RAHEJA QBE

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Health QuBE

Policy wordings

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.

Operative clause

If during the Policy Period an Insured Person is required to be hospitalized for treatment of an Illness or Injury at a Hospital/ Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify Medically necessary, expenses towards the Coverage mentioned in the Policy Schedule.

Provided further that,

a. any amount payable under the policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions contained herein.
b. Maximum liability of the Company under all such Claims for the entire policy period, shall be the Sum Insured opted and mentioned in the Policy Schedule.
c. Maximum liability of the Company under all such Claims for the entire policy period, shall be the Sum Insured opted and mentioned in the Policy Schedule

2. Definitions

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

1. **Accident** means a sudden, unforeseen and involuntary event caused by external. visible and violent means.
2. **Acquired Immune Deficiency Syndrome (AIDS)** means the meaning assigned to it by the World Health Organization and shall include Human Immune deficiency Virus (HIV), Encephalopathy (dementia) HIV Wasting Syndrome and ARC (AIDS Related Condition).
3. **Age** means completed years as at the Policy Start Date specified in the Policy Schedule.
4. **Any one Illness** means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.
5. **Associated Medical Expenses** means medical expenses such as Professional fees, OT charges, Procedure charges, etc., which vary based on the room category occupied by the insured person whilst undergoing treatment in some of the hospitals. If Policy Holder chooses a higher room category above the eligibility defined in policy, then proportionate deduction will apply on the Associated Medical Expenses

in addition to the difference in room rent. Such associated medical expenses do not include Cost of

pharmacy and consumables, Cost of implants and medical devices and Cost of diagnostics.

6. **AYUSH Treatment** refers to the medical and/or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.
7. **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
    a. Central or State Government AYUSH Hospital; or
    b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
    c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
    I. Having at least 5 in-patient beds
    II. Having qualified AYUSH Medical Practitioner in charge round the clock
    III. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out
    IV. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

8. **AYUSH Day Care Centre** Means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health center which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:
    I. Having qualified registered AYUSH Medical Practitioner(s) in charge;
    II. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
    III. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

    (Explanation: Medical Practitioner referred in the definition of "AYUSH Hospital" and "AYUSH Day Care Centre" shall carry the same meaning as defined in the definition of "Medical Practitioner" under Chapter I of Guidelines)

9. **Break in Policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.
10. **Commencement Date** means the commencement date of this Policy as specified in the Policy Schedule.

11. **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.

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

13. **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.

14. **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.

15. **Diagnosis** means the identification of a disease/illness/medical condition made by a Medical Practitioner supported by clinical, radiological and histological, histo-pathological and laboratory evidence and also surgical evidence wherever applicable, acceptable to us.

16. **Diagnostic Test** means investigations such as X-ray or blood tests to find the cause of Your symptoms and medical condition.

17. **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 as under:-
    a. has Qualified Nursing staff under its employment:
    b. has a qualified medical practitioner(s) in charge;
    c. has a fully equipped operation theatre of its own where surgical procedures are carried out;
    d. maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

18. **Day Care Treatment** means medical treatment. and/or surgical procedure which is:
    undertaken under General or Local Anesthesia in a hospital/day care center in less than 24 hrs. because of technological advancement, and
    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

19. **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.

20. **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.

21. **Domiciliary Hospitalization** means medical treatment for an Illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
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.

22. **Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a Medical Practitioner to prevent death or serious long-term impairment of the Insured Person's health.

23. **Endorsement** means written evidence of change to the insurance Policy including but not limited to i ncrease or decrease in the policy period, extent and nature of the cover agreed by the Company in writing.

24. **Excluded hospital** means any hospital which is excluded from the hospital list of the company, due to fraud or moral hazard or misrepresentation indulged by the hospital.

25. **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:
    a. Legally married husband and wife as long as they continue to be married; and/or
    b. Two Dependent Parent/s and/or Two Dependent Parent-in-Law Up-to four of their children who are less than 25 years on the Policy Start Date specified in the Policy Schedule.

26. **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 the Policy in force without loss of continuity benefits pertaining to all the credits

(Sum Insured, No claim bonus, Specific waiting periods and waiting period for pre-existing diseases, moratorium period, etc.) accrued under the policy. Coverage will not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

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

27. **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:
    a. has qualified Nursing staff under its employment round the clock;
    b. has at least 10 inpatient beds, in those towns having a population of less than 10,00,000
    c. and at least 15 inpatient beds in all other places;
    d. has qualified Medical Practitioner(s) in charge round the clock;
    e. has fully equipped operation theatre(s) of its own where surgical procedures are carried out
    f. maintains daily records of patients and will make these accessible to the Insurance company's

authorized personnel.

28. **Hospitalization or Hospitalized** 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.

29. **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.

30. **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.

31. **In Patient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

32. **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.

33. **ICU Charges** (Intensive Care Unit) charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

34. **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.

35. **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.

36. **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.

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

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

39. **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.

40. **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.'

41. **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

42. **Medically necessary treatment** is defined as any treatment, tests, medication. or stay in Hospital or part of a stay in Hospital which:
is required for the medical management of the Illness or injury suffered by the You;
must not exceed the level of care necessary to provide safe. adequate and appropriate medical care in scope, duration. or intensity;
must have been prescribed by a Medical Practitioner;
must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

44. **Migration:** means the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. from one health insurance policy to another with the same insurer.

45. **Material facts** shall mean all relevant information as sought by the company in the proposal form and all other connected documents which form basis on which the policy is issued to enable the Company to take informed decision in the context of underwriting and the risk parameters.

46. **Material Duties** shall mean the essential tasks, functions and operations, and the skills, abilities, knowledge, training & experience, generally required by the Employers from the full-time confirmed employees engaged in a particular occupation and cannot be reasonably modified or omitted.

47. **Material Change:** The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and /or premium, if necessary, accordingly.

48. **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.

49. **No claim Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium or discount in renewal premium.

50. **Non- Network** means any hospital, day care center or other provider that is not part of the network.

51. **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.

52. **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.

53. **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).

54. **Policy Period** means the period between the commencement date and earlier of
    a. The Expiry Date specified in the Policy Schedule
    b. The date of cancellation of this Policy by either Policyholder or Insurer in accordance with General Condition.

55. **Policy Year** means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such a twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule.

56. **Policy Schedule** means that portion of the Policy which sets out Your personal details, the type and plan of insurance cover in force, the Policy duration and sum insured etc. Any Annexure or Endorsement to the Schedule shall also be a part of the Schedule.

57. **Pre-existing Disease** means any condition, ailment, Injury or disease:
    That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer **OR**
    For which medical advice or treatment was recommended by, or received from, a physician not more than 36 months prior to the date of commencement of the policy.

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

59. **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 Hospitalization was required, and

ii. The In-patient Hospitalization claim for such Hospitalization is admissible by Us.

60. **Proposal form** means a form to be filled in by the prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the Insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.

61. **Proposer** means the person who has signed in the proposal form and named in the Policy Schedule.

62. **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc., from the Existing Insurer to the Acquiring Insurer in the previous policy.

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

64. **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.

65. **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.

66. **Room Rent** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

67. **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.

68. **Sub-limit means** a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit.

69. **Subrogation** shall mean the right of the Insurer to assume the rights of the Insured person to recover expenses paid out under the Policy that may be recovered from any other source.

70. **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.

71. **Specific Waiting Periods** means a period up to 36 months from the commencement of a Health Insurance Policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break

72. **"Third Party Administrators or TPA"** means any person who is registered under the lRDAl (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.

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

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

75. **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.

Benefits/Cover

This Policy provides You the options of the following Plans:

Basic, Comprehensive, Super saver and A 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

This policy covers Medical Expenses incurred in respect of the Insured Person in case of Medically Necessary Hospitalization or Day Care Procedures as defined, that arises from an Accident or Illness.

We will cover the Medical Expenses for one or more of the following arising out of an Insured Person's Hospitalization during the Policy Period following an Illness or Injury that occurs during the Policy Period: Reasonable and Customary Charges for Room Rent for accommodation in Hospital room and other boarding charges up to the limits as specified in the Policy Schedule /

Product Benefit Table of this Policy;

ICU Charges; Medical Practitioner's fees, including fees of surgeon, consultants, physicians, specialists and anesthetists treating the Insured Person; Qualified Nurses charges; Operation theatre expenses, Anesthesia, blood, oxygen and blood transfusion charges, Cost of Pacemaker, Diagnostic materials and X rays, Dialysis, Chemotherapy, radiotherapy; Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner; Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized; Surgical appliances and allowable prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

Note: -

1) The Hospitalization is medically necessary and follows the written advice of a Medical Practitioner.

2) If the Insured Person is admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule/ Product Benefit Table of this Policy, then the Insured Person shall bear a ratable proportion of the total Associated Medical Expenses in the proportion of the difference between the Room Rent of the entitled room category to the Room Rent actually incurred.

(i) For the purpose of this Section “Associated Medical Expenses” shall include - Room Rent, nursing charges, operation theatre charges, Practitioner including surgeon/ anesthetist/ specialist within the same Hospital where the Insured Person has been admitted. “Associated Medical Expenses” does not include cost of pharmacy and consumables, cost of implants and medical devices and cost of diagnostics.

(ii) Proportionate deductions are not applicable for ICU charges. (iii) Proportionate deductions are not applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

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 Persons 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, in case of 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 donors pre and post Hospitalization 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 be 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 Hospitalization

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. Diarrhea,
c. All Dysenteries including Gastroenteritis,
d. Pyrexia of unknown origin,
e. Diabetes Mellitus and Insipidus.
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 4 of this Policy and the Policy is renewed with Us without any break, then insured is eligible for a No Claim Bonus which can be redeemed by choosing any one of the following options at the time of renewal.

Option 1: Increase in Sum insured

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.

c) 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.

d) 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.

e) 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.

f) The portability benefit under this Policy will be offered to the extent of sum of previous sum insured and

g) 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 the above provisions of NCB shall become applicable only after the completion of the first PolicyYear.

*Illustrations attached in Annexure V

Option 2: Discount in renewal Premium

A discount of 1% shall be awarded on the renewal premium.

In case a claim is made in any particular year, no discount in premium will be offered at the time of renewal. If a claim is made in the expiring Policy Year and is notified to Us after the acceptance of Renewal premium any discount awarded shall be withdrawn and same needs to be paid to us before policy renewal or Grace period, for policy to be effective and in-force.

Section L: Advance Treatment

We will pay the cost of the treatment listed below or part of the treatments (wherever medically indicated) either as in-patient or as part of domiciliary hospitalization or as day care treatment in a hospital. A co-payment of 50% will be applicable for all admissible claims under this benefit.

1. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
2. Balloon Sinuplasty
3. Deep Brain stimulation

4. Oral chemotherapy
5. Immunotherapy- Monoclonal Antibody to be given as injection
6. Intravitreal injections
7. Robotic surgeries
8. Stereotactic radio surgeries
9. Bronchial Thermoplasty
10. Vaporization of the prostrate (Green laser treatment or holmium laser treatment)
11. IONM - (Intra Operative Neuro Monitoring)
12. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

Section M: 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. Voluntary Co-Payment Option:

It is hereby agreed and declared that the Policyholder shall bear 20% of the final admissible 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

III. Home care treatment expenses

i. If Insured has opted for this Cover, Home Care Treatment means Treatment availed by the Insured Person at home for illness or accident, which in normal course would require care and treatment at a hospital but is actually taken at home maximum up to 14 days per incident provided that:
ii. The Medical practitioner advices the Insured person to undergo treatment at home.
iii. There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment.
iv. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.
v. Insured shall be permitted to avail the services as prescribed by the medical practitioner. Cashless or reimbursement facility shall be offered under homecare expenses subject to claim settlement policy disclosed in the website.
vi. In case the insured intends to avail the services of non-network provider claim shall be subject to reimbursement, a prior approval from the Insurer needs to be taken before availing such services.
vii. The payment under this benefit is within the Base Cover, subject to limits specified, if any.

IV. OPD Rider

If Insured has opted for this cover, we will cover the reasonable and customary charges incurred towards doctor consultation charges for medical illness or injury of the insured person in an outpatient setup as specified in the Policy schedule provided that

i. the medical consultation fees are necessary as per the medical practitioner.
ii. The benefits payable under outpatient cover shall be upto the limit specified in the Policy schedule and the copay and deductible shall be applicable as specified in the Policy schedule.

The payment under this benefit is over and above the Base Cover, subject to limits specified, if any
Specific exclusions for this cover:

1. Dentures, dental treatment, and surgery of any kind.
2. Complications arising out of pregnancy, miscarriage, etc.
3. Sterility, infertility, and other related conditions.
4. Investigational treatments or experiments.
5. Vaccination including inoculation and immunizations except in case of post-bite treatment such as a dog bite.
6. OPD treatment outside India.
7. Cost of spectacles, lenses, implants, hearing aids, prosthetic devices, braces, etc.
8. Treatments for beautification, purification, detoxification, panchakarma, etc.
9. Facilities or services availed for rejuvenation, pleasure, etc.
10. The exclusion mentioned in section 5.18 stands deleted if this cover is opted. All other exclusions mentioned in the policy will be applicable.

4. Waiting Period

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

4.1 Pre-Existing Diseases (Code- Excl01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI Insurance Regulatory and Development Authority of India (Insurance Products) Regulations, 2024 read with Master Circular on IRDAI (Insurance Products) Regulations 2024 - Health Insurance as amended from time to time, then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

4.2. First Thirty Days Waiting Period (Code- Excl03)

i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

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

4.3 Specific Waiting Period: (Code- Excl02)

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

I.24 Months waiting period

i. Calculus diseases of gall bladder including Cholecystitis
ii. Pancreatitis
iii. Fissure/fistula in anus, hemorrhoids, pilonidal sinus
iv. Ulcer and erosion of stomach and duodenum
v. Gastroesophageal Reflux Disorder (GERD)
vi. 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, skin tumors and any type of breast lumps
xvi. Chronic Suppurative Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis, 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

II. **36 Months waiting period**

1. Waiting period of 36 months will be applicable under the Policy to all Pre-existing Diseases, and those specifically declared and accepted at the time of proposal.
2. Schizophrenia (ICD code: F20 to F29)
3. Psychosis (IDC code: F29)
4. Dissociative and conversion disorder (ICD Code: F44.9)

4. Exclusions

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

5.1 Investigation & Evaluation:(Code- ExcI04)

a) Expenses related to any admission primarily for diagnostics and evaluation purposes.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

5.2 Rest Cure, rehabilitation and respite care: (Code- ExcI05)

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

I. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
II. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

5.3 Obesity/ Weight Control: (Code- ExcI06)

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

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
a) greater than or equal to 40 or
b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
i. Obesity-related cardiomyopathy
ii. Coronary heart disease
iii. Severe Sleep Apnea
iv. Uncontrolled Type2 Diabetes

5.4 Change-of-Gender treatments:(Code-ExcI07)

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

5.5 Cosmetic or plastic Surgery: (Code- ExcI08)

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

5.6 Hazardous or Adventure sports: (Code- Excl09)
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

5.7 Breach of law: (Code- Excl10)
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

5.8 Excluded Providers: (Code-Excl11)
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

5.10 Treatments received in heath hydros, nature cure clinics, spas or similar establishments or

private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code- Excl13)**

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

5.12 Refractive Error: (Code- Excl15)
Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 diopters.

5.13 Unproven Treatments: (Code- Excl16)
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

5.14 Sterility and Infertility: (Code- Excl17)
Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, sterilization
(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
(iii) Gestational Surrogacy
(iv) Reversal of sterilization

5.15 Maternity Expenses: (Code - Excl18):

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

5.16 War (whether declared or not) and 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.

5.17 **Nuclear, chemical or biological attack as define below:**

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

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

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

5.18 Any expenses incurred on OPD treatment.

5.19 Treatment taken outside the geographical limits of India.

5.20 In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

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

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

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

6. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever the Sum Insured is enhanced, the completion of sixty continuous months would be applicable from date of enhancement of sums insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the Policy contract.

7. **Claims Intimation, Assessment and Management**

7.1 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 the following:

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 Hospitalization 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 \

(iii) planned Hospitalization.

(iv) 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.

(v) 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 Hospital.

(vi) 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.

7.2 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:

1. 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.

a. 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 Persons Hospitalization.

ii. 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

iii. 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.

III. 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.

IV. 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 Center.

(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 Persons or claimant s expense) to Us immediately and in any event within 15 days of Insured Persons discharge from Hospital.

7.3 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-authorization 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 time frames 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 by Us.
III. Our Medical Practitioner and representatives shall be given access and co- operation to inspect the Insured Persons 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 Master Circular on Operations and Allied Matters of Insurers 2024 - Health Insurance & Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024 and any amendments thereof or any other regulation which is applicable in place thereof.

7.4 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 and if require
X. Death Certificate from the municipal authorities; if require
XI. Death Summary from the Hospital authorities, if death is confirmed by the Hospital; if require
XII. Inquest/Panchanama Report; if require
XIII. Coroner's Report; if require

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 Persons name.

7.5 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 applicable limits.
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 7.5(a) (i) and (ii).

B. The claim amount assessed in Clause 7.5(a) above would be deducted from the following amounts in the following progressive order:
   i. Sum Insured:
   ii. No Claims Bonus;
   iii. Replenish/Recharge of Sum Insured (if applicable).

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.

List of TPA link - https://www.rahejaqbe.com/claims/health-claims

List of Blacklisted hospitals - Share link - https://www.rahejaqbe.com/hospital-locator

7.6 Payment Terms:

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

ii. 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.

iii. We shall have no liability to make payment of a claim under the Policy in respect of an

iv. Insured Person, once the Sum Insured, No Claim Bonus, Replenish/Recharge of Sum Insured(if applicable) for that Insured Person is exhausted during the policy year.

v. 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.

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

vii. 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.

7.7 Claim Settlement (Provision for Penal Interest):

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

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

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

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

7.8 Complete Discharge:

Any payment to the insured person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home or assignee, as the case may be, for any benefit under the policy shall in all cases be a full, valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

8 Conditions

8.1 Disclosure of information:

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

(Note: "Material facts" for the purpose of this policy shall mean all important, essential and relevant information sought by the company in the proposal form and other connected documents to enable him to

take informed decision in the context of underwriting the risk)

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

8.3 Condition Precedent to Admission of Liability:
The due observance and fulfillment of the terms and conditions of the policy by the insured person shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the Policy.

8.4 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.

8.5 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.

8.6 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 through a counteroffer 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 proposed by us.
Following loading shall be applicable for the premium payment options mentioned below.
1. Half Yearly Premium Payment Option: Loading of 2.70%
2.Quarterly Premium Payment Option: Loading of 3.50%

8.7 Mandatory Co-Payment:
The policy is subject to Mandatory 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.

8.8 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.

8.9 Multiple Policies:

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the policy holder 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.

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

iii. If the amount to be claimed exceeds the sum insured under a single Policy, the Insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

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

8.10 Portability:

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

For Detailed Guidelines on portability, kindly refer the link - https://www.rahejaqbe.com/frontend/images/health-basic- guideline/pdf/download/Portability_Migration_Guideline.pdf

8.11 Migration:

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company policy by applying for migration of the policy 30 days before the premium due date of his/her existing policy as per extant guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the proposed insured person will get the accrued continuity benefits in waiting periods as per extant guidelines on migration.
For Detailed Guidelines on migration, kindly refer the link -
https://www.rahejaqbe.com/frontend/images/health-basic-guideline/pdf/download/Portability_Migration_Guideline.pdf

8.12 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.

8.13 Free Look Period:

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting the policy.

The insured shall be allowed a period of thirty days from date of receipt of the Policy, whether received electronically or otherwise, to review the terms and conditions of the Policy. If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

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

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

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

8.14 Renewal Terms:

The Policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person provided that the policy is not withdrawn and also subject to conditions stated under clause 2.15. The renewal premium shall be paid to the Company on or before the date of expiry of the Policy or of the subsequent renewal thereof.

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

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

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

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

v. If not renewed within Grace Period after due renewal date, the Policy shall terminate.

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

8.15 Cancellation/Termination:

a) The policyholder may cancel this policy by giving 7 days written notice.
b) In case the Policyholder requests cancellation of the Policy, where no claims are made under the Policy, the Company shall refund proportionate premium for the unexpired policy period on prorate basis.
c) In case the Policyholder requests for cancellation of the Policy, where there are claims made under the Policy, then there shall be no refund of premium for the unexpired policy period.
d) The Company may cancel the policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud or non-cooperation by the insured person by giving 15

days' written notice. There would be no refund of premium upon cancellation on the abovementioned grounds.

8.16 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.

8.17 Communication:

i. 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.

ii. 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.
iii. 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.

8.18 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.

8.19 Premium Payment In Installment:
If the Insured Person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

Grace Period of following Days would be given to Pay the instalment premium due for the Policy.

Options	Installment Premium Option	Grace Period Applicable
Option 1	Yearly	30 Days
Option 2	Half yearly	30 Days
Option 3	Quarterly	30 Days

i. The Benefits provided under - "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.
ii. No interest will be charged If the instalment premium is not paid on due date.
iii. In case of instalment premium due not received within the grace period, the policy will

get cancelled and a fresh policy would be issued with fresh waiting periods after obtaining consent from the customer.
iv. In case of failure of transaction in ECS mode of payment and/or instalment premium due not received within the grace period, the policy will get cancelled and fresh policy would be issued with fresh waiting periods after obtaining consent from the customer.
v. In case of change in terms and conditions of the policy contract or in premium rate, the ECS authorization shall be obtained afresh ensuring an informed choice to the policy holder.
vi. The insurer can withdraw ECS mode of payment by giving 15 days' notice prior to the due date of premium payable.
vii. All terms and conditions for this product are as per Insurance Regulatory and Development Authority of India (Insurance Products) Regulations, 2024 read with Master Circular on IRDAI (Insurance Products) Regulations 2024 – Health Insurance as amended from time to time in respect of break in policy.

8.20 Fraud:
If any claim made by the insured person, is in any respect fraudulent. or if any false statement. or declaration is made or used in support thereof. or if any fraudulent means or

devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited.

Any amount already paid against claims which are found fraudulent later under this Policy shall be repaid by all person(s) named in the Policy Schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

I. the suggestion, as a fact of that which is not true and which the insured person does not believe to be true:
II. the active concealment of a fact by the insured person having knowledge or belief of the fact;
III. Any other , act fitted to deceive and
IV. any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the policy on the ground of Fraud. if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive. or beneficiaries.

8.21 Withdrawal of Policy:

i. The product will be withdrawn only after due approval from the Authority. We will inform the Policyholder in the event We may decide to withdraw the product.
ii. In such cases, where Policy is falling due for Renewal within 90 days from the date of withdrawal, We will provide the Policyholder one time option to renew the existing Policy with us or migrate to modified or new suitable health insurance policy withUs. Any Policy falling due for Renewal after 90 days from the date of withdrawal will have to migrate to a modified or new suitable health insurance policy with Us.

8.22 Possibility of Revision of Terms of the Policy Including the Premium Rates:

The Company, with prior approval of lRDAl. may revise or modify the terms of the Policy including the premium rates. The Insured Person shall be notified before the changes are effected.

8.23 Nomination:

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

9. Grievances:

In case of any grievance the Insured Person may contact the company through
Website: www.rahejaqbe.com
Toll free: 1800-102- 7723 (9 am to 8 pm, Monday to Saturday)
E-mail: customercare@rahejaqbe.com
Telephone: 022 – 69155050

For Senior Citizen: 1800-102- 7723 (9 am to 8 pm, Monday to Saturday)
E-mail: seniorcitizencare@rahejaqbe.com

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

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at:

RAHEJA QBE GENERAL INSURANCE COMPANY LIMITED
Fulcrum, 501 & 502, A Wing, 5th Floor, IA Project Road, Sahar
Andheri East, Mumbai 400059, India
Tel: 022 - 69155050
Website: www.rahejaqbe.com

Email: complaintsofficer@rahejaqbe.com

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://bimabharosa.irdai.gov.in/ If Insured person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance.

The contact details of Ombudsman offices are mentioned below:

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat, UT of Dadra and Nagar Haveli, Damanand Diu	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02 Email: oio.ahmedabad@cioins.co.in
Karnataka	Office of the Insurance Ombudsman, Jeevansoudha Building, PID No.57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru 560078. Tel.: 080-26652048/26652049, Email: oio.bengaluru@cioins.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, 1st floor, Jeevan Shikha, 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462011. Tel.: 0755 - 2769201 / 2769202 / 2769203 Email: oio.bhopal@cioins.co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneswar – 750009. Tel.: 0674 - 2596461 /2596455/2596429/2596003 Email: oio.bhubaneswar@cioins.co.in
Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.	Office of the Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: oio.chandigarh@cioins.co.in
Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai 600018. Tel. 044 – 24333668/ 24333678. Email: oio.chennai@cioins.co.in

Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel: 011 - 46013992/ 23213504/23232481 Email: oio.delhi@cioins.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Near Pan Bazar, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 / 2631307 Email: oio.guwahati@cioins.co.in
Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Hyundai Showroom, A.C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325 Email: oio.hyderabad@cioins.co.in
Rajasthan	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363 Email: oio.jaipur@cioins.co.in
Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.	Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G. Road, Kochi - 682 011. Tel: 0484 – 2358759 Email: oio.ernakulam@cioins.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands.	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: oio.kolkata@cioins.co.in
Districts of Uttar Pradesh : Lalitpur, 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.	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: oio.lucknow@cioins.co.in
List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: oio.mumbai@cioins.co.in
State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad,	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: oio.noida@cioins.co.in

Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	
Bihar, Jharkhand	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: oio.patna@cioins.co.in
State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region	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.: 020-24471175 Email: oio.pune@cioins.co.in
Area of Navi Mumbai, Thane District, Raigad District, Palghar District and **wards of Mumbai**, M/East, M/West, N, S and T."	Office of the Insurance Ombudsman, 2nd Floor, Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West)- 400604 Tel.: 022-20812868/69 Email: oio.thane@cioins.co.in

The details of Insurance Ombudsman are available on website: https://www.cioins.co.in/Ombudsman

On the website of General Insurance Council: www.gicouncil.in and our website www.rahejaqbe.com or from any of the Our offices.

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Annexure I

List I - Non Payable Items

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE

31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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List II - Items that **are to be subsumed** into Room **Charges**

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET

26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES

30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III - Items that are to be subsumed into Procedure Charges

1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUZE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE

20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE. GYNAEC BUNDLE

List IV- Items that are to be subsumed into costs of treatment.

1	Admission/Registration charges
2	Hospitalization for evaluation/Diagnostic purpose
3	Urine container
4	Blood Reservation charges and antenatal booking charges
5	Bipap Machine
6	CPAP/CAPD Equipment's
7	Infusion pump-cost
8	Hydrogen peroxide/spirit/disinfectant etc
9	Nutrition planning charges-Dietician charges-Diet charges
10	HIV KIT
11	Antiseptic mouthwash
12	Lozenges
13	Mouth paint
14	Vaccination charges
15	Alcohol swabs
16	Scrub solution/sterilium
17	Glucometer and strips
18	Urine Bag

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Annexure II Day Care Procedures (Indicative list) :

DAY CARE SURGERIES MICRO SURGICAL 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
11	Other Operations on the Middle and Internal Ear
12	Myringotomy
13	Benign Tumour removal from the external ear
14	Incision of the mastoid process and Middle ear
15	Simple Mastoidectomy
16	Reconstruction of the middle ear
17	Other excisions of the middle and inner ear
18	Fenestration of the inner ear
19	Revision of fenestration of the inner ear
20	Petrous Apicectomy
21	Other microsurgical operations on the inner Ear
22	Operations on the nose and nasal sinuses
23	Excision and destruction of diseased tissue of the nose
24	Operation on Nasal Turbinates
25	Septoplasty (medically necessitated)
26	Functional Endoscopic Sinus Surgery
27	Endoscopic placement /removal of stents
28	Operations on the Eyes
29	Dacryocystorhinostomy
30	Other Operations for tear gland/ duct lesions

31	Tarsorrhaphy
32	Excision of the diseased tissue of the eyelid
33	Operations of canthus and epicanthus when done for adhesions due to chronic infections
34	Corrective surgery of entropion
35	Corrective surgery for blepharoptosis
36	Excision of lacrimal sae and passage
37	Removal of a deep or embedded foreign body from cornea
38	Corrective surgery of ectropion
39	Operations for Pterygium with or without grafting
40	Other operations on the cornea
41	Removal of a foreign body from the lens of the eye
42	Removal of a foreign body from posterior chamber of the eye
43	Removal of a foreign body from orbit and eyeball
44	Cataract Surgery (ECCE or Phacoemulsification with or without intraocular lens implant)
45	Operation for glaucoma
46	Repair of corneal laceration or wound with conjunctival flap Operations on the skin and subcutaneous tissues
47	Surgery for pilonidal sinus
48	Surgical wound toilet (Wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues under anaesthesia
49	Local excision or destruction of diseased tissue of skin and subcutaneous tissues under anaesthesia
50	Surgery for pilonidal cyst
51	Free skin transplantation, recipient site
52	Revision of skin plasty
53	Chemosurgery for skin cancer
54	Operations on the tongue
55	Incision, excision and destruction of diseased tissue of the tongue.
56	Partial glossectomy
57	Reconstruction of the tongue
58	Other Operations on the tongue
59	Incision and lancing of salivary glands and Salivary ducts
60	Excision of a diseased tissue of salivary glands and Salivary ducts
61	Resection of a salivary gland with or without salivary duct
62	Reconstruction of a salivary gland and salivary duct
63	Open Sialo lithotomy
64	Other operations on the mouth and face
65	External incision and drainage in the region of the mouth, jaw and face aspiration
66	Excision of the diseased hard and soft palate
67	Excision biopsy and/or destruction of diseased structures from the oropharynx.
68	Palatoplasty
69	Other operations in the mouth
70	Operations on the tonsils and adenoids

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71	Transoral incision and drainage of a pharyngeal abscess
72	Tonsillectomy without adenoidectomy
73	Tonsillectomy with adenoidectomy
74	Excision and destruction of a lingual tonsil
75	Drainage of tonsillar abscess/quinsy
76	Trauma surgery and orthopaedics
77	Incision and Drainage of the bone for septic and aseptic conditions
78	Closed reduction of fracture
79	Closed reduction of sub-luxation
80	Epiphyseolysis with osteosynthesis
81	Suture and other Operations on tendons and tendon sheath
82	Reduction of dislocation under GA
83	Arthroscopic knee .
84	S. No. DAY CARE SURGERIES Operations on the breast
85	Incision and Drainage of breast abscess
86	Operations on the nipple except congenitally inverted nipples
87	Operations on the digestive tract
88	Incision and excision of tissue in the perianal region
89	Surgical treatment of anal fistulas
90	Surgical treatment of Haemorrhoids.
91	Division of the anal sphincter (sphincterotomy)
92	Other operations of the anus
93	Ultrasound guided aspiration of deep seated rectal abscess
94	Sclerotherapy
95	Dilation of digestive tract strictures
96	Endoscopic gastrotomy
97	Endoscopic decompression of colon
98	Endoscopic Polypectomy
99	Operations on the female reproductive organs
100	Incision of the ovary
101	Other operations on the Fallopian tubes
102	Dilatation of the cervical canal
103	Conisation of the uterine cervix
104	Incision of the Uterus (Hysterotomy) not done as a part of MTP
105	Therapeutic / diagnostic dilatation and curettage (not done as part of MTP)

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106	Culdotomy
107	Hymenectomy
108	Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
109	Incision and drainage of the Vulva
110	Operations on the Bartholin's glands(cyst)
111	Hysteroscope guided biopsy of uterus
112	Suprapubic cytostomy
113	Operations on the prostate and seminal vesicles
114	Drainage of Prostatic abscess
115	Transurethral excision and destruction of prostate tissue
116	Percutaneous excision and destruction of prostate tissue
117	Excision of seminal vesicle
118	Incision and excision of periprostatic tissue
119	Operations on the Scrotum and tunica vaginalis testis
120	Incision and Drainage of the Scrotum and tunica vaginalis testis
121	Operations on testicular hydrocele
122	Excision or Eversion of Hydrocele
123	Operations on the testis
124	Incision and drainage of the testis
125	Excision or destruction of testicular lesion
126	Unilateral orchidectomy
127	Other operations on the testis
128	Operations on the spermatic cord, Epididymis and ductus deferens
129	Surgical treatment of a varicocele and hydrocele of a spermatic cord
130	S.No. DAY CARE SURGERIES
131	Excision of epididymal cyst
132	Epididymectomy
133	Other operations on the spermatic cord, epididymis and ductus deferens (other than vasectomy)
134	Operations on the Penis
135	Circumcision and other Operations on the foreskin (if medically necessitated)
136	Local excision and destruction of diseased tissue of the penis
137	Other operations on the penis
138	Operations on the Urinary system
139	Cystoscopic removal of stones
140	Lithotripsy
141	Other Operations
142	Coronary angiography

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143	Bronchoscopic treatment of bleeding lesion
144	Bronchoscopic treatment of fistula/stenting
145	Bronchoalveolar lavage and biopsy
146	Pericardiocentesis
147	Insertion of filter in Inferior Vena cava
148	Insertion of gel foam in artery or vein
149	Carotid angioplasty
150	Renal angioplasty
151	Tumor embolization
152	Endoscopic drainage of pseudo pancreatic cyst
153	Varicose vain stripping or ligation
154	Excision of dupuytren's contracture
155	Carpal tunnel Decompression
156	PCNS (Percutaneous neprostomy)
157	PCNL(Percutaneous nephro lithotomy)
158	Nail bed deformity/resection and reconstruction

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Annexure IV: Schedule of Benefits

SI	Limits	Basic		Comprehensive^	Super Saver		A la carte	
		1 to 2 Lakhs	3 to50Lakh	3 to 50Lakh	1 to 2 Lakhs	3 to 50 Lakh	1 to 2 Lakhs	3 to 50Lakh
Section a								
	In patient Hospitalization	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Room Rent	1% of Sum Insured per day		No Limit	1% of Sum Insured per day		1% of Sum Insured Per Day	
	ICU Charges	2% of Sum Insured per day		No Limit	2% of Sum Insured per day		2% of Sum Insured Per Day	
	Doctor Fees (Medical Practitioners fees)	25% of Sum Insured per claim		No Limit	25% of Sum Insured per claim		25% of Sum Insured Per Claim	
Section b								
	Pre Hospitalization	30 Days	60 Days	60 Days	30 Days	60 Days	30 Days	60 Days
	Post Hospitalization	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								

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	Sum Insured Increase	**10% on Cashless claim payment**	**10% on Cashless claim payment**	**10% on Cashless claim payment**	**10% on Cashless claim payment`**	**10% on Cashless claim payment**	**10% on Cashless claim payment**	**10% on Cashless claim payment**
Section j								
	Domiciliary Hospitalization@	**Yes@**	**Yes@**	**Yes@**	**Yes@**	**Yes@**	**Yes@**	**Yes@**
Section k								
	No Claim Bonus	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Section I Optional Cover								
1	**Sub limit waiver***	**NA**	**NA**	**Inbuilt**	**NA**	**NA**	**NA**	**Optional**
2	**Voluntary Co - Pay - 20%**	**NA**	**NA**	**NA**	**NA**	**NA**	**Optional**	**Optional**
2 Year Policy Availability		**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Mandatory 20% Co-pay	**If entry age is 60 years and above**	**If entry age is 60 years and above**	**If entry age is 60 years and above**	**If entry age is 60 years and above**	**Inbuilt for all age/insured person**	**inbuilt for all age/insured person**	**If entry age is 60 years and above**	**If entry age is 60 years and above**

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

"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 doesn't have Sublimit of Section a. ^comprehensive plan is not available for 1 Lakh and 2 Lakh Sum Insured.

Medical Checkup Slab

SI Band	1 to 5 Lakh	6 to 7 Lakh	8 to 10 Lakh	15 to 50 Lakh
Set of Test	Set 1	Set 2	Set 3	Set 4

UIN: RQBHLIP25036V042425

Non-Medical Expenses

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

#Ambulance Charges

SI Band	Maximum Amount Per Hospitalization
1 to 2 Lakh	1000
3 to 9 Lakh	1500
10 to 50 Lakh	2500

@Domiciliary Hospitalization

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

Schizophrenia	50,000
Obsessive Compulsive Disorders	50,000
Psychosis	50,000

Annexure V

Illustration of Recharge/Replenish Benefit:

Policy period- 1st Jan 2023 till 31st Dec 2024

	All Plans (Basic. Super Saver. Comprehensive and A la Carte)		
	Case1	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 2023 (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	75,000	NA	NA

- **Illustration for No Claim Bonus:**
- 1 :

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	No	Increased by 5 %
5,00,000	3	No	Increased by 5 %

- There is no reduction in NCB amount as claim is made 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 %

- 2nd 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.

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