care HEALTH INSURANCE

BEST HEALTH INSURANCE COMPANY OF THE YEAR
INDIA INSURANCE SUMMIT & AWARDS 2023

Domestic Staff Insurance Add-on

Know Your Policy Better

Policy Terms and Conditions

1. Preamble

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

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

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

Please check whether the details given by you about the insured persons in the proposal form (a copy of which was provided at the time of issuance of cover for the first time) are incorporated correctly in the Add-on policy schedule. If you find any discrepancy, please inform us within 15 days from the date of receipt of the Add-on 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 Add-on 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 Add-on Policy, the Company has defined, herein below some of the important words used in the Add-on Policy 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 Add - on Policy are to be construed in accordance with the applicable provisions contained in the Add-on Policy.

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

2. Definitions

2.1 Standard Definitions:

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

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

(a) Central or State Government AYUSH Hospital or

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

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

i. Having at least 5 in-patient beds;

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

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

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

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

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

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

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

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

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

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

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

a. Internal Congenital Anomaly –

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

b. External Congenital Anomaly –

Congenital anomaly which is in the visible and accessible parts of the body

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

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

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

a. has qualified nursing staff under its employment;

b. has qualified Medical Practitioner/s in-charge;

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

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

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

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

b. 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.

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

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

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

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

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

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

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

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

2.1.18 Hospital (not applicable for Overseas Travel Insurance) means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

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.

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

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

(a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery

(b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

(a) It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or

tests;

(b) It needs ongoing or long-term control or relief of symptoms;

(c) It requires rehabilitation for the patient or for the patient to be specially trained to cope with it;

(d) It continues indefinitely;

(e) It recurs or is likely to recur.

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

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

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

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

2.1.25 Maternity expenses shall include—

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

b. Expenses towards lawful medical termination of pregnancy during the policy period.

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

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

2.1.28 Medical Practitioner (not applicable for Overseas Travel Insurance) is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

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

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

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

c. Must have been prescribed by a Medical Practitioner;

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

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

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

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

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

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

2.1.35 OPD Treatment is one in which the Insured Person visits a clinic/Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or In-patient.

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

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

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

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

2.1.38 Pre-hospitalization Medical Expenses means Medical Expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that :

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

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

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

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

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

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

2.1.41 Reasonable and Customary Charges (not applicable for Overseas Travel Insurance) means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness/ Injury involved.

2.1.42 Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

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

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

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

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

2.2 Specific Definitions:

2.2.1 Add-on Policy means these Policy terms and conditions and Annexures there to, the Proposal Form, Policy Schedule and any endorsements which form part of the Policy and shall be read together.

2.2.2 Add-on Policy Period means the period commencing from the Add-on Policy Period Start Date and ending on the Add-on Policy Period, of the Policy as specifically appearing in the Add-on Policy Schedule.

2.2.3 Add-on Policy Period End Date means the date on which the Add-on Policy expires, as specifically appearing in the Add-on Policy Schedule.

2.2.4 Add-on Policy Period Start Date means the date on which the Add-on Policy commences, as specifically appearing in the Add-on Policy Schedule.

2.2.5 Add-on Policy Schedule is a schedule attached to and forming part of this Add-on Policy and which can be endorsed depending on the requirement of the Add-on Policy.

2.2.6 Add-on policy year means a period of one year commencing on the Add-on Policy Period Start Date or any anniversary thereof.

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

2.2.8 Annexure means the document attached and marked as Annexure to this Add-on Policy. For the Purpose of this Add-on Policy , any reference to Annexure will be same as per the Base Policy Annexure.

2.2.9 Base Policy: means or refers to the Policy issued by Care Health Insurance Limited to which this Add-on Policy is attached.

2.2.10 Base Policy Period End Date: means the date on which the Base Policy expires, as specifically appearing in the Base Policy Schedule.

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

2.2.12 Claim means a demand made in accordance with the terms and conditions of the Add-on Policy for payment of the specified benefits in respect of the Insured Person as covered under the Add-on Policy.

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

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

2.2.15 Cover End Date means the date specified in the Add-on Policy Schedule for the respective Insured Person on which the Insured Person's cover under this Policy expires.

2.2.16 Cover Period means the period commencing from the Cover Start Date and ending on the Cover End Date

2.2.17 Cover Start Date means the date specified in the Add-on Policy Schedule for the respective Insured Person on which the Insured Person's cover under the Add-on Policy commences

2.2.18 Cover Year means a period of one year commencing on the Cover Start Date or any anniversary thereof

2.2.19 Domestic Help/Staff means, a person who is employed against a remuneration in any household, part time or full time basis to do the household work, but does not include any member/Relative of the of the employer or his family. Relative in the purview of this definition means a person connected by blood or marriage.

2.2.20 General Ward means a Hospital Ward similar to a dormitory with more than 3 beds and a common washroom. Such room shall be the most basic and most economical of all accommodations available in that Hospital.

2.2.21 Indemnity/Indemnify means compensating the Insured Person up to the extent of Expenses incurred, on occurrence of an event which results in a financial loss and

is covered as the subject matter of the Insurance Cover.

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

2.2.23 **Insured Person (Insured)** means a person whose name specifically appears under Insured in the Policy Schedule and with respect to whom the premium has been received by the Company.

2.2.24 **Policyholder (also referred as You)** means the person named in the Add-on Policy Schedule as the Policyholder.

2.2.25 **Primary Insured Person** means any Domestic Help who satisfies the eligibility criteria as mentioned in the Add-on Policy and who is named in the Proposal form as an Insured Person.

2.2.26 **Scheduled Airline** means any civilian aircraft operated by a civilian scheduled air carrier holding a schedule, license or similar authorization for civilian scheduled air carrier transport issued by the country of the aircraft's registry, and which in accordance therewith flies, maintains and publishes tariffs for regular passenger service between named cities at regular and specified times, on regular or chartered flights operated by such carrier.

2.2.27 **Senior Citizen** means any person who has completed sixty or more years of age as on the date of commencement or renewal of a health insurance policy.

2.2.28 **Add-on Sum Insured** means the amount specified in the Add-on Policy Schedule, for which premium is paid by the Policyholder

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

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

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

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

(c) Investigation expenses incurred towards diagnosis of ailment requiring Hospitalization.

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

2.2.31 **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize, reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence

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

3. Benefits covered under the add-on policy:

General Conditions

1. It is agreed and understood that the Add-on Policy can only be bought along with the Base Policy either on Policy Issuance, Renewal or mid- term through an endorsement and cannot be bought in isolation or as a separate product.

2. In case of mid –term addition of the Add-on Policy with the Base Policy, Premium will be charged on a pro-rata basis depending on the Cover Period, But Mid –term addition of Add-on Policy will not be allowed within last 3 months of the Base Policy Period End Date.

3. In all cases, the Cover End Date will always be same as that of the Add-on Policy End Date.

4. The Add-on Policy is subject to Policy terms, conditions and applicable endorsements of the Base Policy.

5. The Add-on Policy shall be available under Base policy only if the same is specifically opted.

   The Add-on Policy Terms and Conditions will have an overriding effect on the Base Policy Terms and Condition to the extent covered under this Policy.

6. Admissibility of a Claim under this Policy is subject to purview of coverage/Benefits available under this Add-on Policy only and has no relation to coverage/Benefits available under the Base Policy.

7. In case of Endorsement related to change of Domestic Help, there should be a gap of minimum 30 days between two Endorsements. The proposer needs to make an endorsement for such a change and Premium adjustment (if any) will be made. In case of this Endorsement, all the Waiting Periods will be applicable from the Cover Start Date of the new Domestic Help and he/she will be treated as the new Primary Insured Person.

8. Admissibility of a Claim under Benefit 1 (Hospitalization Expenses) is a pre-condition to the admission of a Claim under Benefit 2 (Pre Hospitalization Medical Expenses and Post Hospitalization Medical expenses) and Benefit 4 (Daily Allowance).

9. Coverage for Benefit 3(Personal Accident) is over and above the sum Insured and available only on Individual Sum Insured basis. In case of Family Floater option Coverage for Benefit 3(Personal Accident) will only be available to the Primary Insured Person on an Individual Sum Insured basis.

10. In case, any Claim is paid under the Benefit 3(Personal Accident) and the coverage amount under this benefit gets exhausted, then coverage for that Insured Person under this benefit shall terminate for that Cover Period.

11. Option of Mid-term inclusion of an Insured Family Member is allowed under this Add-on Policy only in case of Marriage and Child Birth.

3.1.1 Benefit 1 : Hospitalization Expenses

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

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

(ii) Day Care Treatment: The Company will indemnify the Insured Person for Medical Expenses incurred on Day Care Treatment due to Injury or Illness through Cashless or Reimbursement Facility, maximum up to the Sum Insured ,as specified in the Add-on Policy Schedule, provided that the Day Care Treatment is listed as per the Annexure to Policy Terms & Conditions of the Base Policy and 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 (Room Rent / Room Category):

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 Add-on Policy Schedule, then,

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

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

1) Lower of 'Up to 1% of the Sum Insured per day' as eligible Room Rent, Or 'General Ward '

2) 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 then ICU Charges will be limited to the amount specified in the Add-on Policy Schedule

2) The Add-on Policy Schedule will specify the limit of ICU Charges applicable for the Insured Person under the Policy.

(c) Expenses incurred on treatment for Named Ailments / Procedures

The Company will indemnify the Insured Person for Medical Expenses incurred in respect of the below mentioned Ailments / Procedures up to the amount specified against each and every Ailment / Procedure mentioned in the Add-on Policy Schedule in a Cover Year, provided that the treatment was taken on the advice of a Medical Practitioner

i. Treatment of Cataract

ii. Treatment of Total Knee Replacement

iii. Surgery for treatment of all types of Hernia /Hysterectomy/ Benign Prostate Hypertrophy (BPH)/stones of renal system

(iv) Advance Technology Methods:

The Company will indemnify the Insured Person for expenses incurred under Benefit 1 (Hospitalization Expenses) for treatment taken through following advance technology methods:

a. Uterine Artery Embolization and HIFU

b. Balloon Sinuplasty

c. Deep Brain stimulation

d. Oral chemotherapy

e. Immunotherapy- Monoclonal Antibody to be given as injection

f. Intra vitreal injections

g. Robotic surgeries

h. Stereotactic radio surgeries

i. Bronchical Thermoplasty

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

k. IONM - (Intra Operative Neuro Monitoring)

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

3.1.2 Benefit 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 Sum Insured, as specified in the Add-on 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 15 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 Cover Start Date; and

(ii) Under Post-hospitalization Medical Expenses, for a period of 30 days immediately after the Insured Person's date of discharge from the Hospital.

(iii) If the provisions of Any One Illness is applicable to a Claim, then:

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

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

3.1.3 Benefit 3: Personal Accident: This Benefit includes "Accidental Death" and "Permanent Total Disablement" which are explained below and are applicable to events arising in India and abroad

(i) Accidental Death

If the Primary Insured Person suffers an Injury during the Cover Period, which directly results in the Insured Person's death within 12 months from the date of Accident (including date of Accident), then the Company will pay the Nominee or the legal heir of the insured , 3 times of the Sum Insured of that Insured Person under this Benefit .

(ii) Permanent Total Disablement (PTD)

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

Sr. No.	Insured Events	Amount payable = % of the Coverage amount of that Insured Person as specified in the Add-on Policy Schedule under this Benefit
I)	Total and irrecoverable loss of sight of both eyes, or of the actual loss by physical separation of two entire hands or two entire feet, or one entire hand and one entire foot, or the total and irrecoverable loss of sight of one eye and loss by physical separation of one entire hand or one entire foot	100%
ii)	Total and irrecoverable loss of (a) use of two hands or two feet; or (b) one hand and one foot; or (c) sight of one eye and use of one hand or one foot	100%
iii)	Total and irrecoverable loss of sight of one eye, or of the actual loss by physical separation of one entire hand or one entire foot	50%
iv)	Total and irrecoverable loss of use of a hand or a foot without physical separation	50%
v)	Paraplegia or Quadriplegia or Hemiplegia	100%

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

For the purpose of this Benefit only:

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

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

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

3.1.4 Benefit 4 :Daily Allowance

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

(i) The Company shall not be liable to make payment under this Benefit for initial 1 day of hospitalization

(ii) The Company shall not be liable to make payment under this Benefit for more than 5 consecutive days of Hospitalization for each period of Hospitalization and more than 30 days of hospitalization in an Add-on Policy Year, arising from Any One Illness or Accident;

(iii) This Benefit is valid for In-patient Care Hospitalization of the Insured Person only

4. EXCLUSIONS

4.1 Standard Exclusions:

(a) Wait Period

(i) Pre-existing Diseases: Code- Excl01

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer for that Insured Person.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase under this Add-on Policy.

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

d. Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

(ii) Specific Waiting Period: Code- Excl02

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

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase under this Add-on Policy.

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

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

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

f. List of specific diseases/procedures under this Add-on Policy:

1. Any treatment related to Arthritis (if non-infective), Osteoarthritis and Osteoporosis, Gout, Rheumatism, Spinal Disorders(unless caused by accident), Joint Replacement Surgery(unless caused by accident), Arthroscopic Knee Surgeries/ACL Reconstruction/Meniscal and Ligament Repair
2. Surgical treatments for Benign ear, nose and throat (ENT) disorders and surgeries for Adenoidectomy, Mastoidectomy, Tonsillectomy and Tympanoplasty), Nasal Septum Deviation, Sinusitis and related disorders and surgeries related to disorders of internal ear, middle ear, external ear disorders, and Upper airway disease
3. Benign Prostatic Hypertrophy
4. Cataract
5. Dilatation and Curettage
6. Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, Gastric and Duodenal Ulcers
7. Surgery of Genito-urinary system unless necessitated by malignancy
8. All types of Hernia & Hydrocele
9. Hysterectomy for menorrhagia or Fibromyoma or prolapse of uterus unless necessitated by malignancy
10. Internal tumours, skin tumours, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant
11. Kidney Stone / Ureteric Stone / Lithotripsy / Gall Bladder Stone
12. Myomectomy for fibroids
13. Varicose veins and varicose ulcers

(iii) 30-day Waiting Period-Code-Excl03

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

b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months under this Add-on Policy.

c. The referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently under this Add-on Policy.

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

(b) Permanent Exclusions:

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

(i) The following list of permanent exclusions is applicable to all the Benefits :

1. Investigation & Evaluation: (Code- Excl04)

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

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

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

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

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

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

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

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

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

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

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

4) Body Mass Index (BMI);

a) greater than or equal to 40 or

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

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

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

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

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

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

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

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

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

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

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

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

Note: Refer Annexure to the base Policy Terms & Conditions.

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

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

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

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

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

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

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

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

Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, sterilization

(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

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

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

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

4.2 Specific Exclusions:

(a) Permanent Exclusions:

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

(i) The following list of permanent exclusions is applicable to all the Benefits :

1. Any item or condition or treatment specified in List of Non-Medical Items (same as per Annexure to Base Policy Terms & Conditions).

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

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

4. 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.

5. Charges incurred for Treatment/Diagnosis in connection with eye, ear and dental and all other external appliances and/or devices whether for diagnosis or treatment.

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

7. Any expenses incurred on external prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, walkers, glucometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome and oxygen concentrator for asthmatic condition, cost of cochlear implants and related surgery.Treatment of any external Congenital Anomaly or Illness or defects or anomalies or treatment relating to external birth defects.

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

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

10. All preventive care, Vaccination, including Inoculation and Immunizations (except in case of post-bite treatment) and tonics.

11. All expenses (or Treatment undergone) related to donor treatment including surgery to remove organs from the donor, in case of transplant surgery.

12. Non-Allopathic Treatment or treatment related to any unrecognized systems of medicine.

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

14. Act of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane or Illness or Injury attributable to consumption, use, misuse or abuse of intoxicating drugs, alcohol ,tobacco(smoking/non - smoking)or hallucinogens or Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants unless prescribed by a medical practitioner.

15. 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:

   1. 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.

   2. 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.

   3. 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.

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

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

18. Remicade, Avastin or similar injectable treatment which is undergone other than as a part of In-Patient Care Hospitalisation or Day Care Hospitalisation is excluded.Treatment sought for any medical condition, not covered under the benefit but arising during the Hospitalization for the condition covered under the benefit.

(ii) Additional Exclusions applicable to any Claim under Personal Accident:

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

1. Any pre-existing injury or disability;

2. An Insured Person operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft or Scheduled Airline or any airline personal;

3. An Insured Person flying in an aircraft other than as a fare paying passenger in a Scheduled Airline;

4. Sexually transmitted disease except arising out of HIV.

5. Participation in actual or attempted felony, riot, civil commotion or criminal misdemeanor;

6. Training for or participating in professional sport of any kind;

7. The Primary Insured Person serving in any branch of the military, navy, air force or any branch of armed forces or any paramilitary forces;

8. Primary Insured Person working in or with mines, tunneling or explosives or involving electrical installation with high tension supply or conveyance testing or oil rigs or ship crew services or as jockeys or circus personnel or aerial photography or engaged in any Hazardous Activities.

9. Resulting due to any disease or infection except where such condition arises directly as a consequence of an accident during the Cover period.

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

11. Bacterial infections (except pyogenic infection which occurs through an Accidental cut or wound).

12. As a result of any curative treatments or interventions that the Insured Person has carried out or have carried out on the Insured Person's body.

Note to 'Permanent Exclusions': In addition to the foregoing, any loss, claim or expense of whatsoever nature

directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above Permanent Exclusions shall also be excluded.

5. GENERAL TERMS AND CLAUSES

5.1 Standard General Terms & Clauses

5.1.1 Portability

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

For Detailed Guidelines on Portability, kindly refer the link: https://www.careinsurance.com/other-disclosures.html

5.1.2 Migration

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

For Detailed Guidelines on Migration, kindly refer the link: https://www.careinsurance.com/other-disclosures.html

5.1.3 Moratorium Period

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

5.1.4 Multiple Policies

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

5.1.5 Grievances

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

Mobile App: Care Health - Customer App

Tollfree (WhatsApp Number): 8860402452

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

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

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

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

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

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

5.1.6 Renewal Terms and Free-Look Period

Renewal Terms and Free-Look Period under this Add-on Policy will be similar to the Base Policy

5.2 Specific General Terms & Clauses

5.2.1 Cancellation / Termination

(a) The Company may at any time, cancel this Add-on Policy independently and irrespective of the Base Policy as per disclosure to information norm 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 independently and irrespective of the Base Policy, to the Company, for the cancellation of this Add-on Policy, in

which case the Company shall from the date of receipt of the notice, cancel the Policy and refund the premium for the balance period of this Policy at the short period scales as mentioned in the Base Policy, provided no Claim has been made under the Policy.

(c) Short Period Scales to be applied on premium received will be same as that of the percentages mentioned in the Base Policy but for the purpose of Refund only Policy Start Date will be replaced with Add-on Policy Start Date .

(d) In-case of Cancellation of the Base Policy by the Policy Holder, then this Add-on Policy will get cancelled automatically and the premium would be refunded for the balance period of this Policy at the short period scales as mentioned in Clause 5.2.1 (c)

(e) In case of Termination of the Base Policy as per disclosure to information norm or any other Terms and Conditions of the Policy, this Add-on Policy shall stand null and void from the date and time of termination of the Base Policy 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.

(f) In case of demise of the Primary Insured Person

I. Where the Add-on Policy covers only the Primary Insured Person, this Policy shall stand null and void from the date and time of demise of the Primary Insured Person. The premium would be refunded (exclusive of taxes) for the balance period of this Policy at the short period as mentioned in Clause 5.2.1 (c) subject to no claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy

II. Where the Policy covers other Insured Persons, this Policy shall continue till the end of Cover 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 Primary Insured Person provided that:

i. Written notice in this regard is given to the Company before the Cover End Date; and

ii. A Person who satisfies the Company's eligibility criteria to become a Primary Insured Person.

5.2.2 Endorsements

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.

Any request for addition or deletion of a Member shall always be reviewed by the underwriter prior to the execution. The underwriter shall have sole discretion whether or not to approve such request based on any additional information as sought for.

This Add-on Policy has a feature where the Proposer in case of change of the Domestic Help can replace the previous Domestic Help with the new Domestic Help even before the Renewal is due after adjusting of the Premium (if any) subject to, there must be a gap of at least 30 days between two endorsements related to this replacement and the new Person (s) must satisfy the eligibility criteria as set out in the Policy Terms and Conditions.

6. OTHER TERMS AND CLAUSES

6.1 Claims Procedure and Management

Claim Procedure and Management under this Add-on Policy Will be same as the Base Policy except for Claim settlement under reimbursement, the Company will pay to the Primary Insured Person (or the Nominee or legal heir of the insured if the Insured Person is deceased).

In case of, age of the Insured at the time of Claim is less than 18 years then the Claim settlement under reimbursement will be made to Nominee of the Insured.

6.1.1 Documents to be submitted for filing a valid Claim

a) The following information and documentation shall be submitted in accordance with the procedures and within the same timeframes as specified under the Base Policy

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;
9. Indoor case papers(if applicable)
10. Original investigation test reports and payment receipts supported by Doctor's reference slip;
11. Ambulance Receipt;
12. Any other document as required by the Company to assess the Claim, in case fraud is suspected.

b) Additional Documents required for a Claim under Personal Accident(Benefit 3):

It is a condition precedent to the Company's liability under these Benefits that the following information and documentation shall be submitted to the Company immediately and in any event within 30 days of the event giving rise to the Claim under these Benefits:

1. Medical reports giving the details of the Accident, nature of Injury and the details of treatment provided, Admission and Death Summary, Accident Report
2. Original Death Certificate; if applicable
3. Disability Certificate issued by CMO (Chief Medical Officer) as appointed by the Hospital Authorities; if applicable
4. A newspaper cutting about accident (if available)

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.

Annexure I - Benefit /Premium illustration

(Illustration 1)

Age of members Insured	Coverage opted on individual basis covering each member of the family separately (at a single point of time)		Coverage opted on individual basis covering multiple members of the family under a single Policy (Sum Insured is available for each member of family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)
44	2019	50,000	NA				3,538	NA	3,538	50,000
39	1079	50,000								
22	1079	50,000								
14	1079	50,000								
Total Premium for all members of family is Rs. 5256, when each member is covered separately. Sum Insured available for each individual is Rs. 50,000			Total Premium for all members of family is Rs. , when they are covered under a single policy Sum Insured available for each family member is Rs.				Total Premium when policy is opted on floater basis is Rs. 3538 Sum Insured of Rs. 50,000 is available for entire family			

Annexure I - Benefit /Premium illustration

(Illustration 2)

<table>
<tr><th rowspan="2">Age of members Insured</th><th colspan="2">Coverage opted on individual basis covering each member of the family separately (at a single point of time)</th><th colspan="4">Coverage opted on individual basis covering multiple members of the family under a single Policy (Sum Insured is available for each member of family)</th><th colspan="4">Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)</th></tr>
<tr><th>Premium (Rs.)</th><th>Sum Insured (Rs.)</th><th>Premium (Rs.)</th><th>Discount (if any)</th><th>Premium after discount (Rs.)</th><th>Sum Insured (Rs.)</th><th>Premium or consolidated premium for all members of family (Rs.)</th><th>Floater Discount (if any)</th><th>Premium after discount (Rs.)</th><th>Sum Insured (Rs.)</th></tr>
<tr><td>55</td><td>2,019</td><td>50,000</td><td colspan="4" rowspan="2">NA</td><td rowspan="2">3,538</td><td rowspan="2">NA</td><td rowspan="2">3,538</td><td rowspan="2">50000</td></tr>
<tr><td>49</td><td>2,019</td><td>50,000</td></tr>
<tr><td colspan="3">Total Premium for all members of family is Rs. 4038, when each member is covered separately.

Sum Insured available for each individual is Rs. 50,000</td><td colspan="4">Total Premium for all members of family is Rs. , when they are covered under a single policy

Sum Insured available for each family member is Rs.</td><td colspan="4">Total Premium when policy is opted on floater basis is Rs. 3538

Sum Insured of Rs. 50,000 is available for entire family</td></tr>
</table>

Annexure I - Benefit /Premium illustration

(Illustration 3)

Age of members Insured	Coverage opted on individual basis covering each member of the family separately (at a single point of time)		Coverage opted on individual basis covering multiple members of the family under a single Policy (Sum Insured is available for each member of family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)
70	5,912	50,000	NA				9,815	NA	9,815	50,000
64	5,912	50,000								
Total Premium for all members of family is Rs. 11,824, when each member is covered separately. Sum Insured available for each individual is Rs. 50,000			Total Premium for all members of family is Rs. , when they are covered under a single policy Sum Insured available for each family member is Rs.				Total Premium when policy is opted on floater basis is Rs. 9815 Sum Insured of Rs. 50,000 is available for entire family			

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

Care Health Insurance Limited

Registered Office: 5th Floor, 19 Chawla House, Nehru Place, New Delhi-110019

Correspondence Office: Vipul Tech Square, Tower C, 3rd Floor, Golf Course Road, Sector-43, Gurugram-122009 (Haryana)

CIN: U66000DL2007PLC161503 UIN: RHIHLIP21407V022021

IRDAI Registration Number - 148

REACH US @

Care Health- Customer App

WhatsApp
8860402452

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

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

Ver: April/23/AP