Health Plus

1. Preamble

This is a contract of insurance between You and Us which is subject to the receipt of the full premium in advance and the terms, conditions and exclusions of this Policy. This Policy has been issued on the basis of the Disclosure to information norm, including the information provided by You in respect of the Insured Person/s in the Proposal form and accompanying documentation.

Note:

- *You/ Insured Person shall on Your/his/her own expense, inform Us immediately of any change in the address, nature of job, state of health, or of any other changes affecting You or any Insured Person*.

- *The terms listed in Section 2 (Definitions & Interpretation) and used elsewhere in the Policy Document with Initial Capitals shall have the meaning set out against them in Section 5 wherever they appear in the Policy Document. For the remaining terms and words used, the usual meaning as described in standard English language dictionaries shall apply. The words and expressions defined in the Insurance Act 1938, IRDAI Act 1999, regulations notified by the IRDAI and circulars and guidelines issued by the IRDAI shall carry the meanings given therein.*

- *Where the context permits, the singular will be deemed to include the plural, one gender shall be deemed to include the other genders and references to any statute shall be deemed to refer to any replacement or amendment of that statute.*

2. Definitions & Interpretation

The terms listed below in Section 2 and used elsewhere in the Policy in Initial Capitals shall have the meaning set out against them in Section 5unless mentioned is any of the sections above separately.

Standard Definitions:

I. **Accident** or **Accidental** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

II. **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.

III. **AYUSH Hospital:** 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:

a. Central or State Government AYUSH Hospital; or
b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
c. 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:

i. Having at least 5 in-patient beds;

ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

IV. **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(s)* in charge;
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.

V. **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.

VI. **Condition Precedent** shall mean a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

VII. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

a. Internal Congenital Anomaly: Congenital Anomaly which is not in the visible and accessible parts of the body.
b. External Congenital Anomaly: Congenital Anomaly which is in the visible and accessible parts of the body.

VIII. **Co-payment** means a cost-sharing requirement under a health insurance policy that provides that the Policyholder/insured will bear a specified percentage of the admissible claim's amount. A Co-payment does not reduce the Sum Insured.

IX. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

X. **Day Care Centre** means any institution established for Day Care Treatment of Illness and/or Injuries or a medical set-up with a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criterion as under:

a. has Qualified Nursing staff under its employment;
b. has qualified Medical Practitioner(s) in charge;
c. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

XI. **Day Care Treatment** refers to medical treatment, and/or Surgical Procedure which is:

a. undertaken under General or Local Anesthesia in a Hospital/Day Care Center in less than 24 hrs. because of technological advancement, and
b. which would have otherwise required a Hospitalization of more than 24 hours.
Treatment normally taken on an outpatient basis is not included in the scope of this definition.

XII. **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.

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

XIV. **Disclosure to Information Norm** means 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.

XV. **Domiciliary Hospitalization** means medical treatment for an Illness/disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

a. the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
b. the patient takes treatment at home on account of non-availability of room in a Hospital.

XVI. **Emergency** means a medical condition or symptom resulting from Illness or Injury which arises suddenly and unexpectedly and requires immediate care and treatment by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

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

XVIII. **Hospital** means any institution established for Inpatient Care and Day Care Treatment of Illness and / or Injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

a. has Qualified Nursing staff under its employment round the clock;
b. has at least 10 Inpatient beds in towns having a population of less than 10,00,000 and at least 15 Inpatient beds in all other places;
c. has qualified Medical Practitioner(s) in charge round the clock;
d. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

XIX. **Hospitalization** or **Hospitalized** means the admission in a Hospital for a minimum period of 24 consecutive Inpatient Care hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

XX. **ICU (Intensive Care Unit) 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.

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

(a) Acute condition - Acute condition is a disease, illness or injury 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/ injury which leads to full recovery

(b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
ii. it needs ongoing or long-term control or relief of symptoms
iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
iv. it continues indefinitely
v. it recurs or is likely to recur

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

XXIII. **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.

XXIV. **Inpatient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

XXV. **Maternity expenses:** Maternity expenses means;

a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
b. expenses towards lawful medical termination of pregnancy during the policy period

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

XXVII. **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.

XXVIII. **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 his licence.

XXIX. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in Hospital or stay in Hospital or part of a stay in hospital which:

a. is required for the medical management of the Illness or Injury suffered by the insured;
b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
c. must have been prescribed by a Medical Practitioner;
d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

XXXI. **Network Provider** means Hospital 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.

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

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

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

XXXV. **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.

XXXVI. **Pre-existing Disease** means any condition, ailment, injury or disease

a. 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
b. 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.

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

a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
b. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

XXXVIII. **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:

a. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalization was required, and
b. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

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

XL. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

XLI. **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.

XLII. **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.

XLIII. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the Associated Medical Expenses.

XLIV. **Specific Waiting period** means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On

completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break

XLV. **Surgery** or **Surgical Procedure** 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 or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

XLVI. **Unproven/Experimental treatment:** Unproven/Experimental treatment means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven

Specific Definitions:

XLVII. **Age** means age of the Insured person on last birthday as on date of commencement of the Policy.

XLVIII. **AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.

XLIX. **Base Sum Insured** means the amount stated in the Policy Schedule.

L. **Bone Marrow Transplant** is the actual undergoing of a transplant of human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner. The following will be excluded:

i. Other stem-cell transplants
ii. Where only islets of Langerhans are transplanted

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

LII. **Associated Medical Expenses** shall include Room Rent, nursing charges, Medical Practitioners' and operation theatre charges

LIII. **Critical Illness**, an Illness, medical event or Surgical Procedure specifically defined in Section 3.7.1

LIV. **Diagnostic Services** means those diagnostic tests and exploratory or therapeutic procedures required for the detection, identification and treatment of a medical condition.

LV. **Evidence Based Clinical Practice** means process of making clinical decisions for Inpatient Care using current best evidence in conjugation with clinical expertise.

LVI. **e-Consultation** means opinion from a Medical Practitioner 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 his license.

LVII. **Family Floater Policy** means a Policy described as such in the Policy Schedule where the family members (two or more) named in the Policy Schedule are Insured Persons under this Policy. Only the following family members can be covered under a Family Floater Policy:

a. Primary Insured Person; and/or
b. Primary Insured Person's legally married spouse (for as long as she/he continues to be married to the Primary Insured Person); and/or

c. Primary Insured Person's children who are less than 25 years of Age on the commencement of the Policy Period (a maximum 4 children can be covered under the Policy as Insured Persons).

LVIII. **First Policy** means for the purposes of this Policy the Policy Schedule issued to the Policyholder at the time of inception of the first Policy mentioned in the Policy Schedule with Us.

LIX. **Information Summary Sheet** means the information and details provided to Us or Our representatives over the telephone for the purposes of applying for this Policy which has been recorded by Us and confirmed by You.

LX. **Individual Policy** means a Policy described as such in the Policy Schedule where the individual named in the Policy Schedule is the Insured Person under this Policy.

LXI. **Inpatient** means admission for treatment in a Hospital for more than 24 hours for an Insured Event.

LXII. **Insured Event** means any event specifically mentioned as covered under this Policy.

LXIII. **Insured Person** means person(s) named as insured persons in the Policy Schedule.

LXIV. **IRDAI** means the Insurance Regulatory and Development Authority of India.

LXV. **Medical Record** means the collection of information as submitted in claim documentation concerning an Insured Person's Illness or Injury that is created and maintained in the regular course of management, made by Medical Practitioners who have knowledge of the acts, events, opinions or diagnoses relating to the Insured Person's Illness or Injury, and made at or around the time indicated in the documentation.

LXVI. **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence.

LXVII. **Off-label drug or treatment** means use of pharmaceutical drug for an unapproved indication or in an unapproved age group, dosage or route of administration.

LXVIII. **Policy** means these terms and conditions, the Policy Schedule (as amended from time to time), Your statements in the Proposal and the Information Summary Sheet and any endorsements attached by Us to the Policy from time to time.

LXIX. **Policy Period** is the period between the inception date and the expiry date of the Policy as specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier.

LXX. **Policy Year** means the period of one year commencing on the date of commencement specified in the Policy Schedule or any anniversary thereof.

LXXI. **Policy Schedule** means a certificate issued by Us, and, if more than one, then the latest in time. The Policy Schedule contains details of the Policyholder, Insured Persons, the Sum Insured and other relevant details related to the coverage.

LXXII. **Primary Insured Person** means the Policyholder if he/she is covered under the Policy as an Insured Person. In case Policyholder is not an Insured Person, then Primary Insured Person will be the eldest Insured Person covered under the Policy.

LXXIII. **Reimbursement** means settlement of claims paid directly by Us to the Policyholder/Insured Person.

LXXIV. **Service Provider** means any person, organization, institution that has been empanelled with Us to provide services specified under the benefits to the Insured Person.

LXXV. **Single Private Room** means an air conditioned room in a Hospital where a single patient is accommodated and which has an attached toilet (lavatory and bath). Such room type shall be

the most basic and the most economical of all accommodations available as a single room in that Hospital.

LXXVI. **Standby Services** are services of another Medical Practitioner requested by treating Medical Practitioner and involving prolonged attendance without direct (face-to-face) patient contact or involvement.

LXXVII. **Sum Insured** means the total of the Base Sum Insured which is Our maximum, total and cumulative liability for any and all claims during the Policy Year in respect of all Insured Person(s) which is specified in the Policy Schedule.

LXXVIII. **Survival Period** means the period, if any, specified under the Policy after the occurrence of an Insured Event that the Insured Person has to survive before a claim becomes admissible under the Policy.

LXXIX. **Waiting Period** means a time-bound exclusion period related to condition(s) specified in the Policy Schedule or the Policy which shall be served before a claim related to such condition(s) becomes admissible.

LXXX. **We/Our/Us** means Niva Bupa Health Insurance Company Limited.
You/Your/Policyholder means the person named in the Policy Schedule who has concluded this Policy with Us.

3. Scope of Cover: Benefits

The terms, conditions and exclusions governing the Benefits under this Policy are described below. The Policy Schedule/Certificate of Insurance will specify which Benefits are in force and available for the Insured Person. Benefits are effective only during the Operative Time as shown in the Policy Schedule/ Certificate of Insurance.

a. The Benefits listed in the sections below will be payable subject to the terms, conditions and exclusions of this Policy, the availability of the Benefit Sum Insured and any limits/sub-limits specified in the Policy Schedule/Certificate of Insurance as applicable under the Benefits in force for the Insured Person.

b. All claims for any Benefits under the Policy must be made in accordance with the claim process defined under the respective section in which the Benefit is being claimed.

c. The expenses that are not covered or subsumed into room charges / procedure charges / costs of treatment are mentioned in Annexure III.

3.1. Hospitalization Cover:

We will indemnify the Medical Expenses incurred in respect of an Insured Person in accordance with the terms and conditions of the Benefits below in relation to any Illness suffered or Injury sustained during the Policy Period provided that the treatment undertaken is Medically Necessary Treatment and is carried out on the written advice of a Medical Practitioner.

3.1.1. Coverage Options:

3.1.1.1. Inpatient Care

What is covered:
We will indemnify the Medical Expenses incurred on the Insured Person's Hospitalization following an Illness or Injury that occurs during the Policy Period.

Conditions:

a. The Hospitalization is for Medically Necessary Treatment, is carried out on the written advice of a Medical Practitioner and follows Evidence Based Clinical Practices and standard treatment guidelines.
b. The Medical Expenses incurred are Reasonable and Customary Charges for one or more of the following:

i. Room Rent;
ii. Nursing charges for Hospitalization as an Inpatient excluding private nursing charges;
iii. Medical Practitioners' fees, excluding any charges or fees for Standby Services;
iv. Physiotherapy, investigation and diagnostics procedures directly related to the current admission;
v. Medicines and drugs as prescribed by the treating Medical Practitioner;
vi. Intravenous fluids, blood transfusion, injection administration charges, allowable consumables and / or enteral feedings.
vii. Operation theatre charges;
viii. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery;
ix. ICU Charges.
x. If the Insured Person is admitted in a Hospital room where the room category opted or Room Rent incurred is higher than the eligibility as specified in the Policy Schedule, then We shall be liable to pay only a pro-rated portion of the total Associated Medical Expenses (including surcharge or taxes thereon) as per the following formula:

(Eligible Room Rent limit / Room Rent actually incurred) * total Associated Medical Expenses

Associated Medical Expenses shall include Room Rent, nursing charges, Medical Practitioners' fees and operation theatre charges.

Proportionate deductions will not be applied If the claim is of a hospital which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

What is not covered:

a. We shall not be liable to pay the visiting fees or consultation charges for any Medical Practitioner visiting the Insured Person unless:

i. The Medical Practitioner's treatment or advice has been sought by the Hospital; and
ii. The visiting fees or consultation charges are included in the Hospital's bill; and
iii. The visiting fees or consultation charges are not more than the treating or referral Medical Practitioner's consultation charges.

3.1.1.2. Pre-hospitalization Medical Expenses

What is covered:

We will indemnify the Insured Person's Pre-Hospitalization Medical Expenses incurred following an Illness or Injury.

Conditions:

a. We have accepted a claim under Section 3.1.1.1 (Inpatient Care) above in respect of that Insured Person for the same period of Hospitalization.
b. We shall not be liable to pay any Pre-Hospitalization Medical Expenses for more than the number of days specified in the Policy Schedule/Certificate of Insurance immediately preceding the Insured Person's admission to Hospital for Inpatient Care or such expenses incurred prior to inception of the First Policy with Us.
c. Pre-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.
d. This Benefit is not applicable for any expenses incurred outside India.
e. Pre-hospitalization Medical Expenses incurred on physiotherapy will also be payable provided that such physiotherapy is Medically Necessary Treatment and advised in writing by the treating Medical Practitioner.

3.1.1.3. Post-hospitalization Medical Expenses

What is covered:

We will indemnify the Insured Person's Post-Hospitalization Medical Expenses incurred following an Illness or Injury.

Conditions:

a. We have accepted a claim under Section 3.1.1.1 (Inpatient Care) above.
b. We shall not be liable to pay any Post-Hospitalization Medical Expenses for more than the number of days specified in the Policy Schedule/Certificate of Insurance immediately following the Insured Person's discharge from Hospital.
c. Post-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.
d. This Benefit is not applicable for expenses incurred outside India.
e. Post-hospitalization Medical Expenses incurred on physiotherapy will also be payable provided that such physiotherapy is Medically Necessary Treatment and advised in writing by the treating Medical Practitioner.

3.1.1.4. Day Care Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Day Care Treatment following an Illness or Injury that occurs during the Policy Period.

Conditions:

a. The Day Care Treatment is for Medically Necessary Treatment and is carried out on the written advice of a Medical Practitioner.
b. The Medical Expenses incurred are Reasonable and Customary Charges for any procedure where such procedure is undertaken by an Insured Person as Day Care Treatment.

c. The list of admissible Day Care Treatment would be as per the list attached.
d. We shall not cover any OPD Treatment and Diagnostic Services under this Benefit.

3.1.1.5. Inpatient Care under Alternative Treatment

What is covered:

We will indemnify the **Charges** for **Medical Expenses** incurred during the **Policy Period**on treatment taken under Ayurveda, Unani, Sidha and Homeopathy in **AYUSH Hospital**
Conditions:

a. The Hospitalization is for Medically Necessary Treatment and is carried out on the written advice of a Medical Practitioner.
b. The Medical Expenses incurred are Reasonable and Customary Charges.
c. If We accept any claim under this Benefit, then We will not make any payment under this Policy for any allopathic treatment taken by the Insured Person in respect of the same Illness or Injury.
d. Our maximum, total and cumulative liability under this Benefit shall be limited to the amount specified in the Policy Schedule/Certificate of Insurance.
e. Pre-hospitalization Medical Expenses incurred for up to the number of days specified in the Policy Schedule/Certificate of Insurance prior to the Alternative Treatment being commenced and Post-hospitalization Medical Expenses incurred for up to the number of days specified in the Policy Schedule/Certificate of Insurance following the Alternative Treatment being concluded will also be indemnified under this Benefit provided that these Medical Expenses relate to the Alternative Treatment only and not to any allopathic treatment.
f. Section 3.1.2.B.ii of the Permanent Exclusions shall not apply only to the extent that this Benefit is applicable.

3.1.1.6. Domiciliary Hospitalization

What is covered:

We will indemnify the Medical Expenses incurred for the Insured Person's Domiciliary Hospitalization following an Illness or Injury that occurs during the Policy Period.

Conditions:

a. The Domiciliary Hospitalization is for Medically Necessary Treatment and is carried out on the written advice of a Medical Practitioner.
b. The Medical Expenses incurred are Reasonable and Customary Charges.
c. Medical Expenses can be claimed under this Section on a Reimbursement basis only.
d. The Domiciliary Hospitalization continues for at least 3 consecutive days in which case We will make payment under this Benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalization.

3.1.1.7. Organ Transplant

What is covered:

We will indemnify the Medical Expenses incurred for a living organ donor's Inpatient treatment for the harvesting of the organ donated during the Policy Period.

Conditions:

a. The donation conforms to The Transplantation of Human Organs Act 1994 and amendments thereafter and the organ is for the use of the Insured Person.
b. The recipient Insured Person has been Medically Advised in writing to undergo an organ transplant.
c. We have accepted the recipient Insured Person's claim under Section 3.1.1.1 (Inpatient Care).
d. The Medical Expenses incurred are Reasonable and Customary Charges.

What is not covered:

We shall not be liable to make any payment in respect of:

a. The living organ donor's stay in a Hospital that is needed for them to donate their organ.
b. Stem cell donation except for Bone Marrow Transplant.
c. Pre-hospitalization Medical Expenses or Post-Hospitalization Medical Expenses of the organ donor.
d. Screening or any other Medical Expenses of the organ donor.
e. Costs directly or indirectly associated with the acquisition of the donor's organ.
f. Transplant of any organ/tissue where the transplant is experimental or investigational.
g. Expenses related to organ transportation or preservation.
h. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

3.1.1.8. Maternity Expenses

What is covered:

We will indemnify the Medical Expenses incurred towards Medically Necessary Treatment of the Insured Person in case of normal delivery, routine or elective Caesarean or Complicated Pregnancy during the Policy Period.

Conditions:

a. This Benefit is available only if
i. the female Insured Person is Age 18 years or above
ii. Both the Insured Person and his / her legally married spouse are covered under a Family Floater Policy.
b. This Benefit cannot be availed under an Individual Cover.
c. The female Insured Person in respect of whom a claim for Maternity Expenses is made must have been covered as an Insured Person for at least the period specified in the Policy Schedule/ Certificate of Insurance of continuous coverage since the inception of the First Policy with Us, with maternity as a Benefit.
d. The Maternity Expenses incurred are Reasonable and Customary Charges.
e. The Maternity Benefit may be claimed under the Policy in respect of eligible Insured Person(s) only twice during the lifetime of the Policy including any Renewal thereafter for the delivery of a child or Medically Necessary Treatment and lawful termination of pregnancy up to maximum of 2 pregnancies or terminations.

f. Any treatment related to the complication of pregnancy or termination will be treated within the maternity limits.
g. On Renewal, if an enhanced Maternity Sum Insured is proposed, the specified period of continuous coverage (as per Section 3.1.1.8.c) would apply afresh to the extent of the increased Benefit amount.
h. Re-Fill Sum Insured Benefit will not be available for any claims made under this Section.
i. XII of the Permanent Exclusions shall not apply only to the extent that this Benefit is applicable.

For the purpose of this Section, "Complicated Pregnancy" means a medical condition arising during the antenatal stages of pregnancy or a medical condition arising during childbirth that requires a recognized obstetric procedure and post-natal check-ups as a result of the complication of pregnancy for a period up to six weeks.

What is not covered:

We shall not be liable to make any payment in respect of the following:
a. Expenses incurred in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future Illnesses;
b. Medical Expenses for ectopic pregnancy will be covered under Section 3.1.1.1 (Inpatient Care) and shall not fall under this Benefit.

3.1.1.9. New Born Baby Cover

What is covered:

We will indemnify the Medical Expenses incurred during the Policy Period, towards the Medically Necessary Treatment of the New Born Baby up to the limit specified in the Policy Schedule/Certificate of Insurance for up to 90 days from the date of delivery.

Conditions:
a. The mother is an Insured Person under the Policy.
b. The Maternity Benefit Cover is in force for the mother under the Policy.
c. We have accepted a claim under Section 3.1.1.8 (Maternity Expenses) above in respect of the same delivery
d. A New Born Baby older than 90 days can be covered under the Policy as an Insured Person only by way of an endorsement or at the next Renewal, whichever is earlier, on payment of the additional premium.

3.1.1.10. New Born Vaccination Cover

What is covered:

We will indemnify the expenses incurred during the Policy Period on vaccination specified in Annexure V of the New Born Baby till he/she completes 1 year of Age.

Conditions:

a. Coverage of the New Born Baby on birth shall be subject to the addition of the New Born Baby as an Insured Person under the Policy by way of an endorsement or at the next Renewal whichever is earlier on payment of the requisite premium.
b. The expenses incurred are Reasonable and Customary Charges.
c. Expenses can be claimed under this Section on a Reimbursement basis only.

3.1.1.11. Pre and Post Natal Expenses

What is covered:

We will indemnify the Medical Expenses incurred during the Policy Year, in respect of pre- natal check-ups since confirmation of pregnancy, postnatal check-ups for a period up to six weeks from delivery, prescribed prenatal medicines and diagnostic tests up to the limit specified in the Policy Schedule/ Certificate of Insurance.

Conditions:
a. The Medical Expenses incurred are Reasonable and Customary Charges.
b. We have accepted a claim under Section 3.1.1.8 (Maternity Expenses) above in respect of the same delivery
c. Expenses can be claimed under this Section on a Reimbursement basis only.

What is not covered:
We will not be liable to make any payment in respect of any Pre-Hospitalization Medical Expenses or Post–hospitalization Medical Expenses under Section 3.1.1.2 or Section 3.1.1.3 in relation to any claims made under this Benefit.

3.1.1.12. Cord Blood Banking Cost Cover

What is covered:

We will indemnify the Medical Expenses incurred during the Policy Period, in respect of the collection and storage of the umbilical cord blood as a one-time benefit for one episode of pregnancy only post-delivery in a lifetime.

Conditions:
a. We have accepted a claim under Section 3.1.1.8 (Maternity Expenses) above in respect of the same delivery
b. Our maximum, total and cumulative liability under this Benefit shall be lower of the actual expenses incurred and the limit specified in the Policy Schedule/ Certificate of Insurance.
c. Exclusion ‘a’ specified under Section 3.1.1.8 (Maternity Benefit) shall not apply only to the extent that this Benefit is applicable.

For the purpose of this Benefit, prophylactic collection and storage of umbilical cord blood is considered investigational and not medically necessary when proposed for an unspecified future use for an autologous stem cell transplant in the original donor or for an unspecified future use as

an allogeneic stem cell transplant in a related or unrelated donor and this Benefit does not provide assurance further about use of umbilical cord blood/stem cell apart from one-time storage.

3.1.1.13. Emergency Ground Ambulance- Within India

What is covered:

We will indemnify the expenses incurred on an ambulance during the Policy Period to transfer the Insured Person by surface transport following an Emergency.

Conditions:

a. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is Injured or is ill to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital with advanced facilities as advised by the treating Medical Practitioner in writing for management of the current Hospitalization.
b. The expenses incurred are Reasonable and Customary Charges.
c. This Benefit is available for only one transfer per period of Hospitalization.
d. The ambulance service is offered by a healthcare or ambulance Service Provider.
e. We have accepted a claim under Section 3.1.1.1 (Inpatient Care) above in respect of the same period of Hospitalization.
f. If the ambulance is provided by a Non-Network Provider, we will cover expenses incurred only up to the amount specified in the Policy Schedule/Certificate of Insurance.

What is not covered:

We will not make any payment under this Benefit if the Insured Person is transferred to any Hospital or diagnostic Centre for evaluation purposes only.

3.1.1.14. Air Ambulance Cover

What is covered:

We will indemnify the expenses incurred on an air ambulance during the Policy Period to transport the Insured Person to the nearest Hospital following an Emergency within India

Conditions:

a. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is Injured or is ill to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital with advanced facilities as advised by the treating Medical Practitioner in writing for management of the current Hospitalization.
b. The expenses incurred are Reasonable and Customary Charges.
c. This Benefit is available for only one transfer per period of Hospitalization.
d. The ambulance service is offered by a healthcare or ambulance Service Provider.

e. We have accepted a claim under Section 3.1.1.1 (Inpatient Care) above in respect of the same period of Hospitalization.
f. The transportation should be provided by medically equipped aircraft which can provide medical care in flight and should have medical equipment vital to monitoring and treating the Insured Person suffering from an Illness/Injury such as but not limited to ventilators, ECGs, monitoring units, CPR equipment and stretchers.

3.1.1.15. Prosthetics Cover

What is covered:

If an Insured Person suffers an Injury or an Illness during the Policy Period that solely and directly results in physical loss of limb(s) within three hundred and sixty-five (365) days from the date of the occurrence of such Accident or Illness, We will indemnify the cost of buying the Prosthetic as specified in Annexure VIII.

Conditions:

a. We have accepted a claim under Section 3.1.1.1 (Inpatient Care) above.
b. Our maximum, total and cumulative liability under this Benefit shall be lower of the actual expenses incurred and the limit as per the option specified in the Policy Schedule/Certificate of Insurance.
c. Medical Expenses can be claimed under this Section on a Reimbursement basis only.
d. This Benefit shall be payable for only one limb once in the Insured Person's lifetime irrespective of single or multiple limb loss.
e. The permanence of total and irreversible loss of limb shall be proved with a disability certificate issued by a Medical Board duly constituted by the Central or the State Government being presented to Us.
For the purpose of this Benefit, Prosthetics means the articles or equipment that replaces all or a part of a limb where limb is defined as the arm / the leg of a person.

What is not covered:

a. Any repairs or replacement of the Prosthetic.
b. Durable Medical Equipment which means equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of an Illness or Injury, and is appropriate for use in the home.
c. Orthotics which means devices that are designed to support a weakened body part and where these appliances are manufactured or custom-fitted to an individual member.

3.1.1.16. Compassionate Visit

What is covered:

If an Insured Person suffers an Injury or an Illness during the Policy Period, that solely and directly results in the Insured Person's Hospitalization for more than seven (7) consecutive days We will

indemnify the expenses incurred in respect of travel of one Immediate Family member of the Insured Person to the place of Hospitalization of the Insured Person.

Conditions:

a. No adult member of the Insured Person's Immediate Family is present within a distance of at least 150 kilometers from the place of Hospitalization of the Insured Person.
b. The treating Medical Practitioner certifies in writing and Our panel Medical Practitioner confirms that the medical condition of the Insured Person is such that repatriation of the Insured Person is not possible and there is a need for a companion to be present while the Insured Person remains Hospitalized.
c. Expenses can be claimed under this Section on a Reimbursement basis only.
d. We will reimburse two-way airfare in a licensed common carrier or two-way railway tickets for the travel of the companion to the place of Hospitalization of the Insured Person.
e. We have accepted a claim under Section 3.1.1.1 (Inpatient Care) above.

For the purpose of this Benefit Immediate Family means any one of the relationships with the Insured Person: spouse, father, mother, father-in-law, mother-in-law, brother, sister-in-law, sister, brother-in-law, son or daughter.

3.1.1.17. Accompanying Person Accommodation Cover

What is covered:

If an Insured Person suffers an Injury or an Illness during the Policy Period that solely and directly results in the Insured Person's Hospitalization We will pay the amount specified in the Policy Schedule/Certificate of Insurance for each continuous and completed 24 hours of Hospitalization in respect of one Immediate Family member of the Insured Person to accompany the Insured Person in Hospital.

Conditions:

a. No adult member of the Insured Person's Immediate Family is present within a distance of at least 150 kilometers from the place of Hospitalization of the Insured Person.
b. Our panel Medical Practitioner confirms that the medical condition of the Insured Person is such there is a need for a companion to be present while the Insured Person remains Hospitalized.
c. We have accepted a claim under Section 3.1.1.1 (Inpatient Care) above.
d. Our liability under this Benefit shall be in excess of the Deductible for each period of Hospitalization.
e. Our maximum liability under this Benefit shall be the lower of 10 days or duration of Hospitalization.

For the purpose of this Benefit Immediate Family means any one of the relationships with the Insured Person: spouse, father, mother, father-in-law, mother-in-law, brother, sister-in-law, sister, brother-in-law, son or daughter.

3.1.1.18. Health Check-up

What is covered:

The Insured Person may avail a health check-up during the Policy Period as per the list specified in Annexure IV or up to the limit specified in the Policy Schedule/Certificate of Insurance only for Diagnostic Tests taken at Our Network Provider which will be arranged by Us:

a. The eligibility of the Insured Person under this Benefit and the frequency of heath check-ups will be as specified in the Policy Schedule/Certificate of Insurance.
b. Any unutilized test or amount in one Policy Year cannot be carry forwarded to the next Policy Year.

3.1.1.19. Home Health Care Services

What is covered:

We will indemnify the Medical Expenses incurred on health care services taken by the Insured Person at home during the Policy Period through Our Empaneled Service Provider.

Conditions:

a. We have accepted a claim under Section 3.1.1.1 (Inpatient Care) above and services under this Benefit are availed immediately following that Hospitalization.
b. This Benefit can be availed on a Cashless Facility basis only.
c. The medical condition of the Insured Person must be such that the treating Medical Practitioner expects the condition to improve in a reasonable and generally predictable period of time.
d. Treatment under this Benefit will be provided under the supervision of a Medical Practitioner to safely and effectively administer the treatment plan for the condition of the Insured Person.
e. The amount, frequency and time period of the services under this Benefit shall be reasonable, and in agreement between treating Medical Practitioner and the Insured Person availing the service.
f. Services under this Benefit are available only through Our Empaneled Service Providers in selected cities. Please contact Us for the updated list of cities where Home Health Care Services are available.

3.1.1.20. Sub-limit on Specified Illness/Conditions

What is covered:

If an Insured Person is Hospitalized during the Policy Period for any of the Specified Illnesses or Conditions specified in Policy Schedule/Certificate of Insurance then it is agreed that Our liability in respect of any claim made under the Policy will be limited to the amount specified in Policy Schedule/Certificate of Insurance.

3.1.1.21. Loyalty Credits: Sum Insured Enhancement

What is covered:

If the Insured Person's cover under the Policy is renewed with Us without a break We will increase the Base Sum Insured applicable under the Policy by the percentage as opted and specified in the Policy Schedule/Certificate of Insurance, for each successive renewal. The Sum Insured increase will be calculated as a percentage of the Base Sum Insured subject to the maximum of 100% of Base Sum Insured as specified in the Policy Schedule/Certificate of Insurance. The sub-limits applicable to various Benefits will remain the same and shall not increase proportionately with the Sum Insured.

Conditions:

a. The Sum Insured shall be increased by a flat percentage for each successive Renewal without a break.
b. At Renewal You/ Insured Person shall have an option to reinstate/ revise the Sum Insured by sending in writing the request for such Sum Insured revision. Any revision to Sum Insured shall always be subject to due underwriting by Us and acceptance of risk by Us in writing.
c. If the Insured Person in the expiring cover under the Policy is covered under an Individual Cover and has an enhanced Sum Insured in the expiring cover under the Policy under this Benefit, and such expiring cover under the Policy is Renewed with Us as a Family Floater Cover, then We shall provide credit for Sum Insured enhancement to the Insured Person only and not to the other members of Family Floater Cover.
d. If the Insured Persons in the expiring cover under the Policy are covered under a Family Floater Cover and have an accumulated Loyalty Credit for each Insured Person in the expiring cover under the Policy under this Benefit, and such expiring cover under the Policy is Renewed with Us as an Individual Cover with same or higher Base Sum Insured, then the accumulated Loyalty Cover to be carried forward for credit in the Renewing cover under the Policy would be the accumulated Loyalty Credit for that Insured Person.
e. In case the Sum Insured of Section 3.1.1.1 (In-patient Care) is reduced at the time of Renewal, the applicable accumulated Loyalty Credit shall also be reduced in proportion to the Sum Insured of Section 3.1.1.1
f. In case the Sum Insured of Section 3.1.1.1 (In-patient Care) under the Policy is increased at the time of Renewal, the applicable accumulated Loyalty Credit shall be carried forward.

3.1.1.22. No Claim Bonus

What is covered:

We will add a Cumulative Bonus in the form of a No Claim Bonus as a percentage specified in the Policy Schedule/Certificate of Insurance of the Sum Insured of Section 3.1.1.1 (In-patient Care) at the end of every Policy Year.

Conditions:

i. No claim has been made under Section 3.1.1.1 (Inpatient Care), 3.1.1.2 & 3.1.1.3 (Pre & Post Hospitalization Expenses), 3.1.1.4 (Day Care Treatment), 3.1.1.6 (Domiciliary treatment), 3.1.1.7 (Organ Transplant), 3.1.1.5 (Inpatient Care under Alternate treatment) & 3.1.1.8 (Maternity Expenses) in the immediately preceding Policy Year.
ii. The No Claim Bonus will be added if the Policy is Renewed with Us by the end of the Grace Period or at the end of each Policy Year if the Policy continues to be in force.

iii. The No Claim Bonus will not be accumulated in excess of 100% of the Base Sum Insured under the current Policy with Us under any circumstances.

iv. Any No Claim Bonus that has accrued will be available for any claims made in the subsequent Policy Year.

v. Merging of Covers under the Policy: If the Insured Persons in the expiring Policy are covered under multiple Individual Covers and such expiring Policy has been Renewed with Us on a Family Floater Cover basis then the No Claim Bonus to be carried forward for credit in such Renewed Policy shall be the lowest percentage of No Claim Bonus of the last Policy Year amongst all the expiring Individual Covers being merged.

vi. Splitting of Covers under the Policy: If the Insured Persons in the expiring cover under the Policy are covered on a Family Floater Cover basis and such Insured Persons Renew their expiring cover with Us by splitting the Sum Insured in to two or more Family Floater/Individual Covers then the No Claim Bonus shall not be carried forward to the split covers.

vii. Reduction in Sum Insured: If the Sum Insured has been reduced at the time of Renewal, the applicable No Claim Bonus shall be calculated on the revised Sum Insured on a pro-rata basis.

viii. Increase in Sum Insured: If the Sum Insured has been increased at the time of Renewal the No Claim Bonus shall be calculated on the Sum Insured of the last completed Policy Year.

ix. The No Claim Bonus is provisional and is subject to decrease by the same percentage as specified in the Policy Schedule/ Certificate of Insurance if a claim is made in the expiring Policy Year.

3.1.1.23. Re-fill Benefit

What is covered:

If the Base Sum Insured, Loyalty Credit (if any) and No Claim Bonus (if any) has been partially or completely exhausted due to claims made and paid or claims made and accepted as payable for a particular Illness during the Policy Year under Section 3.1. (Hospitalization Cover), then We will provide a Re-fill amount of maximum up to 100% of the Base Sum Insured which may be utilized for claims arising in that Policy Year.

Conditions:

a. The re-fill amount may be used for only subsequent claims in respect of the Insured Person and not against any Illness (including its complications or follow up) for which a claim has been paid or accepted as payable in the current Policy Year for the same Insured Person.

b. For Family Floater Covers, the re-fill amount will be available on a floater basis to all Insured Persons in that family in the Policy Year.

c. If the re-fill amount is not utilized in whole or in part in a Policy Year, it cannot be carried forward to any extent in any subsequent Policy Year.

d. The maximum liability for a single claim after applying Re-fill Benefit shall not be more than Base Sum Insured, Loyalty Credits and No Claim Bonus (if any) under Section 3.1.1 (in Hospitalization Cover)

e. Once the Re-fill Benefit is opted in by an Insured Person, it cannot be withdrawn by the Insured Person at subsequent Renewals.

f. Re-fill Benefit shall not be available for the Section 3.1.1.8 (Maternity Benefit) and 3.1.1.18 (Health Check Up)

3.1.1.24. Co-payment

What is covered:

The Insured Person will pay the pre-determined percentage as specified in the Policy Schedule/ Certificate of Insurance as Co-Payment and We will pay the remaining part of the amount that We assess as the admissible amount in respect of any claim under this Section or selected sections as mentioned in the Policy Schedule/ Certificate of Insurance made by an Insured Person.

Conditions:

The Co-Payment percentage will be applicable on all claims under Hospitalization Cover Section except 3.1.1.8 (Maternity Expenses), 3.1.1.9 (New Born Baby Cover), 3.1.1.10 (New Born Vaccination), 3.1.1.11 (Pre & Post Natal), 3.1.1.12 (Cord Blood Banking), 3.1.1.13 (Emergency Ground Ambulance), 3.1.1.14 (Air Ambulance Cover), 3.1.1.15 (Prosthetic cover), 3.1.1.16 (Compassionate Visit), 3.1.1.17 (Accompanying person accommodation cover). 3.1.1.18 (Health Checkup), 3.1.1.20 (Sum-limits for Specified Illness/conditions).

3.1.1.25. Annual Aggregate Deductible

What is covered:

The Insured Person shall bear on his/her own account an amount equal to the Annual Aggregate Deductible specified in the Policy Schedule/ Certificate of Insurance for any and all admissible claim amounts We assess to be admissible in respect of all claims made by that Insured Person under Section 3.1.1(Hospitalization Cover) for In-patient Hospitalization claims under indemnity based options on the admissible claim amount during a Policy Year.

Conditions:

- Our liability to make payment under the Policy in respect of any claim made in that Policy Year will only commence once the Annual Aggregate Deductible has been exhausted.
- The provisions in Section 3.1.1.24 on Co-payment (if applicable) will apply to any amounts payable by Us in respect of a claim made by the Insured Person after the Annual Aggregate Deductible has been exhausted.
- Deductible under the Section 3.1.1.25 (Annual Aggregate Deductible) shall not apply to any claim under 3.1.1.8 (Maternity Expenses), 3.1.1.9 (New Born Baby Cover), 3.1.1.10 (New Born Vaccination), 3.1.1.11 (Pre & Post Natal), 3.1.1.12 (Cord Blood Banking), 3.1.1.13 (Emergency Ground Ambulance), 3.1.1.14 (Air Ambulance Cover), 3.1.1.15 (Prosthetic cover), 3.1.1.16 (Compassionate Visit), 3.1.1.17 (Accompanying person accommodation cover). 3.1.1.18 (Health Checkup), 3.1.1.20 (Sub-limits for Specified Illness/conditions)

3.1.1.26. Annual Catastrophic Claim Deductible

What is covered:

The Insured Person shall bear on his/her own account an amount equal to the Annual Catastrophic Claim Deductible specified in the Policy Schedule/ Certificate of Insurance for any admissible claim amounts We assess to be admissible in respect of all claims made by that Insured Person under Section 3.1. (Hospitalization Cover) for In-patient Hospitalization claims under indemnity based options on the admissible claim amount during Policy Year.

Conditions:

- Our liability to make payment under the Policy in respect of any claim made in that Policy Year will only commence once the Annual Catastrophic Claim Deductible has been exhausted.
- The provisions in Section 3.1.1.24 on Co-payment (if applicable) will apply to any amounts payable by Us in respect of a claim made by the Insured Person after the Annual Catastrophic Claim Deductible has been exhausted.
- Deductible under the Section 3.1.2.6 (Annual Catastrophic Claim Deductible) shall not apply to any claim under 3.1.1.8 (Maternity Expenses), 3.1.1.9 (New Born Baby Cover), 3.1.1.10 (New Born Vaccination), 3.1.1.11 (Pre & Post Natal), 3.1.1.12 (Cord Blood Banking), 3.1.1.13 (Emergency Ground Ambulance), 3.1.1.14 (Air Ambulance Cover), 3.1.1.15 (Prosthetic cover), 3.1.1.16 (Compassionate Visit), 3.1.1.17 (Accompanying person accommodation cover). 3.1.1.18 (Health Checkup), 3.1.1.20 (Sub-limits for Specified Illness/conditions).

3.1.1.27. e-Consultation

What is covered:

If the Insured Person is diagnosed with an Illness or is planning to undergo a planned Surgery or a Surgical Procedure during the Policy Period, the Insured Person can, at the Insured Person's sole direction, obtain an e-Consultation during the Policy Period.

Conditions:

a. e-Consultation shall be requested through Our call centre or website chat.
b. e-Consultation will be arranged by Us (without any liabilities) and will be based only on the information provided by the Insured Person.
c. By seeking e-Consultation under this Benefit, the Insured Person is not restrained or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.
d. The Insured Person is free to choose whether or not to obtain the e-Consultation, and if obtained then whether or not to act on it in whole or in part.
e. e-Consultation under this Benefit shall not be valid for any medico-legal purposes.
f. We do not represent correctness of the e-Consultation and shall not assume or be deemed to assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

3.1.1.28. Inclusion of Cyberknife/ Robotic Surgery

What is covered:

If the Insured Person is undergoingSurgery for the removal and/or treatment of a malignant tumor through cyber knife or robotic Surgery, the Insured Person will bear a 50% Co-Payment and We will indemnify the remaining part of the amount that We assess as admissible in respect of a claim under Section 3.1.1.1 (Inpatient Care).

What is not covered:

a. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
b. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond.
c. Malignant melanoma that has not caused invasion beyond the epidermis.
d. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
e. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below.
f. Chronic lymphocytic leukaemia less than RAI stage 3.
g. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification.
h. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs.
i. All tumors in the presence of HIV infection.

3.1.1.29. Corporate Floater for any Illness/Accident

We will provide a Corporate Floater as specified in the Policy Schedule/Certificate of Insurance during the Policy Year, provided that:

i. This Benefit will be available for those Insured Persons who have already exhausted their Sum Insured limit subject to per Insured Person/ family limit as mentioned in the Policy Schedule/Certificate of Insurance.
ii. This Benefit will be restricted to Individual/ family to the amount specified in the Policy Schedule/Certificate of Insurance in respect of each and every Insured Person/ family, as opted.
iii. If the cover under the Policy is issued on a Family Floater Cover basis, the enhanced Sum Insured on account of the Corporate Floater applicable will also be available on a Family Floater Cover basis.
iv. Any Benefit accrued under this cover cannot be carried forward to the subsequent Policy Year.
v. The Benefit payable will be over and above the Base Sum Insured.
vi. All other terms, exclusions and conditions contained in the Policy or endorsed thereon remain unchanged.

3.1.1.30. Corporate Floater for 11 listed Critical Illnesses

We will provide a Corporate Floater as specified in the Policy Schedule/ Certificate of Insurance during the Policy Year only for medical treatment for Critical Illnesses listed below provided that:

i. This Benefit will be available for those Insured Persons who have already exhausted their Sum Insured limit subject to per Insured Person/ family limit as mentioned in the Policy Schedule/Certificate of Insurance.
ii. This Benefit will be restricted to Individual/ family to the amount specified in the Policy Schedule/Certificate of Insurance in respect of each and every Insured Person/ family, as opted.
iii. If the cover under the Policy is issued on a Family Floater Cover basis, the enhanced Sum Insured on account of the Corporate Floater applicable will also be available on a Family Floater Cover basis.
iv. Any Benefit accrued under this cover cannot be carried forward to the subsequent Policy Year.
v. The Benefit payable will be over and above the Base Sum Insured.
vi. All other terms, exclusions and conditions contained in the Policy or endorsed thereon remain unchanged.

List of 11 Critical Illnesses under Section 3.1.1.30 (Corporate Floater for 11 listed Critical Illnesses)

1. **Cancer of Specified Severity**

A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukaemia, lymphoma and sarcoma.

The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
ix. All tumors in the presence of HIV infection.

2. **Myocardial Infarction -** (First Heart Attack of specific severity)

The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

a) A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

b) New characteristic electrocardiogram changes
c) Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:
i. Other acute Coronary Syndromes
ii. Any type of angina pectoris
iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. Open Chest CABG

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

4. Open Heart Replacement or Repair of Heart Valves

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

5. Coma of Specified Severity

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
i. no response to external stimuli continuously for at least 96 hours;
ii. life support measures are necessary to sustain life; and
iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
II. The condition has to be confirmed by a specialist Medical Practitioner. Coma resulting directly from alcohol or drug abuse is excluded

6. Kidney Failure requiring Regular Dialysis

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist Medical Practitioner

7. Stroke resulting in Permanent Symptoms

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and

evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:
   i. Transient ischemic attacks (TIA)
   ii. Traumatic injury of the brain
   iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. Major Organ /Bone Marrow Transplant

I. The actual undergoing of a transplant of:
   i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
   ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

II. The following are excluded:
   i. Other stem-cell transplants
   ii. Where only islets of Langerhans are transplanted

9. Permanent Paralysis of Limbs

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

10. Motor Neuron Disease with Permanent Symptoms

Motor neuron disease diagnosed by a specialist Medical Practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. Multiple Sclerosis with Persisting Symptoms

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Other causes of neurological damage such as SLE and HIV are excluded.

3.1.1.31. Claim Settlement in Network Provider only (Cashless)

The provisions of this Section shall be applicable if there is only Cashless Facility claim settlement option available under Section 3.1. (Hospitalization Cover)

(a) If an Insured Person is Hospitalized in a Hospital as specified by Us and attached to the Policy Schedule/Certificate of Insurance as specific endorsement then it is agreed that We will pay 100% of any amount We assess for payment.

(b) Any treatment taken at a Non-Network Provider shall not be covered under this Policy.

3.1.1.32. Claim Settlement on Reimbursement Only

The provisions of this Section shall be applicable if there is only Reimbursement Claim settlement option under Section 3.1. (Hospitalization Cover)

(a) If an Insured Person is Hospitalized then it is agreed that We will pay the amount that We assess in respect of any claim under the Policy on reimbursement basis only.

3.1.1.33. Modern Treatments

What is covered:
The following procedures / treatments will be covered either as Inpatient Care or as part of Day Care Treatment as per Section 3.1.1.1 and Section 3.1.1.4 respectively, in a Hospital:

i. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
ii. Balloon Sinuplasty
iii. Deep Brain stimulation
iv. Oral chemotherapy
v. Immunotherapy- Monoclonal Antibody to be given as injection
vi. Intra vitreal injections
vii. Robotic surgeries
viii. Stereotactic radio surgeries
ix. Bronchical Thermoplasty
x. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
xi. IONM - (Intra Operative Neuro Monitoring)
xii. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

a. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses in accordance with Sections 3.1.1.2 and 3.1.1.3 within the overall benefit sub-limit.

b. Special condition applicable for robotic surgeries:
A limit of maximum INR 1 Lac will apply to all robotic surgeries, except the following:

i. Robotic total radical prostatectomy
ii. Robotic cardiac surgeries
iii. Robotic partial nephrectomy
iv. Robotic surgeries for malignancies

3.1.1.34. Restriction on Treatment taken in Specified Provider Network

The provisions of this Section shall be applicable only if there is restriction on treatment in Specified Provider Network.

(a) If an Insured Person is Hospitalized in a Hospital as specified by Us and attached to the Policy Schedule/Certificate of Insurance as specific endorsement then it is agreed that the We will pay 100% of any amount We assess for payment.

(b) If an Insured Person is Hospitalized in a Hospital not specified by Us then it is agreed that We will only pay the percentage as specified on the Policy Schedule/Certificate of Insurance, of any

amount We assess for Reimbursement in respect of any claim under the Policy made by that Insured Person and the balance will be borne by the Insured Person.

3.1.2. Section Specific Conditions

All the Waiting Periods as specified in Policy Schedule/ Certificate of Insurance shall be applicable individually for each Insured Person and claims shall be assessed accordingly. On Renewal, if an enhanced Sum Insured is applied for, the Waiting Periods would apply afresh to the extent of the increase in Sum Insured only. Waiting Periods mentioned below shall not apply to claims under Section 3.1.1.18 (Health Checkup) and Section 3.1.1.8 (Maternity Benefit).

We shall not be liable to make any payment under this Policy directly or indirectly for, caused by, based on, arising out of or howsoever attributable to any of the following, except if any Insured Person suffers an Accident;

A. Waiting Periods

I. **Pre-existing Diseases (Code–Excl01):**

a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of the number of months (as mentioned in Policy Schedule/Certificate of Insurance) of continuous coverage after the date of inception of the first Policy.

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 (Insurance Insurance) regulations 2024, then waiting period for the same would be reduced to the extent of prior coverage.

d. Coverage under the Policy after the expiry of number of months (as mentioned in Policy Schedule/Certificate of Insurance) for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

II. **Specified disease/procedure waiting period (Code- Excl02)**

a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of number of months (as mentioned in Policy Schedule/Certificate of Insurance) of continuous coverage after the date of inception of the first Policy. This exclusion shall not be applicable for claims arising due to an Accident (covered from day 1) or Cancer (covered after 30-day waiting period).

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 unless specifically mentioned in Policy Schedule/Certificate of Insurance:

i. Pancreatitis and stones in biliary and urinary system.

ii. Cataract, Glaucoma and other disorders of lens and disorders of retina.
iii. Hyperplasia of prostate, hydrocele and spermatocele.
iv. Abnormal utero-vaginal bleeding, female genital prolapse, endometriosis/adenomyosis, fibroids, PCOD, or any condition requiring dilation and curettage or hysterectomy.
v. Hemorrhoids, fissure or fistula or abscess of anal and rectal region.
vi. Hernia of all sites.
vii. Osteoarthritis, Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, inflammatory Polyarthropathies, Arthrosis such as RA, Gout, Intervertebral Disc disorders.
viii. Chronic kidney disease and failure.
ix. Varicose veins of lower extremities.
x. Disease of middle ear and mastoid including Otitis Media, Cholesteatoma, Perforation of Tympanic Membrane.
xi. All internal or external benign or in situ neoplasms/tumours, cyst, sinus, polyp, nodules, swelling, mass or lump.
xii. Ulcer, erosion and varices of upper gastro intestinal tract.
xiii. Tonsils and adenoids, nasal septum and nasal sinuses.
xiv. Internal Congenital Anomaly

If these diseases are Pre-Existing Diseases at the time of the Proposal or subsequently found to be Pre-Existing Diseases, the Pre-Existing Disease Waiting Periods as mentioned in the Policy Schedule/ Certificate of Insurance shall apply in respect of that Insured Person.

III. **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.

B. Permanent Exclusions:

A permanent exclusion will be applied on any medical or physical condition or treatment of an Insured Person, if specifically mentioned in the Policy Schedule and has been accepted by You. This option as per company's underwriting policy, will be used for such condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person.

We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following unless specifically mentioned elsewhere in the Policy.

I. **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.

II. **Rest Cure, rehabilitation and respite care (Code-Excl05)**
Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

III. **Obesity/ Weight Control (Code-Excl06)**
Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
a. Surgery to be conducted is upon the advice of the Doctor.
b. The surgery/Procedure conducted should be supported by clinical protocols.
c. The member has to be 18 years of age or older and;
d. Body Mass Index (BMI);
I. greater than or equal to 40 or
II. 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

IV. **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.

V. **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.

VI. **Excluded Providers (Code-Excl11)**
Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our 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. The complete list of excluded providers can be referred to on our website.

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

VIII. 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)**

IX. **Refractive Error (Code-Excl15)**

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

X. **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.

XI. **Sterility and Infertility (Code-Excl17)**
Expenses related to sterility and infertility. This includes:
- **a.** Any type of contraception, sterilization
- **b.** Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- **c.** Gestational Surrogacy
- **d.** Reversal of sterilization

XII. **Maternity (Code-Excl18)**
- a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
- b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

XIII. **Circumcision**
Circumcision unless necessary for the treatment of a disease or necessitated by an Accident.

XIV. **External Congenital Anomaly:**
Screening, counseling or treatment related to external Congenital Anomaly.

XV. **Dental/oral treatment:**
Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident.

XVI. Multifocal Lens and ambulatory devices such as walkers, crutches, splints, stockings of any kind and also any medical equipment which is subsequently used at home.

XVII. **Sexually transmitted Infections & diseases (other than HIV / AIDS):**
Screening, prevention and treatment for sexually related infection or disease (other than HIV / AIDS).

XVIII. **Sleep disorders:**
Treatment for any conditions related to disturbance of normal sleep patterns or behaviors.

XIX. **Artificial life maintenance:** Artificial life maintenance, including life support machine used to sustain a person, who has been declared brain dead, as demonstrated by:
- a. Deep coma and unresponsiveness to all forms of stimulation; or
- b. Absent pupillary light reaction; or
- c. Absent oculovestibular and corneal reflexes; or
- d. Complete apnea.

XX. **Any form of Alternate Treatment**:
- a. Homeopathic, Unani, Yoga and Siddha streams of treatment;

b. Acupuncture, Reflexology, Chiropractic Treatment or any other form of indigenous system of medicine.

XXI. **Unrecognized Physician or Hospital:**

a. Treatment or Medical Advice provided by a Medical Practitioner not recognized by the Medical Council of India or by Central Council of Indian Medicine or by Central Council of Homeopathy or by relevant authorities in the area where the treatment is taken
b. Treatment or Medical Advice related to one system of medicine provided by a Medical Practitioner of another system of medicine
c. Treatment provided by anyone with the same residence as an Insured Person or who is a member of the Insured Person's immediate family or relatives.
d. Treatment provided by Hospital or health facility that is not recognized by the relevant authorities in India or any other country where treatment takes place.

XXII. **Off- label Drug or Treatment:**

Use of pharmaceutical drugs for an unapproved indication or in an unapproved age group, dosage, or route of administration as regulated and approved by Central Drugs Standard Control Organization (CDSCO)

XXIII. **Drugs and Dressings for OPD Treatment or Take-home Use:** Any drugs or surgical dressings that are provided or prescribed in the case of OPD Treatment, or for an Insured Person to take home on leaving Hospital, for any condition, except as included in Post-hospitalization Medical Expenses under Section 3.1.1.3.

XXIV. **OPD Treatment:**

Any OPD Treatment is not covered.

3.1.3. **Claims Process & Requirements:**

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

Claims Administration:

On the occurrence or discovery of any Illness or Injury that may give rise to a claim under this Section, the Claims Procedure set out below shall be followed:

a. The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed. We shall not be obliged to make any payment that arises out of willful failure to comply with such directions, advice or guidance.
b. We or Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.
c. We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.

It is hereby agreed and understood that no change in the Medical Record provided under the Medical Advice information, by the Hospital or the Insured Person to Us or Our Service Provider during the period of Hospitalization or after discharge by any means of request will be accepted by Us. Any decision on request for acceptance of change will be at Our discretion.

Claims Procedure:

On the occurrence or the 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:

A. **For Availing Cashless Facility:** Cashless Facility can be availed only at Our Network Providers or Service Providers. The complete list of Network Providers is available on Our website and at Our branches and can also be obtained by contacting Us over the telephone. In order to avail Cashless Facility, the following process must be followed:

a. Process for Obtaining Pre-Authorization

i. For Planned Treatment:
We must be contacted to pre-authorize Cashless Facility for planned treatment at least 72 hours prior to the proposed treatment. Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorization date at a Network Provider.

ii. In Emergencies
If the Insured Person has been Hospitalized in an Emergency, We must be contacted to pre-authorize Cashless Facility within 48 hours of the Insured Person's Hospitalization or before discharge from the Hospital, whichever is earlier.

iii. Pre-authorization through digital platform:
Pre-authorization in respect to Health Checkup, Second Medical Opinion, OPD Consultation (on Cashless Facility) can also be requested through Our mobile application or website.

Once the final authorization request is received for discharge, the same will be processed within three hours from the final documents received. In case of delay from our end, any additional amount charged by the hospital will be borne by us. This amount will be paid over and above the policy limits.

b. Each request for pre-authorization except for Health Checkup and e-Consultation must be accompanied with completely filled and duly signed pre-authorization form including all of the following details:

I. The health card (if applicable) We have issued to the Insured Person at the time of inception of the cover under the Policy (if available) supported with KYC document;
II. The Policy Number;
III. Name of the Policyholder;
IV. Name and address of Insured Person in respect of whom the request is being made;
V. Nature of the Illness/Injury and the treatment/Surgery required;
VI. Name and address of the attending Medical Practitioner;
VII. Hospital where treatment/Surgery is proposed to be taken;
VIII. Date of admission;
IX. First and any subsequent consultation paper/Medical Record since beginning of diagnosis of that treatment/Surgery;

X. Admission note;
XI. Treating Medical Practitioner certificate for disease/event history with justification of Hospitalization.

If these details are not provided in full or are insufficient for Us to consider the request, We will request additional information or documentation in respect of that request.

When We have obtained sufficient details to assess the request, We will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim, applicable Deductibles/Co-payment and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.

In case of pre-authorization request where chronicity of condition is not established as per clinical evidence based information, We may reject the request for pre-authorization and ask the claimant to claim as Reimbursement. Claim documents submission for Reimbursement should not be considered as an admission of liability.

Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorization date and pre-authorization shall be valid only if all the details of the authorized treatment, including dates, Hospital, locations, indications and disease details, match with the details of the actual treatment received. For Cashless Facility Hospitalization, We will make the payment of the amount assessed to be due, directly to the Network Provider.

We reserve the right to modify, add or restrict any Network Provider or Service Provider for Cashless Facility in Our sole discretion. Before availing Cashless Facility, please check the applicable updated list of providers.

B. Re-Authorization:

Cashless Facility will be provided subject to re-authorization if requested for either change in the line of treatment or in the diagnosis or for any procedure carried out on the incidental diagnosis/finding prior to the discharge from the Hospital.

Note: We offer Cashless Everywhere, even in hospitals which are not part of our network. For More details and process please visit our website: https://transactions.nivabupa.com/cashlessclaims/pages/intimation-claim.aspx

C. For Reimbursement Claims:

For all claims for which Cashless Facility have not been pre-authorized or for which treatment has not been taken at a Network Provider, We shall be informed of the claim along with the following details within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier:

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

Claims Documentation:

We shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense at the earliest possible time.

For claims for which the use of Cashless Facility has been authorised, We will be provided these documents by the Network Provider immediately following the Insured Person's discharge from Hospital:

a. Claim form duly completed and signed by the claimant.
Please provide mandatorily following information, if applicable
i. Current diagnosis and date of diagnosis;
ii. Past history and first consultation details;
iii. Previous admission/Surgery if any.
b. Age/identity proof document of the Insured Person in case of Cashless Facility claim (not required if submitted at the time of pre-authorization request) and in Reimbursement claim.
i. Self-attested copy of valid Age proof (passport/driving license/PAN card/class X certificate/ birth certificate);
ii. Self-attested copy of identity proof (passport/driving license/PAN card/voter identity card);
iii. Recent passport size photograph.
c. Cancelled cheque/bank statement/copy of passbook mentioning account holder's name, IFSC code and account number printed on it of the Insured Person/Nominee (in case of death of the Insured Person).
d. Original Hospital discharge summary.
e. Additional documents required in case of Surgery/Surgical Procedure.
Bar code sticker and invoice for implants and prosthesis (if used);
f. Original final bill from Hospital with detailed break-up and paid receipt.
g. Room tariff of the entitled room category (in case of a Non-Network Provider and if room tariff is not a part of Hospital bill): duly signed and stamped by the Hospital in which treatment is taken.
(In case the Insured Person/claimant are unable to submit such document, then We shall consider the Reasonable and Customary Charges of the Insured Person's eligible room category of the Our Network Provider within the same geographical area for identical or similar services.)
h. Original bills of pharmacy/medicines purchased, or of any other investigation done outside Hospital with reports and requisite prescriptions.
i. Copy of death certificate (in case of demise of the Insured Person).
j. For Medico-legal cases (MLC) or in case of Accident
i. MLC/First Information Report (FIR) copy attested by the concerned Hospital/police station (if applicable);
ii. Original self-narration of incident in absence of MLC/FIR.
k. Original laboratory investigation, diagnostic and pathological reports with supporting prescriptions.
l. Original X-Ray/MRI/ultrasound films and other radiological investigations.
m. Certificate of disability issued by a Medical Board duly constituted by the Central and/or the State Government, if available (only in case of prosthetic cover)
n. The retail invoice of the prosthetic with the packaging (only in case of prosthetic cover)

Claims Assessment:

a. All admissible claims under this Section shall be assessed by Us in the following progressive order:-
i. If a room has been opted in a Hospital for which the room category is higher than the eligible limit as applicable for that Insured Person as specified in the Policy Schedule/Certificate of Insurance, then the

Associated Medical Expenses payable shall be pro-rated as per the applicable limits specified in the Policy Schedule/Certificate of Insurance.

ii. The Deductible (if applicable) shall be applied to the aggregate of all claims that are either paid or payable under this Section. Our liability to make payment shall commence only once the aggregate amount of all eligible claims as per Policy terms and conditions exceeds the Deductible limit within the same Policy Year.

iii. Co-payment (if applicable) as specified in the Policy Schedule/Certificate of Insurance shall be applicable on the amount payable by Us.

b. The claim amount assessed as mentioned above would be deducted from the amount mentioned against each Benefit and Sum Insured as specified in the Policy Schedule/Certificate of Insurance. The re-fill amount will be applied only once the Base Sum Insured is exhausted in the Policy Year.

3.2. Fixed Benefit Coverage for Named Illnesses

If an Insured Person suffers a Named Illness specified in Policy Schedule/Certificate of Insurance during the Policy Period, We will pay the Named Illness Sum Insured specified in the Policy Schedule/Certificate of Insurance.

Conditions:

a. The Named Illness occurs or first manifests itself during the Policy Period; and

b. The signs or symptoms of the Named Illness commence after the completion of the specified Pre-existing Disease and initial waiting period from the date of commencement of coverage of the Insured Person under the Policy as specified in the Policy Schedule/Certificate of Insurance.

c. Our maximum, total and cumulative liability in respect of the Insured Person under this Benefit shall be limited to the Named Illness Sum Insured.

d. We will pay the Benefit under this Section only once per Insured Person for each Named Illness during Policy Year.

e. Claim for a Surgical Procedure would be paid only once per Insured Person in his lifetime.

3.2.1. Section Specific Condition

All the Waiting Periods as specified in Policy Schedule/ Certificate of Insurance shall be applicable individually for each Insured Person and claims shall be assessed accordingly. On Renewal, if an enhanced Sum Insured is applied for, the Waiting Periods would apply afresh to the extent of the increase in Sum Insured only.

We shall not be liable to make any payment under this Policy directly or indirectly for, caused by, based on, arising out of or howsoever attributable to any of the following, except if any Insured Person suffers an Accident;

A. Waiting Periods

I. **Pre-existing Diseases (Code–Excl01):**

a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of the number of months (as mentioned in Policy Schedule/Certificate of Insurance) of continuous coverage after the date of inception of the first Policy.

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 (Insurance Insurance) regulations2024, then waiting period for the same would be reduced to the extent of prior coverage.

d. Coverage under the Policy after the expiry of number of months (as mentioned in Policy Schedule/Certificate of Insurance) for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

II. **Specified disease/procedure waiting period (Code- Excl02)**

a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of number of months (as mentioned in Policy Schedule/Certificate of Insurance) of continuous coverage after the date of inception of the first Policy. This exclusion shall not be applicable for claims arising due to an Accident (covered from day 1) or Cancer (covered after 30-day waiting period).

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 (Below mentioned diseases/procedures can be modified and in that case the list will be mentioned in Policy Schedule/Certificate of Insurance):

i. Pancreatitis and stones in biliary and urinary system.
ii. Cataract, Glaucoma and other disorders of lens and disorders of retina.
iii. Hyperplasia of prostate, hydrocele and spermatocele.
iv. Abnormal utero-vaginal bleeding, female genital prolapse, endometriosis/adenomyosis, fibroids, PCOD, or any condition requiring dilation and curettage or hysterectomy.
v. Hemorrhoids, fissure or fistula or abscess of anal and rectal region.
vi. Hernia of all sites.
vii. Osteoarthritis, Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, inflammatory Polyarthropathies, Arthrosis such as RA, Gout, Intervertebral Disc disorders.
viii. Chronic kidney disease and failure.
ix. Varicose veins of lower extremities.
x. Disease of middle ear and mastoid including Otitis Media, Cholesteatoma, Perforation of Tympanic Membrane.
xi. All internal or external benign or in situ neoplasms/tumours, cyst, sinus, polyp, nodules, swelling, mass or lump.
xii. Ulcer, erosion and varices of upper gastro intestinal tract.
xiii. Tonsils and adenoids, nasal septum and nasal sinuses.
xiv. Internal Congenital Anomaly

III. **Initial waiting period:**

a. A Waiting Period since beginning of cover under the First Policy, specified in the Policy Schedule/ Certificate of Insurance shall apply to any Illness contracted and/or Medical Expenses incurred in respect of any Illness by the Insured Person other than Hospitalization due to Accident.
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.

If these diseases are Pre-Existing Diseases at the time of the Proposal or subsequently found to be Pre-Existing Diseases, the Pre-Existing Disease Waiting Periods as mentioned in the Policy Schedule/ Certificate of Insurance shall apply in respect of that Insured Person.

B. Permanent Exclusions:

A permanent exclusion will be applied on any medical or physical condition or treatment of an Insured Person, if specifically mentioned in the Policy Schedule and has been accepted by You. This option as per company's underwriting policy, will be used for such condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person.

We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following unless specifically mentioned elsewhere in the Policy.

I. **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.

II. **Rest Cure, rehabilitation and respite care (Code-Excl05)**
Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

III. **Obesity/ Weight Control (Code-Excl06)**
Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
a. Surgery to be conducted is upon the advice of the Doctor.
b. The surgery/Procedure conducted should be supported by clinical protocols.
c. The member has to be 18 years of age or older and;
d. Body Mass Index (BMI);
(I) greater than or equal to 40 or
(II) 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

IV. **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.

V. **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.

VI. **Excluded Providers (Code-Excl11)**
Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our 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. The complete list of excluded providers can be referred to on our website.

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

VIII. 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)**

IX. **Refractive Error (Code-Excl15)**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 diopters.

X. **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.

XI. **Sterility and Infertility (Code-Excl17)**
Expenses related to sterility and infertility. This includes:
a. Any type of contraception, sterilization
b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c. Gestational Surrogacy
d. Reversal of sterilization

XII. **Maternity (Code-Excl18)**
a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

XIII. **Circumcision**
Circumcision unless necessary for the treatment of a disease or necessitated by an Accident.

XIV. **External Congenital Anomaly:**

Screening, counseling or treatment related to external Congenital Anomaly.

XV. **Sexually transmitted Infections & diseases (other than HIV / AIDS):**
Screening, prevention and treatment for sexually related infection or disease (other than HIV / AIDS).

XVI. **Sleep disorders:**
Treatment for any conditions related to disturbance of normal sleep patterns or behaviors.

XVII. Any expenses incurred on OPD treatment

XVIII. **Artificial life maintenance:** Artificial life maintenance, including life support machine used to sustain a person, who has been declared brain dead, as demonstrated by:

a. Deep coma and unresponsiveness to all forms of stimulation; or
b. Absent pupillary light reaction; or
c. Absent oculovestibular and corneal reflexes; or
d. Complete apnea

XIX. **Any form of Alternate Treatment**:

a. Homeopathic, Unani, Yoga and Siddha streams of treatment;
b. Acupuncture, Reflexology, Chiropractic Treatment or any other form of indigenous system of medicine.

XX. **Unrecognized Physician or Hospital:**

a. Treatment or Medical Advice provided by a Medical Practitioner not recognized by the Medical Council of India or by Central Council of Indian Medicine or by Central Council of Homeopathy or by relevant authorities in the area where the treatment is taken.
b. Treatment or Medical Advice related to one system of medicine provided by a Medical Practitioner of another system of medicine.
c. Treatment provided by anyone with the same residence as an Insured Person or who is a member of the Insured Person's immediate family or relatives.
d. Treatment provided by Hospital or health facility that is not recognized by the relevant authorities in India or any other country where treatment takes place.

XXI. **Off- label Drug or Treatment:**
Use of pharmaceutical drugs for an unapproved indication or in an unapproved age group, dosage, or route of administration as regulated and approved by Central Drugs Standard Control Organization (CDSCO)

XXII. **Drugs and Dressings for OPD Treatment or Take-home Use:** Any drugs or surgical dressings that are provided or prescribed in the case of OPD Treatment, or for an Insured Person to take home on leaving Hospital, for any condition, except as included in Post-Hospitalization Medical Expenses under Section 3.1.1.3.

3.2.2. Claims Process & Requirements:

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

Claims Administration:

On the occurrence or discovery of any Illness or Injury that may give rise to a claim under this Section, the Claims Procedure set out below shall be followed:

a. The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed. We shall not be obliged to make any payment that arises out of willful failure to comply with such directions, advice or guidance.

b. We or Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.

c. We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.

It is hereby agreed and understood that no change in the Medical Record provided under the Medical Advice information, by the Hospital or the Insured Person to Us or Our Service Provider during the period of Hospitalization or after discharge by any means of request will be accepted by Us. Any decision on request for acceptance of change will be at Our discretion.

Claims Procedure:

On the occurrence or the 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:

We shall be informed of the claim along with the following details within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier:

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;

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

Claims Documentation

We shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense within 30 days of the Insured Person's discharge from Hospital.

a. Claim form duly completed and signed by the claimant.

Please provide mandatorily following information, if applicable

i. Current diagnosis and date of diagnosis;
ii. Past history and first consultation details;
iii. Previous admission/Surgery if any.

b. Age/identity proof document of the Insured Person.

i. Self-attested copy of valid Age proof (passport/driving license/PAN card/class X certificate/ birth certificate);
ii. Self-attested copy of identity proof (passport/driving license/PAN card/voter identity card);
iii. Recent passport size photograph.

c. Cancelled cheque/bank statement/copy of passbook mentioning account holder's name, IFSC code and account number printed on it of the Insured Person/Nominee (in case of death of the Insured Person).

d. Original Hospital discharge summary.
e. Additional documents required in case of Surgery/Surgical Procedure.
i. Bar code sticker and invoice for implants and prosthesis (if used);
f. Original final bill from Hospital with detailed break-up and paid receipt.
g. Original bills of pharmacy/medicines purchased, or of any other investigation done outside Hospital with reports and requisite prescriptions.
h. Copy of death certificate (in case of demise of the Insured Person).
i. For Medico-legal cases (MLC) or in case of Accident
i. MLC/First Information Report (FIR) copy attested by the concerned Hospital/police station (if applicable);
ii. Original self-narration of incident in absence of MLC/FIR.
j. Original laboratory investigation, diagnostic and pathological reports with supporting prescriptions.
k. Original X-Ray/MRI/ultrasound films and other radiological investigations.

Claims Assessment

The claim would be assessed and the payout would be made as per the Sum Insured specified in the Policy Schedule/Certificate of Insurance.

3.3. Hospital Cash Benefit:

3.3.1. Coverage Options

3.3.1.1. Daily Cash Benefit

What is covered:

If an Insured Person suffers an Illness or sustains an Injury that solely and directly leads to the Insured Person's Hospitalization during the Policy Period, then We will pay the daily cash amount specified in the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization

Conditions:

a. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Intensive Care Unit.
b. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization or Maternity Expenses or New Born Baby coverage.

3.3.1.2. ICU Cash Benefit

What is covered:

If an Insured Person is required to be admitted to the Intensive Care Unit of a Hospital solely and directly due to an injury arising from an Accident or due to an Illness, then We will pay twice the

Daily Cash specified in the Certificate of Insurance for each continuous and completed period of 24 hours of admission in the Intensive Care Unit.

Conditions:

a. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Hospital room.

b. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization or Maternity Expenses or New Born Baby coverage.

3.3.1.3. Daily Cash Benefit with Franchise

What is covered:

If an Insured Person suffers an Illness or sustains an Injury that solely and directly leads to the Insured Person's Hospitalization during the Policy Period, then We will pay the daily allowance amount specified in the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization

Conditions:

a. The Insured Person is Hospitalized for at least the minimum period specified in the Policy Schedule/Certificate of Insurance following which the Benefit amount will be payable from the first completed day of Hospitalization.

b. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Intensive Care Unit.

c. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization or Maternity Expenses or New Born Baby coverage.

3.3.1.4. ICU Cash Benefit with Franchise

What is covered:

If an Insured Person is required to be admitted to the Intensive Care Unit of a Hospital solely and directly due to an injury arising from an Accident or due to an Illness, then We will pay twice the Daily Cash specified in the Certificate of Insurance for each continuous and completed period of 24 hours of admission in the Intensive Care Unit.

Conditions:

a. The Insured Person is Hospitalized for at least the minimum period specified in the Policy Schedule/Certificate of Insurance following which the Benefit amount will be payable from the first completed day of Hospitalization.

b. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Hospital room.

c. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization or Maternity Expenses or New Born Baby coverage.

3.3.1.5. Daily Hospital Cash with Deductible

What is covered:

If an Insured Person suffers an Illness or sustains an Injury that solely and directly leads to the Insured Person's Hospitalization during the Policy Period, then We will pay the daily allowance amount specified in the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization.

Conditions:

a. The Insured Person is Hospitalized for at least the minimum period specified in the Policy Schedule/Certificate of Insurance following which the Benefit amount will be payable for completed days of Hospitalization following the completion of the Deductible.
b. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Intensive Care Unit.
c. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization or Maternity Expenses or New Born Baby coverage.

3.3.1.6. Accidental Hospital Cash Benefit

What is covered:

If an Insured Person sustains an Injury that solely and directly leads to the Insured Person's Hospitalization during the Policy Period, then We will pay the Accidental Hospital Cash amount specified in the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization.

Conditions:

a. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Intensive Care Unit.
b. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization or Maternity Expenses or New Born Baby coverage.

3.3.1.7. Accidental Hospital ICU Cash Benefit

What is covered:

If an Insured Person is required to be admitted to the Intensive Care Unit of a Hospital solely and directly due to an injury arising from an Accident, then We will pay twice the Accidental Hospital Cash specified in the Certificate of Insurance for each continuous and completed period of 24 hours of admission in the Intensive Care Unit.

Conditions:

a. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Hospital room.

b. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization or Maternity Expenses or New Born Baby coverage.

3.3.1.8. Accidental Hospital Cash Benefit with Franchise

What is covered:

If an Insured Person suffers an Injury that solely and directly leads to the Insured Person's Hospitalization during the Policy Period, then We will pay the daily Accidental Hospital Cash amount specified in the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization

Conditions:

a. The Insured Person is Hospitalized for at least the minimum period specified in the Policy Schedule/Certificate of Insurance following which the Benefit amount will be payable from the first completed day of Hospitalization.

b. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Intensive Care Unit.

c. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization or Maternity Expenses or New Born Baby coverage.

3.3.1.9. Accidental Hospital ICU Cash Benefit with Franchise

What is covered:

If an Insured Person is required to be admitted to the Intensive Care Unit of a Hospital solely and directly due to an injury arising from an Accident, then We will pay twice the Accidental Hospital Cash Benefit specified in the Certificate of Insurance for each continuous and completed period of 24 hours of admission in the Intensive Care Unit.

Conditions:

a. The Insured Person is Hospitalized for at least the minimum period specified in the Policy Schedule/Certificate of Insurance following which the Benefit amount will be payable from the first completed day of Hospitalization.

b. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Hospital room.

c. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization or Maternity Expenses or New Born Baby coverage.

3.3.1.10. Accidental Hospital Cash Benefit with Deductible

What is covered:

If an Insured Person suffers an Injury that solely and directly leads to the Insured Person's Hospitalization during the Policy Period, then We will pay the Accidental Hospital Cash amount specified in the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization.

Conditions:

a. The Insured Person is Hospitalized for at least the minimum period specified in the Policy Schedule/Certificate of Insurance following which the Benefit amount will be payable for completed days of Hospitalization following the completion of the Deductible.
b. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Intensive Care Unit.
c. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization or Maternity Expenses or New Born Baby coverage.

3.3.2. Section Specific Condition

All the Waiting Periods as specified in Policy Schedule/ Certificate of Insurance shall be applicable individually for each Insured Person and claims shall be assessed accordingly. On Renewal, if an enhanced Sum Insured is applied for, the Waiting Periods would apply afresh to the extent of the increase in Sum Insured only.

We shall not be liable to make any payment under this Policy directly or indirectly for, caused by, based on, arising out of or howsoever attributable to any of the following, except if any Insured Person suffers an Accident;

A. Waiting Periods

I. **Pre-existing Diseases (Code–Excl01):**

a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of the number of months (as mentioned in Policy Schedule/Certificate of Insurance) of continuous coverage after the date of inception of the first Policy.
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 (Insurance Insurance) regulations2024, then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under the Policy after the expiry of number of months (as mentioned in Policy Schedule/Certificate of Insurance) for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

II. **Specified disease/procedure waiting period (Code- Excl02)**

a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of number of months (as mentioned in Policy Schedule/Certificate of Insurance) of continuous coverage after the date of inception of the first Policy. This exclusion shall not be applicable for claims arising due to an Accident (covered from day 1)) or Cancer (covered after 30-day waiting period).
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 (Below mentioned diseases/procedures can be modified and in that case the list will be mentioned in Policy Schedule/Certificate of Insurance):

i. Pancreatitis and stones in biliary and urinary system.
ii. Cataract, Glaucoma and other disorders of lens and disorders of retina.
iii. Hyperplasia of prostate, hydrocele and spermatocele.
iv. Abnormal utero-vaginal bleeding, female genital prolapse, endometriosis/adenomyosis, fibroids, PCOD, or any condition requiring dilation and curettage or hysterectomy.
v. Hemorrhoids, fissure or fistula or abscess of anal and rectal region.
vi. Hernia of all sites.
vii. Osteoarthritis, Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, inflammatory Polyarthropathies, Arthrosis such as RA, Gout, Intervertebral Disc disorders.
viii. Chronic kidney disease and failure.
ix. Varicose veins of lower extremities.
x. Disease of middle ear and mastoid including Otitis Media, Cholesteatoma, Perforation of Tympanic Membrane.
xi. All internal or external benign or in situ neoplasms/tumours, cyst, sinus, polyp, nodules, swelling, mass or lump.
xii. Ulcer, erosion and varices of upper gastro intestinal tract.
xiii. Tonsils and adenoids, nasal septum and nasal sinuses.
xiv. Internal Congenital Anomaly

If these diseases are Pre-Existing Diseases at the time of the Proposal or subsequently found to be Pre-Existing Diseases, the Pre-Existing Disease Waiting Periods as mentioned in the Policy Schedule/ Certificate of Insurance shall apply in respect of that Insured Person.

III. **Initial waiting period:**

a. A Waiting Period since beginning of cover under the First Policy, specified in the Policy Schedule/ Certificate of Insurance shall apply to any Illness contracted and/or Medical Expenses incurred in respect of any Illness by the Insured Person other than Hospitalization due to Accident.
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.

B. Permanent Exclusions:

A permanent exclusion will be applied on any medical or physical condition or treatment of an Insured Person, if specifically mentioned in the Policy Schedule and has been accepted by You. This option as per company's underwriting policy, will be used for such condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person.

We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following unless specifically mentioned elsewhere in the Policy.

I. **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.

II. **Rest Cure, rehabilitation and respite care (Code-Excl05)**

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

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

III. **Obesity/ Weight Control (Code-Excl06)**

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

a. Surgery to be conducted is upon the advice of the Doctor.
b. The surgery/Procedure conducted should be supported by clinical protocols.
c. The member has to be 18 years of age or older and;
d. Body Mass Index (BMI);

(I) greater than or equal to 40 or

(II) 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

IV. **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.

V. **Excluded Providers (Code-Excl11)**

Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our 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. The complete list of excluded providers can be referred to on our website.

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

VII. 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)**

VIII. **Refractive Error (Code-Excl15)**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 diopters.

IX. **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.

X. **Circumcision**
Circumcision unless necessary for the treatment of a disease or necessitated by an Accident.

XI. **External Congenital Anomaly:**
Screening, counseling or treatment related to external Congenital Anomaly.

XII. **Dental/oral treatment:**
Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident.

XIII. **Sexually transmitted Infections & diseases (other than HIV / AIDS):**
Screening, prevention and treatment for sexually related infection or disease (other than HIV / AIDS).

XIV. **Sleep disorders:**
Treatment for any conditions related to disturbance of normal sleep patterns or behaviors.

XV. Any treatment or medical services received outside the geographical limits of India.

XVI. **Artificial life maintenance:** Artificial life maintenance, including life support machine used to sustain a person, who has been declared brain dead, as demonstrated by:

a. Deep coma and unresponsiveness to all forms of stimulation; or
b. Absent pupillary light reaction; or
c. Absent oculovestibular and corneal reflexes; or
d. Complete apnea.

XVII. **Any form of Alternate Treatment**:

a. Homeopathic, Unani, Yoga and Siddha streams of treatment;

b. Acupuncture, Reflexology, Chiropractic Treatment or any other form of indigenous system of medicine.

XVIII. **Unrecognized Physician or Hospital:**

a. Treatment or Medical Advice provided by a Medical Practitioner not recognized by the Medical Council of India or by Central Council of Indian Medicine or by Central Council of Homeopathy or by relevant authorities in the area where the treatment is taken
b. Treatment or Medical Advice related to one system of medicine provided by a Medical Practitioner of another system of medicine
c. Treatment provided by anyone with the same residence as an Insured Person or who is a member of the Insured Person's immediate family or relatives.
d. Treatment provided by Hospital or health facility that is not recognized by the relevant authorities in India or any other country where treatment takes place.

3.4. OPD Coverage

3.4.1. Coverage Options

3.4.1.1. OPD Treatment & Diagnostic Cover (Excl. Dental Expenses & Vision Expenses):

What is covered:

We will indemnify the Reasonable and Customary Charges incurred in respect of the Insured Person for OPD Treatment taken during the Policy Period, as specified to be applicable to the Insured Person in the Policy Schedule/Certificate of Insurance.

For the purpose of this Benefit, OPD Treatment will include the following provided that it is specified to be applicable for the Insured Person in the Policy Schedule/Certificate of Insurance:

a. Consultation changes
b. OPD procedures
c. Diagnostic Tests based on the written advice of a Medical Practitioner
d. Prescribed medicines followed by consultation and Diagnostic Test.

Conditions:

i. Expenses under this Benefit are covered for ayurvedic or homeopathic or unani or siddha or allopathic treatment only and We will not pay any expenses where Alternative Treatment and allopathic treatment are taken in conjugation with each other.
ii. For treatment taken under ayurveda, homeopathy, unani or sidha, expenses are covered only if taken in a government Hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health.
iii. The OPD Treatment and/or Diagnostic Tests are Medically Necessary Treatment and follow the written advice of a Medical Practitioner.
iv. Diagnostic Tests are performed on an outpatient basis with or without local anesthetics for topical, infiltration, nerve block anesthesia and require Hospitalization for less than 24 hours.

3.4.1.2. OPD Dental Expenses:

What is covered:

We will indemnify the Reasonable and Customary Charges incurred in respect of the Insured Person towards Dental Treatment taken during the Policy Period up to the limit specified in the Policy Schedule/Certificate of Insurance. We will indemnify only those expenses incurred in excess of the Co-payment specified in the Policy Schedule/Certificate of Insurance.

What is not covered:
We will not be liable to make any payment in respect of the following treatments under this Benefit:

a. Replacing any dental appliance which is lost or stolen.
b. Plastic surgery or cosmetic surgery unless necessary as a part of Medically Necessary Treatment and certified in writing by the attending Medical Practitioner.

3.4.1.3. OPD Vision Expenses excluding spectacles & lenses

What is covered:
We will indemnify the Reasonable and Customary Charges incurred in respect of the Insured Person towards any vision treatment by an Optometrist or Ophthalmologist taken during the Policy Period up to the limit specified in the Policy Schedule/Certificate of Insurance. We will indemnify only those expenses incurred in excess of the Co-payment specified in the Policy Schedule/Certificate of Insurance.

What is not covered:
We will not be liable to make any payment in respect of the following under this Benefit:

a. Cost of frames for the prescribed lenses.
b. Sunglasses, unless medically prescribed by the treating Medical Practitioner.
c. Any lenses including contact lenses.

3.4.1.4. OPD Vision Expenses including spectacles & lenses

What is covered:
We will indemnify the Reasonable and Customary Charges incurred in respect of the Insured Person towards any vision treatment by an Optometrist or Ophthalmologist taken during the Policy Period up to the limit specified in the Policy Schedule/Certificate of Insurance. We will indemnify only those expenses incurred in excess of the Co-payment specified in the Policy Schedule/Certificate of Insurance.

3.4.2. Claims Process & Requirements:

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

Claims Documentation:

a. Claim form duly completed and signed by the claimant.
b. Original Bills with detailed breakup of charges (including but not limited to pharmacy, purchase bill, consultation bill, and diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.

c. Original payment receipts
d. All reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries, OPD treatment card, consultation notes.

Claims Assessment & Repudiation:
All admissible claims under this Policy shall be assessed by Us post considering Co-Payment (if applicable) as specified in the Policy Schedule/ Certificate of Insurance shall be applicable on the amount payable by Us.

3.5. International Coverage:
The following Benefits shall be available only outside the geographical boundaries of India and only in those territories specified in the Policy Schedule/Certificate of Insurance.

3.5.1. Coverage Options:

3.5.1.1. Emergency Medical Evacuation:

What is covered:

We will indemnify the Reasonable and Customary Charges incurred for the Insured Person's Medical Evacuation in an Emergencyduring the Policy Period and for which medical facilities are not available locally, but only within the regions specified in the Policy Schedule/Certificate of Insurance.

Conditions:
a. We will provide this Benefit from the place of Insured Person's Hospitalization to a Hospital where adequate treatment is available, if necessary treatment is not available locally or Medical Evacuation is required for Medically Necessary Treatment for saving the life of the Insured Person.
b. Medical Evacuation is required for stabilizing the Insured Person and is advised in writing by the treating Medical Practitioner.
c. All claims under this Section shall be considered on a Cashless Facility basis only.
d. We or Our Service Provider has approved the request for Medical Evacuation.
e. We or Our Service Provider, will arrange for the evacuation utilizing the means (including air ambulance or commercial flight) best suited to do so, based on the medical severity of Insured Person's condition.
f. We will also cover the costs of transportation of an attending Medical Practitioner if Medically Necessary Treatment is required to be provided during the course of Medical Evacuation and advised in writing by the treating Medical Practitioner.
g. Under this Benefit, We will cover expenses for services provided and/or arranged by Us for the transportation of the Insured Person and shall include medical services and cost for medical supplies necessarily incurred as a result of the Emergency Medical Evacuation.
h. We shall not be liable to make any payment under this Benefit if necessary medical treatment can be provided at the Hospital where the Insured Person is situated at the time of the Emergency.
i. In addition, We will cover the reasonable costs of travel incurred for the return journey (economy class) of the Insured Person and such person accompanying the Insured Person after receipt of appropriate Medically Necessary Treatment.

3.5.1.2. Emergency Hospitalization:

What is covered:

If the Insured Person is required to be admitted in a Hospital immediately after the Emergency Medical Evacuation for the same diagnosis during the Policy Period, We will indemnify the Medical Expenses incurred on Hospitalization of that Insured Person until the Insured Person reaches a medically stable condition during the Policy Period.

Conditions:

a. The Hospitalization is for Medically Necessary Treatment and follows the written advice of the treating Medical Practitioner.
b. The Insured Person is required to be admitted in a Hospital in an Emergency when the Insured Person is outside India, but within one of those regions specified in the Policy Schedule/Certificate of Insurance.
c. We have accepted a claim under Section 3.5.1.1 (Emergency Medical Evacuation).
d. All claims under this Section shall be considered on a Cashless Facility basis only.
e. The Medical Expenses incurred are Reasonable and Customary Charges for one or more of the following:

i. Room Rent;
ii. Nursing charges for Hospitalization as an Inpatient;
iii. Medical Practitioners' fees, excluding any charges or fees for Standby Services;
iv. Physiotherapy, investigation and diagnostics procedures directly related to the current admission;
v. Medicines, drugs as prescribed by the treating Medical Practitioner;
vi. Intravenous fluids, blood transfusion, injection administration charges and /or consumables;
vii. Operation theatre charges;
viii. The cost of prosthetics and other devices or equipment if implanted internally during a Surgical Procedure;
ix. ICU Charges.

f. We shall not be liable to indemnify any Medical Expenses incurred in respect of Hospitalization of the Insured Person that commences or continues after the completion of the Policy Period.

3.5.1.3. Specified Illness Cover:

i. What is covered

If the Insured Person suffers a Specified Illness (as defined below) during the Policy Period, We will indemnify the Reasonable and Customary Charges in respect of Medical Expenses of the Insured Person incurred towards treatment of that Specified Illness that would otherwise have been payable under Section 3.1.1.1 (Inpatient Care).

Conditions:

a. The symptoms of the Specified Illness first occur or manifest itself during the Policy Period and after completion of 90 days from the inception of the First Policy with Us.

b. The Specified Illness is diagnosed by a Medical Practitioner within India during the Policy Period and after completion of the 90 day from the inception of the First Policy with Us.
c. Medical treatment for the Specified Illness is taken outside India within the Policy/Coverage Period but only within those regions specified in the Policy Schedule/Certificate of Insurance.
d. All claims under this Section shall be considered on a Cashless Facility basis only.

ii. What is not covered:
a. Any claims for Reimbursement of the costs incurred in relation to the treatment of the Specified Illness or any claims which are not pre-authorized by Us.
b. Any costs or expenses incurred in relation to any persons accompanying the Insured Person during any period of treatment, even if such person(s) are also Insured Person(s).
c. Any costs or expenses incurred in relation to the travel to or from the overseas location where treatment is being taken.
d. Any costs or expenses incurred in relation to personal stay or transportation in the overseas location where treatment is being taken.
e. Any Pre-Hospitalization Medical Expenses or Post-Hospitalization Medical Expenses incurred by or on behalf of the Insured Person.
f. Any costs or expenses incurred in relation to transportation of repatriation of the mortal remains of the Insured Person.
g. Any costs or expenses incurred by any organ donor in relation to harvesting of organs.
h. Any OPD Treatment taken outside India

iii. For the purposes of this Benefit, Specified Illness means the following Illnesses or procedures:

a. **Cancer of Specified Severity**

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

II. The following are excluded –
i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

ix. All tumors in the presence of HIV infection

b. **Myocardial Infarction** (First Heart Attack of specific severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

ii. New characteristic electrocardiogram changes

iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

III. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease or following an intra-arterial cardiac procedure

c. Open Chest CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:

i. Angioplasty and/or any other intra-arterial procedures

d. **Major Organ /Bone Marrow Transplant**

I. The actual undergoing of a transplant of:

i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of Langerhans are transplanted

e. **Stroke resulting in Permanent Symptoms**

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

II. The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic injury of the brain

iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

f. **Surgery of Aorta**

Surgery of aorta including graft, insertion of stents or endovascular repair.

Specific Exclusion: Surgery for correction of an underlying Congenital Anomaly

g. **Angioplasty**

I. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

II. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

III. Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

h. **Primary (Idiopathic) Pulmonary Hypertension**

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

iii. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

i. Brain Surgery

Any brain (intracranial) Surgery required to treat traumatic or non-traumatic conditions.

Specific Exclusion: Surgery for treating Neurocysticercosis

3.5.1.4. Medical Repatriation

What is covered:

Following any Emergency Medical Evacuation in respect of which we have accepted a claim under Section 3.5.1.1 above during the Policy Period, We reserve the right to request the repatriation of the Insured Person to a Hospital in the Insured Person's country of domicile or to the original work location or the location from which the Insured Person was evacuated when a Medical Practitioner named by Our Service Provider, after speaking with a local attending Medical Practitioner, decides that the Insured Person is fit to undertake the journey.

We will pay the Reasonable and Customary Charges for the most economical cost of travel (transport only) for the Insured Person and any individual who, because of medical necessity, has to accompany the Insured Person. If such transportation needs to be medically supervised, a

qualified medical attendant will escort the Insured Person. If any mode of transportation other than the above is required and it is determined by the attending Medical Practitioner and agreed by Our Service Provider, We will arrange accordingly and such will be covered by Us.

Medical repatriation must be determined by Our medical team to be medically necessary to prevent the immediate and significant effects of Illness, Injury or conditions which if left untreated could result in a significant deterioration of health and it has been determined that the treatment is not available locally, and that it is necessary for medical reasons for the Insured Person to be returned to his/her country of domicile, Our Service Provider will arrange for the transport under proper medical supervision as soon as reasonably practicable.

3.5.1.5. Repatriation of Mortal Remains

What is covered:

We will cover the costs associated with the transportation of mortal remains of the Insured Person during the Policy Period from the place of death to the home country. In addition, assistance will be provided by Us or Our Service Provider for organizing or obtaining the necessary clearances for the repatriation of mortal remains.

3.5.2. Section Specific Condition

All the Waiting Periods as specified in Policy Schedule/ Certificate of Insurance shall be applicable individually for each Insured Person and claims shall be assessed accordingly. On Renewal, if an enhanced Sum Insured is applied for, the Waiting Periods would apply afresh to the extent of the increase in Sum Insured only.

We shall not be liable to make any payment under this Policy directly or indirectly for, caused by, based on, arising out of or howsoever attributable to any of the following, except if any Insured Person suffers an Accident;

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 the number of months (as mentioned in Policy Schedule/Certificate of Insurance) of continuous coverage after the date of inception of the first Policy.

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 (Insurance Insurance) regulations2024, then waiting period for the same would be reduced to the extent of prior coverage.

d. Coverage under the Policy after the expiry of number of months (as mentioned in Policy Schedule/Certificate of Insurance) for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

2. 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 number of months (as mentioned in Policy Schedule/Certificate of Insurance) of continuous coverage after the date of inception of the first Policy. This exclusion shall not be applicable for claims arising due to an Accident (covered from day 1) or Cancer (covered after 30-day waiting period).
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 (Below mentioned diseases/procedures can be modified and in that case the list will be mentioned in Policy Schedule/Certificate of Insurance):

i. Pancreatitis and stones in biliary and urinary system.
ii. Cataract, Glaucoma and other disorders of lens and disorders of retina.
iii. Hyperplasia of prostate, hydrocele and spermatocele.
iv. Abnormal utero-vaginal bleeding, female genital prolapse, endometriosis/adenomyosis, fibroids, PCOD, or any condition requiring dilation and curettage or hysterectomy.
v. Hemorrhoids, fissure or fistula or abscess of anal and rectal region.
vi. Hernia of all sites.
vii. Osteoarthritis, Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, inflammatory Polyarthropathies, Arthrosis such as RA, Gout, Intervertebral Disc disorders.
viii. Chronic kidney disease and failure.
ix. Varicose veins of lower extremities.
x. Disease of middle ear and mastoid including Otitis Media, Cholesteatoma, Perforation of Tympanic Membrane.
xi. All internal or external benign or in situ neoplasms/tumours, cyst, sinus, polyp, nodules, swelling, mass or lump.
xii. Ulcer, erosion and varices of upper gastro intestinal tract.
xiii. Tonsils and adenoids, nasal septum and nasal sinuses.
xiv. Internal Congenital Anomaly

3. 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.

If these diseases are Pre-Existing Diseases at the time of the Proposal or subsequently found to be Pre-Existing Diseases, the Pre-Existing Disease Waiting Periods as mentioned in the Policy Schedule/ Certificate of Insurance shall apply in respect of that Insured Person.

B. Permanent Exclusions:

A permanent exclusion will be applied on any medical or physical condition or treatment of an Insured Person, if specifically mentioned in the Policy Schedule and has been accepted by You. This option as per company's underwriting policy, will be used for such condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person.

We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following unless specifically mentioned elsewhere in the Policy.

I. **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.

II. **Rest Cure, rehabilitation and respite care (Code-Excl05)**

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

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

III. **Obesity/ Weight Control (Code-Excl06)**

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

a. Surgery to be conducted is upon the advice of the Doctor.
b. The surgery/Procedure conducted should be supported by clinical protocols.
c. The member has to be 18 years of age or older and;
d. Body Mass Index (BMI);

I. greater than or equal to 40 or
II. 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

IV. **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.

V. **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.

VI. **Excluded Providers (Code-Excl11)**
Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our 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. The complete list of excluded providers can be referred to on our website.

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

VIII. 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)**

IX. **Refractive Error (Code-Excl15)**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 diopters.

X. **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.

XI. **Sterility and Infertility (Code-Excl17)**
Expenses related to sterility and infertility. This includes:
a. Any type of contraception, sterilization
b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c. Gestational Surrogacy
d. Reversal of sterilization

XII. **Maternity (Code-Excl18)**
a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

XIII. **Circumcision**
Circumcision unless necessary for the treatment of a disease or necessitated by an Accident.

XIV. **External Congenital Anomaly:**
Screening, counseling or treatment related to external Congenital Anomaly.

XV. **Dental/oral treatment:**
Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident.

XVI. Multifocal Lens and ambulatory devices such as walkers, crutches, splints, stockings of any kind and also any medical equipment which is subsequently used at home.

XVII. **Sexually transmitted Infections & diseases (other than HIV / AIDS):** Screening, prevention and treatment for sexually related infection or disease (other than HIV / AIDS).

XVIII. **Sleep disorders:**
Treatment for any conditions related to disturbance of normal sleep patterns or behaviors.

XIX. OPD Treatment
Any expenses incurred on OPD treatment

XX. **Artificial life maintenance:** Artificial life maintenance, including life support machine used to sustain a person, who has been declared brain dead, as demonstrated by:

a. Deep coma and unresponsiveness to all forms of stimulation; or
b. Absent pupillary light reaction; or
c. Absent oculovestibular and corneal reflexes; or
d. Complete apnea.

XXI. **Any form of Alternate Treatment**:

a. Homeopathic, Unani, Yoga and Siddha streams of treatment;
b. Acupuncture, Reflexology, Chiropractic Treatment or any other form of indigenous system of medicine.

XXII. **Unrecognized Physician or Hospital:**

a. Treatment or Medical Advice provided by a Medical Practitioner not recognized by the Medical Council of India or by Central Council of Indian Medicine or by Central Council of Homeopathy or by relevant authorities in the area where the treatment is taken
b. Treatment or Medical Advice related to one system of medicine provided by a Medical Practitioner of another system of medicine
c. Treatment provided by anyone with the same residence as an Insured Person or who is a member of the Insured Person's immediate family or relatives.
d. Treatment provided by Hospital or health facility that is not recognized by the relevant authorities in India or any other country where treatment takes place.

XXIII. **Off- label Drug or Treatment:**
Use of pharmaceutical drugs for an unapproved indication or in an unapproved age group, dosage, or route of administration as regulated and approved by Central Drugs Standard Control Organization (CDSCO)

XXIV. **Drugs and Dressings for OPD Treatment or Take-home Use:** Any drugs or surgical dressings that are provided or prescribed in the case of OPD Treatment, or for an Insured Person to take home on leaving Hospital, for any condition, except as included in Post-Hospitalization Medical Expenses under Section 3.1.1.3.

3.5.3. Claims Process & Requirements:

For Section 3.5.1.1 (Emergency Medical Evacuation)

a. In the event of an Emergency, Our Service Provider shall be contacted immediately on the helpline number specified in the Insured Person's health card.
b. Our Service Provider will evaluate the necessity for evacuation of the Insured Person and if the request for Medical Evacuation is approved, the Service Provider shall pre-authorize the type of travel that can

be utilized to transport the Insured Person and provide information on the Hospital that may be approached for medical treatment of the Insured Person.

c. If the Service Provider pre-authorizes the Medical Evacuation of the Insured Person by means of Air Transportation through an air ambulance or commercial flight whichever is best suited, the Service Provider shall also arrange for the same to be provided to the Insured Person unless there are any logistical constraints or the medical condition of the Insured Person prevents Emergency Medical Evacuation.

d. It is agreed and understood that We shall not cover any claims for Reimbursement of the costs incurred in the evacuation or transportation of the Insured Person or which are not pre-authorized by Our Service Provider.

For Section 3.5.1.2 (Emergency Hospitalization- outside the geographical boundaries of India)

The health card We provide will enable the Insured Person to access medical treatment at any Network Provider outside India, but within those regions specified in the Policy Schedule/Certificate of Insurance, on a cashless basis only by the production of the card to the Network Provider prior to admission, subject to the following:

i. In the event of an Emergency, the Insured Person or Network Provider shall call Our Service Provider immediately, on the helpline number specified in the Insured Person's health card, requesting for a pre-authorization for the medical treatment required.

ii. Our Service Provider will evaluate the request and the eligibility of the Insured Person under the Policy and call for more information or details, if required. Our Service Provider will communicate directly to the Hospital whether the request for pre-authorization has been approved or denied.

iii. If the pre-authorization request is approved, Our Service Provider will directly settle the claim with the Hospital. Any additional costs or expenses incurred by or on behalf of the Insured Person beyond the limits pre-authorized by the Service Provider shall be borne by the Insured Person.

iv. It is agreed and understood that We shall not cover any claims for Reimbursement of the costs incurred in relation to the Hospitalization of the Insured Person while inside or outside India or any claims which are not pre-authorized by Our Service Provider.

For Section 3.5.1.3 (Specified Illness Cover – outside the geographical boundaries of India)

a. In the event of the diagnosis of a Specified Illness, the Insured Person should call Us immediately and in any event before the commencement of the travel for treatment overseas on the helpline number specified on in the Insured Person's health card, requesting for a pre-authorization for the treatment.

b. We will evaluate the request and the eligibility of the Insured Person's Policy and call for more information or details, if required.

c. We will communicate directly to the Service Provider and the Insured Person whether the request for pre-authorization has been approved or denied.

d. If the pre-authorization request is approved, Our Service Provider will directly settle the claim with the Hospital. Any additional costs or expenses incurred by or on behalf of the Insured Person beyond the limits pre-authorized by the Service Provider or at any Non-Network Hospital shall be borne by the Insured Person.

e. This Benefit is available only as Cashless Facility through pre-authorization by Us.

For Section 3.5.1.4 (Medical Repatriation)

i. In the event of an Insured Person requiring repatriation, Our Service Provider shall be contacted immediately on the helpline number specified in the Insured Person's health card, requesting for a pre-authorization for the medical repatriation required.

ii. Our Service Provider will evaluate the necessity for repatriation of the Insured Person and if the request is approved, the Service Provider shall pre-authorize the type of travel that can be utilized to transport

the Insured Person and provide information on the Hospital that may be approached for medical treatment of the Insured Person.

For Section 3.5.1.5 (Repatriation of Mortal Remains)

i. In the event of an Insured Person requiring repatriation, Our Service Provider shall be contacted immediately on the helpline number specified in the Insured Person's health card, requesting for a pre-authorization for Repatriation of Mortal Remains.
ii. Once the request is approved by Niva Bupa, the Service Provider on behalf of Niva Bupa shall pre-authorize the type of travel that can be utilized to transport the mortal remains.

3.6. Accidental Cover

The Benefits offered under this Section shall be available to the Insured Person up to the Accidental Cover Sum Insured subject to any specific limits stated in the Policy Schedule/Certificate of Insurance as per the eligibility under the opted Benefits.

3.6.1. Coverage Options:

3.6.1.1. Accidental Death (AD)

What is covered:

If an Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period and which solely and directly results in the Insured Person's death within three hundred and sixty-five (365) days from the date of occurrence of such Accident, We will pay the Accidental Cover Sum Insured specified in the Policy Schedule/ Certificate of Insurance.

Conditions:

a. We will deduct any amounts already paid under Section 3.6.1.2 (Accidental Permanent Total Disability), 3.6.1.3(Accidental Permanent Partial Disability) and 3.6.1.4(Temporary Total Disability) from the amount payable under this Benefit.
b. We shall not be liable to make any payment under Section3.6.1.1 (Accidental Death) if We have already paid or accepted any claims under Section 3.6.1.2 (Accidental Permanent Total Disability) or 3.6.1.3(Accidental Permanent Partial Disability) or 3.6.1.4(Temporary Total Disability) in respect of that Insured Person and the total amount paid or payable under those claims is cumulatively greater than or equal to the Sum Insured.

3.6.1.2. Accidental Permanent Total Disability (PTD)

What is covered:

If an Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period and which solely and directly results in the Insured Person's Permanent Total Disability of the nature specified in the grid below, within three hundred and sixty-five (365) days from the date of occurrence of such Accident, We will make payment in accordance with the grid below.

Conditions:

a. The Permanent Total Disability is proved with a disability certificate issued by a Medical Board duly constituted by the Central or the State Government being presented to Us;
b. We will admit a claim under Section 3.6.1.2 only if the Permanent Total Disability continues for a continuous period of at least six (6) calendar months from the commencement of the disability and such disability is permanent at the end of this period;
c. If the Insured Person dies before a claim has been admitted under Section 3.6.1.2, We shall not be liable to make any payment under Section 3.6.1.2;
d. We shall not be liable to make payment under Section3.6.1.2 in respect of an Insured Person for any and all Policy Periods more than once in the Insured Person's lifetime;
e. We will deduct any amounts already paid under Section 3.6.1.3(Accidental Permanent Partial Disability) or 3.6.1.4(Temporary Total Disability) from the amount payable under this Benefit.
f. We shall not be liable to make any payment under Section 3.6.1.2 if We have already paid or accepted any claims under Section 3.6.1.3 or 3.6.1.4 in respect of that Insured Person and the total amount paid or payable under those claims is cumulatively greater than or equal to the Sum Insured.

Nature of Permanent Total Disability	% of the Accidental Cover Sum Insured Payable
Actual loss by physical separation or total and permanent loss of use of both hands	100%
Actual loss by physical separation or total and permanent loss of use of both feet	100%
Loss of sight in both eyes	100%
Actual loss by physical separation or total and permanent loss of use of one hand and one foot	100%
Actual loss by physical separation or total and permanent loss of use of one hand and sight in one eye	100%
Actual loss by physical separation or total and permanent loss of use of one foot and sight in one eye	100%
Loss of speech and loss of hearing in both ears	100%
Permanent and incurable paralysis of all limbs	100%
Permanent total loss of mastication	100%
The Insured Person suffers Injuries which do not fall within any of the categories specified above but are such that the Insured Person is unlikely to ever be able to physically engage in any occupation or employment or business for remuneration or profit.	100%

3.6.1.3. Accidental Permanent Partial Disability(PPD)

What is covered:

If an Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period and which solely and directly results in the Insured Person's Permanent Partial Disability which is of the nature specified in the grid below, within three hundred and sixty-five (365) days from the date of occurrence of such Accident, We will make payment in accordance with the grid below.

Conditions:

a. The Permanent Partial Disability is proved with a disability certificate issued by a Medical Board duly constituted by the Central or the State Government being presented to Us;
b. We will admit a claim under Section 3.6.1.3 only if the Permanent Partial Disability continues for a period of at least six (6) continuous calendar months from the date of commencement of the disability and such disability is continuous and permanent at the end of this period;
c. If the Insured Person dies before a claim has been admitted under Section 3.6.1.3, We shall not be liable to make any payment under Section 3.6.1.3;
d. If We have admitted a claim under Section 3.6.1.2, then We shall not admit any claim under Section 3.6.1.3 in respect of the Insured Person;
e. We will deduct any amounts already paid under Section 3.6.1.3 (Accidental Permanent Partial Disability) and 3.6.1.4 (Accidental Temporary Total Disability) from the amount payable under this Benefit.
f. We shall not be liable to make any payment under Section 3.6.1.3(Accidental Permanent Partial Disability) if We have already paid or accepted any claims under Section 3.6.1.1 (Accidental Death) or 3.6.1.2 (Accidental Permanent Total Disability) or 3.6.1.4(Accidental Temporary Total Disability) in respect of that Insured Person and the total amount paid or payable under those claims is cumulatively greater than or equal to the Sum Insured.

Nature of Permanent Partial Disability	% of Accidental Cover Sum Insured payable
Total and irreversible loss of hearing in both ears	50%
Total and irreversible loss of speech	50%
Actual loss by physical separation or total and permanent loss of use of one hand	50%
Actual loss by physical separation or total and permanent loss of use of one foot	50%
Total and irreversible loss of sight in one eye	50%
Actual loss by physical separation or total and permanent loss of use of four fingers and thumb of one hand	40%
Actual loss by physical separation or total and permanent loss of use of four fingers	30%
Total and irreversible loss of hearing in one ear	30%
Actual loss by physical separation or total and permanent loss of use of thumb and index finger of the same hand	25%
Actual loss by physical separation of all toes	20%
Actual loss by physical separation or total and permanent loss of use of thumb	15%
Actual loss by physical separation or total and permanent loss of use of index finger	10%
Non union of fractured leg or kneecap	10%
Shortening of leg by at least 5 cm	7.5%
Actual loss by physical separation or total and permanent loss of use of middle finger	6%
Actual loss by physical separation or total and permanent loss of use of ring finger	5%
Actual loss by physical separation or total and permanent loss of use of little finger	4%
Actual loss by physical separation of great toe (both phalanges)	5%
Actual loss by physical separation of great toe (one phalanx)	2%

Actual loss by physical separation of any toes other than the great toe, provided that more than one toe is lost	1% each
Loss of metacarpals - first or second (additional) or third, fourth or fifth (additional)	3%

3.6.1.4. Temporary Total Disability (TTD)

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period and which solely and directly results in the Insured Person's Temporary Total Disability, We will pay the lower of the Insured Person's weekly earning per week and weekly limit opted for each week that the Temporary Total Disability continues, or the amount as specified in the Policy Schedule/Certificate of Insurance.

Conditions:

a. For the purpose of Section 3.6.1.4, "weekly earning" shall not include any overtime, bonuses, tips, commissions, allowances or special compensations or any components of variable pay that the Insured Person may have otherwise been eligible to receive.
b. We will make payment under Section3.6.1.4 for only a part of the week if the Insured Person has suffered Temporary Total Disability for that part of the week.
c. We shall not be liable to make any payment under Section 3.6.1.4 in respect of more than 100 continuous weeks, subject always to the Accidental Cover Sum Insured.
d. The amount payable under Section 3.6.1.4 is calculated on a per day basis and shall be payable after 3 continuous days of temporary disability.
e. We will make payment of the amount due under Section3.6.1.4on a weekly basis unless the Temporary Total Disability continues for a continuous period of more than 30 days in which case We will make payment of the amount due under Section 3.6.1.4 at the end of every calendar month until the Temporary Total Disability ceases.
f. We will deduct any amounts already paid under Section 3.6.1.3 (Accidental Permanent Partial Disability) and 3.6.1.4 (Accidental Temporary Total Disability) from the amount payable under this Benefit.

3.6.1.5. Air Accident Death

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident occurring whilst travelling by air as a fare paying passenger on an aircraft registered to an airline company for the transport of paying passengers on regular and published scheduled routes, during the Policy Period which solely and directly results in the Insured Person's death within three hundred and sixty five (365) days from the date of occurrence of such Accident, We will make a onetime payment of the amount specified in thePolicy Schedule/Certificate of Insurance.

Conditions:

We will deduct any amounts already paid under Section 3.6.1.2 (Accidental Permanent Total Disability), 3.6.1.3 (Accidental Permanent Partial Disability) and 3.6.1.4 (Accidental Temporary Total Disability) from the amount payable under this Benefit.

3.6.1.6. Accidental Medical Reimbursement

Option A

i. What is covered:

If the Insured Person is Hospitalized solely and directly due to an Injury sustained during the Policy Period, We will indemnify the Medical Expenses incurred on Hospitalization during the Policy Period as a result of the Injury.

ii. Conditions:

a. We shall not be liable to make any payment under this Benefit unless a claim has been admitted under Section 3.6.1.1 (Accidental Death) or Section 3.6.1.2 (Accidental Permanent Total Disability) or Section 3.6.1.3 (Accidental Permanent Partial Disability) or 3.6.1.4 (Accidental Temporary Total Disability)

Option B-

i. If the Insured Person is Hospitalized solely and directly due to an Injury sustained during the Policy Period, We will indemnify the following:

a. The Medical Expenses incurred on Hospitalization during the Policy Period as a result of the Injury;
b. The Medical Expenses incurred on OPD Treatment during the Policy Period as a result of the Injury.

ii. Conditions:

a. We shall not be liable to make any payment under this Benefit unless a claim has been admitted under Section 3.6.1.1 (Accidental Death) or Section 3.6.1.2 (Accidental Permanent Total Disability) or Section 3.6.1.3 (Accidental Permanent Partial Disability) or 3.6.1.4 (Accidental Temporary Total Disability)
b. Our maximum, total and cumulative liability to indemnify Medical Expenses incurred on OPD Treatment under this Benefit shall be limited to 20% of the Sum Insured for this Benefit.

Option C-

i. What is covered:

If the Insured Person is Hospitalized solely and directly due to an Injury sustained during the Policy Period, We will indemnify the following:

a. The Medical Expenses incurred on Hospitalization during the Policy Period as a result of the Injury;
b. The Medical Expenses incurred on OPD Treatment during the Policy Period as a result of the Injury.

ii. Conditions:

a. Our maximum, total and cumulative liability to indemnify Medical Expenses incurred on OPD Treatment under this Benefit shall be limited to 20% of the Sum Insured for this Benefit.

3.6.1.7. Education Allowance for Children

What is covered:

In the event of the Insured Person's Accidental death or Permanent Total Disability during the Policy Period, We will make a onetime payment of the amount specified in the Policy Schedule/Certificate of Insurance for the education of the Insured Person's Dependent Children.

Conditions:
This Benefit shall be payable only if We have accepted a claim under Section 3.6.1.1 (Accidental Death) or 3.6.1.2 (Accidental Permanent Total Disability (PTD)).

3.6.1.8. Residential or Vehicle Modification Allowance

What is covered:

In the event of the Insured Person's Permanent Total Disability, We will reimburse, the expenses incurred up to the amount specified in the Policy Schedule/ Certificate of Insurance towards the modification of residential accommodation and the vehicle of the Insured Person to adapt to the altered lifestyle of the Insured Person necessitated by the Permanent Total Disability condition.

Conditions:
This Benefit shall be payable only if We have accepted a claim under Section 3.6.1.2 (Accidental Permanent Total Disability (PTD)).

3.6.1.9. Family Transportation Allowance

What is covered:

If an Insured Person suffers an Injury due to an Accident which occurs during the Policy Period that solely and directly results in the Insured Person's Accidental Death or Permanent Total Disability We will indemnify the expenses incurred in respect of travel of one Immediate Family member of the Insured Person to the place where the Insured Person is located.

Conditions:

a. No adult member of the Insured Person's Immediate Family is present within a distance of at least 150 kilometers from the place the Insured Person is located.
b. Our panel confirms that a companion is required.
c. Expenses can be claimed under this Section on a Reimbursement basis only.
d. We will reimburse two-way airfare in a licensed common carrier or two-way railway tickets for the travel of the companion to the place of Hospitalization of the Insured Person.
e. We have accepted a claim under Section 3.6.1.1 (Accidental Death) or 3.6.1.2 (Accidental Permanent Total Disability (PTD).

For the purpose of this Benefit Immediate Family means any one of the relationships with the Insured Person: spouse, father, mother, father-in-law, mother-in-law, brother, sister-in-law, sister, brother-in-law, son or daughter.

3.6.1.10. Last rites Expenses

What is covered:

In the event of the Accidental death of the Insured Person during the Policy Period, We will make a onetime payment to the Nominee/legal heir of the Insured Person of amount specified in the Policy Schedule/Certificate of Insurance towards the funeral expenses of that Insured Person.

Conditions:
This Benefit shall be payable only if We have accepted a claim under Section 3.6.1.1 (Accidental Death).

3.6.1.11. Broken Bones

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident which solely and directly results in a fracture of the Insured Person's bones within thirty (30) days from the date of occurrence of such Accident, We will make payment in accordance with the grid below.

Conditions:

a. We shall not be liable to make any payment under Section 3.6.1.11 unless the fracture is medically recognized and a physician has certified in writing the extent and nature of the fracture.
b. If an Injury results in more than one fracture specified in the grid below, We will be liable to pay the amount payable for each such fracture, subject to availability of the Broken Bones Sum Insured specified in the Policy Schedule/Certificate of Insurance.

Nature of Fracture	**% of Broken Bones Sum Insured payable**	
	If treated with surgery under anesthesia	**It treated without surgery**
Fracture of skull, vertebral column (excluding coccyx)	100%	50%
Fracture of pelvis, thigh or knee cap	50%	25%
Fracture of lower leg (excluding small bones of hand and foot, fingers and toes), ankle, arm or forearm, elbow, facial bones	30%	15%
Fractures of rib or ribs, nose, collar bone, lower jaw, shoulder bone, small bones of hand and foot (excluding fingers and toes)	10%	5%
Fractures of fingers or toes, coccyx	6%	3%

3.6.1.12. Child Wedding

What is covered:
In the event of the Insured Person's Accidental Death or Accidental Permanent Total Disability during the Policy Period, We will make a onetime payment of the amount specified in the Policy

Schedule/Certificate of Insurance for the wedding expenses of the Insured Person's Dependent Children.

Conditions:
This Benefit shall be payable only if We have accepted a claim under Section 3.6.1.1 (Accidental Death) or 3.6.1.2 (Accidental Permanent Total Disability (PTD)).

3.6.1.13. Burns

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident which solely and directly results in second or third degree burns, We will make payment in accordance with the grid below.

Conditions:

a. If the Injury results in more than one of the descriptions in the grid below, then We shall be liable to make payment in respect of the largest description only.
b. If an Insured Person dies or is permanently disabled as the result of the Injury, then any amount claimed and paid to an Insured Person under this Section will be deducted from any payment made under Section 3.6.1.1 (Accidental Death) or Section 3.6.1.2 (Accidental Permanent Total Disability (PTD)).

Table of Benefits:

	Description	**% of Burns Sum Insured payable**
Head	a) Third degree burns of 8% or more of the total head surface area	100%
	b) Second degree burns of 8% or more of the total head surface area	50%
	c) Third degree burns of 5% or more, but less than 8% of the total head surface area	80%
	d) Second degree burns of 5% or more, but less than 8% of the total head surface area	40%
	e) Third degree burns of 2% or more, but less than 5% of the total head surface area	60%
	f) Second degree burns of 2% or more, but less than 5% of the total head surface area	30%
Rest of Body	a) Third degree burns of 20% or more of the total body surface area	100%
	b) Second degree burns of 20% or more of the total body surface area	50%
	c) Third degree burns of 15% or more, but less than 20% of the total body surface area	80%

	d) Second degree burns of 15% or more, but less than 20% of the total body surface area	40%
	e) Third degree burns of 10% or more, but less than 15% of the total body surface area	60%
	f) Second degree burns of 10% or more, but less than 15% of the total body surface area	30%
	g) Third degree burns of 5% or more, but less than 10% of the total body surface area	20%
	h) Second degree burns of 5% or more, but less than 10% of the total body surface area	10%

3.6.1.14. Medical Insurance Premium Indemnity

What is covered:

In the event of the Insured Person's Accidental Death during the Policy Period, We willpay in lump sum the cost of the medical insurance premiums for the Insured Person's surviving spouse and Dependent Children up to the amount stated in the Policy Schedule/Certificate of Insurance per year for up to the number of years stated in the Policy Schedule/ Certificate of Insurance.

Conditions:

This Benefit shall be payable only if We have accepted a claim under Section 3.6.1.1 (Accidental Death).

3.6.1.15. Physiotherapy charges following Accidental Injury

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident during the Policy Period, We will pay the Reasonable and Customary Charges up to limit as specified in the Policy Schedule/ Certificate of Insurance incurred on physiotherapy for the Insured Person's Injury

Conditions:

a. This Benefit shall be payable only if We have accepted a claim under Section 3.6.1.2 (Accidental Permanent Total Disability (PTD)), 3.6.1.3 (Permanent Partial Disablement (PPD)) or 3.6.1.4 (Total Temporary Disablement (TTD)) in respect of the same Injury.
b. The physiotherapy is Medically Necessary Treatment.

3.6.1.16. Chauffeur Benefit

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident during the Policy Period, We will indemnify the expenses incurred up to the limit specified in the Policy Schedule/Certificate of Insurance as a monthly allowance for the hire of a taxi or chauffeur driven

car or other necessarily incurred extra costs to maintain the Insured Person's mobility to meet his/her business commitments.

Conditions:

a. This Benefit shall be payable only if We have accepted a claim under Section 3.6.1.2 (Accidental Permanent Total Disability (PTD)), 3.6.1.3 (Permanent Partial Disablement (PPD)) or 3.6.1.4 (Total Temporary Disablement (TTD)) in respect of the same Injury.
b. We shall not be liable to make any payment under this Benefit in excess of the period specified in the Policy Schedule/Certificate of Insurance.

3.6.1.17. Reconstructive Surgery

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period and which requires Reconstructive Surgery within six (6) months of the date of the Accident, then We will pay the actual costs of such Reconstructive Surgery up to the limit specified in the Policy Schedule/ Certificate of Insurance.

Conditions:

- For the purpose of this Benefit the Reconstructive Surgery means surgery to reconstruct cutaneous or underlying tissue, prescribed as necessary by a Medical Practitioner.

- The Benefit under this option shall be payable only if the Claim under Section 3.6.1.2 (Accidental Permanent Total Disability (PTD)) or 3.6.1.3 (Permanent Partial Disablement (PPD)) is admitted by Us.

What is not covered:

We shall not be liable to make any payment in respect of any Insured Person for:

- any Reconstructive Surgery not performed by a fully registered and licensed cosmetic surgeon.
- Any Reconstructive Surgery an Insured Person elects to have.

3.6.1.18. Air Ambulance for Accidental Injuries

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period. We will, on a Reimbursement basis, pay the Reasonable and Customary Charges incurred towards transportation of the Insured Person to the nearest Hospital by an air ambulance or to move the Insured Person to and from healthcare facilities during an Emergency within India only up to the limit specified in the Policy Schedule/Certificate of Insurance.

Conditions:

i. We have accepted any claims under Sections 3.6.1.1 (Accidental Death) or 3.6.1.2 (Accidental Permanent Total Disability) in respect of that Insured Person.

ii. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is injured to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital with advanced facilities as advised by the treating Medical Practitioner for management of the current Hospitalization.
iii. This Benefit is available for one transfer per Accident.
iv. The ambulance service is offered by a healthcare or ambulance Service Provider
v. The transportation should be provided by medically equipped aircraft which can provide medical care in flight and should have medical equipment's vital to monitoring and treating the Insured Person suffering from an Illness/Injury such as but not limited to ventilators, ECG's, monitoring units, CPR equipment and stretchers.

3.6.1.19. Comatose Benefit

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident which directly and independently of all other causes results in the Insured Person being in a Hospital in a Comatose State, within thirty (30) days of the Accident, then We will pay the amount specified in the Policy Schedule/ Certificate of Insurance.

Conditions:

1) The Insured Person must be in the Hospital Intensive Care Unit for the duration of the Comatose State for any benefits to be payable.
2) The comatose state must continue for three (3) months or more for this Benefit to be payable.
3) Our liability to make payment will be in excess of three (3) months. In case of successive Comatose State with less than ten (10) days between each one for a same cause, the Deductible will only apply once, as the Comatose State will be deemed as one.
4) The maximum payout of this Benefit will be up to 52 weeks from the Accident.

For the purpose of this Benefit, Comatose State means a state of profound unconsciousness, characterized by the absence of spontaneous eye openings, response to painful stimuli, and vocalization.

3.6.1.20. Common Accident

What is covered:

If the Insured Person and his or her spouse sustain Injury in the same Accident during the Policy Period which, directly and independently of all other causes, results in the death of both (the Insured Person and the spouse) within three sixty-five (365) days of the date of the Accident, then We will pay two (2) times the Accidental Death Sum Insured applicable to the Insured Person.

Conditions:

1. The Benefit under this option shall be payable only if a claim under Section 3.6.1.1 (Accidental Death) is admitted by Us.

3.6.1.21. Outstanding Loan Cover

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident during the Policy Period which solely and directly results in Death or Permanent Total Disability within three sixty-five (365) days of the date of the Accident, We will pay the principle outstanding amount of the Insured Person's loan as on the date of the Accident up to the limit specified in the Policy Schedule/ Certificate of Insurance.

Conditions-

i. For the purpose of this Benefit the maximum amount payable under this benefit shall be the loan amount at the time of the inception of cover of the Insured Person under the Policy.
ii. In case the Sum Insured under this Benefit is lower that the loan amount at the time of the inception of the Policy, We shall be liable to pay only a pro-rated proportion of the total loan amount in the proportion of the difference between the actual Sum Insured and the required Sum Insured as per Clause 'i' above to the actual Sum Insured.
iii. We shall pay only the principal amount that should have been outstanding on the date of claim had the Insured Person/s been paying all EMIs in due time as per loan schedule. Any interest, penalty, any additional charges levied by the Financer or Lender or any past defaults by the Insured Person in payment of EMI including the principal amount leading to accumulation of the principal and/or the interest are specifically excluded.
iv. In case an amortization schedule is attached with the Policy, the outstanding principal amount shall be calculated as per the amortization schedule attached with the Policy Schedule/ Certificate of Insurance.

3.6.2. Section specific Exclusions:

We shall not be liable to make any payment under this Benefit directly or indirectly for, caused by, based on, arising out of or howsoever attributable to any of the following unless specifically mentioned elsewhere in the Policy or in Policy Schedule/Certificate of Insurance.

i. Death or any disablement resulting from, caused by, contributed to or aggravated or prolonged by child birth or from pregnancy.
ii. Participation in aviation other than as a fare-paying passenger in an aircraft that is authorized by the relevant regulations to carry such passengers between established aerodromes.
iii. Any disability arising out of Pre-Existing Disease if not accepted and endorsed by Us on the Policy Schedule/Certificate of Insurance.
iv. Body or mental infirmity or any disease except where such condition arises directly due to an Accident occurring during the Policy Period.
v. Death or disability due to mental disorders or disturbances of consciousness, strokes, fits or convulsions which affect the entire body and pathological disturbances caused by the mental reaction to the same.

3.6.3. Claims Process and Requirements:

On the occurrence or the 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.

Claims Procedure:

a. Written notice of any occurrence which may give rise to a claim under this Policy must be given to Us as soon as practicable and in any case within thirty (30) Days after such occurrence. Written notice of claim must be given to Us immediately in the case of death, or within thirty (30) Days after the Date of Loss in all other cases.

b. All certificates, information and evidence required by Us shall be furnished at no expense to Us and shall be in such form and of such nature as We may prescribe. When required by Us, at its own expense, You/Insured Person shall submit to medical examination in respect of any alleged claim that may give rise to a Benefit being paid.

Claims Documentation:

Complete, written proof of loss must be given to Us at the earliest possible time

a. **Accidental Death**

i. Duly filled and signed claim form and Age / identity proof documents
ii. Copy of Death Certificate (issued by the office of Registrar of Births and Deaths or any other authorized legal institution)
iii. Copy of First Information Report (FIR) /Panchnama, if applicable
iv. Copy of Medico Legal Certificate duly attested by the concerned Hospital, if applicable.
v. Copy of Hospital record, if applicable
vi. Copy of post mortem report wherever applicable

b. **Accident Permanent Total Disability**

i. Duly filled and signed claim form and Age / identity proof documents
ii. Hospital discharge summary (in original) / self-attested copies if the originals are submitted with another insurer.
iii. Final Hospital bill (in original) / self-attested copies if the originals are submitted with another insurer.
iv. Medical consultations and investigations done from outside the Hospital.
v. Certificate of Disability issued by a Medical Board duly constituted by the Central and/or the State Government.
vi. Copy of First Information Report (FIR) / Panchnama if applicable
vii. Copy of Medico Legal Certificate duly attested by the concerned Hospital, if applicable.

c. **Accident Permanent Partial Disability**

i. Duly filled and signed claim form and Age / identity proof documents
ii. Hospital discharge summary (in original) / self-attested copies if the originals are submitted with another insurer.
iii. Final Hospital bill (in original) / self-attested copies if the originals are submitted with another insurer.
iv. Medical consultations and investigations done from outside the Hospital.
v. Certificate of Disability issued by a Medical Board duly constituted by the Central and/or the State Government.
vi. Copy of First Information Report (FIR) /Panchnama if applicable
vii. Copy of Medico Legal Certificate duly attested by the concerned Hospital, if applicable.

d. **Accidental Temporary Total Disability**

i. Duly filled and signed claim form
ii. Hospital discharge summary (in original) / self-attested copies if the originals are submitted with another insurer.
iii. Copy of First Information Report (FIR) /Panchnama / Inquest report duly attested by the concerned police station
iv. Copy of Medico Legal Certificate duly attested by the concerned hospital.
v. Attendance record of employer / Certificate of employer confirming period of absence
vi. Latest salary certificate with grade and designation
vii. Newspaper cuttings / news articles covering the Accident (if available)

e. **Accidental Medical Expenses**

1. In addition to the documents required for the Accidental Death, Accidental Permanent Total Disability, Accidental Permanent Partial Disability or Temporary Total Disability Benefits
2. Final Hospital bill with receipt /copies attested by other insurer if the originals are submitted with them.
3. Original bills with supporting prescriptions and reports for investigations done outside the Hospital/ copies attested by other insurer if the originals are submitted with them.
4. Original bills with supporting prescriptions for medicines purchased from outside the Hospital / copies attested by other insurer if the originals are submitted with them.

f. **Residential Accommodation and Vehicle Modification Allowance**

1. Duly filled and signed claim form
2. Documents required for Accidental Permanent Total Disability (if not already submitted)
3. Bills for residential accommodation or vehicle modification.
4. Narration from architect / civil engineer / affidavit from the customer detailing the modifications done to the house.
5. Narration from vehicle workshop detailing the modifications done

g. **Family Transportation**

i. Duly filled and signed claim form
ii. Documents required for Accidental Death or Accidental Permanent Total Disability Benefits (if not already submitted)
iii. Copy of ticket and invoice
iv. Copy of boarding pass (if journey performed by air)

h. **Last Rites**

i. Duly filled and signed claim form
ii. Documents required for Accidental Death Benefits (if not already submitted)

i. **Broken bones cover**

1. Duly filled and signed claim form
2. Hospital discharge summary (in original) / self-attested copies if the originals are submitted with another insurer / consultation notes (if hospitalization has not occurred)
3. X-Ray and MRI films along with reports
4. Copy of First Information Report (FIR) /Panchnama / Inquest report duly attested by the concerned police station

5. Copy of Medico Legal Certificate (MLC) duly attested by the concerned hospital.
6. Narration of events of Accident if no FIR / MLC available
7. Newspaper cuttings / news articles covering the Accident (if available)

j. **Education Allowance for Children/ Child Wedding:**

i. Duly filled and signed claim form
ii. Documents required for Accidental Death or Accidental Permanent Total Disability Benefits (if not already submitted)
iii. Letter from employer or group administrator confirming the number of children of Insured Person.

Claims Assessment & Repudiation:

All admissible claims under this Section shall be assessed by Us in the following progressive order:-
The claim amount assessed as mentioned above would be deducted from the amount mentioned against each Benefit and Sum Insured as specified in the Policy Schedule/Certificate of Insurance.

3.7. Critical illness Cover:

What is covered:

We will pay the amount specified in the Policy Schedule/Certificate of Insurance if the Insured Person is diagnosed with Critical Illness which is part of the selected option (as mentioned in Policy Schedule/Certificate of Insurance) during the Policy/Coverage Period or the Critical Illness first manifests itself in the Insured Person during the Policy Period.

Conditions:

a. We shall not be liable to make any payment under this Benefit if the Insured Person does not survive the Survival Period specified in the Policy Schedule/Certificate of Insurance.
b. We will not make payment under this Policy in respect of an Insured Person and for any and all Policy Period more than once in the Insured Person's lifetime. In any Policy Period a claim can be triggered for one life only except in co-applicant's/ spouse option wherein the claim can be triggered for both the lives in the same Policy Period.
c. The diagnosis of a Critical illness must be verified by a Medical Practitioner.
d. The list of applicable Critical Illnesses for the Insured Person is provided in the Policy Schedule/ Certificate of Insurance.

3.7.1. For the purpose of Section 3.7, 'Critical Illness' means the following Illnesses:

1. **Cancer of Specified Severity**

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

II. The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive,

including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or be low and with mitotic count of less than or equal to 5/50 HPFs;

ix. All tumors in the presence of HIV infection.

2. **Myocardial Infarction -** (First Heart Attack of specific severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

ii. New characteristic electrocardiogram changes

iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. **Open Chest CABG**

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded: Angioplasty and/or any other intra-arterial procedures

4. **Open Heart Replacement or Repair of Heart Valves**

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s).

I. The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist Medical Practitioner.

II. This excludes:

Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

5. **Coma of Specified Severity**

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

i. no response to external stimuli continuously for at least 96 hours;

ii. life support measures are necessary to sustain life; and

iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

6. **Kidney Failure requiring Regular Dialysis**

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist Medical Practitioner

7. **Stroke resulting in Permanent Symptoms**

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

II. The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic injury of the brain

iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. **Major Organ /Bone Marrow Transplant**

I. The actual undergoing of a transplant of:

i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of Langerhans are transplanted

9. **Permanent Paralysis of Limbs**

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

10. **Motor Neuron Disease with Permanent Symptoms**

Motor neuron disease diagnosed by a specialist Medical Practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be

progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. **Multiple Sclerosis with Persisting Symptoms**

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

12. **Benign Brain Tumor**

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.
II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.
   i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
   ii. Undergone surgical resection or radiation therapy to treat the brain tumor.
III. The following conditions are excluded:
   Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

13. **Blindness**

I. Total, permanent and irreversible loss of all vision in both eyes as a result of Illness or Accident.
II. The Blindness is evidenced by:
   i. corrected visual acuity being 3/60 or less in both eyes or;
   ii. the field of vision being less than 10 degrees in both eyes.
III. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure

14. **Deafness**

I. Total and irreversible loss of hearing in both ears as a result of Illness or Accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means “the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing” in both ears**.**

15. **End Stage Lung Failure**

I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
   i. FEV1 test results consistently less than 1 liter measured on 3 occasions 3 months apart; and
   ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and

iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
iv. Dyspnea at rest.

16. **End Stage Liver Failure**

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
i. Permanent jaundice; and
ii. Ascites; and
iii. Hepatic encephalopathy.
II. Liver failure secondary to drug or alcohol abuse is excluded.

17. **Loss of Speech**

I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.
II. All psychiatric related causes are excluded

18. **Loss of Limbs**

I. The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

19. **Major Head Trauma**

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The Accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.
II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.
III. The Activities of Daily Living are:
i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
iv. Mobility: the ability to move indoors from room to room on level surfaces;
v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
vi. Feeding: the ability to feed oneself once food has been prepared and made available.
IV. The following are excluded:
i. Spinal cord injury;

20. **Primary (Idiopathic) Pulmonary Hypertension**

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

21. **Third Degree Burns**

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

22. **Fulminant Viral Hepatitis**

I. A sub-massive to massive necrosis of the liver by any virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:

i. rapid decreasing of liver size as confirmed by abdominal ultrasound; and

ii. necrosis involving entire lobules, leaving only a collapsed reticular framework (histological evidence is required); and

iii. rapid deterioration of liver function tests; and

iv. deepening jaundice; and

v. hepatic encephalopathy.

II. This excludes:

i. Hepatitis infection or carrier status alone does not meet the diagnostic criteria.

ii. Fulminant Viral Hepatitis caused by alcohol, toxic substance or drug.

23. **Aplastic Anaemia**

I. Aplastic Anaemia is chronic persistent bone marrow failure. A certified haematologist must make the diagnosis of severe irreversible aplastic anaemia. There must be permanent bone marrow failure resulting in bone marrow cellularity of less than 25% and there must be two of the following:

i. Absolute neutrophil count of less than 500/mm^3

ii. Platelets count less than 20,000/mm^3

iii. Reticulocyte count of less than 20,000/mm^3

The Insured Person must be receiving treatment for more than 3 consecutive months with frequent blood product transfusions, bone marrow stimulating agents, or immunosuppressive agents or the Insured Person has received a bone marrow or cord blood stem cell transplant. Temporary or reversible Aplastic Anaemia is excluded and not covered under this Policy

24. **Muscular Dystrophy**

I. A group of hereditary degenerative diseases of muscle characterised by weakness and atrophy of muscle based on three (3) out of four (4) of the following conditions:

1. Family history of other affected individuals;
2. Clinical presentation including absence of sensory disturbance, normal cerebro-spinal fluid and mild tendon reflex reduction;
3. Characteristic electromyogram; or
4. Clinical suspicion confirmed by muscle biopsy.

II. The diagnosis of muscular dystrophy must be unequivocal and made by a consultant neurologist.

III. The condition must result in the inability of the Life Insured to perform (whether aided or unaided) at least 3 of the following 6 "Activities of Daily Living" for a continuous period of at least 6 months.

Activities of Daily Living are defined as:

a. Washing: the ability to maintain an adequate level of cleanliness and personal hygiene
b. Dressing: the ability to put on and take off all necessary garments, artificial limbs or other surgical appliances that are Medically Necessary
c. Feeding: the ability to transfer food from a plate or bowl to the mouth once food has been prepared and made available
d. Toileting: the ability to manage bowel and bladder function, maintaining an adequate and socially acceptable level of hygiene
e. Mobility: the ability to move indoors from room to room on level surfaces at the normal place of residence
f. Transferring: the ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa

25. **Bacterial Meningitis**

Bacterial infection resulting in inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit.

I. The neurological deficit must persist for at least 3 months.
II. This diagnosis must be confirmed by:
III. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
IV. A consultant neurologist.
V. This excludes:
Bacterial Meningitis in the presence of HIV infection is excluded.

26. **Abdominal Aortic Aneurysm**

The actual undergoing of surgery for abdominal aortic aneurysm, needing excision and surgical replacement of the diseased part of the aorta with a graft.

i. The term "aorta" means the thoracic and abdominal aorta but not its branches.
ii. A cardiologist must confirm the diagnosis and realization of surgery
iii. Surgery performed using only minimally invasive or intra-arterial techniques are excluded.

27. **Pneumonectomy**

The undergoing of surgery on the advice of a consultant medical specialist to remove an entire lung due to any physical injury or disease.

I. The following conditions are excluded:
   i. Removal of a lobe of the lungs (lobectomy)
   ii. Lung resection or incision

28. **Apallic Syndrome**

Universal necrosis of the brain cortex with the brainstem remaining intact.

I. The Diagnosis must be definitely confirmed by a Registered Medical Practitioner, who is also a Neurologist holding such an appointment at an approved hospital.
II. This condition must be documented for at least 30 days with no hope of recovery.

29. **Aortic Dissection**

The actual undergoing of surgery for aortic dissection, needing excision and surgical replacement of the diseased part of the aorta with a graft.

I. The term "aorta" means the thoracic and abdominal aorta but not its branches.
II. A cardiologist must confirm the diagnosis and realization of surgery.
III. This excludes:
   i. Surgery performed using only minimally invasive or intra-arterial techniques are excluded

30. **Severe Rheumatoid Arthritis**

The unequivocal diagnosis of Severe Rheumatoid Arthritis with all of the following factors:

I. Is in accordance with the criteria on Rheumatoid Arthritis of the American College of Rheumatology and has been diagnosed by the Rheumatologist.
II. At least 3 joints are damaged or deformed such as finger joint, wrist, elbow, knee joint, hip joint, ankles, cervical spine or feet toe joint as confirmed by clinical and radiological evidence and cannot perform at least 3 types of daily routines permanently for at least 180 days.

31. **Progressive Scleroderma**

A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs.

I. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.
II. The following conditions are excluded: Localized scleroderma (linear scleroderma or morphea); Eosinophilic fasciitis; and CREST syndrome.

32. **Loss of Independent Existence**

Loss of Independent Existence Confirmation by a Consultant Physician of the loss of independent existence due to illness or trauma, lasting for a minimum period of 6 months and resulting in a permanent inability to perform at least three (3) of the following Activities of Daily Living activities either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent", shall mean beyond the scope of recovery with current medical knowledge and technology.

Activities of Daily Living:

1. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
2. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Mobility: the ability to move indoors from room to room on level surfaces;

5. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
6. Feeding: the ability to feed oneself once food has been prepared and made available.

33. **Systematic Lupus Erythematosus with Renal Involvement**

I. Multi-system, autoimmuno disorder characterized by the development of auto-antibodies, directed against various self-antigens. For purposes of the definition of "Critical Illness", SLE is restricted to only those forms of systemic lupus erythematosus, which involve the kidneys and are characterized as Class III, Class IV, Class V or Class VI lupus nephritis under the Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS) classification of lupus nephritis (2003) below based on **renal biopsy.** There must be positive antinuclear antibody test.

II. Other forms such as discoid lupus, and those forms with only hematological and joint involvement are specifically excluded.

Abbreviated ISN/RPS classification of lupus nephritis (2003):
Class I - Minimal mesangial lupus nephritis
Class II - Mesangial proliferative lupus nephritis
Class III - Focal lupus nephritis
Class IV - Diffuse segmental (IV-S) or global (IV-G) lupus nephritis
Class V - Membranous lupus nephritis
Class VI - Advanced sclerosis lupus nephritis the final diagnosis must be confirmed by a certified doctor specializing in Rheumatology and Immunology

34. **Parkinson's Disease**

I. The unequivocal diagnosis of progressive degenerative primary idiopathic Parkinson's disease (all other forms of Parkinsonism are excluded) made by a consultant neurologist.
II. This diagnosis must be supported by all of the following conditions:

- The disease cannot be controlled with medication**; and**
- Objective signs of progressive impairment; **and**
- There is an inability of the Life assured to perform (whether aided or unaided) at least 3 of the following 6 "Activities of Daily Living" for a continuous period of at least 6 months.

The Activities of Daily Living are:

1. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
2. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Mobility: the ability to move indoors from room to room on level surfaces;
5. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
6. Feeding: the ability to feed oneself once food has been prepared and made available

Section i(c) of Specific Exclusions shall not apply to the extent this condition is applicable

III. The following is excluded:
a. Drug-induced or toxic causes of Parkinsonism are excluded.

35. **Alzheimer's Disease**

I. Progressive and permanent deterioration of memory and intellectual capacity as evidenced by accepted standardized questionnaires and cerebral imaging.
II. The diagnosis of Alzheimer's disease must be confirmed by an appropriate consultant and supported by the Company's appointed doctor.
III. There must be significant reduction in mental and social functioning requiring the continuous supervision of the life assured.
IV. There must also be an inability of the Life Assured to perform (whether aided or unaided) at least 3 of the following 6 "Activities of Daily Living" for a continuous period of at least 3 months:

Activities of Daily Living are defined as:

1. Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
2. Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring – the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Toileting – the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
5. Feeding – the ability to feed oneself once food has been prepared and made available.
6. Mobility - the ability to move from room to room without requiring any physical assistance.

V. The following are excluded:
a. Any other type of irreversible organic disorder/dementia
b. Non-organic disease such as neurosis and psychiatric illnesses; and
c. Alcohol-related brain damage.

Section i(c) of Specific Exclusions shall not apply to the extent this condition is applicable

36. **Uterine Rupture**

A (spontaneous) full-thickness disruption of the uterine wall that also involves the overlying visceral peritoneum which results in clinically significant uterine bleeding and expulsion of uterine content into abdominal cavity, (also in pregnant women associated fetal distress) and requires a prompt cesarean delivery or uterine repair or hysterectomy.

I. A waiting period of 10 months is applicable for this Illness.
II. This excludes uterine scar rupture caused due to a preexisting scarred Uterus due to previous LSCS or any other uterine surgery that is before the inception of the Policy.

Section vii (e) of Specific Exclusions shall not apply to the extent this benefit is applicable

37. **Uterine inversion**

The actual surgery for the treatment of uterine inversion in which the corpus (body of uterus) turns inside out and protrudes into the vagina or beyond the introitus, as a result of cause of excessive pressure on the fundus during delivery of the placenta, a flaccid uterus, or placenta accreta (abnormally adherent placenta).

i. The diagnosis and requirement of surgery must be confirmed medically necessary clinically by a registered obstetrician
ii. This benefit shall be available only as onetime benefit
iii. A waiting period of 10 months is applicable for this Illness.

Section vii (e) of Specific Exclusions shall not apply to the extent this benefit is applicable.

38. **Medullary Cystic Kidney Disease**

Medullary Cystic Kidney Disease where the following criteria are met:

I. the presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;
II. clinical manifestations of anemia, polyuria, renal loss of sodium progressing to deterioration in kidney function; and
III. the Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.
IV. This excludes:
i. Isolated or benign kidney cysts.

39. **Pituitary apoplexy in pregnancy**

Pituitary apoplexy in pregnancy is abrupt destruction of pituitary tissue resulting from infarction or hemorrhage into the pituitary in women without any pre-existing pituitary lesion but where the pituitary is physiologically enlarged as a result of pregnancy.
The realization of the diagnosis must be established by a registered neurosurgeon or neurologist with investigations including but not limited to MRI scan of the brain.

I. This include treatment surgical and/or medical treatment under registered medical practitioner and neurosurgeon
II. A waiting period of 10 months is applicable for this Illness

Section vii (e) of Specific Exclusions shall not apply to the extent this Benefit is applicable

40. **Cardiomyopathy including Peri-partum and postpartum Cardiomyopathy**

I. An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a Registered Medical Practitioner who is a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association Classification Class IV or its equivalent, for at least six (6) months based on the following classification criteria:

Class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced.

II. The Diagnosis of Cardiomyopathy has to be supported by echographic findings of compromised ventricular performance.
III. A waiting period of 10 months is applicable for this Illness if it is related to Maternity
IV. The following is excluded:
I. Cardiomyopathy directly related to alcohol or drug abuse is excluded.

Section vii (e) of Specific Exclusions shall not apply to the extent this Benefit is applicable

41. **Nephrotic Syndrome**

I. Nephrotic syndrome is the onset of heavy proteinuria (>3.0 g/24 h), hypertension, hypercholesterolemia, hypoalbuminemia, edema/anasarca, and microscopic hematuria.

II. A confirmed diagnosis of glomerulonephritis with nephrotic syndrome must be made by an appropriate Medical Practitioner along with relevant reports and should confirm a treatment regimen appropriate to the clinical presentation has been followed throughout the period to which syndrome relates.

III. The syndrome must have continued for a period of at least 6 months from the date of confirmed diagnosis with or without intervening periods of remission.

3.7.2. Benefits Options under Section 3.7:

3.7.2.1. Sum Insured Enhancement

What is covered:

In consideration of additional premium received from You/Insured Person, it is hereby understood and agreed that, the Critical Illness Sum Insured mentioned in the Policy Schedule/ Certificate of Insurance shall be increased automatically per annum by the percentage chosen, by the Insured Person and accepted by Us and mentioned in the Policy Schedule/Certificate of Insurance. It is hereby clarified that the increase every time would be computed on the Critical Illness Sum Insured at which the cover under the Policy had been issued the first time and not the increased Sum Insured in years succeeding the first year of cover under the Policy.

Conditions:

a. The Sum Insured shall be increased by a flat percentage for every completed Policy Year.
b. At Renewal the Insured Person shall have an option to revise the Sum Insured by sending in writing the request for such Sum Insured revision. Any revision to Sum Insured shall always be subject to due underwriting by Us and acceptance of risk by Us in writing.

3.7.2.2. Loan Protector

What is covered:

Subject to Us accepting Our liability for a claim in respect of the Insured Person under Section 3.7.1 of this Policy and in consideration of additional premium received from You/Insured Person at the time of issuance of the Policy, it is hereby understood and agreed that We shall, in addition to the Sum Insured for the Insured Person also pay any one of the following two amounts whichever is lesser:

1. The principal outstanding amount of the Insured Person's loan on the date of occurrence of the event giving rise to the claim in case of only one Insured Person being covered or 50% of the principal outstanding amount in case of two Insured Persons being covered under the same Certificate of Insurance.
2. 100% of the Base Sum Insured for that Insured Person mentioned in the Certificate of Insurance

Conditions:

The payout of the Loan Protector amount mentioned above shall be subject to all the following;

- We shall pay only the principal amount that should have been outstanding on the date of claim had the Insured Person/s been paying all EMIs in due time as per loan schedule. Any interest, penalty, any additional charges levied by the Financer or Lender or any past defaults by the Insured Person in payment of EMI including the principal amount leading to accumulation of the principal and/or the interest are specifically excluded.
- In case an amortization schedule is attached with the Policy Schedule/Certificate of Insurance, the outstanding principal amount shall be calculated as per the amortization schedule attached with the Policy Schedule/Certificate of Insurance.

The Insured Person is required to submit the latest statement of loan account duly certified by the Financer/Lender along with all other documents required for claim assessment under Critical Illness cover

3.7.2.3. Income Protector

What is covered:

Subject to Us accepting Our liability for a claim in respect of the Insured Person under Section 3.7.1 of this Policy and in consideration of additional premium received from You/Insured Person at the time of issuance of the Policy, it is hereby understood and agreed that in the event of Insured Person losing his job due to Critical Illness covered under this Section We shall, in addition to the Critical illness Sum Insured also pay the amount as prescribed in the Policy Schedule/ Certificate of Insurance up to the specified number of months as specified in Policy Schedule/ Certificate of Insurance as income to the Insured Person.

Conditions:

1. For eligibility under this cover the job of the Insured Person must be permanent and not temporary or casual or seasonal or contractual or off roll and the Insured Person must be employed in that permanent job at the time of inception of the cover under the Policy and 90 days immediately following thereafter within the Policy/Coverage Period including the day of inception of the Policy.
2. You/Insured Person has to provide all the documentary evidence of such loss of job
3. We shall, in case it deems fit to do so, shall have the discretion to even pay all the specified monthly income benefits as mentioned in the Policy Schedule/ Certificate of Insurance in lump sum instead of monthly.

What is not covered:

1. We shall not be liable to make any payment under this Section in event the Insured Person unemployment is a consequence of his termination, dismissal, suspension because of his involvement in any act of dishonesty and/or fraud and/or poor performance on the part of the Insured Person and/or his willful violation of any rules of the employer and/or laws for the time being in force and/or any disciplinary action against him by the employer.
2. We shall not be liable to make any payment under this Section:

a. If the Insured Person is a self-employed person during the entire Policy Period;
b. During the entire Policy Period/ Coverage Period in case of any claim relating to unemployment from such job which is casual, temporary, seasonal or contractual in nature or any claim relating to an employee not on the direct rolls of the employer;
c. In case of voluntary unemployment due to resignation during the entire Policy Period;
d. In case of unemployment at the time of inception of the Policy/Coverage Period or unemployment arising within the first 90 days of inception of the Policy Period/ Coverage Period for any reason whatsoever including without limitation even if the Insured Person suffers Critical Illness.
e. In case of unemployment during the entire Policy Period/ Coverage Period from a job under which no salary or any remuneration is provided to the Insured Person
f. In case of suspension from employment on account of any pending enquiry being conducted by the employer/ public authority.

g. In case of unemployment during the entire Policy Period/ Coverage Period due to retirement whether voluntary or otherwise.

In case of any unemployment during the entire Policy Period/ Coverage Period due to non-confirmation of employment after or during such period under which the Insured Person was under probation.

3.7.2.4. Staggered Payout

What is covered:

Subject to Us accepting Our liability against the claim under section 3.7.1 of this Policy and in consideration of additional premium received from You/Insured Person, not withstanding anything contrary contained in the Policy, it is hereby understood and agreed that, in the event of claim We, in addition to Sum Insured for the Insured Person as mentioned in the Policy Schedule/ Certificate of Insurance shall also pay equal to 10% of the Sum Insured per annum for next 5 years. This is the staggered payout which shall be calculated on the Insured Person's Critical Illness Sum Insured or on the increased sum insured if the Sum Insured Enhancement option is opted for.

Conditions:
Claim under this cover will be payable only when the claim under Section 3.7.1 under this Policy is payable.

3.7.2.5. Death Benefit

What is covered:

In the event of the Insured Person dies within the Survival period specified in the Policy Schedule/ Certificate of Insurance due to Critical Illness covered under Section 3.7.1 of this Policy, We shall pay in lump sum the amount as prescribed in the Policy Schedule/ Certificate of Insurance to the nominee/ legal heir/s of the Insured Person as Death Benefit. In this case Our total liability under Section 3.7.1 shall be limited only to the limit specified in the Policy Schedule/ Certificate of Insurance as Death Benefit.

3.7.2.6. Second Medical Opinion for Critical Illness

What is covered:

If the Insured Person is diagnosed with a Critical Illness as defined under Section 3.7.1 or is planning to undergo a planned Surgery or a Surgical Procedure for that Critical Illness, the Insured Person can, at the Insured Person's choice, obtain a Second Medical Opinion from a Medical Practitioner arranged by Us:

a. We/ Our Service Provider are contacted seeking the Second Medical Opinion.

b. The Second Medical Opinion will be arranged by Us or Our Service Provider and will be based only on the information and documentation provided by the Insured Person that will be shared with the Medical Practitioner.
c. This Benefit can be availed only once by an Insured Person during a Policy Year/ Coverage Period for the same Critical Illness or planned Surgery.
d. By seeking the Second Medical Opinion under this Benefit the Insured Person is not prohibited or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.
e. The Insured Person is free to choose whether or not to obtain the Second Medical Opinion, and if obtained then whether or not to act on it in whole or in part.
f. The Second Medical Opinion under this Benefit shall be limited to defined criteria and not be valid for any medico legal purposes.

We do not assume any liability and shall not be deemed to assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

3.7.3. Waiting Period Options under Section 3.7:

All the Waiting Periods as specified in Policy Schedule/ Certificate of Insurance shall be applicable individually for each Insured Person and claims shall be assessed accordingly. On Renewal, if an enhanced Sum Insured is applied for, the Waiting Periods would apply afresh to the extent of the increase in Sum Insured only.

We shall not be liable to make any payment under this Policy directly or indirectly for, caused by, based on, arising out of or howsoever attributable to any of the following, except if any Insured Person suffers an Accident;

A. Waiting Periods

I. **Pre-existing Diseases (Code–Excl01):**

a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of the number of months (as mentioned in Policy Schedule/Certificate of Insurance) of continuous coverage after the date of inception of the first Policy.
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 (Insurance Insurance) regulations2024, then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under the Policy after the expiry of number of months (as mentioned in Policy Schedule/Certificate of Insurance) for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

II. **Survival Period**

The payment of the Benefit shall be subject to survival of the Insured Person for the duration specified in Policy Schedule/ Certificate of Insurance post the first diagnosis of the Critical Illness

a. The Critical Illness cover is not applicable in the event of Death of Insured Person during the Survival Period as specified in Policy Schedule/ Certificate of Insurance following diagnosis of Critical Illness
b. If diagnosis takes place on or before the Policy/ Coverage expiry date, but the Survival Period expires after the Policy/ Coverage end date, We will pay a claim provided that the Insured Person survives duration as specified in Policy Schedule/ Certificate of Insurance from the date of diagnosis.

III. **Initial waiting period:**

a. A Waiting Period since beginning of cover under the First Policy, specified in the Policy Schedule/ Certificate of Insurance shall apply to any Illness contracted and/or Medical Expenses incurred in respect of any Illness by the Insured Person other than Hospitalization due to Accident.
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.

If these diseases are Pre-Existing Diseases at the time of the Proposal or subsequently found to be Pre-Existing Diseases, the Pre-Existing Disease Waiting Periods as mentioned in the Policy Schedule/ Certificate of Insurance shall apply in respect of that Insured Person.

B. Permanent Exclusions:

A permanent exclusion will be applied on any medical or physical condition or treatment of an Insured Person, if specifically mentioned in the Policy Schedule and has been accepted by You. This option as per company's underwriting policy, will be used for such condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person.

We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following unless specifically mentioned elsewhere in the Policy.

I. **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.

II. **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.

III. **Excluded Providers (Code-Excl11)**
Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our 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. The complete list of excluded providers can be referred to on our website.

IV. 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)**

V. **Sterility and Infertility (Code-Excl17)**

Expenses related to sterility and infertility. This includes:

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

VI. **Maternity (Code-Excl18)**

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

VII. **External Congenital Anomaly:**

Screening, counseling or treatment related to external Congenital Anomaly.

VIII. **Sexually transmitted Infections & diseases (other than HIV / AIDS):**

Screening, prevention and treatment for sexually related infection or disease (other than HIV / AIDS).

IX. **Alternative Treatments:**

Any covered Critical Illnesses diagnosed and/or treated by Medical Practitioner who practices z Medicine.

X. **Unrecognized Physician or Hospital:**

a. Treatment or Medical Advice provided by a Medical Practitioner not recognized by the Medical Council of India or by Central Council of Indian Medicine or by Central Council of Homeopathy or by relevant authorities in the area where the treatment is taken.
b. Treatment or Medical Advice related to one system of medicine provided by a Medical Practitioner of another system of medicine.
c. Treatment provided by anyone with the same residence as an Insured Person or who is a member of the Insured Person's immediate family or relatives.
d. Treatment provided by Hospital or health facility that is not recognized by the relevant authorities in India or any other country where treatment takes place.

3.7.4. Claims Process & Requirements:

The fulfillment of the terms and conditions of this Policy (including payment of full premium in advance by the due dates mentioned in the Certificate of Insurance) in so far as they relate to anything to be done or complied with by the Insured Person, including complying with the following in relation to claims, shall be Condition Precedent to admission of Our liability under this Policy.

Claims Administration:

On the occurrence or discovery of any Illness or Injury that may give rise to a claim under this Section, the Claims Procedure set out below shall be followed**:**

a. The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed. We shall not be obliged to make any payment that arises out of willful failure to comply with such directions, advice or guidance.
b. We and Our representatives must be permitted to inspect the Medical Records and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.
c. We and Our representatives must be given all reasonable co-operations in investigating the claim in order to assess its liability and quantum in respect of the claim.

It is hereby agreed and understood that no change in the Medical Record provided under the Medical Advice, by the Hospital or the Insured Person to Us or Our Service Provider during the period of Hospitalization or after discharge by any means of request will be accepted by Us. Any decision on request for acceptance of change will be at Our discretion.

Claims Procedure

a. If the Insured Person is diagnosed / underwent a Surgical Procedure or any medical condition falling under purview of the definition of Critical Illness as mentioned in the Policy that may result in a claim, then the Insured Person must provide intimation to Us immediately and in any event within 7 days of the aforesaid Illness/ condition/ surgical event or completion of Survival Period and which can be received from You/Insured Person through various modes like email / telephone/ fax/ in person or may be via letter or any other suitable mode. Upon receipt of information We will register the claim under a unique claim number.

b. The following details are to be provided at the time of intimation of claim:

i. The Policy Number/Certificate Number,
ii. Name of the Policyholder;
iii. Employee No./ Member ID
iv. Name and address of the Insured Person in respect of whom the request is being made;
v. Nature of Illness or Injury and the treatment/Surgery taken;
vi. Name and address of the attending Medical Practitioner;
vii. Hospital where treatment/Surgery was taken;
viii. Date of Occurrence of Insured Event or/and date of admission;
ix. Any other information that may be relevant to the Illness/ Injury/ Hospitalization.

Claims Documentation

We shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense at the earliest possible time.

a. Claim form duly completed and signed by the Insured Person.
Please provide mandatorily following information if applicable

i. Current diagnosis and date of diagnosis;
ii. Past history and first consultation details;
iii. Previous admission/Surgery if any.

b. Age/identity proof document of the Proposer.

i. Self-attested copy of valid Age proof (passport / driving license / PAN card / class X certificate / birth certificate);
ii. Self-attested copy of identity proof (passport / driving license / PAN card / voter identity card);
iii. Recent passport size photograph.

c. Cancelled cheque/ bank statement / copy of passbook mentioning account holder's name, IFSC code and account number printed on it of Insured Person / nominee (in case of death of Insured Person)
d. Hospital discharge summary (if applicable)
e. Additional documents required in case of Surgery/Surgical Procedure (If applicable)
i. Bar code sticker and invoice for implants and prosthesis (if used)
f. Original final bill from Hospital with detailed break-up and paid receipt (If applicable)
g. Copy of death certificate (in case of demise of the Insured Person)
h. For Medico-legal cases (MLC) or in case of Accident as may be applicable
i. MLC and First Information Report (FIR) copy duly attested by the concerned Hospital and police station respectively. (if applicable);
ii. Original self-narration of incident in absence of MLC/ FIR.
i. Original laboratory investigation, diagnostic & pathological reports with supporting prescriptions.
j. Original X-Ray/ MRI / ultrasound films and other radiological investigations.

Claims Documents applicable to Section 3.7.2.3 (Income Protector):

In the event of a claim arising out of an Insured Event covered under Section 3.7.2.3 above, You/Insured Person shall provide following necessary information and documentation in respect of all claims at Your/Insured Person's expense at the earliest possible time.:

1. Duly completed claim form;
2. Certificate from the employer of the Insured Person confirming the severance from employment the date of and the reasons for the same.

If these details are not provided in full or are insufficient for Us to consider the request, We will request additional information or documentation in respect of that request.

Claims Assessment & Repudiation

We shall be under no obligation to make any payment under this Policy unless it has been provided with the documentation and information which We have requested to establish the circumstances of the claim, its quantum or liability for it, and unless the Insured Person has complied with his obligations under this Policy.

a. We shall not be liable to make any payment under this Section in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means whether by the Insured Person or by any other person acting on his behalf.
b. If We, for any reasons to be recorded in writing and communicated to the Insured Person, decide to reject a claim under the Policy, it shall do so within a period of 30 days from the receipt of last necessary information and documentation set out above.
c. In the unfortunate event of the Insured Person death, We will pay the Nominee named in the Certificate of Insurance or the Insured Person's legal heirs or legal representatives holding a valid succession certificate.
d. Our total liability in aggregate of all claims under the Policy for a specific Insured Person shall not exceed the respective Sum Insured as specified in the Certificate of Insurance of that Insured Person

3.8. Wellness Benefits:

This Section is available either to either the Insured Person only or along with his/her spouse as specified in the Policy Schedule/Certificate of Insurance. Subject to the Policy terms and conditions and to encourage good health and well-being, We shall provide the following wellness related services to You/Insured Person(s) covered under this Benefit through Our empaneled Service Providers.

3.8.1. Personalized health coaching:

This Benefit is available either to the Insured Person or the Insured Person along with his/her spouse. Subject to Policy terms and conditions and to encourage good health and well-being, We shall provide the following wellness related services to the Insured Person(s) covered under this Benefit and We shall be assisted in administering these services through Our Service Provider:

a. Personalized health coaching – The Insured Person will have the facility to connect with a personal coach through a mobile application to guide and motivate the Insured Person to achieve his/her personal health goals. The health coach facility assists in identifying factors relating to the Insured Person's lifestyle and habits and also suggests ways to shift these habits to improve activity and wellness and to encourage overall well-being.

The health coaching facility is unlimited and can be availed any number of times during the Policy Period. In order to obtain access to the health coach facility, the Insured Person would be required to download the mobile application and register his/her specified details through the mobile application. When registration is complete, the Insured Person's health coach will notify him/her through the mobile application to set up the Insured Person's introductory call where Insured Person will discuss with the health coach to establish his/her short and long term goals. Once these goals are recorded, the health coach will provide on-going daily support, motivation and interpretation of the Insured Person's tracking data to help the Insured Person stay on track to reach his/her goals. The Insured Person and the health coach will also be able to connect frequently to review the progress and revise the existing goals or set new goals.

The mobile application shall also keep track of Insured Person's steps taken, daily food logs etc., which can be accessed by the Insured Person, personal health coach and Our empaneled Medical Practitioners under this Benefit.

b. Calculation of health score - Health Score shall be calculated as per the table below:

Health Score Model		
Task Based	**Tasks to be Completed**	**Complete & win (Points/task)**
One time	Sign up & Activation	500
	Selecting your own goals	500
	Taking your first Health assessment	750
	Completing your first tele-consultation with Our empaneled Medical Practitioner	500
	Uploading your first health record	750
Weekly	Coach engagement (>3 interactions / week)	250
	Walking - Steps count (5000 steps /day --- 5 times /week)	300
	Daily food logs (minimum 10 logs/ week)	250
Monthly	Habit tracking (minimum 15 check in)	500
	Monthly Coach review – Call	500
Quarterly	Health Assessment	500

Half Yearly	Tele-consultation with Our empaneled Medical Practitioner	1200
	Sharing your test reports / records	1500

Performance Based	Parameters for performance review	Score - based on your performance (Max points / review)
One time	Health Assessment at the time of on boarding	2000
Monthly	Monthly performance - Quality score by personal health coach	2000
Quarterly	On completion of goal set by personal health coach	500
	Based on health assessment results	2000
Annual Health score	(Task based points + Performance based points)	Earn up to 1 lac points in a year

One-time Task Based points in second and subsequent Policy Year will get replaced with Renewal points awarded on Renewal of the Policy along with Health Coach Benefit. For Health Score calculation, monthly scores will be calculated and accumulated to arrive at the annual Health Score.

c. Discount in renewal premium basis Health Score:
We will provide a discount in Renewal Base Premium based on the Insured Person's Health Score under this Benefit as per following table:

Health Score	Discount in Renewal Base Premium
0-9999	0%
10000-69999	5%
70000-79999	10%
80000-89999	15%
90000-100000	20%

The Health Score of the Insured Person (average health score if both the Insured Person and spouse are covered under this Benefit) shall be considered for calculating the discount in Renewal Base Premium applicable to the Insured Person.
For the first Renewal, the Health Score at the end of nine Policy months shall be considered and pro-rated to arrive at the twelve months' score for calculating the discount in Renewal Base Premium for the Insured Person. For subsequent Renewals, Health Score for the next twelve Policy months from the date of last annual Health Score calculation, shall be considered for calculating the discount in Renewal Base Premium for the Insured Person.

The above Benefits will be subject to following conditions:

i. For services that are availed over phone or through online/ digital mode, the Insured Person will be required to provide the details as sought by Our Service Provider in order to establish authenticity and validity prior to availing such services.
ii. It is entirely for the Insured Person(s) to decide whether to obtain these services, the extent to which he/she wishes to avail these services and further to decide whether to use any of these services and if so to which extent.
iii. The services are intended to provide support information to the Insured Person to improve well-being and habits through working towards personalized health goals. These services are not medical advice and are not meant to substitute the Insured Person's visit/ consultation to an independent Medical Practitioner.

iv. The information services provided under this Benefit, including information provided through personalized health coaching services, does not constitute medical advice of any kind and it is not intended to be, and should not be, used to diagnose or identify treatment for a medical or mental health condition. The information services provided under this Benefit, including information provided through personalized health coaching services, does not substitute for any medical advice as well.

v. The Insured Person shall be free to consider or not consider the suggestions of the health coach and make any lifestyle changes based on information provided through these services. For any change the Insured Person makes to his lifestyle whether or not on the advice of the health coach, We or Our Service Provider shall in no manner be liable for any harm or injury, whether bodily or otherwise that may occur as a result of such lifestyle changes. The Insured Person must seek immediate medical advice if there is any adverse effect or discomfort on making any lifestyle changes.

vi. We or Our Service Provider do not warrant the validity, accuracy, completeness, safety, quality, or applicability of the content or anything said or written by any personal health coach or any suggestions provided. We or Our Service Provider will not be liable for any damages sustained due to reliance by the Insured Person on such information or suggestions provided by any personal health coach.

Health Coaching through a personal health coach and calculation of the Health Score are being provided through Our Service Provider. For details on terms and conditions for use of health coaching services, please visit www.nivabupa.com/HealthCoach.

3.8.2. OPD Services

The Insured Person may avail OPD services from Our empaneled Service Provider through its mobile application or website. The cost for the OPD treatment shall be borne by the Insured Person. However, We shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further for OPD treatment taken from Our empaneled Service Provider is the Insured Person's absolute discretion and choice.

3.8.3. Pharmacy Services

The Insured Person may purchase medicines from Our empaneled Service Provider through its mobile application or website. The cost for the purchase of the medicines shall be borne by the Insured Person. However, We shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further purchase of medicines from Our empaneled Service Provider is the Insured Person's absolute discretion and choice.

3.8.4. Diagnostic Services

The Insured Person may avail various diagnostic tests from Our empaneled Service Provider through its mobile application or website. The cost of diagnostic tests shall be borne by the Insured Person. However, We shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further the diagnostic tests taken from Our empaneled Service Provider is the Insured Person's absolute discretion and choice.

4. General Exclusions (applicable to all Sections under the Policy unless specified otherwise):

We shall not be liable to make any payment under this Policy directly or indirectly for, caused by, based on, arising out of or howsoever attributable to any of the following unless specifically mentioned elsewhere in the Policy or in Policy Schedule/Certificate of Insurance.

i. Conflict & Disaster: Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader).

ii. Caused by or contributed to by or arising from ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel. For the purpose of this exclusion, combustion shall include any self-sustaining process of nuclear fission.

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

iv. Any injury as a result of Intentional self-inflicted Injury, suicide or attempted suicide by any means.

v. Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences thereof Code Excl 12

vi. Intentional Inhaling any gas or fumes, except in the course of duty

vii. Participation in aviation other than as a fare-paying passenger in an aircraft that is authorized by the relevant regulations to carry such passengers between established aerodromes.

viii. Any disability arising out of Pre-Existing Disease if not accepted and endorsed by Us on the Policy Schedule or Certificate of Insurance.

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

x. 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.

xi. Loss/damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any action taken in controlling, preventing, suppressing or in any way relating to any act of terrorism.

xii. Any Injury/ Illness caused due to animal bite/ attack unless opted for the specific cover and same to be mentioned in the Policy Schedule/Certificate of Insurance.

xiii. Any exclusion mentioned in the Policy Schedule/Certificate of Insurance or the breach of any specific condition mentioned in the Policy Schedule/Certificate of Insurance.

5. General Terms and Conditions

Standard Terms and Conditions:

5.1. Migration

In case of migration of one policy to another with the same Insurer, the policyholder (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy.

The insurer may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months.

5.2. Free Look Period

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

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.. If he/she is not satisfied with any of the terms and conditions , he/she has the option to cancel his/her policy.
In the event the policyholder disagrees to any of the policy terms or conditions, or otherwise and has not made any claim, he/she shall have the option to retun the policy to the insurer for cancellation, stating the reasons for the same.

Irrespective of the reasons mentioned, the policyholder shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges.

5.3. Cancellation

The policy holder may cancel his/her policy at any time during the term, by giving 7 days' notice in writing. The insurer shall:

a. Refund proportionate premium for unexpired policy period, if the term of the policy upto one year and there is no claim(s) made during the policy period.
b. Refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years are not commenced.

I. 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.

5.4. Premium Payment in Installments:

If the Insured Person has opted for payment of premium on an installment basis, i.e. Half yearly, Quarterly, or monthly, as mentioned in the Policy Schedule/Certificate of Insurance, the following conditions shall apply (notwithstanding any terms contrary elsewhere in the policy);

a. Grace Period of 30 days in all types of policies, and a period of 15 days in case of monthly instalments.
b. For policies where premium is paid in instalments only, the coverage will be given during grace period.
c. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
d. No interest will be charged lf the instalment premium is not paid on due date
e. ln case of instalment premium due not received within the grace period, the policy will get cancelled.
f. ln the event of a claim, all subsequent premium instalments shall immediately become due and payable.
g. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

5.5. Renewal of Policy

A health insurance policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured.

An insurer shall not deny the renewal of a health insurance policy on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy.

a. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
b. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days (annual installment) to maintain continuity of benefits without break in policy.
c. Coverage is available during the grace period.
d. No loading shall apply on renewals based on individual claims experience. However, discount in premium may be provided by insurers to individual policyholders for good claims experience.
e. Insurer shall not resort to fresh underwriting by calling for medical examination, fresh proposal form etc at renewal stage where there is no change in sum insured offered. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured

5.6. 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. The insurer shall obtain nomination at the time of new business and at the time of renewal for existing policies.

5.7. 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.

5.8. Claims Settlement (Provision for Penal Interest)

I. The Company shall settle or reject a claim, as the case may be, within 15 days from the claim submission date.

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 claim intimation until the date of payment of claim at a rate of 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)

5.9. 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 affected.

5.10. 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.

5.11. Redressal of Grievance:

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

Website: www.nivabupa.com

Courier: Customer Services Department

Niva Bupa Health Insurance Company Limited
D-5, 2nd Floor, Logix Infotech Park
opp. Metro Station, Sector 59, Noida, Uttar Pradesh, 201301

Fax No.: +91 11 41743397

Customer Care no: 1860-500-8888

Email ID: Email us through our service platform https://rules.nivabupa.com/customer-service/
Senior citizens may write to us at:seniorcitizensupport@nivabupa.com

b. 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

Head – Customer Services

Niva Bupa Health Insurance Company Limited
D-5, 2nd Floor, Logix Infotech Park
opp. Metro Station, Sector 59, Noida, Uttar Pradesh, 201301
Fax No.: +91 11 41743397
Customer Care no: 1860-500-8888
Email ID:
Email our Grievance officer through our Grievance Redressal platform https:// transactions.nivabupa.com/pages/grievance-redressal.aspx

For updated details of grievance officer, kindly refer the link https://www.nivabupa.com/customer-care/health-services/grievance-redressal.aspx

If the Insured person is not satisfied with the above, they can escalate to GRO@nivabupa.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 (at the addresses given in Annexure III).

Grievance may also be lodged at IRDAI integrated Grievance Management System – www.bimabharosa.irdai.gov.in

5.12. 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 the grounds of non-disclosure, misrepresentation, except on grounds of established fraud. The period of sixty continuous months is called as moratorium period. The moratorium will be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would applicable from the date of enhancement of sums insured only on the enhanced limits.

The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the Policy contract.

Note: the accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium Period.

5.13. Multiple Policies

I. Indemnity **Based Policies:**

b. 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 Policyholder shall be considered as the Primary Insurer and will 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.

c. If the amount to be claimed exceeds the available coverage of the said policy, then the primary insurer shall seek the details of other available policies of the policyholder and shall coordinate with other insurers to ensure settlement pf the balance amount as per the policy conditions, without causing any hassles to the policy holder.

I. Benefit **Based Policies:**

d. On occurrence of the insured event, the policy holder can claim from all Insurers under all policies.

5.14. 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)

5.15. 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.

5.16. Complete Discharge

Any payment to the policy holder, insured person or his/her nominees or his/her legal representatives 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.

5.17. Portability

A Policyholder has the choice to port his/ her policies from one Insurer to another irrespective of individual or group policy subject to the Board approved underwriting policy of the insurers.

The policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease , Moratorium period etc. from the Existing Insurer to the Acquiring Insurer in the previous policy.

Specific Terms and Conditions:

5.18. Automatic Cancellation:

i. **Individual Cover**:

The Certificate of Insurance coverage shall automatically terminate in the event of death of the Insured Person.

ii. For **Family Floater Cover**

The cover under the Policy coverage shall automatically terminate in the event of the death of all the Insured Persons under the Family Floater Cover.

5.19. Cancellation by Us:

We may terminate the Policy/ Certificate of Insurance during the Policy Period /Coverage Period by sending 15 days' prior written notice to You/ Insured Person at the address shown in the Policy Schedule/Certificate of Insurance without refund of premium (for cases other than non-cooperation) if:

i. Insured Person or any person acting on behalf of either has acted in a dishonest or fraudulent manner under or in relation to this Policy; and/or
ii. Insured Person has not disclosed the Material Facts or misrepresented in relation to the Policy; and/or

For avoidance of doubt, it is clarified that no claims shall be admitted and/or paid by Us during the notice period in case of cancellation by Us.

5.20. For installment premium, We will refund premium on pro rata basis after deducting Our expenses

5.21. Cancellation in case of Credit Linked Cases:

In cases the Policy is linked to the credit/ loan tenure, the coverage will continue till the end of loan tenure subject to maximum tenure of 5 years, closure of the loan or Policy Period/ Coverage Period Term whichever is earlier. The Insured Person shall inform Us of such closure of the loan immediately in order to cancel the cover under the Policy. For loan linked policy, claim will admissible only for active loans.

5.22. Other Renewal Conditions

a. Continuity of Benefits on Timely Renewal:

i. The Renewal premium is payable on or before the due date and in any circumstances before the expiry of Grace Period, at such rate as may be reviewed and notified by Us before completion of the Policy Period provided that all such changes are approved by IRDAI and in accordance with the IRDAI's rules and regulations as applicable from time to time.
ii. Renewal premium rates for this Policy may be further altered by Us including in the following circumstances:

A. You/Insured Person proposed to add an Insured Person to the Policy
B. You/Insured Person change any coverage provision

iii. Renewal premium will alter based on individual Age. The reference of Age for calculating the premium for Family Floater Policies shall be the Age of the eldest Insured Person.

b. Reinstatement:

i. The Policy shall lapse after the expiration of the Grace Period. If the Policy is not renewed within the Grace Period then We may agree to issue a fresh Policy subject to Our underwriting criteria, as per Our Board approved underwriting Policy and no continuing benefits shall be available from the expired Policy.
ii. We will not pay for any Medical Expenses which are incurred between the date the Policy expires and the date immediately before the reinstatement date of Your/Insured Person's Policy.
iii. If there is any change in the Insured Person's medical or physical condition, We may add exclusions or charge an extra premium from the reinstatement date.

c. Disclosures on Renewal:

You/Insured Person shall make a full disclosure to Us in writing of any material change in the health condition or geographical location of any Insured Person at the time of seeking Renewal of this Policy, irrespective of any claim arising or made. The terms and condition of the existing Policy will not be altered.

d. Addition of Insured Persons on Renewal:

Where an individual is added to this Policy either by way of endorsement or at the time of Renewal, the Pre-Existing Disease clause, exclusions and Waiting Periods will be applicable considering such Policy Year as the first year of the Policy for that newly added individual with Us.

e. Changes to Sum Insured on Renewal:

You/Insured Person may opt for enhancement of Sum Insured at the time of Renewal, subject to underwriting. Any enhanced Sum Insured applied on Renewal will not be available for an Illness or Injury already contracted under the preceding Policy Periods. All Waiting Periods as defined in the Policyshall apply afresh for this enhanced limit from the effective date of such enhancement.

5.23. Obligations in case of a minor

If an Insured Person is less than 18 years of Age, You/ Insured Person or another adult Insured Person or legal guardian (in case of the Insured Person's and all other adult Insured Person's demise) shall be completely responsible for ensuring compliance with all the terms and conditions of this Policy on behalf of that minor Insured Person.

5.24. Assignment

The Benefits under this Policy are assignable subject to applicable Laws.

5.25. Records to be maintained:

As a Condition Precedent, You/Insured Person shall keep an accurate record containing all relevant medical records and shall allow Us or Our representative(s) to inspect such records. You/Insured Person shall furnish such information as We may require under this Policy at any time during the Policy Period/ Coverage Period.

5.26. Authorization to obtain all pertinent records or information:

As a Condition Precedent to the payment of Benefits, We and/or Our Service Provider shall have the authority to obtain all pertinent records or information from any Medical Practitioner, Hospital, clinic, insurer, individual or institution to assess the validity of a claim submitted by or on behalf of any Insured Person.

5.27. Notification of Claim and Delay in Intimation:

The notification of all claims should be sent to Us via one of the following:

By calling Us at 1860-500-8888

By registered post sent to:

Customer Services Department

Niva Bupa Health Insurance Company Limited

D-5, 2nd Floor, Logix Infotech Park

opp. Metro Station, Sector 59, Noida, Uttar Pradesh, 201301

Email us through our service platform https://rules.nivabupa.com/customer-service/

If the claim is not notified to Us or claim documents are not submitted within the stipulated time as mentioned in the above sections, 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.

If You/Insured Person holds multiple sections (Indemnity & Benefit) under this Policy with Us, a single notification for claim will apply to all the sections of the Policy.

5.28. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein shall be governed by Indian law and shall be subject to the jurisdiction of the Indian Courts.

5.29. Territorial Jurisdiction

All Benefits are available in India only, and all claims shall be payable in India in Indian Rupees only.

5.30. Role of Group Administrator

The role of Group Policyholder as an administrator will only be to facilitate the insurance cover to its members. Any subsequent Policy servicing or claims related assistance shall directly be done by Us.

5.31. Notices

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

a. The Insured Person at the address specified in the Policy Schedule/Certificate of Insurance or at the changed address of which We must receive written notice.

b. Us at the following address:

Niva Bupa Health Insurance Company Limited
D-5, 2nd Floor, Logix Infotech Park
opp. Metro Station, Sector 59, Noida, Uttar Pradesh, 201301
Fax No.: +91 11 41743397

c. No insurance agents, brokers or other person/entity is authorized to receive any notice on Our behalf.

d. In addition, We may send You/Insured Person other information through electronic and telecommunications means with respect to the Policy from time to time.

5.32. Alteration to the Policy

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by Us, which approval shall be evidenced by a written Endorsement signed and stamped by Us.

Annexure I - List of Insurance Ombudsmen

Office Details	Jurisdiction of Office Union Territory,District)
AHMEDABAD - Shri Kuldip Singh 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@ecoi.co.in	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Smt. Neerja Shah 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@ecoi.co.in	Karnataka.
BHOPAL - Shri Guru Saran Shrivastava 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 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh Chhattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
CHANDIGARH - Dr. Dinesh Kumar Verma 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 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh.
CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	Tamil Nadu,UT- Pondicherry Town and Karaikal (which are part of UT of Pondicherry).

DELHI - Shri Sudhir Krishna 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@ecoi.co.in	Delhi.
GUWAHATI - Shri Kiriti .B. Saha 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@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Shri I. Suresh Babu 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 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, UT of Yanam and part of UT of Pondicherry.
JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, UT of (a)Lakshadweep,(b) Mahe-a part of UT of Pondicherry.
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, UT of Andaman & Nicobar Islands.
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331	Districts of Uttar Pradesh : Laitpur, 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,

Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah 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@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

EXECUTIVE COUNCIL OF INSURERS,
3rd Floor, Jeevan SevaAnnexe,
S. V. Road, Santacruz (W),
Mumbai - 400 054.

Tel.: 022 - 26106889 / 671 / 980
Fax: 022 - 26106949
Email:inscoun@ecoi.co.in
Shri. M.M.L. Verma, Secretary General
Smt. Moushumi Mukherji, Secretary

Ombudsmen details are subject to change. Please refer this link for the updated details: CIO (cioins.co.in)"

EXECUTIVE COUNCIL OF INSURERS,
3rd Floor, Jeevan SevaAnnexe,
S. V. Road, Santacruz (W),
Mumbai - 400 054.

Tel.: 022 - 69038801/03/04/05/06/07/08/09

Email: inscoun@cioins.co.in

Shri B. C. Patnaik, Secretary General
Smt Poornima Gaitonde, Secretary

ANNEXURE II

List of Critical Illnesses

Sr	List of Critical Illness	Basic	Intermediate	Advanced	Women	Child - 2 years and above
1	Abdominal Aortic Aneurysm	?	?	?	?	?
2	Alzheimer's Disease	?	?	?	?	?
3	Aortic Dissection	?	?	?	?	?
4	Apallic Syndrome	?	?	?	?	?
5	Aplastic Anaemia	?	?	?	?	?
6	Bacterial Meningitis	?	?	?	?	?
7	Benign brain tumor	?	?	?	?	?
8	Blindness	?	?	?	?	?
9	Cancer of specified severity	?	?	?	?	?
10	Cardiomyopathy including Peripartum and postpartum Cardiomyopathy	?	?	?	?	?
11	Coma of specified severity	?	?	?	?	?
12	Deafness	?	?	?	?	?
13	End stage liver failure	?	?	?	?	?
14	End stage lung failure	?	?	?	?	?
15	Fulminant Viral Hepatitis	?	?	?	?	?
16	Kidney failure requiring regular dialysis	?	?	?	?	?
17	Loss of independent existence	?	?	?	?	?
18	Loss of limbs	?	?	?	?	?
19	Loss of speech	?	?	?	?	?
20	Major head trauma	?	?	?	?	?
21	Major organ /bone marrow transplant	?	?	?	?	?
22	Medullary Cystic Kidney Disease	?	?	?	?	?
23	Motor neuron disease with permanent symptoms	?	?	?	?	?
24	Multiple sclerosis with persisting symptoms	?	?	?	?	?
25	Muscular Dystrophy	?	?	?	?	?
26	Myocardial infarction	?	?	?	?	?
27	Nephrotic syndrome	?	?	?	?	?

28	Open chest CABG	?	?	?	?	?
29	Open heart replacement or repair of heart valves	?	?	?	?	?
30	Parkinson's Disease	?	?	?	?	?
31	Permanent paralysis of limbs	?	?	?	?	?
32	Pituitary apoplexy in pregnancy	?	?	?	?	?
33	Pneumonectomy	?	?	?	?	?
34	Primary (idiopathic) pulmonary hypertension	?	?	?	?	?
35	Progressive Scleroderma	?	?	?	?	?
36	Severe Rheumatoid Arthritis	?	?	?	?	?
37	Stroke resulting in permanent symptoms	?	?	?	?	?
38	Systematic Lupus Erythematous with Renal Involvement	?	?	?	?	?
39	Third degree burns	?	?	?	?	?
40	Uterine inversion	?	?	?	?	?
41	Uterine Rupture	?	?	?	?	?

* We will not make payment under the Section 2.7 (Critical Illness) in respect of an Insured Person and for any and all Policy period/ Coverage Period more than once in the Insured Person's lifetime. In any Policy period/ Coverage Period a claim can be triggered for one life only except in co-applicants/ spouse option wherein claim can be triggered for both the lives in the same Policy period/ Coverage Period.

ANNEXURE III-

EXPENSES NOT COVERED OR SUBSUMED INTO ROOM CHARGES / PROCEDURE CHARGES / COSTS OF TREATMENT

List I – Expenses not covered

Sl. 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)
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

Sl. 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
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

Sl. 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, HARMONICSCALPEL,SHAVER
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

Sl. 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/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
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

ANNEXURE IV

List of Health Check Ups

Health Check-up Options						
Sr	Tests	Option 1	Option 2	Option 3	Option 4	Option 5
1	CBC-(Haemoglobin, PCV, TLC, RBC Count, MCV, MCH, MCHC, Platelet Count, Automated DLC, Absolute Differential Counts, RDW	✓	✓	✓	✓	Up to the limit chosen without any prescribed limit
2	Urine -Routine and Microscopic	✓	✓	✓	✓	
3	Random Blood Sugar	✓	✓	✗	✗	
4	Blood Sugar-Fasting and Post Prandial	✗	✗	✓	✓	
5	Serum Cholesterol	✓	✓	✗	✗	
6	Lipid Profile	✗	✗	✓	✓	
7	Serum Creatinine and Urea	✓	✓	✓	✓	
8	Serum LDL	✓	✗	✗	✗	
9	Serum LDL and HDL	✗	✓	✗	✗	
10	HBA1C	✗	✓	✓	✓	
11	Renal Function Test	✗	✓	✓	✓	
12	Liver Function Test	✗	✓	✓	✓	
13	Thyroid function test	✗	✓	✓	✓	
14	X-ray, Ultra Sound	✗	✓	✓	✓	
15	Pap Smear (For Female),PSA-Male	✗	✓	✓	✓	
16	ECG	✗	✓	✓	✓	
17	Serum Electrolytes	✗	✓	✓	✓	
18	Uric acid	✗	✓	✓	✓	
19	Calcium	✗	✓	✓	✓	
20	Vitamin B12	✗	✗	✓	✓	
21	Vitamin D3	✗	✗	✓	✓	
22	Bone densitometry test	✗	✗	✓	✓	
23	2D ECHO	✗	✗	✗	✓	
24	TMT	✗	✗	✗	✓	
25	Mammography & Female hormones (For female)	✗	✗	✗	✓	
26	ESR	✗	✗	✗	✓	
27	Dental consultation	✗	✗	✗	✓	
28	Physician Consultation	✓	✓	✓	✓	

Annexure V
List of covered vaccinations

Time interval	Vaccination to be done (Age)	Frequency
0-3 months	BCG (From birth to 1 weeks)	1
	OPV (1 week) + IPV1 (6 week,10 weeks)	3
	DPT (6& 10 week)	2
	Hepatitis-B (0 & 6 week,)	2
	Haemophilus influenzae type B (Hib) (6 & 10 Week)	2
	Rota (6 & 10 Week)	2
3-6 months	OPV (6 month) + IPV (14 week)	2
	DPT (14 week)	1
	Hepatitis-B (6 month)	1
	Haemophilus influenzae type B (Hib) (14 week)	1
	Rota (14 week)	1
9 months	MMR (9 Months)	1
	OPV (9 Months)	1
12 months	Typhoid(12 Months)	1
	Hepatitis A (12 Months)	1

Annexure VI
List of Named Illnesses

Air Borne Communicable Disease	
S. No.	**Disease**
1	Pulmonary Tuberculosis
2	Avian Flu (H5 N1)
3	Swine Flu
4	Meningitis

Water Borne Communicable Disease	
S. No.	**Disease**
1	Cholera
2	Infectious Hepatitis- A&E
3	Gastroenteritis
4	Typhoid

Vector Borne Communicable Disease	
S.No.	**Disease**
1	Malaria
2	Dengue
3	Chikungunya
4	Japanese Encephalitis
5	Lymphatic Filariasis

Common Surgical Procedure		
S.No.	**System**	**Procedure**
1	Cardiology	Angiography (Day Care)
2	Cardiology	Pacemaker Implantation (temporary /permanent) including cost of implant
4	Cardiology	EPS and RFA
5	Dental Surgery	Impacted Wisdom Tooth extraction (one tooth per year)
6	E.N.T	Tonsillectomy
7	E.N.T	Adenotonsillectomy
8	E.N.T	Tympanoplasty (unilateral/bilateral)
11	E.N.T	Nasal Polyps/ Sinusitis (FESS)- (Unilateral/Bilateral)
12	E.N.T	Cortical Mastoidectomy With/without Myringoplasty (unilateral/bilateral)

14	E.N.T	Septoplasty with or without Turbinoplasty (unilateral/bilateral)
15	E.N.T	Myringotomy with Grommet insertion (unilateral/bilateral)
16	General Surgery	Haemorrhoidectomy with/without fissurectomy including cost of stapler
20	General Surgery	Appendicectomy (Lap)
21	General Surgery	Cholecystectomy (Lap)
22	General Surgery	Excision Of Pilonidal Sinus With Flap Cover
23	General Surgery	Mastectomy
25	General Surgery	Thyroidectomy (Total/Subtotal)
26	General Surgery	Herniorraphy/Hernioplasty- Unilateral /Bilateral (including cost of tacker and mesh)
29	General Surgery	Circumcision (medically necessary)
31	General Surgery	Lumpectomy
32	General Surgery	AV Fistula
33	General Surgery	Hydrocele
34	General Surgery	Right or left Hemi Colectomy
35	General Surgery	Exploratory Laparotomy
37	General Surgery	Varicose Veins(surgical or laser)
38	Neurology	VP Shunting
39	Obstetrics & Gynecology	Laparoscopic Hysterectomy (Abdominal/Vaginal)
40	Obstetrics & Gynecology	Ovarian Cystectomy or Ovarian Drilling (laproscopic or conventional)
41	Obstetrics & Gynecology	Dilatation & Curettage (D&C)
42	Obstetrics & Gynecology	Vaginal-Vault Prolapse Repair
44	Obstetrics & Gynecology	Myomectomy
45	Obstetrics & Gynecology	Surgery for Ectopic pregnancy
46	Ophthalmology	Cataract including cost of lens (unilateral/bilateral)
47	Ophthalmology	Retinal Detatchment Correction (unilateral/bilateral)
48	Ophthalmology	Vitrectomy (unilateral/bilateral)
54	Orthopaedics	Fracture Neck Femur (Bipolar Arthroplasty/Multiple Screw Fixation including cost of implant
56	Orthopaedics	Arthroscopic surgery of knee (Other Than ACL) / Menisectomy) (unilateral/bilateral)
57	Orthopaedics	ACL Reconstruction (unilateral/bilateral)
58	Orthopaedics	Stabilization of spinal column including cost of implant
59	Orthopaedics	Carpal Tunnel Release (unilateral/bilateral)

60	Orthopaedics	Fracture of any kind requiring Closed Reduction and Internal Fixation / Open Reduction and Internal Fixation
63	Orthopaedics	MCL Reconstruction/Repair (unilateral/bilateral)
64	Orthopaedics	Reduction of dislocation under general anesthesia (including cost of implant is any)
65	Urology	Removal of renal stones
67	Urology	Meatotomy
69	Urology	TURP
71	Urology	Orchidectomy (unilateral/bilateral)
72	Urology & Nephrology	Nephrectomy/Nephrolithotomy/Pyelolithotomy (unilateral/bilateral)

Annexure VII
List for Sub-limits

Sr	Procedure	Group	Specialisation	Options		
				A	B	C
1	Tonsillectomy	Tonsillectomy	E.N.T	25,000	21,000	18,000
2	Mastoidectomy	Mastoidectomy	E.N.T	40,000	34,000	29,000
3	Septoplasty	Deviated Nasal Septum	E.N.T	35,000	30,000	26,000
4	Haemorrhoidectomy including Cost of stapler	Piles/Haemorrhoid	General Surgery	40,000	34,000	29,000
5	Haemorrhoidectomy and Fissurectomy in a single sitting	Piles/Haemorrhoid	General Surgery	35,000	30,000	26,000
6	Fissure Dilatation	Anal fissure	General Surgery	20,000	17,000	14,000
7	Fissurectomy	Anal fissure	General Surgery	30,000	26,000	22,000
8	Fistulectomy	Fistula	General Surgery	30,000	26,000	22,000
9	Cholecystectomy	Cholelithiasis/Cholecystitis	General Surgery	35,000	30,000	26,000
10	Excision Of Pilonidal Sinus	Pilonidal Sinus/abcess	General Surgery	30,000	26,000	22,000
11	Thyroidectomy (Total/Subtotal)	Goitre/Thyroid Cancer	General Surgery	50,000	43,000	37,000
12	Hernioplasty/Herniorraphy- Unilateral including cost of mesh and tacker	Hernia	General Surgery	45,000	38,000	32,000
13	Hernioplasty/Herniorraphy- Bilateral including Cost of mesh and tacker	Hernia	General Surgery	50,000	43,000	37,000
14	URS (therapeutic) Including cost of laser treatment	Renal stone removal	General Surgery	35,000	30,000	26,000
15	PCNL- Unilateral	Renal stone removal	Urology & Nephrology	50,000	43,000	37,000
16	PCNL- Bilateral	Renal stone removal	Urology & Nephrology	60,000	51,000	43,000
17	TURP/Laser Holmium	BPH	Urology & Nephrology	50,000	43,000	37,000
18	Varicose Veins(surgical as well as laser) Unilateral	Varicose Veins	Vascular Surgery	45,000	38,000	32,000
19	Varicose Veins(surgical as well as laser) Bilateral	Varicose Veins	General Surgery	50,000	43,000	37,000
20	Hydrocele	Hydrocele	General Surgery	25,000	21,000	18,000
21	Appendicectomy	Appendicitis	General Surgery	45,000	38,000	32,000
22	Cataract per eye including Cost of Lens	Cataract	Opthalmology	25,000	21,000	18,000
23	Hysterectomy (Abdominal/Vaginal)	Abnormal Uterine Bleeding/Fibroid Uterus/Endometriosis	Obstretics & Gynae.	55,000	47,000	40,000
24	Total Knee Replacement (Unilateral) including cost of implants	Knee replacement	Orthopaedics	1,00,000	85,000	72,000
25	Total Knee Replacement (Bilateral) including cost of implants	Knee replacement	Orthopaedics	1,50,000	1,28,000	1,09,000
26	Hip Replacement (Unilateral) including cost of implants	Hip Replacement	Orthopaedics	1,00,000	85,000	72,000
27	Hip Replacement (Bilateral) including cost of implants	Hip Replacement	Orthopaedics	1,50,000	1,28,000	1,09,000
28	Arthroscopic Surgery (Other Than ACL / Menisectomy)	Arthroscopic Surgery for knee pain	Orthopaedics	40,000	34,000	29,000
29	CABG	CABG	Cardiology	2,00,000	1,70,000	1,45,000
30	Angioplasty including cost of implants and angiography	IHD	Cardiology	1,50,000	1,28,000	1,09,000
31	Valve Replacement including cost of implants	Valve Replacement in heart	Cardiology	2,00,000	1,70,000	1,45,000
32	Temporary Pacemaker Implantation including cost of temporary pacemaker	Temporary Pacemaker Implantation including cost of temporary pacemaker	Cardiology	20,000	17,000	14,000
33	EPS and RFA	EPS and RFA for Arrythmia	Cardiology	70,000	60,000	51,000

Annexure VIII

List of Prosthetics

Prosthetic	Subtype	Option I	Option II
Upper limb	Below elbow (**standard type**) with cosmetic hand prosthesis	30,000	50,000
	Below elbow myoelectric prosthesis	3,25,000	50,00,000
	Shoulder disarticulation prosthesis	70,000	50,00,000
	Above elbow	60,000	50,00,000
	Wrist with finger	40,000	35,00,000
Lower Limb	Below knee	30,000	16,00,000
	Above knee	70,000	22,00,000
	Hip disarticulation	1,00,000	40,00,000