SCHEME DOCUMENT

Customized exclusively for the registered customers of RBL

ABOUT CARE HEALTH INSURANCE LIMITED

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

POLICY CONDITIONS & BENEFITS

Particulars	***Description***
Coverage Details	
Cover Type	Individual
Relationship Type	Self
Entry Age – Min	Adult: 18 years
Entry Age – Max	Adult: 65 years
Exit Age	Adult: Lifelong*
Pre-policy Medical Check-up	NO, Good health declaration basis,
Membership	**Loan Customers of RBL BANK**
Policy Tenure	1/2/3/4/5 Year
Claims payout	Re-imbursement
Claims Servicing	In – house
Covered Benefits	
Convalescence Benefit	
Convalescence Benefit:- **(provided only in case of Comprehensive hospitalization)**	Coverage amount – Rs 100 to 50,000, Minimum hospitalization Duration – 5 days This Benefit will be allowed for maximum 2 times in cover year and maximum 3 payments per hospitalization Payment Periodicity – Once in 5 days
Wait Period	
30 Days	Yes(except for Injuries/Accident)
Named Ailment (as defined in Group Care 360 Product)	24 Month
Pre-existing diseases	24 Month

TERMS AND CONDITIONS APPLICABLE TO CARE HEALTH INSURANCE LIMITED

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

taken in a way so as to take advantage of the Company by filing a claim which deviates from the purpose of Insurance.

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

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

Policy Terms & Conditions

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

Definitions

1. **Accidental / Accident** is a sudden, unforeseen and involuntary event caused by external and visible means.
2. **Act of God Perils** means and includes lightening, storm, tempest, flood, inundation, subsidence, landslide, earthquake, cyclone, tsunami, volcano and other similar calamities;
3. **Actively at Work** Refers to an employee who is actually at work on his/her eligibility date and performing each and every duty of his/her present occupation on a customary and full- time basis. An employee shall also be deemed actively at work if he/she is on annual leave and is not absent from work due to long term illness, irrecoverable condition etc. If an employee is not actively at work on his/her cover start date, he/she will not be covered.
4. **Activities of Daily Living** Applies to a member (who is eligible for cover under this policy) and who is aged at least five 5 years old who cannot perform the following activities:
   - Dressing: The ability to put on, take off, secure, and unfasten all garments and as appropriate, any braces, artificial limbs, or other surgical appliances;
   - Feeding: The ability to feed one's self once food has been prepared and made available;
   - Mobility: The ability to move indoors from room to room on level surfaces;
   - Toileting: The ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
   - Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
   - Washing: The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.
5. **Age** means the completed age of the Insured Member as on his last birthday.
6. **Alternative treatments** are forms of treatments other than treatment "Allopathy" or "modern medicine" and include Ayurveda, Unani, Sidha and Homeopathy in the Indian context.
7. **Ambulance** means a road vehicle operated by a licensed/ authorized service provider and equipped for the transport and paramedical treatment of persons requiring medical attention.
8. **Annexure** means the document attached and marked as Annexure to this Policy.
9. **Any one illness (not applicable for Travel and Personal Accident Insurance)** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

10. **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH *Medical Practitioner*(s) comprising of any of the following:
    a. Central or State Government AYUSH Hospital or
    b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
    c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH *Medical Practitioner* and must comply with all the following criterion:
        i. Having at least 5 in-patient beds;
        ii. Having qualified AYUSH *Medical Practitioner* in charge round the clock;
        iii. Having dedicated AYUSH therapy sections as required;
        iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative; and
        v. Having either Pre-entry level Certificate (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or State Level Certificate (or higher level of certificate) under National Quality Assurance Standards (NQAS), issued by National Health Systems Resources Centre (NHSRC)

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

12. **Assistance Service Provider** means the service provider specified in the Policy Schedule or as appointed by the Company from time to time.
13. **Cashless Facility** means a facility extended by the insurer to the Insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network Provider by the company to the extent pre-authorization approved.
14. **Certificate of Insurance** means the certificate the Company issues to an Insured Member evidencing cover under the Policy.
15. **Claim** means a demand made in accordance with the terms and conditions of the Policy for payment of the specified Benefits in respect of the Insured Member as covered under the Policy.
16. **Claimant** means a person who possesses a relevant and valid Insurance Policy which is issued by the Company and is eligible to file a Claim in the event of a covered loss.
17. **Common Carrier** means any civilian land or water conveyance or Scheduled Airline in each case operated under a valid license for the transportation of passengers for hire.
18. **Company (also referred as Insurer/We/Us)** means CARE Health Insurance Company Limited (formally known as Religare Health Insurance Co. Ltd).
19. **Condition Precedent** shall mean a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

20. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position :

(a) Internal Congenital Anomaly –

Congenital anomaly which is not in the visible and accessible parts of the body

(b) External Congenital Anomaly –

Congenital anomaly which is in the visible and accessible parts of the body

21. **Co-payment** is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured.

22. **Cover End Date** means the date specified in Annexure 'A'(Certificate of Insurance) for the respective Insured Member on which the Insured Member's cover under the Policy expires.

23. **Cover Period** means the period commencing from the Cover Start Date and ending on the Cover End Date for each Insured Member as specified in Annexure 'A' (Certificate of Insurance).

24. **Cover Start Date:** means the date specified in Annexure 'A' (Certificate of Insurance) for the respective Insured Member on which the Insured Member's cover under the Policy commences.

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

26. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under—

(a) has qualified nursing staff under its employment;

(b) has qualified Medical Practitioner/s in-charge;

(c) has a fully equipped operation theatre of its own, where Day Care Treatment is carried out.

(d) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

27. **Day Care Treatment** means medical treatment, and/ or Surgical Procedure which is:

(a) undertaken under general or local anesthesia in a Hospital/ Day Care Centre in less than 24 consecutive hours because of technological advancement, and

(b) which would have otherwise required a Hospitalization of more than 24 consecutive hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition. As listed in Annexure "I"

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

Note: Under this Policy, deductible for a specified number of days/hours is applicable on the following Benefits in addition to the deductible applicable on Indemnity / hospital cash benefits

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

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

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

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

33. **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

(a) The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or

(b) The patient takes treatment at home on account of non-availability of room in a Hospital.

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

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

36. **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

37. **Hazardous Activities** (or Adventure sports) means any sport or activity or Adventure sport, which is potentially dangerous to the Insured whether he is trained or not. Such sport/activity includes stunt activities of any kind, adventure racing, base jumping, biathlon, big game hunting, black water rafting, BMX stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/ pot holing, cave tubing, rock climbing/ trekking/ mountaineering, cycle racing, cyclo cross, drag racing, endurance testing, hand gliding, harness racing, hell skiing, high diving , hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, lugging, risky manual labor, marathon running, martial arts, micro – lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/ parapenting, piloting aircraft, polo, power lifting, power boat racing, quad biking, river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting or wrestling of any type.

38. **Hospital** (not applicable for Overseas Travel Insurance) means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
    (a) has qualified nursing staff under its employment round the clock;
    (b) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
    (c) has qualified Medical Practitioner(s) in charge round the clock;
    (d) has a fully equipped operation theatre of its own where surgical procedures are carried out;
    (e) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

39. **Hospitalization** (not applicable for Overseas Travel Insurance) means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

40. **Immediate Family Member** means an Insured Member's lawful spouse, children only.

41. **Indemnity/Indemnify** means compensating the Policy Holder/Insured Member up to the extent of Expenses incurred, on occurrence of an event which results in a financial loss and is covered as the subject matter of the Insurance Cover.

42. **Illness** means a sickness or a disease or a pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    (a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
    (b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
        I. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests;
        II. It needs ongoing or long-term control or relief of symptoms;
        III. It requires rehabilitation for the patient or for the patient to be specially trained to cope with

IV. It continues indefinitely;
V. It recurs or is likely to recur.

43. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

44. **In-patient Care** (not applicable for Overseas Travel Insurance) means treatment for which the Insured Member has to stay in a Hospital for more than 24 hours for a covered event.

45. **Insured Event** means an event that is covered under the Policy; and which is in accordance with the Policy Terms & Conditions.

46. **Insured Member (Insured)** means a person whose name specifically appears under Insured in the Annexure A or the Certificate of Insurance and is a covered group member.

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

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

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

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

51. **Medical Expenses** means those expenses that an Insured Member has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Member had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.

52. **Medical Practitioner** (not applicable for Overseas Travel Insurance) is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

For Benefits / optional Extensions effective outside India:

Medical Practitioner means a person who holds a valid registration issued by the Medical Council/Statutory Regulatory Authority for Medical Education in that Country and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

53. **Medically Necessary Treatment** (not applicable for Overseas Travel Insurance) means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

(a) Is required for the medical management of the Illness or Injury suffered by the Insured Member;
(b) Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
(c) Must have been prescribed by a Medical Practitioner;
(d) Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

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

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

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

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

59. **OPD Treatment** (Out-patient Care) is one in which the Insured visits a clinic/hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

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

61. **Preferred Provider** means the Hospital empanelled by the Company or TPA and enlisted on the Preferred Provider Network List, specified in the Policy Schedule (and as updated by the Company from time to time).

An updated list of 'Preferred Provider Network' may be obtained from the Company's website or the call centre.

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

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

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

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

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

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

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

69. **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

70. **Post-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days immediately after the Insured Member is discharged from the Hospital provided that:

    i. Such Medical Expenses are incurred for the same condition for which the Insured Member's Hospitalization was required and
    ii. The inpatient Hospitalization claim for such Hospitalization is admissible by the Company.

71. **Pre-existing Diseases** means any condition, ailment, injury or disease:

    (a) That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
    (b) For which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

72. **Pre-hospitalization Medical Expenses** Means Medical Expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Member, provided that :

    i. Such Medical Expenses are incurred for the same condition for which the Insured Member's Hospitalization was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

87. **Surgery/Surgical Procedure** means manual and/or operative procedure(s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or a Day Care Centre by a Medical Practitioner.

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

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

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

91. **AYUSH treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems

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

93. **Medical Practitioner** means a person who holds a valid registration issued by the Medical Council/Statutory Regulatory Authority for Medical Education in that Country and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

Refers to a person (other than you, your member, or a business partner or a relative of yours or your member) has the primary degrees in the practice of Allopathy and surgery following attendance at a recognized medical school and who is licensed to practice Allopathy by the relevant licensing authority where the treatment is given. By 'recognized medical school' we mean "a medical school which is listed in AVICENNA Directory, which is in collaboration with the World Health Organization and the World Federation for Medical Education".

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

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

96. **Reasonable and customary (R&C)** means charges or treatment for medical care which shall be considered by the Company or by Company's medical advisers to be reasonable and customary to the extent that they do not exceed the general level of charges or treatment being made by others of similar standing in the locality where the charges or treatment are incurred when giving like or comparable treatment.
If the charges are higher than customary or the treatment is not reasonable and customary, the Company will only pay the amount which is, in the Company's experience, customarily charged and Insured has to pay the rest.

Scope of Cover

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

Convalescence Benefit

If the Insured Member undergoes Medically Necessary Hospitalization, during the Cover Year, then We will pay the amount as opted, for every completed period (5 days) of hospitalization for each Claim provided that:

(i) We shall be liable to make payment under this benefit for any Claim in respect of the Insured Member only when the Minimum Hospitalization Duration (5 days) on that Claim is exhausted.
(ii) This Benefit will be payable for a maximum of 2 times in a Cover Year (for different injury causing events leading to Hospitalization) and maximum 3 payments per hospitalization.

The combination of Coverage Amount, Minimum Hospitalization Duration and Period of Hospitalization should be same for all the policies under the group

The coverage amount can be selected in multiples of '000 ranging from 100 to 50,000

Permanent Exclusions

Below mentioned are the common exclusions which are applicable to all the Base and Optional benefits of Group Care 360:-

1. Any item or condition or treatment specified in List of Non-Medical Items (Annexure – II).
2. Any pre-existing injury / illness or disability and any complications thereof and its associated medical conditions unless we had agreed otherwise in writing
3. 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.
   Note: Refer BLACKLISTED hospital list on www:carehealthinsurance.com for list of excluded hospitals.
4. Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis,

Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T-Cell Lymphotropic Virus Type III (HTLV–III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind;

5. Maternity: Code Excl18
    a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
    b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
    c. Any treatment directly related to surrogacy whether the member is acting as surrogate, or is the intended parent;
    d. Any treatment begun or for which the need has arisen during the first ninety (90) days after birth, for any child conceived by artificial means or any form of assisted conception or if the child is born via surrogacy;
6. Birth control, Sterility and Infertility: Code- Excl17
    a. Expenses related to Birth Control, sterility and infertility. This includes:
    b. Any type of contraception, sterilization
    c. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
7. Gestational Surrogacy
8. Reversal of sterilization;
9. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication;
10. Charges incurred in connection with routine eye examinations and ear examinations, dentures, crowns, artificial teeth and all other similar external appliances and / or devices whether for diagnosis or treatment;
11. Refractive Error: (Code- Excl15)
    Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres
12. 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.
13. Expenses incurred on advanced treatment methods other than as mentioned in clause 2.1 (h)
14. Any expenses incurred on providing or fitting any external prosthesis or orthosis or appliance or medical aids or durable medical equipment of any kind, like wheelchairs, walkers, crutches, ambulatory devices, unless allowed under the Policy, cost of Cochlear implants;
15. Any treatment related to sleep disorder or sleep apnea syndrome, general debility convalescence and any treatment in an establishment that is not a Hospital;
16. Treatment of any external Congenital Anomaly or Illness or defects or anomalies including their associated medical conditions or chronic medical conditions or vegetative state cover (on the basis of declaration by the treating doctor) or treatment relating to external birth defects;
17. We define vegetative state as a condition of profound non-responsiveness with no sign of awareness or consciousness or a functioning mind, even if the Insured can open their eyes and breathe unaided, and the person does not respond to stimuli such as calling their name or touching. This state must have remained for at least four (4) weeks with no sign of improvement or there could be no recovery;
    a. Treatment whilst staying in a hospital for more than ninety (90) continuous days for permanent neurological damage on the basis of declaration by the treating doctor. It is stated that treatment up to 90 days for permanent neurological damage will be covered under this Policy;
18. Treatment of mental retardation, arrested or incomplete development of mind of a person, subnormal intelligence or mental intellectual disability

19. Obesity/ Weight Control(Code- Excl06)
    a. Expenses related to the surgical treatment of obesity that does not fulfill all the below conditions:
    b. Surgery to be conducted is upon the advice of the Doctor
    c. The surgery/Procedure conducted should be supported by clinical protocols
    d. The member has to be 18 years of age or older and
    e. Body Mass Index (BMI);

i. greater than or equal to 40 or
ii. 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:
    1. Obesity-related cardiomyopathy
    2. Coronary heart disease
    3. Severe Sleep Apnea
    4. Uncontrolled Type2 Diabetes

20. 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;
21. 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;
22. Out-patient treatment;
23. Treatment received outside India;
24. Domiciliary hospitalization or treatment;
25. Investigation & Evaluation(Code- Excl04)
    a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
    b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded;
26. Rest Cure, rehabilitation and respite care- Code- Excl05
    Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
    a. 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.
    b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs;
27. An Insured Member operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft or Scheduled Airline or any airline personal;
28. An Insured Member flying in an aircraft other than as a fare paying passenger in a Scheduled Airline;
29. Participation in actual or attempted felony, riot, civil commotion or criminal misdemeanor or activity;
30. Professional fees charged by a member of the Insured Member's immediate family or by a person normally resident in the household of the Insured or under his employment;
31. Training for or participating in professional sport of any kind or any sport for which the insured receives a salary or monetary reimbursement, including grants or sponsorship;
32. The Insured Member serving in any branch of the military, navy, air force or any branch of armed forces or any paramilitary forces;
33. Radioactive contamination whether arising directly or indirectly ionizing radiation, toxic, explosive or other hazardous properties of nuclear material;
34. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident;
35. All preventive care, Vaccination including Inoculation and Immunizations (except in case of post-bite treatment) and tonics;
36. 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);
37. All expenses related to donor treatment, including screening, surgery to remove organs from the donor, in case of transplant surgery;
38. Non-Allopathic Treatment or treatment related to any unrecognized systems of medicine;
39. 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;
40. 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;

41. Act of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane.
42. Any charges incurred to procure documents related to treatment or Illness pertaining to any period of Hospitalization or Illness or any administration costs or any other charges of a non-medical nature in connection with the provision and/or performance of medical supplies and/or services;
43. Personal comfort and convenience items or services including but not limited to T.V. (wherever specifically charged separately), charges for access to cosmetics, hygiene articles, body care products and bath additives, as well as similar incidental services and supplies;
44. Expenses related to any kind of RMO charges, Service charge, Surcharge, night charges levied by the hospital under whatever head or any room upgrades, menu items not included as standard or visitors meals;
45. 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;
    d. In addition to the foregoing, any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above is also excluded.
46. Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants unless prescribed by a medical practitioner;
47. Continuous ambulatory peritoneal dialysis. Coverage for 'Continuous ambulatory peritoneal dialysis' is available on OPD basis and as part of Pre-Post hospitalization expenses;
48. Charges for items not listed in the policy schedule applicable to the member or considered as not medically necessary or which may be considered as elective;
49. Alopecia wigs and/or toupee and all hair or hair fall treatment and products including any investigations; all forms of acne;
50. Any treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification center, sanatorium, home for the aged, remodeling clinic or similar institutions;
51. Any medical or physical condition or treatment or service, which is specifically excluded under the Policy Schedule including the associated medical conditions shown on the endorsement;
52. Cryopreservation or harvesting or storage of stem cells as a preventive measure against possible disease/illness/injury, or implantation or re-implantation of living cells or living tissue whether autologous or provided by a donor;
53. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- Excl12
54. Any other weight management services, treatment and supplies unless requires hospitalization and surgery ;
55. 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)
56. Hormone Replacement Therapy;
57. 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;

58. The evacuation would involve moving Insured Member from a remote location where there is no or limited access;
59. Dental, Orthodontics, Periodontics, Endodontic or any preventative dentistry no matter who gives the treatment;
60. Charges for residential stays in Hospital which are not medically necessary or are incurred for social or domestic reasons or for reasons which are not directly connected with treatment or where the Hospital has effectively become the place of domicile or permanent abode;
61. Any charges made by the medical practitioner, hospital, laboratory or any such medical services which are not reasonable and customary;
62. Genetic tests undertaken to establish whether or not the Insured may be genetically disposed to the development of a medical condition in the future unless requires for current medical treatment;
63. Insured Person suffering from or has been diagnosed with or has been treated for Down's Syndrome/Turner's Syndrome/Sickle Cell Anaemia/ Thalassemia Major/G6PD deficiency prior to the first Policy Start Date, then costs of treatment related to or arising from the disorder whether directly or indirectly will be treated as a Pre-existing Disease and will not be covered within first 36 months from the date of first issuance of the Policy
64. Ear or body piercing and tattooing or treatment needed as a result of any of these;
65. Any charges for treatment incurred during a period for which the premium is not paid;
66. Any claim or part of a claim in which the member has to pay a deductible or co-insurance (where applicable). In such a claim, we will only pay the balance of the claim after we have deducted the excess (or deductible or co-insurance) amount;
67. All bank or credit or foreign exchange charges when the claims payment is made in a currency other than the policy currency upon the member's request;
68. Bacterial infections (except pyogenic infection which occurs through an Accidental cut or wound);
69. Any Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs, alcohol, hallucinogens, smoking.

70. Any treatment or part of treatment or any expenses incurred under this Policy that is not reasonable and customary and/or not medically necessary

Note: In addition to the foregoing, any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above Permanent Exclusions shall also be excluded.

WAITING PERIODS & EXCLUSIONS

Wait Periods applicable under this Policy for All Conditions under Convalescence Benefit are

Initial wait period

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

Specific Wait Period for Named Ailments

I. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with the Company. This exclusion shall not be applicable for claims arising due to an accident.

II. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
III. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
IV. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
V. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
VI. List of specific diseases/procedures:

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

Wait Period for Pre-existing Diseases:

I. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.
II. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
III. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
IV. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer
excluded.

CLAIMS

How to file your Claim

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

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

Reimbursement Process:

Step 1: Claim Intimation

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

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

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

Claims can be intimated to us through the WhatsApp no: - 8860402452 or CHIL customer app i,e. Genie portal.

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

Step 2: Initiating the Claim process

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

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

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

Additional documents needed to claim under Personal Accident benefit:-

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

- Medical reports giving the details of the Accident, nature of Injury and the details of treatment provided, Admission and Death Summary, Accident Report
- Original Death Certificate; if applicable
- Disability Certificate issued by CMO (Chief Medical Officer) as appointed by the Hospital Authorities; if applicable
- A newspaper cutting about accident (if available)
- Certificate from Bank for outstanding amount of loan

The claim form and additional documents are to be sent to us at the following address:
CARE Health Insurance Company Limited
3rd Floor Sector, Tower C,
Vipul Tech Square, Sector-43, Golf Course Road
Gurugram-122009 (Haryana)

Step 3: Claim Processing

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

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

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

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

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

Free Look Period

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

Cancellation / Termination

- The policyholder may cancel this policy by giving 7 days' written notice and in such an event, the Company shall refund proportionate premium for the unexpired policy period.

- 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.
- If the risk under the Policy has already commenced, or only a part of the insurance coverage has commenced, and the option of Policy cancellation is exercised by the Policyholder, then the expenses such as pre- policy medical examination etc. incurred by the Company will also be deducted before refunding of premium.
- The Company may cancel the Policy at any time on grounds of mis-representations, 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-representations, non-disclosure of material facts or fraud.

In case of demise of the Primary Insured Member,

- Where the Policy covers only the Primary Insured Member, this Policy shall stand null and void from the date and time of demise of the Primary Insured Member and the Company shall refund proportionate premium for unexpired Policy Period subject to no claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.
- Where the Policy covers other Insured Members, this Policy shall continue till the end of Cover Period for the other Insured Members. If the other Insured Members wish to continue with the same Policy, the Company will renew the Policy subject to the appointment of a Primary Insured Member provided that:
  - I. Written notice in this regard is given to the Company before the Cover End Date; and
  - II. A Person who satisfies the Company's criteria to become a Primary Insured Member. The criteria being:
    - (a) He / She should become a member of the Group against whom the Master policy is issued.

(b) He / She should satisfy the age limit criteria as mentioned in the product.

Limitation of Liability

Any Claim under this Policy for which the notification or intimation of Claim is received 12 calendar months after the event or occurrence giving rise to the Claim shall not be admissible, unless the Policyholder or the Insured Member proves to the Company satisfaction that the delay in reporting of the Claim was for reasons beyond the Insured Member's control.

Communication

- Any communication meant for the Company must be in writing and be delivered to its address shown in the Policy Schedule/ Certificate of Insurance. Any communication meant for the Policyholder or Insured Member will be sent by the Company to his last known address or the address as shown in the Policy Schedule/ Certificate of Insurance.
- All notifications and declarations for the Company must be in writing and sent to the address specified in the Policy Schedule/ Certificate of Insurance. Agents are not authorized to receive notices and declarations on the Company's behalf.
- Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company.
Out of all the details of the various benefits provided in the Policy Terms and Conditions, only the details pertaining to benefits chosen by policyholder as per Policy Schedule shall be considered relevant

Electronic Transactions

The Policyholder and Insured Member agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the Policy or its terms shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. Any terms and conditions related to electronic transactions shall be within the approved Policy Terms and Conditions

Continuity Benefits

The company will grant continuity of benefits which were available to the Insured Members under a group insurance policy in the immediately preceding Cover Period provided that:

i. The company shall be liable to provide continuity of only those benefits (for e.g: Initial wait period, wait period of Specific Diseases etc)which are applicable under the Policy;
ii. The Insured Members to whom continuity benefits will be provided should be covered under the group insurance policy;
iii. Insured Members covered under this Policy shall have the right to migrate from this Policy to an individual health insurance policy or a family floater policy offered by the company and the credit for wait periods would be given in the opted individual health insurance policy or a family floater policy offered by the

company. Application for this Policy is made within 45 days before, but not earlier than 60 days from the expiry of that group insurance policy

iv. Insured Member can apply only at the time of renewal of the group Policy.

Obligation in respect to minor

If an Insured Member is less than 18 years of age, the Primary Insured Member shall be responsible for ensuring compliance with all terms and conditions of this Policy on behalf of that Insured Member.

Nominee

The Primary Insured Member can at the inception or at any time before the expiry of the Policy, make the nomination for the purpose of payment of Claims.

Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement to the Policy is made by the Company.

In case of any Insured Member other than the Primary Insured Member under the Policy, for the purpose of payment of Claims in the event of death, the default nominee would be the Primary Insured Member.

Proximate Clause

The Company covers the Policyholder/Insured Member only to the extent of Proximity cause which means active and efficient cause that sets in motion a chain of events which brings about a result, without the intervention of any force started and working actively from a new and independent source.

Sanctions and Compliance with Laws

This insurance does not apply to the extent that trade or economic sanctions or other similar laws or regulations prohibit the coverage provided by this insurance.

GRIEVANCE PROCESS

The Company has developed proper procedures and effective mechanism to address complaints, if any of the customers. The company is committed to comply with the Regulations, standards which have been set forth in the Regulations, Circulars issued from time to time in this regard.

If you or the Insured Member or Dependent have a grievance that You or the Insured Member or Dependent wish Us to redress, You or the Insured Member may contact Us with the details of their grievance through:

Website	www.careinsurance.com
WhatsApp No.	8860402452
Post /Courier	Any of Our branch offices or our correspondence address, during normal business days

If the Insured Member is not satisfied with our redressal of their grievance through one of the above methods, You or the Insured Member may contact Our Head of Customer Service at:

The Grievance Cell,
3rd Floor Sector, Tower C,
Vipul Tech Square, Sector-43, Golf Course Road
Gurugram-122009 (Haryana)

If the Insured Member is not satisfied with our redressal of their grievance through one of the above methods, You or the Insured Member may approach the nearest Insurance Ombudsman for resolution of their grievance.

DISCLAIMER

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

STATUTORY WARNING

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

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

VOLUNTARY PURCHASE

The purchase of insurance is purely voluntary and not linked to the availing / granting of any other banking product or service from RBL Bank.

RBL Bank Terms & Conditions Policy Conditions

Data Privacy: By agreeing to Terms & Conditions of EMI Protect Plan under cross sell program by RBL bank, you acknowledge and consent to the use of data such as but not limited to, address, email id, mobile number, Date of Birth for the purpose of issuing your policy. Bank may share your information with relevant third parties solely for the purpose of fulfilling our contractual obligations to you towards issuing the policy, such as underwriting, claims processing, and regulatory compliance