RAHEJA QBE

Raheja QBE General Insurance Company Limited
5th Floor, A Wing, Fulcrum, IA Project Road, Sahar, Andheri East, Mumbai – 400059, India.
Tel: 022 69155050 I Email: customercare@rahejaqbe.com I Website: www.rahejaqbe.com
CIN: U66030MH2007PLC173129, IRDAI Reg. No. 141

GROUP HEALTH INSURANCE POLICY

Prospectus

The Prospectus is intended to facilitate an easier understanding of the Policy terms, conditions and exclusions. It only gives a summary of the significant benefits and exclusions associated with this product. When issued the Policy attached with this statement represents the legal contract between yourself and Raheja QBE and should be seen for complete details.

If you need any clarification on coverage, please call your nearest Raheja QBE office or your insurance adviser.

1. Group Health Insurance Policy

Scope of cover:

This policy covers the following:

In the event of Accidental Bodily Injury or Sickness first occurring or manifesting itself during the Policy Period and causing the Insured's Hospitalization, a hospitalization indemnity or benefit will be payable as per the conditions below and subject to the Deductible or copay as defined.

Who can take this Policy?

1. Employer – Employee Group
2. Non – Employer – Employee Group
3. Minimum Group Size – 7 lives

2. Coverage:

There is base cover and optional cover and can be opted in combination with base cover by paying Premium for the opted cover.

Family Definition	Self, Spouse, Dependent Children up to 5 Kids, Parents up to Two Parents/Parent in law & Siblings	
Age Limit	Adults covered from the age of 18 yrs. Maximum Age: No Limit Child covered: From 91 Days upto the age of 25 yrs (no upper age limit for widow daughter and disabled child)	
Sum Insured	From Rs. 25,000 to Rs. 1 crore	On Individual basis – SI shall apply to each individual family member On Floater basis – SI shall apply to the entire family
Basic Cover		
A.	In-patient Hospitalization Accident & illness Cover	Medical Expenses of Hospitalization for Illness or injury for a minimum period of 24 consecutive hours only shall be admissible upto the Sum Insured specified.

A.1.	**Day Care treatment**	Medical Expenses for Illness or injury which are treated on the same day, which would have otherwise required hospitalization of more than 24 hrs
A.2.	**Domiciliary Hospitalization**	Medical Expenses incurred by Insured for any illness or Injury requiring medical treatment taken at home, which would otherwise have required Hospitalization subject to conditions specified in Policy wording.
A.3.	**Pre-Hospitalization**	For mentioned days in the policy schedule/certificate of insurance prior to the date of hospitalization/home care treatment
A.4.	**Post-Hospitalization**	For mentioned days in the policy schedule/certificate of insurance from the date of discharge from the hospital/completion of home care treatment
B.	**In-patient Hospitalization Accident**	Medical Expenses of Hospitalization for injury for a minimum period of 24 consecutive hours only shall be admissible upto the Sum Insured specified in the policy schedule/Certificate of insurance
B.1.	**Day Care treatment**	Medical Expenses for accidental injury which are treated on the same day, which would have otherwise required hospitalization of more than 24 hrs.
B.2.	**Domiciliary Hospitalization**	Medical Expenses incurred by Insured for any accidental Injury requiring medical treatment taken at home, which would otherwise have required Hospitalization subject to conditions specified in Policy wording.
B.3.	**Pre-Hospitalization**	For mentioned days in the policy schedule/certificate of insurance prior to the date of hospitalization/home care treatment
B.4.	**Post-Hospitalization**	For mentioned days in the policy schedule/certificate of insurance from the date of discharge from the hospital/completion of home care treatment
2	**Advance Treatment**	Listed advance treatment are covered upto the limit mentioned in the policy schedule/certificate of insurance.
3	**AYUSH**	Medical Expenses incurred for Inpatient Care treatment for illness or injury under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered during the Policy period.
Addon covers		
3	Home Care treatment	The Company shall indemnify costs of treatment incurred by the Insured person on availing treatment at home for illness or injury maximum up to 14 days per incident , which in the normal course would require care and treatment at a hospital but is actually taken while confined at home subject to policy terms and conditions.
4	Organ Donor Cover	Medical Expenses incurred towards in- patient Hospitalization of an organ donor for Insured Person's organ transplant Surgery during the Policy period as specified in the Policy schedule/certificate of insurance.

5	Health Check up	The Insured Person/s covered under the policy may avail the set of health check-ups as specified in the Policy Schedule/Certificate of Insurance with Our Network Provider.
6	Maternity a) With 9 months waiting period b) Without 9 months waiting period	Maternity Expenses of first two living children incurred towards the delivery of a baby and/or treatment related to any complication of pregnancy or medically necessary termination during the Policy period upto the limit specified in the policy schedule/Certificate of Insurance.
7	Baby Day One cover	We shall cover newborn baby from birth upto the sum insured.
8	Pre and Post Natal Expenses	We will pay for pre and post-natal medical expenses as an outpatient/inpatient treatment, including but not limited to expenses for antenatal check-ups, doctor's consultations, arising therefrom up to maternity sum insured specified in the Policy schedule/ Certificate of Insurance.
9	Reinstatement of Sum Insured	The insured can reinstate basic sum insured upto 100%, incase the original sum insured is all used up in treatment. This reinstated sum insured cannot be used for same illness/injury that the Insured person was treated for during the Policy Period.
10	Recharge of Sum Insured	The insured can recharge basic sum insured upto 100%, in case the original sum is all used up in treatment. This recharged sum insured can be used for same illness/injury that the Insured person was treated for during the Policy Period.
11	Emergency Ambulance	We will pay for the expenses incurred towards transportation of Insured to the nearby Hospital or health care center incase of an medical emergency on the medical practitioners recommendation upto the sum insured specified in the Policy schedule/ Certificate of Insurance.
12	Air Ambulance	We will pay for the expenses incurred towards Insured's transportation in an airplane or helicopter certified to be used as an ambulance to the nearest Hospital with adequate facilities in an Emergency following an Illness or Injury which occurs during the Policy Period upto the limit specified in the Policy schedule/ Certificate of Insurance.
13	Corporate Buffer	An additional sum insured as mentioned in the Policy schedule will be available to the Insured which is in addition to the basic Sum Insured mention in the Policy Schedule/ Certificate of Insurance.
14	Outpatient Cover	We will cover the reasonable and customary charges incurred towards medical illness or injury of the insured person in an outpatient setup as specified in the Policy schedule/ Certificate of Insurance.
15	Well Child Cover	We will provide cover for expenses incurred towards regular preventive care, diagnostic tests and vaccines upto the first 2 years of child birth and upto the limit specified in the Policy schedule/ Certificate of Insurance.
16	Well Women Cover	We will provide cover for expenses incurred towards preventive care like screening, lab tests and counselling for women upto the limit specified in the Policy schedule/ Certificate of Insurance.

17	Wellness benefit	We intend to incentivize the Insured Person(s) for taking care of his/her health/fitness and maintaining healthy lifestyle through such preventative and wellness services as mentioned in the Policy schedule/ Certificate of Insurance.
18	Disease wise sublimit	The disease sub limit shall be applicable for the mentioned limit in the Policy schedule/ Certificate of Insurance.
19	Accidental Death	Policy provides for payment of compensation on the Insured Person's death caused by injury arising out of accidental, violent, external and visible means during the policy period and resulting in death within 365 days from the date of accident.
20	Permanent Total Disablement	Policy provides cover if insured suffers an Injury due to an Accident during the Policy Period, which is the sole and direct cause of "Permanent Total Disablement" within 365 days from the Date of accident, then We will pay the sum insured as specified in the table of losses.
21	Permanent Partial Disablement	Policy provides cover if insured suffers an Injury due to an Accident during the Policy Period, which is the sole and direct cause of "Permanent Partial Disablement" within 365 days from the Date of accident, then We will pay the sum insured as specified in the table of losses.
22	Convalescence benefit	We will pay Insured the amount as mentioned in the Policy Schedule/ Certificate of Insurance for this benefit if the Insured Person is admitted in a Hospital for a minimum period as specified in the Policy schedule/ Certificate of Insurance.
23	Critical illness Indemnity cover	Medical Expenses of Hospitalization for Critical illness specified in the Policy schedule only after the base sum insured is exhausted the additional sum insured will be used for the treatment of the listed critical illness.
24	Critical illness benefit Cover	We will pay Insured the additional Sum Insured as mentioned in the Policy Schedule/ Certificate of Insurance, in case Insured is diagnosed as suffering from any of the Critical Illnesses or undergoing covered Surgical Procedures of the listed critical illness.
25	Vaccination	We will pay vaccination expenses of the New Born baby including inoculation and immunization up to the limits specified in the Policy schedule/ Certificate of Insurance.
26	Family Transportation	We will reimburse the amount up to the limit specified against this family transportation in the Policy Schedule/Certificate of Insurance, incurred in respect of a maximum of two of Insured Person's Immediate Family Members for two way airfare or two way first class railway ticket in a licensed common carrier to the place where Insured Person is Hospitalized.
27	Daily Hospital Cash Benefit	We will pay daily cash as specified in the policy schedule/certificate, if the Insured person is admitted in hospital due to sickness/injury and such hospitalization is medically necessary & recommended by the Medical Practitioner.
28	Lasik Cover	We will pay in case of compound myopic astigmatism, to the level of refractive errors specified.

29	Infertility treatment	We will pay for Invitro fertilization (IVF), Gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures, and any related prescription medication treatment. This extension would also cover embryo transport, donor ovum and semen and related costs, including collection and preparation, required towards treatment related to infertility and sterilization, up to the amount mentioned in the Policy Schedule. The Insured Person should be between 18 and 50 years old.
30	Super Top up	We will pay Insured if he/she suffers an Illness or Accident during the Policy Year requiring Hospitalization on an inpatient basis or treatment defined as a Day Care Procedure, and cumulative Hospitalization Expenses during the Policy Year exceeds the Deductible specified in the Policy Schedule/ Certificate of Insurance, We will reimburse the portion of the Medical Expenses for such Hospitalization or any subsequent Hospitalization which exceeds the Deductible.
31	Tele Consultation	We will provide services to insured upto the limit specified in the Policy schedule/ Certificate of Insurance to take consultation from a Doctor through virtual medium, such as audio, video, online portal, chat or mobile application for a routine health query or for first and second opinions. This will also include consulting a professional expert through a hotline number for any social, mental, emotional, and environmental or other issue faced by the Insured Person which affects his / her wellbeing. This facility is meant to give him / her access to consultations and is not a substitute for meeting a doctor.
32	Assistance Services	We will provide services to insured if he/she is more than 150 Kilometers away from home (the address last known), is within Indian territory, and has not been away from that address for more than 90 days.
33	Co-payment a) All claims b) Parents claims only	If Insured has opted for this benefit, then insured will be liable to bear the percentage of the claimed amount opted for, if the claim is payable as per terms and condition.
34	Excess/deductible	If Insured has opted for this cover, all admissible claims under this Policy is subject to the excess/deductible amount as specified in the Policy schedule/ Certificate of Insurance for all Insured Persons covered under the Policy.
35	Second Opinion	If the Insured Person is diagnosed with any specified critical Illness or has to undergo any Surgery or Surgical Procedure during the Policy Year then at the Insured Person's request, We will arrange the second opinion from a Medical Practitioner selected by the Insured Person from Our Service Provider's panel.

Sum Insured

Individual basis – SI shall apply to each individual member

Floater basis – SI shall apply to the entire family

Period of Insurance

1 Year

Mode of Premium:

Monthly, Quarterly, Half Yearly and Annually

Endorsements

Following type of endorsement are permissible under the Policy.

Premium Bearing

- Increase in Sum Insured: Subject to underwriting permissible at Renewal.
- Decrease in Sum Insured: Permissible at Renewal unless Policy wrongly issued by us
- Change in coverage (addition or deletion of coverage)
- Addition of member: Newly married spouse or New born baby after completion of 90 days of age permissible at Renewal
- Policy cancellation
- Change in mode of premium payment

Non-Premium Bearing

- Address change
- Corrections: Names, address etc
- Change in name, address etc
- Change of Occupation
- Correction in wording
- Change in Policy period

3. 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:

A. Exclusions (which can be waived off on payment of additional premium)

3.1 Waiting period

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

3.1.A. 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 36/24/12 months of continuous coverage after the date of inception of the first policy with insurer.

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

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

d. Coverage under the policy after the expiry of 36/24/12 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

3.1.B. Specific Illness Waiting Period: (Code- Excl02)

a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first policy with the Insurer. This exclusion shall not be applicable for claims arising due to an accident.

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

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

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

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

List of applicable disease for 12 months waiting period are:

1. Benign ENT disorders
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal or external benign tumours, cyst, sinus, polyps of any kind including benign breast lump
8. Benign prostate hypertrophy
9. Cataract and Senile Cataract
10. Gastric and Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types

13. Hydrocele

14. Non-Infective Arthritis

15. Piles, Fissures and Fistula in anus

16. Pilonidal sinus, Sinusitis and related disorders

17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident

18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.

19. Varicose Veins and Varicose Ulcers.

3.1.C. 30-day 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.

3.2 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 has to 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 Apnea

iv. Uncontrolled Type2 Diabetes

3.3 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.

3.4 Refractive Error: (Code- Excl15)

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

3.5 Sterility and Infertility: (Code- Excl17)

Expenses related to Birth Control, 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

3.6 Maternity Expenses (Code: Excl 18):

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.

3.7 Any expenses incurred on Outpatient treatment (OPD treatment).

3.8 Any expenses related to cochlear implants, Gamma knife/cyber knife, sleep apnea, injection of Remicade/Avastin.

3.9 Any medical expenses incurred on new-born /children below age of 91 days will not be covered under the Policy.

3.10 External Congenital Anomaly: Any expenses incurred towards screening, counselling and treatment related to external congenital anomalies.

B. Exclusions (which cannot be waived)

3.11 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.

3.12 Exclusion Name: 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.

3.13 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.

3.14 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.

3.15 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.

3.16 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.

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

3.18 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)

3.19 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)

3.20 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.

3.21 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.

3.22 Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing any illness, incapacitating disablement or death.

b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

3.23 Any treatment and/or diagnostic reports taken or any other medical expenses incurred outside the geographical limits of India.

4. General Terms and Conditions applicable when the claim arises

4.1 Cashless Facility:

(i) Treatment may be taken in a network provider and is subject to pre authorization by the Company or its authorized TPA.

(ii) Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization. (iii) The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification. (iv) At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non- medical and inadmissible expenses. (v) The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details. (vi)In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company / TPA for reimbursement.

4.2 Reimbursement:

Notice of claim with particulars relating to Policy numbers, name of the Insured Person in respect of whom claim is made, nature of illness/ injury and name and address of the attending Medical Practitioner/ Hospital/ Nursing Home should be given to Us immediately on hospitalization/ injury/ death, failing which admission of claim would be based on the merits of the case at our discretion. The Insured Person/s shall after intimation as aforesaid, further submit at his/her own expense to the TPA as specified below.

Sr No	Type of Claim	Prescribed Time Limit
1.	Reimbursement of hospitalization, day care and pre hospitalization expenses	Within 30 days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within 15 days from completion of post hospitalization treatment.

4.3. Notification of claim:

Notice with full particulars shall be sent to the company/TPA(if applicable) as under:

I. Within24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.

II. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

4.4. Documents

4.4.1 List of documents to be submitted as per following table:

Sr. no.	List of Documents / information	Inpatient Hospitalization claim	Outpatient OPD claim	Critical Illness (Benefit)	Hospital Daily cash	AD/PTD/PPD
1	Claim form duly completed in all respects	√	√	√	√	√
2	Medical Case History / Summary	√	X	√	√	√
3	Medical Records (Optional Documents may be asked on need basis: Indoor case papers, OT notes, PAC notes etc.)	√	X	√	√	√
4	Original Hospital Main Bill	√	X	x	x	x
5	Original Hospital Bill Break Up	√	X	x	x	x
6	Original Pharmacy Bills	√	√	x	x	x
7	Prescriptions for the Medicines purchased (except hospital supply) and investigations done outside the Hospital	√	√	x	x	x
8	Consultation Papers	√	√	√	x	√
9	Investigation Reports	√	√	√	x	√
10	Digital Images/CDs of the Investigation Procedures (if required)	√	√	x	x	√
11	MLC/FIR Report (If applicable)	√	X	√	x	√
12	Inquest Panchanama report issued by the Police	√	X	√	x	√
13	Original Invoice/Sticker (If applicable)	√	X	x	x	x
14	Post Mortem Report (If applicable)	√	X	x	x	√
15	Disability Certificate (If applicable)	√	X	√	x	√
16	Attending Physician Certificate (If applicable)	√	X	√	x	√
17	Ante-natal Record (If applicable)	√	X	x	x	x
18	Birth discharge Summary (If applicable)	√	X	x	x	x
19	Death Certificate (If applicable)	√	X	√	x	√
20	*KYC (Photo ID card) (If applicable)	√	√	√	√	√
21	Bank Details with Cancelled Cheque	√	√	√	√	√

The Company may call for additional documents / information and / or carry out verification on a case to case basis to ascertain the facts collect additional information/documents of the case to determine the extent of loss. Verification carried out will be done by professional Investigators or a member of the Service Provider and costs for such investigations shall be borne by the Company.

4.4.2 The Company may accept claims where documents have been provided after a delayed interval in case such delay is proved to be for reasons beyond the control of the Insured/ Insured Person/s. The Insured shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder.

4.5 Payment of Claims

I. We shall be under no obligation to make any payment under this Policy unless We have received all the premium payments in full and all payments have been realized and We have been provided with the documentation and information. We have requested to establish the circumstances of the claim, its quantum or Our liability for it.

II. We will only make payment to You under this Policy. In the event of Your death, We will make payment to the Nominee (as named in the Policy Schedule)/ legal heir as the case may be.

III. Payments under this Policy shall only be made in Indian Rupees.

IV. Our liability to make payment under this policy will only begin when the Aggregate Deductible as mentioned in Schedule is exceeded.

V. All admissible claims shall be assessed basis following order:

Note

a) Basis of claim payment shall be aggregate of Medical expenses incurred for all hospitalization (s) incepting during each policy year payable under this Policy and which exceeds the Aggregate Deductible applicable per policy year basis as mentioned in the Policy Schedule.

b) Any claim under this Policy shall be payable by Us only if the sum of the amount of covered Medical Expenses in respect to Hospitalization(s) of Insured Person (on Individual basis in case of Individual Policy and on Family Floater basis in case of Family Floater Policy) exceeds the Aggregate Deductible applicable on per year.

In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents listed under condition and claim settlement advice, duly certified by the other insurer. .

4.6 Time limit for submission of claim documents to the Company/ TPA

i. Documents supporting the pre-hospitalization and hospitalization claim must be submitted within 30 days from the date of discharge from the Hospital.

ii. Documents supporting the post hospitalization claim must be submitted within 30 days from completion of post hospitalization treatment.

iii. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person.

iv. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer or reimbursement provider, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer or reimbursement provider.

4.7 Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as may be the case, within 30 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 from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. . In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days the Insurer shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(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)

4.8 Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of the claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

4.9 Services Offered by TPA

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include

i. Claim settlement and claim rejection;

ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

List of TPA:

https://www.rahejaqbe.com/claims/health-claims

List of Blacklisted Hospitals:

https://www.rahejaqbe.com/hospital-locator

4.10 Complete Discharge

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

4.11 Disclaimer

If the Company shall disclaim liability to the insured person for any claim hereunder and if the insured person shall not within twelve calendar months from the date of receipt of the notice of such disclaimer notify the Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

4.12 Payment of Claim

All claims under the policy shall be payable in Indian currency and through NEFT/ RTGS/Cheque or DD only.

Conditions Precedent to the contract

4.13 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.

(Note: “Material facts” for the purpose of this policy shall mean all important, essential and relevant information sought by the company in the proposal form and other connected documents to enable him to take informed decision in the context of underwriting the risk)

4.14 Condition Precedent to Admission of Liability

The due observance and fulfilment of the terms and conditions of the Policy, by the insured person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the Policy.

4.15 No Constructive Notice

Any knowledge or information of any circumstances or condition in relation to the Insured Person which is in the possession of the Company other than that expressly disclosed in the Proposal Form or otherwise in writing to, shall not be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

4.16 Electronic Transactions

The Insured agrees to adhere to and comply with policy terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide

Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the Policy or its terms, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

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.

Conditions applicable during Contract

4.17 Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and /or premium, if necessary, accordingly.

4.18 Notice & Communication

I. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.

II. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.

III.The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

4.19 Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

have to be taken in India only.

4.20 Application of Aggregate Deductible

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed to pay and/or reimburse actual expenses incurred in excess of the Aggregate Deductible as specified in the Policy Schedule.

The company will pay for the Medical Expenses, in excess of aggregate deductible stated in the Policy Schedule on the aggregate of covered medical expenses exceeds the aggregate deductible applicable on policy per year basis depending upon the plan opted.

However, Our total liability under this Policy for payment of any and all Claims in aggregate during each Policy Year of the Policy Period shall not exceed the Sum Insured and Restored Sum Insured if any available to the Insured and stated in the Policy Schedule.

4.21 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 insurers 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.

4.22 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 pa(y acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

- the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
- the active concealment of a fact by the insured person having knowledge or belief of the fact;
- any other act fitted to deceive; and
- 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.

4.23 Grace Period

A Grace Period of 30 days is available for Renewal of the Policy. Any Illness, disease or condition contracted during Grace Period will not be covered and will be treated as Pre-existing diseases.

The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

Policies for which Premium is received after the Grace Period shall be considered as a fresh policy.

4.24 Premium Payment Options:

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

Grace Period of as per the following Days would be given to Pay the instalment premium due for the Policy.

The Benefits provided under – “Waiting Periods”, “Specific Waiting Periods” Sections shall continue in the event of payment of Premium within the stipulated grace Period.

No interest will be charged If the instalment premium is not paid on due date.

In case of instalment premium due not received within the grace period, the Policy will get cancelled.

Options	Instalment Premium Option	Grace Period Applicable
Option 1	Yearly	30 Days
Option 2	Half Yearly	30 Days
Option 3	Quarterly	30 Days
Option 4	Monthly	15 Days

i. In case of failure of transaction in ECS mode of payment and/or instalment premium due not received within the grace period, the policy will get cancelled and fresh policy would be issued with fresh waiting periods after obtaining consent from the customer.

ii. In case of change in terms and conditions of the policy contract or in premium rate, the ECS authorization shall be obtained afresh ensuring an informed choice to the policy holder.

iii. The insurer can withdraw ECS mode of payment by giving 15 days’ notice prior to the due date of premium payable.

iv. All terms and conditions for this product is as per the Regulation 2(i)(e) of HIR 2016 in respect of break in policy.

4.25 Cancellation

a) The policyholder may cancel this policy by giving 7 days written notice.

b) In case the Policyholder requests cancellation of the Policy, where no claims are made under the Policy, the Company shall refund proportionate premium for the unexpired policy period on prorate basis.

c) In case the Policyholder requests for cancellation of the Policy, where there are claims made under the Policy, then there shall be no refund of premium for the unexpired policy period.

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

4.26 Group Administrator

The Group Administrator i.e. Policyholder shall take all reasonable steps to cover their members or employees of the company and ensure timely payment of premium in respect of the persons covered. The Group administrator will collect premium from members wherever applicable as mentioned in the Group/Master policy issued to the Group administrator. The Group administrator will neither charge more premium nor alter the scope of coverage offered under the Group/Master policy.

Group/Master policy will be issued to the group administrator and all members wherever required will be provided with the certificate of insurance by Us. Wherever mutually agreed group administrator will issue the certificate of insurance to its member as per agreed terms and conditions and in the format prescribed by us and shall keep the record of such issuance.

We reserve the right to inspect the record at any time to ensure that terms and conditions of group policy and provisions of IRDAI group guidelines contained in circular ref: Master Circular on Operations and Allied Matters of Insurers 2024 - Health Insurance & Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024 and any amendments thereto are being adhered. We may also require submission of certificate of compliance from Your Group Administrator auditors.

The Group administrator will provide all possible help to its member and facilitate any service required under the Policy including claims. Notwithstanding this a member of the group covered under the Policy shall be free to contact Us directly for filing the claim or any assistance required under the Policy.

4.27 Automatic change in Coverage under the policy

The coverage for the Insured Person shall automatically terminate: In the case of his/ her (Insured Person) demise

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 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. Provided no Claim has been made, and termination takes place on account of death of the Insured Person, pro-rata refund of premium of the deceased Insured Person for

the balance period of the Policy will be effective. Upon exhaustion of sum insured and cumulative bonus, for the Policy year. However, the Policy is subject to renewal on the due date as per the applicable terms and conditions.

4.28 Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

4.29 Portability

The Insured Person will have the option to port the Policy to other insurers as per extant Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

The waiting periods specified in section 6 shall be reduced by the number

of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.

Portability benefit will be offered to the extant of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on portability, kindly refer the link
http://www.rahejaqbe.com/frontend/images/health- basic-guideline/pdf/download/Portability_Migration_Guideline.pdf

4.30 Renewal of Policy

The Policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person provided that the policy is not withdrawn and also subject to conditions stated under clause 4.32. The renewal premium shall be paid to the Company on or before the date of expiry of the Policy or of the subsequent renewal thereof.

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

ii. Renewal shall not be denied on the ground that the insured 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 to maintain continuity of benefits without Breakin Policy. Coverage is not available during the grace period.

v. If not renewed within Grace Period after due renewal date, the Policy shall terminate.

4.31 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.

4.32 Withdrawal of Policy

The product will be withdrawn only after due approval from the Authority. We will inform the Policyholder in the event We may decide to withdraw the product.

In such cases, where Policy is falling due for Renewal within 90 days from the date of withdrawal, We will provide the Policyholder one time option to renew the existing Policy with us or migrate to modified or new suitable health insurance policy with Us. Any Policy falling due for Renewal after 90 days from the date of withdrawal will have to migrate to a modified or new suitable health insurance policy with Us.

Individual members will also have an option to opt for suitable health insurance Policy with Us subject to applicable Portability norms in vogue.

4.33 Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no 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, the completion of sixty continuous months would be applicable from date of enhancement of sums insured only on the enhanced limits.

4.34 Free look period

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting the policy.

The insured shall be allowed a period of thirty days from date of receipt of the Policy, whether received electronically or otherwise, to review the terms and conditions of the Policy. 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, 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

4.35 Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved, evidenced by a written endorsement signed and stamped by the Company.

4.36 Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal, subject to underwriting by the Company. For any increase in Sum Insured, the waiting period shall start afresh for the incremental portion of the sum insured.

4.37 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.

4.38 Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company policy by applying for migration of the policy 30 days before the premium due date of his/her existing policy as per extant 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 proposed insured person will get the accrued continuity benefits in waiting periods as per extant guidelines on migration. For Detailed Guidelines on migration, kindly refer the link - https://www.rahejaqbe.com/frontend/images/health-basic-guideline/pdf/download/Portability_Migration_Guideline.pdf

4.39 Nomination:

The policy holder 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 policy holder. 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. For claims settlement under reimbursement, the Company will pay the policy holder. In the event of death of policy holder, the company will pay the nominee (as named in the policy schedule/Policy Certificate/Endorsement 9if any)) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policy holder whose discharge shall be treated as full and final of its liability under the policy.

4.40 Revision of Product

In case of revision of this product we will communicate to you at least 3 months prior to the revision. Existing policy will continue to remain in force till its expiry, and for existing policyholders the revision will be applicable only from the date of renewal.

Disclaimer

This is only a summary of the product features. The actual benefits shall be described in the policy, and will be subject to the policy terms, conditions and exclusions.

For more details on risk factors, terms and conditions, read the sales brochure carefully before concluding a sale.

IRDA Regulation

This Policy is subject to regulation Master Circular on Operations and Allied Matters of Insurers 2024 - Health Insurance & Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024 or any amendment thereof from time to time.

Prohibition of Rebates: Section 41 of the Insurance Act, 1938 (and amendments thereof)

1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out 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 premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the prospectus or tables of the insurers.

2) Any person making default in complying with the provisions of this section shall be liable for penalty which may extend to ten lakh rupees.

Dispute Resolution:

Product Information Statement:

This Product Information Statement is intended to facilitate an easier understanding of the policy terms, conditions and exclusions. It only gives a summary of the significant benefits and risks associated with this product. The policy represents the legal contract between yourself and Raheja QBE General Insurance Co. Ltd and should be seen for complete details.

If you need any clarification on coverage please call your nearest RQBE office or your insurance advisor.

Important Note:

The details furnished above are only a summary of product features and do not describe the entire terms, conditions and exclusions of the Policy. For further details or clarifications on the Policy, contact RQBE officials or your insurance advisor. We shall be pleased to furnish further details.

Insurance is the subject matter of solicitation.