SECTION 1: ELIGIBILITY CRITERIA

i. Policy can be availed by adults between the age of 18 years and 65 years and children (i.e. naturally or legally adopted and financially dependent on the Proposer) can be covered from 1 year to 17 years of age.

ii. Policy can be proposed for self or the following family members
   a. Legally wedded spouse
   b. Brothers, Sisters,, Grand Children, Daughter in law and Son-in-law
   c. Children (i.e. natural or legally adopted) between the age of 1 year to 17 years.

iii. Age means "Age as on last birthday" as determined on the date of first Policy issuance or at Renewal. In case of change in Age during the proposal stage then "Age" shall be determined on the date of Proposal Form submission would be considered for premium calculation.

iv. This Policy can be issued to an individual.

v. There is no maximum cover ceasing age on continuous renewals.

SECTION 2: SUM INSURED

INR per annum	4 lakhs	5 lakhs

SECTION 3: POLICY PERIOD

The Policy can be purchased for 1 year.

SECTION 4: COVERAGES

4.1 In-Patient Treatment

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy Year, up to the Sum insured as specified in the Policy Schedule (other than any sub-limits, co-pay as specified in the policy), for:

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to maximum of 1% of the Sum Insured per day.

ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up maximum of to 2% of Sum Insured per day.

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

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

Other expenses

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

ii. Dental treatment necessitated due to disease or injury (for inpatient care only).

iii. Plastic surgery necessitated due to disease or injury.

iv. All day care treatments

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 and associated medical expenses incurred at the Hospital, with the exception of cost of medicines, shall be affected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ ICU/ICCU charges.
3. Proportionate deductions is not applicable in case of admission in an ICU/ICCU room with rates exceeding the defined limit.
4. The above-mentioned Medical Expenses shall be payable only after the first commencement of the Policy with the Company.

4.2 AYUSH Treatment

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to 50% of sum insured as specified in the policy schedule in any AYUSH Hospital.

4.3 Pre-Hospitalization Medical Expenses:

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 during the policy period.

Conditions:

i. The claim is accepted under Section 4.1 (Inpatient Care) or Section 4.2(AYUSH Treatment) or Section 4.7 (Modern Treatments) in respect of that Insured Person.

ii. Pre-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

4.4 Post- Hospitalization Medical Expenses:

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 during the policy period.

Conditions:

i. The claim is accepted under Section 4.1 (Inpatient Care) or Section 4.2(AYUSH Treatment) or Section 4.7 (Modern Treatments) in respect of that Insured Person.

ii. Post-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

4.5 Emergency Ground Ambulance

The Company will reimburse Reasonable and Customary Charges for expenses incurred towards ambulance charges for transportation of an Insured person, per hospitalization as

per the limit mentioned in Policy Schedule.

Specific Conditions:

The Company will reimburse payments under this Benefit provided that.

i. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is Injured or is suffering from an Illness to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital as advised by the treating Medical Practitioner in writing for management of the current Hospitalization.

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

iii. The ambulance service is offered by a healthcare or Registered Ambulance Service Provider.

iv. The original Ambulance bills and payment receipt is submitted to the Company.

v. The Company has accepted a claim under Section 4.1 (Inpatient Care) above in respect of the same period of Hospitalization or Section 4.2(AYUSH Treatment) or Section 4.7 (Modern Treatments).

vi. Any payment under this Benefit will be excluded if the Insured Person is transferred to any Hospital or diagnostic center for evaluation purposes only.

4.6 Cataract Treatment

The company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of Rs.40,000/-, per each eye in one policy year.

4.7 Modern Treatment

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. Bronchial 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.

SECTION 5: WAITING PERIOD

5.1 Pre-Existing Disease Waiting Period (Code: Excl01)

i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months for pre-existing disability/ 48 months for all pre-existing conditions other than HIV/AIDS and Disability (as mentioned in Policy Schedule) of continuous coverage after the date of inception of the first policy with insurer.

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

iii. 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.

iv. Coverage under the policy after the expiry of number of months (as mentioned in Policy Schedule) for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

5.2 Specific waiting period (Code:Excl02)

i. Expenses related to the treatment of the listed Conditions; surgeries/treatments shall be excluded until the expiry of 24 months as (mentioned in Policy Schedule) of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

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

iii. 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.

iv. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

v. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

24 Months waiting period.

1. Benign ENT disorders
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumors, 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

5.3 First 30 days waiting period – Code – Excl03 :

i. Expenses related to the treatment of any Illness within 30 days from 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 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.

SECTION 6: SPECIFIC CONDITIONS APPLICABLE FOR PERSONS WITH HIV-AIDS

The Company will indemnify the Reasonable and Customary Charges for any Medical Condition which requires Inpatient Hospitalization of the Insured Person, up to the sum insured opted as mentioned in the Policy Schedule, provided,

Conditions

i. The CD4 count of the patient is above 500

ii. This cover will exclude cost for any Anti-Retroviral Treatment.

iii. In case the CD4 count of insured is/goes below 150, then we will pay 50% of Sum insured or the balance sum insured available under the policy, whichever is lower, as lumpsum amount to the insured. This payment will trigger only if the CD4 count of insured is/goes below 150 after a waiting period of 90 days from commencement of policy.

iv. The claim under point (iii) mentioned above shall be payable once in the lifetime of the Insured Person and shall not be necessarily linked to an Inpatient Hospitalization claim made under the policy.

v. On payment of such claim (lumpsum amount), the policy shall cease for the insured person, if only HIV/AIDS is covered under the policy and will not be available for renewal in the subsequent year.

vi. Any claims made under this benefit shall reduce the sum insured.

vii. In case specific conditions mentioned under section 6 and section 7 both are applicable to any single individual i.e. both Disability and HIV/AIDS are covered under the policy, then On payment of a claim (lumpsum amount) as given under point iii above, the policy shall cease for the insured person in respect of HIV/AIDS cover and may not be available for renewal in the subsequent year for HIV/AIDS cover. The remaining 50% sum insured or balance sums insured shall be available for Disability cover and all illnesses other than HIV/AIDS during the policy period. Such policy can be renewed for covering Disability at subsequent renewal as per the premium applicable for Disability cover only.

viii. Our maximum liability for all claims made under the policy during the policy year shall be restricted to the sum insured amount as specified in the policy schedule.

SECTION 7: EXCLUSIONS

7.1 Standard Exclusions

1. Investigation & Evaluation- Code- Excl04

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

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

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.

3. Obesity/ Weight Control: Code- Excl06

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1) Surgery to be conducted is upon the advice of the Doctor.

2) The surgery/Procedure conducted should be supported by clinical protocols.

3) The member must 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 Apnoea

iv. Uncontrolled Type2 Diabetes

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.

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.

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.

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.

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

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

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**

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**

12. Refractive Error: Code - Excl15

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

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.

14. Sterility and Infertility: Code - Excl17

Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, sterilization

(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

15. Maternity: Code Excl18

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy.

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

7.2 Specific Exclusions

1. Any medical treatment taken outside India.
2. Hospitalization for donation of any body organs by an Insured including complications arising from the donation of organs.
3. Nuclear damage caused by, contributed to, by or arising from ionising radiation or contamination by radioactivity from:
   a. Any nuclear fuel or from any nuclear waste; or
   b. From the combustion of nuclear fuel (including any self-sustaining process of nuclear fission);
   c. Nuclear weapons material.
   d. Nuclear equipment or any part of that equipment.
4. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.
5. Injury or Disease caused by or contributed to by nuclear weapons/materials.
6. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or as may be necessitated due to an accident.
7. Treatment with alternative medicines or Treatment, experimental or any other treatment such as acupuncture, acupressure, magnetic, osteopath, naturopathy, chiropractic, reflexology and aromatherapy.
8. Suicide, Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) and any violation of law or participation in an event/activity that is against law with a criminal intent.
9. Vaccination or inoculation except as post bite treatment for animal bite.
10. Convalescence, general debility, "Run-down" condition, rest cure, Congenital external illness/disease/defect.
11. Outpatient diagnostic, medical and surgical procedures or treatments, non-prescribed drugs and medical supplies, hormone replacement therapy and expenses related to Domiciliary hospitalization shall not be covered.
12. Dental treatment or Surgery of any kind unless requiring Hospitalisation as a result of accidental Bodily Injury.
13. Venereal/ Sexually Transmitted disease
14. Stem cell storage.
15. Any kind of service charge, surcharge levied by the hospital.
16. Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.
17. Non-Payable items: The expenses that are not covered in this Policy are placed under List-I of Annexure-II
18. Any medical procedure or treatment, which is not medically necessary or not performed by a Medical Practitioner.

SECTION 8: GENERAL TERMS AND CONDITIONS

8.1 Standard terms & Conditions

I. Condition Precedent to the contract

1. Disclosure of Information

The Policy shall be void and all premiums paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description, or non-disclosure of any Material Fact by the Insured Person.

2. Condition Precedent to Admission of Liability

The Due observance and fulfillment of the terms and conditions of the Policy, by the Insured Person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the Policy.

3. Claim Settlement (provision for Penal interest)

i. The Company shall settle or reject a claim as the case may be, 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 to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

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 earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

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

4. Complete Discharge

Any payment to the Insured Person or his/her nominees or his/her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim

5. Multiple Policies

i. In case of multiple policies taken by an Insured person during a period from the same or one or more insurers to indemnify treatment costs, the insured person 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 chosen by the insured person 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

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

iii. If the amount to be claimed exceeds the Sum Insured under a single policy, the Insured Beneficiary shall have the right to choose Insurer from whom he/she wants to claim the balance amount.

iv. Where an Insured person has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

v. Under this product, no insured can take more than one policy from any or all insurers.

vi. In case of this product, the maximum liability of all policies put together from all insurers cannot exceed the maximum sum insured under this product.

6. Fraud

If any claim made by the Insured Person, is any respect of 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.

7. Cancellation

The Insured may cancel this Policy by giving 15days' 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%
91 days to 180 days	25.00%
181 days to 365 days	0.00%

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 You under this Policy.

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.

8. 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 5 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 insured and accrued bonus (as part of the sum insured), migration benefit shall not apply to any other additional increased Sum Insured.

iii. Migration under this product shall be allowed only due to withdrawal of the product subject to IRDAI Regulations

For Detailed Guidelines on Migration, kindly refer the link -

https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

9. Portability

The Insured Person will have the option to port the Policy to same product of other insurers as per extant Guidelines related to portability, If such person is presently covered and has been continuously covered without any lapses under this 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 5 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 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/whatsNew_Layout.aspx?page=PageNo3987&flag=1

10. 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.

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.

11. Premium Payment in Instalments

If the insured person has opted for Payment of Premium on an instalments 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 installment premium due for the Policy.

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

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 installment premium is not paid on due date.

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

12. Moratorium Period

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called

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

13. 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 (3) months before the changes are affected.

14. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals of the Policy. The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

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

15. Redressal of Grievance

Grievance—In case of any grievance relating to servicing the Policy, the insured person may submit in writing to the Policy issuing office or regional office for redressal.

For details of grievance officer, kindly refer the link http://ecoi.co.in/ombudsman.html

IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

Insurance Ombudsman —The insured person many also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Annexure-I

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

16. Nomination

The policy holder 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 policy holder. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the Insured Person, the Company will pay the nominee (as named in the Policy Schedule/ endorsement (if any)) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Insured Person whose discharge shall be treated as full and final discharge of its liability under the Policy.

8.2 Specific Conditions

I. Condition Precedent to the contract

a. Arbitration clause

i. If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independent of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties thereto, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of 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 who shall act as the presiding arbitrator 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 referable to arbitration, as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

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

b. Change of Sum Insured

Sum Insured can be changed (increase / decrease) only at the time of Renewal or at any time, subject to underwriting by the Company. For any increase in Sum Insured, the waiting period shall start afresh only for the enhance portion of the Sum Insured.

c. Material Change

The Insured Person 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.

d. Notice and 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/certificate of insurance.

e. 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 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.

f. 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.

g. Eligibility Criteria

i. All Persons with Disability who have at least one of the disabilities as defined under Specified Disability under The Rights Of Persons With Disabilities Act, 2016 with valid disability certificate are eligible to enroll this product.

ii. Any person suffering from HIV/AIDS, with diagnostic test

report confirming the evidence of HIV/AIDS with minimum eligibility CD4 count 500 and above, during inception of the policy.

II. Conditions applicable during the contract

a. Alterations in the Policy

The Proposal Form, Policy Schedule constitute the complete contract of insurance. This Policy constitutes the complete contract of insurance between the Policyholder and the Company. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement, signed, and stamped by Company. All endorsement requests will be made by the Insured Person only. This Policy cannot be changed by anyone (including an insurance agent or broker) except the Company.

b. Revision and Modification of the Policy Product-

i. Any revision or modification will be done with the approval of the Authority. We shall notify You about revision /modification in the Policy including premium payable thereunder. Such information shall be given to You at least ninety (90) days prior to the effective date of modification or revision coming into effect.

ii. Existing Policy will continue to remain in force till its expiry, and revision will be applicable only from the date of next renewal. Credit of continuity/waiting periods for all the previous policy years would be extended in the new policy on Renewal with Us.

c. Terms and conditions of the Policy

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

SECTION 9: CLAIM PROCEDURE

9.1 Procedure for Cashless claims:

i. Treatment may be taken in a network provider and is subject to preauthorization by the Company or its authorized TPA,

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

iii. The Company/ TPA 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 / TPA 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 / TPA for reimbursement.

9.2 Procedure for reimbursement of claims:

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

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

9.3 Notification of Claim

Notice with full particulars shall be sent to the Company/TPA (if applicable) 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.

9.4 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

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/invoices of the Implants, wherever applicable.

x. MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, wherever 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/TPA for assessment of the claim.

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

4. In case of lumpsum payment for HIV/AIDS, Insured will need to submit the below mentioned documents for the processing of Claim:

   a. Identity proof of the claimant

   b. Dully filled Claim form

   c. Copy of Hospital summary/Discharge card/treatment advise / medical reference

   d. Copy of Medical reports/records

   e. Copy of Investigation reports

   f. Medical Practitioner's certificate

   g. Any other relevant document as requested by the Insurer.

   h. On receipt of claim documents from Insured

Insurer shall assess the admissibility of claim as per Policy terms and conditions. Upon satisfactory completion of assessment and admission of claim, the Insurer will make the payment of benefit as per the contract. In case if the claim is repudiated Insurer will inform the Insured about the same in writing with reason for repudiation.

9.5 Pre-Policy Medical Check up

All the proposed insured Person are required to undergo mandatory Pre-Policy Medical Check-up across all ages and Sum insured. The Company shall bear 50% of pre-policy medical check-up in case of acceptance of proposal. In case of rejected proposals or where a revised offer is not accepted by the customer, the cost for such tests will be bear by the customer.

9.6 Co-payment

Each and every claim under the Policy shall be subject to a Co-payment of 20% 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.

This co-payment can be waived off by paying an additional premium(optional).

9.7 Services Offered by TPA

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

The services offered by a TPA shall not include:

i. Claim settlement and claim rejection.

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

9.8 Payment of Claim

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

SECTION 10: TABLE OF BENEFITS

Name	Model Policy for Reliance General Insurance Co. Ltd.
Coverage Basis	Individual basis only
Category of Cover	Indemnity
Sum insured	On Individual basis - SI shall apply to each individual member
Sum insured available(in INR)	4 lacs and 5 lacs
Policy Period	1 Year
Eligibility	Policy can be availed by availed on Individual basis. Age eligibility for adults: 18 years to 55 years Age eligibility for Children: 1 year to 17 years
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.
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 in respect of Day Care Treatment.
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/ Medical Practitioner`s fee	1. Room Rent, Boarding, Nursing Expenses all-inclusive as provided by the Hospital/ Nursing Home up to maximum of 1% of the sum 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 maximum of 2% of the sum insured per day.
Cataract Treatment	Up to Rs.40,000/-, per each eye in one policy year
Modern Treatment	Covered for listed procedures up to 50% of sum insured available for Inpatient Hospitalisation Care
Emergency Ground Ambulance	Expenses covered up to Rs. 2000 per hospitalisation
AYUSH	Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered up to 50% of 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.
Initial Waiting period	30 days for all claims except resulting from Accident and 90 days for lumpsum benefit under Section 7
PED waiting period	48 months (For pre-existing diseases other than the pre-existing Disability and HIV/ AIDS covered)
Specific Disease/ illness waiting period	24 months
Waiting Period and specific Sublimit for HIV AIDS Cover	For HIV/AIDS cover: a. Initial waiting period of 30 days will be applicable for Indemnity basis cover and 90 days shall be applicable for Benefit basis cover b. Sum Insured would be available for Hospitalisation Expenses as per terms and conditions of the policy. c. In case the CD4 count of insured is/goes below 150, then we will pay 50% of Sum insured or the balance sum insured available under the policy, whichever is lower, as lumpsum amount to the insured. d. The claim mentioned above shall be payable once in the lifetime of the Insured Person and shall not be necessarily linked to an Inpatient Hospitalisation claim made under the policy. e. On payment of such claim (lumpsum amount), the policy shall cease for the insured person and may not be available for renewal in the subsequent year.

Waiting Period and specific Sublimit for Disability Cover	For Disability Cover: a. 24 months initial waiting period is applicable for the pre-existing Disability covered under the policy. b. In case of Life-threatening emergency arising for the pre-existing disability covered, 25% of Sum insured will be available for the treatment of same from 3rd year onwards. c. In case of Life-threatening emergency arising for the pre-existing disability covered, 50% of Sum insured will be available for the treatment of same from 4th year onwards or any subsequent continuously renewed policy year.
Co-pay	20% on all claims made under the policy unless waiver for Co-pay is opted and premium is paid for the same

SECTION 11: PREMIUM RATE & ILLUSTRATION

Please refer to the premium chart attached herewith.

SECTION 12: CONTACT US

For any product or service related information or assistance, here's how you can reach us.

SMS To reach us **SMS 'protect'** to **55454**

Contact details for Policy Servicing	**Contact details for Claim Servicing**
Name: Reliance General Insurance Company Limited Correspondence Address: Reliance General Insurance, Winway Building 2nd & 3rd Floor, 11/12 Block No-4, Old no-67, South Tukoganj, Indore(M.P) -452001 Email ID: rgicl.services@relianceada.com Contact No.: 022-41112600 Website: www.reliancegeneral.co.in	Name: Reliance General Insurance Company Limited Correspondence Address: RCare Health: Claims and care management Reliance General Insurance Co. Limited, No. 1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire Building, Madhapur, Hyderabad - 500081 Near Durgam Cheruvu Metro Station. Contact No.: 022 - 41112600 Website: www.reliancegeneral.co.in

SECTION 13: 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 our insurance advisor if you require any further information or clarification.

SECTION 14: STATUTORY WARNING

Section 41 of Insurance Act 1938 (Prohibition of Rebates)

i. 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 life 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.

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