

INDUSIND HEALTH SUPER TOP UP - PROSPECTUS

1. ELIGIBILITY CRITERIA

- i. Policy can be availed by persons between the age of 18 years and 65 years, as Proposer. Policy can be availed for self and the following family members
 - a. Legally wedded spouse
 - b. Parents and Parents-in-law.
 - c. Dependent Children (i.e. natural or legally adopted) between the age of 3 months to 25 years. If the child above 18 years of age is financially independent, the child will be ported to an Individual Policy having a separate Sum Insured and treated as an Adult.

NOTE:

- Parents or Parents -in -law are allowed to be covered in a separate family floater Policy.
- If the child above 18 years of age is financially independent, the child will be ported to an Individual Policy having a separate Sum Insured and treated as an Adult'
- ii. Age means "Age as on last birthday" as on the date of first Policy issuance or at renewal. If any age changes during proposal stage, then "age" at submission of proposal from would be considered for premium calculation.
- iii. This Policy can be issued to an individual and/or a family.
- iv. There is no maximum cover ceasing age on continuous renewals.
- v. Individual Policy: A maximum of 10 member can be covered in a single individual policy on individual sum insured basis. The family includes, Self, Spouse, Son, Daughter, Father, Mother, Father in law, Mother in law (Note-maximum 6 number of children can be covered)
- vi. Floater Policy: In case of Family Floater, one family will share a single Sum Insured as opted. A maximum of 8 members can be covered in a single-family floater policy with a maximum of 2 Adults.

The following combinations are allowed under:

- a) Self and/or Spouse with up to 6 dependent Children
- b) Parents
- c) Parents-in-Law

2. POLICY PERIOD

The Policy can be purchased for 1 year

3. COVERAGES

3A. BASE COVERS

BENEFIT - 3.1: HOSPITALIZATION EXPENSES

If any of the Insured Person, during the Policy Year, is diagnosed with any Illness or suffers any Injury that requires Inpatient Treatment or Day Care Treatment, then the Company will pay Medical Expenses incurred by the Policyholder/Insured Person in excess of Deductible amount and up to the Sum Insured, subject to the below mentioned terms, conditions and exclusions mentioned under this Policy, for:

3.1.1. IN PATIENT TREATMENT

If during the Policy Year any of the Insured Person undergoes Hospitalization for Inpatient Treatment on the written advice of a Medical Practitioner, then the Company will indemnify the Policyholder/Insured Person for the below incurred Medical Expenses:

- i. Room Rent
- ii. Nursing Expenses,
- iii. Intensive Care Unit (ICU) Charges,
- iv. Medical Practitioner(s) fees,
- v. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances expenses,
- vi. Medicines, drugs and Consumables expenses
- vii. Diagnostic procedures expenses
- viii. The cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure

3.1.2. PRE- HOSPITALIZATION

The Company will indemnify the Policyholder/ Insured Person for the Medical Expenses incurred in the 90 days immediately before the Policyholder/Insured Person was Hospitalized, provided that:

- i. such Medical Expenses are incurred in respect of the same condition for which Insured Person has taken Inpatient Treatment, and
- ii. Company has accepted the Claim for these Inpatient Treatment expenses under Section 3.1.1, 3.1.4, 3.2, 3.3, 3.5, 3.8, 3.10, 3.15

3.1.3. POST HOSPITALIZATION

The Company will indemnify the Policyholder/Insured Person for the Medical Expenses incurred in the 180 days immediately after the Insured Person was discharged post Hospitalization provided that:

- i. Such costs are incurred in respect of the same condition for which the Insured Person has taken Inpatient Treatment, and
- ii. Company has accepted the Claim for these Inpatient Treatment expenses under Section 3.1.1, 3.1.4, 3.2, 3.3, 3.5, 3.8, 3.10, 3.15

3.1.4. DAY CARE TREATMENT

The Company will indemnify the Policyholder/Insured Person for the Medical Expenses on the written advice of the Medical

Practitioner, if during the Policy Year, any of the Insured Person undergoes a Day Care Treatment as defined under this Policy.

3.2. BENEFIT-2: DOMICILIARY HOSPITALIZATION

The Company will indemnify the Insured Person(s) for the Medical Expenses incurred during Domiciliary Hospitalization as defined under this Policy, provided that the condition for which the medical treatment is required continues for at least three continuous and completed days, during the Policy Year, in which case the Company will pay the Reasonable and Customary Charges of any necessary medical treatment for the entire period, subject to Deductible.

The Company shall not be liable for payment of any Claim under this Benefit in relation to treatment of any of the following diseases

- i. Asthma
- ii. Bronchitis
- iii. Chronic Nephritis and Chronic Nephritic/Nephrotic Syndrome
- iv. Diarrhoea and all types of Dysenteries including Gastro-enteritis
- v. Epilepsy
- vi. Influenza, Cough and Cold
- vii. Pyrexia of unknown origin for less than 10 days
- viii. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis
- ix. Arthritis, Gout and Rheumatism

3.3. BENEFIT - 3: MATERNITY COVER

The Company will indemnify the Policyholder/Insured Person up to Rs.2 lakhs for Maternity Expenses incurred on Inpatient Treatment during the Policy Year subject to the following:

- i. The Company will cover the Maternity Expenses in excess of Deductible as specified under the Policy Schedule.
- ii. This benefit shall become available only after the expiry of 12 months from the date of inception of the first Policy with the Company.
- iii. The payment under this benefit is limited to maximum two deliveries or termination(s) or either, during the lifetime of the Insured Person.
- iv. For a covered delivery or termination, Pre-natal Medical Expenses from the date of conception and upto the child birth and Postnatal Medical Expenses for a period of one month from the date of childbirth shall be covered within the Maternity limit of Rs. 2 lakhs.

- v. For a covered delivery, Medical Expenses incurred by the Insured Person's New Born Baby from date of birth till 90 days of age towards In Patient Treatment shall be covered within the Maternity limit of Rs 2 lakhs.

Subject to the terms & conditions, the Policy will cover New Born Baby beyond 90 days only after the receipt of requisite premium for the addition.

3.4. BENEFIT 4: ORGAN DONOR

The Company will indemnify the Policyholder/Insured Person for the Medical Expenses incurred during In Patient Treatment, in respect of donor for any organ transplant Surgery conducted on the Insured Person during the Policy Year, provided that:

- i. The organ donated is for the use of the Insured Person, and
- ii. Company shall not pay the donor's Pre and Post Hospitalization Expenses
- iii. Company has accepted In patient Hospitalization Claim under Benefit 3.1.1 In Patient Treatment.

An organ donor is any person whose organ has been made available in accordance and compliance with The Transplantation of Human Organs Act, 1994 (amended).

3.5. BENEFIT - 5: AYUSH TREATMENT

The Company will indemnify the Policyholder /Insured Person for the Medical Expenses which are incurred on treatment under Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy up to the Sum Insured in excess of Deductible under the Policy. The AYUSH Treatment should be carried out in an AYUSH Hospital or AYUSH Day Care Centre as defined under the Policy.

The Company shall not be liable for payment of any Claim under this Benefit arising out of or relating to:

- i. Treatment other than Inpatient Treatment or Day Care Treatment
- ii. Medical Expenses incurred for evaluation, Investigation only.
- iii. Treatment availed outside India.
- iv. Treatment at a healthcare facility which is NOT an AYUSH Hospital or AYUSH Day Care Centre.
- v. All preventive and rejuvenation treatments (non-curative in nature), or treatments that are not Medically Necessary. This

includes treatments at Spa, Massages and Health Rejuvenation Procedure.

3.6. BENEFIT - 6: AMBULANCE COVER

The Company will indemnify the Policyholder/Insured Person upto an amount of Rs 3500 per Hospitalization for expenses incurred on availing Ambulance services offered by a Hospital or by an Ambulance service

provider that

- i. Such life-threatening emergency condition is certified by the Medical Practitioner.
- ii. Company has accepted Inpatient Hospitalization Claim under Section 3.1.1 In Patient Treatment.
- ii. The coverage includes the cost of the transportation of the Insured Person to the nearest Hospital or from one Hospital to another Hospital, which is prepared to admit the Insured Person and provide the necessary medical services, provided that transportation has been prescribed by a Medical Practitioner and is Medically Necessary.

3.7. BENEFIT - 7: EMERGENCY AIR AMBULANCE COVER

The Company will indemnify the Policyholder/ Insured Person upto the limits specified below, for the expenses incurred on availing

Air Ambulance services during the Policy Year, provided

- i. The amount payable under this benefit shall be upto Rs 2lakhs for policies having Sum Insured less than Rs 10 lakhs and upto Rs 5 lakhs for policies having Sum Insured greater than and equal to Rs 10 lakhs.
- ii. The air Ambulance service benefit is available to Insured Person only in case of an Emergency Care which requires immediate and rapid ambulance transportation as prescribed by the Medical Practitioner and is Medically Necessary, which in actual cannot be provided by a ground Ambulance.
- iii. The expenses are payable only from the place of first occurrence of the Illness/Accident to the nearest Hospital
- iv. The Origin and Destination of Emergency Air Ambulance Service are within the geographical boundaries of Republic of India
- v. Company has accepted Inpatient Hospitalization Claim under Scope of Cover- Section 3.1.1 In Patient Treatment.
- vi. This benefit can be availed once in a Policy Year.
- vii. Such Air Ambulance should have been duly licensed to operate as such by the Competent Authorities of the Government.

3.8. BENEFIT-8: MODERN TREATMENTS

The Company will indemnify the Insured Person, to the extent of Sum Insured subject to Deductible for the Medical Expenses incurred during the Policy Year on Inpatient Treatment or Day Care Treatment or Domiciliary Treatment of below mentioned Modern Treatment:

- i. Uterine Artery Embolization and HIFU
- ii. Balloon Sinuplasty

- iii. Deep Brain Stimulation
- iv. Oral Chemotherapy
- v. Immunotherapy-Monoclonal Antibody to be given as injection
- vi. Intra Vitreal injections
- vii. Robot surgeries
- viii. Stereotactic radio surgeries
- ix. Bronchial Thermoplasty
- x. Vaporization of the prostate (Green laser treatment or holmium laser treatment)
- xi. IONM- (Intra Operative Neuro Monitoring)
- xii. Stem Cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered

The claim under this benefit shall be subject to all other terms under Benefit 3.1 to 3.15

3.9 BENEFIT - 9: ADDITIONAL ITEM COVER

The Company shall pay the Reasonable and Customary expenses incurred by the Policyholder / Insured Person, during the Policy Year, which are listed in 'Annexure A- List I as Optional Items' of this Policy, provided:

- i. such consumables or items are prescribed by the treating Medical Practitioner and are medically necessary for the treatment of the same condition for which Insured Person has taken In-Patient or Daycare Treatment, and
- ii. The Company has accepted Claim for Hospitalisation expenses under the Policy.
- iii. The amount payable towards this Benefit in conjunction with the payment for all the other benefits under the Policy, shall be within the Sum Insured limit, and subject to Aggregate Deductible as specified under the Policy Schedule. No Separate Deductible shall be applicable for this benefit.

3B. PERSONAL ACCIDENT COVER

3.10 BENEFIT - 10: WAIVER OF DEDUCTIBLE FOR ACCIDENTAL CLAIMS

In case any of the Insured Person covered under the Policy, sustains an injury, from an Accident, resulting in Hospitalization of the Insured Person, during the Policy Year, then the General Exclusion -5(15) Deductible under the Policy will be waived off by the Company for that Accidental Hospitalization claim, provided:

- i. The Insured Person has taken an In-Patient or Daycare Treatment for such Accidental Claim.
- ii. Pre and Post Hospitalization Medical Expenses are payable.
- iii. The benefit Waiver of Deductible for Accidental

Claims shall be available to Insured Person(s) at each Policy Year, starting from day 1 of the Policy Start Date.

- iv. The amount claimed under this benefit shall be considered towards the Deductible for any illness related claims.

NOTE: The benefit, Waiver of Deductible for Accidental claims shall not be applicable on availing Benefit-14 (Deductible-Buy Back) under the Policy.

3C. RENEWAL BENEFITS

3.11 BENEFIT - 11: WAIVER OF PREMIUM- ON FIRST DIAGNOSIS OF CRITICAL ILLNESS

If any of the Insured Person other than Dependent children as covered under the Policy is diagnosed for the first time, for any of the listed Critical Illness which is admissible and payable under this Cover, during the Policy Year, then the renewal Policy premium for a period of one year shall be waived off. For long term policies, the Company shall waive one-year proportionate renewal Policy premium. This is subject to the following

- i. This benefit is provided once in the lifetime of the Insured Person
- ii. The Critical Illness has been diagnosed during the Policy Year
- iii. Such Renewal shall be done on the same basis as the expiring Policy.
- iv. The Cumulative Bonus will not be accrued in the year claim has been made under the Policy
- v. Aggregate Deductible shall not be applicable to this Benefit

For the purpose of this Benefit, Critical illness is as defined below:

3.11.1 CRITICAL ILLNESS MEANS DISEASE / ILLNESS / SURGERY LIMITED TO THE FOLLOWING

i. Cancer of specified severity

- a. A malignant tumour characterized by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded

- All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
- Any non-melanoma skin carcinoma unless

there is evidence of metastases to lymph nodes or beyond;

- Malignant melanoma that has not caused invasion beyond the epidermis;
- All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
- All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- Chronic lymphocytic leukaemia less than RAI stage 3
- Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
- All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs; • All tumors in the presence of HIV infection

ii. Open Heart Replacement or Repair of Heart Valves

- a. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease- affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

iii. Major Organ /Bone Marrow Transplant

- a. The actual undergoing of a transplant of:
 - One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
 - Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner
- b. The following are excluded:
 - Other stem-cell transplants
 - Where only islets of langerhans are transplanted

iv. Coma of specified severity

- a. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

- no response to external stimuli continuously for at least 96 hours;
- life support measures are necessary to sustain life; and
- Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

b. The condition has to be confirmed by a Specialist Medical Practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

v. Surgery of Aorta

a. The actual surgical repair of an aortic aneurysm (an abnormal bulge in the wall of the aortic blood vessel causing the aorta to dilate or widen and the aortic valve to leak leading to bursting of arterial wall) for the first time by a surgeon. The diagnosis to be evidenced by any two of the following:

- Computerised tomography (CT) scan
- Magnetic resonance imaging (MRI) scan
- Echocardiography (an ultrasound of the heart)
- Abdominal ultrasound (for associated abdominal aneurysms)
- Angiography (an x-ray of the blood vessels)

vi. Benign Brain Tumor

a. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

b. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

- Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
- Undergone surgical resection or radiation therapy to treat the brain tumor.

c. The following conditions are excluded:

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, and tumors of skull bones, and tumors of the spinal cord.

vii. Kidney Failure Requiring Regular Dialysis

a. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation

is carried out. Diagnosis has to be confirmed by a specialist Medical Practitioner

viii. End Stage Lung Failure

a. End stage lung disease, causing chronic respiratory failure, as confirmed by a physician and evidenced by all of the following:

- FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
- Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
- Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO₂ < 55mmHg); and
- Dyspnea at rest.

ix. End Stage Liver Failure

a. Permanent and irreversible failure of liver function that has resulted in all three of the following:

- Permanent jaundice; and
- Ascites; and
- Hepatic encephalopathy.

x. Stroke resulting in permanent symptoms

a. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

b. The following are excluded:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain

Vascular disease affecting only the eye or optic nerve or vestibular

xi. Permanent Paralysis of Limbs

a. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

xii. Multiple Sclerosis with persisting symptoms

a. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

- Investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
 - There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.
- b. Other causes of neurological damage such as SLE and HIV are excluded.

xiii. Blindness

- a. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.
- b. The Blindness is evidenced by:
- corrected visual acuity being 3/60 or less in both eyes or ;
 - the field of vision being less than 10 degrees in both eyes.
- c. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

xiv. Third Degree Burns

- a. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

xv. Bacterial Meningitis

- a. Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks. This diagnosis must be confirmed by:
- The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
 - A consultant neurologist.

Bacterial Meningitis in the presence of HIV infection is excluded.

3.12 BENEFIT-12: CUMULATIVE BONUS

The Company shall provide 10% of the Base Sum Insured as Cumulative Bonus at the end of each completed and continuous

Policy Year, provided that no claim has been made in the expiring Policy Year. This benefit is subject to the following:

- i. In any Policy Year, the accrued Cumulative Bonus, including the one credited under Portability if any, shall not exceed 50% of the Base Sum Insured

available in this renewed Policy.

- ii. The Cumulative Bonus shall not enhance the available Room Category limit and other such limits which are a function of Sum Insured which shall always be applicable on the Base Sum Insured.
- iii. In relation to a Floater, the Cumulative Bonus, shall be available on Floater basis. The Cumulative Bonus which accrued during
- a claim-free Policy Year will only be available to those Insured Persons who were insured in such claim-free Policy Year and continue to be insured in the subsequent Policy Year.
- iv. If the Insured Persons in the expiring Policy are covered on an Individual basis and the expiring Policy has been Renewed on a Floater basis, then the Cumulative Bonus to be carried forward for such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons
- v. In case of Floater Policy where Insured Persons renew their expiring Policy by splitting the Policy in to two or more Floater Policies/Individual Policies ,the Cumulative Bonus shall be split equally amongst Insured Persons ;except where the Policy is split due to the child attaining the age of 25 years, in which case both the Renewed Policies shall carry the full accrued Cumulative Bonus.
- vi. If a claim is made in the expiring Policy Year, and is notified to the Company after the acceptance of Renewal premium any incremental Cumulative Bonus awarded basis the expiring Policy Year shall be withdrawn.
- vii. Entire Cumulative Bonus will be lost if Policy is not continued / renewed within the Grace Period.
- viii. Cumulative Bonus shall be applicable on an annual basis subject to continuation of the Policy with the Company.
- ix. In case of a claim in any given Policy Year the accrued Cumulative Bonus amount shall not be reduced in the subsequent year, unless the Cumulative Bonus amount has been utilized partially or fully for settlement of claim.
- x. The Cumulative Bonus will be carried forward to next Renewal Year, even if the Policyholder avails the Benefit -14 (Deductible-Buy Back)
- xi. This clause does not alter the Company's right to decline renewal or to cancel the Policy.
- xii. For a claim to be admissible under Cumulative Bonus it should be admissible under the Benefit 3.1 to 3.10 and 3.15

3.13 BENEFIT - 13: HEALTH CHECK UP

Irrespective of Claim, at the end of every three

consecutive and continuous Policy Years, the Company shall provide the listed diagnostic or preventive medical check-up expenses with respect to the Insured Person's, on Individual or Floater basis. This benefit is subject to following:

- i. The Policy has been continuously renewed with the Company without any break
- ii. The cost of medical check-up is limited to Rs 3000 for policies with Deductible less than Rs 10 lakhs and upto Rs 5000 for policies with Deductible equal to and greater than Rs10 lakhs
- iii. In case of a Floater Policy, the medical check-up limit mentioned above in point (ii) is available on Floater basis.
- iv. This benefit has a separate limit and does not affect the Cumulative Bonus under the Policy.
- v. The Deductible shall not be applicable for this Benefit.
- vi. The Insured Person can execute the listed medical tests anytime within the period of four months of eligibility.
- vii. The benefit will be available only on Cashless basis and arranged with Company's Empaneled Service Providers.
- viii. The benefit shall only be applicable to those Insured Person's who were insured under the Policy during the last three consecutive and continuous Policy Years
- ix. After availing Benefit-14 Deductible-Buy Back, the cost of medical check-up payable under this benefit is limited to Rs 5000.

Following are the list of medical tests:

Organ/ Disease	Specific Tests
Heart	ECG, 2D Echo, TMT, Lipid Profile
Liver	Liver Profile, Sonography Abdomen
Kidney	Kidney Profile, Sonography Abdomen
Lungs	Chest X-Ray, PFT
Eyes	Vision Test, Colour Vision Test, Eye Dilation Test, Intraocular Pressure Measurement
Female	Specific PAP Smear, Sonography Abdomen and Pelvis, Mammography
Thyroid	Gland Thyroid Function Test
ENT	ENT check Up, Audiometry Test
Dental	OPG Dental (X Ray)
Diabetes	Blood Sugar (PP/Fasting), HbA1c
General	CBC, C-Reactive Protein, Urine Routine, Serum Electrolytes (Calcium, Potassium, Sodium, Phosphorus, Chloride), Vitamin D, Vitamin B-12

3.14 BENEFIT - 14: DEDUCTIBLE- BUY BACK (OPTIONAL BENEFIT)

At the end of four consecutive and continuous Policy Years if there has been no In-patient or Day Care Hospitalization in respect of any of the Insured Persons in the Policy, the Company shall provide the Policyholder, with the option to buy back the Deductible amount. If the Policyholder chooses to exercise this option, and make appropriate payment for such option, the Base Sum Insured shall be the sum of:

- i. The expiring Policy's Base Sum Insured and
- ii. The expiring Policy's Deductible

No Deductible shall apply on such renewal where buy back option has been exercised and paid for.

This benefit is subject to the following:

- i. The buy back option shall be subject to underwriting approval
- ii. The Policyholder can exercise this option at the time of renewal, provided that the Policy was in force for four consecutive and continuous years immediately preceding such renewal, and all renewing members (except new born baby) had been continuously covered under the Policy for such four Policy Years, and had no In-Patient or Day Care Hospitalization during this period.
- iii. On exercising of the buy back option, Insured Person will be offered continuity of coverage to the extent of the full amount of the enhanced Sum Insured, in terms of Waiting Period with respect to Pre-Existing Diseases and time bound exclusions as specified in Section - 4 of this Policy.
- iv. The buyback option will not alter the Cumulative Bonus. The accrued Cumulative Bonus under the expiring Policy will be carried forward to subsequent renewal.
- v. Even on availing buy back option, the sub-limits applicable to the other benefits/section of this Policy will remain unchanged.
- vi. If Policy holder opts buy back option under the Policy then
 - Benefit-10: Waiver of Deductible for Accidental Claims shall not be applicable under the Policy.
 - Benefit-13- Health Check up under the Policy shall be limited to Rs 5000.
- vii. Buy back option shall not be available if Policy is not renewed on or before expiry of Grace Period.
- viii. Except for enhancement in Base Sum Insured due to Deductible buyback, the Policy shall be renewed on the same basis as the expiring Policy. Any change in terms and conditions shall be subject to underwriting approval.
- ix. Waiting Periods may be applied afresh for any change in Policy terms and conditions, addition or deletion of



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member at the time of renewal, subject to underwriting.

Underwriting Norms applicable to Deductible- Buy Back (Optional Benefit)

The Company shall accept the request for Deductible -Buy Back on satisfaction of all the three criteria mentioned below:

- No claim has been made under this Policy in the four (consecutive and continuous) years immediately preceding the date of application for Deductible -Buy Back.
- The Proposer has declared in writing that none of the Insured Persons has undergone Hospitalization (whether In-patient or Day Care treatment) in the four (consecutive and continuous) years immediately preceding the date of application for Deductible -Buy Back
- All the Insured Persons aged 18 and above have undergone the below listed Medical Tests and the results of the medical tests are within the normal ranges.

Following are the list of medical tests:

Age in Years	In all cases
18 - 55	Category 1
55 - 60	Category 1
61 - 65	Category 2
#	Description
Category 1	MER, CBC, FBS, RUA, S. Creatinine
Category 2	MER, CBC, FBS, HbA1c, Lipid profile, SGOT, SGPT, GGT, RUA, ECG, HBsAg, S. Creatinine
Test Abbreviation	Description
MER	Medical Examination Report
CBC	Complete Blood Count
HbA1c	Glycosylated Haemoglobin
Lipid Profile	HDL, LDL, Serum Total Cholesterol, Serum Triglycerides, Sr. Total Cholesterol/HDL ratio
SGOT	Serum Glutamic Oxaloacetic Transaminase (also called AST - Aspartate Aminotransferase)
SGPT	Serum Glutamic Pyruvic Transaminase (also called ALT - Alanine Aminotransferase)
GGT	Gamma Glutamyle Transferase
RUA	Routine Urine Analysis

TMT	Exercise Electro cardiogram (Tread Mill Test)
ECG	Resting Electro Cardiogram
2D Echo	2D Echocardiogram with Color Doppler
HbsAg	Australia Antigen
HIV	HIV (I&II)
S Creatinine	Serum Creatinine
USG (Abdo & Pelvis)	Ultrasound Sonography of Abdomen and Pelvis
PSA	Prostate Specific Antigen (for Males only)
PAP	Papanicolaou test (PAP Smear Test) - For females only

Note: The Company may ask additional tests for Insured Persons whose test results vary from the normal ranges. Where request for Deductible - Buy Back is accepted by the Company, the Company shall bear 100% of the cost of the medical tests requested for underwriting.

In case where the request for Deductible- Buy Back is rejected by the Company, the Policyholder shall have the right to renew the Policy on the same terms as the expiring policy (with Deductible).

3D. GLOBAL COVER

3.15 BENEFIT - 15: WORLDWIDE EMERGENCY COVER

In the event, the Insured Person has a Medical Emergency whilst being overseas, during the Policy Year, and if such Medical Emergency shall, upon the written Medical Advice of a Medical Practitioner/ Physician, require any such Insured Person, to incur Hospitalization within the Policy Year at any Hospital, for the Medically Necessary Treatment of the Insured Person, then the Company will indemnify the Insured Person for the amount of such Medical Expenses, which should be Reasonable and Customary Charges and are incurred by the Policyholder/Insured Person up to the extent of Sum Insured as specified in the Policy Schedule.

The Aggregate Deductible shall not be applied for claims under this benefit. However, an amount (in INR) equivalent to USD 100 shall be deducted from each and every claim made under this benefit.

For a given Medically Necessary Treatment that is admissible as a Claim under the Benefit, the following are covered:

- In-Patient Treatment in a local Hospital at the place the Insured Person is staying at the time of occurrence of an insurable event or at the nearest Hospital. The below mentioned medical expenses are covered under In-Patient Treatment

- a. Room Rent Charges
- b. Nursing Expense
- c. Intensive care Unit (ICU) charges
- d. Medical Practitioner(s) fees
- e. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances expenses, Medicines, drugs and Consumables expenses
- f. Diagnostic procedures expenses
- g. The cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure
- ii. Day Care Treatment as defined under the Policy
- iii. Out-Patient treatment, provided, the same is critical and cannot be deferred till the Insured Person's return to the Republic of India.
- iv. Medical aid that is prescribed by a Physician as necessary part of the treatment for broken limbs or injuries (e.g. plaster casts, bandages and walking aids).
- v. Cost of Road Transportation, including necessary medical care en-route, by an Ambulance to the nearest Hospital or to the nearest Physician.
- vi. Cost of being transferred by Road to a special clinic if this is Medically Necessary Treatment and is prescribed by the Physician.
Special Clinic shall mean a Clinic (or Hospital or equivalent medical facility) where the Insured is required to be transferred for a specialised treatment or specialised testing or consultation from an expert Medical Practitioner, which is not available at the current place of treatment.
- vii. Emergency Air Ambulance Service: The transportation cost for availing Air Ambulance Service during the Policy Year from the place of first occurrence of the Illness/Accident to the nearest Hospital will be payable only in case of an Medical Emergency which requires immediate and rapid ambulance transportation as prescribed by the Medical Practitioner/Physician and is Medically Necessary, which in actual cannot be provided by a ground Ambulance. The total liability of the Company with respect to Emergency Air Ambulance service shall be upto Rs 2 lakhs for policies having Sum Insured less than Rs. 10 lakhs and upto Rs 5lakhs for policies having Sum Insured greater than and equal to Rs 10 lakhs provided that a corresponding claim for Hospitalization has been made and accepted under this benefit.
- viii. Lifesaving unforeseen emergency measures provided to the Insured Person by the Physician for Hospitalization arising out of
 - a. Pre-Existing Disease in case of Life Threatening Medical Conditions. The treatment for these emergency measures would be paid till the Insured Person becomes medically stable. All further medical

cost to maintain medically stable condition or to prevent the onset of acute pain would have borne by the Insured Person.

Specific Exclusion applicable to 3D.Global Cover:

The Company shall not be liable to make any payment under this section in connection with or in respect of any expenses whatsoever incurred by the Insured Person for:

- i. Travelling for Medical Treatment only: Traveling against the Medical advice of the Medical Practitioner or for receiving Medical treatment abroad if that is the reason for temporary stay abroad.
 - ii. Pre and Post Hospitalization Expenses
 - iii. Pre-existing Diseases:Any claim arising that is related to Pre-Existing Disease except for Lifesaving unforeseen emergency measures as described under Benefit-15 (Worldwide Emergency Cover)
 - iv. Treatment that could be delayed: Treatment which could reasonably be delayed until the Insured/Insured Person's return to the Republic of India. The question of what can or what cannot be reasonably delayed will be decided jointly by the treating Medical Practitioner/Physician and the Emergency Assistance Service Provider.
 - v. Degenerative, Orthopedic and Cancer related: Treatment of orthopedic, degenerative, diseases and any cancer, malignant / benign tumors and such related conditions to Neoplasm, unless the medical assistance provided abroad involves unforeseen emergency measures to save the Insured Person's life or measures solely designed to relieve acute pain in any case excluding chemotherapy or radiotherapy expenses.
 - vi. Maternity Expenses
 - 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 Year
 - vii. Pregnancy related check-ups: Medical check-ups during pregnancy or treatment of the pregnancy.
 - viii. General Exclusions:Any exclusion mentioned in the Section-5 General Exclusions of this Policy.
- #### 4. WAITING PERIOD
- The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below. The waiting periods mentioned below shall not apply to Section 3D. Global Cover.
- I. **PRE-EXISTING DISEASE (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 24/36 months (as specified in the Policy Schedule) of continuous coverage after the date of inception of the first Policy with Insurer

- 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 24/36 months (as specified in the Policy Schedule) for any Pre-Existing Disease is subject to the same being declared at the time of application and accepted by Insurer

II. SPECIFIED DISEASE/PROCEDURE WAITING PERIOD (CODE: EXCL02)

- a. 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 us. 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
- f. List of specific diseases/procedures in respect of which 24 months waiting period is imposed is mentioned below:

Organ / Organ System	Illness /Diagnosis (irrespective of treatment being medical or surgical)	Surgeries / Surgical Procedure (irrespective of any Illness / diagnosis)
Ear, Nose, Throat (ENT)	• Sinusitis • Rhinitis • Tonsillitis	• Adenoidectomy • Mastoidectomy • Tonsillectomy

		• Tympanoplasty • Surgery for nasal septum deviation • Surgery for turbinate hypertrophy • Nasal concha resection • Nasal polypectomy
Gynaecological	• Cysts, polyps, including breast lumps • Polycystic ovarian diseases • Fibromyoma • Adenomyosis • Endometriosis • Prolapsed uterus	• Hysterectomy unless necessitated by malignancy
Orthopaedict	• Non-infective arthritis • Gout and rheumatism • Osteoporosis • Ligament, tendon and meniscal tear • Prolapsed intervertebral disk	• Joint replacement surgery
Gastrointestinal	• Cholelithiasis • Cholecystitis • Pancreatitis • Fissure/ fistula in anus, haemorrhoids, pilonidal sinus • Gastro Esophageal Reflux Disorder (GERD), ulcer and erosion of stomach and duodenum	• Cholecystectomy Surgery of hernia


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	• Cirrhosis (however alcoholic cirrhosis is permanently excluded) • Perineal and perianal abscess • Rectal prolapse	
Urogenital	• Calculus diseases of urogenital system including kidney, ureter, bladder stones • Benign hyperplasia of prostate • Varicocele	• Surgery on prostate unless necessitated by malignancy • Surgery for hydrocele/rectocele
Eye	• Cataract • Retinal detachment • Glaucoma	• Surgery for correction of eye sight due to refractive error above dioptre 7.5
Others	• Congenital internal disease	• Surgery of varicose veins and varicose ulcers
General (Applicable to all organ systems/ organs whether or not described above)	• Benign tumors of non-infectious etiology Such as cysts, nodules, polyps, lumps or growth.	• Nil

5. EXCLUSIONS (APPLICABLE TO ALL BENEFITS UNDER THE POLICY)

5.1 GENERAL EXCLUSIONS

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

1) Investigation & Evaluation (Code:Excl 04)

- Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
- Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are except under the Benefit-13- Health Check Up.

2) Rest Cure, rehabilitation and respite care (Code:Excl 05)

- Expenses related to any admission primarily for

enforced bed rest and not for receiving treatment. This also includes:

- 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.
- Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

3) Obesity/ Weight Control (Code:Excl 06): Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

- Surgery to be conducted is upon the advice of the Doctor
- The surgery/Procedure conducted should be supported by clinical protocols
- The member has to be 18 years of age or older and
- Body Mass Index (BMI);
 - greater than or equal to 40 or
 - 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:
 - Obesity-related cardiomyopathy
 - Coronary heart disease
 - Severe Sleep Apnea
 - Uncontrolled Type2 Diabetes

4) Change-of-Gender treatments (Code:Excl 07): Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex

5) Cosmetic or Plastic Surgery (Code:Excl 08): 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

6) Hazardous or Adventure sports (Code:Excl 09): Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

7) Breach of law (Code: Excl 10): Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

8) Excluded Providers (Code: Excl 11): 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. (For updated and detailed list of Excluded Providers refer website www.indusindinsurance.com)

- 9) Substance Abuse and Alcohol (Code: Excl 12): Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.
- 10) Wellness and Rejuvenation (Code: Excl 13): Treatments received in health spas, 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.
- 11) Dietary Supplements & Substances (Code: Excl 14): 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
- 12) Refractive Error (Code: Excl 15): Expenses related to the treatment for correction of eye sight due to refractive error less than

7.5 DIOPTERS

- 13) Unproven Treatments-Code (Code: Excl 16): 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.
- 14) Sterility and Infertility (Code: Excl 17): 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
- 15) Deductible: Company is not liable for any payments under this Policy unless the Medical Expenses incurred during the Policy Year exceeds the Aggregate Deductible (as specified in the Policy Schedule) except for Benefit-10 (Waiver of Deductible for Accidental Claims) and on availing Benefit-14 (Deductible-Buy Back (Optional Benefit)) under the Policy.
However, under Benefit-14 (Worldwide Emergency Cover), an amount (in INR) equivalent to USD 100 shall be deducted from each and every claim made under the benefit.
- 16) External Congenital Anomaly: Treatment of External Congenital Anomaly

- 17) Treatment other than Medically Necessary Treatment: Any treatment or part of a treatment that is not Medically Necessary Treatment
- 18) Outpatient treatment: Treatment which has been done on an outpatient basis without any Hospitalization, except for Benefit-15 (Worldwide Emergency Cover)
- 19) Overseas treatment: Any treatment taken by Insured Person outside India, except for Benefit-15 (Worldwide Emergency Cover)
- 20) Charges other than Reasonable & Customary Charges: Any Medical Expenses which are not reasonable and Customary Charges.
- 21) Self-injury or suicide: Any intentional self-inflicted Injury, suicide or attempted suicide.
- 22) Treatment outside discipline: Treatment taken from anyone not falling within the scope of definition of Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication
- 23) Nuclear Attack: Nuclear, Chemical or Biological attack/ 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 Clause:
 - a. Nuclear attack / 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/ 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/ weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.
- 24) 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.

5.2 PERMANENT EXCLUSIONS

A permanent exclusion will be applied on Pre-Existing medical or physical condition or treatment of an Insured Person, if such exclusion is accepted by the Proposer and specifically mentioned in the Policy Schedule.

This option, as per Company's underwriting policy, will be used for such condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person. The list of such diseases/ conditions or treatments are enclosed as an Annexure-F.

6. DEDUCTIBLE AND SUM INSURED LIMITS

Below mentioned are the Deductible Vs Sum Insured combination options available under the Policy

Deductible (in lakhs)	Sum Insured (in lakhs)				
2	5	8	13		
3	7	12	22	47	
4	6	11	21	46	
5	5	10	20	45	95
6	9	19	44	94	
9	16	41	91		
10	15	40	90		
12	13	38	88		
15	35	60	85		
18	32	57	82		
20	30	55	80	130	
30	45	70	120		

7. POLICY PLAN

There are two plans under the Policy. Plan A and Plan B

PLAN A: Deductible applicable under Plan A is Annual Aggregate Deductible.

PLAN B: Deductible applicable under Plan B is Long Term Aggregate Deductible

8. IMPACT OF DEDUCTIBLE BUY BACK (OPTIONAL BENEFIT)

Subject to terms and conditions under the Policy, if the Policyholder avails Benefit-14 Deductible -Buy back, then the Policy will not have any Plans (A or B) and No Deductible shall apply on such renewed Policy. The renewed Policy shall have revised limits which are mentioned below.

Cover	The Policy shall convert into a Zero Deductible Policy on exercising Benefit-14-Deductible -Buy back. Limits on Renewed Policy after availing Deductible Buy Back (Optional Benefit) are detailed below
-------	--

Revised Sum Insured	The Policy will have a Revised Sum Insured which will be sum total of Expiring Policy's Base Sum Insured and Deductible.
Base Covers	
Benefit 1. Hospitalization Expenses	Within revised Sum Insured
Benefit 2. Domiciliary Hospitalization	Within revised Sum Insured
Benefit 3. Maternity Cover	Limited to Rs. 2 lakhs
Benefit 4. Organ Donor	Within revised Sum Insured
Benefit 5. AYUSH Treatment	Within revised Sum Insured
Benefit 6. Ambulance Cover	Rs. 3500 per hospitalization
Benefit 7. Emergency Air Ambulance Cover	If revised Sum Insured is less than 10 lakhs then maximum amount payable is upto Rs. 2 lakhs If revised Sum Insured is greater than and equal to Rs 10 lakhs then amount payable is upto Rs. 5 lakhs
Benefit 8. Modern Treatments	Within revised Sum Insured
Benefit 9. Additional Item Cover	Within revised Sum Insured
Personal Accident Cover	
Benefit 10. Waiver of Deductible for Accidental Claims	Benefit will not be applicable under the Policy
Renewal Benefit	
Benefit 11. Waiver of Premium-On first Diagnosis of Critical Illness	No change
Benefit 12. Cumulative Bonus	Bonus earned before Buyback shall be carried forward. Future Cumulative Bonus at 10% of revised Sum Insured for every claim free year subject to cumulative maximum of 50% of revised Sum Insured
Benefit 13. Health Check Up	Maximum upto Rs. 5000.

Global Cover	
Benefit 15. Worldwide Emergency Cover	Within revised Sum Insured subject to a deduction of USD100 on each and every claim. Available for up to 45 days of international travel on cumulative basis

9. CLAIMS PROCEDURE

The fulfillment of the terms and conditions of this Policy (including the realization of premium by their respective due dates) in so far as they relate to anything to be done or complied with by the Policyholder or any Insured Person, including complying with the following steps, shall be the Condition Precedent to the admissibility of the Claim. Upon the discovery or happening of any disease or Illness / Injury that may give rise to a Claim under this Policy, then as a Condition Precedent to the admissibility of the Claim, the Insured Person shall undertake the following:

9.1 CLAIM INTIMATION

In the event of any Disease or Illness / Injury or occurrence of any other contingency which has resulted in a Claim or may result in a Claim covered under the Policy, the Insured Person, must notify to the TPA / Emergency Assistance Service Provider / Company either at the call centre or in writing immediately, in the event of:

- i. Planned Hospitalization, the Insured Person will intimate such admission at least 48 hours prior to the planned date of admission.
- ii. Emergency Hospitalization, the Insured Person will intimate such admission within 24 hours of such admission.

The following details are to be provided to the TPA/ Emergency Assistance Service Provider /Company at the time of intimation of Claim:

- i. Policy Number
- ii. Name of the Policyholder
- iii. Name of the Insured Person in whose relation the Claim is being lodged
- iv. Nature of Illness / Injury
- v. Name and address of the attending Medical Practitioner and Hospital
- vi. Date of Admission
- vii. Any other information as requested by the Company

Claim Intimation under Section 3D. Global Cover (Benefit-15 Worldwide Emergency Cover)

- a. The Insured Person shall immediately contact the Help Line of Emergency Assistance Service Provider stating necessary details. The details of phone numbers and Help Line shall be available

on Company's website and specified in the Policy Schedule attached to this Policy.

- b. The Insured Person needs to contact the Help Line number while abroad as soon as possible and inform in case the Insured Person is/will be filing any Claim, even if assistance is not required. The Company will not be liable to pay any Claim that has not been informed by the Insured Person while being abroad to the Help Line
- c. The Help Line of the Emergency Assistance Service Provider will verify the identity of the caller by asking appropriate information.
- d. In the event of an Illness / Injury where it is not possible to contact the Help Line before consulting a Physician or going to the Hospital, the Insured Person shall contact the Help Line as soon as possible. In either case, when being admitted as a patient, the Insured Person shall show the concerned Physician or personnel this Policy.

9.2 PROCEDURE FOR CASHLESS AND REIMBURSEMENT OF CLAIMS

I Cashless:

Cashless facility is available only at a Network Hospital. The Insured Person can avail Cashless facility at the time of admission into any Network Hospital, by presenting the health card as provided by the TPA/ Emergency Assistance Service Provider / Company with this Policy, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by the Company). To avail Cashless facility, the following procedure must be followed by the Insured Person:

- a. Pre-authorization: Prior to Hospitalization, the Insured Person must call the call centre of the TPA/ Emergency Assistance Service Provider / Company and request authorization by way of submission of a completed Pre-authorization form at least 48 hours before a planned Hospitalization and in case of an Emergency situation, within 24 hours of Hospitalization.
- b. The TPA/ Emergency Assistance Service Provider /Company will process the Insured Person's request for authorization after having obtained accurate and complete information for the Illness/ Injury for which Cashless facility for Hospitalization is sought by the Insured Person and the TPA/ Emergency Assistance Service Provider /Company will confirm such Cashless authorization / rejection in writing or by other means.
- c. If the procedure above is followed and the Insured Person's request for Cashless facility is authorized, the Insured Person will not be required to pay for the Hospitalization Expenses

which are covered under this Policy and fall within the Company's liability (within the authorized limit). Original bills and evidence of treatment in respect of the same shall be left with the Network Hospital.

- d. The Company/TPA / Emergency Assistance Service Provider (On behalf of Company) reserves the right to review each Claim for Hospitalization expenses and coverage will be determined according to the terms and conditions of this Policy. The Insured Person shall, in any event, be required to settle all other expenses, co-payment (if applicable) and / or Deductibles, directly with the Hospital.
- e. Cashless facility for Hospitalization Expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Hospital for Illness or Injury which are covered under the Policy.
- f. There can be instances where the TPA/Company / Emergency Assistance Service Provider may deny Cashless facility for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case the Insured Person may be required to pay for the treatment and submit the Claim for reimbursement to the TPA/ Emergency Assistance Service Provider /Company which will be considered subject to the Policy Terms & Conditions.
- g. The Insured Person shall be required to submit the documents as mentioned in Clause- 6.5 Claim Documents with the Network Hospital.

Note:

- Under Cashless facility, the TPA/ Emergency Assistance Service Provider /Company may authorize upon the Insured Person's request for direct settlement of admissible Claim as per agreed charges & terms and conditions between Network Hospital and the TPA/ Emergency Assistance Service Provider /Company. In such cases, the TPA/ Emergency Assistance Service Provider /Company will directly settle all eligible amounts as per the Policy Terms & Conditions with the Network Hospital to the extent the Claim is covered under the Policy.
 - The Company, at its sole discretion, reserves the right to modify, add or restrict any Network Hospital for Cashless services available under the Policy. Before availing the Cashless service, the Insured Person is required to check the applicable list of Network Hospital on the Company's website.
- ii. Re-imbursement:**
- In case of any Claim under the Benefits, where Cashless facility is not availed, the list of documents

as mentioned in Clause shall be provided by the Insured Person, to TPA/ Emergency Assistance Service Provider /Company immediately but not later than 30 days of discharge from the Hospital, at the Policyholder's/ Insured Person's expense to avail the Claim. Procedure for Cashless and Reimbursement Claim under Section 3D. Global Cover

- i. If the procedure stated above (Clause 9.1 Claim Intimation under Section 3D. Global Cover (Benefit-15 Worldwide Emergency Cover)) is complied with, Emergency Assistance Service Provider may provide Cashless Facility, under which it will guarantee to the Hospital / other providers the costs of Hospitalisation, transportation for emergency services. All costs will be directly settled by Emergency Assistance Service Provider on the Company's behalf and the same shall constitute due discharge of the Company's obligations hereunder.
- ii. If the Hospital / other providers do not accept the guarantee of payment from Emergency Assistance Service Provider, the Company cannot be held liable for the same. The cost will then have to be borne by the Insured Person and the same will then be reimbursed by the Company on submission of required documents.
- iii. Reimbursement of all claims will be made by the Company in Indian Rupees on the Insured Person's return back to the Republic of India, at the exchange rate specified by the Reserve Bank of India, as applicable on the date the amount is billed.

9.3. RESPONSIBILITY OF INSURED PERSON

- i. Forthwith intimate / file / submit a Claim in accordance with Clause-9 of this document
- ii. If so requested by the TPA/ Emergency Assistance Service Provider /Company, the Insured Person will have to submit himself for a medical examination by the TPA/ Emergency Assistance Service Provider /Company's nominated Medical Practitioner as often as it considers reasonable and necessary. The cost of such examination will be borne by the Company.
- iii. The Insured Person is required to check the applicable list of Network Hospitalization the TPA/ Emergency Assistance Service Provider / Company's website or call centre before availing the Cashless services.
- iv. In case where initial covered Medical expenses were not expected to exceed the Aggregate Deductible but subsequently found to be exceeding the opted Aggregate Deductible, notification must be done immediately along with the copy of intimation made to other Insurer.
- v. On occurrence of an event which will lead to a

Claim under this Policy, the Insured Person shall:

- Allow the Medical Practitioner or any of the Company's representatives to inspect the medical and Hospitalization records, investigate the facts and examine the Insured Person.
- Assist and not hinder or prevent the Company's representatives in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.
- If the Insured Person does not comply with the provisions of these conditions all benefits under this Policy shall be forfeited at the Company's option.

9.4 CLAIM DOCUMENTS

The Insured Person shall submit to the TPA/ Emergency Assistance Service Provider /Company/ Network Hospital (as applicable) the following documents for or in support of the Claim, substantiating expenses up to and above the Deductible amount:

- Duly completed and signed Claim Form, in original
- Medical Practitioner's referral letter advising Hospitalization
- Medical Practitioner's prescription advising drugs /diagnostic tests / consultation
- Original bills, receipts and discharge card from the Hospital / Medical Practitioner
- Original bills from pharmacy / chemists
- Original pathological / diagnostic test reports and payment receipts
- Ambulance receipt and bill
- First Information Report/ Final Police Report, if applicable
- Post mortem report, if applicable

The Company may call for any other document required by the Company to assess the Claim

When original bills, receipts, prescriptions, reports and other documents are given to any other insurer or to the reimbursement provider, verified photocopies attested by such other insurer/reimbursement provider along with an original certificate of the extent of payment received from them needs to be submitted.

Apart from above mentioned documents, additional claim documents required for Section 3D.Global Cover (Benefit-15-Worldwide Emergency Cover) are following:

- Copy of Air tickets and boarding passes for the sector travelled.
- Copy of passport, visa with exit and entry stamp

Note:

- Claim once paid under one Benefit cannot be paid again under any other Benefit.

- All invoices / bills should be in Insured Person's name.

9.5. PROPORTIONATE DEDUCTIONS

Subject to the other Terms and Conditions of this Policy, as per the provisions of the IRDAI's 'Modified Guidelines on Product Filing in Health Insurance Business – Norms on Proportionate Deductions' Dated 11th June 2020, The Associate Medical Expenses (and the Room Rent) incurred by the Insured Person pertaining to a Hospitalization shall be proportionately reduced in deriving at the payable amount of the corresponding Claim, in the event of (as the case maybe):

- The Insured Person chooses a higher room category than the category that is eligible as per the terms and conditions of the Policy. In this case, higher room category means a room category in which the room rent expenses charged by the Hospital is more expensive than the eligible room category as per the terms and conditions of the Policy.
- The Insured Person chooses a room category in which the room rent charges are more than the applicable Sum Insured sub-limit (in percentage or Rupee terms) on the room rent as per the Policy terms and conditions.

In the above, Associate Medical Expense, means all admissible invoice break ups (or bill heads) of the Hospitalization Medical Expenses as mentioned in section 3.1.1(i.e. Inpatient Treatment) barring the below mentioned expense break ups:

- Cost of Pharmacy and Consumables
- Cost of Implants and Medical Devices
- Cost of Diagnostics

The proportional reduction will be done in a manner consistent with the below table

Sr. No.	Header	Explanation
i	Actual Room Rent	Room Rent (Including items to be subsumed under Room Rent as defined under Annexure A)
ii	Eligible Room Rent Limit	Room Rent allowed as per policy is Single Private A.C Room (upto Deluxe Room)
A	Actual Medical Bills Incurred	As per submitted documents
(-)	Any expense not covered under Policy Benefits	
B	= Covered Medical Expenses	

	(-)	cost of Pharmacy and consumables, implants and medical devices and diagnostics	
D	=	Covered Medical Expenses which shall be subject to Proportionate Deduction	
	(*)	(Eligible Room Rent Limit)/ (Actual Room Rent)	
E	=	Claim after Proportionate Deduction	If Actual Room Rent is within eligibility, then no deduction to be applied (E=D)
	(+)	cost of Pharmacy and consumables, implants and medical devices and diagnostics	
F	=	Ground up claim amount	
	(-)	Deductions for Policy Deductibles and Limits*	
G	=	Payable claim amount	

*The Final Claim amount would be deducted, in the following progressive order, from:

- Deductible
- Base Sum Insured
- Cumulative Bonus

Proportionate Deduction is subject to the following:

- Apart from the Associate Medical Expenses, no other expenses will be proportionately reduced
- If the given Hospital do not follow differential billing or if there are items in the claim for which the Hospital do not follow differential billing, the Insurer shall not be proportionately reducing the Claims. This shall be applied in case of admissions in Government Hospitals and the Network Hospitals of the Insurer.
- ICU charges shall not be proportionately reduced in all cases.

9.2 PAYMENT TERMS

- This Policy covers medical treatment taken within India except for Global Cover (Benefit-15-Worldwide Emergency Cover), and payments under this Policy shall be made in Indian Rupees within India.
- Claims shall not be admissible under this Policy unless the TPA/Company/ Emergency Assistance Service Provider has been provided with the complete documentation / information which the Company has requested to establish its liability for the Claim, its circumstances and its quantum unless the Policyholder / Insured Person have complied with the obligations under this Policy.
- The Company shall not indemnify the Insured Person for any period of Hospitalization of less than 24 hours except for the Day Care Treatment
- The Sum Insured of the Insured Person shall be reduced by the amount payable / paid under the Benefit(s) and the balance shall be available as the Sum Insured for the unexpired Policy Year.
- For Cashless Claims, the payment shall be made to the Network Hospital / TPA/ Emergency Assistance Service Provider whose discharge would be complete and final.
- For the Reimbursement Claims, the Company will pay to the Policyholder/Insured Person.
- The Company will only be liable to pay for such Benefits for which the Insured Person has specifically claimed in the Claim Form. The Company shall settle the Claim within 30 days from the date of receipt of last necessary document. However, where the circumstances of a Claim warrant an investigation in Company's opinion it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, Company shall settle the Claim within 45 days from the date of receipt of last necessary document.
- The Company shall also decide and communicate any rejection of claim within 30 days from the date of receipt of last necessary document. However, where the circumstances of a claim warrant an investigation in Company's opinion it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, Company shall also decide and communicate any rejection of the claim within 45 days from the date of receipt of last necessary document.

10. PRE POLICY MEDICAL CHECK UP (PPMC)

- All persons between the age group 55 years of age and above and/or proposals with Deductible +Sum Insured amount is >=25 lakhs will undergo

Pre-Policy Medical Checkup.

- ii. Where the Proposal is accepted by the Company and the Policy is issued, 100% of the PPMC Cost will borne by the Company
- iii. Where the Proposal is rejected, or the Proposer denies the accepted proposal, 100% of the PPMC Cost will borne by the Customer

Age	In all SI cases
55 - 60	Category 1
61 - 65	Category 2
#	Description
Category 1	MER, CBC, FBS, RUA, S. Creatinine
Category 2	MER, CBC, FBS, HbA1c, Lipid profile, SGOT, SGPT, GGT, RUA, ECG, HBsAg, S. Creatinine
Test Abbreviation	Description
MER	Medical Examination Report
CBC	Complete Blood Count
HbA1c	Glycosylated Haemoglobin
Lipid Profile	HDL, LDL, Serum Total Cholesterol, Serum Triglycerides, Sr. Total Cholesterol/HDL ratio
SGOT	Serum Glutamic Oxaloacetic Transaminase (also called AST - Aspartate Aminotransferase)
GGT	Gamma Glutamyl Transferase
RUA	Routine Urine Analysis
TMT	Exercise Electro cardiogram (Tread Mill Test)
ECG	Resting Electro Cardiogram
2D Echo	2D Echocardiogram with Color Doppler
HbsAg	Australia Antigen
HIV	HIV (I&II)
S Creatinine	Serum Creatinine
USG (Abdo & Pelvis)	Ultrasound Sonography of Abdomen and Pelvis
PSA	Prostate Specific Antigen (for Males only)
PAP	Papanicolaou test (PAP Smear Test) - For females only

The lists of medical tests covered above are indicative and Company may modify or amend this list on approval from the Head of Health Underwriting/Chief Underwriting Officer.

The Company may ask additional tests depending on health condition of insured. Cost of PPMC is borne by IndusInd General Insurance if proposal is accepted by IndusInd. If proposal got rejected or proposer denies the accepted proposal then cost of PPMC will be recovered from customer.

11. CANCELLATION

- i. The Policyholder may cancel this policy by giving 7 days' written notice to the Company and in such an event, the Company shall refund the premium as detailed below:

- **In case of no claim in the policy**

In the event of cancellation by the insured the refund amount shall be on pro-rata basis and shall be calculated as per the terms laid out below:

Calculation of Pro-Rata refund:

Return Premium = Total Policy Premium * (1 - ((Number of Policy days expired) / (Total Policy Days)))

For e.g. If Policy Premium for 1 year (365 days) policy is Rs. 10000, and if cancellation is effected on expiry of 243 days from policy inception, then The Return Premium = 10000 * (1 - (243 / 365)) = Rs. 3342.47.

- **In case of claim in the policy**

Where any claim has been admitted or has been lodged by the person under the Policy, there shall be no refund of premium for the Policy Year in which the claim occurs.

For e.g. If Policy Premium for 1 year (365 days) policy is Rs. 10000. Considering the claim year is 1st Year (200 days), then no refund shall be made for the Policy Year.

- ii. The Company may cancel the Policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

12. RENEWAL OF POLICY

- i. The Policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the Insured Person.
- ii. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- iii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- iv. Request for renewal along with the requisite premium shall be received by the Company before the end of the Policy Period
- v. At the end of the Policy Period, the policy shall

terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy.

- vi. Coverage is not available during the grace period, except in case where the premium is paid in instalment
- vii. No loading shall apply on renewals based on individual claims experience

13. ALTERATION 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. However, change or alteration with respect to increase/ decrease of the Base Sum Insured shall be permissible only at the time of renewal of the Policy subject to underwriting decision of the Company

14. PREMIUM PAYMENT IN INSTALMENTS (WHEREVER APPLICABLE)

If the Insured Person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

- i. The grace period of fifteen days (where premium is paid on a monthly instalments) and thirty days (where premium is paid in quarterly/half-yearly/ annual instalments) is available on the premium due date, to pay the premium.
- ii. If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected
- iii. The Insured Person will get the accrued continuity benefit in respect of the 'Waiting Periods' ' Specific Waiting Periods' in the event of payment of premium within the stipulated grace Period
- iv. No interest will be charged If the instalment premium is not paid on due date.
- v. In case of instalment premium due not received within the Grace period, the policy will get cancelled.
- vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- vii. The Company has the right to recover and deduct all the pending installments from the claim amount due under the Policy.

15. POSSIBILITY OF REVISION OF TERMS OF THE POLICY INCLUDING THE PREMIUM RATES

The Company, with prior approval of IRDAI, may

revise or modify the terms of the policy including the premium rates. The Insured Person shall be notified three months before the changes are effected.

16. FREE LOOK PERIOD

The Free Look Period shall be applicable on new individual health insurance policies and not on 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.

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

- i. A refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
- ii. Where the risk has already commenced and the option of return of the policy is exercised by the insured 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

17. WITHDRAWAL OF POLICY

- i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the Policy.
- ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break

18. MIGRATION

The Insured Person 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 atleast 30 days before the Policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/ plan offered by the Company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration

For Detailed Guidelines on migration, kindly refer the www.irdai.gov.in (Circular-IRDA/HLT/REG/ CIR/003/012020, Dated-01012020)

19. PORTABILITY

The Insured Person 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 30 days before, but not earlier than 60 days from the Policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed Insured Person will get the accrued continuity benefits in Waiting Periods as per IRDAI guidelines on portability.

For Detailed Guidelines on portability, kindly refer the www.irdai.gov.in (Circular-IRDA/HLT/REG/CIR/003/012020, dated 01/01/2020).

20. MORATORIUM PERIOD

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

21. REDRESSAL OF GRIEVANCE

In case of any grievance the Insured Person may contact the Company through

Website: www.indusindinsurance.com

Dedicated Senior Citizen helpline: 022-33834185 (paid line)

E-mail: services@indusindinsurance.com

Fax: +91 22 3303 4662 Courier: Any branch office the correspondence address, during normal business hours.

Write to us at: IndusInd General Insurance, Winway Building 2nd and 3rd Floor, 11/12 Block No - 4, Old No - 67, South Tukoganj, Indore (M.P) - 452001

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

If Insured Person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may

contact the grievance officer at:

Grievance Redressal officer

The Grievance Cell,

IndusInd General Insurance Co. Limited

No. 1-89/3/B/40 to 42/ks/301, 3rd floor,

Krishe Block, Krishe Sapphire, Madhapur

Hyderabad - 500 081

Grievance Redressal officer email ID: Headgrievances@indusindinsurance.com

(For updated details of grievance officer, kindly refer the link: <https://www.indusindinsurance.com/Insurance/About-Us/Grievance-Redressal.aspx>

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

Insurance Ombudsman - The insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance.

22. COVERAGE SUMMARY

This Policy would trigger when the incurred admissible expenses exceed the Aggregate Deductible under the Policy. This means that all the claims, including those falling within the Aggregate Deductible, will be assessed based on the terms and conditions of this Policy for working out the admissible expenses. Expenses related to Pre Hospitalization and Post Hospitalization in respect of all previous claims would also be taken into consideration. The benefits 1 to 13 and 15 are in-built Policy benefits and shall be available to the Insured Person in accordance with the procedures set out in the Policy. The benefit 14 is an optional cover under the Policy which shall be available at the end of four continuous and consecutive Hospitalization free Policy Years.

Policy Term Available	Plan A 1 year, 2 years, 3 years	Plan B 2 years, 3 years
Room Category	Single Private A.C Room (upto Deluxe Room)	
Type of Deductible**	Annual Aggregate Deductible	Long Term Aggregate Deductible

Base Covers			
Cover	Brief Description	Limits	
Hospitalization Expenses	This cover indemnifies the insured for any medical expenses incurred on In-patient Treatment. Pre-Hospitalization and Post-Hospitalization is also covered for the insured for that instance	Sum Insured is limited to the selected combination of Annual Aggregate Deductible	Sum Insured is limited to the selected combination of Long term Aggregate Deductible.

	inpatient treatment. This shall also cover Day Care Treatment - i.e. indemnify the insured for the medical expenses incurred under Day care procedure as advised by Medical Practitioner.			Organ Donor	This cover will indemnify the Insured Person for the Medical Expenses incurred during Hospitalization, in respect of donor for any organ transplant Surgery performed on Insured	Within the Sum Insured subject to Annual Aggregate Deductible	Within the Sum Insured subject to Long Term Aggregate Deductible
Domiciliary Hospitalization	This cover indemnifies the Insured Person for the medical expenses incurred for treatment under Domiciliary hospitalization	Within the Sum Insured subject to Annual Aggregate Deductible	Within the Sum Insured subject to Long Term Aggregate Deductible	AYUSH Treatment	This cover will indemnify the Insured Person for the Medical Expenses incurred on treatment under Ayurveda, Yoga & Naturopathy, Unani, Siddha, and Homeopathy	Within the Sum Insured subject to Annual Aggregate Deductible	Within the Sum Insured subject to Long Term Aggregate Deductible
Maternity Cover	This cover will indemnify the Insured Person for the Medical Expenses related to pregnancy, childbirth, or medically recommended and lawful termination of pregnancy. This cover also includes pre and post natal medical expenses and medical expenses incurred for In-patient treatment of new born baby from day 1 to 90 days	Limited to Rs. 2 lakhs subject to Annual Aggregate Deductible	Limited to Rs. 2 lakhs subject to Long Term Aggregate Deductible	Ambulance Cover	The cover indemnifies the Insured Person for expenses on availing Ambulance services offered by a Hospital or by an Ambulance service provider on Inpatient hospitalization.	Rs. 3500 per hospitalization (Within the Sum Insured limits)	Rs. 3500 per hospitalization (Within the Sum Insured limits)
				Emergency Air Ambulance Cover	The cover indemnifies the Insured Person for expenses incurred on availing Air Ambulance services from the place of first occurrence of the Illness/ Accident to the nearest Hospital	The cover indemnifies the Insured Person for expenses incurred on availing Air Ambulance services from the place of first occurrence of the Illness/ Accident to the nearest Hospital	Maximum upto Rs 2 lakhs for Policies having Sum Insured less than Rs 10 lakhs and Rs 5 lakhs for Policies having Sum Insured greater than and equal to Rs 10 lakhs Available once in each Policy Year



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IRDAI Registration No. 103 IndusInd General Insurance Company Limited (Formerly known as Reliance General Insurance). An ISO 9001:2015 Certified Company For complete details on the benefits, coverage, terms & conditions and exclusions, do read the sales brochure, prospectus and policy wordings carefully before concluding sale. Registered & Corporate Office: 6th Floor, Oberoi Commerz, International Business Park, Oberoi Garden City, Off. Western Express Highway, Goregaon (E), Mumbai-400063. Corporate Identity Number: U66603MH2000PLC128300. IndusInd Health Super Top Up. UIN No.: RELHLIP21617V012021. IGI/MCOM/CO/IHSTP/PROSPECTUS/Ver. 1.0/010426.



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Modern Treatments	This cover indemnifies the insured for the medical expenses incurred on treatment of listed Modern Treatments	Within the Sum Insured subject to Annual Aggregate Deductible	Within the Sum Insured subject to Long Term Aggregate Deductible
Additional Item Cover	This cover indemnifies the Insured Person for Reasonable and customary expenses incurred towards Optional Items listed in Annexure A	Within the Sum Insured subject to Annual Aggregate Deductible	Within the Sum Insured subject to Long Term Aggregate Deductible
Personal Accident			
Waiver of Deductible for Accidental Claims	This cover waives off the General Exclusion no. 5 (15) - 'Deductible' for Accidental Hospitalization Claims		
Renewal Benefits			
Waiver of Premium-On first Diagnosis of Critical Illness	This benefit automatically waives off the renewal Policy premium for one year for the next renewal in case of Diagnosis of any of the listed Critical Illness. For long term policies, the Company shall waive one-year proportionate renewal Policy premium of the next renewal. Aggregate Deductible shall not be applicable to this benefit. This benefit is provided once in the lifetime of the Insured Person		
Cumulative Bonus	This renewal benefit will provide 10% of expiring Policy Year Base Sum Insured as Cumulative Bonus at the end of a claim-free Policy Year, subject to a maximum of 50% of Base Sum Insured		
Health Check Up	After every 3 consecutive and continuous Policy Years, this benefit shall provide the listed medical check up expenses. The benefit is limited to Rs. 3000 for policies with Deductible less than 10 lakhs and upto Rs 5000 for policies with Deductible greater than and equal to 10 lakhs. The benefit shall be available on Cashless basis only		

Deductible-Buy Back (Optional Benefit)*	At the end of four consecutive and continuous Hospitalization free Policy Years, if the Policyholder avails the option to buy back the Deductible amount then no Deductible shall apply on such renewal and the Base Sum Insured under the Policy shall be sum of expiring Policy's Base Sum Insured and expiring Policy's Deductible.	
Global Cover		
Worldwide Emergency Cover	This cover indemnifies the Insured Person for the Medical Expenses incurred on Medical Emergency Inpatient, Day Care or outpatient treatment, whilst overseas.	Within the Sum Insured subject to a deduction of USD100 on each and every claim. Available for up to 45 days of international travel on cumulative basis

The maximum liability of the Company to pay the claims under the Policy is limited to the sum of Sum Insured and Cumulative Bonus. Additionally, the Company shall indemnify the Insured Person as per limits specified above under Benefit-11- Waiver of Premium-On first Diagnosis of Critical Illness and Benefit-13-Health Check Up; and upto the Deductible amount under Benefit-10-Waiver of Deductible for Accidental Claims.

*If Policyholder opts Benefit-14-Deductible Buy back under the Policy then

- Benefit-10: Waiver of Deductible for Accidental Claims shall not be applicable under the Policy.
- Benefit-13- Health Checkup shall be limited to Rs 5000.

23. ILLUSTRATION - THE WORKING FOR PLAN A AND PLAN B IS EXPLAINED BELOW

Policy Details	
Sum Insured (INR)	3 lakhs
Deductible (INR)	2 lakhs
Policy Period	2 years
Policy Start Date	23-11-2020
Policy End Date	22-11-2022

Policy Year	Illness/ Hospitalization No.	Date of Admission	Medical Expenses	Payable claim amount	
				Plan A	Plan B
Policy Year 1 (23-11-2020 to 22-11-2021)	Claim1	12-01-2021	1,00,000	-	-
	Claim2	02-04-2021	2,00,000	1,00,000	1,00,000
End of Policy Year 1 (Sum Insured Replenished in both cases>>>)	-	-	-	Deductible reset>>>	No deductible reset>>>
Policy Year 2 (23-11-2021 to 22-11-2022)	Claim3	28-12-2021	2,00,000	-	2,00,000
	Claim2	27-06-2022	1,00,000	1,00,000	1,00,000
Total: Policy Year 1 & Policy Year 2 (23-11-2020 to 22-11-2022)	-	-	6,00,000	2,00,000	4,00,000
End of Policy Year2: Sum Insured Replenished in both cases>>>	-	-	-	Deductible reset>>>	Deductible reset>>>

in above chart

- The policy has a Sum Insured of 3 lakhs which replenishes every year
- The Deductible of Rs. 2 lakhs, resets every year for Plan A (Annual Aggregate Deductible) and resets at the end of the Policy term (2 years) for Plan B (Long term Aggregate Deductible)
- Hence there is no difference in outcomes for plans A and B for the first year of the policy, where claim becomes payable once the expenses cross Rs. 2 lakhs in aggregate
- The policyholder in Plan B gets a higher claim payment in year 2 since the deductible is not reset. It is important to note that Sum Insured is replenished at the year-end in all cases.

24. ILLUSTRATION FOR BENEFIT - WAIVER OF DEDUCTIBLE FOR ACCIDENTAL CLAIMS

Case 1.

Policy type: Floater

No. of Insured - 2 Adults

Sum Insured - 10 lakhs

Deductible - 5 lakhs

Policy Period - 1 year

Policy Start Date - 1/1/2020

Policy End Date - 31/12/2020

Accident1 happens on 15/5/2020

During the Policy Year Insured person 1 met with an Accident and was hospitalized for it. The Claim amount

is Rs. 12 lakhs The total Amount payable for this claim (assuming no further deductions need to be applied on 12 lakhs):

5 lakhs from Waiver of Deductible for Accidental Claims + 7 lakhs from Sum Insured = 12 lakhs

Balance Sum Insured = Rs. 3 lakhs

Balance Aggregate Deductible = 0 (The Aggregate Deductible is considered to have been completely exhausted by the accident claim. No deductible will apply on future claims in the same Policy Year)

Case 2

Policy type: Floater

No. of Insured - 2 Adults

Sum Insured - 10 lakhs

Deductible - 5 lakhs

Policy Period - 1 year

Policy Start Date - 1/1/2020

Policy End Date - 31/12/2020

Accident 1 happens on 15/5/2020

During the Policy Year Insured person 1 met with an Accident and was hospitalized for it. The Claim amount is Rs. 3 lakhs

The total Amount payable for this claim (assuming no further deductions need to be applied on 3 lakhs):

3 lakhs from Waiver of Deductible for Accidental Claims + 0 lakhs from Sum Insured = 3 lakhs

Balance Sum Insured = Rs. 12 lakhs

Balance Aggregate Deductible = Rs. 2 lakhs (Rs. 3



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lakhs from the Aggregate Deductible is considered to have been exhausted by the accident claim. The balance Rs. 2 lakhs deductible will apply for future illness claims in the same Policy Year)

25. DISCOUNTS AND LOADING

The following discounts and loadings are applicable:

Discounts and Loadings	
IGI Health Policy discount	
IGI Retail Policy discount (non-health)	5% for each category, maximum total 7.5%
Digital Discount	5.00%
Girl child discount (for covering two or more girl children)	5%
2 year Policy Discount	6%
3 year Policy Discount	11%
Worksite Marketing discount	15%
Medical Loading	Upto 100% per illness, max. 150% per life

Maximum Discount applicable per policy is limited to 25%, 30% and 35% for 1 year, 2 year and 3 year policies respectively. The abovementioned Discounts shall be available to the Policyholder on first buy and on every renewal.

Medical underwriting loading may be applied on premium

basis the declarations made by the proposer and the medical test reports.

26. PREMIUM RATES AND ILLUSTRATION

Premium Rates are attached as an Annexure to this document.

An Illustration of premium calculation for a Family Floater Policy has been included below

Policy Details:	
Insured Members:	Self (45 years), Spouse (44 years), Son (18 years), Daughter (15 years), Daughter (14 years)
Sum Insured	INR 20 lacs
Deductible	INR 5 lacs
Policy Period	2 Years
Deductible Type Annual/Long Term)	Long Term
PED Waiting Period	24 months
Issuance Mode	Digital
Existing IGI Health Policy	Yes
Existing IGI Retail Policy (non-health)	Yes

	Premium Calculation	Logic	Input	Year 1	Year 2	Year 3	Total
(i)	Base Premium by chart	Lookup from chart by age at start of Policy Year		8,444	10,602		19,046
(ii)	Base Premium Additional Child	Lookup from chart		756	756		1,512
(iii)	Total Base Premium	(i) + (ii)		9,200	11,358		20,558
(iv)	Waiting Period	(iii)* loading by chart		920	1,136		2,056
(v)	Subtotal 1	(iii) + (iv)		10,120	12,494		22,614
(vi)	Long Term Deductible charges	(v)* loading by chart		4,655	6,497		11,152
(vii)	Subtotal 2	(v) + (vi)		14,775	18,991		33,766
(viii)	Discounts	(vii)* Multiplicative discount capped at Maximum limit	29%	4,340	5,579		9,919
	IGI Policy discount (Health + Non-Health)	Sum of discount% for Health + Non-Health from chart, max. 7.5%	7.50%				
	Digital Discount		5.00%				
	Two girl child		5.00%				
	2 year Policy Discount		6.00%				
	Worksite Marketing		10%				

(ix)	Underwriting Loading	(vii)* Family level loading from Under-writer's input	10%	1,478	1,899	3,377
(x)	Premium before Taxes	(vii)-(viii)+(ix)		11,912	15,311	27,224
*Not to be charged on Call Option						

27. CONTACT US

For any product or service related information or assistance, here's how you can reach us.

SMS To reach us **SMS 'protect'** to **55454**

Contact details for Policy Servicing	Contact details for Claim Servicing
Name - IndusInd General Insurance Company Limited Correspondence Address - IndusInd General Insurance., Winway Building 2nd & 3rd Floor, 11/12 Block No-4, Old No-67, South Tukoganj, Indore (M.P.) - 452001 Email ID - services@indusindinsurance.com Website - www.indusindinsurance.com Contact No.: 02248903009 (Paid No.)	Name - IndusInd General Insurance Company Limited Correspondence Address - Health Care: Claims and care management IndusInd General Insurance Co. Limited, No. 1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire Building, Madhapur, Hyderabad - 500081. Near Durgam Cheruvu Metro Station. Website - www.indusindinsurance.com Contact No.: 02248903009 (Paid No.)

28. DISCLAIMER

This is only a summary of the product features. The actual benefits available are as described in the policy, and will be subject to the policy terms, conditions and exclusions. Please seek the advice of Company's insurance advisor if you require any further information or clarification.

29. STATUTORY WARNING

Section 41 of Insurance Act 1938 (Prohibition of Rebates)

- 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 life or property in India any rebate of the whole or part of the commission payable or any rebate of 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 prospectus or tables of the insurers.
- Any person making default in complying with the provisions of this section shall be punishable with fine, which may extend to five hundred rupees.