Cancer Insurance Policy

1. PREAMBLE

1.1. This Policy is a contract of insurance issued by Raheja QBE General Insurance Company Limited (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the 'Insured Persons'). The policy is based on the statements and declaration provided in the proposal Form by the proposer (which are to form part of the contract of insurance) and Disclosure to Information Norm, Raheja QBE has agreed to issue this Policy and is subject to receipt of the requisite premium.

1.2. This Policy is being issued to record the said terms and conditions mentioned hereinafter.

2. OPERATIVE CLAUSE

2.1. Subject to the terms, conditions and exclusions contained hereinafter, if the Insured during the Period of Insurance specified in the Schedule, is diagnosed with Cancer and if this requires diagnostic investigation or treatment by a duly qualified Medical Practitioner, Raheja QBE shall pay to the Insured:

2.1.1. 50% of the Sum Insured or Rs. 250,000.00 whichever is less, as a lump sum amount on the acceptance of a claim under the Policy; and

2.1.2. Reasonable Charges for Medical Expenses actually incurred by the Insured in the diagnostic investigation or medical treatment on the Medical Advise of a Medical Practitioner of Cancer, in excess of 75% of the benefit amount paid in accordance with Clause 2.1.1, as indemnities.

2.2. The total liability of Raheja QBE under this Policy for any and all claims made in respect of the Insured is restricted to the Sum Insured mentioned in the Schedule.

2.3. Reimbursement of Medical Expenses will be based on submission of original bills only, unless the Insured has already submitted a claim and the original bills under any insurance policy with any other Indian insurance company in which case Raheja QBE will accept certified true copies of the bills from the Insured provided that written documentation from the Indian insurance company is provided confirming its liability under its insurance policy issued to the Insured for that claim and that it has received the original bills from the Insured.

2.4. If an Insured is diagnosed as suffering from Cancer and reports the claim during the Period of Insurance, he/she can continue to receive benefits under the Policy up to the Sum Insured limit even after the expiry of the Policy for up to 5 years from the inception of the Policy.

2.5. The Insured for the purposes of this Policy shall mean the Insured specified in the Schedule only.

3. Scope of Cover

3.1. The Policy is valid for a period of one year from the date of commencement specified in the Schedule unless the Policy is renewed for subsequent periods of one year in accordance with the terms of Clause 6.

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3.2. If after the waiting period of thirty days and thereafter during the currency of the Policy, or subsequent renewals, if the Insured, contracts Cancer or is suspected of having contracted Cancer and makes an initial claim under the Policy, the Policy shall be deemed to have been invoked and the liability of Raheja QBE shall continue to the extent of the Sum Insured

3.3. CUMULATIVE BONUS: If no claims have been made for a Period of Insurance and the Policy is subsequently renewed in accordance with the terms of the Policy, Raheja QBE will increase the amount payable towards Reasonable Charges for Medical Expenses per Clause 2.1.2 by 5% for the immediately following Period of Insurance provided that the Cumulative Bonus over all Periods of Insurance shall not exceed 25%.

3.4. The earned Cumulative Bonus will not be lost if the Policy is renewed within the 30 day Grace Period specified in Clause 6.

4. Claims Process

4.1. Notification of Claims: A notice of claim shall be served upon Raheja QBE or its TPA within a period of 30 days of the happening of any event which gives rise to a claim under the Policy with full particulars. The TPA details are attached with this Policy document. It is agreed and understood that Raheja QBE retains the right to change the TPA during the Period of Insurance. It is further agreed and understood that Raheja QBE will inform the Insured in writing of any change in TPA at least 30 days before such change shall come into force.

4.2. Proof of Claims: The claim shall be substantiated in full with all necessary supporting documents including but not limited to the following as a Condition Precedent to the consideration of the claim by Raheja QBE:

4.2.1. Raheja QBE's claim form which shall be duly completed;

4.2.2. All original diagnostic, investigative and treatment reports;

4.2.3. All original of bills and receipts of tests carried out and treatment taken;

In respect of Clauses 4.2.2 and 4.2.3 above, if the Insured has already submitted a claim and the original reports, bills or receipts under any insurance policy with any other Indian insurance company Raheja QBE will accept certified true copies of the reports, bills and receipts from the Insured provided that written documentation from the Indian insurance company is provided confirming its liability under its insurance policy issued to the Insured for that claim and that it has received the original reports, bills and receipts from the Insured.

4.2.4. All original/certified copies of prescriptions of doctors

4.2.5. Hospital case records and Discharge Ticket, if treatment taken there.

4.2.6. any other necessary information or documentation sought by Raheja QBE or its TPA on its behalf.

4.3. The claim and the requisite information, particulars and documents in respect of and pertaining to a claim shall be submitted within 15 days of notification of the claim.

4.4. Raheja QBE may request the Insured to undergo a medical examination by a Medical Practitioner that is an oncologist. The cost for this examination will be borne by Raheja QBE

4.5. Acceptance and Payment of Claims: It is agreed and understood that:

4.5.1. If a claim is accepted, the payment of the due amount shall be made within 30 days from the date of acceptance of the claim.

4.5.2. Claims shall be paid by Raheja QBE or through its TPA only in Indian currency to the Insured or his/her legal heir for claims pertaining to diagnosis, investigation and medical/surgical treatment for Cancer, taken entirely within India only.

4.6. Claim for reimbursement of Reasonable Charges of Medical Expenses incurred may be submitted by the Insured to Raheja QBE or the TPA on a quarterly basis along with the information and documentation specified in Clause 4.2 above.

4.7. In the event the intimation of the claim in not within the time line specified at Clause 4.1 and is delayed due to reasons which are proven to be genuine and for reasons beyond the control of the claimant, Raheja QBE may condone such delay and process the claim. It is agreed and understood that Raheja QBE reserves the right to decline any such requests for processing a claim where there is no genuine reason for a delayed claim.

5. Exclusions

5.1. First 30days Waiting Period

- No claim, however, shall be payable on any account whatsoever, if the Insured is diagnosed with Cancer within a period of thirty days from the commencement of the initial Period of Insurance specified in the Schedule.

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

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

5.2. Nuclear, chemical or biological attack as define below.

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.

5.3. Raheja QBE shall not be liable for making any payment under the Policy for any cancer or cancer related condition which is a Pre – Existing Disease. All Insureds above the age of 65 years to whom cover under this insurance is extended by Raheja QBE after medical examination and confirmation of no Cancer that is a Pre – Existing Disease in the proposal form and are later on detected with Cancer in advanced stages will not be denied cover on the basis of the disease being a Pre – Existing Disease .

5.4. Raheja QBE shall not be liable to make any payment under the Policy for any costs or expenses incurred on AYUSH treatments.

5.5. This Policy will not be renewed for an Insured once a claim in is admitted under this Policy.

5.6. No claim shall be payable under this Policy unless the diagnostic investigation reveals positive existence or presence of Cancer. Raheja QBE reserves its right to ask the Insured to present himself/herself for examination by a Medical Practitioner who is an oncologist for acceptance a claim under this Policy.

6. 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. The Policy will not be renewed for an Insured once a claim in is admitted under this Policy.

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 of 30days to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.

iv. If not renewed within Grace Period of 30days after due renewal date, the Policy shall terminate.

7. Standard General Terms and Clauses:

7.1 Disclosure of Information-

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

(Explanation: “Material facts” for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk).

7.2 Condition Precedent to Admission of Liability-

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

7.3 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 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.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

(Note to Insurers: The Clause shall be suitably modified by the insurer based on the amendment(s), if any to the relevant provisions of Protection of Policyholder's Interests Regulations, 2017)

7.4 Complete Discharge

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

7.5 Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, within tent 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.

7.6 Cancellation

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

Not with standing anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

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

The Insured would be entitled to a return of premium at Raheja QBE's short period scales as mentioned in the table below, for the period the Policy had been in force.

For a period not exceeding	15 days	Full Annual Premium
-do-	1 month	85% of the Annual Premium
-do-	2 months	80% of the Annual Premium
-do-	3 months	75% of the Annual Premium40
-do-	4 months	70% of the Annual Premium
-do-	5 months	60% of the Annual Premium
-do-	6 months	50% of the Annual Premium
-do-	7 months	40% of the Annual Premium
-do-	8 months	30% of the Annual Premium
-do-	9 months	15% of the Annual Premium
For a period exceeding	9 months	10% of the Annual Premium specified in the Schedule (Annual Premium)

7.7 Portability:

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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 6 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 …http://www.rahejaqbe.com/health-insurance

7.8 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 6 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…. http://www.rahejaqbe.com/health-insurance

7.9 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.

7.10 Withdrawal of Policy

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

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.**7.11 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.

7.12 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

7.13. 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 thelegal 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.

7.14. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.6.17. **7.15. 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.

7.16. 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.

7.17 REDRESSAL OF GRIEVANCE

In case of any grievance the insured person may contact the company through

Website: www.rahejaqbe.com

Toll free: 1800-102-7723 (Toll Free)

E-mail: complaints@rahejaqbe.com

Fax : 022- 42313777

Courier: Any branch office or the correspondence address, during normal business hours

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at The Grievance Cell,

Raheja QBE General Insurance Company Limited

Ground Floor, P & G Plaza, Cardinal Gracious road,

Chakala, Andheri (East), Mumbai - 400 099, India

Toll free: 1-800-102- (RQBE) 7723

E-mail customercare@rahejaqbe.com

Telephone : 1800-102-7723 (Toll Free - 9 Am to 8 PM, Monday to Saturday)

022- 4171 5050

For updated details of grievance officer, kindly refer the link …http://www.rahejaqbe.com/health-insurance

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

7.18 Insurance Ombudsman –If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Annexure-B. [Insurers to take note of the change in domain of the email ids mentioned at Annexure – B, the domain may be changed from gbic.co.in to ecoi.co.in. Insurers are further advised to note the revised details of insurance ombudsman as and when amended as available in the website http://ecoi.co.in/ombudsman.html and ensure that updated details are prospectively incorporated in the policy documents for the information of the policyholders.]

8. **Cancer Definition-**

CANCER means a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissue. CANCER also includes leukemia and malignant diseases of the lymphatic system such as Hodgkin's disease. Cancer shall also include 'Carcinoma in situ' with a probability of progression into invasive carcinoma.

Cancer does not include Kaposi's Sarcoma or any other malignant tumor in the presence of any Human Immuno-deficiency virus;

9. Other Definitions

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

9.1. Age means age of the Insured person on last birthday as on date of commencement of the Policy.

9.2 Break in Policy means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof

9.3 Condition Precedent means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

9.4 Congenital Anomaly refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
a) Internal Congenital Anomaly Congenital anomaly which is not in the visible and accessible parts of the body.
b) External Congenital Anomaly Congenital anomaly which is in the visible and accessible parts of the body.

9.5 Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

9.6 Day Care Centre means any institution established for day care treatment of disease/ injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:
i. has qualified nursing staff under its employment;
ii. has qualified medical practitioner (s) in charge;
iii. has a fully equipped operation theatre of its own where surgical procedures are carried out
iv. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

9.7 Day Care Treatment means medical treatment, and/or surgical procedure which is:
i. undertaken under general or local anesthesia in a hospital/day care centre in less than twenty four hours because of technological advancement, and
ii. which would have otherwise required a hospitalisation of more than twenty four hours.
Treatment normally taken on an out-patient basis is not included in the scope of this definition.

9.8 Disclosure to information norm: 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.

9.9 Emergency Care: Emergency care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

9.10 Grace Period means specified period of time immediately following the premium due date

during which a payment can be made to renew or continue the Policy in force without loss of continuity benefits such as waiting period and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

9.11 Hospital means any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:
i. has qualified nursing staff under its employment round the clock;
ii. has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;
iii. has qualified medical practitioner (s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out
v. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

9.12 Hospitalisation means admission in a hospital for a minimum period of twenty four (24) consecutive 'In-patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.

9.13 Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.
i. Acute Condition means a disease, illness or injury that is likely to response quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
ii. Chronic Condition means a disease, illness, or injury that has one or more of the following characteristics
a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
b) it needs ongoing or long-term control or relief of symptoms
c) it requires rehabilitation for the patient or for the patient to be special trained to cope with it
d) it continues indefinitely
e) it recurs or is likely to recur

9.14 Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a medical practitioner.

9.15 In-Patient Care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

9.16 Insured Person means person(s) named in the schedule of the Policy.

9.17 Intensive Care Unit means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

9.18 ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

9.19 Medical Advice means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

9.20 Medical Expenses means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of illness or accident on the advice of a medical

practitioner, as long as these are no more than would have been payable if the insured person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

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

9.22 Medically Necessary Treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which
i. is required for the medical management of illness or injury suffered by the insured;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. must have been prescribed by a medical practitioner;
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

9.23 Migration means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

9.24 Notification of Claim means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

9.25 Out-Patient (OPD) Treatment means treatment in which the insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a medical practitioner. The insured is not admitted as a day care or in-patient.

9.26 Pre-Existing Disease (PED): Preexisting disease means any condition, ailment, injury or disease
a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or
b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.
c) A condition for which any symptoms and or signs if presented and have resulted within three months of the issuance of the policy in a diagnostic illness or medical condition.

9.27 Policy means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured person

9.28 Policy period means period of one policy year as mentioned in the schedule for which the Policy is issued

9.29 Policy Schedule means the Policy Schedule attached to and forming part of Policy

9.30 Policy year means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule

9.31 Portability means the right accorded to an individual health insurance policyholder (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

9.32 Qualified Nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

9.33 Renewal: Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

9.34 Room Rent means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

9.35 Sum Insured means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.

9.36 Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

9.37 Third Party Administrator (TPA) means a Company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

9.38 Waiting Period means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

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	SPIROMETRE
36	STEAM INHALER
37	ARMSLING
38	THERMOMETER
39	CERVICAL COLLAR
40	SPLINT
41	DIABETIC FOOT WEAR
42	KNEE BRACES (LONG/ SHORT/ HINGED)
43	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
44	LUMBO SACRAL BELT
45	NIMBUS BED OR WATER OR AIR BED CHARGES
46	AMBULANCE COLLAR
47	AMBULANCE EQUIPMENT

48	ABDOMINAL BINDER
49	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
50	SUGAR FREE TABLETS
51	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
52	ECG ELECTRODES
53	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
54	KIDNEY TRAY
55	OUNCE GLASS
56	PELVIC TRACTION BELT
57	PAN CAN
58	TROLLY COVER
59	UROMETER, URINE JUG

List II – Items that are to be subsumed into Room Charges

Sl No	**Item**
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	CRADLE CHARGES
4	COMB
5	EAU-DE-COLOGNE / ROOM FRESHNERS
6	GOWN
7	SLIPPERS
8	TISSUE PAPER
9	TOOTH PASTE
10	TOOTH BRUSH
11	BED PAN
12	FLEXI MASK
13	HAND HOLDER
14	SPUTUM CUP
15	DISINFECTANT LOTIONS
16	LUXURY TAX
17	HVAC
18	HOUSE KEEPING CHARGES
19	AIR CONDITIONER CHARGES
20	IM IV INJECTION CHARGES
21	CLEAN SHEET
22	BLANKET/WARMER BLANKET
23	ADMISSION KIT
24	DIABETIC CHART CHARGES
25	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
26	DISCHARGE PROCEDURE CHARGES
27	DAILY CHART CHARGES
28	ENTRANCE PASS / VISITORS PASS CHARGES
29	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
30	FILE OPENING CHARGES
31	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
32	PATIENT IDENTIFICATION BAND / NAME TAG
33	PULSEOXYMETER CHARGES

List III – Items that are to be subsumed into Procedure Charges

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

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

Annexure B - List of Insurance Ombudsmen

The contact details of the **Insurance Ombudsman** offices are as below-

Areas of Jurisdiction	**Office of the Insurance Ombudsman**
Gujarat , UT of Dadra and Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, JeevanPrakash Building, 6th floor, TilakMarg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka	Office of the Insurance Ombudsman, JeevanSoudhaBuilding,PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road,JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab , Haryana, Himachal Pradesh, Jammu and Kashmir, UT of Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in
Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in
Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, JeevanNivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh, Telangana and UT of Yanam	Office of the Insurance Ombudsman,

– a part of the UT of Pondicherry	6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Rajasthan	Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
Kerala , UT of (a) Lakshadweep, (b) Mahe – a part of UT of Pondicherry	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam-682015. Tel.: 0484 - 2358759/2359338 Fax: 0484-2359336 Email: bimalokpal.ernakulam@ecoi.co.in
West Bengal, UT of Andaman and Nicobar Islands, Sikkim	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, JeevanSevaAnnexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in
State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in
Bihar, Jharkhand.	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road,

	Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	Office of the Insurance Ombudsman, JeevanDarshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in