HDFC ERGO General Insurance Company Limited
Prospectus

Arogya Sanjeevani Policy, HDFC ERGO (Group)

Introduction

This policy has been designed to have a standard product with common policy wordings across the industry and to facilitate seamless portability among insurers. The Product offers coverage against expenses incurred during Hospitalization, Day care procedures.

1. Coverage

The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

1.1 Hospitalization

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the policy schedule, for,

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/-, per day.

ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs.10,000/- per day.

iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital

iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

1.2 Other expenses

i. Expenses incurred on treatment of cataract subject to the sub limits

ii. Dental treatment, necessitated due to disease or injury

iii. Plastic surgery necessitated due to disease or injury

iv. All the day care treatments

v. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalisation.

Note:

1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment
2. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

1.3 AYUSH Treatment

The Company shall indemnify medical expenses incurred only for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the limit of sum insured as specified in the policy schedule/certificate of insurance in any AYUSH Hospital.

1.4 Cataract Treatment

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured orRs.40,000/-, whichever is lower, per each eye in one policy year.

1.5 Pre Hospitalization

The company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

1.6 Post Hospitalisation

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

1.7 The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the policy schedule, during the policy period:

A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)

B. Balloon Sinuplasty

C. Deep Brain stimulation

D. Oral chemotherapy

E. Immunotherapy- Monoclonal Antibody to be given as injection

F. Intra vitreal injections

G. Robotic surgeries

H. Stereotactic radio surgeries

I. Bronchical Thermoplasty

J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)

K. IONM - (Intra Operative Neuro Monitoring)

L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

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

2 Cumulative Bonus (CB)

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

Notes:

i. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.

ii. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the Insured Persons.

iii. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.

iv. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons

v. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/ individual policies or in cases where the policy is split due to the child attaining the age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy

vi. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.

vii. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.

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viii. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn

3 Waiting Period

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

3.1 Pre-Existing Diseases(Code- Excl01)

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

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If the Insured Person is continuously covered without any break as defined under the portability 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 us.

3.2 First Thirty Days Waiting Period(Code- Excl03)

i. 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.

ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

iii. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

3.3 Specific Waiting Period: (Code- Excl02)

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24/48 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. 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.

i.24 Months waiting period

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

ii. 48 Months waiting period

1. Treatment for joint replacement unless arising from accident
2. Age-related Osteoarthritis & Osteoporosis

4 Exclusions

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

4.1 Investigation & Evaluation(Code- Excl04)

a) Expenses related to any admission primarily for diagnostics and evaluation purposes.

b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

4.2 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.

4.3 Obesity/ Weight Control(Code- Excl06)

Expenses related to the surgical treatment of obesity that does not fulfill 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

4.4 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.

4.5 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.

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4.6 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.

4.7 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.

4.8 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 following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

4.9 Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code- Excl12)**

4.10 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)**

4.11 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)**

4.12 Refractive Error:(Code- Excl15)

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

4.13 Unproven Treatments:(Code- Excl16)

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.

4.14 Sterility and Infertility: (Code- Excl17)

Expenses related to sterility and infertility. This includes:

i. Any type of 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

4.15 Maternity Expenses (Code - Excl 18):

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.

4.16 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.

4.17 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.

4.18 Any expenses incurred on Domiciliary Hospitalization and OPD treatment

4.19 Treatment taken outside the geographical limits of India

4.20 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.

5 Moratorium Period

After completion of eight continuous years under this policy no look back would 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 eight continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy 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 as per the policy.

6 Table Of Benefits

Name	Arogya Sanjeevani Policy, HDFC ERGO (Group)
Product Type	Individual/ Floater
Category of Cover	Indemnity
Sum insured	INR On Individual basis – SI shall apply to each individual family member On Floater basis – SI shall apply to the entire family Min 1 lakh subject to a max of Rs 10 Lakhs in the multiples of Rs 50,000/-
Policy Period	1 year
Eligibility	Policy can be availed by persons between the age of 18 years and 65 years, as Proposer. Proposer with higher age can obtain policy for family, without covering self. Policy can be availed for Self and the following family members i. legally wedded spouse ii. Parents and Parents-in-law. iii. Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals
Grace Period	For Yearly payment of mode, a fixed period of 30 days is to be allowed as Grace Period and for all other modes of payment a fixed period of 15 days be allowed as grace period.

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Hospitalisation Expenses	Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible
	Time limit of 24 hrs shall not apply when the treatment is undergone in a Day Care Centre.
Pre Hospitalisation	For 30 days prior to the date of hospitalization
Post Hospitalisation	For 60 days from the date of discharge from the hospital
Sublimit for room/ doctors fee	1. Room Rent, Boarding, Nursing Expenses all inclusive as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/- per day.
	2. Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all inclusive as provided by the Hospital / Nursing Home up to 5% of the sum insured subject to maximum of Rs.10,000/-, per day
Cataract Treatment	Up to 25% of Sum insured or Rs.40,000/-, whichever is lower, per eye, under one policy year.
AYUSH	Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered upto sum insured, during each Policy year as specified in the policy schedule.
Pre Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the company shall be covered after a waiting period of 4 years
Cumulative bonus	Increase in the sum insured by 5% in respect of each claim free year subject to a maximum of 50% of SI. In the event of claim the cumulative bonus shall be reduced at the same rate.
Co Pay	5% co pay on all claims

Pre Policy Check ups

1. The PPC tests required will be as per the below PPC grid. This grid may be subject to change based on te company policy in future & will be guided by our experience

PED	Sum Insured	Upto 55 years	> 55 years
Yes	Rs. 1 Lakh to Rs. 3 Lakhs	Tele MER followed by PPC (if Required) (Set 2)	Tele MER and PPC (Set 3)
	> 4 Lakhs	Tele MER followed by PPC (if Required) (Set 2)	PPC (Set 3)
No	Rs. 1 Lakh to Rs. 3 Lakhs	STP	Tele MER and PPC (Set 2)
	> 4 Lakhs	STP	PPC (Set 2)

Set 1: ME, RUA, CBC, Sr Creatinine, Lipid Profile, SGPT, GGTP, SGOT, HBA1C, ECG

Set2 2: ME, RUA, CBC, Sr Creatinine, Lipid Profile, SGPT, GGTP, SGOT, HBA1C, ECG, HBsAg, TMT/2D Echo, USG Abdomen & Pelvis, Chest X ray, CEA

Set 3: Set 2, PSA (Males), Pap Smear & Sonomamography (Females), Micro albumin, BUN, Sr Uric Acid, ANA

2. Guidelines for Pre Policy Check ups

- Pre Policy Check-up will be conducted at our Network provider
- Where ever Pre Policy Check-up is conducted at our Network provider, 100% of the Medical test charges will be reimbursed on acceptance of proposal. In case Customer Insists on a Check-up outside our Network provider, 50% of the Medical test charges will be reimbursed on acceptance of Proposal.
- If Proposal is declined post Pre Policy Check-up, 50% of the Medical test charges incurred will be reimbursed
- Medical Reports are considered valid for up to 3 months
- In case of any positive health declaration on the proposal form the relevant medical tests shall be advised in addition to the above grid tests
- In case of any additional tests advised besides the ones mentioned above,100% of the cost incurred on such test will be borne by customer

7 Claim Procedure

7.1 Procedure for Cashless claims:

(i) Treatment may be taken in a network provider and is subject to pre authorization by the Company.

(ii) Cashless request form available with the network provider and shall be completed and sent to the Company for authorization.

(iii) The Company upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification.

(iv) At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.

(v) The Company reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.

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

7.2 Procedure for reimbursement of claims:

For reimbursement of claims the insured person may submit the necessary documents to the Company within the prescribed time limit as specified hereunder.

Sl No	Type of Claim	Prescribed Time limit
1.	Reimbursement of hospitalization, day care and pre hospitalization expenses	Within thirty days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

7.3 Notification of Claim

Notice with full particulars shall be sent to the Company as under:

i. Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.

ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

7.4 Documents to be submitted

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

i. Duly Completed claim form

ii. Photo Identity proof of the patient

iii. Medical practitioner's prescription advising admission

iv. Original bills with itemized break-up

v. Payment receipts

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vi. Discharge summary including complete medical history of the patient along with other details.

vii. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner

viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).

ix. Sticker/Invoice of the Implants, wherever applicable.

x. MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, where ever applicable.

xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque

xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines

xiii. Legal heir/succession certificate , wherever applicable

xiv. Any other relevant document required by Company for assessment of the claim.

Note:

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

7.5 Co-payment

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

7.6 Claim Settlement (provision for Penal Interest)

i. 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.

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

iii. 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 earliestin any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document.

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

7.7 Payment of Claim

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

8 General Terms &Conditions

8.1 Disclosure of Information

The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis- description or non-disclosure of any material fact.

8.2 Condition Precedent to Admission of Liability

The due observance and fulfilment of the terms and conditions of the policy, by the insured person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the policy.

8.3 Material Change

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

8.4 Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy

8.5 Complete Discharge

Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall in all cases be a full, valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

8.6 Notice & Communication

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

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

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

8.7 Territorial Limit

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

8.8 Multiple Policies

1. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer if chosen by the policy holder shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
2. Policyholder having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall independently settle the claim subject to the terms and conditions of this policy.
3. If the amount to be claimed exceeds the sum insured under a single policy after, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
4. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

8.9 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 shall be forfeited.

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue a insurance Policy:-

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(a) the suggestion ,as a fact of that which is not true and which the Insured Person does not believe to be true;

(b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

(c) any other act fitted to deceive; and

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

The company shall not repudiate the policy on the ground of fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

8.10 Cancellation

a) The Insured may cancel this Policy by giving 15 days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

Refund %	
Refund of Premium (basis Policy Period)	
Timing of Cancellation	**1 Yr**
Up to 30 days	75.00%
31 to 90 days	50.00%
3 to 6 months	25.00%
6 to 12 months	0.00%

For Instalment options-

1. In case of Instalment option, 50% of current instalment premium will be refunded when policy is cancelled within 6 months else no refund will be payable.
2. In case of admissible claim under the policy, future instalments will be adjusted in the claim amount.

No refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.

b) The Company may cancel the Policy at any time on grounds of mis-represenation, 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 mis-represenation, non-disclosure of material facts or fraud.

8.11 Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate:

1. In the case of his/ her (Insured Person) demise.

   However the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/ her relationship with the insured person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.

2. Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

8.12 Territorial Jurisdiction

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

8.13 Arbitration

i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

ii. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy.

iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

8.14 Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

i. The waiting periods specified in Section 3 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.

ii. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Migration, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_ Layout.aspx?page=PageNo3987

8.15 Portability

The Insured Person will have the option to port the Policy to other insurers as per extant Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/ Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

i. The waiting periods specified in Section 3 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.

ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Portability, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_ Layout.aspx?page=PageNo3987

8.16 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. The Company is not bound to give notice that it is due for renewal.

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

ii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.

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

iv. If not renewed within Grace Period after due renewal date, the Policy shall terminate.

8.17 Premium Payment in Instalments

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in Your Policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

i. Grace Period of 15 days would be given to pay the instalment premium due for the Policy.

ii. During such grace period, Coverage will not be available from the instalment premium payment due date till the date of receipt of premium by Company.

iii. The Benefits provided under – "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.

iv. No interest will be charged If the instalment premium is not paid on due date.

v. In case of instalment premium due not received within the grace Period, the Policy will get cancelled.

8.18 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 affected.

8.19 Free look period

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting the policy.

The insured shall be allowed a period of fifteen days from date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

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, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

8.20 Endorsements (Changes in Policy)

i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.

ii. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.

8.21 Change of Sum Insured

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

8.22 Terms and conditions of the Policy

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

8.23 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. For Claim settlement under reimbursement, the Company will pay the policyholder. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy 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

Section 41 of Insurance Act 1938 (Prohibition of Rebates):

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take 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 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 prospectus or tables of the insurers.
2. Any person making default in complying with the provision of this section shall be punishable with fine which may extend to Rupees Ten Lakh Rupees.

IRDAI Regulation no 5- This policy is subject to regulation 5 of IRDAI (Protection of Policyholder's Interests) Regulation

DISCLAIMER: THE ABOVE IS DESCRIPTIVE ONLY. THE ACTUAL TERMS AND CONDITIONS CAN BE FOUND IN THE POLICY DOCUMENT. INSURED'S ARE ADVISED TO READ THE POLICY DOCUMENT COMPLETELY FOR A FULL DESCRIPTION OF THE TERMS AND CONDITIONS OF COVERAGE AND THE EXCLUSIONS RELATING THERETO.

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

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Annexure-A

List I – Items for which coverage is not available in the policy

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)

Sl No	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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List IV – Items that are to be subsumed into costs of treatment

Sl No	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES-DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer& Strips
18	URINE BAG