Prospectus
Group Health Insurance Policy

This Policy provides cover for hospitalisation expenses incurred for treatment of the Insured Persons in respect of disease, illness, injury. The Policy among other things, covers Hospital (Room & Boarding and Operation theatre) charges, fees of Surgeon, Anaesthetist, Nurses, Specialists, the cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs etc. The Policy provides cover against hospitalisation treatment of specified Critical Illnesses as well, and further provides for payment of daily allowance for the days the Insured Person has been hospitalised.
The Policy offers varying options and can also be issued to cover either Critical Illness only or Hospital Daily cash allowance only.

Eligibility

The Policy covers individuals between the ages 91 days to 80 years. However, children below the age of 5 years can be covered only in the event of either or both the parents being covered

The Policy can be issued to a group or association of persons or body corporate covering the members of a group or association of persons or employees of a body corporate including members of their family upto a maximum of six persons per family comprising of the Insured Person, spouse, parents and two children upto the age of 23 years.

SCOPE OF COVERAGE

The Policy provides for -

1. **Hospitalisation Benefit**
Payment or reimbursement of hospitalisation expenses that are reasonably and necessarily incurred by the Insured/Insured Person for treatment of disease, illness, injury in a Hospital as an in-patient which includes, among other things, cover for Hospital (Room & Boarding and Operation theatre) charges, fees of Surgeon, Anaesthetist, Nurses, Specialists, the cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs etc.

2. **Domiciliary Hospitalisation**
Reimbursement of domiciliary hospitalisation expenses involving medical treatment for a period exceeding three days for disease, illness, injury which in the normal course would require care and treatment at a Hospital/Nursing Home but is actually taken whilst confined at home in India under any of the following circumstances namely: -
i) the condition of the patient is such that he / she cannot be removed to Hospital / Nursing Home, or
ii) the patient cannot be admitted to Hospital/Nursing Home for lack of accommodation therein.

3. **Day Care Treatment**
Payment or reimbursement of hospitalisation expenses incurred in case of day care treatment (where 24 hours of hospitalisation is not required) such as dialysis, chemotherapy, radiotherapy,

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eye surgery, lithotripsy (kidney stone removal), D & C, tonsillectomy taken in a Hospital / Nursing Home.

4. **Pre and post hospitalisation expenses**
   Payment or reimbursement of pre-hospitalisation expenses incurred for specified number of days prior to hospitalisation and post-hospitalisation expenses incurred for specified number of days following discharge from Hospital / Nursing Home.

ADDITIONAL BENEFITS

The following Additional Benefits upto the limits of Sum Insured specified can be included in the Policy. A valid claim should have been admitted under the Hospitalisation Section of the Policy, for admission of liability under these Sections.

1. **Pre-existing diseases (PED)**
   Payment or reimbursement of expenses incurred in a Hospital/ Nursing Home for treatment relating to pre-existing diseases, illness, injury after a specified waiting period from the inception of the Policy .
   This can be on various methods as agreed and specified with appropriate additional premium payment. Some of them may be:
   - The coverage may be from inception of the Policy without any waiting period.
   - A deductible of certain percentage of hospitalisation expenses for PED either only for the first year or on a gradual downward scale or no deductible allowing 100% of expenses from inception of cover.
   - The benefit may be limited only for employees and the family excluding parents or all can be included under the benefit.
   - Variance in utilization of Sum Insured i.e. only 50% of Sum Insured can be used for one PED treatment during the first year or so.

2. **Critical Illness**
   Coverage of expenses incurred for treatment of specified Critical Illnesses. The coverage can be either in the form of payment of lump sum benefit amount or payment /reimbursement of expenses incurred for treatment of such specified Critical Illness in a Hospital / Nursing Home as selected by the Insured Person.

   In case the cover opted is on benefit basis, the Policy will provide for payment of lump sum compensation of an amount equal to the Sum Insured in case the Insured Person is diagnosed as having contracted any of the specified Critical Illnesses and survives for more than 30 days post such diagnosis.

   In case the cover opted is for Hospitalisation, the Policy will provide for payment or reimbursement of hospitalisation expenses upto the limit of Sum Insured incurred by the Insured Person if the Insured Person is diagnosed as having contracted any specified Critical Illnesses and has undertaken treatment in a Hospital for the same.

   This benefit is available after a waiting period of 30 days from the date of inception of the Policy in the first year of cover.

The Sum Insured available under this benefit is separate and additional to the Sum Insured available under the Hospitalisation benefit Section of the Policy.

3. **Dread Disease recuperation**-
Payment of an allowance towards recuperation expenses incurred by the Insured Person post discharge from the Hospital treatment, in case the Insured Person contracts any of the Critical Illnesses and undertakes treatment for the same in a Hospital as an in-patient for which a valid claim under the Policy is admissible. This benefit is payable for 60 days subject to medical requirement as certified by the attending Medical Practitioner.

4. **Transplantation of Organs**
Payment or reimbursement of hospitalisation expenses incurred towards donor for a major organ transplant in case the Insured Person contracts any of the specified Critical Illnesses requiring major organ transplantation surgery and undergoes surgery and treatment in a Hospital as an in-patient for which a valid claim under this Policy is admissible. This benefit is subject to overall limit of the Sum Insured.

5. **Hospital Cash Allowance**
Payment of daily allowance for the days the Insured Person is hospitalised beyond a specified number of days for treatment of any disease / illness / injury for which a valid claim is admissible under the Policy. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits agreed.

6. **ICU Allowance**
Payment of daily allowance for the days the Insured Person is in ICU beyond a specified number of days for treatment of any disease / illness / injury for which a valid claim is admissible under the Policy. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits agreed.

7. **Second Opinion Cover**
Reimbursement of expenses incurred for availing second opinion in case of hospitalisation for surgical treatment or major ailment treatment upto a limit specified and agreed.

8. **Home Nursing**
Payment of an allowance towards expenses incurred for availing medical care services of a nurse at the residence of the Insured Person following discharge from Hospital after treatment for a disease / illness / injury and/or critical illness, if the same is recommended as necessary by the attending Medical Practitioner and is related directly to the treatment of disease, illness or injury and/or for critical illness, for which the Insured Person has been hospitalized. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits agreed.

9. **Ambulance Charges**

Reimbursement of expenses incurred for the transportation of the Insured Person by ambulance to and from the Hospital for treatment of disease, illness or injury in a Hospital as an in-patient for which a valid claim under this Policy is admissible. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits agreed.

10. **In-patient Physiotherapy Charges**
Reimbursement of charges incurred towards physiotherapy in the Hospital as an in-patient that is confirmed as being necessary by the attending Medical Practitioner and the same relates directly to the disease, illness or injury for which the Insured Person has undertaken treatment in the Hospital for which a valid claim is admissible under this Policy. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits agreed.

11. **Recovery Grant**
Payment of a fixed allowance as agreed, in case, the Insured Person is hospitalized for a period of 8 consecutive days or more for treatment of any disease / illness / injury for which a valid claim is admissible under the Policy. This benefit is applicable irrespective of the number of occurrences during the Policy period.

12. **Accompanying Person's Expenses**
Payment of an allowance towards expenses incurred on the accompanying person at the Hospital/Nursing home during hospitalisation treatment of the Insured Person for the disease, illness or injury for which a valid claim is admissible under the Policy. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits agreed.

13. **Parent Accommodation as Companion for Child**
Payment of a fixed daily allowance towards meeting the expenses for the stay of one of the parents at the Hospital when a child below the age of 12 years is hospitalized. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits agreed.

14. **Parents Cover**
Reimbursement or payment of hospitalisation expenses incurred for the parents of the employee / member covered under the Policy.
This can have variations -
(a) Separate Sum Insured for parents and floater for employee spouse and 2 kids
(b) If parents are in the floater - to fix a limit of any one illness for parents to 50% of Floater Sum Insured
(c) Altogether separate policy for parents with any one illness limit
(d) Limit for PED treatment - any one treatment limit or % of Sum Insured limit etc

15. **Corporate Buffer**
A buffer which can be upto the limit of 10 to 50 times of the individual floater Sum Insured depending upon the number of employees is extended to the Insured. This option is available only

for corporate employer policies and not for groups. Individual employee and family units can avail from this buffer whenever they exhaust their family floater limit (with permission from Management HR) - the variations could be number of times the withdrawal can be allowed for any one employee family, deductible when withdrawing from buffer.

16. **Out-patient Dental Emergency Treatment (arising out of Accident only)**
    This benefit provides for reimbursement of medical expenses incurred towards emergency treatment by a Dentist following an accident where the Insured Person suffers injuries or damage to his natural teeth and/or gums. This benefit further provides cover for medical expenses incurred for follow up treatment for the same accidental dental injury up to a maximum of 15 days by the same Dentist. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits agreed.

17. **Out-patient Emergency Treatment for Accidents**
    Reimbursement of medical expenses incurred towards emergency treatment by a Medical Practitioner following an accidental injury to the Insured Person and such emergency treatment was administered within 24 hours following the accident.

    It also provides cover for medical expenses incurred for follow-up treatment by the same Medical Practitioner in respect of the same accidental injury up to 30 days from the date of accident, including expenses incurred for medication prescribed on a written basis by the attending Medical Practitioner for that same treatment or consultation. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits agreed.

18. **Children Education Fund**
    Payment of a fixed amount per dependent child, upto a maximum of two dependant children who pursue studies and are below the age of 23 years, in the event of death of the Insured Person whilst treatment in a Hospital as an in-patient for a disease / illness / injury and/or critical Illness for which a valid claim is payable under the Policy. The benefit is limited to the amount agreed.

19. **Mortal Remains**
    Reimbursement of expenses incurred for transportation of the mortal remains of the deceased Insured Person from hospital to his/her residence in the event of death at the Hospital as an in-patient whilst treatment of a disease / illness / injury and/or critical Illness for which a valid claim is payable under the Policy, subject to the limits agreed.

20. **Maternity Hospitalisation Expenses**
    The Policy can be extended to cover Maternity Benefits subject to the condition that all members/ employees of the Insured are covered under this extension. Maternity Benefits have to be opted of at inception of the Policy. The specific Sum Insured applicable for this Section will have to be agreed for.

    These benefits are applicable only if the expenses are incurred in Hospital/Nursing Home as an in-patient. A waiting period of 9 months is applicable for payment of any claim relating to normal

delivery or caesarean section or abdominal operation for extra uterine pregnancy. The waiting period may be relaxed only in case of delivery, mis-carriage or abortion induced by accident or other medical emergency.

However, where specifically agreed to between the parties, the waiting period may be waived for all cases. This will be considered at an additional premium.

Claim in respect of delivery for only first two children and/or operations associated therewith will be considered in respect of any one Insured Person covered under the Policy or any renewal thereof. Those Insured Persons who are already having two or more living children will not be eligible for this benefit.
Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12 weeks from the date of conception are not covered. Pre-natal and post-natal expenses are not covered unless the Insured member/employee is admitted in Hospital/Nursing Home and treatment is taken there.

21. **Floater Cover**
Where agreed the cover can be offered on family floater basis covering the family members of member / employee of the Group on a floater Sum Insured basis. Where the Policy is obtained on floater basis covering the family members, the Sum Insured will be available to the Insured and all and any one of the Insured Persons for one or more claims during the Policy period. There can be a maximum of six family members covered in a floater.

22. **Other add-on benefits**
Where it is agreed on the request of the Insured, the following add-ons will be allowed on payment appropriate additional premium:
    - Deletion of 30 days waiting period
    - Deletion of first year exclusion
    - Baby cover for first three months – either within the Sum Insured of the mother / Floater Sum Insured or with defined limit of Sum Insured specifically agreed for this cover
    - Doctor on call for emergency for suggestion and guidance
    - Any other extension/alteration as required specifically by the Group/Corporate Insured
    - Introduction of sub limits for any of the benefits / expense heads as required specifically by the Group/Corporate Insured.

ADDITIONAL FEATURES

Additional Features

1. **Income Tax Relief**
Premium paid under the Policy shall be eligible for income tax deduction benefit under Sec 80 D as per the Income Tax Act.

2. **Renewal Discount**
Discount equivalent to 5% of renewal premium every year on a progressive scale will be given back to the Insured as No claim Bonus at the time of renewal, where the Policy which is renewed is claim free in the expiring year. This renewal discount on a progressive scale will be allowed upto 25%.

In case of renewal of a Policy where there is a loss, the Insured will lose the entire Renewal Discount accumulated.

This additional benefit is available only on renewal of the policies taken and renewed with the Company. Further the Policy for renewal should have been taken in the Insured's name.

3. **Cost of Health Check-up**
   This benefit provides for reimbursement of cost of medical check-up once at the end of a block of every four continuous underwriting years provided there were no claims reported /made under the Policy during the block. This benefit is limited to 1% of the average Sum Insured per person during the block of four underwriting years.

   This additional benefit is available on the policies taken and renewed with our Company for four continuous years without any claim.

   However, this benefit is also available in respect of similar health insurance policies of any other general insurance company/s in India which are taken and renewed for a period of four continuous years without any claim.

4. **Policy Period**
   Policy will be issued for a period of 12 months.

5. **Free-look period**
   The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.
   The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document 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
   i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
   ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of coveror
   iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

EXCLUSIONS UNDER THE POLICY

A Exclusion Name: 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 48/36/24 months of continuous coverage after the date of inception of the first policy with insurer as selected by the Insurer.

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 / migration norms of the extant 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 Insurer.

B. Exclusion Name: Specified disease/procedure waiting period- Code- Excl02
a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24/12 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases/procedures

1. Any types of gastric or duodenal ulcers
2. Benign prostatic hypertrophy
3. All types of sinuses
4. Hemorrhoids
5. Dysfunctional uterine bleeding
6. Endometriosis
7. Stones in the urinary and biliary systems
8. Surgery on ears/tonsils/adenoids/ paranasal sinuses
9. Cataracts,
10. Hernia of all types and Hydrocele
11. Fistulae in anus
12. Fissure in anus
13. Fibromyoma
14. Hysterectomy
15. Surgery for any skin ailment
16. Surgery on all internal or external tumours/ cysts/ nodules/polyps of any kind including breast lumps with exception of Malignancy
17. Dialysis required for Chronic Renal Failure.
18. Joint Replacement Surgeries unless necessitated by Accident happening after the Policy risk inception date.

19. Dilatation and curettage
20. Varicose Veins and Varicose Ulcers
21. Non Infective Arthritis and other form arthritis
22) Gout and Rheumatism
23) Prolapse inter Vertebral Disc and Spinal Diseases including spondylitis/spondylosis unless arising from Accident

C. 30-day 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.

D. Investigation & Evaluation- Code- Excl04
a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

E. Exclusion Name: Rest Cure, rehabilitation and respite care- Code- Excl05
a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

F. Obesity/ Weight Control: Code- Excl06
Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
a) greater than or equal to 40 or
b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
i. Obesity-related cardiomyopathy
ii. Coronary heart disease
iii. Severe Sleep Apnea
iv. Uncontrolled Type2 Diabetes

G. Change-of-Gender treatments: Code- Excl07
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

H. Cosmetic or plastic Surgery: Code- Excl08
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

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

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

K. Excluded providers: Code- Excl 11
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

L. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code- Excl 12**

M. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code- Excl13**

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

O. Refractive Error: Code- Excl15
Expenses related to the treatment for correction of eye sight due to refractive error less than 7. 5 dioptres.

P. Unproven Treatments: Code- Exel 16

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

Q. Sterility and Infertility: Code- Excl 17
Expenses related to sterility and infertility. This includes:
(i)Any type of contraception, sterilization
(ii)Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
(iii)Gestational Surrogacy
(iv)Reversal of sterilization

R. Maternity: Code Excl18
i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

S. 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.

T. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

U. Any expenses incurred on Domiciliary Hospitalization and OPD treatment

V. Treatment taken outside the geographical limits of India

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

CONDITIONS TO BE FULFILLED BY THE INSURED/INSURED PERSON

(This list is not exhaustive. For detailed conditions see the Policy document.)

1. Insured shall pay the premium under this Policy in advance.
2. The Insured is required to ensure there is no misrepresentation, misdescription or nondisclosure of any material fact.
3. The Insured/Insured Person shall ensure due observance and fulfillment of the terms, conditions and endorsements on the Policy.
4. Every notice and communication to the Company shall be in writing addressed to the Policy issuing office of the Company.
5. Upon the happening of any event giving rise or likely to give rise to a claim under the Policy, the Insured Person shall -
   a. give notice in writing to the Policy issuing office of the Company within 7 days from the date of hospitalisation;
   b. file the claim within 30 days from the date of discharge from Hospital/ Nursing Home;
   c. furnish all original bills, receipts and other documents upon which the claim is based and shall give such other information and assistance as may be required for claim settlement;
   d. submit, if so required, to examination by a Medical Practitioner authorized by the Company.

PREMIUM PAYABLE

As per Premium Schedule

PREMIUM SCHEDULE

Sum insured	**1 lakh**			**2 lakhs**			**3 lakhs**		
Geographic location / Family profile	**Metros**	**Major Cities**	**Rest of India**	**Metros**	**Major Cities**	**Rest of India**	**Metros**	**Major Cities**	**Rest of India**
Self	990	880	770	1210	1100	990	1485	1375	1210
Self, spouse and 2 children	1595	1430	1265	2145	1925	1540	2585	2090	1760
Self, Spouse, Children and parents	4400	4125	3300	6600	6050	4675	7975	6875	5225

Disclosure of Information

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

Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

Claim Settlement

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

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

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

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

Complete Discharge

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

Multiple Policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers toindemnify treatment costs, the insured person shall have the right to require a settlement of his/herclaim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle theclaim as long as the claim is within the limits of and according to the terms of the chosen policy.

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

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

iv. Where an insured person has policies from more than one insurer to cover the same risk onindemnity basis, the insured person shall only be indemnified the treatment costs in accordancewith the terms and conditions of the chosen policy.

Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by

the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.
Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim,who shall be jointly and severally liable for such repayment to the insurer.
Forthepurposeofthisclause,theexpression"fraud"meansanyofthefollowingactscommittedbytheinsured personorbyhisagentor the hospital/doctor/any other party acting on behalf of the insured person, withintenttodeceivetheinsurerortoinducetheinsurertoissueaninsurancepolicy:

a) the suggestion, as a fact of that whichisnottrueandwhichtheinsured persondoes not believetobetrue;
b) theactive concealmentof afactbytheinsured personhavingknowledgeorbeliefofthefact;
c) anyother act fitted to deceive; and
d) anysuchactoromissionasthelawspeciallydeclarestobefraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits 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 misstatement of or suppression of material fact are within the knowledge of the insurer.

Renewal of policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

- The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
- No loading shall apply on renewals based on individual claims experience.

Withdrawal of Policy

In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

TERMINATION / CANCELLATION

• The policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policyperiod as detailed below.

Period on Risk	Rate of Premium to be retained

Up to 1 month	25% of annual rate
Up to 3 months	50% of annual rate
Up to 6 months	75% of annual rate
Exceeding six months	100%

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, anyclaim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

• The Company may cancel thepolicy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured personby 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.

Portability

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

For Detailed Guidelines on portability, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policyatleast30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently co\/ered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

Moratorium Period

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

Possibility of Revision of Terms of the Policy Including the Premium Rates
The Company, with 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 effected.

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

Claim Settlement
- The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

Claim Notification Multi Model Intimation:
It is the endeavor of Company to give multiple options to the Insured Person/Insured Person's representative to intimate the claim to the Company. The intimation can be given in following ways:
- Toll Free call Centre of the Insurance Company(24x7) - 1800-103-2292
- Toll Free call Centre of TPA (24x7) - 1800-103-2292 (TPA Toll Free Number shall not be included in case of general insurance products)
- Login to the website of the Insurance Company and intimate the claimta http://www.bharti-axagi.co.in/contact-us
- Send an email to the Company- customersupportba@icicilombard.com
- Post/courier to TPA/Company - ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad-500032.

- Directly contact our Company office but in writing. - ICICI Lombard House, 414, Veer Savarkar Marg, Prabhadevi, Mumbai – 400025

In all the above, the intimations are directed to a central team for prompt and immediate action.

Information Details

When the insured/covered person/patient's care taker intimate the claim as mentioned above the following information should be kept handy & given for prompt services.

Policy number

Name of the Insured/Covered person

Contact details

Nature of the disease, illness or injury

Name and address, phone number of the attending medical practitioner/hospital

Claim Form

Upon the notification of the claim the TPA/Company will dispatch the claim form to the Insured/Covered person. Claim forms will also be available with the network hospitals and Company offices and on its website

Claim Procedure

Cashless hospitalisation:

Company will work with one or more TPAs for providing cashless facility to the Insured/Covered person.

List of network Hospitals is provided to the Insured/Covered person along with the Policy .Insured/Covered person can view the updated Hospitals list from the website of the TPA/Company too.

Insured/covered person on admission (emergency) or willing to admit (planned admission) in the network Hospitals, a preauthorization request form has to be filled in by the treating doctor/ Hospital and the same has to be faxed to the TPA by the insured/Hospital. The TPA after verifying the same will decide on the issuance of authorization after necessary discussion(approval) with insurance company. The action of pre-authorization will be done within 6 hours for emergency admission and 48 hours for planned admission.

The preauthorization request form will be available in the guide issued along with the Policy, and also will be available in the Hospitals or can be downloaded from the website of the TPA/Company or can request for the same to the TPA/Company via email or fax or can be collected in person from the branches of the TPA/Company.

Denial of the cashless does not mean the claim has been rejected. Such claims will be examined on merits and will be paid on reimbursement basis later if admissible.

The Insured/covered person can send the requisite claim documents to the TPA/Company seeking reimbursement.

The Insured/covered person need not pay any amount to the Hospital if he/she has received the authorization letter except;

If the bill amount is in excess of the Sum insured
Non-medical expenses
Unrelated treatments
Excess/deductible, if any which has to be borne by insured
The Hospital will receive the payment from Company within 21 days from the date of receipt of complete claim documents.

Reimbursement claims

All reimbursement claims should be intimated to TPA/Insurance company within 7 days from date of discharge.

Insured/covered person admitted in a non-network Hospital can send the claim documents to the TPA/ Company for the reimbursement within 30 days from the date of discharge. However Pre and post hospitalization bills can be sent within 15 days from the end of post hospitalization period as specified in the Policy.

Claim Service Guarantee

Notwithstanding the above, upon the receipt of all required documents and processing of the claim, tthe claim will be settled 30 days from the date of submission of the said documents. Settlement (payment) of claim will be made within 7 days of receipt of acceptance in response to offer of settlement, failing which penal interest (in compliance with applicable regulations) at a rate of 2% higher than bank rate (prevailing as on the date of beginning of financial year in which the claim is reviewed) will be paid.

CUSTOMER SERVICE – SENIOR CITIZENS

In case of any grie\lance the insured person may contact the company through via:

•Website: www.bharti-axagi.co.in

•Email: customersupportba@icicilombard.com

•Phone: 18001032292

•Courier: Any of the Company's Branch office or corporate office

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

Escalation Level 1

In case the Policyholder/Insured/Insured Person has not got his/her grievances redressed through one of the above methods (After 5 days of intimating of your complaint), Policyholder/ Insured/ Insured Person may contact the National Grievance Redressal Officer at :

Write to: ICICI Lombard House, 414, Veer Savarkar Marg, Prabhadevi, Mumbai – 400025

Call: 18001032292

Email: https://www.bharti-axagi.co.in/grievance-redressal/procedure

Escalation Level 2

In case the Policyholder/ Insured/Insured Person has not got his/her grievances redressed through any of the above methods (After 5 days of approaching National Grievance Redressal Officer), Policyholder/ Insured/ Insured Person may contact the Chief Grievance Redressal Officer at:

Email : https://www.bharti-axagi.co.in/grievance-redressal/procedure

Escalation Level 3

In case the Policyholder/ Insured/Insured Person has not got his/her grievances redressed by the Company within 14 days, or, If Policyholder/ Insured/Insured Person is not satisfied with Company's redressal of the grievance through one of the above methods, Policyholder/ Insured/ If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.
The contact details of the Insurance Ombudsman offices are provided in the Policy Wordings. These details can also be found at http://www.cioins.co.in/ombudsman.html.
Policy holder may also obtain copy of IRDAI circular Ref No. F. No. IRDAI/Reg/8/145/2017, notification on Insurance Regulatory and Development Authority (Protection of Policy holders' interests) Regulations, 2017 from any of our offices.

Grievance of Senior Citizens:

In respect of Senior Citizens, the Company has established a separate channel to address the grievances. Any concerns may be directly addressed to the Senior Citizen's channel of the Company for faster attention or speedy disposal of grievance, if any.

•Website: www.bharti-axagi.co.in

•Email: customersupportba@icicilombard.com

•Phone: 18001032292

•Courier: Any of the Company's Branch office or corporate office

Insured/ Insured Person may also approach the grievance cell at any of the Company's branches with the details of the grievance during working hours from Monday to Friday.

Grievance Redressal Cell of the Consumer Affairs Department of IRDAI

The insurance company should resolve the complaint within a reasonable time. In case if it is not resolved within 15 days or if the Insured/Insured Person is unhappy with their resolution you can approach the Grievance Redressal Cell of the Consumer Affairs Department of IRDAI.

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

•Website: igms.irda.gov.in

•Email: complaints@irda.gov.in

•Toll Free Number 155255 (or) 1800 4254 732

Withdrawal:

In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

PROHIBITION OF REBATES (UNDER SECTION 41 OF INSURANCE ACT, 1938)

No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an Insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the Policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurers which shall be in conformity with regulations.

Any person making default in complying with the provision of this section shall be liable for a penalty which may extend to ten lakh rupees. .

Disclaimer

This document is only a summary of the product features. The actual benefits available are as described in the Policy, and will be subject to the Policy terms, conditions and exclusions. Please approach your insurance advisor if you require any further information or clarification.

Insurance is the subject matter of the solicitation. For more details you may refer to the Policy wordings which may be collected on request

IRDA REGULATION NO 5: This policy is subject to regulation 5 of IRDA (Protection of Policyholder's Interests) Regulation.

GENERAL NOTE

1. The Proposer can contact the agent / intermediary / any of our offices for a full version of the Policy document.
2. In all the cases, where any clarification is required regarding classification of risks or rating etc., the agents have to necessarily contact the Regional Office/Branch office to which they are attached for further guidance.