carē HEALTH® INSURANCE

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

INDIA INSURANCE SUMMIT & AWARDS 2024

supreme enhancē

Know Your Policy Better

Policy Terms and Conditions

1. Preamble

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

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

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

Please check whether the details given by you about the Insured Persons in the proposal form (a copy of which was provided at the time of issuance of cover for the first time) are incorporated correctly in the policy schedule. If you find any discrepancy, please inform us within 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.

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

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

2. DEFINITIONS

2.1. Standard Definitions:

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

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

(a) Central or State Government AYUSH Hospital or

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

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

i. Having at least 5 in-patient beds;

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

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

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

2.1.3. AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such center which is registered with the local authorities, wherever applicable, and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on

day care basis without in-patient services and must comply with all the following criterion:

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

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

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

2.1.4. **AYUSH treatment**: refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga, 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 (not applicable for Overseas Travel Insurance) means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

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

2.1.24. 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 (not applicable for Overseas Travel Insurance) means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

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

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

c. Must have been prescribed by a Medical Practitioner;

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

2.1.31. 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. 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.

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

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

2.2.5. 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.

2.2.6. 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.

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

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

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

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

2.2.11. **Indemnity/Indemnify** means compensating the Insured Person up to the extent of Expenses incurred, on occurrence of an event which results in a financial loss and is covered as the subject matter of the Insurance Cover.

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

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

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

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

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

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

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

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

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

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

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

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

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

2.2.25. **Rehabilitation** means assisting an Insured Person who, following a Medical Condition,

requires assistance in physical, vocational, independent living and educational pursuits to restore him to the position in which he was in, prior to such medical condition occurring.

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

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

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

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

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

3. BENEFITS COVERED UNDER THE POLICY

GENERAL CONDITIONS APPLICABLE TO ALL THE BENEFITS AND OPTIONAL BENEFITS

1. 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. Deductible will be applicable on the aggregate basis of all admissible claims in a Policy year under Plan A while Deductible will be applicable on per claim basis of all admissible claims in a Policy year under Plan B.

3. 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, unless eligible as Adult to be covered under this Policy.

4. 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.

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.

5. Deductible is applicable for Base Benefits – Hospitalization Expenses, Road Ambulance Cover, Optional Benefits – Global Coverage, Unlimited Care and Air Ambulance Cover .

6. Coverage under 'Global Coverage' Optional Benefit is restricted only to Base Benefits – In-patient Care and Day Care Treatments.

7. Any Claim paid for Benefits under Hospitalization Expenses, Road Ambulance Cover, Global Coverage, Air Ambulance Cover the amount 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.

8. Admissibility of a Claim under Benefit "In-patient Care/ Day Care treatment" is a pre-condition to the admission of Claim under Road Ambulance Cover, Pre and Post Hospitalization Medical Expenses, Organ Donor Cover, Optional Benefits: Daily Cash Allowance, Air Ambulance Cover in the event giving rise to a Claim under Benefit "In-patient Care" shall be within the Policy Period for the Claim of such Benefit to be accepted.

9. If Insured Persons are covered on an Individual basis, then every Insured Person can opt from different Sum Insured and Deductible Options. If Insured Persons are covered on Floater basis, then the Sum Insured and Deductibles opted shall be available to all Insured Persons under floater policy unless specifically mentioned/catered to in the Policy.

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

3.1. BASE BENEFITS (Plan A)

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

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

(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 eimbursement 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 180 days from the date of discharge from the hospital.

(vi) **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.

(vii) 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.

(viii) 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 defined AYUSH treatment 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'.

(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.

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

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

ii. The eligible Room Rent or Room Category applicable for the Insured Person under the Policy is 'Single Private AC room".

iii. 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.

iv. 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.

3.1.2 Road Ambulance Cover

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

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

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

(iii) Such Transportation is from one Hospital to another Hospital for the purpose of providing 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 10% flat, on a cumulative basis, as a Cumulative Bonus 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) The 'Unlimited Automatic Recharge' amount shall not be considered while calculating 'Cumulative Bonus'.

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

(xi) Cumulative Bonus would be credited automatically to the subsequent Policy year, even in case of multi-year Policies (with 2 or 3 year policy tenure).

3.1.4 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 has been completely exhausted in that Policy Year.

(ii) A Claim will be admissible under the Recharge only if the Claim is admissible

under Benefit 'Hospitalization Expenses'.

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

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

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

(vi) Applicable Cumulative Bonus Benefit shall not be considered while calculating 'Unlimited Automatic Recharge'.

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

3.2. OPTIONAL BENEFITS (Plan A)

3.2.1 Global Coverage:

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

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

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

Note: The above condition is applicable for Option1.

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

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

1. Planned & Emergency Hospitalization is covered as per the opted plan mentioned in the policy schedule.
2. This Benefit is available only up to the purview of Coverage available under this Policy
3. The Medical expenses payable shall be limited to Inpatient Care & Day Care Treatment under Benefit: Hospitalization Expenses only;
4. The Advance Technology Methods shall be covered under Inpatient Care & Day Care Treatment as listed in Base Benefit 3.1.1(iii)
5. 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.
6. Optional Benefit: Room Rent Modification is not applicable for any Claims made under Global Coverage
7. Clause 6.1.7(a) of Payment Terms under Claims Procedure and Management is superseded to the extent covered under this Benefit.

3.2.2 Room Rent Modification

Notwithstanding anything to the contrary in the Policy, if this Optional Benefit is opted, the Company agrees to modify the Room Rent / Room Category to Twin sharing room or No Limit 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. 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 .

ii. **No Limit** If the Policy Schedule states as " No Limit" which means that there is no separate restriction on Room Category / Rent incurred towards stay during Hospitalization.

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.

3.2.3 Daily Cash Allowance

If this Optional Benefit is opted, the Company will pay a fixed amount as specified against this Benefit in the Policy Schedule provided that, the claim is admissible under Inpatient Hospitalization Treatment under this Policy for each continuous and completed period of 24 hours of Hospitalization of the Insured Person, subject to the conditions specified below:

(i) Minimum 48 hours of Medically Necessary Hospitalization is required.

(ii) The Company shall not be liable to make payment under this cover for more than 30 days of Hospitalization during a Policy Year.

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

(iv) In case the Insured Person is admitted in an ICU, the Company will pay twice the fixed amount as specified against this Cover in the Policy Schedule, for each continuous and completed period of 24 hours of Hospitalization in an ICU.

(v) At one point of time, an Insured Person cannot stay both in a regular Hospital room as well as in an ICU room. Hence, only either one of the rooms would be considered for pay-out as per the Insured Person's room occupancy in the Hospital.

(vi) Transit period from one hospital to another will not be considered as Hospitalization.

Note: Mid-term addition is allowed under this Optional Benefit whereas premium will be charged on pro-rata basis.

3.2.4 Air Ambulance cover

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

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

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

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

(iv) Payment under this Optional Benefit is subject to a Claim for the same Illness or Injury being admitted by the Company under Benefit: Hospitalization Expenses

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

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

b) Medical reports and transportation details issued by the air ambulance service provider, prescriptions and medical report by the attending Medical Practitioner furnishing the

name of the Insured Person and details of treatment rendered along with the statement confirm the necessity of air ambulance services.

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

3.2.5 International Second Opinion:

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

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

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

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

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

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

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

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

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

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

ii) For the purposes of this Benefit only:

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

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

1. Benign Brain Tumor
2. Cancer
3. End Stage Lung Failure
4. Myocardial Infarction
5. Coronary Artery Bypass Graft
6. Heart Valve Replacement
7. Coma
8. End Stage Renal Failure
9. Stroke
10. Major Organ Transplant
11. Paralysis
12. Motor Neuron Disorder
13. Multiple Sclerosis
14. Major Burns
15. Total Blindness

3.2.6 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.

3.2.7 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.

3.2.8 Modification on Advance Technology Methods

If this Optional Benefit is opted, then there shall be sub-limit on Advance Technology Method treatments up to the limit specified in the Policy Schedule and Company's liability shall be limited to such extent.

Note:Advance Technology Methods under this Benefit: Hospitalization Expenses shall be limited to the extent covered under this Benefit.

3.2.9 Unlimited Care

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

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 Year.

iii. This cover shall be applicable only once in lifetime of the policy for the claim admissible under Hospitalization Expenses.

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

v. The total payout under this Benefit will also constitute: Base Sum Insured+ Cumulative Bonus.

vi. This Benefit shall not be applicable for Optional Benefit: Global coverage.

3.3 Plan B

The plan is applicable on indemnity basis for the coverage with sub limits in the active base policy of the Insured Person to provide over and above coverage of the incurred reasonable and customary charges towards the benefit/s availed.

Applicability

	Deductible
Benefit 1: Proportionate Charges Cover	The sub limits applicable on Room Rent/Room Category and Associated Medical Expenses (Definition 2.2.2)as per the active base policy acts as the deductible, thereafter this benefit will provide coverage up to actuals over and above the mentioned sub limit.
Benefit 2: Cataract Treatment	The sub-limit on Cataract as mentioned in the active base policy shall act as a deductible, thereafter this Benefit will provide coverage up to Sum Insured over and above the active base policy limit.

Note:

1. In case of base policy is not active at the time of claim under Plan B, then premium for unexpired period shall be refunded and policy shall be canceled by Company. The unexpired period means the period from date of claim reporting up to policy period end date

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

3. Any Benefit/ Any combination/ Any Option or All of the Benefits / Options from the above table can be opted by the Insured Person.

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.

(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, Vaccination including Inoculation, Immunizations 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 Hospitalisation or

Day Care Hospitalisation is excluded.

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

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 his/her policy at any time during the term, by giving 7 days notice in writing. The Company shall refund proportionate premium for unexpired Policy Period.

(i) 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

(ii) 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.

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

Notes:

In case of demise of the Policyholder,

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

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

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

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

In case Premium Installment mode is opted for, then:

(i) If Policyholder cancels the Policy after the Free look period or demise of Policyholder where he/she is the only Insured in the Policy, then the Company will refund 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 one-time option to renew the existing product, if renewal falls within the 90 days from the date of withdrawal of the product or Migrate to any other suitable product available with the Company at the time of renewal (any other existing pro-duct or modified version of the withdrawn product) as per the choice of the policyholder with all the accrued continuity benefits 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 15 days where premium mode is monthly and 30 days for 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 instalments 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.

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 30 days from date of receipt of the policy document to review the termsand 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 III.

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 for approval. Only upon due approval from the Company, Cashless Facility can be availed at any Network Hospital.

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

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

Hospitalization.

(iv) Company's Authorization:

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

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

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

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

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

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

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

(ix) Claims incurred outside India: The Company's Assistance Service Provider should be intimated for availing Cashless Facility outside India under Optional Benefit 3.2.6 (International Second Opinion) and Benefit 3.2.1(Global Coverage)

(b) Re-imbursement Facility

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

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

mentioned upon the merits of the case.

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

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

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

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

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

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

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

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

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

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

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

6.1.4. Claims Intimation

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

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

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

Note: 6.1.4 (i) and 6.1.4 (ii) are precedent to admission of liability under the policy.

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

1. Policy Number;
2. Name of the Policyholder;
3. Name 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 shall be notified either at the Company's call center or in writing immediately and in any event within 48 hours of Hospitalization commencing or before the Insured Person's discharge from Hospital.

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

6.1.5. Documents to be submitted for filing a valid Claim

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

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

Notes:

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

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

6.1.6. Claim Assessment

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

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

Plan A

a. 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).

(ii) The Deductible 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) 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

b. 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) Cumulative Bonus

(iii) Unlimited Automatic Recharge

Plan B

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

I. Basis the benefit been opted, the limits applicable as per the base policy shall act as the deductible and admissible claim over and above the Deductible shall be payable up to the Sum Insured as opted.

II. The Deductible shall be applied on per claim basis that are either paid or payable under this Policy.

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.

Illustration I (Applicable for Plan A)

(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:

Case	Sum Insured	Deductible	Claim 1	Claim 2	Claim 3
1	25,00,000	10,00,000	750,000	12,50,000	10,00,000
2	25,00,000	10,00,000	750,000	15,00,000	30,00,000
3	25,00,000	10,00,000	12,50,000	40,00,000	40,00,000

Case	Sum Insured	Deductible	Payable1	Payable2	Payable3
1	25,00,000	10,00,000	-	10,00,000	10,00,000
2	25,00,000	10,00,000	-	12,50,000	12,50,000
3	25,00,000	10,00,000	2,50,000	22,50,000	Claim not payable as Sum Insured is exhausted

Illustration II (Applicable for Plan B)

(I) The claim amount assessed by the Company for a particular claim for coverage with sub-limits shall be educed by the Deductible (Sub limit as per the base policy) 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 per claim basis made by the Insured Person in a Policy Year.

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

Benefit 1: Proportionate Charges Cover

Case: Room Rent Rs. 5000 per day (as per base policy)

Opted Enhance Plus Benefit: Proportionate Charges Cover

*Claim arising on the same policy year.

Deductible (Base Policy cover Sub Limits)	Actual Incurred	Payable as per Base Policy	Payable as per Enhance Plus
Room rent Sub limit I.e Rs.5000 per day	Rs. 10,000 per day Insured has opted for higher room category and hospitalized for 5 days where the expenses incurred is Rs. 50,000^	Rs.5000*5 days =Rs.25,000^^	Rs.50,000^ - Rs.25,000^^= Rs.25,000 (over&above the base policy limit)

Benefit 2: Cataract Treatment

Case : Cataract Treatment (as per base policy)

Opted Enhance Plus Benefit 2: Cataract treatment

*Claim arising on the same policy year.

Case	Sum Insured	Deductible (Base Policy cover Sub Limits)	Actual Incurred	Payable as per Base Policy	Payable as per Enhance Plus
1	1,00,000	Cataract Treatment per eye I.e Rs. 30,000 as opted	Rs. 50,000^ per eye	Rs. 30,000^^ per eye	Rs. 50,000^ - Rs. 30,000^^= Rs.20,000 (over& above the base policy limit)

Note:

- The above illustration applicable only in case of coverage with applicable sub-limits as per the base policy.
- The plan B can not be opted without an ongoing active base policy.
- The Plan caters to the incurred cost over and above the base policy limit.

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

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

Sr. No.	List - II - Items that are to be subsumed into Room Charges	Sr. No.	List III – Items that are to be subsumed into Procedure Charges
1	Baby Charges (unless	1	Hair Removal Cream
	Specified/indicated)	2	Disposables Razors Charges (for Site Preparations)
2	Hand Wash	3	Eye Pad
3	Shoe Cover	4	Eye Sheild
4	Caps	7	Camera Cover
5	Cradle Charges	6	Dvd, Cd Charges
6	Comb	7	Gause Soft
7	Eau-de-cologne / Room Freshners	8	Gauze
8	Foot Cover	9	Ward And Theatre Booking Charges
9	Gown	10	Arthroscopy And Endoscopy Instruments
10	Slippers	11	Microscope Cover
11	Tissue Paper	12	Surgicalblades, Harmonicscalpel, Shaver
12	Tooth Paste	13	Surgical Drill
13	Tooth Brush	14	Eye Kit
14	Bed Pan	15	Eye Drape
15	Face Mask	16	X-ray Film
16	Flexi Mask	17	Boyles Apparatus Charges
17	Hand Holder	18	Cotton
18	Sputum Cup	19	Cotton Bandage
19	Disinfectant Lotions	20	Surgical Tape
20	Luxury Tax	21	Apron
21	Hvac	22	Torniquet
22	House Keeping Charges	23	Orthobundle, Gynaec Bundle
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 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

S.No.	HOSPITAL NAME	ADDRESS	ZONE
1	Nulife Hospital and Maternity Centre	1616 Outram Lines, Kingsway Camp, Guru Teg Bahadur Nagar, New Delhi	North
2	Taneja Hospital	Q-Block,South City-2, Sohna Road, Main Sector-47, Preet Vihar, New Delhi	North
3	Shri Komal Hospital & Dr. Saxena's Nursing Home	Silver Plaza Complex, Opposite Rupali Cinema, Rander Road, Rewari, Haryana	North
4	Sona Devi Memorial Hospital & Trauma Centre	Sohna Road, Badshahpur, Badshahpur, Gurgaon, Haryana	North
5	Amar Hospital	Sector-70,S.A.S.Nagar, Mohali, Sector 70, Mohali, Punjab	North
6	Brij Medical Centre	Sec-6, Jain Narayan Vyas Colony, Kavi Nagar Industrial Area Sec.-17, Ghaziabad, U.P.	North
7	Famliy Medicare	A-55, Sector 61, Rajat Vihar Sector 62, Noida, U.P.	North
8	Jeevan Jyoti Hospital	162, Lowther Road, Bai Ka Bagh, Allahabad, U.P.	North
9	City Hospital & Trauma Centre	C-1,Cinder Dump Complex, Opposite Krishna Cinema Hall, Kanpur Road, Alambagh, Lucknow, U.P.	North
10	Dayal Maternity & Nursing Home	No.953/23, D.C.F.Chowk, DLF Colony, Rohtak, Haryana	North
11	Metas Adventist Hospital	No.24,Ring-Road, Athwalines, Surat, Gujarat	West
12	Surgicare Medical Centre	Sai Dwar Oberoi Complex, S.A.B.T.V. Lane Road, Lokhandwala, Andheri, Mumbai, Maharashtra	West
13	Paramount General Hospital & I.C.C.U.	42-1,Chettipalayam Road, Palladam, Andheri, Mumbai, Maharashtra	West
14	Gokul Hospital	Battan Lal Road, District Fatehgarh Sahib, Kandivali East, Mumbai, Maharashtra	West
15	Shree Sai Hospital	Gokul Nagri I, Thankur Complex, Western Express Highway, Kandivali East, Mumbai, Maharashtra	West
16	Shreedevi Hospital	Akash Arcade, Bhanu Nagar, Dr. Deepak Shetty Road, Kalyan D.C., Thane, Maharashtra	West
17	Saykhedkar Hospital And Research Centre Pvt. Ltd.	Trimurthy Chowk, Kamatwada Road,Cidco Colony, Nashik, Maharashtra	West
18	Arpan Hospital And Research Centre	No.151/2,Imli Bazar, Near Rajwada, Imli Bazar, Indore, Madhya Pradesh	West
19	Ramkrishna Care Hospital	Aurobindo Enclave,Pachpedhi Naka, Dhamtri Road,National Highway No 43, Raipur, Chhattisgarh	East
20	Gupta Multispeciality Hospital	Mezzanine Floor, Shakuntal B, Near Sanghvi Tower, Gujrat, Gas Circle, Adajan Road, Vivek Vihar, Delhi	North
21	R.K.Hospital	3C/59,BP, Near Metro Cinema, New Industrial Township 1, Faridabad, Haryana	North
22	Prakash Hospital	D -12,12A,12B, Noida, Sector 33, Noida, Uttar Pradesh	North
23	Aryan Hospital Pvt. Ltd.	Old Railway Road, Near New Colony, New Colony, Gurgaon, Haryana	North
24	Medilink Hospital Research Centre Pvt. Ltd.	Near Shyamal Char Rasta, 132,Ring Road, Satellite, Ahmedabad, Gujarat	West
25	Mohit Hospital	Khoya B-Wing,Near National Park, Borivali(E), Kandivali West, Mumbai, Maharashtra	West
26	Scope Hospital	628,Niti Khand-I, Indirapuram, Indirapuram, Ghaziabad, Uttar Pradesh	North
27	Agarwal Medical Centre	E-234, -, Greater Kailash 1, New Delhi	North
28	Oxygen Hospital	Bhiwani Stand, Durga Bhawan, Rohtak, Haryana	North
29	Prayag Hospital & Research Centre Pvt. Ltd.	J-206 A/1, Sector 41, Noida, Uttar Pradesh	North
30	Karnavati Superspeciality Hospital	Opposite Sajpur Tower, Naroda Road, Naroda Road, Ahmedabad, Gujarat	West
31	Palwal Hospital	Old G.T. Road, Near New Sohna Mod, Palwal, Haryana	North
32	B.K.S. Hospital	No.18,1st Cross, Gandhi Nagar, Adyar, Bellary, Karnataka	South
33	East West Medical Centre	No.711, Sector 14, Sector 14, Gurgaon, Haryana	North
34	Jagtap Hospital	Anand Nagar, Sinhgood Road, Anandnagar, Pune, Maharashtra	West
35	Dr. Malwankar's Romeen Nursing Home	No 14,Cunningham Road, Sheriffs Chamber, Vikhroli East, Mumbai, Maharashtra	West
36	Noble Medical Centre	C.K. Emerald No., N.S. Palya, Kaveriappa Industrial Area, Borivali West, Mumbai, Maharashtra	West
37	Rama Hospital	Sonepat Road, Bahalgarh, Bahalgarh, Sonipat, Haryana	North
38	S.B.Nursing Home & ICU	Lake Bloom 16 to18 Opp. Solaris Estate, L.T. Gate No.6, Tunga Gaon, Powai, Mumbai, Maharashtra	West

S.No.	HOSPITAL NAME	ADDRESS	ZONE
39	Saraswati Hospital	103-106, Vrurel Appt., Opp. Navjivan Post Office, Ajwa Road, Malad West, Mumbai, Maharashtra	West
40	Shakuntla Hospital	3-B Tashkant Marg, Near St. Joseph Collage, Allahabad, Uttar Pradesh	North
41	Mahaveer Hospital & Trauma Centre	Plot No-25,B/H Old Mount Carmel School, Near Lokmat Square, Panki, Kanpur, Uttar Pradesh	North
42	Eashwar Lakshmi Hospital	Plot No. 9, Near Sub Registrar Office, Gandhi Nagar, Hyderabad, Andhra Pradesh	South
43	Amrapali Hospital	Plot No. NH-34,P-2, Omega -1, Greater Noida, Noida, Uttar Pradesh	North
44	Hardik Hospital	29C, Budh Bazar, Vikas Nagar, New Delhi, Delhi	North
45	Jabalpur Hospital & Research Centre Pvt. Ltd.	Russel Crossing, Naptier Town, Jabalpur, Madhya Pradesh	West
46	Panvel Hospital	Plot No. 260A, Uran Naka, Old Panvel, Navi Mumbai, Maharashtra	West
47	Santosh Hospital	L-629/631, Hapur Road, Shastri Nagar, Meerut, Uttar Pradesh	North
48	Sona Medical Centre	5/58, Near Police Station, Vikas Nagar, Lucknow, Uttar Pradesh	North
49	City Super Speciality Hospital	Near Mohan Petrol Pump, Gohana Road, Rohtak, Haryana	North
50	Navjeevan Hospital & Maternity Centre	753/21, Madanpuri Road, Near Pataudi Chowk, Gurgaon, Haryana	North
51	Abhishek Hospital	C-12, New Azad Nagar, Kanpur, Uttar Pradesh	North
52	Raj Nursing Home	23-A, Park Road, Allahabad, Uttar Pradesh	North
53	Sparsh Medicare and Trauma Centre	Shakti Khand - III/54 , Indirapuram, Ghaziabad, Uttar Pradesh	North
54	Saras Healthcare Pvt. Ltd.	K-112, SEC-12, Pratap Vihar, Ghaziabad, Uttar Pradesh	North
55	Getwell Soon Multispeciality Institute Pvt. Ltd.	S-19, Shalimar Garden Extn. , Near Dayanand Park, Sahibabad, Ghaziabad, Uttar Pradesh	North
56	Shivalik Medical Centre Pvt. Ltd.	A-93 , Sector 34, Noida, Uttar Pradesh	North
57	Aakanksha Hospital	126, Aaradhnanagar Soc., B/H. Bhulkabhavan School, Aanand-Mahal Rd., Adajan, Surat, Gujarat	West
58	Abhinav Hospital	Harsh Apartment, Nr Jamna Nagar Bus Stop, God Dod Road, Surat, Gujarat	West
59	Adhar Ortho Hospital	Dawer Chambers, Nr. Sub Jail, Ring Rd., Surat, Gujarat	West
60	Aris Care Hospital	A 223-224, Mansarovar Soc, 60 Feet , Godadara Road, Surat, Gujarat	West
61	Arzoo Hospital	Opp. L.B. Cinema, Bhatar Rd., Surat, Gujarat	West
62	Auc Hospital	B-44 Gujarat Housing Board ,Nandeshara, Surat, Gujarat	West
63	Dharamjivan General Hospital & Trauma Centre	Karmayogi - 1, Plot No. 20/21, Near Piyush Point, Pandesara, Surat, Gujarat	West
64	Dr. Santosh Basotia Hospital	Bhatar Road, Surat, Gujarat	West
65	God Father Hospital	344, Nandvan Soc., B/H. Matrushakti Soc., Puna Gam, Surat, Gujarat	West
66	Govind-Prabha Arogya Sankool	Opp. Ratna-Sagar Vidhyalaya, Kaji Medan, Gopipura, Surat, Gujarat	West
67	Hari Milan Hospital	L H Road, Surat, Gujarat	West
68	Jaldhi Ano-Rectal Hospital	103, Payal Apt., Nxt To Rander Zone Office, Tadwadi, Surat, Gujarat	West
69	Jeevan Path Gen. Hospital	2nd Floor, Dwarkesh Nagri, Nr. Laxmi Farsan, Sayan, Surat, Gujarat	West
70	Kalrav Children Hospital	Yashkamal Complex, Nr. Jivan Jyot, Udhna, Surat, Gujarat	West
71	Kanchan General Surgical Hospital	Plot No. 380, Ishwarnagar Soc, Bhamroli-Bhatar, Pandesara, Surat, Gujarat	West
72	Krishnavati General Hospital	Bamroli Road, Surat, Gujarat	West

S.No.	HOSPITAL NAME	ADDRESS	ZONE
73	Niramayam Hosptial & Prasutigruah	Shraddha Raw House, Near Natures Park, Surat, Gujarat	West
74	Patna Hospital	25, Ashapuri Soc - 2, Bamroli Road, Surat, Surat, Gujarat	West
75	Poshia Children Hospital	Harekrishan Shoping Complex 1St Floor, Varachha Road, Surat, Gujarat	West
76	R.D. Janseva Hospital	120 Feet Bamroli Road, Pandesara, Surat, Gujarat	West
77	Radha Hospital & Maternity Home	239/240 Bhagunagar Society, Opp Hans Society, L H Road, Varachha Road, Surat, Gujarat	West
78	Santosh Hospital	L H Road, Surat, Gujarat	West
79	Sparsh Multy Specality Hospital & Trauma Care Center	G.I.D.C Road, Nr Udhana Citizan Co-Op.Bank, Surat, Gujarat	West

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 - 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, Baily Road, Patna Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand
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 IV - Service Request Form - For Change in Occupation / Nature of Job

(Refer Clause 5.2.1 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

Policy Number :

☐ Mr. ☐ Ms.

Name :

(First Name) (Last Name)

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

☐ Mr. ☐ Ms.

Name :

(First Name) (Last Name)

Occupation :

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)

Signature of the Policyholder : _____

Place :

(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 V - List of 32 Critical Illness

i. Cancer (Varies from IRDAI Standard Definitions 2016)

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

(II) The term cancer includes

A. leukemia, lymphoma, and sarcoma.

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

The following are excluded:

A. Benign lesions

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

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

D. Microcarcinoma of the bladder;

E. All tumours in the presence of HIV infection.

ii. Pulmonary Thromboembolism

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

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

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

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

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

Following are excluded:

A. Pulmonary hypertension associated with occupational and environmental factors

B. Substance abuse (like tobacco etc.),

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

iv. Infective Endocarditis

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

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

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

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

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

A. The actual undergoing of open-heart valve surgery to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valves. The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist Medical Practitioner.

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

vi. Surgery of Aorta

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

vii. Cardiomyopathy

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

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

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

viii. Surgery for cardiac arrhythmia

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

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

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

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

ix. Angioplasty

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

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

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

x. Balloon Valvotomy/Valvuloplasty

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

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

xi. Carotid Artery Surgery

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

A. Either:

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

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

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

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

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

Exclusion: Any key-hole or laser surgery.

xiii. Pericardectomy

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

The actual undergoing of pericardiectomy secondary to chronic constrictive pericarditis.

The following are specifically excluded:

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

B. Acute pericarditis due to any reason

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

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

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

The following are excluded:

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

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

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

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

B. New characteristic electrocardiogram changes;

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

The following conditions are excluded:

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

B. Other acute Coronary Syndromes;

C. Any type of angina pectoris.

xvi. Implantation of Pacemaker of Heart:

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

Following will be excluded:

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

xvii. Implantable Cardioverter Defibrillator:

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

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

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

Following will be excluded:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Following will be excluded:

A. Cysts;

B. Granulomas;

C. Vascular malformations;

D. Haematomas;

E. Calcification;

xxi. Parkinson's Disease

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

Following will be excluded:

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

xxii. Alzheimer's Disease

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

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

Following will be excluded:

A. Non organic diseases such as neurosis;

B. Alcohol related brain damage;

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

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

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

A. Permanent jaundice;

B. Uncontrollable ascites;

C. Hepatic encephalopathy;

D. Oesophageal or Gastric Varices and portal hypertension;

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

xxiv. Motor Neurone Disorder

Motor neurone disease diagnosed by a Neurophysician as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn

cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction with a clear causation relation to MND.

xxv. End Stage Lung Disease

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

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

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

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

xxvi. Bacterial Meningitis

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

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

B. A consultant neurologist.

Bacterial Meningitis in the presence of HIV infection is excluded.

xxvii. Aplastic Anaemia

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

A. Blood product transfusion;

B. Marrow stimulating agents;

C. Immunosuppressive agents; or

D. Bone marrow transplantation

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

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

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

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

xxviii. Major Organ Transplant

The actual undergoing of a transplant of:

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

B. Human bone marrow using hematopoietic stem cells.

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

The following are excluded:

A. Other stem-cell transplants;

B. Where only islets of Langerhans are transplanted.

xxix. Stroke (Varies from IRDAI Standard Definitions 2016)

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

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

The following are excluded:

I. Transient ischemic attacks (TIA);

II. Traumatic injury of the brain;

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

xxx. Paralysis (Varies from IRDAI Standard Definitions 2016)

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

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

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

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

Burns arising due to self-infliction are excluded.

xxxii. Blindness (Varies from IRDAI Standard Definitions 2016)

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

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

Following will be excluded:

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

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

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

(IV) Cost of prosthesis for cosmetic correction

(V) Visual aids implantable or external

Annexure VI - Benefit / Premium illustration

Illustration No. 1

Age of members Insured	Coverage opted on individual basis covering each member of the family separately (at a single point of time)		Coverage opted on individual basis covering multiple members of the family under a single Policy (Sum Insured is available for each member of family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)
28	1,972	10,00,000	1,972	NA	1972	10,00,000	2,683	NA	2,683	10,00,000
30	1,972	10,00,000	1,972	5%	1873	10,00,000				
Total Premium for all members of family is Rs.3,944 , when each member is covered separately. Sum Insured available for each individual is Rs.10,00,000			Total Premium for all members of family is Rs..3,845, when they are covered under a single policy Sum Insured available for each family member is Rs. 10,00,000				Total Premium when policy is opted on floater basis is Rs.2,683 Sum Insured of Rs.10,00,000 is available for entire family			

Annexure VI- Benefit / Premium illustration

Illustration No. 2

Age of members Insured	Coverage opted on individual basis covering each member of the family separately (at a single point of time)		Coverage opted on individual basis covering multiple members of the family under a single Policy (Sum Insured is available for each member of family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)
56	8,258	10,00,000	8,258	NA	8,258	10,00,000	12,053	NA	12,053	10,00,000
60	8,258	10,00,000	8,258	5%	7,845	10,00,000				
17	1750	10,00,000	1750	5%	1,662	10,00,000				
Total Premium for all members of family is Rs.18,266 when each member is covered separately. Sum Insured available for each individual is Rs.10,00,000			Total Premium for all members of family is Rs.17,765, when they are covered under a single policy Sum Insured available for each family member is Rs. 10,00,000				Total Premium when policy is opted on floater basis is Rs.12,053 Sum Insured of Rs. 10,00,000 is available for entire family			

Notes:

1. Premium rates (excl. taxes) specified in above illustration shall be standard premium rates without considering any loading.
2. Deductible assumed is Rs.2,00,000

Care Health Insurance Limited
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Correspondence Office: Vipul Tech Square, Tower C, 3rd Floor, Golf Course Road,
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IRDAI Registration Number - 148

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