Group Assurance Health Plan - Prospectus

Suitability

- The Group Assurance Health Plan will be offered to cover the employees of the corporate, non-employer groups like professional associations, Banks, Self Help Groups, NGO's, etc.
- The coverage can be extended to the dependents which include spouse, dependent children, either set of dependent parents or parent in laws.
- The policy will be issued for a 1 year period.
- Policy covers individuals from 91 days. Children aged between 91 days and 5 years can be insured provided either parent is getting insured under this Policy.
- There is no maximum cover ceasing age on continuous renewals.
- The policy can be issued on individual/family floater sum insured basis.
- In a family floater option a single sum insured would be applicable to the entire family and the same can be utilized by any of the insured family member.

Note:

Dependents means only the family members listed below:

i) Your legally married spouse as long as she continues to be married to You;

ii) Your children Aged between 91 days and 25 years if they are unmarried and financially dependent on the primary Insured or Proposer and does not have his/her independent source of income.

iii) Your natural parents or parents that have legally adopted You, provided that the parent was below 65 years at his initial participation in the Group Assurance Health Plan Insurance policy.

Base Policy Benefits

	We will cover the Medical Expenses for:	**We will not cover treatment, costs or expenses for*:** *The following exclusions apply in addition to the waiting periods and general exclusions specified in Section 2
a.	In-patient Treatment This includes • Hospital room rent or boarding • Nursing; • Intensive Care Unit • Medical Practitioners (Fees) • Anesthesia • Blood • Oxygen • Operation theatre • Surgical appliances; • Medicines, drugs & consumables; • Diagnostic procedures.	
b.	Pre-Hospitalisation Pre-Hospitalisation Medical Expenses for consultations, investigations and medicines incurred upto 30 days before the date of admission to the Hospital.This is applicable for Inpatient, Day Care Treatment or domiciliary treatment.	i) Claims which have NOT been admitted under Inpatient, Day Care Treatment or domiciliary treatment. ii) Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.
c.	Post-Hospitalisation Post-Hospitalisation Medical Expenses for consultations, investigations and medicines incurred upto 60 days after discharge from the Hospital.This is applicable for Inpatient,Day Care Treatment or domiciliary treatment.	i) Claims which have NOT been admitted under Inpatient, Day Care Treatment or domiciliary treatment. ii) Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.
d.	Day Care Treatment :Medical treatment or surgical procedure which is undertaken under general or local anaesthesia, which require admission in a Hospital/Day Care Centre for stay less than 24 hours because of technological advancement. Treatment normally taken on out-patient basis is not included in the scope of this definition.	i) Treatment that can be and is usually taken on an out-patient basis is not covered. ii) Treatment NOT taken at a Hospital or a Day Care centre.
e.	Domiciliary Hospitalisation 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	i) Treatment of less than 3 days ii) Expenses for treatment for first three days only will be covered if treatment period is greater than 3 days
f.	Organ Donor: Medical and surgical Expenses of the organ donor for harvesting the organ where an Insured Person is the recipient.IMPORTANT: Expenses incurred by an insured person while donating an organ is NOT covered.	1) Claims which have NOT been admitted under 1a) for Insured Person. 2) Admission not compliant under the Transplantation of Human Organs Act, 1994 (as amended). 3) The organ donor's Pre and Post-Hospitalisation expenses.
g.	Ambulance CoverExpenses incurred on transportation of Insured Person to a Hospital for treatment in case of an Emergency, subject to a maximum of Rs. 2000 per Hospitalisation.	1) Claims which have NOT been admitted under Section 1a) and 1d) 2) Healthcare or ambulance service provider not registered with road traffic authority.

Additional Benefits (if opted)

On payment of additional premium the following benefits shall be added to the Policy coverage

Optional Benefit No. 1 - Room Rent Limit

Room and boarding expenses are subject to a limit as specified in the below table.

Group Assurance Health Plan - Prospectus

Options available

Options	Details
I	No room rent limit (Default Option)
II	1% of sum insured Per day limit option and 2% of sum insured Per day limit option for ICU
III	2% of sum insured Per day limit option and 4% of sum insured Per day limit option for ICU

Applicable to Option II &**I II**:

In case of admission to a room at rates exceeding the aforesaid limits, the reimbursement/payment of Room Rent (including Associated Medical Expenses) incurred at the Hospital shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ ICU charges.

Optional Benefit No. 2 – Pre-hospitalisation Expenses

The coverage under Pre-Hospitalisation benefit is as per limit specified in the table below.

Pre-hospitalisation Expenses	[XX] Days*

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned in the above Table.

Pre-hospitalisation Expenses	*15 Days	60 Days	90 Days

*The premium will be suitably reduced.

Optional Benefit No. 3 – Post hospitalisation Expenses

The coverage under Post Hospitalisation benefit is subject to the limit as specified in the table below.

Pre-hospitalisation Expenses	[XX] Days*

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned in the above Table.

Pre-hospitalisation Expenses	*30 Days	90 Days	180 Days

*The premium will be suitably reduced.

Optional Benefit No. 4 – Hospital Daily Cash

If an Insured Person suffers an Illness or an Accident during the Policy Period that requires the Insured Person's Hospitalisation as an inpatient, then

i) We will pay Daily Cash amount for each continuous and completed period of 24 hours that the Insured Person is Hospitalised subject to maximum number of days as specified in the table below,

Benefit	Description	
Hospital Daily Cash	Per Day Amount (Rs.)*	Maximum No. of Days *
	XXXX	XX

ii) Our maximum liability shall be restricted to the amount mentioned in the table above and limit for the benefit will apply on individual basis.

iii) We will pay twice the Daily Cash amount for each continuous and completed period of 24 hours that the Insured Person is admitted in an Intensive Care Unit, subject to maximum of 15 days per Policy Year. Whenever Intensive Care Unit benefit is admissible under the Policy, We will not pay for Daily Cash benefit in i) above for the period when the Insured Person is in Intensive Care Unit.

iv) Any claim made in respect of this benefit will not be subject to In-patient Sum Insured and will not affect entitlement to Cumulative Bonus or Health Check-up benefit, if applicable.

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned in the above Table.

Per day Amount (Rs.)	50 per day	100 per day	150 per day	200 per day	250 per day	300 per day
	400 per day	500 per day	750 per day	1000 per day	1500 per day	2000 per day
	2500 per day	3000 per day	3500 per day	4000 per day	4500 per day	5000 per day

Maximum No. Of Days	15	30	60	90	180

Optional Benefit No. 5 – Preventive Health Checkup (For every claim free Year)

We will reimburse the reasonable costs incurred by an Insured Person of obtaining a health check-up as per details below

i. If no claim has been made in respect of Section 1 under this Policy, then at each claim free renewal We will pay the amount (mentioned below) towards the cost of a preventive medical check-up

ii. This benefit is available ONLY to those Insured Persons who were insured in the previous Policy Year.

iii. In case of family floater, if any of the members have made a claim under this Policy, the health check-up benefit will not be offered to the whole family

iv. Any claim made in respect of this benefit will not be subject to In-patient Sum Insured and will not affect entitlement to Cumulative Bonus, if applicable.

Option 1

Plan	1 L – 15.00 L
Individual Plan	Upto 1% of Sum Insured per Insured Person, at the end of every Policy Year subject to max of Rs 7500
Family Floater Plan	Upto 1% of Sum Insured per Policy, at the end of every Policy Year subject to max of Rs 7500

Option 2

Rs 500 to Rs 7500 (in multiples of 500) on per member basis for individual policy and policy basis for floater policies.

IMPORTANT: This benefit is not available for expenses incurred on a preventive health check-up in the first policy year. This benefit will NOT be carried forward if it is not claimed and would not be provided if the Group Assurance Health Plan Insurance policy is not renewed further

Optional Benefit No. 6 – Preventive Health Check-up Benefit (at every renewal irrespective of claim status)

We will reimburse the reasonable costs incurred by an Insured Person of obtaining a health check-up as per details below

i. At the end of each year We will pay the amount mentioned below towards the cost of a preventive medical check-up.

ii. This benefit is available ONLY to those Insured Persons who were insured in the previous Policy Year.

iii. Any claim made in respect of this benefit will not be subject to In-patient Sum Insured and will not affect entitlement to Cumulative Bonus, if applicable.

Group Assurance Health Plan - Prospectus

Option 1

Plan	1 L – 15.00 L
Individual Plan	Upto 1% of Sum Insured per Insured Person, at the end of every Policy Year subject to max of Rs 7500
Family Floater Plan	Upto 1% of Sum Insured per Policy, at the end of every Policy Year subject to max of Rs 7500

Option 2

Rs 500 to Rs 7500 (in multiples of 500) on per member basis for individual policy and policy basis for floater policies.

IMPORTANT: This benefit is not available for expenses incurred on a preventive health check-up in the first policy year. This benefit will NOT be carried forward if it is not claimed and would not be provided if the Group Assurance Health Plan Insurance policy is not renewed further

Optional Benefit No. 7 – Co-payment

If opted, a Co-payment of [X%] shall apply to all claims admitted under Section 1)a) of Policy. The Insured Person shall bear percentage as specified , of the eligible claim amount under the Policy and Our liability, if any, shall only be in excess of that sum and would be subject to the Sum Insured.

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned.

Copayment	10%	15%	20%	30%

Optional Benefit No. 8 – Reduction / waiver of Pre-existing Disease waiting period

The waiting period for Pre-existing Conditions have been reduced to [XX]* months instead of 48 months as provided under Section 2 A)iii) of policy wording.

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned above.

Waiting Period	Waived	12 months	24 months	36 months

Optional Benefit No. 9 – Reduction / waiver of 24 months waiting period for listed conditions

The waiting period for listed disease/conditions under Section 2 A)ii) of policy wordings have been reduced to [XX]* months instead of 24 months.

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned above.

Waiting Period	Waived	12 months

Optional Benefit No. 10 – 30 days waiting period waiver

Waiting period of 30 days under Section 2 A)i) of policy wording have been waived.

Optional Benefit No. 11 – AYUSH Benefit

We will cover the Medical Expenses for AYUSH Benefit	**In addition to the waiting periods (Section 2A) and general exclusions (Section 2B) of policy wordings, We will also not cover expenses**
Expenses incurred on treatment taken under Ayurveda, Unani, Sidha and Homeopathy.	1. Claims which have NOT been admitted under 1a).

AYUSH Benefit	[XX]%* of Inpatient Sum Insured

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned in the above Table.

AYUSH Benefit	10% of In-patient Sum Insured	25% of In-patient Sum Insured	50% of In-patient Sum Insured	100% of Inpatient Sum Insured

Optional Benefit No. 12 – E-Opinion in respect of Critical Illness

We will cover Second Opinion in respect of Critical Illness	In addition to the waiting periods (Section 2a) and general exclusions (Section 2b), We will also not cover expenses
We shall arrange and pay for a second opinion from Our panel of Medical Practitioners, if: • The Insured Person suffers a Critical Illness during the Policy Period; and • He requests an E-opinion; and The Insured Person can choose one of Our panel Medical Practitioners. The opinion will be directly sent to the Insured Person by the Medical Practitioner. "Critical Illness" includes Cancer of specified severity, Open Chest CABG, Myocardial Infarction (First Heart Attack of specific severity), Kidney Failure requiring regular dialysis, Major Organ/Bone Marrow Transplant, Multiple Sclerosis with persisting symptoms, Permanent Paralysis of Limbs and Stroke resulting in permanent symptoms.	1. More than one claim for this benefit in a Policy Year. 2. More than one claim for the same Critical Illness. 3. Any other liability due to any errors or omission or representation or consequences of any action taken in reliance of the E-opinion provided by the Medical Practitioner.

Optional Benefit No. 13 – Restore Benefit

Instant addition of 100% Basic Sum Insured on complete or partial utilization of Your existing Policy Sum Insured and Cumulative Bonus (if applicable) during the Policy Year. The Total amount (Basic sum insured, Cumulative Bonus and Restore sum insured) will be available to all Insured Persons for all claims under In-patient Benefit during the current Policy Year and subject to the condition that single claim in a Policy Year cannot exceed the sum of Basic Sum Insured and the Cumulative Bonus (if applicable).

Conditions for Restore benefit:

a. The Sum Insured will be restored only once in a Policy Year.

b. If the Restored Sum Insured is not utilized in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

c. In case of a Family Floater Policy, Restore Sum Insured will be available on floater basis for all Insured Persons in the Policy.

d. This benefit would only be offered where Base Sum Insured is 1 lac and above.

e. The Restore Sum Insured can be used for claims made by the Insured Person in respect of the benefits stated in Section 1

Optional Benefit No. 14 – Double Restore Benefit

i. Instant addition of 100% Basic Sum Insured on complete or partial utilization of Your existing Policy Sum Insured and Cumulative Bonus (if applicable) during the Policy Year. The Total amount (Basic sum insured, Cumulative Bonus and Restore Sum Insured when added)

will be available to all Insured Persons for all claims under In-patient Benefit during the current Policy Year and subject to the condition that single claim in a Policy Year cannot exceed the sum of Basic Sum Insured and the Cumulative Bonus (if applicable).

ii. Post complete utilization of your Basic Sum Insured and Cumulative Bonus (if applicable), if You partially or completely utilize your Restore Sum Insured (as given in i above), another 100% of Basic sum insured would be added to Your Restored sum insured available to all Insured Persons for claims under In-patient Benefit during the current Policy Year and subject to the condition that single claim in a Policy Year cannot exceed the Basic Sum Insured.

a. The Restore or Double Restore Sum Insured will be applied only once for the Insured Person during a Policy Year

b. If the Restore or Double Restore Sum Insured is not utilized in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

c. In case of a Family Floater Policy, Restore or Double Restore Sum Insured will be available on floater basis for all Insured Persons in the Policy.

d. This benefit would only be offered where Base Sum Insured is 1 lac and above.

e. The Restore or Double Restore Sum Insured can be used for claims made by the Insured Person in respect of the benefits stated in Section 1

Optional Benefit No. 15 – Cumulative Bonus

A Cumulative Bonusof 10%will be applied on the Sum Insured for the next Policy Year by automatically increasing the Sum Insured under the Policy after every CLAIM FREE Policy Year, provided that the Policyis renewed with Us and without a break. The maximum Cumulative Bonus shall not exceed [XX%]*of the Sum Insured in any Policy Year. In the event of a claim, then in the following Policy Year We will automatically decrease theCumulative Bonusby 10% of the Sum Insured.

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned above.

Maximum (%)	50%	100%

Optional Benefit No. 16 – Daily Cash for choosing shared Accommodation

We will cover the Medical Expenses for Daily Cash for choosing Shared Accommodation	**In addition to the waiting periods (Section 2A) and general exclusions (Section 2B) of policy wordings, We will also not cover expenses**
Daily cash amount will be payable per day as per table below, if the Insured Person is Hospitalised in Shared Accommodation in a Network Hospital for each continuous and completed period of 24 hours if the Hospitalisation exceeds 48 hours.	1. Daily Cash Benefit for time spent by the Insured Person in an intensive care unit 2. Claims which have NOT been admitted under 1a).

Sum Insured	Limit (Rs)
[XXXX]	Rs. [XX] per day maximum of Rs. [XXXX]

Important terms you should know:

Shared Accommodation *means hospitalisation in a Hospital room with two or more Inpatient beds*

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned above.

Sum Insured (Rs) per day	500 per day	800 per day	1000 per day	1500 per day	2000 per day

Maximum Number of Days	6	10	15

Optional Benefit No. 17 – Critical Illness

We will pay the Critical Illness Sum Insured as a lump sum in addition to Our Payment under this Policy, provided that:

a) The Insured Person is first diagnosed as suffering from a Critical Illness during the Policy Period, and

b) The Insured Person survives atleast 30 days following such diagnosis,

c) This benefit is payable once during the Policy Period and would terminate on the occurrence of the first Critical Illness. The Insured Person shall receive the sum insured as per applicable guidelines post which the benefit will cease andcoverage under this benefit would not be renewed any further. However the other insured members (if any) will continue to be covered under this benefit if opted.

d) This benefit is offered only on Individual Sum Insured basis.

e) Any claim made in respect of this benefit will not be subject to In-patient Sum Insured and will not affect entitlement to Cumulative Bonus or Health Check-up benefit, if applicable.

We will not make payment if:

a) The Insured Person is first diagnosed as suffering from a Critical Illness within 90 days of the Commencement Date and the Insured Person has not previously been insured continuously and without interruption under this Policy.

S.No*	**Critical Illness***
Waiting Period	90 days
Survival Period	30 days
Important terms You should know: Survival period means the period after an insured event that the insured person has to survive before a claim is payable	

Please refer to Section A (Definition 9) of Policy wordings for the definitions of the Critical Illnesses and also exclusions specifically applicable to the critical illness covered.

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned above.

Sum insured basis	Upto 100% of base SI, subject to min of 50000 and max of 15 Lacs	
Number of CI	4	12
Waiting Period	90 days	
Survival Period	30 days	

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Option 1	Option 2
1. Cancer of specified severity	1. Cancer of specified severity
2. Myocardial Infarction (First Heart Attack of specific severity)	2. Myocardial Infarction (First Heart Attack of specific severity)
3. Stroke resulting in Permanent Symptoms	3. Stroke resulting in Permanent Symptoms
4. Major Organ/Bone Marrow Transplant	4. Major Organ/Bone Marrow Transplant
	5. Open Chest CABG
	6. Open Heart Replacement or Repair of Heart Valves
	7. Kidney Failure Requiring Dialysis
	8. Coma of Specified Severity
	9. Permanent Paralysis of Limbs
	10. Motor Neuron Disease with Permanent Symptoms
	11. Multiple Sclerosis with Persisting Symptoms
	12. Major Head Trauma

Optional Benefit No. 18 – Critical Illness (Indemnity Basis)

An additional limit of Rs [XX]* shall be available for coverage of expenses incurred on Inpatient and Day Care treatment of the below listed number of critical illnesses.

- [XX]*
- [XX]*

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned above.

Critical Illness (Rs)	100000	200000	300000	400000	500000	750000	1000000	1500000

The following listed critical Illnesses would be mentioned above as opted by the customer

Option 1	Option 2
1. Cancer of specified severity	1. Cancer of specified severity
2. Myocardial Infarction (First Heart Attack of specific severity)	2. Myocardial Infarction (First Heart Attack of specific severity)
3. Stroke resulting in Permanent Symptoms	3. Stroke resulting in Permanent Symptoms
4. Major Organ/Bone Marrow Transplant	4. Major Organ/Bone Marrow Transplant
	5. Open Chest CABG
	6. Open Heart Replacement or Repair of Heart Valves
	7. Kidney Failure Requiring Dialysis
	8. Coma of Specified Severity
	9. Permanent Paralysis of Limbs
	10. Motor Neuron Disease with Permanent Symptoms
	11. Multiple Sclerosis with Persisting Symptoms
	12. Major Head Trauma

Optional Benefit No. 19 – Double Sum Insured for Critical Illness (Indemnity Based)

We will increase the sum insured for an insured person by 100% if he is diagnosed as suffering from a critical Illness under this policy, provided that:

i) The insured person is first diagnosed as suffering from a critical illness during the policy period, and

ii) The benefit is utilised only by the insured person diagnosed with the critical illness, and

iii) We have accepted an inpatient hospitalisation claim under in-patient treatment benefit

For this benefit Critical Illness means:

- [XX]*
- [XX]*

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned above.

Option 1	Option 2
1. Cancer of specified severity	1. Cancer of specified severity
2. Myocardial Infarction (First Heart Attack of specific severity)	2. Myocardial Infarction (First Heart Attack of specific severity)
3. Stroke resulting in Permanent Symptoms	3. Stroke resulting in Permanent Symptoms
4. Major Organ/Bone Marrow Transplant	4. Major Organ/Bone Marrow Transplant
	5. Open Chest CABG
	6. Open Heart Replacement or Repair of Heart Valves
	7. Kidney Failure Requiring Dialysis
	8. Coma of Specified Severity
	9. Permanent Paralysis of Limbs
	10. Motor Neuron Disease with Permanent Symptoms
	11. Multiple Sclerosis with Persisting Symptoms
	12. Major Head Trauma

Optional Benefit No. 20 – Double sum insured for Cancer of specified severity (Indemnity based)

We will increase the sum insured for an insured person by 100% if he is diagnosed as suffering from cancer of specified severity under this policy, provided that:

i) The insured person is first diagnosed as suffering from a cancer during the policy period, and

ii) The benefit is utilised only by the insured person diagnosed with the illness, and

iii) We have accepted an inpatient hospitalisation claim under in-patient treatment benefit

Cancer of specified severity means:

- A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

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- The following are excluded:
  a) All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
  b) Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
  c) Malignant melanoma that has not caused invasion beyond the epidermis;
  d) All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
  e) All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
  f) Chronic lymphocytic leukaemia less than RAI stage 3
  g) Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
  h) All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

Optional Benefit No. 21 – Outpatient Benefit

Reasonable costs of outpatient treatment after completion of the specified waiting period of [XX]* years. The coverage for this benefit will be on individual basis for an individual policy & on family floater basis for a family floater policy.

Benefit	Maximum Sum Insured (Rs.)
Out-patient Benefit with waiting period of [X]years	XXXXXX

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned above.

Sum Insured (Rs)

1000	2000	3000	4000	5000

Waiting Period

1 year	2 years	3 years

Optional Benefit No. 22 – Health and Wellness Portal

Health and Wellness services to be offered to the Insured person through an integrated portal providing solutions on healthy living, health and lifestyle information.

Optional Benefit No. 23 – Geographical Premium

For the purpose of policy issuance, the premium will be computed based on point of sale location.

The premium that would be applicable zone wise and the cities defined in each zone are as under:

• Zone 1 - Delhi NCR/Mumbai MMR - Delhi, Gurgaon, Noida, Faridabad, Ghaziabad, Greater Noida, Mumbai, Navi Mumbai, Thane, Kalyan, Dombivali, Bhayandar, Ulhasnagar, Bhiwandi, Vasai, Virar

• Zone 2 - Rest of India- All other cities

The premium will be modified in case of mid-term address change involving migration from one zone to another and would be calculated on pro-rata basis. Also, We will not apply any co-payment where an Insured Person pays psremium in Zone 2 and avails treatment in Zone 1.

Optional Benefit No. 24 – Personal Accident

It is hereby agreed that in the event of any Accidental Bodily Injury we will provide the Benefits as detailed below for an event or occurrence described in any of the Benefits that occurs during the Policy Period.

Each Benefit is subject to its Sum Insured, but Our liability to make payment in respect of any and all Benefits shall be limited to the Accidental Death Sum Insured unless expressly stated to the contrary. Sum Insured limit for the benefit will apply on individual basis.

For regulatory reference

If opted by the customer, Accident Death Benefit is mandatory under this benefit. However, all other benefits i.e. Optional Benefit 24.2 to Optional Benefit 24.6 would be added if opted by the customer.

Benefit	Sum Insured
Accidental Death [AD]	Ten times annual income
Transportation of Mortal Remains	2 % of AD Sum Insured; maximum up to Rs 10,000
Cremation Ceremony	2 % of AD Sum Insured; maximum up to Rs 10,000
Permanent Total Disablement	upto AD Sum Insured
Permanent Partial Disablement	upto AD Sum Insured
Emergency Ambulance Charges	Upto Rs 2,000
Accident Out-patient Expenses	Out-patient SI limit maximum up to Rs 20,000Deductible of Rs. 200/ Rs. 500 per Out-patient Claim
Broken Bones	20 % of AD Sum Insured; maximum up to Rs 100,000

Optional Benefit No. 24.1 – Accidental Death

1) Accidental Death

   If an Insured Person suffers an Accident during the Policy Period and this is the sole and direct cause of his death within 365 days from the date of the Accident, then We will pay the Sum Insured.

2) Transportation of Mortal Remains

   If We have accepted a claim under 1), then We will in addition reimburse the lower of 2% of the Sum Insured under Benefit 1 above and the actual amount incurred in transporting the mortal remains of the Insured Person from the place of the Accident or the Hospital to his residence or Hospital or to a cremation or burial ground.

3) Cremation Ceremony

   If We have accepted a claim 1), then We will in addition pay the lumpsum Sum Insured towards the costs of the cremation or burial of the Insured Person.

Optional Benefit No. 24.2 – Permanent Total Disablement

- If an Insured Person suffers an Accident during the Policy Period and within 365 days from the date of the Accident this is the sole and direct cause of his permanent total disablement in one of the ways detailed in the table below, then We will pay the percentage of the Sum Insured shown in the table.

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	% of Sum Insured
Loss of 2 Limbs (both hands or both feet or one hand and one foot)	100%
Loss of a Limb and an eye	100%
Complete and irrecoverable loss of sight of both eyes	100%
Complete and irrecoverable loss of speech & hearing of both ears	100%
Loss of a Limb	50%
Complete and irrecoverable loss of sight of an eye	50%

- In this Benefit:
  a. Limb means a hand at or above the wrist or a foot above the ankle.
  b. Loss of Limb means:
     i. the physical separation of a Limb above the wrist or ankle respectively, or
     ii. the total loss of functional use of a Limb for at least 365 days from the date of onset of such disability provided that We must be satisfied at the expiry of the 365 days that there is no reasonable medical hope of improvement.

Optional Benefit No. 24.3 – Permanent Partial Disablement

- If an Insured Person suffers an Accident during the Policy Period and within 365 days from the date of the Accident this is the sole and direct cause of his permanent partial disablement in one of the ways detailed in the table below, then We will pay the percentage of the Sum Insured shown in the table.

Loss of:	% of Sum Insured
Each arm at the shoulder joint	70%
Each arm to a point above elbow joint	65%
Each arm below elbow joint	60%
Each hand at the wrist	50%
Each thumb	20%
Each index finger	10%
Each other finger	5%
Each leg above center of the femur	70%
Each leg up to a point below the femur	65%
Each leg to a point below the knee	50%
Each leg up to the center of tibia	45%
Each foot at the ankle	40%
Each big toe	5%
Each other toe	2%
Each eye	50%
Hearing in each ear	30%
Sense of smell	10%
Sense of taste	5%

- In this Benefit:
  a) Loss means:
     i. the physical separation of a body part, or
     ii. the total loss of functional use of a body part or organ provided this has continued for at least 365 days from the onset of such disability provided that We are satisfied at the expiry of the 365 days that there is no reasonable medical hope of improvement.
- If an Insured Person suffers a Loss not mentioned in the table above, then We will assess the degree of disablement with Our medical advisors and determine the amount of payment to be made.
- If a claim in respect of a whole member (any organ, organ system or a limb) also encompasses some or all of its parts, Our liability to make payment will be limited to the member only and not any of its parts or constituents.

Optional Benefit No. 24.4 – Emergency Ambulance

If We have accepted a claim under this Policy and following the Accident it is necessary to immediately transfer the Insured Person to the nearest Hospital by ambulance offered by a healthcare or ambulance service provider, then We will in addition reimburse the actual expenses of the transfer using the shortest route upto Rs 2000.

Optional Benefit No. 24.5 – Out-patient Accident Treatment

If any Insured Person suffers an Accident during the Policy Period that requires Outpatient Treatment, then We will in addition reimburse the Medical Expenses incurred for such Insured Person provided that the Treatment commences within the Policy Period. Our liability to meet Medical Expenses caused by such Accident will be upto Benefit Sum Insured as mentioned in Policy Schedule.

Optional Benefit No. 24.6 – Broken Bones

If an Accident causes an Insured Person to suffer a fracture (a break in the continuity of a bone) and this is certified by a Doctor and also confirmed by imaging investigations such as by X-ray, then We will pay the percentage of the Sum Insured specified in the table below.

	% of Sum Insured
Injury to vertebral body resulting in spinal cord damage	100%
Pelvis	100%
Skull (excluding nose and teeth)	30%
Chest (all ribs and breast bone)	50%
Shoulder (collar bone and shoulder blade)	30%
Arm	25%
Leg	25%
Vertebra – vertebral arch (excluding coccyx)	30%
Wrist (collies or similar fractures)	10%
Ankle (Potts or similar fracture)	10%
Coccyx	5%
Hand	3%
Finger	3%
Foot	3%
Toe	3%
Nasal bone	3%

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Special Terms and Conditions

A. Waiting Period

All Illnesses, treatments and their associated complications shall be covered subject to the waiting periods specified below:

i) 30-day waiting period

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.

ii) Specified Disease/Procedure waiting period

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 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 accidentor underlying cause is cancer(s).

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/ migration stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases/procedures: -

Sl. No.	Organ / Organ System	Illness / diagnoses (irrespective of treatments medical or surgical)	Surgeries / procedures (irrespective of any illness/ diagnosis other than cancers)
a.	Ear, Nose and Throat (ENT)	• Sinusitis • Rhinitis • Tonsillitis	• Adenoidectomy • Mastoidectomy • Tonsillectomy • Tympanoplasty • surgery for nasal septum deviation • Surgery for Turbinate hypertrophy • nasal concha resection • Nasal polypectomy
b.	Gynaecological	• cysts, polyps including breast lumps • Polycystic ovarian disease • Fibromyoma • Adenomyosis • Endometriosis • Prolapsed Uterus	• Hysterectomy
c.	Orthopaedic	• Non infective arthritis • Gout and Rheumatism • Osteoarthritis	• Joint replacement surgeries
		• Ligament, Tendon and Meniscal tear • Prolapsed inter vertebral disk	
d.	Gastrointestinal	• Cholelithiasis • Cholecystitis • Pancreatitis • Fissure/fistula in anus, Haemorrhoids, Pilonidal sinus • Gastro Esophageal Reflux Disorder (GERD), Ulcer and erosion of stomach and duodenum • Cirrhosis (However Alcoholic cirrhosis is permanently excluded) • Perineal and Perianal Abscess • Rectal Prolapse	• Cholecystectomy • Surgery of hernia
e.	Urogenital	• Calculus diseases of Urogenital system including Kidney, ureter, bladder stones • Benign Hyperplasia of prostate • Varicocele	• Surgery on prostate • Surgery for Hydrocele/ Rectocele
f.	Eye	• Cataract • Retinal detachment • Glaucoma	• NIL
g.	Others	• NIL	• Surgery of varicose veins and varicose ulcers
h.	General (Applicable to all organ systems/ organs/disciplines whether or not described above)	• Benign tumors of Non infectious etiologye.g. cysts, nodules, polyps, lump, growth, etc.	• NIL

iii. Pre-Existing Diseases

a) Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with 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.

Important terms You should know

Pre-existing Conditionmeans any condition, ailment, injury or disease:

a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement

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b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

B. General Exclusions

We will not pay for any claim which is caused by, arising from or attributable to the following including their associated complications.

Non Medical Exclusions

1. War or similar situations:

   Treatment arising from or consequent upon war or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind.

2. Breach of Law:

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

3. Intentional self-injury or attempted suicide while sane or insane.

4. Hazardous or Adventure sportsExpenses 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.

Medical Exclusions

5. **Investigation & Evaluation:**Code Excl04
   a. Expenses related to any admission primarily for diagnostic 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.

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

7. **Obesity/Weight control:**Code – Excl06: Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   a. Surgery to be conducted is upon the advice of the doctor
   b. The surgery/procedure conducted should be supported by clinical protocols
   c. The member has to be 18 years of age or older and
   d. Body Mass Index (BMI)
      i. Greater than or equal to 40 or,
      ii. 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:
         1. Obesity related cardiomyopathy
         2. coronary heart disease
         3. severe sleep apnoea
         4. uncontrolled type2 diabetes

8. **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.

9. **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.**

10. **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.

11. **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.

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

13. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code – Excl12

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

15. 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

16. Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.Code – Excl15

17. **Unproven Treatments –** 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. Code – Excl16

18. **Sterility and Infertility –** Code – Excl17 -Expenses related to sterility and infertility. This includes:
   a. Any type of contraception, sterilization
   b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
   c. Gestational Surrogacy
   d. Reversal of sterilization

19. **Maternity :** Code – Excl18
   a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
   b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the **Policy** period.

20. War or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, **Nuclear**, **Chemical** or**Biological** attack or weapons, radiation of any kind.

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21. Any **Insured Person** committing or attempting to commit intentional self-injury or attempted suicide or suicide while mentally sound or unsound.
22. Any **Insured Person**'s participation or involvement in naval, military or air force operation.
23. Investigative treatment for Sleep-apnoea, General debility or exhaustion ("run-down condition").
24. Congenital external diseases, defects or anomalies,
25. Stem cell harvesting,.
26. Investigative treatments for analysis and adjustments of spinal subluxation,diagnosis and treatment by manipulation of the skeletal structure or for muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities).
27. Circumcisions (unless necessitated by **Illness** or **Injury** and forming part of treatment).
28. Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care.
29. Preventive care,; and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.
30. Vaccination including inoculation and immunisations (Except post Animal bite treatment),
31. **Non-Medical expenses** such as Food charges (other than patient's diet provided by hospital), laundry charges, attendant charges, ambulance collar, ambulance equipment, baby food, baby utility charges and other such items. Full list of Non-Medical expenses is attached and also available at www.hdfcergo.com.
32. Treatment taken on Outpatient basis
33. The provision or fitting of hearing aids, spectacles or contact lenses.
34. Any treatment and associated expenses for alopecia, baldness including corticosteroids and topical immunotherapy wigs, toupees, hair pieces,any non-surgical hair replacement methods, Optometric therapy.
35. Any treatment or part of a treatment that is not of a Reasonable and Customary charge, not Medically Necessary; treatments or drugs not supported by a prescription.
36. Expenses for Artificial limbs and/or device used for diagnosis or treatment (except when used intra-operatively).prosthesis, corrective devices external durable medical equipment of any kind, wheelchairs, crutches, and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical expenses attached and also available on www.hdfcergo.com.
37. Any Claim arising due to Non-disclosure of Pre-existing **Illness** or Material fact as sought to be declared on the Proposal form.
38. Non Allopathic treatments
39. Prosthetic and other devices which are self-detachable /removable without surgery involving anaesthesia
40. Treatment availed outside India
41. Treatment at a healthcare facility which is NOT a Hospital.
42. Dental treatment and surgery of any kind, unless requiring Hospitalisation.
43. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed.
44. Treatments rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover.
45. Admission for administration of Intra-articular or Intra-lesional injections, Supplementary medications like Zolendronic acid (Trade name Zometa, Reclast, etc.) or IV immunoglobulin infusion

Special Exclusions for Personal Accident Benefit

a. Special Exclusions to Optional Benefit No 24.1 – 24.5

i. Bacterial infections (except pyogenic infection which occurs through an Accidental cut or wound).

ii. Medical or surgical treatment except as necessary solely and directly as a result of an Accident.

b. Special Exclusion to Optional Benefit No 24.6

i. Sickness or disease.

ii. Any fracture due to osteoporosis or a malignant disease.

iii. Any hair line fracture.

c. General Exclusion applicable to all Benefits

i. Any Pre-existing Condition or any complication arising from the same.

ii. Intentional self-injury or attempted suicide while sane or insane.

iii. War or similar situations : Treatment arising from or consequent upon war or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind.

iv. Hazardous or Adventure Sports: Code- Excl09Expenses 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.

v. Breach of Law: Code – Excl10Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

vi. Treatment forAlcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code – Excl12

vii. Maternity: code –Excl18

a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred duringhospitalization) except ectopic pregnancy;

b) Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

viii. External congenital diseases, defects or anomalies or in consequence thereof.

ix. Treatments rendered by a Doctor who shares the same residence as an Insured Person or who is a member of an Insured Person's family.

x. Any non-allopathic treatment.

Sum Insured (Rs)

25000, 50000, 100000, 200000, 300000, 400000, 500000, 750000, 1000000 and 1500000

Requirement

- Completed proposal form
- Minimum group size of 7 members at the inception of the policy

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Claim Procedure

All claims under this policy will be processed and settled byHDFC ERGO Health Insurance Ltd. At network centers claims would be settled on cashless basis and on reimbursement basis in non network centers.

a) Intimation & Assistance - Please contact HDFC ERGO atleast 7 days prior to an event which might give rise to a claim. For any emergency situations, kindly contact HDFC ERGO within 24 hours of the event.

b) Procedure for reimbursement of Medical Expenses –

- HDFC ERGO must be informed no later than 7 days of completion of such treatment, consultation or procedure using the Claim Intimation Form.
- Please send the duly signed claim form and all the information/ documents mentioned therein to HDFC ERGO 15 days of the occurrence of the Incident. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the insured.

  * Please refer to claim form for complete documentation.
- If there is any deficiency in the documents/information submitted by You, HDFC ERGO will send the deficiency letter within 7 days of receipt of the claim documents.
- On receipt of the complete set of claim documents, HDFC ERGO will send admissible amount, along with a settlement statement within 30 days.
- The payment will be made in the name of the Policyholder.

  Note: Payment will only be made for items covered under Your policy and upto the limits therein.

c) Claim Procedure to avail Cashless facility -

- For any emergency Hospitalisation, HDFC ERGO must be informed no later than 24 hours after hospitalization.
- For any planned hospitalization, kindly seek cashless authorization from HDFC ERGO atleast 48 hours prior to the hospitalization.
- HDFC ERGO will check Your coverage as per the eligibility and send an authorization letter to the provider. In case there is any deficiency in the documents sent, the same shall be communicated to the hospital within 6 hours of receipt of documents.
- Please pay the non-medical and expenses not covered to the hospital prior to the discharge.
- In case the ailment /treatment is not covered under the policy a rejection letter would be sent to the provider within 6 hours.

Note:

- Insured person is entitled for cashless coverage only in Our empanelled hospitals.
- Please refer to the list of empanelled hospitals on Our website or the list provided along with Policy kit or call us on Our toll free number at +91 22 6234 6234/+91 120 6234 6234.
- Rejection of cashless facility in no way indicates rejection of the claim.

Special Conditions applicable with Personal Accident Benefit: In addition to the General Conditions mentioned in the Section 3 of policy wordings, the below mentioned conditions are applicable for Personal Accident Benefit as and when applicable.

i. Notification of claim

  i. We must be informed of any event or occurrence that may give rise to a claim under this Policy within 30 days of it happening

  ii. For all benefits contingent on Our prior acceptance of a claim under Optional Benefit 24.1 – 24.3, We must be informed within 30 days of the event or occurrence that may give rise to a contingent benefit claim.

  iii. If any time period is specifically mentioned in Optional Benefit 24, then this shall supersede the time periods mentioned at i) and ii) above.

ii. Claims Payment Supporting Documentation & Examination

  i. We must be provided with any documentation and information We may request to establish the circumstances of the claim, its quantum or Our liability for it including, in English, Our claim form duly completed and all reports, including death certificate, post mortem report, disability certificate, medical reports, case histories, investigation reports, treatment papers and discharge summaries. Please note that in case of a non-disclosure or/and a fraud suspicion we may ask for additional documentation/ reports.

  ii. The Insured Person additionally hereby consents to:

    a) The disclosure to Us of documentation and information that may be held by medical professionals and other insurers.

    b) The Insured Person shall be examined by any medical practitioner Weauthorise for this purpose when and so often as We may reasonably require.

iii. Claims Payment

  i) If We accept a claim and become liable to make payment under Permanent Total Disablement Benefit, Permanent Partial Disablement Benefit and Broken Bones (the first claim) and there is a subsequent claim under other Benefit or Accidental Death Benefit in respect of the same Insured Person and the same Accident within 365 days of the date of the Accident (the second claim), then We will only be liable to pay the difference between the amount payable for the first claim and the amount payable for the second claim.

  ii) Payments under this Benefit shall only be made in Indian Rupees irrespective of the location of accident which has given rise to the claim.

iv. Insured Person

If an Insured Person opts for Optional Benefit No. 24, then We will cover any Insured Persons from the age of 91 days onwards and there is no cover ceasing age for this benefit.

v. Change of Occupation

You will give Us a written notice in the format prescribed by Us of any change in the business or occupation of any Insured Person within 30 days of such change and We will issue an endorsement to this effect.

If at the time a claim arises under this Policy the Insured Person has changed his occupation without Us being notified, then Our maximum liability will be limited to the amount that would have been payable for the premium paid and the new occupation.

vi. Geography

This Benefit of Personal Accident applies to events or occurrences taking place anywhere in the world unless limited by Us in a particular Benefit or definition or through an endorsement.

vii. Nomination

You can change the nominee to whom such payment is to be made at any time during the Policy Period, provided that such change shall only be effective when You have notified Us and We have recorded the change by an endorsement to this effect.

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Renewal of Policy:

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

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

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

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

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

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

Withdrawal of Policy

i. 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.

ii. 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.

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.

Cancellation

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

Length of time Policy in force	Refund of premium
Upto 1 Month	75.00%
Upto 3 Months	50.00%
Upto 6 Months	25.00%
Exceeding 6 Months	Nil

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

ii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

Non-Disclosure or Misrepresentation:

i. If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:

- cancelledab initio from the inception date or the renewal date (as the case may be), at Our sole discretion, upon 15 day notice by sending an endorsement to Your address shown in the Schedule/ Certificate of Insurance or the Policy may be modified with the consent of the customer.
- the claim under such Policy if any, shall be rejected/repudiated forthwith.

ii. We may also exercise any of the below listed options for the purpose of continuing the health insurance coverage in case of Non-Disclosure/Misrepresentation of Pre-existing diseases subject to your prior consent;

a) Permanently exclude the disease/condition and continue with the Policy

b) Incorporate additional waiting period of not exceeding 4 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.

c) Levy underwriting loading from the first year of issuance of policy or renewal, whichever is later.

The above options will not prejudice the rights of the Company to invoke cancellation under clause 3 i above.

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.

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

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the 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.

Portability

The **Insured Person** will have the option to port the Policy to other insurers by applying to such **Insurer** to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the 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**

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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 policyatleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the 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**

Section 41 of Insurance Act 1938as amended by Insurance Laws Amendment Act, 2015 (Prohibition of Rebates):

- 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 prospectuses or tables of the insurers.
- Any person making default in complying with the provision of this section shall be liable for a penalty which may extend to 10 lakh rupees.

IRDA REGULATION NO 12: This policy is subject to regulation 12 of IRDAI (Protection of Policyholder's Interests) Regulations, 2017.

Note: Policy Term and Conditions & Premium rates are subject to change with prior approval from IRDA.

Disclaimer

This 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 seek the advice of Your insurance advisor if You require any further information or clarification.

Annexure I - List of Non-Medical Expenses

S. No.	Item	S. No.	Item
1	BABY FOOD	35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
2	BABY UTILITIES CHARGES	36	SPACER
3	BEAUTY SERVICES	37	SPIROMETRE
4	BELTS/ BRACES	38	NEBULIZER KIT
5	BUDS	39	STEAM INHALER
6	COLD PACK/HOT PACK	40	ARMSLING
7	CARRY BAGS	41	THERMOMETER
8	EMAIL / INTERNET CHARGES	42	CERVICAL COLLAR
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	43	SPLINT
10	LEGGINGS	44	DIABETIC FOOT WEAR
11	LAUNDRY CHARGES	45	KNEE BRACES (LONG/ SHORT/ HINGED)
12	MINERAL WATER	46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
13	SANITARY PAD	47	LUMBO SACRAL BELT
14	TELEPHONE CHARGES	48	NIMBUS BED OR WATER OR AIR BED CHARGES
15	GUEST SERVICES	49	AMBULANCE COLLAR
16	CREPE BANDAGE	50	AMBULANCE EQUIPMENT
17	DIAPER OF ANY TYPE	51	ABDOMINAL BINDER
18	EYELET COLLAR	52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
19	SLINGS	53	SUGAR FREE TABLETS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	54	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	55	ECG ELECTRODES
22	TELEVISION CHARGES	56	GLOVES
23	SURCHARGES	57	NEBULISATION KIT
24	ATTENDANT CHARGES	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	59	KIDNEY TRAY
26	BIRTH CERTIFICATE	60	MASK
27	CERTIFICATE CHARGES	61	OUNCE GLASS
28	COURIER CHARGES	62	OXYGEN MASK
29	CONVEYANCE CHARGES	63	PELVIC TRACTION BELT
30	MEDICAL CERTIFICATE	64	PAN CAN
31	MEDICAL RECORDS	65	TROLLY COVER
32	PHOTOCOPIES CHARGES	66	UROMETER, URINE JUG
33	MORTUARY CHARGES	67	AMBULANCE
34	WALKING AIDS CHARGES	68	VASOFIX SAFETY