care HEALTH® INSURANCE

BEST HEALTH INSURANCE COMPANY IN RURAL SECTOR

CLAIMS SERVICE LEADER OF THE YEAR

INDIA INSURANCE SUMMIT & AWARDS 2024

group care 360°

Know Your Policy Better

Policy Terms and Conditions

Preamble:

The proposal and declaration given by the proposer and other documents if any shall form the basis of this Contract and is deemed to be incorporated herein. The two parties to this contract are the Policy Holder/Insured Members (also referred as Insured) and Care Health insurance Company Ltd. (also referred as Company), and all the Provisions of Indian Contract Act, 1872, shall hold good in this regard. The references to the singular include references to the plural; references to the male include the references to the female; and references to any statutory enactment include subsequent changes to the same and vice versa. The sentence construction and wordings in the Policy documents should be taken in its true sense and should not be taken in a way so as to take advantage of the Company by filing a claim which deviates from the purpose of Insurance.

In return for premium paid, the Company will pay the Insured in case a valid claim is made:

In consideration of the premium paid by the Policy Holder, subject to the terms & conditions contained herein, the Company agrees to pay/indemnify the Insured Member(s)/Claimant, the amount of such expenses that are reasonably and necessarily incurred up to the limits specified against respective benefit in any Cover Period.

For the purposes of interpretation and understanding of the product the Company has defined, herein below some of the important words used in the product and for the remaining language and the words the Company believes to mean the normal meaning of the English language as explained in the standard language dictionaries. The words and expressions defined in the Insurance Act, IRDA Act, regulations notified by the Insurance Regulatory and Development Authority ("Authority") and circulars and guidelines issued by the Authority shall carry the meanings described therein. The terms and conditions, insurance coverage and exclusions, other benefits, various procedures and conditions which have been built-in to the product are to be construed in accordance with the applicable provisions contained in the product.

The terms defined below have the meanings ascribed to them wherever they appear in this Policy and, where appropriate.

1. Definitions

1.1 Standard Definitions:

1.1.1 **Accidental / Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

1.1.2 **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.

1.1.3 **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such 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.

1.1.4 **Any One Illness** (not applicable for Travel and Personal Accident Insurance) means a continuous Period of Illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where the treatment was taken.

1.1.5 **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.

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

1.1.7 **Congenital Anomaly** refers to a condition which is present since birth, and which is abnormal with reference to form, structure or position :

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

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

1.1.8 **Co-payment** is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured.

1.1.9 **Cumulative Bonus** shall mean any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

1.1.10 **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup within 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 criteria as under—

i. Has qualified nursing staff under its employment;

ii. Has qualified Medical Practitioner/s in-charge;

iii. Has a fully equipped operation theatre of its own, where Day Care Treatment is carried out.

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

1.1.11 **Day Care Treatment** means medical treatment, and/ or Surgical Procedure which is:

i. undertaken under general or local anesthesia in a Hospital/ Day Care Centre in less than 24 consecutive hours because of technological advancement, and

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

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

1.1.12 **Deductible** is 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.

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

1.1.14 **Disclosure to Information Norm:** The Policy shall be void and all premium paid thereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

1.1.15 **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:

i. The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or

ii. The patient takes treatment at home on account of non-availability of room in a Hospital.

1.1.16 **Emergency Care (Emergency)** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured Person's health.

1.1.17 **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

1.1.18 **Hospital** (not applicable for Overseas Travel Insurance) means any institution established for in-patient 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 the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

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

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

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

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

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

1.1.19 **Hospitalization** (not applicable for Overseas Travel Insurance) means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

1.1.20 **Illness** means a sickness or a disease or a 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:

(a) It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests;

(b) It needs ongoing or long-term control or relief of symptoms;

(c) It requires rehabilitation for the patient or for the patient to be specially trained to cope with it;

(d) It continues indefinitely;

(e) It recurs or is likely to recur.

1.1.21 **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.

1.1.22 **In-patient Care** (not applicable for Overseas Travel Insurance) means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

1.1.23 **Intensive Care Unit (ICU)** 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 criticalcondition, 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.

1.1.24 **ICU Charges** or (Intensive care Unit) Charges means the amount charged by a Hospital towards ICU expenses on a per day basis 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.

1.1.25 **Maternity expenses shall include —**

(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.

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

1.1.27 **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.

1.1.28 **Medical Practitioner** (not applicable for Overseas Travel Insurance) is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

1.1.29 **Medically Necessary Treatment** (not applicable for Overseas Travel Insurance) means any treatment, tests, medication, 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 Person;

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.

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

1.1.31 **Network Provider** (not applicable for Overseas Travel Insurance) means the Hospitals enlisted by an Insurer, TPA or jointly by an Insurer and TPA to provid medical services to an Insured by a Cashless Facility.

1.1.32 **Newborn baby** means baby born during the Policy Period and is aged up to 90 days.

1.1.33 **Non - Network Provider:** Non-Network means any hospital, day care centre or other provider that is not part of the network.

1.1.34 **Notification of Claim** means the process of intimating a Claim to the Insurer or TPA through any of the recognized modes of communication.

1.1.35 **OPD Treatment** is one in which the Insured Person 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.

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

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

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

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

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

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

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

1.1.39 **Post-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the Hospital provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's

Hospitalization was required and

ii. The inpatient Hospitalization claim for such Hospitalization is admissible by the Company.

1.1.40 **Qualified Nurse** (not applicable for Overseas Travel Insurance) is a person who holds a valid registrationfrom the Nursing Council of India or the Nursing Council of any state in India.

1.1.41 **Reasonable and Customary Charges** (not applicable for Overseas Travel Insurance) 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.

1.1.42 **Renewal** defines 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.

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

1.1.44 **Subrogation** (Applicable to other than Health Policies and health sections of Travel and PA policies) means the right of the Insurer to assume the rights of the Insured Person to recover expenses paid out under the Policy that may be recovered from any other source.

1.1.45 **Surgery/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 a Day Care Centre by a Medical Practitioner.

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

1.1.47 **AYUSH treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

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

1.1.49 **Specific waiting period** (Named Ailment 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.

1.2 **Specific Definitions:**

1.2.1 **Act of God Perils** means and includes lightening, storm, tempest, flood, inundation, subsidence, landslide, earthquake, cyclone, tsunami, volcano and other similar calamities;

1.2.2 **Actively at Work** Refers to an employee who is actually at work on his/her eligibility date and performing each and every duty of his/her present occupation on a customary and full- time basis. An employee shall also be deemed actively at work if he/she is on annual leave and is not absent from work due to long term illness, irrecoverable condition etc. If an employee is not actively at work on his/her cover start date, he/she will not be covered.

1.2.3 **Activities of Daily Living** Applies to a member (who is eligible for cover under this policy) and who is aged at least five 5 years old who cannot perform the following activities:

- Dressing: The ability to put on, take off, secure, and unfasten all garments and as appropriate, any braces, artificial limbs, or other surgical appliances;
- Feeding: The ability to feed one's self once food has been prepared and made available;
- Mobility: The ability to move indoors from room to room on level surfaces;
- Toileting: The ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
- 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.

1.2.4 **Age** means the completed age of the Insured Member as on his last birthday.

1.2.5 **Alternative Treatments** Treatment refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy system

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

1.2.7 **Annexure** means the document attached and marked as Annexure to this Policy.

1.2.8 **Area/Area** of Cover Refers to one of the following as stated on Policy Schedule and/or endorsement:

(a) Zone 1:Worldwide: worldwide

(b) Zone 2:Worldwide excluding USA: worldwide excluding the USA and US Minor Outlying Islands

(c) Zone 3:India

Insured member's principal country of residence: The country where the Insured lives or intends to live for most of the Policy Year being one hundred eighty-five (185) days or

more and which will be shown as the place of residence in our records.

1.2.9 **Assistance Service Provider** means the service provider specified in the Policy Schedule or as appointed by the Company from time to time.

1.2.10 **Certificate of Insurance** means the certificate the Company issues to an Insured Member evidencing cover under the Policy.

1.2.11 **Claim** means a demand made in accordance with the terms and conditions of the Policy for payment of the specified Benefits in respect of the Insured Member as covered under the Policy.

1.2.12 **Claimant** means a person who possesses a relevant and valid Insurance Policy which is issued by the Company and is eligible to file a Claim in the event of a covered loss.

1.2.13 **Common Carrier** means any civilian land or water conveyance or Scheduled Airline in each case operated under a valid license for the transportation of passengers for hire.

1.2.14 **Company** (also referred as Insurer/We/Us) means Care Health Insurance Limited.

1.2.15 **Cover End Date** means the date specified in Annexure 'A'(Certificate of Insurance) for the respective Insured Member on which the Insured Member's cover under the Policy expires.

1.2.16 **Cover Period** means the period commencing from the Cover Start Date and ending on the Cover End Date for each Insured Member as specified in Annexure 'A' (Certificate of Insurance).

1.2.17 **Cover Start Date:** means the date specified in Annexure 'A' (Certificate of Insurance) for the respective Insured Member on which the Insured Member's cover under the Policy commences.

1.2.18 **Country of Residence** means the country in which the Insured Member is currently residing and as specified in the Insured's address in the Certificate of Insurance

1.2.19 **Critical Illnesses** (Indemnity basis): Coverage for Critical Illnesses is limited to the below definitions and extent of coverage. These definitions should be read in conjunction with the Critical Illness opted against Optional Benefit 1 (Hospitalization Expenses) in the Certificate of Insurance. Coverage will only be as per the Critical Illness opted

i. Cancer (Varies from IRDAI Standard Definitions 2016)

(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 and confirmed by a pathologist.

(II) The term cancer includes

A. leukemia, lymphoma, and sarcoma.

B. Tumor's showing the malignant changes of carcinoma in situ and tumours which are histologically described as pre-malignant or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3

The following are excluded:

A. Benign lesions

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

C. Papillary micro - carcinoma of the thyroid less than 1 cm in diameter;

D. Microcarcinoma of the bladder;

E. All tumours in the presence of HIV infection.

Heart Related Conditions

ii. Pulmonary Thromboembolism

Acute Pulmonary Thromboembolism: means the blockage of an artery in the lung by a clot or other tissue from another part of the body. The Pulmonary Embolus must be unequivocally diagnosed by a specialist on either a V/Q scan (the isotope investigation which shows the ventilation and perfusion of the lungs), angiography or echocardiography, with evidence of right ventricular dysfunction and conformation with D Dimer assay findings, and requiring medical or surgical treatment on an inpatient basis.

iii. Primary(Idiopathic) Pulmonary Hypertension (Varies from IRDAI Standard Definitions 2016)

A. 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.

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

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

Following are excluded:

A. Pulmonary hypertension associated with occupational and environmental factors

B. Substance abuse (like tobacco etc.)

C. lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, any heart disease and all secondary causes

iv. Infective Endocarditis

Inflammation of the inner lining of the heart caused by infectious organisms, where all of the following criteria are met:

A. Positive result of the blood culture proving presence of the infectious organism(s)

B. Presence of at least moderate heart valve incompetence (meaning regurgitate fraction of twenty percent (20%) or above) or moderate heart valve stenosis (resulting in heart valve area of thirty percent (30%) or less of normal value) directly attributable to Infective Endocarditis; without any other valvular disease/risk factors and

C. The Diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a consultant cardiologist.

v. Heart Valve Replacement/repair (Varies from IRDAI Standard Definitions 2016)

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

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

vi. Surgery of Aorta

The actual undergoing of major surgery/minimally invasive surgical repair(i.e. via percutaneous intra-arterial route) to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen with a graft. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. The treatment will be including but not limited to Angioplasty.

vii. Cardiomyopathy

A. An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a consultant cardiologist who has been treating the patient, and which results in permanent physical impairment to the degree of New York Heart Association classification Class IV, or its equivalent, based on the following classification criteria: Class IV - Inability to carry out any activity without discomfort.

B. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced. The Diagnosis of Cardiomyopathy has to be supported by echographic findings of compromised ventricular performance.

Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.

viii. Surgery for cardiac arrhythmia

Ablative Procedure is defined as catheter ablation procedures using radiofrequency or cryothermal energy for treatment of a recurrent or persistent symptomatic arrhythmia refractory to antiarrhythmic drug therapy. Ablation procedures should immediately follow the diagnostic electorphysiology study. The ablative procedure must be certified to be absolutely necessary by a consultant cardiologist (electrophysiologist).

Pre-procedural evaluation prior to ablation procedures and ablation procedures as below should be completely documented:

A. Strips from ambulatory Holter monitoring in documenting the arrhythmia.

B. Electrocardiographic and electrophysiologic recording, cardiac mapping and localization of the arrhythmia during the ablative procedure.

ix. Angioplasty

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).

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

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

x. Balloon Valvotomy/Valvuloplasty

The actual undergoing of Valvotomy or Valvuloplasty necessitated by damage of the heart valve as confirmed by a specialist in the relevant field where the procedure is performed totally via intravascular catheter based techniques.

The diagnosis of heart valve abnormality must be supported by cardiac catheterization or Echocardiogram and the procedure must be considered medically necessary by a consultant cardiologist

xi. Carotid Artery Surgery

The actual undergoing of surgery to the Carotid Artery to treat carotid artery stenosis of fifty percent (50%) and above, as proven by angiographic evidence, of one (1) or more carotid arteries. Both criteria (a) and (b) below must be met:

A. Either:

i. Actual undergoing of endarte rectomy to alleviate the symptoms; or

ii. Actual undergoing of an endovascular intervention such as angioplasty and/or stenting or at herectomy to alleviate the symptoms; and

B. The Diagnosis and medical necessity of the treatment must be confirmed by a cardio-thoracic surgeon.

xii. Coronary Artery Bypass Graft (Varies from IRDAI Standard Definitions 2016)

The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is / are narrowed or blocked, by Coronary Artery Bypass Graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist Medical Practitioner.

Exclusion: Any key-hole or laser surgery.

xiii. Pericardectomy

The undergoing of a pericardectomy performed by open heart surgery or keyhole techniques as a result of pericardial disease. The surgical procedures must be certified to be medically necessary by a consultant cardiologist. Other procedures on the pericardium including pericardial biopsies, and pericardial drainage procedures by needle aspiration are excluded.

The actual undergoing of pericardiectomy secondary to chronic constrictive pericarditis.

The following are specifically excluded:

A. Chronic constrictive pericarditis related to alcohol or drug abuse or HIV

B. Acute pericarditis due to any reason

xiv. Surgery to Place Ventricular Assist Devices or Total Artificial Hearts

This is an open chest procedure for implantation of Left Ventricular Assist Device/Ventricular Assist Device as bridges to cardiac transplantation or destination therapy for long term use for the Refractory Heart Failure with reduced ejection fraction as defined below:

NYHA Class IV symptoms who failed to respond to optimal medical management for >= 45 of the past 60 days, or have been intra-aortic balloon pump dependent for 7 days, or IV inotrope dependent for14 days.

The following are excluded:

A. Ventricular dysfunction or Heart failure directly related to alcohol or drug abuse

xv. Myocardial Infarction (Varies from IRDAI Standard Definitions 2016)

The occurrence of 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 this will be evidenced by 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 conditions are excluded:

A. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T;

B. Other acute Coronary Syndromes;

C. Any type of angina pectoris.

xvi. Implantation of Pacemaker of Heart:Actual undergoing of Insertion of a permanent cardiac pacemaker to correct serious cardiac arrhythmia which cannot be treated via other means. The insertion of the cardiac pacemaker must be certified to be

medically necessary by a specialist in the relevant field.

Following will be excluded:

A. Cardiac arrest secondary to alcohol, substance abuse or drug misuse

xvii. Implantable Cardioverter Defibrillator:

A. Actual undergoing of insertion of an implantable cardiac defibrillator to correct serious cardiac arrhythmia which cannot be treated via other methods or the insertion of permanent cardiac defibrillator to correct sudden loss of heart function with cessation of blood circulation around the body resulting in unconsciousness .

Insertion of Cardiac Defibrillator means surgical implantation of either Implantable Cardioverter-Defibrillator (ICD), or Cardiac Resynchronization Therapy with Defibrillator (CRT-D)

B. The insertion of a permanent Cardioverter-Defibrillator (ICD) must be certified to be absolutely necessary by a specialist in the relevant field.

Following will be excluded:

i. Cardiac arrest secondary to alcohol, substance abuse or drug misuse

xviii. Heart Transplant

The actual undergoing of a transplant of heart that resulted from irreversible end-stage failure of Heart.

The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

Following will be excluded:

i. Ventricular dysfunction or Heart failure directly related to alcohol or drug abuse

Conditions other than Heart and Cancer

xix. End Stage Renal Failure (Varies from IRDAI Standard Definitions 2016)

End stage renal disease presenting as chronic irreversible failure of both kidneys to function documented with raise level of S Creatinine and S Urea, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a Nephrologist.

xx. Multiple Sclerosis (Varies from IRDAI Standard Definitions 2016)

The definite occurrence of multiple sclerosis, the diagnosis of which must be supported by following, and certified by a Physician/Neurophysician:

A. Investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;

B. There must be current clinical impairment of motor or sensory function

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

xxi. Benign Brain Tumor (Varies from IRDAI Standard Definitions 2016)

A benign tumour in the brain where following conditions are met and Its presence must be confirmed by a neurologist or neurosurgeon:

A. Has potential to cause permanent damage to the brain;

B. If it has undergone surgical removal or, if inoperable, has caused a permanent neurological deficit such as but not restricted to characteristic symptoms of increased intracranial pressure such as papilloedema, mental symptoms, seizures and sensory impairment; and

C. Diagnosis is supported by findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable

imaging techniques.

D. The treatment is advised and justified medically by a certified Neurologist

Following will be excluded:

A. Cysts;

B. Granulomas;

C. Vascular malformations;

D. Haematomas;

E. Calcification;

xxii. Parkinson's Disease

Hospitalization for treatment directly related to progressive degenerative idiopathic Parkinson's Disease, certified and diagnosed by a consultant neurologist.

Following will be excluded:

A. Parkinson's disease secondary to drug and/or alcohol abuse

B. Psychiatric treatment directly or indirectly related to Parkinson's disease

This Benefit shall supersede exclusion of Parkinson's disease specified under Clause 5.2 (2) (13) of Permanent Exclusions.

xxiii. Alzheimer's Disease

A. Alzheimer's (presenile dementia) disease is a progressive degenerative disease of the brain characterized by diffuse atrophy throughout the cerebral cortex with distinctive histopathologic changes.

B. Deterioration or loss of intellectual capacity as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning requiring the continuous supervision of the Insured Person. This diagnosis must be supported by the clinical confirmation of an appropriate consultant neurologist and supported by the Company's appointed doctor.

Following will be excluded:

A. Non organic diseases such as neurosis and psychiatric illnesses;

B. Alcohol related brain damage;

C. Any other type of irreversible organic disorder/dementia;

D. Psychiatric treatment directly or indirectly related to Alzheimer's disease

This Benefit shall supersede exclusion of Parkinson's disease specified under 5.2 (2) (13) of Permanent Exclusions.

xxiv. End Stage Liver Disease (Varies from IRDAI Standard Definitions 2016)

End stage liver disease resulting in cirrhosis and irreversible liver damage, evidenced by the following criteria and certified by a Gastroenterologist :

A. Permanent jaundice;

B. Uncontrollable ascites;

C. Hepatic encephalopathy;

D. Oesophageal or Gastric Varices and portal hypertension;

Liver disease arising out of or secondary to alcohol or drug misuse is excluded.

xxv. Motor Neurone Disorder

Motor neurone disease diagnosed by a Neurophysician 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 with a clear causation relation to MND.

xxvi. End Stage Lung Disease

End Stage Respiratory Failure including Chronic Interstitial Lung Disease. Following criteria must be met:

A. Requiring permanent oxygen therapy as a result of a consistent FEV1 test value of less than one litre. (Forced Expiratory Volume during the first second of a forced exhalation);

B. Arterial Blood Gas analysis with partial oxygen pressures of 55mmHg or less;

C. This diagnosis must be confirmed by a chest/Respiratory physician.

xxvii. Bacterial Meningitis

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. This diagnosis must be confirmed by:

A. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture;

B. A consultant neurologist.

Bacterial Meningitis in the presence of HIV infection is excluded.

xxviii. Aplastic Anaemia

Chronic persistent bone marrow failure which results in Anaemia, Neutropenia and Thrombocytopenia requiring treatment with at least one of the following:

A. Blood product transfusion;

B. Marrow stimulating agents;

C. Immunosuppressive agents; or

D. Bone marrow transplantation

The diagnosis must be confirmed by a hematologist using relevant laboratory investigations including Bone Marrow Biopsy. Two out of the following three values should be present:

A. Absolute Neutrophil count of 500 per cubic millimetre or less;

B. Absolute Reticulocyte count of 20,000 per cubic millimetre or less;

C. Platelet count of 20,000 per cubic millimetre or less.

xxix. Major Organ Transplant The actual undergoing of a transplant of:

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

B. Human bone marrow using hematopoietic stem cells.

The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

The following are excluded:

A.Other stem-cell transplants;

B.Where only isletsLangerhans are transplanted.

xxx. Stroke (Varies from IRDAI Standard Definitions 2016)

A. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intra-cranial 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.

B. Evidence of permanent neurological deficit lasting for has to be produced.

The following are excluded:

I. Transient ischemic attacks (TIA);

II. Traumatic injury of the brain;

III. Vascular disease affecting onlytheeye or optic nerve or vestibular functions.

xxxi. Paralysis (Varies from IRDAI Standard Definitions 2016)

A. Total and irreversible loss of use of two or more limbs as a result of Injury or disease of the brain or spinal cord. A specialist Medical Practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery. Reconstruction surgeries required to attain best possible mobility will be included

B. Rehabilitative treatment, prosthesis and suppo rting aids like crutches/wheelchair/ vehicle/home modification will be excluded

xxxii. Major Burns (Varies from IRDAI Standard Definitions 2016)

Third degree (full thickness of the skin) burns covering at least 20% of the surface of the Insured Person's body. The condition should be confirmed by a consultant physician.

Burns arising due to self-infliction are excluded.

xxxiii. Blindness (Varies from IRDAI Standard Definitions 2016)

A. Blindness' is defined as visual acuity of less than 3/60, or a corresponding visual field loss to less than 10°, in the better eye with the best possible correction.

B. Treatments required for correction of blindness or improvement in visual acuity will be covered

Following will be excluded:

(I) Treatment for Low vision: 'low vision' is defined as visual acuity of less than 6/18 but equal to or better than 3/60, or a corresponding visual field loss to less than 20°, in the better eye with the best possible correction.

(II) Cases of blindness with Low Vision before the inception of policy

(III) Cost of enucleation related to tumor's or other eye defects

(IV) Cost of prosthesis for cosmetic correction

(V) Visual aids implantable or external

1.2.20 Critical Illness (Benefit basis): Coverage for Critical Illnesses is limited to the below definitions and extent of coverage. These definitions should be read in conjunction with the Critical Illness opted against Optional Benefit 7 (Critical Illness Fixed Benefit) in the Certificate of Insurance. Coverage will only be as per the Critical Illness opted

I. CANCER OF SPECIFIED SEVERITY

I. A malignant tumor characterized by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. 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 behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & 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 lymphocyctic 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 Tumours 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.

II. 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.

III. 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

IV. Open Heart Replacement Or Repair Of Heart Valves

I. 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.

V. 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.

VI. Kidney Failure Requiring Regular Dialysis

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

VII. 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.

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.

VIII. 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

IX. Permanent Paralysis Of Limbs

I. 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.

X. Motor Neurone Disease With Permanent Symptoms

I. Motor neurone 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.

XI. 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.

XII. 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, and tumors of skull bones, and tumors of the spinal cord.

XIII. 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 aides or surgical procedure.

XIV. 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 litre 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.

XV. 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.

XVI. Third Degree Burns

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.

XVII. Parkinson's Disease

The unequivocal diagnosis of progressive degenerative primary idiopathic Parkinson's disease (all other forms of Parkinsonism are excluded) made by a consultant neurologist. 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 five (6) "Activities of Daily Living" for a continuous period of at least 6months.

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 Drug-induced or toxic causes of Parkinsonism are excluded

This Benefit shall supersede exclusion of Parkinson's disease specified under Clause 5.2 (2) (13) of Permanent Exclusions..

XVIII. Alzheimer's Disease

Progressive and permanent deterioration of memory and intellectual capacity as evidenced by accepted standardized questionnaires and cerebral imaging.The diagnosis of Alzheimer's disease must be confirmed by an appropriate consultant and supported by the Company's appointed doctor. There must be significant reduction in mental and social functioning requiring the continuous supervision of the life assured. 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:

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. Toileting – the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

V. Feeding – the ability to feed oneself once food has been prepared and made available.

VI. Mobility - the ability to move from room to room without requiring any physical assistance.

The following are excluded:

I. Any other type of irreversible organic disorder/dementia

II. Non-organic disease such as neurosis and psychiatric illnesses; and

III. Alcohol-related brain damage.

This Benefit shall supersede exclusion of Alzheimer's disease specified under Clause 5.2 (2) (13) of Permanent Exclusions.

XIX. Bacterial Meningitis

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

Bacterial Meningitis in the presence of HIV infection is excluded.

XX. Aplastic Anaemia

Chronic Irreversible persistent bone marrow failure which results in Anaemia, Neutropenia and Thrombocytopenia requiring treatment with at least TWO of the following:

I. Regular blood product transfusion;

II. Marrow stimulating agents;

III. Immunosuppressive agents; or

IV. Bone marrow transplantation.

The diagnosis and suggested line of treatment must be confirmed by a Hematologist acceptable to the Company using relevant laboratory investigations, including bone-marrow biopsy. Two out of the following three values should be present:

I. Absolute neutrophil count of 500 per cubic millimeter or less;

II. Absolute erythrocyte count of 20 000 per cubic millimeter or less; and

III. Platelet count of 20 000 per cubic millimeter or less. Temporary or reversible aplastic anaemia is excluded.

1.2.21 **Dependent** means a person who is a member of the Primary Insured Member's family who is legally wedded spouse, natural or legally adopted child, dependent parents, dependent parent-in-law, dependent brothers , dependent sisters or who is named in Annexure "A" to the Policy as an Insured Member;

1.2.22 **Dependent Child** refers to a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his/her independent sources of income.

1.2.23 **Diagnosis** means pathological conclusion drawn by a registered medical practitioner, supported by acceptable Clinical, radiological, histological, histo-pathological and laboratory evidence wherever applicable.

1.2.24 **Geographical Scope** means the countries or geographical boundaries in which the coverage under the Policy is valid as specified in the Certificate of Insurance

1.2.25 **Hazardous Activities** (or Adventure sports) means any sport or activity or Adventure sport, which is potentially dangerous to the Insured whether he is trained or not. Such sport/activity includes stunt activities of any kind, adventure racing, base jumping, biathlon, big game hunting, black water rafting, BMX stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/ pot holing, cave tubing, rock climbing/ trekking/ mountaineering, cycle racing, cyclo cross, drag racing, endurance testing, hand gliding, harness racing, hell skiing, high diving , hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, lugging, risky manual labor, marathon running, martial arts, micro – lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/ parapenting, piloting aircraft, polo, power lifting, power boat racing, quad biking, river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting or wrestling of any type.

1.2.26 **Immediate Family Member** means an Insured Member's lawful spouse, children only.

1.2.27 **Indemnity/Indemnify** means compensating the Policy Holder/Insured Member up to the extent of Expenses incurred, on occurrence of an event which results in a financial loss and is covered as the subject matter of the Insurance Cover.

1.2.28 **Insured Event** means an event that is covered under the Policy; and which is in accordance with the Policy Terms & Conditions.

1.2.29 **Insured Member** (Insured) means a person whose name specifically appears under Insured in the Annexure A or the Certificate of Insurance and is a covered group member.

1.2.30 **Life Threatening Medical Condition** means a medical condition suffered by the Insured Member which has the following characteristics:

(a) Markedly unstable vital parameters (blood pressure, pulse, temperature and respiratory rate); or

(b) Acute impairment of one or more vital organ systems (involving brain, heart, lungs, liver, kidneys and pancreas); or

(c) Critical care being provided, which involves high complexity decision making to assess, manipulate and support vital system functions to treat single or multiple vital organ failures and requires interpretation of multiple physiological parameters and application of advanced technology; or

(d) Critical care being provided in critical care area such as coronary care unit, intensive care unit, respiratory care unit, or the emergency department;

and certified by the attending Medical Practitioner as a Life Threatening Medical Condition

1.2.31 **Medically Dependent** means mentally or physically disabled, unable to perform 'Activities of Daily living' without the assistance or direction of another person

1.2.32 **Nominee** means the person named in the Certificate

of Insurance who is nominated to receive the benefits under this Policy in accordance with the terms of the Policy, if the Insured Member is deceased.

1.2.33 **Non-Allopathic Medical Practitioner** for the purpose of Alternative Forms of Medicine means a Medical Practitioner qualified and practicing Ayurveda or Unani or Sidha or Homeopathic forms of Medicine for treatment of Illness/Injury, and registered as per Indian Medicine Central Council Act, 1970.

1.2.34 **Physiotherapist** refers to a person who is licensed to practice as a physiotherapist where the treatment is to take place and is recognized as a physiotherapist.

1.2.35 **Preferred Provider** means the Hospital empanelled by the Company or TPA and enlisted on the Preferred Provider Network List, specified in the Policy Schedule (and as updated by the Company from time to time).

An updated list of 'Preferred Provider Network' may be obtained from the Company's website or the call centre.

1.2.36 **Policy means** these Policy Terms & Conditions, Optional Extensions (if any), the Proposal Form, Policy Schedule, Endorsements, Member List and Annexures which form part of the policy contract and shall be read together.

1.2.37 **Policy Schedule** is a Schedule attached to and forming part of this Policy.

1.2.38 **Policy Year** means a period of one year commencing on the Policy Period Start Date or any anniversary thereof.

1.2.39 **Policyholder** (also referred as You) means the person or the entity who is the Group Administrator and named in the Policy Schedule as the Policyholder.

1.2.40 **Policy Period** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date of the Policy as specifically appearing in the Policy Schedule.

1.2.41 **Policy Period End Date** means the date on which the Policy expires, as specifically appearing in the Policy Schedule.

1.2.42 **Policy Period Start Date** means the date on which the Policy commences, as specifically appearing in the Policy Schedule.

1.2.43 **Prescription** Refers to out-patient drugs (excluding supplements, vitamins and traditional medicine) and dressings as prescribed by a medical practitioner for the treatment of a medical condition covered by your member's plan. For avoidance of doubt, prescription will not include vitamins nor supplements nor over the counter medication even if they are prescribed by a medical practitioner.

1.2.44 **Preventive Care** means any kind of treatment taken as a pro-active care measure without actual requirement or symptoms of a disease or illness.

1.2.45 **Primary Insured Member** means employee or a member of group who satisfies and continues to satisfy the eligibility criteria specified in the Certificate of Insurance and who is named in Annexure "A" to the Policy as an Insured Member.

1.2.46 **Rehabilitation** means assisting an Insured Member who, following a medical condition, requires assistance in physical, vocational, independent living and educational pursuits to restore him to the position in which he was in, prior to such medical condition occurring.

1.2.47 **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.

1.2.48 **Scheduled Airline** means any civilian aircraft operated by a civilian scheduled air carrier holding a certificate, license or similar authorization for civilian scheduled air carrier transport issued by the country of the aircraft's registry, and which in accordance therewith flies, maintains and publishes tariffs for regular passenger service between named cities at regular and specified times, on regular or chartered flights operated by such carrier.

1.2.49 **Senior Citizen** means any person who has completed sixty or more years of age as on the date of commencement or renewal of the policy.

1.2.50 **Specialized Practitioner** refers to a or practitioner who specializes in at least one of the following acupuncture, osteopathy, chiropractic or Chinese traditional medicine and is qualified and registered in the country where the out-patient treatment is to take place.

1.2.51 **Service Provider** means any person, organization, institution that has been empanelled with the Company to provide Services specified under the benefits.

1.2.52 **Sum Insured** (Base Coverage Amount) means the amount specified against each Benefit for Member in the Policy Schedule which represents Our maximum liability for that Insured Member for any and all Claims incurred in respect of that Insured Member during the Cover Period.

1.2.53 **Third Party Administrator or TPA** means any person who is licensed under the IRDA (Third Party Administrators-Health Services) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an Insurance Company, for the purposes of providing health services.

1.2.54 **Twin Sharing Room** means a Hospital room where at least two patients are accommodated at the same time. Such room shall be the most basic and the most economical of all accommodations available as twin sharing rooms in that Hospital.

1.2.55 **Associate Medical Expenses** means those Medical Expenses as listed below which vary in accordance with the Room Rent or Room Category applicable in a Hospital:

(a) Room, boarding, nursing and operation theatre expenses as charged by the Hospital where the Insured Member availed medical treatment;

(b) Fees charged by surgeon, anesthetist, Medical Practitioner;

Note: Associate Medical Expenses are not applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

'Outside India': The following definitions are redefined:

1.2.56 **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities in that country or complies with all minimum criteria as under:

(a) has qualified nursing staff under its employment round the clock;

(b) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient 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.

1.2.57 **Medical Practitioner** means a person who holds a valid registration issued by the Medical Council/Statutory Regulatory Authority for Medical Education in that Country and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

Refers to a person (other than you, your member, or a business partner or a relative of yours or your member) has the primary degrees in the practice of Allopathy and surgery following attendance at a recognized medical school and who is licensed to practice Allopathy by the relevant licensing authority where the treatment is given. By 'recognized medical school' we mean "a medical school which is listed in AVICENNA Directory, which is in collaboration with the World Health Organization and the World Federation for Medical Education".

1.2.58 **Network Provider** means Hospitals enlisted by an insurer or by a Assistance Service Provider together to provide services to an insured on payment by a cashless facility;

1.2.59 **Qualified Nurse** means a person who holds a valid registration issued by the Nursing Council/Statutory Regulatory Authority for Medical Education in that Country and thereby entitled to render Nursing Care within the scope and jurisdiction of license.

1.2.60 **Reasonable and customary (R&C)** means charges or treatment for medical care which shall be considered by the Company or by Company's medical advisers to be reasonable and customary to the extent that they do not exceed the general level of charges or treatment being made by others of similar standing in the locality where the charges or treatment are incurred when giving like or comparable treatment.

If the charges are higher than customary or the treatment is not reasonable and customary, the Company will only pay the amount which is, in the Company's experience, customarily charged and Insured has to pay the rest.

1.2.61 **Unproven/Experimental Treatment** means a treatment, procedure including drug experimental therapy and/or supply which is not based on established medical practice, is treatment experimental or unproven or investigational when it does not comply with the following requirements:

(a) It is medically accepted by a consensus of peer professionals and like specialists with evidence-based medicine (best practices) that a beneficial effect and demonstrated efficacy for a specific diagnosis exists.

(b) It is supported by evidence-based medicine with conclusive clinical research and demonstrated benefits.

(c) The service, procedure, drug, or treatment must meet the standard of practice guidelines accepted in the United States of America, regardless of the place where the service is performed. Drugs must have approval from the Food and Drug Administration (FDA) in the United States for use for the diagnosed condition, or other federal or state government agency approval required in the United States of America, independent of where the medical treatment is incurred or bills issued.

(d) All treatments must have passed through and completed all phases of human clinical trials, studies, and protocols under the supervision of appropriate medical review, investigational review boards, hospital ethics committees, and/or international scientific community or associations.

2. Scope Of Cover

General Conditions Applicable To All The Optional Benefits And Optional Extensions:

1. **Deductible options available are on aggregate basis:**

- Deductible options available for 'Optional Benefit 1 (Hospitalization Expenses)' and its Optional Extensions : No deductible/5k/10k/20k/30k/40k /50k/75k/1lac/2lacs/3lacs/4lacs/5lacs/7.5lacs/10lac/ 15lac/20lac
- Deductible options available for Optional Extensions under 'Optional Benefit 6 (Personal Accident)', Optional Benefit 8 (Dental Care), Optional Benefit 9 (Vision Care) and for 'Additional Optional Benefits' (as applicable): No deductible/5k/10k/20k/30k/40k/50k/75k/1lac/2lac

2. The applicability of any Optional Benefit or Optional Extension is subject to the Policyholder having opted that Optional Benefit or Optional Extension and such applicability is specified in the Policy Schedule.

Coverage will be restricted to the opted geographical scope.

3. Optional Extension will be available only when the respective Optional Benefit is opted by Insured Member/Policyholder.

4. All Claims shall be payable subject to the terms, conditions, wait periods and exclusions of the Policy and subject to availability of the Coverage amount against each and every Optional Benefit and Optional Extension.

5. Coverage Amount of any Optional Extension (excluding except Optional Extension 24: Corporate Floater of Optional Benefit 1) cannot be greater than the Coverage Amount of its respective Optional Benefit (wherever applicable) except Optional Benefit 6: Personal Accident & its Optional Extensions.

6. Coverage Amount of Optional Extension will always be a part of Coverage Amount of its respective Optional Benefit except Optional Extension 24: Corporate Floater, Optional Extension 27 : Additional Coverage Amount In Case Of Accident, Optional Extension 28 :Additional Coverage Amount In Case Of 32 Critical Illnesses under Optional Benefit 1 (Hospitalization Expenses), Optional Extensions under Optional Benefit 2: Out- patient Care, Optional Benefit 3: Daily Cash Allowance, Optional Benefit 6: Personal Accident, Optional Benefit 7: Critical Illness Fixed Benefit.

7. Any Optional Benefit or Optional Extension mentioned in the Policy Schedule can be availed either under Cashless or Reimbursement basis or both, which will be specified in the Policy Schedule.

8. Under Optional Benefit 1 (Hospitalization Expenses), a Policyholder can opt either Optional Extension 22 (Limit on Illness / Surgeries / Procedures) or Optional Extension 5 (Sub-limits on Hospitalization Expenses)

9. All the limits and sub-limits mentioned here above are subject to modification based on the customized Plan offered to group

10. The wait periods opted for Named Ailments and Maternity should be less than or equal to PED wait period opted.

11. If Policyholder has opted for both Optional Extension 15: Parent Accommodation and Optional Extension 16: Dependent Accommodation, then the Insured will be entitled to claim only under one of the benefits at a time but not under both.

12. Deductible, Co-payment, Franchise deductible is applicable on any Optional Benefit / Optional Extension only if opted for. The Company shall be liable to make payment under the Policy for any Claim in respect of the Insured only when the Deductible (if applicable), Co-payment (if applicable), Franchise deductible (if applicable) on that Claim is exhausted

13. Initial wait period, Named ailment and Pre-existing disease wait periods, will be applicable on Optional Benefit 1: Hospitalization Expenses & its Optional Extensions, Optional Benefit 3:Daily Cash Allowance & its Optional Extensions, Optional Benefit 4: Convalescence Benefit, Optional Benefit 5: Surgical Cash

14. The wait periods opted for Pre-Existing Diseases (PED), Named Ailments and Maternity for any Optional Benefit and its Optional Extensions should be applicable to other Optional Benefit and its Optional Extensions (wherever applicable). In case different wait periods are selected, then maximum wait period will be applied.

15. Under Optional Benefit 5: Surgical Cash, Coverage amount opted for 5(b) cannot exceed 5(a) and similarly Coverage amount opted for 5(c) cannot exceed 5(b)

16. The event giving rise to a Claim under Optional Benefits and Optional Extensions shall be within the Cover Year for the Claim of such Benefit to be accepted.

17. The maximum, total and cumulative liability of the Company towards an Insured Member, for any and all Claims arising under this Policy during the Cover Year, on occurrence of an insured event in relation to that Insured Member, shall not exceed the Coverage Amount of that Insured Member which is specified against every Optional Benefit / Optional Extension, mentioned in the Policy Schedule.

18. All the valid OPD claim expenses incurred by the Insured Member in a Cover Year will be payable / reimbursed by the Company. However, claim can be filed with the Company, only quarterly during that Cover Year, as and when that Insured Member may deem fit. However, claimant will be allowed only 1 more filing within 30 days after the Cover Year.

19. Admissibility of a Claim under Optional Benefit 1 (Hospitalization Expenses) is a pre-condition to the admission of a Claim under Optional Extension 1 (Pre Hospitalization & Post Hospitalization Medical Expenses), Optional Extension 6 (AYUSH Treatment), Optional Extension 4 (Donor Expenses), Optional Extension 11 (Durable Medical Equipment), Optional Extension 14(Inpatient Rehabilitation), Optional Extension 15 (Parent Accommodation), Optional Extension 16 (Dependent Accommodation), Optional Extension 18 (Modern Treatment Methods), Optional Extension 20 (Room Rent Modification), Optional Extension 27 (Addl. SI in case of Accident), Optional Extension 28 (Addl. SI in case of 32 CI), Optional Extension 29 (Coverage of Non-medical Expenses), Optional Extension 33 (Ambulance

Expenses).

20. Linear interpolation & extrapolation methodology will be applied to calculate the premium rates if an intermittent value of Coverage Amount and Age is chosen by the Policyholder

21. Option of Mid-term inclusion of a Member in the Policy will be only upon marriage or childbirth; Additional differential premium will be calculated on a pro rata basis

22. Maximum tenure of Policy will be applicable if tenure is varying for different benefits

23. Coverage under Optional Benefit 1 (Hospitalization Expenses – Critical Illness Indemnity), Optional Benefit 3 (Daily cash Allowance), Optional Benefit 4 (Convalescence Benefit), Optional Benefit 5 (Surgical Cash), Optional Benefit 6 (Personal Accident) & its Optional Extensions, Optional Benefit 7 (Critical Illness Fixed Benefit), Optional Benefit 10 (e) (Healthy Rewards Program), Optional Benefit A (Repatriation of Mortal Remains), Optional Benefit B (Compassionate Visit), Optional Benefit D (Patient Care), Optional Benefit F (Loss of Employment), Optional Benefit J (Accidental Hospitalization Cash)will be on individual basis only.

24. Coverage for Doctor on Call/Chat, Domestic Second Opinion, International Second Opinion, Dietician on call is on family basis and Medical Room Management is on Policy basis under Optional Benefit 10 (Health services)

25. The Company will provide coverage under the Optional Benefits 6 and its Optional extensions 1, 2, 3, 6, 8, 9, 13, 14, 15, 16, 17 to any Insured Event arising worldwide. Coverage under Optional extensions 4, 5, 7, 10, 11 & 12 is available only in Indian geography

26. Coverage under Optional Benefit 6 (Personal Accident) and Optional Benefit 7 (Critical Illness Fixed Benefit) should be in line with financial liability of Policyholder.

27. Coverage options (Worldwide, Worldwide excl. US) can be offered only under Optional Benefit 1: Hospitalization expenses (only in case of all conditions), Optional Benefit 2 : Out-patient Expenses, Optional Benefit 3 : Daily Cash Allowance, Optional Benefit 4 : Convalescence Benefit, Optional Benefit 5 : Surgical Cash, Optional Benefit 8 : Dental Care, Optional Benefit 9 : Vision Care, Optional Benefit A : Repatriation of Mortal Remains, Optional Benefit B : Compassionate Visit for non-employer employee groups

28. Under this Product, the Company will provide Policy Schedule to Policyholder and access of Certificate of Insurance will be provided to each Insured Member, therefore the references to the 'Policy Schedule' shall include references to the 'Certificate of Insurance'.

1. Optional Benefit 1 : Hospitalization Expenses

If Policyholder has opted for one of the following:

a) Coverage for only listed Critical illnesses or

b) Coverage for only surgeries or

c) Coverage for all Hospitalization conditions; and

If an Insured Member is diagnosed with an Illness or suffers an Injury which requires the Insured Member to be admitted in a Hospital due to Medically Necessary conditions, subject to the Coverage opted, during the Cover Year, and while the Policy in force for:

(a) In-patient Care (Hospitalization)

The Company will indemnify the Medical Expenses incurred which are Reasonable and Customary Charges that are Medically Necessary towards In-patient Care Hospitalization of the Insured Member, maximum up to the Coverage Amount, as specified in the Certificate of Insurance, provided that the Hospitalization is for a minimum period of 24 consecutive hours and was prescribed in written, by a Medical Practitioner, where Insured is covered for hospital charges incurred for eligible treatment given between admission and discharge of hospital.

(b) Day Care Treatment

The Company will indemnify the Medical Expenses incurred which are Reasonable and Customary Charges that are Medically Necessary towards Day Care Treatment of the Insured Member, up to the Coverage Amount specified in the Certificate of Insurance provided that:

a) the Day Care Treatment is listed as per the Annexure-I to Policy Terms & Conditions; and

b) the period of treatment of the Insured Member in Hospital/Day Care Centre does not exceed 24 hours; and

c) the Day Care Treatment was taken on the advice of a Medical Practitioner

(c) Road Ambulance Cover

The company will indemnify for the reasonable and Customary Charges necessarily incurred on availing Ambulance services offered by a Hospital or by an Ambulance service provider as specified in the Certificate of Insurance, for the Insured Member's necessary transportation provided that the necessity of such Ambulance transportation is certified by the treating Medical Practitioner and subject to the conditions specified below:

(i) Such Transportation is from the place of occurrence of Medical Emergency of the

Insured Member, to the nearest Hospital; and/or

(ii) Such Transportation is from one Hospital to another Hospital for the purpose of providing better Medical aid to the Insured Member, following an Emergency.

(d) Domiciliary Hospitalization

The Company will indemnify the Insured Member, only through Reimbursement Facility, maximum up to the Coverage Amount as specified in the Certificate of Insurance, for the Medical Expenses incurred towards Domiciliary Hospitalization, i.e.,Coverage extended when Medically Necessary treatment is taken at home (as explained in Definition 1.1.15), subject to the conditions specified below:

(i) The Domiciliary Hospitalization continues for a period exceeding 3 consecutive days.

(ii) The Medical Expenses are incurred during the Cover Year.

(iii) The Medical Expenses are Reasonable and Customary Charges which are necessarily incurred.

(iv) Any Pre Hospitalization and Post Hospitalization Medical Expenses shall not be payable under this Benefit.

(v) Any Maternity related expenses shall not be payable under this Benefit

(vi) Any Medical Expenses incurred for the treatment in relation to any of the following diseases shall not be payable under this Benefit:

1. Asthma;
2. Bronchitis;
3. Chronic Nephritis and Chronic Nephritic Syndrome;
4. Diarrhoea and all types of Dysenteries including Gastro-enteritis;
5. Diabetes Mellitus and Diabetes Insipidus;
6. Epilepsy;
7. Hypertension;
8. Influenza, cough or cold;
9. All Psychiatric or Psychosomatic Disorders;
10. Pyrexia of unknown origin for less than 10 days;
11. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis;
12. Arthritis, Gout and Rheumatism.
13. Terminal and Mental Illness

(e) Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses

The Company will indemnify the Insured Member for Relevant Medical Expenses incurred which are Medically Necessary, only through Reimbursement Facility, maximum up to the Coverage Amount, as specified in the Certificate of Insurance, provided that the Medical Expenses so incurred are related to the same Illness/Injury for which the Company has accepted the Insured Member's Claim under Optional Benefit 1 (Hospitalization Expenses) and subject to the conditions specified below:

(i) Under Relevant Pre-hospitalization Medical Expenses, for a period of 30 days immediately prior to the Insured Member's date of admission to the Hospital, provided that the Company shall not be liable to make payment for any Pre-hospitalization Medical Expenses that were incurred before the Cover Start Date;

(ii) Under Relevant Post-hospitalization Medical Expenses, for a period of 60 days immediately after the Insured Member's date of discharge from the Hospital.

(iii) The number of consultations covered by this benefit is limited to once per day.

(iv) This benefit does not cover follow-up consultation or treatment after the Insured Member is discharged from an in-patient rehabilitation facility.

(v) If the provisions of Clause 7.6(f) is applicable to a Claim, then:

a) The date of admission to Hospital for the purpose of this Benefit shall be the date of the first admission to the Hospital for the Illness deemed or njury sustained to be Any One Illness; and

b) The date of discharge from Hospital for the purpose of this Benefit shall be the last date of discharge from the Hospital in relation to the Illness deemed or Injury sustained to be Any One Illness.

(f) Psychiatric Treatment (Applicable only if all hospitalization conditions cover opted for)

The Company will indemnify the Insured Member, which are Reasonable and Customary Charges that are Medically Necessary maximum up to the coverage amount as specified in the Certificate of Insurance, for the Medical Expenses incurred towards psychiatric treatment.

(g) Bariatric Surgery (Applicable only if 'All Hospitalization Conditions or 'only Surgeries' cover opted for)

The Company will indemnify the Insured Member, which are Reasonable and Customary Charges that are Medically Necessary maximum up to the amount as specified in the Certificate of Insurance, for the Medical Expenses incurred towards Bariatric Surgery treatment provided that:

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);

a) greater than or equal to 40 or

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

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

All treatments under this Benefit must be pre-authorised by the Company in writing.

(h) Modern Treatment Methods:

The Company will indemnify the Insured Member, which are Reasonable and Customary Charges that are Medically Necessary maximum up to the amount as specified in the Certificate of Insurance, for the Medical Expenses incurred towards treatment done through following modern treatment methods:

I Uterine Artery Embolization and HIFU

II Balloon Sinuplasty

III Deep Brain stimulation

IV Oral chemotherapy

V Immunotherapy- Monoclonal Antibody to be given as injection

VI Intra vitreal injections

VII 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.

(i) Age related Macular Degeneration (Applicable only if 'All Hospitalization Conditions or 'only Surgeries' cover opted for): The Company will indemnify the Insured Member, which are Reasonable and Customary Charges that are Medically Necessary maximum up to the amount as specified in the Certificate of Insurance, for the Medical Expenses incurred towards Age related Macular Degeneration.

All Treatment under this Benefit must be pre-authorised by the Company in writing.

(j) Conditions applicable for Hospitalization Expenses (Optional Benefit 1):

(a) Room/Boarding and nursing expenses as charged by the Hospital where the Insured Member availed medical treatment (Room Rent / Room Category):

If the Insured Member is admitted in a Hospital room where the Room Category opted or Room Rent incurred is higher than the eligible Room Category/ Room Rent as specified in the Certificate of Insurance, then,

I. The Insured Member shall bear the ratable proportion of the total Associate Medical Expenses (including applicable surcharge and taxes thereon) in the proportion of the difference between the Room Rent actually incurred and the Room Rent specified in the Certificate of Insurance or the Room Rent of the entitled Room Category to the Room Rent actually incurred.

The Certificate of Insurance will specify the eligibility of Room Rent or Room Category applicable for the Insured Member under the Policy. Room Rent or Room Category available under this Policy is mentioned as follows:

1) Single Private Room: If the Certificate of Insurance states 'Single Private Room' as eligible Room Category, it means the maximum eligible Room Category in case of Hospitalization of the Insured Member payable by the Company is limited to stay in a Single Private Room.

2) If the Certificate of Insurance states 'up to 1% of the Coverage Amount per day' as eligible Room Rent, it means the maximum eligible Room Rent of the Insured

Member payable by the Company is limited to 1% of the Coverage Amount per day of Hospitalization. Any amount accrued as No Claims Bonus under (Optional Extension 3), shall not form part of Coverage Amount

3) The nomenclature of Room categories may vary from one hospital to the other. Hence, the final consideration will be as per the definition of the Rooms mentioned in the Policy.

(b) Intensive Care Unit Charges (ICU Charges):

The Certificate of Insurance will specify the Limit of ICU Charges applicable for the Insured Person under the Policy. The ICU Charges available under this Policy are as follows:

1) If the Certificate of Insurance states 'up to 2% of the Coverage Amount per day' as eligible ICU Charges per day of Hospitalization, it means the maximum eligible ICU charges of the Insured Member payable by the Company is limited to 2% of the Coverage Amount per day of Hospitalization. Any amount accrued as No Claims Bonus under (Optional Cover 3), shall not form part of Coverage Amount

2) If the Certificate of Insurance states the eligibility of ICU Charges of the Insured Member as 'no sub-limit', it means that there is no separate restriction on ICU Charges incurred towards stay in ICU during Hospitalization

1.1 Optional Extension 1: Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses Modification

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Extension, the Company agrees to modify:

a. the maximum amount payable

b. the Duration

as specified against this Optional Extension in the Certificate of Insurance, provided that:

i) the Medical Expenses incurred are admissible under Hospitalization Expenses (Optional Benefit 1)

ii) the Company shall not be liable to make payment for any Pre-hospitalization Medical Expenses that were incurred before the Cover Start Date unless it is continuation of Policy for the Insured; and

iii) the Company shall not be liable to make payment for any Post-hospitalization Medical Expenses that were incurred 60 days or more after the Cover End Date

1.2 Optional Extension 2: Maternity Expenses (Pregnancy and Childbirth)

a) Pregnancy and Childbirth

The Company will indemnify up to amount specified in the Certificate of Insurance, for the Medical Expenses associated with Hospitalization of the Insured Member for the pregnancy & delivery of a child, provided that:

(a) The Company will be liable to make payment under this Optional Extension, only if the Insured Member who has delivered the child is the Primary Insured Member or the Primary Insured Member's spouse and over the age of eighteen (18) years of age.

(b) The delivery occurs after the completion of the waiting period (specified in the Certificate of Insurance). The wait period will start from the Cover Start Date or on attaining age of 18 years, whichever is later;

(c) The Company shall be liable to make payment for any :

(i) Pre- Hospitalization Medical Expenses (routine pre-natal care and check-ups which includes common screening and follow-up tests as required during a pregnancy) or Post-Hospitalization Medical Expenses (routine post-natal care and check-ups) received by the insured mother up to sixty (60) days of any Claim arising under this Optional Extension, maximum up to 10% of Maternity Expenses Coverage amount as specified in Certificate of Insurance;

(ii) Birth through normal delivery, midwife fees (during labour only) and medically necessary caesarean section for the childbirth delivery costs up to the amount specified in Certificate of Insurance

(iii) For birth through elective or non-medically necessary caesarean section as confirmed by treating Medical Practitioner, the childbirth delivery costs will be limited up to the costs of a normal delivery. Any complications

arising from such delivery will be paid up to the remaining Coverage amount of this Benefit.

(d) The Company shall be liable to make payment for any 'Well Baby Care' expenses or 'Well Mother Expenses', for any Claim arising under this Optional Extension, maximum up to 10% of Maternity Expenses Coverage amount as specified in Certificate of Insurance;

Definitions for the purpose of this Optional Extension only:

i) Well Baby Care: 'Well Baby Care' is the routine medical care provided to a new born baby, which includes limited to appropriate customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures carried out immediately following birth, routine preventive care services and immunizations (within the same hospitalization period). For multiple birth babies born, subject to any benefit limit in place.

ii) Well Mother care: 'Well Mother Care' is routine medical care provided to an insured female (Mother), immediately after giving birth to a new born baby, which includes routine preventive care services and immunizations (within the same Hospitalization period).

(e) The Company shall be liable to make payment in respect of any Hospitalization arising due to involuntary medical termination of pregnancy only as per India MTP Act, 1971(amended) and other applicable laws and rules.

(f) The Company shall be liable to make payment in respect of surrogacy, as per the then applicable surrogacy laws in India

Notwithstanding anything stated under exclusion clause 5.1.(2)(15) by opting for this optional extension, the Insured would be covered for 'Maternity Expenses' and 'treatment related to childbirth' up to the purview of this cover.

The amount specified in the Certificate of Insurance is for each:

(i) Cover Year, even if there is more than one pregnancy in that Cover Year

(ii) Benefit amount payable will be limited to applicable Coverage Amount for that Cover Year

b) New Born Accommodation

This benefit provides cover to a new born child (age not greater than 90 days), when the mother who is an Insured Member under this benefit is receiving eligible in-patient treatment and the new born is required to stay in the Hospital with the insured mother.

This benefit pays for new born nursery accommodation of a standard class only where the new born only receives nursery care during the stay in Hospital and is paid from the Insured mother's benefit.

1.3 Optional Extension 3: No Claim Bonus

a) At the end of each Cover Year, the Company will enhance the Coverage Amount under Hospitalization Expenses (Optional Benefit 1) by XX percentage (as specified in Certificate of Insurance), on a cumulative basis, as a No Claims Bonus for each completed and continuous Cover Year, provided that no Claim has been paid by the Company in the expiring Cover Year for that Insured Member, and subject to the conditions specified below:

i. In any Cover Year, the accrued No Claims Bonus shall not exceed 100% of the Coverage Amount available in the renewed Policy.

ii. The No Claims Bonus shall not enhance or be deemed to enhance any Conditions as prescribed under Clause 1(j).

iii. For a Floater policy, the No Claims Bonus shall be available on Floater basis and shall accrue only if no Claim has been made in respect of any Insured Member during the expiring Cover Year. The No Claims Bonus which is accrued during the claim-free Cover Year will only be available to those Insured Members who were insured in such claim-free Cover Year and continue to be insured in the subsequent Cover Year.

iv. The entire No Claims Bonus will be forfeited if the Policy is not continued / renewed on or before Cover End Date or the expiry of the Grace Period whichever is later.

v. The No Claims Bonus shall be applicable on an annual basis subject to continuation of the Policy.

vi. If the Insured Members in the expiring policy are covered on Individual basis and thus have accumulated the No Claims Bonus for each Insured Member in the expiring policy, and such expiring policy is renewed with the Company on a Floater basis, then the No Claims Bonus to be carried forward for credit in this Policy would be the least No Claims Bonus amongst all the Insured Members.

vii. If the Insured Members in the expiring policy are covered on a Floater basis and such Insured Members renew their expiring Policy with the Company by splitting the Floater Coverage Amount in to 2 (two) or more Floater / Individual covers, then the No Claims Bonus of the expiring Policy shall be apportioned to such renewed Policy in the proportion of the Coverage Amount of each of the renewed Policy.

viii. In the event of a Claim occurring during any Cover Year, the accrued No Claims Bonus will be reduced at same rate at which it is accrued at the commencement of next Cover Year.

ix. If Claim has been reported in expiring Cover Year but No Claims Bonus has been made available by the Company in the next Cover Year and if such Claim is ultimately paid, the No Claims Bonus which is made available for that Cover Year will be reduced/recovered (in case claim amount has been paid against No Claim Bonus amount)

x. In case Coverage Amount under the Policy is reduced at the time of renewal, the applicable No Claims Bonus shall also be reduced in proportion to the Coverage Amount.

xi. In case Coverage Amount under the Policy is increased at the time of renewal, the No Claims Bonus shall be calculated on the Coverage Amount applicable on the last completed Cover Year.

xii. Accrued 'No Claims Bonus' under this Policy can be utilized for Optional Benefit 1 (Hospitalization Expenses) and for all its Optional Extensions except for Optional Extension 24 (Corporate floater) if opted under Optional Benefit 1.

xiii. In case no claim is made in a particular Cover Year, No Claims Bonus would be credited automatically to the subsequent Cover year, even in case of multi-year Policies

xiv. All conditions applicable to Hospitalization Expenses (Optional Benefit 1) will be applicable for this Optional Extension.

xv. This Optional Extension is not available for Employer - Employee Policies

b) In addition to the above, the Policyholder has the option to opt for no reduction in the accrued No Claims Bonus in the event of a Claim occurring during any Cover Year

1.4 Optional Extension 4: Donor Expenses

The Company will indemnify the Insured Member, through Cashless or Reimbursement Facility, up to the amount specified against this Optional Extension in the Certificate of Insurance, for the Medical Expenses incurred in respect of the donor, for any organ transplant surgery during the Cover Year, subject to the conditions specified below:

(i) The Organ donor is an eligible donor in accordance with The Transplantation of Human Organs Act, 1994 (amended) and other applicable laws and rules.

(ii) The Insured Member is the recipient of the Organ so donated by the Organ Donor.

(iii) The Company indemnifies for transplantation of kidneys, heart, liver, lung or bone marrow required as a result of an eligible medical condition and provided these organ(s) came from a relative or a legally certified and verified source of donation

(iv) The Company will not be liable to pay the Medical Expenses incurred by the Insured Member towards Pre-Hospitalization and Post Hospitalization Medical Expenses (Optional Extension 1) or any other Medical Expenses in respect of the donor consequent to the harvesting.

(v) Clause 5.2 (2) (26) under Permanent Exclusions, is superseded to the extent covered under this Optional Extension.

1.5 Optional Extension 5: Sub-limits on Hospitalization Expenses

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Extension, the Company's maximum liability to make payment for Medical Expenses incurred under any admissible Claim under the Hospitalization Expenses (Optional Benefit 1) for the total amount for that Hospitalization shall be limited to the amount opted and as defined below:

i) Sub-limits on Surgeries: The Company's maximum liability to make payment for Medical Expenses in respect of Hospitalization due to Surgeries and Hospitalization other than due to Surgeries under the Hospitalization Expenses (Optional Benefit 1)shall be limited to amount opted, as specified in Certificate of Insurance

ii) Sub-limits on Accidents: The Company's maximum liability to make payment for Medical Expenses in respect of Accidental and Non-Accidental Hospitalization under the Hospitalization Expenses (Optional Benefit 1)shall be limited to amount opted, as specified in Certificate of Insurance

Note: Only one of the above mentioned options either (i) or (ii) can be opted but not in any combination

1.6 Optional Extension 6: AYUSH Treatment

The Company will indemnify the Insured Member, up to the amount specified in the Certificate of Insurance, towards Medical Expenses incurred with

respect to the Insured Member's medical treatment undergone at any AYUSH Hospitals as per definition 1.1.2 and 1.1.3, for any of the listed AYUSH Treatment namely Ayurveda, Yoga and Naturopathy, Sidha, Unani and Homeopathy, subject to the conditions specified below:

(i) Medical Treatment should be rendered from a registered Medical Practitioner who holds a valid practicing license in respect of such AYUSH Treatment; and

(ii) Such treatment taken is within the jurisdiction of India

Clause 5.2(2)(27) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

1.7 Optional Extension 7: Psychiatric Treatment

Clause 5.2(2)(27) under Permanent Exclusions, is superseded to the extent covered under this Benefit

a.) If Insured Member opts for no coverage for Psychiatric treatment wherein Company with have no liability for any kind of Psychiatric Treatment; OR

b.) If Insured Member opts for sub-limits then Company agrees to indemnify up to the sub-limit as specified in the Certificate of Insurance on the following listed conditions for medically necessary psychiatric treatment:

S.L.	Disorder/condition
1	Severe Depression
2	Schizophrenia
3	Bipolar Disorder
4	Post-Traumatic Stress Disorder
5	Eating Disorder
6	Generalized Anxiety Disorder
7	Obsessive Compulsive Disorder
8	Panic Disorder
9	Personality Disorders
10	Conversion Disorders
11	Dissociative Disorders

Note: For ICD codes, please refer to Annexure – VI of Policy Terms & Conditions

1.8 Optional Extension 8: Infertility Treatment

The Company will indemnify up to the amount specified in the Certificate of Insurance, for the Medical Expenses incurred by the Insured Member for infertility treatment.

The Company shall not be liable to make payment under this Optional Extension in respect of an Insured Member (both male and female) more than once during that Insured Member's lifetime.

Notwithstanding anything stated under exclusion clauses 5.1(2)(14), by opting for this optional extension, the Insured would be covered for 'treatment related to infertility' up to the purview of this cover.

1.9 Optional Extension 9: Bariatric Surgery

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Extension, the Company agrees to modify the Coverage for medically necessary Bariatric Surgery treatment as specified in the Certificate of Insurance.

1.10 Optional Extension 10: Lasik Surgery

The Company will indemnify up to the amount specified in the Certificate of Insurance, for the medically necessary Expenses incurred by the Insured Member in respect of Lasik Surgery provided the power of eye is above +/- 5 d or as specified in Certificate of Insurance.

All treatments under this Benefit must be pre-authorised by the Company in writing.

Notwithstanding anything stated under exclusion 5.1(2)(12), by opting for this optional extension, the Insured would be covered for 'Lasik Surgery' up to the purview of this cover.

1.11 Optional Extension 11: Durable Medical Equipment

a) Durable Medical Equipment and Medical Aid

The Company will indemnify up to the amount specified in the Certificate of Insurance, for the Reasonable and Customary charges necessarily incurred by the Insured Member, for procuring, fitting or hiring instruments, apparatuses or devices which are medically prescribed at the time of discharge as a medical aid and limited to compression stockings, hearing aids, speaking aids (electronic larynx), standard wheelchairs, crutches, orthopaedic supports/braces/corrective splints, orthotics and stoma supplies following an Hospitalization during the Cover Year and this benefit should be availed within 60 days of hospitalization or as defined by medical practitioner in discharge summary.

b) Artificial Limbs

The Company will indemnify up to the amount specified in the Certificate of Insurance, for the Reasonable and Customary charges necessarily incurred by the Insured Member, for procuring necessary prosthetic or artificial devices replacing body parts which is associated with fitting artificial limbs, its maintenance, consultation and necessary medical or surgical procedures immediately following an Hospitalization during the Cover Year and this benefit should be availed within 60 days of hospitalization or as defined by medical practitioner in discharge summary.

The benefit is only payable following a surgery or an accident for an eligible medical condition provided that the Insured has been covered under this policy since before the accident or surgery happened.

For the purpose of this Optional Extension, Durable Medical Equipment, Medical Aids, Artificial limbs or devices must satisfy the following conditions:

(a) Procurement amount of the durable

medical equipment must not exceed the reasonable purchase price of the durable medical equipment for relevant geography/location.

(b) Spectacles, Thermometer, contact lenses, hearing aids, blood pressure monitoring machine and diabetes monitoring machine are not included in the list of durable medical equipment for the purpose of this Optional Extension.

(c) Any Durable Medical Equipment or device cannot be procured more than once.

(d) The Durable Medical Equipment, Medical Aid or device is not part of the care for a chronic condition or terminal illness condition or vegetative state of insured.

In addition to the foregoing, the Company will also indemnify the reasonable repair charges, maximum up to 50% of the Purchase price of equipment as specified in the Certificate of Insurance, incurred towards the repair of the purchased prosthetic devices or other purchased durable medical equipment originally obtained under this Optional Extension provided this benefit is available under the policy and the Insured Member is covered under the in-forced Policy.

Notwithstanding anything stated under exclusion clause 5.2(2)(9), by opting for this optional extension, the Insured would be eligible to claim for 'expenses related to Durable Medical Equipment', Medical Aid up to the purview of this cover.

1.12 Optional Extension 12: Maternity Complications

The Company will indemnify up to the amount specified in the Certificate of Insurance, for the Medical Expenses incurred in respect of the Hospitalization of the Insured Member for treatment of any of the complications specified below, occurring after the completion of the waiting period as specified in the Certificate of Insurance:

S.L.	Pre-Post Natal Complication
1	Antiphospholipid syndrome
2	Cervical incompetence
3	Gestational diabetes
4	Hydatidiform mole – molar pregnancy
5	Hyperemesis gravidarum
6	Obstetric cholestasis
7	Pre-eclampsia / Eclampsia
8	Rhesus (RH) factor
9	Miscarriage Requiring Immediate Surgical Treatment
10	Post partum haemorrhage
11	Retained placental membrane

This benefit pays for treatment of an eligible medical condition which is due and occurs to the Primary Insured Member or the Primary Insured Member's spouse over the age of eighteen (18) years during the pregnancy prior to the delivery or after the delivery of child.

Under post-natal complications, the Company will only pay for treatment received within sixty (60) days following the delivery of child. This benefit is only payable where the Insured Member is covered under 'Maternity Expenses' benefit.

Coverage under this Optional Extension is available only after the completion of the wait period (specified in Certificate of Insurance). The wait period will start from the Cover Start Date or on attaining age of 18 years, whichever is later;

The Company shall be liable to make payment in respect of surrogacy, as per the then applicable surrogacy laws in India

This benefit does not cover:

- the costs of delivery of any child (including still born) whether such delivery is normal, by caesarean section or by any other assisted means, or
- any complication arising from elective or non-Medically Necessary caesarean section birth, or
- treatment of any Medical Condition which is due to and occurs during the pregnancy prior to the delivery or after the delivery if the pregnancy was a result of any form of assisted conception.
- Complications arising from infertility treatment.

Notwithstanding anything stated under exclusion clause 5.1(2) (15) & 5.2 (2) (4), by opting for this optional extension, the Insured would be covered for 'Maternity Expenses' and 'treatment related to childbirth' up to the purview of this cover.

1.13 Optional Extension 13: HIV Cover

The Company will indemnify up to the amount specified in the Certificate of Insurance, for the reasonable and necessary Medical Expenses incurred by the Insured Member at a Hospital, towards treatment for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) as a result of occupational accident or blood transfusion, subject to the following criteria:

i. Infection with HIV through a blood transfusion, provided that all of the following conditions are met:

(i) the blood transfusion was given as part of a medical treatment in the treating Hospital during the Cover Year;

(ii) HIV infection is not resulted from any other means including sexual activity and/or transmission from the Insured Member's parent and

(iii) Insured Member does not suffer from Thalassaemia major or Haemophilia.

ii. Both, Infection with HIV and accident from which it resulted should occur in the Cover Year of the Policy, provided that the accident involved a definite source of HIV infected fluids

Exclusions Applicable to HIV Cover:

(i) Any Claim with respect to an HIV infection detected, diagnosed or which manifested prior to Cover Start Date or during Initial Wait Period

Clause 5.2 (2) (3) under Permanent Exclusions is superseded to the extent covered under this Optional Extension.

1.14 Optional Extension 14: Inpatient Rehabilitation

The Company will indemnify up to an amount, as specified in the Certificate of Insurance, towards rehabilitation of the Insured Member.

The scope of cover under Optional Benefit 1 (Hospitalization Expenses) is extended to cover Reasonable and medically necessary expenses incurred for treatment of rehabilitation at a government authorized rehabilitation center, subject to admissibility of claim under Optional Benefit 1 (Hospitalization Expenses), during the Cover Year, provided that:

i. it is an integral part of treatment for an eligible medical condition ; and

ii. it is carried out by a medical practitioner specialized in rehabilitation; and

iii. the Company should be informed before the rehabilitation begins

For cases such as in severe central nervous system damage caused by external trauma, the Company will not pay for in-patient rehabilitation for more than one hundred eighty (180) days.

Notwithstanding anything stated under exclusion clauses 5.2(2)(10), by opting for this optional extension, the Insured would be covered for 'treatment related to Rehabilitation measures' only up to the purview of this cover.

1.15 Optional Extension 15: Parent Accommodation

a) The Company will indemnify the Insured Member, up to the amount specified in the Certificate of Insurance, for the expenses incurred towards accommodation in the hospital of the Parent, during the Hospitalization of a Child (who is an Insured Member) due to any covered Injury or Illness suffered during the Cover Year, provided that:

i. Claim is admitted under Optional Benefit 1 (Hospitalization Expenses); and

ii. The Hospitalized child's age should be less than 12 years of Age at the time of admission; and

iii. The Hospitalized Child's Parent, who is availing accommodation, should be covered under this Policy as Insured Member for the same Cover Year; and

iv. The treating Medical Practitioner certifies that the Hospitalized Child requires min. Hospitalization for at least XX consecutive days as specified in Certificate of Insurance.

b) The Company will reimburse the Reasonable and Customary Charges for an extra bed incurred by father and /or mother staying in Hospital;

c) The Company will pay only one benefit entitlement of either Parent accommodation or Dependent accommodation, if opted for.

1.16 Optional Extension 16: Dependent Accommodation

a) The Company will indemnify the Insured Member, up to the amount specified in the Certificate of Insurance, for the expenses incurred towards accommodation in the hospital of an Immediate Family Member, during the Hospitalization of an Insured Member due to any covered Injury or Illness suffered during the Cover Year, provided that:

i. Claim is admitted under Optional Benefit 1 (Hospitalization Expenses); and

ii. The Insured Member's Immediate Family Member is also covered under this Policy as Insured Member for the same Cover Year; and

iii. The treating Medical Practitioner certifies that the Hospitalized Insured member requires Hospitalization for minimum XX consecutive days as specified in Certificate of Insurance.

b) The Company will reimburse the Reasonable and Customary Charges for an extra bed incurred by two dependent Insured Members;

c) The Company will pay only one benefit entitlement of either Parent accommodation or Dependent accommodation, if opted for.

1.17 Optional Extension 17: Cochlear Implant

The Company will indemnify up to the amount specified in the Certificate of Insurance, for the Medical Expenses incurred by the Insured Member in respect of cochlear implant.

Notwithstanding anything stated under exclusion clauses 5.2(2)(9), by opting for this optional extension, the Insured would be covered for 'expenses related to cochlear implants' up to the purview of this cover.

1.18 Optional Extension 18: Modern Treatment

Methods

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Extension, the Company agrees to modify the Coverage for medically necessary treatments done through modern technologies, as specified in the Certificate of Insurance

1.19 Optional Extension 19: Sub-limit on Fees charged by a Surgeon, Anesthetist and Medical Practitioner

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Extension, the Company agrees to make payment towards total Fees paid to the Surgeon, Anesthetist and Medical Practitioner for a claim admissible under Optional Benefit 1 (Hospitalization expenses) shall be limited to the percentage (%) of claim amount, as specified in the Certificate of Insurance.

1.20 Optional Extension 20: Room Rent Modification

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Extension, the Company agrees to the following under this Policy:

a) Non-ICU Room Category:

The Company agrees to make payment for Medical Expenses incurred under Non-ICU room category of Optional Benefit 1 (Hospitalization expenses) shall be limited to the percentage (%) of the Coverage Amount per day or specific Room Category or No Sub-limit as specified in Certificate of Insurance

b) ICU Room Category:

The Company agrees to make payment for Medical Expenses incurred under ICU room category of Optional Benefit 1 (Hospitalization expenses) shall be limited to twice the percentage (%)opted for Non ICU Room Category of the Coverage Amount per day as specified in the Certificate of Insurance.

Note: No Sub-limit for Coverage Amount if either Single Private Room or Twin Sharing Room or No sub-limit is opted under Non ICU Room Category

1.21 Optional Extension 21: Proportion Charge waive off

Notwithstanding anything to the contrary in the Policy, by opting this Optional Extension, the Insured Member will not bear the ratable Proportion on Associate Medical Expenses except Room Rent charges as per Clause 2.1 (j).

1.22 Optional Extension 22: Limit on Illness/ Surgeries/Procedures

a) Notwithstanding anything to the contrary in the Policy, by choosing this Optional Extension, the Company agrees to make payment for Medical Expenses incurred in respect of below mentioned treatments under Optional Benefit 1 (Hospitalization expenses) for the total amount for that Hospitalization is limited to the amount opted against each defined treatment, as specified in Certificate of Insurance

b) Sub-limit opted on any defined treatment cannot be greater than the Coverage Amount opted under Hospitalization Expenses (Optional Benefit 1) and can be chosen in any combination from the below:

Treatment Set	Treatment
1	Cataract
2	Total Knee Replacement
3	Treatment for each and every Ailment / Procedure mentioned below: i. Surgery for treatment of all types of Hernia ii. Hysterectomy iii. Surgeries for Benign Prostate Hypertrophy (BPH)
	iv. Surgical treatment of stones of renal system
4	Treatment for each and every Ailment / Procedure mentioned below: i. Treatment of Cerebrovascular and Cardiovascular disorders ii. Treatments/Surgeries for Cancer iii. Treatment of other renal complications and Disorders iv. Treatment for breakage of bones
5	Medical Management

c) This benefit is available only if geography India opted

1.23 Optional Extension 23: Recharge of Coverage Amount

If a Claim is payable under the Policy, then the Company agrees to automatically make the re-instatement of up to the Coverage Amount once in a

Cover Year which is valid for that Cover Year only, subject to the conditions specified below:

(i) The Recharge shall be utilized only after the Coverage Amount, No Claims Bonus (Optional Extension 3), Additional Coverage Amount for Accidental Hospitalization (Optional Extension 27), Additional Coverage Amount for 32 Critical Illnesses (Optional Extension 28) has been completely exhausted in that Cover Year.

(ii) A Claim will be admissible under the Recharge only if the Claim is admissible under Optional Benefit 1 (Hospitalization Expenses).

(iii) 'Recharge of Coverage Amount' shall be same as base Coverage Amount.

(iv) Any unutilized recharged amount cannot be

carried forward to any subsequent Cover Year.

(v) If the Policy is issued on a Floater basis, then the Recharge will also be available only on Floater basis.

1.24 Optional Extension 24: Corporate Floater

If an Insured Member has exhausted his respective base Coverage Amount under Optional Benefit 1 (Hospitalization Expenses), and further incurs any medical expenses, the same would be payable from the Coverage Amount of Corporate Floater (as specified in the Certificate of Insurance). The amount payable under this Optional Extension for an Insured Member shall be restricted to any one of the following options, as specified in the Certificate of Insurance:-

(i) Restricted to Named Illnesses and up to the Coverage Amount of Optional Benefit 1 for an Insured Member; Or

(ii) For any illness, restricted only up to the Coverage Amount of Optional Benefit 1 for an Insured Member;

Named illnesses which are referred above are:

- Cancer;
- End Stage Renal Failure;
- Multiple Sclerosis;
- Major Organ Transplant;
- Heart Valve Replacement;
- Coronary Artery Bypass Graft / Angioplasty (PTCA);
- Stroke excluding transient ischemic attack (TIA);
- Paralysis;
- Myocardial Infarction
- Brain surgery
- Road traffic accident with the following conditions:
- Head injury or
- Fractures in two or more limbs (upper / lower) or
- RTA injury requiring ventilation support

Notes:

i) The maximum and cumulative liability of the Company will be up to Corporate Floater Coverage Amount, collectively for all insured members under the policy.

ii) This benefit is available only if geography India opted

1.25 Optional Extension 25: Modification of 'Named Ailments' Wait Period

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Extension, the Company agrees to:

a) The amount of coverage for Named Ailments will be limited to the Coverage Amount as specified against this Optional Extension in the Certificate of Insurance.

b) Co-payment shall be applicable on the amount payable by the Company as specified in the Certificate of Insurance. Co – payment is applicable only in case of a claim due to Named ailments.

Note:

The conditions prescribed under this Clause will be applicable only for the balance Wait Period as defined in the Policy.

1.26 Optional Extension 26: Modification of 'Pre-Existing Diseases' Wait Period

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Extension, the Company agrees to:

a) The amount of coverage for Pre-existing diseases will be limited to the Coverage Amount as specified against this Optional Extension in the Certificate of Insurance.

b) Co-payment shall be applicable on the amount payable (post completion of PED wait period as opted) by the Company as specified in the Certificate of Insurance. Please note that Co-payment is applicable only in case of a claim due to Pre-existing disease.

Note: The conditions prescribed under this Clause will be applicable only for the balance Wait Period as defined in the Policy.

1.27 Optional Extension 27 – Additional Coverage Amount In Case Of Accident

In case any Claim is made for Emergency Care of any Injury due to an Accident during the Cover Year, the Company shall provide an additional Coverage amount for In-patient Care for that Insured Person who is hospitalized, as specified in Certificate of Insurance, provided that:

I. The 'additional Coverage Amount for Accidental Hospitalization' shall be utilized only after the Coverage Amount has been completely exhausted

II. The total amount payable under this Optional Extension shall not exceed the sum total of the Coverage Amount, No Claims Bonus, and 'Additional Coverage Amount for Accidental Hospitalization'

III. The 'Additional Coverage Amount for Accidental Hospitalization' is applicable only in case of accidental claim is admissible under Optional Benefit 1 (Hospitalization Expenses)

IV. The 'Additional Coverage Amount for Accidental Hospitalization' shall be applied only once during the Cover Year.

1.28 Optional Extension 28 – Additional Coverage amount in Case Of Critical Illness

In case any Claim is made for any illness or Injury due to 32 Critical illnesses as per Definition 1.2.19 during the Cover Year, the Company shall provide an additional Coverage amount for In-patient Care for that Insured Person who is hospitalized, as specified in Certificate of Insurance, provided that:

I. The 'additional Coverage Amount for CI' shall be utilized only after the Coverage Amount has been completely exhausted

II. The total amount payable under this Optional Extension shall not exceed the sum total of the Coverage Amount, No Claims Bonus, 'additional Coverage Amount for CI';

III. The 'additional Coverage Amount for CI' is applicable only if Claim is admissible under Optional Benefit 1 (Hospitalization expenses)

IV. The 'additional Coverage Amount for CI' shall be applied only once during the Cover Year.

1.29 Optional Extension 29– Coverage for non-medical expenses

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Extension, the Company agrees to cover the non-medical expenses as specified in Annexure II, up to the Coverage amount, as specified in Certificate of Insurance

1.30 Optional Extension 30– Age Related Macular Degeneration

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Extension, the Company agrees to modify the Coverage for medically necessary Age related macular degeneration treatment as specified in the Certificate of Insurance

1.31 Optional Extension 31: Hormone Replacement Therapy

The Company will indemnify up to the amount specified in the Certificate of Insurance, for the Medical Expenses incurred by the Insured Member towards undergoing Hormone Replacement Therapy.

The Company will pay for the consultations and the cost of the implants, injections, patches, tablets or any other medically approved form of administration of medications, when it is medically indicated. There must be a clear treatment plan from the Medical Practitioner with an end point and expected outcome.

This Benefit will not cover treatment to get relief from menopausal symptoms.

Notwithstanding anything stated under exclusion clauses 5.2(2)(42), by opting for this optional extension, the Insured would be covered for 'Hormone Replacement Therapy' up to the purview of this cover and covered only during Post Hospitalization.

1.32 Optional Extension 32: Maternity – only delivery

The Company will indemnify up to amount specified in the Certificate of Insurance, for the Medical Expenses associated with Hospitalization of the Insured Member for the delivery of a child only, provided that:

(a) The Company will be liable to make payment under this Optional Extension, only if the Insured Member who has delivered the child is the Primary Insured Member or the Primary Insured Member's spouse and over the age of eighteen (18) years of age.

(b) The delivery occurs after the completion of the waiting period (specified in the Certificate of Insurance). The wait period will start from the Cover Start Date or on attaining age of 18 years, whichever is later;

(c) The Company shall be liable to make payment for any :

(i) Birth through normal delivery, midwife fees (during labour only) and medically necessary caesarean section for the childbirth delivery costs up to the amount specified in Certificate of Insurance

(ii) For birth through elective or non-medically necessary caesarean section as confirmed by treating Medical Practitioner, the childbirth delivery costs will be limited up to the costs of a normal delivery. Any complications arising from such delivery will be paid up to the remaining Coverage amount of this Benefit.

(d) The Company shall be liable to make payment in respect of any Hospitalization arising due to involuntary medical termination of pregnancy, as per India MTP Act, 1971(amended) and other applicable laws and rules.

(e) The Company shall be liable to make payment in respect of surrogacy, as per the then applicable surrogacy laws in India

Notwithstanding anything stated under exclusion clause 5.1 (2) (15) & 5.2 (2) (4) by opting for this optional extension, the Insured would be covered for 'Maternity Expenses' up to the purview of this cover.

The amount specified in the Certificate of Insurance is for each:

(i) Cover Year, even if there is more than one pregnancy in that Cover Year

(ii) Benefit amount payable will be limited to applicable Coverage Amount for that Cover Year

1.33 Optional Extension 33: Ambulance Expenses

The Company will indemnify the Insured Member, through Cashless or Reimbursement Facility, up to amount as specified in Certificate of Insurance, for the Reasonable and Customary Charges necessarily incurred on availing Ambulance services offered by a Hospital or by an Ambulance service provider for the Insured Member's necessary transportation , provided that the necessity of such Ambulance

transportation is certified by the treating Medical Practitioner and subject to the conditions specified below:

(i) Such Transportation is from the place of occurrence of Medical Emergency of the Insured Member, to the nearest Hospital; and/or

(ii) Such Transportation is from one Hospital to another Hospital for the purpose of providing better Medical aid to the Insured Member, following an Emergency.

2. Optional Benefit 2: Out-Patient Care

The Company will indemnify the Insured Member, up to the Coverage Amount and/or up to number of visits, towards Out-patient treatment subject to the sub limits if any, as specified in the Certificate of Insurance.

Notwithstanding anything stated under exclusion clauses 5.2(2)(14), by opting for this optional Benefit, the Insured would be covered for 'Out-Patient Treatment' up to the purview of this cover. 'Day Care Treatment' which is covered under 'Hospitalization', will not be covered under this Optional Benefit.

Coverage under Optional Benefit 2(a), 2 (b), 2(c) can be opted in any combination but one of the following has to be opted mandatorily to avail any Optional Extensions under Optional Benefit 2.

(a) Optional Benefit 2(a): Medical consultations

The Company will indemnify on 'Medical Consultations' i.e. for the Out-patient Consultations taken from a Medical Practitioner and Specialist during the Cover Year, as specified in Certificate of Insurance and is limited to:

a. No. of Visits or/and

b. Amount mentioned against this benefit

(b) Optional Benefit 2(b): Diagnostic Test Expenses

The Company will indemnify up to the amount as specified in the Certificate of Insurance, for the Medical Expenses incurred towards undergoing Diagnostic Tests by the Insured Member.

These diagnostic tests will be limited to computerized tomography, magnetic resonance imaging, positron emission tomography, ultrasound scans (pelvis, abdomen, thyroid gland and breast), mammogram, bone densitometry, X-rays and gait scans and laboratory & pathology tests received as part of only outpatient treatment and if claim for diagnostic tests is already made elsewhere, then for those diagnostic tests, the claim will not be payable under this benefit

Insured Member can also opt for sub-limit on amount per diagnostic visit, as specified against this Benefit in the Certificate of Insurance

(c) Optional Benefit 2c: Pharmacy Expenses

The Company will indemnify the Insured Member, up to the amount specified in the Certificate of Insurance, for Allopathic Pharma Expenses incurred in respect of that Insured Member, provided that :

(a) Any Pharmacy related expenses covered under Hospitalization, Pre-Hospitalization Medical Expenses, Post-Hospitalization Medical Expenses, will not be covered under this Optional Benefit.

2.1 Optional Extension 1: Vaccination

The Company will indemnify up to the amount specified in the Certificate of Insurance, for the Expenses incurred by the Insured Member up to age of 10 years, towards Vaccination of the Insured Member, provided that any one of the below option is specified in Certificate of Insurance:

(a) All Vaccines as prescribed by treating Medical Practitioner or

(b) Vaccination so administered is approved by the World Health Organization (WHO) and as prescribed by treating Medical Practitioner.

Notwithstanding anything stated under exclusion clauses 5.2 (2) (25) by opting for this optional extension, the Insured would be covered for 'Vaccination Expenses', up to the purview of this cover.

2.2 Optional Extension 2: Wellness Consultation

The Company will indemnify up to the Coverage amount specified in the Certificate of Insurance, for the Consultations incurred by the Insured Member towards Wellness Consultations. Insured Member can also opt for sub-limit on the No. of Visits up to the Coverage amount as specified against this Optional Extension in the Certificate of Insurance.

For the purpose of this Optional Extension, 'Wellness Consultation' means any consultation to a certified Medical Practitioner intended for regaining/ improving the condition of good physical, mental and emotional health, especially when maintained by an appropriate diet, exercise, and other lifestyle modifications

2.3 Optional Extension 3: AYUSH Treatment (on OPD basis)

The Company will indemnify the Insured Member, up to the Coverage Amount specified in the Certificate of Insurance, towards Medical Expenses incurred on out-patient basis with respect to the Insured Member's medical treatment undergone at any AYUSH Hospital as per definition 1.1.2 and 1.1.3, for any of the listed AYUSH Treatment namely Ayurveda, Yoga and Naturopathy, Sidha, Unani and Homeopathy, subject to the conditions specified below:

(i) Medical Treatment should be rendered from a

registered Medical Practitioner who holds a valid practicing license in respect of such AYUSH Treatment; and

(ii) Such treatment taken is within the jurisdiction of India

Insured Member can also opt for sub-limit on No. of Visits, up to the Coverage Amount as specified against this Optional Extension in the Certificate of Insurance.

Clause 5.2(2) (27) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

2.4 Optional Extension 4: Psychiatric Consultations

The Company will indemnify up to the Coverage Amount specified in the Certificate of Insurance, for the Medically necessary Consultations incurred by the Insured Member towards undergoing Psychiatric treatment.

Insured Member can also opt for sub-limit on No. of Visits, up to the Coverage Amount as specified against this Optional Extension in the Certificate of Insurance.

Notwithstanding anything stated under exclusion clauses 5.2(2)(13), by opting for this optional extension, the Insured would be covered for 'Psychiatric Treatment' up to the purview of this cover.

2.5 Optional Extension 5: Physiotherapy, occupational and speech Treatment or Therapy

The Company will indemnify up to the Coverage Amount specified in the Certificate of Insurance, for the Medically necessary expenses incurred by the Insured Member towards undergoing Physiotherapy, occupational and speech Treatment or Therapy and such treatment must be given by a qualified Medical Practitioner.

Treatment given by any of these practitioners must be under the medical supervision of a medical practitioner. Medical supervision means that the reason for referral, where applicable, has been initiated by the medical practitioner who has defined a diagnosis.

There must be a clear treatment plan from the Medical Practitioner with defined timelines and expected outcome.

Insured Member can also opt for sub-limit on No. of Visits, up to the Coverage Amount as specified against this Optional Extension in the Certificate of Insurance.

2.6 Optional Extension 6: Extended Alternative methods of Treatments

The Company will indemnify up to the Coverage Amount specified in the Certificate of Insurance, for Medical expenses incurred towards the consultation and treatment given by a qualified Specialized Practitioner (for specific treatment) for Reasonable and Customary Charges actually incurred for courses of Chiropractic Treatment, Acupuncture, Osteopathy and Traditional Chinese Medicine received by the Insured as part of an Out-patient Treatment at a medical facility.

A referral letter from a Medical Practitioner is required for any chiropractic treatment, osteopathy, acupuncture and traditional Chinese medicine, stating the reason for the Insured Member to have such treatment. Treatment given by a chiropractor, acupuncturist, osteopath, or Chinese Physician must be under the Medical Supervision of a Medical Practitioner.

Treatment given by the Policyholder or Insured or a member of the Insured's family member who is a qualified Specialized Practitioner is not admissible.

There must be a clear treatment plan from the chiropractor, acupuncturist, osteopath and Chinese Physician with defined timelines and expected outcome.

Insured Member can also opt for sub-limit on No. of Visits, up to Coverage Amount as specified against this Optional Extension in the Certificate of Insurance.

Notwithstanding anything stated under exclusion clause 5.2 (2) (27), by opting for this optional extension, the Insured would be covered for 'Non-Allopathic Treatment or treatment related to any unrecognized systems of medicine' up to the purview of this cover

2.7 Optional Extension 7: Major Diagnostic Tests

The Company will indemnify up to the Coverage Amount as specified in the Certificate of Insurance, for the Medical Expenses incurred towards undergoing CT and MRI Scan by the Insured Member, provided that:

(a) The treating Medical Practitioner has prescribed such diagnostic tests; and

(b) Hospitalization is not required for performing such tests.

These diagnostic scans shall be received as part of an outpatient treatment.

Such treatment must be under the medical supervision of a medical practitioner. Medical supervision means that the reason for referral, where applicable, has been initiated by the medical practitioner who has requested such diagnostic scans.

The Company will pay only under this benefit for major diagnostic scans, if opted for and not under Diagnostic Test Expenses (Optional Benefit 2 (b))

3. Optional Benefit 3 : Daily Cash Allowance

The Company will pay a fixed amount, as specified against this Optional Benefit in the Certificate of Insurance, for each continuous and completed period of 24 hours of Hospitalization of an Insured Member, subject to the conditions specified below:

(i) The Company shall not be liable to make payment under this Optional Benefit until the deductible (in no. of days) opted (as specified in the Certificate of

Insurance) is exhausted

(ii) The Company is liable to make payment under this Optional Benefit up to a maximum defined number of days (as specified in the Certificate of Insurance) in a Cover Year

(iii) This Benefit is valid only during the Cover Year and only for Medically Necessary In-patient Hospitalization of that Insured Member subject to submission of evidence of hospitalization.

3.1 Optional Extension 1: Maternity Benefit

The Company will pay a fixed amount per day to an Insured Member as specified against this Optional Extension in the Certificate of Insurance, for the Maternity Expenses incurred in respect of the Hospitalization of that Insured Member, for the delivery of the child, maximum up to 15 days, subject to the following conditions:

i. This Optional Extension is available for all Insured Members of age 18 years or above but payment under this benefit is not admissible in case the Insured Member's age is greater than 40 years.

ii. Coverage is available only if the delivery occurs after the completion of the wait period (specified in Certificate of Insurance). The wait period will start from the Cover Start Date or on attaining age of 18 years, whichever is later

iii. Clause 5.1 (2) (15) & 5.2 (2) (4) under Permanent Exclusions, is superseded to the extent covered under this Optional Extension.

3.2 Optional Extension 2: ICU Cash Benefit

Under this Optional Extension, the Company will pay fixed amount opted under Daily Cash Allowance (Optional Benefit 3) as specified in the Certificate of Insurance, for each continuous and completed period of 24 hours of Intensive Care Unit (ICU) Stay during Hospitalization of an Insured Member, subject to the conditions specified below:

i. The Company shall not be liable to make payment under this Optional Extension for a specified number of days (deductible) which will be same as opted under Daily Cash Allowance (Optional Benefit 3); for each period of ICU Stay during Hospitalization arising from Any One Illness or Injury; and

ii. The Company is liable to make payment under this Optional Extension up to a maximum defined number of days (as specified in the Certificate of Insurance) in a Cover Year)

iii. This Optional Extension is valid only during the Cover Year and only for Medically Necessary ICU Stay during Hospitalization of that Insured Member provided hospitalization claim is approved

4. Optional Benefit 4 : Convalescence Benefit

If the Insured Member undergoes Medically Necessary Hospitalization, during the Cover Year, then Company will pay the amount specified against this Optional Benefit in the Certificate of Insurance, for every completed period (which has defined number of days, as specified in the Certificate of Insurance) of hospitalization for each Claim provided that:

(i) The Company shall be liable to make payment under this benefit for any Claim in respect of the Insured Member only when the Minimum Hospitalization Duration (Deductible) on that Claim is exhausted.

(ii) This Benefit will be payable for a maximum of 2 times in a Cover Year (for different injury causing events leading to Hospitalization) and maximum 3 payments per hospitalization.

The combination of Coverage Amount, Minimum Hospitalization Duration and Period of Hospitalization should be same for all the policies under the group

5. Optional Benefit 5: Surgical Cash

Coverage under 5 (a), 5 (b), 5 (c) can be opted in any combination.

If an Insured member undergoes a Surgery (which is medically necessary) due to Illness or Injury, during the Cover Year, the Company will pay a fixed amount as defined below:

a) Major Surgical Benefit: If the Insured member undergoes any Surgery from the list of surgeries mentioned in the table below, then the Company's maximum liability under 'Major Surgical Benefit' will be as specified in the Certificate of Insurance against this Benefit.

SL.No.	Category	Surgeries
1	Heart related surgeries	Any Open / Closed Surgeriesr elated to Heart
2	Cancer related surgeries	Malignant Cancer Surgeries excep Chemo and Radio therapy
3	Kidney related surgeries	Nephrectomy
4	Brain and Spinal surgeries	Any Surgery related to Brain or Spinal cord
5	Surgery related to abdominal organs	Any Surgery related to Liver, Spleen or Pancreas
6	Bone Related Surgeries	Any Surgery related to fracture – Internal fixation required in hip, knee, long bone (thigh, leg, arm and forearm), and shoulder complex

		Amputation of legs, arms, toes and foot for non-malignant lesions
7	Open surgery of Chest and related organs	Any Surgery related to Lungs or Thorax
8	Major Burns	Any Surgery related to second and third degree full thickness burns (excluding Cosmetic purposes)
9	Oro-maxillofacial surgery	Major reconstructive oro-maxillofacial surgery for Trauma (excluding Cosmetic purposes)
10	Major Organ Transplant	Transplant of Kidney Liver or Heart

b) Surgeries other than Major surgeries requiring Hospitalization: If the Insured member undergoes any Surgery which requires Hospitalization, for more than 24 consecutive hours and is not listed under Major surgeries (as listed in Clause 5 (a)), then the Company's maximum liability, under 'Surgeries other than Major surgeries requiring Hospitalization', will be as specified in the Certificate of Insurance against this Benefit.

c) Surgeries other than Major surgeries performed on Day Care Basis: If the Insured member undergoes any Surgery which is performed on a Day Care basis and is not listed under Major surgeries (as listed in Clause 5 (a)), then the Company's maximum liability under 'Surgeries other than Major surgeries performed on Day Care Basis' will be as specified in the Certificate of Insurance against this Benefit.

6. Optional Benefit 6: Personal Accident Cover

The Company will provide coverage under Benefits 6(a), 6(b) and 6(c) of Benefit 'Personal Accident Cover' to any Insured Event arising worldwide. In case any Claim is admissible under Benefit 6(a) 'Accidental Death', Coverage under the Policy for that Insured Member shall immediately and automatically terminate. However, the family members of the deceased, who are other Insured Members under the Policy, shall continue to be covered under this Policy. The Company's liability will commence subject to the availability of the Coverage Amount and while the policy is in force for insured events namely Accidental Death, Permanent Total Disablement and Permanent Partial Disablement which are explained below

Coverage under Optional Benefit 6(a), 6 (b), 6(c) can be opted in any combination but one of the following has to be opted mandatorily to avail any Optional Extensions under Optional Benefit 6.

(a) Optional Benefit 6 (a): Accidental Death

If the Insured Member suffers an Injury during the Cover Period, which directly results in the Insured Member's death within 12 months from the date of Accident (including date of Accident), the Company will pay the Coverage Amount as specified in the Certificate of Insurance against this Benefit.

(b) Optional Benefit 6 (b): Permanent Total Disablement

i. If the Insured Member suffers an Injury during the Cover Period, which directly results in the Insured Member's Permanent Total Disablement within 12 months from the date of Accident (including date of Accident), the Company will pay the amount as specified against this Benefit in the Certificate of Insurance and as per the 'PTD Table' below :

S.L. No.	Insured Events	Amount payable = % of the Coverage Amount specified in the Certificate of Insurance against Optional Benefit 6 (b)
I	Total and irrecoverable loss of sight of both eyes, or of the actual loss by physical separation of two entire hands or two entire feet, or one entire hand and one entire foot, or the	100%
	total and irrecoverable loss of sight of one eye and loss by physical separation of one entire hand or one entire foot	
II	Total and irrecoverable loss of (a) use of two hands or two feet; or (b) one hand and one foot; or (c) sight of one eye and use of one hand or one foot	100%
III	Total and irrecoverable loss of sight of one eye, or of the actual loss by physical separation of one entire hand or one entire foot	50%
IV	Total and irrecoverable loss of use of a hand or a foot without physical separation	50%
V	Paraplegia or Quadriplegia or Hemiplegia	100%

Note: For the purpose of Sr. No. I to IV above, physical separation of a hand or foot shall mean separation of the hand at or above the wrist, and of the foot at or above the ankle.

It is further agreed that in case of multiple events, the Company's maximum liability shall not exceed the

amount specified against this benefit.

i. For the purpose of this Benefit only:

(i) "Hemiplegia" means complete and irrecoverable paralysis of the arm, leg, and trunk on the same side of the body;

(ii) "Paraplegia" means complete and irrecoverable paralysis of the whole of the lower half of the body (below waist) including both the legs;

(iii) "Quadriplegia" means complete and irrecoverable paralysis of all four limbs.

(c) Optional Benefit 6c: Permanent Partial Disablement

If the Insured Member suffers an Injury during the Cover Period, which directly results in the Insured Member's Permanent Partial Disablement within 12 months from the date of Accident (including date of Accident), the Company will pay the amount as specified against this Benefit in the Certificate of Insurance and as per the 'PPD Table' below :

S.L. No.	Insured Events	Amount payable = % of the Coverage Amount specified in the Certificate of Insurance against Optional Benefit 6 (c)
I	Total and irrecoverable loss of hearing in: -	
	a) Both ears	75%
	b) One ear	20%
II	Loss of toes	
	a) All	20%
	b) Both phalanges of great toes bilateral	5%
	c) Both phalanges of one great toe	2%
	d) Both phalanges of other than great toes	1%
III	Loss of four fingers and thumb of one hand	40%
IV	Loss of four fingers of one hand	35%
V	Loss of thumb	
	a) both phalanges	25%
	b) one phalanx	10%
VI	Loss of index finger	
	a) three phalanges	10%
	b) two phalanges	8%
	c) One phalanx	4%
VII	Loss of middle finger	
	a) three phalanges	6%
	b) two phalanges	4%
	c) One phalanx	2%
VIII	Loss of ring finger	
	a) three phalanges	5%
	b) two phalanges	3%
	c) One phalanx	2%
IX	Loss of little finger	
	a) three phalanges	4%
	b) two phalanges	3%
	c) One phalanx	2%
X	Loss of metacarpus	
	first or second	3%
XI	third, fourth or fifth Permanent partial disablement not otherwise provided for under Sr. No. I to X inclusive.	2% Percentage of the Coverage Amount will be determined in accordance with the medical assessment carried out by the Medical Practitioner provided that the percentage under Insured Event Sr. No. XI shall not exceed 50% of the Coverage Amount

Note: For the purpose of Insured Events II to X, loss means either actual physical separation or total and irrecoverable loss only.

It is further agreed that in case of multiple events, the Company's maximum liability shall not exceed the amount specified against this benefit.

6.1 Optional Extension 1: Temporary Total Disablement (TTD)

If the Injury suffered by the Insured Member immediately results in Temporary Total Disablement of the Insured Member during the Cover Year, which completely prevents Insured Member from performing each and every duty pertaining to his employment or occupation, then the Company will pay a fixed lump sum, for each continuous and completed week of that Insured Member's Temporary Total Disablement, as specified in the Certificate of Insurance, provided that:

(i) For a single claim, maximum duration till which this Optional Extension will be payable is 104 weeks from the date of the Accident and if the Insured Member is disabled for a part of a week, then only a proportionate part of the weekly benefit will be payable.

(ii) For the purpose of this Optional Extension only, Temporary Total Disablement means the temporary and total inability of an Insured Member to engage in his/her occupation/employment while that Insured Member is under the regular care of, and acting in accordance with, the instructions or on the written advice from the treating Medical Practitioner and is confined to bed.

(iii) The Company will not pay any amount in excess of the Insured Member's base weekly income and this will specifically exclude

overtime, bonuses, tips, commissions, special compensation or any compensation of similar nature.

(iv) The Company's liability to make payment under this Optional Extension shall commence only upon completion of the excess period (in number of days), as specified in the Certificate of Insurance.

(v) If a Claim arising out of an Injury is admissible under Optional Benefit 6.(b) or 6.(c), then a Claim arising out of the same Injury shall not be admitted under 'Temporary Total Disablement'.

(vi) If an Insured Member suffers a relapse / recurrence of Temporary Total Disablement after a Claim has been admitted under this Optional Extension and during the Cover Period due to the same or related causes, the subsequent period of Temporary Total Disablement shall be deemed to be a continuation of the prior period of Temporary Total Disablement, unless the Insured Member has worked for at least 7 (Seven) days between the 2 (Two) periods. For the purpose of this provision, the Excess Period specified in the Certificate of Insurance shall be calculated from the commencement of the Temporary Total Disablement in each Claim

6.2 Optional Extension 2: Permanent Total Disablement Improvement

(i) Notwithstanding anything contrary to the coverage terms and conditions stated under Clause 6 (b) ('Permanent Total Disablement'), the Company agrees to pay the amount as specified against this Optional Extension in the Certificate of Insurance and as per the 'PTD Table' stated under Clause 6(b), in case the Insured Member suffers an Injury during the Cover Period, which directly results in the Insured Member's Permanent Total Disablement within 12 months from the date of Accident (including date of Accident).

(ii) The Coverage amount applicable under this Optional Extension will be in addition to the amount payable under Benefit 'Permanent Total Disablement'.

(iii) Claim pay-out under this Optional Extension triggers only when claim pay-out is triggered under Benefit 6 (b).

6.3 Optional Extension 3: Permanent Partial Disablement Improvement

(i) Notwithstanding anything contrary to the coverage terms and conditions stated under Clause 6© (Benefit 'Permanent Partial Disablement'), the Company agrees to pay the amount as specified against this Optional Extension in the Certificate of insurance and as per the 'PPD Table' stated under Clause 6 (c), in case the Insured Member suffers an Injury during the Cover Period, which directly results in the Insured Member's Permanent Partial Disablement within 12 months from the date of Accident (including date of Accident).

(ii) The Coverage amount applicable under this Optional Extension will be in addition to the amount payable under Benefit 'Permanent Partial Disablement'.

(iii) Claim pay-out under this Optional Extension triggers only when claim pay-out is triggered under Benefit 6 c.

6.4 Optional Extension 4: Accidental Hospitalization

If the Insured Member's medically necessary Hospitalization occurs solely and directly due to Injury suffered by that Insured Member, then the Company will indemnify the Medical Expenses incurred for such Hospitalization, provided that:

(i) The Hospitalization is on the written advice of a Medical Practitioner; and

(ii) The Hospitalization commences within 7 (seven) days from the date of occurrence of the Injury.

6.5 Optional Extension 5: Accidental Out-patient care

If the Insured Member's medically necessary out-patient treatment occurs solely and directly due to Injury suffered by that Insured Member, then the Company will indemnify the Medical Expenses incurred for such out-patient treatment, as specified in Certificate of Insurance, provided that:

1. Out-patient treatment undergone, is on the written advice of a Medical Practitioner; and

2. Out-patient treatment commences within 7 (seven) days from the date of occurrence of the Injury.

6.6 Optional Extension 6: Funeral Expenses

If the Insured Member's demise happens and the Claim is payable under Optional Benefit 6(a), then the Company will pay a fixed amount, as specified in Certificate of Insurance, towards conducting the funeral ceremony of the Insured Member.

6.7 Optional Extension 7: Ambulance Service

If a Claim for any event under Benefit 6(a) or Benefit 6 (b) or Benefit 6 (c) or Optional Extension 4 (Accidental Hospitalization) of the Policy has been admitted, the Company will indemnify up to the amount as specified against this Optional Extension in the Certificate of Insurance, in addition to any amount payable under that Benefit / Optional Extension, for the reasonable expenses necessarily incurred on availing Ambulance services offered by a Hospital or by an Ambulance service provider for the Insured Member's necessary transportation to the nearest Hospital in case of an Emergency provided that the necessity of the Ambulance transportation is certified by the treating Medical Practitioner.

6.8 Optional Extension 8: Children's Education

If a Claim for any Insured Event under Accidental Death (Optional Benefit 6 (a)) or Permanent Total Disablement (Optional Benefit 6 (b)) of the Policy

has been admitted, then in addition to any amount payable under that Optional Benefit, the Company will pay a fixed amount specified in the Certificate of Insurance against this Optional Extension, for the education of the Insured Member's dependent child/children subject to following conditions:

(a) A valid document establishing the Age of child and relationship between the child and the Insured Member is submitted.

(b) For the purpose of this Optional Extension, "Child" means a child (natural or legally adopted), who is :

(i) Student in a regular course; and

(ii) Financially dependent on the Insured Member; and

(iii) Has not attained 25 years of Age at the time of claim

6.9 Optional Extension 9: Marriage Allowance

If a Claim for any Insured Event under Accidental Death (Optional Benefit 6 (a)) or Permanent Total Disablement (Optional Benefit 6 (b)) of the Policy has been admitted, then in addition to any amount payable under that Optional Benefit, the Company will pay a fixed amount, towards the marriage expenses of an unmarried son (of Age 21 Years or above) or unmarried daughter (of Age 18 Years or above), as on the date of the Injury of the Insured Parent of the Insured Member.

6.10 Optional Extension 10: Home Modification

The Company will indemnify the relevant expenses incurred during the Cover Year, as specified in the Certificate of Insurance, for the reasonable and necessary modification of the Insured Member's regular place of residence, to facilitate the Insured Member's activities of daily living, consequent to an Injury, resulting in a Claim which is payable under Optional Benefit 6.(b): Permanent Total Disablement and provided that:

1. The expenses incurred shall not exceed the reasonable level of charges for similar alterations

2. The modifications are carried out in the house where Insured Member resides after Injury, within India

Additional conditions specific to Optional Extension 10:

a) The modifications are exclusively for the benefit of the Insured Member only

b) The modifications are carried out within 3 (three) months from the Insured Member's intimation of claim under Optional Benefit 6.(b): Permanent Total Disablement

c) The expenses are not related to repair of normal wear and tear or renovation or improvisation of existing set-up

d) This Optional Extension will be applicable only if the Policyholder has opted for Optional Benefit 6.(b): Permanent Total Disablement

6.11 Optional Extension 11: Vehicle Modification

The Company will indemnify the relevant expenses incurred during the Cover Year, as specified in the Certificate of Insurance, for the reasonable and necessary modification of the Insured Member's Vehicle, to facilitate the Insured Member's activities of daily living, consequent to an Injury, resulting in a Claim which is payable under Optional Benefit 6.(b): Permanent Total Disablement and provided that:

a) The Vehicle so modified is the same Vehicle being used by the Insured member before the occurrence of such Injury

b) The expenses incurred shall not exceed the reasonable level of charges for similar Vehicle modification, within India

Additional conditions specific to Optional Extension 11:

a) The modifications are exclusively for the benefit of the Insured Member only

b) The modifications are carried out within 3 (three) months from the Insured Member's intimation of claim under Optional Benefit 6.(b): Permanent Total Disablement

c) The expenses are not related to repair of normal wear and tear or renovation or improvisation of existing set-up

d) This Optional Extension will be applicable only if the Policyholder has opted for Optional Benefit 6.(b): Permanent Total Disablement

6.12 Optional Extension 12: Mobility Extension

The Company will indemnify the reasonable and customary charges necessarily incurred by the Insured Member, for procuring medically necessary prosthetic devices (artificial devices replacing body parts, including artificial legs, arms or eyes), orthopedic braces (including but not limited to arm, back or neck braces) and durable medical equipment (including but not limited to wheelchairs and Hospital beds) which fulfills the Insured Member's basic mobility needs, consequent to an Injury for which a Claim is payable under Optional Benefit 6.(b) and provided that such devices or equipment are procured on the written advice of the treating Medical Practitioner.

For the purpose of this Optional Extension only, durable medical equipment or devices should satisfy the following minimum criteria:

1. Procurement amount must not exceed the reasonable purchase price of the durable medical equipment; and

2. Spectacles, contact lenses, hearing aids, blood pressure monitoring machine and diabetes monitoring machine are not included in the list of durable medical equipment for the purpose of this Optional Extension.

Notwithstanding anything stated under exclusion clause 5.2(2) (9), by opting for this optional extension, the Insured would be covered for 'expenses related to durable medical equipment' up to the purview of this cover.

6.13 Optional Extension 13: Disappearance

(a) The Company shall admit its liability under this optional extension, if the Insured Member's full body cannot be located within a period of consecutive 365 Days after a forced landing, stranding, sinking or wrecking of a Common Carrier wherein the Insured Member was a fare paying passenger or in any event arising as a result of any Acts of God Perils during the Cover Period, where it is reasonable to believe that such Insured Member has died as a result of an Injury.

(b) The Company will only pay, when the nominee or legal heir provides a legally binding and irrevocable indemnity bond or any other document as required by the Company which guarantees, that the amount the Company pays will be repaid to the Company immediately, if it is later found that the Insured Member survived such an Accident / Injury for which the Company had paid the Claim.

6.14 Optional Extension 14: Fractures

(a) If the Insured Member suffers an Injury during the Cover Year, which directly results in any of the fractures as specified below, the Company will pay the amount as specified against this Optional Extension in the Certificate of Insurance and as per the 'Fractures Table' below

S.L. No.	Description of Fracture	**Amount payable =** % of the Coverage Amount specified in the Certificate of Insurance against this Optional Extension
I	Hip or Pelvis (excluding thigh or coccyx): Multiple fractures – at least one Compound Fracture and one Complete Fracture	100%
II	Hip or Pelvis (excluding thigh or coccyx) - All other Compound Fractures	50%
III	Thigh or Heel: Multiple fractures – at least one Compound Fracture and one Complete Fracture	100%
IV	Thigh or Heel: Multiple fractures – at least one Complete Fracture	50%
V	Lower leg, skull, clavicle, ankle, elbows, upper or lower arm (including wrist but excluding Colles-type fractures): Multiple Fractures – at least one Compound Fracture and one Complete Fracture	100%
VI	Lower leg, skull, clavicle, ankle, elbows, upper or lower arm (including wrist but excluding Colles-type fractures) : All other Compound Fractures	30%
VII	Colles type fracture of the lower arm – If Compound Fracture	100%
VIII	Colles type fracture of the lower arm – If Complete Fracture	50%

(b) It is further agreed that:

(i) If an Injury results in more than one of the 'Description of Fractures' above, then the Company's maximum liability shall not exceed the amount specified against this Optional Cover.

(ii) The Company shall not be liable to make any payment in respect of dislocation of bones or joints or in respect of Hairline Fractures or Simple Fractures.

(c) For the purpose of this Optional Cover only:

(i) Complete Fracture means a fracture where the bone is completely broken across and no connection is left between the pieces.

(ii) Compound Fracture means a fracture where the bone breaks the skin and is exposed.

(iii) Hairline Fracture means a mere crack in the bone.

(iv) Simple Fracture means a fracture in which there is a basic and uncomplicated break in the bone and which in the opinion of a Medical Practitioner requires minimal and uncomplicated medical treatment.

6.15 Optional Extension 15: Burns

(a) If the Insured Member suffers an Injury during the Cover Year, which directly results in any of the following second or third degree burn injuries, the Company will pay the amount as specified against this Optional Extension in the Certificate of Insurance and as per 'Burns Table' below:

S.L. No.	Description of Extent of Burn Injury	**Amount payable** = % of the Coverage Amount specified in the Certificate of Insurance against this Optional Extension
I	Third degree burns of 30% or more of the total body surface area	100%
II	Second degree burns of 30% or more of the total body surface area	50%

III	Third degree burns of 20% or more, but less than 30% of the total body surface area	80%
IV	Second degree burns of 20% or more, but less than 30% of the total body surface area	40%
V	Third degree burns of 10% or more, but less than 20% of the total body surface area	40%
VI	Second degree burns of 10% or more, but less than 20% of the total body surface area	20%
VII	Third degree burns of 5% or more, but less than 10% of the total body surface area	20%
VIII	Second degree burns of 5% or more, but less than 10% of the total body surface area	10%

(b) If an Injury results in more than one of the 'Descriptions of Extent of Burn Injury' above, then the Company's maximum liability shall not exceed the amount specified against this Optional Extension

6.16 Optional Extension 16: Blood Expenses

If Insured Member's medically necessary Hospitalization occurs solely and directly due to Injury suffered by that Insured Member and there is a requirement for blood infusion, then the Company will indemnify the administrative Expenses incurred for such blood infusion, up to the amount as specified in Certificate of Insurance.

6.17 Optional Extension 17: Clothes Expenses

If Insured Member's medically necessary Hospitalization occurs solely and directly due to Injury suffered by that Insured Member, then the Company will indemnify the expenses for 1 set of clothes, up to the amount as specified in Certificate of Insurance.

7. Optional Benefit 7: Critical Illness Fixed Benefit

(a) If, during the Cover Period, an Insured Member made a Claim for any Critical Illness condition as per definition 1..2.20, as specified in the Certificate of Insurance, then the Company will pay the Coverage Amount as specified in the Certificate of Insurance against this Optional Benefit subject to 30 days Survival Period

(b) In case any Claim is admissible under this Optional Benefit, coverage under this Optional Benefit for that Insured Member shall immediately and automatically terminate. However, other Insured Members under the Policy shall continue to be covered under this Policy.

(c) Exclusions applicable to this Optional Benefit

(i) Any Claim with respect to any Critical Illness diagnosed or which manifested prior to Cover Start Date or during Initial Wait Period (i.e. 90 days)

7.1. Optional Extension 1: Modification Of Survival Period

Notwithstanding anything to the contrary in the Policy, by choosing this Option, the Company agrees to modify the 'Survival Period' of 30 days (defined in Clause 7) to the Survival Period as specified against this Optional Extension in the Certificate of Insurance

7.2. Optional Extension 2: Modification Of Initial Wait Period

Notwithstanding anything to the contrary in the Policy, by choosing this Option, the Company agrees to modify the 'Initial Wait Period' of 90 days (defined in Clause 7) to the Wait Period as specified against this Optional Extension in the Certificate of Insurance

7.3. Optional Extension 3: HIV Cover

a. If, during the Cover Period, an Insured Member is first diagnosed to be suffering from an HIV Infection, then the Company will pay the Coverage Amount mentioned against this Optional Extension in the Certificate of Insurance and the Coverage under this Optional Extension shall be terminated for that Insured Member provided that, the HIV Infection is caused by any of the reasons below:

i. Infection with HIV through a blood transfusion, provided that all of the following conditions are met:

(i) the blood transfusion was medically necessary or given as part of a medical treatment;

(ii) HIV infection is not resulted from any other means including sexual activity and/or transmission from the Insured Member's parent and

(iii) Insured Member does not suffer from Thalassaemia major or Haemophilia.

ii. Both, Infection with HIV and accident from which it resulted should occur in the Cover Year of the Policy, provided that the accident involved a definite source of HIV infected fluids

b. The coverage under the Policy for other Optional Benefits / Extensions for that Insured Member shall continue under this Policy.

c. Clause 5.2(2) (3) under Permanent Exclusions is superseded to the extent covered under this Optional Extension.

d. Exclusions Applicable to HIV Cover:

(i) Any Claim with respect to an HIV infection detected, diagnosed or which manifested prior to Cover Start Date or during Initial Wait Period

8. Optional Benefit 8: Dental Care (on OPD basis)

The Company will indemnify up to the amount specified in the Certificate of Insurance, subject to sub-limit on treatment if opted, for the Dental Expenses incurred by the Insured Member towards the following:

1. Dental consultations - Emergency Palliative Treatment of Dental pain and minor procedures
2. Conservative – per tooth
   a. Amalgam 1 – 5 surfaces, Permanent
   b. Metallic Inlay, 1 – 5 surfaces, Permanent (Gold Inlay)
   c. Composite resin 1-5 surfaces, Permanent
3. Extractions - per tooth
   a. Simple extraction – erupted tooth or exposed root
   b. Complicated extraction, tooth or root partially bony
   c. Removal of impacted, completely bony
4. Radiology
   a. X-ray intra-oral / bitewing
   b. Posterior – anterior or lateral skull and facial bone survey film
   c. Each additional x-ray bitewing
   d. Panoramic x-ray
5. Periodontal
   a. Provision splinting – extracoronal
   b. Gingivectomy or ginigivoplasty Per tooth
   c. Root amputation – per root
6. Endontic
   a. Root canal– x-ray included
   b. Therapeutic pulotomy (excluding final restoration)

Subject to any Waiting Period applicable under this Optional Extension as specified in Certificate of Insurance.

Accidental Damage to natural teeth following the accident:

The Company will indemnify up to the amount specified in the Certificate of Insurance, for the initial treatment required immediately within thirty (30) days following damage to natural teeth caused by an accident and provided the Insured has been covered under the policy since before the accident happened.

Benefit is not payable if:

(i) injury caused during participation in professional /Adventurous sports;

(ii) the damage was caused by normal wear and tear;

(iii) the damage was caused by tooth brushing or any other oral hygiene procedure;

(iv) the damage was caused as the result of consumption of food or drink;

(v) damage was not apparent within 7 days of impact which caused the injury

Note: All dental treatments must be carried out by a qualified dentist.

9. Optional Benefit 9: Vision Care

The Company will indemnify up to the amount specified in the Certificate of Insurance, subject to sub-limit on treatment if opted, for the Medical Expenses related to consultations / prescribed diagnostic tests / treatments incurred by the Insured Member for Vision care.

The Company will pay for the Reasonable and Customary fees charged for corrective spectacle lenses (with frame) or contact lenses as prescribed by the ophthalmologist or optometrist. This benefit also pays for one time routine eye examination carried out by an ophthalmologist or optometrist per Cover Year.

This benefit does not pay for tinted / reactive lenses, sunglasses, non-corrective contact lenses, lasik / laser eye surgery, medical or surgical treatment of the eye(s) and/or similar, whether prescribed or not.

10. Optional Benefit 10: Health Services

The Company shall offer any of the following subject to specified in Certificate of Insurance:

a) Doctor on Call/Chat

Up on the Insured Member's request, the Company shall arrange for a Doctor on Call and / or Doctor on Chat from a Medical Practitioner. The Medical Information /advice will be based only on the information and documentation provided to Medical Practitioner. This is for additional information purposes only and does not and should not be deemed to substitute the Insured Member's visit or consultation to an independent Medical Practitioner.

Note: This benefit is available only in Company's or Assistance Service Provider's network

b) Domestic Second Opinion

If the Insured Member is diagnosed with any Major Illness during the Cover Year, up on that Insured Member's request, the Company shall arrange for a Second Opinion from a Medical

Practitioner within India from its network regarding the diagnosis of such Major Illness.

Second Opinion will be based only on the information and documentation provided to the Company, which will be shared with the Medical Practitioner, and is subject to the conditions specified below:

a) This Benefit can be availed maximum once by an Insured Member during the Cover Year for each Major Illness.

b) The Insured Member is free to choose whether or not to obtain the Second Opinion and, if obtained, then whether or not to act on it.

c) This Benefit is for additional information purposes only and does not and should not be deemed to substitute the Insured Member's visit or consultation to an independent Medical Practitioner.

d) The Company does not provide a Second Opinion or make any representation as to the adequacy or accuracy of the same, the Insured Member's or any other person's reliance on the same or the use to which the Second Opinion is put.

e) The Company does not assume any liability for and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner or in any Second Opinion or for any consequences of actions taken or not taken in reliance thereon.

f) The Policyholder/Insured Member shall hold the Company harmless for any loss or damage caused by or arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions or representations made by the Medical Practitioner or for any consequences of any action taken or not taken in reliance thereon.

g) Any Second Opinion provided under this Benefit shall not be valid for any medico-legal purposes.

h) The Second Opinion does not entitle the Insured Member to any consultation from or further opinions from that Medical Practitioner.

i) For the purposes of this Benefit only, Major Illness means any one of the following only:

1. Benign Brain Tumor
2. Cancer
3. End Stage Lung Failure
4. Myocardial Infraction
5. Coronary Artery Bypass Graft
6. Heart Valve Replacement
7. Coma
8. End Stage Renal Failure
9. Stroke
10. Major Organ Transplant
11. Paralysis
12. Motor Neuron Disorder
13. Multiple Sclerosis
14. Major Burns
15. Total Blindness

c) International Second Opinion

Notwithstanding anything to the contrary in the Policy, by choosing this Option, the Company agrees to extend the scope of coverage under clause 10 (b): Domestic Second Opinion to 'Worldwide excluding India' subject to all provisions stated in clause 10 (b) holds true for this clause 10 (c) as well.

d) Medical Room Management

Up on the Policyholder's request, the Company shall arrange for on-site arrangement of a Medical Practitioner, as specified in Policy schedule.

e) Healthy Rewards Program

(i) The Company shall recognize the fitness activities by making use of activity tracking apps, devices and visits to the Fitness centre or yoga centres to track and record the activities of the members engage in.

(ii) Rewards can be earned by any of the following:

(1) Recording minimum 10,000 steps in a day (tracked through mobile application or a wearable device) or burning 300 calories in one exercise session per day.

(2) Participation in a recognized Marathon/ Walkathon/ Cyclothon or a similar activity which offers a completion certificate with timing

(3) Participation in Annual Health Check-up provided the same is availed in registered diagnostic centre

(iii) Reward points can be earned as per the grid mentioned below:

S.L. No.	Category	Sub Category	Reward* Earned
I	Joining Bonus		200 (One time)

II	ActiveWeekz	Active Daysper week	
	1 active day = 10000 steps or 300 calories burned in activity	2 days	10/Week
		3 days	15/Week
		4 days	30/Week
		5 days	50/Week
		>=6 days	100/Week
III	Participation in Annual Health Check-up	Annual Health Check-up	200/Year
IV	Participation in Walkathons/ Marathons / Cyclothons (Completion Certificate to be provided)	At least 10km	200/Event
V	Membership at Gym, Fitness Club, Swimming Club, Yoga, Dancing, Zumba etc.	Annual Membership	200/ Membership

* Each Reward point is equivalent to 1 INR

(iv) Each Insured Member would be tracked separately and shall earn Rewards individually and utilized by that Insured Member only

(v) Earned Rewards can be utilized for:

i. In-patient Medical Expenses and Day Care Treatment, provided that the Coverage amount, Cumulative Bonus and Recharge of Coverage amount (if applicable) are exhausted during the Cover Year.

ii. Payment of Co-payment, Deductible, over and above sub-limit amount specified (wherever applicable).

iii. For non payable claims, in case of an In-patient Hospitalization or Day Care Treatment.

iv. Non-Medical expenses listed in Annexure II that would not otherwise be payable under the Policy.

v. Out-patient expenses, subject to complete utilization of OPD Expenses (if opted under the Policy).

Maximum of 75% of Rewards earned in a particular year can be carried forward to next Cover Year subject to Policy continuation with the Company and in accordance with the Renewal Terms under the Policy, provided such Rewards earned in a particular year can be carried only up to two years.

f) Dietician on Call

Up on the Insured Member's request, the Company shall arrange for a Dietician on Call. The Information /advice will be based only on the information and documentation provided to Dietician. This is for additional information purposes only and does not and should not be deemed to substitute the Insured Member's visit or consultation to an independent Medical Practitioner.

Note: This benefit is available only in Company's network within India

11. OPTIONAL BENEFIT 11 : Health Check-up

The Company will indemnify the Insured member, up to the amount specified in the Certificate of Insurance, for the Medical Expenses incurred in respect of that Insured Member's Health check-up tests (as specified in the Certificate of Insurance) either offered as a standard or customized package as per customer needs.

3. Additional Optional Benefits

The following Additional Benefits shall be opted with any base Optional Benefit opted or as specified under each Additional Benefit

1. Optional Benefit A : Repatriation Of Mortal Remains

If the Insured Member's demise happens solely and directly due to an Accident during the Cover year, then the Company will indemnify the Insured member's Nominee or the legal heir, up to the amount specified in the Certificate of Insurance, for the costs of repatriation of the mortal remains of that Insured Member to the City of Residence or for the costs of a local burial / cremation at the place where death has occurred.

2. Optional Benefit B : Compassionate Visit

The Company will indemnify the transportation expenses incurred by an Insured Member, up to the amount specified in the Certificate of Insurance, for the actual cost of a two – way economy class air ticket or equivalent by the most direct route, from the City of Residence of an Immediate Family Member (one adult) to the place of Hospitalization of the Insured Member, provided that:

i. The Insured Member is hospitalized for Medically Necessary Emergency Care of any Injury or Illness suffered during the Cover Year; and

ii. The treating Medical Practitioner prescribes that the attendance of an Immediate Family Member is necessary during the hospitalization of the Insured; and Insured's Immediate Family Member (one adult) travel from the Country of Residence should commence within the period of hospitalization of the Insured for which period his/her presence is necessary; and

iii. The treating Medical Practitioner certifies that the hospitalized Insured Member requires hospitalization for at least XX consecutive days; and

iv. The Immediate Family Member's return travel to the City of Residence shall commence not later than the date of the Insured Member's return to the City of Residence or maximum within 30 days of discharge from the hospital, whichever is earlier; and

v. The claim under this Cover will be admissible provided that no adult member of Insured's Immediate Family is present at the place of Insured's hospitalization.

3. Optional Benefit C : Emergency Worldwide Cover – Outside Area Of Cover

Notwithstanding anything contrary in the Policy, by opting for this Optional Benefit, coverage for medically necessary emergency hospitalization under Optional Benefit 1 (Hospitalization Expenses) is provided which arises suddenly whilst Insured member is outside Area of cover, up to the limit as specified in the Certificate of Insurance.

The coverage nevertheless provided for temporary stay up to maximum number of days per trip, and not exceeding defined number of days in a year outside Area of cover, as specified in Certificate of Insurance. The coverage is no longer effective for stays of over defined number of days per trip or exceeds the maximum defined number of days in a year outside Area of cover, whichever occurs earlier.

This benefit does not provide cover:

(a) for treatment of any condition if the member travelled outside Area of cover to get treatment (whether or not that was the only reason) or for any treatment which was, or may have reasonably been known about, before the travel commenced ; or

(b) for any aspect of pregnancy or childbirth whilst the member is outside Area of cover of this policy.

Once the treating medical practitioner certifies that the eligible medical condition is stabilized or the member's health status allows him/her to travel back to Area of cover, the company shall stop paying for such emergency hospitalization in-patient treatment or once the benefit limits has attained whichever occurs earlier.

4. Optional Benefit D : Patient Care

The Company will indemnify the Insured Member for the expenses incurred up to the amount per day as specified in the Certificate of Insurance, only through Reimbursement towards the hiring of a Qualified Nurse with the purpose of providing necessary care and convenience to the Insured Member to perform his Activities of Daily Living, and are recommended and certified by a Medical Practitioner to be mandatory in writing that the Insured is unable to perform at least two of the Activities of Daily Living , provided that:

i. A Claim will be admissible under this Benefit only if Hospitalization claim is admissible

ii. The Company shall not be liable to make payment under this Benefit for the first defined number of days of hiring the Qualified Nurse in respect of an Illness/Injury;

iii. This Benefit can only be availed within 30 days of discharge date from the Hospital.

iv. The Company shall not be liable to make payment under this Benefit for more than 7 consecutive days arising from Any One Illness or Injury or related ailment or its direct complication; and

v. The Company shall not be liable to make payment under this Benefit for more than 90 days per Cover Year per Insured Member;

vi. Clause 5.1(2) (2) under Permanent Exclusions, is superseded to the extent covered under this Benefit

5. Optional Benefit E : Loyalty Bonus

For each continuous and completed Cover Year, on subsequent renewal, the Company will enhance the Coverage amount of Optional Benefit 6 (a), Optional Benefit 6 (b), Optional Benefit 6 (c), Optional Benefit 7 of last Cover Year, by fixed percentage (%) of the Coverage amount as specified in Certificate of Insurance, on a cumulative basis, as a Loyalty Bonus.

The Benefit offering is subject to the conditions specified below:

(i) The accrued Loyalty Bonus available in the renewed Policy at any point of time shall not exceed 100% of the Coverage amount (pertaining to Optional Benefit 6 (a), Optional Benefit 6 (b), Optional Benefit 6 (c), Optional Benefit (7).

(ii) The entire Loyalty Bonus will be forfeited if the Policy is not continued / renewed on or before Cover End Date or the expiry of the Grace Period whichever is later.

(iii) If Coverage amount under the Policy is increased (or decreased) at the time of renewal, then the applicable Loyalty Bonus shall also be increased (or decreased) in

proportion to the Sum Insured, on the subsequent renewal.

(iv) A credit for accrued Loyalty Bonus would be provided regardless of Claim history in the previous Cover Year(s).

(v) Accrued Loyalty Bonus will be applicable on Individual basis

Notes:

i) This Optional Benefit can be opted only with Personal Accident (Optional Benefit 6) or Critical Illness Fixed Benefit (Optional Benefit 7)

ii) This Benefit is not available for Employer – Employee Policies

6. Optional Benefit F : Loss Of Employment

This Optional Benefit can be chosen with only one of the following Optional benefits:

(i) Personal Accident (Optional Benefit 6) or

(ii) Critical Illness Fixed Benefit (Optional Benefit 7)

Claim under this Optional Benefit is available only on:

· Admission of claim under Optional Benefit 6.(b): Permanent Total Disablement or Optional Benefit 6.(c): Permanent Partial Disablement; or Optional Benefit 7: Critical Illness Fixed Benefit; and

· Termination of Insured Member from his full time employment which results into no salary pay-out(part/full) is a prerequisite for admissibility of claim under this Optional Benefit

Basis of above two conditions fulfilled, the Company will pay a fixed amount maximum up to 6 times of EMI, as specified in the Certificate of Insurance with in a Cover Year.

(a) Exclusions Applicable to Optional Benefit F:

i. The Company shall not be liable to make any payment under this Section in the event of termination, dismissal, temporary suspension or retrenchment from employment of the Insured being attributed to any dishonesty or fraud or poor performance on the part of the Insured or his wilful violation of any rules of the employer or laws for the time being in force against the Insured by the employer.

ii. Unemployment at the time of inception of the Cover Year or arising within the first 90 days of inception of the Cover Year.

iii. Any unemployment from a job under which no salary or any remuneration is provided to the Insured

iv. Any suspension from employment on account of any pending enquiry being conducted by the employer/ Public Authority

v. Any unemployment due to resignation, retirement whether voluntary or otherwise

vi. Any unemployment due to non-confirmation of employment after or during such period under which the Insured was under probation.

7. Optional Benefit G : Network Limited To Preferred Providers

Notwithstanding anything to the contrary in the Policy, it is hereby declared that, the Company will indemnify the Medical Expenses incurred for Hospitalization under Hospitalization Expenses (Optional Benefit 1) and its Optional extensions (as applicable), Out-Patient Care (Optional Benefit 2) and its Optional extensions (as applicable) only if a Claim is incurred in a Hospital which is on the Preferred Provider Network List, as specified in the Certificate of Insurance.

If any Claim is incurred in a Hospital which is not on the updated Preferred Provider Network List, the Insured Member shall bear a Co-payment (in addition to any other applicable Copay or deductible) as specified in the Certificate of Insurance of the final claim amount assessed by the Company.

8. Optional Benefit H : Network Limited To Specified Geographies

Notwithstanding anything to the contrary in the Policy, it is hereby declared that, the Company will indemnify the Medical Expenses incurred for Hospitalization under Hospitalization Expenses (Optional Benefit 1) and its Optional extensions (as applicable), Out-Patient Care (Optional Benefit 2) and its Optional extensions (as applicable) only if a Claim is incurred in a Network located in specified geography, as specified in the Certificate of Insurance.

If any Claim is incurred in the Network which is not in geography as specified in certificate of Insurance, the Insured Member shall bear a Co-payment (in addition to any other applicable Copay or deductible) as specified in the Certificate of Insurance of the final claim amount assessed by the Company.

9. Optional Benefit I : Cover During Duty

The Company's liability under this Special Condition for Optional Benefit 6 (Personal Accident), is restricted to 'duration of the duty period' only or 'specified event' as specified in Certificate of Insurance.

For the purpose of this benefit, 'duty period' means coverage is restricted only to office hours

10. Optional Benefit J : Cover Restricted To Accident

The Company's liability under this Special Condition, for Optional Benefit 1 (Hospitalization Expenses) and its Optional extensions (as applicable) is restricted to Injury caused (during the Cover Year)

solely and directly due to an Accident that occurs during the Cover Year, as specified in certificate of Insurance.

11. Optional Benefit K : Accidental Hospitalization Cash

(a) If an Insured Member undergoes Medically Necessary In-Patient Hospitalization, due to an Injury which is suffered during the Cover Year, the Company will pay the amount specified against this Optional Benefit in the Certificate of Insurance, for each continuous and completed period of 24 hours of such Hospitalization of the Insured Member, provided that:

(i) The amount assessed by the Company on each admitted Claim for the Insured Member under this Optional Benefit shall be reduced by a Deductible on number of days as specified in the Certificate of Insurance. The Company shall be liable to make payment under the Policy for any Claim in respect of the Insured Member only when the Deductible on that Claim is exhausted.

(ii) The Company is liable to make payment under this Optional Benefit maximum up to 90 days in a Cover Year.

(b) This Optional Benefit can be chosen with only Personal accident (Optional Benefit 6)

12. Optional Benefit L : Modification Of Wait Periods

(a) Initial Wait Period Modification

Notwithstanding anything to the contrary in the Policy, by choosing this option, the Company agrees to modify the 'Initial Wait Period' of 30 days (defined in Clause 5.1(1)(a)) to the Wait Period as specified in the Certificate of Insurance

(b) Named Ailments Wait Period Modification

Notwithstanding anything to the contrary in the Policy, by choosing this option, the Company agrees to modify the Wait Period of 24 months for 'Specific Wait Period for Named Ailments' (defined in Clause 5.1(1)(b)) to the Wait Period as specified in the Certificate of Insurance

(c) Pre-Existing Diseases Wait Period Modification

Notwithstanding anything to the contrary in the Policy, by choosing this option, the Company agrees to modify the Wait Period of 36 months for 'Pre-existing diseases' (defined in Clause 5.1(1)c) to the Wait Period as specified in the Certificate of Insurance

Note: This option is applicable only on Optional Benefit 1: Hospitalization Expenses, Optional Benefit 3: Daily Cash Allowance, Optional Benefit 4: Convalescence Benefit, Optional Benefit 5: Surgical Cash

4. Special Conditions

The following special conditions are available and as applicable to the Optional benefits and their Optional Extensions (if opted):

1. Area of Cover

The Company will pay up to the amount specified in the Certificate of Insurance for Medical Expenses towards ailments incurred in area or area of cover specified in Certificate of Insurance, subject to the following terms for admissibility of Claim under this Special Conditions:

1. Notwithstanding anything stated under exclusion clause 5.2(2).(15), the Insured would be covered for 'Treatment received in area of cover' as specified in Certificate of Insurance, up to the purview of this cover.

2. Notwithstanding anything stated under 'Payment Terms' clause 7.6.(a), the Insured would be covered for 'Treatment received in area of cover' as specified in Certificate of Insurance, up to the purview of this cover.

3. For all admissible reimbursement Claims, currency exchange rate is the rate on date of payment of Medical Expenses to the Hospital made by Insured Member or Date of Loss in case of benefit shall apply.

4. The member's principal country of residence must be in a country within his/her selected area of cover. The member's level declaration specifies a Principal Country of Residence and if the Company found the member declaration and actual status is different, then country specific regulations may impact a person's eligibility to be a member. The Company may be required to apply legitimate international sanctions to this policy and may be unable to meet its full obligations under the terms of this policy where to do so would render it subject to legal action under international or domestic law. The Company and other service providers will not provide cover or pay claims under this policy if doing so would expose the Company or the service provider to a breach of international economic sanctions, laws or regulations. If a potential breach is discovered, where possible the Company will advise the member in writing

2. Floater Cover

(a) The maximum liability of the Company, for any and all Claims arising under this Policy, on occurrence of an insured event during the

Cover Year shall not exceed the Coverage Amount which is specifically mentioned in the Certificate of Insurance.

(b) Only for the purpose of 'Floater Cover', 'Coverage Amount' is modified and defined as below:

Coverage Amount: The amount specified in the Certificate of Insurance which represents the Company's maximum, total and cumulative liability for all Insured Members, for any and all Claims specifically mentioned against each & every Optional Benefit/Optional Extension individually and collectively incurred during the Cover Year.

3. Co-payment

Notwithstanding anything to the contrary in the Policy, it is hereby stated that the Insured Member will bear a Co-payment, as specified in the Certificate of Insurance, in accordance with Clause 7.5 and Company's liability shall be restricted to the balance amount payable.

The Co-payment shall be applicable to each and every claim for each Insured Member as defined in the Policy.

4. Deductible

The Claim amount assessed by the Company towards Insured Member(s), made during the Cover Year shall be reduced by a Deductible, as specified in the Certificate of Insurance. The Company shall be liable to make payment under the Policy for any Claim in respect of the Insured Member only when the Deductible on that Claim is exceeded.

For the purpose of this Special Condition, Deductible may be on 'number of Days', 'hours' or 'Claim amount' basis.

5. Additional Services

The Company or Assistance Service Provider (as applicable) may arrange for the Insured Member to avail any of the following services , subject to details as specified in the Certificate of Insurance, as follows:

i. The Company shall provide to the Insured Member, upon request, with the name, address, telephone number and, if available, office hours of physicians, hospitals, clinics, dentists and dental clinics (collectively "Medical Service Providers"). The Company shall not be responsible for providing medical diagnosis or treatment. Although the Company shall make such referrals, it cannot guarantee the quality of the Medical Service Providers and the final selection of a Medical Service Provider shall be the decision of the Insured Member.

ii. The Company shall assist the Insured Member in taking appointments with local Medical Practitioner.

iii. Health Portal: The Insured Member may access health related information and services such as health risk assessment, Special rates for OPD, Diagnostics and Pharmacy through network providers etc as available on the Company's website

iv. Health Coach services

v. Medical Evacuation services

vi. The Company will arrange for the provision of medical translation to the Insured Member over the telephone.

vii. The Company will arrange to deliver to the Insured Member essential medicine, drugs and medical supplies that are necessary for a User's care and/or treatment but which are not available at the Insured Member's location. The delivery of such medicine, drugs and medical supplies will be subject to the laws and regulations applicable locally. The Company will not pay for the costs of such medicine, drugs or medical supplies and any delivery costs thereof.

viii. The Company shall provide the address, telephone number and hours of opening of the nearest appropriate consulate and embassy worldwide.

ix. The Company shall assist the Insured Member to arrange for emergency document to be delivered to the Insured Member's Immediate Family Member, upon the Insured Member's request to do so.

x. If the medical condition of the Insured Member is of such gravity as to require qualified nurse, the Company will assist such Insured Member to provide reference of such qualified nurse.

xi. The Company shall assist the Insured Member by arranging for appointments with local diet and nutrition consultation.

xii. The Company will arrange to provide emergency alerts for the country the Insured Member is travelling.

xiii. Any other similar services

It is declared by the Company that:

(i) The Insured Member is free to avail the above additional services and, if obtained, then whether or not to act is at his/her sole responsibility and the Company do not assume any liability for and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner or in any

service or for any consequences of actions taken or not taken in reliance thereon.

(ii) The Insured Member shall indemnify the Company and hold the company harmless for any loss or damage caused by or arising out of or in relation to any opinion, advise, prescription, actual or alleged errors, omissions or representations made by the Medical Practitioner or service provider or for any consequences of any action taken or not taken in reliance thereon.

(iii) This is for additional information purposes only and does not and should not be deemed to substitute the Insured Member's visit/ consultation to an independent Medical Practitioner.

5. Exclusions

5.1 Standard Exclusions

1. Wait Periods applicable under this Policy for Optional Benefit 1c :All Conditions under Hospitalization Expenses & its Optional Extensions, Optional Benefit 3:Daily Cash Allowance & its Optional Extensions, Optional Benefit 4: Convalescence Benefit, Optional Benefit 5: Surgical Cash:

a. Initial wait period

(i) 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.

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

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

b. Specific Wait Period for Named Ailments

(i) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with the Company. This exclusion shall not be applicable for claims arising due to an accident.

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

(iii) 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.

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

(v) 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.

(vi) List of specific diseases/ procedures:

1. Any treatment related to Arthritis (if non-infective), Osteoarthritis and Osteoporosis, Gout, Rheumatism, Spinal Disorders(unless caused by accident), Joint Replacement Surgery(unless caused by accident), Arthroscopic Knee Surgeries/ACL Reconstruction/Meniscal and Ligament Repair
2. Surgical treatments for Benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to Adenoidectomy, Mastoidectomy, Tonsillectomy and Tympanoplasty), Nasal Septum Deviation, Sinusitis and related disorders
3. Benign Prostatic Hypertrophy
4. Cataract
5. Dilatation and Curettage
6. Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, Gastric and Duodenal Ulcers
7. Surgery of Genito-urinary system unless necessitated by malignancy
8. All types of Hernia & Hydrocele
9. Hysterectomy for menorrhagia or Fibromyoma or prolapse of uterus unless necessitated by malignancy
10. Internal tumours, skin

tumours, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant

11. Kidney Stone / Ureteric Stone / Lithotripsy / Gall Bladder Stone
12. Myomectomy for fibroids
13. Varicose veins and varicose ulcers
14. Genetic disorders
15. Parkinson's or Alzheimer's disease or Dementia;

c. Wait Period for Pre-existing Diseases:

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

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

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

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

d. The Wait Periods as defined in Clauses 5.1(a), 5.1(b) and 5.1(c) shall be applicable individually for each Insured Member and Claims shall be assessed accordingly.

e. If Coverage for Benefits or Optional Extensions is added afresh at the time of renewal, the Wait Periods as defined above in Clauses 5.1(a), 5.1(b) and 5.1(c) shall be applicable afresh to the newly added Benefits or Optional Extensions (as applicable), from the time of such renewal

2. Permanent Exclusions:

The following list of permanent exclusions is applicable to all the Optional Benefits and Optional Extensions of Optional Benefits.

Any Claim in respect of any Insured Member for, arising out of or directly or indirectly due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy.

1. Investigation & Evaluation: (Code- Excl04)

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

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

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

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

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

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

3. Obesity/ Weight Control: (Code- Excl06)

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

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

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

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

4) Body Mass Index (BMI);

a) greater than or equal to 40 or

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

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

4. Change-of-Gender treatments:

(Code- Excl07)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

5. **Cosmetic or plastic Surgery:(Code-Excl08)**

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

6. **Hazardous or Adventuresports: (Code-Excl09)**

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

7. **Breach of law: (Code- Excl10)**

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

8. **Excluded Providers: (Code- Excl11)**

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

Note: Refer Annexure – III of the Policy Terms & Conditions for list of excluded hospitals.

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

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

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

12. **Refractive Error: (Code- Excl15)**

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

13. **Unproven Treatments: (Code-Excl16)**

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

14. **Sterility and Infertility: (Code-Excl17)**

Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, sterilization

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

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

15. **Maternity: (Code Excl18)**

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.

5.2 Specific Exclusions:

1. Wait Period (applicable to Optional Benefit 1(a) :Critical illness cover, 1 (b): All Surgeries under Hospitalization Expenses & its Optional Extensions, Optional Benefit 7:Critical Illness Fixed Benefit & its Optional Extensions):

a. 90-Day Initial wait period

(i) The Company shall not be liable to make any payment under Optional Benefit 7 and

its Optional Extensions in respect of any Insured Event whose signs or symptoms first occur within 90 days of the Cover Start Date.

This exclusion shall not apply for subsequent Cover Years provided that there is no break in insurance cover for that Insured Member and that the Policy has been renewed with the Company for that Insured Member within the Grace Period and for the same or lower Coverage Amount.

2. Permanent Exclusion

The following list of permanent exclusions is applicable to all the Optional Benefits and Optional Extensions of Optional Benefits.

Any Claim in respect of any Insured Member for, arising out of or directly or indirectly due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy.

1) Any item or condition or treatment specified in List of Non-Medical Items (Annexure – II).

2) Any pre-existing injury / illness or disability and any complications thereof and its associated medical conditions unless we had agreed otherwise in writing;

3) Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T-Cell Lymphotropic Virus Type III (HTLV–III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind;

4) Any treatment directly related to surrogacy whether the member is acting as surrogate, or is the intended parent;

5) Any treatment begun or for which the need has arisen during the first ninety (90) days after birth, for any child conceived by artificial means or any form of assisted conception or if the child is born via surrogacy;

6) Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication;

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

8) Expenses incurred on advanced treatment methods other than as mentioned in clause 2.1 (h)

9) Any expenses incurred on providing or fitting any external prosthesis or orthosis or appliance or medical aids or durable medical equipment of any kind, like wheelchairs, walkers, crutches, ambulatory devices,unless allowed under the Policy, cost of Cochlear implants;

10) Any treatment related to sleep disorder or sleep apnea syndrome, general debility convalescence and any treatment in an establishment that is not a Hospital;

11) Treatment of any external Congenital Anomaly or Illness or defects or anomalies including their associated medical conditions or chronic medical conditions or vegetative state cover (on the basis of declaration by the treating doctor) or treatment relating to external birth defects;

We define vegetative state as a condition of profound non-responsiveness with no sign of awareness or consciousness or a functioning mind, even if the Insured can open their eyes and breathe unaided, and the person does not respond to stimuli such as calling their name or touching. This state must have remained for at least four (4) weeks with no sign of improvement or there could be no recovery;

12) Treatment whilst staying in a hospital for more than ninety (90) continuous days for permanent neurological damage on the basis of declaration by the treating

doctor. It is stated that treatment up to 90 days for permanent neurological damage will be covered under this Policy;

13) Treatment of mental retardation, arrested or incomplete development of mind of a person, subnormal intelligence or mental intellectual disability

14) Out-patient treatment;

15) Treatment received outside India;

16) Domiciliary hospitalization or treatment;

17) An Insured Member operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft or Scheduled Airline or any airline personal;

18) An Insured Member flying in an aircraft other than as a fare paying passenger in a Scheduled Airline;

19) Participation in actual or attempted felony, riot, civil commotion or criminal misdemeanor or activity;

20) Professional fees charged by a member of the Insured Member's immediate family or by a person normally resident in the household of the Insured or under his employment;

21) Training for or participating in professional sport of any kind or any sport for which the insured receives a salary or monetary reimbursement, including grants or sponsorship;

22) The Insured Member serving in any branch of the military, navy, air force or any branch of armed forces or any paramilitary forces;

23) Radioactive contamination whether arising directly or indirectly ionizing radiation, toxic, explosive or other hazardous properties of nuclear material;

24) Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident;

25) All preventive care, Vaccination including Inoculation and Immunizations (except in case of post-bite treatment) and tonics;

26) All expenses related to donor treatment, including screening, surgery to remove organs from the donor, in case of transplant surgery;

27) Non-Allopathic Treatment or treatment related to any unrecognized systems of medicine;

28) War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds;

29) Act of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane;

30) Any charges incurred to procure documents related to treatment or Illness pertaining to any period of Hospitalization or Illness or any administration costs or any other charges of a non-medical nature in connection with the provision and/or performance of medical supplies and/or services;

31) Personal comfort and convenience items or services including but not limited to T.V. (wherever specifically charged separately), charges for access to cosmetics, hygiene articles, body care products and bath additives, as well as similar incidental services and supplies;

32) Expenses related to any kind of RMO charges, Service charge, Surcharge, night charges levied by the hospital under whatever head or any room upgrades, menu items not included as standard or visitors meals;

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

(a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death;(b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death;

(c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins

(including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death;

In addition to the foregoing, any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above is also excluded.

34) Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants unless prescribed by a medical practitioner;

35) Continuous ambulatory peritoneal dialysis. Coverage for 'Continuous ambulatory peritoneal dialysis' is available on OPD basis and as part of Pre-Post hospitalization expenses;

36) Charges for items not listed in the policy schedule applicable to the member or considered as not medically necessary or which may be considered as elective;

37) Alopecia wigs and/or toupee and all hair or hair fall treatment and products including any investigations; all forms of acne;

38) Any treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification center, sanatorium, home for the aged, remodeling clinic or similar institutions;

39) Any medical or physical condition or treatment or service, which is specifically excluded under the Policy Schedule including the associated medical conditions shown on the endorsement;

40) Cryopreservation or harvesting or storage of stem cells as a preventive measure against possible disease/illness/injury, or implantation or re-implantation of living cells or living tissue whether autologous or provided by a donor;

41) Any other weight management services, treatment and supplies unless requires hospitalization and surgery ;

42) Hormone Replacement Therapy;

43) The evacuation would involve moving Insured Member from a remote location where there is no or limited access;

44) Dental, Orthodontics, Periodontics, Endodontics or any preventative dentistry no matter who gives the treatment;

45) Charges for residential stays in Hospital which are not medically necessary or are incurred for social or domestic reasons or for reasons which are not directly connected with treatment or where the Hospital has effectively become the place of domicile or permanent abode;

46) Any charges made by the medical practitioner, hospital, laboratory or any such medical services which are not reasonable and customary;

47) Genetic tests undertaken to establish whether or not the Insured may be genetically disposed to the development of a medical condition in the future unless requires for current medical treatment;

48) Insured Person suffering from or has been diagnosed with or has been treated for Down's Syndrome/Turner's Syndrome/Sickle Cell Anaemia/ Thalassemia Major/G6PD deficiency prior to the first Policy Start Date, then costs of treatment related to or arising from the disorder whether directly or indirectly will be treated as a Pre-existing Disease and will not be covered within first 36 months from the date of first issuance of the Policy

49) Ear or body piercing and tattoing or treatment needed as a result of any of these;

50) Any charges for treatment incurred during a period for which the premium is not paid;

51) Any claim or part of a claim in which the member has to pay a deductible or co-insurance (where applicable). In such a claim, we will only pay the balance of the claim after we have deducted the excess (or deductible or co-insurance) amount;

52) All bank or credit or foreign exchange charges when the claims payment is made in a currency other than the policy currency upon the member's request;

53) Bacterial infections (except pyogenic infection which occurs through an Accidental cut or wound);

54) Any Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs, alcohol, hallucinogens, smoking.

55) Any treatment or part of treatment or any expenses incurred under this Policy that is not reasonable and customary and/or not medically necessary;

Note: In addition to the foregoing, any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above Permanent Exclusions shall also be excluded.

6. General Terms And Conditions

6.1 Standard General Terms & Clauses

1 Disclosure to Information Norm

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

Note:

a. "Material facts" for the purpose of this clause 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.

b. In continuation to the above clause the Company may also adjust the scope of cover and / or the premium paid or payable, accordingly.

2 Condition Precedent to Admission of Liability

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

3 Complete Discharge

Any payment to the policyholder, Insured Person or his/ her nominees or his/ her legal representative or Assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim

4 Multiple Policies

1. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
2. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy/ policies, even if the sum insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this policy.
3. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurers from whom he/she wants to claim the balance amount.
4. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy

5 Renewal Notice

The policy shall ordinarily be renewable except on grounds of established fraud, or non-disclosure or misrepresentation by the insured person.

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

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

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

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

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

6 Cancellation / Termination

a. The policyholder may cancel this policy by giving 7 days' written notice and in such an event, the Company shall refund proportionate premium for the unexpired policy period.

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

c. If the risk under the Policy has already commenced, or only a part of the insurance coverage has commenced, and the option of Policy cancellation is exercised by the Policyholder, then the expenses such as pre- policy medical examination etc. incurred by the Company will also be deducted before refunding of premium.

d. The Company may cancel the Policy at any time on grounds of mis-representations, 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 mis-representations, non-disclosure of material facts or fraud

Notes:

In case of demise of the Primary Insured Member,

i. Where the Policy covers only the Primary Insured Member, this Policy shall stand null and void from the date and time of demise of the Primary Insured Member and the Company shall refund proportionate premium for unexpired Policy Period. Subject to no claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.

ii. Where the Policy covers other Insured Members, this Policy shall continue till the end of Cover Period for the other Insured Members. If the other Insured Members wish to continue with the same Policy, the Company will renew the Policy subject to the appointment of a Primary Insured Member provided that:

I. Written notice in this regard is given to the Company before the Cover End Date; and

II. A Person who satisfies the Company's criteria to become a Primary Insured Member. The criteria being:

(a) He / She should become a member of the Group against whom the Master policy is issued.

(b) He / She should satisfy the age limit criteria as mentioned in the product.

iii. Cancellation in case of premium installment is opted -

If Policyholder cancels the Policy after the Free look period or demise of Insured where he/she is the only insured in the Policy, then the Company will refund the installment premium for the unexpired installment period, provided no Claim has been made under the Policy.

7 Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. lf such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits as per IRDAI guidelines on migration

For Detailed Guidelines on Migration, kindly refer the link: https://www.careinsurance.com/other-disclosures.html.

8 Withdrawal of Policy

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.

Insured Person will have a one-time option to renew the existing product, if renewal falls within the 90 days from the date of withdrawal of the product or 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.

9 Moratorium Period

After completion of five continuous years under the policy no look back to be applied. This period of five years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of five continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would

however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

10 Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company may revise or modify the terms of the policy including the premium rates. The insured person shall be notified before the changes are affected

11 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 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 a 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

12 Claim Settlement (provision for Penal Interest)

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

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

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest in any case not later than 15 days from the date of intimation on receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of intimation on receipt of last necessary document.

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

Bank rate shall mean the rate fixed by the Reserve Bank of lndia (RBl) at the beginning of the financial year in which claim has fallen due

13 Portability

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

For Detailed Guidelines on Portability, kindly refer the link: https://www.careinsurance.com/other-disclosures.html

14 Premium Installment facility

lf 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)

i. Grace Period of fifteen days where premium payment mode is monthly and thirty days in all other cases would be given to pay the installment premium due for the policy.

ii. During such grace period, coverage shall be available if the premium is paid in instalments during the policy period.

iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

iv. No interest will be charged lf the installment premium is not paid on due date

v. ln case of installment premium due not received within the grace period, the policy will get cancelled.

vi. ln the event of a claim, all subsequent premium installments shall immediately become due and payable.

vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

15 Grievances

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

Website/link:
https://www.careinsurance.com/customer-grievance-redressal.html

Mobile App : Care Health- Customer App

Toll free (whatsapp number): 8860402452

Courier: Any of Company's Branch Office or corporate office

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 Branch Office or corporate office. For updated details of grievance officer, kindly refer the link https://www.careinsurance.com/customer-grievance-redressal.html

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.

Grievance may also be lodged at IRDAI integrated Grievance Management System -

https://bimabharosa.irdai.gov.in/

Note: The Contact details of the Insurance Ombudsman offices have been provided as Annexure VII.

16 Nominee

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. ln 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.

6.2 Specific General Terms & Clauses

1 Material Change

It is a condition precedent to the Company's liability under the Policy that the Policyholder shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business at his own expense or any material information that the Insured Member and/or Policyholder is aware of, or could reasonably be expected to know, that relates to questions in the Proposal Form and which is relevant to the Company in order to accept the risk of insurance and if so on what terms. The Insured Member/Policyholder must exercise the duty of disclosure to Company before Renewal, extension, variation, endorsement. The Company may, in its discretion, adjust the scope of cover and / or the premium paid or payable, accordingly.

2 Records to be maintained

Policyholder and the Insured Members shall keep an accurate record containing all relevant medical records and shall allow the Company or the Company representatives to inspect such records. Policyholder or the Insured Member shall furnish such information as the

Company may require under this Policy at any time during the Cover Period and up to three years after the Policy Period End Date, or until final adjustment (if any) and resolution of all Claims under this Policy.

3 No constructive Notice

Any knowledge or information of any circumstance or condition in relation to Policyholder, the Insured Members which is in the Company possession and other than that information expressly disclosed in the Proposal Form or otherwise in writing to the Company, shall not be held to be binding or prejudicially affect the Company or absolve the Policyholder or Insured from their duty of disclosure.

4 Free Look Period

i. The Policyholder/Insured Member may, within 30 days from the receipt of the Policy document, return the Policy stating reasons for his objection, if the Policyholder disagrees with any Policy terms and conditions.

ii. If no Claim has been made under the Policy, the Company will refund the premium received after deducting proportionate risk premium for the period on cover, expenses for medical examination and stamp duty charges. If only part of the risk has commenced, such proportionate risk premium shall be calculated as commensurate with the risk covered during such period. All rights under the Policy will immediately stand extinguished on the free look cancellation of the Policy.

iii. Provision for Free look period is not applicable and available at the time of renewal of the Policy.

5 Policy Disputes

Any and all disputes or differences under or in relation to the validity, construction, interpretation and effect to this Policy shall be determined by the Indian Courts and in accordance with Indian law.

6 Communication

a. Any communication meant for the Company must be in writing and be delivered to its address shown in the Policy Schedule/ Certificate of Insurance. Any communication meant for the Policyholder or Insured Member will be sent by the Company to his last known address or the address as shown in the Policy Schedule/ Certificate of Insurance.

b. All notifications and declarations for the Company must be in writing and sent to the address specified in the Policy Schedule/ Certificate of Insurance. Agents are not authorized to receive notices and declarations on the Company's behalf.

c. Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

7 Alterations in the Policy

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

8 Out of all the details of the various benefits provided in the Policy Terms and Conditions, only the details pertaining to benefits chosen by policyholder as per Policy Schedule shall be considered relevant

9 Electronic Transactions

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

10 Limitation of Liability

Any Claim under this Policy for which the notification or intimation of Claim is received 12 calendar months after the event or occurrence giving rise to the Claim shall not be admissible, unless the Policyholder or the Insured Member proves to the Company satisfaction that

the delay in reporting of the Claim was for reasons beyond the Insured Member's control.

11 Obligation in respect to minor

If an Insured Member is less than 18 years of age, the Primary Insured Member shall be responsible for ensuring compliance with all terms and conditions of this Policy on behalf of that Insured Member.

12 Proximate Clause

The Company covers the Policyholder/Insured Member only to the extent of Proximity cause which means active and efficient cause that sets in motion a chain of events which brings about a result, without the intervention of any force started and working actively from a new and independent source.

13 Sanctions and Compliance with Laws

This insurance does not apply to the extent that trade or economic sanctions or other similar laws or regulations prohibit the coverage provided by this insurance.

7. Claims Intimation, Assessment And Management (other Terms And Clauses)

1. Upon occurrence of any Illness or Injury that may give rise to a Claim under this Policy, then as a condition precedent to the Company's liability under the Policy, the Insured Member shall undertake all of the following:

(a) Claims Intimation

(i) If any Illness is diagnosed or discovered or any Injury is suffered or any other contingency occurs which has resulted in a Claim or may result in a Claim under the Policy, the Insured Member (or Nominee or legal heir if the Insured Member is deceased), shall notify the Company either at Company call Centre or in writing immediately and in any event within the timeframe (if any) specified in the Benefit under which the Claim is made.

(ii) Claim must be filed within 15 days from the date of discharge from the hospital in case of hospitalization and actual date of loss in case of non-hospitalization benefits.

Note: 7.1 (a) (i) and 7.1 (a) (ii) are precedent to admission of liability under the policy.

(iii) If the Insured Member is to undergo planned Hospitalization, the Insured Member shall give written intimation to the Company of the proposed Hospitalization at least 48 hours prior to the planned date of admission to Hospital.

(iv) The following details are to be provided to the Company at the time of intimation of Claim:

I Policy Number ;

II Name of Primary Insured Member;

III Name and unique identification number of the Insured Member in respect of whom the Claim is being made;

IV Nature of Illness or Injury and the Benefit and/or Optional Extension under which the Claim is being made;

V Date and place of Injury or Death and/or date and place of admission to Hospital (as applicable);

VI Name and address of the attending Medical Practitioner and Hospital;

VII Date of admission to Hospital or proposed date of admission to Hospital for planned Hospitalization;

VIII Any other information / document as required by the Company or Assistance Service Provider to assess the Claim, in case fraud is suspected.

(v) A Claim has to be notified to the Company within 24 hours or before discharge (whichever is earlier) for Emergency Hospitalization.

2. Claims Procedure

(a) Cashless :

Cashless facility is available only at Network Hospitals of the Company or Assistance Service Provider. The Insured Members can avail cashless facility at the time of admission into a Network Hospital, by presenting the health card, provided by the Company under this Policy, along with a valid photo identification document (like: Voter ID card / Driving License / Passport / PAN Card / any other identification documentation as approved by the Company).

(b) In addition to the above, in order to avail cashless facility, the following procedure must be followed:

(i) Pre-authorization: the Insured Member must call the Company or Assistance Service Provider call centre (1800-102-4488) and request authorization for the proposed treatment by way of submission of a completed pre-authorization form at least 48 hours prior before the commencement of a planned Hospitalization or within 24 hours of admission to Hospital, if the Hospitalization is required in an Emergency.

(ii) The Company will process the request for authorization after having obtained accurate and complete information in respect of the Illness or Injury for which cashless facility is sought to be availed. The Company or Assistance Service Provider will confirm in writing authorization or rejection of the request to avail cashless facility for the Insured Member's Hospitalization.

(iii) If the request for availing cashless facility is authorized by the Company or Assistance Service Provider, then payment for the Medical Expenses incurred in respect of the Insured Member shall not have to be made to the extent that such Medical Expenses are covered under this Policy and fall within the amount authorized in writing by the Company for availing cashless facility. Payment in respect of co-payments (if applicable) or within Deductible (if applicable) or any other costs and expenses not authorized under the cashless facility shall be made directly by the Insured Member to the Network Hospital. All original bills andevidence of treatment for the Medical Expenses incurred in respect of the Hospitalization of the Insured Member and all other information and documentation specified at Clause 7.4 shall be submitted to the Network Hospital immediately and in any event before the Insured Member's discharge from Hospital.

(iv) In case Policyholder/Insured Member cannot avail the cashless facility, payment for the treatment will have to be made by the Insured Member to the Network Hospital, following which a Claim for reimbursement may be made to the Company and the same will be considered by the Company subject to the Policy.

(c) The list of updated Network Hospitals is available with the Company or Assistance Service Provider and is subject to amendment or modification of the Network Hospitals and/or the extent of cashless facilities available at particular Network Hospitals from time to time.

(d) Before availing the cashless facility, Policyholder or the Insured Member is required to check the applicable list of Network Providers for the area where he intends to avail the cashless facility through the call center number as provided in the Certificate of Insurance.

(e) Health card issued by the Company shall not be used

(i) On termination or cancellation of this Policy

(ii) After Cover End Date

(iii) On death of Insured Member

(f) Re-imbursement :

(i) It is agreed and understood that in all cases where intimation of a Claim has been provided under Reimbursement Facility and/or the Company specifically states that a particular Benefit is payable only under Reimbursement Facility, all the information and documentation specified in Clause 7.1 and Clause 7.4 shall be submitted to the Company at Insured Member's own expense, immediately and in any event within 30 days of Insured Member's discharge from Hospital.

(ii) The Company shall give an acknowledgement of collected documents. However, in case of any delayed submission, the Company may examine and relax the time limits mentioned upon the merits of the case.

(iii) In case a reimbursement claim is received after a Pre-Authorization letter has been issued for the same case earlier, before processing such claim, a check will be made with the Network Provider whether the Pre-authorization has been utilized. Once such check and declaration is received from the Network Provider, the case will be processed.

(iv) For Claim settlement under reimbursement, the Company will pay the Insured Member. In the event of

death of the Insured Member, the Company will pay the nominee (as named in the Certificate of Insurance) and in case of no nominee, to the legal heirs or legal representatives of the Insured Member whose discharge shall be treated as full and final discharge of its liability under the Policy.

(v) 'Date of Loss' under Reimbursement Facility is the 'Date of Admission' to Hospital in case of Hospitalization & actual Date of Loss for non-Hospitalization related Benefits.

(vi) Insured Member (or Nominee or legal heir if the Insured Member is deceased) shall (at his expense) give the documentation specified at Clause 7.4 and any additional documentation specified in the Benefit provision and/or Optional Extension under which the Claim is being made to the Company immediately and in any event within 30 days of the occurrence of the Injury.

(g) Claims incurred outside India: The Company's Assistance Service Provider should be intimated for availing cashless facility under the applicable Benefits.

3. Policyholder's and Insured Member's duty at the time of Claim

(a) The Insured Member shall check the updated list of Network Hospitals before submission of a pre-authorization request for cashless facility; and

(b) As a condition precedent for a Claim to be considered under this Policy:

(i) All reasonable steps and measures must be taken to avoid or minimize the quantum of any Claim that may be made under this Policy.

(ii) Intimation of the Claim, notification of the Claim and submission or provision of all information and documentation shall be made promptly and in any event in accordance with the procedures and within the timeframes specified in Clause 7 of the Policy.

(iii) The Insured Member will, at the Company request submit himself/herself for a medical examination by the Company's/Assistance Service Provider nominated Medical Practitioner as often as the Company consider reasonable and necessary. The cost of such medical examination shall be borne by the Company.

(iv) The Company's /Assistance Service Provider Medical Practitioner and representatives shall be given access and co-operation to inspect the Insured Member's medical and Hospitalization records and to investigate the facts and examine the Insured Member.

(v) The Company shall be provided with complete documentation and information which the Company has requested to establish the Company liability for the Claim, its circumstances and its quantum.

4. Documents to be submitted for registration of Claim

(a) The following information and documentation shall be submitted to the Company /Assistance Service Provider in accordance with the procedures and within the timeframes specified in Clause 7 of the Policy in respect of all Claims and claim will be registered only on submission of below documents. The date of submission of such information shall be deemed as date of claim registration for the purpose of claim processing:

(i) Duly completed and signed Claim form, in original;

(ii) Identity proof with photo, Age proof and Address Proof;

(iii) Medical Practitioner's first consultation paper and referral letter advising Hospitalization;

(iv) Medical Practitioner's prescription advising drugs / diagnostic tests / consultation;

(v) Original numbered bills/ receipts and discharge card from the Hospital / Medical Practitioner;

(vi) Original numbered bills from licensed pharmacy / chemists;

(vii) Original pathological / diagnostic test reports and payment receipts;

(viii) Emergency Notes, Initial Assessment Sheet and Indoor case papers (if applicable);

(ix) Accident proof - First Information Report/ final police report, if applicable;

(x) Disability Certificate from Government Medical Board, Fitness Certificate, Medical

Prescription

(xi) Post mortem report, if conducted;

(xii) Any other information/document as required by the Company or Assistance Service Provider to assess the Claim, in case fraud is suspected

(b) Only in the event that original bills, receipts, prescriptions, reports or other documents have already been given to any other insurance company or to a reimbursement provider. The Company will accept properly verified photocopies of such documents attested by such other insurance company/reimbursement provider along with an original certificate of the extent of payment received from such insurance company/reimbursement provider.

(c) The Company will only accept bills/invoices which are made in the Insured Member's name.

(d) The Company may give a waiver to one or few of the above mentioned documents depending upon the case.

(e) However, claims filed even beyond the timelines mentioned above should be considered if there are valid reasons for any delay

(f) Additional Claim documents for Personal Accident (Optional Benefit 6):

It is a condition precedent to the Company's liability under these Benefits that the following information and documentation shall be submitted to the Company immediately and in any event within 30 days of the event giving rise to the Claim under these Benefits:

1. Medical reports giving the details of the Accident, nature of Injury and the details of treatment provided, Admission and Death Summary, Accident Report
2. Original Death Certificate; if applicable
3. Disability Certificate issued by CMO (Chief Medical Officer) as appointed by the Hospital Authorities; if applicable
4. A newspaper cutting about accident (if available)
5. Certificate from Bank for outstanding amount of loan

(g) Additional Claim documents for Critical illness Fixed Benefit (Optional Benefit 7)

It is a condition precedent to the Company's liability under this Benefit that the following information and documentation shall be submitted to the Company immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

1. Certificate from the attending Medical Practitioner of the Insured Member confirming that the Claim does not relate to any Pre-Existing Illness or any Illness or Injury which was diagnosed or existed within the first xx days of the Cover Start Date, as specified in Certificate of Insurance.
2. Original investigation test reports, indoor case papers and medical documents as specified under the respective Critical Illness, Covered Surgical Procedure or Covered Medical Event.
3. Certificate from Bank for outstanding amount of loan

5. Claim Assessment

(a) The Company shall scrutinize the Claim and supportive documents, once received. In case of any deficiency, the Company may call for any additional documents or information as required, based on the circumstances of the Claim.

(b) All admissible Claims under this Policy shall be assessed by the Company in the following progressive order:

(i) If a room accommodation has been opted for where the rent or category is higher than the eligible limit for that Insured Member under the Policy, then, the Insured Member shall bear the ratable proportion of the Associate Medical Expenses (including surcharge or taxes thereon) in the proportion of the room rent actually incurred less room rent limit and divided by room rent actually incurred.

(ii) If any sub-limits on Medical Expenses are applicable as specified in the Certificate of Insurance, the Company's liability to make payment shall be limited to the extent of the applicable sub-limit for that Medical Expense.

(iii) Co-payments, Deductibles and Franchise Deductibles, if any, shall be applicable on the amount payable by the Company after applying Clause 7.5.(b)(I), (ii).

(c) The Claim amount assessed in Clause 7.5(b) above would be deducted from the Coverage Amount of respective Optional Benefit or Optional Extension.

(d) All claims incurred in India are dealt by the Company directly.

6. Payment Terms

(a) This Policy covers only medical treatment taken entirely within India and within area of cover as shown in the Certificate of Insurance .

(b) Only for reimbursement cases, payments under this Policy shall be made in Indian Rupees and within India. For all admissible reimbursement Claims and benefit (fixed pay-out) Claims, the exchange rate on the date of loss shall be applied.

(c) If the Assistance Service Provider or the Company requests that bills or vouchers in a local language or vernacular be accompanied by an appropriate translation into English then the costs of such translation must be borne by the Policyholder or the Insured Member.

(d) The Claim amount assessed for any Benefit or for any Optional Extensions would be deducted from the Coverage Amount and for the unexpired Cover Year, balance Coverage Amount shall be available.

(e) The Company shall have no liability to make payment of a Claim under the Policy in respect of an Insured Member, once the Coverage Amount for that Insured Member is exhausted.

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

(g) Under cashless facility, the payment of Claims shall be made to the Network Hospital and the Company discharge would be complete and final.

(h) For the Reimbursement Claims, the Company will pay to the Primary Insured Member unless specified otherwise in th Certificate of Insurance. In the event of death of the Primary Insured Member, unless specified otherwise in the Certificate of Insurance, the Company will pay the nominee (as named in Annexure A to the Policy) and in case of no nominee to the legal heir of the Primary Insured Member whose discharge shall be treated as full and final discharge of its liability under the Policy.

(i) The Company shall settle or reject any Claim within 15 days of intimation on receipt of all the necessary documents / information as required for settlement of such Claim and sought by the Company. The Company shall provide the Policyholder / Insured Member an offer of settlement of Claim and upon acceptance of such offer by the Policyholder / Insured Member, the Company shall make payment within 7 days from the date of receipt of such acceptance.

(j) The Claim shall be paid only for the Cover Year in which the Insured event which gives rise to a Claim under this Policy occurs.

(k) The Company may change the Assistance Service Provider or utilize the service of any other assistance service provider by giving written notification to the Policyholder.

(l) The Policy covers Reasonable and Customary Charges incurred towards medical treatment taken or any other expenses triggers under any Benefit during the Policy Period.

(m) Under this Policy, the Company's total, cumulative, maximum liability during the Policy Year is maximum up to the Sum Insured unless any additional Sum Insured available or accrued under any Benefit.

(n) For diseases or conditions or procedure that have a specified sub-limit then all related expenses shall be covered up to the sub-limit specified for that disease or condition or procedure. In case there is a specified sub-limit then the Company's total, cumulative, maximum liability during the Policy Year is maximum up to the specified sub-limit subject to the available Sum Insured in the Policy Year.

For example- if the Policy specifies a sub-limit of Rs. 50,000 for a particular disease then all expenses related to the treatment of that disease (including but not limited to pre-hospitalization, hospitalization and post-hospitalization) will be covered up to Rs. 50,000, subject to Sum Insured availability in the Policy Year even if the overall Sum Insured is higher.

Annexure – I

		Plan options			
Sr.No	**Related Procedures***	**1 CI**	**17 CI**	**32 CI**	**All Surgeries**
1	Cardiology	No	Yes	Yes	Yes
2	Critical Care Related	No	Yes	Yes	Yes
3	Dental Related(Except FNAC)	No	No	No	No
4	FNAC	Yes	No	Yes	Yes
5	ENT Related	Yes	No	Yes	Yes
6	Gastroenterology	Yes	No	Yes	Yes
7	General Surgery Related	Yes	No	Yes	Yes
8	Gynecology	Yes	No	Yes	Yes
9	Neurology	Yes	No	Yes	Yes
10	Oncology	Yes	No	Yes	No
11	Operations on the Salivary glands and Salivary ducts	Yes	No	Yes	Yes
12	Operations on the skin & Subcutaneous tissues	Yes	No	Yes	Yes
13	Operations on tongue	Yes	No	Yes	Yes
14	Ophthalmology related except Cataract	Yes	No	Yes	Yes
15	Cataract	No	No	No	Yes
16	Orthopaedic related	No	No	No	Yes
17	Other operations of mouth and face	Yes	No	Yes	Yes
18	Pediatric surgery related	Yes	No	Yes	Yes
19	Plastic Surgery related	Yes	No	Yes	Yes
20	Thoracic Surgery related	Yes	No	Yes	Yes
21	Urology except Hemodialysis	Yes	No	Yes	Yes
22	Hemodialysis	Yes	No	Yes	No

***** Please refer below for details of Procedures Covered

Annexure I - List of Day Care Surgeries

1. Cardiology Related:

1. CORONARY ANGIOGRAPHY

2. Critical Care Related:

2. INSERT NON- TUNNEL CV CATH
3. INSERT PICC CATH (PERIPHERALLY INSERTED CENTRAL CATHETER)
4. REPLACE PICC CATH (PERIPHERALLY INSERTED CENTRAL CATHETER)
5. INSERTION CATHETER, INTRA ANTERIOR
6. INSERTION OF PORTACATH

3. Dental Related:

7. SPLINTING OF AVULSED TEETH
8. SUTURING LACERATED LIP
9. SUTURING ORAL MUCOSA
10. ORAL BIOPSY IN CASE OF ABNORMAL TISSUE PRESENTATION
11. FNAC
12. SMEAR FROM ORAL CAVITY

4. ENT Related:

13. MYRINGOTOMY WITH GROMMET INSERTION
14. TYMPANOPLASTY (CLOSURE OF AN EARDRUM PERFORATION / RECONSTRUCTION OF THE AUDITORY OSSICLES)
15. REMOVAL OF A TYMPANIC DRAIN
16. KERATOSIS REMOVAL UNDER GA
17. OPERATIONS ON THE TURBINATES (NASAL CONCHA)
18. TYMPANOPLASTY (CLOSURE OF AN EARDRUM PERFORATION /RECONSTRUCTION OF THE AUDITORY OSSICLES)
19. REMOVAL OF KERATOSIS OBTURANS
20. STAPEDOTOMY TO TREAT VARIOUS LESIONS IN MIDDLE EAR
21. REVISION OF A STAPEDECTOMY
22. OTHER OPERATIONS ON THE AUDITORY OSSICLES
23. MYRINGOPLASTY (POST-AURA/ENDAURAL APPROACH AS WELL AS SIMPLE TYPE -I TYMPANOPLASTY)
24. FENESTRATION OF THE INNER EAR
25. REVISION OF A FENESTRATION OF THE INNER EAR
26. PALATOPLASTY
27. TRANSORAL INCISION AND DRAINAGE OF A PHARYNGEAL ABSCESS
28. TONSILLECTOMY WITHOUT ADENOIDECTOMY
29. TONSILLECTOMY WITH ADENOIDECTOMY
30. EXCISION AND DESTRUCTION OF A LINGUAL TONSIL
31. REVISION OF A TYMPANOPLASTY
32. OTHER MICROSURGICAL OPERATIONS ON THE MIDDLE EAR
33. INCISION OF THE MASTOID PROCESS AND MIDDLE EAR
34. MASTOIDECTOMY
35. RECONSTRUCTION OF THE MIDDLE EAR
36. OTHER EXCISIONS OF THE MIDDLE AND INNER EAR
37. INCISION (OPENING) AND DESTRUCTION (ELIMINATION) OF THE INNER EAR
38. OTHER OPERATIONS ON THE MIDDLE AND INNER EAR
39. EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE NOSE
40. OTHER OPERATIONS ON THE NOSE
41. NASAL SINUS ASPIRATION
42. FOREIGN BODY REMOVAL FROM NOSE
43. OTHER OPERATIONS ON THE TONSILS AND ADENOIDS
44. ADENOIDECTOMY
45. LABYRINTHECTOMY FOR SEVERE VERTIGO
46. STAPEDECTOMY UNDER GA
47. STAPEDECTOMY UNDER LA
48. TYMPANOPLASTY (TYPE IV)
49. ENDOLYMPHATIC SAC SURGERY FOR MENIERE'S DISEASE
50. TURBINECTOMY
51. ENDOSCOPIC STAPEDECTOMY
52. INCISION AND DRAINAGE OF PERICHONDRITIS
53. SEPTOPLASTY
54. VESTIBULAR NERVE SECTION
55. THYROPLASTY TYPE I
56. PSEUDOCYST OF THE PINNA - EXCISION
57. INCISION AND DRAINAGE - HAEMATOMA AURICLE
58. TYMPANOPLASTY (TYPE II)
59. REDUCTION OF FRACTURE OF NASAL BONE
60. THYROPLASTY TYPE II
61. TRACHEOSTOMY

62. EXCISION OF ANGIOMA SEPTUM
63. TURBINOPLASTY
64. INCISION & DRAINAGE OF RETRO PHARYNGEAL ABSCESS
65. UVULO PALATO PHARYNGO PLASTY
66. ADENOIDECTOMY WITH GROMMET INSERTION
67. ADENOIDECTOMY WITHOUT GROMMET INSERTION
68. VOCAL CORD LATERALISATION PROCEDURE
69. INCISION & DRAINAGE OF PARA PHARYNGEAL ABSCESS
70. TRACHEOPLASTY

5. Gastroenterology Related:

71. CHOLECYSTECTOMY AND CHOLEDOCHOJEJUNOSTOMY/ DUODENOSTOMY /GASTROSTOMY /EXPLOR ATION COMMON BILE DUCT
72. ESOPHAGOSCOPY, GASTROSCOPY, DUODENOSCOPY WITH POLYPECTOMY/ REMOVAL OF FOREIGN BODY/DIATHERMY OF BLEEDING LESIONS
73. PANCREATIC PSEUDOCYST EUS & DRAINAGE
74. RF ABLATION FOR BARRETT'S OESOPHAGUS
75. ERCP AND PAPILLOTOMY
76. ESOPHAGOSCOPE AND SCLEROSANT INJECTION
77. EUS + SUBMUCOSAL RESECTION
78. CONSTRUCTION OF GASTROSTOMY TUBE
79. EUS + ASPIRATION PANCREATIC CYST
80. SMALL BOWEL ENDOSCOPY (THERAPEUTIC)
81. COLONOSCOPY ,LESION REMOVAL
82. ERCP
83. COLONSCOPY STENTING OF STRICTURE
84. PERCUTANEOUS ENDOSCOPIC GASTROSTOMY
85. EUS AND PANCREATIC PSEUDO CYST DRAINAGE
86. ERCP AND CHOLEDOCHOSCOPY
87. PROCTOSIGMOIDOSCOPY VOLVULUS DETORSION
88. ERCP AND SPHINCTEROTOMY
89. ESOPHAGEAL STENT PLACEMENT
90. ERCP + PLACEMENT OF BILIARY STENTS
91. SIGMOIDOSCOPY W / STENT
92. EUS + COELIAC NODE BIOPSY
93. UGI SCOPY AND INJECTION OF ADRENALINE, SCLEROSANTS BLEEDING ULCERS

6. General Surgery Related:

94. INCISION OF A PILONIDAL SINUS / ABSCESS
95. FISSURE IN ANO SPHINCTEROTOMY
96. SURGICAL TREATMENT OF A VARICOCELE AND A HYDROCELE OF THE SPERMATIC CORD
97. ORCHIDOPEXY
98. ABDOMINAL EXPLORATION IN CRYPTORCHIDISM
99. SURGICAL TREATMENT OF ANAL FISTULAS
100. DIVISION OF THE ANAL SPHINCTER (SPHINCTEROTOMY)
101. EPIDIDYMECTOMY
102. INCISION OF THE BREAST ABSCESS
103. OPERATIONS ON THE NIPPLE
104. EXCISION OF SINGLE BREAST LUMP
105. INCISION AND EXCISION OF TISSUE IN THE PERIANAL REGION
106. SURGICAL TREATMENT OF HEMORRHOIDS
107. OTHER OPERATIONS ON THE ANUS
108. ULTRASOUND GUIDED\ASPIRATIONS
109. SCLEROTHERAPY, ETC.
110. LAPAROTOMY FOR GRADING LYMPHOMA WITH SPLENECTOMY/LIVER/LYMPH NODE BIOPSY
111. THERAPEUTIC LAPAROSCOPY WITH LASER
112. APPENDICECTOMY WITH/WITHOUT DRAINAGE
113. INFECTED KELOID EXCISION
114. AXILLARY LYMPHADENECTOMY
115. WOUND DEBRIDEMENT AND COVER
116. ABSCESS-DECOMPRESSION
117. CERVICAL LYMPHADENECTOMY
118. INFECTED SEBACEOUS CYST
119. INGUINAL LYMPHADENECTOMY
120. INCISION AND DRAINAGE OF ABSCESS
121. SUTURING OF LACERATIONS
122. SCALP SUTURING
123. INFECTED LIPOMA EXCISION
124. MAXIMAL ANAL DILATATION

125. PILES
126. A) INJECTION SCLEROTHERAPY
127. B) PILES BANDING
128. LIVER ABSCESS- CATHETER DRAINAGE
129. FISSURE IN ANO - FISSURECTOMY
130. FIBROADENOMA BREAST EXCISION
131. OESOPHAGEAL VARICES SCLEROTHERAPY
132. ERCP - PANCREATIC DUCT STONE REMOVAL
133. PERIANAL ABSCESS I&D
134. PERIANAL HEMATOMA EVACUATION
135. UGI SCOPY AND POLYPECTOMY ESOPHAGUS
136. BREAST ABSCESS I& D
137. FEEDING GASTROSTOMY
138. OESOPHAGOSCOPY AND BIOPSY OF GROWTH OESOPHAGUS
139. ERCP - BILE DUCT STONE REMOVAL
140. ILEOSTOMY CLOSURE
141. COLONOSCOPY
142. POLYPECTOMY COLON
143. SPLENIC ABSCESSES LAPAROSCOPIC DRAINAGE
144. UGI SCOPY AND POLYPECTOMY STOMACH
145. RIGID OESOPHAGOSCOPY FOR FB REMOVAL
146. FEEDING JEJUNOSTOMY
147. COLOSTOMY
148. ILEOSTOMY
149. COLOSTOMY CLOSURE
150. SUBMANDIBULAR SALIVARY DUCT STONE REMOVAL
151. PNEUMATIC REDUCTION OF INTUSSUSCEPTION
152. VARICOSE VEINS LEGS - INJECTION SCLEROTHERAPY
153. RIGID OESOPHAGOSCOPY FOR PLUMMER VINSON SYNDROME
154. PANCREATIC PSEUDOCYSTS ENDOSCOPIC DRAINAGE
155. ZADEK'S NAIL BED EXCISION
156. SUBCUTANEOUS MASTECTOMY
157. EXCISION OF RANULA UNDER GA
158. RIGID OESOPHAGOSCOPY FOR DILATION OF BENIGN STRICTURES
159. EVERSION OF SAC
160. UNILATERAL
161. ILATERAL
162. LORD'S PLICATION
163. JABOULAY'S PROCEDURE
164. SCROTOPLASTY
165. CIRCUMCISION FOR TRAUMA
166. MEATOPLASTY
167. INTERSPHINCTERIC ABSCESS INCISION AND DRAINAGE
168. PSOAS ABSCESS INCISION AND DRAINAGE
169. THYROID ABSCESS INCISION AND DRAINAGE
170. TIPS PROCEDURE FOR PORTAL HYPERTENSION
171. ESOPHAGEAL GROWTH STENT
172. PAIR PROCEDURE OF HYDATID CYST LIVER
173. TRU CUT LIVER BIOPSY
174. PHOTODYNAMIC THERAPY OR ESOPHAGEAL TUMOUR AND LUNG TUMOUR
175. EXCISION OF CERVICAL RIB
176. LAPAROSCOPIC REDUCTION OF INTUSSUSCEPTION
177. MICRODOCHECTOMY BREAST
178. SURGERY FOR FRACTURE PENIS
179. SENTINEL NODE BIOPSY
180. PARASTOMAL HERNIA
181. REVISION COLOSTOMY
182. PROLAPSED COLOSTOMY- CORRECTION
183. TESTICULAR BIOPSY
184. LAPAROSCOPIC CARDIOMYOTOMY (HELLERS)
185. SENTINEL NODE BIOPSY MALIGNANT MELANOM
186. LAPAROSCOPIC PYLOROMYOTOMY (RAMSTEDT)

7. Gynecology Related:

187. OPERATIONS ON BARTHOLIN'S GLANDS (CYST)
188. INCISION OF THE OVARY
189. INSUFFLATIONS OF THE FALLOPIAN TUBES
190. OTHER OPERATIONS ON THE FALLOPIAN TUBE
191. DILATATION OF THE CERVICAL CANAL
192. CONISATION OF THE UTERINE CERVIX
193. THERAPEUTIC CURETTAGE WITH COLPOSCOPY/ BIOPSY /DIATHERMY / CRYOS URGERY/
194. LASER THERAPY OF CERVIX FOR VARIOUS

LESIONS OF UTERUS

195. OTHER OPERATIONS ON THE UTERINE CERVIX
196. INCISION OF THE UTERUS (HYSTERECTOMY)
197. LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE VAGINA AND THE POUCH OF DOUGLAS
198. INCISION OF VAGINA
199. INCISION OF VULVA
200. CULDOTOMY
201. SALPINGO-OOPHORECTOMY VIA LAPAROTOMY
202. ENDOSCOPIC POLYPECTOMY
203. HYSTEROSCOPIC REMOVAL OF MYOMA
204. D&C
205. HYSTEROSCOPIC RESECTION OF SEPTUM
206. THERMAL CAUTERISATION OF CERVIX
207. MIRENA INSERTION
208. HYSTEROSCOPIC ADHESIOLYSIS
209. LEEP
210. CRYOCAUTERISATION OF CERVIX
211. POLYPECTOMY ENDOMETRIUM
212. HYSTEROSCOPIC RESECTION OF FIBROID
213. LLETZ
214. CONIZATION
215. POLYPECTOMY CERVIX
216. HYSTEROSCOPIC RESECTION OF ENDOMETRIAL POLYP
217. VULVAL WART EXCISION
218. LAPAROSCOPIC PARAOVARIAN CYST EXCISION
219. UTERINE ARTERY EMBOLIZATION
220. LAPAROSCOPIC CYSTECTOMY
221. HYMENECTOMY(IMPERFORATE HYMEN)
222. ENDOMETRIAL ABLATION
223. VAGINAL WALL CYST EXCISION
224. VULVAL CYST EXCISION
225. LAPAROSCOPIC PARATUBAL CYST EXCISION
226. REPAIR OF VAGINA (VAGINAL ATRESIA)
227. HYSTEROSCOPY, REMOVAL OF MYOMA
228. TURBT
229. URETEROCOELE REPAIR - CONGENITAL INTERNAL
230. VAGINAL MESH FOR POP
231. LAPAROSCOPIC MYOMECTOMY
232. SURGERY FOR SUI
233. REPAIR RECTO- VAGINA FISTULA
234. PELVIC FLOOR REPAIR (EXCLUDING FISTULA REPAIR)
235. URS + LL
236. LAPAROSCOPIC OOPHORECTOMY
237. NORMAL VAGINAL DELIVERY AND VARIANTS

8. Neurology Related:

238. FACIAL NERVE PHYSIOTHERAPY
239. NERVE BIOPSY
240. MUSCLE BIOPSY
241. EPIDURAL STEROID INJECTION
242. GLYCEROL RHIZOTOMY
243. SPINAL CORD STIMULATION
244. MOTOR CORTEX STIMULATION
245. STEREOTACTIC RADIOSURGERY
246. PERCUTANEOUS CORDOTOMY
247. INTRATHECAL BACLOFEN THERAPY
248. ENTRAPMENT NEUROPATHY RELEASE
249. DIAGNOSTIC CEREBRAL ANGIOGRAPHY
250. VP SHUNT
251. VENTRICULOATRIAL SHUNT

9. Oncology Related:

252. RADIOTHERAPY FOR CANCER
253. CANCER CHEMOTHERAPY
254. IV PUSH CHEMOTHERAPY
255. HBI-HEMIBODY RADIOTHERAPY
256. INFUSIONAL TARGETED THERAPY
257. SRT-STEREOTACTIC ARC THERAPY
258. SC ADMINISTRATION OF GROWTH FACTORS
259. CONTINUOUS INFUSIONAL CHEMOTHERAPY
260. INFUSIONAL CHEMOTHERAPY
261. CCRT-CONCURRENT CHEMO + RT
262. 2D RADIOTHERAPY
263. 3D CONFORMAL RADIOTHERAPY
264. IGRT- IMAGE GUIDED RADIOTHERAPY
265. IMRT- STEP & SHOOT
266. INFUSIONAL BISPHOSPHONATES
267. IMRT- DMLC
268. ROTATIONAL ARC THERAPY
269. TELE GAMMA THERAPY
270. FSRT-FRACTIONATED SRT
271. VMAT-VOLUMETRIC MODULATED ARC

THERAPY

272. SBRT-STEREOTACTIC BODY RADIOTHERAPY
273. HELICAL TOMOTHERAPY
274. SRS-STEREOTACTIC RADIOSURGERY
275. X-KNIFE SRS
276. GAMMAKNIFE SRS
277. TBI- TOTAL BODY RADIOTHERAPY
278. INTRALUMINAL BRACHYTHERAPY
279. ELECTRON THERAPY
280. TSET-TOTAL ELECTRON SKIN THERAPY
281. EXTRACORPOREAL IRRADIATION OF BLOOD PRODUCTS
282. TELECOBALT THERAPY
283. TELECESIUM THERAPY
284. EXTERNAL MOULD RACHYTHERAPY
285. INTERSTITIAL BRACHYTHERAPY
286. INTRACAVITY BRACHYTHERAPY
287. 3D BRACHYTHERAPY
288. IMPLANT BRACHYTHERAPY
289. INTRAVESICAL BRACHYTHERAPY
290. ADJUVANT RADIOTHERAPY
291. AFTERLOADING CATHETER BRACHYTHERAPY
292. CONDITIONING RADIOTHEARPY FOR BMT
293. EXTRACORPOREAL IRRADIATION TO THE HOMOLOGOUS BONE GRAFTS
294. RADICAL CHEMOTHERAPY
295. NEOADJUVANT RADIOTHERAPY
296. LDR BRACHYTHERAPY
297. PALLIATIVE RADIOTHERAPY
298. RADICAL RADIOTHERAPY
299. PALLIATIVE CHEMOTHERAPY
300. TEMPLATE BRACHYTHERAPY
301. NEOADJUVANT CHEMOTHERAPY
302. ADJUVANT CHEMOTHERAPY
303. INDUCTION CHEMOTHERAPY
304. CONSOLIDATION CHEMOTHERAPY
305. MAINTENANCE CHEMOTHERAPY
306. HDR BRACHYTHERAPY

10. Operations on the salivary glands & salivary ducts:

307. INCISION AND LANCING OF A SALIVARY GLAND AND A SALIVARY DUCT
308. EXCISION OF DISEASED TISSUE OF A SALIVARY GLAND AND A SALIVARY DUCT
309. RESECTION OF A SALIVARY GLAND
310. RECONSTRUCTION OF A SALIVARY GLAND AND A SALIVARY DUCT
311. OTHER OPERATIONS ON THE SALIVARY GLANDS AND SALIVARY DUCTS

11. Operations on the skin & subcutaneous tissues:

312. OTHER INCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
313. SURGICAL WOUND TOILET (WOUND DEBRIDEMENT) AND REMOVAL OF DISEASED TISSUE OF THE SKIN AND SUBCUTANEOUS TISSUES
314. LOCAL EXCISION OF DISEASED TISSUE OF THE SKIN AND SUBCUTANEOUS TISSUES
315. OTHER EXCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
316. SIMPLE RESTORATION OF SURFACE CONTINUITY OF THE SKIN AND SUBCUTANEOUS TISSUES
317. FREE SKIN TRANSPLANTATION, DONOR SITE
318. FREE SKIN TRANSPLANTATION, RECIPIENT SITE
319. REVISION OF SKIN PLASTY
320. OTHER RESTORATION AND RECONSTRUCTION OF THE SKIN AND SUBCUTANEOUS TISSUES.
321. CHEMOSURGERY TO THE SKIN.
322. DESTRUCTION OF DISEASED TISSUE IN THE SKIN AND SUBCUTANEOUS TISSUES
323. RECONSTRUCTION OF DEFORMITY/DEFECT IN NAIL BED
324. EXCISION OF BURSIRTIS
325. TENNIS ELBOW RELEASE

12. Operations on the Tongue:

326. INCISION, EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE TONGUE
327. PARTIAL GLOSSECTOMY
328. GLOSSECTOMY
329. RECONSTRUCTION OF THE TONGUE
330. OTHER OPERATIONS ON THE TONGUE

13. Ophthalmology Related:

331. SURGERY FOR CATARACT
332. INCISION OF TEAR GLANDS
333. OTHER OPERATIONS ON THE TEAR DUCTS
334. INCISION OF DISEASED EYELIDS
335. EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE EYELID
336. OPERATIONS ON THE CANTHUS AND EPICANTHUS
337. CORRECTIVE SURGERY FOR ENTROPION AND ECTROPION

338. CORRECTIVE SURGERY FOR BLEPHAROPTOSIS
339. REMOVAL OF A FOREIGN BODY FROM THE CONJUNCTIVA
340. REMOVAL OF A FOREIGN BODY FROM THE CORNEA
341. INCISION OF THE CORNEA
342. OPERATIONS FOR PTERYGIUM
343. OTHER OPERATIONS ON THE CORNEA
344. REMOVAL OF A FOREIGN BODY FROM THE LENS OF THE EYE
345. REMOVAL OF A FOREIGN BODY FROM THE POSTERIOR CHAMBER OF THE EYE
346. REMOVAL OF A FOREIGN BODY FROM THE ORBIT AND EYEBALL
347. CORRECTION OF EYELID PTOSIS BY LEVATOR PALPEBRAE SUPERIORIS RESECTION (BILATERAL)
348. CORRECTION OF EYELID PTOSIS BY FASCIA LATA GRAFT (BILATERAL)
349. DIATHERMY/CRYOTHERAPY TO TREAT RETINAL TEAR
350. ANTERIOR CHAMBER PARACENTESIS/ CYCLODIATHERMY/CYCLOCRYO-THERAPY / GONIOTOMY / TRABECULOTOMY AND FILTERING AND ALLIED OPERATIONS TO TREAT GLAUCOMA
351. ENUCLEATION OF EYE WITHOUT IMPLANT
352. DACRYOCYSTORHINOSTOMY FOR VARIOUS LESIONS OF LACRIMAL GLAND
353. LASER PHOTOCOAGULATION TO TREAT RATINAL TEAR
354. BIOPSY OF TEAR GLAND
355. TREATMENT OF RETINAL LESION

14. Orthopedics Related:

356. SURGERY FOR MENISCUS TEAR
357. INCISION ON BONE, SEPTIC AND ASEPTIC
358. CLOSED REDUCTION ON FRACTURE, LUXATION OR EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
359. SUTURE AND OTHER OPERATIONS ON TENDONS AND TENDON SHEATH
360. REDUCTION OF DISLOCATION UNDER GA
361. ARTHROSCOPIC KNEE ASPIRATION
362. SURGERY FOR LIGAMENT TEAR
363. SURGERY FOR HEMOARTHROSIS / PYOARTHROSIS
364. REMOVAL OF FRACTURE PINS/NAILS
365. REMOVAL OF METAL WIRE
366. CLOSED REDUCTION ON FRACTURE, LUXATION
367. REDUCTION OF DISLOCATION UNDER GA
368. EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
369. EXCISION OF VARIOUS LESIONS IN COCCYX
370. ARTHROSCOPIC REPAIR OF ACL TEAR KNEE
371. CLOSED REDUCTION OF MINOR FRACTURES
372. ARTHROSCOPIC REPAIR OF PCL TEAR KNEE
373. TENDON SHORTENING
374. ARTHROSCOPIC MENISCECTOMY - KNEE
375. TREATMENT OF CLAVICLE DISLOCATION
376. HAEMARTHROSIS KNEE-LAVAGE
377. ABSCESS KNEE JOINT DRAINAGE
378. CARPAL TUNNEL RELEASE
379. CLOSED REDUCTION OF MINOR DISLOCATION
380. REPAIR OF KNEE CAP TENDON
381. ORIF WITH K WIRE FIXATION- SMALL BONES
382. RELEASE OF MIDFOOT JOINT
383. ORIF WITH PLATING- SMALL LONG BONES
384. IMPLANT REMOVAL MINOR
385. K WIRE REMOVAL
386. POP APPLICATION
387. CLOSED REDUCTION AND EXTERNAL FIXATION
388. ARTHROTOMY HIP JOINT
389. SYME'S AMPUTATION
390. ARTHROPLASTY
391. PARTIAL REMOVAL OF RIB
392. TREATMENT OF SESAMOID BONE FRACTURE
393. SHOULDER ARTHROSCOPY / SURGERY
394. ELBOW ARTHROSCOPY
395. AMPUTATION OF METACARPAL BONE
396. RELEASE OF THUMB CONTRACTURE
397. INCISION OF FOOT FASCIA
398. CALCANEUM SPUR YDROCORT INJECTION
399. GANGLION WRIST HYALASE INJECTION
400. PARTIAL REMOVAL OF METATARSAL
401. REPAIR / GRAFT OF FOOT TENDON
402. REVISION/REMOVAL OF KNEE CAP
403. AMPUTATION FOLLOW-UP SURGERY
404. EXPLORATION OF ANKLE JOINT
405. REMOVE/GRAFT LEG BONE LESION
406. REPAIR/GRAFT ACHILLES TENDON

407. REMOVE OF TISSUE EXPANDER
408. BIOPSY ELBOW JOINT LINING
409. REMOVAL OF WRIST PROSTHESIS
410. BIOPSY FINGER JOINT LINING
411. TENDON LENGTHENING
412. TREATMENT OF SHOULDER DISLOCATION
413. LENGTHENING OF HAND TENDON
414. REMOVAL OF ELBOW BURSA
415. FIXATION OF KNEE JOINT
416. TREATMENT OF FOOT DISLOCATION
417. SURGERY OF BUNION
418. INTRA ARTICULAR STEROID INJECTION
419. TENDON TRANSFER PROCEDURE
420. REMOVAL OF KNEE CAP BURSA
421. TREATMENT OF FRACTURE OF ULNA
422. TREATMENT OF SCAPULA FRACTURE
423. REMOVAL OF TUMOR OF ARM/ELBOW UNDER RA/GA
424. REPAIR OF RUPTURED TENDON
425. DECOMPRESS FOREARM SPACE
426. REVISION OF NECK MUSCLE (TORTICOLLIS RELEASE)
427. LENGTHENING OF THIGH TENDONS
428. TREATMENT FRACTURE OF RADIUS & ULNA
429. REPAIR OF KNEE JOINT

15. Other operations on the mouth & face:

430. EXTERNAL INCISION AND DRAINAGE IN THE REGION OF THE MOUTH, JAW AND FACE
431. INCISION OF THE HARD AND SOFT PALATE
432. EXCISION AND DESTRUCTION OF DISEASED HARD AND SOFT PALATE
433. INCISION, EXCISION AND DESTRUCTION IN THE MOUTH
434. OTHER OPERATIONS IN THE MOUTH

16. Pediatric surgery Related:

435. EXCISION OF FISTULA-IN-ANO
436. EXCISION JUVENILE POLYPS RECTUM
437. VAGINOPLASTY
438. DILATATION OF ACCIDENTAL CAUSTIC STRICTURE OESOPHAGEAL
439. PRESACRAL TERATOMAS EXCISION
440. REMOVAL OF VESICAL STONE
441. EXCISION SIGMOID POLYP
442. STERNOMASTOID TENOTOMY
443. INFANTILE HYPERTROPHIC PYLORIC STENOSIS PYLOROMYOTOMY
444. EXCISION OF SOFT TISSUE RHABDOMYOSARCOMA
445. MEDIASTINAL LYMPH NODE BIOPSY
446. HIGH ORCHIDECTOMY FOR TESTIS TUMOURS
447. EXCISION OF CERVICAL TERATOMA
448. RECTAL-MYOMECTOMY
449. RECTAL PROLAPSE DELORME'S PROCEDURE)
450. DETORSION OF TORSION TESTIS
451. EUA + BIOPSY MULTIPLE FISTULA IN ANO
452. CYSTIC HYGROMA - INJECTION TREATMENT

17. Plastic Surgery Related:

453. CONSTRUCTION SKIN PEDICLE FLAP
454. GLUTEAL PRESSURE ULCER-EXCISION
455. MUSCLE-SKIN GRAFT, LEG
456. REMOVAL OF BONE FOR GRAFT
457. MUSCLE-SKIN GRAFT DUCT FISTULA
458. REMOVAL CARTILAGE GRAFT
459. MYOCUTANEOUS FLAP
460. FIBRO MYOCUTANEOUS FLAP
461. BREAST RECONSTRUCTION SURGERY AFTER MASTECTOMY
462. SLING OPERATION FOR FACIAL PALSY
463. SPLIT SKIN GRAFTING UNDER RA
464. WOLFE SKIN GRAFT
465. PLASTIC SURGERY TO THE FLOOR OF THE MOUTH UNDER GA

18. Thoracic surgery Related:

466. THORACOSCOPY AND LUNG BIOPSY
467. EXCISION OF CERVICAL SYMPATHETIC CHAIN THORACOSCOPIC
468. LASER ABLATION OF BARRETT'S OESOPHAGUS
469. PLEURODESIS
470. THORACOSCOPY AND PLEURAL BIOPSY
471. EBUS + BIOPSY
472. THORACOSCOPY LIGATION THORACIC DUCT
473. THORACOSCOPY ASSISTED EMPYAEMA DRAINAGE

19. Urology Related:

474. HAEMODIALYSIS
475. LITHOTRIPSY/ NEPHROLITHOTOMY FOR RENAL CALCULUS
476. EXCISION OF RENAL CYST

477. DRAINAGE OF PYONEPHROSIS /PERINEPHRIC ABSCESS
478. INCISION OF THE PROSTATE
479. TRANSURETHRAL EXCISION AND DESTRUCTION OF PROSTATE TISSUE
480. TRANSURETHRAL AND PERCUTANEOUS DESTRUCTION OF PROSTATE TISSUE
481. OPEN SURGICAL EXCISION AND DESTRUCTION OF PROSTATE TISSUE
482. RADICAL PROSTATOVESICULECTOMY
483. OTHER EXCISION AND DESTRUCTION OF PROSTATE TISSUE
484. OPERATIONS ON THE SEMINAL VESICLES
485. INCISION AND EXCISION OF PERIPROSTATIC TISSUE
486. OTHER OPERATIONS ON THE PROSTATE
487. INCISION OF THE SCROTUM AND TUNICA VAGINALIS TESTIS
488. OPERATION ON A TESTICULAR HYDROCELE
489. EXCISION AND DESTRUCTION OF DISEASED SCROTAL TISSUE
490. OTHER OPERATIONS ON THE SCROTUM AND TUNICA VAGINALIS TESTIS
491. INCISION OF THE TESTES
492. EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE TESTES
493. UNILATERAL ORCHIDECTOMY
494. BILATERAL ORCHIDECTOMY
495. SURGICAL REPOSITIONING OF AN ABDOMINAL TESTIS
496. RECONSTRUCTION OF THE TESTIS
497. IMPLANTATION, EXCHANGE AND REMOVAL OF A TESTICULAR PROSTHESIS
498. OTHER OPERATIONS ON THE TESTIS
499. EXCISION IN THE AREA OF THE EPIDIDYMIS
500. OPERATIONS ON THE FORESKIN
501. LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE PENIS
502. AMPUTATION OF THE PENIS
503. OTHER OPERATIONS ON THE PENIS
504. CYSTOSCOPICAL REMOVAL OF STONES
505. CATHETERISATION OF BLADDER
506. LITHOTRIPSY
507. BIOPSY OFTEMPORAL ARTERY FOR VARIOUS LESIONS
508. EXTERNAL ARTERIO-VENOUS SHUNT
509. AV FISTULA - WRIST
510. URSL WITH STENTING
511. URSL WITH LITHOTRIPSY
512. CYSTOSCOPIC LITHOLAPAXY
513. ESWL
514. BLADDER NECK INCISION
515. CYSTOSCOPY & BIOPSY
516. CYSTOSCOPY AND REMOVAL OF POLYP
517. SUPRAPUBIC CYSTOSTOMY
518. PERCUTANEOUS NEPHROSTOMY
519. CYSTOSCOPY AND "SLING" PROCEDURE.
520. TUNA- PROSTATE
521. EXCISION OF URETHRAL DIVERTICULUM
522. REMOVAL OF URETHRAL STONE
523. EXCISION OF URETHRAL PROLAPSE
524. MEGA-URETER RECONSTRUCTION
525. KIDNEY RENOSCOPY AND BIOPSY
526. URETER ENDOSCOPY AND TREATMENT
527. VESICO URETERIC REFLUX CORRECTION
528. SURGERY FOR PELVI URETERIC JUNCTION OBSTRUCTION
529. ANDERSON HYNES OPERATION
530. KIDNEY ENDOSCOPY AND BIOPSY
531. PARAPHIMOSIS SURGERY
532. INJURY PREPUCE-CIRCUMCISION
533. FRENULAR TEAR REPAIR
534. MEATOTOMY FOR MEATAL STENOSIS
535. SURGERY FOR FOURNIER'S GANGRENE SCROTUM
536. SURGERY FILARIAL SCROTUM
537. SURGERY FOR WATERING CAN PERINEUM
538. REPAIR OF PENILE TORSION
539. DRAINAGE OF PROSTATE ABSCESS
540. ORCHIECTOMY
541. CYSTOSCOPY AND REMOVAL OF FB

Annexure II - List of Expenses Generally Excluded ("Non-medical") in Hospital Indemnity Policy

Sl No.	List I – Optional Items
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

Sl No.	Item
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

Sl No.	List II – Items that are to be subsumed into Room Charges
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

Sl No.	List III – Items that are to be subsumed into Procedure Charges
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

Sl No.	List IV – Items that are to be subsumed into costs of treatment
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

Sl No.	List IV – Items that are to be subsumed into costs of treatment
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

Sl No.	List V – Additional Non Payable Items
1	BRUSH
2	COSY TOWEL
3	MOISTURISER PASTE BRUSH
4	POWDER
5	BARBER CHARGES
6	OIL CHARGES
7	BED UNDER PAD CHARGES
8	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS, ETC.,
9	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION
10	HOME VISIT CHARGES
11	DONOR SCREENING CHARGES
12	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES
13	BLADE
14	MAINTAINANCE CHARGES
15	PREPARATION CHARGES
16	WASHING CHARGES
17	MEDICINE BOX
18	COMMODE
19	DIGESTION GELS
20	NOVARAPID
21	VOLINI GEL/ ANALGESIC GEL
22	ZYTEE GEL
23	AHD
24	VISCO BELT CHARGES
25	EXAMINATION GLOVES
26	OUTSTATION CONSULTANT'S/ SURGEON'S FEES
27	PAPER GLOVES
28	REFERAL DOCTOR'S FEES
29	SOFNET
30	SOFTOVAC
31	STOCKINGS

Annexure III - List of Hospitals where Claim will not be admitted

Hospital Name	Address
Nulife Hospital And Maternity Centre	1616 Outram Lines,Kingsway Camp,Guru Teg Bahadur Nagar , New Delhi , Delhi
Taneja Hospital	F-15,Vikas Marg, Preet Vihar , New Delhi , Delhi
Shri Komal Hospital & Dr.Saxena's Nursing Home	Opp. Radhika Cinema,Circular Road , Rewari , Haryana
Sona Devi Memorial Hospital & Trauma Centre	Sohna Road, Badshahpur , Gurgaon , Haryana
Amar Hospital	Sector-70,S.A.S.Nagar, Mohali, Sector 70 , Mohali , Punjab
Brij Medical Centre	K K 54, Kavi Nagar , Ghaziabad , Uttar Pradesh
Famliy Medicare	A-55,Sector 61, Rajat Vihar Sector 62 , Noida , Uttar Pradesh
Jeevan Jyoti Hospital	162,Lowther Road, Bai Ka Bagh, Allahabad, Uttar Pradesh
City Hospital & Trauma Centre	C-1,Cinder Dump Complex,Opp. Krishna Cinema Hall,Kanpur Road,Alambagh, Lucknow, U.P.
Dayal Maternity & Nursing Home	No.953/23,D.C.F.Chowk, DLF Colony , Rohtak , Haryana
Metas Adventist Hospital	No.24,Ring-Road,Athwalines, Surat , Surat , Gujarat
Surgicare Medical Centre	Sai Dwar Oberoi Complex,S.A.B.T.V.Lane Road,Lokhandwala,Near Laxmi Industrial Estate, Andheri, Mumbai, Maharashtra
Paramount General Hospital & I.C.C.U.	Laxmi Commercial Premises, Andheri Kurla Road, Andheri, Mumbai, Maharashtra
Gokul Hospital	Thakur Complex, Kandivali East, Mumbai, Maharashtra
Shree Sai Hospital	Gokul Nagri I,Thankur Complex,Western Express Highway, Kandivali East, Mumbai, Maharashtra
Shreedevi Hospital	Akash Arcade,Bhanu Nagar,Near Bhanu Sagar Theatre,Dr.Deepak Shetty Road, Kalyan D.C. , Thane , Maharashtra
Saykhedkar Hospital & Research Centre Pvt. Ltd.	Trimurthy Chowk,Kamatwada Road,Cidco Colony , Nashik , Maharashtra
Arpan Hospital And Research Centre	No.151/2,Imli Bazar,Near Rajwada, Imli Bazar , Indore , Madhya Pradesh
Ramkrishna Care Hospital	Aurobindo Enclave,Pachpedhi Naka,Dhamtri Road,National Highway No 43, Raipur , Chhattisgarh
Gupta Multispeciality Hospital	B-20, Vivek Vihar, New Delhi, Delhi
R.K.Hospital	3C/59, BP, Near Metro Cinema, New Industrial Township 1, Faridabad, Haryana
Prakash Hospital	D -12,12A,12B,Noida, Sector 33 , Noida , Uttar Pradesh
Aryan Hospital Pvt. Ltd.	Old Railway Road, Near New Colony, New Colony, Gurgaon, Haryana
Medilink Hospital Research Centre Pvt. Ltd.	Near Shyamal Char Rasta,132,Ring Road, Satellite, Ahmedabad, Gujarat
Mohit Hospital	Khoya B-Wing, Near National Park, Borivali(E), Kandivali West, Mumbai, Maharashtra
Scope Hospital	628, Niti Khand-I, Indirapuram, Ghaziabad, Uttar Pradesh
Agarwal Medical Centre	E-234, Greater Kailash 1, New Delhi , Delhi
Oxygen Hospital	Bhiwani Stand, Durga Bhawan, Rohtak, Haryana
Prayag Hospital & Research Centre Pvt. Ltd.	J-206 A/1, Sector 41, Noida, Uttar Pradesh
Karnavati Superspeciality Hospital	Opposite Sajpur Tower, Naroda Road, Ahmedabad, Gujarat
Palwal Hospital	Old G.T. Road, Near New Sohna Mod, Palwal, Haryana
B.K.S. Hospital	No.18,1st Cross,Gandhi Nagar, Adyar, Bellary, Karnataka
East West Medical Centre	No.711,Sector 14, Sector 14, Gurgaon, Haryana
Jagtap Hospital	Anand Nagar,Sinhgood Road , Anandnagar , Pune , Maharashtra
Dr. Malwankar's Romeen Nursing Home	Ganesh Marg,Tagore Nagar , Vikhroli East , Mumbai , Maharashtra
Noble Medical Centre	SVP Road, Borivali West , Mumbai , Maharashtra
Rama Hospital	Sonepat Road,Bahalgarh, Sonipat , Haryana
S.B.Nursing Home & ICU	Lake Bloom 16,17,18 Opposite Solaris Estate, L.T.Gate No.6,Tunga Gaon, Saki-Vihar Road, Powai , Mumbai , Maharashtra
Sparsh Multi Speciality Hospital & Trauma Care Center	G.I.D.C Road, Nr Udhana Citizan Co-Op.Bank , Surat , Gujarat

Hospital Name	Address
Saraswati Hospital	Divya Smruti Building, 1st Floor, Opp. Toyota Showroom, Malad Link Road, Malad West, Mumbai, Maharashtra
Shakuntla Hospital	3-B Tashkant Marg, Near St. Joseph Collage, Allahabad, Uttar Pradesh
Mahaveer Hospital & Trauma Centre	76-E, Station Road, Panki, Kanpur, Uttar Pradesh
Eashwar Lakshmi Hospital	Plot No. 9, Near Sub Registrar Office, Gandhi Nagar, Hyderabad, Andhra Pradesh
Amrapali Hospital	Plot No. NH-34, P-2, Omega -1, Greater Noida, Noida, Uttar Pradesh
Hardik Hospital	29c, Budh Bazar, Vikas Nagar, New Delhi, Delhi
Jabalpur Hospital & Research Centre Pvt Ltd	Russel Crossing, Naptier Town, Jabalpur, Madhya Pradesh
Panvel Hospital	Plot No. 260A,Uran Naka, Old Panvel , Navi Mumbai , Maharashtra
Santosh Hospital	L-629/631,Hapur Road, Shastri Nagar, Meerut, Uttar Pradesh
Sona Medical Centre	5/58,Near Police Station, Vikas Nagar, Lucknow, Uttar Pradesh
City Super Speciality Hospital	Near Mohan Petrol Pump,Gohana Road, Rohtak , Haryana
Navjeevan Hospital & Maternity Centre	753/21,Madanpuri Road, Near Pataudi Chowk, Gurgaon, Haryana
Abhishek Hospital	C-12, New Azad Nagar, Kanpur, Kanpur, Uttar Pradesh
Raj Nursing Home	23-A, Park Road, Allahabad, Uttar Pradesh
Sparsh Medicare and Trauma Centre	Shakti Khand - III/54 ,Behind Cambridge School , Indirapuram, Ghaziabad , Uttar Pradesh
Saras Healthcare Pvt Ltd.	K-112, SEC-12 ,Pratap Vihar , Ghaziabad , Uttar Pradesh
Getwell Soon Multispeciality Institute Pvt Ltd	S-19, Shalimar Garden Extn. , Near Dayanand Park, Sahibabad , Ghaziabad , Uttar Pradesh
Shivalik Medical Centre Pvt Ltd	A-93, Sector 34 , Noida , Uttar Pradesh
Aakanksha Hospital	126, Aaradhnanagar Soc,B/H. Bhulkabhavan School, Aanand-Mahal Rd. , Adajan , Surat , Gujarat
Abhinav Hospital	Harsh Apartment,Nr Jamna Nagar Bus Stop, Goddod Road , Surat , Gujarat
Adhar Ortho Hospital	Dawer Chambers,Nr. Sub Jail, Ring Road , Surat , Gujarat
Aris Care Hospital	A 223-224, Mansarovar Soc,60 Feet, Godadara Road , Surat , Gujarat
Arzoo Hospital	Opp. L.B. Cinema, Bhatar Rd. , Surat , Gujarat
Auc Hospital	B-44, Gujarat Housing Board, Pandeshara , Surat , Gujarat
Dharamjivan General Hospital & Trauma Centre	Karmayogi - 1, Plot No. 20/21, Near Piyush Point, Pandesara , Surat , Gujarat
Dr. Santosh Basotia Hospital	Bhatar Road , Bhatar Road , Surat , Gujarat
God Father Hosp.	344, Nandvan Soc., B/H. Matrushakti Soc. , Puna Gam , Surat , Gujarat
Govind-Prabha Arogya Sankool	Opp. Ratna-Sagar Vidhyalaya,Kaji Medan, Gopipura , Surat , Gujarat
Hari Milan Hospital	L H Road , Surat , Gujarat
Jaldhi Ano-Rectal Hospital	103, Payal Apt., Nxt To Rander Zone Office, Tadwadi , Surat , Gujarat
Jeevan Path Gen. Hospital	2nd. Floor, Dwarkesh Nagri, Nr. Laxmi Farsan, Sayan , Surat , Gujarat
Kalrav Children Hospital	Yashkamal Complex, Nr. Jivan Jyot, Udhna , Surat , Gujarat
Kanchan General Surgical Hospital	Plot No. 380, Ishwarnagar Soc, Bhamroli-Bhatar, Pandesara , Surat , Gujarat
Krishnavati General Hospital	Bamroli Road , Surat , Gujarat
Niramayam Hosptial & Prasutigruah	Shraddha Raw House, Near Natures Park , Surat , Gujarat
Patna Hospital	25, Ashapuri Soc - 2, Bamroli Road, Surat , Gujarat
Poshia Children Hospital	Harekrishan Shoping Complex 1St Floor, Varachha Road , Surat , Gujarat
R.D Janseva Hospital	120 Feet Bamroli Road, Pandesara , Surat , Gujarat
Radha Hospital & Maternity Home	239/240 Bhagunagar Society, Opp Hans Society, L H Road, Varachha Road, Surat , Gujarat
Santosh Hospital	L H Road, Varachha , Surat , Gujarat
Sparsh Multy Specality Hospital & Trauma Care Center	G.I.D.C Road, Nr Udhana Citizan Co-Op.Bank , Surat , Gujarat

Notes:
1. For an updated list of Hospitals, please visit the Company's website.
2. Only in case of a medical emergency, Claims would be payable if admitted in the above Hospitals on a reimbursement basis.

Annexure – IV:

Care Health Insurance Limited

Registered Office Address: 5th floor, 19 Chawla House, Nehru Place, New Delhi – 110019
Correspondence Address: Vipul Tech Square, Tower C, 3rd Floor, Golf Course Road,
Sector-43, Gurugram-122009 (Haryana)
CIN : U66000DL2007PLC161503 | www.careinsurance.com

SERVICE REQUEST FORM
For Change in Occupation / Nature of Job

(Refer Clause 6.2 (1) of Policy Terms and Conditions)

1. To be filled in by Policyholder in CAPITAL LETTERS only.
2. If there is insufficient space, please provide further details on a separate sheet. All attached documents form part of this service request.
3. This form has to be filled in and submitted to the company whenever the nature of job / occupation of any insured covered under the Policy changes subsequent to the issuance of the Policy.

Policyholder Details

a) Policy No. :

b) Name :
(First Name) (Last Name)

Details of the Insured Persons for whom details are to be updated

a) Occupation :

b) Name :
(First Name) (Last Name)

Declaration

I hereby declare, on my behalf and on behalf of all persons insured, that the above statement(s), answer(s) and / or particular(s) given by me are true and complete in all respects to the best of my knowledge and that I am authorized to provide / request for updation of the details on behalf of Insured Persons.

Place:

Date: / /

Signature of the Policyholder:_____
(On behalf of all the persons insured under the Policy)

Note - The company shall update its record with respect to the information provided above subsequently.
the company may review the risk involved and any may alter the coverage and /or premium payable accordingly.

Annexure – V: Availability of Optional Extensions under Optional Benefit 1 (Hospitalization Expenses)

Optional Extensions of Optional Benefit 1 (Hospitalization Expenses)	Availability of Optional Extensions based on Coverage opted under Optional Benefit 1 (Hospitalization Expenses)
(I) Optional Extension 2 : Maternity Expenses	Can be opted with b) All Surgeries & c) All Conditions
(ii) Optional Extension 5: Sub-limits on Hospitalization Expenses	Can be opted with c) All Conditions
(iii) Optional Extension 7 : Psychiatric Treatment	Can be opted with c) All Conditions
(iv) Optional Extension 8: Infertility Treatment	Can be opted with b) All Surgeries & c) All Conditions
(v) Optional Extension 9: Bariatric Surgery	Can be opted with b) All Surgeries & c) All Conditions
(vi) Optional Extension 10: Lasik Surgery	Can be opted with b) All Surgeries & c) All Conditions
(vii) Optional Extension 12 : Maternity Complications	Can be opted with b) All Surgeries & c) All Conditions
(viii) Optional Extension 13 : HIV Cover	Can be opted with c) All Conditions
(ix) Optional Extension 17 : Cochlear implant	Can be opted with b) All Surgeries & c) All Conditions
(x) Optional Extension 18 : Modern Treatment Methods	Can be opted with b) All Surgeries & c) All Conditions
(xi) Optional Extension 27 : Additional Coverage Amount for Accidental Hospitalization	Can be opted with b) All Surgeries & c) All Conditions
(xii) Optional Extension 28 : Additional Coverage Amount In Case Of 32 Critical Illnesses	Can be opted with a) 32 CI
(xiii) Optional Extension 30:Age related macular degeneration	Can be opted with b) All Surgeries & c) All Conditions
(xiv) Optional Extension 32:Maternity – only delivery	Can be opted with b) All Surgeries & c) All Conditions

Note: Optional Extensions other than above can be opted with a) Critical illness cover or b) All surgeries or c) All conditions

Annexure –VI (ICD codes for the specified disorders / conditions)

Disorder / Condition	ICD Codes
Severe Depression	F33.0, F33.1, F33.2, F33.4, F33.5, F33.6, F33.7, F33.8, F33.9, O90.6, F34.1, F32.81, F32.0, F32.1, F32.2, F32.4, F32.5, F32.6, F32.7, 32.8, F32.9, F33.9, F30.0, F30.1, F30.2, F30.4, F30.5, F30.6, F30.7, F30.8, F30.9, F32.3, F33.3, F43.21, F32.8, F33.40, F32.9
Schizophrenia	F20.0, F20.1, F20.2, F20.3, F20.5, F21, F22, F23, F24, F20.8, F25.0, F25.1, F25.8, F25.9
Bipolar Disorder	F31.0, F31.1, F31.2, F31.4, F31.5, F31.6, F31.7, F31.8, F31.9
Post-traumatic stress disorder	F43.0, F43.1, F43.2, F43.8, F43.9
Eating disorder	F50.0, F50.2, F50.8, F98.3, F98.21, F50.8
Generalized anxiety disorder	F40.1, F41.0, F40.2, F40.8, F40.9, F41.1, F41.3, F41.8
Obsessive compulsive disorders	F42
Panic disorders	F41.1, F40.1, F60.7, F93.0, F94.0
Personality disorders	F60.0, F60.1, F60.2, F60.3, F60.4, F60.8, F60.6, F60.7, F60.5
Conversion disorders	F44.4, F44.5, F44.6, F44.7
Dissociative disorders	F44.5, F44.8, F48.1, F44.1, F44.2

Annexure VII - Office of the Ombudsman

OFFICE OF THE OMBUDSMAN	CONTACT DETAILS	JURISDICTION OF OFFICE (UNION TERRITORY, DISTRICT)
Ahmedabad	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Prakash, 6th floor, Tilak Marg, Near S.V College Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 E-mail : bimalokpal.ahmedabad@cioins.co.in	Gujarat , Dadra & Nagar Haveli, Daman and Diu
Bengaluru	Office of the Insurance Ombudsman, Jeevan Soudha Building ,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
Bhopal	Office of the Insurance Ombudsman, LIC of India Zonal Office Building, 1st Floor, South Wing, Jeevan Shikha, opp. Gayatri Mandir, 60-B, Hoshangabad Road, Bhopal-462011Tel.: 0755 - 2769201 / 2769202/ 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh & Chhattisgarh
Bhubaneshwar	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar – 751 009. Tel.: 0674 - 2596461 /2596455/ 2596429/ 2596003 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa
Chandigarh	Office of the Insurance Ombudsman, Jeevan Deep, Ground Floor, LIC of India Building, SCO 20-27, Sector 17-A, Chandigarh – 160 017. Tel.: 0172 – 2706468/ 2707468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh
Chennai	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)
Delhi	Office of the Insurance Ombudsman, 2/2 A, 1st Floor, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481 / 23213504/ 46013992 Email: bimalokpal.delhi@cioins.co.in	Delhi, Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
Guwahati	Office of the Insurance Ombudsman, Jeevan Nivesh Building, 5th Floor, Nr. Panbazar, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 – 2632204/ 2632205 / 2631307 Email: bimalokpal.guwahati@cioins.co.in	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
Hyderabad	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Hyundai Showroom, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122/ 23376599/ 23376991/ 23328709/ 23325325 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana and Yanam – a part of Territory of Pondicherry
Jaipur	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Ambedkar Circle Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@cioins.co.in	Rajasthan

Kochi	Office of the Insurance Ombudsman, 10TH Floor, LIC Building, Jeevan Prakash Opp. Maharaj College Ground M. G. Road, Ernakulam - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe – a part of Pondicherry
Kolkata	Office of the Insurance Ombudsman, 7th Floor of Hindusthan Bldg.(Annex), 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Andaman & Nicobar Islands, Sikkim
Lucknow	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 – 4002082/ 3500613 Email: bimalokpal.lucknow@cioins.co.in	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, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
Mumbai	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz West, Mumbai - 400 054. Tel.: 022 –69038800/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
Patna	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Baily Road, Patna Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand
Noida	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120- 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of 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
Pune	Office of the Insurance Ombudsman, Jeevan Darshan- LIC of India Bldg., 3rd Floor, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

The updated details of Insurance Ombudsman are available on website of IRDAI: www.irda.gov.in, on the website of General Insurance Council: www.gicouncil.org.in, on the Company's website www.carehealthinsurance.com or from any of the Company's offices. Address and contact number of Executive Council of Insurers –

Office of the 'Executive Council of Insurers'

3rd Floor, Jeevan Seva Annexe,

S.V. Road, Santacruz(W),

Mumbai – 400 054.

Tel : 022-69038800/33

Email- inscoun@cioins.co.in

Care Health Insurance Limited
Registered Office: 5th Floor, 19 Chawla House, Nehru Place, New Delhi-110019
Correspondence Office: Vipul Tech Square, Tower C, 3rd Floor, Golf Course Road,
Sector-43, Gurugram-122009 (Haryana)
CIN: U66000DL2007PLC161503 UIN: CHIHLGP25038V022425
IRDAI Registration Number - 148

REACH US @

Care Health-
Customer App

WhatsApp
8860402452

Self Help Portal:
www.careinsurance.com/self-help-portal.html

Submit Your Queries/Requests:
www.careinsurance.com/contact-us.html

Ver:Dec24/ASH