

Prospectus

1. Eligibility Criteria

Entry Age – Minimum	18 Years
Entry Age – Maximum	Lifelong
Exit age	No Exit age
Policy Term	1/2/3 Years
How can You cover Yourself	Individual basis (maximum up to 6 Persons having same/different Sum Insured) or Floater basis
Floater combinations	2 Adults
Who are covered (Relationship with	<ol style="list-style-type: none"> 1. Individual: Self, Legally married spouse, son, daughter, father, mother, brother, sister, mother-in-law, father-in law, grandmother, grandfather, grandson, granddaughter, uncle, aunt, nephew, niece, employee or any other relationship having an insurable interest. 2. Family Floater: Self, Legally married spouse, son, daughter, father, mother, employee and his/her dependents (Legally married Spouse, Children & Parents) or any other relationship having an insurable interest.

Note:-

- All the Age calculations are as per “Age Last Birthday” as on the date of first issue of Policy and / or at the time of Renewal.
- Option of Mid-term inclusion of a Person in the Policy will be only upon marriage .Additional differential premium will be calculated on a pro rata basis.
- Your Eligibility Criteria is Subject to Underwriting Criteria of the Company

2. Scope of Cover

A. GENERAL CONDITIONS APPLICABLE TO ALL THE BENEFITS AND OPTIONAL BENEFITS

1. The Eligibility Criteria, Benefits & Optional Covers mentioned in this Prospectus & Sales Literature form part of the coverage provided under the Policy.
2. In this document, words like “We”, “Us” or “Our/Ours” represents the Insurer i.e., “Religare Health Insurance Company” and “You” or “Your/Yours” represents the “Proposer” or “Insured Person(s).
3. The maximum, total and cumulative liability of the Company in respect of You for any and all Claims arising under this Policy during the Policy Year shall not exceed the Total Sum Insured for that Insured Person.
 - I. On Floater Basis, the Company's maximum, total and cumulative liability, for any and all Claims incurred during the Policy Year in respect of You, shall not exceed the Total Sum Insured.
 - II. For any single Claim during a Policy Year, the maximum Claim amount payable shall be sum total of Sum Insured and No Claims Bonus, Automatic Recharge, OPD Care (Optional Benefit) and Home Care (Optional Benefit).
 - III. All Claims shall be payable subject to the terms, conditions, exclusions, sub-limits and wait periods of the Policy and subject to availability of the Total Sum Insured.
 - IV. The Company's liability shall be restricted to the payment of the balance amount subject to the available Total Sum Insured.
4. The Co-payment proportion as specified in the Policy Schedule, shall be borne by You on each Claim which will be applicable on Benefit 1 (Hospitalization Expenses), Benefit 2 (Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses, Benefit 3 (Alternative Treatments), Benefit 4 (Ambulance Cover) and Benefit 5 (Domiciliary Hospitalization).
5. Deductible if opted is applicable on the Benefits namely Benefit 1 (Hospitalization Expenses), Benefit 2 (Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses), Benefit 3 (Alternative Treatments), Benefit 4 (Ambulance Cover) and Benefit 5 (Domiciliary Hospitalization).
6. Any Claim paid for Benefits namely Hospitalization Expenses, Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses, Alternative Treatments, Ambulance Cover, Domiciliary Hospitalization, shall reduce the Sum Insured for the Policy Year and only the balance shall be available for all the future claims for that Policy Year.
7. Admissibility of a Claim under Benefit “Hospitalization Expenses” is a pre-condition to the admission of a Claim under Pre Hospitalization Medical Expenses and Post Hospitalization Medical expenses, Alternative Treatment, Ambulance Cover, Automatic Recharge and Home Care subject to the event giving rise to a Claim under Benefit “Hospitalization Expenses” shall be within the Policy Period for the Claim of such Benefit to be accepted.
8. If You suffer a relapse within 45 days from the date of last discharge / consultation from the Hospital for which a Claim has been made, then such relapse shall be deemed to be part of the same Claim and all the limits of Per Claim Limit under this Policy shall be applied as if they were under a single Claim.
9. Option of Mid-term inclusion of a Person in the Policy will be only upon marriage. Additional differential premium will be calculated on a pro rata basis.
10. Coverage amount limits for Benefits 'OPD Care' and Home Care' are covered over and above the 'Sum Insured'.
11. Optional covers opted are available for all members in a floater policy. If You or any one belonging to the same family of Yours are covered on an Individual basis, then each can opt for different Sum Insured and different Optional Covers.
12. Any Claims made under the Benefits : Cardiac Health Check -up , OPD Care (Optional Benefit) , International Second Opinion (Optional Benefit) Active Health Check-up (Optional Benefit) and Home Care (Optional Benefit) will not affect the no claims bonus accrual under the Benefit :No Claims Bonus.

B. SPECIFIC CONDITIONS

Specific Conditions shall be applicable only if the Specific Condition is specified to be applicable to the Insured Person in the Policy Schedule.

- a) You will bear a Co-payment per Claim (as specified in the Policy Schedule) of the final amount admitted as payable by the Company in accordance with Clause 5.6 and the Company's liability shall be restricted to payment of the balance amount subject to the available Sum Insured.
- b) The applicable Co-payment will increase by 10% per Claim in the Policy Year following the Insured Person (or eldest Insured Person in the case of a Floater cover) attaining Age 71. If an Insured Person (or eldest Insured Person in the case of a Floater cover) attains age 71 years during the Policy Period, additional 10% co-payment will be applicable to the Policy only at the time of subsequent renewal.
- c) However, if your age at the time of issue of the first Policy with the Company is 70 years or below, then the Insured Person has an option to waive the condition for the additional 10% Co-payment upon payment of extra premium in this regard.
- d) The Co-payment shall be applicable to each and every Claim made, for each Insured Person.

2.1 Benefit 1 : Hospitalization Expenses

- (i) In-patient Care: Hospitalization for at least 24 hours - If You are admitted to a hospital for in-patient care due to Illness or Injury, which should be Medically Necessary, for a minimum period of 24 consecutive hours, We will pay for the medical expenses, through Cashless or Reimbursement Facility maximum up to Sum Insured, incurred by You at the hospital - from room charges, nursing expenses and intensive care unit charges to Surgeon's fee, Doctor's fee, Anesthesia, blood, oxygen, Operation theater charges which forms a part of Hospitalization. Please refer to the Schedule of Benefits for limits/sub-limits.
- (ii) Day Care Treatment: Hospitalization involving less than 24 hours – Some surgeries doesn't require or need not necessarily require Hospitalization Stay for minimum 24 Hours. It may be for Your convenience or it may happen that the surgery underwent is minor or of intermediate complexity. We will pay through Cashless or Reimbursement Facility for all such day care treatments as per Annexure-I to Prospectus, maximum up to Sum Insured.

2.2 Benefit 2 : Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses

- (i) Pre-Hospitalization Medical Expenses:
Examination, tests and medication - Sometimes the procedures that finally lead You to hospital, such as Investigative tests, Consultation Fees and medication, can be quite financially draining. We cover the medically necessary expenses (as per specified amount/limit) incurred by You for a period of 30 days immediately before the Date of Your Admissible Hospitalization, provided that We shall not be liable to make payment for any Pre-hospitalization Medical Expenses that were incurred before the Policy Start Date.
- (ii) Post-Hospitalization Medical Expenses:
Back home and till You are back on Your feet - The expenses don't end once You are discharged. There might be follow-up visits to Your medical practitioner, medication that is required and sometimes even further confirmatory tests. We also cover the medically necessary expenses (as per specified amount/limit) incurred by You for a period of 60 days immediately after the Date of Discharge of Your Admissible Hospitalization.

Note: Payment under this benefit will only be on re-imburement basis.

2.3 Benefit 3: Alternative Treatments

It has been observed at times that a combination of conventional medical treatment and alternative therapies quicken & aid the process of recovery. Therefore, We will pay You through Cashless or Reimbursement Facility up to a specified amount/limit for in-patient medical expenses incurred by You towards Your in-patient admission in a AYUSH Hospital registered with a Government authority under appropriate Act in the State/UT and having at least fifteen in-patient beds; minimum five qualified and registered AYUSH doctors; qualified paramedical staff under its employment round the clock; dedicated AYUSH therapy sections; and maintains daily records of patients and makes these accessible to the insurance company's authorized personnel or teaching hospitals of AYUSH colleges recognized by Central Council of Indian Medicine and Central Council of Homeopathy, in India, which administers treatment related to the disciplines of medicine namely Ayurveda, Unani, Sidha and Homeopathy. Clause 4.2 (20) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

2.4 Benefit 4: Ambulance Cover

It is one of our utmost concerns that you get the medical attention which you require as soon as possible, especially in an emergency. Towards that end, we will pay you up to a specified amount per hospitalization, for expenses that you incur on an ambulance service offered by the hospital or any service provider, in an emergency situation. Through this cover, we will also pay your necessary transportation fares from one Hospital to another Hospital, for advanced/better equipped medical support/aid required for rescuing your health condition.

2.5 Benefit 5: Domiciliary Hospitalization

Despite suffering from an Illness /Injury (which would normally require care and treatment at a Hospital), Hospitalization may not be possible - perhaps Your state of health is such that You are not in a condition to be moved to a Hospital or a Hospital room may not be available when you need the medical treatment the most. Under Our Domiciliary Hospitalization Benefit, We will pay you up to Sum Insured, for the Medical Expenses incurred during your treatment at home, as long as it involves medical treatment for a period exceeding 3 consecutive days. 'Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses' shall not be payable in respect of a claim made under this Benefit.

Any Medical Expenses incurred for the treatment in relation to any of the *following diseases shall not be payable under this Benefit:*

- (i) Asthma;
- (ii) Bronchitis;
- (iii) Chronic Nephritis and Chronic Nephritic Syndrome;
- (iv) Diarrhoea and all types of Dysenteries including Gastro-enteritis;
- (v) Diabetes Mellitus and Diabetes Insipidus;
- (vi) Epilepsy;
- (vii) Hypertension;
- (viii) Influenza, cough or cold;
- (ix) All Psychiatric or Psychosomatic Disorders;
- (x) Pyrexia of unknown origin for less than 10 days;
- (xi) Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis;

(xii) Arthritis, Gout and Rheumatism.

2.6 **Benefit 6: Automatic Recharge**

A refill is always welcome! So your sum insured is reinstated just when you need it the most.

If, due to claims made, you ever utilize the maximum limit of Sum Insured and thereby run out of/exhaust your health cover, we reinstate the entire sum insured immediately, once in the policy year.

This re-instated amount can be used for future claims which are not in relation to any Illness or Injury for which a Claim has already been admitted for You during that Policy Year. In case of a floater policy, the insured(s) who have not claimed will be eligible to utilize the Recharge amount for any illness or injury pertaining to that Policy Year.

- For any single Claim during a Policy Year the maximum Claim amount payable shall be sum of:
 - Sum Insured
 - No Claims Bonus (Benefit – 7)
- During a Policy Year, the aggregate Claim amount payable, subject to admissibility of the Claim, shall not exceed the sum of:
 - Sum Insured
 - No Claims Bonus (Benefit – 7)
 - Automatic Recharge (Benefit-6)
- Any unutilized Recharge cannot be carried forward to any subsequent Policy Year.
- Please note that No Claims Bonus (Benefit – 7) shall not be considered while calculating 'Automatic Recharge'.
- A Claim will be admissible under the Recharge only if the Claim is admissible under Benefit 1 (Hospitalization Expenses);
- The Sum Insured available under recharge can only be utilized for Benefit 1 (Hospitalization Expenses), Benefit 2 (Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses), Benefit 3 (Alternative Treatments), Benefit 4 (Ambulance Cover), Benefit 5 (Domiciliary Hospitalization).

2.7 **Benefit 7: No Claims Bonus:**

If no Claim has been paid by Us in the expiring Policy Year, we raise a cheer to your good health in the form of a bonus for you. You receive a flat increase of 10 per cent in your sum insured for the next Policy year. In any case the No Claims bonus will not exceed 50% of the Sum insured under the policy and in the event there is a claim in a policy year, then the No Claims bonus accrued will be reduced by 10% of the sum insured but in no case shall the Total Sum insured be less than the Sum insured. For every year that you enjoy un-interrupted good health, your bonus keeps building up! It's just our way to tell you that we're there with you in good times and in bad. The Recharge amount ('Automatic Recharge') shall not be considered while calculating 'No Claims Bonus'. Accrued 'No Claims Bonus' can only be utilized for Base Benefits. In case no claim is made in a particular Policy Year, No Claims Bonus would be credited automatically to the subsequent Policy year.

2.8 **Benefit 8: Cardiac Health Check-up**

Our prime concern is Your good health! To pre-empt Your ever having to visit a hospital, as a preventive measure, We provide a Cardiac health check-up on a Cashless basis for the set of medical tests specified below as per the Sum Insured (SI) at Our Network Provider/ Empanelled Provider in India for all the Insured Persons covered under the Policy, on a Cashless basis. This Benefit shall be available only once during a Policy Year per Insured Person.

a) Medical Tests Covered in the Cardiac Health Check-up applicable for SI=2L/ 3L/4L/5L

Cardiac Health Check – up set
Complete Blood Count with ESR
Urine RE
Blood Group
HbA1C
TMT
Lipid Profile
Kidney Function test
Liver Function test
TSH
Medical Examination Report
Hbs Ag
Chest X Ray

b) Medical Tests Covered in the Cardiac Health Check-up applicable for SI=7L/10L

Cardiac Health Check – up set
Complete Blood Count with ESR
Urine RE
Blood Group
HbA1C
TMT
Lipid Profile
Kidney Function test
Liver Function test
TSH
Medical Examination Report
Hbs Ag
Chest X Ray
2D Echo
APTT

3. Optional Benefits

The Policy provides the following Optional Benefits which can be opted either at the inception of the policy or at the time of renewal. The Policy Schedule will specify the Optional Benefits that are in force for the Insured Persons.

3.1 **Optional Benefit 1: OPD Care:**

We understand how trivial but important are bills pertaining to OPD consultations, diagnostics and medicines. Collectively, they can sum-up to cause a major financial impact.

Hence through this Optional Cover, we will pay you, through Reimbursement/Cashless facility maximum up to a specified amount/limit, for the following Out-patient care Services during the Policy Year -

- (a) Out Patient consultations
- (b) Diagnostic Examinations
- (c) Pharmacy

Note:

Coverage amount for Diagnostics will be 50% of the Coverage amount for OPD Care. Coverage for Optional Cover 'OPD Care' is provided for entire Policy year and is available to all the Insured members in a Floater Policy type along with Individual Policy type. All the valid OPD claim expenses incurred by You in a policy year will be payable / reimbursed by Us. However, claim can be filed with Us, only twice during that Policy year, as and when that You may deem fit.

3.2 **Optional Benefit 2: International Second Opinion:**

We take your illnesses as seriously as you do. If you are suffering from a serious illness (namely Benign Brain Tumor, Cancer, End Stage Lung Failure, Myocardial Infarction, Coronary Artery Bypass Graft, Heart Valve Replacement, Coma, End Stage Renal Failure, Stroke, Major Organ Transplant, Paralysis, Motor Neuron Disease, Multiple Sclerosis, Major Burns & Total Blindness) and feel uncertain about your diagnosis or wish to get a second opinion from a doctor anywhere in the world on your medical reports for any other reason, we arrange one for you without any impact on Sum Insured amount. This second opinion is available to every Insured Person, once for each Major Illness / Injury per Policy year.

3.3 **Optional Benefit 3: Home Care:**

We will indemnify only through Reimbursement for the expenses incurred towards hiring a Qualified Nurse with the purpose of providing necessary care and convenience to the Insured Person to perform his Activities of Daily Living, and are recommended by a Medical Practitioner in writing that the Insured is unable to perform at least two of the Activities of Daily Living, provided that the Claim is already admitted under Hospitalization Expenses for the same ailment and We will not indemnify for the expenses incurred for more than 7 consecutive days arising from Any One Illness or an Injury and for the first day of hiring the Qualified Nurse subject to a maximum of 45 days in a Policy Year per Insured Person.

Please note that this Benefit can only be availed within 30 days of last Discharge Date from the Hospital.

Exclusion for only Rehabilitation measures, private duty nursing, respite care private duty nursing mentioned in Clause 4.2 (12) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

3.4 **Optional Benefit 4: Active Health Check-up:**

On the Insured Person's request, the Company will arrange for the Insured Person's Health Check-up for the set of medical tests specified below irrespective of the Sum Insured at its Network Provider or any other Empanelled Providers with the Company to provide the services on a Cashless basis, in India provided that this Benefit shall be available only thrice (one set at a time) during a Policy Year for each insured covered under the Policy.

Please note that coverage under this Benefit is over and above the coverage for Benefit 8: Cardiac Health Check –up .set of Medical Tests covered under this Benefit are as below:

Active Health Check-up set
Blood Pressure
Lipid Profile
Fasting & PP Blood Sugar

4. Exclusions

4.1. Wait Period

(i) Initial Waiting Period

- a) Claim for any Medical Expenses incurred for treatment of any Illness during the first 30 days from the Policy Period Start Date shall not be admissible, except those Medical Expenses incurred as a result of an Injury within the Policy Period.
- b) This exclusion shall not apply for subsequent Policy Years provided that there is no Break in Policy for that Insured Person and that the Policy has been renewed with us for that Insured Person within the Grace Period and for the same or lower Sum Insured.

(ii) Specific Waiting Period

Any Claim for or arising out of any of the following Illnesses or Surgical Procedures shall not be admissible during the first 24 (twenty four) consecutive months of coverage of the Insured Person by us from the first Policy Period Start Date:

- I Arthritis (if non-infective), Osteoarthritis and Osteoporosis, Gout, Rheumatism and Spinal Disorders, Joint Replacement Surgery;
- II Surgical treatments for Benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to Adenoidectomy, Mastoidectomy, Tonsillectomy and Tympanoplasty), Nasal Septum Deviation, Sinusitis and related disorders;
- III Benign Prostatic Hypertrophy;
- IV Cataract;
- V Dilatation and Curettage;
- VI Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, Ulcers of Gastro Intestinal tract;
- VII Surgery of Genito urinary systems;
- VIII All types of Hernia, Hydrocele;
- IX Hysterectomy for menorrhagia or fibromyoma or prolapse of uterus;
- X Internal tumors, skin tumors, cysts, nodules, polyps including breast lumps;
- XI Kidney Stone / Ureteric Stone / Lithotripsy / Gall Bladder Stone;
- XII Myomectomy for fibroids;
- XIII Varicose veins and varicose ulcers;
- XIV Pancreatitis;
- XV End stage liver disease;
- XVI Procedures for Retinal disorders;
- XVII Cerebrovascular accident;
- XVIII Renal Failure / End Stage Renal Disease;
- XIX Cardiomyopathies;
- XX Myocardial Infarction;
- XXI Heart failure, Arrhythmia / Heart blocks ,ASD/VSD/PDA;
- XXII All types of Cancer;
- XXIII Arthroscopic Knee Surgeries/ACL Reconstruction/Meniscal and Ligament Repair.

If an Insured Person is suffering from any of the above Illnesses, conditions or Pre-existing Diseases at the time of commencement of first policy with the Company, any Claim in respect of that Illness, condition or Pre-existing Disease shall not be covered until the completion of 24 months of continuous insurance coverage with the Company from the first Policy Period Start Date.

- (iii) **Wait Period for Pre-existing Diseases:** Claims will not be admissible for any Medical Expenses incurred for Hospitalization in respect of diagnosis/treatment of any Pre-existing Disease until 24 months of continuous coverage has elapsed, since the inception of the first Policy with us.
- (iv) If the Sum Insured is enhanced on any renewal of this Policy, the waiting periods as defined above in Clauses 4.1(i), 4.1(ii) and 4.1(iii) shall be applicable afresh to the incremental amount of the Sum Insured only.
- (v) If the Sum Insured is reduced on any renewal of this Policy, the credit for waiting periods as defined above in Clauses 4.1(i), 4.1(ii) and 4.1(iii) shall be restricted to the lowest Sum Insured under the previous Policy.

- (vi) The Waiting Periods as defined in Clauses 4.1(i), 4.1(ii) and 4.1(iii) shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.
- (vii) If Coverage for Benefits (in case of change in Product Plan) or Optional Benefits are added afresh at the time of renewal of this Policy, the Waiting Periods as defined above in Clauses 4.1 (i), 4.1(ii) and 4.1(iii) shall be applicable afresh to the newly added Benefits or Optional Benefits, from the time of such renewal.

4.2. Permanent Exclusions:

Any Claim in respect of any Insured person for, arising out of or directly or indirectly due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy terms and conditions.

The following list of permanent exclusions is applicable to all the Benefits including Optional Benefits:

1. Any item or condition or treatment specified in List of Non-Medical Items (Annexure – II to Policy Terms & Conditions).
2. The Company shall not admit any Claim in respect of an Insured Person which involves treatment/consultation in any of the hospitals as listed in Annexure – III to the Policy Terms & Conditions.
3. Treatments rendered by a Doctor who shares the same residence as an Insured Person or who is a member of an Insured Persons's family.
4. Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T-Cell Lymphotropic Virus Type III (HTLV–III or IITLB-III) or Lymphadenopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.
5. Any treatment arising from or traceable to pregnancy (including voluntary termination), miscarriage (unless due to an Accident), childbirth, maternity (including caesarian section), abortion or complications of any of these.
6. Any treatment arising from or traceable to any fertility, sterilization, birth control procedures, contraceptive supplies or services including complications arising due to supplying services or assisted reproductive technology.
7. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.
8. Charges incurred for Treatment/Diagnosis in connection with eye, ear and dental and all other external appliances and/or devices whether for diagnosis or treatment.
9. Unproven/Experimental or investigational treatments which are not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness for which confinement is required at a Hospital. Any Illness or treatment which is a result or a consequence of undergoing such experimental or unproven treatment.
10. Expenses incurred (or Treatment undergone) on High Intensity Focused Ultra Sound, Balloon Sinuplasty, Enhanced External Counter Pulsation Therapy and related therapies, Deep Brain Stimulation, Hyperbaric Oxygen Therapy, Robotic Surgery ((whether invasive or non-invasive), Holmium Laser Enucleation of Prostate, KTP Laser surgeries, cyber knife treatment, Femto laser surgeries.
11. Any expenses related to instruments used in treatment of sleep disorder or sleep apnea syndrome and oxygen concentrator for asthmatic condition, cost of cochlear implants and related surgery.
12. Any treatment related to general debility convalescence, cure, rest cure, health hydros, nature cure clinics, sanatorium treatment, Rehabilitation measures, private duty nursing, respite care, long-term nursing care, custodial care or any treatment in an establishment that is not a Hospital.
13. Treatment of any external Congenital Anomaly or Illness or defects or anomalies or treatment relating to external birth defects.
14. Treatment of mental illness or psychological disorders or Parkinson's or Alzheimer's disease even if caused or aggravated by or related to an Accident or Illness.
15. Cosmetic surgery or plastic surgery or related treatment of any description, including any complication arising from these treatments, other than as may be necessitated due to an Injury, cancer or burns.
16. Any treatment / surgery for change of sex or gender reassignments including any complication arising from these treatments.
17. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident.
18. All preventive care (except eligible and entitled for Benefit 8: Cardiac Health Check-up and Optional Benefit 4: Active Health Check-up), Vaccination, including Inoculation and Immunizations (except in case of post-bite treatment), vitamins and tonics.
19. All expenses (or Treatment undergone) related to donor treatment including surgery to remove organs from the donor, in case of transplant surgery.
20. Non-Allopathic Treatment or treatment related to any unrecognized systems of medicine. This exclusion will not be applicable for Inpatient Hospitalization of the Insured to the extent covered under the Benefit 3: Alternative Treatments.
21. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
22. Any Illness or Injury directly or indirectly resulting or arising from or occurring during commission of any breach of any law by the Insured Person with any criminal intent.
23. Act of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane or Illness or Injury attributable to consumption, use, misuse or abuse of intoxicating drugs, alcohol, tobacco (smoking/non -smoking) or hallucinogens.
24. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
 - a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
 - b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

- c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.
25. Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants.
 26. Alopecia wigs and/or toupee and all hair or hair fall treatment and products.
 27. Any treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification center, sanatorium, home for the aged, mentally disturbed, remodeling clinic or similar institutions.
 28. Stem cell implantation/surgery and storage except for allogeneic bone marrow transplantation.
 29. All the Hazardous Activities
 30. Taking part or is supposed to participate in a naval, military, air force operation or aviation in a professional or semi-professional nature.
 31. Remicade, Avastin or similar injectable treatment not requiring 24 hour hospitalization.
 32. Oral Chemotherapy.
 33. Treatment sought for any medical condition, not covered under the Benefit but arising during the Hospitalization for the condition covered under the Benefit.
 34. In-case the Insured Person is suffering from or has been diagnosed with or has been treated for any of the following disorders prior to the first Policy Start Date, then costs of treatment related to or arising from the disorder whether directly or indirectly will be treated as a Pre-existing Disease and will not be covered within first 24 months from the date of first issuance of the Policy:-
 - I Chronic Bronchitis;
 - II Esophageal Stricture or stenosis;
 - III Unoperated Varicose Veins;
 - IV Deep Vein Thrombosis (DVT);
 - V Spondyloarthropathies (Spondylosis/Spondylitis/Spondylolisthesis);
 - VI Residual Poliomyelitis;
 - VII Avascular Necrosis, Idiopathic;
 - VIII Unoperated Hyperthyroidism;
 - IX Renal/Ureteric/Bladder Calculi;
 - X DUB/Endometriosis;
 - XI Unoperated Fibroid Uterus;
 - XII Retinal Detachment;
 - XIII Otosclerosis;
 - XIV Deafness;
 - XV Blindness;
 - XVI Any implant in the body except Cardiac stents
 - XVII Down's Syndrome/Turner's Syndrome/Sickle Cell Anaemia/Thalassemia Major/G6PD deficiency.

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

5. Claims Procedure and Management

This section explains about procedures involved to file a valid Claim by the Insured Person and related processes involved to manage the Claim by us.

5.1 **Pre-requisite for admissibility of a Claim:**

Any claim being made by You or attendant of Your's during Hospitalization on behalf of You should comply with the following conditions:

- (i) The Condition Precedent Clause has to be fulfilled.
- (ii) The health damage caused, Medical Expenses incurred, subsequently the Claim being made, should be with respect to the Insured Person only. We will not be liable to indemnify the Insured Person for any loss other than the covered benefits and any other person who is not accepted by the Us as an Insured Person.
- (iii) The holding Insurance Policy should be in force at the event of the Claim. All the Policy Terms and Conditions, wait periods and exclusions are to be fulfilled including the realization of Premium by their respective due dates.
- (iv) All the required and supportive Claim related documents are to be furnished within the stipulated timelines. We may call for additional documents wherever required.

5.2 **Claim settlement - Facilities**

(a) **Cashless Facility**

We extend Cashless Facility as a mode to indemnify the medical expenses incurred by the Insured Person at a Network Provider. For this purpose, the

Insured Person will be issued a "Health card" at the time of Policy purchase, which has to be preserved and produced at any of the Network Providers in the event of Claim being made, to avail Cashless Facility. The following is the process for availing Cashless Facility:-

- (i) **Submission of Pre-authorization Form:** A Pre-authorization form which is available on Our Website or with the Network Provider, has to be duly filled and signed by the Insured Person and the treating Medical Practitioner, as applicable, which has to be submitted Electronically by the Network Provider to us for approval. Only upon due approval from us, Cashless Facility can be availed at any Network Hospital.
- (ii) **Identification Documents:** The “Health card” provided by us under this Policy, along with one Valid Photo Identification Proof of the Insured Person are to be produced at the Network Provider, photocopies of which shall be forwarded to us for authentication purposes. Valid Photo Identification Proof documents which will be accepted by us are Voter ID card, Driving License, Passport, PAN Card, Aadhar Card or any other identification proof as stated by us.
- (iii) **Our Approval:** We will confirm in writing, authorization or rejection of the request to avail Cashless Facility for the Insured Person's Hospitalization.
- (iv) **Our Authorization:**
 - a) If the request for availing Cashless Facility is authorized by us, then payment for the Medical Expenses incurred in respect of the Insured Person shall not have to be made to the extent that such Medical Expenses are covered under this Policy and fall within the amount authorized in writing by us for availing Cashless Facility.
 - b) An Authorization letter will include details of Sanctioned Amount, any specific limitation on the Claim, and any other details specific to the Insured Person, if any, as applicable.
 - c) In the event that the cost of Hospitalization exceeds the authorized limit, the Network Provider shall request us for an enhancement of Authorization Limit stating details of specific circumstances which have led to the need for increase in the previously authorized limit. We will verify the eligibility and evaluate the request for enhancement on the availability of further limits.
- (v) **Event of Discharge from Hospital:** All original bills and evidence of treatment for the Medical Expenses incurred in respect of the Hospitalization of the Insured Person and all other information and documentation specified under Clauses 5.4 and 5.5 shall be submitted by the Network Provider immediately and in any event before the Insured Person's discharge from Hospital.
- (vi) **Our Rejection:** If We do not authorize the Cashless Facility due to insufficient Sum Insured or insufficient information provided to us to determine the admissibility of the Claim, then payment for such treatment will have to be made by the Policyholder / Insured Person to the Network Provider, following which a Claim for reimbursement may be made to us which shall be considered subject to the Insured Person's Policy limits and relevant conditions. Please note that rejection of a Pre-authorization request is in no way construed as rejection of coverage or treatment. The Insured Person can proceed with the treatment, settle the hospital bills and submit the claim for a possible reimbursement.
- (vii) **Network Provider related:** We may modify the list of Network Providers or modify or restrict the extent of Cashless Facilities that may be availed at any particular Network Provider. For an updated list of Network Providers and the extent of Cashless Facilities available at each Network Provider, the Insured Person may refer to the list of Network Providers available on Our website or at the call center.
- (viii) **Claim Settlement:** For Claim settlement under Cashless Facility, the payment shall be made to the Network Provider whose discharge would be complete and final.

(b) Re-imburement Facility

- (i) It is agreed and understood that in all cases where intimation of a Claim has been provided under Reimbursement Facility and/or We specifically states that a particular Benefit is payable only under Reimbursement Facility, all the information and documentation specified in Clause 5.4 and Clause 5.5 shall be submitted to us at Policyholder's / Insured Person's own expense, immediately and in any event within 30 days of Insured Person's discharge from Hospital.
- (ii) We shall give an acknowledgement of collected documents. However, in case of any delayed submission, We may examine and relax the time limits mentioned upon the merits of the case.
- (iii) In case a reimbursement claim is received after a Pre-Authorization letter has been issued for the same case earlier, before processing such claim, a check will be made with the Network Provider whether the Pre-authorization has been utilized. Once such check and declaration is received from the Network Provider, the case will be processed.
- (iv) For Claim settlement under reimbursement, We will pay the Policyholder. 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, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.
- (v) Date of Loss' under Reimbursement Facility is the 'Date of Admission' to Hospital in case of Hospitalization & actual Date of Loss for non-Hospitalization related Benefits.

5.3 Duties of a Claimant/ Insured Person in the event of Claim

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

- (i) The Policyholder / Insured Person shall check the updated list of Network Provider before submission of a pre-authorization request for Cashless Facility.
- (ii) All reasonable steps and measures must be taken to avoid or minimize the quantum of any Claim that may be made under this Policy.
- (iii) Intimation of the Claim, notification of the Claim and submission or provision of all information and documentation shall be made promptly and in any event in accordance with the procedures and within the timeframes specified in Clause 5 (Claims Procedure and Management) of the Policy.
- (iv) If We request You to submit 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.
- (v) Our Medical Practitioner and representatives shall be given access and co-operation to inspect the Insured Person's medical and Hospitalization records and to investigate the facts and examine the Insured Person.
- (vi) We shall be provided with complete necessary documentation and information which We have requested to establish its liability for the Claim, its circumstances and its quantum.

5.4 Claims Intimation

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

- (i) If any Illness is diagnosed or discovered or any Injury is suffered or any other contingency occurs which has resulted in a Claim or may result in a Claim under the Policy, We shall be notified with full particulars within 48 hours from the date of occurrence of event either at the Our call center or in writing.
- (ii) Claim must be filed within 30 days from the date of discharge from the hospital in case of hospitalization and actual date of loss in case of non-hospitalization benefits.
Note: 5.4 (i) and 5.4 (ii) are precedent to admission of liability under the policy.
- (iii) The following details are to be disclosed to us at the time of intimation of Claim:
 1. Policy Number;
 2. Name of the Policyholder;
 3. Name of the Insured Person in respect of whom the Claim is being made;
 4. Nature of Illness or Injury and Benefit under which the Claim is being made
 5. Name and address of the attending Medical Practitioner and Hospital;
 6. Date of admission to Hospital or proposed date of admission to Hospital for planned Hospitalization;
 7. Any other necessary information, documentation or details requested by us
- (iv) In case of an Emergency Hospitalization, We shall be notified either at Our call center or in writing immediately and in any event within 48 hours of Hospitalization commencing or before the Insured Person's discharge from Hospital.
- (v) In case of an Planned Hospitalization, We shall be notified either at Our call center or in writing at least 48 hours prior to planned date of admission to Hospital

5.5 Documents to be submitted for filing a valid Claim

The following information and documentation shall be submitted in accordance with the procedures and within the timeframes specified in Clause 5 in respect of all Claims:

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

Notes:

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

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

5.6 Claim Assessment

- (a) We shall scrutinize the Claim and supportive documents, once received. In case of any deficiency, We may call for any additional documents or information as required, based on the circumstances of the Claim.
- (b) All admissible Claims under this Policy shall be assessed by us in the following progressive order:
 - (i) If a Room/ICU accommodation has been opted for where the Room Rent or Room Category or ICU Charges is higher than the eligible limit as applicable for that Insured Person as specified in the Policy Schedule, then the Variable Medical Expenses payable shall be pro-rated as per the applicable limits.
Variable Medical Expenses' means those Medical Expenses as listed below which vary in accordance with the Room Rent or Room Category or ICU Charges in a Hospital:
 - I. Room, boarding, nursing and Operation theatre expenses as charged by the Hospital where the Insured Person availed medical treatment;
 - II. Intensive Care Unit (ICU) charges;

III. Fees charged by surgeon, anesthetist, Medical Practitioner;

IV. Investigation Expenses.

- (ii) If any sub-limits on Medical Expenses are applicable as specified in the Policy Schedule, the Our liability to make payment shall be limited to the extent of the applicable sub-limit for that Medical Expense.
- (iii) The Deductible (if applicable) shall be applied to the aggregate of all Claims that are either paid or payable under this Policy. Our liability to make payment shall commence only once the aggregate amount of all Claims payable or paid exceed the Deductible. Similarly, if 'Deductible per claim' is applicable, Our liability to make payment shall commence only once the 'Deductible per claim' limit is exceeded Co-payment shall be applicable on the amount payable by us.
- (iv) Co-payment (if applicable) shall be applicable on the admissible claim amount payable by us.
- (v) The balance amount, if any, subject to the applicability of sub-limits on expenses on treatment of Named Ailments / Procedures, our liability to make payment shall be limited to such extent as applicable and shall be the claim payable.
- (c) The Claim amount assessed in Clause 5.6 (b) above would be deducted from the following amounts in the following progressive order:
 - (i) Sum Insured;
 - (ii) No Claims Bonus (if applicable);
 - (iii) Automatic Recharge (if applicable).
- (d) All claims incurred in India are dealt by the Company directly.

5.7 **Payment Terms**

- (a) This Policy covers only medical treatment taken entirely within India. All payments under this Policy shall be made in Indian Rupees and within India.
- (b) We shall have no liability to make payment of a Claim under the Policy in respect of an Insured Person during the Policy Period, once the Total Sum Insured for that Insured Person is exhausted.
- (c) We shall settle or reject any Claim within 30 days of receipt of all the necessary documents / information as required for settlement of such Claim and sought by us. We shall provide the Policyholder / Insured Person an offer of settlement of Claim and upon acceptance of such offer by the Policyholder / Insured Person We shall make payment within 7 days from the date of receipt of such acceptance. However, if a claim warrants an investigation in the opinion of the insurer, it shall settle the claim within 45 days from the date of receipt of last necessary document. In case there is delay in the payment beyond the stipulated timelines from the date of receipt of last necessary document to the date of payment of claim, We shall pay additional amount as interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it. For the purpose of this clause, 'bank rate' shall mean the existing bank rate as notified by Reserve Bank of India, unless the extent regulation requires payment based on some other prescribed interest rate.
- (d) If the Policyholder / 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 and all the limits for Any One Illness under this Policy shall be applied as if they were under a single Claim.
- (e) The Claim shall be paid only for the Policy Year in which the Insured event which gives rise to a Claim under this Policy occurs.
- (f) The Premium for the policy will remain the same for the policy period mentioned in the Policy Schedule.

6. **Salient Features**

6.1 **Cashless Facility**

With Cashless Facility, You no longer need to run around paying off hospital bills and then follow up for a reimbursement. All You now need to do is get admitted to any of Our Network Provider and concentrate only on Your recovery. Leave the bill payment arrangements to Us, except for any non-medical expenses as specified in Annexure – II that You incur at the Network Provider.

6.2 **Reimbursement**

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 as required shall be submitted (at the Insured person's expense) to Us immediately and in any event within 30 days of Insured person's discharge from Hospital or completion of treatment or date of loss, whichever is later.

6.3 **Multiple Policies**

- a. In case any Policyholder/Insured Person is covered under more than one indemnity insurance policies, with us or with other insurers, the Policyholder/Insured Person shall have the right to settle the Claim with any of the Company, provided that the Claim amount payable is up to the Sum Insured of such Policy.
- b. In case the Claim amount under a single policy exceeds the Sum Insured, then Policyholder/Insured Person shall have the right to choose the companies with whom the Claim is to be settled. Further, policyholder/Insured Person shall have the right to choose the companies from whom he/she wants to claim the balance amount. Insured shall only be indemnified the hospitalization costs in accordance with terms & conditions of chosen Policy.
- c. Policyholder/Insured Persons shall also have the right to prefer claims from other policy / policies for the amounts disallowed under the earlier chosen policy / policies, even if the sum insured is not exhausted.
- d. In case of multiple policies which provide fixed benefits, each insurer shall make the claim payments independent of payments received under other similar policies.

6.4 **Free Look Period**

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

of the Policy.

C. Provision for Free look period is not applicable and available at the time of renewal of the Policy.

6.5 Underwriting Loading:

Based on the Underwriter's assessment of the extra risk on account of medical or any other conditions of the proposed to be insured, the premium (at the time of issuance of the policy and subsequent renewals) may get loaded. Such extra premium shall be communicated to the Insured person for their consent before issuance of the Policy. Loading will not exceed 50% of Premium. Criteria for such loading are objectively mentioned in the Underwriting Manual (in line with Our Underwriting Policy).

In case the Policyholder requires further clarification pertaining to Underwriting Loading, he/she may contact Us.

6.6 Renewal Terms

- (a) This Policy will automatically terminate on the Policy Period End Date. All renewal applications should reach the Company on or before the Policy Period End Date.
- (b) The premium payable on renewal shall be paid to the Company on or before the Policy Period End Date and in any event before the expiry of the Grace Period.
- (c) For the purpose of this provision, Grace Period means a period of 30 days immediately following the Policy Period End Date during which a payment can be made to renew this Policy without loss of continuity Benefits. Coverage is not available for the period for which premium is not received by the Company and the Company shall not be liable for any Claims incurred during such period.
- (d) The policy will be renewed except on grounds of misrepresentation / Non-disclosure of material fact as declared in the proposal form and at the time of claim, fraud committed / moral hazard or non-cooperation of the insured.
- (e) The Company may carry out underwriting in accordance with its Board approved underwriting policy in relation to any request for change in Sum Insured or Deductible at the time of renewal of the Policy.
- (f) This product may be withdrawn / modified by the Company after due approval from the Authority (IRDAI). In case this product is withdrawn / modified by the Company, this Policy can be renewed under the then prevailing Health Insurance Product or its nearest substitute approved by the Authority (IRDAI). The Company shall duly intimate the Policyholder at least three months prior to the date of such modification / withdrawal of this product and the options available to the Policyholder at the time of Renewal of this Policy.
- (g) The Company may revise the renewal premium payable under the Policy provided that revisions to the renewal premium are in accordance with the Authority's (IRDAI) rules and regulations as applicable from time to time. Change in rates will be applicable only post approval by the Authority and be effective from the date of launch of the revised Product and shall be applied only prospectively thereafter for new policies and at the date of renewal for renewals.
- (h) Renewal shall be offered lifelong. The Insured Person shall be given an option to port this Policy into any other health insurance product of the Company and credit shall be given for number of years of continuous coverage under this Policy for the standard waiting periods.
- (i) No loading based on individual claim experience shall be applicable on renewal premium payable.

6.7 Cancellation / Termination

- (a) We may at any time, cancel this Policy on grounds of misrepresentation, mis-description or non-disclosure of any material particulars or any material information having been withheld, or if a Claim is fraudulently made or any fraudulent means or devices are used by You, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to the Policyholder at his last known address and We shall have no liability to make payment of any Claims and the premium paid shall be forfeited and no refund of premium shall be effected by us.
- (b) The Policyholder may also give 15 days' notice in writing, to us, for the cancellation of this Policy, in which case We shall from the date of receipt of the notice, cancel the Policy and refund the premium for the unexpired period of this Policy at the short period scales as mentioned below, provided no Claim has been made under the Policy.

Refund % to be applied on premium received:

Cancellation date from Policy Period Start Date	Policy Tenure – 1 Year	Policy Tenure – 2 Year	Policy Tenure – 3 Year
Up to 1 month	75.00%	87.50%	91.50%
1 month to 3 months	50.00%	75.00%	88.50%
3 months to 6 months	25.00%	62.50%	75.00%
6 months to 12 months	0.00%	50.00%	66.50%
12 months to 15 months	N.A.	25.00%	50.00%
15 months to 18 months	N.A.	12.50%	41.50%
18 months to 24 months	N.A.	0.00%	33.00%
24 months to 30 months	N.A.	N.A.	8.00%
Beyond 30 months	N.A.	N.A.	0.0%

- (c) In case of demise of the Policyholder,
 - (i) Where the Policy covers only the Policyholder, this Policy shall stand null and void from the date and time of demise of the Policyholder. The premium would be refunded for the unexpired period of this Policy at the short period scales.
 - (ii) Where the Policy covers other Insured Persons, this Policy shall continue till the end of Policy Period for the other Insured Persons. If the other

Insured Persons wish to continue with the same Policy, We will renew the Policy subject to the appointment of a policyholder provided that:

- I. Written notice in this regard is given to us before the Policy Period End Date; and
- II. A person of Age 18 years or above, who satisfies Our criteria applies to become the Policyholder.

6.8 **Pre-Policy Medical Check-up**

There are no pre medical tests irrespective of age. The previous medical records including details of treatment needs to be submitted along with the proposal.

6.9 **Tax Benefit**

The Insured person can avail tax benefit on the premium paid towards health insurance, under Section 80D of the Income Tax Act, 1961, as applicable. (Tax benefits are subject to changes in the tax laws, please consult tax advisor for more details).

6.10 **Portability and Continuity Benefits**

- (i) Insured(s) have an option to migrate from their existing health insurance policy of any other Indian non-life insurer/standalone health insurer to any other similar policy with us, at the time of renewal, provided the previous policy/policies has been maintained without any break and the policy holder shall apply to us at least 45 days prior to policy renewal date of his or her existing policy in prescribed format.
- (ii) The Waiting Periods as defined in Clauses 4.1(i), 4.1(ii) and 4.1(iii) of this Policy shall be reduced by the number of months of continuous coverage under such health insurance policy with the previous insurer to the extent of the sum insured and the deductible under the expiring health insurance policy.
- (iii) The Waiting Periods under Clauses 4.1(i), 4.1(ii) and 4.1(iii) shall be applicable afresh to the amount by which the Sum Insured under this Policy exceeds the sum insured and the deductible under the terms of the expiring policy.
- (iv) The Waiting Periods as defined in Clauses 4.1(i), 4.1(ii) and 4.1(iii) shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.
- (v) Credit for the sum insured of the expiring policy shall additionally be available as under:
 - a) If the Insured Person was covered on a Floater basis under the expiring policy and is proposed to be covered on a Floater basis with us, then the sum insured to be carried forward for credit under this Policy would also be applied on a Floater basis only.
 - b) In all other cases the sum insured to be carried forward for credit in this Policy would be applied on an individual basis only.
- (vi) In case the Policyholder has opted to switch to any other insurer under portability and the outcome of acceptance of the portability is awaited from the new insurer on the date of renewal:
 - a) We may at the request of the Policyholder, extend the Policy for a period not less than 1 month at an additional premium to be paid on a pro-rated basis.

In case any Claim is reported during the extended Policy Period, the Policyholder shall first pay the premium so as to make the extended Policy Period part of Policy, as applicable. In such cases, Policyholder shall be liable to pay the premium for the balance period and continue with us for that Policy year.

6.11 **Assignment**

1. This policy may be transferred/assigned, wholly or in part, with or without consideration.
2. An Assignment may be effected in a policy by an endorsement upon the policy itself or by a separate instrument under notice to the Insurer.
3. The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made.
4. The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.
5. The transfer or assignment shall not be operative as against an Insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy there of certified to be correct by both transferor and transferee or their duly authorized agents have been delivered to the Insurer.
6. The Insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is (a) not bonafide or (b) not in the interest of the policyholder or (c) not in public interest or (d) is for the purpose of trading of the insurance policy.
7. In case of refusal to act upon the endorsement by the Insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the Insurer.

Note: This is only a simplified version of (Assignment or Transfer) for general information purpose only. For full texts of this section please refer to Section 38 of Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015.

7. **Grievances**

We have developed proper procedures and effective mechanism to address Your complaints. We are committed to comply with the Regulations, standards which have been set forth in the Regulations, Circulars issued by the Authority (IRDAI) from time to time in this regard.

- (a) If You / Insured Person has a grievance that You / Insured Person wishes Us to redress, You / Insured Person may contact Us with the details of the grievance through:

Website: www.religarehealthinsurance.com

Email: customerfirst@religarehealthinsurance.com

Contact No.: 1800-102-4488

Courier: Any of Our Branch Office or corporate office

You / Insured person may also approach the grievance cell at any of Our branches with the details of Your grievance during Our working hours from Monday to Friday.

Exclusively for Senior Citizens, We have a separate extension on the Customer Service Toll Free Number. This separate customer service channel

prioritizes and routes any kind of request / grievance raised by Senior Citizens through various fast track internal escalations leading to lesser Turn -Around-Time (TAT) for request / grievance addressal

- (b) If You / Insured person is not satisfied with Our redressal of the Your / Insured person 's grievance through one of the above methods, You / Insured person may contact Our Head of Customer Service at:

Head – Customer Services,
Religare Health Insurance Company Limited,
Vipul Tech Square, Tower C,
3rd Floor, Golf Course Road, Sector - 43,
Gurugram, Haryana – 122009.

You / Insured person may approach the nearest Insurance Ombudsman for resolution of the grievance. Details of Insurance Ombudsman offices are available at IRDAI website: www.irdaindia.org, or on the Company's website at www.religarehealthinsurance.com

8. Schedule of Discounts / Loading

Sr. No.	Description	Parameters	Rates
1	Family Discount - This discount shall be applicable on the Gross Premium of all the members, if 2 to 6 persons of the same family are covered in the same policy, on individual Sum Insured basis	No. of persons	Discount
		2 or 3 members	2.5%
		4, 5 or 6 members	7.5%
2	Discount for Employees and / or their dependents of:	-	15.00%
	RHICL		
	RHICL Promoters		
3	Tenure Discount	Policy Tenure	
		2 years	7.5%
		3 years	10%

Notes: – Any other discount offered, other than mentioned above, is due to product features (e.g. offering deductible and Co-payment) or pricing related considerations (e.g. adding additional Insured Person). They are adequately explained in the premium rates annexed hereto with the prospectus.

All discounts mentioned in the Schedule above, are multiplicative in nature, subject to aggregate maximum discount (which will not exceed 25% of the Premium)

9. Schedule of Benefits:

Plan Details

Plan Name	Care Heart-Plan Details					
Sum Insured – on annual basis (in Rs.)	2L	3L	4L	5L	7L	10L
Deductible – on annual basis (in Rs.)	No deductible/ 10K/25K/50K/1L/2L/3L	No deductible/ 10K/25K/50K/1L/2L/3L	No deductible/ 10K/25K/50K/1L/2L/3L	No deductible/ 10K/25K/50K/1L/2L/3L	No deductible/ 10K/25K/50K/1L/2L/3L	No deductible/ 10K/25K/50K/1L/2L/3L
Entry Age – Minimum	Adult : 18 years	Adult : 18 years	Adult : 18 years	Adult : 18 years	Adult : 18 years	Adult : 18 years
Entry Age – Maximum	Life Long	Life Long	Life Long	Life Long	Life Long	Life Long
Exit Age	Lifelong	Lifelong	Lifelong	Lifelong	Lifelong	Lifelong
Cover Type	Individual: Maximum up to 6 Persons Floater : 2A (Self and Spouse)	Individual: Maximum up to 6 Persons Floater : 2A (Self and Spouse)	Individual: Maximum up to 6 Persons Floater : 2A (Self and Spouse)	Individual: Maximum up to 6 Persons Floater : 2A (Self and Spouse)	Individual: Maximum up to 6 Persons Floater : 2A (Self and Spouse)	Individual: Maximum up to 6 Persons Floater : 2A (Self and Spouse)
Pre-policy Issuance Medical Check up	None	None	None	None	None	None
Tenure in Years	1/2/3 Years	1/2/3 Years	1/2/3 Years	1/2/3 Years	1/2/3 Years	1/2/3 Years
Eligibility Criteria	<i>Person/either one Person in case of a Floater Policy with 2 Adults, who have been diagnosed with a cardiac ailment/disorder in the past and undergone a Cardiac surgical intervention or procedure for the same</i>					
Benefits						
Hospitalization Expenses						
In-Patient Care	up to Sum Insured	up to Sum Insured	up to Sum Insured	up to Sum Insured	up to Sum Insured	up to Sum Insured
Day Care Treatment	up to Sum Insured	up to Sum Insured	up to Sum Insured	up to Sum Insured	up to Sum Insured	up to Sum Insured
Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses	Pre-Hospitalization for 30 days & Post-Hospitalization for 60 days; Maximum up to 5% of SI	Pre-Hospitalization for 30 days & Post-Hospitalization for 60 days; Maximum up to 5% of SI	Pre-Hospitalization for 30 days & Post-Hospitalization for 60 days; Maximum up to 5% of SI	Pre-Hospitalization for 30 days & Post-Hospitalization for 60 days; Maximum up to 5% of SI	Pre-Hospitalization for 30 days & Post-Hospitalization for 60 days; Maximum up to 5% of SI	Pre-Hospitalization for 30 days & Post-Hospitalization for 60 days; Maximum up to 5% of SI
Alternative Treatments	Up to 25% of Sum Insured	Up to 25% of Sum Insured	Up to 25% of Sum Insured	Up to 25% of Sum Insured	Up to 25% of Sum Insured	Up to 25% of Sum Insured
Ambulance Cover	Up to Rs 2,000 per hospitalization	Up to Rs 2,000 per hospitalization	Up to Rs 2,000 per hospitalization	Up to Rs 2,000 per hospitalization	Up to Rs 3,000 per hospitalization	Up to Rs 3,000 per hospitalization
Domiciliary Hospitalization	up to 100% of Sum Insured covered after 3 days	up to 100% of Sum Insured covered after 3 days	up to 100% of Sum Insured covered after 3 days	up to 100% of Sum Insured covered after 3 days	up to 100% of Sum Insured covered after 3 days	up to 100% of Sum Insured covered after 3 days
Automatic Recharge	100% of original SI upon exhaustion of SI	100% of original SI upon exhaustion of SI	100% of original SI upon exhaustion of SI	100% of original SI upon exhaustion of SI	100% of original SI upon exhaustion of SI	100% of original SI upon exhaustion of SI
No Claims Bonus	10% increase in SI per Policy Year in case of claim-free year; Max up to 50% of SI (10% decrease in SI per Policy Year in case a claim has been paid; Such decrease is only in SI accrued as NCB)	10% increase in SI per Policy Year in case of claim-free year; Max up to 50% of SI (10% decrease in SI per Policy Year in case a claim has been paid; Such decrease is only in SI accrued as NCB)	10% increase in SI per Policy Year in case of claim-free year; Max up to 50% of SI (10% decrease in SI per Policy Year in case a claim has been paid; Such decrease is only in SI accrued as NCB)	10% increase in SI per Policy Year in case of claim-free year; Max up to 50% of SI (10% decrease in SI per Policy Year in case a claim has been paid; Such decrease is only in SI accrued as NCB)	10% increase in SI per Policy Year in case of claim-free year; Max up to 50% of SI (10% decrease in SI per Policy Year in case a claim has been paid; Such decrease is only in SI accrued as NCB)	10% increase in SI per Policy Year in case of claim-free year; Max up to 50% of SI (10% decrease in SI per Policy Year in case a claim has been paid; Such decrease is only in SI accrued as NCB)

Plan Name	Care Heart-Plan Details					
Sum Insured – on annual basis (in Rs.)	2L	3L	4L	5L	7L	10L
Cardiac Health Check-up	Annually(Please refer Appendix 1 For details)	Annually(Please refer Appendix 1 For details)	Annually(Please refer Appendix 1 For details)	Annually(Please refer Appendix 1 For details)	Annually(Please refer Appendix 1 For details)	Annually(Please refer Appendix 1 For details)
Wait Periods						
Initial Waiting Period	30 Days	30 Days	30 Days	30 Days	30 Days	30 Days
Specific Waiting Period	24 months	24 months	24 months	24 months	24 months	24 months
Pre-existing Diseases	24 months	24 months	24 months	24 months	24 months	24 months
Co-payment	20% / 30% per claim (Please refer point 4 of Notes for further details)	20% / 30% per claim (Please refer point 4 of Notes for further details)	20% / 30% per claim (Please refer point 4 of Notes for further details)	20% / 30% per claim (Please refer point 4 of Notes for further details)	20% / 30% per claim (Please refer point 4 of Notes for further details)	20% / 30% per claim (Please refer point 4 of Notes for further details)
Sub-limits						
Room Rent / Room Category	Up to 1% of SI per day	Up to 1% of SI per day	Up to 1% of SI per day	Single Private Room	Single Private Room	Single Private Room
ICU Charges	Up to 2% of SI per day	Up to 2% of SI per day	Up to 2% of SI per day	No Limit	No Limit	No Limit
Treatment of Cataract	Up to Rs.20,000 per eye	Up to Rs.20,000 per eye	Up to Rs.20,000 per eye	Up to Rs.30,000 per eye	Up to Rs.30,000 per eye	Up to Rs.30,000 per eye
Treatment of Total Knee Replacement	Up to Rs.70,000 per knee	Up to Rs. 80,000 per knee	Up to Rs. 80,000 per knee	Up to Rs. 1,00,000 per knee	Up to Rs. 1,20,000 per knee	Up to Rs. 1,20,000 per knee
Treatment for each and every Ailment / Procedure mentioned below:- i. Surgery for treatment of all types of Hernia ii. Hysterectomy iii. Surgeries for Benign Prostate Hypertrophy (BPH) iv. Surgical treatment of stones of renal system.	Up to Rs 35,000	Up to Rs 50,000	Up to Rs 55,000	Up to Rs 65,000	Up to Rs 80,000	Up to Rs 80,000
Treatment for each and every Ailment / Procedure mentioned below:- i. Treatment of Cerebrovascular disorders ii. Treatments/Surgeries for Cancer iii. Treatment of other renal complications and Disorders iv. Treatment for breakage of bones	Up to Rs 150,000	Up to Rs 200,000	Up to 225,000	Up to 250,000	Up to Rs 300,000	Up to Rs 300,000

Plan Name	Care Heart-Plan Details					
Sum Insured – on annual basis (in Rs.)	2L	3L	4L	5L	7L	10L
Optional Covers						
OPD Care	Up to 2k/3k/5k/7k/10k/15k/20k/25k for consultations/diagnostics /pharmacy; Max. up to 50% of covered amount for diagnostics	Up to 2k/3k/5k/7k/10k/15k/20k/25k for consultations/diagnostics /pharmacy; Max. up to 50% of covered amount for diagnostics	Up to 2k/3k/5k/7k/10k/15k/20k/25k for consultations/diagnostics /pharmacy; Max. up to 50% of covered amount for diagnostics	Up to 2k/3k/5k/7k/10k/15k/20k/25k for consultations/diagnostics /pharmacy; Max. up to 50% of covered amount for diagnostics	Up to 2k/3k/5k/7k/10k/15k/20k/25k for consultations/diagnostics /pharmacy; Max. up to 50% of covered amount for diagnostics	Up to 2k/3k/5k/7k/10k/15k/20k/25k for consultations/diagnostics /pharmacy; Max. up to 50% of covered amount for diagnostics
International Second Opinion	Once per Major Illness / Injury per policy year	Once per Major Illness / Injury per policy year	Once per Major Illness / Injury per policy year	Once per Major Illness / Injury per policy year	Once per Major Illness / Injury per policy year	Once per Major Illness / Injury per policy year
Home Care	Up to Rs.1,000 per day; Max. 7 days per occurrence & Max. 45 days per policy year per Insured Person; Covered after a deductible of 1 day	Up to Rs.1,000 per day; Max. 7 days per occurrence & Max. 45 days per policy year per Insured Person; Covered after a deductible of 1 day	Up to Rs.1,000 per day; Max. 7 days per occurrence & Max. 45 days per policy year per Insured Person; Covered after a deductible of 1 day	Up to Rs.1,000 per day; Max. 7 days per occurrence & Max. 45 days per policy year per Insured Person; Covered after a deductible of 1 day	Up to Rs.2,000 per day; Max. 7 days per occurrence & Max. 45 days per policy year per Insured Person; Covered after a deductible of 1 day	Up to Rs.2,000 per day; Max. 7 days per occurrence & Max. 45 days per policy year per Insured Person; Covered after a deductible of 1 day
Active Health Check-up	3 times a year (Refer Appendix 2 for Details)	3 times a year (Refer Appendix 2 for Details)	3 times a year (Refer Appendix 2 for Details)	3 times a year (Refer Appendix 2 for Details)	3 times a year (Refer Appendix 2 for Details)	3 times a year (Refer Appendix 2 for Details)

Appendix 1 (Cardiac Health Check –Up set)

Cardiac Health Check – up (For SI 2L/3L/4L/5L)	Cardiac Health Check-up (For SI 7L/10L)
Complete Blood Count with ESR	Complete Blood Count with ESR
Urine RE	Urine RE
Blood Group	Blood Group
HbA1C	HbA1C
TMT	TMT
Lipid Profile	Lipid Profile
Kidney Function test	Kidney Function test
Liver Function test	Liver Function test
TSH	TSH
Medical Examination Report	Medical Examination Report
Hbs Ag	Hbs Ag
Chest X Ray	Chest X Ray
	2D Echo
	APTT

Appendix 2 (Active Health Check –Up set for all Sum Insured)

Blood Pressure
Lipid Profile
Fasting and PP Blood Sugar

Notes:

- Coverage under Optional Cover “OPD Care” and “Home Care” is over and above the Sum Insured of the plan opted for.
- The Co-payment proportion as specified in the Policy Schedule, shall be borne by the Policyholder / Insured Person on each Claim which will be applicable on Benefits :Hospitalization Expenses, Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses, Alternative Treatments, Ambulance Cover and Domiciliary Hospitalization
- Deductible if opted is applicable on the Benefits namely Hospitalization Expenses, Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses, Alternative Treatments, Ambulance Cover and Domiciliary Hospitalization
- The applicable Co-payment will increase by 10% per Claim in the Policy Year following the Insured Person (or eldest Insured Person in the case of a Floater cover) attaining Age 71. If an Insured Person (or eldest Insured Person in the case of a Floater cover) attains age 71 years during the Policy Period, additional 10% co-payment will be applicable to the Policy only at the time of subsequent renewal. However, if the age of the Insured Person or eldest Insured Person (in case of Floater) at the time of issue of the first Policy with the Company is 70 years or below, then the Insured Person has an option to waive the condition for the additional 10% Co-payment upon payment of extra premium in this regard.

NOTES:

1. All the Sum Insured mentioned are on a Policy Year basis..
2. If the Insured Person suffers a relapse within 45 days from the date of last discharge / consultation from the Hospital for which a Claim has been made, then such relapse shall be deemed to be part of the same Claim and all the limits of Per Claim Limit under this Policy shall be applied as if they were under a single Claim.

About Us**Religare Health Insurance Company Limited**

Religare Health Insurance (RHI), the health insurance arm of Religare Enterprises Limited (REL), is a specialized Health Insurer offering health insurance services to employees of corporates, individual customers and for financial inclusion as well. With RHI's operating philosophy being based on the principal tenet of 'consumer-centricity', the company has consistently invested in the effective application of technology to deliver excellence in customer servicing, product innovation and value-for-money services.

Religare Health Insurance currently offers products in the retail segment for Health Insurance, Critical Illness, Personal Accident, Top-up Coverage, International Travel Insurance and Maternity along with Group Health Insurance and Group Personal Accident Insurance for corporates.

The organization has been adjudged the 'Best Health Insurance Company' at the ABP News-BFSI Awards & 'Best Claims Service Leader of the Year – Insurance India Summit & Awards. Religare Health Insurance has also received the 'Editor's Choice Award for Best Product Innovation' at Finnoviti and was conferred the 'Best Medical Insurance Product Award' at The FICCI Healthcare Awards.

Best Health Insurance Company - ABP News – BFSI Awards 2015, Best Claims Service Leader of the Year - Insurance India Summit & Awards 2018, Best Product Innovation - Editor's Choice Award Finnoviti 2013, Best Medical Insurance Product - FICCI Healthcare Awards 2015.

Contact details for Claims & Policy Servicing**Religare Health Insurance Company Limited**

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Correspondence Office: Vipul Tech Square, Tower C, 3rd Floor, Golf Course Road, Sec-43, Gurugram - 122009 (Haryana)

Website: www.religarehealthinsurance.com E-mail: customerfirst@religarehealthinsurance.com Call: 1800-102-4488 | 1860-500-4488

Disclaimer: This is only a summary of features of Car^e HEART⁺. The actual benefits available are as described in the Policy, and will be subject to the Policy terms, conditions and exclusions. Please seek the advice of Your insurance advisor if You require any further information or clarification.

Statutory Warning : Prohibition of Rebates (under Section 41 of Insurance Act, 1938): No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer. Any person making default in complying with the provision of this section shall be liable for a penalty which may extend to ten lakh rupees.

Insurance is a subject matter of solicitation. CIN: U66000DL2007PLC161503 UAN: XXXXXX UIN: RHIHLIP19066V011819

IRDA Registration Number - 148

NOTES:

1. The foregoing is only an indication of the cover offered. For details, please refer to the Policy terms and conditions, available on request.
2. The Proposal Form shall form the basis of the insurance contract. It is mandatory for You to provide Us a duly filled in and signed Proposal Form and retain a copy as an evidence of the basis of the insurance contract.
3. Any risk under the Policy shall commence only once We receive the premium (including all taxes and levies thereto).
4. In case You have not understood any of the details, coverage, etc. in this document, You can seek for a clarification or a copy of this document in a language understood by You.
5. For full details of this product, please log on to www.religarehealthinsurance.com
6. The product is in conformity with the IRDAI approval and health insurance regulations and standardization guidelines.