care HEALTH INSURANCE

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

protect plus

Know Your Policy Better

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 Person(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 Person in case a valid claim is made:

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

Please check whether the details given by you about the insured Person in the proposal form (a copy of which was provided at the time of issuance of cover under this Add-on) 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 Add-on Policy issued is correct and the claims if any arise under the Add-on Policy will be dealt with based on proposal / Add-on 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.

1. DEFINITIONS

1.1. Standard Definitions:

This Add-on Policy shall follow the standard definitions as mentioned in the Base Policy.

1.2. Specific Definitions:

1.2.1. **Add-on Policy** means these Policy terms and conditions and Annexures thereto, the Proposal Form, Policy Schedule and any endorsements which form part of this Policy shall be read together.

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

1.2.3. **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.

1.2.4. **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.

1.2.5. **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.

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

1.2.7. **Annexure** means the document attached and marked as Annexure to this Add- on Policy.

1.2.8. **Assistance Service Provider** means the service provider specified in the Add-on Policy Schedule and as appointed by the Company from time to time.

1.2.9. **Base Policy** means retail Policy issued by the Company including Policy terms and conditions and Annexures thereto, the Proposal Form, Add-on Policy Schedule and to which this Add-on

shall be attached.

1.2.10. **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.

1.2.11. **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

1.2.12. **Country/Place/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 .

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

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

1.2.15. **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.

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

1.2.17. **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.

1.2.18. **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

1.2.19. **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.

1.2.20. **Medical device/Device** - means any, instrument, apparatus or device including any component, part or accessory thereof, manufactured solely for medical purpose which intends to treatment and mitigation of a medical condition or to physically support the function of human body.

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

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

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

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

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

The following definitions are redefined which supersedes those respective definitions mentioned above, for Benefits effective out of India:

1.2.23. **Hospital** 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 in that country or complies with all minimum criteria as under:

- has qualified nursing staff under its employment round the clock;
- has at least 10 in-patient beds in towns having a population of less than 1,00,000 and at least 50 in-patient beds in all other places;
- has qualified Medical Practitioner(s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out;
- Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

1.2.24. **Medical Practitioner** means a person who holds a valid registration issued by the Medical Council/ Statutory Regulatory Authority for Medical Education in that Country and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

1.2.25. **Network Provider** means Hospitals enlisted by the Company or by a Assistance Service Provider together to provide services to an Insured on payment by a cashless facility;

1.2.26. **Qualified Nurse** means a person who holds a valid registration issued by the Nursing Council/Statutory Regulatory Authority for Medical Education in that Country and thereby entitled to render Nursing Care within the scope and jurisdiction of license.

1.2.27. **Reasonable and customary (R&C)** means charges or treatment for medical care which shall be considered by the Company or by Company's medical advisers to be reasonable and customary to the extent that they do not exceed the general level of charges or treatment being made by others of similar standing in the locality where the charges or treatment are incurred when giving like or comparable treatment.

If the charges are higher than customary or the treatment is not reasonable and customary, the Company will only pay the amount which is, in the Company's experience, customarily charged and Insured has to pay the rest.

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

2. BENEFITS COVERED UNDER THE ADD-ON POLICY:

GENERAL CONDITIONS:

1. The Add-on policy can only be bought along with the Base Policy either on Policy Issuance or on Renewal and cannot be bought as a separate product.

2. The Add-on does not allow mid-term inclusion of Insured Persons except on marriage or child birth and subject to addition of same person in Base Policy. Additional differential premium will be calculated on a pro rata basis.

3. This Add-on shall be available for only those Insured Person covered under Base Policy.

4. The Add-on policy is subject to the terms and conditions and applicable endorsements stated herein and in the Base Policy.

5. All Claims shall be payable subject to the limits, terms, conditions, wait periods, exclusions of the Add-on Policy and/or Base policy and subject to availability of the amount against each and every Benefit.

6. Sum Insured offered under this Add-on shall be part of Base Policy Sum Insured

7. The maximum, total and cumulative liability of the Company towards an Insured Person for any and all Claims arising under this Add-on Policy during the Add-on Policy Year, on occurrence of an Insured event in relation to that Insured Person, shall not exceed the amount/limit of that Insured Person which is specified against every Benefit, mentioned in the Add-on Policy Schedule.

8. Policyholder/Insured Person has to choose Section 1 - Global Plus mandatorily in order to opt for any Optional Benefit under Section 1- Global Plus. Section 1 - Global Plus or Benefits under Section 2 - Plus, can be opted in any combination.

9. Coverage under Section 1- Global Plus is available only outside India and Coverage under Section 2- Plus is available within India

10. If any benefit or coverage is opted in the Base Policy or its Optional Benefits, then same or similar coverage/benefit cannot be opted in Add-on Policy either as Base Benefit/Optional Benefit.

11. Linear interpolation methodology will be applied to calculate premium rates if an intermittent value of Sum Insured is chosen by Policyholder.

3. SECTION 1: GLOBAL PLUS

3.1. BASE BENEFITS

The Add-on Policy provides the following Base Benefits which can be opted along with Base Policy either at the inception of the Add-on Policy or at the time of renewal. Coverage is available for Medical Expenses incurred outside India either Worldwide or Worldwide excl. US & Canada for covering either 'All Conditions' or '32 Critical Illness', as specified in the Add- on Policy schedule.

3.1.1 Hospitalization Expenses

3.1.1 a) Inpatient Care & Day Care Treatment:

The Company shall indemnify the Insured Person, through Cashless or Reimbursement facility, for Medically Necessary Hospitalization Expenses incurred outside India up to the Sum Insured specified against this Benefit in the Add-on Policy Schedule, during the Policy Year, subject to the conditions specified below:

(i) In case of 'Planned Hospitalization', the diagnosis shall be made in India and Insured Person travels abroad for treatment. Insured Person shall submit the following for admissibility of claim:

- Proof of diagnosis within India
- Insured's Passport and Visa

Note: The above condition is applicable for 'Basic' & 'Premium' plan only.

(ii) In case of 'Emergency Hospitalization', while the Insured Person is travelling outside India and suffers an Injury or is diagnosed with an Illness which is an Emergency condition that require Medically Necessary Hospitalization, then Company shall indemnify such Medical Expenses incurred by Insured Person.

Notes:

1) Planned & Emergency Hospitalization is covered under 'Elite' plan.

2) Emergency Hospitalization is not covered under 'Basic' & 'Premium' plans.

(iii) No limit on Room Rent/ICU charges applicable under this benefit provided the charges are reasonable and customary.

3.1.1 b) Advance Technology Methods:

The Company shall indemnify the Insured Person up to the specified limit, as specified in the Add-on Policy Schedule, during the Policy Year for expenses incurred outside India under Benefit 'In-patient Care and/or Day Care Treatment' 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.

3.1.1 c) Organ Donor Cover:

The Company will indemnify the Insured Person, through Cashless or Reimbursement Facility, up to the Sum Insured, as specified in the Add-on Policy Schedule, during the Policy Year for the Medical Expenses incurred outside India in respect of the donor for any organ transplant surgery during the Policy Year, subject to the conditions specified below:

(i) The Organ donor is an eligible donor in accordance and in compliance with local regulations of the country and other applicable laws and rules.

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

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

3.1.1 d) Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses

The Company will indemnify the Insured Person for Medical Expenses incurred outside or within

India which are Medically Necessary, only through Reimbursement Facility, up to the Sum Insured, as specified in the Add-on Policy Schedule, during the Policy Year, provided that the Medical Expenses so incurred are related to the same Illness/Injury for which the Company has accepted the Insured Person's Claim under Benefit 'Hospitalization Expenses' and subject to the conditions specified below:

(i) Under Pre-hospitalization Medical Expenses, for a period as specified in the Add- on Policy schedule 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 Add- on Policy Start Date provided this Add-on Policy is renewed continuously; and

(ii) Under Post-hospitalization Medical Expenses, for a period as specified in the Add- on Policy schedule immediately after the Insured Person's date of discharge from the Hospital.

3.1.2 Road Ambulance Cover

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

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

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

(iii) Such Transportation is from one Hospital to another Hospital for the purpose of providing advanced/better equipped medical support/aid to the Insured Person which is medically necessary subject to treating Medical Practitioner certification.

3.1.3 Air Ambulance cover

The Company will indemnify the Insured Person through Cashless or Reimbursement Facility, up to the Sum Insured as specified in Add-on Policy Schedule , for the Reasonable and Customary Charges necessarily incurred on availing Air Ambulance services offered by a Hospital or by an Ambulance service provider for the Insured Person's necessary transportation, during the Policy Year outside India , provided that:

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

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

(iii) Payment under this Benefit is subject to a Claim for the same Illness or Injury being admitted by the Company under Benefit 3.1.1 (Hospitalization Expenses);

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

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

b) Medical reports and transportation details issued by the Air Ambulance Service Provider, prescriptions and medical report by the attending Medical Practitioner furnishing the name of the Insured Person and details of treatment rendered along with the statement confirm the necessity of Air Ambulance services.

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

3.1.4 Repatriation of Mortal Remains

If the Insured Person dies outside India during the Policy Year, the Company will indemnify, up to the amount specified against this Benefit in the Add-on Policy Schedule, the costs of repatriation of the mortal remains of the Insured Person back to the Country of Residence/Place of Residence or for a local burial or cremation at the place where death has occurred.

Note:

Assistance Service Provider will arrange for transporting the Insured's mortal remains from the place of death to his/her home country or arrange for local burial at the place of death as requested by the Insured's family.

3.1.5 Compassionate visit

The Company will reimburse, up to the Sum Insured specified against this Benefit in the Add-on Policy Schedule, during the Policy Year, the reasonable expenses incurred for the cost of a return economy class air ticket or equivalent by the most direct route from the Country of Residence of an Immediate Family Member (one adult) to the place of hospitalization of the Insured Person outside India, provided that:

(i) The claim is admissible under Hospitalization Expenses (Clause 3.1.1) ;

(ii) The treating Medical Practitioner prescribes that the attendance of an Immediate Family Member is necessary during the hospitalization of the Insured; and Insured's Immediate Family Member (one adult) travel from the Country of Residence should commence within the period of hospitalization of the Insured for which period his/her presence is necessary;

(iii) The treating Medical Practitioner certifies that the Insured Person is required to be hospitalized for at least 5 consecutive days;

(iv) The Immediate Family Member's return travel to the Country of Residence shall commence not later than the date of the Insured Person's return to the Country of Residence;

(v) The claim under this Cover will be admissible provided that no adult member of Insured's Immediate Family is present at the place of Insured's hospitalization.

3.2. Optional Benefits

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

3.2.1 Maternity Expenses

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

(a) The Company shall be liable to make payment under this Benefit, only if the Insured Person who has delivered the child is over the age of eighteen (18) years and is enrolled as Adult in Policy.

(b) The delivery shall occur after the completion of the 9 month waiting period under this Benefit. The wait period shall start from the Add-on Policy Start Date. A fresh 9 month waiting period will apply following a claim under this benefit.

(c) Coverage under this Benefit is not available in case the Insured Person's age is greater than 45 years at the time of Add-on Policy start date

(d) Medical Expenses for ectopic pregnancy are not covered under this Benefit. However, these expenses are covered under Benefit 'In-Patient Care'.

(e) The Company shall be liable to make payment in respect of any Hospitalization arising due to involuntary medical termination of pregnancy, as per applicable laws and rules of the country.

(f) Permanent Exclusion, 4.2 (Code: Excl18), shall be superseded to the extent covered under this Benefit.

3.2.2 OPD Cover

The Company will indemnify the Insured Person, through Reimbursement/Cashless Facility, for availing Out-Patient Consultations, Diagnostic Examinations and Pharmacy as prescribed by Medical Practitioner outside India, up to the amount specified against this Optional Benefit in the Add-on Policy Schedule, during the Policy Year.

The above benefit is subject to the following conditions:

1. All the valid claim expenses incurred by the Insured Person under this Optional Benefit in a Policy Year will be payable / reimbursed by the Company. However, claim can be filed with the

Company, only quarterly during that Policy Year, as and when that Insured may deem fit. However, claimant will be allowed only 1 more filing within 30 days after the Policy Year.

3.2.3 Modification of Waiting Period

By choosing this Optional Benefit, the applicable waiting period of 48 months for Claims related to Pre-existing diseases shall be modified to specific time period as mentioned in the Add-on Policy Schedule and / or applicable waiting period of 24 months for Claims related to Names ailments shall be modified to specific time period as mentioned in the Add-on Policy Schedule.

Hence all the provisions stated under Clause 4.1 (a) (i) and/or Clause 4.1 (a) (ii) holds good for this benefit as well, except that the claims will be admissible for any Medical Expenses incurred for Hospitalization in respect of diagnosis/treatment of any Pre Existing Disease and/or Named ailment disease after specific time period of continuous coverage has elapsed as mentioned in the Add-on Policy Schedule, since the inception of the Add-on Policy with the Company renewed without any break.

3.2.4 International Second Opinion

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

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

a) This Benefit can be availed only once by an Insured Person during the Policy Year for each Major Illness / Injury.

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

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

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

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

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

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

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

ii) For the purposes of this Benefit only:

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

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

1. Benign Brain Tumor
2. Cancer
3. End Stage Lung Failure
4. Myocardial Infarction
5. Coronary Artery Bypass Graft
6. Heart Valve Replacement
7. Coma
8. End Stage Renal Failure

9. Stroke
10. Major Organ Transplant
11. Paralysis
12. Motor Neuron Disorder
13. Multiple Sclerosis
14. Major Burns
15. Total Blindness

SECTION 2: PLUS

Base Benefits

3.3. Unlimited E-Consultations

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

3.4. Pre-Post Hospitalization Expenses Modification

By choosing this Benefit, 'Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses' under Base Policy shall be modified to number of days as specified in the Add-on Policy Schedule, subject to:

(i) Under Pre-hospitalization Medical Expenses, for the specified number of 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 Add-on Policy Start Date; and

(ii) Under Post-hospitalization Medical Expenses, for the specified number of days immediately after the Insured Person's date of discharge from the Hospital and claim documents to be submitted within 30 days after completion of number of days specified in the Add-on Policy Schedule, from the date of discharge from Hospital.

Note:

Benefit 3.3 and 3.4 can be opted in any combination along with Base Policy

4. EXCLUSIONS (Applicable for Section 1: Global Plus)

4.1 Standard Exclusions:

a) Waiting Periods:

(i) Pre-Existing Diseases: Code-Excl01

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

b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

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

d. Coverage under the Policy after the expiry of 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, as may be the case after the date of inception of the first Policy with the Company. This exclusion shall not be applicable for claims arising due to an accident.

b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

c. If any of the specified disease/procedure falls under

the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

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

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

f. List of specific diseases/procedures:

1. Any treatment related to Arthritis (if non-infective), Osteoarthritis and Osteoporosis, Gout, Rheumatism, Spinal Disorders, Joint Replacement Surgery, Arthroscopic Knee Surgeries/ ACL Reconstruction/Meniscal and Ligament Repair
2. Surgical treatments for Benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to Adenoidectomy, Mastoidectomy, Tonsillectomy and Tympanoplasty), Nasal Septum Deviation, Sinusitis and related disorders
3. Benign Prostatic Hypertrophy
4. Cataract
5. Dilatation and Curettage
6. Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, Gastric and Duodenal Ulcers
7. Surgery of Genito -urinary system unless necessitated by malignancy
8. All types of Hernia & Hydrocele
9. Hysterectomy for menorrhagia or Fibromyoma or prolapse of uterus unless necessitated by malignancy
10. Internal tumours, skin tumours, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant
11. Kidney Stone / Ureteric Stone / Lithotripsy / Gall Bladder Stone
12. Myomectomy for fibroids
13. Varicose veins and varicose ulcers
14. Parkinson's or Alzheimer's disease or Dementia

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

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

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

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

Notes:

(i) The Waiting Periods as defined above shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

b) Permanent Exclusions:

Any Claim of an Insured Person arising due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy Terms and conditions.

1. Investigation & Evaluation: (Code-Excl04)

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

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

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

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

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

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

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

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

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

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

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

4) Body Mass Index (BMI);

a) greater than or equal to 40 or

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

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

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

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

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

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

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

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

7. Breach of law: (Code- Excl10)

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

8. Excluded Providers: (Code- Excl11)

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

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

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

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

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

12. Refractive Error: (Code- Excl15)

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

13. Unproven Treatments: (Code- Excl16)

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

14. Sterility and Infertility: (Code- Excl17)

Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, sterilization

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

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

15. Maternity: (Code Excl18)

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

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

4.2 Specific Exclusions:

Any Claim of an Insured Person arising 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 item or condition or treatment specified in List of Non-Medical Items (as per Annexure to Base Policy Terms & Conditions).
2. Taking part or is supposed to participate in a naval, military, air force operation or aviation in a professional or semi -professional nature.
3. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication as applicable in local laws.
4. Charges incurred in connection with routine eye examinations and ear examinations, dentures, artificial teeth and all other similar external appliances and / or Devices whether for diagnosis or treatment
5. Any expenses incurred on external prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, walkers, glucometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome and oxygen concentrator for asthmatic condition, cost of cochlear implants and related surgery.
6. Alopecia wigs and/or toupee and all hair or hair fall treatment and products.
7. Screening, counseling or treatment of any external Congenital Anomaly, Illness or defects or anomalies or treatment relating to external birth defects.
8. Treatment of mental retardation, arrested or incomplete development of mind of a person, subnormal intelligence or mental intellectual disability.
9. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident.
10. All preventive care , Vaccination including Inoculation and Immunizations (except in case of post-bite treatment) and tonics.
11. Expenses incurred for Artificial life maintenance, including life support machine use, post confirmation of

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

12. Non-Allopathic Treatment, Hydrotherapy, Acupuncture, Reflexology, Chiropractic treatment or treatment related to any unrecognized systems of medicine.

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

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

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

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

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

18. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

    a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

    b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

    c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

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

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

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

22. Expenses related to any kind of Advance Technology Methods other than mentioned under clause 3.1.1.

23. Hormone replacement therapy.

24. Any other exclusion as specified in the Add-on Policy Schedule.

Note: In addition to the foregoing, any loss, claim or expense of whatsoever nature 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 Disclosure of Information

Conditions under this section are same as Base Policy.

5.2 Condition Precedent to Admission of Liability

Conditions under this section are same as Base Policy.

5.3 Claim Settlement (provision for Penal Interest)

Conditions under this section are same as Base Policy.

5.4 Complete Discharge

Conditions under this section are same as Base Policy.

5.5 Multiple Policies

Conditions under this section are same as Base Policy.

5.6 Fraud

Conditions under this section are same as Base Policy.

5.7 Cancellation / Termination

Conditions under this section are same as Base Policy.

5.8 Migration

Conditions under this section are same as Base Policy.

5.9 Portability

Conditions under this section are same as Base Policy.

5.10 Renewal of Policy

Conditions under this section are same as Base Policy.

5.11 Withdrawal of Policy

Conditions under this section are same as Base Policy.

5.12 Moratorium Period

Conditions under this section are same as Base Policy.

5.13 Premium payment Installment

Conditions under this section are same as Base Policy

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

Conditions under this section are same as Base Policy.

5.15 Free Look Period

Conditions under this section are same as Base Policy.

5.16 Grievances

Conditions under this section are same as Base Policy.

5.17 Nomination:

Conditions under this section are same as Base Policy.

5.18 Material Change

Conditions under this section are same as Base Policy.

5.19 Records to be maintained

Conditions under this section are same as Base Policy.

5.20 No constructive Notice

Conditions under this section are same as Base Policy.

5.21 Policy Disputes

Conditions under this section are same as Base Policy.

5.22 Limitation of liability

Conditions under this section are same as Base Policy.

5.23 Communication

Conditions under this section are same as Base Policy.

5.24 Alterations in the Policy

Conditions under this section are same as Base Policy.

5.25 Electronic Transactions

Conditions under this section are same as Base Policy.

6. OTHER TERMS AND CLAUSES

1. Claims Intimation, Assessment and Management

Upon occurrence of any Illness or Injury that may give rise to a Claim under this Add- on Policy, then as a condition precedent to the Company's liability under the Add-on Policy, the Insured Person shall undertake all of the following:

(a) Claims Intimation

(i) If any Illness is diagnosed or discovered or any Injury is suffered or any other contingency occurs which has resulted in a Claim or may result in a Claim under the Add-on Policy, the Insured Person (or Nominee or legal heir if the Insured Person is deceased), shall notify the Company / Assistance Service Provider either at call Centre or in writing immediately.

(ii) Claim must be filed within 30 days from the date of discharge from the hospital in case of hospitalization and actual date of loss in case of non-hospitalization benefits.

Note: 6.1 (a) (i) and 6.1 (a) (ii) are precedent to admission of liability under the Add- on policy.

(iii) If the Insured Person is to undergo planned Hospitalization, the Insured Person shall give written intimation to the Company / Assistance Service Provider of the proposed Hospitalization at least 48 hours prior to the planned date of admission to Hospital.

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

I Policy Number ;

II Name of Primary Insured Person;

III Name and unique identification number of the Insured Person in respect of whom the Claim is being made;

IV Nature of Illness or Injury and the Benefit and/or Optional Benefit under which the Claim is being made;

V Date and place of Injury or Death and/or date and place of admission to Hospital (as applicable);

VI Name and address of the attending Medical Practitioner and Hospital;

VII Date of admission to Hospital or proposed date of admission to Hospital for planned Hospitalization;

VIII Passport copy with entry and exit stamp

IX Any other information / document as required by the Company to assess the Claim, in case fraud is suspected.

(v) A Claim has to be notified to the Company within 48 hours or before discharge (whichever is earlier) for Emergency Hospitalization.

2. Claims Procedure

(a) Cashless :

Cashless facility is available only at Network Hospitals of the Company or Assistance Service Provider. The Insured Person can avail cashless facility at the time of admission into a Network Hospital, by presenting the health card, provided by the Company under this Add-on Policy, along with a valid photo identification document (like: Voter ID card / Driving License / Passport / PAN Card / any other identification documentation as approved by the Company).

(b) In addition to the above, in order to avail cashless facility, the following procedure must be followed:

(i) Pre-authorization: the Insured Person must call the Company or Assistance Service Provider call centr and request authorization for the proposed treatment by way of submission of a completed pre-authorization form at least 48 hours prior before the commencement of a planned Hospitalization or within 48 hours of admission to Hospital, if the Hospitalization is required in an Emergency.

(ii) The Company will process the request for authorization after having obtained accurate and complete information in respect of the Illness or Injury for which cashless facility is sought to be availed. The Company or Assistance Service Provider will confirm in writing authorization or rejection of the request to avail cashless facility for the Insured Person's Hospitalization.

(iii) If the request for availing cashless facility is authorized by the Company or Assistance Service Provider, 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 Add-on Policy and fall within the amount authorized in writing by the Company for availing cashless facility. Payment in respect of co-payments (if applicable) or within Deductible (if applicable) or any other costs and expenses not authorized under the cashless facility shall be made directly by the Insured Person to the Network 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 at Clause 6.4 shall be submitted to the Network Hospital immediately and in any event before the Insured Person's discharge from Hospital.

(iv) In case Policyholder/Insured Person cannot avail the cashless facility, payment for the treatment will have to be made by the Insured Person to the Network Hospital, following which a Claim for reimbursement may be made to the Company and the same will be considered by the Company subject to the Policy.

(c) The list of updated Network Hospitals is available with the Company or Assistance Service Provider and is subject to amendment or modification of the Network Hospitals and/or the extent of cashless facilities available at particular Network Hospitals from time to time.

(d) Before availing the cashless facility, Policyholder or the Insured Person is required to check the applicable list of Network Providers for the area where he intends to avail the cashless facility through the call center number as provided in the Add-on Policy Schedule.

(e) Health card issued by the Company shall not be used

(i) On termination or cancellation of this Add- on Policy

(ii) After Add-on Policy Period End Date

(iii) On death of Insured Person

(f) Re-imbursement :

(i) It is agreed and understood that in all cases where intimation of a Claim has been provided under Reimbursement Facility and/or the Company specifically states that a particular Benefit is payable only under Reimbursement Facility, all the information and documentation specified in Clause 6.1 and Clause 6.4 shall be submitted to the Company at Insured Person's own expense, immediately and in any event within 30 days of Insured Person's discharge from Hospital.

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

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

(iv) For Claim settlement under reimbursement, the Company will pay the Insured Person. In the event of death of the Insured Person, the Company will pay the nominee (as named in the Certificate of Insurance) and in case of no nominee, to the legal heirs or legal representatives of the Insured Person whose discharge shall be treated as full and final discharge of its liability under the Add-on 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.

(vi) Insured Person (or Nominee or legal heir if the Insured Person is deceased)

shall (at his expense) give the documentation specified at Clause 6.4 and any additional documentation specified in the Benefit provision under which the Claim is being made to the Company immediately and in any event within 30 days of the occurrence of the Injury.

3. Duties of a Claimant/ Insured Person at the time of Claim

(a) The Insured Person shall check the updated list of Network Hospitals before submission of a pre-authorization request for cashless facility; and

(b) As a condition precedent for a Claim to be considered under this Add-on Policy:

(i) All reasonable steps and measures must be taken to avoid or minimize the quantum of any Claim that may be made under this Add-on Policy.

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

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

(iv) The Company's /Assistance Service Provider 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 documentation and information which the Company has requested to establish the Company liability for the Claim, its circumstances and its quantum.

4. Claim Documents

(a) The following information and documentation shall be submitted to the Company /Assistance Service Provider in accordance with the procedures and within the timeframes specified in the Add-on Policy in respect of all Claims:

(i) Duly completed and signed Claim form, in original;

(ii) Identity proof with photo, Age proof and Address Proof;

(iii) Medical Practitioner's referral letter advising Hospitalization;

(iv) Medical Practitioner's prescription advising drugs / diagnostic tests / consultation;

(v) Original bills, receipts and discharge card from the Hospital / Medical Practitioner;

(vi) Original bills from pharmacy / chemists;

(vii) Original pathological / diagnostic test reports and payment receipts;

(viii) Indoor case papers (if applicable);

(ix) Accident proof - First Information Report/ final police report, if applicable;

(x) Disability Certificate from Government Medical Board, Fitness Certificate, Medical Prescription

(xi) Post mortem report, if conducted;

(xii) Passport copy with entry and exit stamp

(xiii) Any other information/" document as required by the Company or Assistance Service Provider to assess the Claim, in case fraud is suspected

(b) Only in the event that original bills, receipts, prescriptions, reports or other documents have already been given to any other insurance company or to a reimbursement provider The Company will accept properly verified photocopies of such documents attested by such other insurance company/reimbursement provider along with an original certificate of the extent of payment received from such insurance company/reimbursement provider.

(c) The Company will only accept bills/invoices which are made in the Insured Person's name.

(d) The Company may give a waiver to one or few of the above mentioned documents depending upon the case.

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

5. 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 Add-on Policy shall be assessed by the Company in the following progressive order:

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

(c) The Claim amount assessed in Clause 6.5(b) above would be deducted from the Sum Insured of respective Benefit.

6. Payment Terms

(a) Section 1- Global Plus under this Add-on Policy covers only medical treatment taken entirely outside India and Section 2- Plus offers coverage within India as shown in the Add-on Policy Schedule. All payments under Section 2- Plus shall be made in Indian rupees and within India.

(b) The payment of any Claim under Section 1- Global Plus will be based on the rate of exchange as on the Date of Loss published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian Rupees for payment of Claims. If on the Insured Person's Date of Loss, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.

(c) If the Assistance Service Provider or the Company requests that bills or vouchers in a local language or vernacular be accompanied by an appropriate translation into English then the costs of such translation must be borne by the Policyholder or the Insured Person.

(d) The Claim amount assessed for any Benefit or for any Optional Benefit would be deducted from the Coverage Amount and for the unexpired Policy Period, balance Coverage Amount shall be available.

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

(f) If the 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 Add-on Policy shall be applied as if they were under a

single Claim.

(g) Under cashless facility, the payment of Claims shall be made to the Network Hospital and the Company discharge would be complete and final.

(h) For the Reimbursement Claims, the Company will pay to the Primary Insured Member. In the event of death of the Primary Insured Person, unless specified otherwise in the Add-on Policy Schedule, the Company will pay the nominee (as named in Add- on Policy Schedule) and in case of no nominee to the legal heir of the Primary Insured Person whose discharge shall be treated as full and final discharge of its liability under the Add-on Policy.

(i) 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.

(j) The Claim shall be paid only for the Add-on Policy Period in which the Insured event which gives rise to a Claim under this Add-on Policy occurs.

(k) The Company may change the Assistance Service Provider or utilize the service of any other Assistance Service Provider by giving written notification to the Policyholder.

List of 32 Critical Illness

i. Cancer (Varies from IRDAI Standard Definitions 2016)

(I) A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy and confirmed by a pathologist.

(II) The term cancer includes

A. leukemia, lymphoma, and sarcoma.

B. Tumor's showing the malignant changes of carcinoma in situ and tumours which are histologically described as pre-malignant or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3

The following are excluded:

A. Benign lesions

B. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0;

C. Papillary micro - carcinoma of the thyroid less than 1 cm in diameter;

D. Microcarcinoma of the bladder;

E. All tumours in the presence of HIV infection.

ii. Pulmonary Thromboembolism

Acute Pulmonary Thromboembolism: means the blockage of an artery in the lung by a clot or other tissue from another part of the body. The Pulmonary Embolus must be unequivocally diagnosed by a specialist on either a V/Q scan (the isotope investigation which shows the ventilation and perfusion of the lungs), angiography or echocardiography, with evidence of right ventricular dysfunction and conformation with D Dimer assay findings, and requiring medical or surgical treatment on an inpatient basis.

iii. Primary(Idiopathic) Pulmonary Hypertension (Varies from IRDAI Standard Definitions 2016)

A. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization.There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

B. The NYHA Classification of Cardiac Impairment are as follows:

Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

Following are excluded:

A. Pulmonary hypertension associated with occupational and environmental factors

B. Substance abuse (like tobacco etc.),

C. lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, any heart disease and all secondary causes

iv. Infective Endocarditis

Inflammation of the inner lining of the heart caused by infectious organisms, where all of the following criteria are met:

A. Positive result of the blood culture proving presence of the infectious organism(s)

B. Presence of at least moderate heart valve incompetence (meaning regurgitate fraction of twenty percent (20%) or above) or moderate heart valve stenosis (resulting in heart valve area of thirty percent (30%) or less of normal value) directly attributable to Infective Endocarditis; without any other valvular disease/risk factors and

C. The Diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a consultant cardiologist.

v. Heart Valve Replacement/repair (Varies from IRDAI Standard Definitions 2016)

A. The actual undergoing of open-heart valve surgery to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valves. The diagnosis of the valve.

The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist Medical Practitioner.

B. Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty.

vi. Surgery of Aorta

The actual undergoing of major surgery/minimally invasive surgical repair(i.e. via percutaneous intra-arterial route) to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen with a graft. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. The treatment will be including but not limited to Angioplasty.

vii. Cardiomyopathy

A. An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a consultant cardiologist who has been treating the patient, and which results in permanent physical impairment to the degree of New York Heart Association classification Class IV, or its equivalent, based on the following classification criteria: Class IV - Inability to carry out any activity without discomfort.

B. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced. The Diagnosis of Cardiomyopathy has to be supported by echographic findings of compromised ventricular performance.

Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.

viii. Surgery for cardiac arrhythmia

Ablative Procedure is defined as catheter ablation procedures using radiofrequency or cryothermal energy for treatment of a recurrent or persistent symptomatic arrhythmia refractory to antiarrhythmic drug therapy. Ablation procedures should immediately follow the diagnostic electorphysiology study. The ablative procedure must be certified to be absolutely necessary by a consultant cardiologist (electrophysiologist).

Pre-procedural evaluation prior to ablation procedures and ablation procedures as below should be completely documented:

A. Strips from ambulatory Holter monitoring in documenting the arrhythmia.

B. Electrocardiographic and electrophysiologic recording, cardiac mapping and localization of the arrhythmia during the ablative procedure.

ix. Angioplasty

Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

A. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

x. Balloon Valvotomy/Valvuloplasty

The actual undergoing of Valvotomy or Valvuloplasty necessitated by damage of the heart valve as confirmed by a specialist in the relevant field where the procedure is performed totally via intravascular catheter based techniques.

The diagnosis of heart valve abnormality must be supported by cardiac catheterization or Echocardiogram and the procedure must be considered medically necessary by a consultant cardiologist

xi. Carotid Artery Surgery

The actual undergoing of surgery to the Carotid Artery to treat carotid artery stenosis of fifty percent (50%) and above, as proven by angiographic evidence, of one (1) or more carotid arteries. Both criteria (a) and (b) below must be met:

A. Either:

i. Actual undergoing of endarte rectomy to alleviate the symptoms; or

ii. Actual undergoing of an endovascular intervention such as angioplasty and/or stenting or atherectomy to alleviate the symptoms; and

B. The Diagnosis and medical necessity of the treatment must be confirmed by a cardio-thoracic surgeon.

xii. Coronary Artery Bypass Graft (Varies from IRDAI Standard Definitions 2016)

The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is / are narrowed or blocked, by Coronary Artery Bypass Graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist Medical Practitioner.

Exclusion: Any key-hole or laser surgery.

xiii. Pericardectomy

The undergoing of a pericardectomy performed by open heart surgery or keyhole techniques as a result of pericardial disease. The surgical procedures must be certified to be medically necessary by a consultant cardiologist. Other procedures on the pericardium including pericardial biopsies, and pericardial drainage procedures by needle aspiration are excluded.

The actual undergoing of pericardiectomy secondary to chronic constrictive pericarditis.

The following are specifically excluded:

A. Chronic constrictive pericarditis related to alcohol or drug abuse or HIV

B. Acute pericarditis due to any reason

xiv. Surgery to Place Ventricular Assist Devices or Total Artificial Hearts

This is an open chest procedure for implantation of Left Ventricular Assist Device/Ventricular Assist Device as bridges to cardiac transplantation or destination therapy for long term use for the Refractory Heart Failure with reduced ejection fraction as defined below:

NYHA Class IV symptoms who failed to respond to optimal medical management for >= 45 of the past 60 days, or have been intra-aortic balloon pump dependent for 7 days, or IV inotrope dependent for14 days.

The following are excluded:

A. Ventricular dysfunction or Heart failure directly related to alcohol or drug abuse

xv. Myocardial Infarction (Varies from IRDAI Standard Definitions 2016)

The occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by the following criteria:

A. A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain);

B. New characteristic electrocardiogram changes;

C. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following conditions are excluded:

A. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T;

B. Other acute Coronary Syndromes;

C. Any type of angina pectoris.

xvi. Implantation of Pacemaker of Heart:

Actual undergoing of Insertion of a permanent cardiac pacemaker to correct serious cardiac arrhythmia which cannot be treated via other means. The insertion of the cardiac pacemaker must be certified to be medically necessary by a specialist in the relevant field.

Following will be excluded:

A. Cardiac arrest secondary to alcohol, substance abuse or drug misuse

xvii. Implantable Cardioverter Defibrillator:

A. Actual undergoing of insertion of an implantable cardiac defibrillator to correct serious cardiac arrhythmia which cannot be treated via other methods or the insertion of permanent cardiac defibrillator to correct sudden loss of heart function with cessation of blood circulation around the body resulting in unconsciousness .

Insertion of Cardiac Defibrillator means surgical implantation of either Implantable Cardioverter-Defibrillator (ICD), or Cardiac Resynchronization Therapy with Defibrillator (CRT-D)

B. The insertion of a permanent Cardioverter-Defibrillator (ICD) must be certified to be absolutely necessary by a specialist in the relevant field.

Following will be excluded:

i. Cardiac arrest secondary to alcohol, substance abuse or drug misuse

xiii. End Stage Renal Failure (Varies from IRDAI Standard Definitions 2016)

End stage renal disease presenting as chronic irreversible failure of both kidneys to function documented with raise level of S Creatinine and S Urea, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a Nephrologist.

xix. Multiple Sclerosis (Varies from IRDAI Standard Definitions 2016)

The definite occurrence of multiple sclerosis, the diagnosis of which must be supported by following, and certified by a Physician/Neurophysician:

A. Investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;

B. There must be current clinical impairment of motor or sensory function

Other causes of neurological damage such as SLE and HIV are excluded.

xx. Benign Brain Tumor (Varies from IRDAI Standard Definitions 2016)

A benign tumour in the brain where following conditions are met and Its presence must be confirmed by a neurologist or neurosurgeon:

A. Has potential to cause permanent damage to the brain;

B. If it has undergone surgical removal or, if inoperable, has caused a permanent neurological deficit such as but not restricted to characteristic symptoms of increased intracranial pressure such as papilloedema, mental symptoms, seizures and sensory impairment; and

C. Diagnosis is supported by findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques.

D. The treatment is advised and justified medically by a certified Neurologist

Following will be excluded:

A. Cysts;

B. Granulomas;

C. Vascular malformations;

D. Haematomas;

E. Calcification;

xxi. Parkinson's Disease

Hospitalization for treatment directly related to progressive degenerative idiopathic Parkinson's Disease, certified and diagnosed by a consultant neurologist.

Following will be excluded:

A. Parkinson's disease secondary to drug and/or alcohol abuse

xxii. Alzheimer's Disease

A. Alzheimer's (presenile dementia) disease is a progressive degenerative disease of the brain characterized by diffuse atrophy throughout the cerebral cortex with distinctive histopathologic changes.

B. Deterioration or loss of intellectual capacity as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning requiring the continuous supervision of the Insured Person. This diagnosis must be supported by the clinical confirmation of an appropriate consultant neurologist and supported by the Company's appointed doctor.

Following will be excluded:

A. Non organic diseases such as neurosis;

B. Alcohol related brain damage;

C. Any other type of irreversible organic disorder/dementia/mental retardation;

xxiii. End Stage Liver Disease (Varies from IRDAI Standard Definitions 2016)

End stage liver disease resulting in cirrhosis and irreversible liver damage, evidenced by the following criteria and certified by a Gastroenterologist :

A. Permanent jaundice;

B. Uncontrollable ascites;

C. Hepatic encephalopathy;

D. Oesopageal or Gastric Varicesas spinal m

Liver disease arising out of or secondary to alcohol or drug misuse is excluded.

xxiv. Motor Neurone Disorder

Motor neurone disease diagnosed by a Neurophysician as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction with a clear causation relation to MND.

xxv. End Stage Lung Disease

End Stage Respiratory Failure including Chronic Interstitial Lung Disease. Following criteria must be met:

A. Requiring permanent oxygen therapy as a result of a consistent FEV1 test value of less than one litre. (Forced Expiratory Volume during the first second of a forced exhalation);

B. Arterial Blood Gas analysis with partial oxygen pressures of 55mmHg or less;

C. This diagnosis must be confirmed by a chest/Respiratory physician.

xxvi. Bacterial Meningitis

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. This diagnosis must be confirmed by:

A. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture;

B. A consultant neurologist.

Bacterial Meningitis in the presence of HIV infection is excluded.

xvii. Aplastic Anaemia

Chronic persistent bone marrow failure which results in Anaemia, Neutropenia and Thrombocytopenia requiring treatment with at least one of the following:

A. Blood product transfusion;

B. Marrow stimulating agents;

C. Immunosuppressive agents; or

D. Bone marrow transplantation

The diagnosis must be confirmed by a hematologist using relevant laboratory investigations including Bone Marrow Biopsy. Two out of the following three values should be present:

A. Absolute Neutrophil count of 500 per cubic millimetre or less;

B. Absolute Reticulocyte count of 20,000 per cubic millimetre or less;

C. Platelet count of 20,000 per cubic millimetre or less.

xviii. Major Organ Transplant

The actual undergoing of a transplant of:

A. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ; or

B. Human bone marrow using hematopoietic stem cells.

The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

The following are excluded:

A. Other stem-cell transplants;

B. Where only islets of Langerhans are transplanted.

xxix. Stroke (Varies from IRDAI Standard Definitions 2016)

A. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intra-cranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain.

B. Evidence of permanent neurological deficit lasting for has to be produced.

The following are excluded:

I. Transient ischemic attacks (TIA);

II. Traumatic injury of the brain;

III. Vascular disease affecting only the eye or optic nerve or vestibular functions.

xxx. Paralysis (Varies from IRDAI Standard Definitions 2016)

A. Total and irreversible loss of use of two or more limbs as a result of Injury or disease of the brain or spinal cord. A specialist Medical Practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery. Reconstruction surgeries required to attain best possible mobility will be included

B. Rehabilitative treatment, prosthesis and supporting aids like crutches/wheel chair/vehicle/home modification will be excluded

xxxi. Major Burns (Varies from IRDAI Standard Definitions 2016)

Third degree (full thickness of the skin) burns covering at least 20% of the surface of the Insured Person's body. The condition should be confirmed by a consultant physician.

Burns arising due to self-infliction are excluded.

xxxii. Blindness (Varies from IRDAI Standard Definitions 2016)

A. 'Blindness' is defined as visual acuity of less than 3/60, or a corresponding visual field loss to less than 10°, in the better eye with the best possible correction.

B. Treatments required for correction of blindness or improvement in visual acuity will be covered

Following will be excluded:

(I) Treatment for Low vision: 'low vision' is defined as visual acuity of less than 6/18 but equal to or better than 3/60, or a corresponding visual field loss to less than 20°, in the better eye with the best possible correction.

(II) Cases of blindness with Low Vision before the inception of policy

(III) Cost of enucleation related to tumor's or other eye defects

(IV) Cost of prosthesis for cosmetic correction

(V) Visual aids implantable or external

Annexure - Benefit / Premium illustration

Illustration No.1

Age of members Insured	Coverage opted on individual basis covering each member of the family separately (at a single point of time)		Coverage opted on individual basis covering multiple members of the family under a single Policy (Sum Insured is available for each member of family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)
46	385	5,00,000	385	NA (As per Base Policy)	385	5,00,000	800	NA (As per Base Policy)	800	5,00,000
51	514	5,00,000	514	NA (As per Base Policy)	514	5,00,000				
Total Premium for all members of family is Rs. 899 when each member is covered separately Sum Insured available for each individual is Rs. 5,00,000			Total Premium for all members of family is Rs. 899 when they are covered under a single policy Sum Insured available for each family member is Rs. 5,00,000 Care Advantage Policy is taken as the base policy with same SI				Total Premium when policy is opted on floater basis is Rs.800 Sum Insured of Rs. 5,00,000 is available for entire family Care Advantage Policy is taken as the base policy with same SI			

Illustration No. 2

Age of members Insured	Coverage opted on individual basis covering each member of the family separately (at a single point of time)		Coverage opted on individual basis covering multiple members of the family under a single Policy (Sum Insured is available for each member of family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)
56	666	5,00,000	666	NA (As per Base Policy)	666	5,00,000	1167	NA (As per Base Policy)	1167	5,00,000
60	666	5,00,000	666	NA (As per Base Policy)	666	5,00,000				
17	162	5,00,000	162	NA (As per Base Policy)	162	5,00,000				
Total Premium for all members of family is Rs. 1,494 when each member is covered separately. Sum Insured available for each individual is Rs. 5,00,000			Total Premium for all members of family is Rs. 1,494 when they are covered under a single policy Sum Insured available for each family member is Rs. 5,00,000 Care Advantage Policy is taken as the base policy with same SI				Total Premium when policy is opted on floater basis is Rs. 1,167 Sum Insured of Rs. 5,00,000 is available for entire family Care Advantage Policy is taken as the base policy with same SI			

Illustration No. 3

Age of members Insured	Coverage opted on individual basis covering each member of the family separately (at a single point of time)		Coverage opted on individual basis covering multiple members of the family under a single Policy (Sum Insured is available for each member of family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)
61	945	5,00,000	945	NA (As per Base Policy)	945	5,00,000	1,531	NA (As per Base Policy)	1,531	5,00,000
64	945	5,00,000	945	NA (As per Base Policy)	945	5,00,000				
Total Premium for all members of family is Rs. 1,890 when each member is covered separately Sum Insured available for each individual is Rs. 5,00,000			Total Premium for all members of family is Rs. 1,890 when they are covered under a single policy Sum Insured available for each family member is Rs. 5,00,000 Care Advantage Policy is taken as the base policy with same SI				Total Premium when policy is opted on floater basis is Rs.1,531 Sum Insured of Rs. 5,00,000 is available for entire family Care Advantage Policy is taken as the base policy with same SI			

Notes:
1. Premium rates (excl. taxes) specified in above illustration shall be standard premium rates without considering any loading.
2. Premiums considered are of Basic Plan Worldwide Including U.S.A.& Canada

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