Health QuBE

Contents

1. Preamble

Raheja QBE General Insurance Company Limited will cover all Insured Persons under this Policy up to the Sum Insured. The insurance cover is governed by, and subject to, the terms, conditions and exclusions of this Policy.

2. Definitions

i. **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

ii. **Age** means completed years as at the Policy Start Date specified in the Policy Schedule.

iii. **Any one illness means** continuous Period o f illness and it includes relapse within 45 days from the date o f last consultation with the Hospital/Nursing Home where treatment may have been taken.

iv. **"AYUSH Treatment"** refers to the medical and / or hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

i. **Cashless Facility** means a facility extended by Us to You where the payments, of the costs of treatment undergone by You in accordance with the policy terms and conditions, are directly made to the Network Provider by Us to the extent pre-authorization approved.

ii. **Condition Precedent** means a policy term or condition upon which Our liability under the Policy is conditional upon.

iii. **Congenital Anomaly** means a condition(s) 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

iv. **Co-payment** means a cost-sharing requirement under a health insurance policy that provides that the Policyholder will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

v. **Cumulative Bonus:** Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

vi. **Day Care Center** means any institution established for Day Care Treatment of illness and/or injuries or a medical set-up 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 asunder:-

- has Qualified Nursing staff under itsemployment;
- has a qualified medical practitioner(s) incharge;
- has a fully equipped operation theatre of its own where surgical procedures are carried out;
- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

vii. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:

(i) undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
(ii) 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.

viii. **Deductible:** Deductible means 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.

ix. **Diagnostic Tests** means investigations, such as X-Ray or blood tests, to find the cause of the Insured Person"s symptoms and medical condition

x. **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.

xi. **Domiciliary Hospitalisation** 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:

- the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
- the patient takes treatment at home on account of non-availability of room in a hospital.

xii. **Emergency** means a severe 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.

xiii. **Family Floater Policy** means a Policy in terms of which, two or more persons of a Family are named in the Policy Schedule as Insured Persons. In a Family Floater Policy, Family means a unit comprising of up to six members who are related to each other in the following manner:

(i) Legally married husband and wife as long as they continue to be married; and/or
(ii) Up-to four of their children who are less than 21 years on the Policy Start Date specified in the Policy Schedule.

xiv. **Grace Period:** Grace period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in

force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

xv. **Hospital** means any institution established for Inpatient 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:
(i) has qualified Nursing staff under its employment round the clock;
(ii) has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
(iii) has qualified Medical Practitioner(s) in charge round the clock;
(iv) has fully equipped operation theatre(s) of its own where surgical procedures are carried out
(v)maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

xvi. **Hospitalisation or Hospitalised** means the admission in a Hospital for a minimum period of 24 Inpatient Care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

xvii. **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.

xviii. **Information Summary Sheet** means the record and confirmation of information provided to Us or Our representatives over the telephone for the purposes of applying for this Policy.

xix. **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.

xx. **Illness** means sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

i) 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.
ii) Chronic condition- A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests- it needs ongoing or long-term control or relief of symptoms -it requires your rehabilitation or for you to be specifically trained to cope with it- it continues indefinitely – it recurs or is likely to recur.

xxi. **Inpatient** means the Insured Person's admission to for treatment in a Hospital for more than 24 hours for a covered event.

xxii. **Inpatient Care** means treatment for which the Insured Person has to stay in a hospital for more than 24 hours for a covered event.

xxiii. **Insured Person** means person named in the Policy Schedule. Any Family (as specified under the definition of Family Floater Policy above) member may be added as an Insured Person during the Policy Period if We have accepted his proposal for insurance and issued an endorsement confirming the addition of such person as an Insured Person.

xxiv. **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.

xxv. **Medical Practitioner** means 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 setup 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.

xxvi. **Medically necessary treatment** is defined as any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

i) is required for the medical management of the Illness or injury suffered by the You;
ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii) must have been prescribed by a Medical Practitioner;
iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

xxvii. **Network Provider** means Hospital enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by cashless facility..

xxviii. **Notification of Claim** means the process of notifying a claim to the insurer or TPA in accordance with the specified timelines as well as the address /telephone number to which it should be notified set out under the Policy.

xxix. **OPD Treatment** means 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 Person is not admitted as a day care or In-Patient.

xxx. **Policy** means these terms and conditions, any annexure thereto and the Policy Schedule (as amended from time to time), Your statements in the proposal form and the Information Summary Sheet and the Policy wording (including endorsements, if any).

xxxi. **Policy Period** means the period between the Policy Start Date and the Policy End Date as specified in the Policy Schedule.

xxxii. **Policy Year** means the period of one year commencing on the Policy Start Date specified in the Policy Schedule or any anniversary thereof.

xxxiii. **Pre-existing Disease** means any condition, ailment or injury or related condition(s) for which the Insured Person had signs or symptoms, and / or were diagnosed, and / or received medical advice/ treatment, within 48 months prior to the first Policy issued by Us.

xxxiv. **Pre-hospitalization** Disease Medical Expenses means Medical Expenses incurred immediately before the Insured Person is Hospitalised, provided that:
i) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii)The In-patient Hospitalization claim for such Hospitalization is admissible by Us.

xxxv. **Post-hospitalization** Medical Expenses means Medical Expenses incurred 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 Hospitalisation was required, and
ii)The In-patient Hospitalization claim for such Hospitalization is admissible by Us.

xxxvi. **Portability** means transfer by an individual health insurance policy holder (including family cover) of the credit gained for Pre-existing Disease and time bound exclusions if he/she chooses to switch from one insurer to another.

xxxvii. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

xxxviii. **Rehabilitation** means treatment aimed at restoring health or mobility, or to allow a person to live an independent life, such as after a stroke.

xxxix. **Reasonable and Customary Charges** 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.

xl. **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..

xli. **Room Rent** means the amount charged by a Hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated Medical Expenses.

xlii. **Policy Schedule means** the schedule provided in the insurance certificate issued by Us, and, if more than one, then the latest in time.

xliv. **Sum Insured** means the sum shown in the Policy Schedule which represents Our maximum total and cumulative liability for any and all claims under the Policy in respect of the single Insured Person during the Policy Period and in relation to a Family Floater represents Our maximum liability for any and all claims made in respect of all the Insured Persons covered under the Policy during the Policy Period.Our Liability for any and all benefits claimed during the Policy Period.

xlv. **Surgery or 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 of suffering or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

xlvi. **"Third Party Administrators or TPA"** means any person who is registered under the IRDAI (Third Party Administrators – Health Services) Regulations,2016 notified by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services as defined in those Regulations.

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

xlviii. **We/Our/Us** means Raheja QBE General Insurance Company Limited

xlix. **You/Your/Policyholder** means the person named in the Policy Schedule who has concluded this Policy with Us. Any reference to any statute shall be deemed to refer to any replacement or amendment to that statute.

3. Benefits/Cover

This Policy provides You the options of the following Plans:

- Basic;
- Comprehensive;
- Super saver; and
- À la carte.

The Policy Schedule will specify the Plan which is in force for each of the Insured Person. For a complete description of the benefits available under the applicable Plan as well as any specific limits on the amount payable under any particular benefit under the applicable Plan, please refer to the Policy Schedule.
This Policy provides the following benefits to the persons covered as Insured Person(s) under the Policy. However, the Insured Person(s) shall only be covered under the following Section(s) which are specifically set out to be in force in the Policy Schedule for the Insured Person.

A claim under Sections b,c,d,e,f,h and i shall become payable under the Policy in respect of an Insured Person only if there is a corresponding claim admitted by Us under Section a in respect of the Insured Person and in relation to same Illness/condition.

A claim under Sections b,e and f shall become payable under the Policy in respect of an Insured Person only if there is a corresponding claim admitted by Us under Section j in respect of the Insured Person and in relation to same Illness/condition.

Section a: Inpatient Benefit/Hospitalization Benefit

The following benefits are available to all Insured Persons who suffer an Illness or Accident during the Policy Period which requires Hospitalisation on an Inpatient basis or a treatment that is listed as a Day Care Procedure under Annexure II to the Policy. We will cover the reasonable and customary Medical Expenses specified below incurred in respect of the Insured Person in case of Medically Necessary Hospitalization or Day Care Procedure listed under Annexure II to the Policy that arises from an Accident or Illness. The Medical Expenses covered under this benefit includes Hospital Room Rent or boarding expenses, nursing charges, Intensive Care Unit(ICU) charges, Medical Practitioner's charges, diagnostic procedures, anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines, drugs and consumables, cost of prosthetics if implanted during Surgical Procedures subject to the limits on the Room Rent, room category, ICU Charges and Medical Practitioner fees as specified under the Policy Schedule.

Section b : Pre/Post Hospitalization Benefit

We will reimburse the Pre- Hospitalisation Medical Expenses incurred in respect of the Insured Person at actual up to the fixed number of days immediately prior to the Insured Person"s date of Hospitalization or commencement of treatment as Domiciliary Hospitalization as mentioned on the Policy Schedule

In addition, We will reimburse the Post- Hospitalisation Medical Expenses incurred in respect of the Insured Person at actuals up to the fixed number of days as specified in the Policy Schedule after discharge from the Hospital or end of treatment as Domiciliary Hospitalization

Section c: Ambulance Cover

We will cover the Reasonable and Customary Charges incurred at actual on an Ambulance in course of an Emergency in respect of the Insured Person, subject to the amount mentioned on the Policy Schedule. Ambulance from home to hospital or inter-hospital shifts is covered under the policy, validating the medical emergency.

Section d: Daily Allowance

In case of Hospitalization of the Insured Person during the Policy Period We will pay the Daily Cash Allowance as set out in the Policy Schedule in respect of the Insured Person for each completed day of the Hospitalization. Further, the benefit under this section is only payable for continuous and completed periods of 24 hours of Hospitalization (as an In-patient) and is subject to a limit of 6 consecutive days of Hospitalization per claim.

Section e: Organ Donor Benefit

We will cover the Medical Expenses of the organ donor for harvesting the organ for the use of the Insured Person who has been asked to undergo an organ transplant on medical advice, at actual up to the limit specified in the Policy Schedule However, we will not pay for:

1. The claims which are not admitted under Section a.
2. The admission is not compliant under Transportation of Human Organs Act 1991 as amended.
3. The organ donor's pre and post Hospitalisation charges.

Section f: Recharge/Replenish Benefit

If the applicable Sum Insured under the Policy in respect of the Insured Person is exhausted due to claims paid during the Policy Year, then We will reinstate the Sum Insured to the full original amount at the policy inception subject to the following conditions:

1. We will reinstate the Sum Assured only once in each Policy Year.
2. The claim under this section would only be admissible if the claim is admissible under Section a.
3. The recharged/replenished Sum Assured cannot be carried forward to other Policy Years.
4. The recharged/replenish Sum Assured would only be available for all future claims and not in relation to any Illness or injury for which a claim has already been admitted for that Insured Person during the Policy Year.
5. No Claim Bonus under Section k will not applicable on the recharged/replenished Sum Assured.

Section g: Health Check-up

The Insured Person/s covered under the policy may avail the set of health check-ups as specified in the Policy Schedule with Our Network Provider. Health Check Ups will be and arranged by Us and conducted at Our Network Providers.

provided that:

1. The Insured Person is an Adult(Aged 18 Years and above)
2. It is available only once a year.

Set Serial Number	List of Tests
1	Complete Blood Count(CBC), Urine routine, Fasting Blood Sugar, SGPT, Creatinine , Blood Group,
2	Complete Blood Count(CBC), Urine routine, Fasting Blood Sugar, SGPT, Serum Creatinine, ECG, Blood Group S Cholesterol
3	Complete Blood Count(CBC), Urine routine, Fasting Blood Sugar, SGPT, Serum Creatinine, ECG, Blood Group S Cholesterol, Lipid Profile, Kidney Function Test
4	Complete Blood Count(CBC), Urine routine, Fasting Blood Sugar, SGPT, Serum Creatinine, ECG, Blood Group S Cholesterol, Lipid Profile, Kidney Function Test, TMT

Section h: Non Medical Expenses

We will reimburse the Expenses that are not admissible in Annexure I to this Policy, incurred in respect of the Insured Person subject to the Maximum amount as noted under „Non Medical Expenses" limit specified in the Policy Schedule, provided that these expenses are incurred in course of the continuous and completed period of at least 24 hours of Hospitalization (as an In-patient) of the Insured Person and Cashless Facility is opted for at Our Network Providers..

Section i: Sum Insured Increase

In case of Cashless Hospitalization, insured will get benefit of additional sum insured of 10% of the Claimed amount. I.e, We will reduce only 90% of the claim amount from the sum insured of the member, if the Cashless Facility is opted for at Our Network Providers, and provided that the claim is admissible under Section a. (Illustration attached in Annexure V)

Section j: Domiciliary Hospitalisation

We will cover the Medical Expenses incurred in respect of the Insured Person during the Policy Year for Domiciliary Hospitalisation up to the limit specified in the Policy Schedule, subject to the exclusions listed below and provided that the treatment continues for at least more than three consecutive days .

We will not be liable to cover any Medical Expenses under this Section which are incurred for the treatment in relation to any of the following diseases:

a. Chronic Nephritis and Nephritic Syndrome,
b. Diarrhoea,
c. All Dysenteries including Gastroenteritis,
d. Pyrexia of unknown origin,
e. Diabetes Mellitus and Insupidus,
f. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis,
g. Cough and Cold, Influenza,
h. Arthritis, Gout and Rheumatism,
i. Epilepsy,
j. Hypertension,
k. Psychiatric or Psychosomatic Disorders of all kinds.

Section k: NCB (No Claim Bonus)

a. If no claim has been made under Section a of this Policy and the Policy is renewed with Us without any break, We will apply a No Claim Bonus (NCB) to the next Policy Year by automatically increasing the Sum Insured for the next Policy Year by 5% of the Sum Insured for the expiring Policy Year, provided that the maximum NCB in any Policy Year will not exceed 100% of the original Sum Insured at the time of inception of the Policy for the first time.

b. In case of a Family Floater Policy, the NCB shall be available on a floater basis and accrue only if no claims have been made in respect of any Insured Person during the expiring Policy Year.

   i. If a NCB has been applied and a claim is made in two consecutive Policy Years, then in the subsequent (third) Policy Year We will automatically decrease the accrued NCB at the same rate at which it accrued in the expiring Policy Year. Any claims for Health check up or claims amounting up to 10 % of sum insured or INR 50000/-, whichever is less, will not be considered for reduction in NCB.

c. However, this reduction will not reduce the Sum Insured below the Sum Insured applicable before the commencement of the expiring Policy Year, and only the accrued NCB will be decreased.

d. If the Insured Persons in the expiring policy are covered on individual basis and thus have accumulated the NCB for each member in the expiring policy, and such expiring policy is renewed with Us on a Family Floater basis, then the NCB which will be carried forward for credit in the Policy will be the least NCB amongst all the Insured Persons.

e. The portability benefit under this Policy will be offered to the extent of sum of previous sum insured and accrued NCB, portability benefit shall not apply to any other additional increased Sum Insured.

f. In policies with a two-year Policy Period, the application of above provisions of NCB shall be become applicable only after the completion of the first Policy Year.

*Illustrations attached in Annexure V

4. Exclusions:

5. (i) Waiting Period:

A. Initial waiting period (30 Day waiting period)

Claims for any Medical Expenses incurred for treatment of any Illness during the first 30 days from the Policy Start Date specified in the Schedule are not admissible under this Policy except for those

Medical Expenses incurred as a result of an Injury. All the waiting period shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

This exclusion doesn't apply for the Insured Person having any health insurance indemnity policy in India at least for a period of 30 days prior to taking this Policy and accepted under portability cover, as well as for subsequent Renewals with Us without a break.

B: Specific Waiting Period:

A waiting period of 24 months from the Policy Start Date shall apply to the treatment, whether medical or surgical, of the disease/conditions mentioned below along with the surgical procedures mentioned below:

i. Calculus diseases of gall bladder includingCholecystitis
ii. Pancreatitis
iii. Fissure/fistula in anus, hemorrhoids, pilonidalsinus
iv. Ulcer and erosion of stomach and duodenum
v. GastroEsophageal Reflux Disorder(GERD)
vi. All forms of cirrhosis (cirrhosis due to alcohol will be permanent exclusion).
vii. Perineal and/or Perianal Abscesses
viii. Cholecystectomy and/or Surgery of hernia
ix. Surgery of Hydrocele/Rectocele
x. Calculus diseases of Urogenital System and/or Surgery of prostate
xi. Cataract
xii. Dilatation and curettage (D&C)
xiii. Non infective arthritis , Osteoarthrosis /Gout / Rheumatism / Spondylosis / Spondylitis / Intervertebral Disc Prolapse and joint replacement surgeries (other than cause by an accident).
xiv. Varicose veins and Varicose Ulcers.
xv. Internal tumors, cysts, nodules, polyps, skintumors and any type of breast lumps
xvi. Chronic Suppurative Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis & related disorders, Surgery on Tonsils/ Adenoids, Tympanoplasty and any other benign ear, nose and throat disorder or surgery.
xvii. Hysterectomy for menorrhagia or fibromyoma or prolapsed of uterus unless necessitated by malignancy, myomectomy for fibroids
xviii. Congenital Internal diseases and anomalies.

C: A waiting period of 48 months will be applicable under the Policy to all Pre-existing Diseases, and those specifically declared and accepted at the time of proposal.

D: Reduction in Waiting Period (Portability)

If the Insured Person is covered and has been continuously covered without break under:

i.) Any health insurance plan with an Indian non life insurer/health Insurer in accordance with the prevalent regulatory framework of the IRDAI for portability, Or

ii.) Any similar health insurance policies from Us.

Then,
The waiting period set out under this Policy shall be reduced by the number of months of continuous coverage under such health policy with the previous insurer to the extent of the Sum Insured and eligible no claim bonus under the expiring health insurance policy.

If the Sum Insured for an Insured Person is more than the sum insured applicable under the previous health insurance policy, then the reduced waiting period shall only apply to the extent of the sum insured and any other accrued sum insured under the previous health insurance policy.

4.(ii) Any claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

(a) Any expense, condition or treatment not admissible in Annexure – I (Non Medical Expenses) except to the extent covered under Section h – Non-Medical Expenses (if applicable) under the Policy.

(b) Any condition directly or indirectly caused by or associated with any sexually transmitted disease which includes Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.

(c) Any treatment arising from or traceable to pregnancy (including voluntary termination), miscarriage (unless due to an Accident), childbirth, maternity (including caesarian section), abortion or complications of any of these. This exclusion will not apply to ectopicpregnancy.

(d) Any treatment arising from or traceable to any fertility, sterilization, birth control procedures, contraceptive supplies or services including complications arising due to supplying services or assisted reproductivetechnology.

(e) 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.

(f) charges incurred in connection with cost of routine eye and ear examinations, dentures, artificial teeth and all external appliances and/or devices whether for diagnosis or treatment.

(g) Dental Treatment, dentures or surgery of any kind unless necessitated due to an accident and requiring minimum 24 hours hospitalization.

(h) Laser Surgery for treatment of focal error correction other than for focal error of +/-7 or more and is medically necessary.

(i) Unproven/Experimental treatments or investigational treatments which are not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness for which confinement is required at a Hospital. Any Illness or treatment which is a result or a consequence of undergoing such Unproven/Experimental treatment.

(j) Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind which includeswheelchairs, walkers, belts, collars, caps, splints, braces, stockings of any kind, diabetic footwear, glucometer/thermometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome (C.P.A.P) or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for asthmatic condition, cost of cochlear implants and an exhaustive list is appended in Annexure 1 (Non Medical Expenses)

(k) Any treatment related to sleep disorder or sleep apnea syndrome, general debility convalescence, cure, rest cure, health hydros, nature cure clinics, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care, custodial care or any treatment in an establishment that is not a Hospital.

(l) Treatment of any Congenital External Anomaly or Illness

(m) Stem Cell Implantation /surgery, harvesting, storage or any kind of treatment using stem cells and any complications arising out of it.

(n) Aesthetic treatment, cosmetic surgery or plastic surgery or related treatment of any description, including any complication arising from these treatments, other than as may be necessitated due to an Injury, cancer orburns.

(o) Any treatment/surgery for change of sex or gender reassignments including any complication arising from these treatments.

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

(q) All preventive care, vaccination, including inoculation and immunizations (except in case of post-bite treatment), vitamins and tonics.

(r) Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.

(s) Non-allopathic treatment.

(t) Any OPD Treatment.

(u) Treatment received outside India.

(v) Charges incurred at Hospital primarily for diagnostic, X-ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury, for which In-patient Care/ Day Care Treatment is required.

(w) 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.

(x) Any Illness or Injury directly or indirectly resulting or arising from or occurring during commission of any breach of any law by the Insured Person with any criminal intent.

(y) Act of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane or Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs and alcohol orhallucinogens.

(z) Any charges incurred to procure any medical certificate, treatment or Illness related documents pertaining to any period of Hospitalization or Illness. except to the extent covered under Section h – Non-Medical Expenses (if applicable) under the Policy.

(aa) Personal comfort and convenience items or services including T.V. (wherever specifically charged separately), charges for access to telephone and telephone calls (wherever specifically charged separately), foodstuffs (except patient‟s diet), cosmetics, hygiene articles, body or baby care products and bath additive, barber or beauty service, guest service as well as incidental services andsupplies and other items mentioned in Annexure 1. except to the extent covered under Section h – Non-Medical Expenses (if applicable) under the Policy.

(bb) Expenses related to any kind of RMO charges, service charge, surcharge, night charges levied by the hospital under whatever head except to the extent covered under Section h – Non-Medical Expenses (if applicable) under the Policy.

(cc) 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:

I 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.

II 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.

III 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.

In addition to the foregoing, any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above shall also be excluded.

(dd) Impairment of an Insured Person’s intellectual faculties by abuse of stimulants or depressants.

(ee) Alopecia, wigs and/or toupee and all hair or hair fall treatment and products.

(ff) Any treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification center, sanatorium, home for the aged, mentally disturbed, remodeling clinic.

(gg) Deliberate failure to seek and/or follow medical advice.

(hh) Any treatment for cirrhosis due to alcohol and complications arising from its treatment.

6. Claims Intimation, Assessment and Management

6.1. Upon the occurrence of any Illness or Injury that may give rise to a Claim under this Policy, then as a Condition Precedent to the Our liability under the Policy, the Policyholder or Insured Person or the claimant shall undertake all of thefollowing:

(a) Claims Notification

(i) The Policyholder or Insured Person or the claimant, shall notify Us in writing or at Our call center within 48 hours of Hospitalisation or before the discharge whichever is earlier.

(ii) You shall give us written intimation about the Hospitalization either directly or at Our call center at least 48 hours before the commencement of a planned Hospitalization.

(iii) However, We may condone the delay on merits of the claim subject to getting satisfied that the delay in notification was due to reasons beyond the control of the Insured/Insured Person/claimant.

(iv) If the Insured Person is to undergo planned Hospitalization, the Policyholder or Insured Person shall give written intimation to Us of the proposed Hospitalization at least 48 hours prior to the planned date of admission toHospital.

(v) It is agreed and understood that the following details are to be provided to Us at the time of Notification of Claim:

I Policy Number;

II Name of the Policyholder;

III Name of the Insured Person in respect of whom the Claim is beingmade;

IV Complete address and contact nos. Where the Insured was residing at the time of Hospitalization

V Nature of Illness or Injury and itscause

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

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

VIII Any other information, documentation or details requested by the Company.

6.2. Claims Procedure

(a) Cashless

(i) Cashless Facility is available only at Our Network Providers. The Insured Person can avail of this Cashless Facility at the time of admission into a Network Provider, by presenting the health membership number provided by Us under this Policy along with a valid photo identification document (Voter ID card/Driving License/Passport/PAN Card or any other identification documentation as approved/issued by Us).

(ii) In addition to the foregoing, in order to avail the Cashless Facility, the following procedure must be followed:

I. Pre-authorization: The Policyholder or Insured Person or the claimant must call Our call center and request authorization for the proposed treatment by way of submission of a completed pre-authorization form at least 48 hours before the commencement of planned Hospitalization or within 48 hours of admission to Hospital or before the discharge from Hospital whichever is earlier, in case of an Emergency.

II. We will process the request for authorization after having obtained accurate and complete information in respect of the Illness or Injury and treatment for which Cashless Facility is sought to be availed. We will confirm in writing authorization or rejection of the request to avail Cashless Facility for the Insured Person"s Hospitalization.

III. If the request for availing Cashless Facility is authorized by Us, 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 Us for availing Cashless Facility. Payment in respect of Co-payments (if applicable) or any other costs and expenses not authorized under the Cashless Facility shall be made directly by the Policyholder or Insured Person or claimant to the Network Provider. All original bills and evidence of treatment for the Medical Expenses incurred in respect of the Hospitalization of the Insured Person and all other information and documentation specified at Clause 5.4 shall be submitted to the Network Provider immediately and in any event before the Insured Person"s discharge from Hospital.

IV. If We do not authorize the Cashless Facility due to insufficient Sum Insured or if insufficient information is provided to Us to determine the admissibility of the claim, payment for the treatment will have to be made by the Policyholder or Insured Person or the claimant to the Network Provider, following which a claim for reimbursement may be made to Us and the same will be considered by Us subject to the terms and conditions of this Policy.

(iii) For an updated list of Network Provider, the Policyholder or Insured Person or claimant can refer to the list of Network Provider available on Our website or with Our call centre.

(b) Re-imbursement

We shall be give written intimation about the Hospitalization either directly or at Our call center at least 48 hours before the commencement of a planned Hospitalization or within 48 hours of admission to Hospital or before discharge from hospital whichever is earlier, if the Hospitalization is required in an Emergency. It is agreed and understood that in all cases where intimation of a claim has been provided under this provision, all the information and documentation specified in Clause 5.4 below shall be submitted (at the Policyholder or Insured Person‟s or claimant‟s expense) to Us immediately and in any event within 15 days of Insured Person‟s discharge from Hospital.

6.3. Policyholder's or Insured Person's duty at the time of Claim

(a) The Policyholder or Insured Person or claimant shall check the updated list of Network Provider before submission of a pre-authorisation request for Cashless Facility; and

(b) It is agreed and understood that as a Condition Precedent for a claim to be considered under this Policy:

(i) 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 5 of the Policy.

(ii) The Insured Person will, at Our request, submit himself for a medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary. The cost of such examination will be borne byUs.

(iii) Our 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 as may be reasonably required by Us.

(iv) We shall be provided with complete documentation and information which We have requested to establish Our liability for the claim, its circumstances and its quantum.

(v) Claims processing and settlement will be as per the IRDA (Protection of Policyholder‟s Interests), Regulation 2017 and any amendments thereof or any other regulation which is applicable in placethereof.

(vi) In case of death of the Insured Person, written notice of the death must, unless reasonable cause is shown, be so given before internment/cremation.

6.4. Claim Documents

The following information and documentation shall be submitted in accordance with the procedures set out above and within 15 days of discharge of the Insured Person from the hospital. Failure to furnish such evidence within the time required shall not invalidate nor reduce any claim if the Insured Person/claimant can satisfy Us that it was not reasonably possible for the Insured Person/claimant to give proof/documents within such time:

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

(ii) Medical Practitioner"s referral letter advising Hospitalization;

(iii) Medical Practitioner"s prescription advising drugs/Diagnostic Tests/consultation;

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

(v) Original bills from pharmacy/chemists;

(vi) Original pathological/Diagnostic Test reports/radiology reports and payment receipts;

(vii) Indoor case papers;

(viii) First Information Report, final police report, if applicable;

(ix) Post mortem report, if conducted;

(x) Death Certificate from the municipalauthorities;

(xi) Death Summary from the Hospital authorities, if death is confirmed by the Hospital;

(xii) Inquest/Panchnama Report;

(xiii) Coroner"s Report;and

Please note:-Any other document as required by Us to assess the Claim in relation to your claim submitted to Us.

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

(b) We will only accept bills/invoices which are made in the Insured Person"s name.

6.5. Claim Assessment

(a) All admissible claims under this Policy shall be assessed by Us in the following progressive order:

(i) If a room/ICU accommodation has been opted for where the rent or category is higher than the eligible limit as applicable in accordance with the Schedule of Benefits under the Policy Schedule for that Insured Person, then, the Medical Expenses except medicines and consumables payable shall be pro-rated as per the applicablelimits.

(ii) If any sub-limits on Medical Expenses are applicable in accordance with Policy Schedule, Our liability to make payment shall be limited to such extent as applicable.

(iii) Co-payment, if any, shall be applicable on the amount payable by Us after applying Clause 5.5(a)(i) and (ii).

(b) The claim amount assessed in Clause 5.5(a) above would be deducted from the following amounts in the following progressiveorder:

(i) Sum Insured;

(ii) No Claims Bonus;

(iii) ;

(iv) Replenish/Recharge of Sum Insured (ifapplicable).

(c) If the claim event falls within two policy periods, the claims shall be paid taking into consideration the available sum insured in the two policy periods, including the deductibles for each policy period. Such eligible claim amount to be payable to the insured shall be reduced to the extent of premium to be received for the renewal/due date of premium of health insurance policy, if not received earlier.

6.6. 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 Sum Insured of the Insured Person shall be reduced by the amount payable or paid under the Policy terms and conditions and only the balance amount shall be available as the Sum Insured for the unexpired Policy Year.

(c) We shall have no liability to make payment of a claim under the Policy in respect of an Insured Person, once the Sum Insured, No Claim Bonus, ,Replenish/Recharge of Sum Insured(if applicable) for that Insured Person is exhausted.

(d) We will settle or reject any claim within 30 days of receipt of all the necessary documents/ information as required for settlement of such claim and sought by Us in accordance with with the provisions of Regulations 27 of IRDAI (Health Regulations) ,2016. In case there is a delay in the payment beyond the stipulated timeline, We will pay additional amount as interest which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by Us.

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

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

(f) If the Policyholder or Insured Person suffers a relapse within 45 days of the date of discharge from the Hospital for which a claim has been made, then such relapse shall be deemed to be part of the same claim.

(g) For cashless claims, the payment shall be made to the Network Provider whose discharge would be complete and final.

(h) For the reimbursement claims, We will pay the Policyholder/claimant. In the event of death of the Policyholder, We will pay the nominee (as named in the Policy Schedule) and in case of no nominee at its discretion to the legal heirs of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

7. Conditions

6.1 Disclosure to information norm

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

6.2 Geography

This Policy only covers medical treatment taken within India. All payments under this Policy will only be made in Indian Rupees within India.

6.3 Observance of Terms and Conditions

The due observance and fulfilment of the terms and conditions of this Policy (including the

realization of premium by their respective due dates and compliance with the specified procedure on all claims) in so far as they relate to anything to be done or complied with by the Policyholder or any Insured Person, shall be Condition Precedent to Our liability under the Policy.

6.4 Material Change

It is a Condition Precedent to the Our liability under the Policy that the Policyholder shall immediately notify Us in writing of any material change in the risk on account of change in nature of occupation or business at his own expense. We may, as per board approved Underwriting Policy, adjust the scope of cover and/or the premium paid or payable, accordingly.

6.5 Records to be maintained

The Policyholder/Insured Person/claimant shall keep an accurate record in relation to claims made under the Policy including all relevant medical records and shall allow Us and Our representatives to inspect such records. The Policyholder/Insured Person/claimant shall furnish such information as We may require under this Policy at any time during the Policy Period and up to three years after the Policy Period End Date, or until final adjustment (if any) and resolution of all claims under this Policy.

6.6 Loadings

We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance). The maximum risk loading applicable for an individual shall not exceed above 100% per diagnosis/medical condition and an overall risk loading of over 150% per person. These loadings are applied from inception of the Policy including subsequent renewal(s) with Us or on the receipt of the request of increase in Sum Insured. We will inform You about the applicable risk loading or exclusion or both as the case may be through a counter offer letter/email/phone. You shall revert to Us with your acceptance and additional premium (if any), within 15 days of the issuance of such counter offer. In case, You neither accept the counter offer nor revert to Us within 15 days, We shall refund the premium paid within the next 15 days as per Policy terms and conditions. We would issue the policy only, once we have your acceptance and additional premium(if any) for the loading and/or any exclusions proposed by us.

6.7 Co-Payment

The policy is subject to Co-payment of 20% of each and every claim amount for fresh as well as renewal policies for insured persons whose age at the time of entry is above 60 years.

6.8. 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 Us other than that information expressly disclosed in the Proposal Form or otherwise in writing to Us, shall not be held to be binding or prejudicially affect Us.

6.9. Complete discharge

Payment made by Us to the Policyholder or Insured Person or the claimant or the nominee of the Policyholder or the legal representative of the Policyholder or to the Hospital, as the case may be, of any Medical Expenses or compensation or benefit under the Policy shall in all cases be complete and construe as an effectual discharge in favor of Us.

6.10. A-Multiple Policies

1 In case of multiple policies which provide fixed benefits, on the occurrence of the insured event in accordance with the terms and conditions of the policies, each insurer shall make the claim payments independent of payments received under other similar polices.

2 If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies.

1. In all such cases the insurer who has issued the chosen policy shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
2. Claims under other policy/ies may be made after exhaustion of Sum Insured in the earlier chosen policy / policies. The policyholder having multiple policies shall also have the right to prefer claims from other policy / policies for the amounts disallowed under the earlier chosen policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall settle the claim subject to the terms and conditions of the other policy / policies so chosen.

3. If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.

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

6.10 B Portability

You/Insured Person may port Your/Insured Person‟s existing health insurance policy from another company to this Policy subject to the following conditions:

(a) You/Insured Person has been covered under a health insurance policy issued by an Indian non-life insurance company/Health Insurance company without any break;

(b) We have received Your/Insured Person"s application for Portability with complete documentation at least 45 days before the expiry of Your/Insured Person"s previous period of insurance;

(c) If You/Insured Person were covered on a floater basis under the expiring policy and apply for a floater cover under this Policy, then the eligible no claim bonus to be carried forward on this Policy shall also be available on a floater basis. If You/Insured Person were covered on an individual basis in the expiring Policy then the eligible no claim bonus to be carried forward onthis Policy shall be available on an individualbasis.

(d) We may subject Your proposal to Our medical underwriting, restrict the terms upon which We may offer cover, the decision as to which shall be in Our sole and absolute board approved Underwriting policy. There is no obligation on Us to insure all Insured Persons on the proposed terms, even if You have

given Us all documentation. All our decisions would be strictly based upon the Board approved underwriting policy of the company.

(e) We should have received the database and claim history from the previous insurance company for Your previous policy.

The Portability provisions will apply to You, if You wish to migrate from this Policy to any other health insurance policy on Renewals. All health insurance policies are portable. You should initiate action to approach another insurer, to take advantage of portability, well before the renewal date to avoid any break in the policy coverage due to delays in acceptance of the proposal by the other insurer.

6.11 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.

6.12 Free Look Period

(a) The Policyholder may, within 15 days from the receipt of the Policy document, return the Policy stating reasons for his objection, if the Policyholder disagrees with any Policy terms and conditions. If no claim has been made under the Policy, We will refund the premium received after deducting proportionate risk premium for the period on cover, expenses for medical examination and stamp duty charges. If only part of the risk has commenced, such proportionate risk premium shall be calculated as commensurate with the risk covered during such period.

(b) It is agreed and understood that this clause cannot be exercised on any Renewal of this Policy, if the Policy terms and conditions remainunchanged.

6.13 Renewal Terms

(a) This Policy will automatically terminate on the Policy Period End Date specified in the Policy Schedule. All Renewal applications should reach Us on or before the Policy Period End Date.

(b) The renewal premium may be revised upon the approval of the same by the IRDAI as per guidelines issued from time to time.. The premium payable on Renewal shall be paid to Us on or before the Policy Period End Date and in any event before the expiry of the Grace Period.

(c) For the purpose of this provision, Grace Period means a period of 30 days immediately following the Policy Period End Date during which a payment can be made to renew this Policy without loss of continuity benefits such as waiting periods and coverage of Pre-existing Diseases. Coverage is not available for the period for which premium is not received by Us and We will not be liable for any claims incurred during such period. The provisions of Section 64VB of the Insurance Act shall be applicable.

(d) We will ordinarily not refuse to renew the Policy except on ground of fraud, moral hazard or misrepresentation or non-co-operation by the Insured Person/Policyholder or their representatives.

(e) We reserve the right to carry out underwriting in relation to any request for increase of the Sum Insured at the time of Renewal of the Policy.

(f) This product may be withdrawn by Us after due approval from the IRDAI. In case this product is withdrawn by Us, this Policy can be renewed under Our then prevailing health insurance product or its nearest substitute approved by the IRDAI. We shall duly intimate the Policyholder regarding withdrawal of this product and the options available to the Policyholder at the time of Renewal of this Policy.

(g) Any revision or modification in a policy which is approved by the Authority shall be notified to You at least three months prior to the date when such revision or modification comes into effect. The notice shall set out the reasons for such revision or modification, in particular the reason for an increase in premium and the quantum of such increase.

6.14 Cancellation/Termination

(a) We may at any time, cancel this Policy on grounds of misrepresentation, mis-description or non-disclosure of any material fact by You without any refund of premium, by giving 15 days" notice in writing by Registered Post Acknowledgment Due/recorded delivery to the Policyholder at his last known address.

(b) The Policyholder may also give 15 days" notice in writing, to Us, for the cancellation of this Policy, in which case We will from the date of receipt of the notice, cancel the Policy and refund the premium for the unexpired period of this Policy at the short period scales as mentioned below, provided no claim has been made under thePolicy.

(c) We may at any time, cancel this Policy on grounds of non-cooperation by You by refunding premium on a pro-rata basis, by giving 15 days" notice in writing by Registered Post

Acknowledgment Due/recorded delivery to the Policyholder at his last known address.

(d) Refund % to be applied on premiumreceived

Cancellation date up to (x months) from Policy Start Date(1 Year Policy)	1 Year Policy	Cancellation date up to (x months) from Policy Start Date(2 Year Policy)	2 Year Policy
upto 1 month	85%	upto 2 month	85%
upto 2 months	75.0%	upto 4 months	75.0%
upto 3 months	65.0%	upto 6 months	65.0%
upto 4 months	55.0%	upto 8 months	55.0%
upto 5 months	45.0%	upto 10 months	45.0%
upto 6 months	35.0%	upto 12 months	35.0%
upto 7 months	25.0%	upto 14 months	25.0%
upto 8 months	15.0%	upto 16 months	15.0%
upto 9 months	5.0%	upto 18 months	5.0%
over 9 months	0.0%	Over 18 months	0.0%

(e) 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.

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

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

II. A person over Age 18 who satisfies Our criteria to become a Policyholder.

6.15 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 Our satisfaction that the delay in reporting of the claim was for reasons beyond his control.

6.16 Communication

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

(b) All notifications and declarations for Us 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 Our 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.

6.17 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 Us, which approval shall be evidenced by a written endorsement signed and stamped by Us. 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.

8. Grievances

(a) We have developed proper procedures and effective mechanism to address complaints, if any of the customers. We are committed to comply with the regulations and standards and laid down by the IRDAI from time to time in this regard.

(b) In case of a complaint or grievance, We may be contacted for its redressal on the following details:

Website : www.rahejaqbe.com

e-mail : complaints@rahejaqbe.com

Telephone : 1800-102-7723 (Toll Free)

Fax : 022- 42313777

Post/Courier : Any branch office or the correspondence address, during normal business hours

(c) If You/Insured Person are not satisfied with Our Redressal of the Policyholder's complaint/grievance through one of the above channels, You/Insured Person may contact the Our Grievance Officer at:

The Grievance Cell,

Raheja QBE General Insurance Company Limited Ground

Floor, P&G Plaza, Cardinal Gracious Road,

Chakala, Andheri East, Mumbai 400099

(d) If You/Insured Person is not satisfied with Our redressal of the complaint/grievance through one of the above channels, You/Insured Person may approach the nearest Insurance Ombudsman for resolution of the grievance/complaint. The contact details of Ombudsman offices are mentioned below:

Office of the Omudsman	Contact Details	Jurisdiction
Ahmedabad	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.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 Bengaluru – 560 Tel.: 080 - 26652048 / Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka.
Bhopal	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Bhopal – 462 011. Tel.:- 0755-2769201/202 Fax:- 0755-2769203 Email:- bimalokpal.bhopal@gbic.co.in	Madhya Pradesh and Chattisgarh.
Bhubaneshwar	Office of the Insurance Ombu Tel.:- 0674-2596461/2596455 Fax:- 0674-2596429 Email:- bimalokpal.bhubaneswar@gbic.co.in	Orissa.

Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.:- 0172-2706196/6468 Fax:- 0172-2708274 Email:-bimalokpal.chandigarh@gbic.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Chandigarh.
Chennai	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.:- 044-24333668/24335284 Fax:- 044-24333664 Email:- bimalokpal.chennai@gbic.co.in	Tamil Nadu and Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.:- 011-23239633/23237539 Fax:- 011-23230858 Email:- bimalokpal.delhi@gbic.co.in	Delhi.
Guwahati	Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.:-0361-2132204/2132205 Fax:- 0361-2732937 Email:- bimalokpal.guwahati@gbic.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
Hyderabad	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court" Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.:- 040-65504123/23312122 Fax:- 040-23376599 Email:- bimalokpal.hyderabad@gbic.co.in	Andhra Pradesh, Telangana, Yanam and part of the Territory of Pondicherry.

Jaipur	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 -2740363 Fax: 0141 -Bimalokpal.jaipur@gbic.co.in	Rajasthan.
Ernakulam	Office of the Insurance Ombudsman, 2nd Floor, CC 27 / 2603, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.:-0484-2358759/9338 Fax:-0484-2359336 Email:- bimalokpal.ernakulam@gbic.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
Kolkata	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4, C.R. Avenue, 4th Floor, KOLKATA - 700 072. TEL : 033-22124340/22124339 Fax : 033-22124341 Email:- bimalokpal.kolkata@gbic.co.in	West Bengal, Sikkim, and Andaman and Nicobar Islands.
Lucknow	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow-226 001. Tel.:- 0522-2231330/1 Fax:-0522-2231310 Email:-bimalokpal.lucknow@gbic.co.inmailto:ioblko@sanch arnet.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.

Mumbai	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.:- 022-26106552/6960 Fax:- 022-26106052 Email: bimalokpal.mumbai@gbic.in	Goa, Mumbai Metropolitian Region excluding Navi Mumbai & Thane
Noida	**Shri. Ajesh Kumar** Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector Distt: Gautam Buddh Nagar, 201301. Tel.: 0120-2514250 / 2514252 / 2514253 bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, U.P-Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Email: Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region

The details of Insurance Ombudsman are available on IRDA website: www.irda.gov.in, on the website of General Insurance Council: www.gicouncil.in, Our website www.rahejaqbe.com or from any of the Our offices.

Address and contact number of Governing Body of Insurance Council –

EXECUTIVE COUNCIL OF INSURERS

3rd Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz(W),
MUMBAI – 400 054
Tel:022-26106245
Fax : 022-26106949
Email-inscoun@ecoi.co.in

Smt Moushumi Mukherji,
The Secretary

3rd Floor, Jeevan SevaAnnexe,
S.V. Road, Santacruz (W),
MUMBAI – 400 054.
Tel : 022 26106980
Fax : 022-26106949

Annexure I (Non Medical Expenses)

Sl. No	Expenses Not Admissible	Admissibility	Remarks
1	Abdominal Belt / Binder	Essential and should be paid in post surgery patients of major abdominal surgery including TAH LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.	
3	Admission Fee	Not Payable	
4	Admission Kit	Not Payable	
5	Aesthetic Treatment/ Surgery	Not Payable	
6	Sugar Free Tablets	Payable- Sugar free variants of admissible medicines are not Excluded	
7	Nimbus Bed or Water or Air Bed Charges	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at reasonable cost of approximately Rs. 200/ Day	
8	Ambulance Collar	Not Payable	
9	Ambulance Equipment	t Payable	
10	Ambulance	Payable-Ambulance from home to hospital or inter-hospital shifts is payable/ RTA as Specific	
11	Walking Aids Charges	Not Payable	
13	Any Expenses when the patient is diagnosed Retro Virus + or suffering from /HIV/ Aids etc is detected/ directly or indirectly	Not Payable as per HIV/AIDS exclusion	
14	Any Kit with no details mentioned [Delivery kit, Orthokit, Recovery kit, etc]	Not Payable unless medically required	To find out the contents of the Kit and if they are medically required, payable
15	Apron	Not Payable unless it is	If it is disposable one, to allow

		Disposable	
16	Slings	Reasonable costs for one sling in case of upper arm fractures should be considered	
17	Arthroscopy & Endoscopy Instruments	Rental charged by the hospital allowed. Purchase of instruments not payable.	
18	Attendant Charges	Not Payable	
19	Baby Bottles	Not Payable	
20	Baby Food	Not Payable	
21	Baby Set	Not Payable	
22	Band Aid	Not Payable	Part of Dressing Charges
23	Bandages	Not Payable	Part of Dressing Charges
24	Barber Charges	Not Payable	
25	Beauty Services	Not Payable	
26	Bed Pan	Not Payable	
27	Belts	Essential and may be paid specifically for cases who have undergone surgery of thoracic or lumbar spine.	
28	Betadine \Scrub solution \Hydrogen Peroxide\Disinfectants etc	May be payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital	
29	Birth Certificate	Not Payable	
30	Blade	Not Payable, however Surgical Blades are payable in case of Surgery	
31	Blanket/Warmer Blanket	Not Payable	Part of Room Charges
33	Braces	Essential and may be paid specifically for cases who have undergone surgery of thoracic or lumbar Spine	
34	Brush	Not Payable	
35	Camera Cover	Not Payable	
36	Caps	Not Payable, however in case of Surgery, up to 5 will be payable	

37	CD / DVD/ Video cassette	Not Payable, however if CD is specifically sought by insurer/TPA then payable	
38	Cervical Collar	Not Payable	
39	Charges paid to Organ Donors	Not Payable	
40	Clean Sheet	Part of Laundry/Housekeeping. Not payable separately. However, disposable items that cannot be reused will be payable	Disposable items that cannot be reused will be payable
41	Cliniplast	Not Payable	
42	Cold Pack/Hot Pack	Not Payable	
43	Collars	Not Payable	
44	Comb	Not Payable	
45	Commode	Not Payable	
46	Cosmetics	Not Payable	
47	Cost of Spectacles/ Contact Lenses/ Hearing Aids etc.,	Not Payable	
48	Cotton	Not Payable, however in case of open wound and post-operative infected wounds – payable if dressing charges are not charged in the bill	
49	Cotton Bandage	Not payable, however, in case of open wound and post -operative infected wounds - payable if dressing charges are not charged in the bill	In case of open wound And post -Operative infected wounds - payable if Dressing charges are not charged in the bill
50	Cozy Towel	Not Payable	
51	CPAP/ CAPD Equipments	Not Payable	Hospital Rental only payable
52	Creams	Payable only if prescribed for medicinal use	
53	Crepe Bandage	Not payable unless in case of Varicose Vein Surgery/ Accident with open wounds	
54	Curapore/ Hansaplast- Adhesive Bandages	Not Payable	Part of Dressing Charges
55	Daily Chart Charges	Not Payable	

56	Dental Treatment Expenses that do not require Hospitalisation	Not Payable	
57	Diabetic Chart Charges	Not Payable	
58	Diabetic Foot Wear	Not Payable	
59	Diaper of any type	Not Payable	
60	Digestion Gel	Payable only when Prescribed	
61	Documentation Charges / Adminstrative Expenses	Not Payable	
62	Donor Screening Charges	Payable in accordance with the terms and conditions of the Policy	
63	Eye Drapes	Payable under OT charges, not separately	Disposable items that cannot be reused will be payable
64	Eau-de-Cologne / Room Freshners	Not Payable	
65	Email / Internet Charges	Not Payable	
66	Entrance Pass / Visitors Pass Charges	Not Payable	
67	Examination Gloves	Payable upto 15 No. in case of Surgery & two gloves per day for open wound when dressing charge is not charged	
68	Expenses for investigation/ Treatment irrelevant to the disease for which admitted or diagnosed	Not Payable	
69	Expenses related to Prescription on Discharge	To be claimed by patient under Post hosp where admissible	Not payable under Cashless
71	Eye Kit	To find out the contents of the Kit and if they are medically required, Payable	
72	Eyelet Collar	Not Payable	
73	Eye Pad	Only disposable items that cannot be reused will be payable	
74	Eye Shield	Only payable in case of eye surgery	Payable in case of eye surgery
75	File Opening Charges	Not Payable	
76	Foot Cover	Not Payable	
77	Gauze	Not payable, however, in case of open wound and post -operative	

		infected wounds - payable if dressing charges are not charged in the bill	
78	Gauze Soft	t payable, however, in case of open wound and post -operative infected wounds - payable if dressing charges are not arged in the bill	
79	Volini/ Zytee	Payable when prescribed for medicinal use	
80	Gloves - Sterile (For Surgery)	Payable for up to 10 in general and 25 in case of Surgery	
81	Accu Check (Glucometery/ Strips)	Not Payable pre hospitalisation or post hospitalisation/ Reports and charts required/Device not Payable	
82	Gown	Not Payable	
83	Guest Services	Not Payable	
84	Hand Holder	Not Payable	
85	Health Drinks - Horlicks, Viva, Bournvita & Protein Powder including Lactogen	Not Payable	
86	HIV Kit	Payable pre-operative Screening	
87	Home Visit Charges	Not Payable	
88	Hormone Replacement Therapy	Not Payable	Hospitalisation for an exclusive Harmonal Replacement therapy not warranted.
89	Hospitalisation for Evaluation/ Diagnostic Purpose	Not Payable	
90	IM/ IV Injection charges when Nursing is charged	Not Payable	Part of nursing charges
91	Incidental Expenses / Misc. Charges (Not Explained)	Not Payable	
92	Infertility/ Sub-fertility/ Assisted Conception Procedure	Not Payable	
93	Infusion Pump - Cost	Not Payable	Hospital Rental only payable
94	Kidney Tray	Not Payable	
95	Knee Braces (long/ short/ hinged)	Not Payable	
96	Knee Immobilizer/Shoulder	Not Payable	

	Immobilizer		
97	Laundry Charges	Not Payable	
98	Leggings	Essential in hariartric and varicose vein surgery and should be considered for these conditions where surgery itself is payable	
99	Lotions	Payable when Prescribed	
100	Lumbo Sacral Belt	Essential and should be paid specifically for cases who have undergone surgery of lumbar spine	
101	Luxury Tax	Actual tax levied by government is payable. Part of room charge for sub limits	
102	Oxygen Mask	Not Payable	
103	Medical Certificate	Not Payable	
104	Medicine Box	Not Payable	
105	Medico Legal Charges / MLC Charges	Not Payable	
106	Microshield	Not Payable	
107	Micropore	Not Payable, payable by the patient when prescribed, otherwise included as dressing Charges	
108	Microscope Cover	Payable under OT charges, not separately	
109	Mineral Water	Not Payable	
110	Moisturiser / Paste / Brush	Not Payable	
111	Mortuary Charges	Payable up to 24 hours, Shifting charges not payable	
112	Mouth Paint	Payable when Prescribed	
113	Mouth Washes like Listerene	Payable when Prescribed	
114	Napkins/ Towels	Not Payable	
115	Nebulizer Kit	Not Payable	
117	Novarapid	Payable when Prescribed	

118	Nutrition Planning Charges / Dietician Charges	Patient Diet provided by Hospital is payable	
119	Obesity (Including Morbid Obesity) Treatment	Not Payable	
120	Ortho-bundle, Gynaec Bundle	Not Payable	Part of dressing charges
121	Ounce Glass	Not Payable	
122	Outstation Consultant's/ Surgeon's Fees	Not Payable except for telemedicine consultations where covered by policy	
123	Oxygen Cylinder (for usage outside the hospital)	Not payable unless in case of Post-Hospitalisation expenses, cost of oxygen prescribed payable but not the cost of the cylinder	
124	Oxygen Mask	Not Payable	
125	Pan Can	Not Payable	
126	Paper Gloves	Not Payable	
127	Patient Identification Band / Name Tag	Not Payable	
128	Pelvic Traction Belt	Should be payable in case of PIVD requiring traction as this is generally not reused	
129	Photocopy Charges	Not Payable	
130	Preparation Charges	Not Payable	
131	Private Nurses Charges- Special Nursing Charges	Post hospitlization nursing charges not Payable	
132	Psychiatric & Psychosomatic Disorders	Not Payable	
133	Referral Doctor's Fees	Not Payable	
134	Admission/Registration Charges	Not Payable	
135	Abdomen Binder	Essential and should be paid in post surgery patients of major abdominal surgery including TAH LSCS incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.	
136	Sanitary Pad / Sanitary Napkins	Not Payable	
137	Service Charges Where Nursing Charge also Charged	Part of room charge not payable separately	

138	Shoe Cover	Not Payable	
140	Slippers	Not Payable	
141	Creams Powders Lotions (Toileteries are not payable,only prescribed medical pharmaceuticals payable)	Payable when prescribed	
142	Sofnet	Not Payable	
143	Softovac	Not Payable	
144	Spacer	Not Payable	
145	Spectacles	Not Payable	
146	Spirometre	Not Payable	
147	Splint	Not Payable	
148	SPO2 Probe	Not Payable	
149	Sputum Cup	Payable under investigation charges, not as consumables	
150	Steam Inhaler	Not Payable	
151	Stem Cell Implantation/ Surgery and storage	Not Payable except Bone Marrow Transplantation where covered by policy	
152	Stockings	Essential for case like CABG etc. where it should be paid	
153	Surcharges	Part of room charge, Not Payable separately	
155	Surgical Blades,Harmonic Scalpel,Shaver	Payable under OT charges and not separately, however disposable items that cannot be reused will be payable	
156	Surgical Drill	Payable under OT charges not separately	
157	TED Stockings\ Stockings	Not Payable	
158	Telephone Charges	Not Payable	
159	Television & Air Conditioner Charges	Payable under room charges and not if levied separately	
160	Thermometer	Not Payable	
161	Tissue Paper	Not Payable	
162	Tooth Brush	Not Payable	
163	Tooth Paste	Not Payable	
164	Tourniquet	Not Payable(service is charged by hospitals, consumables cannot be separately charged)	
165	Treatment of Sexually	Not Payable	

	Transmitted Diseases		
166	Trolley Cover	Not Payable	
167	Under Pads	Not Payable	
168	Urometer/ Urine Jug	Not Payable	
169	Vaccine Charges for Baby	Not Payable	
170	Washing Charges	Not Payable	
171	Weight Control Programs/ Supplies/ Services	Not Payable	
172	X-ray Film	Payable under radiology charges, not as consumable	

Annexure II Day Care Procedures:

Please Note: Below mentioned list is indicative, for additional updated list please refer to our website.

	DAY CARE SURGERIES
	Microsurgical Operations on the middle ear
1	Stapedotomy
2	Stapedectomy
3	Revision of Stapedectomy
4	Other operations on the auditory Ossicles
5	Myringoplasty (Type-I Tympanoplasty)
6	Tympanoplasty (Closure of Eardrum Perforation / reconstruction of the Auditory Ossicles)
7	Myringotomy with grommet insertion
8	Closure of Mastoid fistula
9	Revision of a Tympanoplasty
10	Other microsurgical operations on the Middle Ear
	Other Operations on the Middle and Internal Ear
11	Myringotomy
12	Benign Tumour removal from the external ear
13	Incision of the mastiod process and Middle ear
14	Simple Mastoidectomy
15	Reconstruction of the middle ear
16	Other excisions of the middle and inner ear
17	Fenestration of the inner ear
18	Revision of fenestration of the inner ear
19	Petrous Apicectomy
20	Other microsurgical operations on the inner Ear
	Operations on the nose and nasal sinuses
21	Excision and destruction of diseased tissue of the nose
22	Operation on Nasal Turbinates
23	Septoplasty (medically necessitated)
24	Functional Endoscopic Sinus Surgery
25	Endoscopic placement /removal of stents
	Operations on the Eyes
26	Dacrocystorhinostomy
27	Other Operations for tear gland/ duct lesions
28	Tarsorraphy
29	Excision of the diseased tissue of the eyelid
30	Operations of canthus and epicanthus when done for adhesions due to chronic infections
31	Corrective surgery of entropion
32	Corrective surgery for blepharoptosis
33	Excision of lacrimal sac and passage
34	Removal of a deep or embedded foreign body from cornea

35	Corrective surgery of ectropion
36	Operations for Pterygium with or without grafting
37	Other operations on the cornea
38	Removal of a foreign body from the lens of the eye
39	Removal of a foreign body from posterior chamber of the eye
40	Removal of a foreign body from orbit and eyeball
41	Cataract Surgery (ECCE or Phacoemulsification with or without intraocular lens implant)
42	Operation for glaucoma
43	Repair of corneal laceration or wound with conjunctival flap
	Operations on the skin and subcutaneous tissues
44	Surgery for pilonidal sinus
45	Surgical wound toilet (Wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues under anaesthesia
46	Local excision or destruction of diseased tissue of skin and subcutaneous tissues under anaesthesia
47	Surgery for pilonidal cyst
48	Free skin transplantation, recipient site
49	Revision of skin plasty
50	Chemosurgery for skin cancer
	Operations on the tongue
51	Incision, excision and destruction of diseased tissue of the tongue.
52	Partial glossectomy
53	Reconstruction of the tongue
54	Other Operations on the tongue
55	Incision and lancing of salivary glands and Salivary ducts
56	Excision of a diseased tissue of salivary glands and Salivary ducts
57	Resection of a salivary gland with or without salivary duct
58	Reconstruction of a salivary gland and salivary duct
59	Open Sialolithotomy
	Other operations on the mouth and face
60	External incision and drainage in the region of the mouth, jaw and face
61	Excision of the diseased hard and soft palate
62	Excision biopsy and/or destruction of diseased structures from the oropharynx.
63	Palatoplasty
64	Other operations in the mouth
	Operations on the tonsils and adenoids
65	Transoral incision and drainage of a pharyngeal abscess
66	Tonsillectomy without adenoidectomy
67	Tonsillectomy with adenoidectomy
68	Excision and destruction of a lingual tonsil
69	Drainage of tonsillar abscess/quinsy
	Trauma surgery and orthopaedics
70	Incision and Drainage of the bone for septic and aseptic conditions
71	Closed reduction of fracture
72	Closed reduction of sub-luxation
73	Epiphyseolysis with osteosynthesis
74	Suture and other Operations on tendons and tendon sheath
75	Reduction of dislocation under GA
76	Arthoscopic knee aspiration

S.No.	DAY CARE SURGERIES
	Operations on the breast
77	Incision and Drainage of breast abscess
78	Operations on the nipple except congenitally inverted nipples
	Operations on the digestive tract
79	Incision and excision of tissue in the perianal region
80	Surgical treatment of anal fistulas
81	Surgical treatment of Haemorrhoids.
82	Division of the anal sphincter (sphincterotomy)
83	Other operations of the anus
84	Ultrasound guided aspiration of deep seated rectal abscess
85	Sclerotherapy
86	Dilation of digestive tract strictures
87	Endoscopic gastrotomy
88	Endoscopic decompression of colon
89	Endoscopic Polypectomy
	Operations on the female reproductive organs
90	Incision of the ovary
91	Other operations on the Fallopian tubes
92	Dilatation of the cervical canal
93	Conisation of the uterine cervix
94	Incision of the Uterus (Hysterotomy) not done as a part of MTP
95	Therapeutic / diagnoistic dilatation and curettage (not done as part of MTP)
96	Culdotomy
97	Hymenectomy
98	Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
99	Incision and drainage of the Vulva
100	Operations on the Bartholin's glands(cyst)
101	Hysteroscope guided biopsy of uterus
102	Suprapubic cytostomy
	Operations on the prostate and seminal vesicles
103	Drainage of Prostatic abscess
104	Transurethral excision and destruction of prostate tissue
105	Percutaneous excision and destruction of prostate tissue
106	Excision of seminal vesicle
107	Incision and excision of periprostatic tissue
	Operations on the Scrotum and tunica vaginalis testis
108	Incision and Drainage of the Scrotum and tunica vaginalis testis
109	Operations on testicular hydrocele
110	Excision or Eversion of Hydrocele
	Operations on the testis
111	Incision and drainage of the testis
112	Excision or destruction of testicular lesion
113	Unilateral orchidectomy
114	Other operations on the testis
	Operations on the spermatic cord,Epididymis and ductus deferens
115	Surgical treatment of a varicocele and hydrocele of a spermatic cord
S.No.	**DAY CARE SURGERIES**
116	Excision of epididymal cyst
117	Epididymectomy

118	Other operations on the spermatic cord, epididymis and ductus deferens (other than vasectomy)
	Operations on the Penis
119	Circumcision and other Operations on the foreskin (if medically necessitated)
120	Local excision and destruction of diseased tissue of the penis
121	Other operations on the penis
	Operations on the Urinary system
122	Cystoscopic removal of stones
123	Lithotripsy
	Other Operations
124	Coronary angiography
125	Bronchoscopic treatment of bleeding lesion
126	Bronchoscopic treatment of fistula/stenting
127	Bronchoalveolar lavage and biopsy
128	Pericardiocentesis
129	Insertion of filter in Inferior Vena cava
130	Insertion of gel foam in artery or vein
131	Carotid angioplasty
132	Renal angioplasty
133	Tumor embolisation
134	Endoscopic drainage of pseudo pancreatic cyst
135	Varicose vain stripping or ligation
136	Excision of dupuytren's contracture
137	Carpal tunnel Decompression
138	PCNS (Percutaneous neprostomy)
139	PCNL(Percutaneous nephro lithotomy)
140	Nail bed deformity/resection and reconstruction

Annexure III: Optional Covers

I. Sub Limit Waiver:

In consideration of the payment of additional premium to Us, it is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, the sub limits specified for the Room Rent, ICU Charges and Medical Practitioner fees as specified in the Policy Schedule are waived off. subject otherwise to the terms, conditions and exclusions of the Policy.

II. Co-Payment Add on:

It is hereby agreed and declared that the Policyholder shall bear 20% of the final claim amount (assessed by Us in accordance with Clause 5.5) above and Our liability under the Policy shall be restricted to only the balance 80% of the final claim amount assessed by Us in accordance with Clause 5.5 of the Policy

Annexure IV: Schedule of Benefits*

Note: Family floater starts at 2 lakh Sum insured and above

In 20 Lakh and above Sum Insured, the Base coverage don"t have Sublimits of Section 1.

SI Limits→		Basic		Comprehensive^	Super Saver		A la carte	
		1 to 2Lakhs	3to50Lakh	3to50Lakh	1 to 2Lakhs	3to50Lakh	1 to 2Lakhs	3to50Lakh
Section a								
	In patient Hospitalisation	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Room Rent	1% of Sum Insured*		No Limit	1% of Sum Insured *		1% of Sum Insured * (can be waived with addon)	
	ICU Charges	2% of Sum Insured *		No Limit	2% of Sum Insured *		2% of Sum Insured * (can be waived with addon)	
	Doctor Fees	25% of Sum Insured *		No Limit	25% of Sum Insured *		25% of Sum Insured * (can be waived with addon)	
Section b								
	Pre Hospitalisation	30 Days	60 Days	60 Days	30 Days	60 Days	30 Days	60 Days
	Post Hospitalisation	60 Days	90 Days	90 Days	60 Days	90 Days	60 Days	90 Days
Section c								
	Ambulance Charges	Yes#	Yes#	Yes#	Yes#	Yes#	Yes#	Yes#
Section d								
	Daily Allowance	500 per day	NA	NA	500 per day	NA	500 per day	NA
Section e								
	Organ Donor Benefit	NA	20% of SI	20% of SI	NA	20% of SI	NA	20% of SI
Section f								

	Recharge/Replenish Benefit	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Section g								
	Medical Checkup(Slab Attached)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Section h								
	Non Medical Expenses (on Cashless Facility)	NA	Yes~	Yes~	NA	Yes~	NA	Yes~
Section i								
	Sum Insured Increase	10% on cashless	10% on cashless	10% on cashless	10% on cashless	10% on cashless	10% on cashless	10% on cashless
Section j								
	Domiciliary Hospitalisation@	Yes@	Yes@	Yes@	Yes@	Yes@	Yes@	Yes@
Section k								
	No Claim Bonus	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Addon Cover								
1	Sub limit waiver*	NA	NA	Inbuilt	NA	NA	NA	Optional
2	Co - Pay - 20%	NA	NA	NA	Inbuilt	Inbuilt	Optional	Optional
2 Year Policy Availability		Yes	Yes	Yes	Yes	Yes	Yes	Yes

"Optional" means available on payment of extra premium as per slab "Inbuilt" means available as part of plan without payment of premium

* In 20 Lakh and above Sum Insured, the Base coverage don"t have Sublimits of Section 1.

^comprehensive plan is not available for 1 Lakh and 2 Lakh Sum Insured.

Medical Checkup Slab

SI Band	1 to 5 Lakh	6 & 7 Lakh	8 to10 Lakh	11 to 50 Lakh
Set of Test>	Set 1	Set 2	Set 3	Set 4

~Non-Medical Expenses

SI Band	**Maximum Amount Per Day**
3 to 6 Lakh	1000
7 to 9 Lakh	2000
10 to 15 Lakh	3000
16 to 50 Lakh	5000

#Ambulance Charges

SI Band	**Maximum Amount Per Hospitalisation**
1 to 2 Lakh	500
3 to 9 Lakh	1500
10 to 50 Lakh	2500

@Domiciliary Hospitalisation

SI Band	**Max Amount**
1 to 2 Lakh	15,000
3 to 9 Lakh	25,000
10 to 20 Lakh	50,000
21 to 50 Lakh	1,50,000

Illness / Procedure Sub limits:

Surgery	**Maximum Amount Payable (INR)**
Cataract (inclusive of lens charges)-per eye	50000
Joint replacement surgery (inclusive of implants and revision surgery)-per joint	300000

Annexure V

Illustration of Restore/Recharge Benefit:

Policy period 1st Jan 2016 till 31st March 2016

	All Plans (Basic, Super Saver, Comprehensive and A la Carte)		
	Case 1	Case 2	Case 3
Sum Assured at beginning of the Year	5,00,000	5,00,000	5,00,000
NCB SI added	1,00,000	NA	NA
Total eligible SI	6,00,000	5,00,000	5,00,000
Claim on 15th Sep 2016 (Amount Payable by US)	6,00,000	5,00,000	4,00,000
Recharge/Replenish Benefit:	Triggered	Triggered	Not Triggered
SI applicable for reminder period of the policy	5,00,000	5,00,000	1,00,000
SI on Policy renewal	5,00,000	5,00,000	5,00,000
NCB SI on renewal	50,000	NA	NA

- Illustration for No Claim Bonus:
- 1 :

Sum Insured	Policy Yr	Claim (Yes / No) & amount	Change in NCB (Increaded /Decreased)
5,00,000	1	Yes - 1,00,000	Increased by 5 %
5,00,000	2	No	Increased by 5 %
5,00,000	3	No	Increased by 5 %

- There is no reduction in NCB amount as claim reported for one year only.

2.

Sum Insured	Policy Yr	Claim (Yes / No) & amount	Change in NCB (Increaded /Decreased)
5,00,000	1	Yes - 1,00,000	Increased by 5 %
5,00,000	2	Yes - 20,000	Increased by 5 %
5,00,000	3	No	Increased by 5 %

- 2 nd year claim amount is less than INR 50,000 or 10 % of opted Sum insured .So at renewal NCB increased by 5%

3.

Sum Insured	Policy Yr	Claim (Yes / No) & amount	Change in NCB (Increased /Decreased)
5,00,000	1	Yes - 7,000	Increased by 5 %
5,00,000	2	Yes - 15,000	Increased by 5 %
5,00,000	3	Yes - 25000	Increased by 5 %
5,00,000	4	Yes- 19000	Increased by 5 %

Though continuous claim for consecutive two years , but claim amount is less than INR 50,000 or 10% of opted Sum Insured.So at renewal ,NCB increased by 5%

4.

Sum Insured	Policy Yr	Claim (Yes / No) & amount	Change in NCB (Increaded /Decreased)
5,00,000	1	Yes - 7,000	Increased by 5 %
5,00,000	2	Yes - 150000	Decreased by 5 %
5,00,000	3	Yes - 250000	Decreased by 5 %
5,00,000	4	Yes- 19000	Increased by 5 %

- Consecutive 2 years claim where claim amount is greater than INR 50,000 or 10 % of opted Sum Insured; so NCB got decreased at renewal of 2nd and 3rd year. At renewal of 4th year,NCB got increased by 5% as claim amount (INR 19000) is less than INR 50,000 or 10% of opted Sum Insured

- However this reduction will not reduce the Sum Insured below the Sum Insured applicable before the commencement of the expiring Policy Year, and only the accrued NCB will be decreased.

- If the Insured Persons in the expiring policy are covered on individual basis and thus have accumulated the NCB for each member in the expiring policy, and such expiring policy is renewed with Us on a Family Floater basis, then the NCB which will be carried forward for credit in the Policy will be the least NCB amongst all the Insured Persons.

- The portability benefit under this Policy will be offered to the extent of sum of previous sum insured and accrued NCB, portability benefit shall not apply to any other additional increased Sum Insured.

- In policies with a two year Policy Period, the application of above provisions of NCB shall be become applicable only after the completion of the first Policy Year.

Illustration of Sum Insured Increase Benefit:

	All Plans(Basic, Super Saver, Comprehensive and A la Carte)		
	Case 1	Case 2	Case 3
Sum Assured at beginning of the Year	5,00,000	5,00,000	5,00,000
NCB SI added	1,00,000	NA	NA
Total eligible SI (A)	6,00,000	5,00,000	5,00,000
Claim (Amount Payable by US) (Cashless)---(B)	6,00,000	NA	4,00,000
90% of (B) deducted ----- (C)	5,40,000		3,60,000
Claim (Amount Payable by US) (Reimbursement)—(D)	NA	5,00,000	NA
SI applicable for reminder period of the policy (A-C-D)	60,000	0	1,40,000