

## INDUSIND HEALTHWISE POLICY (PROSPECTUS)

### SECTION-1 INTRODUCTION

We offer you healthcare insurance with IndusInd HealthWise policy that provides financial assistance to you and your family, it covers you against hospitalization expenses towards illness / injury in India along with a host of value added covers. The Policy provides basic cover for medical expenses on hospitalisation incurred for medical treatment of illness, injury the Insured. The policy among other things covers Hospital (Room & Boarding and Operation theatre) charges, fees of Surgeon, Anaesthetist, Nurses, Specialists, the cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs. This one year policy can also be issued to cover the Insured Persons family of maximum four persons comprising of the Insured person, spouse and dependent children upto the age of 25 years.

### SECTION- 2 ELIGIBILITY CRITERIA

- Policy can be availed by persons between the age of 18 years and 65 years as Proposer. Dependent children (i.e. naturally or legally adopted and financially dependent on the Proposer) can be covered from 91 days to 25 years of age.
- Policy can be availed for self and the following family members
  - Legally wedded spouse
  - Dependent Children (i.e. natural or legally adopted) between the age of 91 days to 25 years.
- 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.
- This policy can be issued to an individual and / or a family.
- There is no maximum cover ceasing age on continuous renewals.
- Individual Policy: A maximum of 4 members can be covered in a single individual policy on individual sum insured basis.
- Floater Policy: In case of Family Floater, one family will share a single sum Insured as opted. A maximum of 4 members can be covered in a single-family floater policy i.e. Insured person, legally wedded spouse and two dependent children up to the age of 25 years.

### SECTION- 3 SUM INSURED

The policy offers varies Sum Insured options ranging from Rs. 1 lac to Rs. 5 lacs with a multiple of Rs. 1 lac each. The Sum Insured options are 1 Lac, Rs. 2 Lacs, Rs. 3 Lacs, Rs. 4 Lacs and Rs. 5 Lacs which are available on both Individual and Floater basis

### SECTION- 4 POLICY PERIOD

The Policy can be purchased for 1 year

### SECTION- 5 COVERAGES

#### 5 A Basic Covers

##### 5.1 In-Patient Hospitalization

This benefit covers Medical Expenses incurred by the Insured Person during the Policy Period on In-Patient Hospitalization (including AYUSH Hospitalization) for illness / injury contracted or sustained by the Insured Person. Medical Expenses shall include:

- Room Rent
- Nursing Expenses
- Intensive Care Unit (ICU) Charges
- Fees of Medical Practitioner including Surgeon and anesthetist
- Anesthesia, blood, oxygen, operation theatre charges, surgical appliances
- Medicines, drugs and consumables
- Diagnostics procedures
- The cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure unless specifically excluded

##### 5.2 DOMICILIARY HOSPITALIZATION

This benefit covers payment of Medical Expenses incurred during the Policy Period for Medically Necessary Treatment pertaining to Domiciliary Hospitalization of the Insured Person provided that:

- The condition for which the medical treatment is required continues for at least 3 continuous and completed days, in which case the Company will pay for the Medical Expenses incurred from the first day of Domiciliary Hospitalisation, and
- The payment under Domiciliary Hospitalization benefit shall be limited to 10% of the Sum Insured, and shall, in no case cover expenses incurred for:
  - Treatment of any of the following illness / injury:
    - Asthma
    - Bronchitis
    - Chronic nephritis and nephritic syndrome
    - Diarrhea & all types of dysenteries including gastroenteritis
    - Diabetes mellitus and insipidus
    - Epilepsy
    - Hypertension
    - Influenza, cough and cold
    - All psychiatric or psychosomatic disorders
    - Pyrexia of unknown origin for less than 10 days
    - Tonsillitis and upper respiratory tract infection including laryngitis & pharyngitis
    - Arthritis, Gout and Rheumatism.

Domiciliary Hospitalization benefit also covers Medical Expenses on Qualified Nurses engaged on the written medical advice of the attending Medical Practitioner.

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### 5.3 DAY CARE TREATMENT

This benefit covers, up to the Sum Insured, the Medical Expenses incurred for medically necessary treatment pertaining to Day Care treatment of the Insured Person, on the written advice of a Medical Practitioner.

The list of covered Day Care Treatments is appended as per Annexure D(attached to the Policy Wordings).

### 5.4 PRE-HOSPITALIZATION MEDICAL EXPENSES

This benefit covers relevant Pre-Hospitalization Medical Expenses incurred by the Insured Person during the Policy Period, for number of days as specified in Policy Schedule

### 5.5 POST-HOSPITALIZATION MEDICAL EXPENSES

This benefit covers relevant Post-Hospitalization Medical Expenses incurred by the Insured Person during the Policy Period, for number of days as specified in Policy Schedule

### 5.6 PRE-EXISTING DISEASE

This Policy covers Medical Expenses of the Insured Person incurred from the 3rd continuous year & 5th continuous year of the Policy with the Company, (depending upon the plan chosen and as specified in the Policy Schedule), for Medically Necessary Treatment of Pre-Existing Disease subject to all other terms and conditions under the Policy This cover may be made available earlier than 3rd or 5th continuous Policy year in accordance with any reduction applicable to the Section 6.1 Pre-Existing Disease Waiting Period according to the terms and conditions of the Policy.

### 5.7 CRITICAL ILLNESS

This benefit, if applicable to the chosen plan and specified in the Policy Schedule, provides for an additional amount equivalent to the Sum Insured opted under Inpatient Hospitalization, towards treatment of listed Critical Illnesses. For the purposes of this Policy and the determination of the Company's liability under it, the Insured Event in relation to the Insured, shall mean any illness, medical event or surgical procedure as specifically defined below whose signs or symptoms first commence and first diagnosis occurs more than 30 days after the Policy Period Start Date and shall only include those defined hereunder.

#### 1. Cancer of Specified Severity

- A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. 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 leukemia 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.

#### 2. Open Chest CABG

- The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
- The following are excluded:
  - Angioplasty and/or any other intra-arterial procedures.

#### 3. Myocardial Infarction (First Heart Attack of specific severity)

- The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
  - A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
  - New characteristic electrocardiogram changes
  - Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.
- The following are excluded:
  - Other acute Coronary Syndromes
  - Any type of angina pectoris
  - A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure



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#### 4. **Kidney Failure requiring Regular Dialysis**

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.

#### 5. **Multiple Sclerosis with persisting symptoms**

- i. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
  - a. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
  - b. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.
- ii. Other causes of neurological damage such as SLE and HIV are excluded.

#### 6. **Major Organ / Bone Marrow Transplant**

The actual undergoing of a transplant of:

- i. One of the following organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
- ii. Human bone marrow using hematopoietic stem cell- The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner  
The following are excluded:
  - i. Other stem-cell transplants
  - ii. Where only islets of Langerhans are transplanted

#### 7. **Stroke resulting in permanent symptoms**

- i. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation 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.
- ii. The following are excluded:
  - a) Transient ischemic attacks (TIA)
  - b) Traumatic injury of the brain
  - c) Vascular disease affecting only the eye or optic nerve or vestibular functions.

#### 8. **Aorta Graft Surgery**

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:

- i. Computerized tomography (CT) scan
- ii. Magnetic resonance imaging (MRI) scan
- iii. Echocardiography (an ultrasound of the heart)
- iv. Abdominal ultrasound (for associated abdominal aneurysms)
- v. Angiography (an x-ray of the blood vessels)

#### 9. **Permanent Paralysis of Limbs**

Total and irrecoverable 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.

#### 10. **Primary (Idiopathic) Pulmonary Hypertension**

- i. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Catheterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.
- ii. The NYHA Classification of Cardiac Impairment are as follows:
  - a. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
  - b. Class IV: Unable to engage in any physical activity without discomfort.  
Symptoms may be present even at rest.
- iii. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

#### 5.8 **DONOR EXPENSES**

This benefit covers the Medical expenses incurred during the Policy Period towards the In-patient Hospitalization of donor in case of a major organ transplant subject to the overall limit of the Sum Insured and Plan opted and specified in the Policy Schedule, provided that

- i. The organ donation is in accordance with The Transplantation of Human Organs Act, 1994 (amended) and other applicable laws and rules.
- ii. The Company has admitted the Insured Person's Hospitalization claim under the Policy.
- iii. The organ donated is for the use of the Insured Person
- iv. Company shall not pay the donor's Pre and Post Hospitalization Expenses



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## 5.9 COST OF HEALTH CHECK UP

The Company shall provide Reimbursement of the cost of medical check-up up to 1% of average Sum Insured for Individual Policies and up to 1.25% of Sum Insured for Floater covers, once at the end of a block of four consecutive and continuous Policy years provided there are no claims reported under the Policies by any Insured Person, during this block. The limit specified for Individual Policies applies to each Insured Person, and that specified for floater cover is the overall limit available for all members

## 5.10 MODERN TREATMENT

This benefit covers the Insured Person up to 50% of Sum Insured for the Medical Expenses incurred during the Policy Period on Hospitalization or Domiciliary Hospitalization for the below mentioned Modern Treatment Methods:

- 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 Neutro Monitoring)
  - xii. Stem Cell therapy: including Hematopoietic stem cells for bone marrow transplant for hematological conditions
- The claim under this benefit shall be subject to all other terms under Sections 5.1 to 5.15

## 5 B VALUE ADDED COVERS

Benefits under this Section are Value added services payable up to the limit as specified in the Policy Schedule and shall not exceed Sum Insured opted by the Insured during the Policy Period. Benefits under each value-added cover shall be available separately to each Insured Person and available per Hospitalization.

A valid claim should have been admitted under the basic cover of the Policy, for admission of liability under each of the value added covers.

## 5.11 DAILY HOSPITALIZATION ALLOWANCE

This benefit provides for payment to the Insured Person of Daily Hospital Allowance up to limits specified in the Policy Schedule in case of hospitalization exceeding 3 days.

## 5.12 NURSING ALLOWANCE

This benefit provides an allowance up to the limit as specified in the Policy Schedule for services of a Qualified Nurse at the Insured Person's residence or the Hospital on the medical advice which is confirmed as medically necessary by the attending Medical practitioner and the same relate directly to an illness / injury for which the Company has admitted a Hospitalization claim for Insured Person

## 5.13 LOCAL ROAD AMBULANCE SERVICE

This benefit indemnifies the Insured Person for Reasonable and Customary charges up to the limit as specified in the Policy Schedule incurred for his / her transportation by Ambulance to the Hospital for which a claim is admitted by the Company under Benefits 5.1 or 5.3 of this Policy.

## 5.14 RECOVERY BENEFIT

This Policy provides for payment of the sum as specified in the Policy Schedule in the event that a covered Hospitalization of the Insured Person exceeds a period of 10 days. This benefit is applicable, separately, to all the members of the floater irrespective of the number of occurrences during the Policy Period. It is subject to overall limit of the Sum Insured.

## 5.15 EXPENSES ON ACCOMPANYING PERSON

This benefit provides a per day amount to Insured Person as specified in the Policy Schedule, for the expenses incurred by the accompanying person during In-Patient Hospitalization of the Insured Person for which the Company has admitted a claim under Benefit 5.1 of this Policy

## SECTION- 5 C OPTIONAL COVERS

### 5.16 VOLUNTARY AGGREGATE DEDUCTIBLE

Under this option, the Company shall provide a discount in the premium, if the Policyholder opts annual Aggregate Deductible under the Policy. The agreed limits of annual Aggregate Deductible shall be expressly mentioned in the Policy Schedule. This benefit is subject to following:

- i. Deductible under this benefit is an annual Aggregate Deductible. For a claim to become payable, the sum of all admissible claims under the Policy, subject to Policy terms and conditions, in a given Policy Period has to exceed the annual Aggregate Deductible as mentioned in the Policy Schedule.
- ii. In case of Individual Policy, the Aggregate Deductible shall apply on individual basis and in case of a floater policy, shall apply on floater basis.
- iii. The annual Aggregate Deductible shall not be applicable on Benefit no-5.9 Cost of health check up, Benefit no - 5.11 Daily Hospitalization Allowance, Benefit no-5.12 Nursing Allowance, Benefit no -5.14 Recovery Benefit no-5.15 Expenses on accompanying person

### 5.17 CO-PAYMENT

Under this option, the Company shall provide a discount in the premium, if the Policyholder opts a Co-payment under the Policy. The agreed limits of Co-Payment shall be expressly mentioned in the Policy Schedule. This benefit is subject to following:

- Co-Payment shall be applicable on each and every claim admissible and payable under the Policy.
- In case of Individual Policy, the Co-Payment shall apply on individual basis and in case of a floater policy, shall apply on floater basis.
- The Co-Payment shall not be applicable on Benefit no-5.9 Cost of health check up, Benefit no -5.11 Daily Hospitalization Allowance, Benefit no-5.12 Nursing Allowance, Benefit no -5.14 Recovery Benefit no-5.15 Expenses on accompanying person

Note: The Policyholder can opt either Benefit 5.16 Voluntary Aggregate Deductible or Benefit 5.17 Co-Payment under the Policy.

### 5.18 CHANGE IN ROOM RENT LIMIT

Under this option, the Policyholder shall be allowed to opt the Room Rent category (as specified in the Coverage Summary) for hospitalizations allowable under Section 5 of this document, if so requested by the Policyholder and explicitly accepted by the Company. The agreed Room Rent category shall be expressly mentioned in the Policy Schedule.

### SECTION- 6 WAITING PERIOD:

The Waiting Periods as defined in Clause 6.1, 6.2 & 6.3 shall be applicable individually for each Insured Person and Claims shall be assessed accordingly, irrespective of whether the Sum Insured is on individual or floater basis.

If there is any Break in Policy, then the waiting periods including that for Pre-existing Disease shall be applicable afresh and the look-back period of 4 years for Pre-existing Disease shall be counted from the fresh Policy Period Start Date.

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

#### 6.1 PRE-EXISTING DISEASES (CODE- EXCL 01)

- Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24/48 months (as specified in the Policy Schedule) of continuous coverage after the date of inception of the first policy with us.
- In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- 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.

- Coverage under the policy after the expiry of 24/48 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 us.

#### 6.2 SPECIFIC WAITING PERIOD (CODE- EXCL 02)

Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 12 months of continuous coverage, as may be the case after

- The date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.
- In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- 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.
- The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- 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.

12 months waiting period list:

- Cataract
- Benign Prostatic Hypertrophy
- Myomectomy, Hysterectomy or menorrhagia or fibromyoma unless because of malignancy
- Dilation and curettage
- Hernia, hydrocele, congenital internal anomaly/ diseases, fistula in anus, sinusitis
- Skin and all internal tumors/ cysts/nodules/ polyps of any kind including breast lumps unless malignant /adenoids and hemorrhoids
- Dialysis required for chronic renal failure
- Gastric and Duodenal ulcers

#### 6.3 FIRST THIRTY DAYS WAITING PERIOD (CODE- EXCL 03)

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



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## SECTION- 7 EXCLUSIONS:

### 7.1 GENERAL EXCLUSIONS

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

#### i. Investigation & Evaluation (Code: Excl04)

- Expenses related to any admission primarily for diagnostics and evaluation purposes
- Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

#### ii. Rest Cure, rehabilitation and respite care (Code:Excl05)

Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

- 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.

#### iii. Obesity/ Weight Control (Code:Excl06):

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

#### iv. 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

#### v. 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

#### vi. 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, parajumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

#### vii. 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

#### viii. 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](http://www.indusindinsurance.com))

#### ix. Substance Abuse and Alcohol (Code: Excl12):

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof

#### x. Wellness and Rejuvenation (Code:Excl13):

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.

#### xi. Dietary Supplements & Substances (Code: Excl14):

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

#### xii. Refractive Error (Code: Excl 15):

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

#### xiii. 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.



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**xiv. Sterility and Infertility (Code: Excl 17):**

Expenses related to sterility and infertility. This includes:

- Any type of contraception, sterilization
- Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- Gestational Surrogacy
- Reversal of sterilization

**xv. Maternity Expenses (Code - Excl 18)**

- Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
- expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy Period.

**xvi. Circumcision:**

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

**xvii. Dental Treatment:**

Any dental treatment or surgery unless necessitated due to an Injury and requiring Hospitalization

**xviii. 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

**xix. Hearing Aids and Spectacles:**

Any charges incurred on hearing aids, cost of spectacles, contact lenses and routine eye and ear examinations

**xx. Documentation charges:**

Any charges incurred to procure any medical certificate, treatment/illness related documents pertaining to any period of Hospitalization/illness

**xxi. Artificial Life Support Equipment:**

Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health

**xxii. RMO charges, service charges and alike:**

Expenses related to any kind of RMO charges, service charge where nursing charges are also charged, night charges levied by the Hospital under whatever head.

**xxiii. STDs:**

Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, Human T-Cell Lymphotropic Virus Type III (HTLV-III or

IITLB-III) or Lymphadenopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.

**xxiv. External durable medical equipment:**

Any expenses incurred on corrective devices, external durable medical equipment of any kind, like wheelchairs, walkers, belts, collars, caps, splints, braces, stockings of any kind, diabetic footwear, glucometer/thermometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome (C.P.A.P) or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for asthmatic condition

**xxv. Transplant other than from human body:**

Expenses incurred on organ transplant surgery involving organs not harvested from a human body

**xxvi. Sleep Apnea:**

Any treatment related to sleep apnea, general debility convalescence, External Congenital Anomaly: Treatment of External Congenital Anomaly.

**xxvii. Self-injury**

Any intentional self-inflicted Injury

**xxviii. Vaccination and Immunization:**

All preventive care, vaccination, including inoculation and immunizations (except in case of post-bite treatment).

**xxix. Prostheses:**

Prostheses, corrective devices and medical appliances, which are not, required intra-operatively or for the disease / illness / injury for which the Insured Person was hospitalised.

**xxx. Donor Transplant Expenses:**

All expenses related to donor screening, treatment, including surgery to remove organ(s) from the donor, in case of transplant surgery.

**xxxi. Non - Allopathy:**

Any expenses related to Non-allopathic treatment, except for AYUSH treatment.

**xxxii. Overseas Treatment :**

Treatment received outside India

**xxxiii. Non-medical expenses:**

Any non-medical expenses mentioned in Annexure A (attached to the Policy Wordings)

**xxxiv. 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 mean 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.


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- b. Chemical attack / weapons mean 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. Also excluded herein is any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above.

#### **xxxv. War:**

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.

- ii. Emergency Hospitalization, the Company should be notified of such admission within 24 hours of such admission. The following details are to be provided to the 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

## **8.2 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 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 Policyholder / Insured Person:

- a. Pre-authorization: Prior to Hospitalization, the Policyholder / Insured Person must call the call center of the 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 Company will process the Policyholder's / 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 Policyholder / Insured Person and the Company will confirm such Cashless authorization / rejection in writing or by other means.
- c. If the procedure above is followed and the Policyholder's / Insured Person's request for Cashless facility is authorized, the Policyholder / 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.

## **7.2 PERMANENT EXCLUSION**

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

## **SECTION- 8 CLAIM 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 Illness / Injury that may give rise to a Claim under this Policy, then as a condition precedent to the admissibility of the Claim, the Policyholder / Insured Person shall undertake the following

### **8.1 CLAIMS INTIMATION**

In the event of any Illness or Injury or occurrence of any other contingency which has resulted in a Claim or may result in

- a. Claim covered under the Policy, the Policyholder / Insured Person, must notify the Company either at the call center or in writing immediately.

In the event of

- i. Planned Hospitalization, the Company should be notified of such admission at least 48 hours prior to the planned date of admission.



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- d. The 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 Policyholder/ Insured Person shall, in any event, be required to settle all other expenses, co-payment and / or deductibles (if applicable), 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 Company may deny Cashless facility for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case the Policyholder / Insured Person may be required to pay for the treatment and submit the Claim for reimbursement to the Company which will be considered subject to the Policy Terms & Conditions.
- g. The Policyholder/ Insured Person shall be required to submit the documents as mentioned in Clause 8.4 with the Network Hospital.
- iii. Forthwith pay the entire premium for the cover period in case of EMI applicable
- iv. If so requested by the Company, the Insured Person will have to submit himself for a medical examination by the Company's nominated Medical Practitioner as often as it considers reasonable and necessary. The cost of such examination will be borne by the Company.
- v. The Policyholder / Insured Person is required to check the applicable list of Network Hospitalization the Company's website or call center before availing the Cashless services.
- vi. On occurrence of an event which will lead to a Claim under this Policy, the Policyholder / Insured Person shall:
  - a. 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.
  - b. 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 Policyholder / Insured Person does not comply with the provisions of these conditions all benefits under this Policy shall be forfeited at the Company's option.

**NOTE:** Under Cashless facility, the Company may authorize upon the Policyholder 's/ Insured Person's request for direct settlement of admissible Claim as per agreed charges & terms and conditions between Network Hospital and the Company. In such cases, the 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 Policyholder / Insured Person is required to check the applicable list of Network Hospital on the Company's website

ii. Reimbursement:

In case of any Claim under the Benefits, where Cashless Facility is not availed, the list of documents as mentioned in Clause 8.4 shall be provided by the Policyholder/Insured Person, immediately but not later than 15 days of discharge from the Hospital, at the Policyholder's / Insured Person's expense to avail the Claim.

### 8.3 POLICYHOLDER'S / INSURED PERSON'S DUTY AT THE TIME OF CLAIM

- i. The Policyholder / Insured Person must take reasonable steps or measure to avoid or minimize the quantum of any Claim that may be made under this Policy.
- ii. Forthwith intimate / file / submit a Claim in accordance with Clause 8 of this Policy.

### 8.4 CLAIM DOCUMENTS

The Policyholder / Insured Person shall submit to the Company / Network Hospital (as applicable) the following documents for or in support of the Claim:

- i. Duly completed and signed Claim Form, in original
- ii. Medical Practitioner's referral letter advising Hospitalization
- iii. Medical Practitioner's prescription advising drugs / diagnostic tests / consultation
- iv. Original bills, receipts and discharge card from the Hospital / Medical Practitioner
- v. Original bills from pharmacy / chemists
- vi. Original pathological / diagnostic test reports and payment receipts
- vii. Indoor case papers
- viii. Ambulance receipt and bill
- ix. First Information Report / Final Police Report, if applicable
- x. Post mortem report, if available
- xi. Any other document as 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



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attested by such other insurer/reimbursement provider along with an original certificate of the extent of payment received from them needs to be submitted.

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.

### 8.5 PROPORTIONATE DEDUCTIONS

Subject to the other Terms and Conditions of this Policy, 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 Benefit-2.1 (i.e. Hospitalization) 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                                                                                                                          |
|--------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| A      | Actual Medical Bills Incurred                                              | As per submitted documents                                                                                                           |
| B      | Covered Medical Expenses                                                   | A - Any expense not covered under Policy Benefits                                                                                    |
| C      | Actual Room Rent                                                           | Room Rent (Including items to be subsumed under Room Rent as defined under Annexure A)                                               |
| D      | Covered Medical Expenses which shall be subject to Proportionate Deduction | B - cost of Pharmacy and consumables, implants and medical devices and diagnostics                                                   |
| E      | Claim after Proportionate Deduction                                        | D* Eligible Room Rent Limit ÷ Actual Room Rent<br>(If Actual Room Rent is within eligibility, then no deduction to be applied (E=D)) |

|   |                        |                                                                                    |
|---|------------------------|------------------------------------------------------------------------------------|
| F | Ground up claim amount | E + cost of Pharmacy and consumables, implants and medical devices and diagnostics |
| G | Amount after Co-pay    | F - Co-payment, if any on account of age                                           |
| H | Payable claim amount   | G - Deductions for Policy Deductibles and Limits*                                  |

### 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

### 8.6 PAYMENT TERMS

- This Policy covers medical treatment taken within India, and payments under this Policy shall be made in Indian Rupees within India.
- Claims shall not be admissible under this Policy unless the Company 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 Policyholder / Insured Person for any period of Hospitalization of less than 24 hours except for the Day Care Treatment, the list of which is annexed as per Annexure 1 (List of Day Care Treatments).
- 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 Period.
- The Company is not obliged to make payment for any Claim or that part of any Claim that could have been avoided or reduced if the Policyholder / Insured Person could reasonably have minimized the costs incurred, or that is brought about or contributed to by the Policyholder / Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.



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- vi. For Cashless Claims, the payment shall be made to the Network Hospital whose discharge would be complete and final.
- vii. For the Reimbursement Claims, the Company will pay the Policyholder. In the event of death of the Policyholder, the Company will pay the nominee (as named in the Policy Schedule) and in case of no nominee at its discretion to any adult Insured Person in the Policy whose discharge shall be treated as full and final discharge of its liability under the Policy.
- viii. The Company will only be liable to pay for such Benefits for which the Policyholder has specifically claimed in the Claim Form.

#### SECTION- 9 DISCLOSURE TO INFORMATION NORM

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

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of under-writing the risk)

#### SECTION- 10 CANCELLATION (OTHER THAN FREE LOOK)

- i. The Policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period on short period scale detailed below

| Period on risk       | % of Premium Refunded |
|----------------------|-----------------------|
| Up to 1 month        | 75%                   |
| Up to 3 months       | 50%                   |
| Up to 6 months       | 25%                   |
| Exceeding six months | Nil                   |

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

In case of demise of the Policyholder / Insured Person, this Policy shall continue till the end of Policy Period or next premium due whichever is earlier. In case the other Insured Person want to continue with the same Policy, the Company would renew the Policy providing all continuity benefits, subject to there being at least one adult member as an Insured Person who would then become the Policyholder. This will be subject to the Company receiving a written application in this regard before Policy Period End Date.

- 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 15 days' written notice. There would be no refund of

premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

#### SECTION- 11 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

#### SECTION- 12 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 at least 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](http://www.irdai.gov.in)(Circular-IRDA/HLT/REG/CIR/003/012020, Dated-01012020)

#### SECTION- 13 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 45 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](http://www.irdai.gov.in)(Circular- IRDA/HLT/REG/CIR/003/012020, dated 01012020)

#### SECTION- 14 MORATORIUM PERIOD

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

#### SECTION- 15 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 fifteen 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

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

#### SECTION- 16 RENEWAL OF POLICY

The Policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the Insured Person.

- The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- Request for renewal along with the requisite premium shall be received by the Company before the end of the Policy Period
- 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. Coverage is not available during the grace period.
- No loading shall apply on renewals based on individual claims experience.

Note- Refer Clause - 21 Additional Condition with respect to applicable discount / loading, increase or decrease in Sum Insured condition at the time of renewal.

#### SECTION- 17 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.

#### SECTION- 18 ALTERATIONS IN THE POLICY

This Policy constitutes the complete contract of Insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company. However, change or alteration with respect to increase/ decrease of the Sum Insured shall be permissible only at the time of renewal of the Policy subject to underwriting decision of the Company

#### SECTION- 19 PRE-POLICY HEALTH CHECK-UP

Medical test would be applicable in the following scenario:

- Persons below and equal to 45 years of age - If the member(s) declare Pre-existing at the proposal level
- All persons who are above 45 years of age

The prospect whose medical test is conducted and for whom the company grants an insurance cover under this policy and whose name specifically appears as Insured Person in the Schedule, the Company shall be liable to re-imburse 50% of the cost of such medicals conducted at the Company's designated centre

Basic Medical tests - Medical Test Cost = Rs. 470/- (as per the Company tie ups) and Reimburse Amount = Rs. 235

| MER (Medical Examination Report) | SGPT           |
|----------------------------------|----------------|
| CBC with ESR                     | Sr. Creatinine |
| HbA1C                            | ECG            |

For calculation of Sum Insured for determining the cut off for medicals the company may opt for considering the aggregate of all Sum insured's under all the Health Policy(ies) under which an individual is covered whether with the Company or with any other Insurance Company.

The company would continuously evaluate the medical tests/ report format mentioned above/below and may alter the tests/questions/ format depending upon its experience on the effectiveness of these tests in its decision making. With changing health trends and actual incidence or diseases in its portfolio company may introduce new tests and in the event of cost of tests changes the same shall be shared with the prospect

The result of medical underwriting is used as a guide for risk acceptance alone. There is no premium impact due to a substandard medical tests results (i.e. if the risk is accepted).

#### SECTION- 20 REDRESSAL OF GRIEVANCES

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

Website: [www.indusindinsurance.com](http://www.indusindinsurance.com)  
 Telephone Number: 022 4890 3009 (paid)  
 Dedicated Senior Citizen helpline: 022 - 33834185 (paid line)  
 E-mail: [services@indusindinsurance.com](mailto: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, (Correspondence Only) Correspondence Unit, Winway Building 2nd & 3rd Floor, 11/12 Block No. 4, Old no-67, South Takoganj, 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://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.

## SECTION- 21 ADDITIONAL CONDITION

### i. Income Tax Benefit

Premium paid under the policy shall be eligible for Income tax deduction benefit under Sec 80 D per the Income Tax Act

### ii. Family Floater

Where the Policy is obtained on floater basis covering the family members, the Sum Insured as specified in the Policy Schedule, shall be available to the Insured and all and any one of the Insured Persons for one or more claims during the Policy Period, up to the limit of Sum Insured specified in the Policy Schedule. Where the Policy is issued on Floater basis, the Policy can cover only the Insured Person, his/her lawful spouse and

2 dependent children who are upto the age of 25 years. A Floater Policy cannot cover any other person apart from the above category of persons.

### iii. Discounts applicable

- 4% discount on the premium if a 'daughter' (girl child) is covered in a family floater policy (i.e. in a 2 adults + 1 child or 2 adults + 2 children option)
- 7% discount on the premium if two 'daughter' (girl child) is covered in a family floater policy (i.e. in a 2 adults + 2 children option)
- 12% discount on the premium if the policy is purchased through internet channel or through tele-marketing.

### iv. Co-pay

Geographical Rating structure is being introduced i.e. Zone A – (Maharashtra, Gujarat, Delhi, Haryana, Uttar Pradesh & Bangalore) has 25% higher premium rates than Zone B (Rest of India). In order to avoid any hassle in case of claims being administered from a zone different from the policy pricing zone (zone A/zone B) geographical Co-pay is introduced. Below is the illustration of co-pay applicability:

| Pricing/ premium Paying Zone | Claims Zone | Co - pay (Yes/No) |
|------------------------------|-------------|-------------------|
| Zone A                       | Zone A      | No Co-pay         |
| Zone B                       | Zone B      | No Co-pay         |
| Zone A                       | Zone B      | No Co-pay         |
| Zone B                       | Zone A      | Co -pay of 25%    |

The basis of co-payment would primarily prevent any claims leakage prevalent due to treatment in a zone different than the pricing zone.

Please Note-In addition to above, If optional cover Co-Payment is opted by the Policyholder then Co-Payment of 10% or 25% shall be applicable on each and every claim made under the Policy.

### v. Renewals

Cases which are categorized as high risk need to be mandatorily referred to Corporate Underwriter.

#### a. Renewal Discount:

Renewal Discount equivalent to 5%, on cumulative basis, of renewal premium for each continuous claim free year will be offered as No Claim Bonus subject to maximum upto 20%, where the Policy which is claim free & is renewed without a break. In case of claim all discount shall be forfeited at renewal.

#### b. Any policy which is due for renewal and the proposer requests for one or more of the following alterations in the expiring policy may be subject to review of Underwriter:

- Increase in Sum Insured

| Proposal Category           | Request Mode                                   | Documents required                                                                                                                            |
|-----------------------------|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| Below and equal to 45 years | To be routed to services@indusindinsurance.com | Completely filled & duly signed proposal form, renewal notice, policy copy & claims confirmations from TPA (if other than Health Claims team) |
| > 45 years                  | Request routed through PPHC                    | Completely filled & duly signed proposal form, renewal notice, policy copy & claims confirmations from TPA (if other than Health Claims Team) |



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Note: NCD shall not be applicable for increased SUM insured. illustration as mentioned below.

| Existing policy with 3L sum insured |             |     |  | Renewal with increase in sum insured to 5L |             |     |
|-------------------------------------|-------------|-----|--|--------------------------------------------|-------------|-----|
| Member                              | Sum Insured | NCD |  | Member                                     | Sum Insured | NCD |
| Self & Spouse                       | 3L          | 10% |  | Self & Spouse                              | 3L          | 10% |
|                                     |             |     |  |                                            | 2L          | 0%  |

- Decrease in Sum Insured

Authority lies with Branch Sales Manager in all cases (claim as well as claim free) subject to:

- Minimum of 1 Lacs sum insured
- Collection of completely filled & duly signed proposal form by the proposer.

- Upgrade of plan

Not permitted

- Downgrade of plan

Authority lies with Branch Sales Manager in all cases (claim as well as claim free) subject to collection of completely filled & duly signed proposal form by the proposer.

- Change in policy type/cover (merging/splitting of HealthWise policy):

Allowed only at the time of renewals subject to Corporate Underwriter's approval. Such cases to be routed to email id services@indusindinsurance.com along with completely

filled and duly signed proposal form by the proposer, RN, policy copy and claim confirmation (if other than Health Care)

## SECTION- 22 PREMIUM PAYMENT

As per the premium Schedule enclosed

- The proposer can contact the agent / intermediary/ any of our offices / website for a full version of the Policy document.
- In all cases, where any clarification is required regarding classification of risks or rating etc. the agents have to necessarily contact the Regional Office / Branch office to which they are attached for further guidance
- The premium applicable (for fresh/renewal policies) would be as per the rate prevailing & age, Sum Insured applicable on policy start date /date of renewal
- The Company reserves the right to change renewal premium, coverages, policy terms & conditions subject to requisite approvals.
- The premium applicable (for fresh/renewal policies) would be as per the prevalent premium rates for the plan/age/Sum Insured/members covered applicable on the Policy start date/Renewal Date

## SECTION- 23 COVERAGE SUMMARY

| Particulars                           | Standard Plan                                                                                                                                                                                                                                                                      | Silver Plan                          | Gold Plan                                                      |
|---------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|----------------------------------------------------------------|
| <b>Base Cover</b>                     |                                                                                                                                                                                                                                                                                    |                                      |                                                                |
| In-patient Hospitalisation            | Covers In-patient Hospitalisation expenses up to the Sum Insured.                                                                                                                                                                                                                  |                                      |                                                                |
| Domiciliary Hospitalisation           | Limited to 10% of Sum Insured, for medical expenses incurred for availing Medical treatment at home which would have otherwise required hospitalisation                                                                                                                            |                                      |                                                                |
| Day care treatment                    | Covered as listed in Annexure D(attached to the Policy wordings)                                                                                                                                                                                                                   |                                      |                                                                |
| Pre-Hospitalisation Medical Expenses  | 30 days                                                                                                                                                                                                                                                                            | 60 days                              | 60 days                                                        |
| Post-Hospitalisation Medical Expenses | 60 days                                                                                                                                                                                                                                                                            | 90 days                              | 90 days                                                        |
| Pre-Existing Disease coverage         | 5th Policy Year onward                                                                                                                                                                                                                                                             | 3rd Policy Year onward               | 3rd Policy Year onward                                         |
| Critical Illness                      | Not covered                                                                                                                                                                                                                                                                        | Not covered                          | Covered for an additional amount equivalent to the Sum Insured |
| Donor Expenses                        | Not covered                                                                                                                                                                                                                                                                        | Covered within the Sum Insured limit | Covered within the Sum Insured limit                           |
| Cost of Health Check-up               | Reimbursement of cost of medical check-up upto 1% of average Sum Insured for individual policies and upto 1.25% for Floater covers, once at the end of a block of four consecutive years provided there are no claims reported under the policies by any member, during the block. |                                      |                                                                |



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|                                                 |                                                                                                                                   |                                                                                                                                   |                                                                                                                                                 |
|-------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|
| Modern Treatment                                | Covered upto 50% of Sum Insured                                                                                                   |                                                                                                                                   |                                                                                                                                                 |
| Value Added Covers                              |                                                                                                                                   |                                                                                                                                   |                                                                                                                                                 |
| Daily Hospitalisation Allowance                 | Not covered                                                                                                                       | Not covered                                                                                                                       | Rs. 250 per day, upto 7 days, starting from day 4 to day 10. In case of listed Critical Illness, said allowance will be payable upto 14 days.   |
| Nursing Allowance(Per day amount)               | Not covered                                                                                                                       | Rs.250 per day for a maximum period of 5 days                                                                                     | Rs.300 per day for a maximum period of 5 days In case of listed Critical Illness, the said reimbursement will be extended to maximum of 10 days |
| Local Road Ambulance (maximum of)               | Upto Rs. 500/-                                                                                                                    | Upto Rs. 500/-                                                                                                                    | Upto Rs. 1000/-                                                                                                                                 |
| Recovery Benefit                                | Not covered                                                                                                                       | Covered -If in case an insured person is hospitalized for more than 10 days, a lump-sum of Rs. 10,000/- will be paid.             |                                                                                                                                                 |
| Expenses on accompanying person(per day amount) | Rs. 200/- per day for a maximum period of 5 days subject to Insured Person is hospitalized for a period of 5 days at a given time | Rs. 250/- per day for a maximum period of 5 days subject to Insured Person is hospitalized for a period of 5 days at a given time | Rs. 300/- per day for a maximum period of 5 days subject to Insured Person is hospitalized for a period of 5 days at a given time               |

#### OPTIONAL COVERS

| Voluntary Aggregate Deductible * | Sum Insured                                                                                                                                  | Annual Aggregate Deductible limit (options) | Sum Insured                                                                                                                                  | Annual Aggregate Deductible limit (options) | Sum Insured                                                                                                                                  | Annual Aggregate Deductible limit (options) |
|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|
|                                  | 1 lakh                                                                                                                                       | 15,000<br>25,000                            | 1 lakh                                                                                                                                       | 15,000<br>25,000                            | 1 lakh                                                                                                                                       | 15,000<br>25,000                            |
|                                  | 2 lakh                                                                                                                                       | 15,000<br>25,000<br>50,000                  | 2 lakh                                                                                                                                       | 15,000<br>25,000<br>50,000                  | 2 lakh                                                                                                                                       | 15,000<br>25,000<br>50,000                  |
|                                  | 3 lakh                                                                                                                                       | 15,000<br>25,000<br>50,000                  | 3 lakh                                                                                                                                       | 15,000<br>25,000<br>50,000                  | 3 lakh                                                                                                                                       | 15,000<br>25,000<br>50,000                  |
|                                  | 4 lakh                                                                                                                                       | 15,000<br>25,000<br>50,000<br>1,00,000      | 4 lakh                                                                                                                                       | 15,000<br>25,000<br>50,000<br>1,00,000      | 4 lakh                                                                                                                                       | 15,000<br>25,000<br>50,000<br>1,00,000      |
|                                  | 5 lakh                                                                                                                                       | 15,000<br>25,000<br>50,000<br>1,00,000      | 5 lakh                                                                                                                                       | 15,000<br>25,000<br>50,000<br>1,00,000      | 5 lakh                                                                                                                                       | 15,000<br>25,000<br>50,000<br>1,00,000      |
| Co-Payment*                      | Options:10% or 25% on each and every claim                                                                                                   |                                             | Options:10% or 25% on each and every claim                                                                                                   |                                             | Options:10% or 25% on each and every claim                                                                                                   |                                             |
| Change in Room Rent Limit        | Category of Room capped to Non-ICU: 2% of Sum Insured or ₹ 5,000 whichever is lower<br>ICU: 5% of Sum Insured or ₹ 10,000 whichever is lower |                                             | Category of Room capped to Non-ICU: 2% of Sum Insured or ₹ 5,000 whichever is lower<br>ICU: 5% of Sum Insured or ₹ 10,000 whichever is lower |                                             | Category of Room capped to Non-ICU: 2% of Sum Insured or ₹ 5,000 whichever is lower<br>ICU: 5% of Sum Insured or ₹ 10,000 whichever is lower |                                             |

\*The Policyholder can opt either Benefit -Voluntary Aggregate Deductible or Benefit Co-Payment under the Policy.


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## SECTION- 24 PREMIUM RATE AND ILLUSTRATION

### i. Rate Chart

For premium rates please refer to the premium chart.

### ii. Premium Illustration

Below is the Premium Illustration for both Individual and Floater Plan

#### a. Individual Plan

Consider the following insured details:

Individual Aged: 27 Years

Sum Insured: 3 Lakhs

Location: Mumbai

Channel: Tele Marketing

Plan: Standard

Business Type :Fresh Business

PED: No

• According to Rate Chart the premium payable before GST is Rs.6,646/-

• Channel discount for tele marketing = 12%

• Final premium to be charged to the customer =  $6646 * (1 - 12) = 5848$

### ii. Family Floater Plan

Quote demography:

| Member   | Age      | Gender | Relationship | Zone | Sum Insured     |
|----------|----------|--------|--------------|------|-----------------|
| Member 1 | 45 Years | Male   | Self         | A    | 5 Lakhs Floater |
| Member 2 | 41 Years | Female | Spouse       | A    |                 |
| Member 3 | 12 Years | Male   | Son          | A    |                 |
| Member 4 | 8 Years  | Female | Daughter     | A    |                 |

Sales Channel is 'online' and this is 2nd renewal with no claims in the past.  
 Premium Illustration (amounts in INR)

Premium from the rate chart (Zone A - Standard - Floater (2A + 2 Children) - 5 Lakhs SI) [A]

24,236

Daughter Discount [B]

4%

Channel Discount [C]

12%

Renewal Discount - 2nd claim free renewal [D]

10%

Total discount [E = B+C+D]

26%

Final Premium [F = A\*(1-E)]

17,935

### Contact details for Policy 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  
 Contact No. - 022 - 41112600  
 Website - www.indusindinsurance.com  
 Telephone Number.- 022 4890 3009 (paid)

### Contact details for Claim Servicing

Name - IndusInd General Insurance Company Limited  
 Correspondence Address - IndusInd Management, IndusInd General Insurance., No. 1-89/3/B/40 to 42/ks/301, 3rd Flr., Krishe Block Krishe Sapphire, Madhapur, Hyderabad-500081  
 Near DurgamCheruvu Metro  
 Email ID :- healthcare@indusindinsurance.com  
 Contact No. - 022-41112600  
 Website - www.indusindinsurance.com  
 Telephone Number.- 022 4890 3009 (paid)

## SECTION- 26 DISCLAIMER:

This is only a summary of our 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 our Insurance advisor of you require any further information or clarification.

## SECTION- 27 STATUTORY WARNING

Prohibition of Rebates - Section 41 of the Insurance Laws (Amendment) Act, 2015

- No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.
- Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

## SECTION- 25 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



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Individual and Floater Premium Illustration - IndusInd HealthWise Policy

| Individual and Floater Premium Illustration - IndusInd Health Wise Policy                                                                        |                                                                                                              |                   |                                                                                                                                                           |                  |                              |                   |                                                                                                                          |                   |                   |                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|-------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------|-------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------|-------------------|
| Age of the members insured                                                                                                                       | Coverage opted on individual basis covering each member of the family separately (at a single point in time) |                   | Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family) |                  |                              |                   | Coverage opted on familyfloater basis with overall Sum insured (Only one sum insured is available for the entire family) |                   |                   |                   |
|                                                                                                                                                  | Premium (Rs.)                                                                                                | Sum insured (Rs.) | Premium (Rs.)                                                                                                                                             | Discount, if any | Premium after discount (Rs.) | Sum insured (Rs.) | Premium or consolidated premium for all members of family (Rs.)                                                          | Sum insured (Rs.) | Sum insured (Rs.) | Sum insured (Rs.) |
| 51 years                                                                                                                                         | 15,104                                                                                                       | 3 lakhs           | 15,104                                                                                                                                                    | 0%               | 15,104                       | 3 lakhs           | 26,338                                                                                                                   | 0%                | 26,338            | 3 lakhs           |
| 44 years                                                                                                                                         | 10,391                                                                                                       | 3 lakhs           | 10,391                                                                                                                                                    |                  | 10,391                       | 3 lakhs           |                                                                                                                          |                   |                   |                   |
| 23 years                                                                                                                                         | 4,718                                                                                                        | 3 lakhs           | 4,718                                                                                                                                                     |                  | 4,718                        | 3 lakhs           |                                                                                                                          |                   |                   |                   |
| 18 years                                                                                                                                         | 4,718                                                                                                        | 3 lakhs           | 4,718                                                                                                                                                     |                  | 4,718                        | 3 lakhs           |                                                                                                                          |                   |                   |                   |
| Total Premium for all members of the family is Rs. 34931 when each member is covered separately.                                                 |                                                                                                              |                   | Total Premium for all members of the family is Rs. 34931 when they are covered under a single policy.                                                     |                  |                              |                   | Total Premium when policy is opted on floater basis is Rs. 26338.                                                        |                   |                   |                   |
| Sum insured available for each individual is Rs. 3 lakhs                                                                                         |                                                                                                              |                   | Sum insured available for each family member is Rs. 3 lakhs                                                                                               |                  |                              |                   | Sum insured of Rs. 3 lakhs is available for the entire family.                                                           |                   |                   |                   |
| Note: Premium rates specified in the above illustration are for Zone A Standard plan. Also, the premium rates are exclusive of taxes applicable. |                                                                                                              |                   |                                                                                                                                                           |                  |                              |                   |                                                                                                                          |                   |                   |                   |


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