Zurich Kotak General Insurance Company (India) Limited
(Formerly known as Kotak Mahindra General Insurance Company Limited)
Registered & Corporate Office: 401, 4th Floor, Silver Metropolis, Jai Coach Compound, Off Western Express Highway, Goregaon (East), Mumbai - 400063. Maharashtra, India.

EMPOWER
Policy Wording

ZK - 24-25/v1

1. PREAMBLE

This Policy is a contract of insurance issued by Zurich Kotak General Insurance Company (India) Limited (hereinafter called the 'Company') to the policy holder mentioned in the schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the "Insured Persons"). The policy is based on the statements and declaration provided in the Proposal Form by the policy holder and is subject to receipt of the requisite premium.

2. OPERATIVE CLAUSE

If during the Policy Period an Insured Person is required to be hospitalized for treatment of an Illness or Injury at a Hospital/ Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify Medically necessary, expenses towards the Coverage mentioned in the Policy Schedule.

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

3. DEFINITIONS

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and other gender and references to any statutory enactment includes subsequent changes to the same.

1. **Accident** means sudden, unforeseen, and involuntary event caused by external, visible, and violent means.

2. **Adventurous/Hazardous Sports** means any sport or activity involving physical exertion and skill in which an Insured Person participates or competes for entertainment or as part of his profession whether he / she is trained or not

3. **Age** means completed years on last birthday as on Commencement Date

4. **Ambulance** means a motor vehicle operated by a licensed/ authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention

5. **Any one Illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital / Nursing Home where treatment was taken.

6. **Associated Medical Expenses** means expenses incurred during hospitalization which vary due to the differential billing system as per room rent category including but not limited to
   - Room Rent,
   - nursing charges,
   - operation theatre charges,
   - fees of Medical Practitioners (including surgeons, anesthetists and specialists)
   - In-patient Physiotherapy Charges

   Associated medical expenses shall not include:

   a. Cost of pharmacy and consumables, b. Cost of implants and medical devices, c. Cost of diagnostics

7. **Alternative / AYUSH Treatment** refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

8. **AYUSH Hospital** means an AYUSH Hospital is a healthcare facility wherein medical / surgical/ para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

   i. Central or State Government AYUSH Hospital; or

   ii. Teaching hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/ Central Council for Homeopathy; or

   iii. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

      a) Having at least 5 in-patient beds.

      b) Having qualified AYUSH Medical Practitioner in charge round the clock;

      c) Having dedicated AYUSH therapy sections as required and / or has equipped operation theatre where surgical procedures are to be carried out;

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

9. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical / para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

   i. Having qualified registered AYUSH Medical Practitioner in charge round the clock;

   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

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

10. **Break in Policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

11. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the Network Provider by the insurer to the extent pre-authorization is approved.

12. **Claims** means a demand made by the Policyholder/Insured Person

    or on his behalf, for payment of Medical Expenses under any other Benefit, as covered under the Policy

13. **Commencement Date** means the date of inception of first policy with Us as specified in the Policy Schedule

14. **Condition Precedent** means a policy term or condition upon which

the Insurer's liability under the policy is conditional upon.

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

    i. Internal Congenital Anomaly – Congenital Anomaly which is not in the visible and accessible parts of the body.

    ii. External Congenital Anomaly – Congenital Anomaly which is in the visible and accessible parts of the body

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

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

    i. has qualified nursing staff under its employment.

    ii. has qualified medical practitioner/s in charge.

    iii. has fully equipped operation theatre of its own where surgical procedures are carried out

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

18. **Day Care Treatment** means medical treatment, and/or surgical procedure which is

    i. Undertaken under General or Local Anesthesia in a hospital/day care center in less than 24 hours because of technological advancement, and

    ii. which would have otherwise required hospitalization of more than 24 hours.

    Treatment normally taken on an out-patient basis is not included in the scope of this definition.

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

    The Deductible will apply on aggregate basis for all hospitalisation expenses during the policy year.

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

21. **Diagnostic Centre** means a place where diagnostic tests and exploratory or therapeutic procedures required for the detection, identification and treatment of a medical condition are done.

22. **Disclosure of information** norm means the policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

23. **Emergency Care** means management for an Illness which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the insured person's health.

24. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre – existing diseases. Coverage is not available for the period for which no premium is received.

25. **Home Care Treatment** means treatment availed by the Insured Person at home for illness/ injuries, which in normal course would require hospitalization but is actually taken at home provided that:

    a) The Medical practitioner advices the Insured person to undergo treatment at home.

    b) There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment.

    c) Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.

26. **Hospital** means any institution established for In-patient Care and Day Care Treatment of diseases, injuries and which has been registered as a Hospital with the local authorities under the clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act or complies with all minimum criteria as under:

    i. has qualified nursing staff under its employment round the clock,

    ii. has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and 15 inpatient beds in all other places,

    iii. has qualified Medical Practitioner(s) in charge round the clock,

    iv. has a fully equipped operation theatre of its own where surgical procedures are carried out,

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

27. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

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

29. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

    i. Acute condition - Acute condition is a disease, Illness that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ Illness which leads to full recovery

    ii. Chronic condition - A chronic condition is defined as a disease, Illness that has one or more of the following characteristics:

        a. it needs ongoing or long-term monitoring through consultations, examinations, checkups, and /or tests

        b. it needs ongoing or long-term control or relief of symptoms

        c. it requires your rehabilitation for the patient or for the patient to be specially trained to cope with it

        d. it continues indefinitely.

        e. it recurs or is likely to recur.

30. **In-patient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

31. **Insured Person/You/Your** means the person named in the Policy Schedule who is insured under the Policy and is citizen of India, in respect of whom the applicable premium has been received by the Company

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

33. **ICU Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

34. **Life-threatening emergency** shall mean a serious medical condition or symptom, which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long-term impairment of the Insured Person's health, until stabilization at which time this medical condition or symptom is not considered an Emergency anymore

35. **Material Facts** means 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 underwriting the risk.

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

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

38. **Medical Necessary Treatment** means any treatment, tests, medication, or stay in Hospital or part of stay in Hospital which:

    i. is required for the medical management of the illness or injury suffered by the Insured Person.

    ii. must not exceed the level of care necessary to provide safe, adequate, and appropriate medical care in scope, duration, or intensity.

    iii. must have been prescribed by a medical practitioner.

    iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

39. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

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

41. **Network Provider** means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a Cashless facility.

42. **New born Baby** means baby born during the Policy Period and is aged up to 90 days.

43. **Non-Network Provider** means any Hospital, Day Care Centre or other provider that is not part of the Network.

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

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

46. **Pre-Hospitalization Medical Expenses** means medical expenses incurred during pre- defined number of days preceding the hospitalization of the Insured Person, provided that:

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

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

47. **Pre-Existing Disease (PED)**: means any condition, ailment, injury or disease:

    i. that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer or

    ii. for which medical advice or treatment was recommended by, or received from, a physician not more than 36 months prior to the date of commencement of the policy.

48. **Post-Hospitalization Medical Expenses** means medical expenses incurred during pre- defined number of days immediately after the insured person is discharged from the hospital provided that:

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

    ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

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

50. **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof, as amended from time to time, and shall be read together. The Policy contains details of the extent of cover available to the Insured Person, applicable exclusions, and the terms & conditions applicable under the Policy

51. **Policy Period** means the period between the Commencement Date and either the Expiry Date specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier

52. **Policyholder** means the entity or person named as such in the Schedule.

53. **Policy Schedule** means the Policy Schedule attached to and forming part of this Policy specifying the details of the Insured Persons, the Sum Insured, the Policy Period and the Sub-limits to which benefits under the Policy are subject to, including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

54. **Policy Year** means a period of twelve months beginning from the Commencement Date and ending on the last day of such twelve-month period. For the purpose of subsequent years, Policy Year shall mean a period of twelve months commencing from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Expiry Date, as specified in the Policy Schedule.

55. **Proposal Form** means a form to be filled in by the Prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.

56. **Qualified Nurse** is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India.

57. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of Grace Period for treating the Renewal continuous for the purpose of gaining credit for Pre-Existing Diseases, time-bound exclusions and for all waiting periods.

58. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

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

60. **Sub-limit** means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit. The Sub- limit as applicable under the Policy is specified in the Policy Schedule against the relevant Cover in force under the Policy.

61. **Sum Insured** means the pre-defined limit specified in the Policy Schedule and represents the maximum, total and cumulative liability for any and all claims under the Policy in respect of each insured person as mentioned in the Policy Schedule.

62. **Surgery or Surgical Procedures** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a Medical Practitioner.

63. **Unproven/Experimental Treatment** is a treatment including drug experimental therapy, which is based on established medical practice in India, is a treatment experimental or unproven.

64. **Waiting Period** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the Waiting Period, diseases/ treatments shall be covered provided the Policy has been continuously renewed without any break.

65. **We/Our/Us/Company** means Zurich Kotak General Insurance Company (India) Limited

4. WHAT WE WILL PAY (SCOPE OF COVER OF BENEFITS AVAILABLE UNDER THE POLICY)

The Benefits available under this Policy are described below. Benefits will be payable in excess of Deductible stated in the Policy Schedule, subject to

i) availability of Base Annual Sum Insured

ii) the terms, conditions and exclusions of this Policy and

iii) any sub-limits specified in respect of that Benefit and co-pay as specified in the Policy Schedule.

4.1 Inpatient Care

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person commenced during the Policy Year, up to the Sum insured as specified in the Policy Schedule (other than any sub-limits, co-pay, Deductible as specified in the policy), for:

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to maximum of 1% of the Sum Insured per day subject to maximum of Rs.5000 /day.

ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to maximum of 2% of Sum Insured per day.

iii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating Medical Practitioner/ surgeon or to the hospital

iv. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

Note:

1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible.
2. In case of admission to a room at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ charges.

4.2 Day Care Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Day Care Treatment during the Policy Year following an Illness or Injury provided that:

(a) the Day Care Treatment is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;

(b) the Medical Expenses incurred are Reasonable and Customary;

Further,

(a) We will not cover any OPD Treatment under this Benefit.

Note:

1. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

4.3 AYUSH Treatment

Expenses incurred for Inpatient/ Day care treatment under AYUSH systems of medicines is covered up to Sum Insured, during each Policy Year as specified in the Policy Schedule.

4.4 Pre-Hospitalization Medical Expenses

The Company shall indemnify Pre-Hospitalization Medical Expenses incurred, related to an admissible Hospitalization, for a fixed period of 30 days prior to the date of admissible Hospitalization covered under the Policy provided that the company shall not liable to make payment for any pre-hospitalization medical expenses that were not incurred during the policy period.

Conditions:

i. The claim is accepted under Section 4.1 (Inpatient Care), Section 4.2 (Day Care Treatment), Section 4.3 (AYUSH Treatment) or Section 4.7 (Modern Treatment) in respect of that Insured Person.

ii. Pre-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

4.5 Post-Hospitalization Medical Expenses

The Company shall indemnify Post Hospitalization Medical Expenses incurred, related to an admissible Hospitalization, for a fixed period of 60 days from the date of discharge from the hospital, upto maximum of 10% of hospitalization expenses (Hospital Bill -- Nursing charges, room rent, consultant charges, diagnostics and medicines) following an admissible hospitalization covered under the Policy during the policy period.

Conditions:

i. The claim is accepted under Section 4.1 (Inpatient Care), Section 4.2 (Day Care Treatment), Section 4.3 (AYUSH Treatment) or Section 4.7 (Modern Treatment) in respect of that Insured Person.

ii. Post-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

4.6 Emergency Road Ambulance

The Company will reimburse Reasonable and Customary Charges for expenses incurred towards ambulance charges for transportation of an Insured person upto the limit mentioned in Policy Schedule.

Specific Conditions:

The Company will reimburse payments under this Benefit provided that.

a. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is Injured or is suffering from an Illness to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital as advised by the treating Medical Practitioner in writing for management of the current Hospitalization.

b. Expenses incurred on road Ambulance subject to a maximum of Rs.10000/- per Policy year.

c. The ambulance service is offered by a healthcare or Registered Ambulance Service Provider.

d. The original Ambulance bills and payment receipt is submitted to the Company.

e. The Company has accepted a claim under Section 4.1 (Inpatient Care), Section 4.2 (Day Care Treatment), Section 4.3 (AYUSH Treatment) or Section 4.7 (Modern Treatment) in respect of that Insured Person.

f. Any payment under this Benefit will be excluded if the Insured Person is transferred to any Hospital or diagnostic center for evaluation purposes only.

4.7 Modern Treatment

The following procedures will be covered (wherever medically indicated) either as In patient or as part of Day Care Treatment in a Hospital up to 50% of Sum Insured, specified in the Policy Schedule, during the Policy Period.

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

b. Balloon Sinuplasty

c. Deep Brain stimulation

d. Oral chemotherapy

e. Immunotherapy- Monoclonal Antibody to be given as injection.

f. Intra Vitreal injections

g. Robotic surgeries

h. Stereotactic radio Surgeries

i. Bronchial Thermoplasty

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

k. IONM- (lntra Operative Neuro Monitoring)

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

4.8 Home Care Treatment

We will indemnify the Insured Person up to the amount as specified in Policy Schedule, for the Medical Expenses incurred by the Insured Person on availing treatment at home which in normal course would require Hospitalization but is actually taken at home provided that:

a) The Medical Practitioner advises the Insured person to undergo treatment at home

b) There is a continuous active line of treatment with monitoring of the health status by a Medical practitioner for each day through the duration of the home care treatment

c) Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained

d) Insured can avail "Home Care Treatment" only on reimbursement basis subject to prior approval from Us

List of Conditions covered under Home care treatment

a. Fever and Infectious diseases which can be managed as Inpatient

b. Uncomplicated Urinary tract infections but needing Parenteral Antibiotics

c. Asthma and COPD -Mild Exacerbations needing Home Nebulization

d. Acute Gastritis/Gastroenteritis

e. I.V. Chemotherapy [Where advised by the doctor]

f. Palliative Cancer care requiring medical assistance

g. Acute Vertigo

h. Diabetic foot and Cellulitis

i. IVDP [Cervical and Lumbar disc diseases]

j. Major Surgeries/Arthroplasties needing IV Antibiotics Post Discharge

k. Care for Brain and Spinal Injury Cases Post Discharge

l. Post CVA Care at Home after Discharge

m. Chronic Severe Refractory Asthma (by Advanced Medicine)

Sub-Limits applicable to the Policy

The company shall indemnify medical expenses upto the limits mentioned incurred for treatment of

i. Cataract, subject to a limit of Rs.25,000/- per eye for each Policy Year

ii. Expenses incurred on dialysis (inclusive of AV fistula /graft creation charges) are payable upto Rs.1,000/- per sitting commencing from the Policy Year in which Chronic Kidney disease occurs and payable for up to 5 dialysis sessions per month provided the policy is in force.

iii. Expenses incurred on Pre-existing Disease and its complications are payable upto 50% of Sum Insured after completion of Pre-existing waiting Period as mentioned 5.A.1

- **Co payment**

Each and every claim under the Policy shall be subject to a Co-payment of 20% applicable to the claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.
Co-payment will not be applicable for Claims pertaining to Cataract, Dialysis & Home Care Treatment

5. WAITING PERIOD

The Company is not liable to make any payment under the Policy in connection with or in respect of the following expenses till the expiry of the waiting period and any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or any way attributable to any of the following unless expressly stated to the contrary in this Policy.

A. Waiting Periods

1. Pre-Existing Diseases (Code- Excl01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.

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

c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

2. First 30 days waiting period- Code- Excl03

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

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

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

3. Specified disease/procedure waiting period- Code- Excl02

a) Expenses related to the treatment of the listed Conditions; surgeries/treatments shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

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

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

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

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

f) List of specific diseases/procedures

1. Cataract and age related eye ailments
2. Benign Prostatic Hypertrophy;
3. Myomectomy, Hysterectomy unless because of malignancy;
4. All types of Hernia, Hydrocele;
5. Fissures and/or Fistula in anus, haemorrhoids/piles, pilonoidal sinus;
6. Arthritis, gout, rheumatism and spinal disorders; Arthroscopic Knee Surgeries/ ACL Reconstruction/ Meniscal and Ligament Repair
7. Joint replacements unless due to Accident;
8. Sinusitis and related disorders;
9. Stones in the urinary and biliary systems;
10. Dilatation and curettage, Endometriosis;
11. All types of skin and internal tumors/ cysts/ nodules/ polyps of any kind including breast lumps unless malignant;
12. Dialysis required for chronic renal failure;
13. Surgical treatments for Benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to Tonsillitis, adenoids and sinuses;
14. Gastric and duodenal erosions and ulcers;
15. Deviated nasal septum;
16. Varicose Veins/ Varicose Ulcers.
17. Parkinson's or Alzheimer's disease or Dementia
18. Surgery of Genito-urinary system unless necessitated by malignancy

6. EXCLUSIONS

1. Investigation & Evaluation- Code- Excl04

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

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

2. Rest Cure, rehabilitation, and respite care- Code- Excl05

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

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

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

3. Obesity/ Weight Control: Code- Excl06

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

1) Surgery to be conducted is upon the advice of the Doctor.

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

3) The member must be 18 years of age or older and

4) Body Mass Index (BMI).

a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. coronary heart disease

iii. Severe Sleep Apnoea

iv. Uncontrolled Type2 Diabetes

4. Change-of-Gender treatments: Code- Excl07
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

5. Cosmetic or plastic Surgery: Code- Excl08
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

6. Hazardous or Adventure sports: Code- Excl09
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

7. Breach of law: Code- Excl10
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

8. Excluded Providers: Code- Excl11
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

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

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

12. Refractive Error: Code- Excl15

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

13. Unproven Treatments: Code- Excl16

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

14. Sterility and Infertility: Code- Excl17

Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, sterilization

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

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

15. Maternity: Code Excl18

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

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

16. Upto Deductible amount mentioned in the Policy Schedule

17. Any medical treatment taken outside India.

18. Hospitalization for donation of any body organs by an Insured including complications arising from the donation of organs.

19. Nuclear damage caused by, contributed to, by or arising from ionising radiation or contamination by radioactivity from:

a. any nuclear fuel or from any nuclear waste; or

b. from the combustion of nuclear fuel (including any self-sustaining process of nuclear fission);

c. nuclear weapons material.

d. nuclear equipment or any part of that equipment.

20. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.

21. Injury or Disease caused by or contributed to by nuclear weapons/materials.

22. Charges incurred in connection with routine eye examinations and ear examinations, dentures, artificial teeth and all other similar external appliances and / or devices whether for diagnosis or treatment

23. Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, crutches, instruments used in treatment of sleep apnea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively;

24. Any expenses incurred on personal comfort, erectile dysfunction, cosmetics, convenience and hygiene related items and services, medical supplies including elastic stockings, diabetic test strips, and similar products

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

26. Treatment related to any experimental or unrecognized systems of medicine.

27. Any consequential or indirect loss arising out of or related to Hospitalization

28. Suicide, Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) and any violation of law or participation in an event/activity that is against law with a criminal intent.

29. Vaccination or inoculation except as post bite treatment for animal bite.

30. Convalescence, general debility, "Run-down" condition, rest cure, Congenital external illness/disease/defect.

31. Outpatient diagnostic, medical and surgical procedures or treatments, non-prescribed drugs and medical supplies, hormone replacement therapy and expenses related to Domiciliary hospitalization shall not be covered.

32. Dental treatment or Surgery of any kind unless requiring Hospitalisation as a result of accidental Bodily Injury.

33. Venereal/ Sexually Transmitted disease.

34. Stem cell storage.

35. Non-Payable items: The expenses that are not covered in this Policy are placed under List-I of Annexure-II.

36. Any medical procedure or treatment, which is not medically necessary or not performed by a Medical Practitioner.

37. Expenses related to any kind of advance technology methods other than mentioned in the
4.7 Modern Treatment

38. Alopecia wigs and/or toupee and all hair or hair fall treatment and products.

39. Any charges incurred to procure documents related to treatment or Illness pertaining to any period of Hospitalization or Illness.

40. Remicade, Avastin or similar injectable treatment which is undergone other than as a part of In-Patient Care Hospitalisation or Day Care Hospitalisation is excluded.

41. Expenses related to any kind of RMO charges, Service charge, Surcharge, night charges levied by the hospital under whatever head or transportation charges by visiting consultant.

42. Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.

43. Treatment such as External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), and Hyperbaric Oxygen Therapy will not be covered unless it forms a part of In-Patient Treatment in case of hospitalisation or part of discharge

44. Any physical, medical condition or treatment that is specifically excluded in the Policy Schedule under Important Conditions

7. CLAIM ADMINISTRATION

The fulfillment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Schedule) insofar as they relate to anything to be done or complied with by You or any Insured Person, including complying with the following in relation to claims, shall be Condition Precedent to admission of Our liability under this Policy:

(a) On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed;

(b) If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the facts surrounding the Claim. Such medical examination will be carried out only in case of reimbursement claims with prior consent of the Insured Person;

© We/Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of such Claim;

(d) If the Insured Person suffers a relapse within 45 days of the date of discharge from Hospital for a Claim that has been made, then such relapse shall be deemed to be part of the same Claim and all limits for Any One Illness under this Policy shall be applied as if they were part of a single claim.

8. CLAIMS PROCEDURE

On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, then as a Condition Precedent to Our liability under the Policy the following procedure shall be complied with:

- **For Cashless Facility**

Cashless Facility will be available at a Network Provider of the Company. The complete list of Providers is available on Our website (The list is updated as and when there is any change in the Network Provider) or can be obtained from Our call centre. In order to avail of Cashless Facility, the following procedure shall be followed:

(a) Pre-authorization for Planned Hospitalization:

At least 48 hours prior to a planned Hospitalization, We or Our TPA shall be contacted to request pre-authorization for availing the Cashless Facility for that planned Hospitalisation. Each such request must be accompanied by all the following details:

(i) Pre-authorization form available at the hospital helpdesk to be duly filled in and signed by Insured and treating doctor

(ii) Copy of the Health Card We have issued to the Insured Person;

(iii) Proposed date of Admission.

(iv) Medical papers viz. All prescriptions, medical investigation reports etc.

(v) Photo ID

(vi) Address proof, and photo to comply with KYC norms

If the foregoing information is not provided in full or is insufficient to ascertain the eligibility of the Claim under the Policy, then We/Our TPA will request additional information or documentation in respect of that request.

Once there is sufficient information to assess the eligibility of the Claim under the Policy, We/Our TPA will issue the authorisation letter specifying the sanctioned amount, any specific limitation on the Claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.

Turn Around Time (TAT) for issue of Pre-Authorization within 1 hours from receipt of complete documents for initial and within 3 hours from receipt of complete documents for final approval at the time of discharge.

In Case of Claim Contact Us at:

24x7 Toll Free number: 1800 266 4545 or may write an e- mail at care@zurichkotak.com

In the event of claims, please send the relevant documents to:

<Details of the TPA>

(b) Pre-authorization for Emergency Care:

If the Insured Person has been admitted into Hospital for Emergency Care, We or Our TPA shall be contacted to request pre-authorization for availing the Cashless Facility for that Emergency Care within 24 hours of commencement of Hospitalisation. Each such request must be accompanied by all the following details:

(i) Pre-authorization form available at the hospital helpdesk to be duly filled in and signed by Insured and treating doctor

(ii) Copy of the Health Card We have issued to the Insured Person;

(iii) Medical papers viz. All prescriptions, medical investigation reports etc.

(iv) Photo ID

(v) Address proof, and photo to comply with KYC norms

If the foregoing information is not provided in full or is insufficient to ascertain the eligibility of the Claim under the Policy, then We/ Our TPA will request additional information or documentation in respect of that request with the provider.

Once there is sufficient information to assess the eligibility of the Claim under the Policy, We/Our TPA will issue the authorisation letter specifying the sanctioned amount, any specific limitation on the Claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection. In circumstances where We/Our TPA refuse the request for pre-authorisation as there is insufficient Base Sum Insured or there is insufficient information to determine the admissibility of the request for pre-authorisation, a claim for reimbursement may be submitted to Us in accordance with the procedure set out below and We will consider the Claim in accordance with the policy terms, conditions and exclusions.

Turn Around Time (TAT) for settlement of Reimbursement is within 30 days from the receipt of the complete documents.

We reserve the right to modify, add or restrict any Network Provider for Cashless Facilities in Our sole discretion. Before availing Cashless Facilities, please check the applicable updated list of Network Providers on Our website or by calling Our call centre.

- **For Reimbursement Claims**

We shall be given written notice of the Claim for reimbursement along with the following details at least within 30 days of the Insured Person's discharge from Hospital:

(i) The Policy Number;

(ii) Name of the Policyholder;

(iii) Name and address of the Insured Person in respect of whom the request is being made;

(iv) Nature of Illness or Injury and the treatment/surgery taken;

(v) Name and address of the attending Medical Practitioner;

(vi) Hospital where treatment/surgery was taken;

(vii) Date of Admission and date of discharge;

(viii) Approximate claim amount (if available)

(ix) Any other information that may be relevant to the Illness/ Injury/ Hospitalization.

If the Claim is not notified to Us within 30 days of the Insured Person's discharge from Hospital, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

9. CLAIM DOCUMENTS

We shall be provided the following necessary information and documentation in respect of all Claims within 30 days of the Insured Person's discharge from Hospital. For Claims under which the use of Cashless Facility has been approved, We will be provided with these documents by the Network Provider immediately following the Insured Person's discharge from Hospital:

(a) Duly completed Claim form signed by You and the Medical Practitioner (only for reimbursement claims);

(b) Hospital discharge summary;

(c) First consultation and follow up treatment papers;

(d) Original bills and receipts from the Hospital/Medical Practitioner;

(e) Original bills from chemists supported by proper prescription;

(f) Original investigation test reports (including CT/MR/ USG/ECG, as applicable) and payment receipts;

(g) Indoor case papers, if available;

(h) Implant Invoice/ Sticker, if available;

(i) Ambulance Invoice, if applicable;

(j) FIR (if done) or MLC (if conducted) for Accident cases;

(k) Post mortem report (if conducted);

(l) KYC documents viz. Photo ID and address proof along with duly completed form.

(m) Any other document as required by Us or Our TPA to investigate the Claim or Our obligation to make payment for it.

For claims under which cashless facility has been approved, following documents will be provided by the Network hospital along with the above:

(n) Original Pre – authorization request

(o) Copy of Pre – authorization approval letter

(p) Copy of the photo identity document of the Insured Person;

(q) KYC documents obtained at the time of cashless facility.

- **Claims For Pre-Hospitalisation Medical Expenses And Post-Hospitalisation Medical Expenses**

(a) All Claims for Pre-Hospitalisation Medical Expenses shall be submitted to Us within 30 days of the Insured Person's discharge from Hospital along with the following information and documentation:

(i) Duly Completed Claim Form

(ii) Investigation Payment Receipt

(iii) Original Investigation Report

(iv) Original Pharmacy Bills

(v) Original Pharmacy Prescription

(vi) Copy of Discharge Summary

(b) All Claims for Post-Hospitalisation Medical Expenses shall be submitted to Us within 30 days of the completion of post hospitalisation period as mentioned in your plan. You need to send Medical Expenses being incurred along with the following information and documentation:

(i) Duly Completed Claim Form

(ii) Original bills and receipts from the Hospital/Medical Practitioner;

(iii) Investigation Payment Receipt

(iv) Original Investigation Report

(v) Original Pharmacy Bills

(vi) Original Pharmacy Prescription

(vii) Copy of Discharge Summary

(c) Claims for Home Care Treatment

i. Duly filled and signed Claim Form in original

ii. Copy of Insured Person's passport, if available (All pages)

iii. Photo Identity proof of the patient (if insured person does not own a passport)

iv. Medical practitioners' prescription advising hospitalization

v. A certificate from medical practitioner advising treatment at home or consent from the insured person on availing home care benefit.

vi. Original bills with itemized break-up

vii. Payment receipts in original

viii. Copy of investigation reports including Insured Person's test reports from Authorized diagnostic centre for COVID

ix. Discharge Certificate from medical practitioner specifying date of start and completion of home care treatment.

x. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained

xi. Copy of PAN Card

xii. Copy of photo ID proof with address

- **Sequence for payment of Claim**

The sequence for payment of Claim will be done as per below order depending on the terms and conditions of the respective Covers

1. Deductible on admissible claim amount
2. Sub-Limit if any
3. Co-Pay

Illustration 1

Policy Period	Sum Insured	Deductible	Ailment	Claim Number	Claim Amount	Deductible Exhaustion	Balance Deductible	Payable Amount	Balance Sum Insured	Remarks
1/1/24 to 31/12/24	500000	100000	NA	NA	NA	NA	NA	NA	500000	
1/1/25 to 31/12/25	500000	100000	NA	NA	NA	NA	NA	NA	500000	
1/12/26 13/12/26	500000	100000	Dengue	Claim 1	75000	75000	25000	0	500000	Claim Deductible
			Accident	Claim 2	50000	75000 + 25000	0	20,000 20% Payable)	480000	1) Deductible 75000 Claim 2 25000 = 5000
			Cataract	Claim 3	25000	100000	0	25000	455000	Co-pay not Cataract

Illustration 2

Insured has declared Chronic Renal Failure as Pre-existing Disease

Policy Period	Sum Insured	Deductible	Ailment	Claim Number	Claim Amount	Deductible Exhaustion	Balance Deductible	Payable Amount	Balance Sum Insured	Remarks
1/1/24 to 31/12/24	500000	100000	NA	NA	NA	NA	NA	NA	500000	
1/1/25 to 31/12/25	500000	100000	NA	NA	NA	NA	NA	NA	500000	
1/1/26 to 31/12/26	500000	100000	NA	NA	NA	NA	NA	NA	500000	
1/1/27 to 31/12/27	500000	100000	Dengue	Claim 1	100000	100000	0	0	500000	Claim within Deductible
			Kidney Failure (Pre-existing Disease)	Claim 2	500000	100000	0	200000	300000	1) Deductible Amount deducted from Claim 1 2) PED claim, hence payable amount capped to 50% of Sum Insured 3) Co-pay on admissible Claim amount i.e. 20% of 250000 = 50000

10. GENERAL TERMS AND CONDITIONS

1. Disclosure of Information

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

2. Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

3. Complete Discharge

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

4. Multiple Policies

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

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

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

5. Fraud

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

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

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

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

6. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

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

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

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

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

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

7. Cancellation

a. The policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. The Insurer shall refund proportionate premium for unexpired policy period subject to no claim(s) were made during the policy period.

Additional Deductions - Notwithstanding the above, if (i) the risk under the Policy has already commenced, or (ii) only a part of the insurance coverage has commenced, and the option of Policy cancellation is exercised by the Policyholder, then expenses incurred by the Company on medical examination of the Policyholder will also be deducted before refunding of premium.

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

8. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

9. Migration

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

i. The waiting periods specified in Section 5 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.

ii. Migration benefit will be offered to the extent of sum of previous insured and accrued bonus (as part of the base sum

insured), migration benefit shall not apply to any other additional increased Sum Insured.

iii. Migration under this product shall be allowed only due to withdrawal of the product subject to IRDAI regulations.

10. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of atleast 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

v. No loading shall apply on renewals based on individual claims experience.

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.

12. 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.

13. Moratorium Period

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

14. Nomination

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

15. Redressal of Grievance

In case of any grievance the insured person may contact the company through

Website: www.zurichkotak.com

Toll free: 18002664545

E-mail: care@zurichkotak.com

Courier:

Zurich Kotak General Insurance Company (India) Limited, 401, 4th Floor, Silver Metropolis, Jai Coach Compound, Off Western Express Highway, Goregaon (East), Mumbai- 400063. Maharashtra, India.

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 grievanceofficer@zurichkotak.com

For updated details of grievance officer, kindly refer the link:

https://www.zurichkotak.com/customer-support/grievance-redressal-process

For senior citizens, please contact the respective branch office of the Company or call at 18002664545 or may write an e- mail at seniorcitizen@zurichkotak.com

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

The details of the Insurance Ombudsman is available at:

https://www.zurichkotak.com/customer-support/grievance-redressal-process

The updated details of Insurance Ombudsman offices are also available on the website of Council for Insurance Ombudsmen: www.cioins.co.in/ombudsman

The details of the Insurance Ombudsman is available at Annexure I

Grievance may also be lodged through the Bima Bharosa Portal – https://bimabharosa.irdai.gov.in

16. Claim Settlement (Provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

17. Eligibility

Policy Type – Individual Basis
Age limit – No limit for age at entry
Policy Period - 1year
Relationship covered - Self, Spouse, Dependent Sibling (Unmarried & Financially Dependent), Dependent Child(Unmarried & Financially Dependent), Parents/ In Laws

18. Material Change

Material information to be disclosed to Us includes every matter that You are aware of or could reasonably be expected to know that relates to questions in the Proposal Form and which is relevant to Us in order to accept the risk and the terms of acceptance of the risk.

19. No constructive Notice

Any knowledge or information of any circumstances or condition in Your connection in possession of any of Our personnel and not specifically informed to Us by You shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

20. Terms and condition of the Policy

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

21. Underwriting and Loadings

We may apply a risk loading up to a maximum of 200 % per Insured Person on the premium payable (excluding statutory levies & taxes) based on the declarations made in the proposal form and the health status of the persons proposed for insurance.

Loadings will be applied from Inception Date of the first Policy including subsequent renewal(s). There will be no loadings based on individual claims experience.

In case of loading on 2 or more ailments, the loadings shall apply in conjunction, however maximum risk loading per individual shall not exceed 200% of Premium excluding applicable Taxes.

We will inform You about the applicable risk loading or special condition through a counter offer letter and We will only issue the Policy once We receive your consent on the applicable additional premium.

In case policies are accepted with loadings, waiting period for Pre-Existing Disease Waiting Period (Section 5.1) as well as 3 Year Waiting Period (Section 5.3) shall continue to be applicable.

Sum Insured can be changed (increase / decrease) only at the time of Renewal or at any time, subject to underwriting by the Company. For any increase in Sum Insured, the waiting period shall start afresh only for the enhance portion of the Sum Insured.

22. Cause of Action/ Currency for payments

No Claims shall be payable under this Policy unless the cause of action arises in India, unless otherwise specifically provided in Policy. All Claims shall be payable in India and shall be in Indian Rupees only.

23. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed by both You and Us to be adjudicated or interpreted in accordance with Indian law and only competent Courts of India shall have the exclusive jurisdiction to try all or any matters arising hereunder. The matter shall be determined or adjudicated in accordance with the law and practice of such Court.

24. Special Provision for Insured Person who are Senior citizen

The premium charged for health Insurance products offered to Senior citizens shall be fair, justified, transparent and duly disclosed upfront. The insured shall be informed in writing of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall beobtained before issuance of policy.

25. Communications & Notices

Any communication, notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to:

In Your case, at Your last known address per Our records in respect of this Policy.

In Our case, at Our address specified in the Policy Schedule.

No insurance agent, broker or any other person is authorised to receive any notice on Our behalf.

26. Customer Service

If at any time You require any clarification or assistance, You may contact Our offices at the address specified in the Policy Schedule, during normal business hours or contact Our call centre.

27. Electronic Transactions

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

Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Insured. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated/confirmed by the Insured.

28. Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate in the case of any Insured Person's demise during the policy period/year:

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

29. Sanction Exclusion Clause

Notwithstanding any other terms under this agreement, no insurer shall be deemed to provide coverage or will make any payments or provide any service or benefit to any insured or other party to the extent that such cover, payment, service, benefit and/or any business or activity of the insured would violate any applicable trade or economic sanctions law or regulation.

ANNEXURE I
Details of Insurance Ombudsman

Office Details	Jurisdiction of Office Union Territory, District
Ahmedabad: Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
Bengaluru: Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
Bhopal: Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh and Chattisgarh.
Bhubneshwar: Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455; Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
Chandigarh: Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468, Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
Chennai: Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
Delhi: Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
Guwahati: Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205, Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
Hyderabad: Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122, Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
Jaipur: Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
Ernakulam: Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
Kolkata: Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
Lucknow: Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.

Office Details	Jurisdiction of Office Union Territory, District
Mumbai: Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
Noida: Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U. P- 201301. Tel.: 0120-2514252 / 2514253, Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
Patna: Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068, Email: bimalokpal.patna@cioins.co.in	Bihar and Jharkhand.
Pune: Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555, Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

ANNEXURE II – NON-MEDICAL EXPENSES

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

SI No	Item
1	Baby Food
2	Baby Utilities Charges
3	Beauty Services
4	Belts/braces
5	Buds
6	Cold Pack/hot Pack
7	Carry Bags
8	Email/ Internet Charges
9	Food Charges Other Than Patient's Diet Provided By Hospital
10	Leggings
11	Laundry Charges
12	Mineral Water
13	Sanitary Pad
14	Telephone Charges
15	Guest Services
16	Crepe Bandage
17	Diaper Of Any Type
18	Eyelet Collar
19	Slings
20	Blood Grouping And Cross Matching Of Donors Samples
21	Service Charges Where Nursing Charge Also Charged
22	Television Charges
23	Surcharges
24	Attendant Charges
25	Extra Diet Of Patient (other Than That Which Forms Part Of Bed Charge)
26	Birth Certificate
27	Certificate Charges
28	Courier Charges
29	Conveyance Charges
30	Medical Certificate
31	Medical Records
32	Photocopies Charges
33	Mortuary Charges
34	Walking Aids Charges
35	Oxygen Cylinder For Usage Outside The Hospital

SI No	Item
36	Spacer
37	Spirometre
38	Nebulizer Kit
39	Steam Inhaler
40	Armsling
41	Thermometer
42	Cervical Collar
43	Splint
44	Diabetic Foot Wear
45	Knee Braces Long/ Short/ Hinged
46	Knee Immobilizer/shoulder Immobilizer
47	Lumbo Sacral Belt
48	Nimbus Bed Or Water Or Air Bed Charges
49	Ambulance Collar
50	Ambulance Equipment
51	Abdominal Binder
52	Private Nurses Charges- Special Nursing Charges
53	Sugar Free Tablets
54	Creams Powders Lotions (toiletries Are Not Payable, Only Prescribed Medical Pharmaceuticals Payable)
55	Ecg Electrodes
56	Gloves
57	Nebulisation Kit
58	Any Kit With No Details Mentioned [delivery Kit, Orthokit, Recovery Kit, Etc]
59	Kidney Tray
60	Mask
61	Ounce Glass
62	Oxygen Mask
63	Pelvic Traction Belt
64	Pan Can
65	Trolly Cover
66	Urometer, Urine Jug
67	Ambulance
68	Vasofix Safety

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

Sr No	Item
1	Baby Charges (Unless Specified/Indicated)
2	Hand Wash
3	Shoe Cover
4	Caps
5	Cradle Charges
6	Comb
7	Eau-De-Cologne / Room Freshners
8	Foot Cover
9	Gown
10	Slippers
11	Tissue Paper
12	Tooth Paste
13	Tooth Brush
14	Bed Pan
15	Face Mask
16	Flexi Mask
17	Hand Holder
18	Sputum Cup
19	Disinfectant Lotions

Sr No	Item
20	Luxury Tax
21	Hvac
22	House Keeping Charges
23	Air Conditioner Charges
24	Im Iv Injection Charges
25	Clean Sheet
26	Blanket/Warmer Blanket
27	Admission Kit
28	Diabetic Chart Charges
29	Documentation Charges / Administrative Expenses
30	Discharge Procedure Charges
31	Daily Chart Charges
32	Entrance Pass / Visitors Pass Charges
33	Expenses Related To Prescription On Discharge
34	File Opening Charges
35	Incidental Expenses / Misc. Charges (Not Explained)
36	Patient Identification Band / Name Tag
37	Pulseoxymeter Charges

List III - Items that are to be subsumed into Procedure Charges

Sr No.	Item
1	Hair Removal Cream
2	Disposables Razors Charges (for Site Preparations)
3	Eye Pad
4	Eye Sheild
5	Camera Cover
6	Dvd, Cd Charges
7	Gause Soft
8	Gauze
9	Ward And Theatre Booking Charges
10	Arthroscopy And Endoscopy Instruments
11	Microscope Cover
12	Surgical Blades, Harmonic Scalpe, Shaver

Sr No.	Item
13	Surgical Drill
14	Eye Kit
15	Eye Drape
16	X-ray Film
17	Boyles Apparatus Charges
18	Cotton
19	Cotton Bandage
20	Surgical Tape
21	Apron
22	Torniquet
23	Orthobundle, Gynaec Bundle

List IV - Items that are to be subsumed into costs of treatment

SI No.	Item
1	Admission/registration Charges
2	Hospitalisation For Evaluation/ Diagnostic Purpose
3	Urine Container
4	Blood Reservation Charges And Ante Natal Booking Charges
5	Bipap Machine
6	Cpap/ Capo Equipments
7	Infusion Pump- Cost
8	Hydrogen Peroxide\spirit\ Disinfectants Etc
9	Nutrition Planning Charges - Dietician Charges- Diet Charges

SI No.	Item
10	Hiv Kit
11	Antiseptic Mouthwash
12	Lozenges
13	Mouth Paint
14	Vaccination Charges
15	Alcohol Swabes
16	Scrub Solution/sterillium
17	Glucometer & Strips
18	Urine Bag