Technology** with its grammatical variations and cognate expressions, means **all techniques** that attempt to obtain a pregnancy by handling the sperm or the oocyte outside the human body and transferring the gamete or the embryo into the reproductive system of a woman;
3. **Embryo** means a fertilized egg where cell division has commenced/ under the process and has completed the pre-embryonic stage.
4. **Infertility** means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. However the one year period may be waived, provided a medical practitioner determines existence of a medical condition rendering conception impossible through unprotected sexual intercourse, including but not limited to congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments.

1.2.9 HIV/ AIDS Cover

The Company shall indemnify the Medical Expenses for In-patient Care, Pre-Hospitalisation expenses and Post-Hospitalisation expenses, related to following stages of HIV infection:

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

1.2.10 Mental Illness Cover

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

Exclusions

1. Any kind of Psychological counselling, cognitive/ family/ group/ behavior/ palliative therapy or other kinds of psychotherapy for which Hospitalisation is not necessary shall not be covered.
2. Any treatment of the following Mental Illnesses shall be covered after Waiting Period of 2 years:
   i. Depression (ICD - F32; F33)
   ii. Schizophrenia (ICD - F20; F21; F25)

1.2.10 Modern Treatment

The Company shall indemnify the following Medical Expenses for Modern Treatments, incurred as In-Patient Care or Day Care Procedure (wherever medically indicated), subject to coverage of each Modern Treatment and maximum amount admissible as mentioned below

Modern Treatment	**SI INR 5,00,000**	**SI INR 10,00,000**	**SI INR 15,00,000 & INR 25,00,000**	**Coverage**
UAE & HIFU	INR 1,25,000 per Hospitalisation	INR 1,25,000 per Hospitalisation	INR 1,50,000 per Hospitalisation	Limit is for component cost only
Balloon Sinuplasty	INR 75,000 per Hospitalisation	INR 75,000 per Hospitalisation	INR 1,00,000 per Hospitalisation	Limit is for Balloon cost only
Deep Brain Stimulation	INR 1,25,000 per Hospitalisation	INR 2,50,000 per Hospitalisation	INR 3,50,000 per Hospitalisation	Limit is for implants including batteries only
Oral Chemotherapy	INR 75,000 per Hospitalisation, and 50% of SI during the Policy Period	INR 75,000 per Hospitalisation, and 50% of SI during the Policy Period	INR 1,00,000 per Hospitalisation, and 50% of SI during the Policy Period	Only cost of medicines payable under this limit, other incidental charges like investigations and consultation charges not payable.
Immunotherapy	INR 1,25,000 per Hospitalisation, and 50% of SI during the Policy Period	INR 1,50,000 per Hospitalisation, and 50% of SI during the Policy Period	INR 2,50,000 per Hospitalisation, and 50% of SI during the Policy Period	Limit is for cost of injections only.
Intravitreal injections	INR 75,000 per Hospitalisation, and 50% of SI during the Policy Period	INR 75,000 per Hospitalisation, and 50% of SI during the Policy Period	INR 1,00,000 per Hospitalisation, and 50% of SI during the Policy Period	Limit is for complete treatment, including Pre & Post Hospitalization

Robotic Surgery	INR 1,25,000 per Hospitalisation	INR 2,00,000 per Hospitalisation	INR 3,00,000 per Hospitalisation	Limit is for robotic component only.
Stereotactic Radio surgeries	INR 1,25,000 per Hospitalisation	INR 2,50,000 per Hospitalisation	INR 3,50,000 per Hospitalisation	Limit is for radiation procedure.
Bronchial Thermoplasty	INR 1,00,000 per Hospitalisation	INR 1,00,000 per Hospitalisation	INR 2,00,000 per Hospitalisation	Limit is for complete treatment, including Pre & Post Hospitalization
Vaporization of the prostrate	INR 1,00,000 per Hospitalisation	INR 1,00,000 per Hospitalisation	INR 2,00,000 per Hospitalisation	Limit is for LASER component only.
IONM	INR 50,000 per Hospitalisation	INR 50,000 per Hospitalisation	INR 1,00,000 per Hospitalisation	Limit is for IONM procedure only.
Stem cell therapy	INR 1,25,000 per Hospitalisation	INR 2,50,000 per Hospitalisation	INR 3,50,000 per Hospitalisation	Limit is for complete treatment, including Pre & Post Hospitalization

Any expenses related to the above Modern Treatments other than the coverage as specified above, shall be admissible as per the terms and conditions of the Policy.

1.2.12 Morbid Obesity Treatment

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

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

3.1.13 Correction of Refractive Error

The Company shall indemnify the Medical Expenses for In-patient Care, Pre-Hospitalisation expenses and Post-Hospitalisation expenses, incurred for expenses related to the treatment for correction of eye sight due to refractive error equal to or more than 7.5 dioptres, subject to Waiting Period of two (02) years as per Section 4.2.f.iii.

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

Note: Aggregate of all the benefits are subject to the Sum Insured.

1.3 OTHER BENEFITS

1.3.1 Reinstatement of Basic Sum Insured

In the event of available Sum Insured being exhausted anytime during the Policy Year on account of Hospitalisation claim(s), the Company shall reinstate the exhausted Basic Sum Insured (i.e., excluding any CB) to be utilized in any subsequent Hospitalisation(s) during the same Policy Year, provided that

i. Reinstatement of Basic Sum Insured shall be effected only after the date of discharge from the Hospital for the Hospitalisation claim which resulted in exhaustion of the Sum Insured.
ii. Any Illness/ Injury for which a claim has been admitted or paid under the Policy prior to such reinstatement, shall not be considered under the Reinstated Basic Sum Insured
iii. In a policy issued on Individual Basis, Reinstated Basic Sum Insured shall be available in respect of the Insured Person whose Sum Insured is exhausted as specified above by the Insured Person. In a policy issued on Floater Basis, Reinstated Basic Sum Insured shall be available to all Insured Person(s) subject to exhaustion of Sum Insured as specified above by any or multiple Insured Person(s).
iv. Reinstatement shall be allowed only once during the Policy Year of the Policy Period for each Insured Person (Individual Basis)/ each Policy (Floater Basis).
v. Reinstated Basic Sum Insured, if not exhausted, will not be carried forward to next Policy Year or Policy Period on Renewal.
vi. Reinstated Basic SI shall not be applicable to 11 defined **Critical Illnesses (CIs)**, i.e., Cancer of Specified Severity, First Heart Attack of Specified Severity, Open Chest Coronary Artery Bypass Graft Surgery, Open Heart Replacement or Repair of Heart Valves, Coma of Specified Severity, Kidney Failure requiring Regular Dialysis, Stroke Resulting in Permanent Symptoms, Major Organ/Bone Marrow Transplant, Permanent Paralysis of Limbs, Motor Neuron Disease with Permanent Symptoms, Multiple Sclerosis with Persisting Symptoms.

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

Case I: Basic SI – ₹ 5L (Individual Basis), CB – ₹ 1L
Claim 1 (disease) – ₹ 3L
Balance SI – ₹ 6L (i.e., 5+1), Amount admissible – ₹ 3L

Case II: Basic SI – ₹ 5L (Individual Basis), CB – ₹ 1L
Claim 1 (RTA) – ₹ 10L
Balance SI – ₹ 6L (i.e., 5+1), Amount admissible – ₹ 10L

Payable – ₹ 3L, SI exhausted – No, SI remaining – ₹ 3L
Basic SI reinstated – **No**

Claim 2 (RTA) – ₹ 5L
SI remaining – ₹ 3L, Amount admissible – ₹ 5L
Payable – ₹ 3L, SI exhausted – Yes, SI remaining – ₹ 0
Basic SI reinstated – **Yes [₹ 5L, i.e., Basic SI only]**
(Reinstated SI will be available from next claim)

Claim 3 (disease) – ₹ 2L
Balance Reinstated SI – 5L Amount admissible – ₹ 2L
Reinstated SI remaining – ₹ 3L

Case III: Basic SI – ₹ 5L (Floater Basis), CB – ₹ 1L
Insured 1 Claim 1 (disease) – ₹ 3L
Balance SI – ₹ 6L (i.e., 5+1), Amount admissible – ₹ 3L
Payable – ₹ 3L, SI exhausted – No, SI remaining – ₹ 3L
Basic SI reinstated – **No**

Insured 2 Claim 1 (RTA) – ₹ 5L
SI remaining – ₹ 3L, Amount admissible – ₹ 5L
Payable – ₹ 3L, SI exhausted – Yes, SI remaining – ₹ 0
Basic SI reinstated – **Yes [₹ 5L, i.e., Basic SI only]**
(Reinstated SI will be available from next claim)

Insured 1 Claim 2 (disease) – ₹ 2L
Balance Reinstated SI – 5L Amount admissible – ₹ 2L
Reinstated SI remaining – ₹ 3L

Payable – ₹ 6L, SI exhausted – Yes, SI remaining – ₹ 0
Basic SI reinstated – **Yes [₹ 5L, i.e., Basic SI only]**
(Reinstated SI will be available from next claim)

Claim 2 (Critical Illness, CI) – ₹ 2L
Balance Reinstated SI – ₹ 5L, Amount not admissible, **since not applicable to 11 CIs**.

Claim 3 (disease) – ₹ 8L
Balance Reinstated SI – ₹ 5L, Amount admissible – ₹ 8L
Payable – ₹ 5L, Reinstated SI remaining – ₹ 0
SI reinstated – **No**
(Basic SI is reinstated only once during the Policy Period)

Case IV: Basic SI – ₹ 5L (Floater Basis), CB – ₹ 1L
Insured 1 Claim 1 (RTA) – ₹ 10L
Balance SI – ₹ 6L (i.e., 5+1), Amount admissible – ₹ 10L
Payable – ₹ 6L, SI exhausted – Yes, SI remaining – ₹ 0
Basic SI reinstated – **Yes [₹ 5L, i.e., Basic SI only]**
(Reinstated SI will be available from next claim)

Insured 2 Claim 1 (Critical Illness, CI) – ₹ 2L
Balance Reinstated SI – ₹ 5L, Amount not admissible, **since not applicable to 11 CIs**.

Insured 1 Claim 2 (disease) – ₹ 8L
Balance Reinstated SI – ₹ 5L, Amount admissible – ₹ 8L
Payable – ₹ 5L, Reinstated SI remaining – ₹ 0
SI reinstated – **No**
(Basic SI is reinstated only once during the Policy Period)

1.3.2 Personal Accident Cover

The Company shall pay the specified benefit(s) on occurrence of the event(s) as mentioned below to the Insured Persons, in addition to any other pay out under the Policy.

In a Policy issued on Individual Basis, the Personal Accident benefit shall apply to each Insured Person individually with the maximum liability of the Company being the individual Basic Sum Insured.

In a Policy issued on Floater Basis, the Personal Accident benefit shall apply to the Proposer only with the maximum liability of the Company being the floater Basic Sum Insured.

a) **Death**: 100% of Sum Insured shall be payable, on death of the Insured Person, due to an Injury sustained in an Accident during the Policy Period, provided that the Insured Person's death occurs within 12 months from the date of the Accident. Where claim payment has been made owing to disappearance of Insured Person following an Accident, if after the payment of accidental death claim, it is found that the Insured Person has survived the Accident, then the policyholder has to refund the payment back to the Company in consideration of the obligatory guarantee as provided during the claim.
b) **Permanent Total Disablement:** 100% of Sum Insured shall be payable, if an Insured Person suffers Permanent Total Disablement of the nature specified below, solely and directly due to an Accident during the Policy Period, provided that the Permanent Total Disablement occurs within 12 months from the date of the Accident:

a) Total and irrecoverable loss of sight of both eyes or
b) Physical separation or loss of use of both hands or feet or
c) Physical separation or loss of use of one hand and one foot or
d) loss of sight of one eye and Physical separation or loss of use of hand or foot
e) If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Insured Person from engaging in any employment or occupation of any description whatsoever.

c) **Permanent Partial Disablement:** Following percentage of Sum Insured shall be payable, if the Insured Person suffers Permanent Partial Disablement of the nature specified below solely and directly due to an Accident during the Policy Period provided that the Permanent Partial Disablement shall occur within 12 months of the date of the Accident.

Sl. No.	Loss Covered	Percentage of Sum Insured
1.	Loss of Use/ Physical Separation:	
	One entire hand	50%
	One entire foot	50%
	Loss of Sight of one eye	50%
	Loss of toes – all	20%
	Great both phalanges	5%
	Great – one phalanx	2%
	Other than great if more than one toe lost	1%
2.	Loss of Use of both ears	50%
3.	Loss of Use of one ear	20%
4.	Loss of four fingers and thumb of one hand	40%
5.	Loss of four fingers	35%

6.	Loss of thumb - both phalanges - one phalanx	 25% 10%
7.	Loss of Index finger - three phalanges two phalanges one phalanx	 10% 8% 4%
8.	Loss of middle finger – three phalanges two phalanges one phalanx	 6% 4% 2%
9.	Loss of ring finger - three phalanges two phalanges one phalanx	 5% 4% 2%
10.	Loss of little finger – three phalanges two phalanges one phalanx	 4% 3% 2%
11.	Loss of metacarpus - first or second (additional) third, fourth or fifth (additional)	 3% 2%
12	Any other permanent partial disablement	Percentage as assessed by the independent Medical Practitioner

Maximum amount payable in respect of multiple nature of disablements shall be restricted to Sum Insured and Cumulative Bonus.

Note:

a) The Basic Sum Insured, is applicable cumulatively for all the three covers specified under (a), (b) and (c) above i.e., there is a single Sum Insured for all the three covers namely, Accidental Death, Permanent Total Disability and Permanent Partial Disability.
b) If the Accident occurs during the Policy Period, benefits covered under (a), (b) and (c) above are payable, even if Death or Permanent Total Disablement or Permanent Partial Disablement or any combination thereof occurs after the completion of Policy Period, but within 12 months from the date of Accident.

Exclusions specific to this Section, in addition to any common Exclusions,

The Company shall not be liable to make any payments under this policy in respect of:

a) Any claim for death or disablement (whether of a permanent nature or of a temporary nature), directly or indirectly due to War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
b) Any claim for death, disablement (whether of a permanent nature or of a temporary nature)
    a. from intentional self-injury unless in self-defense or to save life, suicide or attempted suicide;
    b. whilst under the influence of intoxicating liquor or drugs or other intoxicants except where the Insured Person is not directly responsible for the injury / accident though under influence of intoxication.
    c. whilst engaging in aviation or ballooning, or whilst mounting into, or dismounting from or travelling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any Scheduled Airlines in the world.
    [Standard type of aircraft means any aircraft duly licensed to carry passengers (for hire or otherwise) by appropriate authority irrespective of whether such an aircraft is privately owned or chartered or operated by a regular airline or whether such an aircraft has a single engine or multiengine]
    d. arising or resulting from the Insured Person committing any breach of law with criminal intent.
c) Any claim for death, disablement (whether of a permanent nature or of a temporary nature), 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.
d) Any claim resulting or arising from or any consequential loss directly or indirectly caused by or contributed to or arising from:
    A. Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel or from any nuclear waste from combustion (including any self-sustaining process of nuclear fission) of nuclear fuel.
    B. Nuclear weapons material
    C. The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.
    D. Nuclear, chemical and biological terrorism
e) Any loss arising out of the Insured Person's actual or attempted commission of or wilful participation in an illegal act or any violation or attempted violation of the law.

1.3.3 Domestic Travel Cover

The Company will pay the Insured Person the Benefits as detailed in the Sections below provided the events described therein occurs during the Policy Period as mentioned in the Schedule, while the Insured person is on a Trip travelling as a fare paying passenger on any Common Carrier (other than a two wheeler) with valid ticket/ travel document.

Common Carrier for the purpose of this Policy shall mean any scheduled airline, scheduled railway, scheduled-motor transport, scheduled waterborne vessel (which shall include ocean going and / or coastal vessels) or contract carriage commercial vehicle operating under license issued by the appropriate authority for transportation of passengers for hire by issuing valid ticket/ travel

document. Common carrier does not include automobiles owned by the Insured Person, private vehicles and any two-wheeled motor vehicle.

Any journey shall only be considered as a Trip if it involves destination(s) outside the municipal limits of the Place of Residence of the Insured Person as mentioned in Schedule. The Trip shall start at the Place of Residence of the Insured Person and end, either on return to the Place of Residence or on expiry of the Trip Duration of 15 days or on expiry of the Policy, whichever is earlier. A Trip may include one or more destination(s).

All inter-city and intra-city travel during a Trip by Common Carriers at locations outside the municipal limits of the Place of Residence shall be covered under the Policy.

Local intra-city travel within the municipal limit at the Place of Residence will not be covered. However, only on following conditions intra-city travel within the municipal limit related to a Trip are covered:

a) While embarking on a Trip, travelling directly from the Place of Residence to the stand/ station/ depot of Common Carrier provided the Insured Person has a valid advance/ pre booked ticket for the Common Carrier.

b) While returning from a Trip, disembarking at the stand/ station/ depot of Common Carrier and travelling directly therefrom to the Place of Residence.

Each Benefit is subject to its own Sub Limits as mentioned below.

Section	Benefits	Sub Limits (in INR
1	Repatriation Of Mortal Remains	Up to INR 2,000
2	Trip Delay (applicable only for air travel) (beyond **12** hour)	Fixed benefit of INR 1000 per Trip
3	Trip cancellation & Interruption	Up to INR 1000 per Trip
4	Carrier Cancellation (applicable only for air travel)	Fixed benefit of INR 1000 per Trip
5	Loss Of Checked-in Baggage (applicable only for air travel)	Fixed benefit of INR 1000 per Trip
6	Compassionate Allowance	Fixed benefit of INR 1000 per Trip

Section- 1: Repatriation of Mortal Remains

Following Death due to Accident during a Trip, the Company shall pay for repatriation of mortal remains of the Insured Person from the place of death to the Insured's Place of Residence up to the limits mentioned in the Table of Benefits, provided the death of the Insured Person occurred in a location that is not the Place of Residence of the Insured Person and the place of death is at least 100 kilometers by road from the recorded Place of Residence. If it is not possible to repatriate the mortal remains to Place of Residence then the Company will pay for expenses incurred for the burial or cremation of the Insured in the place where the death has occurred subject to a maximum of the Sum Insured specified in the Table of Benefits.

Section-2. Trip Delay - beyond 12 hours (applicable only for Air Travel)

The Company shall pay the amount as specified in the Table of Benefits if an Insured Person's journey on scheduled commercial airline is delayed beyond the number of hours specified in the Table of Benefits of its scheduled departure time.

This Benefit will be payable provided that:

a) The Insured Person provides the Company a written proof from the Common Carrier of the length of the delay unless this proof is available directly from a reliable source in the public domain.
b) The delay is in excess of the Deductible from the time of scheduled departure of the Common Carrier.

Exclusions applicable to Section 2.

In addition to the General Exclusions, this section shall not cover

a) any delay due to a hazard which was made public or known to the Insured Person prior to the purchase of this Policy or prior to booking of flight ticket
b) any departure which is delayed as a result of the Insured or any other person who is arranged to travel with the Insured failing to check in correctly as required by the Common Carrier.

Section-3. Trip cancellation & Interruption

The Company shall compensate up to the amount as specified in the Table of Benefits to the Insured Person if the Trip is cancelled before departure or interrupted during the Trip, due to one of the circumstances specified below:

a) Any disruptions such as mass bandhs or widespread strikes which the Insured Person could not reasonably avoid or aware in time;

b) Pandemic & epidemic as declared by WHO or any appropriate government authorities occurring at and in the vicinity of any destination involved in the Insured's Trip.

c) Catastrophic events occurring at and in the vicinity of any destination involved in the Insured's Trip which shall mean the following:

i. Earthquake.
ii. Lighting, Storm, Tempest, Typhoon, Hurricane, Inundation, Subsidence
iii. Landslide and rockslide
iv. Avalanche
v. Floods resulting from unseasonal rains, storm or cyclone.
vi. Terrorism
vii. Tsunami
viii. Volcano Eruption.

d) In case of death or serious injury or sudden sickness of any Insured Person requiring at least 2 days of hospitalization, within 7 days before the date of departure for the covered Trip or during the Trip.

This Cover Benefit will be payable provided that:

a) The event giving rise to a claim under this Cover Benefit must be such as to reasonably cause a journey to be cancelled or interrupted;

b) The benefits will not exceed the cost of economy airfare by the most direct route, less any refunds paid or payable or the insured is entitled to.
c) The Company shall not be liable to reimburse any expenses under this Cover Benefit for any facts or matters of which the Insured Person was aware or should have been aware might result in the cancellation or interruption of the journey.
d) The Company will reimburse the unused and non-refundable portion of the pre-paid lodging cost and/or the ticket cancellation charges (up to the maximum amount specified in the schedule) if the Trip is cancelled or interrupted.
e) The booking should have been made in advance prior to the hospitalization.

In event of any of the contingencies covered, resulting in the interruption of necessitating cancellation of the Trip, immediate notice thereof shall be given by the Insured to the Company.

Section-4. Carrier Cancellation (applicable only for Air Travel)

The Company will pay the amount as specified in the Table of Benefits if the Insured Person's booked and confirmed journey is cancelled by the Common Carrier within 48 hours prior to the scheduled departure by the scheduled airline.

The Benefit will be payable provided that, the Insured Person provides the Company with a written proof from the Common Carrier of the cancellation of the journey unless this proof is available to the Company directly from a reliable source in the public domain. Any cancellation of the journey by the Insured Person is not payable under the policy.

Section-5: Loss of Checked-in Baggage (applicable only for Air travel)

If the Insured Person's Checked-In Baggage is lost by the scheduled commercial airline to which it was entrusted, then the Company will pay a fixed amount as specified in the Table of Benefits. The compensation shall be relating to the loss of baggage as a whole. Should the lost Checked-in Baggage be traced and delivered to the Insured, the Insured shall return to the Company the entire amount paid hereunder.

Terms and conditions applicable to Section 5.

a) In the event of loss of property whilst in the custody of the airline, a Property Irregularity Report (PIR) must be obtained from the airline immediately upon discovering the loss, which must be submitted to the Company in the event of a claim.
b) The baggage should be totally lost. No partial loss or damage shall become payable.
c) The Company's liability under this cover will be limited to the travel destinations specified in the main travel tickets and return trip back. All halts and destinations included in this main travel ticket will also be considered for payment under this cover.
d) The liability of the Company to make payment shall not arise until liability is admitted by the airline.
e) The Company is not liable for loss arising from any delay, detention or confiscation by customs officials, police or other public authorities;
f) If the lost or undelivered Checked-In Baggage or portion of it is subsequently traced and offered for delivery to the Insured Person, the Insured Person shall refund the amount paid by the Company under this Benefit in full irrespective of whether delivery of the Baggage is taken or not.

Section 6. Compassionate Allowance

In event of the Insured being Hospitalized in Intensive Care Unit (ICU) of a Hospital consequent upon any Accidental Injury sustained while on a Trip during the Period of Insurance, the Insurer shall pay the amount as specified in the Table of Benefits for any cost incurred by any one Family Member to travel to the place of hospitalization of the insured person and return.

The benefit is payable provided that

a. Hospitalization under Section 4. Hospitalization due to Accident has been accepted by the company.
b. The Insured Person is hospitalized at a distance of at least 100 kilometers by road from his Place of Residence.
c. Insured shall as far as possible seek for such special assistance from any one of his/ her relatives, either at the place of Hospitalization or any other nearest place
d. The company shall not accept more than one claim under this Cover Benefit in respect of the Insured Person following the same Accident.

For the purpose of this cover,

Air Travel means travel through aircraft or helicopter for the purpose of flying as a passenger

Catastrophe means an unexpected natural event such as an earthquake, tsunami, flood, inundation, storm, tempest, cyclone, volcanic eruption, landslide, rockslide disrupting travel.

Checked-In Baggage means the baggage entrusted by the Insured and accepted by a Scheduled Airline for transportation in the same mode of conveyance as the Insured Person travels and for which a baggage receipt is issued to the Insured.

Family consists of the self and any one or more of the family members as mentioned below:

a) Legally wedded spouse.
b) Parents and Parents-in-law.
c) All natural or legally adopted Children

Place of Residence means any city, town or village in which the Insured Person is currently residing in India and as specified in the Insured Person's corresponding address in the Policy Schedule.

Exclusions specific to this Section, in addition to any common Exclusions,

The Company shall not be liable to make any payments under this policy in respect of:

1. Any loss arising while travelling by a Common Carrier for local intra city conveyance while on a Trip.
2. Any loss arising out of the Insured Person's actual or attempted commission of or wilful participation in an criminal or illegal act or any violation or attempted violation of the law.
3. If the insured is aware of any circumstances that could reasonably be expected to give rise to a claim.

4. Liability arising out of suicide, attempted suicide or wilful self-inflicted injury or illness, anxiety, stress or depression, venereal disease except HIV/AIDS, alcoholism, drunkenness or the use/abuse of drugs.
5. Liability arising out of from the Insured person engaging in Air Travel unless he or she flies as a passenger on an aircraft properly licensed to carry passengers. For the purpose of this exclusion, Air Travel means being in or on, or boarding an aircraft for the purpose of flying therein or alighting there from following a flight.
6. Any claim relating to events occurring before the commencement of the Period of Insurance or after the completion of the Period of Insurance.
7. Claims increased by the Insured Person's own act or omission.
8. Liability arising out of accidents to the journey through two wheeled motorised vehicles.
9. Liability arising out of journey by the Insured Person through one's own motor vehicle.
10. Liability arising out of journey where the Insured Person is driving the Common Carrier.
11. Deliberate exposure to exceptional danger (except in an attempt to save human life).
12. Liability arising out of any loss or damage due to insured being under the influence of drugs, alcohol, or other intoxicants or hallucinogens unless properly prescribed by a Physician and taken as prescribed.
13. Participation in an actual or attempted felony, riot, crime, misdemeanour, or civil commotion.
14. Act of Terrorism by the Insured or which is abetted by the Insured in any manner.
15. Participation in any hazardous activities. **Hazardous Activities (or Adventure sports)** means any sport or activity, which is potentially dangerous to the Insured whether he is trained or not. Such sport/activity includes (but not limited to) stunt activities of any kind, adventure racing, base jumping, biathlon, big game hunting, black water rafting, BMX stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/ pot holing, cave tubing, rock climbing/ trekking/ mountaineering, cycle racing, cyclo cross, drag racing, endurance testing, hand gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, lugging, risky manual labor, marathon running, martial arts, micro – lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/ parapenting, piloting aircraft, polo, power lifting, power boat racing, quad biking, river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ timetrials, triathlon, water ski jumping, weight lifting or wrestling of any type

1.4 OPTIONAL COVER

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

1.4.1 Waiting period waiver of pre-existing Diabetes and/or Hypertension – Optional

The Company shall indemnify Medical Expenses incurred for treatment of pre-existing diabetes and/ or hypertension, from the inception of the Policy.

Waiting Period for any related complications to diabetes and/ or hypertension existing at the time of issuance of the Policy shall not be waived and not covered under this Optional Cover.

On completion of the Waiting Period, the Optional Cover and additional premium shall not apply.

1.5 GOOD HEALTH INCENTIVE

1.5.1 Cumulative Bonus

For each claim free Policy Year (i.e., no claims are reported), Cumulative Bonus allowed shall be an amount equal to 10% of the Basic Sum Insured (excluding CB) of the expiring Policy Year.

If a claim is made in any particular Policy Year, the CB accrued shall be reduced at the same rate at which it has accrued. However, Basic Sum Insured will be maintained and will not be reduced.

CB shall be accumulated and available on renewal. Maximum CB shall not exceed 40% of the Basic Sum Insured of the renewed Policy. Wherever, due to reduction in Basic Sum Insured on renewal, if the accumulated CB exceeds 40% of the reduced Basic Sum Insured, then CB shall be restricted to 40% of the reduced Basic Sum Insured.

Notes:

i. In case where the Policy is on Individual Basis, the CB shall be added and available individually to the Insured Person if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.
ii. In case where the Policy is on Floater Basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any Insured Person. CB shall reduce in case of claim from any of the Insured Persons.
iii. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
iv. 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 CB for each Insured Person under the expiring policy, and such expiring policy has been Renewed on a Floater Basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons.
v. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to 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 CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy
vi. If a claim is made in the expiring Policy Year, and is notified to the Company after the acceptance of Renewal premium any awarded CB shall be withdrawn.
vii. Claim under Personal Accident Cover or Domestic Travel Cover only, without any related Hospitalisation, shall not affect CB.

1.6 Hospitalisation Options

The Policy provides for Cashless Facility and/ or reimbursement of Hospitalisation expenses for treatment of Illness or Injury.

Cashless Facility is available only in Network Providers if TPA service is opted in the Policy.

2.1 Type of Policy

Policy can be issued on

i. Individual Basis (i.e., separate Basic Sum Insured and Cumulative Bonus shall apply on each Insured Person) or
ii. Floater Basis (i.e., common Basic Sum Insured and Cumulative Bonus shall apply on all Insured Persons)

2.2 Eligibility

i. Entry age of Proposer should be between eighteen (18) years and forty five (45) years.
ii. Maximum entry age of any family member is forty five (45) years.
iii. Minimum 2 Insured Persons shall be covered on Floater Basis.
iv. Children over the age of three (03) months may be covered for the first time, provided parent(s) is/are covered at the same time. Up to 3 children can be covered under the same Policy.
v. Family members allowed under same policy.
    a. Proposer
    b. Spouse
    c. Natural or legally adopted children, till their marriage
vi. Renewal terms are as per Section 2.9 below.
vii. Midterm inclusion of family members at pro-rata premium is allowed only in case of
    a. newborn between the age of three (03) months and six (06) months
    b. spouse within sixty (60) days of marriage

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

No other relation even within the eligible age band can be covered under the Policy. Age in completed years.

2.3 Policy Period

The Policy can only be issued for a period of 1 year (i.e., 12 calendar months or 1 Policy Year), 2 years (i.e., 24 calendar months or 2 Policy Years) or 3 years (i.e., 36 calendar months or 3 Policy Years), as opted by the Insured.

2.4 Basic Sum Insured (Basic SI)

The Policy is available with options of Basic SI of ₹ **5/ 10/ 15/ 25 L.**

2.4.1 Enhancement of Basic Sum Insured

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

2.5 Discounts

2.5.1 Discount for Direct Sale

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

2.5.2 Wellness Discount

Discount of 1% on renewal premium is allowed for opting for evidence based wellness activities in expiring policy (e.g., gym membership for 1 year, participation in marathon, swimathon, walkathon, etc.).

2.5.3 Long Term Discount

Discount of 3% on a 2-year policy and 6.25% on a 3-year policy, is allowed on total premium if opting for long term policy.

2.6 Tax Rebate

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

2.7 Completion of Proposal Form

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

2.8 Payment of Premium

i. Individual Basis, Premium for each individual shall depend on the Basic SI and completed age, as provided in the 'Rate Chart' for the opted Zone. Floater Basis, Premium for the family shall depend on the Basic SI and completed age of the senior most member, as provided in the 'Rate Chart' for the opted Zone.
ii. The proposer has the option of claims being serviced by TPA (in which case both Cashless Facility and Reimbursement Facility will be available) or the Company (in which case Cashless Facility shall not be available). If Cashless Facility is to be availed, the premium payable is inclusive of TPA charges. If Cashless Facility is required, the premium shall be selected from Rate Chart with TPA Charges, otherwise to be selected from Rate Chart without TPA charges.

iii. Base premium of the policy shall be total premium for all individuals, calculated as mentioned above.
iv. Discounts, if any, shall apply on the Individual/ total Base Premium (as specified).
v. For long term policy, total premium to be calculated as mentioned above, multiplied by no. of Policy Year to calculate Long Term Total Premium. Long Term Discount shall apply on the Long Term Total Premium.
vi. As opted in the Proposal Form for Annual Policies only, Insured have the option to either pay the premium annually, or in half yearly or quarterly instalment as per factors provided in Rate Chart.
vii. Full premium/ first instalment of premium shall be paid in full before the commencement of the Policy.
viii. Premium can be paid online for Renewals without break, provided there is no material change in the Policy.
ix. PAN details must be submitted by the Proposer.
x. In case PAN is not available, Form 60 or Form 61 as per Rule 114B of the Income-tax Rule, 1962 must be submitted.

2.9 Renewal of Policy

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

3 DEFINITIONS

Standard Definitions

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

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

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

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

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

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

3.5 Cashless Facility means a facility extended by the Company to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the Network Provider by the Company to the extent pre-authorization approved.

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

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

a) Internal Congenital Anomaly

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

b) External Congenital Anomaly

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

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

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

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

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

3.11 Day Care Treatment means medical treatment, and/or Surgical Procedure (as listed in Appendix I) which is:

i. undertaken under general or local anesthesia in a Hospital/Day Care Centre in less than twenty four (24) hrs because of technological advancement, and
ii. which would have otherwise required a Hospitalisation of more than twenty four (24) hours.

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

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

3.13 Hospital means any Institution established for In-Patient Care and Day Care Treatment of Illness/ Injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:

i. has qualified nursing staff under its employment round the clock;
ii. has at least ten (10)In-Patient beds, in those towns having a population of less than ten lacs and fifteen (15) inpatient beds in all other places;
iii. has qualified Medical Practitioner (s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out
v. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

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

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

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

i. **Acute Condition** means a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics

a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
b) it needs ongoing or long-term control or relief of symptoms
c) it requires rehabilitation for the patient or for the patient to be special trained to cope with it
d) it continues indefinitely
e) it recurs or is likely to recur

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

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

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

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

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

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

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

3.24 Medically Necessary Treatment means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which

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

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

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

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

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

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

3.30 Pre Existing Disease means any condition, ailment, injury or disease

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

3.31 Pre-hospitalisation Medical Expenses means Medical Expenses incurred during predefined number of days preceding the Hospitalisation of the Insured Person, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Company.

3.32 Post-hospitalisation Medical Expenses means Medical Expenses incurred during predefined number of days immediately after the Insured Person is discharged from the Hospital provided that:

i. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The inpatient Hospitalisation claim for such Hospitalisation is admissible by the Company.

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

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

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

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

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

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

Specific Definitions

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

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

3.41 Contract means Prospectus, Proposal, Policy, and the Policy Schedule. Any alteration with the mutual consent of the Insured Person and the Company can be made only by a duly signed and sealed endorsement on the Policy.

3.42 Critical Illnesses means Cancer of Specified Severity, First Heart Attack of Specified Severity, Open Chest Coronary Artery Bypass Graft Surgery, Open Heart Replacement or Repair of Heart Valves, Coma of Specified Severity, Kidney Failure requiring Regular Dialysis, Stroke Resulting in Permanent Symptoms, Major Organ/Bone Marrow Transplant, Permanent Paralysis of Limbs, Motor Neurone Disease with Permanent Symptoms, Multiple Sclerosis with Persisting Symptoms.

a) Cancer of Specified Severity

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

The following are excluded

i. All tumours which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non- invasive, including but not limited to:
Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
ii. Any non- melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0;
v. All Thyroid cancers histologically classified as T1N0M0 (TNM classification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3
vii. Non- invasive Papillary cancer of bladder histologically described as TaN0M0 (TNM Classification) or of a lesser classification;
viii. All Gastro-intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

b) Myocardial Infarction (First Heart Attack of Specified Severity)

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

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

The following are excluded

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

c) Open Chest Coronary Artery Bypass Graft Surgery (CABG)

The actual undergoing of Heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via sternotomy (cutting through breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

The following are excluded

Angioplasty and/or any other intra-arterial procedures.

d) Open Heart Replacement or Repair of Heart Valve

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

The following are excluded

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

e) Coma of Specified Severity

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

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

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

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

The following are excluded

Coma resulting directly from alcohol or drug abuse is excluded.

f) Kidney Failure requiring Regular Dialysis

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

g) Stroke Resulting in Permanent Symptoms

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

The following are excluded

i. Transient ischemic attacks (TIA)
ii. Traumatic injury of the brain
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

h) Major Organ/ Bone Marrow Transplant

The actual undergoing of a transplant of:

i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
ii. Human bone marrow using haematopoietic stem cells.

The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded

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

i) Permanent Paralysis of Limbs

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

j) Motor Neurone Disease with Permanent Symptoms

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

k) Multiple Sclerosis with Persisting Symptoms

The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following

i. Investigations including typical MRI findings, which unequivocally confirm the diagnosis to be multiple sclerosis and
ii. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months
iii. Neurological damage due to SLE is excluded.

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

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

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

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

3.47 Policy Period means period of one policy year / three policy years as mentioned in the schedule for which the Policy is issued.

3.48 Policy Year means a period of twelve months beginning from the date of commencement of the Policy Period and ending on the last day of such twelve month period. For the purpose of subsequent years, Policy Year shall mean a period of twelve months commencing from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Policy Period, as mentioned in the Schedule.

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

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

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

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

3.53 Sum Insured means the Basic Sum Insured specified in the Policy Schedule and the Cumulative Bonus (CB) accrued in respect of the Insured Person(s) as mentioned in the Schedule and represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year

3.54 Surrogacy means a practice whereby one woman bears and gives birth to a child for an intending couple with the intention of handing over such child to the intending couple after the birth.

3.55 Surrogate mother means a woman who agrees to bear a child (who is genetically related to the intending couple or intending woman) through surrogacy from the implantation of embryo in her womb.

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

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

4 EXCLUSIONS (Standard Exclusions)

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

4.1. Pre-Existing Diseases (Excl 01)

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

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

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 90 days/ one year/ two year/ four years (as specified against specific disease/ procedure) of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing Diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f) List of specific diseases/procedures

i. 90 Days Waiting Period (Life style conditions)
a. Hypertension and related complications
b. Diabetes and related complications
c. Cardiac conditions
ii. One year Waiting Period
a. Benign ENT disorders
b. Tonsillectomy
c. Adenoidectomy
d. Mastoidectomy
e. Tympanoplasty
iii. Two years Waiting Period
a. Cataract and age related eye ailments
b. Refractive error of the eye more than 7.5 dioptres.
d. Benign prostatic hypertrophy
e. Hernia
f. Hydrocele
g. Fissure/Fistula in anus
h. Piles (Haemorrhoids)
i. Sinusitis and related disorders
j. Polycystic ovarian disease
k. Non-infective arthritis
l. Pilonidal sinus
m. Gout and Rheumatism
n. Calculus diseases
o. Surgery of gall bladder and bile duct excluding malignancy
p. Surgery of genito-urinary system excluding malignancy
q. Surgery for prolapsed intervertebral disc unless arising from accident
r. Surgery of varicose vein
s. Congenital Internal Anomaly

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

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

4.3. First 30 days waiting period (Excl 03)
a) Expenses related to the treatment of any illness within thirty (30) days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve (12) months.
c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4.4. Investigation& Evaluation (Excl 04)
a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

4.5. Rest Cure, Rehabilitation and Respite Care (Excl 05)
a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

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

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

4.8. Cosmetic or Plastic Surgery (Excl 08)

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

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

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

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

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

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

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

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

4.16. Unproven Treatments (Excl 16)
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

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

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

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

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

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

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

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

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

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

5.9. Domiciliary Hospitalization & Out Patient Department (OPD) treatment

Any expenses incurred on Domiciliary Hospitalization and OPD treatment

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

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

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

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

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

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

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

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

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

5.19. Radioactivity
Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

5.20. Treatment taken outside the geographical limits of India

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

6 GENERAL TERMS AND CLAUSES

Standard General Terms and Conditions

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

6.2 Condition Precedent to Admission of Liability
The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

6.3 Claim Settlement

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

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

6.4 Multiple Policies

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

6.5 Fraud

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

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

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

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

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

6.6 Cancellation

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

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

iii. For policies with a term exceeding one year, the insured may at any time cancel the Policy and in such an event, the Company shall allow pro-rata refund of premium for the unexpired policy period after retaining 10% of the pro-rata premium, provided claim are not reported up to the date of cancellation

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

6.7 Migration

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

6.8 Portability

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

6.9 Renewal of Policy

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

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the Grace Period.
v. No loading shall apply on renewals based on individual claims experience.

6.10 Withdrawal of Product

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

6.11 Moratorium Period

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

6.12 Premium Payment in installments

lf the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly or Quarterly, as mentioned in the policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy).

i. Grace Period of 15 days would be given to pay the instalment premium due for the policy.
ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged lf the instalment premium is not paid on due date
v. ln case of instalment premium due not received within the grace period, the policy will get cancelled.
vi. ln the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

6.13 Revision of Terms of the Policy Including the Premium Rates

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

6.14 Free Look Period

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

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

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

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

6.15 Nomination

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

subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

Specific General Terms and Conditions

6.16 Communication

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

6.17 Physical Examination

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

6.18 Claim Procedure

6.18.1 Notification of Claim

In order to lodge a claim under the Policy for any Hospitalisation, the Insured Person/Insured Person's representative shall notify the TPA (if claim is processed by TPA)/Company (if claim is processed by the Company) in writing by letter, e-mail, fax providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit.

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

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

6.18.2 Procedure for Cashless Claims

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

6.18.3 Procedure for Reimbursement of Claims

For reimbursement of claims the Insured Person shall submit the necessary documents to TPA (if claim is processed by TPA)/Company (if claim is processed by the Company) within the prescribed time limit.

6.18.4 Documents

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

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

ix. Any other document required by Company/TPA.

x. The documents required in support of claim under Personal Accident Cover:

Death

i. Attending Doctors Report
ii. Original policy for cancellation
iii. Original Death Certificate
iv. Original / attested Post Mortem / Coroners Report, where applicable
v. Attested copy of FIR / Panchnama
vi. Police Inquest report, where applicable
vii. Any other document required by the company

Post mortem report if necessary, be furnished within the space of fourteen days after demand in writing

Disablement/Permanent Total Disablement

i. Attending Doctors Report
ii. Original policy for cancellation in case of Permanent Total Disablement
iii. Disability Certificate from Govt. Registered Medical Practitioners, where applicable
iv. Diagnostic reports like laboratory test, X- rays and/ or any other reports confirming injury
v. Police Inquest report, where applicable
vi. Any other document required by the company

xi. The documents required in support of claim under Domestic Travel Cover:

Claim documents must be submitted to the Company not later than one (1) month after occurrence of the event or after completion of the treatment.

a) Details of the inception of covered Trip (tickets, invoices) to support no. of days of Trip.
b) Other documents to be submitted to claim under respective sections are provided below

Section	Sections	Documents to be submitted
1	Repatriation Of Mortal Remains	• In case of transportation of the body of the deceased to the Place of Residence, the receipt for expenses incurred towards preparation and packing of the mortal remains of the deceased and also for the transportation of the mortal remains of the deceased. • Copy of Embalming certificate, if any • Flight itinerary and Boarding pass and/or ticket details as applicable • Copy of death certificate. • Post mortem report, if conducted.
2	Trip Delay (applicable only for air travel) (beyond 12 hour)	• Copy of ticket & boarding pass, • Certificate from the Common Carrier confirming the delay and detailing the circumstances of delay. (Mandatory) • Copies of correspondence with airline authorities certifying the delay, along with details of compensation received from airlines / other authorities (if any)
3	Trip cancellation & Interruption	• Confirmation of cancellation of the Trip detailing the circumstances of cancellation; • Original ticket/ boarding pass issued by the Common Carrier indicating the cost of the ticket and receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the Trip, the cancellation charges retained; • Original bill and a receipt / letter obtained from the hotel and / or guest house and / or any other paid residential accommodation (available for fee) indicating the amount paid for the accommodation, the refund given and the cancellation charges retained, wherever such accommodation has been arranged at the place of cancellation of the Trip; • Ticket issued by the Common Carrier in original for the covered Trip which indicate the cost of the tickets together with the receipts for the refunds obtained towards the unfulfilled portion of the Trip. • In case the cancellation of the Trip shall result because of personal contingencies defined or a decision taken at the instance of the Insured arising out of the contingencies namely earthquake, storm, flood, inundation, cyclone, tempest & terrorism, the duly completed claims form to be accompanied by: o Declaration from the Insured furnishing the circumstances that compelled him / her to cancel the Trip; o Medical evidence as may be required by the Company in case of the cancellation of the Trip arising out of personal contingencies of the Insured; • And any other document as may be appropriately applicable for the claims preferred under this section of the Policy
4	Carrier Cancellation (applicable only for air travel)	• Confirmation from the Common Carrier of the cancellation of flight along with the reasons for cancellation.

5	Loss Of Checked-in Baggage (applicable only for air travel)	• Copies of correspondence with airline authorities / others about loss of checked baggage, along with details of compensation received from airlines / other authorities (if any), • Property Irregularity Report (Mandatory, to be obtained from airline), • Undertaking in writing stating that in the event if the baggage is traced and returned to the Insured, he / she will be refunding the entire claim amount settled under this policy • Flight itinerary
6	Compassionate Allowance	• Medical records showing admission in ICU

Note:

1. The Company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
2. 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 of the Company

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

Type of claim	Time limit
Reimbursement of Hospitalisation, Pre Hospitalisation expenses and ambulance charges	Within thirty (30) days of date of discharge from Hospital
Reimbursement of post Hospitalisation expenses	Within thirty (30) days from completion of Post Hospitalisation treatment

Waiver

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

6.18.6 Services Offered by TPA

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the Policy.

The services offered by a TPA shall not include

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

6.18.7 Classification of Zone and Copayment

Depending upon the zone for which premium has been paid and the zone where treatment has been taken, Copayment shall apply.

** The country has been divided into two zones.*

Zone I – Delhi, National Capital Region (NCR), Mumbai, Mumbai Suburban, Thane and Navi Mumbai, Gujarat, Hyderabad, Chennai, Indore

Zone II – Rest of India

Where treatment has been taken in a zone, other than the one for which premium has been paid, the claim shall be subject to copayment.

i. Insured paying premium as per Zone I can avail treatment in Zone I, Zone II without copayment
ii. Insured paying premium as per Zone II
    a. Can avail treatment in Zone II without any copayment
    b. Availing treatment in Zone I will be subject to a copayment of 25%

6.19 Payment of Claim

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

6.20 Territorial Limit

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

6.21 Territorial Jurisdiction

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

6.22 Arbitration

i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred for arbitration as per Arbitration and Conciliation Act 1996, as amended from time to time.
ii. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the Policy.

iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the Policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

6.23 Disclaimer

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

6.24 Enhancement of Basic Sum Insured

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

6.25 Adjustment of Premium for Overseas Travel Insurance Policy

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

7 REDRESSAL OF GRIEVANCE

In case of any grievance related to the Policy, the insured person may submit in writing to the Policy Issuing Office or Grievance cell at Regional Office of the Company for redressal. If the grievance remains unaddressed, the insured person may contact Customer Relationship Management Dept., National Insurance Company Limited, Premises No. 18-0374, Plot no. CBD-81, Rajarhat, New Town, Kolkata - 700156, email: customer.relations@nic.co.in, griho@nic.co.in

For more information on grievance mechanism, and to download grievance form, visit our website https://nationalinsurance.nic.co.in

IRDAI Integrated Grievance Management System - https://irdai.gov.in/igms1
Insurance Ombudsman – The Insured person can also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The updated list of Office of Insurance Ombudsman are available on IRDAI website: https://irdai.gov.in/ and on the website of Council for Insurance Ombudsman: https://www.cioins.co.in/

8 DISCLAIMER

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

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

TABLE OF BENEFITS

Name	**National Young India Mediclaim Plus Policy (NYIMPP)**
Sum Insured	**₹ 5L, 10L, 15L, 25L (Basic SI)**
Policy Period	**1 year/ 2 years/ 3 years**
Product Type	**Individual and Floater**
Coverage	
Hospitalisation	**Room Rent** – Single AC room charges (i.e., lowest single AC room category available in Hospital) **ICU Charges** – Actual ICU charges *Proportionate Deduction shall apply if opted for Room of higher category* *Sub limit will not apply in case of Hospitalisation in a Preferred Provider Network (PPN) as per eligible package* **Cataract** - Up to ₹ 40,000 per eye per year, Waiting Period 2 years Coverage for **Modern Treatment** (12 nos) – Subject to treatment wise limits and coverage Expenses due to **hazardous or adventure sports (non-professionals) –** Up to 25% of SI
System of Medicine	**Allopathy and AYUSH** Covered up to SI
In Built Features	**Pre hospitalisation** - 45 days immediately before hospitalisation **Post hospitalisation** - 60 days immediately after discharge
	Day Care Procedures covered upto SI
	Ambulance Charges – Up to max of ₹ 2,000 per year
	Air Ambulance Charges – Up to max of ₹ 50,000 per year
	Hospitalisation coverage for **HIV/AIDS** and **Genetic Disorders**
	Hospitalisation coverage for **Mental Illness**
	Maternity Cover (1 delivery/ termination, Waiting Period 2 years) – up to INR 30,000 (SI 5L), INR 40,000 (SI 10L), INR 50,000 (SI 15L/25L) **Surrogacy Cover** – Surrogate Mother covered up to Maternity Cover limits for maternity expenses only, Non-delivery related surrogacy expenses also covered within Maternity limits, provided no living child, Waiting period of 2 years
	Infertility Cover - Up to INR 50,000 for SI 5/10/15L & Up to INR 75000 for SI 25L, Waiting period of 2 years, To be covered only once in a lifetime
	Treatment of **Morbid Obesity** and **Refractive Error** of at least 7.5D, subject to Waiting Periods
	Reinstatement of SI – Base SI will be restored to its original amount upon exhaustion, available to Policy with Basic SI 5 and above. Not available for defined 11 CIs
	Personal Accident Cover - Up to Basic SI, for death, permanent disability and permanent partial disability In case of Floater, PA cover to be available to Proposer only.
Others	
Pre Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the Company shall be covered after **3 year Waiting Period**
Enhancement of SI	On Renewal
Domestic Travel Cover	In-built annual cover, any number of domestic trips covered, single trip should be within 15 days Any one or multiple modes of common carrier such as Taxi, Bus, Train, Ship or Air travel, with record of travel

Repatriation of Mortal Remains	Indemnity	Upto INR 2000
Trip Delay (applicable only for air travel) (beyond 12 hrs)	Benefit	INR 1000 per trip
Trip cancellation & Interruption	Indemnity	Upto INR 1000 per trip
Carrier Cancellation (applicable only for air travel)	Benefit	INR 1000 per trip
Loss Of Checked-in Baggage (applicable only for air travel)	Benefit	INR 1000 per trip
Compassionate Allowance	Benefit	INR 1000 per trip

Optional Covers	
Waiting period waiver of PED Diabetes and/or Hypertension	Option to waive waiting period of pre-existing Diabetes and/or Hypertension and covered since inception
Good Health Incentives	
Cumulative Bonus	CB to increase by 10% of Basic SI in respect of each claim free Policy Year CB to decrease by 10% of Basic SI for each year with claim reported Maximum accumulation, 4**0% of the Basic SI of the renewed Policy**

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

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

Rate Chart (in ₹ for Individual)

Zone 1				
Eldest Age Band	**500000**	**1000000**	**1500000**	**2500000**
0-5	3931	4856	6120	8248
6-17	3940	4867	6135	8267
18-25	7021	8570	10319	13392
26-30	7145	8709	10483	13592
31-35	8199	10014	12093	15886
36-40	9909	12174	14774	19553
41-45	12933	15837	19859	26437

Zone 2				
Eldest Age Band	**500000**	**1000000**	**1500000**	**2500000**
0-5	2833	3526	4512	6101
6-17	2924	3637	4650	6285
18-25	5555	6840	8276	10816
26-30	6025	7388	8923	11487
31-35	7040	8631	10448	13664
36-40	8114	9993	12154	16068
41-45	10091	12380	15574	20713

Taxes extra

For ages above 45 years, an increase of 5% on the last years' premium would be applicable.

Rate Chart (in ₹ for Floater)

Zone 1					
Category	**Eldest Age Band**	**500000**	**1000000**	**1500000**	**2500000**
2A	**18-25**	8865	10821	13029	16909
	26-30	9005	10979	13215	17136
	31-35	10266	12536	15135	19857
	36-40	12349	15163	18394	24327
	41-45	16850	20641	25799	34325
1A+1C	**18-25**	8432	10293	12393	16084
	26-30	8556	10432	12557	16284
	31-35	9691	11834	14285	18731
	36-40	11401	13995	16966	22397
	41-45	14777	18088	22569	29954
1A+2C	**18-25**	9141	11158	13435	17436
	26-30	9265	11298	13599	17637
	31-35	10480	12798	15445	20236
	36-40	12190	14958	18126	23903
	41-45	15919	19482	24247	32132
2A+1C	**18-25**	10276	12544	15103	19601
	26-30	10417	12701	15289	19828
	31-35	11758	14357	17327	22702
	36-40	13840	16984	20586	27172
	41-45	18694	22892	28509	37842
2A+2C	**18-25**	10985	13409	16145	20954
	26-30	11126	13567	16331	21180
	31-35	12547	15320	18487	24208
	36-40	14630	17947	21746	28677
	41-45	19836	24286	30187	40020

Zone 2					
Category	**Eldest Age Band**	**500000**	**1000000**	**1500000**	**2500000**
2A	**18-25**	7014	8637	10450	13657
	26-30	7484	9184	11096	14328
	31-35	8663	10621	12852	16759
	36-40	10011	12318	14970	19749
	41-45	12874	15808	19743	26224
1A+1C	**18-25**	6672	8215	9939	12990
	26-30	7141	8763	10586	13661
	31-35	8220	10084	12206	15961
	36-40	9294	11446	13912	18365
	41-45	11550	14176	17747	23553
1A+2C	**18-25**	7233	8906	10775	14082
	26-30	7702	9453	11422	14754
	31-35	8844	10853	13137	17177
	36-40	9919	12215	14843	19581
	41-45	12453	15289	19093	25312
2A+1C	**18-25**	8131	10012	12113	15831
	26-30	8600	10559	12760	16502
	31-35	9843	12074	14611	19057
	36-40	11191	13771	16728	22047
	41-45	14333	17604	21917	29065
2A+2C	**18-25**	8692	10702	12949	16923
	26-30	9161	11250	13596	17594
	31-35	10468	12843	15541	20273
	36-40	11816	14540	17658	23263
	41-45	15237	18717	23263	30824

Taxes extra

For ages above 45 years, an increase of 5% on the last years' premium would be applicable.

Floater Rate chart for any Additional child:

Zone 1				
Eldest Age Band	**500000**	**1000000**	**1500000**	**2500000**
18-25	569	694	836	1085
26-30	569	694	836	1085
31-35	649	792	954	1238
36-40	649	792	954	1238
41-45	1001	1222	1472	1910

Zone 2				
Eldest Age Band	**500000**	**1000000**	**1500000**	**2500000**
18-25	450	554	670	876
26-30	450	554	670	876
31-35	513	632	765	1000
36-40	513	632	765	1000
41-45	792	976	1180	1543

Taxes extra

For ages above 45 years, an increase of 5% on the last years' premium would be applicable

Instalment Premium

Half yearly:

1st instalment: 52.50% of annual premium

2nd instalment: 50.00% of annual premium

Quarterly:

1st instalment: 28.50% of annual premium

2nd, 3rd and 4th instalments: 25.00% of annual premium.

***TPA charges of 3.5% will be extra.**

Loading for Optional Cover – Both Individual and Floater

	Optional Cover	Loading on Premium
Optional	Waiver of pre-existing waiting period of Diabetes or Hypertension	10%
	Waiver of pre-existing waiting period of Diabetes and Hypertension	15%