Edelweiss | GENERAL INSURANCE

POLICY WORDING

YOUR POLICY IN DETAIL

Edelweiss | GENERAL INSURANCE

EDELWEISS TOP UP INSURANCE

POLICY WORDINGS

1. Preamble

This is a contract of insurance between the Company and the Policyholder which is subject to realization of the full premium in advance and the terms, conditions and exclusions to this Policy. This Policy has been issued on the basis of the Disclosure to Information Norm, including the information provided by Policyholder in respect of the Insured Persons in the Proposal and the Policy Schedule.

Please inform the Company immediately of any change in the address, or any other changes affecting You or any Insured Person.

2. Definitions

For the purpose of interpretation and understanding of this Policy, the Company has defined below some of the important words used in this Policy. Words not defined below are to be construed in the usual English language meaning as contained in Standard English language dictionaries. The words and expressions defined in the Insurance Act 1938, IRDA Act 1999, regulations notified by the Insurance Regulatory and Development Authority of India ("Authority") and circulars and guidelines issued by the Authority shall carry the meanings described therein.

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 the completed age of the Insured Person as on his last birthday.

3. **Ambulance** means a carrier 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. **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

7. **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.

8. **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.

9. 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.

10. Cashless facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

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

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

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

14. 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.

15. 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.

16. 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.

17. Cumulative Bonus (No Claim Bonus) means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

18. 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.

19. 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.

20. Deductible- Deductible means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured:
i. Deductible (Top Up) - We are not liable for any payment unless the Medical Expenses exceed the Deductible. Deductible shall be applicable for each and every Hospitalisation except claims made for Any One Illness.
ii. Deductible (Super Top Up) - We are not liable for any payment unless the Medical Expenses exceed the Deductible (as opted on Individual basis in case of Individual Policy and on Family Floater basis in case of Family Floater Policy). Deductible shall be applicable per Policy Year basis. The deductible is applicable in aggregate towards hospitalisation expenses (admissible under policy) incurred during the policy period by insured (individual policy) or insured family (in case of family floater).

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

22. 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.

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

24. Edelweiss Group means and includes any company wherein Edelweiss Financial Services Limited wholly owns the shares in that Company or is the majority shareholder

25. 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.

26. 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. Dependent Parent (s)
v. Dependent Parent in law (s)

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

28. Adventurous Sports / Hazardous 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, 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

29. Hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical 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; And

Hospital means an establishment which is legally licensed as a medical or surgical hospital under the laws of the country in which it is situated. (Applicable for outside India)

30. 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.

31. 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

32. 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.
33. Individual Policy means a Policy described as such in the Policy Schedule where the individual named in the Policy Schedule with his/her respective Sum Insured, is insured under this Policy

34. **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.

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

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

37. **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.

38. **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.

39. **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.

40. **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.

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

42. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

43. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license or shall mean a person who is qualified to practice medicine or is a physician, surgeon or an anesthetist and has a valid license issued by the appropriate authority for the same, provided that this person is not an Immediate Family Member of the Insured.

44. **Medically necessary treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
i. is required for the medical management of the illness or injury suffered by the insured;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. must have been prescribed by a medical practitioner;
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

45. **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

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

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

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

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

50. **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.

51. **Pre-Existing Disease** means any condition, ailment, injury or disease:
a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement
or
b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.

52. 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.

53. Policy means these Policy terms and conditions (policy wordings) and Appendices thereto, the Proposal Form, Policy Schedule and Optional Cover (if applicable) which form part of the Policy and shall be read together.

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

55. 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.

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

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

58. Policy Schedule means the certificate attached to and forming part of this Policy.

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

60. Portability means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time-bound exclusions from one insurer to another insurer.

61. 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.

62. Qualified nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India or must conform to the professional standards widely accepted in international medical practice.

63. 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.

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

65. Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

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

67. Standard Single Private Room means an air conditioned room in a Hospital where a single patient is accommodated and which has an attached toilet (lavatory and bath). Such room type shall be the most basic and the most economical of all accommodations available as a Single room in that Hospital.

68. Sum Insured means the amount specified in the Policy Schedule, for which premium is paid by the Policyholder.

69. 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.

70. 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.

71. 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.

72. 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.

73. Critical Illnesses:

1. Cancer of Specified Severity:

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

The following are excluded:

- All tumors which are histologically described as Carcinoma In Situ, benign, premalignant, 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.
- Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- Malignant melanoma that has not caused invasion beyond the epidermis;
- 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
- All thyroid cancers histologically classified as T1N0M0 (TNM classification) or below;
- Chronic lymphocytic leukaemia less than RAI stage 3
- Non-invasive papillary cancer of the bladder histologically described as tan0m0 or of a lesser classification,
- 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,
- all tumors in the presence of HIV infection.

2 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.

3. Multiple Sclerosis With Persisting Symptoms

The unequivocal diagnosis of definite multiple sclerosis confirmed and evidenced by all of the following:

- Investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
- There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

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

4. Major Organ/Bone Marrow Transplant:

I. The actual undergoing of a transplant of:

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

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

II. The following are excluded:

i) Other stem-cell transplants

Where only Islets of Langerhans are transplanted.

5. Open Heart Replacement Or Repair Of Heart Valves

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

6. Open Chest CABG

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

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

7. 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.

8. Myocardial Infarction (First Heart Attack Of Specific Severity):

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

- A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (for e.g. Typical chest pain)
- New characteristic electrocardiogram changes
- Elevation of infarction specific enzymes, troponins or other specific biochemical markers.

The following are excluded:

- Other acute coronary syndromes
- Any type of angina pectoris

• A rise in cardiac biomarkers or troponin t or i in absence of overt ischemic heart disease or following an intra-arterial cardiac procedure.

9. Stroke Resulting In Permanent Symptoms

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

The following are excluded:

• Transient ischemic attacks (tia)
• Traumatic injury of the brain
• Vascular disease affecting only the eye or optic nerve or vestibular functions.

10. Benign Brain Tumor

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.

This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

• Permanent neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
• Undergone surgical resection or radiation therapy to treat the brain tumor.

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.

11. Motor Neuron Disease With Permanent Symptoms

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

12. Coma Of Specified Severity

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:

• No response to external stimuli continuously for at least 96 hours;
• Life support measures are necessary to sustain life; and
• Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

13. End Stage Liver Failure

Permanent and irreversible failure of liver function that has resulted in all three of the following:

• Permanent Jaundice; and
• Ascites; and
• Hepatic encephalopathy.

Liver failure secondary to drug or alcohol abuse is excluded.

14. Primary (Idiopathic) Pulmonary Hypertension

An unequivocal diagnosis of primary (idiopathic) pulmonary hypertension by a cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on cardiac cauterization. There must be permanent irreversible physical impairment to the degree of at least class IV of the New York Heart Association classification of cardiac impairment.

The NYHA classification of cardiac impairment are as follows:

• Class III: marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
• Class IV: unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

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

15. Surgery of Aorta

The actual undergoing of major surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of “aorta” shall mean the thoracic and abdominal aorta but not its branches.

You understand and agree that we will not cover:

• Surgery performed using only minimally invasive or intra-arterial techniques.
• Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.

16. 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.

17. 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 90decibels across all frequencies of hearing" in both ears.

18. Loss Of Speech

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.
All psychiatric related causes are excluded.

19. Muscular Dystrophy

A group of hereditary degenerative diseases of muscle characterized by weakness and atrophy of muscle. The diagnosis of muscular dystrophy must be unequivocal and made by a registered doctor who is a consultant neurologist. The condition must result in the inability of the life insured to perform (whether aided or unaided) at least 3 of the 6 "activities of daily living" for a continuous period of at least 6 months.
Activities of daily living:
• Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;
• Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
• Transferring: the ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;
• Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
• Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.
• Mobility: the ability to move indoors from room to room on level surfaces at the normal place of residence.

20. Alzheimer's Disease

Alzheimer's (Pre-senile Dementia) disease is a progressive degenerative disease of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive Histopathological changes. Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the insured person. The diagnosis must be supported by the clinical confirmation of a neurologist and confirmed by our appointed medical practitioner.
The following conditions are however not covered:
• Non-organic diseases such as neurosis and psychiatric illnesses;
• Alcohol related brain damage; and
• Any other type of irreversible organic disorder/dementia

21. Parkinson's Disease

The unequivocal diagnosis of progressive, degenerative Idiopathic Parkinson's disease by a neurologist acceptable to us.
The diagnosis must be supported by all of the following conditions:
• The disease cannot be controlled with medication;
• Signs of progressive impairment; and
• Inability of the insured person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months:

Activities of daily living:
• Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;
• Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
• Transferring: the ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;
• Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
• Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.
• Mobility: the ability to move indoors from room to room on level surfaces at the normal place of residence

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

22. Pulmonary Artery Graft Surgery

The undergoing of surgery requiring Median Sternotomy on the advice of a cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

23. Medullary Cystic disease

Medullary cystic disease where the following criteria are met:
a. The presence in the kidney of multiple cysts in the Renal Medulla accompanied by the presence of Tubular Atrophy and Interstitial Fibrosis;
b. Clinical manifestations of Anaemia, polyuria and progressive deterioration in kidney function; and
c. The diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.

d. Isolated or benign kidney cysts are specifically excluded from this benefit.

24. Systemic Lupus Erythematous with Lupus Nephritis:-
A multi-system autoimmune disorder characterized by the development of autoantibodies directed against various self-antigens. In respect of this policy, Systemic Lupus Erythematous will be restricted to those forms of Systemic Lupus Erythematous which involve the kidneys (Class III To Class V Lupus Nephritis, established by renal biopsy, and in accordance with the who classification). The final diagnosis must be confirmed by a registered doctor specializing in Rheumatology and Immunology. The WHO classification of lupus nephritis:

Class I Minimal Change Lupus Glomerulonephritis
Class II Mesangial Lupus Glomerulonephritis.
Class III Focal Segmental Proliferative Lupus Glomerulonephritis.
Class IV Diffuse Proliferative Lupus Glomerulonephritis.
Class V Membranous Lupus Glomerulonephritis.

25. Pneumonectomy
The undergoing of surgery on the advice of an appropriate medical specialist to remove an entire lung for disease or traumatic injury suffered by the life assured.
The following conditions are excluded:
- Removal of a lobe of the lungs (Lobectomy)
- Lung Resection or incision

Section I – Top Up Deductible

Base Plan
In consideration of the premium paid and subject to the terms and conditions as set out in the Schedule with all its Parts, the Company by this Policy agrees as under:

That if during the period stated in the Schedule, the insured person shall contract any disease or suffer from any illness or sustain bodily injury through accident and if such disease, illness or injury shall require the insured Person/s, upon the advice of a duly Qualified Physician/Medical Specialist / Medical Practitioner or of duly Qualified Surgeon to incur Hospitalization expenses for medical/surgical treatment at any Nursing Home / Hospital as an in-patient, the Company will pay to the Insured Person/s the amount of such expenses in excess of the deductible per hospitalization indicated in the schedule. Here deductible shall be applicable for each and every Hospitalisation except claims made for Any One Illness

Coverage
1. In-Patient Hospitalization - If an Insured Person is diagnosed with an Illness or suffers an Injury contracted during the Policy Period which requires hospitalization in a hospital, on the advice of a medical practitioner then We will pay You, Reasonable and Customary Medical Expenses incurred as below:

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

2. Pre-hospitalization:-
The Medical Expenses incurred during the Policy Period, for the period as specified in the Schedule to this Policy immediately before the Insured Person was hospitalised, provided that:
i. Such Medical Expenses were incurred for the same condition for which the Insured Person's subsequent Hospitalisation was required, and
ii. There is a valid claim admissible under Section I. Coverages 1&7 (In-patient Hospitalization Expenses & Domiciliary Hospitalisation) of the Policy.

3. Post-hospitalization:-
The Medical Expenses incurred during the Policy Period, for the period as specified in the Schedule to this Policy, immediately after the Insured Person was discharged following Hospitalisation, provided that:
i. Such Medical Expenses were incurred for the same condition for which the Insured Person's earlier Hospitalisation was required, and
ii. There is a valid claim admissible under Section I. Coverages 1&7 (In-patient Hospitalization Expenses & Domiciliary Hospitalisation) of the Policy.

4. AYUSH
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 (AYUSH) in AYUSH Hospital or AYUSH Day Care Centre.

5. No Claim Bonus
At the end of each Policy Year, the Company will enhance the Sum Insured, on a cumulative basis, as a No Claim Bonus for each completed and continuous Policy Year, provided that no

Claim has been lodged or paid by the Company in the expiring Policy Year under any of the cover excluding Dental OPD Cover , vaccination cover subject to the conditions specified below:
1. If you renew your Policy with Us without any break in the Policy Period and there has been no claim in the preceding year, then We will increase the Limit of Indemnity by percentage of Sum Insured per annum 5% of basic sum insured as No claim Bonus. The maximum No claim Bonus increase in the Limit of Indemnity will be limited to 50% of basic Sum insured
2. In case no claim is made in a particular Policy Year, No Claims Bonus would be credited automatically to the subsequent Policy year, even in case of multi-year Policies (with policy term of 2 years and 3 years).
3. In case a claim is made during the Policy Year, the No Claims Bonus will reduce at the same rate at which it is allotted for every claim-free year, but in no case shall the Total Sum Insured be less than the Sum Insured.
This clause does not alter the Company's right to decline renewal or cancellation of the Policy for reasons as specified in Clause 10.4 (Disclosure to Information Norm under Standard Terms and Conditions).

6. Day Care Treatment
The Company will Indemnify the Policy Holder/Insured Person for Medical Expenses incurred on Day Care Treatment which involve a Surgical Procedure, through Cashless or Reimbursement Facility, maximum up to the Sum Insured, provided that the period of treatment of the Insured Person in the Hospital/Day Care Centre does not exceed 24 hours, which would otherwise require an In-patient admission but not in the outpatient department and such Day Care Treatment was prescribed in written, by a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were Medically Necessary.

7. Domiciliary Hospitalization
The Company will Indemnify the Policy Holder/Insured Person, , up to the Sum Insured, for the Medical Expenses incurred towards Domiciliary Hospitalization, i.e. coverage extended when Medically Necessary treatment is taken at home, subject to the conditions specified below:
1. The Medical Expenses are incurred during the Policy Year.
2. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
3. the patient takes treatment at home on account of non-availability of room in a hospital.

Note
1. Expenses on Hospitalization for minimum period of 24 hours only are admissible. However, this time limit will not apply for the day care treatments / procedures, where treatment is taken in the Hospital / Nursing Home and the Insured is discharged on the same day.
2. Our maximum liability for a continuous period of Illness, including relapses within 45 days from the last date of discharge from the Hospital or nursing home where treatment has been taken, shall be limited to the amount mentioned in the Policy Schedule. Occurrence of the same Illness after a lapse of 45 days as stated above will be considered as fresh Illness for the purpose of this Policy.

Section II – Super Top Up Deductible
In consideration of the premium paid and subject to the terms and conditions as set out in the Schedule with all its Parts, the Company by this Policy agrees as under:
i. If You are hospitalized on the advice of a Medical Practitioner because of an Illness or Accidental Bodily Injury sustained or contracted during the Policy Period, then We will pay You, Reasonable and Customary charges/Medical Expenses incurred, subject to One-time deductible as specified on the policy document. One-time deductible 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. The deductible is applicable per policy year basis in aggregate towards hospitalisation expenses (admissible under policy) incurred during the policy period by insured (individual policy) or insured family (in case of family floater).

Coverages :
1. In Patient Hospitalization
If an Insured Person is diagnosed with an Illness or suffers an Injury contracted during the Policy Period which requires hospitalization in a hospital, on the advice of a medical practitioner then We will pay You, Reasonable and Customary charges/Medical Expenses incurred as below
i. Room Rent;
ii. Nursing charges for Hospitalization as an Inpatient excluding private nursing charges;
iii. Medical Practitioners' fees, excluding any charges or fees for standby services;
iv. Physiotherapy, investigation and diagnostics procedures directly related to the current admission;
v. Medicines, drugs as prescribed by the treating Medical Practitioner;
vi. Intravenous fluids, blood transfusion, injection administration charges and /or consumables;
vii. Operation theatre charges;
viii. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery;
ix. Intensive Care Unit charges.

3. Pre-hospitalization:-
The Medical Expenses incurred during the Policy Period, for the period as specified in the Schedule to this Policy immediately before the Insured Person was hospitalised, provided that:

i. Such Medical Expenses were incurred for the same condition for which the Insured Person's subsequent Hospitalisation was required, and

ii. There is a valid claim admissible under Section II. Coverages 1& 7 (In-patient Hospitalization Expenses & Domiciliary Hospitalisation) of the Policy.

3. Post-hospitalization:-

The Medical Expenses incurred during the Policy Period, for the period as specified in the Schedule to this Policy, immediately after the Insured Person was discharged following Hospitalisation, provided that:

i. Such Medical Expenses were incurred for the same condition for which the Insured Person's earlier Hospitalisation was required, and

ii. There is a valid claim admissible under Section II. Coverages 1&7 (In-patient Hospitalization Expenses & Domiciliary Hospitalisation) of the Policy.

4. Day Care Treatment

The Company will Indemnify the Policy Holder/Insured Person for Medical Expenses incurred on Day Care Treatment which involve a Surgical Procedure, through Cashless or Reimbursement Facility, maximum up to the Sum Insured, provided that the period of treatment of the Insured Person in the Hospital/Day Care Centre does not exceed 24 hours, which would otherwise require an In-patient admission but not in the outpatient department and such Day Care Treatment was prescribed in written, by a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were Medically Necessary.

5. AYUSH

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 (AYUSH) in AYUSH Hospital or AYUSH Day Care Centre.

6. No Claim Bonus

At the end of each Policy Year, the Company will enhance the Sum Insured, on a cumulative basis, as a No Claim Bonus for each completed and continuous Policy Year, provided that no Claim has been lodged or paid by the Company in the expiring Policy Year under any of the cover excluding Dental OPD Cover , vaccination cover subject to the conditions specified below:

1. If you renew your Policy with Us without any break in the Policy Period and there has been no claim in the preceding year, then We will increase the Limit of Indemnity by percentage of Sum Insured per annum 5% of basic sum insured as No claim Bonus. The maximum No claim Bonus increase in the Limit of Indemnity will be limited to 50% of basic Sum insured

2. In case no claim is made in a particular Policy Year, No Claims Bonus would be credited automatically to the subsequent Policy year, even in case of multi-year Policies (with policy term of 2 years and 3 years).

3. In case a claim is made during the Policy Year, the No Claims Bonus will reduce at the same rate at which it is allotted for every claim-free year, but in no case shall the Total Sum Insured be less than the Sum Insured.

This clause does not alter the Company's right to decline renewal or cancellation of the Policy for reasons as specified in Clause 10.4 (Disclosure to Information Norm under Standard Terms and Conditions.

7. Domiciliary Hospitalization

The Company will Indemnify the Policy Holder/Insured Person, , up to the Sum Insured, for the Medical Expenses incurred towards Domiciliary Hospitalization, i.e. coverage extended when Medically Necessary treatment is taken at home, subject to the conditions specified below:

1) The Medical Expenses are incurred during the Policy Year.

2) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or

3) the patient takes treatment at home on account of non-availability of room in a hospital.

Note

Expenses on Hospitalization for minimum period of 24 hours only are admissible. However this time limit will not apply for the day care treatments / procedures, where treatment is taken in the Hospital / Nursing Home and the Insured is discharged on the same day.

Section III Optional Benefits –

The benefits below are optional and stand to be effective only if shown in the Policy Schedule as being effective. Our maximum liability will be limited to the amount specified in the Policy Schedule.

1. Pre-existing Disease Waiting Period Waiver/ Reduction

On payment of additional premium pre-existing waiting period shall be reduced or waived.

This cover will be applicable only if specified in the policy Schedule.

Waiting period will be Reduced / waived only for the disclosed pre-existing diseases which has been accepted by Us at the inception of policy.

By opting this cover, Exclusion clause 4.I will be waived / altered

This cover will not be applicable for any permanent exclusions which are specified in the Policy Schedule.

2. Base Policy Co-pay Support

The company will indemnify the expenses towards deduction of co-payment (voluntary co-pay / mandatory co-payment in the base policy upto the amount specified in the policy schedule.

Conditions-

• Amount deducted only for the expenses towards co-payment in base policy will be payable.
• This cover cannot be opted if option Voluntary co-pay is selected in this policy, mentioned under Section IV.
• Amount claimed under this benefit will be payable basis on the terms, conditions & exclusions as per this policy.
• Deductible mentioned in Section I /II will not be applicable for this cover.
• Sub-limit / Co-payment on cover and or diseases will not be applicable.
• Any deduction in base policy will not be indemnified by Us if claimed and covered with any other insurance cover.
• This cover would be applicable in case the Customer has an active base health Insurance Policy with Us or any Health/ General Insurance Company at the time of inception or at the time of renewal of this product

Our maximum liability will be limited to the amount mentioned in the Policy Schedule, which is within the basic Sum Insured of the policy.

3. Base Policy Higher Room Rent Support

The company will indemnify the expenses towards deduction of excess room rent and Associate medical Expenses in the base policy upto the amount specified in the policy schedule.

Conditions-

• Amount deducted only for the expenses towards excess room rent and Associate Medical Expenses in base policy will be payable.
• Amount claimed under this benefit will be payable basis on the terms, conditions & exclusions as per this policy.
• Deductible mentioned in section I /II will not be applicable for this cover
• Any deduction in base policy will not be indemnified by Us if claimed and covere d with any other insurance cover.
• This cover would be applicable in case the Customer has an active base health Insurance Policy with Us or any Health/ General Insurance Company at the time of inception or at the time of renewal of this product

Our maximum liability will be limited to the amount mentioned in the Policy Schedule, which is within the basic Sum Insured of the policy.

4. Newborn Care

New born babies of the policy holder/Insured shall be covered from day one i.e. from day of baby's birth or delivery and the maximum limit of liability under this cover as opted by insured / policy holder, allowed maximum up to two children.

Sum insured options are as below:

1) Baby covered from day one limited to maternity sum insured (Deductible for Maternity Sum insured will be applicable).
2) Baby covered from day one up to sum insured opted by members (Deductible mentioned in base cover section I/II will be applicable).

Coverage-

We will cover the baby's in-patient hospitalization for an Illness or Injury during the Policy Period which needs hospitalization in a hospital , on the advice of a medical practitioner.

Pre-Post hospitalization expenses for Your baby will be payable as per the basic cover under this Policy, upto maternity limit/full Sum Insured as opted by You.

Policy period / coverage for Newborn Care is for a period of 90 days i.e. from date of birth to 90 days of baby's age any time during the policy period.

Our maximum liability will be limited to the amount mentioned in the Policy Schedule, which is within the basic Sum Insured of the policy.

III. Special conditions for this cover (Other than those of this Policy)

1. This cover can be opted only at first policy inception or at the renewal of the Policy.
2. You can't cancel this solely in between the policy year the Policy needs to be cancelled, except at the time of renewal of the Policy, but if the policy is within free look period, then the customer can cancel this cover without this policy being cancelled. If you cancel your Edelweiss Health Top Up Insurance Policy, this cover shall also stand cancelled along with it.
3. This optional cover should be available in your Policy on the date of loss.
4. This coverage will be rendered effective on and from your baby's date of birth, provided this cover has been opted for prior to the said date of birth of Your baby. First 30 days waiting period and pre-existing condition exclusion will not be applicable for the baby.
5. No matter what the waiting period of the maternity benefit in Your existing Policy, the baby will be covered from day one as per the Sum Insured option chosen.
6. This benefit is given for one's self and/or spouse, as mentioned in a family floater under this Policy.
7. This coverage shall cease to be in effect once the baby reaches 91 days of age. The Insured can apply for a fresh Policy for the baby, as per the underwriting guidelines of the Company.
8. The coverage under this option shall be applicable to only one child per policy year.
9.The coverage under this option shall be given to a baby of a legally married couple, up to a maximum of any two children.
10. No charges will be paid for umbilical cord occult blood

preservation.

11. This cover can be opted only at the time of purchase/ renewal of this Policy and prior to birth of the baby subject to underwriting guidelines of the Company.

12. Pre-post benefit for this cover will be available as per this Policy.

13. All other terms & conditions, exclusions & deductibles stay as per this Policy.

5. Vaccination cover

We will cover vaccinations of new born baby Immunization expenses for the amount of Sum Insured mentioned in the policy schedule until the New Born Baby completes one year.

If the Policy ends before the New Born Baby has completed one year, then, We will only cover vaccinations until the baby completes one year, and only if We have accepted the baby as an Insured Person at the time of renewal.

Deductible mentioned in section I /II will not be applicable for this cover

Our maximum liability will be limited to the amount mentioned in the Policy Schedule, which is over and above the basic Sum Insured as opted and mentioned in policy schedule.

6. Double Sum Insured for Critical illness (CI)

By opting this cover the Company will indemnify the Policy Holder/Insured Person, through Cashless/Reimbursement facility, double the basic sum insured which is specified in the policy schedule for the payment under the basic covers of the policy (Section I/II) as opted. If the Double Sum Insured for Critical Illness option is not chosen, then the insured will be indemnified upto base SI as per the terms and conditions under section-I&II as opted by customer.

The conditions are as specified below:

1. The Insured Person is first diagnosed as suffering from a Critical Illness during the Policy Period,

2. The basic sum insured – excluding No Claim Bonus will be reinstated in case of opted critical illness is triggered.

3. In case the additional Critical Illness Sum Insured is not utilized in a Policy Year, it shall not be carried forward to subsequent Policy Year.

4. The Policy shall not cover the expenses if under double sum insured benefit if :

i. The Insured Person is first diagnosed as suffering from a Critical Illness within 90 days of the commencement of the Policy Period and the Insured Person has not previously been insured continuously and without interruption under a Policy.

ii. The Insured Person has already made a claim for the same Critical Illness.

iii. All other terms & conditions, exclusions & deductibles stay as per your basic Policy

5. Waiting Period of 90 days from the date of inception of this cover with us. However this exclusion would not be applicable in case of continuous renewal of this cover and without break in cover.

6. If double Sum Insured option is not opted by the insured, then the waiting period applicable for these Critical illnesses would be as per the base Top up health Insurance policy. However this exclusion would not be applicable in case of continuous renewal of the policy without break in cover.

7. When the insured is admitted for any other illness other than the defined critical illness and in this course of admission and he has been diagnosed subsequently of the defined critical illness he shall be indemnified under this coverage.

List of Critical illnesses plans for Double Sum Insured

Sr. No.	Particulars	Plan name				
		(09 CI) Standard	(12 CI) Enhance	(15 CI) Premium	(18 CI) Elite	(25 CI) Ultima
1	Cancer Of Specified Severity	Yes	Yes	Yes	Yes	Yes
2	Kidney Failure Requiring Regular Dialysis	Yes	Yes	Yes	Yes	Yes
3	Multiple sclerosis With Persisting Symptoms	Yes	Yes	Yes	Yes	Yes
4	Major organ/Bone marrow transplant	Yes	Yes	Yes	Yes	Yes
5	Open heart replacement or repair of heart valves	Yes	Yes	Yes	Yes	Yes
6	Open chest coronary artery bypass graft (CABG)	Yes	Yes	Yes	Yes	Yes
7	Permanent Paralysis of limbs	Yes	Yes	Yes	Yes	Yes
8	Myocardial infarction (First heart attack of specific severity)	Yes	Yes	Yes	Yes	Yes
9	Stroke resulting in permanent symptoms	Yes	Yes	Yes	Yes	Yes
10	Benign brain tumour	X	Yes	Yes	Yes	Yes
11	Motor neuron disease with Permanent Symptoms	X	Yes	Yes	Yes	Yes
12	Coma of specified severity	X	Yes	Yes	Yes	Yes
13	End stage liver failure	X	X	Yes	Yes	Yes
14	Primary (idiopathic) pulmonary hypertension	X	X	Yes	Yes	Yes
15	Surgery of aorta	X	X	Yes	Yes	Yes
16	Third degree burns	X	X	X	Yes	Yes
17	Deafness	X	X	X	Yes	Yes
18	Loss of speech	X	X	X	Yes	Yes
19	Muscular dystrophy	X	X	X	X	Yes
20	Alzheimer's disease	X	X	X	X	Yes
21	Parkinson's disease	X	X	X	X	Yes
22	Pulmonary artery graft surgery	X	X	X	X	Yes
23	Medullary cystic disease	X	X	X	X	Yes
24	Systemic Lupus Erythematous with lupus nephritis	X	X	X	X	Yes
25	Pneumonectomy	X	X	X	X	Yes

7. Assistance Services – Within India & Worldwide

Here the Eligible Domestic or Global Participant means " Insured person who is covered under this policy"

All the below mentioned assistance services would be provided by Us /through our appointed service provider. No claims for reimbursement will be applicable for this service. Hence to avoid any discomfort to insured it is advisable that insured should inform/intimate us in advance to utilize this services.

1. Medical Referrals- On Assistance Services basis

Insured Person(s) will have tele-access to an operations center of Our Service Provider, who with their multilingual staff on duty will provide reference of doctors in the vicinity where the insured person is located for medical consultation.

Insured Person(s) will have telephone access to operations centre staff 24 hours a day every day of the year with multi lingual personnel for medical referral.

This cover is applicable if it is shown on your schedule.

Emergency Medical Evacuation - On Assistance service basis

Definitions:

Emergency Evacuation means:

(a) Your/ Insured Person(s) medical condition warrants immediate Transportation from the place where You/ Insured Person(s) are injured or sick to the nearest Hospital where appropriate medical treatment can be obtained; or (b) after being treated at a local Hospital, Your/ Insured Person(s) medical condition warrants Transportation to the place where the Trip commenced to obtain further medical treatment or to recover; or (c) both (a) and (b) above.

Transportation - means any land, water or air conveyance required to transport You during an Emergency Evacuation.

When an adequate facility is not available proximate to the Insured Person(s) , as determined by service providers consulting physician and Insured Person(s) attending physician, our service provider will arrange transportation under appropriate medical supervision, by an appropriate mode of transport to the nearest medical facility capable of providing the required care

This cover is applicable if it is shown on your schedule.

3. Medical Repatriation - On Assistance Services basis

Our service provider will arrange for transportation under medical supervision to the Insured Person(s) residence in India or to a medical or rehabilitation facility near such residence when our service provider's consulting physicians and the attending physician determines that transportation is medically necessary, at such time the Insured Person(s) is medically cleared for travel by our service provider's consulting physician and attending physician.

This cover is applicable if it is shown on your schedule.

4. Compassionate Visit – On Assistance service basis

When an Insured Person(s) will be hospitalized for more than 7 consecutive days and is travelling in India without a companion, service provider will arrange for a family member or friend to travel to visit the Insured Person(s) in India by providing an appropriate means of transportation via economy carrier transportation as determined by our service provider. The family member or friend is responsible to meet all VISA and travel document requirements if applicable.

This cover is applicable if it is shown on your schedule.

5. Medical Monitoring – On Assistance service basis

Medical Personnel will monitor Insured Person(s) condition and will i) Stay in regular communication with the attending Physician and / or Hospital and ii) Relay necessary and legally permissible information to family members.

This cover is applicable if it is shown on your schedule.

6. Second Medical Opinion – On Assistance service basis

Our appointed service provider will arrange for second medical opinions for Insured Person(s) for such services upon request in the following instances: i) When a Participant's medical condition is undiagnosed by a treating physician; ii) when a Participant seeks an additional medical opinion following an original diagnosis; and iii) when the determination of the most appropriate course of medical treatment is required based on a current diagnosis. The participant may contact our Assistance Service Provider's s operation centre to initiate the request for a medical consultation and the Participant is responsible for gathering, obtaining, and submitting to our Assistance Service Provider all required medical reports, charts, data, and medical history pertaining to the Participant's condition and responding to follow up requests for additional information. All information provided to Assistance Service Provider must be legible. The medical review will be undertaken by a physician licensed to practice medicine and within a discipline that relates to the condition / diagnosis.

The second medical opinion will be provided to the Insured Person(s) in the electronic format and such opinion will be reached and rendered within 5 business days after all required medical history, data, reports, charts are properly submitted for consultation and review. The services solely relate to the provision of a medical opinion and does not include personal visits or follow-up for discussions for the implementation of course of treatment. If the Insured Person(s) seeks further involvement from the physician rendering the opinion or seeks to converse with or visit the Physician, such must be arranged on a fee for service basis with Assistance Service Provider facilitating such arrangements. All opinions rendered by the physician are the opinions of the physician and neither Edelweiss General Insurance Company Limited nor Assistance Service Provider is responsible or liable for the content of such opinions.

Exclusions:

Second Medical Opinion is not included for any health related claim where the second medical opinion will serve as a means to evaluate the Insured Person(s) claim in connection with coverage determination.

This cover is applicable if it is shown on your schedule.

7. Return of Mortal Remains – On Assistance Service basis

In the case of Insured Person(s) death in India, our service provider will arrange and pay for the return of mortal remains to an authorized funeral home proximate to the Insured Person(s) residence in India.

This cover is applicable if it is shown on your schedule.

Exclusion applicable to all Assistance services – applicable to coverage both within India and worldwide:

Service provider will not provide any of these services to an Insured Person(s) if i) the eligible participant undertook travel for the purpose of obtaining medical treatment, ii)injuries are sustained as a result of participation in acts of war or insurrection iii) injuries are incurred while participating in criminal activity or as a result of unlawful consumption of drugs iv)injuries are sustained as a result of attempted suicide

Service provider will not repatriate or evacuate an Insured Person(s) if the Insured Person(s) has i) no medical authorization ii)mild lesions, simple injuries such as sprain, simple fractures or mild sickness which can be treated by local doctors and do not prevent the Insured Person(s) from continuing the trip and returning home iii)if Insured Person(s) is pregnant and beyond the end of 28th week and with respect to the child born from the pregnancy, service provider will not evacuate or repatriate a child born while the Insured Person(s) was traveling beyond 28th week or Service provider will not provide services for trips exceeding 90 days from legal residence.

Claims Process Note for Availing services for Medical Referral, Emergency Medical Evacuation, Medical Repatriation, Compassionate Visit, Return of Mortal Remains:

1. Insured / Nominee calls our Assistance Service Provider operations to avail the medical assistance service.
2. Our empanelled Assistance Service Provider will do the validation and proceed with the case for the eligible member.
3. If member is eligible as defined, our Assistance Service Provider will activate the service.
4. If member is not eligible, explanation will be given to insured in a courteous manner.
5. Our Assistance Service Provider will inform to EGIC about the case and the case will be dealt with accordingly.

Claims Process Note for Availing services for Second Medical Opinion:

Option 1

1) Insured will call for SMO to our empanelled Assistance Service Provider operations centre
2) Our empanelled Assistance Service Provider will verify member eligibility based on enrolment data and send the Second Medical Opinion portal link to the member via email with a unique reference of EGIC.
3) Once the case is registered in portal, our empanelled Assistance Service Provider sends an auto mailer to member about the documents received.
4) Followed by notification email by our empanelled Assistance Service Provider to insured stating that your request has been received and proceed with the request.
5) Any further information required if any, our empanelled Assistance Service Provider to call the member directly/send email asking for additional information.
6) Once the insured submits the addition requested information, our empanelled Assistance Service Provider will begin working on Second Medical Opinion & from that date of the receipt of the medical report, Second Medical Opinion will be ready usually within five (5) to seven (7) business days.
7) Insured will receive the direct link on registered email address once report is ready. Insured can download the report can access in e-format or print it.

Option 2

1) Insured will call/email for Second Medical Opinion to our empanelled Assistance Service Provider Operations centre and our empanelled Assistance Service Provider will verify member eligibility based on enrolment data.
2) In case the Insured shows any apprehension to upload report on the Second Medical Opinion portal, our empanelled Assistance Service Provider's coordinator to fill the details on portal on behalf of the member and request member for the reports either by scan copy via email and in case of hard copy will instruct the member to send the reports to address of our empanelled Assistance Service Provider operations centre.
3) Our empanelled Assistance Service Provider to check the report and revert in case of any deficiency to member.
4) Once the insured submits the addition requested information, the SMO team may begin working on SMO opinion & from that date report will be ready within five (5) to seven (7) business days.
5) Our empanelled Assistance Service Provider will send the soft copy of the Report to Member on the registered email address.

8. Hospital Cash

If, during the Policy Period, an Insured Person sustains bodily Injury or illness which, directly results in the Insured Person being in a Hospital as an In-patient, the Company will pay the amount as specified in the Policy Schedule for each continuous and completed period of 24 hours through which the Insured Person is Hospitalised.

The claim is admissible as per section I. 1 (In-Patient Hospitalization) or Section II.1(In-Patient Hospitalization) of the policy as opted.

We will not make payment for the deductible period per event, as mentioned in the Policy Schedule.

This Benefit shall not be payable for more than the number of days per Policy Year, as specified in the Policy Schedule.

Our Maximum liability will be as mentioned in the policy schedule which is over and above the basic sum insured.

9. Dental OPD Cover

Under this Benefit, We will pay Reasonable and Customary Charges to cover the fees of a dental practitioner and associated costs for carrying out the following routine Dental Treatment procedures in respect of an Insured Person:

- Clinical Oral examinations;
- Palliative treatment for dental pain;
- Tooth cleaning;
- Normal compound fillings; or
- Simple non-surgical extractions.

This Benefit excludes orthodontic treatment, restorative treatment and dental implants.

Exclusions Applicable to Dental Benefit

We will not pay benefit for the following treatment:

a) Instruction for plaque control, oral hygiene and diet;

b) Bite registration,

c) a request for Treatment or dental surgery which is not advised and/or recommended by a Dentist, including any Dental Services which are not Medically Necessary

d) any Dental Service solely for cosmetic and/or aesthetics purposes.

e) medications that need to be taken post treatment, expenses for toothbrushes, toothpaste, dental floss, mouthwash

Deductible mentioned in section I /II will not be applicable for this cover.

Our Maximum liability will be as mentioned in the policy schedule which is over and above the basic sum insured.

10. Restoration

The Company will restore 100% of the Sum Insured once in a policy year on indemnity basis in case the Total Sum Insured inclusive of earned No claim Bonus (if any) is insufficient due to claims paid or accepted as payable during the Policy Year, subject to the conditions specified below:

1. This restored Sum Insured can be utilized only for illness / disease unrelated to the illness / diseases for which claim/s was / were made in the particular policy year.

2. The Restoration Benefit will be triggered by Section I.1 & Section II.1(In-Patient Hospitalization), Section I.2, II.2, I.3 & II.3, (Pre Hospitalization and Post Hospitalization), Section I.7 & II.7 (Domiciliary Hospitalization), Section I.6 & II.4 (Day Care treatment), Section III.16 (Emergency Ambulance if opted), Section III.15 (Organ Donor if opted), Section I.4 and Section II.5, (AYUSH), Section III.14 (Maternity if opted)

3. Restoration will not trigger on the first claim.

4. In case the Restored Sum Insured is not utilized in a Policy Year, it shall not be carried forward to subsequent Policy Year.

5. Any restored Sum Insured will not be used to calculate the No claim Bonus.

6. No Claim Bonus shall not be considered while calculating restored Sum Insured.

7. For Individual policies, restored Sum Insured will be available on individual basis whereas in case of a Family Floater policy it will be available on floater basis.

8. For any single claim during a policy year, the maximum claim amount payable shall be sum of:

i. The Sum Insured

ii. No Claim Bonus (if earned).

9. During a Policy Year, the aggregate claim amount payable, subject to admissibility of the Claim, shall not exceed the sum of:

i. The Sum Insured

ii. No Claim Bonus (if earned)

iii. Restored Sum Insured.

10. 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.

11. This benefit would be applicable if specially opted for by the Insured.

12. Deductibles if any will stay as per this Policy.

11. Recharge

The Company will replenish 100% of the Sum Insured on indemnity basis once in a policy year in case the Total Sum Insured inclusive of earned No Claim Bonus (if any) is insufficient due to claims paid or accepted as payable during the Policy Year, subject to the conditions specified below:

1. The Recharge Benefit will be triggered by Section I.1 & Section II.1(In-Patient Hospitalization), Section I.2, II.2, I.3 & II.3, (Pre Hospitalization and Post Hospitalization), Section I.7 & II.7 (Domiciliary Hospitalization), Section I.6 & II.4 (Day Care treatment), Section III.16 (Emergency Ambulance if opted), Section III.15 (Organ Donor if opted), Section I.4 and Section II.5, (AYUSH), Section III.14 (Maternity if opted)

2. Recharge Benefit can be utilized even for the same hospitalization or for the treatment of diseases / illness / injury / for which claim was paid / payable under the policy.

3. In case the Recharge Sum Insured is not utilized in a Policy Year, it shall not be carried forward to subsequent Policy Year.

4. Any Recharge Sum Insured will not be used to calculate the No claim Bonus.

5. No Claim Bonus shall not be considered while calculating the Recharge Sum Insured.

6. For Individual policies, Sum Insured will be available on individual basis whereas in case of a Family Floater policy it will be available on floater basis.

7. 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.

8. It is not mandatory that Restoration benefit amount should be triggered or exhausted for Recharge benefit to apply. In case of valid and accepted claim for the same illness, we will honour the claim by paying through the recharge benefit. In such circumstance, the exhaustion of Sum insured would not take into account the restored Sum Insured.

9. This benefit would be applicable if specially opted for by the Insured.
10. Deductibles if any will stay as per this Policy.

Worldwide Coverage (Extended Coverage)
On payment of additional premium, coverage of this policy will be extended to world wide except Domiciliary Hospitalization (Section I.7 and Section II.7).
This cover will be applicable only if mentioned in policy schedule.

If the insured has opted for worldwide coverage on Renewal, then waiting period will apply afresh for any treatment taken outside India.

Terms and conditions for Worldwide coverages for Assistance Services are as per the "Section III Optional Benefits" sub coverage 7 Assistance Services – Within India & Worldwide

13. Maternity
On Payment of additional premium we will pay the Medical Expenses related to pregnancy, childbirth or medically recommended and lawful termination of pregnancy, limited to maximum 2 deliveries or termination(s) or either, during the lifetime of the insured person as below:-.
i. We will cover the Medical expenses for maternity including complications of maternity over and above the deductible specified against this cover in the policy schedule.
ii. We will also cover expenses towards lawful medical termination of pregnancy during the Policy period.
iii. In patient Hospitalization Expenses of pre-natal and post-natal hospitalization
Conditions:
i. Waiting Period of 12 months from the date of inception of this cover with us. However this 12 months exclusion would not be applicable in case of continuous renewal of this cover and without break in cover.
ii. Medical Expenses for ectopic pregnancy are not covered under this Benefit. However, these expenses are covered under Section I.1/II.1(In-Patient Hospitalization) as opted.

Our Maximum Liability will be within the basic sum insured mentioned in the policy.

Exclusion XVIII will get waived by opting this cover.

14. Organ Donor
The Company will indemnify the Policy Holder/Insured Person, through Cashless or Reimbursement Facility, up to the amount specified against this Benefit, for the Medical Expenses incurred for an organ donor's in-patient treatment for the harvesting of the organ donated, subject to the conditions specified below:
1. The donation conforms to the Transplantation of Human Organs Act 1994 and amendments thereafter and the organ is for the use of the Insured Person.
2. We only pay for transplants carried out and also the the organ procurement is in accordance with applicable laws of particular country.
3. The recipient Insured Person has been Medically Advised to undergo an organ transplant.
4. The Company has accepted the recipient Insured Person's claim under Section I.1/II.1 (Inpatient Hospitalization Expenses) as opted.

The Company shall not be liable to make any payment in respect of below:
1. Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.
2. Screening or Medical Expenses of the organ donor.
3. Costs directly associated with the acquisition of the donor's organ.
4. Expenses related to organ transportation or preservation.
5. medical treatment or complication in respect of the donor, consequent to harvesting.
6. We do not pay for any– Stem cell harvesting,
– Tissue transplants including those from the patient's own body (other than bone marrow transplants),

Our Maximum Liability will be within the basic sum insured mentioned in the policy.

All other terms & conditions, exclusions & deductibles stay as per this Policy.

15. Emergency Ambulance
The Company will indemnify the Policy Holder/Insured Person, through Cashless or Reimbursement Facility, up to the amount specified against this Benefit, for the Reasonable and Customary Charges necessarily incurred on availing Ambulance services offered by a Hospital or by an Ambulance service provider for the Insured Person's necessary transportation, provided that the necessity of such Ambulance transportation is certified by the treating Medical Practitioner, subject to the conditions specified below:
1. Such Transportation is from the place of occurrence of Medical Emergency of the Insured person, to the nearest Hospital; and/or
2. Such Transportation is from one Hospital to another Hospital for the purpose of providing better Medical aid to the Insured Person, following an Emergency.
3. The Company will not make a payment under this Benefit if the insured person is transferred to a Hospital or diagnostic centre for evaluation purposes only and not for treatment purpose.

All other terms & conditions, exclusions stay as per this Policy
Deductible mentioned in section I /II will not be applicable for this cover.
Our Maximum liability will be as mentioned in the policy schedule

which is over and above the basic sum insured.

241. Optional Cover
On receipt of additional premium, we agree to waive the first renewal premium of this Policy, provided:
1. There is no claim paid/ admissible to you during the term of this optional coverage
2. There is no claim paid/admissible against the policy in particular policy year. In Individual policy, the claim paid/admissible will be considered on respective member who has made the claim. For other members who have not made a claim, premium waiver will be applicable in case of renewal.
3. There is no claim paid/admissible against any members in a floater policy. In case if any member has made a claim, premium will be applicable for all the members in a floater policy in case of renewal.
4. This coverage has been purchased with this policy for the first time (Individual + Floater), and not an existing policy.
5. This premium waiver benefit is applicable only for the first renewal of the policy and not available at subsequent renewals.
6. This coverage benefit is offered only once at the time of initial entry of the insured of this Policy.
7. This optional cover is applicable for 1 year policy term only.

I. Specific conditions for this Optional cover:
1. This coverage can be taken only with this Policy that we've issued you.
2. If you make a claim under this Policy and/or other optional covers (except Dental Benefit and Vaccination Cover) that you've taken, it will be considered as a Claim even for the purpose of this cover. The benefits of this cover will end once you make such a Claim.
3. In case of claim in first policy year is reported by insured in a renewal policy where premium is waived, then we will communicate the insured for payment of requisite premium in renewal policy and policy will continue with continuity benefit. If premium is not received within 15 days of receipt of communication from client, then renewal policy will get cancelled ab Initio, Company will not be on risk during the period when the premium is not received by us.
4. You can't cancel only this cover in between the policy year , the entire policy needs to be cancelled, but if the policy is within free look period, then customer can cancel this cover without this Edelweiss Health Top Up Insurance policy being canceled.Similarly, if you cancel Edelweiss Health Top Up Insurance Policy, this cover is also cancelled automatically.
5. You can't include new members for this cover in the middle of your policy term. It has to be taken only at the start.
This cover is subject otherwise to the terms, exceptions, conditions and limitations of Edelweiss Health Top Up Insurance Policy.

Section IV
Discount Covers –

• Voluntary Co-pay
• In Lieu of Insured Person opting a voluntary co-pay cover, the Company shall only pay 90% for 10% co-pay option or 80% for 20% co-pay option of the claim amount that is assessed for the payment or reimbursement under the Policy. Balance of 10% or 20% as the case may be will be borne by the Insured Person.
• This co-pay is applicable for each and every claim made by the Insured Person except fixed Benefit Covers and Maternity.
• Eligible Insured person will get discount on premium on opting this optional cover.

Discounts/Loadings

Discounts Type	Discounts Percentage
1. Family Discount- A discount of 5% on total premium will be given if two or more family members are covered under the same policy under the individual policy option	5%
2. Long Term Discount- A discount of 7.5% and 10% on total premium will be given if a policyholder chooses to pay upfront premium for 2 years and 3 years respectively	2 year: 7.5% 3 year: 10%
3. Edelweiss Group Employee Discount - A 5% discount on the premium if he/she is an employee of Edelweiss Group	5%
4. Online Discount (A discount of 15% on total premium will be given. Applicable only if taken from Edelweiss website)	15%
5. Renewal discount A discount of 5% will be given on each continuous renewal of policy irrespective of whether insured has made claim in past. (Not Applicable if customer has opted for 241 benefit in his first renewal but in second and subsequent renewals, the insured will get this discount)	5%
6. Edelweiss Customer Discount- A discount of 5% shall be given to any proposer who has a valid and existing Unique Customer Identification Number as issued by the Edelweiss Group. Edelweiss Customer discount shall only be given to the proposer when (a) the person is verified customer of the Edelweiss Group as defined on the date when the proposal is made and (b) it is sold through direct sales mode only and not through the intermediaries	5%
7. Loyalty Discount - A discount of 5% will be given to insured who is having any active policy with Edelweiss General Insurance Company	5%

Maximum Discount

The maximum total per policy discount after considering all the discounts (excluding voluntary co-payment discount and family floater discount) will be as per the table below:

Policy Term	Maximum discount available
1 year	20%
2 years	25%
3 years	30%

3. Exclusions Applicable:

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

I. Pre-Existing Diseases - Code- Excl01

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of the 36 months of continuous coverage as specified in the policy schedule, 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 specified months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

II. Specified disease/procedure waiting period- Code- Excl02

1. 24 months waiting period

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with 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

i. 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. 90 Days Waiting Period

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 90 days 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

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.

iii. Cardiac disorder:

III. 30-day waiting period- Code- Excl03
a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

IV. Investigation & Evaluation- Code- Excl04
a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

V. 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.

VI. 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

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

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

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

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

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

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

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

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

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

XVII. Sterility and Infertility: Code- Excl17
Expenses related to sterility and infertility. This includes:
(i) Any type of contraception, sterilization
(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

(iii) Gestational Surrogacy
(iv) Reversal of sterilization

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

XIX. Any Treatment that arises from or is in any way connected with attempted suicide or any injury or illness that the Insured Person or dependant inflicts upon himself.

XX. Any Treatment by way of the intentional Termination of Pregnancy.XXIII. Charges incurred in connection with cost of spectacles and contact lenses, routine eye and ear examinations, hearing aids, all other similar external appliances and /or devices whether for diagnosis or treatment, for the complete exhaustive list kindly refer, **List I - Items for which coverage is not available in the Policy.**

XXI. Any expenses relating to OPD treatments are not covered.

XXII. Injury or disability directly caused or contributed to whilst engaging in or taking part in war, invasion, terrorist activities, rebellion (whether war be declared or not), civil war, commotion, military or usurped power, martial law, riot or the act of any lawfully constituted authority, or while the Insured Person(s) is / are carrying out army, naval or air services operations, whether or not war has been declared.

XXIII. Any Treatment availed outside the territorial limits of the policy unless specifically opted for.

XXIV. 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.

XXV.Any treatment related to Acupressure, acupuncture, magnetic and such other therapies not approved by ICMR or governing authority of respective council.

XXVI. Any charges incurred to procure documents related to treatment or Illness pertaining to any period of Hospitalization or Illness

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

Permanent Exclusions

Irrespective of waiting period or Portability, below mentioned disease are permanently excluded under this policy in case where such disease are pre-existing or disclose by the customer in the proposal form at the time of first proposal of this product with us. These pre-existing illnesses will not be covered even if the optional cover Pre-existing Waiting Period Waiver/Reduction has been opted. We will permanently exclude these conditions with due consent of proposer or persons to be insured.

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behaviour
3	Epilepsy	G40 Epilepsy

4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25) Ischemic heart diseases, I50 Heart failure, I42 Cardiomyopathy; I05-I09 - Chronic rheumatic heart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn'sdisease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis, unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 –Acute delta- (super)infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 -G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
14	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
15	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

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

5. 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

6. Claims Procedure and Management

6.1. Pre-requisite for admissibility of claim

Any claim being made by an Insured Person or attendant of Insured Person during Hospitalization on behalf of the Insured person, should comply with the following conditions:

1. The Condition Precedent Clause has to be fulfilled.
2. The medical condition caused, Medical Expenses incurred, subsequently the Claim being made, should be with respect to the Insured Person only. The Company will not be liable to Indemnify the Insured Person for any loss other than the covered benefits and any other person who is not accepted by the Company as an Insured Person.
3. The holding Policy should be in force at the event of the Claim. All the Policy Terms and Conditions, waiting periods and exclusions are to be fulfilled including the realization of premium by their respective due dates.
4. All the required and supportive Claim related documents are to be furnished within the stipulated timelines. The Company may call for additional documents wherever required.

6.2. Duties of a Claimant/ Insured Person in the event of Claim:-

On the occurrence of any loss, within the scope of cover under the Policy

You shall:

1. The Policyholder / Insured Person shall check the updated list of Network Provider before submission of a pre-authorization request for Cashless Facility.
2. Forthwith file/submit a Claim Form in accordance with 'Claim Procedure' Clause as provided in the Policy.
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 You do not comply with the provisions of this Clause or other obligations cast upon You under this Policy, in terms of the other clauses referred to herein or in terms of the other clauses in any of the Policy documents, all benefits under the Policy shall be forfeited, at Our option.

6.3. Claims Procedure

Intimation must be given at least 72 hours prior to planned hospitalization. In case of emergency hospitalization, intimation must be given within 48 hours of hospitalization or before discharge whichever is earlier.

We may consider the delay in extreme cases of hardship where it is proved to our satisfaction that under the circumstances in which the insured person was placed it was not possible from him/her or any other person to intimate/ notify / submit / file claim within the prescribed time limit.

I. Cashless Facility

The Company extends Cashless Facility as a mode to Indemnify the Medical Expenses incurred by the Insured Person at a Network Provider. In order to avail Cashless Facility, the following process must be followed:

1. Submission of Pre-authorization Form: A Pre-authorization form which is available on the Company's Website or with the Network Provider, has to be duly filled and signed by the Insured Person and the treating Medical Practitioner, as applicable, which has to be submitted electronically by the Network Provider to the Company for approval. Only upon due approval from the Company, Cashless Facility can be availed only at Network Hospital. A health card issued to the insured person at the time of Policy purchase, should be preserved and produced at any of the Network Providers in the event of Claim being made, to avail Cashless Facility.

i. For Planned Treatment: The Company must be contacted to pre-authorize Cashless Facility for planned treatment at least 72 hours prior to the proposed treatment. Once the request for

pre-authorization has been granted, the treatment must take place within 10 days of the pre-authorization date at a Network Provider.

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

iii. Identification documents: Health Card issued by the company and Valid Photo Identification like Voter ID card, Driving License, Passport, PAN Card, Aadhaar Card or any other identification proof.

2. Company's Approval: The Company will confirm in writing, authorization or rejection of the request to avail Cashless Facility for the Insured Person's Hospitalization.

3. Please note that rejection of a Pre-authorization request is in no way construed as rejection of coverage or treatment. The Insured Person can proceed with the treatment, settle the hospital bills and submit the claim for a possible reimbursement.

4. The Company may modify the list of Network Providers or modify or restrict the extent of Cashless Facilities that may be availed at any particular Network Provider.

Insured can also look upon our website and click on the below link of network hospitals available under cashless facility:
https://www.edelweissinsurance.com/health-insurance/-/section/health-home

II. Re-imbursement Facility

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, the following information details should be provided to the Company within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier:

i. The Policy Number
ii. Name of the Policyholder
iii. Nature of Illness or Injury and the treatment/Surgery taken
iv. Hospital where treatment/Surgery was taken
v. Date of admission and date of discharge.

2. In the event of death of the Policyholder, the Company will pay the nominee and in case of no nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

6.4. Documents to be submitted for filing a valid Claim

The Company shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense within 15 days of the Insured Person's discharge from Hospital (in the case of Pre-hospitalization Medical Expenses and Hospitalization Medical Expenses) or within 15 days of the completion of the Post-hospitalization Medical Expenses period (in the case of Post-hospitalization Medical Expenses). For those claims for which the use of Cashless Facility has been authorized, the Company will be provided these documents by the Network Provider immediately following the Insured Person's discharge from Hospital as follows.

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

1. In-patient Treatment /Day Care Procedures
2. Duly filled and signed Claim Form.
3. Photocopy of ID card / Photocopy of current year policy.
4. Original Detailed Discharge Summary / Day care summary from the hospital. Original consolidated hospital bill with bill no and break up of each Item, duly signed by the insured.
5. Original payment Receipt of the hospital bill with receipt number
6. First Consultation letter and subsequent Prescriptions. Original bills, original payment receipts and Reports for investigation supported by the note from Attending Medical Practitioner / Surgeon demanding such test.
7. Surgeons certificate stating nature of Operation performed and Surgeons Bills and Receipts
8. Attending Doctors/ Consultants/ Specialist's/ Anesthetist Bill and receipt and certificate regarding same
9. Original medicine bills and receipts with corresponding Prescriptions.
10. Original invoice/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with original payment receipts.
11. Hospital Registration Number and PAN details from the Hospital
12. Doctors registration Number and Qualification from the doctor
13. For Road Traffic Accident in addition to in patient treatment documents, below details are required:
a. Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate.
14. For Non Medico legal cases
a. In addition to in patient treatment documents we would require treating Doctor's Certificate giving details of injuries (How, when and where injury sustained)
15. For Accidental Death cases
a. In addition to in patient treatment documents, Copy of Post Mortem Report (if conducted) & Death Certificate.
16. Pre and Post-hospitalisation expenses
17. Duly filled and signed Claim Form.
18. Photocopy of ID card / Photocopy of current year policy.
19. Original Medicine bills, original payment receipt with prescriptions.
20. Original Investigations bills, original payment receipt with prescriptions and report.
21. Original Consultation bills, original payment receipt with prescription.
22. Copy of the Discharge Summary of the main claim.

We may call for additional documents/ information as relevant to the claim.

6.5. Claim Assessment

1. The Company shall scrutinize the Claim and supportive documents, once received. In case of any deficiency, the Company may call for any additional documents or information as required, based on the circumstances of the Claim.
2. All admissible Claims under this Policy shall be assessed by the Company in the following progressive order:
i. If the provisions in Clause 8.8(Multiple Policies) are applicable, the Company's liability to make payment under that Claims shall first be apportioned accordingly.
3. The Claim amount assessed in Clause 7.5 (2) above would be deducted from the following amounts in the following progressive order:
i. Sum Insured
ii. No Claims Bonus (if applicable)
iii. Additional Sum Insured for Critical Illness (if applicable)
iv. Restoration (if applicable)
v. Recharge (if applicable)

6.6. Claim Settlement (provision for Penal Interest)

1. This Policy covers only medical treatment taken entirely within India (and worldwide if opted). All payments under this Policy shall be made in Indian Rupees.
2. The Company shall have no liability to make payment of a Claim under the Policy in respect of an Insured Person during the Policy Period, once the Total Sum Insured for that Insured Person is exhausted.
3. 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.
4. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
5. 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.
6. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
(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)

7. Premium Payment in Instalments (Wherever applicable)

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 instalments from the claim amount due under the policy.

8. Tax Benefit

The premium amount paid under this policy qualifies for deduction under Section 80D of the Income Tax Act.

9. Standard Terms and Conditions

9.1. Alterations in the Policy

1. This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company. However, change or alteration with respect to increase/ decrease of the Sum Insured shall be permissible only at the time of renewal of the Policy. On renewal, the policy could be subject to certain changes in terms and conditions including change in premium rate.

2. Where an individual is added to this Policy either by way of endorsement or at the time of Renewal, the Pre-existing Disease clause, exclusions and waiting periods will be applicable considering such Policy Year as the first year of the Policy with Us.

9.2. Cancellation / Termination

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

	Refund Percentage		
Cancellation period	1 Year Policy	2 Year Policy	3 Year Policy
Up to 1 Month	75%	87.50%	92.00%
Up to 3 Months	50%	75.00%	83.00%
Up to 6 Months	25%	62.50%	75.00%
Up to 9 Months	NIL	50.00%	67.00%
Up to 12 Months	NIL	42.00%	55.00%
Up to 15 Months	NIL	25.00%	50.00%
Up to 18 Months	NIL	12.50%	42.00%
Up to 24 Months	NIL	NIL	30.00%
Up to 30 Months	NIL	NIL	8.00%
Up to 36 Months	NIL	NIL	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.

2. 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.

3. In case of demise of the Policyholder,

i. Where the Policy covers only the Policyholder, this Policy shall stand null and void from the date and time of demise of the Policyholder. The premium would be refunded for the unexpired period of this Policy at pro-rata basis.

ii. Where the Policy covers other Insured Persons, this Policy shall continue till the end of Policy Period for the other Insured Persons. If the other Insured Persons wish to continue with the same Policy, the Company will renew the Policy subject to the appointment of a policyholder provided that:

a) Written notice in this regard is given to the Company before the Policy Period End Date; and

b) A person of Age 18 years or above, who satisfies the Company's criteria applies to become the Policyholder.

9.3. Complete discharge

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

9.4. Disclosure to Information

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

9.5. Electronic Transactions

The Policyholder and/or Insured Person agree to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the Policy or its terms, or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

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;

9.7 Limitation of Liability

Any Claim under this Policy for which the notification or intimation of Claim is received 12 calendar months after the event or occurrence giving rise to the claim shall not be admissible, unless the Policyholder proves to the Company's satisfaction that the delay in reporting of the Claim was for reasons beyond his control.

9.8 Material Change

It is a condition precedent to the Company's liability under the Policy that the Policyholder shall immediately notify the Company in writing of any material change in the risk. The Company may

adjust the scope of cover and / or the premium paid or payable accordingly.

9.9 Multiple Policies

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

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

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

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

Notices

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to:

1. You/the Insured Person at the address specified in the Policy Schedule or at the changed address of which the Company must receive written notice.

2. Us at the following address: :- Edelweiss General Insurance Company Limited, 5th Floor, Tower 3, Kohinoor City Mall, Kohinoor City, Kirol Road, Kurla (West), Mumbai - 400070, Registered Office: Edelweiss House, Off CST Road, Kalina, Mumbai -400 098 .

Toll Free No.: 1800 12000.

3. No insurance agents, brokers or other person/entity is authorized to receive any notice on the Company's behalf.

4. In addition, the Company may send You/the Insured Person other information through electronic and telecommunications means with respect to Your Policy from time to time.

9.11 No Constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder or Insured Person which is in possession of the Company other than that information expressly disclosed in the Proposal Form or otherwise in writing to the Company, shall not be held to be binding or prejudicially affect the Company.

9.12 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.

9.13. Obligations in case of a minor

If an Insured Person is less than 18 years of Age, the legal guardian (in case of all other adult Insured Person's demise in a floater basis) shall be completely responsible for ensuring compliance with all the terms and conditions of this Policy on behalf of that minor Insured Person.

9.14 Observance of Terms and Conditions

The due observance and fulfilment of the terms and conditions of this Policy (including the realization of premium by their respective due dates and compliance with the specified procedure on all Claims) in so far as they relate to anything to be done or complied with by the Policyholder or any Insured Person, shall be Condition Precedent to the Company's liability under the Policy

9.15 Overriding effect of Policy Schedule

In case of any inconsistency in the terms and conditions in this Policy vis-a-vis the information contained in the Policy Schedule, the information contained in the Policy Schedule shall prevail.

9.16 Premium Loading

1. Based on the Board approved Company's underwriting guidelines , upon the disclosure of the health status of the persons proposed for insurance and declarations made in the Proposal, the Company may apply underwriting loading on the premium payable (excluding statutory levies and taxes) . The maximum underwriting loading applicable will not exceed more than 100% of the premium for a individual member in case of Individual policies and on a policy level in floater policies.

2. These loadings will be applied from inception date of the First Policy including subsequent Renewal(s) with Us.

3. The Company may apply a specific personal waiting period on a medical condition/ailment depending on the past history or additional waiting periods on Pre-existing Diseases as part of the special conditions on the Policy but it will not exceed the 36 months waiting period. However the permanent exclusions can be applied for diseases as mentioned under Clause 3, Subclause Permanent Exclusion.

9.17. Policy Disputes

Any and all disputes or differences under or in relation to the validity, construction, interpretation and effect to this Policy shall be determined by the Indian Courts and in accordance with Indian law.

9.18 Renewal Terms

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

i. The Company shall endeavour 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 15 Days for installment premium and 30 days for single premium 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.
vi. The Company may carry out underwriting in accordance with its Board approved underwriting policy in relation to any request for change in Sum Insured or Deductible at the time of renewal of the Policy.
vii. This product may be withdrawn / modified by the Company after due approval from the Authority (IRDAI). In case this product is withdrawn / modified by the Company, this Policy can be renewed under the then prevailing Health Insurance Product or its nearest substitute approved by the Authority (IRDAI). The Company shall duly intimate the Policyholder at least three months prior to the date of such modification / withdrawal of this product and the options available to the Policyholder at the time of Renewal of this Policy.
viii. The Company may revise the renewal premium payable under the Policy provided that revisions to the renewal premium are in accordance with the Authority's (IRDAI) rules and regulations as applicable from time to time. Change in rates will be applicable from the date of approval by the Authority and shall be applied only prospectively thereafter for new policies and at the date of renewal for renewals.
ix. Loading if applicable on expiring policy will be applicable on subsequent renewals with the Company

10. Geography

This Policy applies to events or occurrences taking place within India and can be extended worldwide as specified in the policy schedule.

11.Eligibility

Policy Type	Individual	Floater
Relationship covered	Self	Self
	Spouse	Legally wedded Spouse
	Dependent Children	Dependent Parent(s)
	Parent(s)	Dependent Parent In Law(s)
	Parent(s)-in-law	Dependent Children (natural or legally adopted) between the age 3 months to 25 years
	Son-in-law	
	Daughter-in-law	
	Grandparent(s)	
	Grand Child/Children	
	Brother In Law	
	Sister In Law	
	Siblings	
	Niece	
	Nephew	
Minimum Age	91 days (Proposer 18 years)	91 days
Maximum Age	No upper Limit	No upper Limit
Cover ceasing age	No	No

12. 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.

13. 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.

14. 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.

15. 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

16. Customer Services and Grievances Redressal:

TIn case of 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.

- For easy and faster response, please feel free to contact us on
Call us at: 180012000 (Toll Free) or 02242312000 (Call charges applicable)
Email us at: support@edelweissinsurance.com

- Please feel free to contact our Grievance Cell on
Call us at: 1800120216216
Email: grievance@edelweissinsurance.com
Contact Details for Senior Citizens:
- Contact number: 02242312001
- Email ID: senior.citizen@edelweissinsurance.com

Address: Edelweiss General Insurance Company Limited, Kohinoor City Mall, Tower 3, Kirol Road, Kurla West, Mumbai 400070

- The Grievance Redressal Officer
Email: grievanceofficer@edelweissinsurance.com
Call us at: 022 4931 4422
Address: Edelweiss General Insurance Company Limited, Kohinoor City Mall, Tower 3, Kirol Road, Kurla West, Mumbai 400070

If you are not satisfied with the response or do not receive a response from the Company, within 14 days of your complaint, you may approach the Grievance Cell of the Insurance Regulatory and Development Authority of India ('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

In case you are not satisfied with the response provided by the company or no response is received, you may approach the Insurance Ombudsman in your region for the resolution post 30 days from the date of registration of the complaint.

Details of the Insurance Ombudsman Offices are available on the link http://www.policyholder.gov.in/Addresses_of_Ombudsmen.aspx

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.

Insurance Ombudsman –The insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Annexure-A.

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@cioins.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@cioins.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@cioins.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@cioins.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@cioins.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@cioins.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@cioins.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@cioins.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@cioins.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@cioins.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@cioins.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@cioins.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@cioins.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@cioins.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@cioins.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@cioins.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@cioins.co.in**	State of Maharashtra, Area of Navi Mumbai and Thane, excluding Mumbai Metropolitan Region

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

The details of the excluded items can also be viewed on our website: www.edelweissinsurance.com
Link: https://www.edelweissinsurance.com/contact-us

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

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

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

Sl. No.	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE/ ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN

Sl. No.	Item
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

Sl. No.	Item
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.