JAN AROGYA BIMA POLICY

PROSPECTUS

Salient features of the Policy

1.0 COVERAGE: The Policy covers reimbursement of Hospitalisation Expenses or Domiciliary Treatment in India under Domiciliary Hospitalisation benefit for Illness/ Injury sustained.

2.0 In event of any claim being admissible, following Reasonable and Customary expenses are reimbursable under the policy:

A. Room rent, Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection / Drugs and Intra venous fluid administration expenses), as provided by the Hospital

B. Associate Medical Expenses; such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Anaesthesia, Blood, Oxygen, Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment..

C. Cost of Pharmacy and Consumables, Cost of Implants and Medical Devices and Cost of Diagnostics.

D. Specific Coverages:

1. **Impairment of Persons'** intellectual faculties by usage of drugs, stimulants or depressants as prescribed by a medical practitioner is covered subject to it arising during treatment of covered illness.

2. **Artificial life maintenance,** including life support machine use, where such treatment will not result in recovery or restoration of the previous state of Health under any circumstances unless in a vegetative state as certified by the treating medical practitioner, is covered following admission for a covered illness. (Explanation: Expenses up to the date of confirmation by the treating doctor that the patient is in vegetative state shall be covered as per the terms and conditions of the policy contract).

3. **Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders:** Our shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) related to following and they are covered after a waiting period of 36 months.

   The below covers are subject to the patient simultaneously exhibiting the following traits and requiring Hospitalisation as per the treating Psychiatrist's advice

   a. Major Depressive Disorder- when the patient is aggressive or violent.

   b. Acute psychotic conditions – aggressive / violent behavior or hallucinations, incoherent talking or agitation.

   c. Schizophrenia - esp. Psychotic episodes.

   d. Bipolar disorder - manic phase.

   Treatment of any Injury due to Suicidality shall not be covered.

   Condition

Treatment shall be undertaken at a Hospital categorized as Mental Health Establishment or at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Mental Health Professional.

Exclusions

Any kind of Psychological counselling, cognitive / family / group / behavior / palliative therapy or other kinds of psychotherapy for which Hospitalisation is not necessary shall not be covered.

4. **Puberty and Menopause related Disorders:** Treatment for any symptoms, Illness, complications arising due to physiological conditions associated with Puberty, Menopause such as menopausal bleeding or flushing is covered only as Inpatient procedure after 24 months of continuous coverage.
5. **Age Related Macular Degeneration (ARMD)** is covered after 36 months of continuous coverage only for Intravitreal Injections and anti – VEGF medication.
6. **Behavioural and Neuro developmental Disorders:** Disorders of adult personality and Disorders of speech and language including stammering, dyslexia; are covered as Inpatient procedure after 24 months of continuous coverage.
7. **Genetic diseases or disorders** are covered after a 36 months waiting periods.

E. Coverage for Modern Treatments or Procedures: The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital.

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. Intravitreal injections.
g. Robotic surgeries.
h. Stereotactic radio surgeries.
i. Bronchial Thermoplasty.
j. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment).
k. IONM - (Intra Operative Neuro Monitoring).
l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

F. Treatment for Congenital Diseases

Congenital Internal Disease or Defects or anomalies shall be covered after twelve months of Continuous Coverage.

Congenital External Disease or Defects or anomalies shall be covered after forty-eight months of Continuous Coverage.

IMPORTANT:

1. Company's liabilities in respect of all claims admitted during the period of insurance shall not exceed the Sum Insured of Rs. 5,000 per person mentioned in the schedule)
2. For the coverages defined in E, waiting period's, if any, shall be applicable afresh

   i.e. for both New and Existing Policyholders w.e.f 1st October 2020. Coverage for such illness or procedures shall only be available after completion of the said waiting periods.

3.0 EXCLUSIONS:

The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any insured with or in respect of:

i. 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 36 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 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

ii. 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 Ninety Days / 12 / 36 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) 90 Days Waiting Period

1. Diabetes Mellitus
2. Hypertension
3. Cardiac Conditions

(ii) 12 Months waiting period

1. Cataract

2. Benign Prostatic Hypertrophy
3. Hysterectomy for Menorrhagia or Fibromyoma
4. Hernia
5. Hydrocele
6. Congenital Internal diseases
7. Fistula in anus, piles, Sinusitis and related disorders

(iii) 36 Months waiting period

1. Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders.
2. Age Related Macular Degeneration (ARMD)
3. Genetic diseases or disorders
4. External Congenital Diseases

iii. FIRST THIRTY DAYS WAITING PERIOD (Code- Excl03)

a. 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.

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

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

A. 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 However, Treatment for any symptoms, Illness, complications arising due to physiological conditions for which aetiology is unknown is not excluded.

B. 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.

However, Expenses related to any admission primarily for enteral feedings is not excluded, if the Oral intake is absent for a period of at-least 5 days. It will be covered for a Maximum period of 14 days in a Policy Period.

C. OBESITY/ WEIGHT CONTROL (Code- Excl06) Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

a. Surgery to be conducted is upon the advice of the Doctor

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

c. The member has to be 18 years of age or older and

d. Body Mass Index (BMI);

1. greater than or equal to 40 or
2. 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

D. 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.

E. 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.

F. 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.

However, Treatment related to Injury or Illness associated with Hazardous activities related to particular line of employment or occupation (not for recreational purpose) is not excluded.

G. 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.

H. EXCLUDED PROVIDERS (Code-Excl11)

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

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

J. Treatments received in health 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)**

K. 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)**

L. REFRACTIVE ERROR (Code- Excl15)

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

M. 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.

N. STERILITY AND INFERTILITY (Code- Excl17)

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization

b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

c. Gestational Surrogacy

d. Reversal of sterilization

O. MATERNITY EXPENSES (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.

P. Acupressure, acupuncture, magnetic therapies.

Q. Any kind of Service charges, Surcharges, Luxury Tax and similar charges levied by the Hospital.

R. Bodily Injury or Illness due to willful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted Injury and attempted suicide.

However, Failure to seek or follow medical advice or failure to follow treatment is not excluded.

S. Circumcision unless necessary for treatment of an Illness not excluded hereunder or as may be necessitated due to an accident.

T. Convalescence, General debility and Venereal disease.

U. Cost of braces, equipment or external prosthetic devices, non-durable implants, eyeglasses, Cost of spectacles and contact lenses, hearing aids including cochlear implants, durable medical equipment.

V. Dental treatment or Surgery of any kind unless necessitated by accident and requiring Hospitalisation.

W. External and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment including CPAP (Continuous Positive Airway Pressure), Sleep Apnoea Syndrome , CPAD (Continuous Peritoneal Ambulatory Dialysis), Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump etc. Ambulatory devices i.e., walker, crutches, Belts, Collars, Caps, Splints, Slings, Stockings, elastocrepe bandages, external orthopaedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer / Thermometer, alpha / water bed and similar related items etc., and also any medical equipment, which is subsequently used at home .

X. 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.

Y. Stem cell implantation/Surgery for other than those treatments mentioned in clause F of Coverage Section

Z. Treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy

AA. Treatment taken outside the geographical limits of India

BB. Vaccination and/or inoculation

CC. 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.

4.0 CONDITIONS

4.1 Every notice or communication to be given or made under this policy shall be delivered in writing at the addresses as shown in the Schedule.

4.2 PREMIUM: The premium payable under this policy shall be paid in advance. No receipt for Premium shall be valid except on the official form of the Company. The due payment of premium and the observance and fulfillment of the terms, provisions, conditions; and endorsements of this policy by the: Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be Condition Precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid, unless made in writing and signed by an authorized official of the Company.

The Insured Person shall obtain and furnish the Company with all original bills, receipts and other documents upon which a claim is based and shall also give the Company such additional information and assistance as the Company-may require in dealing with the claim.

The Insured Person shall obtain and furnish the Company with all original bills, receipts, and other documents upon which a claim is based and shall also give the company such additional information and assistance as the Company may require in dealing with the claim.

4.3 PHYSICAL EXAMINATION: Any medical practitioner authorized by the Company shall be allowed to examine the Insured Person in case of any alleged Injury or Illness requiring Hospitalisation when and so often as the same may reasonably be required on behalf of the

Company.

4.4 MULTIPLE POLICIES:

i. In case of multiple policies taken by You during a period from Us or one or more Insurers to indemnify treatment costs, You shall have the right to require a settlement of Your claim in terms of any of his/her policies. In all such cases We, if chosen by You, shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of this Policy.

ii. Insured 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 We shall independently settle the claim subject to the terms and conditions of this Policy.

iii. If the amount to be claimed exceeds the Sum Insured under a single policy after, You shall have the right to choose Insurers from whom You wants to claim the balance amount.

iv. 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 Hospitalisation costs in accordance with the terms and conditions of the chosen policy.

Note: The insured Person must disclose such other insurance at the time of making a claim under this Policy.

4.5 WHAT IS ABHA NUMBER?

ABHA stands for AYUSHMAN BHARAT HEALTH ACCOUNT (ABHA), a number is a hassle-free method of accessing and sharing health records digitally. It enables interaction with participating healthcare providers, and allows to receive digital lab reports, prescription and diagnosis seamlessly from a verified healthcare professionals and health service providers.

4.6 CAN ANY CLAIM BE REJECTED OR REFUSED?

Yes, a claim, which is not covered under the Policy conditions, can be rejected. In case You are not satisfied by the reasons for rejection, you can represent to Us within 15 days of such denial. If You do not receive a response to Your representation or if You are not satisfied with the response, You may write to our Grievance Cell, the details of which are provided at our website at http://newindia.co.in/public.asp. You may also call our Call Centre at the Toll free number 1800-209-1415, which is available 24x7.

You also have the right to represent your case to the Insurance Ombudsman. The contact details of the office of the Insurance Ombudsman could be obtained from http://www.irda.gov.in/ADMINCMS/cms/NormalData_Layout.aspx?page=PageNo234&mid=7.2

4.7 CAN I CANCEL THE POLICY?

Yes. You may cancel this policy by giving 7 days written notice and in such an event, the Company shall refund premium for the unexpired policy period at pro rata basis, subject to minimum charges of Rs.

The insurer shall refund-

a. refund proportionate premium for unexpired policy period, if the term of policy up to one year and there is no claim (s) made during the policy period.

b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced

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.

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

In the event of death of insured in the middle of policy year/during the course of policy period, the premium for the unexpired policy period shall be refunded proportionately.

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.

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

4.8 HOW TO GET REIMBURSEMENTS IN CASE OF TREATMENT IN NON-NETWORK HOSPITALS OR DENIAL OF CASHLESS FACILITY?

In case of treatment in a non-Network Hospital, TPA will reimburse You the amount of bills subject to the conditions of the Policy. You must ensure that the Hospital where treatment is taken fulfills the conditions of definition of Hospital in the Policy. Within twenty four hours of Hospitalisation the TPA should be intimated. The following documents in original should be submitted to the TPA within seven days from the date of Discharge from the Hospital:

- Claim Form duly filled and signed by the claimant
- Discharge Certificate from the hospital
- All documents pertaining to the illness starting from the date it was first detected

  i.e. Doctor's consultation reports/history
- Bills, Receipts, Cash Memos from hospital supported by proper prescription
- Receipt and diagnostic test report supported by a note from the attending medical practitioner/surgeon justifying such diagnostics.
- Surgeon's certificate stating the nature of the operation performed and surgeon's bill and receipt
- Attending doctor's / consultant's / specialist's / anesthetist's bill and receipt, and certificate regarding diagnosis
- Details of previous policies if the details are not already with TPA or any other information needed by the TPA for considering the claim.

4.7 CAN I CHANGE HOSPITALS DURING THE COURSE OF MY TREATMENT?

Yes it is possible to shift to another hospital for reasons of requirement of better medical procedure. However, this will be evaluated by the TPA on the merits of the case and as per policy terms and conditions.

4.8 WHAT IS THIRD PARTY ADMINISTRATOR (TPA)?

Third Party Administrator (TPA) is a service provider to facilitate service to You for providing Cashless facility for all hospitalizations that come under the scope of Your policy. The TPA also settles reimbursement claims within the scope of the Policy.

4.9 WHAT IS CASHLESS HOSPITALIZATION?

Cashless hospitalization is service provided by the TPA on Our behalf whereby you are not required to settle the hospitalization expenses at the time of discharge from hospital. The settlement is done directly by the TPA on Our behalf. However those expenses which are not admissible under the Policy would not be paid, and You would have to pay such inadmissible expenses to the Hospital. Cashless facility is available only in Networked Hospitals. Prior approval is required from the TPA before the patient is admitted into the Network Hospital. You may visit our Website at http://newindia.co.in/listofhospitals.aspx The list of Network Hospitals can also be obtained from the TPA or from their website. You will have full freedom to choose the hospitals from the Network Hospitals and avail Cashless facility on production of proof of Insurance and Your identity, subject to the claim being admissible. The TPA might not agree to provide Cashless facility at a Hospital which is not a Network Hospital. In such cases You may avail treatment at any Hospital of Your choice and seek reimbursement of the claim subject to the terms and conditions of the Policy. In cases where the admissibility of the claim could not be determined with the available documents, even if the treatment is at a Network Hospital, the TPA may refuse to provide Cashless facility. Such refusal may not necessarily mean denial of the claim. You may seek reimbursement of the expenses incurred by producing all relevant documents and the TPA may pay the claim, if it is admissible under the terms and conditions of the Policy.

4.10 IS THERE AN AGE LIMIT UPTO WHICH THE POLICY WOULD BE RENEWED?

No. Your Policy can be renewed, as long as You pay the Renewal Premium before the date of expiry of the Policy. There is an age limit for taking a fresh Policy, but there is no age limit for renewal. However, if You do not renew Your Policy before the date of expiry or within thirty days of the date of expiry, the Policy may not be renewed, and only a fresh Policy could be issued, subject to Our underwriting rules. In such cases, it is possible that a fresh Policy could not be issued by Us. It is therefore in Your interest to ensure that Your Policy is renewed before expiry.

4.11 CAN THE INSURANCE COMPANY REFUSE TO RENEW THE POLICY?

We may refuse to renew the Policy only on rare occasions such as fraud, misrepresentation or suppression or non-cooperation being committed by You or any one acting on Your behalf in obtaining insurance or subsequently in relation thereto. If We discontinue selling this Policy, it might not be possible to renew this Policy on the same terms and conditions. In such a case You shall however have the option for renewal under any similar Policy being issued by the Company, provided the benefits payable shall be subject to the terms contained in such other Policy.

In case of revision or modification or withdrawal of the Policy a notice will be provided to You 90 days before such revision or modification or withdrawal.

Renewal can also be refused if the Policy is not renewed before expiry of the Policy or within the Grace Period

4.12 IS THERE ANY GRACE PERIOD FOR RENEWAL OF THE POLICY?

Yes. If Your Policy is renewed within thirty days of the expiry of the previous Policy, then the Continuity Benefits would not be affected. But even if You renew Your Policy within thirty days of expiry of previous Policy, any disease contracted or injuries sustained or Hospitalisation commencing during the break in insurance is not covered. Therefore, it is in Your own interest to see that You renew the Policy before it expires.

4.13 CAN I GET TREATED ANYWHERE?

Yes, the Policy covers treatment and/or services rendered only in India.

4.14 WHAT IS FREE LOOK PERIOD?

The Free Look Period shall be applicable on new individual health insurance policies, except for those policies of less than a year, renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

A period of 30 days (from the date of receipt of the policy document) is available to the policyholder to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy. This option is available in case of policies with a term of one year or more.

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

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

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

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

If You have not made any claim during the free look period, then You shall be entitled to:

1) A refund of the premium paid less any expenses incurred by Us on medical examination of the insured persons and the stamp duty charges or;

2) Where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover.

4.15 PORTABILITY AND MIGRATION:

Migration: means, a facility provided to policyholders (including all members under family cover and group Health insurance policy), to transfer the credit gained for pre-existing conditions and specific waiting period, from one health insurance policy to another with the same insurer.

You will have the option to migrate the policy to other Health Insurance products/plans offered by the company by applying for migration of the policy at-least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If You are presently covered and has been continuously covered without any lapses under any Health Insurance product/plan offered by the Company, then you can transfer the credit gained to the extent of the sum

insured, no claim bonus, specific waiting period for pre-existing diseases, moratorium period etc. in the previous policy to the migrated policy

Portability means the facility provided to the health insurance policyholder (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.

You will have the option to port the policy to other Insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at-least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If policyholder is presently covered and has been continuously covered without any lapses under any Health Insurance policy with an Indian General or Health Insurer, then policyholder can transfer the credit gained to the extent of the sum insured, no claim bonus, specific waiting period for pre-existing diseases, moratorium period etc from the existing insurer to the acquiring insurer in the previous policy

4.16 AGE LIMIT: This Insurance is available to persons between the ages of 5 years to 70 years. Children between ages of 3 months to 5 years can be covered only if the parents are also covered under the policy. Insured may renew his Policy beyond the age of 70 years provided there is no break in Insurance.

4.17 FAMILY DISCOUNT:

The policy is available for Individual or a family comprising the Insured and any one or more of the following:

i. Spouse

ii. Dependent Children (maximum 2)

4.18 PAYMENT OF PREMIUM

Age of the person Insured	Upt 46 years	46-55	56-65	66 and above
Head of the family	81	116	139	162
Spouse	81	116	139	162
Dependent child up to 25 years	58	58	58	58
For family of 2 + 1 dependent child	220	289	336	382
For family of 2 + 2 dependent children	277	347	393	439

Note: Service tax is not applicable to the policy.