SCHEME DOCUMENT

Customized exclusively for the registered customers of RBL BANK LIMITED

ABOUT CARE HEALTH INSURANCE LIMITED

CARE Health Insurance Limited is focused on the delivery of health insurance services. Our promoter's expertise in the spectrum of financial services, healthcare delivery and preventive health solutions, coupled with a robust distribution model, offers us a unique edge to deliver and excel in a business environment that hinges on serviceability and scale. Powered by the best-in-class product design and a customer centric approach, CARE Health Insurance Limited is committed to delivering on its innate values of being a responsible, trustworthy and innovative health insurer. CARE Health Insurance Limited is promoted by strong entities- Religare Enterprise & Union Bank of India.

POLICY CONDITIONS & BENEFITS

Particulars	***Description***
Coverage Details	
Cover Type	Individual/Floater
Relationship Type	Self/Spouse/3 Dependent Children
Entry Age - Min	Adult: 18 years Child:91 Days
Entry Age - Max	Adult: 65 years Child: 24 years
Exit Age	Adult: Lifelong* Child:25 years
Pre-policy Medical Check-up	NO, Good health declaration basis
Membership	**Registered Credit Card Customers of RBL Bank Limited**
Policy Tenure	1 Year
Claims payout	HE :- Cashless(within network)/ Re-imbursement HS_OPD :- Cashless only
Claims Servicing	In - house
Covered Benefits	
Hospitalization Expenses :-	
Sum Insured (SI) in Rs.	5Lacs/ 7 Lacs / 10 Lacs/ 20 Lacs/ 30 Lacs/ 40 Lacs/ 50 Lacs
In - patient care	Up to SI
Day Care Treatment	Up to SI
Pre-hospitalization Medical expenses	30 days
Post-hospitalization Medical expenses	60 days
Domestic Road Ambulance	Up to Rs.1,500 per hospitalization
Donor Expenses	Up to SI
Alternative Treatments (IPD basis)	Up to Rs 20,000
Health Check-up	Once per adult per policy year
Domiciliary Hospitalization	Up to 10% of SI; if it continues for a period exceeding 3 consecutivedays
Add on Coverage	
NCB	**Up to 10% of SI every claim free year maximum up to 50%**
Automatic Recharge	**Up to 100% of SI**

Doctors on calls	**Covered GP only**
OPD Coverage Amount :-	**Up to 5000**
Consultancy	Up to SI
Diagnostics	Up to SI
Pharmacy	Up to 25% of SI
Wait Period	
30 Days	Yes (except for Injuries/Accident)
Named Ailment (as defined in Group Care 360 Product)	24 Months
Pre-existing diseases	24 Months
Sub-limits	
On Room Rent	Single Private Room
ICU charges	No limit

List of Test
Complete Blood Count, Urine Routine, Blood Group, ESR, Fasting Blood Glucose, S Cholesterol, SGPT, Creatinine

Policy Terms and Conditions

Preamble: The proposal and declaration given by the proposer and other documents if any shall form the basis of this Contract and is deemed to be incorporated herein. The two parties to this contract are the Policy Holder/Insured Members (also referred as Insured) and Care Health insurance Ltd. (also referred as Religare Health Insurance Company), and all the Provisions of Indian Contract Act, 1872, shall hold good in this regard. The references to the singular include references to the plural; references to the male include the references to the female; and references to any statutory enactment include subsequent changes to the same and vice versa. The sentence construction and wordings in the Policy documents should be taken in its true sense and should not be taken in a way so as to take advantage of the Company by filing a claim which deviates from the purpose of Insurance.

In return for premium paid, the Company will pay the Insured in case a valid claim is made:

In consideration of the premium paid by the Policy Holder, subject to the terms & conditions contained herein, the Company agrees to pay/indemnify the Insured Member(s)/Claimant, the amount of such expenses that are reasonably and necessarily incurred up to the limits specified against respective benefit in any Cover Period.

Policy Terms & Conditions

For the purposes of interpretation and understanding of the product the Company has defined, herein below some of the important words used in the product and for the remaining language and the words the Company believes to mean the normal meaning of the English language as explained in the standard language dictionaries. The words and expressions defined in the Insurance Act, IRDA Act, regulations notified by the Insurance Regulatory and Development Authority ("Authority") and circulars and guidelines issued by the Authority shall carry the meanings described therein. The terms and conditions, insurance coverage and exclusions, other benefits, various procedures and conditions which have been built-in to the product are to be construed in accordance with the applicable provisions contained in the product.

The terms defined below have the meanings ascribed to them wherever they appear in this Policy and, where appropriate.

Definitions

1. **Accidental / Accident** is a sudden, unforeseen and involuntary event caused by external and visible means.
2. **Act of God Perils** means and includes lightening, storm, tempest, flood, inundation, subsidence, landslide, earthquake, cyclone, tsunami, volcano and other similar calamities;
3. **Actively at Work** Refers to an employee who is actually at work on his/her eligibility date and performing each and every duty of his/her present occupation on a customary and full- time basis. An employee shall also be deemed actively at work if he/she is on annual leave and is not absent from work due to long term illness, irrecoverable condition etc. If an employee is not actively at work on his/her cover start date, he/she will not be covered.
4. **Activities of Daily Living** Applies to a member (who is eligible for cover under this policy) and who is aged at least five 5 years old who cannot perform the following activities:
   - Dressing: The ability to put on, take off, secure, and unfasten all garments and as appropriate, any braces, artificial limbs, or other surgical appliances;
   - Feeding: The ability to feed one's self once food has been prepared and made available;
   - Mobility: The ability to move indoors from room to room on level surfaces;
   - Toileting: The ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
   - Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
   - Washing: The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.
5. **Age** means the completed age of the Insured Member as on his last birthday.
6. **Alternative treatments** are forms of treatments other than treatment "Allopathy" or "modern medicine" and include Ayurveda, Unani, Sidha and Homeopathy in the Indian context.
7. **Ambulance** means a road vehicle operated by a licensed/ authorized service provider and equipped for the transport and paramedical treatment of persons requiring medical attention.
8. **Annexure** means the document attached and marked as Annexure to this Policy.
9. **Any one illness (not applicable for Travel and Personal Accident Insurance)** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
10. **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH *Medical Practitioner*(s) comprising of any of the following:
    a. Central or State Government AYUSH Hospital or
    b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
    c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH *Medical Practitioner* and must comply with all the following criterion:
       i. Having at least 5 in-patient beds;
       ii. Having qualified AYUSH *Medical Practitioner* in charge round the clock;
       iii. Having dedicated AYUSH therapy sections as required;
       iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative; and
       v. Having either Pre-entry level Certificate (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or State Level Certificate

(or higher level of certificate) under National Quality Assurance Standards (NQAS), issued by National Health Systems Resources Centre (NHSRC)

11. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such centre which is registered with the local authorities, wherever applicable, and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH *Medical Practitioner* (s) on day care basis without in-patient services and must comply with all the following criterion:
    i. Having qualified registered AYUSH *Medical Practitioner(s)* in charge;
    ii. Having dedicated AYUSH therapy sections as required;
    iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative; and
    iv. Having either Pre-entry level Certificate (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or State Level Certificate (or higher level of certificate) under National Quality Assurance Standards (NQAS), issued by National Health Systems Resources Centre (NHSRC)

12. **Assistance Service Provider** means the service provider specified in the Policy Schedule or as appointed by the Company from time to time.
13. **Cashless Facility** means a facility extended by the insurer to the Insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network Provider by the company to the extent pre-authorization approved.
14. **Certificate of Insurance** means the certificate the Company issues to an Insured Member evidencing cover under the Policy.
15. **Claim** means a demand made in accordance with the terms and conditions of the Policy for payment of the specified Benefits in respect of the Insured Member as covered under the Policy.
16. **Claimant** means a person who possesses a relevant and valid Insurance Policy which is issued by the Company and is eligible to file a Claim in the event of a covered loss.
17. **Common Carrier** means any civilian land or water conveyance or Scheduled Airline in each case operated under a valid license for the transportation of passengers for hire.
18. **Company (also referred as Insurer/We/Us)** means CARE Health Insurance Company Limited (formally known as Religare Health Insurance Co. Ltd).
19. **Condition Precedent** shall mean a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.
20. **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
21. **Co-payment** is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured.
22. **Cover End Date** means the date specified in Annexure 'A'(Certificate of Insurance) for the respective Insured Member on which the Insured Member's cover under the Policy expires.
23. **Cover Period** means the period commencing from the Cover Start Date and ending on the Cover End Date for each Insured Member as specified in Annexure 'A' (Certificate of Insurance).
24. **Cover Start Date:** means the date specified in Annexure 'A' (Certificate of Insurance) for the respective Insured Member on which the Insured Member's cover under the Policy commences.

25. **Country of Residence** means the country in which the Insured Member is currently residing and as specified in the Insured's address in the Certificate of Insurance

26. **Day Care Centre** means any institution established for day care treatment of illness and/or 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—
    (a) has qualified nursing staff under its employment;
    (b) has qualified Medical Practitioner/s in-charge;
    (c) has a fully equipped operation theatre of its own, where Day Care Treatment is carried out.
    (d) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

27. **Day Care Treatment** means medical treatment, and/ or Surgical Procedure which is:
    (a) undertaken under general or local anesthesia in a Hospital/ Day Care Centre in less than 24 consecutive hours because of technological advancement, and
    (b) which would have otherwise required a Hospitalization of more than 24 consecutive hours.
    Treatment normally taken on an out-patient basis is not included in the scope of this definition. As listed in Annexure "I"

28. **Deductible** is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.
    Note: Under this Policy, deductible for a specified number of days/hours is applicable on the following Benefits in addition to the deductible applicable on Indemnity / hospital cash benefits

29. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

30. **Dependent** means a person who is a member of the Primary Insured Member's family who is legally wedded spouse, natural or legally adopted child, dependent parents, dependent parent-in-law, dependent brothers , dependent sisters and who is named in Annexure "A" to the Policy as an Insured Member;

31. **Dependent Child** refers to a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his/her independent sources of income.

32. **Disclosure to Information Norm:** The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

33. **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home underany of the following circumstances:
    (a) The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
    (b) The patient takes treatment at home on account of non-availability of room in a Hospital.

34. **Diagnosis** means pathological conclusion drawn by a registered medical practitioner, supported by acceptable Clinical, radiological, histological, histo-pathological and laboratory evidence wherever applicable.

35. **Emergency Care (Emergency)** 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 preventdeath or serious long-term impairment of the insured member's health.

36. **Grace Period** means the specified period of time immediately following the premium due date during which payment can be made to renew or continue a Policy in force without loss of continuity benefitssuch as waiting periods and coverage of Pre-existing Diseases. Coverage is not available for the period for which no premium is received.

37. **Hazardous Activities** (or Adventure sports) means any sport or activity or Adventure sport, which is potentially dangerous to the Insured whether he is trained or not. Such sport/activity includes stunt activities of any kind, adventure racing, base jumping, biathlon, big game hunting, black water rafting, BMX stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/ pot

holing, cave tubing, rock climbing/ trekking/ mountaineering, cycle racing, cyclo cross, drag racing, endurance testing, hand gliding, harness racing, hell skiing, high diving , hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, lugging, risky manual labor, marathon running, martial arts,micro – lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/ parapenting, piloting aircraft, polo, power lifting, power boat racing, quad biking, river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo, ski jumping, ski racing, sky diving,small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting or wrestlingof any type.

38. **Hospital** (not applicable for Overseas Travel Insurance) means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with thelocal authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
    (a) has qualified nursing staff under its employment round the clock;
    (b) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
    (c) has qualified Medical Practitioner(s) in charge round the clock;
    (d) has a fully equipped operation theatre of its own where surgical procedures are carried out;
    (e) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.
39. **Hospitalization** (not applicable for Overseas Travel Insurance) means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.
40. **Immediate Family Member** means an Insured Member's lawful spouse, children only.
41. **Indemnity/Indemnify** means compensating the Policy Holder/Insured Member up to the extent of Expenses incurred, on occurrence of an event which results in a financial loss and is covered as the subject matter of the Insurance Cover.
42. **Illness** means a sickness or a disease or a pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    (a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond 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
    (b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
        I. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests;
        II. It needs ongoing or long-term control or relief of symptoms;
        III. It requires rehabilitation for the patient or for the patient to be specially trained to cope with
        IV. It continues indefinitely;
        V. It recurs or is likely to recur.
43. **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.
44. **In-patient Care** (not applicable for Overseas Travel Insurance) means treatment for which the Insured Member has to stay in a Hospital for more than 24 hours for a covered event.
45. **Insured Event** means an event that is covered under the Policy; and which is in accordance with the Policy Terms & Conditions.
46. **Insured Member (Insured)** means a person whose name specifically appears under Insured in the Annexure A or the Certificate of Insurance and is a covered group member.
47. **Intensive Care Unit (ICU)** 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.

48. **ICU Charges** or (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

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

50. **Medically Dependent** means mentally or physically disabled, unable to perform 'Activities of Daily living' without the assistance or direction of another person

51. **Medical Expenses** means those expenses that an Insured Member 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 Member had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.

52. **Medical Practitioner** (not applicable for Overseas Travel Insurance) is 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 license.
For Benefits / optional Extensions effective outside India:
Medical Practitioner means a person who holds a valid registration issued by the Medical Council/Statutory Regulatory Authority for Medical Education in that Country and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

53. **Medically Necessary** (not applicable for Overseas Travel Insurance) means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:
    (a) Is required for the medical management of the Illness or Injury suffered by the Insured Member;
    (b) Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    (c) Must have been prescribed by a Medical Practitioner;
    (d) Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

54. **Network Provider** (not applicable for Overseas Travel Insurance) means the Hospitals enlisted by an Insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured by a Cashless Facility.

55. **Nominee** means the person named in the Certificate of Insurance who is nominated to receive the benefits under this Policy in accordance with the terms of the Policy, if the Insured Member is deceased.

56. **Non-Allopathic Medical Practitioner** for the purpose of Alternative Forms of Medicine means a Medical Practitioner qualified and practicing Ayurveda or Unani or Sidha or Homeopathic forms of Medicine for treatment of Illness/Injury, and registered as per Indian Medicine Central Council Act, 1970.

57. **Non-Network Provider** means any hospital, day care centre or other provider that is not part of the network.

58. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

59. **OPD Treatment** (Out-patient Care) is one 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.

60. **Physiotherapist** refers to a person who is licensed to practice as a physiotherapist where the treatment is to take place and is recognized as a physiotherapist.

61. **Preferred Provider** means the Hospital empanelled by the Company or TPA and enlisted on the Preferred Provider Network List, specified in the Policy Schedule (and as updated by the Company from time to time). An updated list of 'Preferred Provider Network' may be obtained from the Company's website or the call centre.

62. **Policy** means these Policy Terms & Conditions, Optional Extensions (if any), the Proposal Form, Policy Schedule, Endorsements, Member List and Annexures which form part of the policy contract and shall be read together.

63. **Policy Schedule** is a Schedule attached to and forming part of this Policy.

64. **Policy Year** means a period of one year commencing on the Policy Period Start Date or any anniversary thereof.

65. **Policyholder** (also referred as You) means the person or the entity who is the Group Administrator and named in the Policy Schedule as the Policyholder.

66. **Policy Period** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date of the Policy as specifically appearing in the Policy Schedule.

67. **Policy Period End Date** means the date on which the Policy expires, as specifically appearing in the PolicySchedule.

68. **Policy Period Start Date** means the date on which the Policy commences, as specifically appearing in the Policy Schedule.

69. **Post-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days immediately after the Insured Member is discharged from the Hospital provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Insured Member's Hospitalization was required and
    ii. The inpatient Hospitalization claim for such Hospitalization is admissible by the Company.

70. **Pre-existing Diseases** means any condition, ailment, injury or disease:
    (a) That is/are diagnosed by a physician within 48 months prior to the effective date of thepolicy issued by the insurer or its reinstatement 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 issued by insurer or its reinstatement.

71. **Pre-hospitalization Medical Expenses** Means Medical Expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Member, provided that :
    i. Such Medical Expenses are incurred for the same condition for which the Insured Member's Hospitalization was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

72. **Prescription** Refers to out-patient drugs (excluding supplements, vitamins and traditional medicine) and dressings as prescribed by a medical practitioner for the treatment of a medical condition covered by your member's plan. For avoidance of doubt, prescription will not include vitamins nor supplements nor over the counter medication even if they are prescribed by a medical practitioner.

73. **Preventive Care** means any kind of treatment taken as a pro-active care measure without actual requirement or symptoms of a disease or illness.

74. **Primary Insured Member** means employee or a member of group who satisfies and continues to satisfy the eligibility criteria specified in the Certificate of Insurance and who is named in Annexure "A" to the Policy as an Insured Member.

75. **Qualified Nurse** (not applicable for Overseas Travel Insurance) is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

76. **Reasonable and Customary Charges** (not applicable for Overseas Travel Insurance) means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness/ Injury involved.

77. **Rehabilitation** means assisting an Insured Member who, following a medical condition, requires assistance in physical, vocational, independent living and educational pursuits to restore him to the position in which he was in, prior to such medical condition occurring.

78. **Renewal** defines 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.

79. **Room Rent** means the amount charged by a Hospital towards Room & Boarding expenses and shall include the associated medical expenses.

80. **Single Private Room** means an air-conditioned room in a Hospital where a single patient is accommodated and which has an attached toilet (lavatory and bath). Such room type shall be the most basic and the most economical of all accommodations available as a Single room in that Hospital.

81. **Senior Citizen** means any person who has completed sixty or more years of age as on the date of commencement or renewal of the policy.

82. **Specialized Practitioner** refers to a or practitioner who specializes in at least one of the following acupunctures, osteopathy, chiropractic or Chinese traditional medicine and is qualified and registered in the country where the out-patient treatment is to take place.

83. **Service Provider** means any person, organization, institution that has been empanelled with the Companyto provide Services specified under the benefits.

84. **Subrogation** (Applicable to other than Health Policies and health sections of Travel and PA policies) means the right of the Insurer to assume the rights of the Insured Member to recover expenses paid out under the Policy that may be recovered from any other source.

85. **Sum Insured** (Base Coverage Amount) means the amount specified against each Benefit for Member inthe Policy Schedule which represents Our maximum liability for that Insured Member for any and all Claims incurred in respect of that Insured Member during the Cover Period.

86. **Surgery/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 or prolongation of life, performed in a Hospital or a Day Care Centre by a Medical Practitioner.

87. **Third Party Administrator or TPA** means any person who is licensed under the IRDA (Third Party Administrators-Health Services) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an Insurance Company, for the purposes of providing health services.

88. **Twin Sharing Room** means a Hospital room where at least two patients are accommodated at the same time. Such room shall be the most basic and the most economical of all accommodations available as twin sharing rooms in that Hospital.

89. **Unproven/Experimental Treatment** means a treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

90. **Variable Medical Expenses** means those Medical Expenses as listed below which vary in accordance with the Room Rent or Room Category or ICU Charges applicable in a Hospital:
    (a) Room, boarding, nursing and operation theatre expenses as charged by the Hospital where the Insured Member availed medical treatment;
    (b) Intensive Care Unit charges;
    (c) Fees charged by surgeon, anesthetist, Medical Practitioner;
    (d) Investigation expenses incurred towards diagnosis of ailment requiring Hospitalization.
    Expenses related to the Hospitalization will be considered in proportion to the room rent stated inthe Policy.

91. **Medical Practitioner** means a person who holds a valid registration issued by the Medical Council/Statutory Regulatory Authority for Medical Education in that Country and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.
Refers to a person (other than you, your member, or a business partner or a relative of yours or your member) has the primary degrees in the practice of Allopathy and surgery following attendance at a recognized medical school and who is licensed to practice Allopathy by the relevant licensing authority where the treatment is given. By 'recognized medical school' we mean "a medical school which is listed in AVICENNA Directory, which is in collaboration with the World Health Organization and the World Federation for Medical Education".

92. **Network Provider** means Hospitals enlisted by an insurer or by a Assistance Service Provider together to provide services to an insured on payment by a cashless facility;

93. **Qualified Nurse** means a person who holds a valid registration issued by the Nursing Council/Statutory Regulatory Authority for Medical Education in that Country and thereby entitled to render Nursing Care within the scope and jurisdiction of license.

94. **Reasonable and customary (R&C)** means charges or treatment for medical care which shall be considered by the Company or by Company's medical advisers to be reasonable and customary to the extent that

they do not exceed the general level of charges or treatment being made by others of similar standing in the locality where the charges or treatment are incurred when giving like or comparable treatment.
If the charges are higher than customary or the treatment is not reasonable and customary, the Company will only pay the amount which is, in the Company's experience, customarily charged and Insured has to pay the rest.

Scope of Cover

If an Insured Member is diagnosed with an Illness or suffers an Injury which requires the Insured Member to be admitted in a Hospital due to Medically Necessary conditions, subject to the Coverage opted, during the Cover Year, and while the Policy in force for:

In-patient Care (Hospitalization)

The Company will indemnify the Medical Expenses incurred which are Reasonable and Customary Charges that are Medically Necessary towards In-patient Care Hospitalization of the Insured Member, maximum up to the Coverage Amount, as specified in the Certificate of Insurance, provided that the Hospitalization is for a minimum period of 24 consecutive hours and was prescribed in written, by a Medical Practitioner, where Insured is covered for hospital charges incurred for eligible treatment given between admission and discharge of hospital.

Day Care Treatment

The Company will indemnify the Medical Expenses incurred which are Reasonable and Customary Charges that are Medically Necessary towards Day Care Treatment of the Insured Member, up to the Coverage Amount specified in the Certificate of Insurance provided that:

1. the Day Care Treatment is listed as per the Annexure-I to Policy Terms & Conditions; and
2. the period of treatment of the Insured Member in Hospital/Day Care Centre does not exceed 24 hours; and
3. the Day Care Treatment was taken on the advice of a Medical Practitioner

Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses

The Company will indemnify the Insured Member for Relevant Medical Expenses incurred which are Medically Necessary, through Cashless (within network) / Re-imbursement, maximum up to the Coverage Amount, as specified in the Certificate of Insurance, provided that the Medical Expenses so incurred are related to the same Illness/Injury for which the Company has accepted the Insured Member's Claim under Hospitalization Expenses and subject to the conditions specified below:

1. Under Relevant Pre-hospitalization Medical Expenses, for a period of 30 days immediately prior to the Insured Member's date of admission to the Hospital, provided that the Company shall not be liable to make payment for any Pre-hospitalization Medical Expenses that were incurred before the Cover Start Date;
2. Under Relevant Post-Hospitalization Medical Expenses, for a period of 60 days immediately after the Insured Member's date of discharge from *the Hospital*.
3. The number of consultations covered by this benefit is limited to once per day.
4. This benefit does not cover follow-up consultation or treatment after the Insured Member is discharged from an in-patient rehabilitation facility.

Note

i. The date of admission to Hospital for the purpose of this Benefit shall be the date of the first admission to the Hospital for the Illness deemed or Injury sustained to be Any One Illness; and
ii. The date of discharge from Hospital for the purpose of this Benefit shall be the last date of discharge from the Hospital in relation to the Illness deemed or Injury sustained to be Any One Illness.

Domestic Road Ambulance

The company will indemnify for the reasonable and Customary Charges necessarily incurred on availing Ambulance services offered by a Hospital or by an Ambulance service provider up to amt. 1500/- per hospitalization, for the Insured Member's necessary transportation provided that the necessity of such Ambulance transportation is certified by the treating Medical Practitioner and subject to the conditions specified below:

(i) Such Transportation is from the place of occurrence of Medical Emergency of the Insured Member, to the nearest Hospital; and/or

(ii) Such Transportation is from one Hospital to another Hospital for the purpose of providing better Medical aid to the Insured Member, following an Emergency.

Donor Expenses

The Company will indemnify the Insured Member, through Cashless or Reimbursement Facility, up to SI, for the Medical Expenses incurred in respect of the donor, for any organ transplant surgery during the Cover Year, subject to the conditions specified below:

(i) The Organ donor is an eligible donor in accordance with The Transplantation of Human Organs Act, 1994 (amended) and other applicable laws and rules.

(ii) The Insured Member is the recipient of the Organ so donated by the Organ Donor.

(iii) The Company indemnifies for transplantation of kidneys, heart, liver, lung or bone marrow required as a result of an eligible medical condition and provided these organ(s) came from a relative or a legally certified and verified source of donation

(iv) The Company will not be liable to pay the Medical Expenses incurred by the Insured Member towards Pre-Hospitalization and Post Hospitalization Medical Expenses or any other Medical Expenses in respect of the donor consequent to the harvesting.

Alternative Treatments (IPD basis)

We will indemnify the Insured Member, Up to Rs. 20,000, towards Medical Expenses incurred with respect to the Insured Member's medical treatment undergone at any AYUSH Hospitals, through any of the alternative treatments namely Ayurveda, Sidha, Unani and Homeopathy, subject to the conditions specified below:

(i) Medical Treatment should be rendered from a registered Medical Practitioner who holds a valid practicing license in respect of such Alternative Treatments; and

(ii) Such treatment taken is within the jurisdiction of India

Health Check-up

The Company will indemnify the Insured member, once per adult per policy year, up to the amount specified in the Certificate of Insurance, for the Medical Expenses incurred in respect of that Insured Member's Health check-up tests (as specified in the Certificate of Insurance) either offered as a standard or customized package as per customer needs.

Domiciliary Hospitalization

The Company will indemnify the Insured Member, only through Reimbursement Facility, maximum up to 10% of Sum Insured, for the Medical Expenses incurred towards Domiciliary Hospitalization, i.e., Coverage extended when Medically Necessary treatment is taken at home , subject to the conditions specified below:

(i) The Domiciliary Hospitalization continues for a period exceeding 3 consecutive days.
(ii) The Medical Expenses are incurred during the Cover Year.
(iii) The Medical Expenses are Reasonable and Customary Charges which are necessarily incurred.
(iv) Any Pre Hospitalization and Post Hospitalization Medical Expenses shall not be payable under this Benefit.
(v) Any Maternity related expenses shall not be payable under this Benefit
(vi) Any Medical Expenses incurred for the treatment in relation to any of the following diseases shall not be payable under this Benefit:

1. Asthma;
2. Bronchitis;
3. Chronic Nephritis and Chronic Nephritic Syndrome;
4. Diarrhoea and all types of Dysenteries including Gastro-enteritis;
5. Diabetes Mellitus and Diabetes Insipidus;
6. Epilepsy;
7. Hypertension;
8. Influenza, cough or cold;
9. All Psychiatric or Psychosomatic Disorders;
10. Pyrexia of unknown origin for less than 10 days;
11. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis;
12. Arthritis, Gout and Rheumatism.
13. Terminal and Mental Illness

No Claim Bonus (NCB)

At the end of each claim free year, the Company will enhance the Coverage Amount under HospitalizationExpenses by 10% (as specified in Certificate of Insurance), as a No Claims Bonus for each completed and continuous claim free Cover Year, provided that no Claim has been paid by the Company in the expiring Cover Yearfor that Insured Member, and subject to the conditions specified below:

i. In any Cover Year, the accrued No Claims Bonus shall not exceed 50% of the Coverage Amount available in the renewed Policy.
ii. The No Claims Bonus shall not enhance or be deemed to enhance any Conditions as prescribed under Clause 1(j).
iii. For a Floater policy, the No Claims Bonus shall be available on Floater basis and shall accrue only if no Claim has been made in respect of any Insured Member during the expiring Cover Year. The No Claims Bonus which is accrued during the claim-free Cover Year will only be available to those Insured Members who were insured in such claim-free Cover Year and continue to be insured in the subsequent Cover Year.
iv. The entire No Claims Bonus will be forfeited if the Policy is not continued / renewed on or before Cover End Date or the expiry of the Grace Period whichever is later.
v. The No Claims Bonus shall be applicable on an annual basis subject to continuation of the Policy.
vi. If the Insured Members in the expiring policy are covered on Individual basis and thus have accumulated the No Claims Bonus for each Insured Member in the expiring policy, and such expiring policy is renewed with the Company on a Floater basis, then the No Claims Bonus to be carried forward for credit in this Policy would be the least No Claims Bonus amongst all the Insured Members.
vii. If the Insured Members in the expiring policy are covered on a Floater basis and such Insured Members renew their expiring Policy with the Company by splitting the Floater Coverage Amount in to 2 (two) or more Floater / Individual covers, then the No Claims Bonus of the expiring Policy shall be apportioned to such renewed Policy in the proportion of the Coverage Amount of each of the renewed Policy.
viii. In the event of a Claim occurring during any Cover Year, the accrued No Claims Bonus will be reduced at same rate at which it is accrued at the commencement of next Cover Year.

ix. If Claim has been reported in expiring Cover Year but No Claims Bonus has been made available by the Company in the next Cover Year and if such Claim is ultimately paid, the No Claims Bonus which is made available for that Cover Year will be reduced/recovered (in case claim amount has been paid against No Claim Bonus amount)
x. In case Coverage Amount under the Policy is reduced at the time of renewal, the applicable No Claims Bonus shall also be reduced in proportion to the Coverage Amount.
xi. In case Coverage Amount under the Policy is increased at the time of renewal, the No Claims Bonus shall be calculated on the Coverage Amount applicable on the last completed Cover Year.
xii. Accrued **'No Claims Bonus'** under this Policy can be utilized for Optional Benefit 1 (Hospitalization Expenses) and for all its benefit except for Corporate floater if opted under Hospitalization Expenses.
xiii. In case no claim is made in a particular Cover Year, No Claims Bonus would be credited automatically to the subsequent Cover year, even in case of multi-year Policies
xiv. All conditions applicable to Hospitalization Expenses will be applicable for this benefit.
xv. This benefit is not available for Employer - Employee Policies

Automatic Recharge

If a Claim is payable under the Policy, then the Company agrees to automatically make the re-instatement of up to the Coverage Amount once in a Cover Year which is valid for that Cover Year only, subject to the conditions specified below:

(i) The Recharge shall be utilized only after the Coverage Amount, No Claims Bonus, Additional Coverage Amount for Accidental Hospitalization Additional Coverage Amount for 32 Critical Illnesses has been completely exhausted in that Cover Year.
(ii) A Claim will be admissible under the Recharge only if the Claim is admissible under Hospitalization Expenses.
(iii) 'Recharge of Coverage Amount' shall be same as base Coverage Amount.
(iv) Any unutilized recharged amount cannot be carried forward to any subsequent Cover Year.
(v) If the Policy is issued on a Floater basis, then the Recharge will also be available only on Floater basis.

Doctors on calls (Covered GP Only)

Up on the Insured Member's request, the Company shall arrange for a Doctor on Call from a Medical Practitioner. The Medical Information /advice will be based only on the information and documentation provided to Medical Practitioner. This is for additional information purposes only and does not and should not be deemed to substitute the Insured Member's visit or consultation to an independent Medical Practitioner.

Note: This benefit is available only in Company's or Assistance Service Provider's network

OPD Coverage Amount

The Company will indemnify the Insured Member, up to 5000/-, towards Out-patient treatment subject to the sub limits if any, as specified in the Certificate of Insurance.

Notwithstanding anything stated under exclusion clauses, by opting for this optional Benefit, the Insured would be covered for 'Out-Patient Treatment' up to the purview of this cover. 'Day Care Treatment' which is covered under 'Hospitalization', will not be covered under this Optional Benefit.

a. Consultancy

The Company will indemnify on 'Medical Consultations' i.e. for the Out-patient Consultations taken from a Medical Practitioner and Specialist during the Cover Year, as specified in Certificate of Insurance and is limited to:

i. No. of Visits or/and
ii. Amount mentioned against this benefit.

b. Diagnostics

The Company will indemnify up to the amount as specified in the Certificate of Insurance, for the Medical Expenses incurred towards undergoing Diagnostic Tests by the Insured Member.

These diagnostic tests will be limited to computerized tomography, magnetic resonance imaging, positron emission tomography, ultrasound scans (pelvis, abdomen, thyroid gland and breast), mammogram, bone densitometry, X-rays and gait scans and laboratory & pathology tests received as part of only outpatient treatment and if claim for diagnostic tests is already made elsewhere, then for those diagnostic tests, the claim will not be payable under this benefit

Insured Member can also opt for sub-limit on amount per diagnostic visit, as specified against this Benefit in the Certificate of Insurance

c. Pharmacy

The Company will indemnify the Insured Member, up to the amount specified in the Certificate of Insurance, for Allopathic Pharma Expenses incurred in respect of that Insured Member, provided that:

(a) Any Pharmacy related expenses covered under Hospitalization, Pre-Hospitalization Medical Expenses, Post-Hospitalization Medical Expenses, will not be covered under thisOptional Benefit.

Room Rent

The Certificate of Insurance will specify the eligibility of Room Rent or Room Category applicable for the Insured Member under the Policy. Room Rent or Room Category available under this Policy is mentioned as follows:

1) If the Certificate of Insurance states 'Single Private Room' as eligible Room Category, it means the maximum eligible Room Category in case of Hospitalization of the Insured Member payable by the Company is limited to stay in a Single Private Room.

Intensive Care Unit Charges (ICU Charges):

The Certificate of Insurance will specify the Limit of ICU Charges applicable for the Insured Person under the Policy. The ICU Charges available under this Policy are as follows:

1) If the Certificate of Insurance states the eligibility of ICU Charges of the Insured Member as 'no sub-limit', it means that there is no separate restriction on ICU Charges incurred towards stay in ICU during Hospitalization

WAITING PERIODS & EXCLUSIONS

Wait Periods applicable under this Policy for All Conditions under Hospitalization Expenses are

Initial wait period

Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months. The referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

Specific Wait Period for Named Ailments

I. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with the Company. 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.

VI. List of specific diseases/procedures:

- Any treatment related to Arthritis (if non-infective), Osteoarthritis and Osteoporosis, Gout, Rheumatism, Spinal Disorders (unless caused by accident), Joint Replacement Surgery (unless caused by accident), Arthroscopic Knee Surgeries/ACL Reconstruction/Meniscal and Ligament Repair
- Surgical treatments for Benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to Adenoidectomy, Mastoidectomy, Tonsillectomy and Tympanoplasty), Nasal Septum Deviation, Sinusitis and related disorders
- Benign Prostatic Hypertrophy
- Cataract
- Dilatation and Curettage
- Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, Gastric and Duodenal Ulcers
- Surgery of Genito-urinary system unless necessitated by malignancy
- All types of Hernia & Hydrocele
- Hysterectomy for menorrhagia or Fibromyoma or prolapse of uterus unless necessitated bymalignancy
- Internal tumours, skin tumours, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant
- Kidney Stone / Ureteric Stone / Lithotripsy / Gall Bladder Stone
- Myomectomy for fibroids
- Varicose veins and varicose ulcers
- Genetic disorders
- Parkinson's or Alzheimer's disease or Dementia;

Wait Period for Pre-existing Diseases:

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 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 12 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer

CLAIMS

How to file your Claim

Our principal purpose for our existence is to ensure that Insured Members enjoy hassle-free access to best-in-class healthcare delivery facilities, and we live this objective through our seamless claim process.

Please refer to the following steps in the claim procedure to ensure smooth processing of the same

Reimbursement Process:

Step 1: Claim Intimation

It is a condition precedent to our liability under these Benefits that the following information and documentation shall be submitted to us immediately and in any event within 30 days of the event giving rise to the Claim under these Benefits:

The following information is to be provided during the claim intimation-

- Policy holder's name
- Claimant's name and customer ID
- Hospital details
- Diagnosis and treatment details
- Approximate claim amount
- Date of admission if applicable.

We will provide a reference ID for all future communication pertaining to the claim request

Step 2: Initiating the Claim process

The Claim form can be downloaded from our website www.careinsurance.com

The completed claim form has to be sent to us along with the following documents –

- Duly filled and signed claim form
- Original receipts/bills and discharge voucher of the hospital/nursing home
- Original bills of chemists supported by prescriptions
- Original Investigation reports and payment receipts
- Other case papers as mentioned in Claims Form
- Doctor consultation papers and bills
- Any other document which is required by Us to adjudicate the claim

The claim form and additional documents are to be sent to us at the following address:
CARE Health Insurance Company
Limited3rd Floor Sector, Tower C,
Vipul Tech Square, Sector-43, Golf Course
RoadGurugram-122009 (Haryana)

Step 3: Claim Processing

If your request for reimbursement of expenses is approved, you will be duly intimated by us.

In case of any information deficiency or further information requirements, you will be communicated instantly to ensure resolution of the same at the earliest

If your request for claims is declined, you will be communicated the same along with valid reason(s) for rejection. However, if the Insured Member/ Insured Member's representative has further documents to enhance/substantiate his case for claim, the same can also be sent to us; and if found rational, the case will be reopened for review of the documents and response, if any.

We will ensure that you are updated at all important stages of your claim process. To help us serve you better, please ensure the following-

- The Pre-authorization/claim form is filled completely, sincerely and truly and all the required documents are submitted along with the form and in original, wherever specified
- Retain a copy of the duly filled forms
- Please quote the member ID/reference number for all communication related to the above.

Free Look Period

- The Policyholder/Insured Member may, within 30 days from the receipt of the Policy document, return the Policy stating reasons for his objection, if the Policyholder disagrees with any Policy terms and conditions.
- If no Claim has been made during the free look period under the Policy, then CARE Health Insurance will refund the full premium through Master Policy Holder. All rights under the Policy will immediately stand extinguished on the free look cancellation of the Policy.
- Provision for Free look period is not applicable and available at the time of renewal of the Policy.

DISCLAIMER

This is only a summary of product features. The actual benefits available are as described in the policy, and will be subject to the policy Terms and Conditions. Please seek the advice of your insurance advisor if you require any further information or clarification or contact us.

STATUTORY WARNING

Prohibition of Rebates (under section 41 of Insurance Act, 1938): No person shall allow or offer to allow, either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurers. Any person making default in complying with the provision of this section shall be liable for a penalty which may extend to ten lakh rupees.

Insurance is a subject matter of solicitation.
IRDA Registration number: 148