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Guidelines on Standard Individual Health Insurance Product

INDEX

सर्वे नं. 115/1, फाइनेंशियल डिस्ट्रिक्ट, नानकरामगुडा, हैदराबाद-500 032, भारत
: +91-40-2020 4000 वेबसाइट : www.irdai.gov.in
Survey No. 115/1, Financial District, Nanakramguda, Hyderabad-500 032, India
: +91-40-2020 4000 Website : www.irdai.gov.in

To
All General and Health Insurers,

Re: GUIDELINES ON STANDARD INDIVIDUAL HEALTH INSURANCE PRODUCT

A. Preamble:

1. The health insurance market is having a number of individual health insurance products. Each product has unique features and the insuring public may find it a challenge to choose an appropriate product. Therefore, with the following objectives, the Authority has decided to mandate all general and health insurers to offer the standard individual health insurance product:
    - Insurance policy to take care of basic health needs of insuring public
    - To have a standard product with common policy wordings across the industry
    - To facilitate seamless portability among insurers

2. Towards this, the following Guidelines on Standard Individual Health Insurance Product are issued under the provisions of Section 34 (1) (a) of Insurance Act, 1938.

3. The standard product shall have the basic mandatory covers as specified in these Guidelines which shall be uniform across the market.

4. No add-ons or optional covers are allowed to be offered along with the standard product.

5. The insurer may determine the price keeping in view the covers proposed to be offered subject to complying with the norms specified in the IRDAI (Health Insurance) Regulations, 2016 (HIR, 2016)and Guidelines notified there under.

6. The Standard Product shall be offered on indemnity basis only.

7. The policy tenure of the standard product shall be for a period of one year.

8. The standard Product shall comply with all the provisions of IRDAI (Health Insurance) Regulations, 2016, all other applicable Regulations, Guidelines on Standardization in Health Insurance (Ref: IRDA/HLT/REG/CIR/146/07/2016) dated 29th July, 2016, Guidelines on Product Filing in Health Insurance Business (Ref: IRDA/HLT/REG/CIR/150/07/2016) dated 29th July, 2016, Guidelines on Standardization of Exclusions in Health Insurance Contracts (Ref: IRDAI/HLT/REG/CIR/177/09/2019) dated 27thSeptember, 2019 and other applicable Guidelines as amended from time to time.
9. Every General and Stand alone health Insurer, who has been issued a Certificate of Registration to transact General and/or Health Insurance Business, shall mandatorily offer this product.

B. Construct of Standard Health Product: The Standard Health Product shall offer the following mandatory covers.

10. **Hospitalisation Expenses:** The Hospitalisation expenses shall cover the following :
    a) Room, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to 2% of the Sum insured subject to maximum of Rs.5000/- per day.
    b) Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital.
    c) Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities, and such other similar expenses.
    (*Expenses on Hospitalisation for a minimum period of 24 hours are admissible. However, this time limit of 24 hours shall not apply when the treatment does not require hospitalisation as specified in the terms and conditions of policy contract, where the treatment is taken in the Hospitaland the Insured is discharged on the same day.*)
    d) Intensive Care Unit **(ICU)** / Intensive Cardiac Care Unit **(ICCU)** expensesup to 5% of sum insured subject to maximum of Rs.10,000/- per day.

10A.Other Expenses

a) Expenses incurred on treatment of Cataract subject to sub limits as specified under Para "C".
b) Dental treatment necessitated due to disease or injury.
c) Plastic surgery, necessitated due to disease or injury.
d) All the day care treatments.
e) Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalisation.

11. **AYUSH Treatment:** Expenses incurred on hospitalisation under AYUSH (as defined in IRDAI (Health Insurance) Regulations, 2016) systems of medicine shall be covered without any sub-limits.

12. **Pre-Hospitalisation** medical expenses incurred for a period of 30 days prior to the date of hospitalisation shall be admissible.

13. **Post Hospitalisation** medical expenses incurred for a period of 60 days from the date of discharge from the hospital, following an admissible claim shall be included.
14. **Cumulative Bonus (CB)**: Sum insured (excluding CB) shall be increased by 5% in respect of each claim free policy year, provided the policy is renewed without a break subject to maximum of 50% of the sum insured. If a claim is made in any particular year, the cumulative bonus accrued may be reduced at the same rate at which it has accrued.

15. No deductibles are permitted in this product.

C. Other Norms applicable:

Sl.No	Particulars	Norms Applicable
1.	Plan Variants	No plan variants are allowed.
2.	Distributions Channels	Standard product may be distributed across all distribution channels including Micro Insurance Agents, Point of sale persons and Common Public Service Centres. Distribution of standard product shall be governed by the regulations of concerned distribution channels.
3.	Family Floater	Standard product shall be offered on family floater basis also.
4.	Definition of family	Family consists of the proposer and any one or more of the family members as mentioned below: (i) legally wedded spouse. (ii) Parents and Parents-in-law. (iii) dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.
5.	Category of Cover	Standard product shall be offered on indemnity basis, as a standalone product. It shall not be combined with Critical Illness Covers or Benefit Based covers.
6.	Grace Period for premium payment	Standard product shall comply with Regulation 2(i)(e) of HIR 2016 at the time of renewal of the policy. For Yearly payment of mode, a fixed period of 30 days is to be allowed as Grace Period and for all other modes of payment a fixed period of 15 days be allowed as grace period.
7.	Minimum and Maximum Sum Insured	The minimum sum insured under standard product shall be Rs 1,00,000/- Maximum limit shall be Rs 5 lakhs.(in the multiples of fifty thousand)
8.	Policy Period	Standard product shall be offered with a policy term of one year.

9.	Modes of premium payment	All the modes (Yly, Hly, Qly, Mly) shall be allowed for the standard product. ECS (Auto Debit facility) is also allowed in respect of the above mentioned modes.
10.	Entry age	Minimum entry age shall be 18 years for principal insured and maximum age at entry shall be 65, complying to Regulation 12(i) of HIR 2016, along with lifelong renewability. There shall be no exit age. Policy is subject to lifelong renewability. Dependent Child / children shall be covered from the age of 3 months to 25 years subject to the definition of 'Family'
11.	Benefit Structure	The benefit pay out should be explicitly disclosed in the format of application (Form – IRDAI-UNF-HISP) along with other relevant documents.
12.	Co-payment	Fixed Co-pay of 5% shall be applicable across all the ages and it shall be explicitly disclosed in the format of application (Form – IRDAI-UNF-HISP).
13.	Sub limits	Limits on cataract Surgery: The expenses incurred on treatment of Cataract shall be covered up to 25% of Sum insured or Rs.40,000/- whichever is lower, per eye.
14.	SpecificWaiting Period:	Following diseases/treatment are covered subject to a waiting period mentioned below: A.24 Months Waiting Period: 1. Benign ENT disorders 2. Tonsillectomy 3. Adenoidectomy 4. Mastoidectomy 5. Tympanoplasty 6. Hysterectomy 7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps 8. Benign prostate hypertrophy 9. Cataract and age related eye ailments 10. Gastric/ Duodenal Ulcer 11. Gout and Rheumatism 12. Hernia of all types 13. Hydrocele 14. Non Infective Arthritis 15. Piles, Fissures and Fistula in anus 16. Pilonidal sinus, Sinusitis and related disorders

		17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident 18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy. 19. Varicose Veins and Varicose Ulcers 20. Internal Congenital Anomalies B.48 Months waiting period 21. Treatment for joint replacement unless arising from accident 22. Age-related Osteoarthritis & Osteoporosis
15.	Underwriting	The insurer shall specify the non-medical limit and relevant details explicitly in the format specified.
16.	Renewal	The Standard product shall be subject to Renewal duly complying with Regulation 13 of HIR, 2016
17.	Free Look Period	The Standard Product shall have free look period complying with Regulation 14 of HIR 2016
18.	Premium Loading and Discounts	The Standard Product shall comply with Regulation 25 of HIR 2016 in respect of loadings on Renewals.
19.	Portability	The Standard Product shall comply with Portability provisions, as specified in Schedule I of HIR 2016 and applicable Guidelines issued there under from time to time.
20.	Pricing	The premium under this product shall be pan India basis and no geographic location / zone based pricing is allowed.

D: Proposed construct of Terms and Conditions for Standard Product:

16. The Policy Terms and Conditions of the Standard Product shall be in the format specified in Annexure – 1. Insurer may suitably modify the definitions and other clauses of the policy contract prospectively based on the Regulations or Guidelines that may be issued by the Authority time to time.

E: Other Norms:

17. The nomenclature of the product shall be Arogya Sanjeevani Policy, succeeded by name of insurance company, (Arogya Sanjeevani Policy, <name of insurer>). No other name is allowed in any of the documents.

18. The Proposal Form used for the product shall be subject to the norms specified under the Guidelines on Product Filing in Health Insurance.

19. Insurers shall mandatorily issue Customer Information Sheet as per the format specified in Annexure-2.

20. The Standard Product may be offered as MICRO Insurance Product subject to Sum Insured limits specified in IRDAI (Micro Insurance) Regulations, 2015, and other circulars / guidelines issued in this regard by the Authority from time to time.

21. The Standard product shall be launched without prior approval of the Authority subject to complying with the following conditions.
    - **a.** The product shall be approved by the Product Management Committee.
    - **b.** Insurers shall obtain UIN for the standard product by filing the relevant particulars in Form – IRDAI-UNF-HISP (as specified in Annexure – 3 of these Guidelines) along with a certificate from Chief Compliance Officer that the product filed is in compliance with the norms specified under these guidelines.
    - **c.** On review of the application, the Authority may call for such further information as may be required and may issue suitable directions which shall be retrospectively effected in respect of all contracts issued under this product.

22. General and Health Insurers shall offer this product from 01st April, 2020 onwards.

23. This has the approval of the competent authority.

(Suresh Mathur)
Executive Director

Annexure-1

Arogya Sanjeevani Policy,[Company Name]

1. PREAMBLE

This Policy is a contract of insurance issued by *[name of the Company]* (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 and is subject to receipt of the requisite premium.

2. OPERATIVE CLAUSE

If during the policy period one or more Insured Person (s) is required to be hospitalized for treatment of an Illness or Injury at a Hospital/ Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify Medically necessary, expenses towards the Coverage mentioned in the policy schedule.

Provided further that, any amount payable under the policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured (Individual or Floater) opted and Cumulative Bonus (if any) specified in the Schedule.

3. 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.

3.1. Accident means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

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

3.3. Any One Illness means continuous period of illness and it includes relapse within forty five days from the date of last consultation with the hospital where treatment has been taken.

3.4. AYUSH Treatment refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

3.5. An **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 and/or has equipped operation theatre where surgical procedures are to be carried out;

iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

3.6. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health 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 and/or has equipped operation theatre where surgical procedures are to be carried out;

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

3.7. **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

3.8. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured person in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

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

3.10. **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.

3.11. **Co-payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

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

3.13. **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.

3.14. **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.

3.15. **Dental Treatment** means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.

3.16. **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.

3.17. **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.

3.18. **Family** means, the Family that consists of the proposer and any one or more of the family members as mentioned below:

i. legally wedded spouse.
ii. Parents and Parents-in-law.
iii. dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

3.19. **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.

3.20. **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.

3.21. **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.

3.22. **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

3.23. **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.

3.24. **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.

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

3.26. **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.

3.27. **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.

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

3.29. **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.

3.30. **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.

3.31. **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.

3.32. **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.

3.33. **Network Provider** means hospitals enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.

3.34. **Non- Network Provider** means any hospital that is not part of the network.

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

3.36. **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.

3.37. **Pre-Existing Disease (PED):** Pre existing 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.

3.38. **Pre-hospitalisation Medical Expenses** means medical expenses incurred during the period of 30days preceding the hospitalisation of the Insured Person, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

3.39. **Post-hospitalisation Medical Expenses** means medical expenses incurred during the period of 60days immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and

ii. The inpatient hospitalisation claim for such hospitalisation is admissible by the Insurance Company.

3.40. **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

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

3.42. **Policy Schedule** means the Policy Schedule attached to and forming part of Policy

3.43. **Policy year mean**s 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

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

3.45. **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.

3.46. **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.

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

3.48. **Sub-limit** means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit

3.49. **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.

3.50. **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.

3.51. **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.

3.52. **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.

4. COVERAGE

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

4.1. Hospitalization

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

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/-, per day.
ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs.10,000/- per day.
iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

4.1.1.Other expenses

i. Expenses incurred on treatment of cataract subject to the sub limits
ii. Dental treatment, necessitated due to disease or injury
iii. Plastic surgery necessitated due to disease or injury
iv. All the day care treatments
v. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalisation.

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

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

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

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

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

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

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

B. Balloon Sinuplasty

C. Deep Brain stimulation

D. Oral chemotherapy

E. Immunotherapy- Monoclonal Antibody to be given as injection

F. Intra vitreal injections

G. Robotic surgeries

H. Stereotactic radio surgeries

I. BronchicalThermoplasty

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

K. IONM - (Intra Operative Neuro Monitoring)

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

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

5. Cumulative Bonus (CB)

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

Notes:

i. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.
ii. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the Insured Persons.
iii. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
iv. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons
v. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies or in cases where the policy is split due to the child attaining the age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy
vi. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.
vii. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.
viii. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn

6. Waiting Period

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

6.1. Pre-Existing Diseases(Code- Excl01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with us.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

6.2. First Thirty Days Waiting Period(Code- Excl03)

i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

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

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

6.3. Specific Waiting Period: (Code- Excl02)

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24/48 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.

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

c) If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.

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

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

i.24 Months waiting period

23. Benign ENT disorders
24. Tonsillectomy
25. Adenoidectomy
26. Mastoidectomy
27. Tympanoplasty
28. Hysterectomy
29. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
30. Benign prostate hypertrophy
31. Cataract and age related eye ailments
32. Gastric/ Duodenal Ulcer
33. Gout and Rheumatism
34. Hernia of all types
35. Hydrocele
36. Non Infective Arthritis
37. Piles, Fissures and Fistula in anus
38. Pilonidal sinus, Sinusitis and related disorders
39. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
40. Calculi in urinary system,Gall Bladder and Bile duct, excluding malignancy.
41. Varicose Veins and Varicose Ulcers
42. InternalCongenitalAnomalies

ii. 48 Months waiting period

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

7. EXCLUSIONS

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

7.1 Investigation & Evaluation(Code- Excl04)

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

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

7.2 Rest Cure, rehabilitation and respite care(Code- Excl05)

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

7.3 Obesity/ Weight Control(Code- Excl06)

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

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
   a) greater than or equal to 40 or
   b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

7.4 Change-of-Gender treatments: (Code- Excl07)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

7.5 Cosmetic or plastic Surgery: (Code- Excl08)

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

7.6 Hazardous or Adventure sports: (Code- Excl09)

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

7.7 Breach of law: (Code- Excl10)

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

7.8 Excluded Providers: (Code-Excl11)

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

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

7.10 Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code- Excl13)**

7.11 Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure **(Code- Excl14)**

7.12 Refractive Error:(Code- Excl15)
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

7.13 Unproven Treatments:(Code- Excl16)
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

7.14 Sterility and Infertility: (Code- Excl17)
Expenses related to sterility and infertility. This includes:

(i) Any type of sterilization

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

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

7.15 Maternity Expenses (Code - Excl 18):

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

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

7.16 War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

7.17 Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

7.18 Any expenses incurred on Domiciliary Hospitalization and OPD treatment

7.19Treatment taken outside the geographical limits of India

7.20In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule(based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

8. **Moratorium Period**: After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy.

9. CLAIM PROCEDURE

1.1Procedure for Cashless claims:

(i) Treatment may be taken in a network provider and is subject to pre authorization by the Company or its authorized TPA. (ii) Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization. (iii) The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification. (iv) At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses. (v) The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details. (vi)In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company / TPA for reimbursement.

1.2 Procedure for reimbursement of claims:

For reimbursement of claims the insured person may submit the necessary documents to TPA(if applicable)/Company within the prescribed time limit as specified hereunder.

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

9.1 Notification of Claim

, Notice with full particulars shall be sent to the Company/TPA(if applicable) as under:

i. Within24hours from the date of emergency hospitalization required or before the Insured Person'sdischarge from Hospital, whichever is earlier.
ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

9.2 Documents to be submitted:

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

i. Duly Completed claim form

ii. Photo Identity proof of the patient
iii. Medical practitioner's prescription advising admission
iv. Original bills with itemized break-up
v. Payment receipts
vi. Discharge summary including complete medical history of the patient along with other details.
vii. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner
viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
ix. Sticker/Invoice of the Implants, wherever applicable.
x. MLR(Medico Legal Report copyif carried out and FIR (First information report) if registered, where ever applicable.
xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines
xiii. Legal heir/succession certificate , wherever applicable
xiv. Any other relevant document required by Company/TPA for assessment ofthe claim.

[Note: Insurer may specify the documents required in original and waive off any of above required as per their claim procedure]

Note:

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

9.3 Co-payment

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

9.4 Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliestin any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

9.5 Services Offered by TPA(To be stated where TPA is involved)

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

The services offered by a TPA shall not include

i. Claim settlement and claim rejection;

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

9.6 Payment of Claim

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

10. GENERAL TERMS &CONDITIONS

10.1 Disclosure of Information

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

10.2 Condition Precedent to Admission of Liability

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

10.3 Material Change

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

10.4 Records to be Maintained

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

10.5 Complete Discharge

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

10.6 Notice & Communication

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

10.7 Territorial Limit

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

10.8 Multiple Policies

1. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer if chosen by the policy holder shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

2. Policyholder having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall independently settle the claim subject to the terms and conditions of this policy.

3. If the amount to be claimed exceeds the sum insured under a single policy after, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.

4. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

10.9 Fraud

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

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

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

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

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

(c) any other act fitted to deceive; and

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

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

10.10 Cancellation

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

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

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

b) The Company may cancel the Policy at any time on grounds of mis-represenation, non-disclosure of material facts ,fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of mis-represenation ,non-disclosure of material facts or fraud.

10.11 Automatic change in Coverage under the policy

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

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

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

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

10.12 Territorial Jurisdiction

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

10.13 Arbitration

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

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

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

10.14 Migration:

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

i. The waiting periods specified in Section 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 .....
(Note: Insurer to provide link to the extant Guidelines related to Migration)

10.15 Portability

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

i. The waiting periods specified in Section 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 .....
(Note: Link to be provided to the extant Guidelines related to portability)

10.16 Renewal of Policy

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

i. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
iii. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.
iv. If not renewed within Grace Period after due renewal date, the Policy shall terminate.

10.17 Premium Payment in Installments

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

i. Grace Period of 15 days would be given to pay the installment premium due for the Policy.
ii. During such grace period, Coverage will not be available from the installment premium payment due date till the date of receipt of premium by Company.
iii. The Benefits provided under – "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the installment premium is not paid on due date.
v. In case of installment premium due not received within the grace Period, the Policy will get cancelled.

10.18 Possibility of Revision of Terms of the Policy Including the Premium Rates

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

10.19 Free look period

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

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

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges; or
ii. where the risk has already commenced and the option of return of the Policy is exercised by the insured, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

10.20Endorsements (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.

10.21 Change of Sum Insured

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

10.22 .Terms and conditions of the Policy

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

10.23 Nomination:

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. For Claim settlement under reimbursement, the Company will pay the policyholder. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

11. REDRESSAL OF GRIEVANCE

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

For details of grievance officer, kindly refer the link.....

(Link having details of grievance officer on website to be provided)

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

Insurance Ombudsman –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

No loading shall apply on renewals based on individual claims experience.Insurance is the subject matter of solicitation

12. TABLE OF BENEFITS

Name	Arogya Sanjeevani Policy,[Company Name]
Product Type	Individual/ Floater
Category of Cover	Indemnity
Sum insured	INR On Individual basis – SI shall apply to each individual family member On Floater basis – SI shall apply to the entire family
Policy Period	1 year
Eligibility	Policy can be availed by persons between the age of 18 years and 65years, as Proposer. Proposer with higher age can obtain policy for family, without covering self. Policy can be availed for Self and the following family members i. legally wedded spouse. ii. Parents and Parents-in-law . iii. Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals
Grace Period	For Yearly payment of mode, a fixed period of 30 days is to be allowed as Grace Period and for all other modes of payment a fixed period of 15 days be allowed as grace period.
Hospitalisation Expenses	Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible
	Time limit of 24 hrs shall not apply when the treatment is undergone in a Day Care Centre.
Pre Hospitalisation	For 30 days prior to the date of hospitalization
Post Hospitalisation	For 60 days from the date of discharge from the hospital
Sublimit for room/doctors fee	1.Room Rent, Boarding, Nursing Expenses all inclusive as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/- per day. 2.Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all inclusive as provided by the Hospital / Nursing Home up to 5% of the sum insured subject to maximum of Rs.10,000/-, per day
Cataract Treatment	Up to 25% of Sum insured or Rs.40,000/-, whichever is lower, per eye, under one policy year.
AYUSH	Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered upto sum insured, during each Policy year as specified in the policy schedule.
Pre Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the company shall be covered after a waiting period of 4 years
Cumulative bonus	Increase in the sum insured by 5% in respect of each claim free year subject to a maximum of 50% of SI. In the event of claim the cumulative bonus shall be reduced at the same rate.
Co Pay	5% co pay on all claims

Annexure-A

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

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES

49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

Sl No	**Item**
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT

28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	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

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, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@gbic.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@gbic.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@gbic.co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.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@gbic.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@gbic.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.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 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@gbic.co.in
Andhra Pradesh, Telangana and UT of Yanam – a part of the UT of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@gbic.co.in
Rajasthan	Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.I.: 0141 - 2740363 Email: Bimalokpal.jaipur@gbic.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 - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@gbic.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@gbic.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@gbic.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@gbic.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 / 2514251 / 2514253 Email: bimalokpal.noida@gbic.co.in

Bihar, Jharkhand.	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Email: bimalokpal.patna@gbic.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 - 32341320 Email: bimalokpal.pune@gbic.co.in

Annexure-2

Customer Information Sheet (Description is illustrative and not exhaustive)

Sl No.	TITLE	DESCRIPTION	Refer to policy clause number
1.	*Product Name*	**Arogya Sanjeevani Policy,<name of the Insurer>.**	
2.	*What am I covered for*	a. Hospitalization expenses- Expenses incurred on hospitalization for minimum period of 24 hours including pre-hospitalization expenses for a period of 30 days and post hospitalization expenses for a period of 60 days.	4.1
		b. Day Care Procedures- Medical expenses for day care procedures.	4.1.1
		c. AYUSH Coverage- Expenses incurred on hospitalization under AYUSH Treatment.	4.2
		d. Expenses incurred on treatment of cataract.	4.3
		e. Expenses incurred on dental treatment and Plastic Surgery: Necessitated due to disease or injury.	4.1.1
		f. Ambulance Charges: Expenses on road Ambulance subject to a maximum of Rs.2000/- per hospitalization.	
3.	*What are the Major exclusions in the policy*	Following is a partial list of the policy exclusions. Please refer to the policy document for the complete list of exclusions: a. Admission primarily for investigation & evaluation	7.1
		b. Admission primarily for rest Cure, rehabilitation and respite care	7.2
		c. Expenses related to the surgical treatment of obesity that do not fulfill certain conditions	7.3
		d. Change-of-Gender treatments	7.4
		e. Expenses for cosmetic or plastic surgery	7.5
		f. Expenses related to any treatment necessitated due to participation in hazardous or adventure sports	7.6
4.	*Waiting period*	a. Pre-Existing Diseases will be covered after a waiting period of forty eight (48) months of continuous coverage	6.1
		b. 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.	6.2
		c. Specified surgeries/treatments/diseases are covered after specific waiting period of 24 months	6.3
		d. Specified surgeries/treatments/diseases are covered after specific waiting period of 48 months	
5.	*Payment basis*	Payment on indemnity basis (Cashless / Reimbursement)	
6.	*Loss sharing*	In case of a claim, this policy requires you to share the following costs: a. Expenses exceeding the following Sub-limits: i. Room Charges(Hospitalization): a. Room Rent - Up to 2% of SI, subject to max of INR 5,000 per day b. ICU charges - Up to 5% of SI subject to max of INR 10,000 per day. c. In case Room/ICU/ICCU rent exceeds the limits specified the claim shall be subject to the proportionate deduction.	4.1
		ii. Cataract – Up to 25% of Sum Insured or Rs.40,000/- whichever is lower. iii. Modern treatment methods and Advancements in technology: Up to 50% of the Sum insured.	4.3 4.6

<table>
<tr><td></td><td></td><td>b. Each and every claim under the Policy shall be subject to a Copayment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy</td><td>9.3</td></tr>
<tr><td>7.</td><td>Renewal Conditions</td><td>The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years.</td><td>10.16</td></tr>
<tr><td>8.</td><td>Renewal Benefits</td><td>Cumulative bonus:
a. Increase in the sum insured by 5% in respect of each claim free year subject to a maximum of 50% of SI.
b. In the event of claim the cumulative bonus shall be reduced at the same rate.</td><td>5</td></tr>
<tr><td>9.</td><td>Cancellation</td><td>a. The Insured may cancel this Policy by giving 15 days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed in the policy terms and conditions.
b. 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.</td><td>10.10</td></tr>
<tr><td>10.</td><td>Claims</td><td>a. For Cashless Service:
(Insurer to provide the details /web link from where Hospital Network details can be obtained)
b. For Reimbursement of Claim : For reimbursement of claims the insured person may submit the necessary documents to TPA/Company within the prescribed time limit as specified hereunder.
<table>
<tr><th>Sl No</th><th>Type of Claim</th><th>Prescribed Time limit</th></tr>
<tr><td>1</td><td>Reimbursement of hospitalization, day care and pre hospitalization expenses</td><td>Within thirty days of date of discharge from hospital</td></tr>
<tr><td>2</td><td>Reimbursement of post hospitalization expenses</td><td>Within fifteen days from completion of post hospitalization treatment</td></tr>
</table>
For details on claim procedure please refer the policy document.</td><td>9</td></tr>
<tr><td>11.</td><td>Policy Servicing</td><td>Insurer to provide the details of company officials.</td><td></td></tr>
<tr><td></td><td>Grievances/ Complaints</td><td>a. Details of Grievance redressal officer (Insurer to provide the link)
b. IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/
c. Insurance Ombudsman – The contact details of the Insurance Ombudsman offices have been provided as Annexure-B of Policy document.</td><td>11</td></tr>
<tr><td>12.</td><td>Insured's Rights</td><td>a. Free Look period of 15 days from the date of receipt of the policy shall be applicable at the inception.</td><td>10.19</td></tr>
<tr><td></td><td></td><td>b. Lifelong renewability (except on certain specific grounds)</td><td>10.16</td></tr>
<tr><td></td><td></td><td>c. Right to migrate from one product to another product of the company (Note: Insurer to provide e-mail and address of the Person to be contacted)</td><td>10.14</td></tr>
<tr><td></td><td></td><td>d. Right to port the from one company to another company (Note: Insurer to provide e-mail and address of the Person to be contacted)</td><td>10.15</td></tr>
<tr><td></td><td></td><td>e. Change in SI during the policy term or at the time of renewal (Insurer to provide the contact details)</td><td>10.21</td></tr>
<tr><td></td><td></td><td>f. Insurer to specify the norms on TAT for Pre-Auth and Settlement of reimbursement.</td><td></td></tr>
<tr><td>13.</td><td>Insured's Obligations</td><td>Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid.</td><td></td></tr>
<tr><td colspan="4">Legal Disclaimer Note: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the CIS and the policy document, the terms and conditions mentioned in the policy document shall prevail.</td></tr>
</table>

Annexure-3

Form IRDAI-UNF-HISP

[All the items should be filled in properly and carefully. No item must be left blank.]

S No	Item	Particulars (to be filled in by insurer)
Section I: General Information		
1.1	Name of Health / General Insurer	
1.2	Registration No.alloted by IRDAI	
1.3	Name of Appointed Actuary [Please note that his/her appointment should be in force as on the date of this application]	
1.4	Brand Name [Give the name of the product which will be printed in Sales Literature and known in the market. This name should not be altered/modified in any form after launching in the market. This name shall appear in all returns etc. which would be submitted to IRDAI	Arogya Sanjeevani, <Name of the insurer>
1.5	Date of approval by PMC	
Section II: Underwriting		
2.	Underwriting –Selection of Risks [This section should discuss how the different segments of the population will be dealt with for the purpose of underwriting (to the extent they are relevant and a brief detail of procedure adopted for assessment of various risk classes may be given.)	
2.1	Specify Non-medical Limit [Where no pre-medical examination is asked for]	
2.2	Specify when and what classes of lives would be subject to medical examination	
2.3	Whether any loading based on the health status are applicable	Yes / No
2.4	Whether any loading based on the occupation are applicable	Yes / No
2.5	Specify, any other underwriting criteria	
2.6	Whether Underwriting of the product aligned to the Board Approved Underwriting policy of the Company	Yes / No

2.7	Whether full costs of pre policy medical check up are borne by the Insurer		Yes / No					
2.8	If no, specify the percentage proposed to be borne by the Insurer.							
Section III - Distribution Channels								
3	Distribution channels:							
	3.1	Specify the various distribution channels to be used for distributing the product- [reply shall be specific and can not refer to the replies like "as approved by IRDAI]						
	3.1	Commission scales to distribution channels—specify the rates which are to be paid-[reply shall be specific]						
3.2	Expected proportions of business to be procured by each channel shall be indicated for the next 5 years.		Distribution Channel	Year 1	Year 2	Year 3	Year 4	Year 5
			1.Individual Agents					
			2. Corporate Agents					
			3. Insurance Brokers					
			4.Web Aggregators					
			5.Micro Insurance Agents					
			6.CSC					
			7.PoS					
			8.Direct – Only Online					
			9.Direct Marketing - Others					
			(Incorporate separate line for each distribution channel) 10. Others-specify					

		11. Total						
Section IV - Reinsurance arrangements								
4.1	Retention limit							
4.2	Name of the reinsurer (s)							
4.3	Terms of reinsurance(type of reinsurance, commissions, etc.).							
4.4	Any recapture provisions shall be described.							
4.5	Reinsurance rates provided							
4.6	Whether a copy of the reinsurance program and a copy of the Treaty is submitted to the Authority.		Yes/No					
	4.6.1	Whether reinsurance program and a copy of the treaty enclosed (required only if these are not filed with the Authority previously)	Yes/No					
	4.6.2	Whether the reisurance proposed for the product is in line with the Board approved reinsurance program filed with the Authority	Yes / No					
	4.6.3	If no, furnish the particulars						
Section V: Pricing								
5	*Premium Loadings & Discounts* *(Please provide objective and transparent criteria to offer discounts/rebate/Loadings And complete financial justifications by AA to every item referred hereunder.* *In case of General and Health Insurers to be also furnished separately in the Technical Note)*							
	5.1	Sum insured rebates/discounts offered, if any						
	5.2	Rebates/charges for different modes offered:						
	5.3	Premium rebates/discounts						
	5.4	Staff rebates						
	5.5	Any other discounts offered						

	5.6	Maximum cap on all Discounts for all variables taken together	
	5.7	Any loadings proposed	
	5.8	Maximum Cap on all Loading for all variables taken together	
	5.9	Subrogation (Not applicable to Health Insurance)	
5.10	**Pricing Assumptions and Methodology:** The pricing assumptions and the methodology may vary depending on the nature of product. Give details of the following		
5.11	Give the actuarial formulae, if any, used; if not, state how premiums are arrived at briefly explaining the methodology and details:		
5.12	Source of data (internal/industry/ reinsurance)		
5.13	Rate of morbidity [The tables whereever relevant shall be the prescribed one.]		
5.14	Rates of policy terminations. [The rates used must be in accordance with insurer's experience. If such experience is not available, this can be from the industry/reinsurer's experience .]		
5.15	Rate of interest, if any. [The rate or rates must be consistent with the investment policy of the insurer.]		
5.16	Commission scales [Give rates of commission. These are explicit items.]		
5.17	Expenses - Split into First Year, Renewal and Claim related:- [Expense assumptions must be company specific. If such experience is not available, the Appointed Actuary might consider industry experience or make reasonable assumptions.]		
	5.17 .1	First Year expenses by: sum assured related, premium related, per policy related	

First Year Expenses	sum assured related	premium related	per policy related

5.17 .2	Renewal expenses where relevant (including overhead expenses) by : sum assured related, premium related, per policy related	

	Renewal Expenses		sum assured related		premium related		per policy related
	5.17.3	Claim expenses					
	5.17.4	Future inflationary increases, if any					
5.18	Allowance for transfers to shareholder, if any: [Please see section 49 of the Insurance Act, 1938]						
5.19	Taxation. [Please see the relevant sections of the Income Tax Act, 1961 applicable for payment of taxes by the Insurer]						
5.20	Any other parameter relevant to pricing of product –specify						
5.21	Reserving assumptions (please specify all the relevant details)						
5.22	Base rate (risk premium)-furnish the rate table, if any						
5.23	Gross premium- furnish the rate table, if any						
5.24	Annualised Premium						
	5.24.1 Minimum						
	5.24.2 Maximum						
5.25	Expected loss ratio (for the product) -						
5.26	Age-wise loss ratio-		S.No		Age		Loss ratio
5.27	Sum insured-wise- loss ratio		S.No		SA		Loss ratio
5.28	Age and sum insured wise loss ratio -		Table given below (SI band and age bands shall be increased.The format given below is indicative.)				

	S.NO	SI/Age bands	100000	150000	200000	250000	300000
	1	>=0<=2					
	2	>=3<=15					
	3	>=16<=25					
	4	>=26<=30					

	5	>=31<=35					
	6	>=36<=40					
	7	>=41<=45					
	8	>=46<=50					
	9	>=51<=55					
	10	>=56<=60					
	11	>=61<=65					
	12	>=66					

5.29	Expected combined ratio	
5.30	Age-wise combined ratio-	
5.31	Sum insured-wise- combined ratio	
5.32	Age and sum insured wise combined ratio - to be furnished for each option or plan separately	Table given below (SI band and age bands shall be increased.The format given below is indicative.)

	S.NO	SI/Age bands	100000	150000	200000	250000	300000
	1	>=0<=2					
	2	>=3<=15					
	3	>=16<=25					
	4	>=26<=30					
	5	>=31<=35					
	6	>=36<=40					
	7	>=41<=45					
	8	>=46<=50					
	9	>=51<=55					
	10	>=56<=60					
	11	>=61<=65					
	12	>=66					

5.33	Expected cross-subsidy between age/sum insured	
5.34	Experience of similar products, if any for the preceding Five Financial Years	

	S.No	Exposure	Premium – Rs.	Number of claims	Incurred claims -Rs.	Claim frequency	Average cost per claim	Burning cost- Rs.	Loss ratio	Combined ratio
	FY									
	FY-1									
	FY-2									
	FY-3									
	FY-4									

1. Exposure: earned life year (no of life earned during a particular financial year);

2. Premium: premium earned during the financial year;

3.Number of claims: claims occurred during the financial year;

4. Incurred claims: Incurred amount as of today for claims mentioned in "3";

5. Claim frequency: No. of claims/ Exposure;

6. Average cost per claim: Incurred claims / No. of claims;

7. Burning cost: Claims frequency* Average cost per claim;

8. Loss ratio: Incurred claims/ Premium;

9. Combined ratio: Loss ratio + Expense ratio;

5.35	**Results of Financial Projections/Sensitivity Analysis:** [The profit margins should be shown for various model points for base,optimistic and pessimistic scenarios in a tabular format below. The definition of profit margin should be taken as the present value of net profits to the p.v of premiums. Please specify assumptions made in each scenario. For terms less than or equal to one year loss ratio may be used and for terms more than one year, profit margin may be used.]			
5.36	Risk discount rate used in the profit margin			
5.37	Average Sum Insured Assumed			
5.38	Assumptions made under pessimistic scenario			
5.39	Assumptions made under optimistic scenario			
5.40	Age [PM: Profit Margin/Loss Ratio] [Age Band may be revisted based on the product design paratmeters]	*PM (base scenario)*	*PM (pessimistic scenario)*	*PM (optimistic scenario)*
	>=0<=2			
	>=3<=15			
	>=16<=25			
	>=26<=30			

	>=31<=35			
	>=36<=40			
	>=41<=45			
	>=46<=50			
	>=51<=55			
	>=56<=60			
	>=61<=65			
	>=66			

Section VI: Enclosures to the Application:	
The following specimen documents should be enclosed:	
6.1	Sales Literature /Prospectus. This is the literature which is to be used by the various distribution channels for selling the product in the market. This shall enumerate all the salient features of the product along with the exclusions applicable for the basic benefits and shall be in complaince with the relevant circulars issued by the Authority at all times).
6.2	Policy Document& Policy Schedule
6.3	Technical Note on Pricing
6.4	Proposal form, wherever necessary
6.5	Premium Table
6.6	Certificates by Appointed Actuary and Chief Compliance Officer
6.7	CIS

Soft ware used for product design and monitoring --- (for information of the Authority)

The Insurer shall enclose a certificate from the Chief Compliance Officer, Appointed Actuary, countersigned by the principal officer of the insurer, as per specimen given below:(The language of this should not be altered)

Certification by Chief Compliance Officer:

I------- (Name of Chief Compliance Officer) the undersigned, on behalf of the Insurer named below, hereby affirm and declare as follows:

1. That the details of the (Name of product) filled in above are true and correct and reflect what the policy and other documents indicate.
2. That the product complies with the various provisions of the IRDAI Health Insurance Regulations, 2016, Guidelines on Standardization of Health Insurance, Product Filing, Guidelines on Standardization of Exclusions in Health Insurance Contracts, Guidelines on Standard Individual Health Insurance Product, issued thereon and the applicable provisions of extant IRDAI Regulations and all circulars issued by IRDAI from time to time.
3. That this application and all other documents are complete and have been verified for correctness and consistency not only in respect of each item of each document but also vis-a-vis one another.

4. I certify that the policy wordings and Customer Information sheet filed along with this application is in compliance with IRDAI (Health Insurance) Regulations, 2016, Product Filing Guidelines, Guidelines on Standardization of Health Insurance, Guidelines on Standardization of Exclusions in Health Insurance Contracts, Guidelines on Standard Individual Health Insurance Product issued thereon.
5. I further certify that the Prospectus submitted is in compliance with the applicable provisions of Rules, IRDAI Regulations and Guidelines on Product Filing and Insurance Advertisements.

Date: (Chief Compliance Officer)
Name of Insurer

Certification by Appointed Actuary:

" I, (**name of the appointed actuary**), the appointed actuary, hereby solemnly declare that the information furnished in this Application Form is true. I also certify that, in my opinion, the premium rates, advantages, terms and conditions of the above product are workable and sound, the assumptions are reasonable and premium rates are fair."

I have carefully studied the requirements of the Product Filing Procedure in relation to the design and rating of insurance products.

The rates, terms and conditions of the above mentioned product are determined on technically sound basis and are sustainable on the basis of the information and claims experience available in the records of the insurer.

An adequate system has been put in place for collection of data on premiums and claims based on every rating factor that will enable review of the rates and terms of the cover from time to time. It is planned to review the rates, terms and conditions of cover (--- mention periodicity of review) based on emerging experience.

It is further certified that the underwriting of the product now filed shall be within the Board approved underwriting philosophy of the Company.

The requirements of the Product Filing Procedure have been fully complied with in respect of this product or revision or modification of the product.

I further declare that except the Sections mentioned in S.No., no other feature/benefit/clause is modified in the product (applicable only for revision or modification of the product)

Place Signature of the Appointed Actuary
Date:

Certification by Principal Officer or CEO

I (name of the Principal Officer or CEO), (mention designation) hereby confirm that:

1. The rates, terms and conditions of the above-mentioned product filed with this certificate have been determined in compliance with the IRDA Act, 1999, Insurance Act, 1938, and the Regulations and guidelines issued there under, including the File and Use / Product Filing guidelines.

2. The prospectus, sales literature, policy and endorsement documents, and the rates, terms and conditions of the product have been prepared on a technically sound basis and on terms that are fair between the insurer and the client and are set out in language that is clear and unambiguous.

3. These documents are also fully in compliance with the underwriting and rating policy approved by the Board of Directors of the insurer.

4. The statements made in the filing Form -IRDAI-UNF-HISP are true and correct.

5. The requirements of the Product Filing Guidelines have been fully complied with in respect of this product.

Date: Signature of Principal Officer or Designated Officer

Place: Name and designation along with Company's seal