POLICY CERTIFICATE

Policy no.		**Issued at**		**Issue date**	

Intermediary Details

Name		**Code**	
Contact no.			

Policyholder Details

Name					
Correspondence address					
Client Id		**Date of birth**		**Gender**	

Plan Details

Policy Period	Start Date	00:00 hours	End Date	Midnight of
Cover type	Individual / Floater			
Plan name		**Premium payment mode**		

Nominee Details

Name	

Details of the Insured:

	1	*2*	*3*	*4*
Name				
Client ID				
Relationship				
Date of birth (DD-MM-YYYY)				
Occupation				
Pre-existing disease (since)				
Insured with the Company (since)				
Sum Insured (Rs.)				
No Claims Bonus (Rs.)				
Everyday Care Add-on Benefit opted (Yes / No)				
No Claims Bonus Super Add-on Benefit opted (Yes / No)				
No Claims Bonus Super (Rs.)				

X^1 is a permanent exclusion for Insured. Any Claim for treatment of X^1 shall never be payable under this Policy.

Schedule of Benefits[2]

Sr. No.	Benefit	Basis of Offering
1	Hospitalization Expenses Conditions for Medical Expenses	Upto Rs. x^3 per Policy Year i. Room Rent = 1% of Sum Insured per day Room Category = Single Private Room ii. ICU Charges = 2% of Sum Insured per day iii. Doctor / Surgeon Fees = 25% of Sum Insured per Claim

[1] The list may vary for each Insured.
[2] The list may vary depending upon the Plan & Sum Insured
[3] Amount may vary depending upon the Plan

2	Pre-hospitalization & Post-hospitalization	Pre-hospitalization up to 30 days Post-hospitalization up to 60 days
3	Ambulance Cover	Upto Rs. x[4] per Claim
4	Daily Allowance	Rs. x[5] per day, maximum up to 5 days per Claim
5	Organ Donor Cover	Upto Rs. x[6] per Policy Year
6	Recharge of Sum Insured	One re-instatement upto Sum Insured per Policy Year
7	Care Anywhere	Upto Sum Insured per Policy Year
8	No Claims Bonus	Upto Rs. x[7] per Policy Year
9	Domiciliary Hospitalization	Upto 10% of the Sum Insured per Policy Year
10	Health Check-up	1 Health Check-up per adult per Policy Year
11	Second Opinion	1 opinion per Policy Year per Insured Person for each major illness

Special Conditions[8]

Sr. No.	Particulars
1	Floater Cover
2	Co-payment

Portability Details of the Insured

	1	*2*	*3*	*4*
Name of the Previous Insurer				
First Policy no				
Expiring Policy Sum Insured (Original Sum Insured + Cumulative Bonus)				
Date of first enrollment				

Premium Details[9]

Plan Premium Everyday Care Add-on Benefit Premium No Claims Bonus Super Add-on Benefit Premium	
Loading[10] : Underwriting	
Discounts[11] : Family discount Cross sell discount e-policy e-renewal	
Service Tax & Levies	
Total premium	

[4] Amount may vary depending upon the Plan
[5] Amount may vary depending upon the Plan
[6] Amount may vary depending upon the Plan
[7] Amount may vary depending upon the Plan
[8] The list may vary depending upon the Plan
[9] Where Premium Acknowledgement is provided, these details shall be provided in such acknowledgement
[10] Wherever applicable
[11] Wherever applicable

Service Tax Reg. No. : <xxxxxxxxxxxx>

Stamp duty of <Rs. x>paid in cash or by demand draft or by pay order, vide Receipt/Challan no. <Challan no.> dated <Challan date>.

Contact details for Claims & Policy Servicing

Correspondence address			
Contact no.		**Fax no.**	
e-mail ID for Claims			
e-mail ID for Policy servicing			
Website			

For Religare Health Insurance Company Limited

Authorized Signatory

Please Note :

- Attached with this Policy Certificate are the Policy Terms & Conditions, Add-on Benefit (if opted) and Annexures. Please ensure that these documents have been received, read and understood. If any of these documents have not been received, please email <*****> or contact the Company at <*****>.
- This Policy Certificate in original must be surrendered to the Company in case of cancellation of the Policy.

Eligibility of Premium for deduction under section 80D of Income Tax Act, 1961

To,

Name of the Policyholder	
Correspondence address	

This is to certify that Religare Health Insurance Company Limited has received an amount of Rs. <xxx> from Mr. <Name of the Policyholder> towards payment of health insurance premium as per the details mentioned above. The premium paid for this Policy is eligible for applicable tax benefits u/s 80D of the Income Tax Act, 1961 and amendments thereof.

For Religare Health Insurance Company Limited

Authorized Signatory

Note:

1. In case of any discrepancy, the Policyholder is requested to contact the Company immediately.
2. Any amount paid in cash towards the premium would not qualify for tax benefits as mentioned above.
3. This document must be surrendered to the Company in case of cancellation of the Policy or for the issuance of a fresh certificate in the case of any alteration in the Policy.

POLICY TERMS AND CONDITIONS

1. Definitions

For the purposes of interpretation and understanding of the product the Company has defined, herein below some of the important words used in the product and for the remaining language and the words the Company believes to mean the normal meaning of the English language as explained in the standard language dictionaries. The words and expressions defined in the Insurance Act, IRDA Act, Regulations notified by the Authority and Circulars and Guidelines issued by the Authority shall carry the meanings explained therein. The judicial pronouncements of the highest courts in India will have the effect on the definitions and the language used in this product. The terms and conditions, coverage's and exclusions, benefits, various procedures and concepts which have been built in to the product also carry the specified meaning assigned to them in the said language.

The terms defined below have the meanings ascribed to them wherever they appear in this Policy and, where appropriate, references to the singular include references to the plural; references to the male include the female and references to any statutory enactment include subsequent changes to the same and vice versa.

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

1.2. **Acute Condition** means a disease, Illness or Injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/Illness/Injury which leads to full recovery.

1.3. **Age** means the completed age of the Insured Person as on his last birthday.

1.4. **Ambulance** means a road vehicle operated by a licensed / authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.

1.5. **Alternative treatments** are forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

1.6. **Annexure** means a document attached and marked as Annexure to this Policy.

1.7. **Any One Illness** means a continuous period of Illness and it includes relapse within 45 days from the date of last consultation with the Hospital / nursing home where the treatment may have been taken.

1.8. **Break in Policy** occurs at the end of the existing Policy Period, when the premium due for renewal on a given policy is not paid or before the premium renewal date or within 30 days thereof.

1.9. **Cashless facility** means a facility extended by the Company to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the Network Provider by the Company to the extent pre-authorization approved.

1.10. **Chronic Condition** means a a disease, Illness, or Injury that has one or more of the following characteristics:

i. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
ii. It needs ongoing or long-term control or relief of symptoms
iii. It requires your rehabilitation or for you to be specially trained to cope with it
iv. It continues indefinitely
v. It comes back or is likely to come back

1.11. **Claim** means a demand made in accordance with the terms and conditions of the Policy for payment of Medical Expenses or Benefits in respect of the Insured Person.

1.12. **Company** means Religare Health Insurance Company Limited.

1.13. **Condition Precedent** shall mean a policy term or condition upon which the Company's liability under the policy is conditional upon.

1.14. **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** means Congenital anomaly which is not in the visible and accessible parts of the body.
ii. **External Congenital Anomaly** means Congenital anomaly which is in the visible and accessible parts of the body.

1.15. **Contribution** is essentially the right of the Company to call upon other insurers, liable to the same Insured, to share the cost of an indemnity claim on a ratable proportion of Sum Insured.

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

1.17. **Cumulative Bonus (No Claims Bonus)** shall mean any increase in the Sum Insured granted by the Company without an associated increase in premium.

1.18. **Day Care Centre** means any institution established for Day Care Treatment of Illness and/or 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—

i. has qualified nursing staff under its employment;
ii. has qualified Medical Practitioner/s in charge;
iii. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
iv. maintains daily records of patients and will make these accessible to the Company's authorized personnel

1.19. **Day Care Treatment** means medical treatment and/ or a Surgical Procedure which is:

i. undertaken under general or local anesthesia in a Hospital/ Day Care Center in less than 24 hours because of technological advancement, and
ii. which would have otherwise required Hospitalization of more than 24 hours.

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

1.20. **Dependent Child** refers to a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his/her independent sources of income.

1.21. **Dental Treatment** is treatment carried out by a Dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/ implants.

1.22. **Disclosure to information norm** : The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

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

i. The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or

ii. The patient takes treatment at home on account of non-availability of room in a Hospital.

1.24. **Emergency** means a medical condition arising out of any Illness or Injury contracted by the Insured Person and declared and certified by the Medical Practitioner, attending to the Insured Person, that immediate treatment is required to save the life of the Insured Person.

1.25. **Emergency Care** means management for a severe Illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

1.26. **Grace Period** means the specified period of time immediately following the premium due date during which payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of Pre-existing Diseases. Coverage is not available for the period for which no premium is received.

1.27. **Hospital** means any institution established for In-Patient Care and Day Care Treatment of Illness and / or Injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under :

i. has qualified nursing staff under its employment round the clock;

ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

iii. has qualified Medical Practitioner(s) in-charge round the clock;

iv. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;

v. maintains daily records of patients and makes these accessible to the Company's authorized personnel.

1.28. **Hospitalization** means admission in a Hospital for a minimum period of 24 In-patient Care consecutive hours except for specified procedures / treatments, where such admission could be for a period of less than 24 consecutive hours.

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

1.30. **Injury** means accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

1.31. **In-patient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

1.32. **Insured Person (Insured)** means a person whose name specifically appears under Insured in the Policy Certificate and with respect to whom the premium has been received by the Company.

1.33. **Intensive Care Unit (ICU)** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped

for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

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

1.35. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.

1.36. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

1.37. **Medically Necessary** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which

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

1.38. **Network Provider** means the Hospitals or health care providers enlisted by the Company to provide medical services to an Insured on payment by a Cashless Facility.

1.39. **Non-Network** means any Hospital, Day Care Centre or other provider that is not part of the network.

1.40. **Notification of claim (Intimation)** means the process of notifying a Claim to the Company by specifying the timelines as well as the address/telephone number to which it should be notified.

1.41. **OPD Treatment** is one in which the Insured visits a clinic/Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or In-patient.

1.42. **Policy** means these Policy Terms & Conditions, the Proposal Form, Policy Certificate, Add-on Benefits (if applicable) and Annexures which form part of the policy contract and shall be read together.

1.43. **Policy Certificate** means the certificate attached to and forming part of this Policy.

1.44. **Policyholder** means the person named in the Policy Certificate as the Policyholder.

1.45. **Policy Period** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date as specified in the Policy Certificate.
If the Policy Period is more than 12 months, the Sum Insured shall apply on Policy Year basis.

1.46. **Policy Period End Date** means the date on which the Policy expires, as specified in the Policy Certificate.

1.47. **Policy Period Start Date** means the date on which the Policy commences, as specified in the Policy Certificate.

1.48. **Policy Year** means a period of 12 consecutive months commencing from the Policy Period Start Date or any anniversary thereof.

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

1.50. **Post-hospitalization Medical Expenses** means Medical Expenses incurred immediately after the Insured Person is discharged from the Hospital provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

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

1.51. **Pre-existing Disease** means any condition, ailment or Injury or related condition(s) for which the Insured Person had signs or symptoms, and / or were diagnosed, and / or received Medical Advice / treatment within 48 months prior to the first Policy issued by the Company.

1.52. **Pre-hospitalization Medical Expenses** means Medical Expenses incurred immediately before the Insured Person is Hospitalized, provided that :

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

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

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

1.54. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved.

1.55. **Rehabilitation** means assisting an Insured Person who, following a Medical Condition, requires assistance in physical, vocational, independent living and educational pursuits to restore him to the position in which he was in, prior to such medical condition occurring.

1.56. **Renewal** defines 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 all waiting periods.

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

1.58. **Subrogation** shall mean the right of the Company to assume the rights of the Policyholder / Insured Person to recover expenses paid out under the Policy that may be recovered from any other source.

1.59. **Sum Insured** means the amount specified against each Insured Person in the Policy Certificate which represents the Company's maximum, total and cumulative liability for that Insured Person for any and all Claims incurred in respect of that Insured Person during the Policy Year.

1.60. **Surgery/ Surgical Procedure** means manual and / or operative procedure(s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or a Day Care Centre by a Medical Practitioner.

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

1.62. **Variable Medical Expense** means those Medical Expenses which vary in accordance with the Room Rent or room category or ICU charges in a Hospital.

2. Benefits

General Conditions applicable to all Benefits:

(a) Any Benefit shall be available only if the same is specifically mentioned in the Policy Certificate.

(b) Admissibility of a Claim under Benefit 1 is a pre-condition to the admission of a Claim for Benefit 2 to Benefit 5 and the event giving rise to the Claim under the Benefit 1 shall be within the Policy Period for the Claim for such Benefit to be accepted.

(c) The maximum, total and cumulative liability of the Company for an Insured Person for any and all Claims incurred under this Policy during the Policy Year in relation to any Insured Person shall not exceed the Sum Insured for that Insured Person. All Claims shall be payable subject to the terms, conditions and exclusions of the Policy and subject to availability of the Sum Insured.

(d) Any Claim under Benefit 1, Benefit 6, Benefit 7 and Benefit 8 shall always be subject to Clause 5.5.

(e) Any Claim paid for Benefit 1 to Benefit 9 shall reduce the Sum Insured for the Policy Year and only the balance shall be available for all future claims for that Policy Year.

2.1. Benefit 1 : Hospitalization Expenses

If an Insured Person is diagnosed with an Illness or suffers an Injury during the Policy Period and while the Policy is in force that requires:

(a) **In-patient Care :** The Insured Person's Hospitalization, then the Company will indemnify the Medical Expenses incurred on Hospitalization, provided that the Hospitalization was on the written advice of a Medical Practitioner.

(b) **Day Care Treatment :** The Insured Person to undergo Day Care Treatment at a Day Care Centre or Hospital, then the Company will indemnify the Medical Expenses incurred on that Day Care Treatment, provided that the treatment was taken on the written advice of a Medical Practitioner.

(c) **Conditions for Medical Expenses (Applicable only if specifically mentioned in the Policy Certificate)**

(i) **Room, boarding and nursing expenses as charged by the Hospital where the Insured Person availed medical treatment (Room Rent / Room Category) :**

I. If the Insured Person is admitted in a room where the Room Rent incurred or the Room Category is different than the one specified in the Policy Certificate, then the Policyholder shall bear the ratable proportion of the total Variable Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent actually incurred and the Room Rent limit or the Room Rent of the entitled room category to the Room Rent actually incurred.

II. Room Rent = 1% of Benefit 1 Sum Insured per day. Any amount accrued as No Claims Bonus under Clause 2.8 or No Claims Bonus Super under Add-on Benefit 2 shall not form part of Sum Insured.

III. Room Category = Single Private Room Any amount accrued as No Claims Bonus under Clause 2.8 or No Claims Bonus Super under Add-on Benefit 2 shall not form part of Sum Insured.

For the purpose of this Clause only, Single Private Room means a Hospital room where a single patient is accommodated and which has an attached toilet (lavatory and bath). The room should have the provision for accommodating an attendant. Such room shall be the most basic and the most economical of all accommodations available as a single room in that Hospital.

(ii) **Intensive Care Unit Charges (ICU Charges) :**

I. If the Insured Person is admitted in an ICU where the ICU charges incurred are higher than the ICU limit specified above then the Policyholder shall bear the ratable proportion of the Variable Medical Expenses in the proportion of the difference between the ICU Charges actually incurred and ICU Charges limit to the ICU Charges actually incurred.

II. ICU Charges = 2% of Benefit 1 Sum Insured per day. Any amount accrued as No Claims Bonus under Clause 2.8 or No Claims Bonus Super under Add-on Benefit 2 shall not form part of Sum Insured.

(iii) **Fees charged by a surgeon, anesthetist and Medical Practitioner (Doctor / Surgeon Fees)**

I. Upto 25% of Benefit 1 Sum Insured per Claim. Any amount accrued as No Claims Bonus under Clause 2.8 or No Claims Bonus Super under Add-on Benefit 2 shall not form part of Sum Insured.

Any Claim under this Benefit can be made under Clause 5.2(a) & (b).

2.2. Benefit 2 : Pre-hospitalization and Post-hospitalization

(a) The Company will indemnify the Medical Expenses incurred for the Insured Person:

i. during a period of 30 days immediately prior to the date of the Insured Person's admission to the Hospital; and

ii. during a period of 60 days immediately following the date of the Insured Person's discharge from Hospital,

Provided that, the Medical Expenses relate to the same Illness / Injury for which the Company has accepted the Insured Person's Claim.

(b) If the provisions of Clause 5.6(d) of the Policy Terms & Conditions has been invoked, then:

i. The date of admission to Hospital for the purpose of this Benefit shall be the date of the first admission to the Hospital for that Any One Illness; and

ii. The date of discharge from Hospital for the purpose of this Benefit shall be the last date of discharge from the Hospital in relation to that Any One Illness.

(c) Any Claim under this Benefit can be made under Clause 5.2(b).

2.3. Benefit 3 : Ambulance Cover

(a) The Company will indemnify up to the amount specified against this Benefit in the Policy Certificate, for the reasonable expenses necessarily incurred on availing Ambulance services offered by a Hospital or by an Ambulance service provider for the Insured Person's necessary transportation to the nearest Hospital in case of an Emergency provided that the necessity of the Ambulance transportation is certified by the treating Medical Practitioner.

(b) Any Claim under this Benefit can be made under Clause 5.2(a) & (b).

2.4. Benefit 4 : Daily Allowance

(a) The Company will pay the amount specified against this Benefit in the Policy Certificate for each continuous and completed period of 24 hours of Hospitalization of the Insured Person, provided that:

i. The Hospitalization is only for In-patient Care; and
ii. The Company will not be liable to make payment under this Benefit for more than 5 consecutive days of Hospitalization for Any One Illness.

(b) Any Claim under this Benefit can be made under Clause 5.2(b).

2.5. Benefit 5 : Organ Donor Cover

(a) The Company will indemnify up to the amount specified against this Benefit in the Policy Certificate for the Medical Expenses incurred in respect of the donor for any organ transplant surgery conducted on the Insured Person during the Policy Year, provided that:

i. The organ donor is an eligible donor in accordance with The Transplantation of Human Organs Act, 1994 (amended) and other applicable laws and rules.

ii. The organ donated is for the Insured Person's use.

iii. The Company will not be liable to pay the Medical Expenses incurred by the donor's for Benefit 2 or any other Medical Expenses in respect of the donor consequent to the harvesting.

(b) Clause 4.3(a)(xviii) is superseded to the extent covered under this Benefit.

(c) Any Claim under this Benefit can be made under Clause 5.2(a) & (b).

2.6. Benefit 6 : Recharge of Sum Insured

(a) If a Claim is payable under the Policy, then the Company agrees to automatically make the re-instatement of up to the Sum Insured for that Policy Year only provided that:

i. The Recharge shall be utilized only after the Sum Insured, No Claims Bonus and No Claims Bonus Super have been completely exhausted in that Policy Year.
ii. A Claim will be admissible under the Recharge only if the Claim is admissible under the Benefit 1.
iii. The Recharge shall be available only for all future Claims and not in relation to any Illness or Injury for which a Claim has already been admitted for that Insured Person during that Policy Year.
iv. The Recharge shall not be considered while calculating the No Claims Bonus and No Claims Bonus Super.
v. The total amount of Recharge shall not exceed the Sum Insured for that Policy Year.
vi. Any unutilized Recharge cannot be carried forward to any subsequent Policy Year.
vii. If the Policy is issued on a Floater basis, then the Recharge will also be available only on Floater basis.
viii. For any single Claim during a Policy Year the maximum Claim amount payable shall be sum of:
    I The Sum Insured
    II No Claims Bonus
    III No Claims Bonus Super
ix. During a Policy Year, the aggregate Claim amount payable, subject to admissibility of the Claim, shall not exceed the sum of:
    I The Sum Insured
    II No Claims Bonus
    III No Claims Bonus Super
    IV Recharge of Sum Insured
x. The balance of the Recharge shall be available during the Policy Year till it is exhausted completely.
xi. In case of portability, the credit for Sum Insured would be available only to the extent of sum insured of the expiring policy, including the Recharge.

(b) For additional understanding on the terms of this Benefit please refer to Exhibit – 1 in Annexure B.

(c) Any Claim under this Benefit can be made under Clause 5.2(a) & (b).

2.7. Benefit 7 : Care Anywhere

(a) Company will indemnify up to the amount specified against this Benefit in the Policy Certificate for the Medical Expenses incurred outside India, in respect of the Insured Person during the Policy Year, provided that:

i. The Medical Expenses incurred are in respect of the major Illness specified below only:
   I Cancer
   II Benign Brain Tumour
   III Major Organ Transplant / Bone Marrow Transplant
   IV Heart Valve Replacement
   V Coronary Artery Bypass Graft
ii. The Medical Expenses incurred are only for In-patient Care or Day Care Treatment undertaken in any Hospital.
   For the purposes of this Benefit, Hospital shall mean "Any institution established for in-patient care and day care treatment of Injury or Illness and which has been registered as a Hospital or a clinic as per law rules and/or regulations applicable for the country where the treatment is taken. The term Hospital shall not include a place of rest, a place for the aged, a place for drug-addicts or a place for alcoholics or a hotel, health spa or massage center or the like."
iii. Any payments under this Benefit shall always be made in India, in Indian Rupees and on a re-imbursement basis only. The rate of exchange as published by Reserve Bank of India (RBI) as on the date of payment to the Hospital shall be used for conversion of foreign currency amounts into Indian Rupees for payment of any Claim under this Benefit. Where on the date of discharge, RBI rates are not published, the rates next published by RBI shall be considered for conversion.
iv. The Company shall be liable to make payment under this Benefit only if prior written notice of at least 7 days is given to the Company.
v. Clause 4.3(a)(xxi) and Clause 5.6(a) is superseded to the extent covered under this Benefit.

(b) Any Claim under this Benefit can be made under Clause 5.2(b).

2.8. Benefit 8 : No Claims Bonus

(a) At the end of each Policy Year, the Company will provide 10% of the Sum Insured applicable on the last completed Policy Year, on a cumulative basis as a No Claims Bonus for each completed and continuous Policy Year, provided that no Claim has occurred in the expiring Policy Year and subject to :

i. In any Policy Year, the accrued No Claims Bonus, (including any carried forward Cumulative Bonuses if the portability provisions in Clause 4.2 have been applied), shall not exceed 50% of the total of Sum Insured available in the renewed Policy.
ii. The No Claims Bonus shall not enhance or be deemed to enhance any Conditions as prescribed under Clause 2.1(c).
iii. For a Floater policy, the No Claims Bonus, shall be available only on Floater basis and shall accrue only if no Claim has been made in respect of any Insured Person during the expiring

Policy Year. The No Claims Bonus which is accrued during the claim-free Policy Year will only be available to those Insured Persons who were insured in such claim-free Policy Year and continue to be insured in the subsequent Policy Year.

iv. The No Claims Bonus is provisional and is subject to revision if a Claim is made in respect of the expiring Policy Year.
v. The entire No Claims Bonus will be forfeited if the Policy is not continued / renewed on or before Policy Period End Date or the expiry of the Grace Period whichever is later.
vi. The No Claims Bonus shall be applicable on an annual basis subject to continuation of the Policy.
vii. If the Insured Persons in the expiring policy are covered on individual basis and thus have accumulated the No Claims Bonus for each member in the expiring policy, and such expiring policy is renewed with the Company on a Floater basis, then the No Claims Bonus to be carried forward for credit in this Policy would be the least No Claims Bonus amongst all the Insured Persons.
viii. If the Insured Persons in the expiring policy are covered on a Floater basis and such Insured Persons renew their expiring Policy with the Company by splitting the Floater Sum Insured in to 2 or more Floater / individual covers, then the No Claims Bonus of the expiring Policy shall be apportioned to such renewed Policy in the proportion of the Sum Insured of each of the renewed Policy.
ix. This clause does not alter the Company's right to decline renewal or cancellation of the Policy for reasons as specified in Clause 6.1.
x. In the event of a Claim occurring during any Policy Year, the accrued No Claims Bonus will be reduced by 10% of the expiring Sum Insured at the commencement of next Policy Year, but in no case shall the Sum Insured be reduced.
xi. In case Sum Insured under the Policy is reduced at the time of renewal, the applicable No Claims Bonus shall also be reduced in proportion to the Sum Insured.
xii. In case Sum Insured under the Policy is increased at the time of renewal, the No Claim Bonus shall be calculated on the Sum Insured applicable on the last completed Policy Year.

(b) Any Claim under this Benefit can be made under Clause 5.2(a) & (b).

2.9. Benefit 9 : Domiciliary Hospitalization

(a) The Company will indemnify for the Medical Expenses incurred during Policy Year for Domiciliary Hospitalization of the Insured Person up to the amount specified against this Benefit in the Policy Certificate, provided that the treatment continues for a period exceeding 3 consecutive days.

(b) Any Medical Expenses incurred under Benefit 2 shall not be payable under this Benefit.

(c) 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 Insipidus

vi. Epilepsy
vii. Hypertension
viii. Influenza, cough or cold
ix. All Psychiatric or Psychosomatic Disorders
x. Pyrexia of unknown origin
xi. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis
xii. Arthritis, Gout and Rheumatism

(d) Any Claim under this Benefit can be made under Clause 5.2 (b).

2.10. Benefit 10 : Health Check-up

(a) On the Insured Person's request, the Company shall arrange for the Insured Person's Health Check-up in accordance with the table below at its Network Provider, provided that:

i. This Benefit shall be available only to those Insured Persons that are Age 18 or above on the Policy Period Start Date provided further that this Benefit shall not be available to any Insured Person who is covered under the Policy as the Policyholder's child;

ii. This Benefit shall only be available once in every year during the Policy Year.

Set No.	List of Medical Tests covered in the Annual Health Check-up	Age	Plan
1	Complete Blood Count, Urine Routine, Blood Group, ESR, Fasting Blood Glucose, S Cholesterol, SGPT, Creatinine	18 years and above	Care 1
2	Complete Blood Count with ESR, Urine Routine, Blood Group, Fasting Blood Sugar, ECG, Serum Cholesterol, SGPT, Serum Creatinine	18 years and above	Care 2 & Care 6
3	Complete Blood Count with ESR, Urine Routine, Blood Group, Fasting Blood Sugar, Lipid Profile, Kidney Function Test, ECG	18 years and above	Care 3
4	Complete Blood Count with ESR, Urine Routine, Blood Group, Fasting Blood Sugar, Lipid Profile, TMT, Kidney Function Test	18 years and above	Care 4 & Care 5

(b) Any Claim under this Benefit can be made under Clause 5.2(a).

2.11. Benefit 11 : Second Opinion

(a) If the Insured Person is diagnosed with any Major Illness during the Policy Year, then at the Policyholder's / Insured Person's request, the Company shall arrange for a Second Opinion from a Medical Practitioner.

(b) It is agreed and understood that the Second Opinion will be based only on the information and documentation provided to the Company which will be shared with the Medical Practitioner and is subject to the following:

i. This Benefit can be availed a maximum of one time by an Insured Person during the Policy Year for each Major Illness.
ii. The Insured Person is free to choose whether or not to obtain the Second Opinion and, if obtained under this Benefit, then whether or not to act on it.
iii. This Benefit is for additional information purposes only and does not and should not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.
iv. The Company does not provide a Second Opinion or make any representation as to the adequacy or accuracy of the same, the Insured Person's or any other person's reliance on the same or the use to which the Second Opinion is put.
v. The Company does not assume any liability for and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner or in any Second Opinion or for any consequences of actions taken or not taken in reliance thereon.
vi. The Policyholder or Insured Person shall indemnify the Company and hold the Company harmless for any loss or damage caused by or arising out of or in relation to any opinion, advise, prescription, actual or alleged errors, omissions or representations made by the Medical Practitioner or for any consequences of any action taken or not taken in reliance thereon.
vii. Any Second Opinion provided under this Benefit shall not be valid for any medico-legal purposes.
viii. The Second Opinion does not entitle the Insured Person to any consultation from or further opinions from that Medical Practitioner.

(c) For the purposes of this Benefit only:

i. Second Opinion means an additional medical opinion obtained by the Company from a Medical Practitioner solely on the Policyholder or Insured Person's express request in relation to a Major Illness which the Insured Person has been diagnosed with during the Policy Year.

ii. Major Illness means one of the following only:

I. Benign Brain Tumour
II. Cancer
III. End Stage Lung Failure
IV. Heart Attack

V. Open Chest Coronary Artery Bypass Graft
VI. Heart Valve Replacement
VII. Coma
VIII. End Stage Renal Failure
IX. Stroke
X. Major Organ Transplant
XI. Paralysis
XII. Motor Neuron Disease
XIII. Multiple Sclerosis
XIV. Major Burns
XV. End Stage Liver Disease

(d) Any Claim under this Benefit can be made under Clause 5.2(a).

3. Special Conditions

Special Conditions shall be applicable only if the same is specifically mentioned in the Policy Certificate.

3.1. Special Condition 1 : Floater Cover

(a) The Company's maximum, total and cumulative liability, for any and all Claims incurred during the Policy Year in respect of all Insured Persons, shall not exceed the Sum Insured.

(b) Definition 1.59 is deleted entirely and replaced with the following:

Sum Insured: The amount specified in the Policy Certificate which represents the Company's maximum, total and cumulative liability for all Insured Persons for any and all Claims incurred during the Policy Year.

3.2. Special Condition 2 : Co-payment

(a) The Policyholder shall bear 20% of the Final Claim Amount assessed by the Company in accordance with Clause 5.5 in accordance with the table below and the Company's liability shall be restricted to the balance amount payable :

Cover Type	Entry Age* of Insured Person or Eldest Insured Person (in case of Floater)	Applicable to
Individual	>=61 years	Individual Insured Person
Floater	>=61 years	All Insured Person's

**Entry Age means the age of the Insured Person at the time of issue of the first Policy with the Company.*

(b) The Co-payment shall be applicable to each and every Claim, for each Insured Person.

4. Exclusions

4.1. Waiting Period:

(a) **30-Day waiting period**

(i) Claim for any Medical Expenses incurred for treatment of any Illness during the first 30 days of Policy Period Start Date shall not be admissible, except those Medical Expenses incurred as a result of an Injury.

(ii) This exclusion shall not apply for subsequent Policy Years provided that there is no break in insurance cover for that Insured Person and that the Policy has been renewed with the Company for that Insured Person on time and for the same or lower Sum Insured.

(b) **Specific waiting period**

(i) 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 the Company from the first Policy Period Start Date:

I Arthritis (if non-infective), Osteoarthritis and Osteoporosis, Gout, Rheumatism and Spinal Disorders, Joint Replacement Surgery;
II 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, Gastric and Duodenal Ulcers;
VII Surgery of Genito urinary system unless necessitated by malignancy;
VIII All types of Hernia, Hydrocele;
IX Hysterectomy for menorrhagia or fibromyoma or prolapse of uterus unless necessitated by malignancy;
X Internal tumors, skin tumors, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant;
XI Kidney Stone / Ureteric Stone / Lithotripsy / Gall Bladder Stone;
XII Myomectomy for fibroids;
XIII Varicose veins and varicose ulcers

(ii) 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 48 months of continuous insurance coverage with the Company from the first Policy Period Start Date.

(c) **Pre-existing Disease:** Claims will not be admissible for any Medical Expenses incurred as Hospitalization Expenses for diagnosis / treatment of any Pre-existing Disease until 48 months of continuous coverage has elapsed, since the inception of the first Policy with the Company.

(d) If the Sum Insured is enhanced on any renewal of this Policy, the waiting periods as defined above in Clauses 4.1(a), 4.1(b) and 4.1(c) shall be applicable afresh to the incremental amount of the Sum Insured only.

(e) If the Sum Insured is reduced on any renewal of this Policy, the credit for waiting periods as defined above in Clauses 4.1(a), 4.1(b) and 4.1(c) shall be restricted to the lowest Sum Insured under the previous Policy.

(f) The Waiting Periods as defined in Clauses 4.1(a), 4.1(b) and 4.1(c) shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

4.2. Portability:

(a) If the Policyholder and/or Insured Person applies to the Company for a health insurance policy, provided that

(i) The proposed Insured Person has to be covered without any break under any similar individual indemnity health insurance policy from any non-life insurance company registered with the IRDA or any similar group indemnity health insurance policy from the Company; and

The Waiting Periods as defined in Clauses 4.1(a), 4.1(b) and 4.1(c) 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 Eligible Cumulative Bonus under the expiring health insurance policy.

The Waiting Periods under Clauses 4.1(a), 4.1(b) and 4.1(c) shall be applicable afresh to the amount by which the Sum Insured under this Policy exceeds the total of sum insured and Eligible Cumulative Bonus under the terms of the expiring policy.

(b) The Waiting Periods as defined in Clauses 4.1(a), 4.1(b) and 4.1(c) shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

(c) Credit for the sum insured and the Eligible Cumulative Bonus of the expiring policy shall additionally be available as under:

(i) 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 the Company, then the Eligible Cumulative Bonus to be carried forward for credit under this Policy would also be applied on a Floater basis only.

(ii) In all other cases the Eligible Cumulative Bonus to be carried forward for credit in this Policy would be applied on an individual basis only

For the purpose of this provision the "Eligible Cumulative Bonus" shall mean the additional sum insured and cumulative bonus which the Insured Person would have been eligible for, had the same policy been renewed with the same insurance company.

(d) 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:

(i) The Company 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.

(ii) In case any Claim is reported during the extended Policy Period, the Policyholder shall first pay the premium so as to make the Policy Period of 12 full calendar months. The Company's liability for the payment of the Claim shall commence only once such premium is received. Alternately, the Company may deduct the premium payable by the Policyholder and pay the balance Claim amount, if any and issue Policy for the balance Policy Period.

*** Note: Portability provisions will apply even if the Insured Person migrates to any other health insurance policy.**

4.3. Permanent Exclusions :

(a) 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:

(i) Any condition or treatment as specified in Annexure - III

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

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

(iv) Any treatment arising from or traceable to any fertility, sterilization, birth control procedures, contraceptive supplies or services including complications arising due to supplying services or Assisted Reproductive Technology.

(v) Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.

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

(vii) Unproven/Experimental 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.

(viii) Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, walkers, belts, collars, caps, splints, braces, stockings of any kind, diabetic footwear, glucometer/thermometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome (C.P.A.P) or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for asthmatic condition, cost of cochlear implants.

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

(x) Treatment of any Congenital Anomaly or Illness or defects or anomalies or treatment relating to birth defects.

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

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

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

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

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

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

(xvii) All expenses related to donor treatment, including surgery to remove organs from the donor, in case of transplant surgery.

(xviii) Non-allopathic treatment.

(xix) Any OPD Treatment.

(xx) Treatment received outside India.

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

(xxii) 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.

(xxiii) 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.

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

(xxv) Any charges incurred to procure any medical certificate, treatment or Illness related documents pertaining to any period of Hospitalization or Illness.

(xxvi) Personal comfort and convenience items or services including but not limited to T.V. (wherever specifically charged separately), charges for access to telephone and telephone calls (wherever specifically charged separately), foodstuffs (except patient's diet), cosmetics, hygiene articles, body or baby care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies.

(xxvii) Expenses related to any kind of RMO charges, service charge, surcharge, night charges levied by the hospital under whatever head.

(xxviii) Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

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

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

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

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

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

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

(xxxi) 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.

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

5. Claims Intimation, Assessment and Management

5.1. Upon the occurrence of any Illness or Injury that may give rise to a Claim under this Policy, then as a condition precedent to the Company's liability under the Policy, the Policyholder or Insured Person shall undertake all of the following:

(a) **Claims Intimation**

(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, the Policyholder or Insured Person, shall notify the Company either at the Company's call center or in writing immediately.

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

(iii) It is agreed and understood that the following details are to be provided to the Company at the time of intimation of Claim:

I Policy Number;
II Name of the Policyholder;
III Name of the Insured Person in respect of whom the Claim is being made;
IV Nature of Illness or Injury;
V Name and address of the attending Medical Practitioner and Hospital;
VI Date of admission to Hospital or proposed date of admission to Hospital for planned Hospitalization;
VII Any other information, documentation or details requested by the Company.

5.2. Claims Procedure

(a) **Cashless**

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

(ii) In addition to the foregoing, in order to avail of the cashless facility, the following procedure must be followed:

I. Pre-authorization: The Policyholder or Insured Person must call the Company's call center and request authorization for the proposed treatment by way of submission of a completed pre-authorization form at least 48 hours before the commencement of planned Hospitalization or within 24 hours of admission to Hospital, if the Hospitalization is required in an Emergency.

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

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

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

(iii) It is agreed and understood that the Company may, in its sole discretion, modify or add to the list of Network Provider or modify or restrict the extent of Cashless Facilities that may be availed at any particular Network Provider. For an updated list of Network Provider and the extent of Cashless Facilities available at each Network Provider, the Policyholder or Insured Person can refer to the list of Network Provider available on the Company's website or at the call centre.

(b) **Re-imbursement**

The Company shall be given intimation of Hospitalization at its call center or in writing at least 48 hours before the commencement of a planned Hospitalization or within 24 hours of admission to Hospital, if the Hospitalization is required in an Emergency. It is agreed and understood that in all cases where intimation of a Claim has been provided under this provision, all the information and documentation specified in Clause 5.4 below shall be submitted (at the Policyholder or Insured Person's expense) to the Company immediately and in any event within 15 days of Insured Person's discharge from Hospital.

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

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

(b) It is agreed and understood that as a condition precedent for a Claim to be considered under this Policy:

(i) All reasonable steps and measures must be taken to avoid or minimize the quantum of any Claim that may be made under this Policy.

(ii) The Insured Person shall follow the directions, advice or guidance provided by a Medical Practitioner and the Company shall not be obliged to make payment that is brought about or contributed to by the Insured Person failing to follow such directions, advice or guidance.

(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 of the Policy.

(iv) The Insured Person will, at the request of the Company, submit himself for a medical examination by the Company's nominated Medical Practitioner as often as the Company considers reasonable and necessary. The cost of such examination will be borne by the Company.

(v) The Company's 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) The Company shall be provided with complete documentation and information which the Company has requested to establish its liability for the Claim, its circumstances and its quantum.

5.4. Claim Documents

(a) 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:

(i) Duly completed and signed Claim form, in original;
(ii) Medical Practitioner's referral letter advising Hospitalization;
(iii) Medical Practitioner's prescription advising drugs / diagnostic tests / consultation;
(iv) Original bills, receipts and discharge card from the Hospital / Medical Practitioner;
(v) Original bills from pharmacy / chemists;
(vi) Original pathological / diagnostic test reports / radiology reports and payment receipts;
(vii) Indoor case papers;
(viii) First Information Report, final police report, if applicable;
(ix) Post mortem report, if conducted;
(x) Any other document as required by the Company to assess the Claim

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

(c) The Company will only accept bills/invoices which are made in the Insured Person's name.

(d) The Company shall condone delay on merit for delayed Claims where delay is proved to be for reasons beyond the control of the Policyholder or the Insured Person.

5.5. Claim Assessment

(a) All admissible Claims under this Policy shall be assessed by the Company in the following progressive order:
   (i) If the provisions of the Contribution Clause in Clause 6.9 are applicable, the Company's liability to make payment under that Claims shall first be apportioned accordingly.
   (ii) If a room / ICU accommodation has been opted for where the rent or category is higher than the eligible limit as applicable in accordance with Clause 2.1(c)(i) & (ii) for that Insured Person under the Policy, then, the Variable Medical Expenses payable shall be pro-rated as per the applicable limits.
   (iii) If any sub-limits on Medical Expenses are applicable in accordance with Clause 2.1(c)(iii), the Company's liability to make payment shall be limited to such extent as applicable.
   (iv) Co-payment, if any, shall be applicable on the amount payable by the Company after applying Clause 5.5(a)(i), (ii) and (iii).

(b) The Claim amount assessed in Clause 5.5(a) above would be deducted from the following amounts in the following progressive order:
   (i) Sum Insured;
   (ii) No Claims Bonus;
   (iii) No Claims Bonus Super (if applicable);
   (iv) Recharge of Sum Insured (if applicable).

5.6. Payment Terms

(a) This Policy covers only medical treatment taken entirely within India. All payments under this Policy shall be made in Indian Rupees and within India.
(b) The Sum Insured of the Insured Person shall be reduced by the amount payable or paid under the Policy Terms and Conditions and only the balance amount shall be available as the Sum Insured for the unexpired Policy Year.
(c) The Company shall have no liability to make payment of a Claim under the Policy in respect of an Insured Person, once the Sum Insured for that Insured Person is exhausted.
(d) The Company shall settle any Claim within 30 days of receipt of all the necessary documents/ information as required for settlement of such Claim and sought by the Company. The Company shall provide the Policyholder an offer of settlement of Claim and upon acceptance of such offer by the Policyholder the Company shall make payment within 7 days from the date of receipt of such acceptance. In case there is delay in the payment beyond the stipulated timelines, the Company 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.
(e) If the Policyholder or Insured Person suffers a relapse within 45 days of the date of discharge from the Hospital for which a Claim has been made, then such relapse shall be deemed to be part of the

same Claim and all the limits for Any One Illness under this Policy shall be applied as if they were under a single Claim.

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

(g) For the Reimbursement Claims, the Company will pay the Policyholder. In the event of death of the Policyholder, the Company will pay the nominee (as named in the Policy Certificate) and in case of no nominee at its discretion to the legal heirs of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

6. General Terms and Conditions

6.1. Disclosure to information norm

If any untrue or incorrect statements are made or there has been a 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 the Policyholder or the Insured Person or any one acting on his / their behalf, the Company shall have no liability to make payment of any Claims and the premium paid shall be forfeited to the Company.

6.2. Observance of Terms and Conditions

The due observance and fulfillment of the terms and conditions of this Policy (including the realization of premium by their respective due dates and compliance with the specified procedure on all Claims) in so far as they relate to anything to be done or complied with by the Policyholder or any Insured Person, shall be condition precedent to the Company's liability under the Policy.

6.3. Reasonable Care

Insured Persons shall take all reasonable steps to safeguard the interests against any Illness or Injury that may give rise to a Claim.

6.4. Material Change

It is a condition precedent to the Company's liability under the Policy that the Policyholder shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business at his own expense. The Company may, in its discretion, adjust the scope of cover and / or the premium paid or payable, accordingly.

6.5. Records to be maintained

The Policyholder and 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 under this Policy at any time during the Policy Period and up to three years after the Policy Period End Date, or until final adjustment (if any) and resolution of all Claims under this Policy.

6.6. No constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder or Insured Person which is in possession of the Company other than that information expressly disclosed in the Proposal Form or otherwise in writing to the Company, shall not be held to be binding or prejudicially affect the Company.

6.7. Complete discharge

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

6.8. Subrogation

The Policyholder and Insured Person shall at his own expense do or concur in doing or permit to be done all such acts and things that may be necessary or reasonably required by the Company for the purpose of enforcing and / or securing any civil or criminal rights and remedies or obtaining relief or indemnity from any other party to which the Company is or would become entitled upon the Company paying for a Claim under this Policy, whether such acts or things shall be or become necessary or required before or after its payment. Neither the Policyholder nor any Insured Person shall prejudice these subrogation rights in any manner and shall at his own expense provide the Company with whatever assistance or cooperation is required to enforce such rights. Any recovery the Company makes pursuant to this clause shall first be applied to the amounts paid or payable by the Company under this Policy and any costs and expenses incurred by the Company of effecting a recovery, where after the Company shall pay any balance remaining to the Policyholder. This clause shall not apply to any Benefit offered on a fixed benefit basis.

6.9. Contribution

(a) In case any Insured is covered under more than one indemnity insurance policies, with the Company or with other insurers, the Policyholder shall have the right to settle the Claim with any of the Company, provided that the Claim amount payable is up to Sum Insured of such Policy.

(b) In case the Claim amount exceeds the Sum Insured, then Policyholder shall have the right to choose the companies with whom the Claim is to be settled. In such cases, the settlement shall be done as under :

  (i) If at the time when any Claim arises under this Policy, there is any other insurance which covers (or would have covered but for the existence of this Policy), the same Claim (in whole or in part), then the Company shall not be liable to pay or contribute more than its ratable proportion of any Claim.

(c) This clause shall not apply to any Benefit offered on a fixed benefit basis.

6.10. Policy Disputes

Any and all disputes or differences under or in relation to the validity, construction, interpretation and effect to this Policy shall be determined by the Indian Courts and in accordance with Indian law. The disputes on quantum on payment of losses or any other dispute explained in the paragraph shall be preferred to be dealt and resolved under the alternative dispute resolutions system including Arbitration and Conciliation Act of India.

6.11. Free Look Period

(a) The Policyholder may, within 15 days from the receipt of the Policy document, return the Policy stating reasons for his objection, if the Policyholder disagrees with any Policy terms and conditions. If no Claim has been made under the Policy, the Company will refund the premium received after deducting proportionate risk premium for the period on cover, expenses for medical examination (as per the below mentioned grid) 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.

Age / Sum Insured	Sum Insured up to 5 Lac	Sum Insured 7 Lac & 10 Lac	Sum Insured above 10 Lac
6 years to 18 years	Nil	Nil	Rs. 2,200
19 years to 45 years	Nil	Rs. 825	Rs. 2,200
46 years and above	Rs. 825	Rs. 2,200	Rs. 2,200

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

6.12. 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 Company may, in its sole discretion, revise the renewal premium payable under the Policy provided that revisions to the renewal premium are in accordance with the IRDA rules and regulations as applicable from time to time. 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 such as Waiting Periods and coverage of Pre-existing Diseases. 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. The provisions of Section 64VB of the Insurance Act shall be applicable.

(d) The Company will ordinarily not refuse to renew the Policy except on ground of fraud, moral hazard or misrepresentation or non-co-operation by the Insured.

(e) If the Policy Certificate specifies that the Policy has been issued on an auto renewal basis, the conditions specified above shall apply only on the expiry of the entire auto renewal period as specified in the Policy Certificate.

(f) The Company reserves the right to carry out underwriting in relation to any request for increase of the Sum Insured at the time of renewal of the Policy.

(g) This product may be withdrawn by the Company after due approval from the IRDA. In case this product is withdrawn by the Company, this Policy can be renewed under the then prevailing Health Insurance Product or its nearest substitute approved by IRDA. The Company shall duly intimate the Policyholder regarding withdrawal of this product and the options available to the Policyholder at the time of Renewal of this policy.

6.13. Cancellation / Termination

(a) The Company may at any time, cancel this Policy on grounds as specified in Clause 6.1, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to the Policyholder at his last known address.

(b) The Policyholder may also give 15 days' notice in writing, to the Company, for the cancellation of this Policy, in which case the Company 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.

(c) Refund % to be applied on premium received

Cancellation date up to (x months) from Policy Period Start Date	1 Year	2 Year	3 Year
Up to 1 month	75.0%	87.0%	91.0%
Up to 3 months	50.0%	74.0%	82.0%
Up to 6 months	25.0%	61.5%	73.5%
Up to 12 months	0.0%	48.5%	64.5%
Up to 15 months	N.A.	24.5%	47.0%
Up to 18 months	N.A.	12.0%	38.5%
Up to 24 months	N.A.	0.0%	30.0%
Up to 30 months	N.A.	N.A.	8.0%
Beyond 30 months	N.A.	N.A.	0.0%

(d) 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 Policy holder.

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

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

II. A person over Age 18 who satisfies the Company's criteria to become a Policyholder.

6.14. Limitation of Liability

Any Claim under this Policy for which the notification or intimation of Claim is received 12 calendar months after the event or occurrence giving rise to the Claim shall not be admissible, unless the Policyholder proves to the Company's satisfaction that the delay in reporting of the Claim was for reasons beyond his control.

6.15. Communication

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

(b) All notifications and declarations for the Company must be in writing and sent to the address specified in the Policy Certificate. Agents are not authorized to receive notices and declarations on the Company's behalf.

(c) Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

6.16. Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company. However, change or alteration with respect to increase/ decrease of the Sum Insured shall be permissible only at the time of renewal of the Policy.

6.17. Overriding effect of Policy Certificate

In case of any inconsistency in the terms and conditions in this Policy vis-a-vis the information contained in the Policy Certificate, the information contained in the Policy Certificate shall prevail.

6.18. Electronic Transactions

The Policyholder and Insured Person agree to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the Policy or its terms, or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

6.19. Grievances

(a) The Company has developed proper procedures and effective mechanism to address complaints, if any of the customers. The Company is committed to comply with the Regulations, standards which have been set forth in the Regulations, Circulars issued from time to time in this regard.

(b) If the Policyholder has a grievance that the Policyholder wishes the Company to redress, the Policyholder may contact the Company with the details of his grievance through:

Website	: www.xxxxxxxx.xxxx
e-mail	: xxxxxxxxxxxxxxx@xxxx.xx
Telephone	: xxx-xxxxxxxxx
Fax	: xxx-xxxxxxxxxxx
Post/Courier	: Any branch office or the correspondence address, during normal business hours

(c) If the Policyholder is not satisfied with the Company's redressal of the Policyholder's grievance through one of the above methods, the Policyholder may contact the Company's Head of Customer Service at:

The Grievance Cell,
Religare Health Insurance Company Limited
A3, A4, A5 GYS Global,
Sector -125,
Noida – 201301

(d) If the Policyholder is not satisfied with the Company's redressal of the Policyholder's grievance through one of the above methods, the Policyholder may approach the nearest Insurance Ombudsman for resolution of the grievance. The contact details of Ombudsman offices are mentioned below:

Office of the Ombudsman	Name of the Ombudsman	Contact Details	Areas of Jurisdiction
AHMEDABAD	Shri P. Ramamoorthy	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Nr. C.U. Shah College, Ashram Road, **AHMEDABAD-380 014.** Tel.:- 079-27546840 Fax : 079-27546142 Email ins.omb@rediffmail.com	Gujarat , UT of Dadra & Nagar Haveli, Daman and Diu
BHOPAL		Insurance Ombudsman, Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, **BHOPAL(M.P.)-462 023.** Tel.:- 0755-2569201 Fax : 0755-2769203 Email bimalokpalbhopal@airtelmail.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Shri B. P. Parija	Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, **BHUBANESHWAR-751 009.** Tel.:- 0674-2596455 Fax : 0674-2596429 Email ioobbsr@dataone.in	Orissa
CHANDIGARH	Shri Manik Sonawane	Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No.101-103, 2nd Floor, Batra Building. Sector 17-D, **CHANDIGARH-160 017.** Tel.:- 0172-2706468 Fax : 0172-2708274 Email ombchd@yahoo.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir , UT of Chandigarh
CHENNAI		Insurance Ombudsman, Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, **CHENNAI-600 018.** Tel.:- 044-24333668 /5284 Fax : 044-24333664 Email :chennaiinsuranceombudsman@gmail.com	Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry)

NEW DELHI	Shri Surendra Pal Singh	Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, **NEW DELHI-110 002.** Tel.:- 011-23239633 Fax : 011-23230858 Email iobdelraj@rediffmail.com	Delhi & Rajasthan
GUWAHATI	Shri D. C. Choudhury	Insurance Ombudsman, Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, Near Panbazar Overbridge, S.S. Road, **GUWAHATI-781 001 (ASSAM).** Tel.:- 0361-2132204/5 Fax : 0361-2732937 Email ombudsmanghy@rediffmail.com	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD		Insurance Ombudsman, Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, **HYDERABAD-500 004.** Tel : 040-65504123 Fax: 040-23376599 Email insombudhyd@gmail.com	Andhra Pradesh, Karnataka and UT of Yanam – a part of the UT of Pondicherry
KOCHI	Shri R. Jyothindranatha n	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, **ERNAKULAM-682 015.** Tel : 0484-2358759 Fax : 0484-2359336 Email iokochi@asianetindia.com	Kerala , UT of (a) Lakshadweep , (b) Mahe – a part of UT of Pondicherry
KOLKATA	Ms. Manika Datta	Insurance Ombudsman, Office of the Insurance Ombudsman, 4th Floor, Hindusthan Bldg. Annexe, 4, C.R.Avenue, **Kolkatta – 700 072.** Tel: 033 22124346/(40) Fax: 033 22124341 Email:iombsbpa@bsnl.in	West Bengal , Bihar , Jharkhand and UT of Andeman & Nicobar Islands , Sikkim
LUCKNOW	Shri G. B. Pande	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road, Hazaratganj, **LUCKNOW-226 001.** Tel : 0522 -2231331 Fax : 0522-2231310 Email insombudsman@rediffmail.com	Uttar Pradesh and Uttaranchal

MUMBAI		Insurance Ombudsman, Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), **MUMBAI-400 054.** Tel : 022-26106928 Fax : 022-26106052 Email ombudsmanmumbai@gmail.com	Maharashtra , Goa

The details of Insurance Ombudsman are available on IRDA website : www.irda.gov.in, on the website of General Insurance Council : www.generalinsurancecouncil.org.in, the Company's website xxxx. xxxxxxxxxxxx or from any of the Company's offices.

Address and contact number of Governing Body of Insurance Council –

Shri M.V.V. Chalam, Secretary General
3rd Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz(W),
MUMBAI – 400 021
Tel:022-26106245
Fax : 022-26106949
Email- inscoun@gmail.com

The Secretary
3rd Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz (W),
MUMBAI – 400 021.
Tel : 022 26106980
Fax : 022-26106949