Policy Clause Arogya Sanjeevani Policy

POLICY CLAUSE

1. PREAMBLE

This Policy is a contract of insurance issued by The New India Assurance Co. Ltd., (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the 'Insured Persons'). The policy is based on the statements and declaration provided in the proposal Form by the proposer and is subject to receipt of the requisite premium.

2. OPERATIVE CLAUSE

If during the policy period one or more Insured Person (s) 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, 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. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured (Individual or Floater) opted and Cumulative Bonus (if any) specified in the Schedule.

3. 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.

3.1. Accident means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
3.2. Age means age of the Insured person on last birthday as on date of commencement of the Policy.
3.3. Any One Illness means continuous period of illness and it includes relapse within forty five days from the date of last consultation with the hospital where treatment has been taken.
3.4. AYUSH Treatment refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
3.5. 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.

3.6. AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre 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.

3.7. Break in Policy means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof

3.8. Cashless Facility means a facility extended by the insurer to the insured where the payments, ofthe costs of treatment undergone by the insured person in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent preauthorization is approved.

3.9. Condition Precedent means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

3.10.Congenital Anomaly refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
i. Internal Congenital Anomaly Congenital anomaly which is not in the visible and accessible parts of the body.
ii. External Congenital Anomaly Congenital anomaly which is in the visible and accessible parts of the body.

3.11.Co-payment means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A copayment does not reduce the Sum Insured.
3.12.Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.
3.13.Day Care Centre means any institution established for day care treatment of disease/ injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

a. has qualified nursing staff under its employment;
b. has qualified medical practitioner (s) in charge;
c. has a fully equipped operation theatre of its own where surgical procedures are carried out;
d. Maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

3.14. Day Care means medical or/ and surgical procedure(s) required for treatment of an illness or injury, performed in a hospital/day care centre in less than twenty four hours which otherwise require hospitalization of more than twenty four hours.

3.15. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

Dental Treatment

3.16. Dental treatment means treatment carried out by a qualified practitioner including fillings (where appropriate), crowns, extractions and surgery.

Disclosure

3.17. For information norm: The policy is void and all premium paid shall be forfeited to the Company in the event of misrepresentation, mis-disclosure or non-disclosure of material fact.

Emergency Care

3.18. Emergency Care means the immediate management of an illness or injury, which results in symptoms which are sudden, unexpected, and for an acute medical condition by a medical practitioner, to prevent death or serious long term impairment of the insured person’s health.

Family

3.19. Family means the family of the Insured and any one or more of the family members, as mentioned below:
a. Legally wedded spouse.
b. Parents and Parents-in-law.
c. Dependent Children (natural or legally adopted) between the age of 3 months to 18 years. However, for a child of above 18 years of age but still eligible for coverage in subsequent renewals.
d. Parents of the Insured

Grace Period

3.20. Grace period means a period of time immediately following the premium due date during which a payment may be made and continue the Policy in force without loss of benefits until such time as premium or pre-existing conditions are available for continuance of coverage.

Hospital

3.21. Hospital means any institution established for in-patient care and day care treatment of diseases/injuries and registration and Regulation Act), 2010 or under the minimum criteria specified under the Schedule (Section 56) of the said Act, with facilities and staff as per the norms of the Clinical Establishments Act, and
a. has at least 10 beds, in other towns having a population of less than 10 lakhs
b. has qualified nursing staff in all shifts
c. has qualified Medical Officer(s) in its own clock;
d. out-patient department where at least charge of surgical procedures is carried out
e. maintains daily records of patients and shall make these accessible to the Company’s authorized personnel

Hospitalisation

3.22. Hospitalisation means admission in a hospital for a minimum period of twenty four (24) consecutive hours for a period of less than twenty four (24) consecutive hours, where such admission is for any of the purposes of observation of the patient by a medical practitioner.

Illness

3.23. Illness means a sick function or disease or pathological condition leading to the impairment of

normal physiological function which manifests itself during the policy period, till the policy period, as mentioned in the schedule.

Acute Condition

3.24. Acute Condition means a disease, illness or injury that is likely to respond quickly to treatment or which returns to a person to his/her state of health immediately before suffering the disease/condition.

Chronic Illness
3.25. Chronic Illness means a disease, illness, or injury that has one or more of the following characteristics and requires long term monitoring through consultations, examinations, check-ups, and/or ongoing treatment:
a. it needs the ongoing control or relief of symptoms
b. it requires rehabilitation and/pr other therapies
c. it results in life threatening situations
d. it recurs or is likely to recur
e. it continues indefinitely

Injury

3.26. Injury means accidental physical harm excluding illness or disease and directly caused by mechanical, violent and visible evidential means which is verified and certified by a Physician for a covered event.

In-Patient Care

3.27. In-Patient Care means a treatment for which the Insured person has to stay in a hospital for more than 24 hours.

Insured Person

3.28. Insured Person means person(s) named in the Schedule of the Policy.

Intensive Care Unit
3.29. Intensive Care Unit means a dedicated section of a hospital which is specially equipped for the continuous monitoring and treatment of patients, who are critically ill, or under constant supervision of an identified health practitioner(s) and which is required by an Insured Person on the advice of a Physician for the purpose of critical care services.

Intensive Care Unit Charges
3.30. Intensive Care Unit Charges means the amount charged by a Hospital towards ICU expenses provided to any Insured including expenses for ICU bed, general nursing support and intensivist charges.

Medical Advice

3.31. Medical Advice means any consultation or advice from a Medical Practitioner including the issue of any prescription.

Medical Expenses

3.32. Medical Expenses means those expenses that have been payable by the Insured Person actually incurred, as long as there are no account of illness or accident has necessarily had been charged for the same treatment by other hospitals or doctors in the same locality.

Medical Practitioner

3.33. Medical Practitioner means a person who holds a valid registration from the Nursing Council of India and/ or Professional Council or State Council for Indian System of Medicine set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction and conducting the practice of the profession of Homeopathy.

Medically Necessary Treatment

3.34. Medically Necessary means any treatment, tests, medication, or stay in hospital or part of hospital based on opinion of a hospital based on opinion of a qualified and/or experienced medical practitioner:
a. Is required for the medical management of illness or injury, adequate and appropriate
b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care, according to standards generally accepted in international medical practice or profession, community practice
c. must have been recommended by a practitioner.
d. have been carried out as per such recommendation in the hospital

Migration

3.35. Migration means the right accorded to an individual health insurance policyholder (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

Nursing

3.36. 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.

Renewal

3.37. Renewal: 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.

Room Rent

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

Sub-limit

3.39. Sub-limit means cost sharing requirement under a health insurance policy in which an Insured

would not be liable to pay any amount in excess of the pre-defined limit.

Sum Insured

3.40. Sum Insured means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represent the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (On Individual Basis) or all Insured Persons (on Floater Basis) during the Policy Year.

Surgery or Surgical Procedure

3.50. 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 and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

Third Party Administrator (TPA)

3.51. Third Party Administrator (TPA) means a Company registered with the Authority, and engaged by an Insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

Waiting Period

3.52. Waiting Period means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

4.COVERAGE
The coverage listed below are inbuilt Policy benefits and shall be available to all insured Persons in accordance with the procedures set out in this policy.
4.1.Hospitalization
The Company shall indemnify the Insured for listed conditions/hospitalization specified in the policy schedule, during the policy year, and is subject to the sum insured bonus specified in the policy schedule.
For a. Room Rent, Boarding (inclusive of cardic recovery room/ICU) expenses up to 5% of sum insured subject to the maximum of Rs.5000/- per day.
b. In case of emergency ICU/Intensive care as may be certified by hos. pital, the Insured shall be indemnified up to 40% of the sum insured.
c. Surgeon, anesthetist, medical Practioner, consultants, specialist fees whether paid directly to the Insured or doctor/hospital.
d. Anesthesia, town, oxygen, operation theatre charges, surgical appliances, medicines and drugs, blood transfusion, diagnostics imaging, MRI and such similar other expenses.
4.1.1.Other expenses
a. Expenses incurred on treatment of cataract subject to the sub limits
b. Plastic surgery necessitated due to an accident.
c. All dental treatments including bridge
d. Dental surgery necessitated as may be directly attributed herewith.
e. In case of confinement due to an accident, a sum of Rs.2000/- per hospitalization.
Note:
a. Reimbursement of sum insured shall apply irrespective of the hours except the exception of the limit

specified for pre-existing diseases.
b. In case of hospitalization for a minimum period of 24 consecutive hours only, shall be admissible under the aforesaid limit/limits. In respect of consecutive stay, the reimbursement shall be effected as per rates at the hospital, then existing rates.
c. If the Insured Person is continuously covered without any break as defined under the applicable policies on renewal, the benefit of the same would be admissible.
4.2.Ayush Treatment
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:
4.3. Cataract Treatment
The Company shall indemnify Rs.40,000/-, whichever is lower, treatment of one cataract, subject to a limit of 25% of the sum insured in current Policy.
4.4. Pre-hospitalization
The Company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring in patient care, for a fixed period of 30 days prior to the date of the expenses that are not sub-limited and are placed under the appropriate Annexure-A lists cost of treatment of pre-existing disease is subject to the same being declared at the time of application and accepted by us.
5.Cumulative Bonus (CB)
5.1. Cumulative Incase the Insured has been insured with the company without any break a particular sum insured, then the long term policyholders shall apply after the expiry of policy period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
b. 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.
c. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
d. If the Insured Person is continuously covered without any break as defined under the applicable policies on renewal, the benefit of the same would be admissible.
e. In the event of portability stipulated by RDAI, then waiting period for the same would be reduced to the extent of prior coverage.
6.1.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 48 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 applicable portability norms of the IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.
6.2. Specific Waiting Period:(Code: -Excl02)
6.2.1 Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24/48 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.
a. Expenses until the expiry of 24 months of exclusion shall apply afresh to the extent of sum insured increase.
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 policies on renewal, the benefit of the same would be admissible to the extent of prior coverage.

(i)24 Months waiting period
1. Benign ENT disorders
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps

4.5. Post Hospitalization
The company shall indemnify post hospitalization medical expenses incurred, related to an admissible hospitalization requiring in patient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

4.6. The following procedures will be covered (wherever medically indicated), either as in patient or as part of day care treatment in a hospital up to 50% of sum insured, specified in the policy schedule, during the policy period:
a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
b. Deep Brain stimulation.
c. Balloon Sinuplasty.
d. Oral chemotherapy.
e. Immunotherapy- Monoclonal Antibody to be given as injection.
f. Intra retinal injections.
g. Robotic surgeries.
h. Stereotactic radio surgeries.
i. Bronchial Thermoplasty.
j. Vaporization of the prostate (Green laser treatment or holmium laser treatment).
k. IONOM- (Intra Operative Neuro Monitoring)
l. Stem cell therapy. Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered.

4.7. The expenses that are not covered in this policy are placed under List-I of Annexure-A. The list of expenses that are to be submitted into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-A respectively.

5. Cumulative Bonus (CB)
Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported), provided the policy is renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will not be reduced and will not be reduced in the same year.

Notes:
a. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person, if no claim has been reported. CB shall be reduced only in case of claim from on the family floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the insured persons.
b. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis and there is an accumulated CB for such Insured Person under the expiring policy, and if the Insured Persons in the expiring policy are covered on an individual basis specified in the policy Schedule and there is an accumulated CB for such Insured Person under the expiring policy, and if the Insured Persons in the expiring policy has been Renewed from a floater policy shall be issued to the two or more Insured Persons Renewed in such Renewed Policy shall be split due to the child attaining the age of 25 years, the CB of the expiring policy shall be

Waiting Period:
The Company shall not be liable to make any payment under the policy in connection with or in respect of the following diseases/illness till the expiry of waiting period mentioned below:
6.1. Pre-Existing Diseases(Code: - ExcI01)
a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 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 IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.

d. Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

6.2. Specific Waiting Period:(Code:- ExcI02)
a. Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24/48 months of continuous coverage, as may be the case 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 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.

24 Months waiting period:
1. Benign ENT disorders
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Hysterectomy
6. Thympanoplasty
7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
9. Cataract and age related eye ailments
10. Gastric/ Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele
14. Non Infective Arthritis
15. Piles, Fissures and Fistula in anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers
20. Internal Congenital Anomalies
(ii) 48 Months waiting period

1. Treatment for joint replacement unless arising from accident
2. Age-related Osteoarthritis & Osteoporosis
6.3. First Thirty Days Waiting Period(Code- Excl03)
a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.
7. 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:
7.1 Investigation & Evaluation(Code- Excl04)
. Expenses related to any admission primarily for diagnostics and evaluation purposes.
a b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment
7.2 Rest Cure, rehabilitation and respite care (Code- Excl05) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
a. 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. b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
7.3 Obesity/ Weight Control(Code- Exc106) Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
a. Surgery to be conducted is upon the advice of the Doctor
b. The surgery/Procedure conducted should be supported by clinical protocols

7.1 Obesity Treatment: (Code- Excl01)

- Treatment for obesity is excluded unless the member meets the following criteria:
  - The member has a Body Mass Index (BMI) greater than or equal to 40.
  - The member has a BMI 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:
    - Obesity-related cardiomyopathy.
    - Coronary heart disease.
    - Severe Sleep Apnea.
    - Uncontrolled Type 2 Diabetes.

7.2 Change-of-Gender Treatments: (Code- Excl02)

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

7.3 Cosmetic or Plastic Surgery: (Code- Excl03)

- Expenses for cosmetic or plastic surgery or any treatment to change appearance are excluded, unless the surgery or treatment is 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.

7.4 Hazardous or Adventure Sports: (Code- Excl04)

- 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, scuba diving, hand gliding, sky diving, or deep-sea diving are excluded.

7.5 Breach of Law: (Code- Excl05)

- Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent are excluded.

7.6 Excluded Providers: (Code- Excl06)

- Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed on its website or 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.

7.7 Treatment for Alcoholism, Drug, or Substance Abuse: (Code- Excl07)

- Treatment for Alcoholism, drug or substance abuse, or any addictive condition and consequences thereof are excluded.

7.8 Treatments Received in Health Hydros, Nature Cure Clinics, Spas, or Similar Establishments: (Code- Excl08)

- Treatments received in health 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, are excluded.

7.9 Dietary Supplements and Substances: (Code- Excl09)

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

7.12 Refractive Error: (Code - Excl15)
Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 diopters are not covered.

7.13 Unproven Treatments: (Code - Excl16)
Expenses related to any unproven treatment, services, and supplies for or in connection with any treatment are not covered. Unproven treatments are treatments, procedures, or supplies that lack significant medical documentation to support their effectiveness.

7.14 Sterility and Infertility: (Code - Excl17)
Expenses related to sterility and infertility are not covered. This includes:
a. Any type of contraception or sterilization.
b. Assisted Reproduction services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, and ICSI.
c. Gestational Surrogacy.
d. Reversal of sterilization.

7.15 Maternity Expenses (Code - Excl18):
a. Medical treatment expenses traceable to childbirth (including complicated deliveries and cesarean sections incurred during hospitalization) are covered. However, ectopic pregnancy is not covered.
b. Expenses toward miscarriage (unless due to an accident) and lawful medical termination of pregnancy

during the policy period are not covered.

7.16 War and War-like Occurrences:
Expenses resulting from war (whether declared or not), war-like occurrences, invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints, and detention of all kinds are not covered.

7.17 Nuclear, Chemical, or Biological Attacks:
Expenses related to nuclear, chemical, or biological attacks 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 are not covered.

7.18 Domiciliary Hospitalization and OPD Treatment:
Any expenses incurred on domiciliary hospitalization and OPD (outpatient department) treatment are not covered.

7.19 Treatment Outside India:
Treatment taken outside the geographical limits of India is not covered.

7.20 Existing Diseases:
For existing diseases disclosed by the insured and mentioned in the policy schedule (based on the insured's consent), the policyholder is not entitled to coverage for specified ICD codes.

8. Moratorium Period:

After eight continuous years under this policy, a moratorium period begins. During this period, no look-back provision applies. The eight-year moratorium applies to the sums insured of the first policy. For any subsequent enhancement of sums insured, the eight-year moratorium period will commence from the date of enhancement.

After the expiry of the moratorium period, no claim under this policy shall be contestable except in cases of proven fraud or permanent exclusions specified in the policy contract. However, the policies remain subject to all limits, sub-limits, and co-payments as per the policy.

9. CLAIM PROCEDURE:

9.1 Procedure for Cashless Claims:

a. Treatment can be obtained at a network provider and is subject to pre-authorization by the Company or its authorized TPA.

b. A cashless request form is available with the network provider and TPA and must be completed and sent to the Company/TPA for authorization.

c. Upon receiving the cashless request form and related medical information, the Company/TPA will issue a pre-authorization letter to the hospital after verification.

d. At the time of discharge, the insured person must verify and sign the discharge papers and pay for any non-medical and inadmissible expenses.

e. The Company/TPA reserves the right to deny pre-authorization if the insured person is unable to provide relevant medical details.

f. In case of denial of cashless access, the insured person may obtain treatment as per the treating doctor's advice and submit the claim documents to the Company/TPA for reimbursement.

9.2 Procedure for Reimbursement of Claims:

For reimbursement of claims, the insured person must submit the necessary documents to the TPA (if applicable)/Company within the prescribed time limit as specified below.

9.3 Notification of Claim:

Notice with full particulars must be sent to the Company/TPA (if applicable) as follows:

a. Within 24 hours from the date of emergency hospitalization or before the insured person’s discharge from the hospital, whichever is earlier.

b. At least 48 hours prior to admission in the hospital in case of planned hospitalization.

9.4 Documents to be Submitted:

The reimbursement claim must be supported by the following documents and submitted within the prescribed time limit:

a. Duly completed claim form

b. Photo identity proof of the patient

c. Medical practitioner’s prescription advising admission

d. Original bills with itemized breakup

e. Payment receipts

f. Discharge summary, including a complete medical history of the patient and other details

g. Investigation/diagnostic test reports supported by the prescription from the attending medical practitioner

h. OT notes or surgeon’s certificate giving details of the operation performed (for surgical cases)

i. Sticker/invoice of implants, wherever applicable

j. MLR (Medico-Legal Report) copy if carried out and FIR (First Information Report) if registered, wherever applicable

k. NEFT details (to enable direct credit of claim amount in the bank account) and canceled cheque

l. KYC (Identity proof with address) of the proposer, where the claim liability is above Rs. 1 lakh as per AML Guidelines

m. Legal heir/succession certificate, wherever applicable

n. Any other relevant document required by the Company/TPA for assessment of the claim

9.5 Co-payment:

Each and every claim under the policy shall be subject to a co-payment of 5%, applicable to the claim amount admissible and payable as per the terms and conditions of the policy. The amount payable shall

be after the deduction of the co-payment.

9.6 Claim Settlement (Provision for Penal Interest):

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

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

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

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

9.7 Services Offered by TPA (To Be Stated Where TPA Is Involved):

Servicing of claims, i.e., claim admissions and assessments, under this policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include:

a. Claim settlement and claim rejection

b. Any services directly to any insured person or any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

9.8 Payment of Claim:

All claims under the policy shall be payable in Indian currency only.

10. GENERAL TERMS & CONDITIONS:

10.1 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.

10.2 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 claims arising under the policy.

10.3 Material Change:

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

10.4 Records to Be Maintained:

The insured person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The policyholder or insured person shall furnish such information as the Company may require for the settlement of any claim under the policy within a reasonable time limit and within the time limit specified in the policy.

10.5 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 effectual discharge towards payment of a claim by the Company to the extent of that amount for the particular claim.

10.6 Notice & Communication:

a. Any notice, direction, instruction, or any other communication related to the Policy should be made in writing.

b. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.

Certainly! Here’s the complete text:

Communication:
c. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

Territorial Limit:
10.7 All medical treatment for the purpose of this insurance will have to be taken in India only.

Multiple Policies:
10.8
a. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder 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 if chosen by the policyholder shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
b. Policyholder 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.
c. If the amount to be claimed exceeds the sum insured under a single policy after, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
d. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

Fraud:
10.9
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:—
a. The suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
b. The active concealment of a fact by the Insured Person having knowledge or belief of the fact;
c. Any other act fitted to deceive; and
d. Any such act or omission as the law specially declares to be fraudulent.
The company shall not repudiate the 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.

Cancellation:
a. The Insured may cancel this Policy by giving 15 days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below. Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.
b. The Company may cancel the Policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

Automatic Change in Coverage under the policy:
10.11
a. In the case of his/her (Insured Person) demise, the coverage for the Insured Person(s) shall automatically terminate. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case the other insured person is a minor, the policy shall be renewed only through any one of his/her natural guardians or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.
b. Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

Territorial Jurisdiction:
10.12 All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations, and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

Arbitration:
10.13
a. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by

Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).
b.

It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy.
c. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

Migration:
10.14
The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to 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, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:
a. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
b. Migration benefit will be offered to the extent of the sum of the previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefit shall not apply to any other additional increased Sum Insured.
For Detailed Guidelines on Migration [click here](https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_NoYearList.aspx?DF=RL&mid=4.2)

Portability:
10.15
The Insured Person will have the option to port the Policy to other insurers 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 plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:
a. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
b. Portability benefit will be offered to the extent of the sum of the previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.
For Detailed Guidelines on Portability [click here](https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_NoYearList.aspx?DF=RL&mid=4.2)

Renewal of Policy:
10.16
The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. The Company is not bound to give notice that it is due for renewal.
a. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years.
b. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
c. 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.
d. If not renewed within Grace Period after due renewal date, the Policy shall terminate.

Premium Payment in Installments:
10.17

If the insured person has opted for Payment of Premium on an installment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in Your Policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)
a. Grace Period of 15 days would be given to pay the installment premium due for the Policy.
b. During such grace period, Coverage will not be available from the installment premium payment due date till the date of receipt of premium by Company.
c. The Benefits provided under – “Waiting Periods”, “Specific Waiting Periods” Sections shall continue in the event of payment of premium within the stipulated grace Period.
d. No interest will be charged If the installment premium is not paid on due date.
e. In case of installment premium due not received within the grace Period, the Policy will get cancelled.

Possibility of Revision of Terms of the Policy Including the Premium Rates:
10.18
The Company, with the prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are affected.

Free Look Period:
10.19
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 fifteen days from the date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.
If the insured has not made any claim during the Free Look Period, the insured shall be entitled to:
a. A refund of the premium paid less any expenses incurred by the Company on the medical examination of the insured person and the stamp duty charges; or
b. 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 the period of cover or
c. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

Endorsements (Changes in Policy):
10.20
a. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
b. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without a break.
The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.

Change of Sum Insured:
10.21 Sum insured can be changed (increased/decreased) only at the time of renewal subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.

Terms and conditions of the Policy:
10.22 The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document.

Nomination:
10.23 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. For Claim settlement under reimbursement, the Company will pay the policyholder. In the event of the 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.