carē 10 YEARS
HEALTH INSURANCE

carē plus

Know Your Policy Better

Policy Terms and Conditions

1. Preamble

The proposal and declaration given by the proposer and other documents if any shall form the basis of this Contract and is deemed to be incorporated herein. The two parties to this contract are the Policy Holder/Insured/Insured Persons (also referred as You) and Care Health Insurance Limited (also referred as Company/ We/Us), and all the Provisions of Indian Contract Act, 1872, shall hold good in this regard. The references to the singular include references to the plural; references to the male include the references to the female; and references to any statutory enactment include subsequent changes to the same and vice versa. The sentence construction and wordings in the Policy documents should be taken in its true sense and should not be taken in a way so as to take advantage of the Company by filing a claim which deviates from the purpose of Insurance.

In return for premium paid, the Company will pay the Insured in case a valid claim is made:

In consideration of the premium paid by the Policy Holder, subject to the terms & conditions contained herein, the Company agrees to pay/indemnify the Insured Person(s), the amount of such expenses that are reasonably and necessarily incurred up to the limits specified against respective Benefit in any Policy Year.

Please check whether the details given by you about the insured persons in the proposal form (a copy of which was provided at the time of issuance of cover for the first time) are incorporated correctly in the policy schedule. If you find any discrepancy, please inform us within 15 days from the date of receipt of the policy, failing which the details relating to the person/s covered would be taken as correct.

So also the coverage details may also be gone through and in the absence of any communication from you within 15 days from the date of receipt of the policy, it would be construed that the policy issued is correct and the claims if any arise under the policy will be dealt with based on proposal /policy details.

For the purposes of interpretation and understanding of the product the Company has defined, herein below some of the important words used in the product and for the remaining language and the words the Company believes to mean the normal meaning of the English language as explained in the standard language dictionaries. The words and expressions defined in the Insurance Act, IRDA Act, regulations notified by the Insurance Regulatory and Development Authority of India ("Authority") and circulars and guidelines issued by the Authority shall carry the meanings described therein. The terms and conditions, insurance coverage and exclusions, other Benefits, various procedures and conditions which have been built-in to the product are to be construed in accordance with the applicable provisions contained in the product.

The terms defined below have the meanings ascribed to them wherever they appear in this Policy and, where appropriate.

2. Definitions

2.1 Standard Definitions:

2.1.1 **Accidental / Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

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

(a) Central or State Government AYUSH Hospital or

(b) Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy;or

(c) AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;

ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;

ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

2.1.4 **Any One Illness (not applicable for Travel and Personal Accident Insurance)** means a continuous Period of Illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where the treatment was taken.

2.1.5 **Cashless Facility** means a facility extended by the insurer to the Insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network Provider by the insurer to the extent pre-authorization is approved.

2.1.6 **Condition Precedent** shall mean a Policy term or condition upon which the Insurer's liability under the

Policy is conditional upon.

2.1.7 **Congenital Anomaly** refers to a condition which is present since birth, and which is abnormal with reference to form, structure or position :

i. Internal Congenital Anomaly – Congenital anomaly which is not in the visible and accessible parts of the body.

ii. External Congenital Anomaly – Congenital anomaly which is in the visible and accessible parts of the body.

2.1.8 **Co-payment** is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured.

2.1.9 **Cumulative Bonus** shall mean any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

2.1.10 **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under—

i. Has qualified nursing staff under its employment;

ii. Has qualified Medical Practitioner/s in-charge;

iii. Has a fully equipped operation theatre of its own, where Day Care Treatment is carried out.

iv. Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

2.1.11 **Day Care Treatment** means medical treatment, and/ or Surgical Procedure which is:

i. undertaken under general or local anesthesia in a Hospital/ Day Care Centre in less than 24 consecutive hours because of technological advancement, and

ii. which would have otherwise required a Hospitalization of more than 24 hours.

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

2.1.12 **Deductible** is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

2.1.13 **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

2.1.14 **Disclosure to Information Norm:** 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.

2.1.15 **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

i. The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or

ii. The patient takes treatment at home on account of non-availability of room in a Hospital.

2.1.16 **Emergency Care (Emergency)** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured Person's health.

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

2.1.18 **Hospital** (not applicable for Overseas Travel Insurance) means any institution established for in-patient care and day care treatment of illness and/or 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 the 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 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient 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 makes these accessible to the insurance company's authorized personnel.

2.1.19 **Hospitalization** (not applicable for Overseas Travel Insurance) means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

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

(a) Acute condition - Acute condition is 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.

(b) Chronic condition - A chronic condition is defined as 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 specially trained to cope with it;

(d) It continues indefinitely;

(e) It recurs or is likely to recur.

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

2.1.22 **In-patient Care** (not applicable for Overseas Travel Insurance) means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

2.1.23 **Intensive Care Unit (ICU)** 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.

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

2.1.25 **Maternity expenses** shall include—

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.

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

2.1.27 **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.

2.1.28 **Medical Practitioner** (not applicable for Overseas Travel Insurance) is 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 license.

2.1.29 **Medically Necessary Treatment** (not applicable for Overseas Travel Insurance) means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

a. Is required for the medical management of the Illness or Injury suffered by the Insured Person;

b. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

c. Must have been prescribed by a Medical Practitioner;

d. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

2.1.30 **Migration** means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

2.1.31 **Network Provider** (not applicable for Overseas Travel Insurance) means the Hospitals enlisted by an Insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured by a Cashless Facility.

2.1.32 **Newborn baby** means baby born during the Policy Period and is aged up to 90 days.

2.1.33 **Non - Network Provider:** Non-Network means any hospital, day care centre or other provider that is not part of the network.

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

2.1.35 **OPD Treatment** is 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.

2.1.36 **Portability** means the right accorded to individual health insurance policyholders (including all members under family cover) to transfer the credit gained for pre-existing conditions and time-bound exclusions, from one insurer to another insurer.

2.1.37 **Pre-existing Disease** means any condition, ailment, injury or disease

i. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or

ii. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by insurer or its reinstatement.

2.1.38 **Pre-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days

preceding the hospitalization of the Insured Person, provided that :

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

2.1.39 **Post-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the Hospital provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required and

ii. The inpatient Hospitalization claim for such Hospitalization is admissible by the Company.

2.1.40 **Qualified Nurse** (not applicable for Overseas Travel Insurance) is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

2.1.41 **Reasonable and Customary Charges** (not applicable for Overseas Travel Insurance) 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.

2.1.42 **Renewal** defines 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.

2.1.43 **Room Rent** means the amount charged by a Hospital towards Room & Boarding expenses and shall include the associated medical expenses.

2.1.44 **Subrogation** (Applicable to other than Health Policies and health sections of Travel and PA policies) means the right of the Insurer to assume the rights of the Insured Person to recover expenses paid out under the Policy that may be recovered from any other source.

2.1.45 **Surgery/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 from suffering or prolongation of life, performed in a Hospital or a Day Care Centre by a Medical Practitioner.

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

2.2 **Specific Definitions:**

2.2.1 **Age** means the completed age of the Insured Person as on his last birthday.

2.2.2 **Ambulance** means a vehicle operated by a licensed/ authorized service provider and equipped for the transport and paramedical treatment of persons requiring medical attention.

2.2.3 **Annexure** means the document attached and marked as Annexure to this Policy.

2.2.4 **Claim** means a demand made in accordance with the terms and conditions of the Policy for payment of the specified Benefits in respect of the Insured Person.

2.2.5 **Claimant** means a person who possesses a relevant and valid Insurance Policy which is issued by the Company and is eligible to file a Claim in the event of a covered loss.

2.2.6 **Company (also referred as Insurer/We/Us)** means Care Health Insurance Limited.

2.2.7 **Consumer Price Index-** CPI is a measure of inflation; changes in the CPI are used to assess price changes associated with the cost of living. It is a measure that examines the weighted average of prices of a basket of consumer goods and services, such as transportation, food and medical care. It is calculated by taking price changes for each item in the predetermined basket of goods and averaging them.

2.2.8 **Diagnosis** means pathological conclusion drawn by a registered medical practitioner, supported by acceptable Clinical, radiological, histological, histo-pathological and laboratory evidence wherever applicable.

2.2.9 **Hazardous Activities** (or Adventure sports) means any sport or activity, which is potentially dangerous to the Insured whether he is trained or not. Such sport/activity includes (but not limited to) stunt activities of any kind, adventure racing, base jumping, biathlon, big game hunting, black water rafting, BMX stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/ pot holing, cave tubing, rock climbing/ trekking/ mountaineering, cycle racing, cyclo cross, drag racing, endurance testing, hand gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, lugging, risky manual labor, marathon running, martial arts, micro – lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/ parapenting, piloting aircraft, polo, power lifting, power boat racing, quad biking, river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting or wrestling of any type.

2.2.10 **Indemnity/Indemnify** means compensating the Insured Person up to the extent of Expenses incurred, on occurrence of an event which results in a financial loss and is covered as the subject matter of the Insurance Cover.

2.2.11 **Inflation** means a rise in the general level of prices, as measured against some baseline of purchasing power. Inflation measures how much more expensive a set of goods and services has become over a certain period, usually a year.

2.2.12 **Insured Event** means an event that is covered under the Policy; and which is in accordance with the Policy Terms & Conditions.

2.2.13 **Insured Person (Insured)** means a self, legally married spouse, dependent children, dependent parents or any other relationship having an insurable interest and whose name specifically appears under Insured in the Policy Schedule and with respect to whom the premium has been received by the Company.

2.2.14 **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize, 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 characterized by sub normality of intelligence.

2.2.15 **National Statistical Office (NSO)** is a government agency in India under the Ministry of Statistics and Programme Implementation responsible for co-ordination of statistical activities in India, and evolving and maintaining statistical standards.

2.2.16 **Nominee** means the person named in the Policy Schedule or as declared with the Policyholder who is nominated to receive the benefits under this Policy in accordance with the terms of the Policy, if the Insured Person is deceased.

2.2.17 **Preventive Care** means any kind of treatment taken as a pro-active care measure without actual requirement or symptoms of a disease or illness.

2.2.18 **Policy** means these Policy terms and conditions and Annexures thereto, the Proposal Form, Policy Schedule and Optional Cover (if applicable) which form part of the Policy and shall be read together.

2.2.19 **Policy Schedule** is a certificate attached to and forming part of this Policy.

2.2.20 **Policy Year** means a period of one year commencing on the Policy Period Start Date or any anniversary thereof.

2.2.21 **Policyholder** (also referred as You) means the person named in the Policy Schedule as the Policyholder.

2.2.22 **Policy Period** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date of the Policy as specifically appearing in the Policy Schedule.

2.2.23 **Policy Period End Date** means the date on which the Policy expires, as specifically appearing in the Policy Schedule.

2.2.24 **Policy Period Start Date** means the date on which the Policy commences, as specifically appearing in the Policy Schedule.

2.2.25 **Rehabilitation** means assisting an Insured Person who, following a Medical Condition, requires assistance in physical, vocational, independent living and educational pursuits to restore him to the position in which he was in, prior to such medical condition occurring.

2.2.26 **Sum Insured** means the amount specified in the Policy Schedule, for which premium is paid by the Policyholder

2.2.27 **Single Private AC Room** means an air conditioned room in a Hospital where a single patient along with the attendant is accommodated and which has an attached toilet (lavatory and bath). Such room type shall be the most basic and the most economical of all accommodations available as a Single room in that Hospital.

2.2.28 **Third Party Administrator or TPA** means a company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services as mentioned under IRDAI (TPA-Health Services) Regulations as amended from time to time.

2.2.29 **Associate Medical Expenses** means those Medical Expenses as listed below which vary in accordance with the Room Rent or Room Category applicable in a Hospital:

(a) Room, boarding, nursing and operation theatre expenses as charged by the Hospital where the Insured Person availed medical treatment;

(b) Fees charged by surgeon, anesthetist, Medical Practitioner;

Note: Associate Medical Expenses are not applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

3. Benefits Covered Under The Policy:

General Conditions Applicable To All The Benefits And Optional Benefits

1. Benefits / Optional Benefits (if opted) shall be available to the Insured Person, only if the particular Benefit / Optional Benefit are specifically mentioned in the Policy Schedule.

2. The maximum, total and cumulative liability of the Company in respect of an Insured Person for any and all Claims arising under this Policy during the Policy Year shall not exceed the Sum Insured as mentioned in the policy schedule against that benefit for that Insured Person.

   I. On Floater Basis, the Company's maximum, total and cumulative liability, for any and all Claims incurred during the Policy Year in respect of all Insured Persons, shall not exceed the Sum Insured as mentioned in the policy schedule.

   II. For any single Claim during a Policy Year, the maximum Claim amount payable shall be sum total of Sum Insured, Cumulative Bonus, Inflation Shield. (NOTE: This clause is not applicable to Benefit: Personal Accident Cover).

   III. All Claims shall be payable subject to the terms, conditions, exclusions, sub-limits and wait periods of the Policy and subject to availability of the Sum Insured.

3. The Co-payment proportion (if applicable) shall be borne by the Insured Person on each Claim which will be applicable on Benefit namely Hospitalization Expenses, Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses, Ambulance Cover, Organ Donor Cover, Domiciliary Hospitalization,

AYUSH Treatments, Air Ambulance Cover, OPD Cover, Optional Benefit: Maternity and New Born Cover.

4. Deductible Option (if opted) is applicable on the Benefits namely Hospitalization Expenses, Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses, Ambulance Cover, Organ Donor, Domiciliary Hospitalization, AYUSH Treatments, Air Ambulance Cover and Optional Benefit: Maternity & New Born cover.

5. Any Claim paid for Benefits namely Hospitalization Expenses, Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses, Ambulance Cover, Organ Donor, Domiciliary Hospitalization, AYUSH Treatments, Air Ambulance Cover, OPD Coverage and Optional Benefit: Maternity and New Born Cover shall reduce the Sum Insured for the Policy Year and only the balance shall be available for all the future claims for that Policy Year.

6. Admissibility of a Claim under Benefit "Hospitalization Expenses" is a pre-condition to the admission of a Claim under Pre Hospitalization Medical Expenses and Post Hospitalization Medical expenses, Ambulance Cover, Organ Donor Cover, Air Ambulance, Optional Benefit: Maternity & New Born cover, Optional Benefit: Daily Allowance and the event giving rise to a Claim under Benefit "Hospitalization Expenses" shall be within the Policy Period for the Claim of such Benefit to be accepted.

7. If the Insured Person suffers a relapse within 45 days from the date of last discharge / consultation from the Hospital for which a Claim has been made, then such relapse shall be deemed to be part of the same Claim and all the limits of Per Claim Limit under this Policy shall be applied as if they were under a single Claim.

8. Option of Mid-term inclusion of a Person in the Policy will be only upon marriage or child birth. Additional differential premium will be calculated on a pro rata basis.

9. Coverage amount for Benefit: Personal Accident Cover (AD & PTD) and Optional Benefit: Daily Allowance are covered over and above the 'Sum Insured'.

10. If Insured persons belonging to the same family are covered on an Individual basis, then every Insured person can opt for different Sum Insured and different Optional Benefit.

11. Optional Benefits opted are available for all members in a floater policy.

3.1 Base Benefits

3.1.1 Benefit : Hospitalization Expenses

If an Insured Person is diagnosed with an illness or suffers an injury and which requires the Insured Person to be admitted in a Hospital in India which should be Medically Necessary during the Policy Period and while the Policy is in force for:

(i) In-patient Care: The Company will indemnify the Insured Person for Medical Expenses incurred towards Hospitalization through Cashless or Reimbursement Facility, maximum up to the Sum Insured, as specified in the Policy Schedule, provided that the Hospitalization is for a minimum period of 24 consecutive hours and was prescribed in writing, by a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were Medically Necessary.

(ii) Day Care Treatment: The Company will indemnify the Insured Person for Medical Expenses incurred on all Day Care Treatments through Cashless or Reimbursement Facility, maximum up to the Sum Insured ,as specified in the Policy Schedule, provided that the period of treatment of the Insured Person in the Hospital/Day Care Centre does not exceed 24 hours, which would otherwise require an in-patient admission and such Day Care Treatments was prescribed in written, by a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were Medically Necessary.

(iii) Conditions applicable for Benefit "Hospitalization Expenses" :

a) Room, boarding and nursing expenses as charged by the Hospital where the Insured Person availed medical treatment (Room Rent / Room Category):

i. If the Insured Person is admitted in a Hospital room where the Room Category opted or Room Rent incurred is higher than the eligible Room Category/ Room Rent as specified in the Policy Schedule, then,

I. The Policyholder/Insured Person shall bear the ratable proportion of the total Associate Medical Expenses (including applicable surcharge and taxes thereon) in the proportion of the difference between the Room Rent actually incurred and the Room Rent specified in the Policy Schedule or the Room Rent of the entitled Room Category to the Room Rent actually incurred.

The Policy Schedule will specify the eligibility of Room Rent or Room Category applicable for the Insured Person under the Policy. The Room Rent or Room Category available under this Policy is mentioned as follows:

ii. **Single Private AC Room** If the Policy Schedule states 'Single Private AC Room' as eligible Room Category, it means the maximum eligible Room Category in case of Hospitalization of the Insured Person payable by the Company is limited to stay in a Single AC Private Room.

iii. If the Policy Schedule states 'up to 1% of the Sum Insured per day' as eligible Room Rent, it means the maximum eligible Room Rent of the Insured Person payable by the Company is limited to 1% of the Sum Insured per day of Hospitalization. Any amount accrued under "No Claim

Bonus Protect" or "Inflation Shield", shall not be considered under this "Room Rent" limit.

iv. The nomenclature of Room categories may vary from one hospital to the other. Hence, the final consideration will be as per the definition of the Rooms mentioned in the Policy.

b) Intensive Care Unit Charges (ICU Charges):

The Policy Schedule will specify the Limit of ICU Charges applicable for the Insured Person under the Policy. The ICU Charges available under this Policy are as follows:

i. If the Policy Schedule states 'up to 2% of the Sum Insured per day' as eligible ICU Charges per day of Hospitalization, it means the maximum eligible ICU charges of the Insured Person payable by the Company is limited to 2% of the Sum Insured per day of Hospitalization.

ii. If the Policy Schedule states the eligibility of ICU Charges of the Insured Person as 'no limit', it means that there is no separate restriction on ICU Charges incurred towards stay in ICU during Hospitalization.

(iv) Advance Technology Methods:

The Company will indemnify the Insured Person for expenses incurred under Benefit 'Hospitalization Expenses' for treatment taken through following advance technology methods:

A. Uterine Artery Embolization and HIFU

B. Balloon Sinuplasty

C. Deep Brain stimulation

D. Oral chemotherapy

E. Immunotherapy- Monoclonal Antibody to be given as injection

F. Intra vitreal injections

G. Robotic surgeries

H. Stereotactic radio surgeries

I. Bronchical Thermoplasty

J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)

K. IONM - (Intra Operative Neuro Monitoring)

L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

3.1.2 Benefit : Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses

The Company will indemnify the Insured Person for Medical Expenses incurred which are Medically Necessary, only through Reimbursement Facility, maximum up to the amount as specified in the Policy Schedule, provided that the Medical Expenses so incurred are related to the same Illness/Injury for which the Company has accepted the Insured Person's Claim under Benefit 'Hospitalization Expenses' and subject to the conditions specified below:

(i) Under Pre-hospitalization Medical Expenses, for a period of 60 days immediately prior to the Insured Person's date of admission to the Hospital, provided that the Company shall not be liable to make payment for any Pre-hospitalization Medical Expenses that were incurred before the Policy Start Date; and

(ii) Under Post-hospitalization Medical Expenses, for a period of 90 days immediately after the Insured Person's date of discharge from the Hospital and claim documents to be submitted within 30 days after completion of 90 days from the date of discharge from Hospital.

(iii) If the provisions of Clause 6.1.7(d)(Payment terms) is applicable to a Claim, then:

a) The date of admission to Hospital for the purpose of this Benefit shall be the date of the first admission to the Hospital for the Illness deemed or Injury sustained to be Any One Illness; and

b) The date of discharge from Hospital for the purpose of this Benefit shall be the last date of discharge from the Hospital in relation to the Illness deemed or Injury sustained to be Any One Illness.

3.1.3 Benefit : Ambulance Cover

The Company will indemnify the Insured Person, through Cashless or Reimbursement Facility, up to the amount specified against this Benefit in the Policy Schedule, provided that the Medical Expenses so incurred are related to the Illness or Injury for which the Company has accepted the Insured Person's Claim under Benefit 'Hospitalization Expenses' and subject to conditions as specified below:

(i) Such ambulance transportation is offered by a Hospital or by an Ambulance service provider for the Insured Person's necessary transportation; and

(ii) Such Transportation is from the place of occurrence of Medical Emergency of the Insured person, to the nearest Hospital; and/or

(iii) Such Transportation is from one Hospital to another Hospital for the purpose of providing better Medical aid to the Insured Person subject to treating Medical Practitioner certification.

3.1.4 Benefit : Organ Donor Cover

The Company will indemnify the Insured Person, through Cashless or Reimbursement Facility, up to the amount specified against this Benefit in the Policy Schedule, for the Medical Expenses incurred in respect of the donor, for any organ transplant surgery during the Policy Year, subject to the conditions specified below:

(i) The Organ donor is an eligible donor in accordance with The Transplantation of Human Organs Act, 1994 (amended) and other applicable laws and rules.

(ii) The Insured Person is the recipient of the Organ so donated by the Organ Donor.

(iii) The Company will not be liable to pay the Medical Expenses incurred by the Insured Person towards benefit 'Pre-Hospitalization Medical Expenses and Post Hospitalization Medical Expenses' or any other Medical Expenses in respect of the donor consequent to the harvesting.

(iv) The provision mentioned under clause no.3.1.1 (iii) (a) holds good for this benefit.

3.1.5 Benefit : Domiciliary Hospitalization

The Company will indemnify the Insured Person, only through Reimbursement Facility, up to the amount specified against this Benefit in the Policy Schedule, for the Medical Expenses incurred towards Domiciliary Hospitalization, i.e., Coverage extended when Medically Necessary treatment is taken at home (as explained in Definition 2.1.15), subject to the conditions specified below:

(i) The Medical Expenses are incurred during the Policy Year.

(ii) The Medical Expenses are Reasonable and Customary Charges which are necessarily incurred.

(iii) Any Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses shall be payable under this Benefit.

(iv) Any Medical Expenses incurred for the treatment in relation to any of the following diseases shall not be payable under this Benefit :

1. Asthma;
2. Bronchitis;
3. Chronic Nephritis and Chronic Nephritic Syndrome;
4. Diarrhoea and all types of Dysenteries including Gastro-enteritis;
5. Diabetes Mellitus and Diabetes Insipidus;
6. Epilepsy;
7. Hypertension;
8. Influenza, cough or cold;
9. All Psychiatric or Psychosomatic Disorders;
10. Pyrexia of unknown origin;
11. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis;
12. Arthritis, Gout and Rheumatism.

3.1.6 Benefit : Second Opinion

In the event that the Insured Person is diagnosed with any Illness / Injury during the Policy Year, then at the Insured Person's request, the Company shall arrange for a Second Opinion from a Medical Practitioner within India.

(i) It is agreed and understood that the Second Opinion will be based only on the information and documentation provided to the Company which will be shared with the Medical Practitioner and is subject to the conditions specified below:

a) This Benefit can be availed only once by an Insured Person during the Policy Year.

b) The Insured Person is free to choose whether or not to obtain the Second Opinion and, if obtained under this Benefit, then whether or not to act on it.

c) This Benefit is for additional information purposes only and does not and should not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.

d) The Company does not provide a Second Opinion or make any representation as to the adequacy or accuracy of the same, the Insured Person's or any other person's reliance on the same or the use to which the Second Opinion is put.

e) The Company does not assume any liability for and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner or in any Second Opinion or for any consequences of actions taken or not taken in reliance thereon.

f) The Policyholder or Insured Person shall hold the Company harmless for any loss or damage caused by or arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions or representations made by the Medical Practitioner or for any consequences of any action taken or not taken in reliance thereon.

g) Any Second Opinion provided under this Benefit shall not be valid for any medico-legal purposes.

h) The Second Opinion does not entitle the Insured Person to any consultation from or further opinions from that Medical Practitioner.

(ii) For the purposes of this Benefit only:

a) Second Opinion means an additional medical opinion obtained by the Company from a Medical Practitioner solely on the Policyholder's or Insured Person's express request in relation to Illness / Injury which the Insured Person has been diagnosed with during the Policy Year.

3.1.7 Benefit : Annual Health Check-up

(i) On the Insured Person's request, through Cashless Facility, the Company will arrange for the Insured Person's Annual Health Check-up for the list of medical tests specified below at its Network to provide the services, in India, subject to the

conditions specified below:

a) This Benefit shall be available only once during a Policy Year per adult Insured Person; and

b) This benefit does not reduce the Sum Insured.

(ii) Medical Tests covered in the Annual Health Check-up, applicable for Insured Persons who are of Age 18 years or above on the Policy Period Start Date, are as follows :-

Set No.	List of Medical Tests covered as a part of Annual Health Check-up	Sum Insured
1	Complete Blood Count(cbc), Urine Routine, Esr, Abo Group & Rh Type, Blood Sugar Fasting, Cholesterol, Sgpt, Creatinine	<5 Lakhs
2	Complete Blood Count(cbc), Urine Routine, Esr, Abo Group & Rh Type, Blood Sugar Fasting, Cholesterol, Cholesterol Direct Ldl, Cholesterol-hdl, Triglycerides, Total Cholesterol/hdl Ratio, Creatinine, Blood Urea Nitrogen, Bun / Creatinine Ratio, Uric Acid	5Lakhs-10Lakhs
3	Complete Blood Count(cbc), Urine Routine, Esr, Abo Group & Rh Type, Blood Sugar Fasting, Cholesterol, Cholesterol Direct Ldl, Cholesterol-hdl, Triglycerides, Total Cholesterol/hdl Ratio, Creatinine, Blood Urea Nitrogen, Bun/ Creatinine Ratio, Uric Acid, Treadmill Test	Above 10Lakhs

3.1.8 Benefit : Unlimited Automatic Recharge

If a Claim is payable under the Policy, then the Company agrees to automatically make the re-instatement of up to the base Sum Insured unlimited times in a policy year which is valid for that Policy Year only, subject to the conditions specified below:

(i) The Recharge shall be utilized only after the base Sum Insured, 'Cumulative Bonus', 'Inflation Shield' has been completely exhausted in that Policy Year.

(ii) A Claim will be admissible under the Recharge only if the Claim is admissible under Benefit 'Hospitalization Expenses'.

(iii) Recharge amount can be utilized for same illness except for claim under Any one Illness condition.

(iv) The Sum Insured available under Unlimited Automatic Recharge can only be utilized for Benefit 'Hospitalization Expenses', 'Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses', 'Ambulance Cover', 'Domiciliary Hospitalization' and Optional Benefit 'Maternity & New Born Cover'.

(v) In case of a floater policy, all Insured Person will be eligible to utilize the Recharged amount for any illness or injury pertaining to that Policy Year.

(vi) 'Cumulative Bonus' and 'Inflation Shield' shall not be considered while calculating 'Unlimited Automatic Recharge'.

(vii) Any unutilized Recharge cannot be carried forward to any subsequent Policy Year.

(viii) If the Policy is issued on a Floater basis, then the Recharge will also be available only on Floater basis.

3.1.9 Benefit : AYUSH Treatments

The Company will indemnify the Insured Person, through Cashless or Reimbursement Facility, up to the amount specified in the Policy Schedule, towards Medical Expenses incurred with respect to the Insured Person's medical treatment undergone at any AYUSH Hospitals or health care facilities for any of the listed AYUSH treatments namely Ayurveda, Sidha, Unani and Homeopathy, subject to the conditions specified below:

(i) A Claim will be admissible under this Benefit only if the Claim is admissible under 'In-patient Care' of Benefit 'Hospitalization Expenses'.

(ii) Medical Treatment should be rendered from a registered Medical Practitioner who holds a valid practicing license in respect of such AYUSH Treatments; and

(iii) Such treatment taken is within the jurisdiction of India; and

(iv) Clause 4.2 (b) (12) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

3.1.10 Benefit : Air Ambulance Cover

The Company will indemnify the Insured Person up to the amount specified against this Benefit in the Policy Schedule, for the Reasonable and Customary Charges necessarily incurred on availing Air Ambulance services, in India, offered by a Hospital or by an Ambulance service provider for the Insured Person's necessary transportation, provided that:

(i) The treating Medical Practitioner certifies in writing that the severity or the nature of the Insured Person's Illness or Injury warrants the Insured Person's requirement for Air Ambulance;

(ii) The transportation expenses under this benefit include transportation from the place of occurrence of Medical Emergency of the Insured person, to the nearest Hospital; and/or transportation from one Hospital to another Hospital for the purpose of providing better Medical aid to the Insured Person, following an Emergency;

(iii) This benefit will be extended only through Cashless Facility, if the costs are certified and authorized by the Company in advance. In case the Insured Person has a Life Threatening Medical Condition and the Insured Person (or his representatives) arranges for the emergency Air Ambulance at their own expense, then the Company will reimburse such costs incurred in accordance with the terms of this benefit;

(iv) Payment under this benefit is subject to a Claim

for the same Illness or Injury being admitted by the Company under Benefit 'Hospitalization Expenses';

(v) Additional Documents to be submitted for any Claim under this Benefit:

a) It is a condition precedent to the Company's liability under this benefit that the following information and documentation shall be submitted to the Company immediately and inany event within 30 days of the event giving rise to the Claim under this Benefit:

b) Medical reports and transportation details issued by the air ambulance service provider, prescriptions and medical report by the attending Medical Practitioner furnishing the name of the Insured Person and details of treatment rendered along with the statement confirm the necessity of air ambulance services.

c) Documentary proof for expenses incurred towards availing Air Ambulance services.

3.1.11 Benefit : No Claim Bonus Protect:

At the end of each Policy Year, the Company will enhance the Sum Insured by 50% flat, on a cumulative basis, as a Cumulative Bonus for each completed and continuous Policy Year, provided that no Claim has been paid by the Company or total claim amount payable does not exceed the 25% of the base Sum Insured in the expiring Policy Year, and subject to the conditions specified below:

(i) In any Policy Year, the accrued Cumulative Bonus, shall not exceed 200% of the Sum Insured available in the expiring Policy or renewed Policy, wherever Sum Insured is lower;

(ii) For a Floater policy, the Cumulative Bonus shall be available on Floater basis and shall accrue only if no Claim has been made in respect of any Insured Person or total claim amount payable does not exceed the 25% of the base Sum Insured during the expiring Policy Year. The Cumulative Bonus which is accrued during the expiring Policy Year will only be available to those Insured Persons who were insured in that Policy Year and continue to be insured in the subsequent Policy Year;

(iii) The entire Cumulative Bonus will be forfeited if the Policy is not continued / renewed on or before Policy Period End Date or the expiry of the Grace Period whichever is later;

(iv) The Cumulative Bonus shall be applicable on an annual basis subject to continuation of the Policy;

(v) If the Insured Persons in the expiring policy are covered on Individual basis and thus have accumulated the Cumulative Bonus for each Insured Person in the expiring policy, and such expiring policy is renewed with the Company on a Floater basis, then the Cumulative Bonus to be carried forward for credit in this Policy would be the least Cumulative Bonus amongst all the Insured Persons;

(vi) If the Insured Persons in the expiring policy are covered on a Floater basis and such Insured Persons renew their expiring Policy with the Company by splitting the Floater Sum Insured in to 2 (two) or more Floater / Individual covers, then the Cumulative Bonus of the expiring Policy shall be apportioned to such renewed Policy in the proportion of the Sum Insured of each of the renewed Policy;

(vii) In the event of total claim amount payable exceeds 25% of the base Sum Insured during any Policy Year, the accrued Cumulative Bonus will be reduced at same rate at which it is accrued at the commencement of next Policy Year;

(viii) In case Sum Insured under the Policy is reduced at the time of renewal, the applicable Cumulative Bonus shall also be reduced in proportion to the Sum Insured;

(ix) In case Sum Insured under the Policy is increased at the time of renewal, the Cumulative Bonus shall be calculated on the Sum Insured applicable on the last completed Policy Year;

(x) 'Unlimited Automatic Recharge' & 'Inflation Shield' shall not be considered while calculating 'Cumulative Bonus';

(xi) Accrued 'Cumulative Bonus' can be utilized for Benefit 'Hospitalization Expenses', 'Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses', 'Ambulance Cover', 'Organ Donor Cover', 'Domiciliary Hospitalization', 'AYUSH Treatment' and Optional Benefits 'Maternity & New Born Cover' under the Policy.

(xii) In case no claim or total claim amount payable does not exceed the 25% of the base Sum Insured (other than 'Second Opinion' 'Annual Health Check-up', 'OPD Coverage' 'Unlimited E-Consultation' 'Health Services' Optional Benefit 'International Second Opinion') in a particular Policy Year, Cumulative Bonus would be credited automatically to the subsequent Policy year, even in case of multi-year Policies (with 2 or 3 year policy tenure).

3.1.12 Benefit : OPD Coverage

The Company will indemnify the Insured Person, through Reimbursement/Cashless Facility, for availing the following:

a. **Out-patient Consultations:** Any Out-patient Consultation other than Dental and Ophthalmic Treatments up to the amount/limit as specified against this Benefit in the Policy Schedule, during the Policy Year.

b. **Out-patient Dental and Ophthalmic Treatments:**

i. Expenses incurred on acute treatment to a natural tooth or teeth or the services and supplies provided by a licensed dentist, up to the amount as specified against this

Benefit in the Policy Schedule during the Policy Year.

ii. Expenses incurred for the treatment of the eye or the services or supplies provided by a licensed ophthalmologist, that are medically necessary to treat eye problem including cost of spectacles / contact lenses, up to the amount as specified against this Benefit in the Policy Schedule during the Policy Year.

The above benefit is subject to the following conditions:

1. All the valid OPD claim expenses incurred by the Insured Person in a policy year will be payable / reimbursed by the Company. However, claim can be filed with the Company, only quarterly during that Policy Year, as and when that insured may deem fit. However, claimant will be allowed only 1 more filing within 30 days after the Policy Year.
2. Clause 4.2 (b) (10) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

3.1.13 Benefit : Personal Accident Cover (AD & PTD)

This Benefit includes two Benefits namely "Accidental Death" and "Permanent Total Disablement" which are explained below and are applicable to events arising worldwide:-

3.1.13.1 Accidental Death

If the Insured Person suffers an Injury during the Policy Period, which directly results in the Insured Person's death within 12 months from the date of Accident (including date of Accident), then the Company will pay 100% of the coverage amount of that Insured Person.

3.1.13.2 Permanent Total Disablement (PTD)

If the Insured Person suffers an Injury during the Policy Period, which directly results in the Insured Person's Permanent Total Disablement within 12 months from the date of Accident (including date of Accident), then the Company will pay the amount as specified in the table below:

Sr. No.	Insured Events	Amount payable = % of the Sum insured under this Benefit.
1	Total and irrecoverable loss of sight of both eyes, or of the actual loss by physical separation of two entire hands or two entire feet, or one entire hand and one entire foot, or the total and irrecoverable loss of sight of one eye and loss by physical separation of one entire hand or one entire foot	100%
2	Total and irrecoverable loss of (a) use of two hands or two feet; or (b) one hand and one foot; or (c) sight of one eye and use of one hand or one foot	100%
3	Total and irrecoverable loss of sight of one eye, or of the actual loss by physical separation of one entire hand or one entire foot	50%
4	Total and irrecoverable loss of use of a hand or a foot without physical separation	50%
5	Paraplegia or Quadriplegia or Hemiplegia	100%

Note: For the purpose of Sr. No. I to IV above, physical separation of a hand or foot shall mean separation of the hand at or above the wrist, and of the foot at or above the ankle.

For the purpose of this Benefit only:

(i) "Hemiplegia" means complete and irrecoverable paralysis of the arm, leg, and trunk on the same side of the body;

(ii) "Paraplegia" means complete and irrecoverable paralysis of the whole of the lower half of the body (below waist) including both the legs;

(iii) "Quadriplegia" means complete and irrecoverable paralysis of all four limbs.

Only Primary Insured Member is eligible to for coverage under this Benefit 'Personal Accident Cover'.

Insured Event means an event that is covered under the Policy and which is in accordance with the Policy Terms & Conditions.

Additional Exclusions applicable to any Claim under this Benefit:

Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible, unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

1. Any pre-existing injury or physical condition;
2. The Insured Person operating or learning to operate any aircraft or performing duties as a member of a crew on any aircraft or Scheduled Airline or any airline personnel;
3. The Insured Person flying in an aircraft other than as a fare paying passenger in a Scheduled Airline;
4. Participation in actual or attempted felony, riots, civil commotion or criminal misdemeanour;
5. The Insured Person engaging in sporting activities in so far as they involve the training for or participation in competitions of professional sports;
6. The Insured Person serving in any branch of the military, navy or air-force or any branch of armed Forces or any paramilitary forces;
7. The Insured Person working in or with mines, tunnelling or explosives or involving electrical installation with high tension supply or conveyance testing or oil rigs work or ship crew services or as jockeys or circus personnel or aerial photography or engaged in Hazardous Activities;
8. Impairment of the Insured Person's intellectual

faculties by abuse of stimulants or depressants or by the illegal use of any solid, liquid or gaseous substance.

9. Persons whilst working with in activities like racing on wheels or horseback, winter sports, canoeing involving white water rapids, any bodily contact sport.

10. Treatments rendered by a Doctor who shares the same residence as an Insured Person or who is a member of an Insured Person's family.

11. Any change of profession after inception of the

Policy which results in the enhancement of the Company's risk, if not accepted and endorsed by the Company on the Policy Schedule.

3.1.14 Benefit: Inflation Shield

This benefit is designed to provide additional increase in Sum Insured under this Policy on the basis of inflation rate in previous calendar year.

Subject to below conditions:

1. The Inflation would be computed as the change in average CPI of the entire calendar year published by the National Statistical Office (NSO), Ministry of Statistics and Programme Implementation. In case inflation rate of previous year is not available at renewal, then the inflation rate available for penultimate calendar year shall be considered. (For information on Consumer price index you can visit Website-http://mospi.nic.in/cpi.)

2. The percentage increase will be applicable only on base Sum Insured under the Policy on cumulative basis and not on any other benefit which leads to increase in Sum Insured.

3. In case of Sum Insured is changed at the time of renewal, any accumulated sum Insured due to this Benefit will be added to the applicable new Sum Insured opted by Insured at the time of renewal.

3.1.15 Benefit : Unlimited E-Consultation

The Company shall offer unlimited e-consultations with qualified General Physicians at our network during the Policy Year through any mode of communication (Voice/Video Call /Chat /Email Chat/etc.).

3.1.16 Benefit : Earn and Burn

I. The Company offers an integrated program which allows Insured Person to earn & burn points on the compliance of the following healthy regimes through activity tracking apps, devices and visits to the Fitness centre or yoga centres to track and record the activities of the members engage in:

Activity	Maximum number of Points that can be earned in a policy year
Sign-Up	100
Health Risk Assessment	50
Preventive Risk Assessment	200
Membership in a health clubs (pro-rated if monthly membership, valid documents of membership to be submitted)	100
Participation in Marathon, Cyclothon, Walkathon & other similar activities (outdoor participation along with valid certificate)	100
Steps Count: Average Steps per day in a policy year 5000-7,999 steps 8,000-9,999 steps 10,000 and above	 100 150 200
- Weight Management Program (for the Insured Person who is Overweight / Obese) - Sharing Insured Fitness Success Story through adoption of Care Wellness Program (for the Insured who is not Overweight / Obese)	100 50
- Chronic Condition Management Program (for the Insured who is suffering from Chronic Condition/s - Diabetes, Hypertension ,Cardiovascular Disease or Asthma) - De-stress & Mind Body Healing Program (for the Insured who is not suffering from Chronic Condition/s - Diabetes, Hypertension, Cardiovascular Disease or Asthma)	250 125

* 1 Reward point=Rs. 0.25

1. Sign-Up-

Insured Person will get specified Reward Points on singing up through CHIL Mobile app/portal.

2. Completion of Health Risk Assessment (HRA):

The Health Risk Assessment (HRA) questionnaire is an online tool for evaluation of health and quality of life of the Insured Person. It helps the Insured Person to introspect his/ her personal lifestyle. The Insured Person can log into his/her account on app/portal and complete the HRA questionnaire. The Insured Person can undertake this once per policy year.

On Completion of online HRA questionnaire, the Insured Person earns 50 reward points.

Note: To get the reward points mentioned under HRA, the Insured Person has to complete the entire HRA within one month from the time he/she started HRA Activity.

3. Preventive Risk Assessment: The Insured Person can also earn reward points by undergoing diagnostic / preventive tests during the policy year. These tests should include the four mandatory tests mentioned below. Insured Person can take these tests at any diagnostic centre at Insured Person's own expenses;

- If all the results of the submitted test reports are within the normal range, Insured Person earns 200 reward points

- If the result of any one test is not within the normal range as specified in the lab report, Insured earns 150 reward points

- If two or more test results are not within the normal range, Insured earns 100 reward points only

Note: These tests reports should be submitted together and within 30 days from the date of undergoing such Health Check-Up.

List of mandatory tests under Preventive Risk Assessment
1. Complete Haemogram Test
2. Blood Sugar (Fasting Blood Sugar (FBS) + Postprandial (PP) [or] HbA1c)
3. Lipid profile (Total cholesterol, HDL, LDL, Triglycerides, Total Cholesterol /HDL Cholesterol Ratio)
4. Serum Creatinine

4. **Membership in a health club** (pro-rated if monthly membership) - Insured Person will get specified reward points if he/she enrolled in the annual membership in a Gym / Yoga Centre / Zumba Classes / Aerobic Exercise/ Sports Club/ Pilates Classes/ Swimming / Tai Chi/ Martial Arts / Gymnastics/ Dance Classes.

   Note: In case if Insured Person is not a member of any health club, he/she should join into club within 3 months from the date of the policy risk commencement date. Insured person should submit the health club membership.

5. **Participation in outdoor activity:** The Insured Person will get specified reward points if he/she participated in a recognized Marathon/ Walkathon/ Cyclothon or a similar activity which offers a completion certificate with timing.

6. **Step Count:** Insured earns reward points on achieving the step count target on Care Insurance mobile application as mentioned below;

Average number of steps per day in a policy year	
• If the average number of steps per day in a policy year are between - 5000 and 7999	100
• If the average number of steps per day in a policy year are between - 8000 and 9999	150
• If the average number of steps per day in a policy year are between - 10000 and above	200

Note:
- First month and last month in each policy year will not be taken into consideration for calculation of average number of steps per day.
- The mobile app must be downloaded within 30 days of the policy risk start date to avail this benefit.
- The average step count completed by an Insured Person would be tracked on app/portal.

7. **Weight Management Program:**

   a. This Program will help the Insured Person with Over Weight and Obesity to manage their Body Mass Index (BMI) through the empanelled wellness experts who will guide the Insured Person in losing excess weight and maintain their BMI.

   - On acceptance of the Weight Management Program, Insured Person earns 50 reward points

   - An additional 50 reward points will be awarded at the end of policy year in case if the results are achieved and maintained as mentioned below;

S.No	Name of the Ailment	Values to Submitte	Criteria to get the Wellness points
1	Obesity (If BMI is above 29)	Height & Weight (to calculate BMI)	Achieving and maintaining the BMI between 18 and 29
2	Over weight (If BMI is between 25 and 29)	Height & Weight (to calculate BMI)	Reducing BMI by two points and maintaining the same BMI in the policy year
- Values (for BMI) shall be submitted for every 2 months (up to 5 times in each policy year)			

   b. Incase if the Insured person is not overweight / obese, the Insured Person can submit his/her Fitness Success Story through adoption of Care Wellness Activities with us. On submission of the Fitness Success Story through adoption of Care Wellness Activities, Insured Person earns 50 reward points.

8. **Chronic Condition Management Program:**

   a. This Program will help the Insured Person suffering from Diabetes, Hypertension, Cardiovascular Disease or Asthma to track their health through the empanelled wellness experts who will guide the Insured Person in maintaining/ improving the health condition

   - On acceptance of the Chronic Condition Management Program, Insured Person earns 100 reward points

   - The Insured Person has to submit the test result values for every 3 months maximum up to 3 times in a policy year

   - If the test result values are within +/- 10% range of the values given below, for at least 2 times in a policy year, an additional 150 reward points will be awarded

   - These tests reports to be submitted within 1 month from the date of undergoing the Health Check-Up

S. No	Name of the Ailment	Test to be Submitte	Values Criteria to get the additional Wellness points
1	Diabetes(Insured can submit either HbA1c test value (or) Fasting Blood Sugar (FBS) Range and Postprandial test value)	HbA1c	≤ 6.5
		Fasting Blood Sugar (FBS) Range and Postprandial test Value	100 to 125 mg/dl below 160 mg/dl
2	Hypertension	Measured with -BP apparatus	Systolic Range -110 to 140 mm Hg Diastolic Range - 70 to 90 mmHg
3	Cardiovascular Disease	LDL Cholesterol and Total Cholesterol / HDL Cholesterol Ratio	100 to 159 mg/dl ≤ 4.0
4	Asthma	PFT (Pulmonary Function Test)	FEV1 (PFC) is 75% or more FEV1/ FVC is 70% or more

b. In case if the Insured Person is not suffering from Chronic Condition/s (Diabetes, Hypertension, Cardiovascular Disease or Asthma) he/she can opt for "De-Stress & Mind Body Healing Program. This program helps the Insured Person to reduce stress caused due to internal (self-generated) & external factors and increases the ability to handle stress;

- On acceptance of De-stress & Mind Body Healing Program Insured earns 50 reward points
- On completion of De-stress & Mind Body Healing Program Insured Person earns an additional 75 reward points

Note: This is a 10 weeks program which insured needs to complete without any break.

II. Redemption of points (burning of points): Points can be used on the following health related services:

i. 3rd party health-care supplements within network, up to 50% of earned points.

ii. Redemption for renewal premium of this Policy, up to 10% of renewal premium.

iii. Redemption for Non-covered items, Co-payment, Sub limits & Deductible which are non-payable under this Policy.

iv. Redemption for any admissible claim of In-patient Medical Expenses and Day Care Treatment expenses of this Policy provided that the Sum Insured and additional bonus/SI (if applicable) are exhausted during the Policy Year.

III. 80% of unutilised reward points earned in a particular policy year can be carried forward only to next policy year provided that the policy is renewed with us without a break. The earned reward points shall lapse if the policy is not renewed with us.

Example-The Policy period start date is 1st April, 2020 and the points earned by Insured Person are 500 points. The Validity of 80% of unused reward points will be up to 31st March, 2022 provided the policy is renewing with us on 1st April, 2021.

In case Insured Person cancel the Policy, the balance unutilised reward point will be valid till 3 months from the date of cancelation of the Policy.

IV. In case of floater policy, points under Earn & Burn will be aggregated based on points earned by the each adult members of the policy.

3.1.17 Benefit : Health Services

The Company shall provide the following Services:

Health Portal: The Insured Person may access health related information and services such as Doctor on chat, Healthy tips reminder, Digital locker for medical records etc. as available on the Company's website.

Discount Connect: The Insured Person may access to Special rates for OPD, Diagnostics, and Pharmacy etc. through Network as available on the Company's website.

3.2 OPTIONAL BENEFITS:

The Policy provides the following Optional Benefits which can be opted either at the inception of the policy or at the time of renewal. The Policy Schedule will specify the Optional Benefits that are in force for the Insured Persons.

3.2.1 Optional Benefit : Maternity and New Born Baby Cover

The Company shall indemnify, through Cashless or Reimbursement Facility, for the Medical Expenses associated with Hospitalization for the delivery of a child, up to amount specified against this Benefit in the Policy Schedule, subject to the conditions specified below:

(a) The Company shall be liable to make payment under this Benefit, only if the Insured Member who has delivered the child is the Primary Insured Member or the Primary Insured Person's spouse under floater combination of 2A or 2A1C and over the age of eighteen (18) years of age.

(b) The delivery shall occur after the completion of the 24 month waiting period under this Benefit. The wait period shall start from the Policy Start Date or on attaining age of 18 years, whichever is later. A fresh 24 month waiting period will apply following a claim under this benefit.

(c) The Company shall not be liable to make payment under this Benefit in respect of an Insured Person for more than two (2) living children during that Insured Person's lifetime.

(d) Coverage under this Benefit is not available in case the Insured Person's age is greater than 45

years at the time of Policy start date

(e) Maternity Expenses incurred in connection with the voluntary medical termination of pregnancy during the first 12 weeks from the date of conception shall not be admissible under this Benefit.

For this purpose 'week' shall constitute any consecutive 7 days.

(f) Medical Expenses for ectopic pregnancy are not covered under this Benefit. However, these expenses are covered under Benefit 'Hospitalization Expenses'.

(g) The Company shall be liable to make payment in respect of any Hospitalization arising due to involuntary medical termination of pregnancy, as per MTP Act, 1971(amended) and other applicable laws and rules.

(h) Clause 4.1 (a) (15) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

New Born Baby cover

(a) The Medical Expenses incurred in respect of a New Born Baby whose claim under this Optional Benefit is admissible by the Company shall be indemnified up to the 'Optional Benefit : Maternity and New Born Baby cover' coverage amount.

(b) For continuous coverage under this Policy of the child of 91 days and above, an additional premium would be required to be paid.

3.2.2 Optional Benefit : Daily Allowance

If this Optional Benefit is opted, the Company will pay a fixed amount as specified against this Benefit in the Policy Schedule, for each continuous and completed period of 24 hours of Hospitalization of the Insured Person, subject to the conditions specified below:

(i) The Company shall not be liable to make payment under this cover for more than 15 days of Hospitalization during a Policy Year.

(ii) This cover is valid for In-patient Care Hospitalization of the Insured Person only.

(iii) In case the Insured Person is admitted in an ICU, the Company will pay twice the fixed amount as specified against this Benefit in the Policy Schedule, for each continuous and completed period of 24 hours of Hospitalization in an ICU.

(iv) At one point of time, an Insured Person cannot stay both in a regular Hospital room as well as in an ICU room. Hence, only either one of the rooms would be considered for pay-out as per the Insured Person's room occupancy in the Hospital.

(v) Transit period from one hospital to another will not be considered as Hospitalization.

Note: Mid-term addition is allowed under this Optional Benefit whereas premium will be charged on pro-rata basis.

3.2.3 Optional Benefit : International Second Opinion

"International Second Opinion" is an extension to Benefit : Second Opinion and hence all the provisions stated under Clause 3.1.6, holds good for Clause 3.2.3 as well, subject to:

a) The Company shall arrange for International Second Opinion from a Medical Practitioner outside India solely on the Insured Person's express request in relation to a Major Illness / Injury which the Insured Person has been diagnosed with during the Policy Year.

b) Major Illness / Injury means one of the following only:

1. Benign Brain Tumor
2. Cancer
3. End Stage Lung Failure
4. Myocardial Infarction
5. Coronary Artery Bypass Graft
6. Heart Valve Replacement
7. Coma
8. End Stage Renal Failure
9. Stroke
10. Major Organ Transplant
11. Paralysis
12. Motor Neuron Disorder
13. Multiple Sclerosis
14. Major Burns
15. Total Blindness

3.2.4 Optional Benefit : Smart Select

If this Optional Benefit is opted, then Policyholder is entitled for a discount on the total premium (which includes premium of base Benefits and Optional Benefit 'Maternity & New Born Cover) payable as specified in the Policy Schedule, subject to following conditions:

(i) If the Insured Person takes Medical Treatment in hospitals other than those listed in Annexure – III to the Policy Terms and Conditions, then the Policyholder/Insured Person shall bear a Co-Payment of 20% on each and every Claim arising in such regard, which will be in addition to any other co-payment (if any) applicable in the Policy.

(ii) However, no such additional co-payment shall be applicable if treatment is availed in the hospitals listed in Annexure III to the Policy Terms and Conditions.

NOTE: For an updated list of Hospitals mentioned under Annexure – III to the Policy Terms and Conditions, the Policyholder / Insured Person should refer to the Company's Website https://www.careinsurance.com/

3.2.5 Optional Benefit : Deductible Option

If this Optional Benefit is opted, then Policyholder is entitled for a discount on the Premium payable.

(i) The claim amount assessed by the Company for a particular claim shall be reduced by the Deductible as specified in the Policy Schedule and the Company shall be liable to make payment under the Policy for any Claim only when the Deductible on that Claim is exhausted.

(ii) The Deductible shall be applicable on an aggregate basis for all Claims made by the Insured Person in a Policy Year.

(iii) Illustration for applicability of Deductible in the same Policy Year:

Case	Sum Insured	Deductible	Claim 1	Claim 2	Claim 3
1	25,00,000	5,00,000	3,50,000	12,50,000	10,00,000
2	25,00,000	5,00,000	4,50,000	15,00,000	30,00,000
3	25,00,000	5,00,000	10,00,000	40,00,000	40,00,000

Case	Sum Insured	Deductible	Payable 1	Payable 2	Payable 3
1	25,00,000	5,00,000	-	11,00,000	10,00,000
2	25,00,000	5,00,000	-	14,50,000	10,50,000
3	25,00,000	5,00,000	5,00,000	20,00,000	Claim not payable as SI is exhausted

3.2.6 Optional Benefit : Co-Payment Option

Notwithstanding anything to the contrary in the Policy, it is hereby stated that on opting this optional Benefit, the Insured Person or eldest Insured Person (in case of floater) whose age is 61 years or above will bear a Co-payment, which applies to such Insured Person or all Insured Persons (in case of Floater) as specified in the Policy Schedule, in accordance with Clause 6.1.6 and Company's liability shall be restricted to the balance amount payable.

The Co-payment shall be applicable to each and every claim for each Insured Person as defined in the Policy

3.2.7 Optional Benefit : Room Rent Modification

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Benefit, the Company agrees to upgrade the eligibility of Room Rent / Room Category from '1% of SI per day' to 'Single Private AC Room', similarly ICU Charges limit from '2% of SI per day' to 'No limit'.

Note: This Optional Benefit is applicable only for Insured Person whose SI is less than 5Lakhs.

4. Exclusions

4.1. Standard Exclusions:

(a) Waiting Periods:

(i) Pre-Existing Diseases: Code- Excl01

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d. Coverage under the policy after the expiry of 36months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

(ii) Specific Waiting Period: Code- Excl02

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage, as may be the case after the date of inception of the first policy with the Company. This exclusion shall not be applicable for claims arising due to an accident.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f. <u>List of specific diseases/procedures:</u>

1. Any treatment related to Arthritis (if non-infective), Osteoarthritis and Osteoporosis, Gout, Rheumatism, Spinal Disorders(unless caused by accident), Joint Replacement Surgery(unless caused by accident), Arthroscopic Knee Surgeries/ACL Reconstruction/Meniscal and Ligament Repair

2. Surgical treatments for Benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to Adenoidectomy, Mastoidectomy, Tonsillectomy and Tympanoplasty), Nasal Septum Deviation, Sinusitis and related disorders

3. Benign Prostatic Hypertrophy

4. Cataract

5. Dilatation and Curettage

6. Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, Gastric and Duodenal Ulcers

7. Surgery of Genito-urinary system unless necessitated by malignancy

8. All types of Hernia & Hydrocele

9. Hysterectomy for menorrhagia or Fibromyoma or prolapse of uterus unless necessitated by malignancy

10. Internal tumours, skin tumours, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant

11. Kidney Stone / Ureteric Stone / Lithotripsy / Gall Bladder Stone

12. Myomectomy for fibroids

13. Varicose veins and varicose ulcers

14. Parkinson's or Alzheimer's disease or Dementia

(iii) 30-day waiting period- Code- Excl03

a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c. The referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

(iv) The Waiting Periods as defined in Clauses 4.1(a)(i), 4.1(a)(ii) and 4.1(a)(iii) shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

(v) If Coverage for Optional Benefits (if applicable) are added afresh at the time of renewal of this Policy, the Waiting Periods as defined above in Clauses 4.1(a)(I), 4.1(a) (ii) and 4.1(a) (iii) shall be applicable afresh to the newly added Optional Benefits (if applicable), from the time of such renewal.

(b) Permanent Exclusions:

Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy Terms and conditions.

1. Investigation & Evaluation: (Code- Excl04)

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

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

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

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

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

3. Obesity/ Weight Control: (Code- Excl06)

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

1) Surgery to be conducted is upon the advice of the Doctor

2) The surgery/Procedure conducted should be supported by clinical protocols

3) The member has to be 18 years of age or older and

4) Body Mass Index (BMI);

a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

4. Change-of-Gender treatments: (Code- Excl07)

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

5. Cosmetic or plastic Surgery: (Code- Excl08)

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

6. Hazardous or Adventure sports: (Code- Excl09)

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

7. **Breach of law: (Code- Excl10)**

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

8. **Excluded Providers: (Code- Excl11)**

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

Note: Refer Annexure – II of the Policy Terms & Conditions for list of excluded hospitals.

9. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code- Excl12)**

10. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code- Excl13)**

11. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure **(Code- Excl14)**

12. **Refractive Error: (Code- Excl15)**

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

13. **Unproven Treatments: (Code- Excl16)**

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

14. **Sterility and Infertility: (Code- Excl17)**

Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, 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

15. **Maternity: (Code Excl18)**

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

b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

4.2. **Specific Exclusions:**

(a) **Waiting Periods:**

(i) **Maternity & New Born Cover (Optional Benefit) :**

a. Claims will not be admissible for any expenses incurred for diagnosis / treatment related to any Maternity & New Born Expenses until 24 months of continuous coverage has elapsed, under this Benefit.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

(ii) The Waiting Periods as defined in Clauses 4.2(a) (i) shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

(b) **Permanent Exclusions:**

1. Any item or condition or treatment specified in List of Non-Medical Items (Annexure – I to Policy Terms & Conditions).

2. Taking part or is supposed to participate in a naval, military, air force operation or aviation in a professional or semi-professional nature.

3. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.

4. Charges incurred in connection with routine eye examinations and ear examinations, dentures, artificial teeth and all other similar external appliances and / or devices whether for diagnosis or treatment

5. Any expenses incurred on external prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, walkers, glucometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome and oxygen concentrator for asthmatic condition, cost of cochlear implants and related surgery.

6. Alopecia wigs and/or toupee and all hair or hair fall treatment and products.

7. Screening, counseling or treatment of any external Congenital Anomaly, Illness or defects or anomalies or treatment relating to external birth defects.

8. Treatment of mental retardation, arrested or incomplete development of mind of a person, subnormal intelligence or mental intellectual disability.

9. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident.

10. All preventive care (except eligible and entitled for Benefit: 'Annual Health Check-up'), Vaccination including Inoculation and Immunizations (except in case of post-bite treatment) and tonics.

11. Expenses incurred for Artificial life maintenance, including life support machine use, post confirmation of

vegetative state or brain dead by treating medical practitioner where such treatment will not result in recovery or restoration of the previous state of health under any circumstances.

12. Non-Allopathic Treatments (except Ayurveda, Unani, Sidha and Homeopathy), Hydrotherapy, Acupuncture, Reflexology, Chiropractic treatment or treatment related to any unrecognized systems of medicine.

13. 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.

14. Act of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane or Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs, alcohol or hallucinogens.

15. Any charges incurred to procure documents related to treatment or Illness pertaining to any period of Hospitalization or Illness.

16. Personal comfort and convenience items or services including but not limited to T.V. (wherever specifically charged separately), charges for access to cosmetics, hygiene articles, body care products and bath additives, as well as similar incidental services and supplies.

17. Expenses related to any kind of RMO charges, Service charge, Surcharge, night charges levied by the hospital under whatever head or transportation charges by visiting consultant.

18. 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.

19. Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants unless prescribed by a medical practitioner.

20. Any treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification center, sanatorium, home for the aged, remodeling clinic or similar institutions.

21. Remicade, Avastin or similar injectable treatment which is undergone other than as a part of In-Patient Care Hospitalisation or Day Care Hospitalisation is excluded.

22. Expenses related to any kind of Advance Technology Methods other than mentioned in the Clause 3.1.1(iv).

23. Any condition caused by or associated with any sexually transmitted disease except arising out of HIV.

24. Hormone replacement therapy.

25. Any other exclusion as specified in the Policy Schedule.

Note: In addition to the foregoing, any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above Permanent Exclusions shall also be excluded.

5. GENERAL TERMS AND CLAUSES

5.1 Standard General Terms & Clauses

5.1.1 Disclosure of Information

The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact by the policyholder.

Note:

a. "Material facts" for the purpose of this clause 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.

b. In continuation to the above clause the Company may also adjust the scope of cover and / or the premium paid or payable, accordingly.

5.1.2 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.

5.1.3 Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest 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 the claim within 45 days from the date of receipt of last necessary document.

Notes:

In case of demise of the Policyholder,

(i) Where the Policy covers only the Policyholder, this Policy shall stand null and void from the date and time of demise of the Policyholder. The premium would be refunded for the unexpired period of this Policy at the short period scales subject to no claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.

(ii) Where the Policy covers other Insured Persons, this Policy shall continue till the end of Policy Period for the other Insured Persons. If the other Insured Persons wish to continue with the same Policy, the Company will renew the Policy subject to the appointment of a policyholder provided that:

I. Written notice in this regard is given to the Company before the Policy Period End Date; and

II. A person of Age 18 years or above, who satisfies the Company's criteria applies to become the Policyholder.

In case Premium Installment mode is opted for, then:

(i) If Policyholder cancels the Policy after the Free look period or demise of Policyholder where he/she is the only insured in the Policy, then the Company will refund 50% of the installment premium for the unexpired installment period, provided no Claim has been made under the Policy.

5.1.8 Migration

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

For Detailed Guidelines on Migration, kindly refer the link:

https://www.careinsurance.com/other-disclosures.html

5.1.9 Portability

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

For Detailed Guidelines on Portability, kindly refer the link:

https://www.careinsurance.com/other-disclosures.html

5.1.10 Renewal of Policy

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

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period

v. No loading shall apply on renewals based on individual claims experience

5.1.11 Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period, as per IRDAI guidelines, provided the policy has been maintained without a break.

5.1.12 Moratorium Period

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

5.1.13 Premium Payment in Installments

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

i. Grace Period of 15 days would be given to pay the installment premium due for the policy

ii. During such grace period, coverage will not be available from the due date of installment premium till the date of receipt of premium by Company

iv. In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

Bank rate shall mean the rate fixed by the Reserve Bank of lndia (RBl) at the beginning of the financial year in which claim has fallen due.

5.1.4 Complete Discharge

Any payment to the policyholder, Insured Person or his/ her nominees or his/ her legal representative or Assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

5.1.5 Multiple Policies

a. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the 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.

b. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy/ policies, even if the sum insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this policy.

c. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurers from whom he/she wants to claim the balance amount.

d. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the treatment costs in in accordance with the terms and conditions of the chosen policy.

5.1.6 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 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.

5.1.7 Cancellation / Termination

(a) The policyholder may cancel this policy by giving 15 days 'written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Cancellation date from Policy Period Start Date	Policy Tenure 1 Year	Policy Tenure 2 Year	Policy Tenure 3 Year
Up to 1 month	75.00%	87.50%	91.70%
1 month to 3 months	50.00%	75.00%	83.30%
3 months to 6 months	25.00%	62.50%	75.00%
6 months to 12 months	0.00%	50.00%	66.70%
12 months to 15 months	N.A	25.00%	50.00%
15 months to 18 months	N.A	12.50%	41.70%
18 months to 24 months	N.A	0.00%	33.30%
24 months to 30 months	N.A	N.A	8.30%
Beyond 30 months	N.A	N.A	0.0%

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

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

iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period

iv. No interest will be charged If the installment premium is not paid on due date.

v. In case of installment premium due not received within the grace period, the policy will get cancelled

vi. In the event of a claim, all subsequent premium installments shall immediately become due and payable.

vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

Note:

i. Tenure Discount will not be applicable if the Insured Person has opted for Premium Payment in Installments.

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

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

5.1.15 Free Look Period

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

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

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

i. A refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. Where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

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

5.1.16 Grievances

In case of any grievance the insured person may contact the company through

Website/link:
https://www.careinsurance.com/contact-us.html

Mobile App: Care Health - Customer App

Tollfree (WhatsApp Number): 8860402452

Courier: Any of Company's Branch Office or Corporate Office

Insured Person may also approach the grievance cell at any of the Company's branches with the details of grievance.

If Insured Person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at Branch Office or Corporate Office. For updated details of grievance officer, kindly refer the link https://www.careinsurance.com/customer-grievance-redressal.html

If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

Grievance may also be lodged at IRDAI integrated Grievance Management System -

https://bimabharosa.irdai.gov.in/

Note: The Contact details of the Insurance Ombudsman offices have been provided as Annexure VI

5.1.17 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.

5.2 Specific General Terms & Clauses

5.2.1 Material Change

It is a condition precedent to the Company's liability under the Policy that the Policyholder shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business at his own expense The Company may adjust the scope of cover and / or the premium paid or payable, accordingly.

5.2.2 Records to be maintained

The Policyholder or Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require under this Policy at any time during the

Policy Period or Policy Year or until final adjustment (if any) and resolution of all Claims under this Policy.

5.2.3 No constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder or Insured Person which is in possession of the Company other than that information expressly disclosed in the Proposal Form or otherwise in writing to the Company, shall not be held to be binding or prejudicially affect the Company.

5.2.4 Policy Disputes

Any and all disputes or differences under or in relation to the validity, construction, interpretation and effect to this Policy shall be determined by the Indian Courts and in accordance with Indian law.

5.2.5 Limitation of liability

Any Claim under this Policy for which the notification or intimation of Claim is received 12 calendar months after the event or occurrence giving rise to the Claim shall not be admissible, unless the Policyholder proves to the Company's satisfaction that the delay in reporting of the Claim was for reasons beyond his control.

5.2.6 Communication

a. Any communication meant for the Company must be in writing and be delivered to its address shown in the Policy Schedule. Any communication meant for the Policyholder/ Insured Person will be sent by the Company to his last known address or the address as shown in the Policy Schedule.

b. All notifications and declarations for the Company must be in writing and sent to the address specified in the Policy Schedule.Agents are not authorized to receive notices and declarations on the Company's behalf.

c. Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

5.2.7 Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company. However, change or alteration with respect to increase/ decrease of the Sum Insured shall be permissible only at the time of renewal of the Policy.

5.2.8 Out of all the details of the various Benefits provided in the Policy Terms and Conditions, only the details pertaining to Benefits chosen by policyholder as per Policy Schedule shall be considered relevant

5.2.9 Electronic Transactions

The Policyholder and /or Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the Policy or its terms shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. Any terms and conditions related to electronic transactions shall be within the approved Policy Terms and Conditions.

6. Other Terms And Clauses

6.1 Claims Procedure And Management

This section explains about procedures involved to file a valid Claim by the Insured Person and related processes involved to manage the Claim by the Company.

6.1.1 Pre-requisite for admissibility of a Claim:

Any claim being made by an Insured Person or attendant of Insured Person during Hospitalization on behalf of the Insured person, should comply with the following conditions:

(i) The Condition Precedent Clause has to be fulfilled.

(ii) The health damage caused, Medical Expenses incurred, subsequently the Claim being made, should be with respect to the Insured Person only. The Company will not be liable to indemnify the Insured Person for any loss other than the covered Benefits and any other person who is not accepted by the Company as an Insured Person.

(iii) The holding Insurance Policy should be in force at the event of the Claim. All the Policy Terms and Conditions, wait periods and exclusions are to be fulfilled including the realization of Premium by their respective due dates.

(iv) All the required and supportive Claim related documents are to be furnished within the stipulated timelines. The Company may call for additional documents wherever required.

6.1.2 Claim settlement - Facilities

(a) Cashless Facility

The Company extends Cashless Facility as a mode to indemnify the medical expenses incurred by the Insured Person at a Network Provider. For this purpose, the Insured Person will be issued a "Health card" at the time of Policy purchase, which has to be preserved and produced at any of the Network Providers in the event of Claim being made, to avail Cashless Facility. The following is the process for availing Cashless Facility:-

(I) Submission of Pre-authorization Form: A Pre-authorization form which is available on the Company's Website or with the Network Provider, has to be duly filled and signed by the Insured Person and the treating Medical Practitioner, as applicable, which has to be submitted electronically by the Network Provider to the

Company for approval. Only upon due approval from the Company, Cashless Facility can be availed at any Network Hospital.

(ii) **Identification Documents:** The "Health card" provided by the Company under this Policy, along with one Valid Photo Identification Proof of the Insured Person are to be produced at the Network Provider, photocopies of which shall be forwarded to the Company for authentication purposes. Valid Photo Identification Proof documents which will be accepted by the Company are Voter ID card, Driving License, Passport, PAN Card, Aadhar Card or any other identification proof as stated by the Company.

(iii) **Company's Approval:** The Company will confirm in writing, authorization or rejection of the request to avail Cashless Facility for the Insured Person's Hospitalization.

(iv) **Company's Authorization:**

a) If the request for availing Cashless Facility is authorized by the Company, then payment for the Medical Expenses incurred in respect of the Insured Person shall not have to be made to the extent that such Medical Expenses are covered under this Policy and fall within the amount authorized in writing by the Company for availing Cashless Facility.

b) An Authorization letter will include details of Sanctioned Amount, any specific limitation on the Claim, and any other details specific to the Insured Person, if any, as applicable.

c) In the event that the cost of Hospitalization exceeds the authorized limit, the Network Provider shall request the Company for an enhancement of Authorization Limit stating details of specific circumstances which have led to the need for increase in the previously uthorized limit. The Company will verify the eligibility and evaluate the request for enhancement on the availability of further limits.

(v) **Event of Discharge from Hospital:** All original bills and evidence of treatment for the Medical Expenses incurred in respect of the Hospitalization of the Insured Person and all other information and documentation specified under Clauses 6.1.4 and 6.1.5 shall be submitted by the Network Provider immediately and in any event before the Insured Person's discharge from Hospital.

(vi) **Company's Rejection:** If the Company does not authorize the Cashless Facility due to insufficient Sum Insured or insufficient information provided to the Company to determine the admissibility of the Claim, then payment for such treatment will have to be made by the Policyholder / Insured Person to the Network Provider, following which a Claim for reimbursement may be made to the Company which shall be considered subject to the Insured Person's Policy limits and relevant conditions. Please note that rejection of a Pre-authorization request is in no way construed as rejection of coverage or treatment. The Insured Person can proceed with the treatment, settle the hospital bills and submit the claim for a possible reimbursement.

(vii) **Network Provider related:** The Company may modify the list of Network Providers or modify or restrict the extent of Cashless Facilities that may be availed at any particular Network Provider. For an updated list of Network Providers and the extent of Cashless Facilities available at each Network Provider, the Insured Person may refer to the list of Network Providers available on the Company's website or at the call center.

(viii) **Claim Settlement:** For Claim settlement under Cashless Facility, the payment shall be made to the Network Provider whose discharge would be complete and final.

(a) Re-imbursement Facility

(i) It is agreed and understood that in all cases where intimation of a Claim has been provided under Reimbursement Facility and/or the Company specifically states that a particular Benefit is payable only under Reimbursement Facility, all the information and documentation specified in Clause 6.1.4 and Clause 6.1.5 shall be submitted to the Company at Policyholder's / Insured Person's own expense, immediately and in any event within 30 days of Insured Person's discharge from Hospital.

(ii) The Company shall give an acknowledgement of collected documents. However, in case of any delayed submission, the Company may examine and relax the time limits mentioned upon the merits of the case.

(iii) In case a reimbursement claim is received after a Pre-Authorization letter has been issued for the same case earlier, before processing such claim, a check will be made with the Network Provider whether the Pre-authorization has been utilized. Once such check and declaration is received from the Network Provider, the case will be processed.

(iv) For Claim settlement under reimbursement, the Company will pay the Policyholder. In the event of death of the Policyholder, the Company will pay the nominee (as named in the Policy Schedule) and in case of no 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.

(v) 'Date of Loss' under Reimbursement Facility is the 'Date of Admission' to Hospital in case of Hospitalization & actual Date of Loss for non-Hospitalization related Benefits.

6.1.3 Duties of a Claimant/ Insured Person in the event of Claim

It is agreed and understood that as a Condition Precedent for a Claim to be considered under this Policy:

(i) The Policyholder / Insured Person shall check the updated list of Network Provider before submission of a pre-authorization request for Cashless Facility.

(ii) All reasonable steps and measures must be taken to avoid or minimize the quantum of any Claim

that may be made under this Policy.

(iii) Intimation of the Claim, notification of the Claim and submission or provision of all information and documentation shall be made promptly and in any event in accordance with the procedures and within the timeframes specified in Clause 6.1 (Claims Procedure and Management) of the Policy.

(iv) The Insured Person will, at the request of the Company, submit himself / herself for a medical examination by the Company's nominated Medical Practitioner as often as the Company considers reasonable and necessary. The cost of such examination will be borne by the Company.

(v) The Company's Medical Practitioner and representatives shall be given access and co-operation to inspect the Insured Person's medical and Hospitalization records and to investigate the facts and examine the Insured Person.

(vi) The Company shall be provided with complete necessary documentation and information which the Company has requested to establish its liability for the Claim, its circumstances and its quantum.

6.1.4 Claims Intimation

Upon the occurrence of any Illness or Injury that may result in a Claim under this Policy, then as a Condition Precedent to the Company's liability under the Policy, all of the following shall be undertaken:

(i) If any Illness is diagnosed or discovered or any Injury is suffered or any other contingency occurs which has resulted in a Claim or may result in a Claim under the Policy, the Company shall be notified with full particulars within 48 hours from the date of occurrence of event either at the Company's call center or in writing.

(ii) Claim must be filed within 30 days from the date of discharge from the hospital in case of hospitalization and actual date of loss in case of non-hospitalization Benefits.Note: 6.1.4 (i) and 6.1.4 (ii) are precedent to admission of liability under the policy.

(iii) The following details are to be disclosed to the Company at the time of intimation of Claim:

1. Policy Number;
2. Name of the Policyholder;
3. Name of the Insured Person in respect of whom the Claim is being made;
4. Nature of Illness or Injury;
5. Name and address of the attending Medical Practitioner and Hospital;
6. Date of admission to Hospital or proposed date of admission to Hospital for planned Hospitalization;
7. Any other necessary information, documentation or details requested by the Company.

(iv) In case of an Emergency Hospitalization, the Company shall be notified either at the Company's call center or in writing immediately and in any event within 48 hours of Hospitalization commencing or before the Insured Person's discharge from Hospital.

(v) In case of an Planned Hospitalization, the Company shall be notified either at the Company's call center or in writing at least 48 hours prior to planned date of admission to Hospital

6.1.5 Documents to be submitted for filing a valid Claim

The following information and documentation shall be submitted in accordance with the procedures and within the timeframes specified in Clause 6.1 in respect of all Claims:

1. Duly filled and signed Claim form by the Insured Person;
2. Copy of Photo ID of Insured Person;
3. Medical Practitioner's referral letter advising Hospitalization;
4. Medical Practitioner's prescription advising drugs or diagnostic tests or consultations;
5. Original bills, receipts and discharge summary from the Hospital/Medical Practitioner;
6. Original bills from pharmacy/chemists;
7. Original pathological/diagnostic testreports/ radiology reports and payment receipts;
8. Operation Theatre Notes(if applicable);
9. Indoor case papers(if applicable);
10. Original investigation test reports and payment receipts supported by Doctor's reference slip;
11. MLC/FIR report, Post Mortem Report if applicable and conducted;
12. Ambulance Receipt;
13. Any other document as required by the Company to assess the Claim, in case fraud is suspected.

Notes:

- The Company may give a waiver to one or few of the above mentioned documents depending upon the case.
- Additional documents as specified against any Benefit shall be submitted to the company.
- The Company will accept bills/invoices which are made in the Insured Person's name only.
- The company may seek any other document as required to assess the Claim.
- Only in the event that original bills, receipts, prescriptions, reports or other documents have already been given to any other insurance company, the company will accept properly verified photocopies of such documents attested by such other insurance company along with an original certificate of the extent of payment received from such insurance company.

However, claims filed even beyond the timelines mentioned above should be considered if there are valid reasons for any delay.

6.1.6 Claim Assessment

a. The Company shall scrutinize the Claim and supportive documents, once received. In case of any deficiency, the Company may call for any additional documents or information as required, based on the circumstances of the Claim.

b. All admissible Claims under this Policy shall be assessed by the Company in the following progressive order:

(i) If any sub-limits on Room Rent/Category for Medical Expenses are applicable as specified in the Policy Schedule, the Company's liability to make payment shall be limited to the extent of the applicable sub-limit for that Medical Expense

(ii) The Deductible (if applicable) shall be applied to the aggregate of all Claims that are either paid or payable under this Policy. The Company's liability to make payment shall commence only once the aggregate amount of all Claims payable or paid exceed the Deductible.

(iii) Co-payment (if applicable) shall be applicable on the admissible claim amount payable by the Company.

c. The Claim amount assessed in Clause 6.1.6 (b) above would be deducted from the following amounts in the following progressive order:

(i) Sum Insured;

(ii) Inflation Shield;

(iii) Cumulative Bonus;

(iv) Unlimited Automatic Recharge.

d. All claims incurred in India are dealt by the Company directly.

6.1.7 Payment Terms

(a) This Policy covers only medical treatment taken entirely within India. All payments under this Policy shall be made in Indian Rupees and within India.

(b) The Company shall have no liability to make payment of a Claim under the Policy in respect of an Insured Person during the Policy Period, once the Sum Insured for that Insured Person is exhausted.

(c) If the Policyholder / Insured Person suffers a relapse within 45 days of the date of discharge from the Hospital for which a Claim has been made, then such relapse shall be deemed to be part of the same Claim and all the limits for Any One Illness under this Policy shall be applied as if they were under a single Claim.

(d) The Claim shall be paid only for the Policy Year in which the Insured event which gives rise to a Claim under this Policy occurs.

(e) The Premium for the policy will remain the same for the policy period mentioned in the Policy Schedule.

6.2 Special Conditions:

6.2.1 Early Bird Discount:

If the Insured person avails this policy before the age of 36 years and has continuously renewed without any break, then, on completion of 40 years of age the insured person will be offered a discount of 10% on the subsequent renewal premium applicable on the base coverage opted at the inception of this policy. The discount will not be cumulative. This discount will not be applicable if the insured person migrates or purchases any other policy offered by the Company.

- If individual members are covered for different sum insured, then the discount is available on the subsequent renewal premium applicable on the base coverage opted at the inception of this policy.
- If an individual policy is converted into family floater policy or if any member is added in existing floater policy at the time of renewal, then discount will be applicable as per following conditions
  - i. If member is added when the age of the eldest member is greater than 40 years , then the age of member added should be less than 36 years of age for the new policy to be eligible for discount, otherwise no discount will be applicable
  - ii. If the member is added when the age of the eldest member is less than 41 years of age, then there will be a waiting period of 5 years before discount will be applicable on the new policy.
  - iii. The member added age should be less than 36 years
- The discount will not be available if eldest person's age is 36 years and above at the time of porting from any other Company to this policy

Annexure I - List of Expenses Generally Excluded ("Non-medical") in Hospital Indemnity Policy

Sr. No.	LIST - I - OPTIONAL ITEMS	Sr. No.	LIST - I - OPTIONAL ITEMS
1	BABY FOOD		CHARGES
2	BABY UTILITIES CHARGES	49	AMBULANCE COLLAR
3	BEAUTY SERVICES	50	AMBULANCE EQUIPMENT
4	BELTS/ BRACES	51	ABDOMINAL BINDER
5	BUDS	52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
6	COLD PACK/HOT PACK		
7	CARRY BAGS	53	SUGAR FREE Tablets
8	EMAIL / INTERNET CHARGES	54	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)		
10	LEGGINGS	55	ECG ELECTRODES
11	LAUNDRY CHARGES	56	GLOVES
12	MINERAL WATER	57	NEBULISATION KIT
13	SANITARY PAD	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
14	TELEPHONE CHARGES		
15	GUEST SERVICES		
16	CREPE BANDAGE	59	KIDNEY TRAY
17	DIAPER OF ANY TYPE	60	MASK
18	EYELET COLLAR	61	OUNCE GLASS
19	SLINGS	62	OXYGEN MASK
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	63	PELVIC TRACTION BELT
		64	PAN CAN
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	65	TROLLY COVER
		66	UROMETER, URINE JUG
22	TELEVISION CHARGES	67	AMBULANCE
23	SURCHARGES	68	VASOFIX SAFETY
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		

Sr. No.	LIST - II - ITEMS THAT ARE TO BE SUBSUMED INTO ROOM CHARGES	Sr. No.	List III – ITEMS THAT ARE TO BE SUBSUMED INTO PROCEDURE CHARGES
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	1	HAIR REMOVAL CREAM
2	HAND WASH	2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	SHOE COVER	3	EYE PAD
4	CAPS	4	EYE SHEILD
5	CRADLE CHARGES	5	CAMERA COVER
6	COMB	6	DVD, CD CHARGES
7	EAU-DE-COLOGNE / ROOM FRESHNERS	7	GAUSE SOFT
8	FOOT COVER	8	GAUZE
9	GOWN	9	WARD AND THEATRE BOOKING CHARGES
10	SLIPPERS	10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	TISSUE PAPER	11	MICROSCOPE COVER
12	TOOTH PASTE	12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER
13	TOOTH BRUSH	13	SURGICAL DRILL
14	BED PAN	14	EYE KIT
15	FACE MASK	15	EYE DRAPE
16	FLEXI MASK	16	X-RAY FILM
17	HAND HOLDER	17	BOYLES APPARATUS CHARGES
18	SPUTUM CUP	18	COTTON
19	DISINFECTANT LOTIONS	19	COTTON BANDAGE
20	LUXURY TAX	20	SURGICAL TAPE
21	HVAC	21	APRON
22	HOUSE KEEPING CHARGES	22	TORNIQUET
23	AIR CONDITIONER CHARGES	23	ORTHOBUNDLE, GYNAEC BUNDLE
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		

Sr. No.	LIST IV – ITEMS THAT ARE TO BE SUBSUMED INTO COSTS OF TREATMENT		
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		

Annexure II - List of Hospitals where Claim will not be admitted

Hospital Name	*Address*
Nulife Hospital And Maternity Centre	1616 Outram Lines,Kingsway Camp,Guru Teg Bahadur Nagar , New Delhi , Delhi
Taneja Hospital	F-15,Vikas Marg, Preet Vihar , New Delhi , Delhi
Shri Komal Hospital & Dr.Saxena's Nursing Home	Opp. Radhika Cinema,Circular Road , Rewari , Haryana
Sona Devi Memorial Hospital & Trauma Centre	Sohna Road, Badshahpur , Gurgaon , Haryana
Amar Hospital	Sector-70,S.A.S.Nagar, Mohali, Sector 70 , Mohali , Punjab
Brij Medical Centre	K K 54, Kavi Nagar , Ghaziabad , Uttar Pradesh
Famliy Medicare	A-55,Sector 61, Rajat Vihar Sector 62 , Noida , Uttar Pradesh
Jeevan Jyoti Hospital	162,Lowther Road, Bai Ka Bagh, Allahabad, Uttar Pradesh
City Hospital & Trauma Centre	C-1,Cinder Dump Complex,Opp. Krishna Cinema Hall,Kanpur Road,Alambagh, Lucknow, U.P.
Dayal Maternity & Nursing Home	No.953/23,D.C.F.Chowk, DLF Colony , Rohtak , Haryana
Metas Adventist Hospital	No.24,Ring-Road,Athwalines, Surat , Surat , Gujarat
Surgicare Medical Centre	Sai Dwar Oberoi Complex,S.A.B.T.V.Lane Road,Lokhandwala,Near Laxmi Industrial Estate, Andheri, Mumbai, Maharashtra
Paramount General Hospital & I.C.C.U.	Laxmi Commercial Premises, Andheri Kurla Road, Andheri, Mumbai, Maharashtra
Gokul Hospital	Thakur Complex, Kandivali East, Mumbai, Maharashtra
Shree Sai Hospital	Gokul Nagri I,Thankur Complex,Western Express Highway, Kandivali East, Mumbai, Maharashtra
Shreedevi Hospital	Akash Arcade,Bhanu Nagar,Near Bhanu Sagar Theatre,Dr.Deepak Shetty Road, Kalyan D.C. , Thane , Maharashtra
Saykhedkar Hospital & Research Centre Pvt. Ltd.	Trimurthy Chowk,Kamatwada Road,Cidco Colony , Nashik , Maharashtra
Arpan Hospital And Research Centre	No.151/2,Imli Bazar,Near Rajwada, Imli Bazar , Indore , Madhya Pradesh
Ramkrishna Care Hospital	Aurobindo Enclave,Pachpedhi Naka,Dhamtri Road,National Highway No 43, Raipur , Chhattisgarh
Gupta Multispeciality Hospital	B-20, Vivek Vihar, New Delhi, Delhi
R.K.Hospital	3C/59, BP, Near Metro Cinema, New Industrial Township 1, Faridabad, Haryana
Prakash Hospital	D -12,12A,12B,Noida, Sector 33 , Noida , Uttar Pradesh
Aryan Hospital Pvt. Ltd.	Old Railway Road, Near New Colony, New Colony, Gurgaon, Haryana
Medilink Hospital Research Centre Pvt. Ltd.	Near Shyamal Char Rasta,132,Ring Road, Satellite, Ahmedabad, Gujarat
Mohit Hospital	Khoya B-Wing, Near National Park, Borivali(E), Kandivali West, Mumbai, Maharashtra
Scope Hospital	628, Niti Khand-I, Indirapuram, Ghaziabad, Uttar Pradesh
Agarwal Medical Centre	E-234, Greater Kailash 1, New Delhi , Delhi
Oxygen Hospital	Bhiwani Stand, Durga Bhawan, Rohtak, Haryana
Prayag Hospital & Research Centre Pvt. Ltd.	J-206 A/1, Sector 41, Noida, Uttar Pradesh
Karnavati Superspeciality Hospital	Opposite Sajpur Tower, Naroda Road, Ahmedabad, Gujarat
Palwal Hospital	Old G.T. Road, Near New Sohna Mod, Palwal, Haryana
B.K.S. Hospital	No.18,1st Cross,Gandhi Nagar, Adyar, Bellary, Karnataka
East West Medical Centre	No.711,Sector 14, Sector 14, Gurgaon, Haryana
Jagtap Hospital	Anand Nagar,Sinhgood Road , Anandnagar , Pune , Maharashtra
Dr. Malwankar's Romeen Nursing Home	Ganesh Marg,Tagore Nagar , Vikhroli East , Mumbai , Maharashtra
Noble Medical Centre	SVP Road, Borivali West , Mumbai , Maharashtra
Rama Hospital	Sonepat Road,Bahalgarh, Sonipat , Haryana
S.B.Nursing Home & ICU	Lake Bloom 16,17,18 Opposite Solaris Estate, L.T.Gate No.6,Tunga Gaon, Saki-Vihar Road, Powai , Mumbai , Maharashtra
Sparsh Multi Speciality Hospital & Trauma Care Center	G.I.D.C Road, Nr Udhana Citizan Co-Op.Bank , Surat , Gujarat

Hospital Name	*Address*
Saraswati Hospital	Divya Smruti Building, 1st Floor, Opp. Toyota Showroom, Malad Link Road, Malad West, Mumbai, Maharashtra
Shakuntla Hospital	3-B Tashkant Marg, Near St. Joseph Collage, Allahabad, Uttar Pradesh
Mahaveer Hospital & Trauma Centre	76-E, Station Road, Panki, Kanpur, Uttar Pradesh
Eashwar Lakshmi Hospital	Plot No. 9, Near Sub Registrar Office, Gandhi Nagar, Hyderabad, Andhra Pradesh
Amrapali Hospital	Plot No. NH-34, P-2, Omega -1, Greater Noida, Noida, Uttar Pradesh
Hardik Hospital	29c, Budh Bazar, Vikas Nagar, New Delhi, Delhi
Jabalpur Hospital & Research Centre Pvt Ltd	Russel Crossing, Naptier Town, Jabalpur, Madhya Pradesh
Panvel Hospital	Plot No. 260A,Uran Naka, Old Panvel , Navi Mumbai , Maharashtra
Santosh Hospital	L-629/631,Hapur Road, Shastri Nagar, Meerut, Uttar Pradesh
Sona Medical Centre	5/58,Near Police Station, Vikas Nagar, Lucknow, Uttar Pradesh
City Super Speciality Hospital	Near Mohan Petrol Pump,Gohana Road, Rohtak , Haryana
Navjeevan Hospital & Maternity Centre	753/21,Madanpuri Road, Near Pataudi Chowk, Gurgaon, Haryana
Abhishek Hospital	C-12, New Azad Nagar, Kanpur, Kanpur, Uttar Pradesh
Raj Nursing Home	23-A, Park Road, Allahabad, Uttar Pradesh
Sparsh Medicare and Trauma Centre	Shakti Khand - III/54 ,Behind Cambridge School , Indirapuram, Ghaziabad , Uttar Pradesh
Saras Healthcare Pvt Ltd.	K-112, SEC-12 ,Pratap Vihar , Ghaziabad , Uttar Pradesh
Getwell Soon Multispeciality Institute Pvt Ltd	S-19, Shalimar Garden Extn. , Near Dayanand Park, Sahibabad , Ghaziabad , Uttar Pradesh
Shivalik Medical Centre Pvt Ltd	A-93, Sector 34 , Noida , Uttar Pradesh
Aakanksha Hospital	126, Aaradhnanagar Soc,B/H. Bhulkabhavan School, Aanand-Mahal Rd. , Adajan , Surat , Gujarat
Abhinav Hospital	Harsh Apartment,Nr Jamna Nagar Bus Stop, Goddod Road , Surat , Gujarat
Adhar Ortho Hospital	Dawer Chambers,Nr. Sub Jail, Ring Road , Surat , Gujarat
Aris Care Hospital	A 223-224, Mansarovar Soc,60 Feet, Godadara Road , Surat , Gujarat
Arzoo Hospital	Opp. L.B. Cinema, Bhatar Rd. , Surat , Gujarat
Auc Hospital	B-44, Gujarat Housing Board, Pandeshara , Surat , Gujarat
Dharamjivan General Hospital & Trauma Centre	Karmayogi - 1, Plot No. 20/21, Near Piyush Point, Pandesara , Surat , Gujarat
Dr. Santosh Basotia Hospital	Bhatar Road , Bhatar Road , Surat , Gujarat
God Father Hosp.	344, Nandvan Soc., B/H. Matrushakti Soc. , Puna Gam , Surat , Gujarat
Govind-Prabha Arogya Sankool	Opp. Ratna-Sagar Vidhyalaya,Kaji Medan, Gopipura , Surat , Gujarat
Hari Milan Hospital	L H Road , Surat , Gujarat
Jaldhi Ano-Rectal Hospital	103, Payal Apt., Nxt To Rander Zone Office, Tadwadi , Surat , Gujarat
Jeevan Path Gen. Hospital	2nd. Floor, Dwarkesh Nagri, Nr. Laxmi Farsan, Sayan , Surat , Gujarat
Kalrav Children Hospital	Yashkamal Complex, Nr. Jivan Jyot, Udhna , Surat , Gujarat
Kanchan General Surgical Hospital	Plot No. 380, Ishwarnagar Soc, Bhamroli-Bhatar, Pandesara , Surat , Gujarat
Krishnavati General Hospital	Bamroli Road , Surat , Gujarat
Niramayam Hosptial & Prasutigruah	Shraddha Raw House, Near Natures Park , Surat , Gujarat
Patna Hospital	25, Ashapuri Soc - 2, Bamroli Road, Surat , Gujarat
Poshia Children Hospital	Harekrishan Shoping Complex 1St Floor, Varachha Road , Surat , Gujarat
R.D Janseva Hospital	120 Feet Bamroli Road, Pandesara , Surat , Gujarat
Radha Hospital & Maternity Home	239/240 Bhagunagar Society, Opp Hans Society, L H Road, Varachha Road, Surat , Gujarat
Santosh Hospital	L H Road , Varachha , Surat , Gujarat

Notes:

1. For an updated list of Hospitals, please visit the Company's website.
2. Only in case of a medical emergency, Claims would be payable if admitted in the above Hospitals on a reimbursement basis.

Annexure III - List of Hospitals where Co-Payment of 20% is not applicable under Optional Cover "Smart Select"

Note: The below is a Non-exhaustive list of Network Hospitals under Smart Select optional cover. Please check the latest & complete list of Network Hospitals on https://www.careinsurance.com/smart-select-network-locator.html

Hospital Name	*Address*
Fortis Flt.Lt.Rajan Dhall Hospital	Sector B,Pocket 1, Aruna Asif Ali Marg, Vasant Kunj, New Delhi – 110070
Fortis Escorts Ltd.	Majtha-Verka Bypass Road, Khanna Nagar, Amritsar – 143004
Fortis Escorts Hospital	Jawahar Lal Nehru Marg, Opposite Hotel Clarks Amer, Malviya Nagar, Jaipur – 302017
Fortis Sl Raheja Hospital	Raheja Raghunalaya Marg, Near New Police Quarters Colony, Mahim, Mumbai – 400016
Hiranandani Fortis Hospital	Mini Sea Shore Road, Sector 10A, Vashi, Maharashtra – 400703
Fortis Malar Hospital	52,First Main Road, Gandhi Nagar, Adyar, Chennai – 600020
Fortis Hospital	Sector 62,Phase VIII, Sector 62, Mohali – 160062
Maxcure Mediciti Hospitals	5-9-22,Secretariat Road, Hill Fort, Hyderabad – 500063
Maxivision Laser Centre Pvt. Ltd.	40-1-48,Krishna Sai Bhavan, Opposite D.V.Manor Hotel, Labbipeta, Vijayawada – 520010
Maxivision Laser Centre Pvt. Ltd.	1-11-252/1A To 1D,Alladin Mansion, Street No 3, Begumpet, Hyderabad – 500016
Maxivision Laser Centre Pvt. Ltd.	No.16-11-741/D/66, Dilsukhnagar, Moosa Ram Bagh, Hyderabad – 500036
Maxivision Laser Centre Pvt. Ltd.	6-9-903/A/1/1, Somajiguda, Hyderabad – 500082
Fortis Hospitals Ltd	No.730, EM Bypass Road, Anandpur, Kolkata – 700107
Fortis Hospital Ltd	Mulund Goregaon Link Road, Mulund, Mumbai – 400078
Fortis Health Management Ltd	No.23 80 Feet Road,Guru Krupa Layout, 2nd Stage, Nagarbhavi, Bangalore – 560072
Fortis Hospital	A Block, Shalimar Bagh, New Delhi – 110088
Fortis Hospitals Ltd.	111A, Rash Behari Avenue, Rashbehari Avenue, Kolkata – 700029
Fortis Hospital Ltd.-Wockhardt	154,9, Opposite IIM-B, Bannerghatta Road, Bangalore – 560076
Fortis Hospital Ltd.-Wockhardt	No 14,Cunningham Road, Sheriff's Chamber, Cunnigham, Bangalore – 560052
Fortis Hospital Ltd	Opposite APMC Market,Bail Bazaar, Shill Road, Kalyan City, Kalyan - 421301
International Hospital Limited - Fortis Hospital Ltd	No.111,West of Chord Road, 1st Block Junction, Rajajinagar, Bangalore – 560086
Fortis Hospital Ltd.-Wockhardt	No.65,1St Main Road, Seshadripuram, Bangalore – 560020
Fortis Memorial Research Institute	Sector 44, Opposite HUDA Center Metro Station, HUDA Metro Station, Gurgaon – 122002
Fortis C-Doc Healthcare Limited	B-16, Chirag Enclave, Opp Nehru Place, New Delhi – 110041
Max Smart Super Specialty Hospital	Press Enclave Marg, Mandir Marg, Saket, New Delhi – 110017
Fortis Escorts Hospital	2nd Floor,Pt Deen Dayal, Coronation Hospital, Curzon Road, Dehradun – 248001
Fortis Healthcare Limited	Kangra-Dharamshala Road, Near Main Bus Stand, Kangra – 176001
Maxivision Eye Care Medfort Hospitals	No. 78/6, 3rd Avenue, Anna Nagar, Chennai – 600102
Max Vision Eye Care Centre	95,Neel Padam Sarovar Marg, Nursery Circle,Gandhi Path,Nemi Nagar, Vaishali, Jaipur – 302021
Fortis O.P. Jindal Hospital	Patrapali, Kharsia Road, Raigarh – 496001
Fortis Hospital	Radha Swami Satsang, Chandigarh Road,Village - Mundian, Radha Swami Satsang, Ludhiana – 141001
Fortis Medical Centre	2/7, Sarat Bose Road, Kolkata – 700020
Maxcare Hospital And Laparoscopic Surgery Institute	1st Floor,Hyatt Medicare, Plot No.12,Khare Marg, Dhantoli, Nagpur – 440012
Max Care Hospital	Near Ashoka Hotel, Opp.Kuda Office, Hanamkonda, Warangal – 506001
Fortis Suchirayu Hospital	S.No.29/8,9,10,11 Javali Garden, Off Gokul Road,Opp. To Reg. KSRTC Bus Depot,Off NH4 Highway, Hubli - 580030
Max Vision Advanced Eye Care Centre	216-A,Soham Plaza, Soham Gardens,Opp. Manpada Bus Stop,Chitalsar, Chitalsar G.B Road, Thane - 400607

Annexure IV - SERVICE REQUEST FORM

For Change in Occupation / Nature of Job
(Refer Clause 5.2.1 of Policy Terms and Conditions)

To be filled in by Policyholder in CAPITAL LETTERS only.
If there is insufficient space, please provide further details on a separate sheet. All attached documents form part of this service request.
This form has to be filled in and submitted to the company whenever the nature of job / occupation of any insured covered under the Policy changes subsequent to the issuance of the Policy.

Policyholder Details

☐ Mr. ☐ Ms. ☐ M/S. Policy No :

Name :

(First Name) (Middle Name) (Last Name)

Details of the Insured Persons for whom details are to be updated

☐ Mr. ☐ Ms. ☐ M/S.

Name :

(First Name) (Middle Name) (Last Name)

Occupation :

Declaration

I hereby declare, on my behalf and on behalf of all persons insured, that the above statement(s), answer(s) and / or particular(s) given by me are true and complete in all respects to the best of my knowledge and that I am authorized to provide / request for updation of the details on behalf of Insured Persons.

Date : / / (DD/MM/YYYY)

Signature of the Policyholder :__________________

(On behalf of all the persons insured under the Policy)

Place :

Note: The Company shall update its record with respect to the information provided above. Subsequently, the Company may review the risk involved and may alter the coverage and / or premium payable accordingly.

Annexure V - Benefit / Premium illustration

Illustration No. 1

Age of members Insured	Coverage opted on individual basis covering each member of the family separately (at a single point of time)		Coverage opted on individual basis covering multiple members of the family under a single Policy (Sum Insured is available for each member of family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)
44	8,210	3,00,000	8,210	10%	7,389	3,00,000	18,460	NA	18,460	3,00,000
40	8,210	3,00,000	8,210	10%	7,389	3,00,000				
22	6,419	3,00,000	6,419	10%	5,777	3,00,000				
14	6,419	3,00,000	6,419	10%	5,777	3,00,000				
Total Premium for all members of family is Rs.29,256 when each member is covered separately. Sum Insured available for each individual is Rs.3,00,000			Total Premium for all members of family is Rs.26,331 when they are covered under a single policy Sum Insured available for each family member is Rs. 3,00,000				Total Premium when policy is opted on floater basis is Rs. 18,460 Sum Insured of Rs. 3,00,000 is available for entire family			

Illustration No. 2

Age of members Insured	Coverage opted on individual basis covering each member of the family separately (at a single point of time)		Coverage opted on individual basis covering multiple members of the family under a single Policy (Sum Insured is available for each member of family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)
61	28,757	3,00,000	28,757	5%	27,320	3,00,000	50,492	NA	50,492	3,00,000
57	18,940	3,00,000	18,940	5%	17,993	3,00,000				
21	6,419	3,00,000	6,419	5%	6,098	3,00,000				
Total Premium for all members of family is Rs.54,116 when each member is covered separately. Sum Insured available for each individual is Rs. 3,00,000			Total Premium for all members of family is Rs.51,410 , when they are covered under a single policy Sum Insured available for each family member is Rs. 3,00,000				Total Premium when policy is opted on floater basis is Rs. 50,492 Sum Insured of Rs. 3,00,000 is available for entire family			

Illustration No. 3

Age of members Insured	Coverage opted on individual basis covering each member of the family separately (at a single point of time)		Coverage opted on individual basis covering multiple members of the family under a single Policy (Sum Insured is available for each member of family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)
75	51,118	3,00,000	51,118	5%	48,562	3,00,000	82,174	NA	82,174	3,00,000
71	51,118	3,00,000	51,118	5%	48,562	3,00,000				
Total Premium for all members of family is Rs. 1,02,237 when each member is covered separately. Sum Insured available for each individual is Rs. 3,00,000			Total Premium for all members of family is Rs. 97,125 , when they are covered under a single policy Sum Insured available for each family member is Rs. 3,00,000				Total Premium when policy is opted on floater basis is Rs. 82,174 Sum Insured of Rs. 3,00,000 is available for entire family			

Notes:

1. Premium rates (excl taxes) specified in above illustration shall be standard premium rates without considering any loading.

Office of the Ombudsman	Contact Details	Jurisdiction of Office (Union Territory, District)
JAIPUR	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel. : 0141-2740363 Email : Bimalokpal.jaipur@cioins.co.in	Rajasthan
ERNAKULAM	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, ERNAKULAM-682 015. Tel. : 0484-2358759/2359338, Fax : 0484-2359336 E-mail : bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe – a part of Pondicherry
KOLKATA	Insurance Ombudsman, Office of the Insurance Ombudsman, 4th Floor, Hindustan Bldg. Annexe, 4, C.R. Avenue, Kolkata – 700 072. Tel : 033-22124339/22124340, Fax : 033-22124341 E-mail : bimalokpal.kolkata@cioins.co.in	West Bengal, Andaman & Nicobar Islands, Sikkim
LUCKNOW	Insurance Ombudsman, Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-2, Nawal Kishore Road, Hazaratganj, LUCKNOW-226 001. Tel.: 0522 - 2231330 / 2231331, Fax : 0522-2231310 E-mail : bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, 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.
MUMBAI	Insurance Ombudsman, Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), MUMBAI-400 054. Tel.: 022 - 69038821/23/24/25/26/27/28/29/30/31 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA	Office of the Insurance Ombudsman, 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	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, 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 Ombudsman	Contact Details	Jurisdiction of Office (Union Territory, District)
PATNA	Insurance Ombudsman, Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, Near Panbazar Overbridge, S.S. Road, GUWAHATI-781 001 (ASSAM). Tel.: 0361 - 2632204 / 2602205 E-mail : bimalokpal.guwahati@cioins.co.in	Bihar, Jharkhand
PUNE	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 2nd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

The updated details of Insurance Ombudsman are available on website of IRDAI: www.irda.gov.in, on the website of General Insurance Council: www.gicouncil.org.in, on the Company's website www.careinsurance.com or from any of the Company's offices. Address and contact number of Executive Council of Insurers –

Office of the 'Executive Council of Insurers'
Secretary General/Secretary,
3rd Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz(W),
Mumbai - 400 054.
Tel:022-69038801/03/04/05/06/07/08/09
Email- inscoun@cioins.co.in

Annexure VI - Office of the Ombudsman

Office of the Ombudsman	Contact Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 E-mail : bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, BENGALURU - 560 078. Tel.: 080-22222049 / 22222048 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
BHOPAL	Insurance Ombudsman, Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, BHOPAL (M.P.)-462 003. Tel.: 0755-2769201 / 9202 , Fax : 0755-2769203 E-mail : bimalokpal.bhopal@cioins.co.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, BHUBANESHWAR-751 009. Tel.: 0674 - 2596461 / 2596455, Fax : 0674-2596429 E-mail: bimalokpal.bhubaneswar@cioins.co.in	Orissa
CHANDIGARH	Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No.101-103, 2nd Floor, Batra Building. Sector 17-D, CHANDIGARH-160 017. Tel.: 0172 - 2706196 / 2706468, Fax : 0172-2708274 E-mail: bimalokpal.chandigarh@cioins.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh
CHENNAI	Insurance Ombudsman, Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI-600 018. Tel.: 044-24333668 / 24335284, Fax : 044-24333664 E-mail : bimalokpal.chennai@cioins.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)
DELHI	Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, NEW DELHI-110 002. Tel.: 011 - 23232481 / 23213504 E-mail : bimalokpal.delhi@cioins.co.in	Delhi, Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI	Insurance Ombudsman, Office of the Insurance Ombudsman, “Jeevan Nivesh”, 5th Floor, Near Panbazar Overbridge, S.S. Road, GUWAHATI-781 001 (ASSAM). Tel.: 0361 - 2632204 / 2602205 E-mail : bimalokpal.guwahati@cioins.co.in	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Insurance Ombudsman, Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, Lane Opp. Saleem Function Palace, A.C. Guards, Lakdi-Ka-Pool, HYDERABAD-500 004. Tel.: 040 - 23312122 E-mail : bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana and Yanam – a part of Territory of Pondicherry

Care Health Insurance Limited
Registered Office: 5th Floor, 19 Chawla House, Nehru Place, New Delhi-110019
Correspondence Office: Vipul Tech Square, Tower C, 3rd Floor, Golf Course Road, Sector-43, Gurugram-122009 (Haryana)
CIN: U66000DL2007PLC161503 UIN: CHIHLIP22047V012122
IRDAI Registration Number - 148

REACH US @

Care Health-
Customer App

WhatsApp
8860402452

Self Help Portal:
www.careinsurance.com/self-help-portal.html

Submit Your Queries/Requests:
www.careinsurance.com/contact-us.html

Ver/Jan'23/AP