National Young India Mediclaim Policy

PROSPECTUS

1.1 PRODUCT

National Young India Mediclaim 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, AYUSH) or Day Care Treatment Reasonably and Customarily incurred for treatment of an Illness contracted/Injury sustained during the Policy Period. The Policy provides for Pre Hospitalisation (45 days) and Post Hospitalisation (60 days) expenses, any Day Care Procedures, Ambulance Charges, Morbid Obesity Treatment, Correction of Refractive Error, Maternity Benefit and provides for Reinstatement of Basic Sum Insured, if applicable as per terms. Additionally Optional Covers are 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 and 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 at rates exceeding the aforesaid limits, the reimbursement/payment of Associated Medical Expenses incurred at the Hospital, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent charges. Proportionate deduction shall not apply if admitted to ICU.

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

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

3. Sub limits as mentioned above, will not apply in case of treatment undergone as a package for a listed procedure in a Preferred Provider Network (PPN).
4. 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 a claim has been admitted.

1.2.7 Maternity

The Company shall indemnify Maternity Expenses as described below for **any female Insured Person**, and also Pre-Natal and Post-Natal Hospitalisation expenses per delivery, including expenses for necessary vaccination for **New Born Baby**, subject to the limit as shown in the Table of Benefits. The female Insured Person should have been continuously covered for at least **24 months** before availing this benefit.

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

Cover

Maternity Expenses means;

a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization);
b) Expenses towards lawful medical termination of pregnancy during the Policy Period.

Note: Ectopic pregnancy is covered under 'In-patient treatment', 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 **Maternity Expenses** incurred in connection with or in respect of:

1. Covered female Insured Person **below eighteen (18) years** and above forty-five (45) years of age.
2. Delivery or termination within a **Waiting Period of twenty-four (24) months**. However, the Waiting Period may be waived only in the case of delivery, miscarriage or abortion induced by accident.
3. Delivery or lawful medical termination of pregnancy limited to **two deliveries or terminations or either** has been paid under the Policy and its Renewals.
4. More than one delivery or lawful medical termination of pregnancy during a single Policy Period.
5. **Maternity Expenses of Surrogate Mother**, unless claim is admitted under **Section 3.1.15 (Infertility)**
6. **Ectopic pregnancy**
7. **Pre and post hospitalisation expenses**, other than pre and post natal treatment.

1.2.8 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

1.2.9 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 or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post-graduate degree (Siddha) in Sirappu Maruthuvam.

Exclusions

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

2. Any treatment of the following Mental Illnesses shall be covered after Waiting Period of 2 years:
   i. Depression (ICD - F32; F33)
   ii. Schizophrenia (ICD - F20; F21; F25)

1.2.10 Modern Treatment

The Company shall indemnify the Medical Expenses for In-Patient Care, **Domiciliary Hospitalisation** or Day Care Procedure along with pre hospitalisation expenses and post hospitalisation expenses incurred for following **Modern Treatments** (wherever medically indicated), subject to the limit of 25% of the Sum Insured for the related modern procedure/ component/ medicine of each Modern Treatment during the Policy Period.

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

1.2.11 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 three (03) years as per Section 4.2.f.iv:

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

3.1.12 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-I of the Policy. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Appendix-I of the Policy respectively

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

1.3 OTHER BENEFITS

1.3.1 Reinstatement of Basic Sum Insured (available to Basic Sum Insured of ₹ 5L and above)

For Policies with Basic Sum Insured of ₹ 5 lacs and above, in the event of available Sum Insured being exhausted anytime during the Policy Year on account of Hospitalisation claim(s), the Company shall reinstate the 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
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 II: Basic SI – ₹ 5L (Individual Basis), CB – ₹ 1L
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)

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 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

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

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 Section 3.1.

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 Sum Insured. In a Policy issued on Floater Basis, the Personal Accident benefit shall apply cumulatively on all Insured Persons with the maximum liability of the Company being the floater 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.

	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	25%
	- one phalanx	10%
7.	Loss of Index finger -	
	three phalanges	10%
	two phalanges	8%
	one phalanx	4%
8.	Loss of middle finger –	
	three phalanges	6%
	two phalanges	4%
	one phalanx	2%
9.	Loss of ring finger -	
	three phalanges	5%
	two phalanges	4%
	one phalanx	2%
10.	Loss of little finger –	
	three phalanges	4%
	two phalanges	3%
	one phalanx	2%
11.	Loss of metacarpus -	
	first or second (additional)	3%
	third, fourth or fifth (additional)	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 and Cumulative Bonus, if any, 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.

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 1

The Company shall indemnify Medical Expenses as per Section 3.1 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 additional premium **and sub limits** shall not apply.

1.4.2. Double SI for 11 Critical Illnesses – Optional 2

In the event of available Sum Insured being exhausted anytime during the Policy Year on account of Hospitalisation claim(s) and there being continued/ new Hospitalisation(s) for treatment of any one or more of the defined 11 Critical Illnesses (CIs) only, the Company shall indemnify the Medical Expenses up to the Basic SI (i.e, Double SI) incurred for such Hospitalisation(s) only, provided that

i. In a policy issued on Individual Basis, Double SI 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, Double SI shall be available to all Insured Person(s) subject to exhaustion of Sum Insured as specified above by any or multiple Insured Person(s).
ii. Double SI, if not exhausted, will not be carried forward to next Policy Year or Policy Period on Renewal.

iii. Double SI shall be allowed only once during the Policy Year of the Policy Period for each Insured Person (Individual Basis)/ each Policy (Floater Basis), irrespective of the occurrence of one or more critical illnesses.
iv. Double SI shall only be applicable to Hospitalisation for the treatment of 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, and not for any other Hospitalisation.
v. Occurrence of the CI shall be supported by documentary and clinical evidence specified under the respective Definition.

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 5% 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 50% of the Basic Sum Insured of the renewed Policy. Wherever, due to reduction in Basic Sum Insured on renewal, if the accumulated CB exceeds 50% of the reduced Basic Sum Insured, then CB shall be restricted to 50% 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. **Merging of Policies or Migration from Individual to Floater Policy**: If the Insured Persons in the expiring Policy are covered under Individual policy/policies and such expiring Policy has been Renewed with the Company on a Family Floater basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest percentage of Cumulative Bonus applicable on the lowest Sum Insured of the last Policy Period amongst all the expiring individual policies being merged.
v. **Splitting of policies or Migration from Floater to Individual Policy**: If the Insured Persons in the expiring Policy are covered on a Family Floater basis and such Insured Persons Renew their expiring Policy with the Company by splitting the Sum Insured in to two or more Family Floater/Individual policies then the Cumulative Bonus shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
vi. **Revision in Sum Insured**: If the Basic Sum Insured under the Policy has been increased/decreased at the time of Renewal, the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Period.
vii. If a claim is made in the expiring Policy Year, and is notified to the Company after the acceptance of Renewal premium any awarded CB shall be withdrawn.
viii. Claim under Personal Accident 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.

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 three (43) years.
ii. Maximum entry age of any family member is forty three (43) 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.
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

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

No other relation even within the eligible age band can be covered under the Policy. 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) or 3 years (i.e., 36 calendar months or 3 Policy Years).

2.4 Basic Sum Insured (Basic SI)
The Policy is available with options of Basic SI of ₹ **3/ 5/ 10 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 Girl Child
Discount of 1.5% is allowed on total premium of families having a covered girl child aged up to 18 years.

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

2.5.3 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.).

2.5.4 Long Term Discount
Discount of 4.25% 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 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'. 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'.
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 for 3 years to be calculated based on premium for age at inception and opted SI, multiplied by 3. Long Term Discount shall apply on the total 3 year's premium.
vi. Full premium shall be paid in full before the commencement of the Policy.
vii. Premium can be paid online for Renewals without break, provided there is no material change in the Policy.
viii. PAN details must be submitted by the Proposer.
ix. In case PAN is not available, Form 60 or Form 61 as per Rule 114B of the Income-tax Rule, 1962 must be submitted.

2.9 Renewal Terms
i. The Policy can be renewed without break throughout the lifetime of the Insured Persons except for the covered Children or siblings, who can renew till the Insured Person's marriage.
ii. The Policy may be renewed by mutual consent, before the expiry of the Policy or a within a Grace Period of thirty (30) days after expiry of the Policy. Coverage is not available during the Grace Period at Renewal.
iii. If the requisite premium is not paid within the Grace Period, the Break in Policy shall occur.
iv. Any change in the Policy, including Basic Sum Insured, Co-Payment, Insured Person(s), can only be incorporated at the time of Renewal.

3 DEFINITIONS
3.1 Accident means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
3.2 Age / Aged: means completed years on last birthday as on Policy commencement date.

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

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

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

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

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

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

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

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

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

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

3.11 Congenital Anomaly 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.

3.12 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.

3.13 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.

3.14 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

Neurological damage due to SLE is excluded.

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

3.16 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.

3.17 Day Care Treatment means medical treatment, and/or surgical procedure which is:

i. undertaken under general or local anesthesia in a hospital/day care centre in less than twenty four hrs because of technological advancement, and
ii. which would have otherwise required a hospitalisation of more than twenty four hours.

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

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

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

3.20 Grace Period means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to Waiting Periods and coverage of Pre-Existing Diseases. The Grace Period for payment of the premium shall be thirty days.
In case of Renewal, Coverage shall not be available during the period for which no premium is received.

3.21 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.

3.22 Hospitalisation means admission in a hospital for a minimum period of twenty four consecutive **'Inpatient Care'** hours except for procedures/ treatments, where such admission could be for a period of less than twenty four consecutive hours.

3.23 I D Card means the card issued to the Insured Person by the TPA for availing Cashless Facility.

3.24 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

3.25 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.

3.26 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.

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

3.28 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.

3.29 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.

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

3.31 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.

3.32 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.

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

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

3.34 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.

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

3.36 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.

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

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

3.39 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.

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

3.41 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

3.42 Pre-existing disease (PED) means any condition, ailment, injury or disease:
a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

3.43 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.

3.44 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.

3.45 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.

3.46 Portability means a facility provided to the policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

3.47 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.

3.48 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.

3.49 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.

3.50 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.

3.51 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.

3.52 Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the Associated charges.

3.53 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.

3.54 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

3.55 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.

3.56 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.

3.57 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.

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

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

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

4 WAITING PERIOD - EXCLUSIONS

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

4.1. Pre-Existing Diseases (Excl 01)

a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of 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. Specific disease/procedure waiting period (Excl 02)

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 90 days/ one year/ two year/ 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. Three years Waiting Period

Following diseases shall be covered after **three** years of continuous cover from the inception of the Policy:
a. Joint replacement unless necessitated due to an accident
b. Osteoarthritis and osteoporosis
c. Obesity and its complications
d. Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

4.3. First 30 days waiting period (Excl 03)

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

5 GENERAL EXCLUSIONS

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

5.1. Investigation& Evaluation (Excl 04)

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

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

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

5.3. Obesity/ Weight Control (Excl 06)

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

5.4. Change-of-Gender Treatments (Excl 07)

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

5.5. Cosmetic or Plastic Surgery (Excl 08)

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

5.6. Hazardous or Adventure Sports (Excl 09)

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

5.7. Breach of Law (Excl 10)

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

5.8. Excluded Providers (Excl 11)

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

5.9. Drug/Alcohol Abuse (Excl 12)

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

5.10. Non Medical Admissions (Excl 13)

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

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

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

5.13. Unproven Treatments (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.

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

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

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

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

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

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

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

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

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

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

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

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

5.26. 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.

5.27. 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.

5.28. 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.

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

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

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

5.32. 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.

5.33. 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.

5.34. Treatment taken outside the geographical limits of India

6 GENERAL TERMS AND CLAUSES

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

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

6.3 Claim Settlement
i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
*(**Explanation**: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)*

6.4 Multiple Policies
i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.
v. On occurrence of an insured event under specified critical illnesses, the policyholders can claim from all Insurers under all policies.

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

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

a) refund proportionate premium for unexpired policy period, if the term of policy upto one year and there is no claim (s) made during the policy period.
b) refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced and refund proportionate premium for unexpired policy period for the current policy year.

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

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

6.7 Migration

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

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

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

6.8 Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at least **15** days before, but not earlier than **60 days** from the policy renewal date, as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under this Policy offered by the Company,

i. The proposed Insured Person will get all the accrued continuity benefits for specific waiting periods, waiting period for pre-existing diseases and Moratorium period of the Insured Person under the previous health insurance Policy.
ii. Portability benefit will be offered to the extent of Sum Insured of the previous policy. Portability benefit shall not apply to any other additional increased Sum Insured.

6.9 Renewal of Policy

i. A health insurance policy shall be renewable provided the product is not withdrawn, except in case of established fraud or non-disclosure or misrepresentation by the Insured. If the product is withdrawn, the policyholder shall be provided with suitable options to migrate to other similar health insurance products/plans offered by the Company.
ii. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
iii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iv. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
v. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
vi. No loading shall apply on renewals based on individual claims experience.
vii. In case of non-continuance of the Policy by the insured (due to death or any other valid and acceptable reason)
    a. The Policy may be renewed by any insured person above eighteen years of age, as the insured
    b. If only children (less than eighteen years of age) are covered, the Policy shall be allowed till the expiry of the policy period. The grandparents may be allowed to renew the Policy as insured, covering the grandchildren.
viii. In case of death of the eldest insured person
    - The base premium may be calculated based on the age of the next eldest insured person.

When opting for the Policy for the first time (i.e., inception),

a. For Annual Policy, the renewal premium shall remain unchanged for next 2 renewals, provided there is no change in SI.
b. For Long Term Policy, premium for entire 3 years shall be based on age at beginning, with no change in SI allowed mid-term.

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

6.12 Revision of Terms of the Policy Including the Premium Rates

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

6.13 Free Look Period

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

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

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

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

6.14 Nomination

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

6.15 Communication

i. All communication should be made in writing.
ii. For Policies serviced by TPA, ID card, PPN/Network Provider related issues to be communicated to the TPA at the address mentioned in the Schedule. For claim serviced by the Company, the Policy related issues to be communicated to the Policy issuing office of the Company at the address mentioned in the Schedule.

iii. Any change of address, state of health or any other change affecting any of the Insured Person, shall be communicated to the Policy issuing office of the Company at the address mentioned in the Schedule
iv. The Company or TPA shall communicate to the Insured at the address mentioned in the Schedule.

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

6.17 Claim Procedure
6.17.1 Notification of Claim
In order to lodge a claim under the Policy for any Hospitalisation, 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

6.17.2 Procedure for Cashless Claims
i. Cashless Facility can be availed, if TPA service is opted.
ii. Treatment may be taken in a network provider / PPN or **any other provider** and is subject to pre-authorisation by the TPA. Updated list of network provider/PPN is available on the website of the Company and the TPA mentioned in the schedule.
iii. Cashless request form available with the Network Provider and TPA shall be completed and sent to the TPA for authorization.
iv. The TPA upon getting cashless request form and related medical information from the Insured Person/ Network Provider shall issue pre-authorization letter within an hour to the Hospital after verification.
v. At the time of discharge, the Insured Person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
vi. The TPA shall grant the final authorization within three hours of the receipt of discharge authorization request from the Hospital.
vii. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
viii. In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the TPA for processing.

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

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

Note
In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents listed under condition 6.17.4 and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company.

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

Type of claim	**Time limit**

Reimbursement of Hospitalisation, Pre Hospitalisation expenses and ambulance charges	Within 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.

6.17.6 Services Offered by TPA
Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the Policy.
The services offered by a TPA shall not include
i. Claim settlement and claim rejection;
ii. Any services directly to any Insured Person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

6.17.7 Classification of Zone and 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 three zones.*

Zone I – Entire state of Gujarat
Zone II – Delhi, Delhi NCR, Maharashtra, Chennai, Hyderabad, Indore
Zone III – 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 and Zone III without copayment
ii. Insured paying premium as per Zone II
    a. Can avail treatment in Zone II and Zone III without any copayment
    b. Availing treatment in Zone I will be subject to a copayment of 12.5%
iii. Insured paying premium as per Zone III
    a. Can avail treatment in Zone III without any copayment
    b. Availing treatment in Zone I will be subject to a copayment of 35%
    c. Availing treatment in Zone II will be subject to a copayment of 20%

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

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

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

6.21 Arbitration
i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred for arbitration as per Arbitration and Conciliation Act 1996, as amended from time to time.
ii. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the Policy.
iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the Policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

6.22 Disclaimer
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.

6.23 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.

6.24 Adjustment of Premium for Overseas Travel Insurance Policy

If during the Policy Period any of the Insured Person is also covered by an Overseas Travel Insurance Policy 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, New Town, Kolkata - 700156, email: customer.relations@nic.co.in, griho@nic.co.in

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

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

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

Helpline Number: 18003450330
Dedicated Email ID for Senior Citizens: health.srcitizens@nic.co.in

8 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 Policy (NYIMP)**
Type	Individual/ Floater
Category of Cover	Indemnity
Sum Insured	**₹ 3L, 5L, 10L (Basic SI)**
Policy Period	**1 year or 3 years**
Entry Age	Minimum age at entry: 3 months Maximum age at entry: 43 years
Family Members	Self, Spouse and children only.
Renewability	Lifetime
Coverage	
Hospitalisation	**Room Rent** – Upto INR 5,000 per day for Basic SI 3L, 5L and upto INR 10,000 per day for Basic SI 10L **ICU Charges** – Upto INR 10,000 per day for Basic SI 3L, 5L and upto INR 20,000 per day for Basic SI 10L *Proportionate Deduction shall apply if opted for higher Room Rent* *Sub limit will not apply in case of Hospitalisation in a Preferred Provider Network (PPN) as a package* **Cataract** - Up to 10% of Sum Insured, subject to maximum ₹ 50,000 per eye per year. Coverage for **Modern Treatment** (12 nos) – Up to 25% of SI for each treatment Expenses due to **hazardous or adventure sports (non-professionals) –** Up to 25% of SI
System of Medicine	**Allopathy, 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 1% of SI, subject to max of ₹ 2,000 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 (Basic SI 3L), INR 40,000 (Basic SI 5L), INR 50,000 (Basic SI 10L)
	Treatment of **Morbid Obesity** and **Refractive Error** of at least 7.5D, subject to Waiting Periods
	Reinstatement of SI – Basic 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 SI, for death, permanent disability and permanent partial disability
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
Optional Covers	
Waiting period waiver of pre-existing Diabetes and/or Hypertension – Optional 1	Option to waive waiting period of pre-existing Diabetes and/or Hypertension and covered since inception
Double SI for 11 critical Illnesses – Optional 2	Upon exhaustion of the SI, the insured can claim up to another Base SI for the treatment of any/ all of the defined 11 CIs. • Cancer of Specified Severity • Myocardial Infarction (First Heart Attack of Specified Severity) • Open Chest Coronary Artery Bypass Graft Surgery (CABG) • 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
Good Health Incentives	
Cumulative Bonus	CB to increase by 5% of Basic SI in respect of each claim free Policy Year CB to decrease by 5% of Basic SI for each year with claim reported Maximum accumulation, **50% of the Basic SI of the renewed Policy**
Premium	
Zone Based Premium	**Zone** **Area** Zone 1 Gujarat Zone 2 *Delhi, Delhi NCR, Maharashtra, Chennai, Hyderabad, Indore* Zone 3 Rest of India Copayment for opting for treatment outside zone
Premium Fixed for first 3 years	Premium shall remain unchanged for first 3 years of the policy, in spite of any change in age band
Discounts	
Girl child discount	Discount of 1.5% on premium for families having a covered girl child aged upto 18 years
Direct Discount	Discount of 10% on premium for policies through Direct sale or Online sale
Wellness Discount	Discount of 1% on renewal premium for opting for evidence based wellness activities in expiring policy (e.g., gym membership, marathon, etc)
Long Term Discount	Discount of 4.25% on total premium if opting for long term policy
***Add-on** (cover available on payment of additional premium)*	
Non-Medical Expenses (Available for Sum Insured ₹ 5L & Above)	Up to 10% of Basic Sum Insured (excluding Cumulative Bonus, if any) of base Policy and shall be part of the base Policy Basic Sum Insured (excluding Cumulative Bonus, if any).

Note: *SI here means 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)

Premium without TPA Charges				
Zone	**Age-band/SI**	**3,00,000**	**5,00,000**	**10,00,000**
1	**0-5**	5,164	6,183	8,829
	6-17	4,879	6,015	8,555
	18-25	6,786	7,784	10,573
	26-30	8,103	9,830	13,337
	31-35	9,301	10,522	14,394
	36-40	10,240	11,415	15,606
	41-45	10,936	12,462	16,912
	46	11,483	13,085	17,758
	47	12,057	13,739	18,646
	48	12,660	14,426	19,578
	49	13,293	15,147	20,557
	50	13,958	15,905	21,585
	51	14,656	16,700	22,664
	52	15,389	17,535	23,797
	53	16,158	18,412	24,987
	54	16,966	19,332	26,236
	55	17,814	20,299	27,548
	56	18,705	21,314	28,926
	57	19,640	22,380	30,372
	58	20,622	23,499	31,890
	59	21,653	24,674	33,485
	60	22,736	25,907	35,159
2	**0-5**	4,845	5,860	8,380
	6-17	4,571	5,720	8,145
	18-25	6,580	7,526	10,228
	26-30	7,453	9,198	12,485
	31-35	7,918	9,378	12,835
	36-40	8,438	9,918	13,579
	41-45	8,598	10,082	13,715
	46	9,028	10,586	14,401
	47	9,479	11,116	15,121
	48	9,953	11,672	15,877
	49	10,451	12,255	16,671
	50	10,973	12,868	17,505
	51	11,522	13,511	18,380
	52	12,098	14,187	19,299
	53	12,703	14,896	20,264
	54	13,338	15,641	21,277
	55	14,005	16,423	22,341
	56	14,705	17,244	23,458
	57	15,441	18,106	24,631
	58	16,213	19,012	25,862
	59	17,023	19,962	27,155
	60	17,874	20,960	28,513
3	**0-5**	3,647	4,587	6,601
	6-17	3,514	4,381	6,281
	18-25	5,370	6,502	8,841
	26-30	6,154	7,891	10,711
	31-35	6,774	8,406	11,505
	36-40	6,903	8,839	12,115
	41-45	7,355	9,266	12,617
	46	7,723	9,729	13,248
	47	8,109	10,215	13,910
	48	8,515	10,726	14,606
	49	8,940	11,262	15,336
	50	9,387	11,826	16,103
	51	9,857	12,417	16,908
	52	10,350	13,038	17,754
	53	10,867	13,690	18,641
	54	11,410	14,374	19,573
	55	11,981	15,093	20,552
	56	12,580	15,847	21,580
	57	13,209	16,640	22,659
	58	13,869	17,472	23,792
	59	14,563	18,345	24,981
	60	15,291	19,263	26,230

Premium with TPA Charges				
Zone	**Age-band/SI**	**3,00,000**	**5,00,000**	**10,00,000**
1	**0-5**	5,345	6,399	9,138
	6-17	5,050	6,226	8,854
	18-25	7,024	8,056	10,943
	26-30	8,387	10,174	13,804
	31-35	9,627	10,890	14,898
	36-40	10,598	11,815	16,152
	41-45	11,319	12,898	17,504
	46	11,885	13,543	18,380
	47	12,479	14,220	19,299
	48	13,103	14,931	20,263
	49	13,758	15,677	21,276
	50	14,447	16,462	22,340
	51	15,169	17,285	23,457
	52	15,928	18,149	24,630
	53	16,724	19,056	25,862
	54	17,560	20,009	27,154
	55	18,437	21,009	28,512
	56	19,360	22,060	29,938
	57	20,327	23,163	31,435
	58	21,344	24,321	33,006
	59	22,411	25,538	34,657
	60	23,532	26,814	36,390
2	**0-5**	5,015	6,065	8,673
	6-17	4,731	5,920	8,430
	18-25	6,810	7,789	10,586
	26-30	7,714	9,520	12,922
	31-35	8,195	9,706	13,284
	36-40	8,733	10,265	14,054
	41-45	8,899	10,435	14,195
	46	9,344	10,957	14,905
	47	9,811	11,505	15,650
	48	10,301	12,081	16,433
	49	10,817	12,684	17,254
	50	11,357	13,318	18,118
	51	11,925	13,984	19,023
	52	12,521	14,684	19,974
	53	13,148	15,417	20,973
	54	13,805	16,188	22,022
	55	14,495	16,998	23,123
	56	15,220	17,848	24,279
	57	15,981	18,740	25,493
	58	16,780	19,677	26,767
	59	17,619	20,661	28,105
	60	18,500	21,694	29,511
3	**0-5**	3,775	4,748	6,832
	6-17	3,637	4,534	6,501
	18-25	5,558	6,730	9,150
	26-30	6,369	8,167	11,086
	31-35	7,011	8,700	11,908
	36-40	7,145	9,148	12,539
	41-45	7,612	9,590	13,059
	46	7,993	10,070	13,712
	47	8,393	10,573	14,397
	48	8,813	11,101	15,117
	49	9,253	11,656	15,873
	50	9,716	12,240	16,667
	51	10,202	12,852	17,500
	52	10,712	13,494	18,375
	53	11,247	14,169	19,293
	54	11,809	14,877	20,258
	55	12,400	15,621	21,271
	56	13,020	16,402	22,335
	57	13,671	17,222	23,452
	58	14,354	18,084	24,625
	59	15,073	18,987	25,855
	60	15,826	19,937	27,148

Taxes extra

For ages above 60 years, an increase of 5% on the last years' premium would be applicable.

Rate Chart (in ₹ for Floater)

Zone 1 (without TPA Charges)				
Category	**Eldest Age Band**	**3,00,000**	**5,00,000**	**10,00,000**
2A	**18-25**	8569	9829	13351
	26-30	9886	11875	16115
	31-35	11484	13170	17987
	36-40	12746	14250	19484
	41-45	14448	16377	22265
1A+1C	**18-25**	8214	9422	12798
	26-30	9531	11468	15562
	31-35	10817	12261	16757
	36-40	11756	13154	17969
	41-45	12719	14507	19690
1A+2C	**18-25**	8963	10282	13966
	26-30	10280	12328	16730
	31-35	11655	13222	18062
	36-40	12594	14115	19274
	41-45	13823	15773	21410
2A+1C	**18-25**	9997	11467	15576
	26-30	11314	13513	18340
	31-35	13000	14910	20350
	36-40	14262	15989	21847
	41-45	16231	18422	25042
2A+2C	**18-25**	10746	12327	16743
	26-30	12063	14373	19507
	31-35	13838	15871	21655
	36-40	15100	16950	23152
	41-45	17335	19689	26763

Zone 1 (with TPA Charges)				
Category	**Eldest Age Band**	**3,00,000**	**5,00,000**	**10,00,000**
2A	**18-25**	8,869	10,173	13,818
	26-30	10,232	12,291	16,679
	31-35	11,886	13,631	18,617
	36-40	13,192	14,749	20,166
	41-45	14,954	16,950	23,044
1A+1C	**18-25**	8,501	9,752	13,246
	26-30	9,865	11,869	16,107
	31-35	11,196	12,690	17,343
	36-40	12,167	13,614	18,598
	41-45	13,164	15,015	20,379
1A+2C	**18-25**	9,277	10,642	14,455
	26-30	10,640	12,759	17,316
	31-35	12,063	13,685	18,694
	36-40	13,035	14,609	19,949
	41-45	14,307	16,325	22,159
2A+1C	**18-25**	10,347	11,868	16,121
	26-30	11,710	13,986	18,982
	31-35	13,455	15,432	21,062
	36-40	14,761	16,549	22,612
	41-45	16,799	19,067	25,918
2A+2C	**18-25**	11,122	12,758	17,329
	26-30	12,485	14,876	20,190
	31-35	14,322	16,426	22,413
	36-40	15,629	17,543	23,962
	41-45	17,942	20,378	27,700

Zone 2 (without TPA Charges)				
Category	**Eldest Age Band**	**3,00,000**	**5,00,000**	**10,00,000**
2A	**18-25**	8309	9503	12915
	26-30	9182	11175	15172
	31-35	9926	11856	16199
	36-40	10571	12445	17037
	41-45	11492	13484	18372
1A+1C	**18-25**	7965	9110	12380
	26-30	8838	10782	14637
	31-35	9388	11060	15121
	36-40	9908	11600	15865
	41-45	10327	12059	16402
1A+2C	**18-25**	8691	9941	13510
	26-30	9564	11613	15767
	31-35	10201	11989	16383
	36-40	10721	12529	17127
	41-45	11397	13284	18066
2A+1C	**18-25**	9693	11087	15067
	26-30	10566	12759	17324
	31-35	11396	13538	18484
	36-40	12042	14126	19322
	41-45	13221	15461	21059
2A+2C	**18-25**	10420	11918	16197
	26-30	11293	13590	18454
	31-35	12209	14467	19747
	36-40	12854	15055	20585
	41-45	14291	16685	22724

Zone 2 (with TPA Charges)				
Category	**Eldest Age Band**	**3,00,000**	**5,00,000**	**10,00,000**
2A	**18-25**	8,600	9,836	13,367
	26-30	9,503	11,566	15,703
	31-35	10,273	12,271	16,766
	36-40	10,941	12,881	17,633
	41-45	11,894	13,956	19,015
1A+1C	**18-25**	8,244	9,429	12,813
	26-30	9,147	11,159	15,149
	31-35	9,717	11,447	15,650
	36-40	10,255	12,006	16,420
	41-45	10,688	12,481	16,976
1A+2C	**18-25**	8,995	10,289	13,983
	26-30	9,899	12,019	16,319
	31-35	10,558	12,409	16,956
	36-40	11,096	12,968	17,726
	41-45	11,796	13,749	18,698
2A+1C	**18-25**	10,032	11,475	15,594
	26-30	10,936	13,206	17,930
	31-35	11,795	14,012	19,131
	36-40	12,463	14,620	19,998
	41-45	13,684	16,002	21,796
2A+2C	**18-25**	10,785	12,335	16,764
	26-30	11,688	14,066	19,100
	31-35	12,636	14,973	20,438
	36-40	13,304	15,582	21,305
	41-45	14,791	17,269	23,519

Zone 3 (without TPA Charges)				
Category	**Eldest Age Band**	**3,00,000**	**5,00,000**	**10,00,000**
2A	**18-25**	6781	8210	11164
	26-30	7565	9599	13034
	31-35	8432	10532	14391
	36-40	8728	11104	15215
	41-45	9723	12298	16772
1A+1C	**18-25**	6500	7870	10701
	26-30	7284	9259	12571
	31-35	7974	9859	13481
	36-40	8103	10292	14091
	41-45	8766	10974	14940
1A+2C	**18-25**	7093	8588	11678
	26-30	7877	9977	13548
	31-35	8637	10662	14572
	36-40	8766	11095	15182
	41-45	9640	12032	16378
2A+1C	**18-25**	7911	9578	13024
	26-30	8695	10967	14894
	31-35	9632	11985	16366
	36-40	9928	12557	17190
	41-45	11133	14006	19095
2A+2C	**18-25**	8504	10296	14000
	26-30	9288	11685	15870
	31-35	10295	12788	17458
	36-40	10591	13359	18282
	41-45	12007	15064	20533

Zone 3 (with TPA Charges)				
Category	**Eldest Age Band**	**3,00,000**	**5,00,000**	**10,00,000**
2A	**18-25**	7,018	8,497	11,555
	26-30	7,830	9,935	13,490
	31-35	8,727	10,901	14,895
	36-40	9,033	11,493	15,748
	41-45	10,063	12,728	17,359
1A+1C	**18-25**	6,728	8,145	11,076
	26-30	7,539	9,583	13,011
	31-35	8,253	10,204	13,953
	36-40	8,387	10,652	14,584
	41-45	9,073	11,358	15,463
1A+2C	**18-25**	7,341	8,889	12,087
	26-30	8,153	10,326	14,022
	31-35	8,939	11,035	15,082
	36-40	9,073	11,483	15,713
	41-45	9,977	12,453	16,951
2A+1C	**18-25**	8,188	9,913	13,480
	26-30	8,999	11,351	15,415
	31-35	9,969	12,404	16,939
	36-40	10,275	12,996	17,792
	41-45	11,523	14,496	19,763
2A+2C	**18-25**	8,802	10,656	14,490
	26-30	9,613	12,094	16,425
	31-35	10,655	13,236	18,069
	36-40	10,962	13,827	18,922
	41-45	12,427	15,591	21,252

Taxes extra

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

Rate chart for any Additional child:

Without TPA Charges	Eldest Age Band	300000	500000	1000000
Zone 1	**18-25**	614	704	956
	26-30	614	704	956
	31-35	702	805	1094
	36-40	702	805	1094
	41-45	968	1111	1509
Zone 2	**18-25**	595	681	925
	26-30	595	681	925
	31-35	681	779	1058
	36-40	681	779	1058
	41-45	939	1074	1460
Zone 3	**18-25**	486	588	800
	26-30	486	588	800
	31-35	556	673	915
	36-40	556	673	915
	41-45	766	928	1262

With TPA Charges	Eldest Age Band	300000	500000	1000000
Zone 1	**18-25**	635	729	989
	26-30	635	729	989
	31-35	727	833	1,132
	36-40	727	833	1,132
	41-45	1,002	1,150	1,562
Zone 2	**18-25**	616	705	957
	26-30	616	705	957
	31-35	705	806	1,095
	36-40	705	806	1,095
	41-45	972	1,112	1,511
Zone 3	**18-25**	503	609	828
	26-30	503	609	828
	31-35	575	697	947
	36-40	575	697	947
	41-45	793	960	1,306

Taxes extra

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

Loading for Optional Cover – Both Individual and Floater

	Optional Cover	Loading on Premium
Optional 1	Waiver of pre-existing waiting period of Diabetes or Hypertension	10%
	Waiver of pre-existing waiting period of Diabetes and Hypertension	15%
Optional 2	Double SI for 11 critical illness	18%