care HEALTH INSURANCE

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

senior health advantagē

Know Your Policy Better

1. Preamble

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

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

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

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

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

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

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

2. Definitions

2.1. Standard Definitions:

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

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

(a) Central or State Government AYUSH Hospital or

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

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

i. Having at least 5 in-patient beds;

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

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

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

2.1.3. AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such 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 policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured.

2.1.9. **Cumulative Bonus** 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 Company's 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. Age means the completed age of the Insured Person as on his/her last birthday.

2.2.2. Any One Illness under this Product means the period from the date and time of admission till the date and time of discharge from the Hospital/Nursing Home where the treatment was taken.

2.2.3. 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:

1. The following expenses shall not be part of 'associate medical expenses':
   a. Cost of pharmacy and consumables;
   b. Cost of implants and medical devices
   c. Cost of diagnostics
2. 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.

2.2.4. Ambulance means a vehicle (Road/Air) operated by a licensed/ authorized service provider and equipped for the transport and paramedical treatment of persons requiring medical attention.

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

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

2.2.7. 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.

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

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

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

boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting or wrestling of any type.

2.2.11. **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.

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

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

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

2.2.15. **Medical 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

2.2.29. **Therapy** - A therapy is the attempted remediation of a health problem, usually following a medical diagnosis. It means treatment to help or cure a mental or physical illness, usually without drugs or medical operations. This does not include any experimental therapies.

2.2.30. **Twin Sharing Room** means a Hospital room where at least two patients are accommodated at the same time. Such room shall be the most basic and the most economical of all accommodations available as twin sharing rooms in that Hospital

3. BENEFITS COVERED UNDER THE POLICY

GENERAL CONDITIONS APPLICABLE TO ALL THE BENEFITS AND OPTIONAL BENEFITS

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

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

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

   II. For any single Claim during a Policy Year, the maximum Claim amount payable shall

be sum total of Sum Insured, No Claim Bonus,Optional Benefit: No Claim Bonus Super,Optional Benefit: Additional Sum Insured for Accidental Hospitalization, Optional Benefit: Additional Sum Insured for Defined Critical Illnesses.

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

3. The Co-payment proportion (if applicable) shall be borne by the Insured Person on each Claim which will be applicable on Benefits namely In -patient Care, Day Care Treatment, Domiciliary Hospitalization, Organ Donor Cover, AYUSH Treatment, Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses, Road Ambulance Cover, Optional Benefit: Additional Sum Insured for Accidental Hospitalization, Optional Benefit: Additional Sum Insured for Defined Critical Illnesses and Optional Benefit: Air Ambulance Cover.

4. Deductible Option (if opted) is applicable on the Benefits namely In-patient Care, Day Care Treatment, Domiciliary Hospitalization, Organ Donor Cover, AYUSH Treatment, Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses, Road Ambulance Cover, Optional Benefit: Additional Sum Insured for Accidental Hospitalization, Optional Benefit: Additional Sum Insured for Defined Critical Illnesses and Optional Benefit: Air Ambulance Cover.

5. Any Claim paid for Benefits namely In-patient Care, Day Care Treatment, Domiciliary Hospitalization, Organ Donor Cover, AYUSH Treatment, Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses,Road Ambulance Cover and Optional Benefit: Companion Benefit shall reduce the Sum Insured for the Policy Year and only the balance shall be available for all the future claims for that Policy Year.

6. Admissibility of a Claim under Benefit "In -patient Care and/or Day Care Treatment" is a pre -condition to the admission of a Claim under Organ Donor Cover, Pre Hospitalization Medical Expenses and Post Hospitalization Medical expenses, Road Ambulance Cover, Optional Benefit: Additional Sum Insured for Accidental Hospitalization, Optional Benefit: Additional Sum Insured for Defined Critical Illnesses, Optional Benefit: Air Ambulance Cover, Optional Benefit: Companion Benefit and the event giving rise to a Claim under Benefit "In-patient Care and/or Day Care Treatment" shall be within the Policy Period for the Claim of such Benefit to be accepted.

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

8. Coverage amount for Optional Benefit: OPD Care, Optional Benefit: OPD Consultation & Therapy Expenses, Optional Benefit: Additional Sum Insured for Accidental Hospitalization, Optional Benefit: Additional Sum Insured for Defined Critical Illnesses, Optional Benefit: Air Ambulance Cover, and Optional Benefit: Disease Management Program are covered over and above the 'Sum Insured'.

9. Coverage under Optional Benefit: OPD Care, Optional Benefit: OPD Consultation & Therapy Expenses and Optional Benefit: Disease Management Programs shall be offered on Individual basis.

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

11. Optional Benefits opted (except Optional Benefit: OPD Care, Optional Benefit: OPD Consultation & Therapy Expenses and Optional Benefit: Disease Management Programs) are available for all members in a floater policy.

3.1. BASE BENEFITS

3.1.1 Benefit : Hospitalization Expenses

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

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

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

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(iii) **Benefit : Domiciliary Hospitalization**

The Company will indemnify the Insured Person, only through Reimbursement Facility, up to the Sum Insured ,as specified in the Policy Schedule, for the Medical Expenses incurred towards

Domiciliary Hospitalization, i.e., Coverage extended when Medically Necessary treatment is taken at home (as explained in Definition 2.1.15), subject to the conditions specified below:

(i) The Domiciliary Hospitalization continues for a period exceeding 3 consecutive days.

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

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

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

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

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

(iv) Benefit : Organ Donor Cover

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

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

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

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

(IV) The provision mentioned under clause no.3.1.1 (viii) holds good for this benefit.

(v) Benefit : AYUSH Treatment

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

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

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

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

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

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

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

(II) Under Post-hospitalization Medical Expenses, for a period of 90 days immediately after the Insured Person's date

of discharge from the Hospital and claim documents to be submitted within 30 days after completion of 90 days from the date of discharge from Hospital.

(vii) Advance Technology Methods:

The Company will indemnify the Insured Person up to the Sum Insured, as specified in the Policy Schedule, for expenses incurred 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 cellsfor bone marrow transplant for haematological conditions to be covered.

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

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

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

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

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

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

iii. If the Policy Schedule states 'up to 1% of the Sum Insured per day' as eligible Room Rent, it means the maximum eligible Room Rent of the Insured Person payable by the Company is limited to 1% of the Sum Insured per day of Hospitalization Any amount accrued under "No Claim Bonus (NCB)" or "Optional Benefit: No Claim Bonus Super (NCBS)", shall not be considered under this "Room Rent" limit.

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

b) Intensive Care Unit Charges (ICU Charges):

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

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

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

3.1.2 Benefit : Road Ambulance Cover

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

(i) Such 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 better Medical aid to the Insured Person subject to treating Medical Practitioner certification.

3.1.3 Benefit : Automatic Recharge

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

(i) The Recharge shall be utilized only after the base Sum Insured, applicable No Claim Bonus (NCB), Optional Benefit: No Claim Bonus Super and in case of Accidental Claim Optional Benefit: Additional Sum Insured for Accidental Hospitalization and in case of specified Critical Illnesses Claim Optional Benefit: Additional Sum Insured for Defined Critical Illnesses has been completely exhausted in that Policy Year.

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

(iii) Recharge amount can be utilized for same illness as well as different Illnesses.

(iv) The Sum Insured available under Automatic Recharge can only be utilized for Benefit 'In-patient Care' 'Day Care Treatment', 'Domiciliary Hospitalization', 'Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses', 'Road Ambulance Cover'.

(v) All Insured Person will be eligible to utilize the Recharged amount for any illness or injury pertaining to that Policy Year.

(vi) Applicable 'No Claim Bonus (NCB)' and 'Optional Benefit: No Claim Bonus Super' shall not be considered while calculating 'Automatic Recharge'.

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

3.1.4 Benefit: No Claim Bonus (NCB):

At the end of each Policy Year, the Company will enhance the Sum Insured by 25% flat, on a cumulative basis, as a No Claim Bonus for each completed and continuous Policy Year, provided that no Claim has been paid by the Company in the expiring Policy Year, and subject to the conditions specified below:

(i) In any Policy Year, the accrued No Claim Bonus, shall not exceed 100% of the Sum Insured available in the expiring Policy or renewed Policy, wherever Sum Insured is lower;

(ii) The No Claim Bonus shall be available on Floater basis and shall accrue only if no Claim has been made in respect of any Insured Person during the expiring Policy Year. The No Claim Bonus which is accrued during the claim-free Policy Year will only be available to those Insured Persons who were insured in such claim-free Policy Year and continue to be insured in the subsequent Policy Year;

(iii) The entire No Claim Bonus will be forfeited if the Policy is not continued / renewed on or before Policy Period End Date or the expiry of the Grace Period whichever is later;

(iv) The No Claim Bonus shall be applicable on an annual basis subject to continuation of the Policy;

(v) If the Insured Persons in the expiring policy are covered on Individual basis and thus have accumulated the No Claims Bonus for each Insured Person in the expiring policy, and such expiring policy is renewed with the Company on a Floater basis, then the No Claims Bonus to be carried forward for credit in this Policy would be the least No Claims Bonus amongst all the Insured Persons.

(vi) If the Insured Persons in the expiring policy are covered on a Floater basis and such Insured Persons renew their expiring Policy with the Company by splitting the Floater Sum Insured in to 2 (two) Individual covers, then the No Claims Bonus of the expiring Policy shall be apportioned to such renewed Policy in the proportion of the Sum Insured of each of the renewed Policy.

(vii) In the event of a Claim occurring during any Policy Year, the accrued No Claim Bonus will be reduced at same rate at which it is accrued at the commencement of next Policy Year;

(viii) In case Sum Insured under the Policy is reduced at the time of renewal, the applicable No Claim Bonus shall also be reduced in proportion to the Sum Insured;

(ix) In case Sum Insured under the Policy is increased at the time of renewal, the No Claim Bonus shall be calculated on the Sum Insured applicable on the last completed Policy Year;

(x) The 'Automatic Recharge' or 'Optional Benefit: Unlimited Automatic Recharge' amount shall not be considered while calculating 'No Claim Bonus';

(xi) Accrued 'No Claim Bonus' can be utilized for Benefit 'In-patient Care' 'Day Care Treatment', 'Domiciliary Hospitalization', 'Organ Donor Cover', 'AYUSH Treatment', 'Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses' and 'Road Ambulance Cover' under the Policy.

(xii) In case no claim (other than Benefit: 'Annual Health Check-up', 'Unlimited E-Consultations', 'Other Value Added Services', Optional Benefits - 'OPD Care', 'OPD Consultation & Therapy Expenses' and 'Disease Management Programs') is made in a particular Policy Year, No Claim Bonus would be credited automatically to the subsequent Policy year, even in case of multi-year Policies (with 2 or 3 year policy tenure).

3.1.5 Benefit : Annual Health Check-up

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

conditions specified below:

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

b) This benefit does not reduce the Sum Insured.

(ii) Medical Tests covered in the Annual Health Check-up, applicable for Sum Insured up to Rs.75 Lac are as follows:

Set No	List of Medical Tests covered as a part of Annual Health Check-up	Sum Insured
1	Complete Blood Count with ESR, Urine Routine, Blood Group, Fasting Blood Sugar, Serum Cholesterol, SGPT, Serum Creatinine, ECG	SI < Rs.5L
2	Complete Blood Count with ESR, Urine Routine, Blood Group, Fasting Blood Sugar, Lipid Profile, Kidney Function Test, ECG	SI= Rs.5L-Rs.10L
3	Complete Blood Count with ESR, Urine Routine, Blood Group, Fasting Blood Sugar, Lipid Profile, TMT, Kidney Function Test	SI=Above Rs. 10L-Rs.75L

(iii) Medical Tests covered in the Annual Health Check-up, applicable for SI above Rs.75L are as follows:

Infection Markers Complete Blood Count(CBC) ESR ABO Group & Rh Type Urine Routine Stool Routine	**Lipid Profile** Cholesterol LDL HDL Triglycerides VLDL
Liver Function Test S Bilirubin (Total/Direct) SGPT SGOT GGT Alkaline Phosphatase Total Protein Albumin : Globulin	**Kidney Function Test** Creatinine Blood Urea Nitrogen Uric Acid
Lung Function Markers Lung Function Test	**Diabetes Markers** Hba1c
Cardiac Markers Treadmill Test ECG	**Imaging Tests** X-Ray – Chest Ultrasound Abdomen

3.1.6 Benefit : Unlimited E-Consultation

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

3.1.7 Benefit : Other Value Added Services

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

3.2. OPTIONAL BENEFITS:

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

3.2.1 Optional Benefit : Room Rent and ICU Modification

Notwithstanding anything to the contrary in the Policy, if this Optional Benefit is opted, the Company agrees to modify the Room Rent / Room Category and ICU Charges limit as per the following:

Sr. No.	Sum Insured	From Eligibility	To Eligibility
1	SI<Rs.5L	**Room Rent / Room Category:** Up to 1% of SI per day **ICU Limit:** Up to 2% of SI per day	**Room Rent / Room Category:** Single Private AC Room **ICU Limit:** No Sub limit
2	SI>=Rs.5L	**Room Rent / Room Category:** Single Private AC Room **ICU Limit:** No Sub-limit	**Room Rent / Room Category:** No Sub-limit **ICU Limit:** No Sub-limit
3	SI=5L-10L	**Room Rent / Room Category:** Single Private AC Room **ICU Limit:** No Sub-limit	**Room Rent / Room Category:** Twin Sharing Room **ICU Limit:** Up to 2% of Sum Insured per day

Note: Sr. No. 2 and 3 cannot be opted together.

3.2.2 Optional Benefit : Sub-limit on Advance Technology Methods

If this Optional Benefit is opted, then there shall be sub -limits on Advance Technology Methods treatments up to the amount specified against each treatment and procedures in the Policy Schedule and Company's liability shall be limited to such extent.

Note: Clause 3.1.1 (vii) under Benefit: Hospitalization Expenses shall be limited to the extent covered under this Benefit.

3.2.3 Optional Benefit: Unlimited Automatic Recharge

"Unlimited Automatic Recharge" is an extension to Benefit : Automatic Recharge and hence all the provisions stated under Clause 3.1.3, holds good for Clause 3.2.3 as well, except that the Recharge shall be available unlimited times during the Policy Year. However, in case of a single claim payout, the maximum liability of the Company shall not exceed the base Sum Insured.

3.2.4 Optional Benefit : OPD Care

The Company will indemnify the Insured Person, through Reimbursement/Cashless Facility, for availing Out-Patient Diagnostic Examinations, Pharmacy, Medical devices as prescribed by Medical Practitioner, up to the amount/limit specified against this Optional Benefit in the 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.
2. Pharmacy expenses are limited up to 50% of OPD Care Sum Insured per policy year
3. Medical Device expenses are limited up to 50% of OPD Care Sum Insured per policy year
4. Medical Devices that are replaceable can be availed only once in 3 years on continuous renewal of Policy
5. Procurement amount of the Medical Devices must not exceed the reasonable purchase price of the Medical Devices.
6. Spectacles, Thermometer, contact lenses, blood pressure measurement device, oxygen measurement device and diabetes measurement device are not included in the list of Medical Device for the purpose of this Optional Benefit.
7. Clause 4.2 (4), (5) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

3.2.5 Optional Benefit : OPD Consultation & Therapy Expenses

The Company will indemnify the Insured Person, through Reimbursement/Cashless Facility, for availing Out-Patient Consultations and prescribed Therapy expenses, up to the amount specified against this Optional Benefit in the 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.

3.2.6 Optional Benefit : Sub-Limit on Specified Diseases

If this Optional Benefit is opted, then there shall be sub-limits on listed treatments and procedures up to the amount specified against each treatment and procedures in the Policy Schedule and Company's liability shall be limited to such extent.

Listed Treatments and Procedures are as follows:

(i) Treatment of Cataract

(ii) Treatment of Total Knee Replacement

(iii) Cerebrovascular Accident and Cardio vascular Diseases

(iv) Cancer (Including Chemotherapy / Radiotherapy)

(v) Medical Renal Diseases (Including Dialysis)

(vi) Treatment of Breakage of Long Bones

Note:

1- The above Optional Benefit can be opted only if this policy is issued for the first time with the Company.

2- Sub-limits shall apply to total claim amount payable under all Hospitalization related benefits listed in base Plan

3.2.7 Optional Benefit: Voluntary Co-payment:

If this Optional Benefit is opted, then the Insured Person will have an option to bear a Co-payment, as specified in the Policy Schedule, and the Company's liability shall be restricted to the balance amount payable.

Note:

i. If Insured Person or eldest Insured Person (in case of Floater) entry age or renewal age is above 70 years then, additional 10% Co-payment shall be applicable over & above the selected Co-payment.

ii. The above Optional Benefit can be opted at the time of first issue of Policy with the Company and the same cannot be opt out till the completion of 3 years of continuous coverage under this policy and vice versa.

3.2.8 Optional Benefit: No Claim Bonus Super (NCBS)

"No Claims Bonus Super" is an extension to Benefit: No Claim Bonus (NCB) and hence all the provisions stated under Clause 3.1.4, holds good for Clause 3.2.8 as well, except the below clauses which have been modified for the purpose of this Optional Benefit:

(i) If no Claim has been paid in the expiring Policy Year and the Policy is renewed with the Company without any break, the Insured Person would receive a flat 50% increase in the Sum Insured on a cumulative basis as a No Claim Bonus Super (which is over & above the Sum Insured accrued as No Claim Bonus (NCB)), for each completed and continuous Policy Year.

(ii) In any Policy Year, the accrued No Claim Bonus Super (NCBS) shall not exceed 100% of the Sum Insured available in the expiring Policy or renewed Policy, wherever Sum Insured is lower;

(iii) In the event of a Claim occurring during any Policy Year, the accrued No Claim Bonus Super (NCBS) will be reduced at same rate at which it is accrued at the commencement of next Policy Year.

(iv) At the time of Policy renewal if the Policyholder

chooses not to renew this Optional Benefit, then the No Claim Bonus Super (NCBS) under the expiring Policy shall be forfeited.

(v) The Recharge amount ('Automatic Recharge & Optional Benefit: Unlimited Automatic Recharge') shall not be considered while calculating 'No Claim Bonus Super (NCBS)'.

3.2.9 Optional Benefit: Additional Sum Insured for Accidental Hospitalization

In case any Claim is made for Emergency Care of any Injury due to an Accident during the Policy Year, the Company shall automatically provide an additional Sum Insured equal to the Sum Insured for In-patient Care for that Insured Person who is hospitalized, provided that:

(i) The 'Additional Sum Insured for Accidental Hospitalization' shall be utilized only after the Sum Insured has been completely exhausted;

(ii) The total amount payable under this Optional Benefit shall not exceed the sum total of the Sum Insured, No Claim Bonus (NCB), No Claims Bonus Super(NCBS) (if opted) and 'Additional Sum Insured for Accidental Hospitalization';

(iii) The 'Additional Sum Insured for Accidental Hospitalization' shall be available only for such Insured Person for whom Claim for Hospitalization following the Accident has been accepted under the Policy;

(iv) The 'Additional Sum Insured for Accidental Hospitalization' shall be applied only once during the Policy Year.

3.2.10 Optional Benefit: Additional Sum Insured for Defined Critical Illnesses

In case any Claim is made for any of the specified Critical Illnesses under In-patient Care/Day Care Treatment of Benefit: Hospitalization Expenses during the Policy Year, the Company shall automatically provide an additional Sum Insured up to the amount/limit specified against this Optional Benefit in the Policy Schedule, for that Insured Person who is hospitalized, provided that:

(i) The 'Additional Sum Insured for Defined Critical Illnesses' shall be utilized only after the Sum Insured has been completely exhausted;

(ii) The total amount payable under this Optional Benefit shall not exceed the sum total of the Sum Insured, No Claim Bonus (NCB), No Claims Bonus Super(NCBS) (if opted) and 'Additional Sum Insured for Defined Critical Illnesses';

(iii) The 'Additional Sum Insured for Defined Critical Illnesses' shall be available only for such Insured Person for whom Claim under In-Patient Care/ Day Care Treatment due to specified critical illnesses has been accepted under the Policy;

(iv) The 'Additional Sum Insured for Defined Critical Illnesses' shall be applied only once during the Policy Year.

For the purpose of this Optional Benefit list of Critical Illnesses

Sr.No	Critical Illnesses
1	Cancer
2	End Stage Renal Failure
3	Parkinson's Disease
4	Alzheimer's Disease
5	Major Organ Transplant
6	Angioplasty
7	Coronary Artery Bypass Graft
8	Stroke
9	Paralysis
10	Implantation of Pacemaker of Heart
11	Blindness

I. Cancer

(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 histologicallydescribed 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. End Stage Renal Failure

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.

iii. 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

iv. 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;

v. 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.

vi. 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.

vii. Coronary Artery Bypass Graft

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.

viii. Stroke

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.

ix. Paralysis

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

x. 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

xi. Blindness

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

3.2.11 Optional Benefit : Air Ambulance Cover

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

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

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

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

(iv) Payment under this Optional Benefit is subject to a Claim for the same Illness or Injury being admitted by the Company under Benefit 'In -patient Care';

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

a) It is a condition precedent to the Company's liability under this Optional 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 Optional 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.

3.2.12 Optional Benefit : Smart Select

If this Optional Benefit is opted, then Policyholder is entitled for a reduction in the total premium (which includes premium of base Benefits, Optional Benefit: Unlimited Automatic Recharge, Optional Benefit: No Claim Bonus Super (NCBS), Optional Benefit: Modification of No Claim Bonus, Optional Benefit: Additional Sum Insured for Accidental Hospitalization and Optional Benefit: Additional Sum Insured for Defined Critical Illnesses) payable as specified in the Policy Schedule, subject to following conditions:

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

(ii) However, no such additional co-payment shall be

applicable if treatment is availed in the hospitals listed in Annexure III to the Policy Terms and Conditions.

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

3.2.13 Optional Benefit: Increase in PED Waiting Period

Choosing this Optional Benefit increases the applicable waiting period of 12 months for Claims related to Pre existing diseases, to specific time period as mentioned in the Policy Schedule.

Hence all the provisions stated under Clause 4.1 (a) (I) and Definition 2.1.37 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 after specific time period of continuous coverage has elapsed as mentioned in the Policy Schedule, since the inception of the first Policy with the Company.

3.2.14 Optional Benefit: Instant Cover

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Benefit the Company shall waive off the applicable PED waiting period on Diabetes/ Hypertension/ Hyperlipidimia/ Asthma at the time of issuance of first Policy with the Company.

Note: The above Optional Benefit can be opted only if this policy is issued for the first time with the Company.

3.2.15 Optional Benefit: Termination of Automatic Recharge Coverage

Notwithstanding anything to the contrary in the Policy, if this Optional Benefit is opted, then coverage of Benefit: Automatic Recharge as per Clause 3.1.3 shall be ceased under this Policy.

Note: Optional Benefit: Unlimited Automatic Recharge shall not be available if this Optional Benefit is opted.

3.2.16 Optional Benefit : Modification of No Claim Bonus

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Benefit the Benefit: No Claim Bonus (NCB) shall be modified and limited to 10% of Sum Insured for every claim free year, subject to maximum up to 50% of the Sum Insured, hence all the provisions stated under Clause 3.1.4, holds good for this benefit, except the below clauses which have been modified for the purpose of this Optional Benefit:

(i) At the end of each Policy Year, the Company will enhance the Sum Insured by 10% flat, on a cumulative basis, as a No Claim Bonus for each completed and continuous Policy Year, provided that no Claim has been paid by the Company in the expiring Policy Year.

(ii) In any Policy Year, the accrued No Claim Bonus, shall not exceed 50% of the Sum Insured available in the expiring Policy or renewed Policy, wherever Sum Insured is lower;

Note: Optional Benefit: No Claim Bonus Super (NCBS) shall not be available if this Optional Benefit is opted.

3.2.17 Optional Benefit: Disease Management Programs

Insured Person has an option to opt any of the following listed Disease Management Program:

i. Asthma: The Company will indemnify the Insured Person for expenses incurred related to Asthma for consultation, pharmacy up to the amount/limit specified in the Policy Schedule and for diagnostic tests as specified below:

i. Chest X-ray

ii. Spirometry test

iii. Physiotherapy

ii. Diabetes Mellitus: The Company will indemnify the Insured Person for expenses incurred related to Diabetes for consultation, pharmacy up to the amount/limit specified in the policy schedule and for diagnostic tests as specified below:

i. HBA1c

ii. Urine proteins – microalbuminuria

iii. Electrolytes

iii. Hypertension: The Company will indemnify the Insured Person for expenses incurred related to Hypertension for consultation, pharmacy up to the amount/limit specified in the policy schedule and for diagnostic tests as specified below:

i. Electrolytes

ii. Urine proteins – microalbuminuria

iii. 2D-Echo

iv. Hyperlipidimia: The Company will indemnify the Insured Person for expenses incurred related to Hyperlipidimia for consultation, pharmacy up to the amount/limit specified in the policy schedule and for diagnostic tests as specified below:

i. SGOT

ii. SGPT

Note:

i. All the Diagnostic tests under Disease Management Program can be availed only at the Company's network

ii. The Insured Person can avail maximum 4 consultations in a year under each Disease Management Program.

3.2.18 Optional Benefit: Modification of Pre-hospitalization Medical Expenses and Post hospitalization Medical Expenses

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Benefit, the Benefit: Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses shall be modified and limited to 30 days and 60 days respectively, hence all the provisions stated under Clause 3.1.1 (vi), holds good for this benefit, except the below clauses which have been

modified for the purpose of this Optional Benefit:

(i) Under Pre-hospitalization Medical Expenses, for a period of 30 days immediately prior to the Insured Person's date of admission to the Hospital, provided that the Company shall not be liable to make payment for any Pre hospitalization Medical Expenses that were incurred before the Policy Start Date; and

(ii) Under Post-hospitalization Medical Expenses, for a period of 60 days immediately after the Insured Person's date of discharge from the Hospital and claim documents to be submitted within 30 days after completion of 60 days from the date of discharge from Hospital.

Note: The above Optional Benefit can be opted only if this policy is issued for the first time with the Company.

3.2.19 Optional Benefit: Companion Benefit

By choosing this Optional Benefit, the Company will pay the amount specified against this Benefit in the Policy Schedule if the Insured Person has been Hospitalized for at least 10 consecutive days for Illness or Accident provided that:

i. The Hospitalization is only for In-patient Care for the Insured Person; and

ii. The Company shall not be liable to make payment under this Benefit more than once in a Policy Year.

3.2.20 Optional Benefit : Sub-Limit on Hospitalization related Expenses

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Benefit, there shall be sub limit, up to the percentage (%) of Sum Insured per Hospitalization, as specified in the Policy Schedule, for 'Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees' under Benefit: Hospitalization Expenses' and Company's liability shall be limited to such extent.

Note: The above Optional Benefit can be opted at the time of first issue of Policy with the Company and the same cannot be opt out till the completion of 3 years of continuous coverage under this policy and vice versa..

4. EXCLUSIONS

4.1. Standard Exclusions:

(a) Waiting Periods:

(i) Pre-Existing Diseases: Code- Excl01

a. Expenses related to the treatment of a pre -existing Disease (PED) and its direct complications shall be excluded until the expiry of 12 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 a fresh 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 12 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(unless caused by accident), Joint Replacement Surgery(unless caused by accident), Arthroscopic Knee Surgeries/ACL Reconstruction/Meniscal and Ligament Repair

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

3. Benign Prostatic Hypertrophy
4. Cataract
5. Dilatation and Curettage
6. Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, Gastric and Duodenal Ulcers
7. Surgery of Genito-urinary system unless necessitated by malignancy
8. All types of Hernia & Hydrocele
9. Hysterectomy for menorrhagia or Fibromyoma or prolapse of uterus unless necessitated by malignancy
10. Internal tumours, skin tumours, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant
11. Kidney Stone / Ureteric Stone / Lithotripsy / Gall Bladder Stone
12. Myomectomy for fibroids
13. Varicose veins and varicose ulcers
14. Parkinson's or Alzheimer's disease or Dementia

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

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

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

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

Notes:

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

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

(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 peoplewho are terminally ill to address physical, social,emotional and spiritual needs.

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

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

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

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

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

4) Body Mass Index (BMI);

a) greater than or equal to 40 or

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

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

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

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

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

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

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

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

7. Breach of law: (Code- Excl10)

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

8. Excluded Providers: (Code- Excl11)

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

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

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

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

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

12. Refractive Error: (Code- Excl15)

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

13. Unproven Treatments: (Code- Excl16)

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

14. Sterility and Infertility: (Code- Excl17)

Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, sterilization

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

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

15. Maternity: (Code Excl18)

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

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

4.2. Specific Exclusions:

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 (Annexure – I to Policy Terms & Conditions).

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

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

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

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

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

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

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

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

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

11. Expenses incurred for Artificial life maintenance, including life support machine use, post confirmation of vegetative state or brain dead by treating medical practitioner where such treatment will not result in recovery or restoration of the previous state of health under any circumstances.

12. Non-Allopathic 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 ontributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

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

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

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

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

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

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

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

23. Hormone replacement therapy.

24. Any other exclusion as specified in the 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

Standard General Terms & Clauses

5.1. Disclosure of Information

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

Note:

a. "Material facts" for the purpose of this clause policy shall mean all relevant information sought by the Company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

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

5.2. Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

5.3. Claim Settlement (provision for Penal Interest)

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

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate .

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document.

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

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

5.4. Complete Discharge

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

5.5. Multiple Policies

a. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

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

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

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

5.6. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s) / policyholder(s) who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy:-

(a) The suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

(b) The active concealment of a fact by the Insured Person having knowledge or belief of the fact;

(c) Any other act fitted to deceive; and

(d) Any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

5.7. Cancellation / Termination

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

Refund % to be applied on premium received

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

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

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

Notes:

In case of demise of the Policyholder,

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

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

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

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

In case Premium Installment mode is opted for, then:

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

5.8. Migration

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

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

5.9. Portability

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

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

5.10. Renewal of Policy

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

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

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

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

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

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

5.11. Withdrawal of Policy

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

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

5.12. Moratorium Period

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

5.13. Premium payment Installment

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

1. Grace Period of 30 days would be given to pay the installment premium due for the policy
2. During such grace period, coverage will not be available from the due date of installment premium till the date of receipt of premium by Company
3. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period
4. No interest will be charged lf the installment premium is not paid on due date.
5. In case of installment premium due not received within the grace period, the policy will get cancelled
6. In the event of a claim, all subsequent premium installments shall immediately become due and payable.(This clause will not apply to claims arising under 'Annual Health Check-up' and 'Other Value added Services' benefits)
7. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

Note:

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

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

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

5.15. Free Look Period

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

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

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

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

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

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

5.16. Grievances

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

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

Mobile App: Care Health - Customer App

Tollfree (WhatsApp Number): 8860402452

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

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

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

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

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

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

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

5.17. Nomination:

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

Specific General Terms & Clauses

5.18. Material Change

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

5.19. Records to be maintained

The Policyholder or Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require under this Policy at any time during the Policy Period or Policy Year or until final adjustment (if any) and resolution of all Claims under this Policy.

5.20. No constructive Notice

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

5.21. Policy Disputes

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

5.22. Limitation of liability

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

5.23. Communication

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

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

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

5.24. Alterations in the Policy

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

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

5.26. Electronic Transactions

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

6. OTHER TERMS AND CLAUSES

6.1. Claims procedure and management

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

6.1.1. Pre-requisite for admissibility of a Claim:

Any claim being made by an Insured Person or

attendant of Insured Person during Hospitalization on behalf of the Insured person, should comply with the following conditions:

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

(ii) The health damage caused, Medical Expenses incurred, subsequently the Claim being made,

should be with respect to the Insured Person only. The Company will not be liable to indemnify the Insured Person for any loss other than the covered Benefits and any other person who is not accepted by the Company as an Insured Person.

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

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

6.1.2. Claim settlement - Facilities

(a) Cashless Facility

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

(i) Submission of Pre-authorization Form: A Pre-authorization form which is available on the Company's Website or with the Network Provider, has to be duly filled and signed by the Insured Person and the treating Medical Practitioner, as applicable, which has to be submitted electronically by the Network Provider to the Company for approval. Only upon due approval from the Company, Cashless Facility can be availed at any Network Hospital.

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

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

(iv) Company's Authorization:

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

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

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

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

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

rejection of coverage or treatment. The Insured Person can proceed with the treatment, settle the hospital bills and submit the claim for a possible reimbursement.

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

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

(b) Re-imbursement Facility

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

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

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

(iv) For Claim settlement under reimbursement, the Company will pay the Policyholder. In the event of death of the Policyholder, the Company will pay the nominee (as named in the Policy Schedule) and in case of no nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

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

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

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

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

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

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

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

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

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

6.1.4. Claims Intimation

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

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

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

Note: 6.1.4 (i) and 6.1.4 (ii) are precedent to

admission of liability under the policy.

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

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

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

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

6.1.5. Documents to be submitted for filing a valid Claim

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

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

Notes:

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

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

6.1.6. Claim Assessment

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

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

(i) If a room accommodation has been opted for where the Room Rent or Room Category is higher than the eligible limit as applicable for that Insured Person as specified in the Policy Schedule, then, the Associate Medical Expenses payable shall be pro-rated as per the applicable limits in accordance with Clause 3.1.1(viii) (a).

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

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

(iv) The balance amount, if any, subject to the applicability of sub-limits, Company's liability to make payment shall be limited to such extent as applicable and shall be the Claim payable

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

(i) Sum Insured;

(ii) Additional Sum Insured for Accidental Hospitalization / Additional Sum Insured for Defined Critical Illnesses, as applicable;

(iii) No Claim Bonus, as applicable;

(iv) No Claim Bonus Super, as applicable;

(v) Automatic Recharge, as applicable;

(vi) Unlimited Automatic Recharge, as applicable;

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

6.1.7. Payment Terms

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

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

(c) **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.

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

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

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

Sr. No.	LIST - I - OPTIONAL ITEMS	Sr. No.	LIST - I - OPTIONAL ITEMS
1	BABY FOOD		CHARGES
2	BABY UTILITIES CHARGES	49	AMBULANCE COLLAR
3	BEAUTY SERVICES	50	AMBULANCE EQUIPMENT
4	BELTS/ BRACES	51	ABDOMINAL BINDER
5	BUDS	52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
6	COLD PACK/HOT PACK		
7	CARRY BAGS	53	SUGAR FREE Tablets
8	EMAIL / INTERNET CHARGES	54	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)		
10	LEGGINGS	55	ECG ELECTRODES
11	LAUNDRY CHARGES	56	GLOVES
12	MINERAL WATER	57	NEBULISATION KIT
13	SANITARY PAD	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
14	TELEPHONE CHARGES		
15	GUEST SERVICES		
16	CREPE BANDAGE	59	KIDNEY TRAY
17	DIAPER OF ANY TYPE	60	MASK
18	EYELET COLLAR	61	OUNCE GLASS
19	SLINGS	62	OXYGEN MASK
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	63	PELVIC TRACTION BELT
		64	PAN CAN
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	65	TROLLY COVER
		66	UROMETER, URINE JUG
22	TELEVISION CHARGES	67	AMBULANCE
23	SURCHARGES	68	VASOFIX SAFETY
24	ATTENDANT CHARGES		
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)		
26	BIRTH CERTIFICATE		
27	CERTIFICATE CHARGES		
28	COURIER CHARGES		
29	CONVEYANCE CHARGES		
30	MEDICAL CERTIFICATE		
31	MEDICAL RECORDS		
32	PHOTOCOPIES CHARGES		
33	MORTUARY CHARGES		
34	WALKING AIDS CHARGES		
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)		
36	SPACER		
37	SPIROMETRE		
38	NEBULIZER KIT		
39	STEAM INHALER		
40	ARMSLING		
41	THERMOMETER		
42	CERVICAL COLLAR		
43	SPLINT		
44	DIABETIC FOOT WEAR		
45	KNEE BRACES (LONG/ SHORT/ HINGED)		
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER		
47	LUMBO SACRAL BELT		
48	NIMBUS BED OR WATER OR AIR BED		

Sr. No.	LIST - II - ITEMS THAT ARE TO BE SUBSUMED INTO ROOM CHARGES	Sr. No.	List III – ITEMS THAT ARE TO BE SUBSUMED INTO PROCEDURE CHARGES
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	1	HAIR REMOVAL CREAM
2	HAND WASH	2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	SHOE COVER	3	EYE PAD
4	CAPS	4	EYE SHEILD
5	CRADLE CHARGES	5	CAMERA COVER
6	COMB	6	DVD, CD CHARGES
7	EAU-DE-COLOGNE / ROOM FRESHNERS	7	GAUSE SOFT
8	FOOT COVER	8	GAUZE
9	GOWN	9	WARD AND THEATRE BOOKING CHARGES
10	SLIPPERS	10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	TISSUE PAPER	11	MICROSCOPE COVER
12	TOOTH PASTE	12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER
13	TOOTH BRUSH	13	SURGICAL DRILL
14	BED PAN	14	EYE KIT
15	FACE MASK	15	EYE DRAPE
16	FLEXI MASK	16	X-RAY FILM
17	HAND HOLDER	17	BOYLES APPARATUS CHARGES
18	SPUTUM CUP	18	COTTON
19	DISINFECTANT LOTIONS	19	COTTON BANDAGE
20	LUXURY TAX	20	SURGICAL TAPE
21	HVAC	21	APRON
22	HOUSE KEEPING CHARGES	22	TORNIQUET
23	AIR CONDITIONER CHARGES	23	ORTHOBUNDLE, GYNAEC BUNDLE
24	IM IV INJECTION CHARGES		
25	CLEAN SHEET		
26	BLANKET/WARMER BLANKET		
27	ADMISSION KIT		
28	DIABETIC CHART CHARGES		
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES		
30	DISCHARGE PROCEDURE CHARGES		
31	DAILY CHART CHARGES		
32	ENTRANCE PASS / VISITORS PASS CHARGES		
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE		
34	FILE OPENING CHARGES		
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)		
36	PATIENT IDENTIFICATION BAND / NAME TAG		
37	PULSEOXYMETER CHARGES		

Sr. No.	LIST IV – ITEMS THAT ARE TO BE SUBSUMED INTO COSTS OF TREATMENT
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/
	DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE
	NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABS
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

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

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

Hospital Name	*Address*
Mahaveer Hospital & Trauma Centre	76-E,Station Road, Panki , Kanpur , Uttar Pradesh
Eashwar Lakshmi Hospital	Plot No. 9,Near Sub Registrar Office, Gandhi Nagar , Hyderabad , Andhra Pradesh
Amrapali Hospital	Plot No. NH-34,P-2,Omega -1, Greater Noida , Noida , Uttar Pradesh
Hardik Hospital	29c,Budh Bazar, Vikas Nagar , New Delhi , Delhi
Jabalpur Hospital & Research Centre Pvt Ltd	Russel Crossing,Naptier Town, Jabalpur , Madhya Pradesh
Panvel Hospital	Plot No. 260A,Uran Naka, Old Panvel , Navi Mumbai , Maharashtra
Santosh Hospital	L-629/631,Hapur Road, Shastri Nagar , Meerut , Uttar Pradesh
Sona Medical Centre	5/58,Near Police Station, Vikas Nagar , Lucknow , Uttar Pradesh
City Super Speciality Hospital	Near Mohan Petrol Pump,Gohana Road, Rohtak , Haryana
City Super Speciality Hospital	Near Mohan Petrol Pump,Gohana Road, Rohtak , Haryana
Navjeevan Hospital & Maternity Centre	753/21,Madanpuri Road, Near Pataudi Chowk , Gurgaon , Haryana
Abhishek Hospital	C-12,New Azad Nagar, Kanpur , Kanpur , Uttar Pradesh
Raj Nursing Home	23-A, Park Road , Allahabad , Uttar Pradesh
Saras Healthcare Pvt Ltd.	K-112, SEC-12 ,Pratap Vihar , Ghaziabad , Uttar Pradesh
Getwell Soon Multispeciality Institute Pvt Ltd	S-19, Shalimar Garden Extn. , Near Dayanand Park, Sahibabad , Ghaziabad , Uttar Pradesh
Shivalik Medical Centre Pvt Ltd	A-93, Sector 34 , Noida , Uttar Pradesh
Aakanksha Hospital	126, Aaradhnanagar Soc,B/H. Bhulkabhavan School, Aanand-Mahal Rd. , Adajan , Surat , Gujarat
Abhinav Hospital	Harsh Apartment,Nr Jamna Nagar Bus Stop, Goddod Road , Surat , Gujarat
Adhar Ortho Hospital	Dawer Chambers,Nr. Sub Jail, Ring Road , Surat , Gujarat
Aris Care Hospital	A 223-224, Mansarovar Soc,60 Feet, Godadara Road , Surat , Gujarat
Arzoo Hospital	Opp. L.B. Cinema, Bhatar Rd. , Surat , Gujarat
Auc Hospital	B-44, Gujarat Housing Board, Pandeshara , Surat , Gujarat
Dharamjivan General Hospital & Trauma Centre	Karmayogi - 1, Plot No. 20/21, Near Piyush Point, Pandesara , Surat , Gujarat
R.K.Hospital	3C/59,BP,Near Metro Cinema, New Industrial Township 1 , Faridabad , Haryana
Dr. Santosh Basotia Hospital	Bhatar Road , Bhatar Road , Surat , Gujarat
God Father Hosp.	344, Nandvan Soc., B/H. Matrushakti Soc. , Puna Gam , Surat , Gujarat
Govind-Prabha Arogya Sankool	Opp. Ratna-Sagar Vidhyalaya,Kaji Medan, Gopipura , Surat , Gujarat
Hari Milan Hospital	L H Road , Surat , Gujarat
Jaldhi Ano-Rectal Hospital	103, Payal Apt., Nxt To Rander Zone Office, Tadwadi , Surat , Gujarat
Jeevan Path Gen. Hospital	2Nd. Fl., Dwarkesh Nagri, Nr. Laxmi Farsan, Sayan , Surat , Gujarat
Kalrav Children Hospital	Yashkamal Complex, Nr. Jivan Jyot, Udhna , Surat , Gujarat
Kanchan General Surgical Hospital	Plot No. 380, Ishwarnagar Soc, Bhamroli-Bhatar, Pandesara , Surat , Gujarat
Krishnavati General Hospital	Bamroli Road , Surat , Gujarat
Niramayam Hosptial & Prasutigruah	Shraddha Raw House, Near Natures Park , Surat , Gujarat
Patna Hospital	25, Ashapuri Soc - 2, Bamroli Road, Surat , Gujarat
Poshia Children Hospital	Harekrishan Shoping Complex 1St Floor, Varachha Road , Surat , Gujarat
R.D Janseva Hospital	120 Feet Bamroli Road, Pandesara , Surat , Gujarat
Radha Hospital & Maternity Home	239/240 Bhagunagar Society, Opp Hans Society, L H Road, Varachha Road, Surat , Gujarat
Santosh Hospital	L H Road , Varachha , Surat , Gujarat
Sparsh Multy Specality Hospital & Trauma Care Center	G.I.D.C Road, Nr Udhana Citizan Co-Op.Bank , Surat , Gujarat

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

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

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

Annexure IV - Office of the Ombudsman

Office of the Ombudsman	Contact Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 E-mail : bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Office of the Insurance Ombudsman, Jeevan Soudha Building ,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
BHOPAL	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa
CHANDIGARH	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh
CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481 / 23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi, Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana and Yanam – a part of Territory of Pondicherry

Office of the Ombudsman	Contact Details	Jurisdiction of Office (Union Territory, District)
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@cioins.co.in	Rajasthan
ERNAKULAM	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe – a part of Pondicherry
KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Andaman & Nicobar Islands, Sikkim
LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038821/23/24/25/26/27/28/29/30/31 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
PATNA	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand

Office of the Ombudsman	Contact Details	Jurisdiction of Office (Union Territory, District)
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

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

Office of the 'Executive Council of Insurers'

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

Annexure V - SERVICE REQUEST FORM

For Change in Occupation / Nature of Job
(Refer Clause 5.18 of Policy Terms and Conditions)

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

Policyholder Details

☐ Mr. ☐ Ms. ☐ M/S. Policy No :

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

Policy No

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

☐ Mr. ☐ Ms. ☐ M/S.

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

Occupation :

Declaration

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

Date : / / (DD/MM/YYYY)

Place :

Signature of the Policyholder :_____
(On behalf of all the persons insured under the Policy)

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

Annexure VI - 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.)
46	11,440	3,00,000	11,440	2.5%	11,154	3,00,000	21,943	NA	21,943	3,00,000
51	13,731	3,00,000	13,731	2.5%	13,388	3,00,000				
Total Premium for all members of family is Rs. 25,171, when each member is covered separately. Sum Insured available for each individual is Rs. 3,00,000			Total Premium for all members of family is Rs. 24,542, when they are covered under a single policy Sum Insured available for each family member is Rs. 3,00,000				Total Premium when policy is opted on floater basis is Rs. 21,943 Sum Insured of Rs.3,00,000 is available for entire family			

Annexure VI - Benefit / Premium illustration

(Illustration 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	17,619	3,00,000	17,619	2.5%	17,179	3,00,000	28,277	NA	28,277	3,00,000
60	17,619	3,00,000	17,619	2.5%	17,179	3,00,000				
Total Premium for all members of family is Rs. 35,238, when each member is covered separately. Sum Insured available for each individual is Rs. 3,00,000			Total Premium for all members of family is Rs. 34,357, when they are covered under a single policy Sum Insured available for each family member is Rs. 3,00,000				Total Premium when policy is opted on floater basis is Rs. 28,277 Sum Insured of Rs.3,00,000 is available for entire family			

Annexure VI - 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.)
61	27,821	3,00,000	27,821	2.5%	27,125	3,00,000	44,314	NA	44,314	3,00,000
64	27,821	3,00,000	27,821	2.5%	27,125	3,00,000				
Total Premium for all members of family is Rs. 55,642 , when each member is covered separately. Sum Insured available for each individual is Rs. 3,00,000			Total Premium for all members of family is Rs. 54,251, when they are covered under a single policy Sum Insured available for each family member is Rs. 3,00,000				Total Premium when policy is opted on floater basis is Rs. 44,314 Sum Insured of Rs.3,00,000 is available for entire family			

Notes:

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

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: CHIHLIP22223V012122
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