Edelweiss | GENERAL INSURANCE

POLICY WORDING

YOUR POLICY IN DETAIL

EDELWEISS GROUP HEALTH INSURANCE POLICY

POLICY WORDING

Great going! So many people will owe their good health to you.
You're the reason that others won't have to worry about health!

1. Preamble

Thanks for choosing Edelweiss General Insurance for your Group Health Policy! This policy is a contract between you and us, subject to all the terms, conditions, exclusions and full payment of the premium. We're sure that you've given us the correct details about the Insured Persons from your company, the address, etc., but it would be great if you can double-check and confirm that we've got it all right. Once again, we appreciate your trust!

2. Definitions

'Insurance' is a whole different language than 'English', and we're trying our best to bring the two closer. We can't avoid using technical terms, but what we can do is explain in simple words what they mean. Also, the words and phrases defined in the Insurance Act 1938 (as amended from time to time), IRDA Act 1999(as amended from time to time), the regulations notified by the Insurance Regulatory and Development Authority of India ("Authority") and circulars and guidelines issued by the Authority will keep their original meaning

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

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

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

3. Ambulancemeans a road vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.

4. 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.

5. Appendix means a document attached and marked as Appendix to this Policy.

6. Assistance Service Provider - (ASP) means such person or persons as may be appointed by the Company from time to time to provide Worldwide assistance to the Insured in terms of this Policy

7. Aggregate Deductible – It is a cost-sharing requirement under this policy that provides that the company will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the company. A deductible does not reduce the Sum Insured. The deductible is applicable in aggregate towards hospitalisation expenses incurred during the policy period by insured (individual policy) or insured family (in case of floater policy)

8. Associate medical expenses

Associate medical expenses: means proportionate deductions of the medical expenses when a higher room category is chosen than the category that is eligible as per terms and conditions of the policy. Proportionate deduction are not applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

Associate Medical expenses applicable to below categories/ Expenses incurred during Hospitalization-

a) Room Rent
b) Nursing charges for Hospitalization as an Inpatient excluding private nursing charges;
c) Medical Practitioners' fees,
d) Physiotherapy
e) Operation theatre charges;

This shall not apply to the below categories:
a) Cost of pharmacy and consumables, b. Cost of implants and medical devices, c) Cost of diagnostics, d) ICU Charges

9. AYUSH Treatment refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems

10. AYUSH Hospital:

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

a. Central or State Government AYUSH Hospital; or
b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;
ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative

11. AYUSH Day Care Centre:
AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:
i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

12. Break in Policy occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

13. 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.

14. Claim means a demand made in accordance with the terms and conditions of the Policy for payment of the specified Benefits in respect of the Insured Person.

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

16. Company (also referred as We/Us/EGIC) means Edelweiss General Insurance Company Limited.

17. Condition Precedent means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

18. Congenital anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
i. Internal congenital anomaly - Congenital anomaly which is not in the visible and accessible parts of the body.
ii. External congenital anomaly - Congenital anomaly which is in the visible and accessible parts of the body.

19. 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 claims amount. A Co-payment does not reduce the Sum Insured.

20. Day care centre means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner and must comply with all minimum criterion as under–
i. has qualified nursing staff under its employment;
ii. has qualified medical practitioner/s in charge;
iii. has fully equipped operation theatre of its own where surgical procedures are carried out;
iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

21. Day care treatment means medical treatment, and/or surgical procedure which is:
i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
ii. which would have otherwise required hospitalization of more than 24 hours.
Treatment normally taken on an out-patient basis is not included in the scope of this definition.

22. Deductible is a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies, which will apply before any benefits are payable by the insurer. This is to clarify that a deductible does not reduce the sum insured. Deductible shall be applicable per year, per life or per event as stated in schedule.

23. Dental Treatment is treatment carried out by dental practitioner related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and Surgery

24. Diagnostic Tests means investigations, such as X-Ray or blood tests, etc. to determine the cause of symptoms and/or medical conditions.

25. Domiciliary Hospitalization means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
ii. the patient takes treatment at home on account of non-availability of room in a hospital.

26. Diagnosis means pathological conclusion drawn by a registered medical practitioner, supported by acceptable Clinical, radiological, histological, histopathological and laboratory evidence wherever applicable.

27. Edelweiss Group means any company or organization which is directly or indirectly a holding of Edelweiss Group.

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

29. Endorsement means written evidence of change to the Policy including but not limited to increase or decrease in the period, extent and nature of the cover agreed by us in writing.

30. Family means the Primary Insured Person whose name forms the first Insured Person, his/her lawful spouse, child/children, dependent parents/ parent-in-laws and such other persons who are specifically mentioned in the Schedule to this Policy.

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

i. Insured Person; and/or
ii. Insured Person's legally married spouse (for as long as they continue to be married); and/or
iii. Insured Person's children who are upto 25 years of Age on the commencement of the Policy Period (maximum 3 children can be covered).
iv. Insured person's dependent parents and/or dependent parents in law.
v. Insured person's 2 dependent siblings max up to 25 years

32. 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.

33. Group means any association of persons who assemble together with a commonality of purpose or engaging in a common economic activity like employees of a company. Non employer employee groups , like employee welfare associations, holders of credit cards issued by specific company, customers of a particular business where insurance is offered as an add on benefit , borrowers of a bank, professional associations or societies may also be treated as group. However an association of persons coming together with a purpose of availing an insurance cover, will not be treated as a group for the purpose of this policy.

Hazardous or adventurous sports: adventure sports consist of activities having a high level of danger. These activities normally consist of speed, height, elevated levels of physical exertion, combined with highly specialized gear or spectacular stunts.

Racing on wheels, horseback, base jumping, biathlon, big game hunting, black water rafting, bmx stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/ pot holing, cave tubing, climbing/ trekking , cycle racing, cyclo cross, drag racing, endurance testing, hang gliding, harness racing, hell skiing, high diving , hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, luging, manual labour, marathon running, martial arts, micro - lighting, modern pentathlon, motor cycle racing, motor rallying, mountaineering/ rock climbing, parachuting, paragliding/ parapenting, piloting aircraft, polo, powerlifting, power boat racing, quad biking, river boarding, river boardings, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting, wrestling and activities of similar nature, mountaineering, winter sports, Skydiving, Scuba Diving, bungee jumping, skiing, ice hockey, ballooning, hand gliding, diving or under-water activity river rafting, canoeing involving rapid waters, polo, yachting or boating outside coastal waters

35. 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 Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:

i. has qualified nursing staff under its employment round the clock;
ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
iii. has qualified medical practitioner(s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

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

37. Health Service Provider means any person or entity providing healthcare and medical services in individual capacity, or through aggregation under "Health Service Provider Agreement", and shall include but not be limited to any clinic, diagnostic centre, pharmacy, associated facility for diagnosis, treatment or wellness services, and health care providers empanelled with Us/our network TPA to provide services specified under the Benefits (including Extensions) to the Insured Person on cashless /reimbursement basis for OPD Treatment or otherwise. The list of the Health Service Providers is available at our website (https://www.edelweissinsurance.com) and is subject to amendment from time to time

38. Healthcare Professional means a qualified/certified individual/counsellor/ medical practitioner who provides/creates awareness for preventive, curative, rehabilitative healthcare services

39. Health Service Provider Agreement means an agreement prescribing the terms and conditions of the services which may be rendered to the Insured Persons under this Policy, and may be entered into between a) Health Service Provider and Us; or b) Health Service Provider, a TPA and Us

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

i. Acute condition - Acute condition is a disease, illness 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

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

a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
b. it needs ongoing or long-term control or relief of symptoms
c. it requires rehabilitation for the patient or for the patient to be specially

trained to cope with it
d. it continues indefinitely
e. it recurs or is likely to recur

41. Indemnity/Indemnify means compensating the Policy Holder/Insured Person up to the extent of expenses incurred, on occurrence of an event which results in a financial loss and is covered as the subject matter of the insurance cover.

42. 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.

43. Inpatient care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

44. Insured Person (also referred as Insured) means person named as insured in the Policy Schedule.

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

46. 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.

47. Maternity expenses means:
i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
ii. Expenses towards lawful medical termination of pregnancy during the policy period.

48. 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

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

50. 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.

51. 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.

52. 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.

53. Migration means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer

54. Network Provider means hospitals or health care providers enlisted by an EGIC, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

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

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

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

58. Nominee means the person named in the proposal or schedule or who in included as nominee through as endorsement to whom the benefit under the policy is nominated by the insured person

59. Out-patient means the Insured Person who is not Hospitalized but who visits a clinic/ Hospital / or any associated facility like a consultation room for diagnosis or treatment (encompassing but not limited to consultation, diagnostic tests & services, medicines/drugs, vaccination, Medical Procedure, external medical aid). However, any Insured Person undergoing any specified Day Care Treatment will not be considered as an Out-patient.

60. 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.

61. Pre-Existing Disease means any condition, ailment or 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

62. Pre-hospitalization Medical Expenses means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:

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

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

63. Policy means these Policy terms and conditions and Appendices thereto, the Proposal Form, Policy Schedule, any applicable endorsements or extensions and Optional Cover (if applicable) attaching to or forming part thereof ,which form part of the Policy and shall be read together. The policy contains details of the extent of cover available to the insured, what is excluded from the cover and the terms and conditions on which the policy is issued to the insured.

64. Policyholder (also referred as You) means the person named in the Policy Schedule as the Policyholder.

65. Policy Period means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date as specified in the Policy Schedule.

66. Policy Period Start Date means the date on which the Policy commences, as specified in the Policy Schedule.

67. Policy Period End Date means the date on which the Policy expires, as specified in the Policy Schedule.

68. Policy Schedule means Schedule attached to and forming part of this Policy mentioning the details of the Insured/ Insured Persons, the Sum Insured in respect of each Insured Person (s), the period, Coverage and the limits to which benefits under the Policy are subject to.

69. Policy Year means a period of 12 consecutive months commencing from the Policy Period Start Date or any anniversary thereof.

70. Post-hospitalization Medical Expenses means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:

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

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

71. Proposal and Declaration Form means any initial or subsequent declaration made by the Insured/ Insured Person/s and is deemed to be attached and forming part of this Policy.

72. 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.

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

74. Reimbursement means settlement of claims paid directly by the Company directly to the Policyholder/Insured Person.

75. 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.

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

77. Sum Insured means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum , total and cumulative li ability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.

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

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

80. Total Sum Insured is the sum total of Sum Insured and the Sum Insured accrued under optional cover chosen by the Policyholder. It represents the Company's maximum, total and cumulative liability for in respect of the Insured Person for any and all Claims incurred during the Policy Year. If the Policy Period is more than 12 months, then it is clarified that the Sum Insured shall be applied separately for each Policy Year in the Policy Period.

81. 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.

3. Benefits (your policy is full of them!)

Of course, certain obvious conditions apply for all Benefits and Optional Covers:

1. The Policy covers basic charges for the medical treatment taken by the Insured Person during the Policy Period. It is meant for any Illness, Injury or conditions written in the sections below, if it happens to the insured Person during the Policy Period.
2. In the floater system, the maximum we can pay to all Insured Person for any and all Claims under the Policy during the Policy Year will not cross the Total Sum Insured for that policy.

3. Insured /Policy holder has an option to select this base policy with deductible or without deductible sum insured option.
4. Policy with option of buying a base policy with deductible option will work along with insured's current health insurance policy. Current health insurance policy could have been bought by insured individually or provided by his organisation. Also customer has option of paying the opted deductible amount himself/herself to trigger coverage under base policy.
5. If Insured/Policy holder opted for policy with this deductible option, then the coverage/ under this base policy is triggered only when the aggregate deductible limit get exhausted for a policy year.
6. Deductible limit is applicable only for base policy inbuilt coverages, it is not applicable for extension / add on coverages.
7. We are not liable for claims/claim amount falling within Aggregate Deductible limit as opted. For determining the amount of admissible claim, applicable taxes prevailing at the time of claim will be considered as part of claim amount and our aggregate liability , including any payment towards such taxes shall in no case exceed the sum Insured. In case where initial claimed amount or covered medical expenses were not expected to exceed the deductible but subsequently found to be exceeding the opted deductible, notification must be done immediately along with the copy of intimation made to other insurer.

3.1. Benefit 1: Hospitalization Costs

When your life and routine are turned upside-down.

1. If an Insured Person falls ill or suffers an injury during the Policy Period which needs hospitalization, as suggested by a doctor, then we will pay all the medical costs as below
   i. Room Rent cost for the amount given in the policy schedule.
   ii. Nursing charges for Hospitalization of an Inpatient but not any private nursing cost
   iii. Doctor's fees, but not any fees for standby services;
   iv. Physiotherapy, tests and diagnostics treatments for admission;
   v. Medicines as given by the treating doctor;
   vi. Intravenous fluids, blood transfusion, injection administration charges and / or consumables
   vii. Operation theatre cost;
   viii. The cost of prosthetics and other equipment, if implanted internally during Surgery;
   ix. Intensive Care Unit charges.

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2. If the actual room rate is more than the policy's per day limit, then all costs at the Hospital (including surcharges and taxes) except cost of medicines and consumables, will be paid in the same proportion of the difference between the approved room rate and the actual room rate.

3.2. Pre- hospitalization Medical Expenses and Post-hospitalization Medical Expenses

Taking care of the before and after too!

Pre-hospitalization Medical Expenses are covered: - For 30 days (or as given in the policy) just before the insured person is Hospitalized, but only if: this is for the same illness/injury for which hospitalization has happened, and the claim is approved under Inpatient Hospitalization Treatment/ Domiciliary Hospitalization.

Post-hospitalization Medical Expenses are covered: - For 60 days (or as given in the policy) just after the insured person is Hospitalized, but only if: this is for the same illness/injury for which hospitalization has happened, and the claim is approved under Inpatient Hospitalization Treatment/ Domiciliary Hospitalization.

3.3. Day Care Treatment

Some places, you shouldn't do an overnight – like the hospital.

We will pay the medical cost of Day Care Treatment which needed Surgical help, through Cashless coverage or Reimbursement, up to the Sum Insured, only if the period of treatment of the Insured Person in the Hospital/Day Care Centre is not more than 24 hours which would otherwise require an In-patient admission but not in the outpatient department and a doctor should certify that Day Care Treatment was necessary and the Medical Expenses incurred are Reasonable and Customary Charges that were Medically Necessary.

All the day care treatments are covered which falls under the definition of Day care treatment mentioned in the policy.

3.4. Domiciliary Hospitalization

There's no place like home, especially when you're ill.

We will pay the Insured Person, only through Reimbursement, up to the Sum Insured, for the Medical cost treatment at home, only in the situations given below:
   1. It happens during the Policy Year.
   2. The costs are absolutely necessary and within reasonable limits.
   3. This benefit covers pre and post home hospitalization cost as written in Clause 3.2 Benefit 2: Pre- hospitalization Medical Expenses and Post-hospitalization Medical Expenses.
   4. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or the patient takes treatment at home on account of non-availability of room in a hospital.

3.5. Benefit 5: AYUSH

Most people like exploring alternatives, and we respect that.

The Company will Indemnify the Policy Holder/Insured Person, the Reasonable and Customary Charges, up to the amount specified against this Benefit , for Medical Expenses incurred on the Insured Person's Medically Necessary and Medically Advised Inpatient Hospitalization during the Policy Period, on treatment taken under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems in AYUSH Hospitals or AYUSH Day Care Centre

4. What isn't covered? And what's covered only after a while?

4.1. Waiting periods

1. 30-Day waiting period -Code-Excl 03
   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.
2. Specified disease/ Procedure waiting Period- Code-Excl-02
   a) Expenses related to the treatment of the listed Conditions,

surgeries/treatments shall be excluded until the expiry period 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

2.1. 24 months waiting period

Any treatment related to Arthritis (if non-infective), Osteoarthritis and Osteoporosis, Gout, Rheumatism, Spinal Disorders(unless caused by accident), Joint Replacement Surgery (unless caused by accident), Arthroscopic Knee Surgeries/ACL Reconstruction/Meniscal and Ligament Repair

ii. Surgical treatments for Benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to Adenoidectomy, Mastoidectomy, Tonsillectomy and Tympanoplasty), Nasal Septum Deviation, Sinusitis and related disorders

iii. Benign Prostatic Hypertrophy

iv. Cataract

v. Dilatation and Curettage

vi. Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, Gastric and Duodenal Ulcers

vii. Surgery of Genito-urinary system unless necessitated by malignancy

viii. All types of Hernia & Hydrocele

ix. Hysterectomy, unless necessitated by malignancy

x. Internal tumours, skin tumours, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant

xi. Kidney Stone / Ureteric Stone / Lithotripsy / Gall Bladder Stone

xii. Myomectomy for fibroids

xiii. Varicose veins and varicose ulcers

2.2. 90 Days Waiting Period

i. Diabetes & Related complications include: Diabetic Retinopathy, Diabetic Nephropathy, Diabetic Foot / Wound, Diabetic Angiopathy, Diabetic Neuropathy, Hyper /Hypoglycaemic Shocks.

ii. Hypertension & Related complications include: Coronary Artery Disease, Cerebrovascular Accident, Hypertensive Nephropathy, Internal Bleed / Haemorrhages.

3. Pre-existing Disease 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 48 months of continuous coverage after the date of inception of the first policy with insurer.

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

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

d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

4.2. Sorry! We can't cover…

Unless the policy schedule or the terms and conditions actually say so, we can't cover any of the below conditions:

1. Any item or condition or treatment specified in List I (Items for which coverage is not available in the policy)

2. Any condition directly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.

3. Any medical expenses incurred on new-born /children below age of 91 days will not be covered under the Policy unless specifically opted and mentioned in the policy schedule.

4. Sterility and Infertility: Code- Excl-17

Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, sterilization

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

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

Unless specifically opted and as mentioned in policy schedule.

5. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.

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

7. Investigation & Evaluation- Code- Excl-04

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.

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

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

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

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

9. Any expenses incurred on Purchase of external prosthesis, corrective devices, external durable medical equipment wheelchairs, walkers, crutches, ambulatory devices, and oxygen concentrator for asthmatic condition, cost of

cochlear implants and related surgery.
10. Any treatment related to Sleep Apnoea

11. 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- Excl-13

12. Any treatment related to Acupressure, acupuncture, magnetic therapy.

13. Treatment of any external Congenital Anomaly, or Illness or defects or anomalies or treatment relating to external birth defects.

14. Cosmetic or Plastic Surgery -Code-Excl-08
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

15. Unproven Treatments: Code- Excl-16
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

16. Charges incurred in connection with cost of spectacles and contact lenses, hearing aids, routine eye and ear examinations

17. Refractive Error: Code- Exc1-15
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.
Not applicable if specifically opted and mentioned in policy schedule.

18. 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

19. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident.

20. Vaccination including Inoculation and Immunizations (except in case of post-bite treatment),

21. 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- Excl-14

22. All expenses related to donor treatment including surgery to remove organs from the donor, in case of transplant surgery.

23. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

24. Breach of law- Code- Excl-l0
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

25. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- Excl-12

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

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

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

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

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

28. Stem cell storage except for allogeneic bone marrow transplantation

29. Hazardous or Adventure sports - Code- Excl-09
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing , horse racing or scuba diving, hand gliding, sky diving, deep-sea diving

30. Taking part or is supposed to participate in a naval, military, air force operation or aviation in a professional or semi-professional nature
.
31. Any other exclusion as specified in the Policy Schedule.

32. 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

33. Excluded Providers: Code-Excl-11
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.

34. Maternity Expenses: Code – Excl-18
i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
Unless Specifically opted and mentioned in the policy schedule.

4.3 Exclusions applicable to Assistance Services In India:-
We/ Service provider will not provide services in the following instances:
• Travel undertaken specifically for securing medical treatment
• Injuries resulting from participation in acts of war or insurrection Commission of an unlawful act(s)
• Injuries incurred while participating in criminal activity or as result of the unlawful consumption of drugs.
• Attempt at suicide.
• Incidents involving the use of drugs unless prescribed by a physician.
• Eligible insured person is transferred, or is to be transferred, from one medical facility to another of similar capabilities which provides a similar level of care.
• We/ Service provider will not evacuate or repatriate an Eligible insured person, if the Eligible insured person has:-
(i) no medical authorization; (ii) mild lesions, simple injuries such as sprains, simple fractures, or mild sicknesses which can be treated by local doctors and do not prevent the Eligible insured person from continuing the trip and returning home; (iii) if the Eligible insured person is pregnant and beyond the end of the 28th week and with respect to the child born from the pregnancy, We/ Service provider will not evacuate or repatriate a child born while the Eligible insured person was traveling beyond the 28th week;
• We/ Service provider will not provide services for trips exceeding 90 days from legal residence

5. Claiming shouldn't make one feel ill again!
We've kept claims as simple and quick as possible.
5.1. A few terms and conditions for all claims:
1. The Condition Precedent Clause has to be valid .
2. Only the insured person is covered, and only for the Benefits mentioned in the policy.
3. The policy should be valid, premiums paid on time, and all terms and conditions, waiting periods and exclusions fulfilled.
4. All the documents should be sent to us on time. We may call for more documents if required.

5.2. Things to remember while claiming.
1. The insured person should check our list of cashless hospitals before asking for a pre-authorization.
2. Fill and give us a Claim Form.
3. Assist and not hinder or prevent Us or any of Our representative from taking any reasonable steps in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.
4. The Company's Medical Practitioner and representatives shall be given access and co-operation to inspect the Insured Person's medical and Hospitalization records and to investigate the facts and examine the Insured Person and shall be provided with complete necessary documentation and information to establish company's/ its liability for the Claim, its circumstances and its quantum
5. If any of the terms and conditions of the policy is not being followed, we will not be able to pay a claim.

5.3. The Group Administrator is our contact point.
The Group administrator will be a bridge between us and the insured person. He/she will have to:
i. Give us the detailed list of Insured Persons for making ID cards.
ii. Distribute the ID we send him/her.
iii Guide the Insured Person to take the cashless facility.

5.4. How to claim (so easy, you can do it when you're ill!)
Let us know at least 48 hours before planned hospitalization. In case of an emergency, do let us know within 24 hours of the insured person being admitted, or before discharge, whichever is earlier.
Of course, we realise that in medical emergencies, it's not always possible to stick to timelines, so don't stress too much about this point. But either way, do make sure the insured person lets us know at the soonest.
While intimating the claim following details to be furnished:
a) The Policy Number/TPA Health ID card number
b) Name of the Policyholder/ employee
c) Patient Name
d) Nature of Illness or Injury and the treatment/Surgery taken place
e) Hospital Name and Address in case of hospitalisation
f) Date of admission and expected date of discharge.
g) Other information/ claim related documents as specified that may be relevant to the Illness / Injury / Hospitalization.

I. Cashless Facility
In order to use the Cashless Facility at one of our network hospitals, the insured person has to:
1. Deposit the Pre-authorization Form: The insured person can download it from our website or ask the Network Provider. This form has to be filled and signed by the insured person and the treating doctor, then uploaded by the Network Provider for our approval. Once we OK it, Cashless Facility can be used. The insured person will definitely need to show the Network Provider, the Health Card we've given him/her.

i. For Planned Treatment: Get in touch with us to begin Cashless Facility for planned treatment at least 48 hours before the treatment. Once the request has been agreed on, the treatment must take place within 10 days of the date of applying at a Network Provider.

ii. In Emergencies: If the Insured Person has been hospitalized in an emergency, please contact us within 24 hours of the hospitalization or before discharge, whichever is earlier.

iii. Identification documents needed: Our Health Card, and Valid Photo ID like a Voter ID, Driving License, Passport, PAN Card, Aadhaar Card or any other ID proof.

i. Our Approval: We will confirm in writing whether we agree to your request of Cashless Facility for the insured person's hospitalization.

ii. Please note that if the request is rejected, no cashless coverage is given. The insured person can go ahead with the treatment, pay the hospital bills and claim for reimbursement.

iii. We may change the list of Network Providers or change the amount of Cashless Facilities that can be given at any Network Provider.

II. Reimbursement Facility

i. 1. It is agreed and understood that in all cases where intimation of a Claim has been provided under Reimbursement Facility and/or the Company specifically states that a particular coverage is payable only under Reimbursement Facility.

2. In case of death of the Policyholder, we will pay the nominee and in case there is no nominee, to the legal heirs of the Policyholder. This will be considered the full and final payment under the policy.

III. Day care claim process:

This shall be payable subject to the following:

1. We shall not be liable to make any payment under this, if the Day Care Treatment was taken prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Document (unless due to an Accident).

2. If we have admitted a Claim under this, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Base Benefit directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this cover is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

IV. OPD claim Procedure, Documents, Administration applicable

Upon the discovery or happening of any Illness or Injury that may give rise to a Claim under this Policy, then as a Condition Precedent to Our liability under the Policy, the Insured Person shall undertake the following:

1. Claims Procedure

A. Cashless Settlement

Cashless treatment is only available at specific Network Providers/ Health Service Providers on best efforts basis. The list of Network Providers/ Health Service Providers is available at www.edelweissinsurance.com. In order to avail of Cashless facility, the following procedure must be followed:

Authorization Prior to taking treatment and/or incurring Medical Expenses at a Network / Health Service Provider, the Insured person must contact the company or the TPA through online mode or otherwise, accompanied with full particulars namely,

1. Policy Number/ TPA health card number
2. Name of the Insured Patient
3. Relationship with the employee
4. Nature of Illness or Injury;
5. Name and Address of the Medical Practitioner/ medical facility / Health Service Provider
6. Any other information that may be relevant to the Illness/ Injury.

To avail of Cashless facility, the Insured Person/claimant is required to produce the health card (physical or online), as provided with this Policy, subject to the terms and conditions for the usage of the said health card. The request shall be considered after having obtained accurate and complete information for the Illness or Injury, where applicable, for which Cashless facility is sought and We will confirm the request digitally or in writing.

In case the services availed exceed the eligibility, the difference will have to be paid directly to the Hospital/Network Provider/Health Service Provider by the Insured person/claimant.

B. For Reimbursement Settlement

(i) For Outpatient cover, Reimbursement of medically necessary expenses incurred on outpatient basis would be done in cases where the member visits a OPD provider. In case, Insured person visits a Healthcare Service provider, reimbursement of reasonable and necessary charges may be done on the basis of actual payment made or limited to the expenses consistent with the industry prevailing charges or as per agreed charges with network provider, whichever is lower.

(ii) The Insured Person shall give notice in writing at the Company's address with particulars as below:

1) Policy number / TPA health card number
2) Name of the Insured Patient;
3) Relationship with the Insured Person;
4) Nature of Illness or Injury;
5) Name and address of the attending Medical Practitioner and the medical facility;
6) Any other information that may be relevant to the Illness/ Injury.

The procedure for lodging the Claim shall be as under:

Upon the happening of any event giving rise or likely to give rise to a Claim under this policy:

a) The Insured Person shall give immediate notice thereof in writing to us.

b) The Insured Person shall submit the claim documents to Us, within 30 days from the date of completion of treatment, a detailed statement in writing as per the claim form together with bills, vouchers and any other material particular, relevant to the making of such Claim.

c) The Insured Person shall tender to Us all reasonable information, assistance and proofs in connection with any Claim hereunder

d) Any other document as required by Us or the TPA to process the Claim or Our obligation to make any payment for it.

The Insured shall be required to furnish the all documents required for or in support of a Claim. The right to waive off as an exception or accept the document in any other format than specified below remains with Us.

Basis of assessment of OPD claims:

a) The benefit payable shall be such expenses reasonably and necessarily incurred by or on behalf of the Insured Person under the following categories but not exceeding the Sum Insured in respect of such Insured Person as specified in Part I of the Policy. Heads of compensation payable:

(i) Consultation Expenses,
(ii) Procedure Expenses,
(iii) Diagnostics Expenses,
(iv) Pharmacy Expenses
(v) Minor Procedure Expenses
(vi) Others

b) Claim documents:

The Insured shall be required to furnish the following for or in support of a Claim. The right to waive off as an exception or accept the document in any other format than specified below remains with Us.

(i) Duly completed Outpatient claim form signed by the Insured person along with Aadhaar and PAN copy
(ii) Original bills, receipts and copy of prescription, clinical notes from the Medical Practitioner / medical facility
(iii) Original bills from pharmacy supported by proper prescription
(iv) Copy of investigation test reports and original bills, payment receipts
(v) Account details for Electronic Fund Transfer (EFT mandate form and cancelled cheque)
(vi) Any other document as required by Us or the TPA to investigate the Claim or Our obligation to make any payment for it

Wellness and preventive care :-

Claim Procedure applicable to Wellness and preventive care

Cashless Facility is available with specific Network Providers/ Service Providers only. The updated list of our Network Providers/ Service Providers and availability of cashless facility can be accessed on our website www.edelweissinsuarnce.com. In order to avail cashless facility, the following procedure must be followed:

The Insured Person/ group administrator/claimant should notify Us before the usage of the any Benefits under this Section by writing a mail to support@edelweissinsurance.com. To avail Cashless facility, the Insured Person/claimant may be required to produce the health card (physical or online) or access through the web portal by creating self-login on our in-house/ service providers'/ network providers' digital platform, as provided with this Policy Schedule. The said access, however, shall be subject to the terms and conditions for the usage of the said health card/web access.

In case the services availed of exceed the eligibility under the policy, the corresponding difference amount will be payable to the Service Provider/ Network Provider by the Insured person/claimant directly.

VI. Personal Accident Cover

Claim Intimation

In the event of any claim, intimation to be sent to EGIC as soon as reasonably possible but not later than 15 days from the date of actual loss, in order for us to provide prompt and effective assistance.

The following information should be provided while intimating the claim:

- Contact numbers of caller intimating the claim,
- Policy Number,
- Name of Injured person,
- Date & Time of Loss,
- Location of accident,
- Nature of accident,
- Nature of injury,
- Place & contact details where insured person may be visited (home/ hospital)

Following documents required for claims processing

1) Accidental Death

1. Duly filled and signed claim form
2. Original Death Certificate (issued by the office of Registrar of Births and Deaths)
3. Copy of First Information Report (FIR) / Panchnama / Inquest report duly attested by the concerned police station
4. Copy of Medico Legal Certificate duly attested by the concerned hospital.
5. Copy of Post Mortem report wherever applicable (provided Post Mortem was conducted)
6. Newspaper cuttings / news articles covering the accident (if available)
7. Any other document required for claim processing

2&3) Permanent Total Disability and Permanent Partial Disability

1. Duly filled and signed claim form
2. Hospital Discharge Summary (in original) / self-attested copies if the originals are submitted with another insurer
3. Medical consultations and investigations done from outside the hospital.
4. Original certificate of Disability issued by a Medical Board duly constituted by the Central and the State Government.
5. Copy of First Information Report (FIR) / Panchnama / Inquest report duly attested by the concerned police station
6. Copy of Medico Legal Certificate duly attested by the concerned hospital.
7. Newspaper cuttings / news articles covering the accident (if available)
8. Any other document required for claim processing

4) Temporary Total Disability

1. Duly filled and signed claim form
2. Hospital Discharge Summary (in original) / self-attested copies if the originals are submitted with another insurer.
3. Copy of First Information Report (FIR) / Panchnama / Inquest report duly attested by the concerned police station
4. Copy of Medico Legal Certificate duly attested by the concerned hospital.
5. Attendance record of employer / Certificate of employer confirming period of absence
6. Latest salary certificate with grade and designation
7. Newspaper cuttings / news articles covering the accident (if available)
8. Any other document required for claim processing

5.5. Documents to be submitted for filing a valid Claim!

We'll need the following documents within 15 days of the insured person's discharge from hospital (in the case of pre-hospitalization and hospitalization costs) or within 15 days of finishing all treatment (in the case of post-hospitalization costs). For Cashless claims, we should get the following documents from the Network Provider immediately after the insured person's discharge from hospital.

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Suggested Check List for making a Claim

Our TPA, whose name you will find in the Policy Schedule, handles the claim on our behalf. The insured person will have to give the TPA the following documents within 15 days either of discharge, or of finishing treatment (in case of post-hospitalization).

- Correctly filled in claim form(s) and photo ID proof
- Original bills, receipts, discharge /cards from the hospital/doctor
- Original bills from chemist shops along with the prescription
- Original test reports and payment receipts
- MLC/FIR report/Post mortem report if needed
- Doctor's referral letter asking for hospitalisation
- Original bills and receipts for the ambulance charges and doctor's fees
- Prescriptions for claiming benefits for external mobility help.
- Account details for Electronic Fund Transfer (EFT mandate form and cancelled cheque)
- Any other document that the TPA or we may request for.

5.6. Breaking it down: what exactly does hospitalization cost cover?

Within the sum insured, here's what's covered under 'hospitalization cost'.

(i) Room and Boarding costs at the Hospital/ Nursing Home;

(ii) Nursing costs;

(iii) Fee paid to Doctor, Surgeon, Anaesthetics, Consultants and Specialist

(iv) Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & drugs, Diagnostic Materials and X - Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & Cost of Organs and similar costs; and /or

(v) Pre -Hospitalisation and Post -Hospitalisation costs, wherever needed.

Settlement/Rejection of Claim – We'll pay every approved claim within 30 days of getting the last documents we asked for. The payment will happen through Electronic Fund Transfer. In case we delay, make us pay for it! We'll have to pay interest from the date of receiving the last documents, to the actual date of payment, at a rate that's 2% above the bank rate.

Interest will be as per IRDAI (Protection of Policyholders' Interests) Regulations, 2017 or any changes done from time to time.

In India, the claims will be handled by us and or an approved Third Party Administrator (TPA) while

5.7. Some really important things to note (they're like the ABC of this policy)

1. This Policy only covers medical treatment taken fully in India, unless mentioned otherwise. All payments will be made in Indian Rupees.

2. Once the Total Sum Insured is used up, the insured person is no longer covered, even if the policy term is still on.

3. We'll pay every approved claim within 30 days of getting the last documents we asked for, according to Regulation 27 of IRDAI (Health Insurance) Regulations, 2016. The payment will happen through Electronic Fund Transfer. In case we delay, make us pay for it! We'll have to pay interest from the date of receiving the last documents, to the actual date of payment, at a rate that's 2% above the bank rate. However, where a claim needs investigation, we will begin and end the checking quickly, within 30 days from the date of getting the last necessary documents. In such cases, we will settle the claim within 45 days from the date of getting the last documents. In case of any delay beyond 45 days, we will pay interest at a rate that's 2% above the bank rate from the date of getting the last document to the actual date of payment of claim.

4. In case of reimbursement claims claim payable amount shall be paid directly to insured person/ nominee/ Group policy Holder/ Proposer

Claim Submission

In event of any claim documents to be submitted at

- To Our Network TPA/ Assistance Service Provider Address and contact details will be available on www.edelweissinsurance.com
- Our Communication address: :- Edelweiss General Insurance Company Limited, 5th Floor, Tower 3 , B wing Kohinoor City Mall, Kohinoor City, Kirol Road, Kurla west Mumbai -400 070.

6. Toll Free No.: 180012000

Timing is everything!

The insured person should make sure that the policy period is still on, and renew the policy on time to enjoy non-stop cover.

7. Standard Terms and Conditions

7.1. Changes in the Policy

1. This policy can only be changed if the change is given in writing, checked by a written endorsement signed and stamped by us.
2. When a new person is added to this policy either through endorsement or during renewal, the Pre-existing Disease clause, exclusions and waiting periods will apply as his/her first year with us.

7.2. Arbitration clause: the peacemakers

We hope we never disagree with you, but if that ever happens, arbitration steps in. Either we will have to agree on a common arbitrator within 30 days, or if we can't, each of us appoints one arbitrator. These two arbitrators will appoint a third, and together they will take a decision, working under the provisions of The Arbitration and Conciliation Act, 1996.

Of course, no arbitration will be needed if we haven't accepted the liability in the first place.

It is declared that it will be a condition before any right of action on this policy that award by such arbitrator/ arbitrators of the amount of the loss or damage will be first received.

7.3. Know the terms of Cancellation/Termination

i. The policyholder may cancel this policy by giving 1Sdays'written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Length of time Policy in force	Refund of Premium (% of Annual Premium)
Up to 1 Month	75%
Up to 3 Months	50%
Up to 6 Months	25%
Up to 9 Months	NIL

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.

iii) What about the worst case: death of the Policyholder?

a) Where the policy covers only the Policyholder, it will come to an end from the time of his/her passing away. The premium will be refunded for the unexpired period of this at pro-rata basis if there is no claim.

b)Where the policy covers other insured persons, it will continue till the end of the policy period for the other insured persons. If the other Insured Person wish to continue with us after the policy period, and we hope they do, we will renew the policy if a policyholder is added as below:

1) We get a written notice about this before the Policy Period End Date; and
2) The new Policyholder should be at least 18 years old, and should be eligible under the various clauses

7.4. 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.

7.5. Disclaimer

If we don't pass a claim, and no legal action is taken against us within 12 months, the claim will be considered finished and cannot be recovered.

7.6. Disclosure to Information Norm:

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

7.7. Electronic Transactions: you've got mail!

It's the digital age, so it's important to state here that all electronic exchanges and transactions will be considered valid and legally binding. These include: the Internet, World Wide Web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combinations) or by electronic, computer, automated machines or through other means of telecommunication.

7.8. Entry Age: are you old enough (or young enough)?

Minimum/Maximum Age of Entry for Adults – 18 years / no limit on maximum entry age

Dependent children – from the date of birth to up to 25 years, as given in the schedule.

Dependent siblings – up to 25 years as given in the schedule

7.9. Fraud

Fraud

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

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

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

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent

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

7.10. Free Look Period:

Free look period

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

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

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

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

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

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

7.11. Group Discount: the more the merrier!

A group discount will be given only on the Basic premium and not on the Add-on covers. The discount is not cumulative. The applicable scale of the

discount is to be reckoned in accordance with the group size at the inception of the policy.

No. of Persons Insured under the Group Policy	Group Discounts %
Up to 25 persons	0%
26 Persons – 1,000 Persons	1% to 30%
1,001 Persons – 5,000 Persons	31% to 40%
Above 5,000 Persons	41% to 50%

7.12. Limit of the Liability: don't wait too long

Any claim that is made 12 months after the event of the claim, will not be accepted, unless we get proof that the delay in reporting was for reasons beyond your control.

7.13. Material Change

If there is any change that affects the risk we're covering, at any time during the policy period, please let us know as soon as possible. We may change the scope of cover and / or the premium paid or payable accordingly.

7.14. 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 aslong 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.

7.15. Notices: how we should communicate, and how we shouldn't.

Any notice, direction or instruction regarding the policy will only be in writing and delivered by hand, post, or fax to:

1. You/the insured person at the address given in the Policy Schedule or at the changed address (of which we must get a written notice).
2. Us, at our corporate office address:- Edelweiss General Insurance Company Limited, 5th Floor, Tower 3 , B wing Kohinoor City Mall, Kohinoor City, Kirol Road, Kurla west Mumbai -400070.
Toll Free No.: 180012000.
3. No insurance agents, brokers or others will receive any notice on our behalf.
4. We may send you/the insured person other information over email, or we may even call from time to time.

7.16. No Constructive Notice

Unless a detail or some information about the Policyholder/insured person is mentioned in the Proposal Form, or given to us in writing, we won't be able to accept it.

7.17. 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.

7.18. Notice of charge etc.

Unless required under any law of the land, the company shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this policy but the receipt of the Insured or his legal personal representative shall in all cases be an effectual discharge to the company.

7.19. A small matter: what if the insured person is a minor?

If the insured person is less than 18 years old, the legal guardian will be totally responsible for checking all the terms and conditions of the policy on behalf of the minor. (In case it's a floater policy, and none of the insured adults are surviving.)

7.20. Terms and Conditions are really important!

Our liability under this policy depends on you/the insured person checking and following the terms and conditions (including the payment of premiums by due dates and following the rules on all claims).

7.21. Overriding effect of Policy Schedule

In case of any inconsistency in the terms and conditions of this policy, the information in the Policy Schedule will be considered.

7.22. Policy Eligibility Criteria

Policy Type	Individual	Floater
Relationship covered	Self Spouse Dependent Children Parent/s Parent(s)-in-law Siblings	Self Spouse Dependent Children Parent/s Parent(s)-in-law
Minimum Age	0 days (Proposer 18 years)	0 days No upper Limit
Maximum Age	No upper Limit	No
Cover ceasing age	No	No

7.23. Premium Loading/Discounts: saving or spending extra?
At the time of renewal, if claims in the past year have been lesser than expected, a Low Claim Ratio Discount will be given on the total premium, depending upon the incurred: claims ratio for the entire group insured under the policy.
The total premium to be paid at renewal of the group policy will be loaded (increased) depending on the incurred: claims ratio for the entire group insured under the policy.

7.24. Policy Disputes: the long arm of the law
If there ever is any dispute between us that needs to be settled in a court of law, it will be judged by Indian courts and in accordance with Indian law. All such matters will be under the jurisdiction of the High Court of Mumbai.

7.25. 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 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

7.26. Portability!
The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on Portability, kindly refer the link .....
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987&flag=1

7.27. Maintaining Records: just in case you forget
The insured person are requested to keep an exact record of all documents and allow us to check them.

7.28. Special Provisions
Any special provisions entered later and endorsed in the policy (or separately) will be considered to be a part of this policy and will come into effect accordingly.

7.29. Withdrawal of Policy
i) In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
ii) Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

7.30. Increase of Sum insured: more is always better
You can increase the sum insured at the time of renewal, or even during the policy period with our approval.

7.31. Customer Services and Grievances Redressal:
The Company has developed proper procedures and effective mechanism to address of complaints by the customers. The Company is committed to comply with the Regulations, standards which have been set forth in the Regulations, Circulars issued by the Authority (IRDAI) from time to time in this regard.

In case of any grievance the insured person may contact the company through
Website: "http://www.edelweissinsurance.com",
Link: https://www.edelweissinsurance.com/documents/20143/1081704/Service+Parameters+and+Grievance+Mechanism20-03-2020.pdf/6492436c-5e64-c837-b9de-8de5e135ec28
Toll free: 1800120216216 / 180012000
E-mail: grievance@edelweissinsurance.com"
Courier: 5th Floor, Tower 3, Kohinoor City Mall, Kohinoor City, Kirol Road, Kurla (West), Mumbai 400 070:
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 1800120216216 and grievance@edelweissinsurance.com" grievance@edelweissinsurance.com.
For updated details of grievance officer, kindly refer the link.....
https://www.edelweissinsurance.com/documents/20143/1081704/GRO+DETAILS+05-06-2020.pdf/d1c5e1b6-0acc-2e05-f14b-3c5cca0c0797?t=1591374023226
If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

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

GRIEVANCE MECHANISM

Any Grievance of the Complainant sent in a written communication to the Company at any of the touch points as mentioned, shall be addressed within 14 days of the receipt of the complaint.

Escalation Matrix:

Step 1
Call: 1800 12000
Email: support@edelweissinsurance.com

Step 2
If the response is not as per Complainant's expectations he/she may contact the Grievance Cell at the below touchpoints:
- Email: grievance@edelweissinsurance.com
- Address: Edelweiss General Insurance Company Limited, Kohinoor City Mall, Tower 3, Kirol Road, Kurla West, Mumbai 400070

Step 3
If the response is not as per Complainant's expectations he/she may contact the Company's Grievance Redressal Officer at:
- Email: grievanceofficer@edelweissinsurance.com
- Address: Edelweiss General Insurance Company Limited, Kohinoor City Mall, Tower 3, Kirol Road, Kurla West, Mumbai 400070

Step 4
If the Complainant is not still not satisfied with the response or does not receive a response from the Company within 14 days, the Complainant may approach the Grievance Cell of the IRDAI on the following contact details:
- IRDAI Grievance Call Centre (IGCC) TOLL FREE NO: 155255; Email ID: complaints@irda.gov.in
- Register online at: http://www.igms.irda.gov.in/
- Address for communication for complaints by fax/paper: Consumer Affairs Department, Insurance Regulatory and Development Authority of India Sy. No. 115/1, Financial District, Nanakramguda, Gachibowli Hyderabad - 500032

Step 5
If the complaint/grievance has still not been resolved, the Complainant may approach the Office of the Insurance Ombudsman established by the Central Government of India as per Rule 13 and Rule 14 of the Insurance Ombudsman Rules, 2017 ('Ombudsman Rules').
The following complaints can be lodged with the Insurance Ombudsman:
1. Any partial or total repudiation of claims by an insurer;
2. Any dispute in regard to premium paid or payable in terms of the policy;
3. Any dispute on the legal construction of the policies in so far as such disputes relate to claims;
4. Delay in settlement of claims;
5. Non-issue of any insurance document to customers after receipt of premium.

Manner in which complaint is to be made Rule 14 of the Ombudsman Rules:-
1. Any person who has a grievance against the Company, may himself or through his legal heirs make a complaint in writing to the Ombudsman within whose jurisdiction the branch or office of the Company complained against is located.
2. The complaint shall be in writing duly signed by the complainant or through his legal heirs and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against which the complaint is made, the fact giving rise to the complaint.
3. No complaint to the Ombudsman shall lie unless:
- the complainant had before making a complaint to the Ombudsman, made a written representation to the Company/insurer named in the complaint and either insurer had rejected the complaint or the complainant had not received any reply within a period of one month after the insurer concerned received his representation or the complainant is not satisfied with the reply given to him by the insurer;
- the complaint is made not later than one year after the insurer had rejected the representation or sent his final reply on the representation of the complainant; and
- the complaint is not on the same subject matter for which any proceedings before any court or Consumer Forum or arbitrator is pending or was so earlier.

Ombudsman and Addresses

Mentioned below are contact details of Ombudsman:

CONTACT DETAILS	JURISDICTION
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, Union Territory of Dadra & Nagar Haveli & Union Territory of Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No.57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru-560 078. Tel.:- 080-26652048 / 26652049 Email:- bimalokpal.bengaluru@ecoi.co.in	State of Karnataka
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 033. Tel.:- 0755-2769200/201/202, Fax:- 0755-2769203 Email:- bimalokpal.bhopal@ecoi.co.in	States of Madhya Pradesh and Chattisgarh
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 Odisha
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, Union Territory of Jammu & Kashmir, Union Territory of Ladakh and Union Territory of Chandigarh
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 - Puducherry Town and Karaikal (which are part of Union Territory of Puducherry)
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.:- 011-23232481/23232481 Email:- bimalokpal.delhi@ecoi.co.in	State of Delhi
ERNAKULAM Office of the Insurance Ombudsman, 2nd floor, Pulinat Building, Opp. Cochin Shipyard, M.G. Road, Ernakulum - 682 015. Tel.:- 0484-2358759/2359338 Fax:- 0484-2359336 Email:- bimalokpal.ernakulam@ecoi.co.in	State of Kerala, Union Territory of Lakshadweep and Mahe, a part of Puducherry
GUWAHATI Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.:- 0361- 2632204 / 2602205 Email:- bimalokpal.guwahati@ecoi.co.in	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court" Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.:- 040- 67504123 / 23312122 Fax:- 040-23376599 Email:- bimalokpal.hyderabad@ecoi.co.in	States of Andhra Pradesh, Telangana and Union Territory of Yanam - a part of Puducherry

CONTACT DETAILS	JURISDICTION
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi-II Bldg., Ground Floor, Bhawani Singh Marg, Jaipur - 302005. Tel.:- 0141-2740363 Email:- bimalokpal.jaipur@ecoi.co.in	State of Rajasthan
KOLKATA Office of the Insurance Ombudsman, Hindustan Building 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 Territory of Andaman and Nicobar Islands
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow-226 001. Tel.:- 0522-2231330 / 2231331, Fax:- 0522-2231310. Email:- bimalokpal.lucknow@ecoi.co.in	Districts 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
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	State of Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector-15, Distt: Gautam Budh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email:- bimalokpal.noida@ecoi.co.in	State of Uttarakhand 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
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
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Building, 3rd Floor, CTS Nos. 195 to 198, NC Kelkar Road, Narayan Peth, Pune - 411 030 Tel: 020 -41312555 Email:- bimalokpal.pune@ecoi.co.in	State of Maharashtra, Area of Navi Mumbai and Thane, excluding Mumbai Metropolitan Region

Addendum to the Policy Wording (to be attached as applicable)

1 Want to add/remove members? Keep these points in mind:

We will be able to cover the insured persons only as long as they are employees of your company. To add new members to the policy or remove existing ones, please let us know within one month of their joining/leaving dates.

Any new member will be covered from his/her joining date, provided you maintain sufficient premium balance with us for such new members. If this balance is less, we will cover the insured persons in the order of the list you have given us. Where there is no premium balance maintained, the new member's cover will begin once we get the premium payment.

If a member is being removed from the policy, we can refund the premium only if he/she has not made any claims.

The names of all the dependents of insured persons have to be given to us at the time of taking the policy. New dependents will be allowed later only if an insured person gets married, or has a child and insured persons joining the group during the policy period.

In case you let us know about new members after the due date, these members will be covered from the day you tell us, depending on there being enough premium balance.

All other terms, conditions, warranties & exclusions of the Policy remain unchanged.

The Company may issue multiple group insurance policies in tranches to the Group Organizer, subject to minimum group size and maximum policy term, for providing insurance coverage to the new members on an ongoing basis.

2. Premium Payment in Instalments

a. The policy will be issued for a period of 1 year, 2 year or 3 years. The Sum Insured and Benefit will be applicable on Policy Year basis.

The Insured person can choose to pay Premium for this Policy on any one of the following basis:

i. Single premium

ii. Instalment premium

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.

3. 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 policyatleast30 days before the policy renewal date as per IRDAI guide lines 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 .. . .
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987&flag=1

4) 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.

5) 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.

6) 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.

7) Disclosure of information
The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.
(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

8) Claim Settlement (provision for 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 2o/o 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 2o/o above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India

(RBI) at the beginning of the financial year in which claim has fallen due)

Appendix I

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

Sl. No.	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL/ INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT

Sl. No.	Item
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETCl
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

Sl. No.	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE/ ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEX! MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES/ ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS/ VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES/MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND/ NAME TAG
37	PULSEOXYMETER CHARGES

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

Sl. No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

Sl. No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPO 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 SOLUTIONISTERILLIUM
17	Glucometer& Strips
18	URINE BAG

Day Care Treatment: All the day care treatments are covered which falls under the definition of Day care treatment mentioned in the policy.

ENDORSEMENT WORDINGS

These endorsements as we call them, should be considered and attached as part of your Policy No._, unless of course they go against the terms and conditions of the Policy.

Extn. No. 1: Family Floater (Indemnity Cover) - Hospitalization
Good choice, family is everything! You've chosen to give the insured person the family floater facility for the hospitalisation covered under Benefit 3 of the Policy and any endorsements which are limited to the hospitalization. Sum Insured as more specifically mentioned in the relevant endorsement, and you have paid an extra premium for this facility. We're sure the insured person will be grateful. This family floater facility can be used up to the sum insured.
A Family Floater basically means that all the people named in the Policy are covered by a single sum insured. The sum insured, which is stated in the Policy Schedule under Benefit 3, is the maximum that can be paid during the Policy period, putting together all the claims for all those covered.
The Primary Insured Person means the first insured person named in the Policy (typically, this is your employee or a person in a defined relationship with you). The others covered by the Policy are called secondary members.
All other terms and conditions of the Policy remain unchanged.

Extn. No. 2: Pre & Post Hospitalization time period (Indemnity Cover) - Hospitalization
You've taken good care of the before and after, too! You've paid us an additional premium to change the Pre and Post Hospitalisation period. We've changed it to the period that you asked for.
All other terms and conditions of the Policy remain unchanged.

Extn. No. 3: Pre-existing Disease Exclusion Waiver (Indemnity Cover) - Hospitalization
So what if the insured person already had an illness or condition? You've paid us an extra premium to remove Exclusion 4.1 (3) from the Policy. We've done so, and agree to waive this exclusion even for new insured persons who may join the Policy later, once the agreed additional premium is paid.
This exclusion includes a complete waiver for pre-existing diseases for 1 year, 2 years or 3 years, as mentioned in the Policy Schedule.

Extn. No. 4: Deletion of 30 days Waiting Period (Indemnity Cover) - Hospitalization
No waiting is great news! You've paid us an extra premium to remove Exclusion 4.1 (1) from the Policy. Thank you! We've done so, and agree to waive this exclusion even for new insured persons who may join the Policy later, once the agreed additional premium is paid.

Extn. No. 5: Deletion of Two Year and 90 days waiting period (specific waiting period) (Indemnity Cover) - Hospitalization
No waiting is great news! You've paid us an extra premium to remove Exclusion 4.1 (2) from the Policy. We've done so, and agree to waive this exclusion even for new insured persons who may join the Policy later, once the agreed additional premium is paid.

Extn. No. 6: Out-Patient / OPD Treatment (Indemnity Cover)
You've paid us an extra premium to include consultations, medicines, tests, and minor procedures for medical treatment taken on an Out-Patient, up to the amount and sub limit mentioned in the Policy Schedule.

A) Consultation Cover: because the right opinion matters!
We will Pay for the Medical Expenses incurred during the Period of Cover for any of the following consultations with or pay for a second opinion from a Medical Practitioner or Healthcare Professional empanelled with our Health Service Provider / Network Provider, in relation to any Illness contracted or Injury suffered by the Insured Person during the Period of Cover. Based on the information given by the Insured Person while availing any of the facilities under this Cover, medicines including over- the- counter medicines, or other suggestions may be given. We will not be liable for medicines or responsible for any misinformation given, or for the medical advice given by the doctor.
Choosing to use this Coverage is totally the Insured Person's choice and is at his / her own risk. The Insured Person is free to choose services under this Coverage, and, once availed of, take a call on whether or not to act on the medical advice / suggestions received in whole or in part.
While taking the services under this Cover, the Insured Person can still visit any other independent Medical Practitioner and take the treatment advised by that doctor.
The Policy Certificate will give in writing if there is any limit on the number of consultations which may be taken under this Coverage and if any specific consultations are covered or excluded.
1) GP Consultation with a general doctor, who for the purpose of this Base Benefit, is a Registered Doctor and manages the types of Illnesses that show up in different ways at an early stage of development, but may need a doctor's intervention.
2) Specialist Consultation with a specialist doctor, i.e. an expert doctor in any one or more types of medicine, including specialization in, cardiology, diabetology, endocrinology, ENT, gastroenterology, general surgery, gynecology / obstetrics, internal medicine, nephrology, neurology, ophthalmology, orthopedics, pediatrics, psychiatry, urology, dietitian, nutritionist, dermatology and pulmonology.
3) Physiotherapy Consultation with a doctor qualified to treat any Illness, Injury, or Deformity by physical methods such as massage,

heat treatment, and exercise.
4) AYUSH Consultation with a doctor specializing in given AYUSH treatment in any particular mode.
5) Dental Consultation with a dentist who is qualified to treat illnesses of the teeth and gums, particularly the repair and extraction of teeth and the planting of artificial teeth.
6) Counseling Session with a doctor for providing help in dealing with issues such as personal and lifestyle imbalance, speech impairment, and problems related to mental illness.

B) Pharmacy Cover: make sure you take your meds!
We will pay for buying medicines (including over-the-counter medicines), drugs, medical consumables, prosthetics, medically necessary spectacles or cochlear implants, external medical aids, vaccinations, vitamins, tonics or other related products as given in the Policy Schedule from a Network Provider, as long as these are advised by a doctor for any Illness during the Insured Person's Period of Cover.

C) Diagnostic Cover: knowing is everything.
We will pay the costs of Outpatient diagnostics tests including but not limited to biochemistry, hematology, immunology, microbiology, serology, pathology, x-ray, ultrasound and TMT for the Insured Person from a Network Provider during the Period of Cover.
The Policy Schedule will have in writing any limit on the type of medical tests which may be taken under this Coverage and if the Insured Person is required to have a written prescription from a doctor in advance to carry out these tests for any Illness contracted or Injury suffered by the Insured Person during the Period of Cover.

D) Minor Procedures: it's not too small if it's troubling you!
We will pay the cost for any Medical Procedure related to any specialties, including dental procedures, at a Network Provider for any Illness of the Insured Person during the Period of Cover. For this cover, Medical Procedure means: Surgical Procedure and / or non-Surgical Procedure(s) for treatment of an Illness, including but not limited to audiometry, application of cast, cast removal, injection administration, wound switching, retinoscopy, biopsy, drainage of abscess, and any other procedures which can be done on an outpatient basis, except Day Care Treatment and not needing any Hospitalization, performed by a Network Provider.
The Policy Schedule cum Certificate will tell you if there is any limit on the nature and type of Medical Procedures which may be taken under this Coverage.
This Sum Insured **is over and above the Hospitalization Sum Insured** applicable for In-patient Hospital Services as specified in the Policy Schedule.
1) The Insured Person can take OPD Treatment under this Benefit within India. OPD cover will be given by a Network Provider, and we'll try our best to let you get cashless treatment, too.
2) Any unused benefits cannot be carried forward to the next Policy Year.

Extn. No. 7: Maternity Treatment Expenses Cover (Indemnity Cover) with 9 months waiting period.
Motherhood will now have an added joy – no expenses of childbirth! You've paid us an extra premium to cover Maternity Treatment expenses. We will reimburse / provide cashless cover to the Primary Insured or legal spouse, who is mentioned as an Insured Person for maternity costs, benefits during the Policy Period, subject to the following:
a) Payment of Maternity Medical Expenses / treatment related to childbirth(including complicated deliveries and caesarian sections incurred during Hospitalization.
b) Charges for lawful terminations of pregnancy (abortions) during the Policy Period. This benefit will have a waiting period of nine months from the start of the first Policy with us, for all Insured Person/s who have been continuously covered under this extension or earlier policies under such Scheme issued under the terms & conditions governing Edelweiss general insurance company limited.
c) Medical expenses of the newborn baby immediately after birth, while in hospital in connection with any hospitalization treatment. Please note that this benefit will apply only for the first two babies. If the Insured Person already has two children, he / she cannot use this benefit. Of course, if the couple is doubly blessed and has twins from the second delivery, we will still cover all charges.
d) Our maximum liability will be limited to the Sum Insured mentioned in the Policy Schedule, which is over and above the Hospitalization Sum Insured for In-Patient Hospital Services.
e) We will cover the charges for any hospitalisation caused by involuntary medical termination of pregnancy (abortion), as per MTP Act, 1971 (amended) and other applicable laws and rules.
f) A waiting period of 9 months shall apply to any employee and their dependents, who join the Policy after this cover comes into effect.

Extn. No. 8: Maternity Treatment Expenses Cover (Indemnity Cover) without 9 months waiting period.
Motherhood will now have an added joy – no expenses of childbirth! You've paid us an extra premium to cover Maternity Treatment expenses. We will reimburse / provide cashless cover to the Primary Insured or legal spouse, who is mentioned as an Insured Person for maternity costs subject to the following:
a) Payment of Maternity Medical Expenses / treatment related to childbirth (including complicated deliveries and caesarian sections)
b) Charges for lawful terminations of pregnancy (abortions) during the Policy period. This benefit will have no waiting period
c) Medical expenses of the newborn baby immediately after birth, while in hospital. Please note that this benefit will apply only for the first two babies. If the Insured Person already has two children, he / she cannot use this benefit. Of course, if the couple is doubly blessed and has twins from the second delivery, we will still cover all charges.
d) Our maximum liability will be limited to the Sum Insured mentioned in the Policy Schedule, which is over and above the Hospitalization Sum Insured for In-Patient Hospital Services.
e) We will cover the charges for any hospitalisation caused by involuntary medical termination of pregnancy (abortion), as per MTP Act, 1971 (amended) and other laws and rules.

Extn. No. 9: Baby Day One Cover (Indemnity Cover)

You've paid us an extra premium to cover the new born babies of Insured Persons from Day 1. That's so thoughtful of you. Of course, a sufficient advance deposit will have to be kept with us for this cover. You or the Insured Person can also extend the liability of this cover if you choose to. You can choose from:

a) Covering each baby from Day 1, but only up to the Maternity Sum Insured, up to a maximum of three children.

OR

b) Covering each baby from Day 1, up to the full Sum Insured, up to a maximum of three children.

This coverage allows the child to be covered under the Policy from birth. Otherwise, the minimum age for an Insured Person has to be 91 days.

Extn. No. 10: Baby Covered after 90 days (Indemnity Cover)

You've paid us an extra premium to cover the babies of Insured Persons from the age of 91 days. That's so thoughtful of you. Of course, a sufficient advance deposit will have to be kept with us for this cover. You or the Insured Person can also extend the liability of this cover if you choose to.

You can cover each baby from Day 91, up to the full Sum Insured, up to a maximum of three children.

Extn. No. 11: Pre and Post Natal Expenses Cover (Indemnity Cover)

Talk about making a mother-to-be feel special! You've paid us an extra premium to cover the Insured Persons or their spouses for pre-natal care from conception till delivery and post-natal inpatient for care 45 days after childbirth, up to the maternity sub limit specified in the Policy Schedule.

This cover includes pre and post-natal medical expenses as an Out-patient, including but not limited to expenses for antenatal check-ups, doctor's consultations for monitoring of during the pregnancy and any complications, arising therefrom up to 5% of the maternity sub-limit specified in the Policy Schedule.

Extn. No. 12: Emergency Ambulance Expenses (Indemnity Cover)

Getting to hospital on time means getting better faster! You've paid us an extra premium to cover the cost of ambulance charges (either Reimbursement or Cashless) for the Insured Person. Please note that such an ambulance transfer should be recommended by the doctor, and is subject to these conditions:

a) The trip should be from the place of the medical emergency to the nearest hospital; and / or

b) It can also be from one hospital to another, where the required care is not available at the first hospital following an emergency.

c) Trip to another hospital or test centre only for check-ups and tests are not covered.

d) The Company has accepted the recipient Insured Person's claim under Benefit 3.1 (Hospitalization Expenses).

e) The maximum limit up to ` 10,000/- per person applies for the individual Sum Insured and per family for the floater sum insured.

Extn. No. 13: Additional Sum Insured for Hospitalization due to Critical illness

Disaster can strike anyone, anytime. You've paid us an extra premium to cover the Insured Persons against critical illnesses too. It's a wise move, considering how common these once-rare diseases have become.

The additional Sum Insured under this extension will be available only once the original Sum Insured has been used up, and is subject to the below conditions:

a) The Insured Person experiences a Critical Illness specifically listed and defined in this Policy; and

b) The Insured Person is being diagnosed and treated for the first time for this Critical Illness; and

C) Critical Illness coverage is available for Individual / floater Policy up to the Sum Insured as mentioned in the Policy Schedule.

List of "Critical Illness"

1) Cancer of Specified Severity
2) Myocardial infarction (First heart attack of specific severity)
3) Open chest coronary artery bypass graft (CABG)
4) Open heart replacement or repair of heart valves
5) Coma of specified severity
6) Kidney Failure Requiring Regular Dialysis
7) Stroke resulting in permanent symptoms
8) Major organ / Bone marrow transplant
9) Permanent Paralysis of limbs
10) Multiple sclerosis with persisting symptoms
11) Angioplasty
12) Benign brain tumor
13) Blindness
14) Deafness
15) End Stage lung failure
16) End Stage liver failure
17) Loss of Speech
18) Third degree Burns.

C1 - CANCER OF SPECIFIED SEVERITY

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

The following are excluded:

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

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

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

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

5) All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
6) Chronic lymphocytic leukaemia less than RAI stage 3;
7) Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification;
8) All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5 / 50 HPFs;
9) All tumors in the presence of HIV infection.

C2 - MYOCARDIAL INFARCTION (First Heart Attack of specific severity)

1) The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
i) A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain);
ii) New characteristic electrocardiogram changes;
iii) Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.
2) The following are excluded:
i) Other acute Coronary Syndromes;
ii) Any type of angina pectoris;
iii) A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

C3- OPEN CHEST CABG

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

C4 - OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

C5 - COMA OF SPECIFIED SEVERITY

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

C6 - 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.

C7 - STROKE RESULTING IN PERMANENT SYMPTOMS

1) 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.
2) 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.

C8 - MAJOR ORGAN / BONE MARROW TRANSPLANT

1) The actual undergoing of a transplant of:
i) One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
ii) Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.
2) The following are excluded:
i) Other stem-cell transplants
ii) Where only islets of langerhans are transplanted.

C9 - PERMANENT PARALYSIS OF LIMBS

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

C10- MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

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

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

C11- ANGIOPLASTY

1) Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).
2) Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.
3) Diagnostic angiography or investigation procedures without angioplasty / stent insertion are excluded.

C12 - BENIGN BRAIN TUMOR

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

C13 - BLINDNESS

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

C14 - DEAFNESS

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

C15 - END STAGE LUNG FAILURE

End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
1) FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
2) Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
3) Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
4) Dyspnea at rest.

C16 - END STAGE LIVER FAILURE

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

C17 - LOSS OF SPEECH

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

C18- 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.

Extn No. 14: Hospital cash allowance (Benefit)

Even today, for some things only cash will do. You've paid us an extra premium to give us the Insured person a fixed amount of cash, for a maximum of 7 days of stay in a hospital for each Policy year for each continuous and completed period of 24 hours of Hospitalization of the Insured person. We will definitely make this cash available, under the following conditions:

- The hospitalisation is for more than 3 continuous days.
- The Company will be liable to pay from the 4th day till the 10th day for a block of continuous Hospitalization arising from Any One Illness or Accident.
- The Company has accepted the Insured Person's claim under Benefit 3.1 (Hospitalization Expenses). The amount limit is minimum ` 500/- and maximum up to ` 5,000/- per day.

Extn No. 15: Recovery Benefit (Benefit)

You've paid us an extra premium to pay a fixed amount for a maximum of 10 days' overnight stay in a hospital. Thank you! We will definitely pay this amount, under the following conditions:
a) The hospitalisation is for more than 10 continuous days.
b) We will pay from the 11th to the 20th day, for non-stop hospitalisation needed for one illness or accident.
c) The Company has accepted the recipient Insured Person's claim under Benefit 3.1 (Hospitalization Expenses).The amount limit is minimum ` 500/- and maximum up to Rs. 5000/- per day.

Extn. No. 16: Assistance Services in India: when you need help, we're right here!

These services are the Insured Person's for the asking when he / she is more than 150 kilometres away from home (the address last known), is within Indian territory, and has not been away from that

address for more than 90 days. The services would be given by us through our panel Service Provider, with prior intimation and acceptance by the Company. No claims for reimbursement are accepted: - Exclusion 4.4 given in the base Policy is valid for all Insured Persons covered under this benefit. This benefit may be extended to mid-term joiners and their dependants, on payment of additional premium.

a) Medical Referral: a call is all it takes.

The Insured Person can call our operations centre staff twenty-four hours a day, every day of the year, and rely on help in multiple languages.

b) Emergency Medical Evacuation: let's go further!

When a medical facility is not close to the Insured Person, as advised by the Service Provider's doctor and the Insured Person's doctor, we / our Service Provider will arrange transport under due medical supervision, to the nearest medical facility which can give the needed care within India.

c) Medical Repatriation: there's no place like home.

We / our Service Provider will arrange for the Insured Person to be taken back home in India or to a medical facility near home, under medical supervision, when our Service Provider's doctor and the Insured Person's doctor says that such travel is medically necessary and the Insured Person is medically cleared for travel.

d) Medical Monitoring: keeping a close watch. Our doctor will check the Insured Person's condition and will (i) stay in regular touch with the attending doctor and / or hospital and (ii) pass on the necessary information to family members.

e) Compassionate Visit: someone close, close by!

When an Insured Person is hospitalised for more than seven (7) continuous days and is traveling in India without a companion, our Service Provider will arrange for a family member or friend to travel economy class to visit the Insured Person. The family member or friend has to arrange for all the travel documents needed.

f) Return of Mortal Remains: the final journey.

In the case of an Insured Person's death away from home but within India, we / our Service Provider will arrange and pay for the return of mortal remains to an authorised funeral home close to the Insured Person's home in India.

g) Second Medical Opinion: always better to double-check

Our Service Provider will arrange for a second medical opinions for an eligible Insured Person in the following cases: (i) when the medical condition is undiagnosed by a treating physician; (ii) when an additional medical opinion is needed following an original diagnosis; and (iii) when a course of treatment is needed based on a current state. The service only includes a medical opinion and does not include personal visits or follow-up discussions for taking the course of treatment advised.

Extn. No. 17: Reimbursement of Organ donor expenses (Indemnity Cover)

You've paid us an extra premium to cover the hospitalisation costs if an Insured Person needs an organ donation. We salute your generosity! We're happy to provide this cover through cashless or reimbursement, under the following conditions:

a) The donation conforms to The Transplantation of Human Organs Act 1994 and its amendments thereafter, and the organ is for the use of the Insured Person.

b) The Insured Person receiving the organ has been advised by a doctor to undergo an organ transplant.

c) The Company has accepted the recipient Insured Person's claim under Benefit 3.1 (Hospitalization Expenses).

The maximum cover will be as specified in the Policy Schedule. Unfortunately, we can't pay for the following:

1) Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.
2) Screening or any other Medical Expenses of the organ donor.
3) Costs directly or indirectly associated with getting the donor's organ.
4) Transplant of any organ / tissue where the transplant is experimental or investigational.
5) Expenses related to transporting or preserving an organ.
6) Any other medical treatment or complication that happens to the donor after donation.

Extn No. 18: Voluntary Co payment

We agree that the Insured Person will pay a part of the treatment cost (a small part, don't worry!) and we will pay the rest, subject to the terms and conditions of the Policy.

Extn No. 19: Personal Accident Cover

In consideration of additional premium received by the Company and realization thereof from the Insured / Insured Person ,the Policy shall provide compensation to the Insured Person, his or her nominee or legal representatives, as the case may be, the sum or sums as set forth in the Tables of Benefits below, subject to the Capital Sum Insured as specified in the Policy Schedule being the maximum liability of the Company towards Injury, solely and directly from Accident and resulting in death or disability within 12 (twelve) calendar months of occurrence of such Injury. The compensation under more than one clause for same period of disability shall not exceed the Capital Sum Insured.

The Insured Person can select any of the coverage options below:

Option I: Accidental death, permanent total disability, permanent partial disability and temporary total disability

Option II: Accidental death, permanent total disability and permanent partial disability

A) Accidental Death If an Insured Person suffers an Accident during the Policy Period and this is the sole and direct cause of his death

Accidental Death – Table of Benefits	
Loss of	**%ofCSI**
Accidental Death	100%

within twelve calendar months from the date of the Accident, then We will pay the Capital Sum Insured as mentioned in the Policy Schedule.

B) Permanent Total Disability

If an Insured Person suffers from an accidental injury during the Policy Period and within twelve calendar months from the date of Accident, which is the sole and direct cause of his Permanent Total Disability in one of the ways detailed in the table below, We will pay the percentage of the Capital Sum Insured shown in the table. In this benefit.

1) Limb means a hand at or above the wrist or a foot above the ankle.
2) Loss of Limb means physical separation of a limb above the wrist or ankle respectively

Permanent Total Disability – Table of Benefits	
Loss of	**% of CSI**
Limbs (both hands or both feet or one hand and one foot)	100%
Loss of a Limb and an eye	100%
Complete and irrecoverable loss of sight of both eye	100%
Complete and irrecoverable loss of speech & hearing of both ears	100%

C) Permanent Partial Disability

If an Insured Person suffers from an accidental injury during the Policy Period and within twelve calendar months from the date of the Accident this is the sole and direct cause of his Permanent Partial Disability in one of the ways detailed in the table below, then We will pay the percentage of the Capital Sum Insured shown in the table.

Permanent Partial Disability – Table of Benefits	
Loss of	**% of CSI**
Each arm at the shoulder joint	70%
Each arm to a point above elbow joint	65%
Each arm below elbow joint	60%
Each hand at the wrist	55%
Each thumb	20%
Each index finger	10%
Each other finger	5%
Each leg above center of the femur	70%
Each leg up to a point below the femur	65%
Each leg to a point below the knee	50%
Each leg up to the center of tibia	45%
Each foot at the ankle	40%
Each big toe	5%
Each other toe	2%
Each eye	50%
Hearing in each ear	30%
Sense of smell	10%
Sense of taste	5%
Any other Permanent Partial Disability	Percentage as assessed by the registered medical practitioner

D) Temporary Total Disability

If an Insured Person suffers an accidental injury during the Policy Period which is the sole and direct cause of a Temporary Total Disability which completely prevents him / her from performing each and every duty pertaining to his / her employment or occupation of any description whatsoever, then We will pay a weekly benefit, provided that:

1) The temporary total disability is certified by the treating Doctor, and
2) We will pay this weekly amount for a maximum of 104 weeks from the date of accident.

1) Risk Categorization

Risk Group I:

Doctors, Lawyers, Accountants, Architects, Consulting engineers, Teachers, Bankers, Builders, Contractors, Engineers on site engaged in superintending functions only, Veterinary Doctors, business owners wherein the business is not dealing in hazardous goods or not involving manual labor, Persons engaged in clerical functions & administrative functions and such other persons engaged in occupations of similar hazard listed above.

Risk Group II:

Professional Athletics & Sportsmen, Wood working Machinists, Workers, Mechanics, Drivers, and Manual laborers (except those falling under Group III) & such other persons engaged in occupation of similar hazard listed above.

Risk Group III:

Persons working in underground mines, explosives, magazines, workers involved in electrical installation with high tension supply, demolition workers, Jockeys, Circus personnel, Persons engaged in activities like racing on wheels or horseback, big game hunting, mountaineering, winter sports, skiing, ice hockey, ballooning, hand gliding, river rafting, polo, persons working as Air Crew and Ship Crew, and such other persons engaged in occupation of similar hazard listed above.

Where a group of heterogeneous persons are covered, the risk group consideration will be based on the occupation of individual members, where detailed occupational information is available or on the occupation of majority of group members where more than 50% of the group can be classified as belonging to any of the risk groups above. Acceptance of group and loading up to 50% may will be apply as per the underwriting decision and risk group criteria.

2) Special Exclusions applicable to this Endorsement

In addition the General Exclusions listed in the Policy attached this endorsement section shall not cover:

a) In the event the Insured Person is a victim of culpable homicide, i.e. where he dies due to act committed against him, which act is committed with the intention of causing death or with the intention of causing Accidental Injury as is likely to cause death, or with the knowledge that such act is likely to cause death.

b) Any claim of the Insured Person

(i) from intentional self-injury, suicide or attempted suicide

(ii) Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code- Excl-12**

(iii) Hazardous or Adventure sports - **Code- Excl-09**

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

(iv) directly caused by venereal disease insanity

c) Death or disability resulting directly or indirectly caused by, contributed to or aggravated or prolonged by child birth or from pregnancy excluding ectopic pregnancy .

d) Breach of law**- Code-Excl-l0**

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent

e) Any claim arising out of war, civil war, invasion, insurrection, revolution, act of foreign enemy, hostilities (whether War be declared or not), rebellion, mutiny, use of military power or usurpation of government or military power

f) Any claim arising out of Insured Person(s) serving in any branch of the Military or Armed Forces of any country during war or warlike operations.

g) Any claim caused by or contributed to or arising from -

1) ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel and for the purposes hereof, combustion shall include any self-sustaining process of nuclear fission; or

2) nuclear weapons material

h) Any loss whilst flying or taking part in aerial activities (including cabin crew) except as a fare-paying passenger in a regular Scheduled airline or Air Charter Company.

i) We shall not be deemed to provide cover and shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose us to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

The above limit is over and above the Hospitalization Sum Insured applicable for In-patient Hospital Services.

Extn No. 20: Wellness and prevention: it's always better than a cure!

You've paid us an additional premium to provide services that help the Insured Person(s) stay in better health and improve their quality of life. The Insured Persons can enjoy these wellness benefits, only if the Group has opted for such benefit(s) at the time of buying this Policy. The benefits will be available on cashless basis only.

GENERAL CONDITIONS APPLICABLE Wellness and preventive care

a) Where any of the services given under this Section are arranged by Us through our Network Providers, we will not be responsible for any loss or damage caused by any opinion, actual or alleged mistakes, omissions and representations made by the Network Provider. Information about the benefits, as well as tips on general health, will be sent through various modes of communication.

b) The Insured Person is free to choose whether or not to take services under this Section, and, if taken, whether or not to act on the advice received.

c) Based on the information given by the Insured Person while taking any of the features under wellness, medicines, including over-the-counter medicines or other suggestions, may be given or suggested. We will not be responsible for this information and advice.

d) The Insured Person should get help from a doctor when interpreting these suggestions and applying them to his / her life / medical condition. If the Insured Person has any concerns about his / her health, he / she should consult a doctor immediately.

e) After taking services under this Section, the Insured Person is free to visit other independent doctors and start / continue any treatment advised by these doctors.

f) The services we offer under this Section will be on a 'best effort' basis.

We're happy to do more for your employees, and here are some of the ways we help them stay healthier:

1) Outpatient Consultation: You're never 'out' of our thoughts!

This Policy offers Outpatient Consultation to the Insured Person. However, this can only be taken on a cashless basis through us or our Network Provider.

Outpatient Consultation means a visit and consultation with a general medical practitioner, specialist doctor, physiotherapist, dentist or ophthalmologist.

i) Wellness consultation & preventive consultation treatments means any off-site or on-site awareness / training / education program on complete wellbeing, including physical fitness, diet and nutrition, spiritual, occupational, environmental, financial, social and mental wellbeing and safety related parameters, and also vaccinations by relevant Healthcare Professionals.

ii) Lifestyle management programs like how to stop smoking, stress management, etc. to educate the Insured Persons to become more aware of their health and proactively manage it. Each Insured Person will have access to a wellness coach. These programs will be app / web/chat/call based with/without the use of wearable devices.

iii) Disease management programs will be designed to advise Insured Person(s) with any chronic disease or borderline cases such as asthma, diabetes, depression, hypertension, cardiac problems, etc. These programs will help them become more aware about their health and proactively manage it. Each Insured Person will have access to a wellness coach. There will be no cash reimbursement available against this benefit.

iv) Telephonic / Virtual Consultation will mean any consultation given by a doctor through a virtual medium, such as audio, video, online portal, chat or mobile application for a routine health query or for first and second opinions. This will also include consulting a professional expert through a hotline number for any social, mental, emotional, and environmental or other issue faced by the Insured Person which affects his / her wellbeing. This facility is meant to give him / her access to consultations, and is not a substitute for meeting a doctor. Consultation with doctors will be available when needed, through our network providers' helpline. Based on the information given by the Insured Person, medicines, including over-the-counter medicines or other suggestions, may be given. We will not be responsible for any inaccuracy in the advice or information given.

2) Routine Physical & Preventive Health Examination: keep it all in check!

We will cover the cost of routine Physical and Preventive Examinations mentioned in this Policy Schedule during the Period of Cover, on a cashless basis and within India only. For this benefit, Routine Physical and Preventive Examinations will mean on-site or off-site check-ups of all health parameters given below.

Any unutilized benefit will not carried forward to the next Policy Year.

Set I	Set II
CBC, ESR + RUA + Lipid Profile + Serum. Creatinine + HbA1c + ECG	CBC, ESR + RUA + Lipid Profile + Sr. Creatinine + HbA1c + ECG
Set III	
CBC, ESR + RUA + Lipid Profile + Sr Creatinine + HbA1c + ECG + LFT	
Set IV	**Set V**
CBC, ESR + RUA + Lipid Profile + RFT + HbA1c + LFT + ECG + Chest X Ray	CBC, ESR + RUA + Lipid Profile +RFT+HbA1c+ LFT+ TMT+ Chest X Ray + Tumour marker
RUA (Routine Urine Analysis), CBC, ESR (Complete Blood Count, Erythrocyte Sedimentation Rate), Lipid profile, ECG (Electrocardiogram), Serum Creatinine, HbA1c- Glycosylated Haemoglobin, ECG - Electrocaridiogram, LFT- Lung Function Test, RFT - Renal Function Test, TMT - Tread Mill Test	

Extn No. 21: Disease wise Sublimit (indemnity cover)

Voluntary inclusion of sub limits for below disease: (these are all independent add-ons and or a combination of any or all these diseases & customer can select any of the sublimit option from respective diseases.)

Disease	Sub Limits options				
Cataract	20,000	25,000	30,000	35,000	40,000
Hysterectomy	25,000	30,000	35,000	40,000	45,000
Removal of Gall Bladder	25,000	30,000	35,000	40,000	45,000
Surgery for Piles	15,000	20,000	25,000	30,000	40,000
Surgery for Fissure, Fistula	15,000	20,000	25,000	30,000	35,000

Angiography Invasive	15,000	20,000	25,000	30,000	35,000
PTCA	1,40,000	1,50,000	1,60,000	1,70,000	1,80,000
Appendectomy	30,000	35,000	40,000	45,000	50,000
D & C	10,000	12,000	15,000	17,000	20,000
Hernia	25,000	30,000	35,000	40,000	45,000
Deviated Nasal Septum and Sinus	25,000	27,000	30,000	32,000	40,000
Surgery for Renal Stone	35,000	40,000	45,000	50,000	60,000
Prostate Surgery TURP	30,000	35,000	40,000	45,000	50,000
CABG		1,75,000	2,00,000	2,25,000	2,50,000
Bilateral Total Knee / Hip Replacement		2,00,000	2,25,000	2,50,000	2,75,000

Extn No. 22: Room rent Capping

We agree to cover the Insured Person's hospital room rent up to the percentage and per day amount mentioned in the Policy Schedule. If the room rent is higher than what we have agreed on, the Insured Person will have to pay the difference.

All other terms and conditions of the Policy remain unchanged.

Extn No. 23: Lasik Surgery expenses (indemnity cover)

You've paid us an extra premium to cover the Insured Persons for LASIK surgery, in case of compound myopic astigmatism, to the level of refractive errors specified. As per request by customer/proposer, underwriters will specify below conditions in policy documents provided to customer, to confirm the liability under the policy.

Level of refractive errors

Beyond +/- 0.75 Dioptre

Beyond +/- 3.5 Dioptre

Extn No. 24: Infertility Treatment Cover (indemnity cover)

The joy of parenthood is incomparable! We're happy that you have paid us an extra premium to cover the Insured Person for infertility treatment, including Invitro fertilization (IVF), Gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures, and any related prescription medication treatment. This extension would also cover embryo transport, donor ovum and semen and related costs, including collection and preparation, required towards treatment related to infertility and sterilization, up to the amount mentioned in the Policy Schedule. The Insured Person should be between 18 and 50 years old.

This sub limit is a part of the hospitalization Sum Insured for in-patient treatment.

Extn No. 25: Recharge of the Sum Insured (indemnity cover)

Sometimes, getting better takes a lot more than we expected. You've paid us an extra premium to Recharge the Sum Insured by 100%, in case the original Sum Insured is all used up in treatment. Subject to the conditions specified below:

a) The Recharge Benefit can be used for Benefit 3.1 (Hospitalization Expenses), Benefit 3.2 (Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses), Benefit 3.3 (Day Care treatment), Benefit 3.4(Domiciliary Hospitalization), Benefit 3.5 (AYUSH)

b) The Recharge Benefit can be used for the same treatment on which the original Sum Insured was spent.

c) If the Recharge Benefit isn't used, it can't be carried forward to the next year.

d) The No Claim Bonus won't be considered while calculating the Recharge Sum Insured.

e) For Individual policies, the recharged Sum Insured will be available on an individual basis, whereas in case of a Family Floater Policy, it will be available on a floater basis.

f) In case of Portability, the credit for continuity in Sum Insured would be available only to the extent of Sum Insured of the expiring Policy.

g) If the Insured Person has the Restoration Benefit as well, he / she does not need to use this up first for the Recharge Benefit to kick in. If the Sum Insured is used up, we will not take into account the Restoration Sum Insured.

Extn No. 26: Restoration of the Sum Insured (indemnity cover)

Sometimes, getting better takes a lot more than we expected. You've paid us an extra premium to restore the Sum Insured by 100%, in case the original Sum Insured is all used up in treatment. This restored Sum Insured cannot be used for the same illness / accident that the Insured Person was treated for during the Policy year.

a) The Restoration Benefit can be used for Benefit 3.1 (Hospitalization Expenses), Benefit 3.2 (Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses), Benefit 3.3 (Day Care treatment), Benefit 3.4 (Domiciliary Hospitalization), Benefit 3.5 (AYUSH)

b) Restoration can't be used for the first claim the Insured Person makes.

c) If the Restoration Benefit isn't used, it can't be carried forward to the next year.

d) For Individual policies, the restored Sum Insured will be available on an individual basis, whereas in case of a Family Floater Policy, it will be available on a floater basis.

e) For any single claim during a Policy year, the maximum you can claim for is Sum Insured.

f) In a Policy year, the amount of all the claims put together should not be more than the total of:

1) The Sum Insured

2) The Restored Sum Insured.

In case of Portability, the credit for continuity in Sum Insured would be available only to the extent of Sum Insured of the expiring Policy, including Restoration.

Extn No. 27: Corporate Buffer (Indemnity Cover)

You've paid us an extra premium for extra emergencies! In exchange for this, we've set up what is called a Corporate Buffer. This covers the Insured Person (and his / her family) in case the cost of treatment is more than the Sum Insured. This buffer can't be used for the treatment of conditions, or for procedures, which already have a sub-limit under your Policy. Liability of the insurance company will be as per the conditions specified in the Policy document.

Extn. No 28 Cochlear Implant

You've paid us an extra premium to cover the Insured Persons in case he/she needs this procedure.

As per request by customer/proposer underwriters will specify below conditions in policy documents provided to customer, to confirm the liability under the policy.

Acceptance of coverage with,

-Cover upto SI

-Cover with restriction on SI

-Cover with co-pay

Extn. No 29 Sleep Apnoea

The extra premium paid by You will cover the Insured Persons in case he/she needs this procedure.

As per request by customer/proposer underwriters will specify below conditions in policy documents provided to customer, to confirm the liability under the policy.

Acceptance of coverage with,

-Cover upto SI

-Cover with restriction on SI

-Cover with co-pay