# "Health QuBE" INSURANCE POLICY

**Prospectus:**

The Prospectus is intended to facilitate an easier understanding of the Policy terms, conditions and exclusions. It only gives a summary of the significant benefits and exclusions associated with this product. When issued the Policy attached with this statement represents the legal contract between yourself and Raheja QBE and should be seen for complete details.

If you need any clarification on coverage please call your nearest Raheja QBE office or your insurance adviser.

**Why Health Insurance Protection?**

No one plans to get sick or hurt, but most people require medical care at some point in their lives. Health insurance can cover these costs with many other benefits.
Without Health Insurance you may not be able to pay expensive medical expenses when you need them most.
You require health insurance so that you are not out of pocket when paying up your medical expenses.

**The policy will cover whom?**

The Policy would cover all the persons from the age group of 90 days to 65 years. The maximum entry age is restricted to 65 years. The minimum adult entry age for dependents is 18 years and the maximum entry age is 65 years.
Children up to 90 days till 5 years can only be covered provided either of his/her parent or legal guardian is insured with under the same policy( family floater).
Children up to 17 Years of age can be insured under the policy
Maximum cover ceasing age for children is 21 Years.In case of Family floater policies, The young adult would have an option on renewal to continue as an adult with the suitable change in premium slab.If the Plan cannot accommodate the young adult . We would offer him an Individual policy with equivalent SI and NCB vested at corresponding premium slab.
The policy provides for life long renewals.
The Policy can be issued for 1 or 2 years. The benefits are on policy year basis.
The policy can be issued on an Individual or Floater cover basis.
We cover maximum 6 members in a family floater and individual type of cover.
In a family floater policy age of eldest member is taken into consideration while computing the premium.

**Variants offered by the policy**

The Policy is available with sum insured options from Rs.1 Lakh to Rs.50 Lakh. The following four plans are available under the policy:

1. Basic Plan: This plan has in-built health insurance benefits, but does not contain an option to include any Add-on Covers.
2. Comprehensive Plan: This plan contains in-built health insurance benefits and contains Add-on covers for Sub Limit Waiver.
3. Super Saver Plan: This plan contains in-built health insurance benefits and contains Add-on covers for Co-Pay.
4. A la carte Plan: This plan contains in-built health insurance benefits and permits You to select from the Add-on covers available depending on Your requirements.

In this policy you can opt to change your plan on renewal

**In-built Health Insurance Benefits Available under all Variants::**

**Section a. Inpatient Benefit/ Hospitalization Benefit**

This policy covers Medical Expenses incurred in respect of the Insured Person in case of Medically Necessary Hospitalization or Day Care Procedure listed under Annexure II to the Policy Wordings that arises from an Accident or Illness. The Medical Expenses 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 sublimits on the Room Rent, room category, ICU Charges .

**Section b. Pre/Post Hospitalization Benefit**

We will reimburse the Pre- Hospitalisation Medical Expenses incurred in respect of the Insured Person at actuals up to the fixed number of days immediately prior to the Insured Person's date of Hospitalization as mentioned on the Policy Schedule provided that no claim has been admitted by Us under Section j – Domiciliary Hospitalisation.

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 provided that no claim has been admitted by Us under Section 10 – Domiciliary Hospitalisation.

We would not reimburse amount claimed under this section if the claim is not admitted under section 1 (Inpatient Benefit).

**Section c. Ambulance Cover**

We would cover expenses incurred on the Ambulance, subject to a maximum as per the Policy Schedule.

We would not reimburse amount claimed under this section if the claim is not admitted under section a (Inpatient Benefit).

**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.
This section is only applicable if it is mentioned in the schedule of benefit for the plans or SI band you have selected.

We would not reimburse amount claimed under this section if the claim is not admitted under section a (Inpatient Benefit).

**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 advise, at actuals up to the sublimit 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 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 (Inpatient Benefit).
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.

**Sectiong: Health Check-up**

The Insured Person 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 sub 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. We would not reimburse amount claimed under this section if the claim is not admitted under section a (Inpatient Benefit).

**Section i: Sum Insured Increase**

We will reduce the Insured Person's available limit, ie, the applicable Sum Insured plus any sum accrued as No Claim Bonus under Section k of the Policy, by 90% of the claim amount if the Cashless Facility is opted for at Our Network Providers, and provided that the claim is admissible under Section a.

**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 |

**Sectionj: 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 and no claim has been admitted by Us under Section b – Pre/Post Hospitalization Benefit for which the treatment is being taken as “Domicilary”.

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: No Claim Bonus (NCB)**

- 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.

- 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.

- 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

- Illustration

  1 :

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| 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 ( Increased /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 (Increased /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.

**Add-on Cover(s) available:**

We provide 2 add-on covers to make the policy more customized as per your choice.

**Add-on Cover 1: Sub Limit Wavier:**

On payment of additional premium as specified we would waive the sub-limits pertaining to room rent, ICU charges.

**Add-on Cover 2: Co-Pay:**

If you opt for co-pay of 20% we would give you a premium discount.

**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 | 25,000 | NA | NA |

**Portability:**

If you are insured continuously and without interruption under a health insurance plan issued by an Indian non life insurer and you want to shift to us on renewal, “Health QuBE” policy offers you transfer of accrued benefits and make due allowances for waiting periods etc. If the Insured Person transfers from any other insurer and enhances coverage, then the portability benefits will be offered only in respect to the previous sum insured.

The application for portability should be received by Us at least 45 days before the policy renewal date of the existing policy

**Free Look Period:**

You have a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of this Policy. If You have any objections to any of the terms and conditions, You have the option of canceling the Policy stating the reasons for cancellation and You shall be refunded the premium paid by You after adjusting the amounts spent on any medical check-up, stamp duty charges and proportionate risk premium. You can cancel your Policy only if You have not made any claims under the Policy.
Free look provision is not available at the time of renewal of the policy.

**Exclusions**

**Waiting period(s)**

1. The policy has an initial waiting period of 30 days for any illness. This is only applicable on new policies. It is not applicable on renewals or ported policies

2. The policy has a ailment/condition specific waiting period of 24 months from policy start date. The details of the ailments/conditions are

| | |
|---|---|
| Calculus diseases of gall bladder including Cholecystitis | Surgery of prostate |
| Pancreatitis | Surgery of Hydrocele/Rectocele |
| Fissure/fistula in anus, hemorrhoids, pilonidal sinus | Calculus diseases of Urogenital System and/or surgery of Prostate |
| Ulcer and erosion of stomach and duodenum | Cataract |
| GastroEsophageal Reflux Disorder (GERD) | Dilatation and curettage (D&C) |
| All forms of cirrhosis (cirrhosis due to alcohol will be permanent exclusion). | Non infective arthritis , Osteoarthrosis /Gout / Rheumatism / Spondylosis / Spondylitis / Intervertebral Disc Prolapse and joint replacement surgeries (other than cause by an accident). |
| Perineal and/or Perianal Abscesses | Varicose veins & Verocose Ulcers |
| Cholecystectomy and Surgery of hernia | Surgery on tonsils / adenoids |
| Internal tumors, cysts, nodules, polyps, skin tumors & and any type of breast lumps | Sinusitis/Rhinitis/Tonsillitis |
| Fibroids/Polycystic Ovarian Disease | 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 |
| Hysterectomy for menorrhagia or fibromyoma or prolapsed of uterus unless necessitated by malignancy, myomectomy for fibroids | i. Congenital Internal diseases and anomalies. |

**3.** 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.

**4.** Reduction in Waiting period:

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 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 cumulative 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.

**General Exlcusions:**

(i) Any expense, condition or treatment not admissible in Annexure – I (Non Medical Expenses)[Policy Wordings]. except to the extent covered under Section 8 – Non-Medical Expenses (if applicable) under the Policy.

(ii) Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T-Cell Lymphotropic Virus Type III (HTLV–III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.

(iii) 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 ectopic pregnancy.

(iv) 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 reproductive technology.

(v) 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.

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

(vii) 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.

(viii) Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, 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.

(ix) 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.

(x) Treatment of any Congenital External Anomaly or Illness

(xi) Treatment of mental illness, stress or psychological disorders.

(xii) 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 or burns.

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

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

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

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

(xvii) Non-allopathic treatment.

(xviii) Any OPD Treatment.

(xix) Treatment received outside India.

(xx) 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.

(xxi) 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.

(xxii) 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.

(xxiii) 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 or hallucinogens.

(xxiv) 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.

(xxv) Personal comfort and convenience items or services including but not limited to 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 similar incidental services and supplies. . except to the extent covered under Section h – Non-Medical Expenses (if applicable) under the Policy.

(xxvi) 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.

(xxvii) 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.

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

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

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

(xxxi) Any medical or physical condition or treatment or service, which is specifically excluded under the Policy Schedule.

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

**Claim Procedure:**

**Claim 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) 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.

(iii) 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 to 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 being made;

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

V Nature of Illness or Injury and its cause

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.

**Procedure for reimbursement of medical expenses:**

- 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.

**Procedure to avail cashless facility:**

(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 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.

It is agreed and understood that We may, at Our sole discretion, modify or add to the list of Network Provider or modify or restrict the extent of Cashless Facilities that may be availed at any particular Network Provider. For an updated list of Network Provider and the extent of Cashless Facilities available at each 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.

**Renewals:**

- 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.

- 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.
- 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.
- 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.
- 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.
- 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.
- No additional loading would be applied during renewals. For the additional SI enhancement request the loading may apply to the additional limit requested.
- 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.
-

**Tax Benefit:**

The premium amount paid under this policy qualifies for deduction under Section 80D of the Income Tax Act

**Cancellation (other than free look):**

- 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.

- In case you opt to cancel the policy you may do so by giving us 15 days notice. We would refund be premium on a Short scale basis.

| Cancellation date up to (x months) from Policy Start Date( 1Year 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% |

## 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.

| | | Basic | | Comprehensive^ | Super Saver | | A la carte | |
|---|---|---|---|---|---|---|---|---|
| | SI Limits→ | 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% per claim* | | 1% per claim* ( can be waived with addon) | |
| | ICU Charges | 2% of Sum Insured per claim* | | No Limit | 2% per claim* | | 2% per claim* ( can be waived with addon) | |
| | Doctor Fees | 25% Of Sum Insured per claim* | | No Limit | 25% per claim* | | 25% per claim* ( 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 wavier* | 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 to 10 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) | 50000 |
| Joint replacement surgery (inclusive of implants and revision surgery) | 300000 |

Pre- Acceptance Medical Test:

Pre-Policy Checkup at our network hospitals may be required based upon the age and Sum Insured. We will bear 100% of the expenses incurred per insured person on the acceptance of the proposal and also facilitate fixing of appointment for such tests. The medical reports are valid for a period of 90 days from the date of Pre-Policy Checkup.

| Age/Sum Insured | Sum Insured up to 5 Lac | Sum Insured 7 Lac & 10 Lac | Sum Insured above 10 Lac |
|---|---|---|---|
| **91 days to 18 years** | Nil | Nil | MER * |
| **19 years to 50 years** | Nil | Nil | Set 1 |
| **51years to 55 Years** | Set I | Set I | Set II |
| **55 Years and above** | Set II | Set II | Set II |

Set I : Medical Examination Report, Electrocardiogram,Total Cholestrol,HDL,LDL Serum Triglycerides, Hb1AC, Serum Creatinine, Complete Blood Countand Urinalysis
Set II : Medical Examination Report, Electrocardiogram, Complete Blood Count, Lipid Profile, Hb1AC, Serum Creatinine, Urinalysis SGOT, SGPT and GGT.

The Company reserves its right to require any individual to undergo medical tests or where required any further additional tests, at the sole discretion of the Company to determine the acceptance of a Proposal. Cost of additional test would be borne 100% by the company.

**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 cancel Your Policy and refund the premium paid within the next 15 days as per Policy terms and conditions.

**Pricing tables**

**Attached as separate document "Rate Card"**

Payment of Installment Premium is not permitted under this policy. Only single premium payment option is available.

Any revision or modification in the policy which is approved by the Authority shall be notified to Policyholder 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.

The Policy will be serviced by a Third Party Administrator. Initially We would be allocating the TPA of our choice. During Renewals the Policyholder may opt at its choice for any other TPAs empanelled with Us for this product upon giving Us a written application.

**Important Notice:**

This document is for your information and the description herein is a summary only. It does not attempt to provide full details of every aspect of cover, nor all exclusions or limitations which apply. For full details or clarifications, please read our policy wordings which are available on request or contact your insurance advisor.

Insurance is the subject matter of solicitation.