

National Young India Mediclaim Plus Policy

Whereas the Proposer designated in the Schedule hereto has by a proposal together with declaration, which shall be the basis of this Contract and is deemed to be incorporated herein, has applied to National Insurance Company Ltd. (hereinafter called the Company), for the insurance hereinafter set forth, in respect of person(s) named in the Schedule hereto (hereinafter called the Insured Persons) and has paid the premium as consideration for such insurance.

1 PREAMBLE

The Company undertakes that if during the Policy Period stated in the Schedule, any Insured Person(s) shall suffer any illness or disease (hereinafter called Illness) or sustain any bodily injury due to an Accident (hereinafter called Injury), requiring Hospitalisation of such Insured Person(s), for In-Patient Care at any hospital/nursing home (hereinafter called Hospital) or for Day Care Treatment at any Day Care Center, following the Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify the Hospital or the Insured, Reasonable and Customary Charges incurred for Medically Necessary Treatment towards the Coverage mentioned herein.

Provided further that, the amount payable under the Policy in respect of all such claims during the Policy Year of the Policy Period shall be subject to the coverage, terms, exclusions, conditions, definitions and sub limits contained herein as well as shown in the Table of Benefits, and shall not exceed the Basic Sum Insured (Individual or Floater) opted, Cumulative Bonus (if any) and Reinstated Basic Sum Insured (if applicable as per terms).

2 DEFINITIONS

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

2.2 Age / Aged: means completed years on last birthday as on Policy commencement date.

2.3 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.

2.4 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.

2.5 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:

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

2.6 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:

- Central or State Government AYUSH Hospital or
- Teaching hospital attached to AYUSH College recognized by the Central Government/ Central Council of Indian Medicine/ Central Council for Homeopathy; or
- 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:
 - Having at least 5 in-patient beds;
 - Having qualified AYUSH Medical Practitioner in charge round the clock;
 - Having dedicated AYUSH therapy sections as required;
 - Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative

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

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

2.9 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.

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

2.11 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.

2.12 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.

2.13 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.

2.14 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 overt 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.

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

2.16 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.

2.17Day 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.

2.18Dental Treatment means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.

2.19Diagnosis means diagnosis by a Medical Practitioner, supported by clinical, radiological, histological and laboratory evidence, acceptable to the Company.

2.20Grace 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 Premium payment in instalments, if the due instalment premium is paid within the Grace Period, coverage shall be available during the Grace Period.

In case of Renewal, Coverage shall not be available during the period for which no premium is received.

2.21Hospital 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.

2.22Hospitalisation means admission in a Hospital for a minimum period of twenty four (24) consecutive Inpatient Care hours except for procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.

2.23I D Card means the card issued to the Insured Person by the TPA for availing Cashless Facility.

2.24Illness 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

2.25Injury 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.

2.26In-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.

2.27Insured/ Insured Person means person(s) named in the Schedule of the Policy.

2.28Intensive 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.

2.29ICU (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.

2.30Medical Advice means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

- 2.31 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.
- 2.32 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.
- 2.33 Medically Necessary Treatment** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which
- is required for the medical management of Illness or Injury suffered by the Insured Person;
 - must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
 - must have been prescribed by a Medical Practitioner;
 - must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
- 2.34 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.
- 2.35 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.
- 2.36 Network Provider** means Hospitals or Day Care Centers enlisted by the Company, TPA or jointly by the Company and TPA to provide medical services to an Insured Person by a Cashless Facility.
- 2.37 Non- Network Provider** means any Hospital, Day Care Centre that is not part of the network.
- 2.38 Notification of Claim** means the process of intimating a claim to the Company or TPA through any of the recognized modes of communication.
- 2.39 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.
- 2.40 Policy Period** means period of one policy year / three policy years as mentioned in the schedule for which the Policy is issued.
- 2.41 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
- 2.42 Pre-existing disease (PED)** means any condition, ailment, injury or disease:
- 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
 - 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.
- 2.43 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.
- 2.44 Pre-hospitalisation Medical Expenses** means Medical Expenses incurred during predefined number of days preceding the Hospitalisation of the Insured Person, provided that:
- Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
 - The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Company.
- 2.45 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.
- 2.46 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.
- 2.47 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.

2.48 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.

2.49 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.

2.50 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.

2.51 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.

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

2.53 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.

2.54 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

2.55 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.

2.56 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.

2.57 Surrogate mother (as per Surrogacy Act 2021, related amendments and Rules) means a woman who agrees to bear a child (who is genetically related to the insured intending couple or intending woman) through surrogacy from the implantation of embryo in her womb and should possess an eligibility certificate issued by the appropriate authority on fulfillment of below conditions:

- A married woman having a child of her own
- 25 - 35 years of age as on the day of implantation
- Shall not provide her own gametes.
- Shall not act as a 'Surrogate Mother' for more than once in her lifetime.
- Shall possess a certificate of medical and psychological fitness for surrogacy and surrogacy procedures from a registered medical practitioner

2.58 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.

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

2.60 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.

3 BENEFITS COVERED UNDER THE POLICY

3.1 COVERAGE

3.1.1 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 limit as per Section 3.1.1.1

- 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

3.1.1.1 Limit for Room Rent and Intensive Care Unit Charges

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

3.1.1.2 Limit for Cataract

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

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

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

Note:

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

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

- a. Cost of pharmacy and consumables;
- b. Cost of implants and medical devices
- c. Cost of diagnostics
3. Sub limits as mentioned above, will not apply in case of treatment undergone in a Preferred Provider Network (PPN) for a listed procedure as per eligible package.
4. Preferred Provider Network list is dynamic in nature, and will be updated in the Company's website from time to time

3.1.2 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.

3.1.3 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.

3.1.4 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.

3.1.5 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.

3.1.6 Ambulance Charges

The Company shall indemnify the expenses incurred for transportation to the Hospital or from the Hospital to another Hospital or from the Hospital to diagnostic center and return to the Hospital during the same Hospitalisation, up to the limit as shown in the Table of Benefits, provided an In-patient Care claim has been admitted under Section 3.1.1.

Air Ambulance Charges, shall also be payable up to the limit as shown in the Table of Benefits, provided requirement of an Air Ambulance has been prescribed by a medical practitioner and an In-patient Care claim has been admitted under Section 3.1.1.

3.1.7 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 the 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.

Maternity Expenses of Surrogate Mother shall be payable, provided a claim is admitted under Section 3.1.12 (Infertility)

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 any 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 3.1.12 (Infertility)
6. Ectopic pregnancy
7. Pre and post hospitalisation expenses, other than pre and post natal treatment.

3.1.8 Infertility

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

Exclusions

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

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

Conditions

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

Definitions for the purpose of the Section

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

congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments.

3.1.9 HIV/ AIDS Cover

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

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

3.1.10 Mental Illness Cover

The Company shall indemnify the Medical Expenses for In-patient Treatment, 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

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

3.1.11 Modern Treatment

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

Modern Treatment	SI INR 5,00,000	SI INR 10,00,000	SI INR 15,00,000 & INR 25,00,000	Coverage
UAE & HIFU	INR 1,25,000 per Hospitalisation	INR 1,25,000 per Hospitalisation	INR 1,50,000 per Hospitalisation	Limit is for component cost only
Balloon Sinuplasty	INR 75,000 per Hospitalisation	INR 75,000 per Hospitalisation	INR 1,00,000 per Hospitalisation	Limit is for Balloon cost only
Deep Brain Stimulation	INR 1,25,000 per Hospitalisation	INR 2,50,000 per Hospitalisation	INR 3,50,000 per Hospitalisation	Limit is for implants including batteries only
Oral Chemotherapy	INR 75,000 per Hospitalisation, and 50% of SI during the Policy Period	INR 75,000 per Hospitalisation, and 50% of SI during the Policy Period	INR 1,00,000 per Hospitalisation, and 50% of SI during the Policy Period	Only cost of medicines payable under this limit, other incidental charges like investigations and consultation charges not payable.
Immunotherapy	INR 1,25,000 per Hospitalisation, and 50% of SI during the Policy Period	INR 1,50,000 per Hospitalisation, and 50% of SI during the Policy Period	INR 2,50,000 per Hospitalisation, and 50% of SI during the Policy Period	Limit is for cost of injections only.
Intravitreal injections	INR 75,000 per Hospitalisation, and 50% of SI during the Policy Period	INR 75,000 per Hospitalisation, and 50% of SI during the Policy Period	INR 1,00,000 per Hospitalisation, and 50% of SI during the Policy Period	Limit is for complete treatment, including Pre & Post Hospitalization
Robotic Surgery	INR 1,25,000 per Hospitalisation	INR 2,00,000 per Hospitalisation	INR 3,00,000 per Hospitalisation	Limit is for robotic component only.
Stereotactic Radio surgeries	INR 1,25,000 per Hospitalisation	INR 2,50,000 per Hospitalisation	INR 3,50,000 per Hospitalisation	Limit is for radiation procedure.
Bronchial Thermoplasty	INR 1,00,000 per Hospitalisation	INR 1,00,000 per Hospitalisation	INR 2,00,000 per Hospitalisation	Limit is for complete treatment, including Pre & Post Hospitalization
Vaporization of the prostate	INR 1,00,000 per Hospitalisation	INR 1,00,000 per Hospitalisation	INR 2,00,000 per Hospitalisation	Limit is for LASER component only.
IONM	INR 50,000 per Hospitalisation	INR 50,000 per Hospitalisation	INR 1,00,000 per Hospitalisation	Limit is for IONM procedure only.
Stem cell therapy	INR 1,25,000 per Hospitalisation	INR 2,50,000 per Hospitalisation	INR 3,50,000 per Hospitalisation	Limit is for complete treatment, including Pre & Post Hospitalization

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

3.1.12 Morbid Obesity Treatment

The Company shall indemnify the Medical Expenses for In-patient Treatment, 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:

- Treatment has been conducted is upon the advice of the Medical Practitioner, and

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

3.1.13 Correction of Refractive Error

The Company shall indemnify the Medical Expenses for In-patient Treatment, 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 dioptries, 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-I 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 under 3.1.1 to 3.1.13 are subject to the Sum Insured.

3.2 OTHER BENEFITS

3.2.1 Reinstatement of Basic Sum Insured

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

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

3.2.2 Personal Accident Cover

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

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

- a) **Death:** 100% of Sum Insured shall be payable, on death of the Insured Person, due to an Injury sustained in an Accident during the Policy Period, provided that the Insured Person's death occurs within 12 months from the date of the Accident. Where claim payment has been made owing to disappearance of Insured Person following an Accident, if after the payment of accidental death claim, it is found that the Insured Person has survived the Accident, then the policyholder has to refund the payment back to the Company in consideration of the obligatory guarantee as provided during the claim.
- b) **Permanent Total Disablement:** 100% of Sum Insured shall be payable, if an Insured Person suffers Permanent Total Disablement of the nature specified below, solely and directly due to an Accident during the Policy Period, provided that the Permanent Total Disablement occurs within 12 months from the date of the Accident:
 - a) Total and irrecoverable loss of sight of both eyes or
 - b) Physical separation or loss of use of both hands or feet or
 - c) Physical separation or loss of use of one hand and one foot or
 - d) loss of sight of one eye and Physical separation or loss of use of hand or foot
 - e) If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Insured Person from engaging in any employment or occupation of any description whatsoever.
- c) **Permanent Partial Disablement:** Following percentage of Sum Insured shall be payable, if the Insured Person suffers Permanent Partial Disablement of the nature specified below solely and directly due to an Accident during the Policy Period provided that the Permanent Partial Disablement shall occur within 12 months of the date of the Accident.

Sl. No.	Loss Covered	Percentage of Sum Insured
	Loss of Use/ Physical Separation:	
	One entire hand	50%
	One entire foot	50%
1.	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%
	Loss of thumb	
6.	- both phalanges	25%
	- one phalanx	10%
	Loss of Index finger -	
7.	three phalanges	10%
	two phalanges	8%
	one phalanx	4%
	Loss of middle finger –	
8.	three phalanges	6%
	two phalanges	4%
	one phalanx	2%
	Loss of ring finger -	
9.	three phalanges	5%
	two phalanges	4%
	one phalanx	2%
	Loss of little finger –	
10.	three phalanges	4%
	two phalanges	3%
	one phalanx	2%
	Loss of metacarpus -	
11.	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:

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

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

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

- Any claim for death or disablement (whether of a permanent nature or of a temporary nature), directly or indirectly due to War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
- Any claim for death, disablement (whether of a permanent nature or of a temporary nature)
 - from intentional self-injury unless in self-defense or to save life, suicide or attempted suicide;
 - whilst under the influence of intoxicating liquor or drugs or other intoxicants except where the Insured Person is not directly responsible for the injury / accident though under influence of intoxication.
 - whilst engaging in aviation or ballooning, or whilst mounting into, or dismounting from or travelling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any Scheduled Airlines in the world.
[Standard type of aircraft means any aircraft duly licensed to carry passengers (for hire or otherwise) by appropriate authority irrespective of whether such an aircraft is privately owned or chartered or operated by a regular airline or whether such an aircraft has a single engine or multiengine]
 - arising or resulting from the Insured Person committing any breach of law with criminal intent.
- Any claim for death, disablement (whether of a permanent nature or of a temporary nature), due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
- Any claim resulting or arising from or any consequential loss directly or indirectly caused by or contributed to or arising from:
 - Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel or from any nuclear waste from combustion (including any self-sustaining process of nuclear fission) of nuclear fuel.
 - Nuclear weapons material

- C. The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.
- D. Nuclear, chemical and biological terrorism
- e) Any loss arising out of the Insured Person's actual or attempted commission of or wilful participation in an illegal act or any violation or attempted violation of the law.

3.2.3 Domestic Travel Cover

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

Common Carrier for the purpose of this Policy shall mean any scheduled airline, scheduled railway, scheduled-motor transport, scheduled waterborne vessel (which shall include ocean going and / or coastal vessels) or contract carriage commercial vehicle operating under license issued by the appropriate authority for transportation of passengers for hire by issuing valid ticket/ travel document. Common carrier does not include automobiles owned by the Insured Person, private vehicles and any two-wheeled motor vehicle.

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

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

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

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

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

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

Section- 1: Repatriation of Mortal Remains

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

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

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

This Benefit will be payable provided that:

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

Exclusions applicable to Section 2.

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

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

Section-3. Trip cancellation & Interruption

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

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

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

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

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

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

This Cover Benefit will be payable provided that:

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

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

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

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

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

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

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

Terms and conditions applicable to Section 5.

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

Section 6. Compassionate Allowance

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

The benefit is payable provided that

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

For the purpose of this cover,

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

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

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

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

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

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

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

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

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

3.3 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.

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

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 Optional Cover and additional premium shall not apply.

3.4 GOOD HEALTH INCENTIVES

3.4.1 Cumulative Bonus (CB)

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

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

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

Note:

- a) No Cumulative Bonus will be added if the Policy is not renewed with the Company by the end of the Grace Period.
- b) The Cumulative Bonus will not be accumulated in excess of 40% of the Basic Sum Insured under the current Policy with the Company under any circumstances.

- c) Any Cumulative Bonus that has accrued for a Policy Year will be credited at the end of the Policy Period if the policy is renewed with the Company within Grace Period and will be available for any claims made in the subsequent Policy Period.
- d) **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.
- e) **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
- f) Claim under Personal Accident Cover or Domestic Travel Cover only, without any related Hospitalisation, shall not affect CB.

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)

- 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.
- In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
- Coverage under the policy after the expiry of 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)

- Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 90 days/ one year/ two year/ three years (as specified against specific disease/ procedure) of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident
- In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing Diseases, then the longer of the two waiting periods shall apply.
- The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
- List of specific diseases/procedures

i. 90 Days Waiting Period (Life style conditions)

- Hypertension and related complications
- Diabetes and related complications
- Cardiac conditions

ii. One year Waiting Period

- Benign ENT disorders
- Tonsillectomy
- Adenoidectomy
- Mastoidectomy
- Tympanoplasty

iii. Two years Waiting Period

- Cataract and age related eye ailments
- Refractive error of the eye more than 7.5 dioptries.
- Benign prostatic hypertrophy
- Hernia

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:

- Joint replacement unless necessitated due to an accident
- Osteoarthritis and osteoporosis
- Obesity and its complications
- 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)

- 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.
- This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve (12) months.
- The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

- Hydrocele
- Fissure/Fistula in anus
- Piles (Haemorrhoids)
- Sinusitis and related disorders
- Polycystic ovarian disease
- Non-infective arthritis
- Pilonidal sinus
- Gout and Rheumatism
- Calculus diseases
- Surgery of gall bladder and bile duct excluding malignancy
- Surgery of genito-urinary system excluding malignancy
- Surgery for prolapsed intervertebral disc unless arising from accident
- Surgery of varicose vein
- Congenital Internal Anomaly

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 dioptries.

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 (as listed in respective Appendix-I).

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 footwear, glucometer, thermometer and similar related items (as listed in respective Appendix-I) and any medical equipment which could be used at home subsequently.

5.29. Items of personal comfort

Items of personal comfort and convenience (as listed in respective Appendix-I) 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 (as listed in respective Appendix-I) 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, misdescription 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 and accrued Cumulative Bonus (as part of the sum insured) of the previous policy. Migration benefit shall not apply to any other additional increased Sum Insured.

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

6.8 Portability

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

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

6.9 Renewal of Policy

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

- 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.

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 Premium Payment in installments

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

- i. Grace Period (as defined) would be given to pay the instalment premium due for the policy.
- ii. If Installment Premium is not paid within Grace Period, the Policy shall be cancelled and no refund shall be allowed. However, if the premium is paid in instalments within the Grace Period, coverage shall be available during the Grace Period.
- iii. In case of instalment premium due not received within the Grace Period, the Policy will get cancelled.
- iv. In case of a claim being admissible under the Policy, all the remaining installments for the Policy Period shall become due and payable immediately.
- v. Change of Premium Paying Frequency can be opted only at the time of renewal

6.13 Revision of Terms of the Policy Including the Premium Rates

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

6.14 Free Look Period

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

The insured person shall be allowed free look period of 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.

6.15 Nomination

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

6.16 Communication

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

6.17 Physical Examination

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

6.18 Claim Procedure

6.18.1 Notification of Claim

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

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

6.18.2 Procedure for Cashless Claims

- Cashless Facility for treatment in Network Providers or any other provider can be availed, if TPA service is opted.
- Treatment may be taken in a network provider / PPN or any other provider and is subject to pre-authorization by the TPA. Updated list of network provider/PPN is available on the website of the Company and the TPA mentioned in the schedule.
- Cashless request form available with the Network Provider and TPA shall be completed and sent to the TPA for authorization.
- 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.
- At the time of discharge, the Insured Person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
- The TPA shall grant the final authorization within three hours of the receipt of discharge authorization request from the Hospital.
- The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
- 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.

6.18.3 Procedure for Reimbursement of Claims

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

6.18.4 Documents

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

- Completed claim form
- Medical practitioner's prescription advising admission for inpatient treatment.
- Cash-memo from the hospital (s)/chemist (s) supported by proper prescription from attending medical practitioner for Pre Hospitalisation, Hospitalisation and Post Hospitalisation.
- 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.
- Attending medical practitioner's certificate regarding Diagnosis along with date of Diagnosis and bill, receipts etc.
- Surgeon's certificate regarding Diagnosis and nature of operation performed along with bills, receipts etc.
- Bills, receipt, sticker of the Implants.
- Bills, payment receipts, medical history of the patient recorded, discharge certificate/ summary, break up of final bill from the hospital etc.
- Any other document required by Company/TPA.
- The documents required in support of claim under Personal Accident Cover:

Death

- Attending Doctors Report
 - Original policy for cancellation
 - Original Death Certificate
 - Original / attested Post Mortem / Coroners Report, where applicable
 - Attested copy of FIR / Panchnama
 - Police Inquest report, where applicable
 - Any other document required by the company
- Post mortem report if necessary, be furnished within the space of fourteen days after demand in writing

Disablement/Permanent Total Disablement

- i. Attending Doctors Report
 - ii. Original policy for cancellation in case of Permanent Total Disablement
 - iii. Disability Certificate from Govt. Registered Medical Practitioners, where applicable
 - iv. Diagnostic reports like laboratory test, X- rays and/ or any other reports confirming injury
 - v. Police Inquest report, where applicable
 - vi. Any other document required by the company
- xi. The documents required in support of claim under Domestic Travel Cover:
Claim documents must be submitted to the Company not later than one (1) month after occurrence of the event or after completion of the treatment.

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

Section	Sections	Documents to be submitted
1	Repatriation Of Mortal Remains	<ul style="list-style-type: none"> In case of transportation of the body of the deceased to the Place of Residence, the receipt for expenses incurred towards preparation and packing of the mortal remains of the deceased and also for the transportation of the mortal remains of the deceased. Copy of Embalming certificate, if any Flight itinerary and Boarding pass and/or ticket details as applicable Copy of death certificate. Post mortem report, if conducted.
2	Trip Delay (applicable only for air travel) (beyond 12 hour)	<ul style="list-style-type: none"> Copy of ticket & boarding pass, Certificate from the Common Carrier confirming the delay and detailing the circumstances of delay. (Mandatory) Copies of correspondence with airline authorities certifying the delay, along with details of compensation received from airlines / other authorities (if any)
3	Trip cancellation & Interruption	<ul style="list-style-type: none"> Confirmation of cancellation of the Trip detailing the circumstances of cancellation; Original ticket/ boarding pass issued by the Common Carrier indicating the cost of the ticket and receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the Trip, the cancellation charges retained; Original bill and a receipt / letter obtained from the hotel and / or guest house and / or any other paid residential accommodation (available for fee) indicating the amount paid for the accommodation, the refund given and the cancellation charges retained, wherever such accommodation has been arranged at the place of cancellation of the Trip; Ticket issued by the Common Carrier in original for the covered Trip which indicate the cost of the tickets together with the receipts for the refunds obtained towards the unfulfilled portion of the Trip. In case the cancellation of the Trip shall result because of personal contingencies defined or a decision taken at the instance of the Insured arising out of the contingencies namely earthquake, storm, flood, inundation, cyclone, tempest & terrorism, the duly completed claims form to be accompanied by: <ul style="list-style-type: none"> Declaration from the Insured furnishing the circumstances that compelled him / her to cancel the Trip; Medical evidence as may be required by the Company in case of the cancellation of the Trip arising out of personal contingencies of the Insured; And any other document as may be appropriately applicable for the claims preferred under this section of the Policy
4	Carrier Cancellation (applicable only for air travel)	<ul style="list-style-type: none"> Confirmation from the Common Carrier of the cancellation of flight along with the reasons for cancellation.
5	Loss Of Checked-in Baggage (applicable only for air travel)	<ul style="list-style-type: none"> Copies of correspondence with airline authorities / others about loss of checked baggage, along with details of compensation received from airlines / other authorities (if any), Property Irregularity Report (Mandatory, to be obtained from airline), Undertaking in writing stating that in the event if the baggage is traced and returned to the Insured, he / she will be refunding the entire claim amount settled under this policy Flight itinerary
6	Compassionate Allowance	<ul style="list-style-type: none"> Medical records showing admission in ICU

Note:

- The Company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
- In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company

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

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

Waiver

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

6.18.6 Services Offered by TPA

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

The services offered by a TPA shall not include

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

6.18.7 Classification of Zone and Copayment

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

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

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

Zone II – Rest of India

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

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

6.19 Payment of Claim

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

6.20 Territorial Limit

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

6.21 Territorial Jurisdiction

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

6.22 Arbitration

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

6.23 Disclaimer

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

6.24 Enhancement of Basic Sum Insured

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

6.25 Adjustment of Premium for Overseas Travel Insurance Policy

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

7 REDRESSAL OF GRIEVANCE

In case of any grievance related to the Policy, the insured person may submit in writing to the Policy Issuing Office or Grievance cell at Regional Office of the Company for redressal. If the grievance remains unaddressed, the insured person may contact Customer Relationship Management Dept., National Insurance Company Limited, Premises No. 18-0374, Plot no. CBD-81, 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

TABLE OF BENEFITS

Name	National Young India Mediclaim Plus Policy (NYIMPP)		
Sum Insured	₹ 5L, 10L, 15L, 25L (Basic SI)		
Policy Period	1 year/ 2 years/ 3 years		
Product Type	Individual and Floater		
Coverage			
Hospitalisation	Room Rent – Single AC room charges (i.e., lowest single AC room category available in Hospital) ICU Charges – Actual ICU charges <i>Proportionate Deduction shall apply if opted for Room of higher category</i> <i>Sub limit will not apply in case of Hospitalisation in a Preferred Provider Network (PPN) as per eligible package</i> Cataract - Up to ₹ 40,000 per eye per year, Waiting Period 2 years Coverage for Modern Treatment (12 nos) – Subject to treatment wise limits and coverage Expenses due to hazardous or adventure sports (non-professionals) – Up to 25% of SI		
System of Medicine	Allopathy and AYUSH Covered up to SI		
In Built Features	Pre hospitalisation - 45 days immediately before hospitalisation		
	Post hospitalisation - 60 days immediately after discharge		
	Day Care Procedures covered upto SI		
	Ambulance Charges – Up to max of ₹ 2,000 per year		
	Air Ambulance Charges – Up to max of ₹ 50,000 per year		
	Hospitalisation coverage for HIV/AIDS and Genetic Disorders		
	Hospitalisation coverage for Mental Illness		
	Maternity Cover (1 delivery/ termination, Waiting Period 2 years) – up to INR 30,000 (SI 5L), INR 40,000 (SI 10L), INR 50,000 (SI 15L/25L)		
	Surrogacy Cover – Surrogate Mother covered up to Maternity Cover limits for maternity expenses only, Non-delivery related surrogacy expenses also covered within Maternity limits, provided no living child, Waiting period of 2 years		
	Infertility Cover - Up to INR 50,000 for SI 5/10/15L & Up to INR 75000 for SI 25L, Waiting period of 2 years, To be covered only once in a lifetime		
Others	Treatment of Morbid Obesity and Refractive Error of at least 7.5D, subject to Waiting Periods		
	Reinstatement of SI – Base SI will be restored to its original amount upon exhaustion. Not available for defined 11 CIs		
	Personal Accident Cover - Up to Basic SI, for death, permanent disability and permanent partial disability In case of Floater, PA cover to be available to Proposer only.		
Pre Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the Company shall be covered after 3 year Waiting Period		
Enhancement of SI	On Renewal		
Domestic Travel Cover	In-built annual cover, any number of domestic trips covered, single trip should be within 15 days Any one or multiple modes of common carrier such as Taxi, Bus, Train, Ship or Air travel, with record of travel		
	Repatriation of Mortal Remains	Indemnity	Upto INR 2000
	Trip Delay (applicable only for air travel) (beyond 12 hrs)	Benefit	INR 1000 per trip
	Trip cancellation & Interruption	Indemnity	Upto INR 1000 per trip
	Carrier Cancellation (applicable only for air travel)	Benefit	INR 1000 per trip
	Loss Of Checked-in Baggage (applicable only for air travel)	Benefit	INR 1000 per trip
	Compassionate Allowance	Benefit	INR 1000 per trip
Optional Covers			
Waiting period waiver of PED Diabetes and/or Hypertension	Option to waive waiting period of pre-existing Diabetes and/or Hypertension and covered since inception		
Good Health Incentives			
Cumulative Bonus	CB to increase by 10% of Basic SI in respect of each claim free Policy Year CB to decrease by 10% of Basic SI for each year with claim reported Maximum accumulation, 40% of the Basic SI of the renewed Policy		
	Add-on (cover available on payment of additional premium)		
Non-Medical Expenses	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

Please preserve the policy for all future reference.

List I – List of which coverage is not available in the policy	
Sl	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	VASOFIX SAFETY
List II – Items that are to be subsumed into Room Charges	
Sl	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES

6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES
List III – Items that are to be subsumed into Procedure Charges	
Sl	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE
List IV – Items that are to be subsumed into costs of treatment	
Sl	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP- COST
8	HYDROGEN PEROXIDE(SPIRIT) DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer & Strips
18	URINE BAG

The contact details of the Insurance Ombudsman offices are as below-

Areas of Jurisdiction	Office of the Insurance Ombudsman		
Gujarat , UT of Dadra and Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, Ahmedabad Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in	West Bengal, UT of Andaman and Nicobar Islands, Sikkim	Office of the Insurance Ombudsman, Kolkata Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in
Karnataka	Office of the Insurance Ombudsman, Bengaluru Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	Office of the Insurance Ombudsman, Lucknow 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, Bhopal 1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202/ 2769203 Email: bimalokpal.bhopal@cioins.co.in	Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N, S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.	Office of the Insurance Ombudsman, Mumbai 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in
Orissa	Office of the Insurance Ombudsman, Bhubaneswar 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 / 2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshahr, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	Office of the Insurance Ombudsman, Noida Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in
Punjab, Haryana (excluding Gurugram, Faridabad, Sonapat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.	Office of the Insurance Ombudsman, Chandigarh Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: bimalokpal.chandigarh@cioins.co.in	Bihar, Jharkhand.	Office of the Insurance Ombudsman, Patna 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in
Tamil Nadu, UT– Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	Office of the Insurance Ombudsman, Chennai Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region	Office of the Insurance Ombudsman, Pune Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in
Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh.	Office of the Insurance Ombudsman, Delhi 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 46013992/23213504/23232481 Email: bimalokpal.delhi@cioins.co.in		
Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, Guwahati Jeevan Nivesh, 5th Floor, Near Pan Bazar , S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 / 2631307 Email: bimalokpal.guwahati@cioins.co.in		
Andhra Pradesh, Telangana and UT of Yanam – a part of the UT of Pondicherry	Office of the Insurance Ombudsman, Hyderabad 6-2-46, 1st floor, "Moin Court", Lane Opp.Hyundai Showroom , A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325 Email: bimalokpal.hyderabad@cioins.co.in		
Rajasthan	Office of the Insurance Ombudsman, Jaipur Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363 Email: bimalokpal.jaipur@cioins.co.in		
Kerala , UT of (a) Lakshadweep, (b) Mahe – a part of UT of Pondicherry	Office of the Insurance Ombudsman, Kochi 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in		