care HEALTH INSURANCE

BEST HEALTH INSURANCE COMPANY IN RURAL SECTOR | CLAIMS SERVICE LEADER OF THE YEAR

INDIA INSURANCE SUMMIT & AWARDS 2024

ultimate care

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.

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 30 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 30 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.

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. AYUSH treatment refers to the medical and/ or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

2.1.5. Break in policy: means the period of gap that occurs at the end of the existing policy term/ installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

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

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

2.1.8. 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

2.1.9. 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.

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

2.1.11. 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.

2.1.12. 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.

2.1.13. 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.

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

2.1.15. 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.

2.1.16. 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.

2.1.17. 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.

2.1.18. Grace Period means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

Provided the insurers shall offer coverage during the grace period, if the premium is paid in installments during the policy period.

2.1.19. 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 Has 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.

2.1.20. Hospitalization 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.

2.1.21. 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.

2.1.22. 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.

2.1.23. In-patient Care means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

2.1.24. 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.

2.1.25. 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.

2.1.26. 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.

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

2.1.28. 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.

2.1.29. 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.

2.1.30. Medically Necessary Treatment 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.

2.1.31. Migration means a facility provided to policyholders (including all members under family cover and group policies), to transfer the

credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

2.1.32. 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.

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

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

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

2.1.36. 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.

2.1.37. Portability means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

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

i. That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

ii. For which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

2.1.39. 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.

2.1.40. 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.

2.1.41. 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.

2.1.42. 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.

2.1.43. 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.

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

2.1.45. Specific waiting period (Named Ailment Waiting Period) means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break

2.1.46. 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.

2.1.47. 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.

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

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

2.2.4. Assistance Service Provider means the service provider specified in the Policy Schedule appointed by the Company from time to time.

2.2.5. 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.

2.2.6. 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. Country of Residence means the country in which the Insured Person is currently residing and as specified in the Policy Schedule.

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

2.2.11. Excluded Providers means hospital or any other provider specifically excluded by the Insurer.

2.2.12. General Ward means a basic (cheapest) category of shared room in a Hospital with/without air-conditioning with minimum four patient beds.

2.2.13. 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.

2.2.14. 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.

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

2.2.16. 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.

2.2.17. Intending Couple means a couple who have a medical indication necessitating gestational surrogacy and who intend to become parents through surrogacy.

2.2.18. Intending Woman means an Indian woman who is a widow or divorcee between the age of 35 to 45 years and who intends to avail the surrogacy in accordance with the Surrogacy Act

2.2.19. Life Threatening Medical Condition means a medical condition suffered by the Insured Person which has the following characteristics:

(a) Markedly unstable vital parameters (blood pressure, pulse, temperature and respiratory rate); or

(b) Acute impairment of one or more vital organ systems (involving brain, heart, lungs, liver, kidneys and pancreas); or

(c) Critical care being provided, which involves high complexity decision making to assess, manipulate and support vital system functions to treat single or multiple vital organ failures and requires interpretation of multiple physiological parameters and application of advanced technology; or

(d) Critical care being provided in critical care area such as coronary care unit, intensive care unit, respiratory care unit, or the emergency department; and certified by the attending Medical Practitioner as a Life Threatening Medical Condition.

2.2.20. 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.

2.2.21. 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 medical condition or to physically support the function of human body.

2.2.22. Metastasis is spread of cancer from the part of the body where it started (the primary site) to other parts of the body.

2.2.23. 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.

2.2.24. Oocyte means naturally ovulating oocyte in the female genetic tract.

2.2.25. Oocyte Donor is a woman who donates her eggs to another woman, who might not be able to conceive by herself naturally.

2.2.26. Oocyte Retrieval is a procedure in order to remove Oocytes from the ovary of a woman, to enable fertilization.

2.2.27. Period of Insurance means a period within the Policy Period which commences when the Insured Person first boards the Common Carrier by which it is intended that he shall finally leave the Country of Residence and expires automatically on the earliest of:

(a) the actual date on which the Insured returns to the Country of Residence; or

(b) Policy Period End Date; or

(c) the expiry of the "Total no. of Travel days" specified in the Policy Schedule from the commencement of the Period of Insurance.

2.2.28. Place of Destination means the destination place where the journey of the Insured Person, forming part of the Trip, is scheduled to be concluded through a Common Carrier.

2.2.29. Place of Origin means the starting point / place from where the Insured Person's Trip is scheduled to be undertaken through a Common Carrier by which he finally leaves the Country of Residence.

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

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

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

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

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

2.2.35. 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.

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

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

2.2.38. Primary Insured Person means the person named as the policyholder in the Policy Schedule who is also covered under the Policy and responsible for paying premiums.

2.2.39. 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.

2.2.40. Scheduled departure time: Scheduled departure time of the Common Carrier is the departure time declared by the Common Carrier 6 hours before the actual departure time or as stated in the original ticket (whichever is later)

2.2.41. 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.

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

2.2.43. Surrogacy Act means the Surrogacy (Regulation) Act, 2021 and its amendments.

2.2.44. Surrogacy means a practice whereby one woman bears and gives birth to a child for an Intending Couple/ Intending Woman with the intention of handing over such child to the Intending Couple / Intending Woman after the birth.

2.2.45. Surrogacy Clinic means surrogacy clinic, centre or laboratory, conducting assisted reproductive technology services, invitro fertilisation services, genetic counseling centre, genetic laboratory, Assisted Reproductive Technology Banks conducting surrogacy procedure or any clinical establishment, by whatsoever name called, conducting surrogacy procedures in any form.

2.2.46. Surrogacy Procedures means all gynaecological, obstetrical or medical procedures, techniques, tests, practices or services involving handling of human gametes and human embryo in surrogacy.

2.2.47. Surrogate Mother means a woman who agrees to bear a child (who is genetically related to the intending couple or intending woman) through surrogacy from the implantation of embryo in her womb and fulfils the conditions as provided in sub-clause (b) of clause (iii) of section 4 of the Surrogacy (Regulation) Act 2021;

The surrogate mother is in possession of an eligibility certificate issued by the appropriate authority on fulfilment of the following conditions, namely: -

(I) no woman, other than an ever married woman having a child of her own and between the age of 25 to 35 years on the day of implantation, shall be a surrogate mother or help in surrogacy by donating her egg or oocyte or otherwise;

(II) a willing woman shall act as a surrogate mother and be permitted to undergo surrogacy procedures as per the provisions of this Act: Provided that the intending couple or

the intending woman shall approach the appropriate authority with a willing woman who agrees to act as a surrogate mother;

(III) no woman shall act as a surrogate mother by providing her own gametes;

(IV) no woman shall act as a surrogate mother more than once in her lifetime: Provided that the number of attempts for surrogacy procedures on the surrogate mother shall be such as may be prescribed; and

(V) a certificate of medical and psychological fitness for surrogacy and surrogacy procedures from a registered medical practitioner;

2.2.48. Terrorism/ Terrorist Incident means any actual or threatened use of force or violence directed at or causing damage, injury, harm or disruption, or commission of an act dangerous to human life or property, against any individual, property or government, with the stated or unstated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests, whether such interests are declared or not. Terrorism shall also include any act, which is verified or recognized by the relevant Government as an act of terrorism.

2.2.49. 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.

2.2.50. Travelling Companion means named person(s) who is/are booked from the start of the Trip or joins the Insured person during the Period of insurance.

2.2.51. 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.

2.2.52. Valuables shall mean and include photographic, audio, video, painting, computer (excluding softwares) and any other electronic equipment, telecommunications, professional equipment and electrical equipment, telescopes, binoculars, antiques, watches, Perfumes, jewelry and gems, furs and articles made of precious

stones and metals.

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

2.2.53. Hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities in that country or complies with all minimum criteria as under:

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

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

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

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

2.2.57. Reasonable and customary (R&C) means charges or treatment for medical care which shall be considered by the Company or by Company's medical advisers to be reasonable and customary to the extent that they do not exceed the general level of charges or

treatment being made by others of similar standing in the locality where the charges or treatment are incurred when giving like or comparable treatment.

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

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

3. BENEFITS COVERED UNDER THE POLICY:

GENERAL CONDITIONS APPLICABLE TO ALL THE BENEFITS AND OPTIONAL BENEFITS

1. The premium payable for the above plans would be eligible for claiming Tax Benefits under relevant provisions of Income Tax Act, 1961 and amendments thereof.

2. Child would be migrated to separate Policy of Company and treated as adult upon attaining age of 25 years or above at the time of renewal.

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

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

   II. For any single Claim during a Policy Year, the maximum Claim amount payable shall be sum total of Sum Insured, Cumulative Bonus, Loyalty Boost, Infinity Bonus (if applicable), Tenure Multiplier (if applicable), Unlimited Care (if applicable), Plus Benefit (if applicable), Inflation Shield (if applicable), Unlimited Automatic Recharge Booster (if applicable).

   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.

4. Deductible Option (if opted) is applicable on the Benefits namely under

Hospitalization Expenses, Ambulance Cover, Cumulative Bonus, Unlimited Automatic Recharge, Loyalty Boost, Optional Benefits – Infinity Bonus, Unlimited Automatic Recharge Booster, Unlimited Care, Claim Shield, Inflation Shield, Tenure Multiplier, Plus Benefit, Cancer Care

5. The Co-payment proportion (If opted) shall be borne by the Insured Person on each Claim which will be applicable on Benefits namely Hospitalization Expenses, Ambulance Cover, Cumulative Bonus, Unlimited Automatic Recharge, Loyalty Boost, Optional Benefits – Infinity Bonus, Unlimited Automatic Recharge Booster, Unlimited Care, Claim Shield, Inflation Shield, Tenure Multiplier, Plus Benefit, Cancer Care

6. Any Claim paid for Benefits namely Hospitalization Expenses, Ambulance Cover, Optional Benefit- Pre–Post Hospitalization Expenses Modification, Unlimited Care, Claim Shield, Assisted Reproductive Treatment, Cancer Care 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.

7. 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 Pre Hospitalization Medical Expenses and Post Hospitalization Medical expenses, Organ Donor Cover, Ambulance Cover, Optional Benefit- Unlimited Care, Pre–Post Hospitalization Expenses Modification , Claim Shield, Durable Medical Equipment, 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.

8. If Insured Persons are covered on an Individual basis, then every Insured Person can opt for different Sum Insured and different Optional Benefits. If Insured Persons are covered on Floater basis, then the Optional Benefits if opted shall available to all Insured Persons under floater policy unless specifically mentioned/catered to in the Policy.

9. Optional Benefits: Unlimited E-Consultations, Concierge/ Geriatric Care, Maternity Cover, New born Baby Cover, Wellness benefit, Women Care, Mental Health Wellbeing, Annual Health Check-up, Smoking & Alcohol Rehabilitation, Surrogacy Care, Oocyte Care, Travel Plus, Cancer Care, Out-patient Dental and Vision Care, Physical Consultations with General Physicians, Physical Consultations with Specialist Doctors, OPD Diagnostic tests, OPD Pharmacy, Women Support Program, Durable Medical Equipment shall available only on Individual Basis.

10. Linear interpolation methodology will be applied to calculate the premium rates if an intermittent value of Sum Insured/sub-limit/benefit amount is chosen by the Policyholder.

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

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

13. Surrogacy and Oocyte donation should be carried out in recognized centers registered with the National ART and Surrogacy Registry at https://registry.artsurrogacy.gov.in/, under the supervision of a registered Medical Practitioner as per the applicable law.

14. The surrogacy/ART procedures and treatment must be carried out in accordance with the Surrogacy (Regulation) Act 2021, Surrogacy (Regulation) Rules 2022, Assisted Reproductive Technology Act 2021, Assisted Reproductive Technology (Regulation) Rules 2022, and its amendments; as may be applicable.

15. Cumulative Bonus, Unlimited Automatic Recharge, Loyalty Boost, Optional Benefit – Infinity Bonus, Unlimited Automatic Recharge Booster, Unlimited Care, Inflation Shield, Tenure Multiplier, Spouse Care, Plus Benefit, Cancer Care shall not be applicable for Unlimited Sum Insured option.

3.1. BASE BENEFITS

3.1.1 Hospitalization Expenses

If an Insured Person is diagnosed with an illness or suffers an injury and which requires the Insured Person to be admitted in a Hospital in India which should be Medically Necessary during the Policy Year 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 2 or more 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.

Note: Above mentioned minimum period of 2 or more hours is not applicable for AYUSH treatments, any admission for

medical investigation or evaluation or injections, procedures done under OPD services.

(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, which would otherwise require an in-patient admission and such Day Care Treatments was prescribed in written, by a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were Medically Necessary.

(iii) **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 'Hospitalization expenses' for treatment taken through following advance technology methods:

A. Uterine Artery Embolization and HIFU

B. Balloon Sinuplasty

C. Deep Brain stimulation

D. Oral chemotherapy

E. Immunotherapy- Monoclonal Antibody to be given as injection

F. Intra vitreal injections

G. Robotic surgeries

H. Stereotactic radio surgeries

I. Bronchical Thermoplasty

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

K. IONM - (Intra Operative Neuro Monitoring)

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

(iv) **Pre-Hospitalization Medical Expenses**

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) For a period of 60 days immediately prior to the Insured Person's date of admission to the Hospital, provided that the Company shall not be liable to make payment for any Pre-hospitalization Medical Expenses that were not incurred during the Policy Year.

(v) Post-Hospitalization Medical Expenses

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) 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 the completion of 90 days from the date of discharge from the hospital.

(vi) 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, Yoga, Naturopathy, Sidha, Unani and Homeopathy, subject to the conditions specified below:

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

Benefit 'Hospitalization Expenses' with minimum 24 consecutive hours of Hospitalization required.

(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.

(vii) 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 2.1.16), 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.

(viii) 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 Medical Expenses and Post Hospitalization Medical Expenses' or any other Medical Expenses in respect of the donor consequent to the harvesting.

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

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

i. The eligible Room Rent or Room Category applicable

for the Insured Person under the Policy is 'No limit', which means that there is no separate restriction on Room Charges incurred towards stay during Hospitalization

ii. Intensive Care Unit Charges (ICU Charges): The eligible ICU Charges applicable for the Insured Person under the Policy is 'No limit', which means that there is no separate restriction on ICU Charges incurred towards stay in ICU during Hospitalization.

3.1.2 Ambulance Cover

The Company will indemnify the Insured Person, through Cashless or Reimbursement Facility, up to the Sum Insured, for ambulance services utilized through any mode of vehicle not limited to Road, Air, Train provided that the Medical Expenses so incurred are related to the Illness or Injury for which the Company has accepted the Insured Person's Claim under Benefit 'Hospitalization Expenses' and subject to conditions as specified below:

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

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

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

3.1.3 Cumulative Bonus:

At the end of each Policy Year, the Company will enhance the Sum Insured by 50% flat, on a cumulative basis for each completed and continuous Policy Year, and subject to the conditions specified below:

(i) In any Policy Year, the accrued Cumulative Bonus, shall not exceed 100% of the Sum Insured available in the expiring Policy or renewed Policy, wherever Sum Insured is lower.

(ii) The entire Cumulative Bonus will be forfeited if the Policy is not continued / renewed on or before Policy Period End Date

or the expiry of the Grace Period whichever is later.

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

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

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

(vi) In the event of a Claim there is no impact on the accrual of Cumulative Bonus.

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

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

(ix) Base Sum Insured and Plus Benefit (if applicable) shall be considered while calculating 'Cumulative Bonus'.

(x) Accrued 'Cumulative Bonus' can be utilized for 'Hospitalization Expenses', 'Ambulance Cover' under the Policy.

(xi) Cumulative Bonus would be credited automatically to the subsequent Policy year, even in case of multi-year Policies

(xii) The Cumulative Bonus accumulated in the previous Policy Years, will only be available to those Insured Person(s) who were Insured in the previous Policy Years and continue to be Insured with the Company in the subsequent Policy Years.

3.1.4 Unlimited Automatic Recharge

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

(i) The Recharge shall be utilized only after the base Sum Insured, applicable Cumulative Bonus, Infinity Bonus (if applicable), Inflation Shield (if applicable), Plus Benefit (if applicable) have been completely exhausted in that Policy Year.

(ii) This Benefit shall be applicable form the second claim made during the Policy Year.

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

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

(v) The Sum Insured available under this Benefit can only be utilized for Benefits- 'Hospitalization Expenses', 'Ambulance Cover' and Plus Benefit (if applicable).

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

(vii) Base Sum Insured and Plus Benefit (if applicable) shall be considered while calculating 'unlimited Automatic Recharge'.

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

3.1.5 Health Services

The Company shall provide the following Services:

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

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

3.1.6 Loyalty Boost

If the Insured Person does not make any 'Hospitalization Expenses' related claim for 7 consecutive Policy Years then the Company shall provide additional 100% of the Sum Insured as Loyalty Boost.

Note:

a) Waiting Period shall be waived off for this additional Sum Insured.

b) In case of increase in Sum Insured, Initial Sum Insured opted at the inception of the first Policy with the Company shall be considered for calculating 'Loyalty Boost'.

3.1.7 New Born- Wait Period Benefit

If the child is born after the inception of the Policy and added in the policy (subject to underwriting) within 90 days from the date of birth then the wait period already served by existing Primary Insured Person under this Policy shall be considered as served for the new born child as well.

No fresh wait period shall be applicable for new born if added in Policy within 90 days from date of birth whereas fresh wait period shall be applicable if new born is added at the age of 91 days or above.

3.1.8 Medi Voucher

The Company shall provide 2 pharmacy vouchers of specified amount on 1st renewal of Policy with the Company.

3.2. OPTIONAL BENEFITS

3.2.1 Pre-Post Hospitalization Expenses Modification

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

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

(ii) Under Post-hospitalization Medical Expenses, for the specified number of days immediately after the Insured

Person's date of discharge from the Hospital and claim documents to be submitted within 30 days after completion of number of days specified in the Policy Schedule, from the date of discharge from Hospital.

3.2.2 Infinity Bonus

"Infinity Bonus" is an extension to Benefit: Cumulative Bonus and hence all the provisions stated under Clause 3.1.3, holds good for this Benefit as well, except the below clauses which have been modified for the purpose of this Optional Benefit:

(i) The Insured Person would receive a flat 100% of the base Sum Insured on a cumulative basis irrespective of claim for unlimited period (which is over & above the Sum Insured accrued as Cumulative Bonus), for each completed and continuous Policy Year.

(ii) At the time of Policy renewal if the Policyholder chooses not to renew this Optional Benefit, then the 'Infinity Bonus' under the expiring Policy shall be forfeited.

3.2.3 Unlimited Automatic Recharge Booster

Notwithstanding anything to the contrary in the Policy, if this Optional Benefit is opted, the Unlimited Automatic Recharge Benefit shall become payable for 1st claim in a lifetime of Policy and all the provisions stated under Clause 3.1.4 shall be applicable to this benefit as well.

3.2.4 Premium Payback

If the Insured Person has opted for this Benefit and no 'Hospitalization Expenses' related claim is made for the preceding 5 consecutive Policy Years, then the Company shall refund the 1st Policy Year premium of base plan to the Policyholder subject to subsequent renewal of Policy. This Benefit shall be payable only once in every block of 5 years.

3.2.5 Unlimited Care

The Company shall cover the Hospitalization Expenses of the Insured Person without any restriction/ limits on the annual Sum Insured for any one claim in the policy lifetime subject to the following conditions:

(i) This Benefit can be opted only during the inception of

the policy irrespective of Policy tenure.

(ii) Once opted the Insured Person should continue this Benefit for 5 continuous Policy Years.

(iii) Once a claim is made under this Benefit, the cover shall cease and not be available for re-selection during the subsequent renewal.

(iv) The total payout under this Benefit will also constitute: Base Sum Insured, Cumulative Bonus, Loyalty Boost, Infinity Bonus, Unlimited Automatic Recharge Booster, Inflation Shield, Tenure Multiplier, Plus Benefit and any other additional Sum Insured.

(v) This Benefit shall be applicable in India only.

(vi) This Benefit would however be subject to all limits, sub limits, co-payments, deductibles as per the Policy.

3.2.6 Unlimited E-Consultations

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

3.2.7 Cover Pause

If Insured Person(s) travels outside India during the Policy Year then the Policy coverage can be paused for maximum period of 30 continuous days and the Policy Period shall be extended by the number of days the coverage was paused, subject to the following conditions:

(i) This Benefit shall be availed only if all the Insured Person(s) under the Policy travel outside India.

(ii) This benefit can be utilized only once in a Policy Year.

(iii) To pause the cover, intimation must be given to the Company at least 48 hours prior to the date of travel with following documents and details:

a) Date and time of leaving India

b) Date and time of your return to India

c) Flight tickets of the Insured members travelling abroad

d) Flight tickets of the Insured members travelling back to India

(iv) In case Insured Person(s) arrive back to India earlier than the date informed to the company, then Policyholder need to intimate the company to resume the coverage.

(v) If the return to India is later than 30 days after the pause was activated, the coverage shall automatically resume after 30 days irrespective of actual return date.

(vi) If out of all members who travelled, only one or some members return to India earlier than the notified date, then the coverage shall resume from the earliest date of return to India.

(vii) In case one or more Insured Person travel is cancelled due to unavoidable circumstances post confirming to activate the Cover Pause Benefit and before travelling outside India and same was informed by Policyholder to the Company, then the Cover Pause Benefit will be deactivated.

3.2.8 Grace Period cover

Notwithstanding anything to the contrary in the Policy, if this Optional Benefit is opted, the Company shall provide coverage under 'Hospitalization Expenses' Benefit incurred during the grace period for Policies due for renewal.

3.2.9 Tenure Multiplier

This Benefit allows Insured Person to combine the annual Sum Insured of Policy across the entire Policy tenure in case of a multi-year Policy. It can be utilized once during entire Policy Period for a single claim. This Benefit would however be subject to all applicable limits, sub limits, co-payments, deductibles as per the Policy.

For example: If the Insured Person has 3 year Policy with annual Sum Insured of 5 Lacs, the total coverage available under this Benefit shall be 15 Lacs (5 lacs x 3 Year Policy Period = 15 lacs)

Conditions applicable on this Benefit are:

(i) The Sum Insured available under this Benefit can only be utilized for Benefits – 'Hospitalization Expenses' and 'Ambulance Cover'.

(ii) This Benefit can be opted only during the inception of the

policy.

(iii) Base Sum Insured and 'Plus Benefit' shall be considered while calculating 'Tenure Multiplier' Sum Insured.

(iv) This Benefit shall be applicable in India only.

(v) Any claim paid during the Policy Period under the Policy that reduces base Sum Insured will also reduce the combined Sum Insured available under 'Tenure Multiplier'.

3.2.10 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/ Hyperlipidemia/ Asthma /Obesity / Hypothyroidism/Coronary Artery Disease (PTCA prior 1 year) at the time of issuance of first Policy with the Company and coverage shall start from the 31st day of Policy start date after serving Initial wait period of 30 days.

Note: 1) The above Optional Benefit can be opted only if this policy is issued for the first time with the Company and on continues renewal without break in policy.

2) Either Optional Benefit - 'Instant Cover' or 'PED Wait Period Modification' can be opted but not both.

3.2.11 Claim Shield

If a claim has been accepted under this benefit, then the items which are not payable as per List- I, II, II and IV under Annexure I related to the particular claim, will become payable. The maximum claim payout under this benefit shall be limited to applicable Sum Insured under the Policy.

Note: Coverage for any item as per List-I, II, II and IV under Annexure I, shall be available only if the same is not covered under any Base Benefit or Optional Benefit.

3.2.12 Inflation shield

The Inflation Shield is designed to provide additional increase in Sum Insured on the basis of inflation rate in previous calendar year.

The Inflation would be computed as the change in average CPI of the entire calendar year published by the National Statistical Office (NSO), Ministry of Statistics and Programme Implementation. In

case inflation rate of previous year available for penultimate calendar year shall be considered.

For information on Consumer price index you can visit website- http://mospi.nic.in/cpi.

The % increase will be applicable only on Sum Insured under the Base Policy and not on No Claim Bonus or any other benefit which leads to increase in Sum Insured.

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

Please Note that all the accumulated Inflation Shield benefit will lapse and your Sum Insured will roll back to the Sum Insured opted if this Benefit is not continued/ renewed.

3.2.13 Be-Fit Plus Benefit

The Insured Person, who is above 12 years of age, may avail unlimited visits to the Fitness Centers in a Policy year at the Company's network.

Note: The services availed would be subject to the following conditions:

(i) The services will be provided through an empaneled Fitness center only. Choice of the Insured Person in utilizing the services of Fitness Center will be entirely his/ her own and Company will have no liability towards the quality of services provided by the Fitness Centers.

(ii) Global access to specified workout classes related to Strength Training, Power Yoga, Functional Training, etc.

(iii) Health risk assessment.

(iv) The Company shall not be responsible for any disputes or loss in account of availing the services or arising between the Insured Person and the Fitness center.

(v) Any unutilized sessions cannot be carried forward to the next Policy Year

3.2.14 Concierge/ Geriatric Care

If this Optional Benefit is opted then the Company shall provide the following services through the Company's network to the Insured Person during the Policy Period:

i. Emergency Doctor on Call

ii. Access to 24*7 Help Desk

iii. Fortnightly health check-up via electronic mode- Once in a 15 Days

iv. Health related content access

3.2.15 Maternity Cover

The Company shall indemnify the Medical Expenses associated with Hospitalization of an Insured Person for the delivery of a child including pre-natal Medical Expenses & Post natal Medical Expenses, up to specified percentage of Sum Insured, subject to a maximum limit per Policy Year, as specified against this Benefit in the Policy Schedule.

It is agreed and understood that:

(i) Coverage amount under this benefit can accumulate up to 3 times, provided no claim has been made under this Benefit and the Policy is continuous renewed.

(ii) Claim under this Benefit shall be admissible only if the age of the Insured Person and/or Primary Insured Person's spouse is 18 to 45 years.

(iii) Wait Period shall be applicable as specified against this Benefit in the Policy Schedule.

(iv) Medical Expenses for ectopic pregnancy are not covered under this Benefit. However, these expenses are covered under Benefit 1 (Hospitalization Expenses).

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

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

3.2.16 New Born Baby Cover

The Company shall indemnify the Hospitalization Expenses within 'Maternity Cover' Sum Insured up to 90 days, as specified in the Policy Schedule incurred towards newly born baby of an Insured Person whose claim under Benefit 'Maternity Cover' is admissible by the Company during the Policy Period.

For continuous coverage of the child under this Policy beyond 90 days, the Insured Person must notify the Company and pay the additional premium subject to underwriting.

This Benefit shall be available only if the Optional Benefit- 'Maternity Cover' has been opted.

3.2.17 New Born External Congenital Disease/Defects

The Company shall indemnify the Hospitalization Expenses up to amount, as specified in the Policy Schedule incurred towards treatment of medically diagnosed external congenital defects/ disease of new born baby whose claim under Benefit 'Maternity Cover' is admissible by the Company.

This Benefit shall be available only if the Optional Benefit- 'Maternity Cover' has been opted.

Clause 4.2 (7) under Permanent Exclusions, is superseded to the extent covered under this Benefit

3.2.18 New Born Vaccination

The Company shall indemnify the Medical Expenses incurred on Vaccinations of the new born baby till one year of age during the Policy Period up to the amount, as specified in the Policy Schedule.

This cover is available only if Optional Benefit- 'Maternity Cover' has been opted under this Policy.

3.2.19 Assisted Reproductive Treatment

The Company will indemnify the Insured Person, up to the amount, as specified in Policy Schedule, for the medically necessary expenses incurred towards Assisted Reproductive Treatment, where indicated for sub-fertility, subject to the conditions specified below:

(i) A waiting period as specified in the Policy Schedule shall be applicable from the date of first inception of this policy with the Company for the Insured Person.

(ii) This benefit is payable only once in a Policy year after serving applicable waiting period subject to policy renewal.

(iii) To eligible for this benefit both self and spouse should be continuously covered under this Policy.

(iv) Clause 4.1 (b) (14) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

Additional Exclusions applicable to any Claim under this Benefit:

i. Pre and Post Hospitalization medical expenses

ii. Sub-fertility services that are deemed to be unproven, experimental or investigational

iii. Services not in accordance with standards of good medical practice and not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided

iv. Reversal of voluntary sterilization

v. Treatment undergone for second or subsequent pregnancies except where the child from the first delivery/ previous deliveries is/are not alive at the time of treatment

vi. Payment for services rendered to a surrogate

vii. Costs associated with cryopreservation and storage of sperm, eggs and embryos

viii. Selective termination of an embryo.

ix. Services done at unrecognized centre

x. Surgery / procedures that enhances fertility like Tubal Occlusion, Bariatric Surgery, Diagnostic Laparoscopy with Ovarian Drilling and such other similar surgery / procedures.

3.2.20 OPD Reward

Notwithstanding anything to the contrary in the Policy, if this Optional Benefit is opted and no claim related to 'Hospitalization Expenses' has been made other than due to accident or injury for 3 subsequent Policy Years then the Company shall provide OPD voucher of specified amount, as mentioned in the Policy Schedule.

3.2.21 Policyholder – Child Protection

In case of death of Policyholder, the Company shall provide 25% discount on renewal premium till Insured dependent child's age of 30 years. Insured dependent child's maximum entry age should be up to 25 years for availing this Benefit.

Subject to the following conditions:

(i) Discount shall be offered on base plan premium excluding Optional Benefits (if applicable) and/ or add-ons (if applicable).

(ii) This benefit can be opted where child is covered under the Policy with us.

3.2.22 Spouse Care

If this Optional Benefit opted, then the Insured Person has option to add his/her spouse in this Policy. Once added the Insured Person's spouse shall become eligible for the cumulative bonus that already accrued under the Policy and the wait period served in existing Policy shall pass on to spouse as well subject to the following conditions:

(i) Intimation of addition of Spouse in Policy must be made within 180 days from the legally certified marriage.

(ii) The addition of Insured Person's spouse is subject to underwriting.

(iii) Date of marriage must be after the issuance of the Policy or most recent renewal of the policy.

(iv) This Benefit can be opted only at the time of inception of the Policy.

3.2.23 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 Benefits- Pre-Post Hospitalization Expenses Modification, Room Rent Modification, PED Wait Period Modification, Named Ailment Wait Period Modification, Initial Wait Period Modification, Instant Cover, Deductible, Co-payment, Maternity Cover, New Born Cover, New born External Congenital Disease/ Defects, Plus Benefit, Infinity Bonus, Unlimited Automatic Recharge Booster, Unlimited Care, Tenure Multiplier, Claim Shield, Inflation shield, Cancer Care) 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; or
- in hospitals listed in Annexure – III but on reimbursement basis instead of cashless;

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 cashless 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/

3.2.24 Room Rent Modification

Notwithstanding anything to the contrary in the Policy, if this Optional Benefit is opted, the Company agrees to modify the Room Category/ Room Rent to Single Private AC room / Twin sharing room/General Ward/ General ward maximum up to Rs. 3000 per day as specified in Policy schedule. 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, 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.

i. **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 for stay in a Single Private AC Room.

ii. **Twin Sharing Room** If the Policy Schedule states 'Twin Sharing 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 for stay in a Twin Sharing Room.

iii. **General Ward** If the Policy Schedule states 'General ward' 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 for stay in a General ward.

iv. **General Ward** maximum up to Rs. 3000 per day If the Policy Schedule states 'General ward maximum up to Rs. 3000 per day' 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 for stay in a General ward maximum up to Rs. 3000 per day.

Note:

1) 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.

2) No limit on ICU charges under this Optional Benefit.

3.2.25 PED Wait Period Modification

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Benefit, the applicable waiting period of 36 months for Claims related to Pre-existing diseases shall be modified to specific time period as mentioned in the Policy Schedule.

Hence all the provisions stated under Clause 4.1 (a) (i) and Definition 2.1.38 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.

Either Optional Benefit - 'Instant Cover' or 'PED Wait Period Modification' can be opted but not both.

3.2.26 Named Ailment Wait Period Modification

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Benefit, the applicable waiting period of 24 months for

Claims related to Names ailments shall be modified to specific time period as mentioned in the Policy Schedule. Hence, all the provisions stated under Clause 4.1 (a) (ii) holds good for this benefit as well, except that the claims will be admissible for any Medical Expenses incurred for Hospitalization in respect of diagnosis/treatment of any Named ailment 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.

3.2.27 Initial Wait Period Modification

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Benefit, the applicable initial waiting period of 30 days shall be modified to specific time period as mentioned in the Policy Schedule. Hence, all the provisions stated under Clause 4.1 (a) (iii) holds good for this benefit as well, except that the claims will be admissible for any Medical Expenses incurred for Hospitalization 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.

3.2.28 Deductible

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

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

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

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

(Amount in Rs.)

Case	Sum Insured	Deductible	Claim 1	Claim 2	Claim 3	Payable 1	Payable 2	Payable 3
1	25,00,000	10,00,000	750,000	12,50,000	10,00,000	-	10,00,000	10,00,000

2	25,00,000	10,00,000	750,000	15,00,000	30,00,000	-	12,50,000	12,50,000
3	25,00,000	10,00,000	12,50,000	40,00,000	40,00,000	2,50,000	22,50,000	Claim not payable as SI is exhausted

3.2.29 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.

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

3.2.30 Plus Benefit

An additional amount as specified in the Policy Schedule will be available to the Insured Person for all claims (admissible under Base Benefits) during the Policy Year, subject to the following conditions:

(i) This Plus Benefit would be applied on the base Sum Insured only.

(ii) Any unutilized amount will not be carried forward to the subsequent Policy Year.

(iii) The Plus Benefit can be utilized for any number of claims admissible under the Policy during the Policy Year.

(iv) The Plus Benefit will be applicable only after exhaustion of Base Sum Insured.

(v) Coverage as applicable for Base Sum Insured shall hold good for this benefit as well.

3.2.31 Wellness Benefit

a) Insured Person who is covered as Adult aged 18 years and above in the Policy can avail following, provided this benefit is opted for–

Discount on renewal Premium by accumulating Healthy days as per table given below. One Healthy day can be accumulated by recording 10,000 steps (8000 steps for Insured Person of

age 60 years and above) or more in single day through tracking apps, devices, etc.

Healthy Days discount

No. of Healthy days in a year	Discount on Renewal Premium
270	30%
240	20%
180	15%
120	10%
Less than 120	0%

- The above benefit will be applicable on Individual basis. In case of floater, average of number of Healthy days earned by all Insured Members shall be considered for calculating renewal discount. For example,' A' has attained 260 Healthy days and ' B' has attained 230 Healthy days, average of the Healthy days is 245 and accordingly the discount calculated is 20%.In case of multi tenure, average of number of Healthy days earned over the policy tenure shall be considered for discount.
- The above section of benefit is available only for Insured covered as Adults aged 18 and above in the Policy and discount calculated shall be applicable on total premium of Policy.
- Responsibility of mapping device with CHIL system is of the insured/customer
- Number of days completing 10,000 steps (8000 steps for Insured Person of age 60 years and above) or more that are accumulated in last 2 months of the Policy Period would not be considered for discount on renewal premium. The same shall carry forward and will be considered in next policy period.
- In case of instalment premium mode is opted, then discount shall be considered only post payment of first 6 month of premium.
- Vouchers of value equivalent to renewal discount

amount can also be provided to Insured in case he/she does not wish for discount on renewal premium.

b) Access to Digital Fitness Coaching

c) Access to Artificial Intelligence Fitness Coaching

d) Access to Nutritionist/Wellness Coach

The above services (b, c, d) shall be available at Company's Network and available to Insured Members aged above 12 years subject to the following conditions:

a. The services will be provided through an empanelled Provider only. Choice of the Insured Person in utilizing the services of Provider will be entirely his/ her own and Company will have no liability towards the quality of services provided by the Provider.

b. The company shall not be responsible for any disputes arising between the Insured Person and the empanelled Provider.

c. The network under this benefit, does not constitute medical advice of any kind and it is not intended to be, and should not be, used to diagnose or identify treatment for a medical or mental health condition.

3.2.32 Women Care

The Company shall indemnify the Out-Patient Medical Expenses incurred by the female Insured Person up to the limit specified in the Policy Schedule, through cashless facility towards Diagnosis within the Policy Year for the following:

a) Mammography

b) Cervical Cancer screening

c) PCOS/PCOD diagnostic tests

Note: This benefit is available only for women insured members aged 18 years and above.

3.2.33 Mental Health Wellbeing

The Company shall indemnify the Out Patient Medical Expenses incurred by the Insured Person up to the limit specified in the Policy Schedule, through cashless facility towards Consultation,

Counseling and rehabilitation of the Insured Person, within the Policy Year for the following:

a) Acute depression

b) Obsessive compulsive disorder

c) Anxiety

d) Post traumatic stress disorder

3.2.34 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 Insured Persons who are of Age below 18 years on the Policy Period Start Date

List of Medical Tests covered as a part of Annual Health Check-up
Physical Examination (Height, Weight and Body Mass Index (BMI)), Eye Examination, Dental Examination and Scoring, Growth Charting, Doctor Consultation, Urine Examination (Routine and Microscopic)

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

List of Medical Tests covered as a part of Annual Health Check-up	Set No.	Sum Insured
COMPLETE BLOOD COUNT(CBC), URINE ROUTINE, ESR, ABO GROUP & RH TYPE, BLOOD SUGAR FASTING, CHOLESTEROL, CHOLESTEROL DIRECT LDL, CHOLESTEROL-HDL, TRIGLYCERIDES, TOTAL CHOLESTEROL/HDL RATIO, CREATININE, BLOOD UREA NITROGEN, BUN/ CREATININE RATIO, URIC ACID	1	5Lakhs-10Lakhs

COMPLETE BLOOD COUNT(CBC), URINE ROUTINE, ESR, ABO GROUP & RH TYPE, BLOOD SUGAR FASTING, CHOLESTEROL, CHOLESTEROL DIRECT LDL, CHOLESTEROL-HDL, TRIGLYCERIDES, TOTAL CHOLESTEROL/HDL RATIO, CREATININE, BLOOD UREA NITROGEN, BUN/ CREATININE RATIO, URIC ACID, TREADMILL TEST	2	Above 10 Lakhs

3.2.35 Smoking & Alcohol Rehabilitation

The Insured Person, who is above 18 years of age, may avail online tobacco cessation and alcohol de-addiction program during Policy year through the Company's network.

The program includes withdrawal and craving management, session with cessation and de-addiction specialist etc.

3.2.36 Durable Medical Equipment

The Company will indemnify up to the amount specified in the Policy Schedule subject to deductible, for the Reasonable and Customary charges necessarily incurred by the Insured Person, for procuring, fitting or hiring instruments, apparatuses or devices which are medically prescribed at the time of discharge as a medical aid and not limited to compression stockings, hearing aids, speaking aids (electronic larynx), standard wheelchairs, crutches, orthopaedic supports/braces/corrective splints, orthotics and stoma supplies following an Hospitalization during the Policy Year and this benefit should be availed within 60 days of hospitalization or as defined by medical practitioner in discharge summary.

Note: Spectacles, Thermometer, contact lenses, blood pressure monitoring machine and diabetes monitoring machine are not included

Clause 4.2 (5) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

3.2.37 Surrogacy Care

If an Insured Person requires to be admitted in a Hospital in India only for complication arising during Surrogacy pregnancy & Post-partum delivery in respect of the Surrogate Mother then the Company shall indemnify the Insured Person for Medical Expenses incurred towards Hospitalization through Cashless or Reimbursement Facility,

maximum up to the amount, as specified in the Policy Schedule, provided that the Hospitalization was prescribed in writing, by a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were Medically Necessary.

Conditions applicable to this Benefit are:

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

b) This Benefit shall be available for Insured Person who has opted for Policy with minimum 3 years Policy tenure.

c) Maximum coverage available for a surrogate mother under this Benefit is for period of thirty-six (36) continuous months from the date of initiation of the treatment/ procedure.

d) Waiting periods mentioned under Clause 4.1(a) (i),(ii) are not applicable for this Benefit.

e) Clause 4.1 (b) (14) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

f) Medical Expenses that are not payable under this Benefit are:

   (i) Delivery expenses (Normal Delivery or caesarean section)

   (ii) New Born baby through Surrogacy to the Surrogate Mother;

   (iii) Miscarriage (including miscarriage due to accident) except in case of life threatening medical condition to the Surrogate Mother, during the policy period of the Surrogate Mother;

   (iv) Surrogacy Treatment Procedure cost (Injection, tests, Ultra sound, Embryo transfer, Ovum pickup).

   (v) Surrogacy which is for commercial purposes.

   (vi) Costs associated with cryopreservation and storage of sperm, eggs and embryos.

   (vii) Services done at unrecognized center

   (viii) Surgery / procedures that enhance fertility like Tubal Occlusion, Bariatric Surgery, Diagnostic Laparoscopy

with Ovarian Drilling and such other similar surgery / procedures.

(ix) Reversal of voluntary sterilization.

(x) Selective termination of an embryo.

(xi) Pre and Post Hospitalization expenses

3.2.38 Oocyte Care

If an Insured Person requires to be admitted in a Hospital in India only for complications arising due to Oocyte retrieval in respect of the Oocyte Donor then the Company shall indemnify the Insured Person for Medical Expenses incurred towards Hospitalization through Cashless or Reimbursement Facility, maximum up to the amount, as specified in the Policy Schedule, provided that the Hospitalization was prescribed in writing, by a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were Medically Necessary.

Conditions applicable to this Benefit are:

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

b) This Benefit shall be available for Policy period of 1 year.

c) Maximum coverage available for a Oocyte donor under this Benefit is for period of twelve continuous months from the date of initiation of the treatment/procedure

d) Waiting periods mentioned under Clause 4.1(a) (i),(ii) are not applicable for this Benefit.

e) Clause 4.1 (b) (14) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

f) Medical Expenses that are not payable under this Benefit are:

i. Delivery expenses (Normal Delivery or caesarean section)

ii. Costs associated with cryopreservation and storage of sperm, eggs and embryos.

iii. Reversal of voluntary sterilization.

iv. Selective termination of an embryo.

v. Services done at unrecognized center

vi. Surgery / procedures that enhance fertility like Tubal Occlusion, Bariatric Surgery, Diagnostic Laparoscopy with Ovarian Drilling and such other similar surgery / procedures.

vii. Pre and Post Hospitalization expenses

Conditions applicable for Optional Benefit - Surrogacy Care and Optional Benefit- Oocyte Care:

i. The Proposal for insurance has to be made 30 days before the embryo transfer for the surrogate mother and /or 30 days before ovarian stimulation for oocyte donor.

ii. Proposer has to be one of the intending couple or intending women (as applicable).

iii. For Surrogate Mother: After completion of 36 months period, Surrogacy cover will be excluded for the Surrogate Mother and the Coverage other than Surrogacy cover will continue.

iv. For Oocyte Donor: After completion of 12 months period, Oocyte Care cover will be excluded for the Oocyte Donor and the coverage other than Oocyte cover will continue.

3.2.39 Travel Plus

The Benefits under 'Travel Plus' are valid outside India, which will be available for number of continuous days (as specified in Policy Schedule) from the date of travel in a Policy Year as per the geography opted.

a. In-Patient Cover (for Emergency)

If an Insured Person is hospitalized for Emergency Care of any Illness or Injury during the Period of Insurance, then the Company will indemnify the Medical Expenses incurred on Hospitalization up to the amount specified against this Benefit in the Policy Schedule, subject to the conditions specified below:

(i) The In-patient Hospitalization is on the written advice

of a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were Medically Necessary; 'Pre-Hospitalization Medical Expenses' and 'Post-Hospitalization Medical Expenses' are not covered under the purview of this Benefit.

(ii) The treatment for the Illness or Injury commences during the Period of Insurance and immediately after the diagnosis of the Illness or occurrence of the Injury;

(iii) Treatment is in line with the applicable treatment procedures at the treating country where the treatment is sought;

(iv) The amount assessed by the Company on each admitted Claim for the Insured Person under this Benefit shall be reduced by the Deductible amount as specified in Policy Schedule. The Company shall be liable to make payment under the Policy for any Claim in respect of the Insured Person only when the Deductible on that Claim is exhausted.

(v) For any Hospitalization less than 24 hours, any Claim under this Benefit will be treated as Day Care Treatment.

b. OPD Cover (for Emergency)

(i) If an Insured Person while on a foreign land needs Out-Patient Treatment for Emergency Care of any Illness or Injury during the Period of Insurance and then the Company will reimburse the Medical Expenses up to the amount specified against this Benefit in the Policy Schedule.

(ii) The amount assessed by the Company on each admitted Claim for the Insured Person under this Benefit shall be reduced by the Deductible amount as specified in Policy Schedule. The Company shall be liable to make payment under the Policy for any Claim in respect of the Insured Person only when the Deductible on that Claim is exhausted.

Additional Exclusion applicable to In-Patient Care and OPD Cover

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

(i) Any treatment, which could reasonably be delayed until the Insured Person's return to the Country of Residence.

(ii) Any type of pre-existing disease or illness or injury .

(iii) Any treatment of orthopedic diseases or conditions except for fractures, dislocations and / or Injuries suffered during the Period of Insurance.

(iv) Degenerative or oncological (Cancer) diseases and Circumcision.

(v) Rest or recuperation at a spa or health resort, sanatorium, convalescence home or any institution which is not a Hospital or Day Care Center

(vi) Routine physical tests and / or examination of any kind not consistent with or incidental to the diagnosis and treatment of any Illness or Injury either in a Hospital or as an outpatient

(vii) Treatment or surgery or any medical procedure (whether invasive or non-invasive) using a robotic surgical system.

(viii) Expenses incurred will not be payable under following conditions:

- Insured decides against the advice of Assistance Service Provider and his/her Medical Practitioner and not get admitted in the Hospital; or
- Return to India after the date which was advised by our Assistance Service Provider and Insured's Medical Practitioner

Additional Documents to be submitted for any Claim under In-Patient Care and OPD Cover

- Release of Medical Information Form(filled and signed by the Insured)
- Passport and Visa copy with Entry Stamp of Country of Visit and exit Stamp from India.

c. Loss of Passport and / or International Driving License

If the Insured Person loses his/her original passport and/or original International Driving License (IDL) while on a foreign land on a valid trip during the Period of Insurance, the Company will pay a fixed amount on an aggregate basis as specified in the Policy Schedule for obtaining a duplicate or new Passport and/or a duplicate or new IDL provided that:

(i) Maximum amount payable under this benefit is 300$/200€ with a sub-limit of 100$/ 75€ for loss of IDL.

Exclusions applicable to this Benefit

(i) Where the loss is not reported to the appropriate police authority in the foreign land within 24 hours of the discovery of the loss, and in respect of which a police report has not been obtained.

(ii) Where the Insured himself has failed to take reasonable steps to guard against the loss of passport or IDL

(iii) Loss or damage to the Insured's passport or IDL as a result of the confiscation or detention by customs, police or any other authority

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

- Copy of the police report
- Details of the attempts made to trace the lost item
- Original receipt for payment of charges to the authorities for obtaining a new or duplicate passport/IDL
- Copy of lost passport or IDL
- Copy of new/duplicate passport/IDL

d. Loss of Checked-in Baggage

The Company will indemnify on reimbursement basis up to the Sum Insured as specified in the Policy Schedule, if the entire Checked-In Baggage is lost at the final destination of the journey or en-route involving multi destination within the airport premises whilst in the custody of the Common Carrier in which the Insured Person was a ticketed passenger provided

that:

(i) The Company's liability to make payment shall not arise until liability is admitted and paid by the Common Carrier in the form of compensation, supported by documentary proof issued by the Common Carrier; and

(ii) Coverage under this Benefit shall commence only after the Checked-in Baggage is entrusted to the Common Carrier and a receipt obtained; and

(iii) If more than one (1) piece of Checked-In Baggage has been checked-in under the same ticket of the Insured Person, the Company's liability shall be restricted to the Proportionate Sum Insured if all the pieces of Checked-In Baggage are not lost; and

(iv) If any Claim for any item lost in respect of which the claim exceeds INR 5000/- or other currency equivalent must be supported by documentation evidencing the insured's ownership and cost of the same, such documentation to be submitted to the Insurance Company/ Claims Administrator in the event of a claim. In the absence of this, the maximum liability shall be restricted to 50% of the cost of this item, subject to maximum INR 5000/- considering same as one item for multiple numbers or quantity; and

(v) For a single checked-in Baggage only, if documentary proof of ownership and cost of any item which is above INR 5000 cannot be provided then the maximum liability of the Company will be up to 75% of the Sum Insured under this Benefit; and

(vi) If the lost / undelivered Checked-In Baggage or portion of it is subsequently traced and offered for delivery to the Insured Person, the Insured Person shall refund the amount paid by the Company under this Benefit in full irrespective of whether delivery of the Baggage is taken or not; and

(vii) Upon discovering the loss of Checked-in Baggage, Insured shall obtain a relevant property irregularity report from the concerned authority and submit the same to the Insurance Company in the event of a Claim;

and

(viii) Any Claim amount paid already under the "Delay of Checked in Baggage' cover will be deducted from the Claim amount payable under this cover; and

(ix) Any remuneration which the Common Carrier is liable to pay will be deducted from the Claim amount payable under this cover.

Exclusions applicable to this Benefit

(i) Any partial loss or damage of any items contained in the Checked-In Baggage.

(ii) Any loss arising from any delay, detention, confiscation by customs officials or other public authorities.

(iii) Any loss due to damage to the Checked-In Baggage or items.

(iv) Any Claim for loss of Valuables

(v) Any loss of Checked-In Baggage sent in advance or shipped separately.

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

- Property irregularity report issued by the appropriate authority.
- Voucher of the Common Carrier for the compensation paid for the non-delivery / short delivery of the Checked-In Baggage.
- Copies of correspondence exchanged, if any, with the Common Carrier in connection with the non-delivery / short delivery of the Checked-In Baggage.
- Proof of ownership and cost for any item which is above INR 5000/-
- Final communication from the common carrier/airlines confirming the checked-in baggage to be lost or untraceable.

e. Delay of Checked-in Baggage

The Company will reimburse a fixed amount as specified in the Policy Schedule if the delivery of the Insured Person's Checked-In Baggage which has been entrusted to the Common Carrier is delayed beyond 12 consecutive hours from the Common Carrier's actual landing time at the Place of Destination during the Period of Insurance provided that:

For a Claim to be Payable under this Benefit, it is a condition precedent that upon discovering the delay in arrival of the Checked-in Baggage the Insured shall obtain a non-delivery confirmation from the Common Carrier along with the period of delay which must be submitted to the Company in the event of a Claim.

Exclusions applicable to this Benefit

(i) Any loss for which a Claim has already been made under Benefit 'Loss of Check-in Baggage'

(ii) Any delay in delivery of the Checked-In Baggage arising out of or resulting from detention or confiscation of the baggage by the Common Carrier or customs or any Government or other agencies.

(iii) Any delay attributable to damage to the Checked-In Baggage warranting an examined delivery by the Common Carrier.

(iv) Delay of Checked-in Baggage when the intended destination is in India

(v) Self-carried or cabin baggage(s)

Additional Documents to be submitted for any Claim under this Benefit

- Property irregularity report issued by the appropriate authority stating the scheduled time of delivery and actual time of delivery of the Checked-In Baggage.
- Voucher of the Common Carrier for the compensation paid for the delay in delivery of the Checked-In Baggage.
- Copies of correspondence exchanged, if any, with the Common Carrier in connection with the delay in delivery of the Checked-In Baggage.

- Acknowledgement receipt from the Airline mentioning date and time of the delivery of the Baggage.

f. Trip Cancellation

If the Insured Person's outward journey as a fare paying passenger from the Country of Residence to an international Place of Destination on a Common Carrier is cancelled before the commencement of the Period of Insurance due to any of the reasons specified herein below, then the Company will indemnify on a reimbursement basis, up to the amount specified against this Benefit in the Policy Schedule, for those travel and accommodation expenses that the Insured incurred and cannot recover and for which no value can be derived without knowledge of the likelihood of cancellation:

(i) The Insured Person, his/her Immediate Family Member or any one of his/her travelling companion dies or is hospitalized in an Emergency due to an Illness or Injury for at least 2 consecutive days provided that such Illness or Injury shall not first occur earlier than 10 consecutive days from the scheduled commencement of the Period of Insurance; or

(ii) Terrorism, Natural Calamity (Earthquake, storm, flood, inundation, cyclone or tempest) at or in the vicinity of the Place of Origin of the journey, the ultimate scheduled Place of Destination or any intermediate place which is involved in or related to the proposed journey; or

(iii) Strikes and Riots provided that the peril takes place prior to the commencement of the Period of Insurance at or in the vicinity of the Place of Origin of the journey, the ultimate scheduled Place of Destination or any intermediate place which is involved in or related to the proposed journey ;or

(iv) Loss of Passport of the Insured Person not earlier than 10 consecutive days from the scheduled commencement of the Period of Insurance; or

(v) Advisory issued by government of any country not to travel, Compulsory quarantine or prevention of travel by government of any country; or

(vi) Presence of the Insured Person is required by judicial authority or law enforcement agency in the course of its proceedings during the Period of Insurance; or

Provided that:

(i) Any amount refunded to the Insured Person by the Common Carrier or Accommodation Provider in relation to the cancellation shall be deducted from the amount payable to the Insured Person under this Benefit; and

(ii) All Claims must be supported by documentary evidence that the Insured Person has been unable to obtain a full refund from the Common Carrier or the accommodation provider even if refund amount is nil; and

(iii) Company shall pay maximum of only one claim per insured under this cover.

Exclusions applicable to this Benefit

(i) Any Cancellation due to hospitalization resulting from pre-existing disease, Childbirth, Pregnancy or related medical complications to Insured, Insured's immediate family or traveling companion.

(ii) Cancellation of the journey either wholly or in partly at the instance of the Common Carrier or by the travel agent, Air transport Authority or any Government body (apart from the reasons listed above in the Coverage Section

(iii) Natural Calamity not declared by appropriate Government authority.

Additional Documents to be submitted for any Claim under this Benefit

- If the reason for Cancellation/Interruption is Medical, Insured needs to produce a Medical Certificate and a discharge summary from the Medical Practitioner attending the patient. This must confirm the reason and need of Cancellation/Interruption.
- Death Certificate(if applicable)
- Copy of cancellation proof of the booked tickets indicating the cost of ticket and receipt for the refund of the fare of the Common Carrier towards the cancelled

portion of the journey indicating cancellation charges retained by the Common Carrier

- Copy of booking as well as cancellation confirmation form the hotel/original scheduled accommodation
- In case of cancellation due to loss of passport, FIR copies for loss of passport
- Judicial or Law enforcement agency order (if applicable)
- Documentary proof of Cancellation of Visa with reason for Cancellation(only for Trip Cancellation due to Cancellation of Visa)
- A declaration from the Insured Person furnishing the circumstances that compelled him to cancel the journey

g. Trip Interruption

If the Insured Person's overseas Trip is unavoidably curtailed(cutting short by early return to India) after the commencement of the Period of Insurance then the Company will indemnify on reimbursement basis up to the limits shown in the Policy Schedule for

- Additional travel costs for returning to the Country of Residence(in the same class as original booking) (if Insured Person cannot use his/her return ticket);
- Additional Accommodation costs (of a similar standard, that the Insured Person had booked for his/her trip)

If any of the following happen after the onset of the trip:

(i) The Insured Person, his/her Immediate Family Member or his/her travelling companion dies or is hospitalized in an Emergency due to an unforeseen Illness or Injury for at least 2 consecutive days ;or

(ii) The Insured Person is unable to continue his/her Trip due to Terrorism, Natural Calamity (Earthquake, storm, flood, cyclone or tempest) at the place of visit ;or

(iii) Strikes and Riots at the place of visit(other than

Insured's hometown) ;or

(iv) Loss of Passport of the Insured Person ;or

(v) Advisory issued by government India or visiting country not to travel; or

(vi) Presence of the Insured Person is required by judicial authority or law enforcement agency in the course of its proceedings during the Period of Insurance;

Provided that:

(i) Company shall pay maximum of only one claim per insured under this cover.

(ii) For ease of return back to the Country of Residence, Insured should inform Assistance Service Provider prior to travel to the Country of Residence

(iii) Any amount refunded to the Insured Person by the Common Carrier or the original place of accommodation in relation to the interruption shall be deducted from the amount payable to the Insured Person under this Benefit.

Exclusions applicable to this Benefit

(i) Any Hospitalization due to Childbirth, Pregnancy or related medical complications to Insured, Insured's immediate family or traveling companion.

(ii) Trip Interruption due to a Natural Calamity not declared by the appropriate government authority

(iii) Any Claim for Trip Interruption where there is no valid Claim for Emergency Treatment under In-Patient Care for the Insured Person and his/her travelling companion if covered with us in the same policy

(iv) Interruption of the journey either wholly or in partly at the instance of the Common Carrier or by the travel agent, Air transport Authority or any Government body (apart from the reasons listed above in the Coverage Section

Additional Documents to be submitted for any Claim

under this Benefit

Additionally, apart from one's mentioned under Trip Cancellation

- A declaration from the Insured Person furnishing the circumstances that compelled him to interrupt the journey
- Details of new bookings for travel with tickets, invoices and receipts

Optional Cover under Travel Plus Benefit –

h. Life Threatening Condition due to PED

By opting this Optional Cover, coverage for Pre-existing diseases for Life Threatening Conditions will be included for In-patient Cover / OPD Cover under 'Travel Plus' up to the limits mentioned in the Policy Schedule.

The scope of the cover is extended to the Trip Interruption benefits where Insured Person is hospitalized due to Emergency Care of any illness.

Provided that:

(i) All the terms and conditions and limits of the applicable Benefits will remain the same; and

(ii) Any Claim under this Clause shall be admissible only till the Insured Person becomes medically stable ; and

(iii) All further Medical Expenses including but not limited to those expenses related to maintaining the medically stable state or to prevent the onset of Acute pain or any further treatment would not be covered by the Company; and

(iv) Above Coverage is only available in case of Life threatening Condition due to Pre-existing Disease and may be subject to sub-limit (if any), Deductible (if any) and Co-pay (if any) as shown in Policy Schedule

Exclusions applicable to this Benefit

(i) Any treatment or part of the treatment which is not Life threatening in nature, and can safely be postponed till the Insured Person's return to Country of Residence.

(ii) Any routine follow-up or treatments pertaining to pre-existing illness/disease

Notes for Clause 3.2.39 (Travel Plus):

i. Intimation must be given to the Company at least 48 hours prior to the date of travel with following documents and details:

a) Date and time of leaving India

b) Date and time of your return to India

c) Flight tickets of the Insured members travelling abroad

d) Flight tickets of the Insured members travelling back to India

ii. Clause 6.1.7(a) of Payment Terms under Claims Procedure and Management is superseded to the extent covered under this Benefit.

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

iv. **Additional Exclusions applicable to any Claim under this Benefit:**

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

1. Medical treatment taken outside the Country of Residence if that is the sole reason or one of the reasons for the journey.

2. Any treatment which is not Medically Necessary and could reasonably be delayed until the Insured Person's return to the Country

of Residence.

3. Any treatment of orthopedic diseases or conditions except for fractures, dislocations and / or Injuries suffered during the Policy Period.

4. Degenerative or oncological (Cancer) diseases.

5. Rest or recuperation at a spa or health resort, sanatorium, convalescence home or similar institution.

6. Any expenses related to services, including Physiotherapy, provided by Chiropractitioner; and the expenses on prostheses / prosthetics (artificial limbs).

7. Traveling against the advice of a Medical Practitioner; or receiving, or is supposed to receive, medical treatment; or having received terminal prognosis for a medical condition; Or taking part or is supposed to participate in war like or peace keeping operation.

3.2.40 Cancer Care

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Benefit, the Company shall indemnify the Medical Expenses incurred in respect of Insured Person who has been previously diagnosed and treated for Cancer and now in good health as certified by Medical Practitioner, maximum up to the amount, as specified in the Policy Schedule.

A) Coverage related to cancer shall be provided as per the option opted from below:

Option 1: Treated and cured cancer condition (Recurrence of Cancer, Metastasis) - Covered up to 25% of Sum Insured per year;

Note: Other Cancers (second malignancy unrelated to first cancer) diagnosed after policy issuance – Covered up to Sum Insured.

Option 2: Any Cancer (including treated and cured cancer

condition) – covered up to 2 times the base SI for lifetime of the Individual.

B) For other conditions, Insured Person shall be eligible for the coverage as available under the Policy.

Conditions applicable under this Benefit:

(i) For a Claim related to cancer will be admissible under this Benefit only if the Claim is admissible under 'Hospitalization Expenses'.

(ii) This Benefit can be opted only at the time of inception of the Policy irrespective of Policy tenure;

(iii) Once opted out, this benefit shall not be available for re-selection during the subsequent renewals;

(iv) For claim purpose under Option 2, no other Benefit where any additional Sum Insured available or accrued shall be considered.

(v) In case of multiple policies, if claim under this benefit is fully paid under single policy then same cannot be payable under rest of policies

(vi) No other Optional Benefit/ add-on can opted once "Cancer Care" option is opted.

(vii) Only individual Policy will be issued for Cancer Care.

3.2.41 Out-patient Consultations

The Company will indemnify the Insured, for availing Physical Consultations with General Physicians and/or with below specified specialist doctors on out-patient basis up to the amount/limit as specified in the Policy Schedule, during Policy Year.

The above benefit is subject to the following conditions:

1. Per consultation limit of Rs.500 will be applicable.

For the purpose of this Base Benefit, list of specialist doctors as follows:

S. No	Specialist Doctors
1	Paediatrician
2	Obstetrics and Gynecologist

3	Homeopathic Physician
4	Dietician
5	Diabetologist
6	Dermatologist
7	Pulmonologist
8	Psychiatrist
9	Cardiologist
10	Neurologist
11	Orthopedic Surgeon
12	Nephrologist
13	ENT Specialist
14	Gastroenterologist

3.2.42 Out-patient Dental and Vision Care

A. The Company will indemnify the Insured Person up to the amount as specified in the Policy Schedule, for the Dental Expenses incurred by the Insured Person towards the following:

(i) Dental consultations - Emergency Palliative Treatment of Dental pain and minor procedures

(ii) Conservative – per tooth

a. Amalgam 1 – 5 surfaces, Permanent

b. Metallic Inlay, 1 – 5 surfaces, Permanent (Gold Inlay)

c. Composite resin 1-5 surfaces, Permanent

(iii) Extractions - per tooth

a. Simple extraction – erupted tooth or exposed root

b. Complicated extraction, tooth or root partially bony

c. Removal of impacted, completely bony

(iv) Radiology

a. X-ray intra-oral / bitewing

b. Posterior – anterior or lateral skull and facial bone survey film

c. Each additional x-ray bitewing

d. Panoramic x-ray

(v) Periodontal

a. Provision splinting – extracoronal

b. Gingivectomy or ginigivoplasty Per tooth

c. Root amputation – per root

(vi) Endontic

a. Root canal– x-ray included

b. Therapeutic pulotomy (excluding final restoration)

In case of Accidental Damage to natural teeth following the accident, the treatment for the same shall be taken immediately within thirty (30) days following damage, then the Company will indemnify up to the amount specified in the Policy Schedule.

Optional Benefit is not payable if:

(i) injury caused during participation in professional /Adventurous sports;

(ii) the damage was caused by normal wear and tear;

(iii) the damage was caused by tooth brushing or any other oral hygiene procedure;

(iv) the damage was caused as the result of consumption of food or drink;

(v) damage was not apparent within 7 days of impact which caused the injury

Note: All dental treatments must be carried out by a qualified dentist.

B. The Company will indemnify up to the amount as specified in the Policy Schedule, for the Medical Expenses related to consultations/ prescribed diagnostic tests/ treatments incurred by the Insured for Vision Care.

The Company will pay for fees charged for corrective spectacle lenses (with frame) or contact lenses as prescribed

by the ophthalmologist or optometrist. This benefit also pays for one time routine eye examination carried out by an ophthalmologist or optometrist per Policy Year.

This benefit does not pay for tinted / reactive lenses, sunglasses, non-corrective contact lenses, lasik / laser eye surgery, medical or surgical treatment of the eye(s) and/or similar, whether prescribed or not.

Note: -Wait Period shall be applicable as specified in Policy Schedule.

3.2.43 Physical Consultations with General Physicians

The Company will indemnify the Insured, for availing Physical Consultations with General Physicians on out-patient basis up to the amount/limit as specified in the Policy Schedule, during the Policy Year.

The above benefit is subject to the following conditions:

(i) Co-payment of 10% per claim is applicable if per consultation limit opted is greater than Rs.500

3.2.44 Physical Consultations with Specialist Doctors

The Company will indemnify the Insured, for availing physical Consultations with below specified specialist doctors on out-patient basis up to the amount/limit as specified in the Policy Schedule, during the Policy Year.

For the purpose of this Base Benefit, list of specialist doctors as follows:

S. No	Specialist Doctors
1	Paediatrician
2	Obstetrics and Gynecologist
3	Homeopathic Physician
4	Dietician
5	Diabetologist
6	Dermatologist
7	Pulmonologist
8	Psychiatrist
9	Cardiologist
10	Neurologist

11	Orthopedic Surgeon
12	Nephrologist
13	ENT Specialist
14	Gastroenterologist

The above base benefit is subject to the following conditions:

1. Co-payment of 5% per claim is applicable if per consultation limit opted is greater than or equal to Rs.1000.

3.2.45 OPD Diagnostics

If this Optional Benefit is opted, then the Company will indemnify the Insured, up to the amount as specified in the Policy Schedule, for medical expenses incurred by the Insured for outpatient diagnostic tests as prescribed by Medical Practitioner in relation to any Illness contracted or Injury suffered by the Insured during the Policy Year.

For the purpose of this Optional Benefit:

1. Genetic studies shall not be covered under this Optional Benefit.

3.2.46 OPD Pharmacy

The Company will indemnify the Insured, for availing Out-Patient Pharmacy expenses, as prescribed by Medical Practitioner, up to the amount as specified in the Policy Schedule.

The above base benefit is subject to the following conditions:

1. Health supplements, Nutraceuticals, foods for special dietary use, foods for special medical purpose, foods with added probiotics and/or foods with added prebiotics, vaccinations, vitamins, tonics or other related products are not covered under this Benefit.

3.2.47 OPD Care

The Company will indemnify the Insured Person, only through Reimbursement Facility, for availing Out-Patient consultations, Diagnostic Examinations and Pharmacy expenses, up to the amount as specified in the Policy Schedule, during the Policy Year, subject to the following condition:

- Coverage for Optional Benefit 'OPD Care' is provided for

entire Policy Year and is available to all the Insured members in a Floater Policy type along with Individual Policy type.

- All the valid OPD claim expenses incurred by the Insured Person in a Policy Year will be payable / reimbursed by the Company. However, claim can be filed with the Company, only twice during that Policy year, as and when that Insured Person may deem fit.

3.2.48 Women Support Program

If this Optional Benefit is opted then the Company shall provide the online comprehensive services designed to support and enhance the health of female Insured Person through the Company's network during the Policy Period.

The women support program offers services for the following conditions:

a) PCOS/ PCOD, Osteoporosis, PMS

b) Anaemia

c) STI

d) UTI

e) Cervical Cancer/ Breast Cancer

f) Contraception

Services offered under this program are: up to 6 virtual consultations with gynecologist and psychologist, specialized curated content access, unlimited live exercise classes, webinars, personal nutritionist etc.

Note: This benefit is available only for women Insured Person aged 12 years and above.

3.2.49 Premium Freeze

If this Optional Benefit is opted, then the Insured Person age will be locked at entry when a policy is purchased 1st time with the Company until a claim is paid. Once the claim is paid, the premium will be charged as per the Insured Person's current age and will continue to change as per the age at each subsequent renewal.

Conditions applicable:

i) In case of multi tenure policies, the premium for the entire

Policy will be charged as per the age.

ii) If Policy tenure is modified at the renewal from the originally selected Policy term, premium will be recalculated based on locked age of Insured Person corresponding to revised tenure.

iii) No additional premium will be charged In the middle of the Policy tenure in case of claims. Upon renewal after claim, the premium will be charged as per the current age of the Insured Person at the time of renewal.

iv) In case of addition of a member, in an existing floater plan or by converting individual plan to floater plan, then the premiums will be determined based on the entry age of the eldest Insured Person and locked until a claim is paid.

v) If the eldest member exits the floater plan, then the floater premium will be calculated as per the original entry age of the next eldest member in the Policy amongst the remaining members and locked until a claim is paid.

vi) If a floater plan splits into multiple individual policies, then the Company shall carry forward the locked age at which the floater policies were taken by individuals based on claim history, until a claim is paid.

vii) In a multi individual policy, the age will unlock only for the individuals who claim.

viii) In a floater policy, if a claim is paid for anyone in the Policy then the Company will unlock the age for the entire policy.

ix) In the event of premium change due to product revision, the premium will be charged based on the locked age of the revised Product.

x) This Benefit shall lapse, if a 'Hospitalization Expenses' related claim is paid except under Benefit: Travel Plus, Maternity Cover, Born Baby Cover, New born External Congenital Disease/Defects, Assisted Reproductive Treatment, Surrogacy Care, Oocyte Care, Cancer Care.

4. EXCLUSIONS

4.1. Standard Exclusions:

(a) Waiting Periods:

(i) Pre-Existing Diseases: Code- Excl01

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

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

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

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

(ii) Named Ailment Waiting Period: Code- Excl02

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

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

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

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

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

f. List of specific diseases/procedures:

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

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

a. Expenses related to the treatment of any illness within

30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

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

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

Notes:

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

(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.

(iii) Waiting Period defined as per Clause 4.1(a)(i),(ii),(iii) does not apply on Benefits: Health Services, Unlimited E-Consultations, Be-Fit Plus Benefit, Concierge/ Geriatric Care, Annual Health Check-up, Smoking & Alcohol Rehabilitation, Travel Plus, Women Support Program.

(iv) Initial Waiting Period defined as per Clause 4.1(a)(iii) shall only be applicable on Benefits: Women Care, Mental Health Wellbeing, Out-patient Consultations, Physical Consultations with General Physicians, Physical Consultations with Specialist Doctors, OPD Diagnostic tests, OPD Pharmacy, OPD Care.

(b) Permanent Exclusions:

Any Claim of an Insured Person arising due to any of the following shall not be admissible unless expressly stated to the contrary

elsewhere in the Policy Terms and conditions.

1. Investigation & Evaluation: (Code- Excl04)

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

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

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

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

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

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

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

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

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

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

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

4) Body Mass Index (BMI);

a) greater than or equal to 40 or

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

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

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

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

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

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

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

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

7. Breach of law: (Code- Excl10)

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

8. Excluded Providers: (Code- Excl11)

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

Note: Refer Annexure – 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 eligible and entitled for Benefit: 'New Born Vaccination' and 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.

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

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

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

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

    a. Nuclear attack or weapons means the use of any nuclear

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

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

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

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

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

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

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

23. Hormone replacement therapy.

24. Any Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs, alcohol, hallucinogens, smoking.

25. Any treatment or part of treatment or any expenses incurred under this Policy that is not reasonable and customary and/or not medically necessary.

Additional exclusions applicable for 'Travel Plus'

26. The Insured Person is :

(i) Traveling against the advice of a Medical Practitioner; or

(ii) Receiving, or is supposed to receive, medical treatment; or

(iii) Having received terminal prognosis for a medical condition; or

(iv) Travelling for the purpose of obtaining medical treatment; or

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

28. Any dental treatment or surgery unless necessitated due to an Injury or any Acute Pain

29. All expenses related to donor screening, treatment, including surgery to remove organs from the donor, in case of transplant surgery.

30. Stem cell implantation, harvesting, storage or any kind of treatment using stem cells.

31. The Insured Person engaged in any air travel unless he is flying as a passenger on an airline.

32. Travel by any Insured Person against whom general or special travel restrictions have been imposed.

33. Any consequential losses.

34. Any specific time-bound or lifetime exclusions 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 /reject the claim, 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 may be, within 15 days from the date of intimation on 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 intimation 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 15 days from the date of intimation on receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of intimation on 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 intimation 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 7 days 'written notice and in such an event, the Company shall refund proportionate premium for the unexpired policy period.

(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) If the risk under the Policy has already commenced, or only a part of the insurance coverage has commenced, and the option of Policy cancellation is exercised by the Policyholder, then the expenses such as pre- policy medical examination etc. incurred by the Company will also be deducted before refunding of premium.

(d) 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 and the Company shall refund proportionate premium for unexpired Policy Period 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 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 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 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. lf 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 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 established fraud or non-disclosure or misrepresentation by the Insured Person.

i. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.

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

iii. 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.

iv. 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 a one-time option to renew the existing product, if renewal falls within the 90 days from the date of withdrawal of the product or 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 etc. as per IRDAI guidelines, provided the policy has been maintained without a break.

5.12. Moratorium Period

After completion of five continuous years under the policy no look back to be applied. This period of five years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of five 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 fifteen days where premium payment mode is monthly and thirty days in all other cases would be given to pay the installment premium due for the policy
2. During such grace period, coverage shall be available, if the premium is paid in installments during the policy period.
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 hospitalization related 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 may revise or modify the terms of the policy including the premium rates. The Insured Person shall be notified 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 thirty days 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/customer-grievance-redressal.html

Mobile App : Care Health- Customer App

Toll free (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 or current residing address at his own expense. The Company may adjust the scope of cover and / or the premium paid or payable/reject the claim, 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 /Assistance Service Provider for approval. Only upon due approval from the Company / Assistance Service ProviderCashless 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/ Assistance Service Provider 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 or the Assistance Service Provider 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 / Assistance Service Provider, then payment for the Medical Expenses incurred in respect of the Insured Person shall not have to be made to the extent that such Medical Expenses are covered under this 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 / Assistance Service Provider 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 / Assistance Service Provider 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 / Assistance Service Provider 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 or the Assistance Service Provider'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 or the Assistance Service Provider shall be notified with full particulars within 48 hours from the date of occurrence of event either at the Company's / Assistance Service Provider'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 / Assistance Service Provider at the time of intimation of Claim :

1. Policy Number;
2. Name of the Policyholder;
3. Name and address 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 / Assistance Service Provider shall be notified either at the Company's / Assistance Service Provider'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 / Assistance Service Provider shall be notified either at the Company's/ Assistance Service Provider'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 registration of 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 and claim will be registered only on submission of below documents. The date of submission of such information shall be deemed as date of claim registration for the purpose of claim processing:

1. Duly filled and signed Claim form by the Insured Person;
2. Copy of Photo ID and address proof of Insured Person;
3. Medical Practitioner's first consultation paper and referral letter advising Hospitalization;

4. Medical Practitioner's prescription advising drugs or diagnostic tests or consultations;

5. Original numbered bills/ receipts and discharge summary from the Hospital/Medical Practitioner;

6. Original numbered bills from licensed pharmacy/chemists;

7. Original pathological/diagnostic test reports/radiology reports and payment receipts;

8. Operation Theatre Notes(if applicable);

9. Emergency Notes, Initial Assessment Sheet and 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(ix) and 3.2.24.

(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) Plus benefit , as applicable

(iii) Loyalty Boost, as applicable

(iv) Inflation Shield, as applicable

(v) Cumulative Bonus

(vi) Infinity Bonus, as applicable

(vii) Unlimited Automatic Recharge

(viii) Unlimited Automatic Recharge Booster, 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 15 days of intimation on 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.

(f) The Policy covers Reasonable and Customary Charges incurred towards medical treatment taken or any other expenses triggers under any Benefit during the Policy Period.

(g) Under this Policy, the Company's total, cumulative, maximum liability during the Policy Year is maximum up to the Sum Insured unless any additional Sum Insured available or accrued under any Benefit.

(h) For diseases or conditions or procedure that have a specified sub-limit then all related expenses shall be covered up to the sub-limit specified for that disease or condition or procedure. In case there is a specified sub-limit then the Company's total, cumulative, maximum liability during the Policy Year is maximum up to the specified sub-limit subject to the available Sum Insured in the Policy Year.

For example- if the Policy specifies a sub-limit of Rs. 50,000 for a particular disease then all expenses related to the treatment of that disease (including but not limited to pre-hospitalization,

hospitalization and post- hospitalization) will be covered up to Rs.50,000, subject to Sum Insured availability in the Policy Year even if the overall Sum Insured is higher.

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

SR. NO.	List I – Optional Items		
1	Baby Food	30	Medical Certificate
2	Baby Utilities Charges	31	Medical Records
3	Beauty Services	32	Photocopies Charges
4	Belts/ Braces	33	Mortuary Charges
5	Buds	34	Walking Aids Charges
6	Cold Pack/hot Pack	35	Oxygen Cylinder (for Usage Outside The Hospital)
7	Carry Bags		
8	Email / Internet Charges	36	Spacer
9	Food Charges (other Than Patient's Diet Provided By Hospital)	37	Spirometre
		38	Nebulizer Kit
		39	Steam Inhaler
10	Leggings	40	Armsling
11	laundry Charges	41	Thermometer
12	mineral Water	42	Cervical Collar
13	Sanitary Pad	43	Splint
14	Telephone Charges	44	Diabetic Foot Wear
15	Guest Services	45	Knee Braces (long/ Short/ Hinged)
16	Crepe Bandage		
17	Diaper Of Any Type	46	Knee Immobilizer/shoulder Immobilizer
18	Eyelet Collar		
19	Slings		
20	Blood Grouping And Cross Matching Of Donors Samples	47	Lumbo Sacral Belt
		48	Nimbus Bed Or Water Or Air Bed Charges
21	Service Charges Where Nursing Charge Also Charged		
		49	Ambulance Collar
22	Television Charges	50	Ambulance Equipment
23	Surcharges	51	Abdominal Binder
24	Attendant Charges	52	Private Nurses Charges Special Nursing Charges
25	Extra Diet Of Patient (other Than That Which Forms Part Of Bed Charge)		
		53	Sugar Free Tablets
26	Birth Certificate	54	Creams Powders Lotions (toiletries Are Not Payable, Only Prescribed Medical Pharmaceuticals
27	Certificate Charges		
28	Courier Charges		
29	Conveyance Charges		

	Payable)
55	Ecg Electrodes
56	Gloves
57	Nebulisation Kit
58	Any Kit With No Details Mentioned [delivery Kit, Orthokit, Recovery Kit, Etc]
59	Kidney Tray
60	Mask
61	Ounce Glass
62	Oxygen Mask
63	Pelvic Traction Belt
64	Pan Can
65	Trolly Cover
66	Urometer, Urine Jug
67	Ambulance
68	Vasofix Safety

Sr. No.	List II – Items That Are To Be Subsumed Into Room Charges
1	Baby Charges (unless Specified/indicated)
2	Hand Wash
3	Shoe Cover
4	Caps
5	Cradle Charges
6	Comb
7	Eau-de-cologne / Room Freshners
8	Foot Cover
9	Gown
10	Slippers
11	Tissue Paper
	Tooth Paste

12	Tooth Paste
13	Tooth Brush
14	Bed Pan
15	Face Mask
16	Flexi Mask
17	Hand Holder
18	Sputum Cup
19	Disinfectant Lotions
20	Luxury Tax
21	Hvac
22	House Keeping Charges
23	Air Conditioner Charges
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 III – Items That Are To Be subsumed into Procedure Charges
1	Hair Removal Cream
2	Disposables Razors Charges (for Site Preparations)
3	Eye Pad
4	Eye Sheild
5	Camera Cover
6	Dvd, Cd Charges
7	Gause Soft

8	Gauze
9	Ward And Theatre Booking Charges
10	Arthroscopy And Endoscopy Instruments
11	Microscope Cover
12	Surgical Blades, Harmonicscalpel,shaver
13	Surgical Drill
14	Eye Kit
15	Eye Drape
16	X-ray Film
17	Boyles Apparatus Charges
18	Cotton
19	Cotton Bandage
20	Surgical Tape
21	Apron
22	Torniquet
23	Orthobundle, Gynaec Bundle

Sr. No.	List iv – Items that are to be subsumed into costs of treatment
1	Admission/registration Charges
2	Hospitalisation For Evaluation/ Diagnostic Purpose
3	Urine Container
4	Blood Reservation Charges And Ante Natal Booking Charges
5	Bipap Machine
6	Cpap/ Capd Equipments
7	Infusion Pump– Cost
8	Hydrogen Peroxide\spirit\ Disinfectants Etc
9	Nutrition Planning Charges - Dietician Charges- Diet Charges
10	Hiv Kit
11	Antiseptic Mouthwash
12	Lozenges
13	Mouth Paint
14	Vaccination Charges
15	Alcohol Swabes
16	Scrub Solution/sterillium
17	Glucometer & Strips
18	Urine Bag

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

Hospital Name	Address
Nulife Hospital And Maternity Centre	1616 Outram Lines,Kingsway Camp,Guru Teg Bahadur Nagar , New Delhi , Delhi
Taneja Hospital	F-15,Vikas Marg, Preet Vihar , New Delhi , Delhi
Shri Komal Hospital & Dr.Saxena's Nursing Home	Opp. Radhika Cinema,Circular Road , Rewari , Haryana
Sona Devi Memorial Hospital & Trauma Centre	Sohna Road, Badshahpur , Gurgaon , Haryana
Amar Hospital	Sector-70,S.A.S.Nagar, Mohali, Sector 70 , Mohali , Punjab
Brij Medical Centre	K K 54, Kavi Nagar , Ghaziabad , Uttar Pradesh
Famliy Medicare	A-55,Sector 61, Rajat Vihar Sector 62 , Noida , Uttar Pradesh
Jeevan Jyoti Hospital	162,Lowther Road, Bai Ka Bagh , Allahabad , Uttar Pradesh
City Hospital & Trauma Centre	C-1,Cinder Dump Complex,Opposite Krishna Cinema Hall,Kanpur Road, Alambagh , Lucknow , Uttar Pradesh
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

Hospital Name	Address
Shreedevi Hospital	Akash Arcade,Bhanu Nagar,Near Bhanu Sagar Theatre,Dr.Deepak Shetty Road, Kalyan D.C. , Thane , Maharashtra
Saykhedkar Hospital And 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
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

Hospital Name	Address
East West Medical Centre	No.711,Sector 14, Sector 14 , Gurgaon , Haryana
Jagtap Hospital	Anand Nagar,Sinhgood Road , Anandnagar , Pune , Maharashtra
Dr. Malwankar's Romeen Nursing Home	Ganesh Marg,Tagore Nagar , Vikhroli East , Mumbai , Maharashtra
Noble Medical Centre	SVP Road, Borivali West , Mumbai , Maharashtra
Rama Hospital	Sonepat Road,Bahalgarh, Sonipat , Haryana
S.B.Nursing Home & ICU	Lake Bloom 16,17,18 Opposite Solaris Estate, L.T.Gate No.6,Tunga Gaon, Saki-Vihar Road, Powai , Mumbai , Maharashtra
Saraswati Hospital	Divya Smruti Building, 1st Floor, Opp Toyota Showroom, Malad Link Road, Malad West , Mumbai , Maharashtra
Shakuntla Hospital	3-B Tashkant Marg,Near St. Joseph Collage, Allahabad , Uttar Pradesh
Mahaveer Hospital & Trauma Centre	76-E,Station Road, Panki , Kanpur , Uttar Pradesh
Eashwar Lakshmi Hospital	Plot No. 9,Near Sub Registrar Office, Gandhi Nagar , Hyderabad , Andhra Pradesh
Amrapali Hospital	Plot No. NH-34,P-2,Omega -1, Greater Noida , Noida , Uttar Pradesh
Hardik Hospital	29c,Budh Bazar, Vikas Nagar , New Delhi , Delhi
Jabalpur Hospital & Research Centre Pvt Ltd	Russel Crossing,Naptier Town, Jabalpur , Madhya Pradesh
Panvel Hospital	Plot No. 260A,Uran Naka, Old Panvel , Navi Mumbai , Maharashtra
Santosh Hospital	L-629/631,Hapur Road, Shastri Nagar , Meerut , Uttar Pradesh

Hospital Name	Address
Sona Medical Centre	5/58,Near Police Station, Vikas Nagar , Lucknow , Uttar Pradesh
City Super Speciality Hospital	Near Mohan Petrol Pump,Gohana Road, Rohtak , Haryana
Navjeevan Hospital & Maternity Centre	753/21,Madanpuri Road, Near Pataudi Chowk , Gurgaon , Haryana
Abhishek Hospital	C-12,New Azad Nagar, Kanpur , Kanpur , Uttar Pradesh
Raj Nursing Home	23-A, Park Road , Allahabad , Uttar Pradesh
Saras Healthcare Pvt Ltd.	K-112, SEC-12 ,Pratap Vihar , Ghaziabad , Uttar Pradesh
Getwell Soon Multispeciality Institute Pvt Ltd	S-19, Shalimar Garden Extn. , Near Dayanand Park, Sahibabad , Ghaziabad , Uttar Pradesh
Shivalik Medical Centre Pvt Ltd	A-93, Sector 34 , Noida , Uttar Pradesh
Aakanksha Hospital	126, Aaradhnanagar Soc,B/H. 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	Aris Care Hospital
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

Hospital Name	Address
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

Hospital Name	Address
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 Benefit "Smart Select"

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

Hospital Name	Address
Fortis Flt.Lt.Rajan Dhall Hospital	Sector B,Pocket 1, Aruna Asif Ali Marg, Vasant Kunj, New Delhi – 110070
Fortis Escorts Ltd.	Majtha-Verka Bypass Road, Khanna Nagar, Amritsar – 143004
Fortis Escorts Hospital	Jawahar Lal Nehru Marg, Opposite Hotel Clarks Amer, Malviya Nagar, Jaipur – 302017
Fortis Sl Raheja Hospital	Raheja Raghunalaya Marg, Near New Police Quarters Colony, Mahim, Mumbai – 400016
Hiranandani Fortis Hospital	Mini Sea Shore Road, Sector 10A, Vashi, Maharashtra – 400703
Fortis Malar Hospital	52,First Main Road, Gandhi Nagar, Adyar, Chennai – 600020
Fortis Hospital	Sector 62,Phase VIII, Sector 62, Mohali – 160062
Maxcure Mediciti Hospitals	5-9-22,Secretariat Road, Hill Fort, Hyderabad – 500063
Maxivision Laser Centre Pvt. Ltd.	40-1-48,Krishna Sai Bhavan, Opposite D.V.Manor Hotel, Labbipeta, Vijayawada – 520010
Maxivision Laser Centre Pvt. Ltd.	1-11-252/1A To 1D,Alladin Mansion, Street No 3, Begumpet, Hyderabad – 500016
Maxivision Laser Centre Pvt. Ltd.	No.16-11-741/D/66, Dilsukhnagar, Moosa Ram Bagh, Hyderabad – 500036
Maxivision Laser Centre Pvt. Ltd.	6-9-903/A/1/1, Somajiguda, Hyderabad – 500082
Fortis Hospitals Ltd	No.730, EM Bypass Road, Anandpur, Kolkata – 700107
Fortis Hospital Ltd	Mulund Goregaon Link Road, Mulund, Mumbai – 400078

Hospital Name	Address
Fortis Health Management Ltd	No.23 80 Feet Road,Guru Krupa Layout, 2nd Stage, Nagarbhavi, Bangalore – 560072
Fortis Hospital	A Block, Shalimar Bagh, New Delhi – 110088
Fortis Hospitals Ltd.	111A, Rash Behari Avenue, Rashbehari Avenue, Kolkata – 700029
Fortis Hospital Ltd.-Wockhardt	154,9, Opposite IIM-B, Bannerghatta Road, Bangalore – 560076
Fortis Hospital Ltd.-Wockhardt	No 14,Cunningham Road, 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

Hospital Name	Address
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
International Hospital Limited - Fortis Hospital Ltd	No.111,West of Chord Road, 1st Block Junction, Rajajinagar, Bangalore – 560086
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, 6th floor, Tilak Marg, Near S.V College Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 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, LIC of India Zonal Office Building, 1st Floor, South Wing, Jeevan Shikha, opp. Gayatri Mandir, 60-B, Hoshangabad Road, Bhopal-462011Tel.: 0755 - 2769201 / 2769202/ 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh & Chhattisgarh

BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar – 751 009. Tel.: 0674 - 2596461 /2596455/ 2596429/ 2596003 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa
CHANDIGARH	Office of the Insurance Ombudsman, Jeevan Deep, Ground Floor, LIC of India Building, SCO 20-27, Sector 17-A, Chandigarh – 160 017. Tel.: 0172 – 2706468/ 2707468 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 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 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, 1st Floor, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481 / 23213504/ 46013992 Email: bimalokpal.delhi@cioins.co.in	Delhi, Haryana- Gurugram , Faridabad , Sonepat & Bahadurgarh

GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh Building, 5th Floor, Nr. Panbazar, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 – 2632204/ 2632205 / 2631307 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. Hyundai Showroom, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122/ 23376599/ 23376991/ 23328709/ 23325325 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana and Yanam – a part of Territory of Pondicherry
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Ambedkar Circle Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@cioins.co.in	Rajasthan
KOCHI	Office of the Insurance Ombudsman, 10TH Floor, LIC Building, Jeevan Prakash Opp. Maharaj College Ground M.G. Road,Ernakulam - 682 011. Tel.: 0484 - 2358759 Email:bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe – a part of Pondicherry

KOLKATA	Office of the Insurance Ombudsman, 7th Floor of Hindusthan Bldg.(Annex), 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 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 – 4002082/ 3500613 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 West, Mumbai - 400 054. Tel.: 022 –69038800/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
PATNA	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan,	Bihar, Jharkhand

	Baily Road, Patna Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120- 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
PUNE	Office of the Insurance Ombudsman, Jeevan Darshan- LIC of India Bldg., 3rd Floor, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 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.carehealthinsurance.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 : 022-69038800/33

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)

PLEASE NOTE :

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

Policyholder Details

Mr. ☐ Ms. ☐ M/S. ☐ Policy No : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Name : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

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

Mr. ☐ Ms. ☐ M/S. ☐ Policy No : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

Occupation: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ and / or

Proof of Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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 Insure (Rs.)	Premium (Rs.)	Discount (if any)	Premium after discount(Rs.)	Sum Insure (Rs.)	Premium or consolidate premium for all members of famil (Rs.)	Floate Discount (if any)	Premium after discount(Rs.)	Sum Insure (Rs.)
46	13,885	5,00,000	13,885	5.00 %	13,191	5,00,000	24,622	NA	24,622	5,00,000
51	17,402	5,00,000	17,402	5.00 %	16,532	5,00,000				
Total Premium for all members of family is Rs.31,287 when each member is covered separately. Sum Insured available for each individual is Rs. 5,00,000			Total Premium for all members of family is Rs.29,722 when they are covered under a single policy Sum Insured available for each family member is Rs. 5,00,000				Total Premium when policy is opted on floater basis is Rs. 24,622 Sum Insured of Rs. 5,00,000 is available for entire family			

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 consolidate premium for all members of famil (Rs.)	Floate Discount (if any)	Premium after discount(Rs.)	Sum Insured (Rs.)
46	13,885	5,00,000	13,885	5.00 %	13,191	5,00,000	30,120	NA	30,120	5,00,000
51	17,402	5,00,000	17,402	5.00 %	16,532	5,00,000				
17	6,491	5,00,000	6,491	5.00 %	6,166	5,00,000				
Total Premium for all members of family is Rs.37,778 when each member is covered separately Sum Insured available for each individual is Rs. 5,00,000			Total Premium for all members of family is Rs.35,889 when they are covered under a single policy Sum Insured available for each family member is Rs. 5,00,000				Total Premium when policy is opted on floater basis is Rs. 30,120 Sum Insured of Rs. 5,00,000 is available for entire family			

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 Insure (Rs.)	Premium (Rs.)	Discount (if any)	Premium after discount(Rs.)	Sum Insure (Rs.)	Premium or consolidate premium for all members of famil (Rs.)	Floate Discount (if any)	Premium after discount(Rs.)	Sum Insure (Rs.)
61	32,898	5,00,000	32,898	5.00 %	31,253	5,00,000	54,584	NA	54,584	5,00,000
64	39,948	5,00,000	39,948	5.00 %	37,951	5,00,000				
Total Premium for all members of family is Rs.72,846 when each member is covered separately. Sum Insured available for each individual is Rs. 5,00,000			Total Premium for all members of family is Rs.69,203 when they are covered under a single policy Sum Insured available for each family member is Rs. 5,00,000				Total Premium when policy is opted on floater basis is Rs. 54,584 Sum Insured of Rs. 5,00,000 is available for entire family			

Notes:

1. Premium rates (excl. taxes) specified in above illustration shall be standard premium rates for 4th year.
2. Premiums considered are of Zone 1
3. Vintage basis discount on the premiums shall be applicable basis on type of Policy i.e. New / Portability / Migration. In case of Portability or Migration, the discount (if applicable) shall be as per the total continuous Policy Years of previous Policies without break.

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: CHIHLIP25044V012425
IRDAI Registration Number - 148

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Care Health-
Customer App

WhatsApp
8860402452

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

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

Ver: Jan'25/AS