

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 Ltd. (Formerly known as Religare Health Insurance Company 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.

Any Treatment and / or quarantine for any Illness, sickness or disease other than Coronavirus disease (COVID-19) is not covered under this Policy.

Policy Terms & Conditions

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.

1. Definitions

- 1.1 Accidental / Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.
- 1.2 Annexure** means the document attached and marked as Annexure to this Policy.
- 1.3 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
- 1.4 AYUSH Hospital** is a healthcare facility wherein medical/surgical / para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner (s) comprising of any of the following:
- (a) Central or State Government AYUSH Hospital or
 - (b) Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy;or
 - (c) AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
 - i. Having at least 5 in-patient beds;
 - ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
 - iii. Having dedicated AYUSH therapy sections as required 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.
- 1.5 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

- 1.6 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.
- 1.7 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 as covered under the Policy.
- 1.8 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.
- 1.9 Company (also referred as Insurer/We/Us)** means Care Health Insurance Limited. (Formerly known as Religare Health Insurance Company Limited)
- 1.10 Condition Precedent** shall mean a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.
- 1.11 Congenital Anomaly** refers to a condition which is present since birth, and which is abnormal with reference to form, structure or position :
- Internal Congenital Anomaly –**
Congenital anomaly which is not in the visible and accessible parts of the body
 - External Congenital Anomaly –**
Congenital anomaly which is in the visible and accessible parts of the body
- 1.12 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.
- 1.13 Cumulative Bonus** shall mean any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.
- 1.14 Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under—
- has qualified nursing staff under its employment;
 - has qualified Medical Practitioner/s in-charge;
 - has a fully equipped operation theatre of its own, where surgical procedures are carried out.
 - maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
- 1.15 Day Care Treatment** means medical treatment, and/ or Surgical Procedure which is:
- undertaken under general or local anesthesia in a Hospital/ Day Care Centre in less than 24 consecutive hours because of technological advancement, and
 - which would have otherwise required a Hospitalization

of more than 24 hours.

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

- 1.16 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.
- 1.17 Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery .
- 1.18 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.
- 1.19 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:
- The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
 - The patient takes treatment at home on account of non-availability of room in a Hospital.
- 1.20 Diagnosis** means pathological conclusion drawn by a registered medical practitioner, supported by acceptable Clinical, radiological, histological, histo-pathological and laboratory evidence wherever applicable.
- 1.21 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.
- 1.22 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.
- 1.23 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, bobsleighting/ 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.

1.24 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:

- a. has qualified nursing staff under its employment round the clock;
- b. 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;
- c. has qualified Medical Practitioner(s) in charge round the clock;
- d. has a fully equipped operation theatre of its own where surgical procedures are carried out;
- e. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

1.25 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.

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

1.27 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.

1.28 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.

1.29 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.

1.30 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.

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

1.32 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.

1.33 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.

1.34 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.

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

1.36 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.

1.37 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.

1.38 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.
- 1.39 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
- 1.40 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.
- 1.41 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.
- 1.42 Newborn baby** means baby born during the Policy Period and is aged up to 90 days.
- 1.43 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.
- 1.44 Notification of Claim** means the process of intimating a Claim to the Insurer or TPA through any of the recognized modes of communication.
- 1.45 Non - Network Provider:** Non-Network means any hospital, day care centre or other provider that is not part of the network.
- 1.46 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.
- 1.47 Preventive Care** means any kind of treatment taken as a pro-active care measure without actual requirement or symptoms of a disease or illness.
- 1.48 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.
- 1.49 Policy Schedule** is a certificate attached to and forming part of this Policy.
- 1.50 Policy Year** means a period of one year commencing on the Policy Period Start Date or any anniversary thereof.
- 1.51 Policyholder** (also referred as You) means the person named in the Policy Schedule as the Policyholder.
- 1.52 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.
- 1.53 Policy Period End Date** means the date on which the Policy expires, as specifically appearing in the Policy Schedule.
- 1.54 Policy Period Start Date** means the date on which the Policy commences, as specifically appearing in the Policy Schedule.
- 1.55 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.
- 1.56 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.
- 1.57 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.
- 1.58 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.
- 1.59 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.
- 1.60 Quarantine** means a state, period or place of isolation in which people are placed in a Government Authorized Centre due to diagnosis or suspected infection of Corona virus disease (Covid 19).
- 1.61 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.

- 1.62 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.
- 1.63 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.
- 1.64 Room Rent** means the amount charged by a Hospital towards Room & Boarding expenses and shall include the associated medical expenses.
- 1.65 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.
- 1.66 Sum Insured** means the amount specified in the Policy Schedule, for which premium is paid by the Policyholder
- 1.67 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 and prolongation of life, performed in a Hospital or a Day Care Centre by a Medical Practitioner.
- 1.68 Single Private Room** means an air conditioned room in a Hospital where a single patient 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.
- 1.69 Third Party Administrator or TPA** means any person who is licensed under the IRDA (Third Party Administrators-Health Services) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an Insurance Company, for the purposes of providing health services.
- 1.70 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.
- 1.71 Variable Medical Expenses** means those Medical Expenses as listed below which vary in accordance with the Room Rent or Room Category or ICU Charges applicable in a Hospital:
- Room, boarding, nursing and operation theatre expenses as charged by the Hospital where the Insured Person availed medical treatment;
 - Intensive Care Unit charges;
 - Fees charged by surgeon, anesthetist, Medical Practitioner;
 - Investigation expenses incurred towards diagnosis of ailment requiring Hospitalization

GENERAL CONDITIONS APPLICABLE TO ALL THE BENEFITS

- 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 for that Insured Person.
- 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.
- 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.
- Any Claim paid for the Benefits 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.
- Option of Mid-term inclusion of a Person in the Policy will be only upon marriage or childbirth; Additional differential premium will be calculated on a pro rata basis.
- Coverage under this Policy will be available for the Insured Person for medical expenses incurred for treatment and / or quarantine for Coronavirus disease (COVID-19) with positive confirmative diagnosis from Government Authorized Centre.
- In case the claim related to medical expenses is paid by the Company and thereafter Government/Competent Authority has reimbursed the said medical expenses to the Insured Person, in such case the company has the right and authority to recover the said medical expenses from the Insured Person, paid out under the Policy and in case Insured Person does not remit the said medical expenses within 60 days from the receipt of said medical expenses from the Government/Competent Authority, the Company is authorized to take all the necessary legal actions to recover the said medical expenses.
- The Insured Person cannot claim medical expenses from both the Company and Government/Competent Authority, Insured Person can only claim medical expenses from any one of them.

2.1 Benefit 1 : Hospitalization Expenses

If an Insured Person is diagnosed with an illness 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:

- 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.
- Day Care Treatment:** The Company will

2. Scope Of Cover

indemnify the Insured Person for Medical Expenses incurred on Day Care Treatment through Cashless or Reimbursement Facility, maximum up to the Sum Insured, as specified in the Policy Schedule, provided that 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 Treatment 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 Hospitalization Expenses (Benefit 1):

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

- 1) 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 Variable 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:

- 2) **Single Private Room** If the Policy Schedule states 'Single Private 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 Private Room.
- 3) 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.

- 4) 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):

- 1) If the Insured Person is admitted in an ICU where the ICU charges incurred are higher than the ICU Charges specified in the Policy Schedule, then the Policyholder / Insured Person shall bear the ratable proportion of the Variable Medical Expenses (including applicable surcharge and taxes thereon) in the proportion of the difference between the ICU charges actually incurred and the ICU Charges specified in the Policy Schedule to the ICU charges actually incurred.

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:

- 2) 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.
- 3) If the Policy Schedule states the eligibility of ICU Charges of the Insured Person as 'No Sub-limit', it means that there is no separate restriction on ICU Charges incurred towards stay in ICU during Hospitalization

(iv) Sub-limits on Coverage for Quarantine

The Company will indemnify the Insured Person for Medical Expenses incurred maximum up to 1% Sum Insured per day maximum up to 30 days in a Policy Year through Cashless or Reimbursement Facility in case Insured Person gets quarantine due to positive confirmative diagnosis of Coronavirus disease (COVID-19) in Government Authorized Centre.

Exclusion No.6 will not be applicable to the extent for Coverage of Quarantine.

2.1 Benefit 2 : 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 for which the Company has accepted the Insured Person's Claim under Benefit 1 (Hospitalization Expenses) and subject to the conditions specified below:

- (i) Under Pre-hospitalization Medical Expenses, for a period of 30 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 60 days immediately after the Insured Person's date of discharge from the Hospital.
- (iii) If the provisions of Clause 4.7(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.

Note: Maximum of 4 diagnostic tests for Coronavirus disease (COVID-19) is available under this benefit

2.3 Benefit 3: OPD Benefit

The Company will indemnify the Insured Person, through Reimbursement for availing Out-Patient consultations, Diagnostic Examinations and Pharmacy expenses, up to the amount specified against this Benefit in the Policy Schedule, during the Policy Year provided that the Medical Expenses so incurred are after positive confirmative diagnosis of Coronavirus disease (COVID-19).

3. Exclusions

3.1 Waiting Periods:

- (i) 15-day waiting period
 - a. Expenses related to the treatment and / or quarantine for COVID 19 within 15 days from the first policy commencement date shall be excluded.
 - 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.

- (ii) The Waiting Periods as defined in Clauses 3.1 (i) shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

3.2 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. Any Treatment and / or quarantine for any Illness, sickness or disease other than Coronavirus disease (COVID-19).
2. Any claim with respect to Coronavirus disease (COVID-19) contracted or manifested or the onset of diseases is prior to commencement date of this policy.
3. Insured Person travels to any containment zone/city/district/country where travel has been restricted by any Government Authority
4. Any item or condition or treatment specified in List of Non-Medical Items (Annexure – 1 to Policy Terms & Conditions).
5. 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.
6. 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.
7. 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
8. **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.
9. **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.
10. **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.
11. **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.
12. **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.
13. **Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code- Excl12)**
14. **Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Code- Excl13)**
15. **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)**
16. **Refractive Error: (Code- Excl15)**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.
17. **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.
18. **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
19. **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.
20. **No claim shall be payable where Insured Person was living with and sharing the same address as that of Person (s) who were diagnosed with Coronavirus disease (COVID-19) or quarantined at the time of Proposal**
21. **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.**

22. All preventive care, Vaccination including Inoculation, Immunizations and tonics.
23. 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.
24. Non-Allopathic Treatment or treatment related to any unrecognized systems of medicine.
25. 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.
26. Any condition directly or indirectly caused by or associated with any sexually transmitted disease except arising out of HIV.
27. 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 intoxicating drugs, alcohol or hallucinogens.
28. Any charges incurred to procure documents related to treatment or Illness pertaining to any period of Hospitalization or Illness.
29. 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.
30. 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.
31. 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
32. 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.

4. 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.

4.1 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.

4.2 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 authorized 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 4.4 and 4.5 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.

(b) Re-imbursalment 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 4.4 and Clause 4.5 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 acknowledgment of collected documents. However, in case of any delayed submission, the Company may examine and relax the time limits mentioned up on 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.

4.3 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 4 (Claims Procedure and Management) of the Policy.
- (iv) 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.
- (v) 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.

4.4 Claims Intimation

Upon the occurrence any event 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 Coronavirus disease (COVID-19) is diagnosed or discovered 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: 4.4 (i) and 4.4 (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;
 - 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

4.5 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 time frames specified in Clause 5 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

test reports/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. 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.

4.6 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.

4.7 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) **The Company shall settle or reject any Claim within 30 days** of receipt of all the necessary documents / information as required for settlement of such Claim and sought by the Company. The Company shall provide the Policyholder / Insured Person an offer of settlement of Claim and upon acceptance of such offer by the Policyholder / Insured Person the Company shall make payment within 7 days from the date of receipt of such acceptance. However, if a claim warrants an investigation in the opinion of the Company, then the Company shall settle the claim within 45 days from the date of receipt of last necessary document. In case there is delay in the payment beyond the stipulated timelines from the date of receipt of last necessary document to the date of payment of claim, the Company shall pay additional amount as interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it. For the purpose of this clause, 'bank rate' shall mean the existing bank rate as notified by Reserve Bank of India, unless the ext e n s i o n r e g u l a t i o n r e q u i r e s payment based on some other prescribed interest rate.
- (d) 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.
- (e) 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.
- (f) The Premium for the policy will remain

the same for the Policy Period mentioned in the Policy Schedule.

5. General Terms And Conditions

5.1 Disclosure to Information Norm

If any untrue or incorrect statements are made or there has been a misrepresentation, mis-description or non-disclosure of any material particulars or any material information having been withheld, or if a Claim is fraudulently made or any fraudulent means or devices are used by the Policyholder, the Insured Person or any one acting on his or their behalf, the Company shall have no liability to make payment of any Claims and the premium paid shall be forfeited to the Company on cancellation of the Policy or the Company may adjust the scope of cover and / or the premium paid or payable, accordingly.

5.2 Observance of Terms and Conditions

The due observance and fulfillment of the terms and conditions of this Policy (including the realization of premium by their respective due dates and compliance with the specified procedure on all Claims) in so far as they relate to anything to be done or complied with by the Policyholder or any Insured Person, shall be Condition Precedent to the Company's liability under the Policy.

5.3 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.

5.4 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.

5.5 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.

5.6 Complete Discharge

Payment made by the Company to the Policyholder or Insured Person or the nominee of the Policyholder or the legal representative of the Policyholder or to the

Hospital, as the case may be, of any Medical Expenses or compensation or Benefit under the Policy shall in all cases be complete and construed as an effectual discharge in favor of the Company.

5.7 Multiple Policies

- a. In case any Policyholder/Insured Person is covered under more than one indemnity insurance policies, with the Company or with other insurers, the Policyholder/ Insured Person shall have the right to settle the Claim with any of the Company, provided that the Claim amount payable is up to the Sum Insured of such Policy.
- b. In case the Claim amount under a single policy exceeds the Sum Insured, then Policyholder /Insured Person shall have the right to choose the companies with whom the Claim is to be settled. Further, policyholder/Insured Person shall have the right to choose the companies from whom he/she wants to claim the balance amount. Insured shall only be indemnified the hospitalization costs in accordance with terms & conditions of chosen Policy.
- c. Policyholder/Insured Persons shall also have the right to prefer claims from other policy / policies for the balance claim or amounts disallowed under the earlier chosen policy / policies, even if the sum insured is not exhausted.
- d. In case of multiple policies which provide fixed benefits, each insurer shall make the claim payments independent of payments received under other similar policies.

5.8 Free Look Period

- a. The Policyholder may, within 15 days (30 days in case of distance marketing) from the receipt of the Policy document, return the Policy stating reasons for his objection, if the Policyholder disagrees with any Policy terms and conditions.
- b. If no Claim has been made under the Policy, the Company will refund the premium received after deducting proportionate risk premium for the period on cover and stamp duty charges. If only part of the risk has commenced, such proportionate risk premium shall be calculated as commensurate with the risk covered during such period. All rights under the Policy will immediately stand extinguished on the free look cancellation of the Policy.
- c. Provision for Free look period is not applicable and available at the time of renewal of the Policy.

5.9 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.

5.10 Renewal Terms

- (a) This Policy will automatically terminate on the Policy Period End Date. All renewal applications should reach the Company on or before the Policy Period End Date.
- (b) The premium payable on renewal shall be paid to the Company on or before the Policy Period End Date and in any event before the expiry of the Grace Period.
- (c) For the purpose of this provision, Grace Period means a period of 30 days immediately following the Policy Period End Date during which a payment can be made to renew this Policy without loss of continuity Benefits. Coverage is not available for the period for which premium is not received by the Company and the Company shall not be liable for any Claims incurred during such period.
- (d) The policy will be renewed except on grounds of misrepresentation / Non-disclosure of material fact as declared in the proposal form and at the time of claim, fraud committed / moral hazard or non-cooperation of the insured.
- (e) The Company may carry out underwriting in accordance with its Board approved underwriting policy in relation to any request for change in Sum Insured at the time of renewal of the Policy.
- (f) This product may be withdrawn / modified by the Company after due approval from the Authority (IRDAI). In case this product is withdrawn / modified by the Company, this Policy can be renewed under the then prevailing Health Insurance Product or its nearest substitute approved by the Authority (IRDAI). The Company shall duly intimate the Policyholder at least three months prior to the date of such modification / withdrawal of this product and the options available to the Policyholder at the time of Renewal of this Policy.
- (g) The Company may revise the renewal premium payable under the Policy provided that revisions to the renewal premium are in accordance with the Authority's (IRDAI) rules and regulations as applicable from time to time. Change in rates will be applicable only post approval by the Authority and be effective from the date of launch of the revised Product and shall be applied only prospectively thereafter for new policies and at the date of renewal for renewals.
- (h) Renewal shall be offered lifelong. The Insured Person shall be given an option to port this Policy into any other health insurance product of the Company and credit shall be given for number of days of continuous coverage under this Policy for the standard waiting periods.
- (i) No loading based on individual claim

experience shall be applicable on renewal premium payable.

5.11 Cancellation/Termination

- (a) The Company may at any time, cancel this Policy on grounds as specified in Clause 5.1 by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to the Policyholder at his last known address and the Company shall have no liability to make payment of any Claims and the premium paid shall be forfeited and no refund of premium shall be effected by the Company.
- (b) The Policyholder may also give 15 days' notice in writing, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of the notice, cancel the Policy and refund the premium (exclusive of taxes) for the unexpired period of this Policy at the short period scales as mentioned below, provided no Claim has been made under the Policy.

Refund % to be applied on premium received

Cancellation date from Policy Period Start Date	Policy Tenure -1 Year
Up to 1 month	75.00%
1 month to 3 months	50.00%
3 months to 6 months	25.00%
6 months to 12 months	0.00%

- (c) 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 (exclusive of taxes) for the unexpired period of this Policy at the short period scales.
 - (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.

5.12 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.

5.13 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.

5.14 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.

- 5.15** 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

5.16 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

5.17 Portability and Continuity Benefits

- (i) Insured(s) have an option to port from their

existing health insurance policy of any other Indian non-life insurer/standalone health insurer to any other similar policy with the company, at the time of renewal, provided the previous policy/policies has been maintained without any break and the policy holder shall apply to company at least 45 days before, but not earlier than 60 days from the policy renewal date of his or her existing policy in prescribed format.

- (ii) The Waiting Periods as defined in Clauses 3.1(i) of this Policy shall be reduced by the number of days of continuous coverage under such health insurance policy with the previous insurer to the extent of the sum insured under the expiring health insurance policy.
- (iii) The Waiting Periods under Clauses 3.1 (i) shall be applicable afresh to the amount by which the Sum Insured under this Policy exceeds the sum insured under the terms of the expiring policy.
- (iv) The Waiting Periods as defined in Clauses 3.1 (i) shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.
- (v) Credit for the sum insured of the expiring policy shall additionally be available as under:
 - a) Sum insured to be carried forward for credit in this Policy would be applied on an individual basis only.
 - b) If the Insured Person was covered on a Floater basis under the expiring policy and is proposed to be covered on a Floater basis with the Company, then the sum insured to be carried forward for credit under this Policy would also be applied on a Floater basis only.
- (vi) In case the Policyholder has opted to switch to any other insurer under portability and the outcome of acceptance of the portability is awaited from the new insurer on the date of renewal:
 - a) The Company may at the request of the Policyholder, extend the Policy for a period not less than 1 month at an additional premium to be paid on a pro-rated basis.
 - b) In case any Claim is reported during the extended Policy Period, the Policyholder shall first pay the premium so as to make the extended Policy Period part of Policy, as applicable. In such cases, Policyholder shall be liable to pay the premium for the balance period and continue with the

Company for that Policy year.

Note: Such Portability is allowed as per the Guideline as amended from time to time.

5.18 Migration

Policy holder has an option to migrate from their existing Health Insurance Policy to any other Individual Health Insurance Policy or a Family Floater Policy or a Group Health Insurance Policy (only if the member complies with the norms relating to the Health Insurance coverage under the concerned Group Insurance Policy) with the Company.

- (i) The Policy holder should initiate the action to approach the Company to exercise migration option at least 30 days before the renewal date to avoid any break in the policy coverage.
- (ii) The Waiting Periods as defined in Clauses 3.1 (i) of this Policy shall be reduced by the number of months of continuous coverage under such health insurance policy to the extent of the sum insured under the expiring health insurance policy.
- (iii) The Waiting Periods under Clauses 3.1 (i) shall be applicable afresh to the amount by which the Sum Insured under this Policy exceeds the sum insured under the terms of the expiring policy.
- (iv) The Waiting Periods as defined in Clauses 3.1 (i) shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.
- (v) Credit for the sum insured of the expiring policy shall additionally be available as under:
 - a) Sum insured to be carried forward for credit in this Policy would be applied on an individual basis only.
 - b) If the Insured Person was covered on a Floater basis under the expiring policy and is proposed to be covered on a Floater basis with the Company, then the sum insured to be carried forward for credit under this Policy would also be applied on a Floater basis only.

Note: Such migration is allowed as per the Guideline as amended from time to time.

5.19 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 which are found fraudulent later under this Policy shall be repaid by all person(s) named in the Policy Schedule, who shall be jointly and severally liable for such repayment.

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

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

The Company shall not repudiate the policy 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. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

5.20 Grievances

The Company has developed proper procedures and effective mechanism to address complaints by the customers. The Company is committed to comply with the Regulations, standards which have been set forth in the Regulations, Circulars issued by the Authority (IRDAI) from time to time in this regard.

- (a) If the Policyholder / Insured Person has a grievance that the Policyholder / Insured Person wishes the Company to redress, the Policyholder / Insured Person may contact the Company with the details of the grievance through:

Website: www.careinsurance.com

Email: customerfirst@careinsurance.com

Contact No.: 1800-102-4488

Courier: Any of Our Branch Office or corporate

office

The Policyholder/Insured Person may also approach the grievance cell at any of the Company's branches with the details of his/her grievance during the Company's working hours from Monday to Friday.

Exclusively for Senior Citizens, We have a separate extension on the Customer Service Toll Free Number. This separate customer service channel prioritizes and routes any kind of request / grievance raised by Senior Citizens through various fast track internal escalations leading to lesser Turn-Around-Time (TAT) for request / grievance addressal

- (a) If the Policyholder / Insured Person is not satisfied with the Company's redressal of the Policyholder's / Insured Person's grievance through one of the above methods, the Policyholder / Insured Person may contact the Company's Head of Customer Service at:

Head – Customer Services,

Care Health Insurance Limited (Formerly known as Religare Health Insurance Company Limited)

Unit No. 604 - 607, 6th Floor, Tower C,

Unitech Cyber Park, Sector-39,

Gurgaon, Haryana – 122001

- (b) If the Policyholder / Insured Person is not satisfied with the Company's redressal of the Policyholder's / Insured Person's grievance through one of the above methods, the Policyholder / Insured Person may approach the nearest Insurance Ombudsman for resolution of the grievance. The contact details of Ombudsmen offices are mentioned below:

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@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Office of the Insurance Ombudsman, Jeevan Soudha Building ,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka
BHOPAL	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 / 2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa
CHANDIGARH	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh
CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481 / 23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana and Yanam – a part of Territory of Pondicherry

Office of the Ombudsman	Contact Details	Jurisdiction of Office (Union Territory, District)
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan
ERNAKULAM	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 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe – a part of Pondicherry
KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Andaman & Nicobar Islands, Sikkim
LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajganj, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
PATNA	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand

Office of the Ombudsman	Contact Details	Jurisdiction of Office (Union Territory, District)
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.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaut, Bulandshahr, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.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'

3rd Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz(W),
Mumbai - 400 054.
Tel : 022-26106889/671/980
Fax : 022-26106949
Email- inscoun@ecoi.co.in

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	50	Ambulance Equipment
2	Baby Utilities Charges	51	Abdominal Binder
3	Beauty Services	52	Private Nurses Charges- Special Nursing Charges
4	Belts/ Braces	53	Sugar Free Tablets
5	Buds	54	Creams Powders Lotions (toiletries Are Not Payable, Only Prescribed Medical Pharmaceuticals Payable)
6	Cold Pack/hot Pack		
7	Carry Bags		
8	Email / Internet Charges	55	Ecg Electrodes
9	Food Charges (other Than Patient's Diet Provided By Hospital)	56	Gloves
		57	Nebulisation Kit
10	Leggings	58	Any Kit With No Details Mentioned [delivery Kit, Orthokit, Recovery Kit, Etc]
11	Laundry Charges		
12	Mineral Water	59	Kidney Tray
13	Sanitary Pad	60	Mask
14	Telephone Charges	61	Ounce Glass
15	Guest Services	62	Oxygen Mask
16	Crepe Bandage	63	Pelvic Traction Belt
17	Diaper Of Any Type	64	Pan Can
18	Eyelet Collar	65	Trolley Cover
19	Slings	66	Urometer, Urine Jug
20	Blood Grouping And Cross Matching Of Donors Samples	67	Ambulance
		68	Vasofix Safety
21	Service Charges Where Nursing Charge Also Charged		
22	Television Charges		
23	Surcharges		
24	Attendant Charges		
25	Extra Diet Of Patient (other Than That Which Forms Part Of Bed Charge)		
26	Birth Certificate		
27	Certificate Charges		
28	Courier Charges		
29	Conveyance Charges		
30	Medical Certificate		
31	Medical Records		
32	Photocopies Charges		
33	Mortuary Charges		
34	Walking Aids Charges		
35	Oxygen Cylinder (for Usage Outside The Hospital)		
36	Spacer		
37	Spirometre		
38	Nebulizer Kit		
39	Steam Inhaler		
40	Armsling		
41	Thermometer		
42	Cervical Collar		
43	Splint		
44	Diabetic Foot Wear		
45	Knee Braces (long/ Short/ Hinged)		
46	Knee Immobilizer/shoulder Immobilizer		
47	Lumbo Sacral Belt		
48	Nimbus Bed Or Water Or Air Bed Charges		
49	Ambulance Collar		
50	Ambulance Equipment		

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

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		
4	Caps	3	Eye Pad
5	Cradle Charges	4	Eye Sheild
6	Comb	5	Camera Cover
7	Eau-de-cologne / Room Freshners	6	Dvd, Cd Charges
8	Foot Cover	7	Gause Soft
9	Gown	8	Gauze
10	Slippers	9	Ward And Theatre Booking Charges
11	Tissue Paper	10	Arthroscopy And Endoscopy Instruments
12	Tooth Paste		
13	Tooth Brush	11	Microscope Cover
14	Bed Pan	12	Surgical Blades, Harmonicscalpel, Shaver
15	Face Mask		
16	Flexi Mask	13	Surgical Drill
17	Hand Holder	14	Eye Kit
18	Sputum Cup	15	Eye Drape
19	Disinfectant Lotions	16	X-ray Film
20	Luxury Tax	17	Boyles Apparatus Charges
21	Hvac	18	Cotton
22	House Keeping Charges	19	Cotton Bandage
23	Air Conditioner Charges	20	Surgical Tape
24	Im Iv Injection Charges	21	Apron
25	Clean Sheet	22	Torniquet
26	Blanket/warmer Blanket	23	Orthobundle, Gynaec Bundle
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		

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

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 No43, 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
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, Singhood 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
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

Hospital Name	Address
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 -I, 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
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. Bhulabhavan School, Aanand-Mahal Rd. , Adajan , Surat , Gujarat
Abhinav Hospital	Harsh Apartment, Nr Jamma 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. Fl., Dwarakesh Nagri, Nr. Laxmi Farsan, Sayan , Surat , Gujarat
Kalrav Children Hospital	Yashkamal Complex, Nr. Jivan Jyot, Udha , Surat , Gujarat
Kanchan General Surgical Hospital	Plot No. 380, Ishwarnagar Soc, Bhamroli-Bhatar, Pandesara , Surat , Gujarat
Krishnavati General Hospital	Bamroli Road , Surat , Gujarat
Niramayam Hospital & Prasutigrauh	Shradha Raw House, Near Natures Park , Surat , Gujarat
Patna Hospital	25, Ashapuri Soc - 2, Bamroli Road, Surat , Gujarat
Poshia Children Hospital	Harekrishan Shopping Complex 1st Floor, Varachha Road , Surat , Gujarat
R.D Jansava 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
Sparsh Multy Speciality Hospital & Trauma Care Center	G.I.D.C Road, Nr Udhana Citizen Co-Op. Bank , Surat , Gujarat

Notes:

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

