NAVI HEALTH GROUP INSURANCE

POLICY WORDINGS

This is *Your* NAVI HEALTH GROUP INSURANCE POLICY, which has been issued by us, relying on the Information disclosed by you in *Your* Proposal for this *Policy* or its preceding *Policy/Policies* of which this is a *Renewal*. The terms set out in this Policy and its Schedule will be the basis for any claim or benefit under this *Policy*.

Section 1 - General Definitions

In the document, following words are assigned specific meaning. Wherever the context permits, the singular will be deemed to include the plural, one gender shall be deemed to include the other genders and references to any statute shall be deemed to refer to any replacement or amendment of that statute.

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

1.2 **Age** or **Aged –** means completed age in years as at the Commencement Date.

1.3 **Adventure Sports** – Adventure sports (also called action sports, aggro sports, and extreme sports) are a popular term for certain activities perceived as having a high level of inherent danger. These means those sports / activities often which involves speed, height, a high level of physical exertion and highly specialised gear such ashigh degree of inherent danger. Such sports are racing on wheels or horseback, power boat racing, ski racing, hunting or equestrian activities, big game hunting, rock climbing/trekking/mountaineering, winter sports, Skydiving, Parachuting, paragliding/parapenting, Scuba Diving, ski doo riding, cavin/pot holing, bungee jumping, hell skiing, ski acrobatics, ski jumping, water ski jumping, ice hockey, ice speedway, ballooning, hand gliding, river rafting, black water rafting, yachting or boating outside coastal waters, canoeing involving rapid waters, micro-lighting, riding or driving in races or motor rallyies, piloting aircraft, power lifting, quad biking, river boarding, river bugging, rodeo, roller hockey.

1.4 **Ambulance** – means a motor vehicle operated by a licenced/authorised service provider and equipped for taking sick or injured people requiring medical attention to and from *Hospital* in emergencies.

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

1.6 **Authority** - means the Insurance Regulatory and Development Authority of India established under the provisions of section 3 of the Insurance Regulatory and development Authority Act, 1999 (41 of 1999).

1.7 **Ayush Treatment** - means the medical and / or hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

1.8 **AYUSH Hospital** - means 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 recognised 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 atleast 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 authorised representative.

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

i. Having qualifies 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 authorised representative.

1.10 **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.

1.11 **Complaint or Grievance -** means written expression (includes communication in the form of electronic mail or other electronic scripts), of dissatisfaction by a *Complainant* with *Insurer*, distribution channels, intermediaries, insurance intermediaries or other regulated entities about an action or lack of action about the standard of service or deficiency of service of such *Insurer*, distribution channels, intermediaries, insurance intermediaries or other regulated entities.

1.12 **Complainant** - means a policyholder or prospect or any beneficiary of an insurance *Policy* who has filed a complaint or grievance against an *Insurer* or a distribution channel.

1.13 **Condition Precedent** - means a policy term or condition upon which the *Insurer`s* liability under the *Policy* is conditional upon.

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

(a) **Internal Congenital Anomaly** – congenital anomaly which is not in the visible and accessible parts of the body.
(b) **External Congenital Anomaly** - congenital anomaly which is in the visible and accessible parts of the body.

1.15 **Co-Payment -** means a cost-sharing requirement under a health insurance *Policy* that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A Co-Payment does not reduce the *Sum Insured*.

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

i. has qualified nursing staff under its employment;
ii. has qualified *Medical Practitioner* (s) in charge;
iii. has a fully equipped operation theatre of its own where surgical procedures are carried out;
iv. maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

1.17 **Day Care treatment -** means medical treatment, and/or *Surgical Procedure* which is:

i. undertaken under General or Local Anaesthesia in a *Hospital / Day Care Centre* in less than 24 hrs because of technological advancement, and
ii. which would have otherwise required *Hospitalization* of more than 24 hours.

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

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

1.19 **Dependents -** means the persons named in the *Policy Schedule* who are *Your*:

i. Spouse – The *Primary Insured's* legally married spouse as long as he/she continues to be married to the *Primary Insured.*
ii. Children – The *Primary Insured's* children with age group of 91 days or above, as long as they are financially dependent on him/her with no source of independent income and have not established their own independent households.
iii. Parents – The *Primary Insured's* natural parents or parents that have legally adopted him.
iv. Parents in law - The *Primary Insured's* parents in law.
v. Siblings – The *Primary insured`s* siblings as long as they are unmarried and financially dependent on him/her with no source of independent income and have not established their own independent households.

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

1.21 **Diagnosis -** means conclusion drawn by a registered *Medical Practitioner*, supported by acceptable clinical, radiological, histological, histo-pathological, and laboratory evidence wherever applicable.

1.22 **Domiciliary Hospitalisation -** 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*.

1.23 **Emergency -** means a severe *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.

1.24 **Emergency Care -** 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.

1.25 **Family Floater -** means a *Policy* described as such in the *Policy Schedule* where *You* and *Your Dependents* named in the *Policy Schedule* are covered under this *Policy* as at the Commencement Date. The *Sum Insured* for a Family Floater is the amount shown in the *Policy Schedule* which represents *Our* maximum liability for any and all claims made by You and/or all of *Your Dependents* during each *Policy Year*.

1.26 **Franchise** - means an arrangement under a health insurance *Policy* that provides that the *Insurer* will not be liable upto the specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies but will pay for the entire amount of loss and days/hours when exceeds the agreed amount/days/hours.

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

1.28 **Harvesting** – means a surgical procedure to remove organs or tissues from a donor (Cadaveric or live), for the purpose of organ transplantation.

1.29 **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 under Clinical Establishment (Registration and Regulation) Act,2010 or under enactments specified under the Schedule of Section 56 (1) of the said Act Or complies with all minimum criteria as under:

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 inpatient beds in all other places;
iii. has qualified *Medical Practitioner*(s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

1.30 **Hospitalisation** or **Hospitalised -** means admission in a *Hospital* for a minimum 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.

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

a) **Acute Condition** 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** is defined as a disease, *Illness*, or *Injury* that has one or more of the following characteristics: -

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

1.32 **Immediate Family Member** - includes the *Insured Person's* legal spouse, children, parents, parents-in-law, or any other relation specifically mentioned in the *Policy Schedule*.

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

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

1.35 **Insured Person -** means persons named in the *Policy Schedule*.

1.36 **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 critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

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

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

1.39 **Material Fact** – means all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

1.40 **Maternity Expenses -** means:

i. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during *Hospitalisation*);
ii. expenses towards lawful medical termination of pregnancy during the *Policy Period*.

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

1.42 **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.

1.43 **Medical Practitioner -** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license. *Medical Practitioner* should not be the *Insured Person* or his/her Immediate Family Member or anyone who is living in the same household as the *Insured Person*.

1.44 **Medically Necessary Treatment -** means any treatment, tests, medication, or stay in *Hospital* or part of a stay in *Hospital* which:

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

1.45 **Migration** - means the right accorded to health insurance policyholders (including all members under family cover and members of NAVI HEALTH GROUP INSURANCE POLICY), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

1.46 **Network Provider -** means hospital enlisted by an *Insurer*, *TPA* or jointly by an *Insurer* and *TPA* to provide medical services to an insured by a cashless facility.

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

1.48 **Non-Allopathic Treatment -** means forms of treatments other than “Allopathy” or “modern medicine” and includes Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy in the Indian context.

1.49 **New Born Baby -** means baby born during the *Policy Period* and is aged upto 90 days.

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

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

1.52 **Policy -** means *Your* proposal, the Schedule, annexures, insuring clauses that are appearing in each applicable coverage, definitions, exclusions, conditions and other terms contained herein and any endorsement attaching to or forming part hereof, either at inception or during the *Policy Period*.

1.53 **Policyholder** means the person or entity named in the *Policy Schedule* as the Policyholder.

1.54 **Policy Period** - means the period commencing from Policy start date and time as specified in the *Policy Schedule* and terminating at midnight on the Policy end date as specified in the *Policy Schedule*.

1.55 **Policy Year** – means a period of 12 consecutive months commencing from the *Policy Period* start date and such 12 consecutive months thereafter but not beyond the *Policy Period.*

1.56 **Policy Schedule** – means schedule attached to and forming part of this *Policy* mentioning the details of the *Insured Persons*, the *Sum Insured*, the *Policy Period* and the limits and conditions, to which the benefits under the *Policy* are subject to, including any annexures and/or endorsements.

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

a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

1.58 **Primary Insured -** means the person who has been first enrolled by group policyholder as a member under this *Policy* and who in turn has included his/her family members.

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

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

i. Such *Medical Expenses* are incurred for the same condition for which the *Insured Person's* Hospitalisation was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

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

i. Such *Medical Expenses* are for the same condition for which the *Insured Person's Hospitalisation* was required, and
ii. The inpatient *Hospitalization* claim for such *Hospitalization* is admissible by the insurance company.

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

1.63 **Reasonable & Customary charges -** means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of *Illness*/ *Injury* involved.

1.64 **Relaxation Period -** means the specified period of time immediately following the premium instalment due date during which a payment can be made to continue a Policy in force without loss of continuity of waiting periods and coverage of Pre-existing diseases.

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

1.66 **Room Rent -** means the amount charged by a *Hospital* towards Room and Boarding expenses and shall include the associated *Medical Expenses*.

1.67 **Sum Insured -** means the specified amount mentioned in the *Policy Schedule*/Certificate of Insurance which represents *Our* maximum liability for each *Insured Person* or family, in case of *Family Floater* plan for any and all benefits claimed for during the *Policy Year*.

1.68 **Surgery** or **Surgical Procedure -** means manual and/or operative procedure(s) required for treatment of an *Illness* or *Injury*, correction of deformities and defects, *Diagnosis* and cure of diseases, relief of suffering or prolongation of life, performed in a *Hospital* or *Day Care Centre* by a *Medical Practitioner*.

1.69 **TPA -** means any person who is registered under the *IRDAI* (Third Party Administrators - Health Services) Regulations, 2016 notified by the *Authority*, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

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

1.71 **We/Our/Us / Insurer -** means the NAVI General Insurance Limited.

1.72 **You/Your -** means the *Policyholder* or *Primary Insured* named in the *Policy Schedule*.

Section 2 - Coverage

We will cover *Reasonable and Customary Charges* for *Medically Necessary Treatment* taken by the *Insured Person* for a disease, *Illness* or *Injury* that occurs during the *Policy Year* under any of the below mentioned benefits subject to the terms, conditions and exclusions of this *Policy* and up to the *Sum Insured* specified in the *Policy Schedule*/ Certificate of Insurance.

2.1 In-patient Hospitalisation

We will cover the *Medical Expenses* incurred for:

i) *Room Rent* & Nursing charges;
ii) *Intensive Care Unit (ICU) charges*;
iii) Operation Theatre charges;
iv) Fees of *Medical Practitioner*/ Surgeon / Anaesthetist / Specialists;
v) Physiotherapy, Investigation & Diagnostic procedures;

vi) Medicines, Drugs and Consumables;

vii) Blood, Oxygen, Surgical appliances;

viii) The cost of prosthetic and other devices or equipment recommended by the attending *Medical Practitioner* and if implanted internally during a Surgical Procedure.

Modern Treatment Methods

The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to the Sum Insured, specified in the policy schedule, during the policy period:

A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
B. Balloon Sinuplasty
C. Deep Brain stimulation
D. Oral chemotherapy
E. Immunotherapy - Monoclonal Antibody to be given as injection
F. Intra vitreal injections
G. Robotic surgeries
H. Stereotactic radio surgeries
I. Bronchical Thermoplasty
J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
K. IONM - (Intra Operative Neuro Monitoring)
L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

Mental Illness:
We will cover Mental Illness as per the provisions of Mental Healthcare Act, 2017.However, in case of following mental illnesses the Inpatient Hospitalization benefit will be restricted to Policy Sum Insured or 3 lacs, whichever is Lower;

1. Schizophrenia (ICD - F20 ; F21;F25)
2. Bipolar Affective Disorders (ICD - F31; F34)
3. Depression (ICD - F32; F33)
4. Obsessive Compulsive Disorders (ICD - F42 ; F60.5)
5. Psychosis (ICD - F 22 ; F23 ; F28 ; F29)

HIV & AIDS

We will cover upto the Sum Insured in case Inpatient hospitalization (including Day Care Treatment) for the treatment arising out of HIV or any condition caused by or associated with Acquired Immuno-Deficiency Syndrome (AIDS).

2.1.1 Pre-hospitalisation

We will cover *Pre-Hospitalisation Medical Expenses* incurred during thirty (30) days preceding the *Hospitalisation* of the *Insured Person* including *Day Care Treatment*.

***Note** - The date of admission to Hospital for the purpose of this coverage shall be the date of the Insured Person's first admission to the Hospital in relation to Any One Illness.*

2.1.2 Post-hospitalisation

We will cover *Post-Hospitalisation Medical Expenses* incurred during sixty (60) days immediately after the *Insured Person* is discharged from the *Hospital* including *Day Care Treatment*.

Note - *In case of any one illness where insured person undergoes more than one hospitalisation within 45 days, the cover for post hospitalisation expenses cumulatively shall not exceed 60 days.*

2.1.3 Day Care Treatment

We will cover the *Day Care Treatment (including Pre-Hospitalisation & Post-Hospitalisation Medical Expenses)*. List of such treatment is available in Annexure II of this document.

2.1.4 Domiciliary Hospitalisation

We will cover the *Domiciliary Hospitalisation* if medical treatment is continuously required for at least three (3) days, in which case the cost of medical treatment for the entire period shall be payable.

We will also cover the pre and post Hospitalisation medical expenses.

2.1.5 Organ Donor

We will cover the Surgical Expenses incurred towards donor in case of major organ transplant for *Harvesting* of the organ provided that:

i. The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act 1994 and amendments thereof and other applicable laws & rules.
ii. The organ donated is for the use of the *Insured Person*.
iii. The *Insured Person* (recipient) has been medically advised to undergo an organ transplant.
iv. *We* have accepted claim under In-patient Hospitalisation - 2.1.

We will not pay for –

i. Any expense other than specified above.
ii. Cost towards donor screening.
iii. Pre / post hospitalization *Medical Expenses* of the organ donor.
iv. Cost directly or indirectly associated with acquisition of the organ.
v. Any other medical treatment for the donor consequent to the *Harvesting*.
vi. Expenses related to organ transportation or preservation.
vii. Transplant of any organ/tissue where the transplant is experimental or investigational.
viii. *Hospitalisation* or any related *Medical Expenses* if *Insured Person* is *Hospitalised* for donating organ.

2.1.6 Vaccination (Post-bite treatment)

We will cover the *Medical Expenses* incurred for vaccination including inoculation and immunisations in case of post-bite treatment.

However, Medical Expenses incurred on outpatient treatment will be limited to the sub -limit of upto Rs.5000.

2.2 Family Transportation Benefit

We will cover the transportation expenses incurred by any one Immediate Family Member of *Insured Person* up to the limits stated in the *Policy Schedule*/ Certificate of Insurance if –

Insured Person is admitted in a *Hospital* which is not in the city as reflected in the address in the *Policy* and no adult member of his immediate family is present in the hospital at his bedside for the duration of stay in the hospital.

Note: Coverage shall be applicable only if *We* have accepted claim under In-patient Hospitalisation - 2.1.

2.3 Emergency Ambulance / Repatriation of Mortal Remains (RMR) / Funeral expenses

I. *We* will cover the expenses up to the limits stated in the *Policy Schedule*/ Certificate of Insurance, incurred towards transportation of an *Insured Person* by a registered healthcare or *Ambulance* service provider for treatment of a disease / *Illness* / *Injury* in case of an *Emergency*.

Expenses shall include:

i. Transportation Costs towards transferring the *Insured Person* from the place of incident to *Hospital* or from one Hospital to another Hospital or to a diagnostic centre for advanced diagnostic treatment where such facility is not available at the existing Hospital and advised by the treating *Medical Practitioner*.

ii. When the *Insured Person* requires to be moved to a better *Hospital* facility due to lack of super speciality treatment in the existing *Hospital*.

iii. When the *Insured Person* requires to be moved to home after discharge from the *Hospital*. The medical condition of *Insured Person* is such that it requires services of *Ambulance* and is certified by treating *Medical Practitioner*.

II. *We* will also cover the following expenses if the *Insured Person* dies in the *Hospital* during the course of *Hospitalisation*.

(i) Transportation of Mortal remains from *Hospital* to home and/or to cremation ground for funeral purpose;

(ii) Cremation Expenses;

(iii) Coffin Charges.

Coverage shall be applicable only if *We* have accepted claim under In-patient Hospitalisation - 2.1 or under Day Care Procedures - 2.1.3.

Section 3 - Exclusions

3.1 STANDARD EXCLUSIONS APPLICABLE TO ALL POLICIES

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

3.1.2 Chemical & Nuclear Exposure - *We* will not pay for the treatment costs directly or indirectly caused by or contributed to or arising from nuclear weapons/materials, radioactive material, nuclear waste, nuclear fuel, chemical weapons / material or biological weapons/material.

3.1.3 War - *We* will not pay for the treatment related to any condition resulting from, or as a consequence of War, invasion, act of foreign enemy, civil war, public defence, rebellion, revolution, insurrection, military or usurped acts.

3.2 EXCLUSIONS SPECIFIC TO THE POLICY WHICH CANNOT BE WAIVED

3.2.1 Waiting Period for Named Mental Illness - We will not pay for any treatment / Hospitalisation mentioned below or any complication arising from the same, during first twenty four (24) months from the inception of first Policy with Us.

	Organ / Organ Systems	Illness
1.	**Mental Disorders**	**a.** Schizophrenia (ICD - F20 ; F21;F25) **b.** Bipolar Affective Disorders (ICD - F31; F34) **c.** Depression (ICD - F32; F33) **d.** Obsessive Compulsive Disorders (ICD - F42 ; F60.5) **e.** Psychosis (ICD - F 22 ; F23 ; F28 ; F29)

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

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

3.2.4 Circumcision - *We* will not pay for Circumcision unless necessary for the treatment of a disease or necessitated by an *Injury*.

3.2.5 Rest Cure, Rehabilitation and Respite Care – Excl05 - 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.

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

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

3.2.8 **Unproven Treatments – Code – Excl16 -** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

3.2.9 **Change of Gender Treatments – Code – Excl07 -** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

3.2.10 **Medically Necessary Expenses -** *We* will not pay for any treatment or part of a treatment that is not reasonable and medically necessary and drugs or treatments which are not supported by a prescription.

3.2.11 **Non-Medical Expenses -** *We* will not pay for any Non-medical expenses defined in annexure III.

3.2.12 **Obesity / Weight Control – Code – Excl06 -** Expenses related to the surgical treatment of Obesity that does not fulfil all the below conditions -

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);
   a) greater than or equal to 40 or
   b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

3.2.13 **Preventive Vaccinations -** *We* will not pay for the expenses towards any treatment related to preventive care, vaccination including inoculation and immunizations (except in case of post-bite vaccination treatment) unless certified and recommended by the attending *Medical Practitioner* as part of in-patient treatment as a direct consequence of an otherwise covered claim.

3.2.14 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 /VF, ZIFT, GIFT, /ICSI

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

3.2.15 Self-inflicted injuries or attempted suicide - *We* will not pay any expenses for treatment resulting directly or indirectly from self-inflicted *Injury* or suicide, attempted suicide while sane or insane.

3.2.16 Treatment by outside discipline - *We* will not pay any expenses for treatment rendered by someone who is not licensed to practice the discipline.

3.2.17 Investigation & Evaluation – Code – Excl04 -

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

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

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

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

3.3 EXCLUSIONS SPECIFIC TO THE POLICY, WHICH CAN BE WAIVED ON PAYMENT OF ADDITIONAL PREMIUM

3.3.1 Pre-Existing Diseases – Code – Excl01 –

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

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

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

d) Coverage under the policy after the expiry of number of months (as specified in the Policy Schedule) for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

3.3.2 Specified Disease / procedure waiting period – Code – Excl02 – (Named Ailments)

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of number of months (as specified in the Policy Schedule / Certificate of Insurance) of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

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

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

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

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

f) List of specific diseases/procedures are mentioned below -

	Organ / Organ Systems	Illness / Surgeries
1.	**Ear Nose Throat**	a. Sinusitis b. Chronic Suppurative Otitis Media (CSOM) c. Tonsillectomy d. Adenoidectomy e. Mastoidectomy f. Tympanoplasty g. *Surgery* for Deviated Nasal Septum h. *Surgery* for turbinate/Concha i. Any other benign ear, nose and throat disorder or *Surgery*
2.	**Eye**	a. Cataract b. *Surgical* Management of Glaucoma c. Retinopathy
3.	**Gastrointestinal**	a. Calculus Diseases of Gall Bladder including Cholecystectomy b. All types of *Surgery* of Hernia c. Fissure/Fistula in anus, Hemorrhoids, Pilonidal Sinus d. Ulcer of Stomach & Duodenum e. Gastroesophageal Reflux Disorder(GRD) f. Perianal / Perineal Abscess g. Rectal Prolapse
4.	**Gynaecological**	a. Cysts, polyps b. Any type of Breast lumps (unless malignant) c. Polycystic Ovarian Disease (PCOD) d. Fibroids (Fibromyoma) e. Myomectomy for fibroids f. Prolapse of Uterus unless necessitated by malignancy g. Adenomyosis

		h. Endometriosis i. Menorrhagia and Dysfunctional Uterine Bleeding (DUB) j. Dilatation & Curettage (D & C) k. Hysterectomy unless due to malignancy
5.	**Orthopaedic**	a. Non-Infectious Arthritis b. Gout and Rheumatism c. Osteoarthritis and Osteoporosis d. Ligament, Tendon & Meniscal Tear (other than caused by *Accident*) e. Spondylitis/Spondylosis/Spondylolisthesis f. *Surgery* for Prolapsed intervertebral disc (other than caused by *Accident*) g. Joint Replacement *Surgeries* (other than caused by *Accident*)
6.	**Urogenital**	a. Calculus of Urinary system (Kidney Stone/Urinary Bladder/Ureteric Stone) b. Any *Surgery* of the genitourinary system unless necessitated by malignancy. c. Benign Hyperplasia of Prostate d. *Surgery* for Hydrocele/Rectocele
7.	**Others**	a. Varicose veins and Varicose ulcers
8.	**General (Applicable to organ systems/organs/disciplines whether or not described above)**	a. Any type of cysts / Nodules / Polyps / Internal tumours / Skin tumours / Lump / growth

3.3.3 30 - day Waiting Period – Code – Excl03 –

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

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

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

3.3.4 Waiting Period for coverage of Internal Congenital Anomaly - *We* will not pay in respect of *Internal Congenital Anomaly* within first 24 months from inception of first *Policy* with *Us*.

3.3.5 External Congenital Anomaly - We will not cover for screening, counselling and treatment related to External congenital anomalies.

3.3.6 Dental Care - *We* will not pay for the *Dental Treatment* and *Surgery* of any kind, other than arising out of an *Accident* and subsequently requiring *Hospitalisation*.

3.3.7 Eyesight, Hearing Aids & External prosthesis –

(a) *We* will not pay for treatment related to correction of refractive errors of the eye less than 7.5 dioptres, routine eyesight checking or hearing tests including optometric therapy.

(b) *We* will not pay for any cost of hearing aids / Cochlear Implants, Spectacles or Contact Lenses.

(c) *We* will not pay for any cost related to providing, maintaining and fitting of following external and or durable medical/non-medical equipment of any kind used for *Diagnosis* and or treatment (except when used intra-operatively).

Walking Aids ; BIPAP Machine; Commode; Continuous Positive Airway Pressure (CPAP) / Continuous Ambulatory Peritoneal Dialysis (CAPD) Equipments; Infusion Pump; Oxygen Cylinder; Pulse oxymeter; Spacer; Spirometer; SPO2 Probe; Nebulizer Kit; Steam Inhaler; Arm sling; Walkers; Crutches; Caps ; Stockings of any kind ; any artificial limb; Thermometer; Cervical Collar; Splint; Diabetic Foot Wear; Knee Braces; Knee Immobilizer; Lumbo Sacral Belt; Nimbus Bed or Water Bed or Air Bed; Ambulance Collar; Ambulance Equipment; Micro shield; Abdominal binder.

3.3.8 Refractive Error – Code- Excl15 - Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

3.3.9 Non-Allopathic Treatment - *We* will not pay any expenses related to *Non-Allopathic treatment.*

3.3.10 Maternity - Code – Excl18 -

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

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

3.3.11 Time bound Exclusions - *We* will not pay for any specific time bound exclusion(s) applied by *Us* and mentioned in the Schedule and accepted by the policyholder.

3.3.12 Permanent Exclusions - We will not pay for any disease which is permanently excluded and specified in the policy schedule with your due consent.

Section 4 - General Terms & Conditions

4.1 CONDITION PRECEDENT TO THE CONTRACT

4.1.1 **Age -** A person shall be eligible to become an *Insured Person* if he/she is not younger than 91 days. However, there is no maximum age limit.

4.1.2 **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.

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

"Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

4.1.1 **Electronic Transactions -** The *Policyholder* / *Insured Person* agrees to adhere to and comply with all terms and conditions as may be imposed for electronic transactions that *We* may prescribe from time to time which shall be within the terms and conditions of the contract, 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 centres, 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 Us, 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 *Our* terms and conditions for such facilities, as may be prescribed from time to time which shall be within the terms and conditions of the contract. However, the terms and condition shall not override provisions of any law(s) or statutory regulations including provisions of *IRDAI* regulations for protection of policyholders' interests.

4.1.5 **No Constructive Notice -** Any knowledge or information of any circumstance or condition in relation to the *Policyholder/ Insured Person* which is in *Our* possession and not specifically informed by the *Policyholder* / *Insured Person* shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

4.2 CONDITIONS APPLICABLE DURING CONTRACT

4.2.1 **Alterations to the Policy** - The *Proposal Form*, declaration, Certificate, and *Policy* constitutes the complete contract of insurance. For any change(s) / alteration/ modification in contract You are requested to give us in writing. Any change that *We* make will be communicated to You by a written endorsement signed and stamped by Us. This *Policy* cannot be changed by any one (including an insurance agent or broker) except Us.

4.2.2 **Cancellation –**

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

REFUND PERCENTAGE					
Month	1 Year Policy	2 Year Policy	3 Year Policy	4 Year Policy	5 Year Policy
1	77%	86%	89%	91%	92%
2	69%	82%	86%	89%	90%
3	61%	78%	84%	87%	88%
4	53%	74%	81%	85%	87%
5	45%	70%	79%	83%	85%
6	37%	66%	76%	81%	84%
7	29%	62%	73%	79%	82%
8	21%	58%	71%	77%	80%
9	7%	54%	68%	75%	79%
10	0%	50%	65%	73%	77%
11	0%	46%	63%	71%	76%
12	0%	42%	60%	69%	74%
13		39%	57%	67%	73%
14		35%	55%	65%	71%
15		31%	52%	63%	69%
16		27%	49%	61%	68%
17		23%	47%	59%	66%
18		19%	44%	57%	65%
19		15%	42%	55%	63%
20		10%	39%	53%	61%
21		4%	36%	51%	60%
22		0%	34%	49%	58%
23		0%	31%	47%	57%
24		0%	28%	45%	55%
25			26%	43%	53%
26			23%	41%	52%
27			20%	39%	50%
28			18%	37%	49%
29			15%	35%	47%
30			12%	33%	46%
31			10%	31%	44%
32			7%	29%	42%
33			2%	27%	41%
34			0%	25%	39%
35			0%	23%	38%

36			0%	21%	36%
37				19%	34%
38				17%	33%
39				15%	31%
40				13%	30%
41				11%	28%
42				9%	27%
43				7%	25%
44				5%	23%
45				2%	22%
46				0%	20%
47				0%	19%
48				0%	17%
49					15%
50					14%
51					12%
52					11%
53					9%
54					7%
55					6%
56					4%
57					1%
58					0%
59					0%
60					0%

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.

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

4.2.2 Communication & Notices –

i) Any notice, direction or instruction under this *Policy* shall be in writing and if it is:

- To any *Insured Person*, then it shall be sent to You at *Your* last updated address as shown in *Our* records and You shall act for all *Insured Persons* for these purposes.
- To Us, it shall be delivered to *Our* address specified in the Schedule.

ii) No insurance agents, brokers or other person or entity is authorised to receive any notice, direction or instruction on *Our* behalf unless *We* have expressly stated to the contrary in writing.

iii) Notice and instructions will be deemed served ten (10) days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

iv) You must immediately bring to *Our* notice any change in the address or contact details. If You fail to inform Us, *We* shall send notice to the last known address and it would be considered that the notice has been sent to You.

v) You shall immediately notify Us in writing in regard to change in occupation / business at *Your* own expense and *We* may adjust the scope of cover and/or premium after analysing the risk of such a change, if necessary, accordingly.

Note: Please include Your Policy number for any communication with Us.

4.2.2 **Geography -** This *Policy* only covers medical treatment taken within India. All payments under this *Policy* will only be made in Indian Rupees within India.

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

Group/Master policy will be issued to the group administrator and all members wherever required will be provided with the certificate of insurance by Us. Wherever mutually agreed group administrator will issue the certificate of insurance to its member as per agreed terms and conditions and in the format prescribed by us and shall keep the record of such issuance. *We* reserve the right to inspect the record at any time to ensure that terms and conditions of group policy and provisions of *IRDAI* group guidelines contained in circular ref: 015/IRDA/Life/Circular/GI Guidelines/2005 dated 14th July 2005 and any amendments thereto are being adhered. *We* may also require submission of certificate of compliance from *Your* Group Administrator auditors.

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

4.2.2 **Premium Payment in Instalments –**

If the insured person has opted for Payment of Premium on an instalment 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 15 days would be given to pay the instalment premium due for the policy.

ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

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 If the instalment premium is not paid on due date.

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

vi. In the event of a claim, all subsequent premium instalments 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.

IMPORTANT POINTS TO BE NOTED WHILE OPTING FOR INSTALMENT PREMIUM PAYMENT VIA ELECTRONIC CLEARING SERVICE (ECS)

1. Completely filled & signed Electronic Clearing Service Mandate Form is mandatory.
2. Ensure that the Premium amount which would be auto debited & frequency of instalment is duly filled in the ECS Mandate form.
3. New ECS Mandate Form is required to be filled in case of any change in the Premium due to change of Sum Insured / age / plan /coverages/revision in premium.
4. You need to inform us atleast 15 days prior to the due date of instalment premium if you wish to discontinue with the ECS facility.
5. Non-payment of premium on due date as opted by You in the mandate form subject to an additional 15 days of relaxation period will lead to termination of the policy.

4.2.2 **Protection of Policy Holders Interest -** This *Policy* is subject to IRDAI (Protection of Policyholders' Interest) Regulation, 2017 and any amendment thereof.

4.2.2 **Policy Disputes -** Any and all disputes or differences concerning the interpretation of the coverage, terms, conditions, limitations and/ or exclusions under this *Policy* shall be governed by Indian law and shall be subject to the jurisdiction of the Indian Courts.

4.2.2 **Records to be maintained -** You or the *Insured Person*, as the case may be shall keep an accurate record containing all medical records pertaining to the treatment taken for any liability under the policy and shall allow Us or *Our* representative(s) to inspect such records. You or the *Insured Person* as the case may be, shall furnish such information as may be required by Us under this *Policy* at any time during the *Policy Period* and up to three years after the Policy expiration, or until final adjustment (if any) and resolution of all claims under this *Policy*.

4.2.2 **Possibility of Revision of Terms of the Policy including the Premium Rates** - The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

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

4.2.2 Termination of Policy - This *Policy* terminates on earliest of the following events-

a. *Cancellation of Policy* as per the cancellation provision.

b. On the policy expiry date.

5.2.14 Withdrawal of Policy -

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Group Organiser or Administrator / insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

4.3 CONDITIONS FOR RENEWAL OF CONTRACT

4.3.1 Continuity - *Insured Person* would have an option to migrate to *Our* individual health insurance plans if the group *Policy* is discontinued or if *Insured Person* is leaving the group on account of resignation, retirement, termination of employment or otherwise, subject to *Our* underwriting guidelines. Dependent children likewise when exiting on account of reaching upper age limit will have an option to migrate to *Our* individual health insurance plans subject to *Our* underwriting guidelines. *Insured Person* will be entitled for accrued continuity benefits as per prevailing migration guidelines issued by the *Authority.*

4.3.2 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. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link – www.naviinsurance.com

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

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

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

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

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of thirty (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.

4.4 CONDITIONS WHEN A CLAIM ARISES

4.4.1 **Arbitration -** If *We* admit liability for any claim but any difference or dispute arises as to the amount payable for any claim the same shall be decided by reference to Arbitration. The Arbitrator shall be appointed in accordance with the provisions of the Arbitration and Conciliation Act, 1996 or any amendment thereof. No reference to Arbitration shall be made unless *We* have admitted *Our* liability for a claim in writing.

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

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

4.4.4 **Disclaimer of Claim -** If Company disclaim liability to the Insured for any claim and if the insured within twelve (12) calendar months from the date or receipt of the notice of such disclaimer does not, notify the Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable under the *policy*.

4.4.5 **Life Threatening Situations** – If the *Hospitalisation* is under a cover where sub-limit is applicable and *Insured Person* suffers from any medical complication which leads to a life-threatening condition then *we* will waive the sub-limit and extend the coverage upto Policy *Sum insured* provided medical complications are not due to any *Pre–Existing Diseases*/conditions unless specifically covered under the *Policy*. However, life threatening condition due to *Pre–Existing Diseases*/conditions shall be covered after completion of the waiting period specified in the policy.

4.4.6 **Physical Examination -** Any *Medical Practitioner* authorized by the *TPA* /*Us* shall be allowed to examine the *Insured Person* in case of any alleged disease/*Illness*/*Injury* requiring Hospitalization. Non-co-operation by the

Insured Person will result into rejection of claim. *We* will bear the cost towards performing such medical examination (at the specified location) of the *Insured Person*.

4.4.7 Claims Process & Management

Completed claim forms and processing documents must be furnished to *Us* / *TPA* within the stipulated timelines for all reimbursement claims. Failure to furnish this documentation within the time required shall not invalidate nor reduce any claim if You can satisfy that it was not reasonably possible for You to submit / give proof within such time.

Cashless and Reimbursement Claim processing is through *Our* service partner *TPA*, details of the same will be available on the Health Card issued by Us as well as on *Our* /*TPA* website. For the latest list of *Network Providers*, you can log on to *Our* /*TPA* website. *TPA* will facilitate health claims processing.

4.4.7.1 Claim Intimation:

If You meet with any *Accidental* Bodily Injury or suffer an *Illness* that may result in a claim, then as a *Condition Precedent* to *Our* liability, you must comply with the following claims procedures:
You must notify *Your* claim to Us / *Our TPA* in writing or at call centre.

	Type of Hospitalisation	Notify Us or Our TPA
1)	Planned Hospitalisation	Immediately and in any event at least forty eight (48) hours prior to *Your* admission.
2)	Emergency Hospitalisation	Within twenty four (24) hours of *Your* admission to *Hospital* or before discharge whichever is earlier

The following details are to be provided to Us/***TPA*** at the time of intimation of Claim:

- Policy Number
- Health Card ID No.
- Name of the Primary Insured
- Name of the Insured Person in whose relation the Claim is being lodged
- Nature of Illness / Injury
- Name and address of the attending Medical Practitioner and Hospital
- Date of Admission
- Any other information as requested by Us

4.4.7.2 Cashless Facility:

Cashless facility is available for *Hospitalization* only at our *Network Provider*. The *Insured Person* can avail *Cashless facility* at *Network Provider*, by presenting the health card as provided by Us with this *Policy*, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / Aadhar Card , any other identity proof as approved by Us).

(a) For Planned Hospitalization:

i. The *Insured Person* should at least forty-eight (48) hrs prior to admission to the *Hospital* approach the *Network Provider* for *Hospitalization* for medical treatment.
ii. The *Network Provider* will issue the request for authorization letter for *Hospitalization* in the pre-authorization form prescribed by the *IRDAI*.
iii. The *Network Provider* shall electronically send the filled pre-authorization form along with all the relevant details to the twenty-four (24) hour authorization/cashless department of *TPA* along with contact details of the treating *Medical Practitioner* and the *Insured Person*.
iv. Upon receiving the pre-authorization form and all related medical information from the *Network Provider*, the eligibility of cover under the *Policy* will be verified.
v. Wherever the information provided in the request is sufficient to ascertain the authorisation, the authorisation letter will be issued to the *Network Provider*. Wherever additional information or documents are required, the same will be called for from the *Network Provider* and upon satisfactory receipt of last necessary documents the authorisation will be issued. All authorisations will be issued within a period of six (6) hours from the receipt of last complete documents.
vi. The Authorisation letter will include details of sanctioned amount, any specific limitation on the claim, any *Co-Payment* or *Deductible* and non- payable items if applicable.
vii. The authorisation letter shall be valid only for a period of fifteen (15) days from the date of issuance of authorization.

In the event that the cost of *Hospitalization* exceeds the authorized limit as mentioned in the authorization letter:

i. The *Network Provider* shall request for an enhancement of authorisation limit.
ii. Eligibility will be verified and the enhancement will be evaluated on the availability of further limits.

In the event of a change in the treatment during *Hospitalization* of the *Insured Person*, the *Network Provider* shall obtain a fresh authorization letter from Us.

<u>At the time of discharge</u>:

i. The *Network Provider* may forward a final request for authorization for any residual amount along with the discharge summary and the billing format in accordance with the process.
ii. Upon receipt of the final authorisation letter, *Insured Person* may be discharged by the *Network Provider*.
iii. Ensure that the final authorization letter is signed by *Insured Person.*
iv. Ensure to take photocopies of relevant medical records for future reference.

(b) For Emergency Hospitalisation:

i. The *Insured Person* may approach the *Network Provider* for *Hospitalization*
ii. *Insured Person* will need to provide health card / health insurance *Policy* at hospital admission counter.
iii. The *Network Provider* shall forward the request for authorization to *TPA* within twenty-four (24) hours of admission to the *Hospital* or before discharge whichever is earlier.
iv. In the interim, the *Network Provider* may either consider treating the *Insured Person* by taking a token deposit or treating as per their norms.
v. The *Network Provider* shall refund the deposit amount to you barring a token amount to take care of non-covered expenses once the authorization is issued.

The *Network Provider* will send the claim documents to *TPA* within fifteen (15) days from the date of discharge from *Hospital*.

- Claim Form Duly Filled and Signed
- Original signed pre-authorisation request
- Copy of authorisation approval letter (s)
- Copy of Photo ID of Patient Verified by the Hospital
- Original Discharge/Death Summary
- Operation Theatre Notes (if any)
- Original Hospital Main Bill along with break up Bill and original receipts
- Original Investigation Reports, X Ray, MRI, CT Films, HPE etc.
- Details of the implants including the sticker indicating the type as well as invoice towards the cost of implant
- Doctors Reference Slips for Investigations/Pharmacy
- Original Pharmacy Bills
- MLC/FIR Report/Post Mortem Report (if applicable and conducted).

Any additional documents may be called as required based on the circumstances of the claim.

There can be instances where *Cashless Facility* may be denied for *Hospitalization* due to insufficient *Sum Insured* or insufficient information to determine admissibility in which case *You*/*Insured Person* may be required to pay for the treatment and submit the claim for reimbursement to *TPA* which will be considered subject to the *Policy* Terms &Conditions.

We in *Our* sole discretion, reserves the right to modify, add or restrict any *Network Provider* for Cashless services under the *Policy*. Before availing the Cashless service, the *Policyholder* / *Insured Person* is required to check the applicable/latest list of *Network Provider* on *TPA's* website or by calling call centre.

4.4.7.3 Claim Reimbursement Process

Wherever *You* have opted for a reimbursement of expenses, *You* may submit the documents for reimbursement of the claim to *Our* / *TPA* office not later than fifteen (15) days from the date of discharge from the *Hospital*. You can obtain a Claim Form from any of *Our* / *TPA* Offices or download a copy from *Our* website www.naviinsurance.com.

List of necessary claim documents to be submitted for reimbursement are as following:

- Claim Form Duly Filled and Signed
- Original Discharge/Death Summary
- Operation Theatre Notes (if any)
- Original Hospital Main Bill along with break up Bill and original receipts
- Original investigation reports, X Ray, MRI, CT films, HPE etc.
- Doctors Reference Slips for Investigations/Pharmacy
- Original Pharmacy Bills
- MLC/FIR Report/Post Mortem Report (if applicable and conducted).

- Details of the implants including the sticker indicating the type as well as invoice towards the cost of implant
- KYC documents (Photo ID proof, Pan Card, Aadhar Card etc.)
- Cancelled cheque for NEFT payment

We may call for any additional documents/information as required based on the circumstances of the claim.

4.4.7.4 Scrutiny of Claim Documents:

We shall scrutinize the claim and accompanying documents. Any deficiency of documents, shall be intimated to You and the *Network Provider*, as the case may be and subsequent reminders will follow.
During claim processing if the claims are found deficient in documents, *TPA* shall intimate the same to the *Policyholder* / *Insured Person* within three (3) working days of receiving claim documents. First reminder for deficient documents will be sent within seven (7) days of first deficiency letter and Second reminder - within ten (10) days of first reminder deficiency letter. Final reminder letter will be sent within ten (10) days from second reminder.

We will send a maximum of three (3) reminders following which, we will send rejection letter after fifteen (15) days of the final reminder letter if the deficient documents are not received.

4.4.7.5 Claim Investigation:

We may investigate claims if reasonably required to determine the validity of claim. Verification carried out, if any, will be done by Individuals or *Medical Practitioners* or entities authorized by Us to carry out such verification / investigation(s) and the costs for such verification / investigation shall be borne by *Us*.

You additionally hereby consent to disclose Us of documentation and information that may held with *Your* medical professionals and other insurers.

4.4.7.6 Pre-& Post Hospitalisation Claims:

Claim documents for Pre-& Post hospitalisation should be sent to *TPA* within fifteen (15) days of completion of treatment.

4.4.7.7 Claim Settlement (provision of Penal Interest):

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

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

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than

30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

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

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

4.4.7.8 Multiple Policies:

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

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

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

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

4.4.7.9Fraud

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

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

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

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

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

c) any other act fitted to deceive; and

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

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

4.4.7.10 TPA Related Information

For intimation of claim, submission of claim related documents and any claim related query, *You* can contact *TPA* assigned as per zone wise and /or as selected by You and which is appearing on your Policy Schedule and Health Card.

Region	TPA Address & Contact Details
WEST DADRA & NAGAR HAVELI | DAMAN & DIU | GOA | GUJARAT | MADHYA PRADESH | MAHARASHTRA	**PARAMOUNT HEALTH SERVICES & INSURANCE TPA PRIVATE LIMITED** Plot No. A-442, Road No. 28, MIDC Industrial Area, Wagle Estate, Ram Nagar, Near Vitthal Rukhmani Mandir, Thane (W), Maharashtra 400604 **Website** - www.paramounttpa.com **IRDAI Reg No:** 006 **Email** - navigi@paramounttpa.com **Toll Free** - 1800 2256 01
SOUTH ANDAMAN & NICOBAR ISLANDS | ANDHRA PRADESH | KARNATAKA | KERALA | LAKSHADWEEP | TAMIL NADU | TELANGANA | PUDUCHERRY	**FAMILY HEALTH PLAN INSURANCE TPA LIMITED** No:8-2-269/A/2-1 To 6, 2nd Floor, Srinilaya Cyber Spazio, Road No.2, Banjara Hills, Hyderabad, Telangana – 500034 **Website** - www.fhpl.net **IRDAI Reg No:** 013 **Email** - navigi@fhpl.net **Toll Free** - 1800 599 2488
EAST & NORTH ARUNACHAL PRADESH | ASSAM | BIHAR | CHHATTISGARH | JHARKHAND | MANIPUR | MEGHALAYA | MIZORAM | NAGALAND | ODISHA | SIKKIM | TRIPURA | WEST BENGAL | CHANDIGARH | DELHI | HARYANA | HIMACHAL PRADESH | JAMMU & KASHMIR | PUNJAB |	**RAKSHA HEALTH INSURANCE TPA PRIVATE LIMITED** C/O Escorts Corporate Centre, 15/5, Mathura Road, Faridabad - 121003 Haryana **Website** - www.rakshatpa.com **IRDAI Reg No:** 015 **Email** - navigi@rakshatpa.com **Toll Free** - 1800 180 1555

RAJASTHAN | UTTAR PRADESH | UTTARAKHAND	

Section 5 - Redressal of Grievance

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

Website: www.naviinsurance.com
Toll free: 1800-123-0004
E-mail: mycare@navi.com
Courier: **Navi General Insurance Limited**
Salarpuria Business Centre,
4th B Cross Road, 5th Block,
Koramangala Industrial Layout,
Bengaluru, Karnataka – 560095

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 Manager.CustomeExperience@navi.com

For updated details of grievance officer, kindly refer the link - www.naviinsurance.com/service/

For Senior Citizens, we have a special cell and our Senior Citizen customers can email us at seniorcare@navi.com for priority resolution

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.

Ombudsman & Addresses: Refer the link - http://ecoi.co.in/ombudsman.html

S. No.	CONTACT DETAILS	JURISDICTION OF OFFICE
1	**AHMEDABAD** Office of the Insurance Ombudsman. Jeevan Prakash Building, 6th Floor, Tilak Marg, Relief Road, Ahmedabad - 380 001. Tel.: 079 - 25501201 / 02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	State of Gujarat and Union Territories of Dadra & Nagar Haveli and Daman and Diu
2	**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@ecoi.co.in	Karnataka

3	**BHOPAL** Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	States of Madhya Pradesh and Chattisgarh.
4	**BHUBANESHWAR** Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	State of Orissa
5	**CHANDIGARH** Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 - D,Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	States of Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Union territory of Chandigarh.
6	**CHENNAI** Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	State of Tamil Nadu and Union Territories - Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).
7	**DELHI** Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in	State of Delhi
8	**GUWAHATI** Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@ecoi.co.in	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

9	**HYDERABAD** Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	States of Andhra Pradesh, Telangana and Union Territory of Yanam - a part of the Union Territory of Pondicherry
10	**JAIPUR** Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	State of Rajasthan
11	**ERNAKULAM** Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry
12	**KOLKATA** Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax: 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	States of West Bengal, Bihar, Sikkim and Union Territories of Andaman and Nicobar Islands
13	**LUCKNOW** Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	District of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varansi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sulanpur, Maharajganj, Santkabirnagar, Azamgarh, Kaushinagar, Gorkhpur, Deoria, Mau, Chandauli, Ballia, Sidharathnagar.

14	**MUMBAI** Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	States of Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
15	**NOIDA** Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514251 / 2514253 Email: bimalokpal.noida@ecoi.co.in	States 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, Firozabad, Gautam Budh Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
16	**PATNA** Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	States of Bihar and Jharkhand
17	**PUNE** Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 32341320 Email: bimalokpal.pune@ecoi.co.in	States of Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

Section 6 - Annexures

I. Optional Covers

All endorsements issued with this *Policy* or endorsed thereon shall be expressly subject to the terms and conditions and exclusions of this *Policy*, except to the extent expressly varied by the endorsement and shall become applicable only upon endorsement and after *Our* receipt of requisite additional premium.

Optional Cover No. 1 Individual Sum Insured

This *Policy* covers the *Primary Insured* and his *Dependents* (defined in section 1.19) on an Individual sum insured basis, and each Dependent so named in the Schedule shall be an *Insured Person*.

Optional Cover No. 2 Family Floater Sum Insured

This *Policy* covers the *Primary Insured* and his *Dependents* (defined in section 1.19) on a *Family Floater* basis under which the *Policy* definition of the *Sum Insured* shall be replaced with the following:

Sum Insured: Sum Insured means the sum shown in the *Policy Schedule*/ Certificate of Insurance which represents *Our* maximum liability for any and all claims made by *Primary Insured* and / or all *Dependents* during the *Policy Year*.

Optional Cover No. 3 Mid-term addition / deletion of Primary Insured and his Dependents

1) **Addition** – New *Primary Insured* including *dependents* stand included in the *Policy* and coverage in respect of new *Primary Insured* and *Dependents* shall commence from the date of receipt of request or from the date of joining the employment provided:
    - **(1)** Intimation along with information sheet is given to Us.
    - **(2)** Availability of deposit premium with Us is adequate & appropriate for inclusion of the new *Primary Insured* and *Dependents* in the *Policy* (as & when applicable).
    - **(3)** Pro-rata premium shall be charged.

      If any of the conditions (1) & (2) above are not met, coverage will commence only from the date of intimation to Us or premium remittance whichever is later.

2) **Deletion** – In respect of *Primary Insured* whose employment with the *Policyholder* ceases or leaves the group, by whatever means,

    - **(1)** The coverage will automatically expire in respect of that *Primary Insured* and his *Dependents* from date of cessation of employment or from the date of leaving the group.
    - **(2)** Pro-rata refund of premium would be made on intimation provided no claim is made by the *Primary Insured* or his *Dependents.*

Optional Cover No. 4 Room, Boarding & Nursing expense

Room, Boarding & Nursing expenses under the *Policy* shall be subject to the limits as specified in the *Policy* schedule which represent *Our* maximum liability for any and all claims made by an *Insured Person* in respect of this benefit.

If the *Insured Person* is admitted in a room where the *Room Rent* is higher than the limit opted as specified in the *Policy Schedule* then, we will proportionately deduct "associate medical expenses".

Associate Medical Expenses include medical expenses related to Nursing Charges, Operation Theatre Charges, Fees of Medical practitioner/ surgeon/ anaesthetist/ specialist and Physiotherapy charges.

Optional Cover No. 5 Pre-Hospitalisation (Extension / Deletion)

Extension - Coverage for Pre-hospitalisation (2.1.1) under Section 2 stands extended as specified in the *Policy Schedule* for all *Insured Persons* covered under this *Policy*.

Deletion - Coverage for Pre-hospitalisation (2.1.1) under Section 2 stands deleted as specified in the *Policy Schedule* for all *Insured Persons* covered under this *Policy*.

Optional Cover No. 6 Post Hospitalisation (Extension / Deletion)

Extension - Coverage for Post hospitalisation (2.1.2) under Section 2 stands extended as specified in the *Policy Schedule* for all *Insured Persons* covered under this *Policy*.

Deletion - Coverage Post hospitalisation (2.1.2) under Section 2 stands deleted as specified in the *Policy Schedule* for all *Insured Persons* covered under this *Policy*.

Optional Cover No. 7 Domiciliary Treatment (Deletion / Sum Insured Restriction)

Deletion - Coverage Domiciliary Treatment (2.1.4) under Section 2 stands deleted as specified in the *Policy Schedule* for all *Insured Persons* covered under this *Policy.*

Sum Insured Restriction – Sum Insured of Domiciliary Treatment (2.1.4) under Section 2 stands restricted upto the amount as specified in the *Policy Schedule* for all *Insured Persons* covered under this *Policy.*

Optional Cover No. 8 Deletion of Organ Donor

Coverage Organ Donor (2.1.5) under Section 2 stands deleted for all *Insured Persons* covered under this *Policy*.

Optional Cover No. 9 Deletion of Family Transportation

Coverage Family Transportation (2.2) under Section 2 stands deleted for all *Insured Persons* covered under this *Policy*.

Optional Cover No. 10 Deletion of Emergency Ambulance / Repatriation of Mortal Remains (RMR) / Funeral Expenses

Coverage Emergency Ambulance / Repatriation of Mortal Remains (RMR) / Funeral Expenses (2.3) under Section 2 stands deleted for all *Insured Persons* covered under this *Policy*.

Optional Cover No. 11 Waiting Period for Pre-existing Conditions (Reduction / Deletion / Sum Insured Restriction/ Co-pay)

Reduction of Waiting Period – 48 months Waiting Period for "Pre-existing Conditions" (3.3.1) under Section 3 stands reduced to the duration as specified in the *Policy Schedul*e for all *Insured Persons* covered under this *Policy*.

Deletion of Waiting Period – 48 months Waiting Period for "Pre-existing Conditions" (3.3.1) under Section 3 stands deleted as specified in the *Policy Schedul*e for all *Insured Persons* covered under this *Policy*.

Sum Insured Restriction – 48 months Waiting Period for "Pre-existing Conditions" (3.3.1) under Section 3 stands deleted subject to the sum insured restriction as specified in the *Policy Schedul*e for all claims pertaining to the pre-existing condition and for all *Insured Persons* covered under this *Policy*.

Co Pay – 48 months Waiting Period for "Pre-existing Conditions" (3.3.1) under Section 3 stands deleted subject to the co-pay as specified in the *Policy Schedul*e for all claims pertaining to the pre-existing condition and for all *Insured Persons* covered under this *Policy*.

Optional Cover No. 12 Waiting Period for Named Ailments (Deletion / Reduction / Co-Pay)

Deletion – 2 Years Waiting Period for "Named Ailments" (3.3.2) under Section 3 stands deleted as specified in the *Policy Schedul*e for all *Insured Persons* covered under this *Policy*.

Reduction – 2 Years Waiting Period for "Named Ailments" (3.3.2) under Section 3 stands reduced to the duration as specified in the *Policy Schedul*e for all *Insured Persons* covered under this *Policy*.

Co Pay – 2 Years Waiting Period for "Named Ailments" (3.3.2) under Section 3 stands deleted subject to the co-pay as specified in the *Policy Schedul*e for all claims pertaining to the Named Ailments condition and for all *Insured Persons* covered under this *Policy*.

Optional Cover No. 13 Waiting Period for 30 Days (Deletion / Co-Pay)

Deletion –30 days Waiting Period (3.3.3) under Section 3 stands deleted as specified in the *Policy Schedul*e for all *Insured Persons* covered under this *Policy*.

Co Pay – 30 days Waiting Period (3.3.3) under Section 3 stands deleted subject to the co-pay as specified in the *Policy Schedul*e for all claims pertaining to 30 days waiting period and for all *Insured Persons* covered under this *Policy*.

Optional Cover No. 14 External Congenital Disorder (Deletion / Sum Insured Restriction)

Deletion - Exclusion # 3.3.5 under Section 3 – "Exclusions" of the *Policy* stands deleted as specified in the *Policy Schedule* for all *Insured Persons* covered under this *Policy*.

Sum Insured Restriction – Exclusion # 3.3.5 under Section 3 stands deleted subject to the sum insured specified in the *Policy Schedul*e for all claims pertaining to the external congenital disorder and for all *Insured Persons* covered under this *Policy*.

Optional Cover No. 15 Medical Expenses/ Illness/ Surgeries/Procedures – Sub-limits

Our maximum liability to make payment for the *Medical Expenses* incurred during any *Hospitalisation* (including its related Pre- and Post-Hospitalization expenses if applicable) due to the named surgeries/ medical procedures or any medical treatment pertaining to that *Illness*/ *Injury* shall be limited to the amount specified in the *Policy Schedule*.

Medical Expenses/ Illness/ Surgeries/Procedures – Sub-limits			
S. No.	**Illness / Surgeries/ Medical Procedures**	**Sum Insured (Min / Max)**	**Availability**
1	Cataract Per Eye (Including Lens)	₹ 10,000 - ₹ 50,000	In multiples of ₹ 10,000
2	Deviated nasal Septum	₹ 15,000 - ₹ 1,00,000	In multiples of ₹ 10,000
3	Total Knee Replacement / Total Hip Replacement (Inc Implants)	₹ 1.50 - ₹ 2.50 Lacs	In multiples of ₹ 10,000
4	Stone in Urinary System	₹ 10,000 - ₹ 50,000	In multiples of ₹ 10,000
5	All types of Hernia	₹ 10,000 - ₹ 50,000	In multiples of ₹ 10,000
6	Open / Lap Appendectomy	₹ 10,000 - ₹ 75,000	In multiples of ₹ 10,000
7	ACL Reconstruction Surgery	₹ 10,000 - ₹ 1,00,000	In multiples of ₹ 10,000
8	Hysterectomy	₹ 10,000 - ₹ 50,000	In multiples of ₹ 10,000
9	Fissures/ Piles/ Fistulas	₹ 10,000 - ₹ 50,000	In multiples of ₹ 10,000
10	Open / Lap Cholecystectomy	₹ 50,000 - ₹ 1,00,000	In multiples of ₹ 10,000

Optional Cover No. 16 Franchise

All admissible claims under this *Policy* is subject to the *Franchise* amount as specified in the *Policy Schedule* for all *Insured Persons* covered under this *Policy*.

Franchise shall not apply to following coverages if opted –

i. Hospital Daily Cash
ii. Corporate Floater (Including Critical Illness Floater)
iii. Critical Illness
iv. Recovery Benefit
v. Second Opinion
vi. Top Up Cover
vii. Family Transportation Benefit
viii. Emergency Ambulance / Repatriation of Mortal Remains (RMR) / Funeral expenses

Optional Cover No. 17 Co-payment

All admissible claims under this *Policy* is subject to the co-payment as specified in the *Policy Schedule* for all *Insured Persons* covered under this *Policy*.

Co-Payment shall not apply to following coverages if opted –

i. Hospital Daily Cash

ii. Corporate Floater (Including Critical Illness Floater)
iii. Critical Illness
iv. Recovery Benefit
v. Second Opinion
vi. Top Up Cover
vii. Family Transportation Benefit
viii. Emergency Ambulance / Repatriation of Mortal Remains (RMR) / Funeral expenses

Optional Cover No. 18 Deductible

All admissible claims under this *Policy* is subject to the *Deductible* amount as specified in the *Policy Schedule* for all *Insured Persons* covered under this *Policy*.

Deductible shall not apply to following coverages if opted –

i. Hospital Daily Cash
ii. Corporate Floater (Including Critical Illness Floater)
iii. Critical Illness Benefit
iv. Recovery Benefit
v. Second Opinion
vi. Top Up Cover
vii. Family Transportation Benefit
viii. Emergency Ambulance / Repatriation of Mortal Remains (RMR) / Funeral expenses

Optional Cover No. 19 Maternity Benefit (including pre/post-natal) with / without waiting period

We will reimburse the *Medical Expenses* incurred by *Insured Person* for a Normal / Caesarean Delivery in a *Hospital* during the *Policy Year*, provided that:

a) *Medical Expenses* are covered for the delivery of first two living children of the *Insured Person* and/or any Surgical Procedures required to be carried out on the *Insured Person* as a direct result of the delivery.
b) A waiting period as mentioned in the *Policy Schedule* shall apply to the *Primary Insured* and his/her Spouse from the date both are covered under the *Policy*.
c) A waiting period shall not apply to the *Primary Insured* and his / her Spouse if waiver of waiting period is opted and mentioned in the *Policy Schedule*.
d) Policy Exclusion # 3.3.10 under Section 3 – "Exclusion" stands deleted.
e) *Medical Expenses* incurred in connection with the lawful medical termination of pregnancy.
f) This coverage also includes Pre-natal and post-natal *Medical Expenses*:
  i) Coverage of Pre & Post-natal *Medical Expenses* are valid for inpatient / *Outpatient Treatment.*
  ii) Pre- and post-natal *Medical Expenses* includes - expenses incurred on antenatal check-ups, doctor's consultations for monitoring of the pregnancy and any complications arising therefrom.
  iii) *Medical Expenses* incurred towards pre/ post-natal treatment would be considered within the maternity *Sum Insured* limit.
  iv) *Medical Expenses* incurred towards new-born baby in connection with any treatment upto the date of discharge from the *Hospital* would be considered within the maternity *Sum Insured* limit.
  v) *Our* maximum liability under this Endorsement will be limited to the sub-limit specified in the *Policy Schedule*.

Note –

a. Pre-Natal means the period between conception and birth.
b. Post-Natal means the period beginning immediately after the birth of a child and extending for 60 days.

Optional Cover No. 20 New Born Cover from Day 1

If We have accepted your claim under maternity benefit, We will cover the new born baby(ies) of Primary *Insured* Person listed in the *Policy Schedule*, from the date of birth of the baby, provided that:

a) Intimation for inclusion of the new-born in to the *Policy* is given to Us within 30 days from the birth of child,
b) *Our* maximum liability under this Endorsement for the *New Born Baby* shall be limited to the -
- *Family Floater* sum insured opted by the *Primary Insured* at the inception of the *Policy* Or
- *Sum Insured* as opted at the inception of the *Policy*;

The definition of Dependent in Endorsement No. 1 will stand modified to this extent.

Optional Cover No. 21 Hospital Daily Cash

If *We* have accepted a claim under Inpatient Hospitalisation - 2.1, then *We* will pay fixed cash amount for each day in *Hospital*, during the *Policy Year* for treatment of an *Illness* /disease/ *Injury*.

This Benefit shall be payable for a maximum limit of days as specified in the *Policy Schedule*.

Conditions –

a. A *Deductible* as specified in the *Policy Schedule* shall apply under this Benefit thus, the benefits shall become payable only after *Hospitalisation* of *Insured Person* exceeds the specified number of days,
b. *We* will pay twice the daily cash amount for each continuous and completed day that the *Insured Person* spends in an *Intensive Care Unit*,
c. In case, insured person spends a day partly in ICU and partly in Non-ICU then we will pay twice the daily cash amount for such day, and
d. *Our* maximum liability will be limited to five (5) days for each hospitalisation.

Optional Cover No. 22 Corporate Floater - (Including Critical Illness Floater)

Corporate Buffer i.e. an additional *Sum Insured* as stipulated in the *Policy Schedule* will be available to the Insured which is in addition to the basic *Sum Insured* reflected in the *Policy Schedule* per person/family.

Corporate Buffer as stated in the *Policy Schedule* will be available to the insured for additional payment to the *Insured Person* during the *Policy Year* subject to the limits and conditions specified in the *Policy Schedule*.

Optional Cover No. 23 Critical Illness Benefit

We will pay the lumpsum amount as specified in the *Policy Schedule* against each Insured Person for the Critical Illness mentioned below, provided that:

a) The *Insured Person* is diagnosed as suffering from a Critical Illness during the *Policy Year*; and

b) The diagnosed Critical Illness occurs or manifests itself as a first incidence; and

c) The *Insured Person* survives at least the number of days specified in the *Policy Schedule* as "survival period" following such *Diagnosis.*

d) This benefit is payable once during the *Policy Year*.

e) *Our* maximum liability under this Endorsement will be limited to the amount specified in the *Policy Schedule*:

We will not make any payment if:

a) Any claim with respect to any Critical Illness diagnosed or which manifested prior to *Policy Period* Start Date.

b) If any of the listed critical illnesses commence within number of days specified in the *Policy Schedule* as "waiting period" from the date of commencement of the first *Policy*/Certificate of insurance with Us. However, this exclusion shall not apply for the subsequent *Renewals.*

c) The *Insured Person* has already made a claim for the same Critical Illness.

Critical Illness means following illness as defined below only:

1) Cancer of Specified Severity

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

The following are excluded:

i) All tumours which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN 2 and CIN-3;

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

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

iv) All 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;

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

vi) Chronic lymphocytic leukaemia less than RAI stage 3;

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

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

ix) All tumours in the presence of HIV infection.

2) Myocardial Infarction (First Heart Attack- Of Specified Severity):

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

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

b. New characteristic electrocardiogram changes

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

The following are excluded:

a. Other acute Coronary Syndromes

b. Any type of angina pectoris

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

3) Open Chest CABG:

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

The following are excluded

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

4) Open Heart Replacement or Repair of Heart Valves:

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

5) Kidney Failure Requiring Regular Dialysis:

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

6) Stroke resulting in Permanent Symptoms:

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

II. The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic injury of the brain

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

7) Major Organ / Bone Marrow Transplantation:

I. 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 haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist *Medical Practitioner*.

II. The following are excluded:

a. Other stem-cell transplants

b. Where only islets of langerhans are transplanted

8) Permanent Paralysis of Limbs:

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

9) Multiple Sclerosis with Persisting Symptoms:

I. The unequivocal *Diagnosis* of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

a. investigations including typical MRI findings which unequivocally confirm the *Diagnosis* to be multiple sclerosis and

b. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

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

10) 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.

Special Condition:

We will pay for only one critical illness out of each of the three groups mentioned below during the *Policy Period*.

Group 1

1. Myocardial Infarction (First Heart Attack- Of Specified Severity

2. Open Chest CABG

3. Open Heart Replacement or Repair of Heart Valves

Group 2

1. Stroke resulting in Permanent Symptoms

2. Permanent Paralysis of Limbs

Group 3

1. Major Organ / Bone Marrow Transplantation

2. Kidney Failure Requiring Regular Dialysis

3. Cancer of specified severity

Optional Cover No. 24 Out Patient Dental Benefit

We will reimburse the cost of out Patient *Dental Treatment* from a dentist during the *Policy Year*. Exclusion # 3.3.6 under Section 3 "General Exclusions" stands deleted for all *Insured Person*s to this extent, provided that:

i) *We* will only pay for X-rays, extractions, amalgam or composite fillings, root canal treatments and prescribed drugs for the same, and

ii) *We* will not pay for any *Dental Treatment* that comprises cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, orthognathic surgery, jaw alignment or treatment for the temporomandibular (jaw) joint, or upper and lower jaw bone surgery and surgery related to the temporomandibular (jaw) unless necessitated by an acute traumatic injury or cancer, and

iii) *Our* maximum liability under this Endorsement will be limited to the sub-limit specified in the *Policy Schedule*.

iv) Every Claim will be subject to a *Deductible* specified in the *Policy Schedule*.

Optional Cover No. 25 Out-patient Treatment Costs

We will reimburse following *Outpatient Treatment* for the *Insured Person* during the *policy Year* -

1. Out Patient Consultations / procedures (except for *Dental Treatment*) from the registered *Medical Practitioner* / Specialist

2. Out Patient Diagnostic Tests

3. Pharmacy Medicines purchased from a pharmacy provided that such medicines have been prescribed by the treating registered *Medical Practitioner*.

Our maximum liability for reimbursement of expenses will be limited to the amount specified in the *Policy Schedule* during the entire *Policy Year*.

Every Claim will be subject to a *Deductible* specified in the *Policy Schedule*.

Optional Cover No. 26 Health Check-up Benefit

We will reimburse the reasonable costs of health check-up in respect of eligible *Insured Person*s who is 18 years or above, at any of the diagnostic centres including *Our* empanelled centres, provided that:

a) The Health Check-up is undertaken within the *Policy Year*, and

b) *Our* maximum liability under this Endorsement will be limited to the sub-limit specified in the *Policy Schedule.*

Optional Cover No. 27 External Aids and Appliances

If the attending *Medical Practitioner* recommends that the *Insured Person* requires External Aids and Appliances, then *We* will reimburse the costs of the same and Exclusion # 3.3.7 (b) & (c) stands deleted to the extent mentioned below for all *Insured Persons*.

a) For the purposes of this Endorsement, External Aids and Appliances means – Walking Aids ; BIPAP Machine; Commode; Continuous Positive Airway Pressure (CPAP) / Continuous Ambulatory Peritoneal Dialysis (CAPD) Equipments; Infusion Pump; Oxygen Cylinder; Pulseoxymeter; Spacer; Spirometer; SPO2 Probe; Nebulizer Kit; Steam Inhaler; Arm sling; Walkers; Crutches; Caps ; Stockings of any kind ; any artificial limb; Thermometer; Cervical Collar; Splint; Diabetic Foot Wear; Knee

Braces; Knee Immobilizer; Lumbo Sacral Belt; Nimbus Bed or Water Bed or Air Bed; Ambulance Collar; Ambulance Equipment; Microshield; Abdominal binder; hearing Aids; cochlear implants ; and spectacles / contact lenses.

b) Coverage is applicable if claim under Inpatient Hospitalisation - 2.1 is accepted by Us;

c) *Our* maximum liability under this Endorsement will be limited to the sub-limit specified in the *Policy Schedule*.

Optional Cover No. 28 Ayush Benefit

We will cover the *Medical Expenses* incurred on In-patient hospitalisation (2.1) up to the *Policy* Sum Insured for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy treatment taken in:

a) A government hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health.
b) Teaching hospitals of AYUSH colleges recognised by Central Council of Indian Medicine (CCIM) and Central Council of Homoeopathy (CCH).
c) AYUSH Hospitals

Note –
(1) Exclusion # 3.3.9 under Section 3 "General Exclusions" stands deleted for all Insured Persons covered under this *Policy*.
(2) *Our* maximum liability under this Endorsement will be limited to the sub-limit specified in the *Policy Schedule*.
(3) AYUSH Hospitals and AYUSH Day Care Centres should have either pre entry level certificate (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or State Level Certificate (or higher level of certificate) under National Quality Assurance Standards (NQAS), issued by National Health Systems Resources Centre (NHSRC).

Optional Cover No. 29 Recovery Benefit

In case the *Insured Person* is consecutively *Hospitalized* for the number of days or more as specified in the *Policy Schedule* for the treatment of any disease / *Illness* / *Injury* for which a valid claim is admissible under the *Policy*, *We* will pay to the *Insured Person* a fixed amount as specified in the *Policy Schedule*/ certificate of insurance . This benefit is payable only once during the *Policy Year*.

Optional Cover No. 30 Counselling

If *Insured Person* sustains any *Illness* / disease / *Injury* during the *Policy Year* for which a valid claim is admissible under the *Policy* and treating *Medical Practitioner* advises for counselling related to diet / lifestyle changes / psychological upliftment, then *We* will reimburse the counselling session cost upto the sub-limit specified in the *Policy Schedule* / certificate of insurance.

Optional Cover No. 31 Home Nursing allowance

We will reimburse the expenses up to the limits as stated in the *Policy Schedule* /certificate of insurance for the services of a registered *Qualified Nurse* attending to the *Insured Person* at the *Insured Person's* home immediately following his discharge from *Hospital*, provided that:

a) the *Medical Practitioner* treating the *Insured Person* recommends the provision of such care for medical reasons, and

b) *We* have accepted an inpatient Hospitalisation claim under coverage – 2.1, and

c) *Our* maximum liability will be limited to the sub-limit specified in the *Policy Schedule.*

d) *Qualified Nurse* should not be the *Insured Person* or his/her Immediate Family Member or anyone who is living in the same household as the *Insured Person*.

Optional Cover No. 32 Second Opinion

If the *Insured Person* is diagnosed with any specified critical *Illness* listed under Endorsement No. 23 or has to undergo any *Surgery* or *Surgical Procedure* during the *Policy Year* then at the *Insured Person's* request, *We* will arrange the second opinion from a *Medical Practitioner* selected by the *Insured Person* from *Our* Service Provider's panel. This coverage is subject to -

a. The Second Medical Opinion will be based only on the information and documentation provided by the *Insured Person* that will be shared with the *Medical Practitioner*.

b. This benefit can be availed only once by an *Insured Person* during a *Policy Year* for the same *Illness*.

c. *Insured Person* is free to choose whether or not to obtain the expert opinion, and if obtained then whether or not to act on it.

d. Under this Benefit, *We* are only providing the *Insured Person* with access to an E-opinion and *We* shall not be deemed to substitute the *Insured Person's* visit or consultation to an independent *Medical Practitioner*.

e. The opinion provided under this Benefit shall be limited to the covered Illnesses and not be valid for any medico legal purposes

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

Service Provider - means any person, clinic, organization or institution that has been empanelled with Us to provide Second Opinion.

Optional Cover No. 33 Top Up Cover

If the *Insured Person* suffers an *Illness* or *Accident* during the *Policy Year* requiring *Hospitalisation* on an inpatient basis or treatment defined as a Day Care Procedure, and cumulative Hospitalisation Expenses during the *Policy Year* exceeds the *Deductible* (Base Sum Insured) specified in the *Policy Schedule*, *We* will reimburse the portion of the *Medical Expenses* for such Hospitalisation or any subsequent Hospitalisation which exceeds the *Deductible* (Base Sum Insured). Claim shall be payable only if the treatment claimed is within the scope of the *Policy* subject to terms, conditions, exclusions and limitations. *We* shall in no case be liable to pay more than the *Sum Insured* specified in the *Policy Schedule*/ certificate of insurance.

II. Day Care Procedures

Sr. No	System	Procedure
1	ENT	Adenoidectomy with Grommet insertion
2		Adenoidectomy without Grommet insertion
3		Conchoplasty
4		Endolymphatic Sac Surgery for Meniere's Disease
5		Excision and destruction of lingual tonsils
6		Excision of Angioma Septum
7		Fenestration of the inner ear
8		Incision & Drainage of Pharyngeal Abscess
9		Incision and drainage - Hematoma Auricle
10		Incision and drainage of perichondritis
11		Labyrinthectomy for severe Vertigo
12		Myringoplasty
13		Myringotomy with Grommet Insertion
14		Ossiculoplasty
15		Palatoplasty
16		Pseudocyst of the Pinna - Excision
17		Reduction of fracture of Nasal Bone
18		Removal of Tympanic Drain under LA
19		Septoplasty
20		Stapedectomy under GA
21		Stapedectomy under LA
22		Stapedotomy
23		Thyroplasty Type I
24		Tonsillectomy with adenoidectomy
25		Tonsillectomy without adenoidectomy
26		Tracheoplasty
27		Tracheostomy
28		Transoral incision and drainage of a pharyngeal abscess
29		Turbinectomy
30		Turbinoplasty
31		Tympanoplasty
32		Uvulo Palato Pharyngo Plasty
33		Vestibular Nerve section

34		Vocal Cord lateralisation Procedure
35		Mastoidectomy
36	**Ophthalmology**	Biopsy of tear gland
37		Corrective surgery of blepharoptosis
38		Corrective surgery of the entropion and ectropion
39		Excision and destruction of the diseased tissue of the eyelid
40		Incision of diseased eyelids
41		Incision of tear glands
42		Incision of the cornea
43		Operation on the canthus and epicanthus
44		Operations for pterygium
45		Removal of foreign body from eye
46		Surgery for cataract
47		Treatment of retinal lesion
48		Other operation on the tear ducts
49		Other operations on the cornea
50		Enucleation of Eye Without Implant
51		Dacryocystorhinostomy for Various Lesions of Lacrimal Gland
52	**Oncology**	2D Radiotherapy
53		3D Brachytherapy
54		3D Conformal Radiotherapy
55		Adjuvant chemotherapy
56		Adjuvant Radiotherapy
57		Afterloading Catheter Brachytherapy
58		CCRT-Concurrent Chemo + RT
59		Conditioning Radiothearpy for BMT
60		Consolidation chemotherapy
61		Continuous Infusional Chemotherapy
62		Electron Therapy
63		External mould Brachytherapy
64		Extracorporeal Irradiation of Blood Products
65		Extracorporeal Irradiation to the Homologous Bone grafts
66		FSRT-Fractionated SRT
67		Gamma knife SRS
68		HBI-Hemibody Radiotherapy
69		HDR Brachytherapy
70		Helical Tomotherapy
71		IGRT- Image Guided Radiotherapy
72		Implant Brachytherapy
73		IMRT- DMLC
74		IMRT- Step & Shoot

75		Induction chemotherapy
76		Infusional Bisphosphonates
77		Infusional Chemotherapy
78		Infusional Targeted therapy
79		Interstitial Brachytherapy
80		Intracavity Brachytherapy
81		intraluminal Brachytherapy
82		Intravesical Brachytherapy
83		IV Push Chemotherapy
84		LDR Brachytherapy
85		Maintenance chemotherapy
86		Neoadjuvant chemotherapy
87		Neoadjuvant radiotherapy
88		Palliative chemotherapy
89		Palliative Radiotherapy
90		Radical chemotherapy
91		Radical Radiotherapy
92		Rotational Arc Therapy
93		SBRT-Stereotactic Body Radiotherapy
94		SC administration of Growth Factors
95		SRS-Stereotactic Radiosurgery
96		SRT-Stereotactic Arc Therapy
97		TBI- Total Body Radiotherapy
98		Tele gamma therapy
99		Telecesium Therapy
100		Telecobalt Therapy
101		Template Brachytherapy
102		TSET-Total Electron Skin Therapy
103		VMAT-Volumetric Modulated Arc Therapy
104		X-Knife SRS
105	**Plastic Surgery**	Breast reconstruction surgery after mastectomy
106		Construction skin pedicle flap
107		Fibro myocutaneous flap
108		Gluteal pressure ulcer-Excision
109		Muscle-skin graft duct fistula
110		Muscle-skin graft, leg
111		Myocutaneous flap
112		Plastic surgery to the floor of the mouth under GA
113		Removal cartilage graft
114		Removal of bone for graft
115		Sling operation for facial palsy

116		Split Skin Grafting under RA
117		Wolfe skin graft
118	**Urology**	Anderson hynes operation
119		AV fistula - wrist
120		Bladder Neck Incision
121		Cystoscopic Litholapaxy
122		Cystoscopy & Biopsy
123		Cystoscopy and "SLING" procedure.
124		Cystoscopy and removal of FB
125		Cystoscopy and removal of polyp
126		Drainage of prostate abscess
127		ESWL
128		Excision of urethral diverticulum
129		Excision of urethral prolapse
130		Frenular tear repair
131		Haemodialysis
132		injury prepuce- circumcision
133		Kidney endoscopy and biopsy
134		Meatotomy for meatal stenosis
135		Mega-ureter reconstruction
136		Orchiectomy
137		Paraphimosis surgery
138		Percutaneous nephrostomy
139		Removal of urethral Stone
140		Repair of penile torsion
141		Suprapubic cystostomy
142		Surgery filarial scrotum
143		Surgery for fournier's gangrene scrotum
144		Surgery for pelvi ureteric junction obstruction
145		Surgery for watering can perineum
146		TUNA- prostate
147		Ureter endoscopy and treatment
148		URSL with lithotripsy
149		URSL with stenting
150		Vesico ureteric reflux correction
151	**Neurology**	Diagnostic cerebral angiography
152		Entrapment neuropathy Release
153		Epidural steroid injection
154		Facial nerve physiotherapy
155		Glycerol rhizotomy
156		Intrathecal Baclofen therapy

157		Motor cortex stimulation
158		Muscle biopsy
159		Nerve biopsy
160		Percutaneous Cordotomy
161		Spinal cord stimulation
162		Stereotactic Radiosurgery
163		Ventriculoatrial shunt
164		VP shunt
165	**Thoracic Surgery**	Brochoscopic treatment of bleeding lesion
166		Brochoscopic treatment of fistula / stenting
167		Bronchoalveolar lavage & biopsy
168		Coronary Angiography
169		Direct Laryngoscopy with biopsy
170		EBUS + Biopsy
171		Endoscopic thoracic sympathectomy
172		Laser Ablation of Barrett's oesophagus
173		Pleurodesis
174		Thoracoscopy and Lung Biopsy
175		Thoracoscopy and pleural biopsy
176		Thoracoscopy assisted empyema drainage
177		Thoracoscopy ligation thoracic duct
178	**Gastroenterology**	Colonoscopy ,lesion removal
179		Colonoscopy stenting of stricture
180		Construction of gastrostomy tube
181		ERCP
182		ERCP + placement of biliary stents
183		ERCP and choledochoscopy
184		ERCP and papillotomy
185		ERCP and sphincterotomy
186		Esophageal stent placement
187		Esophagoscope and sclerosant injection
188		EUS + aspiration pancreatic cyst
189		EUS + coeliac node biopsy
190		EUS + submucosal resection
191		EUS and pancreatic pseudo cyst drainage
192		Pancreatic pseudocyst EUS & drainage
193		Percutaneous Endoscopic Gastrostomy
194		Proctosigmoidoscopy volvulus detorsion
195		RF ablation for barrett's Esophagus
196		Sigmoidoscopy
197		Small bowel endoscopy (therapeutic)

198	**General Surgery**	Abscess-Decompression
199		Axillary lymphadenectomy
200		Breast abscess I& D
201		Cervical lymphadenectomy
202		Circumcision for Trauma
203		Colonoscopy
204		Colostomy
205		colostomy closure
206		Drainage of pyelonephrosis / perinephric abscess
207		Epididymectomy
208		ERCP - Bile duct stone removal
209		ERCP - pancreatic duct stone removal
210		Esophageal Growth stent
211		Eversion of Sac
212		Excision of Cervical RIB
213		Excision of Ranula under GA
214		Feeding Gastrostomy
215		Feeding Jejunostomy
216		Fibroadenoma breast excision
217		Fissure in Ano- fissurectomy
218		Fissure in ano sphincterotomy
219		Glossectomy
220		Surgical treatment of Hydrocele
221		Ileostomy
222		Ileostomy closure
223		Incision and drainage of Abscess
224		Incision of a pilonidal sinus / abscess
225		Infected keloid excision
226		Infected lipoma excision
227		Infected sebaceous cyst
228		Inguinal lymphadenectomy
229		Intersphincteric abscess incision and drainage
230		Jaboulay's Procedure
231		Laparoscopic cardiomyotomy (Hellers)
232		Laparoscopic pyloromyotomy (Ramstedt)
233		Laparoscopicreduction of intussusception
234		Liver Abscess- catheter drainage
235		Lord's plication
236		Maximal anal dilatation
237		Meatoplasty
238		Microdochectomy breast

239		Oesophageal varices Sclerotherapy
240		Oesophagoscopy and biopsy of growth oesophagus
241		PAIR Procedure of Hydatid Cyst liver
242		Pancreatic Pseudocysts Endoscopic Drainage
243		Parastomal hernia
244		Perianal abscess I&D
245		Perianal hematoma Evacuation
246		Photodynamic therapy or esophageal tumour and Lung tumour
247		Piles
248		Pneumatic reduction of intussusception
249		Polypectomy colon
250		Prolapsed colostomy- Correction
251		Psoas Abscess Incision and Drainage
252		Resection of Salivary Gland
253		Rigid Oesophagoscopy for dilation of benign Strictures
254		Rigid Oesophagoscopy for FB removal
255		Rigid Oesophagoscopy for Plummer vinson syndrome
256		Scalp Suturing
257		Scrotoplasty
258		Sentinel node biopsy
259		Sentinel node biopsy malignant melanoma
260		Splenic abscesses Laparoscopic Drainage
261		Subcutaneous mastectomy
262		Submandibular salivary duct stone removal
263		Surgery for fracture Penis
264		Surgical treatment of varicocele
265		Suturing of lacerations
266		Testicular biopsy
267		Thyroid abscess Incision and Drainage
268		TIPS procedure for portal hypertension
269		Tru cut liver biopsy
270		UGI scopy and injection of adrenaline, sclerosants - bleeding ulcers
271		UGI scopy and Polypectomy oesophagus
272		UGI Scopy and Polypectomy stomach
273		Varicose veins legs - Injection sclerotherapy
274		Wound debridement and Cover
275		ZADEK's Nail bed excision
276	**Orthopedic**	Abscess knee joint drainage
277		Amputation follow-up surgery
278		Amputation of metacarpal bone
279		Arthroplasty

280		Arthroscopic Meniscle repiar
281		Arthroscopic Repair of ACL tear knee
282		Arthroscopic repair of PCL tear knee
283		Arthroscopic Shoulder surgery
284		Arthrotomy Hip joint
285		Aspiration of Hematoma
286		Biopsy elbow joint lining
287		Biopsy finger joint lining
288		Calcaneum spur hydrocort injection
289		Carpal tunnel release
290		Closed reduction and external fixation
291		Closed reduction of dislocation / Fracture
292		Decompress forearm space
293		Elbow arthroscopy
294		Excision of dupuytren's contracture
295		Excision of various lesions in Coccyx
296		Exploration of ankle joint
297		Fixation of knee joint
298		Ganglion wrist hyalase injection
299		Haemarthrosis knee- lavage
300		Implant removal minor
301		Incision of foot fascia
302		Intra articular steroid injection
303		Joint Aspiration - Diagnostic / Theraputic
304		K wire removal
305		Lengthening of hand tendon
306		Lengthening of thigh tendons
307		ORIF with K wire fixation- small bones
308		ORIF with plating- Small long bones
309		Partial removal of metatarsal
310		Partial removal of rib
311		POP application under GA
312		Release of midfoot joint
313		Release of thumb contracture
314		Removal of elbow bursa
315		Removal of fracture pins/ nails
316		Removal of knee cap bursa
317		Removal of tumor of arm/ elbow under RA/GA
318		Removal of wrist prosthesis
319		Remove/graft bone lesion
320		Repair of knee joint

321		Repair of ruptured tendon
322		Revision of neck muscle (Torticollis release)
323		Revision/Removal of Knee cap
324		Surgery of bunion
325		Syme's amputation
326		Tendon lengthening
327		Tendon shortening
328		Tendon transfer procedure
329		Tennis elbow release
330		Treatment fracture of radius & ulna
331		Treatment of clavicle dislocation
332		Treatment of foot dislocation
333		Treatment of fracture of ulna
334		Treatment of scapula fracture
335		Treatment of sesamoid bone fracture
336		Treatment of shoulder dislocation
337		Excision of any other bursitis
338	**Paediatric surgery**	Cystic hygroma - Injection treatment
339		Detorsion of torsion Testis
340		Dilatation of accidental caustic stricture oesophageal
341		EUA + biopsy multiple fistula in ano
342		Excision Juvenile polyps rectum
343		Excision of cervical teratoma
344		Excision of fistula-in-ano
345		Excision of soft tissue rhabdomyosarcoma
346		Excision Sigmoid Polyp
347		High Orchidectomy for testis tumours
348		Infantile Hypertrophic Pyloric Stenosis pyloromyotomy
349		lap.Abdominal exploration in cryptorchidism
350		Mediastinal lymph node biopsy
351		Orchidopexy for undescended testis
352		Presacral Teratomas Excision
353		Rectal prolapse (Delorme's procedure)
354		Rectal-Myomectomy
355		Removal of vesical stone
356		Sternomastoid Tenotomy
357		Vaginoplasty
358	**Gynaecology**	Bartholin Cyst excision
359		Conization
360		Cryocauterisation of Cervix
361		Dilatation and Curettage

362		Endometrial ablation
363		Hymenectomy (imperforate Hymen)
364		Hysteroscopic adhesiolysis
365		Hysteroscopic removal of myoma
366		Hysteroscopic resection of endometrial polyp
367		Hysteroscopic resection of fibroid
368		Hysteroscopic resection of septum
369		Laparoscopic cystectomy
370		Laparoscopic Myomectomy
371		Laparoscopic oophorectomy
372		Laparoscopic cyst excision
373		Large loop excision of the transformation zone
374		Loop Electrosurgical excision procedure
375		MIRENA insertion for therapeutic use
376		Pelvic floor repair(excluding Fistula repair)
377		Polypectomy
378		Repair of vagina (vaginal atresia)
379		Repair recto- vagina fistula
380		Surgery for Stress Urinary Incontinence
381		Thermal Cauterisation of Cervix
382		Transurethral Resection of Bladder Tumour
383		Ureterocoele repair - congenital internal
384		Uterine artery embolization
385		Vaginal mesh For POP
386		Vaginal wall cyst excision
387		Vulval cyst Excision
388		Vulval wart excision
389	**Dental**	FNAC
390		Oral biopsy in case of abnormal tissue presentation
391		Splinting of avulsed teeth
392		Suturing lacerated lip
393		Suturing oral mucosa

Note:

1. The above list is exhaustive. Any addition / deletion in this list shall be subject to IRDAI's approval.
2. The standard exclusions and waiting periods are applicable to all of the above Day Care Procedures.

III. Non-Medical Expenses

SR NO	ITEMS
LIST 1 – Non Payable Items	
1	BABY FOOD
2	BABY UTILITES 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	CONVENYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS

32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG / SHORT / HINGED)
46	KNEE IMMOBILIZER / SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES
53	SUGAR FREE TABLETS
54	CREAMS POWDERS LOTIONS (Toileteries are not payable,only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY
LIST II - ITEMS THAT ARE TO BE SUBSUMED INTO ROOM CHARGES	
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)

2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET / WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES
LIST III – ITEMS THAT ARE TO BE SUBSUMED INTO PROCEDURE CHARGES	
1	HAIR REMOVAL CREAM
2	DISPOSABLE RAZOR CHARGES (FOR SITE PREPARATIONS)

3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONIC SCALPEL, SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE
LIST IV – ITEMS THAT ARE TO BE SUBSUMED INTO COSTS OF TREATMENT	
1	ADMISSION / REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION / DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP / CAPD EQUIPMENTS
7	INFUSION PUMP – COST
8	HYDROGEN PEROXIDE \ SPIRIT \ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer & Strips

18	URINE BAG

IV. Illustrations of Benefits

i. Co-Payment

Scenario	Insured Person, 40 yr old, having Sum Insured of ₹ 7.5 Lac and Co Payment of 10%, then 10% co Payment will apply on each and every claim.
Sum Insured	₹ 7,50,000
Claim Payable Amount	₹ 3,00,000
Co Payment	10% i.e. 10% of ₹ 3,00,000 = ₹ 30,000
Amount Paid by Us	₹ 3,00,000 - ₹ 30,000 = ₹ 2,70,000

ii. Franchise

Scenario	Insured Person, 40 yr old, having Sum Insured of ₹ 1 Lac and Franchise of ₹ 20,000, then Franchise of ₹ 20,000 will apply on each and every claim.		
Sum Insured	₹ 1,00,000		
Claim Payable Amount	₹ 10,000	₹ 20,000	₹ 30,000
Franchise	₹ 20,000	₹ 20,000	₹ 20,000
Amount Paid by Us	NIL	NIL	₹ 30,000
Reason	Claim Amount is less than the Franchise Amount	Claim amount is equivalent to Franchise Amount	Claim amount is more than the Franchise amount

iii. Deductible

Scenario	Insured Person, 20 yr old, having Sum Insured of ₹ 5 Lac and deductible of ₹ 10,000 then deductible of ₹ 10,000 will apply on each and every claim.	
Sum Insured	₹ 5,00,000	
Claim Payable Amount	₹ 3,00,000 (For Dengue)	₹ 30,000 (For Accident)
Deductible	₹ 10,000	₹ 10,000
Amount Paid by Us	₹ 3,00,000 - ₹ 10,000 = ₹ 2,90,000	₹ 30,000 - ₹ 10,000 = ₹ 29,000

iv. Top Up

Scenario 1	**Description of Case**	Insured Person, 35 yr old, having a base Policy Sum Insured of ₹ 1 Lac and Top Up Sum Insured of ₹ 5 Lac. Let's understand how top up cover will work.
	Base Sum Insured	₹ 1,00,000
	Top Up Sum Insured	₹ 5,00,000
	When Top Up Cover will work?	Coverage will start once the insured person incurs a single claim or multiple claims that add up to more than the base sum insured amount (i.e the deductible amount for Top Up cover)
	1st Claim	₹ 40,000 (Accident Case)
	2nd Claim	₹ 60,000 (Jaundice Case)
	Sum Insured of Base Policy is exhausted (₹ 40,000 + ₹ 60,000 = ₹ 1,00,000)	
	3rd Claim	₹ 80,000 (Knee Surgery)
	Amount Paid by Us under Top Up Cover	₹ 80,000 (Since the base policy sum insured was exhausted, hence for 3rd claim, top up cover got triggered and claim is paid out as per terms and conditions.)

Scenario 2	**Description of Case**	Insured Person, 35 yr old, having a base Policy Sum Insured of ₹ 1 Lac with deductible of ₹ 10,000 and Top Up Sum Insured of ₹ 5 Lac. Let's understand how top up cover will work.		
	Base Sum Insured	₹ 1,00,000 with deductible of ₹ 10,000 on each and every claim		
	Top Up Sum Insured	₹ 5,00,000		
	When Top Up Cover will work?	Coverage will start once the insured person incurs a single claim or multiple claims that add up to more than the base sum insured amount (i.e the deductible amount for Top Up cover)		
	1st Claim (Malaria)	**Claim Amount**	**Deductible**	**Payable Amount**
		₹ 60,000	₹ 10,000	₹ 50,000
	2nd Claim (Accident)	**Claim Amount**	**Deductible**	**Payable Amount**
		₹ 80,000	₹ 10,000	₹ 70,000*
	* Amount Paid under Base Policy is ₹ 50,000 Amount Paid under Top Up Policy is ₹ 20,000			

V. Benefit Chart

CORE COVER			Description	Sum Insured Limits
1)	In-Patient Hospitalisation		Coverage for the medical expenses incurred for room rent, ICU, OT charges, Medical Practitioner Fees, Nursing charges, investigation charges, Medicines and cost of prosthetics implanted internally.	Covered upto SI Min SI – ₹ 50,000 Max SI – ₹ 1 Crore (Sublimit on OPD Treatment coverage for Vaccination (post bite treatment) is limited to ₹ 5000)
	a)	Pre-Hospitalisation	Coverage for medical expenses incurred during 30 days before the hospitalisation for same illness/injury	
	b)	Post Hospitalisation	Coverage for medical expenses incurred during 60 days after the hospitalisation for same illness/injury	
	c)	Day Care Treatment	Coverage for medical expenses incurred for a day care procedure requiring less than 24 hrs hospitalisation	
	d)	Domiciliary Hospitalisation	Coverage for medical expenses incurred for treatment taken at home on the advice of the attending Medical Practitioner	
	e)	Organ Donor	Coverage for Surgical Expenses incurred for donor in case of major organ transplant for harvesting the organ	
	f)	Vaccination (Post Bite treatment)	Coverage for medical expenses incurred for vaccination in case of post bite treatment In patient Vaccination-Covered up to the S.I Out Patient Vaccination-Covered up to ₹ 5K	
2)	Family Transportation Benefit		Coverage up to ₹ 50K per Policy period if Insured Person is admitted in a Hospital which is not in the city as reflected in the address in the Policy and no adult member of his immediate family is present in the hospital at his bedside for the duration of stay in the hospital.	Min SI – ₹ 1000 Max SI – ₹ 50,000

3)	Emergency Ambulance/ Repatriation of mortal remains (RMR)/ Funeral Expenses	Coverage up to ₹ 50K per hospitalisation for expenses incurred towards transportation of an insured person from place of incident to the hospital/ transportation of mortal remains, cremation expenses and coffin charges.	Min SI – ₹ 1000 per hospitalisation Max SI – ₹ 50,000 per hospitalisation
OPTIONAL COVER		**Description**	**Sum Insured Limits**
1)	Room , Boarding & Nursing Expense	Normal Room-Covered up to 5% of Sum Insured	Min – 0.5% of Principal SI Max – 5% of Principal SI
		ICU-Covered up to 10% of Sum Insured	Min – 1% of Principal SI Max – 10% of Principal SI
2)	Pre Hospitalisation (Extension / Deletion)	Deletion-Coverage can be deleted	Min / Max - NA
		Extension-Coverage can be extended up to 60 / 90 days	Min – 60 Days Max – 90 days
3)	Post Hospitalisation (Extension / Deletion)	Deletion-Coverage can be deleted	Min / Max - NA
		Extension-Coverage can be extended up to 90/120/150/180 days	Min – 90 Days Max – 180 days
4)	Domiciliary Treatment (Deletion / Sum Insured Restriction)	Deletion-Coverage can be deleted	Min / Max - NA
		SI Restriction -Coverage can be limited up to 100% of Sum Insured	Min – 1% of Principal SI Max – 99% of Principal SI
5)	Deletion of Organ Donor	Coverage can be deleted	Min / Max - NA
6)	Deletion of Family Transportation	Coverage can be deleted	Min / Max - NA
7)	Deletion of Emergency Ambulance/RMR/ Funeral Expenses	Coverage can be deleted	Min / Max - NA
8)	Waiting Period for Pre-Existing Conditions (Reduction / Deletion / Sum Insured Restrictions/ Co-Pay)	Reduction – 48 months waiting period reduced to 36/24/12 months. Min – 12 months / Max – 36 months	
		Deletion - 48 months waiting period can be deleted Min / Max - NA	
		Sum Insured Restrictions – Min - 1% of Principal Sum Insured Max - 99% of Principal Sum Insured	

		Co-Pay – upto 50% on each and every claim related to Pre Ex Conditions Min - 1% Max - 50%	
9)	waiting period for Named Ailments (Deletion / Reduction / Co-Pay)	Deletion – waiting period for named ailments can be deleted Min / Max - NA	
		Reduction – This waiting period is for 2 years and can be reduced to 1 year. Min – NA / Max – 1 Year	
		Co Pay - upto 50% on each and every claim related to Named Ailments Min - 1% Max - 50%	
10)	Waiting period for 30 days (Deletion / Co Pay)	Deletion - 30 days waiting period can be deleted Min / Max - NA	
		Co Pay - upto 50% on each and every claim within first 30 days from the policy inception. Min - 1% Max - 50%	
11)	External Congenital Disorder (Deletion / Sum Insured Restriction)	Deletion - The External Congenital disorder exclusion can be deleted Min / Max - NA	
		Sum Insured Restriction – Min - 1% of Principal Sum Insured Max - 99% of Principal Sum Insured	
12)	Medical Expenses / Illness / Surgeries / Procedures - Sub Limits	Coverage will be limited to the amount opted for the particular disease	Min – ₹10,000 Max – ₹2,50,000
13)	Franchise*	Options up to ₹ 1 Lac on each and every claim	Min – ₹500 Max – ₹1,00,000
14)	Co-Payment*	Options up to 50% on each and every claim	Min – 1% Max – 50%
15)	Deductible*	Options up to ₹ 20K on each and every claim	Min – ₹100 Max – ₹20,000
16)	Maternity Benefit (including pre/post-natal) with / without waiting period	Coverage for the medical expenses for maternity including pre & post-natal expenses	Min – ₹1000 Max – ₹1,00,000
		- Normal Delivery- Up to ₹ 1 Lac	
		- Caesarean Delivery- Up to ₹ 2 Lac	Min – ₹2000 Max – ₹2,00,000
		- Waiting Period- With 9 months or 2 years	Min – 9 months Max – 2 years
		- Without waiting period	Min / Max - NA

17)	New Born Cover from day 1	Coverage for New Born Baby from the date of birth upto the Parent's sum insured as opted at the inception of the Policy.	Min – NA Max – Sum Insured of Parent as opted at inception of the policy
18)	Hospital Daily Cash	Fixed cash amount for each day in hospital	
		Non-ICU- Up to ₹ 15K per day. Min - ₹ 100 per day / Max - ₹ 15,000 per day ICU = Per day amount is 2XNon ICU per day amount.	
		Deductible – upto 2 days Min – NIL / Max – 2 days	
		Maximum Days Limit (Policy Year)- Up to 30 days in a policy year Min – 5 days / Max – 30 days	
		Maximum days for each claim – up to 5 days Min – 1 day / Max – 5 days	
19)	Corporate Floater (including Critical Illness Floater)	Additional Sum Insured for the total group - Coverage Up to 100% of Sum Insured Minimum - ₹ 50,000 Maximum - ₹ 2 Crore	
20)	Critical Illness Benefit	Lump sum payment benefit, if the insured person is diagnosed as suffering from the covered Critical Illness for the first time. Covered up to ₹ 20 Lac on individual basis.	Min – ₹10,000 Max – ₹20,00,000
		Waiting Period – 30 /60 / 90 Days	Min – 30 Days / Max – 90 days
		Survival Period – NIL / 15/ 30 Days	Min – NIL / Max – 30 days
21)	Out Patient Dental Benefit	Coverage up to ₹ 25K for medical expenses towards dental treatment	Min – ₹500 Max – ₹25,000
		Deductible upto ₹ 1000/- per claim	Min – NIL Max – ₹1,000
		Sum Insured Basis – Individual/Family Floater	
22)	Out Patient Treatment Costs	Coverage up to ₹ 1 Lac for medical treatment taken on OPD basis	Min – ₹1000 Max – ₹1,00,000
		Deductible upto ₹ 1000/- per claim	Min – NIL Max – ₹1,000
23)	Health Check-Up Benefit	Coverage up to ₹ 25K Can be given to Insured Persons who is 18 years or above	Min – ₹ 500 Max – ₹25,000
24)	External Aids & appliances	Coverage for 1% of the Sum Insured or ₹ 25K, whichever is lower, towards costs of external aids and appliances for the insured person on the advice of attending medical practitioner	Min – ₹ 500 Max – ₹25,000

25)	AYUSH benefit	Coverage up to ₹ 1 Crore for medical expenses incurred for in-patient treatment taken under AYUSH mode of treatment in a Government hospital or institute recognised by Government	Min – ₹ 50,000 Max – ₹1,00,00,000
26)	Recovery Benefit	Up to ₹ 20K lump sum payment benefit if hospitalisation is continuous for more than 10 days. Applicable once in a policy year.	Min – ₹ 500 Max – ₹20,000
27)	Counselling	Benefit towards counselling (Diet/Lifestyle) up to a maximum of ₹ 15000/- or at actuals, whichever is lower	Min – ₹ 500 Max – ₹15,000
28)	Home Nursing Allowance	Coverage for home nursing expenses up to ₹ 3500/- per day & for a maximum of 30 days	Min – ₹ 100 per day Max – ₹3,500 per day
29)	Second Opinion	Coverage of 1 Consultation on diagnosis of a covered Critical Illness from our panelled doctor	
30)	Top Up Cover	Top Up cover over and above the Policy Sum Insured - Up to ₹ 20 Lac	Min – ₹ 25,000 Max – ₹20,00,000

*Any one of the cost sharing option can be opted by the Policyholder.