OneHealth

Policy Document

Preamble

The insurance cover provided under this Policy up to the Sum Insured is and shall be subject to (a) the terms and conditions of this Policy, (b) the receipt of premium, and (c) Disclosure to information norm (including information and statements which the Policyholder has provided in the proposal form or Information Summary Sheet as applicable) for all persons to be insured. Please inform Us immediately of any change in the address, nature of job, state of health, or of any other changes affecting any Insured Person.

If any claim arising as a result of an Illness or Injury that occurred during the Policy Period becomes payable, then We shall pay the Benefits in accordance with the terms, conditions and exclusions of the Policy subject to availability of Sum Insured and Cumulative Bonus (if any).

Section 1. Definitions

The terms defined below have the meaning ascribed to them wherever they appear in this Policy and, where appropriate, references to the singular include references to the plural, references to male include female and references to any statutory enactment include subsequent changes, replacements or amendments to the same:

1.1 Standard Definitions:

Accident: An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

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 Governemnt 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 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.

AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Poliyclinic 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. Mainitaining daily records of patient and making them accessible to the insurance company's authorized representative

Any One Illness: 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.

Cashless facility: 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.

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

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

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

Co-Payment: 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.

Critical Illness means the following:

1) Cancer of Specified Severity

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

II. The following are excluded-

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

2) Myocardial Infarction (First Heart Attack of specific severity)

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

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

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

3) Open Chest CABG

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

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

4) Open Heart Replacement or Repair of Heart Valves

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

5) Coma of Specified Severity

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

6) Kidney Failure Requiring Regular Dialysis

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

7) Stroke Resulting in Permanent Symptoms

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

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

8) Major Organ/Bone Marrow Transplant

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

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

9) Permanent Paralysis of Limbs

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

10) Motor Neurone Disease with Permanent Symptoms

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

11) Multiple Sclerosis with Persisting Symptoms

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

i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

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

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

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

Day Care Centre: A 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 criteria 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.

Day Care Treatment: Day care treatment means medical treatment, and/or *surgical procedure* which is:

i. undertaken under General or Local Anaesthesia in a *hospital/day care centre* in less than 24 hrs because of technological advancement, and
ii. which would have otherwise required hospitalization of more than 24 hours.

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

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.

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

Disclosure to information norm: The policy shall be void and all premium paid hereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Domiciliary Hospitalization: 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.

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

Grace Period: 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.

Hospital: A 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) of the said act **Or** complies with all minimum criteria as under:

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

Only for the purposes of any claim or treatment permitted to be made or taken outside India in accordance with Section 2.31, **Hospital (outside India)** means an institution (including nursing homes) established outside India for indoor medical care and treatment of Illness and/or Injuries which has been registered and licensed as such with the appropriate local or other authorities in

the relevant area, wherever applicable, and is under the constant supervision of a medical practitioner. The term Hospital shall not include a clinic, rest home, or convalescent home for the addicted, detoxification centre, sanatorium, and old age home.

Hospitalization : 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.

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

(a) **Acute condition** - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
(b) **Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or is likely to recur

Injury: 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.

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

I**ntensive Care Unit:** 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.

ICU Charges: 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.

Maternity expenses: Maternity expenses means:

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

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

Medical Expenses: 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.

Medical Practitioner: 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 setup 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 licence.

Medically Necessary Treatment: 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.

Network Provider: Network Provider means hospitals enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

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

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

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

OPD treatment: 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.

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

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

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

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

i. Such Medical Expenses are 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.

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.

Reasonable and Customary Charges: 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.

Renewal: 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.

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

Surgery or Surgical Procedure: 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*.

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

1.2 Specific Definitions:

Age or Aged means age as on last birthday.

Alternative Treatments or AYUSH are forms of treatments other than treatment of "Allopathy" or “modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

Diagnostic Tests: Investigations, such as X-Ray or blood tests, to find the cause of the Insured Person’s symptoms and medical condition.

Emergency means a severe Illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person’s health.

Family Floater Policy means a policy named as a Family Floater Policy in the Policy Schedule in terms of which, two or more persons of a family are named in the Policy Schedule as Insured Persons. In a Family Floater Policy, family means a unit comprising of up to seven members who are related to the Policyholder in the following manner:

2) Self (ie, the Policyholder); and/or
3) Legally married spouse as long as they continue to be married; and/or
4) Up-to three children (children who are up to 25 years of Age on the Policy Start Date shall be considered as dependent children, if Aged 26 and above, they shall be considered as adults in this Policy); and/or
5) Natural parents or parents that have legally adopted the Policyholder; or
6) Parents-in-law as long as the Policyholder continues to be legally married to the spouse referred above.
7) Grand children
8) Daughter-in-law and Son-in-law
9) Brother(s) and Sister(s)

All parents and parents- in- law referred above must be financially dependent on the Policyholder.

Individual Policy means a policy named as an Individual Policy in the Policy Schedule in terms of which only one person is named in the Policy Schedule as the Insured Person.

IRDAI means the Insurance Regulatory and Development Authority of India.
Information Summary Sheet means the record and confirmation of information provided to Us or Our representatives over the telephone for the purposes of applying for this Policy.

Insured Person/You/Your/Yours means the person(s) named in the Policy Schedule who are covered under this Policy and in respect of whom the appropriate premium has been received.

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

Policy means this Policy document, any annexures thereto and the Policy Schedule including endorsements, if any, Your statements in the proposal form and the Information Summary Sheet as applicable.

Policy Inception Date means the Policy Start Date of the first Policy with Us, as specified in the Policy Schedule, and renewed with Us continuously thereafter.

Policy Start Date means the start date of the Policy as specified in the Policy Schedule.

Policy Expiry Date means the date on which the Policy expires as specified in the Policy Schedule.

Policy Period means the period between the Policy Start Date and the Policy Expiry Date as shown in the Policy Schedule.

Policy Year means a period of twelve consecutive months commencing from the Policy Start Date as specified in the Policy Schedule or any anniversary thereof.

Policyholder means the person named in the Policy Schedule as the policyholder and who has concluded this Policy with Us.

Policy Schedule means the schedule issued by Us along with this Policy mentioning the details of the Policyholder and Insured person, period of Policy and other details. Any changes made to it shall be issued as Endorsement Schedule and shall be considered a part of this Policy.

Portability means rights accorded to an individual health insurance policyholder (including family cover) to transfer the credit gained for Pre-Existing conditions and time bound exclusions from one insurer to another or from one plan to another plan of the same insurer.

Product Benefits Table means the Product Benefits Table issued by Us and accompanying the sales literatures, including the prospectus of this product.

Rehabilitation includes treatment aimed at restoring health or mobility, or to allow a person to live an independent life, such as after a stroke.

Relaxation Period means the specified period of time immediately following the premium instalment due date during which a payment can be made to continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing. Coverage will be available during this period provided instalment is paid before the Relaxation period gets over. Policy will be automatically terminated if the due instalment is not received within this specified time.

Shared Accommodation means a Hospital room with two or more patient beds

Single Private room means basic category of Single room in the Hospital wherein a single patient is accommodated. It may be with or without air conditioning facility.

Sum Insured means:

i) For an Individual Policy, the sum shown in the Policy Schedule/ Product Benefits Table against an Insured Person which represents Our maximum, total and cumulative liability for any and all claims under the Policy during a Policy Year in respect of that Insured Person.
ii) For a Family Floater Policy, the sum shown in the Policy Schedule/ Product Benefits Table which represents Our maximum, total and cumulative liability for any and all claims under the Policy during a Policy Year in respect of any and all Insured Persons.

TPA or Third Party Administrator means a company registered with the Authority, and engaged by an insurer, for a fee, by whatever name called and as may be mentioned in the agreement, for providing health services.

We/Our/Us means MAGMA HDI General Insurance Company Ltd.

Section 2. Benefits

The Benefits under this Policy are subject always to the Sum Insured and Cumulative Bonus, if any, any subsidiary limit specified in the Policy Schedule/Product Benefits Table, the terms, conditions, limitations and exclusions mentioned in the Policy and eligibility as per the insurance plan opted for in the Product Benefits Table and as shown in the Policy Schedule:

Base Covers:

2.1 Inpatient Care

We shall cover the Reasonable and Customary Charges for the following Medical Expenses incurred by You if during the Policy Period, You require Hospitalization on the written Medical Advice of a Medical Practitioner, for any Illness or Injury which is contracted or sustained by You during the Policy Period and is covered under this Policy:

a) Medical Practitioners' fees

b) Room Rent and other boarding charges

c) ICU Charges

d) Operation theatre charges

e) Diagnostic procedures' charges

f) Medicines, drugs and other consumables as prescribed by the Medical Practitioner

g) Qualified Nurses' charges

h) Intravenous fluids, blood transfusion, injection administration charges

i) Anaesthesia, Blood, Oxygen, operation theatre charges, surgical appliances

j) The cost of prosthetics and other devices or equipment if implanted internally during a Surgical Procedure

Room Rent Capping:

(1) For Support plan (all Sum Insured):
Reimbursement or payment of Room Rent and associated charges incurred at the Hospital shall not exceed 1% of the Sum Insured per day. In case of admission to Intensive Care Unit or Intensive Cardiac Care Unit (ICCU), reimbursement or payment of such Medical Expenses shall not exceed 2% of the Sum Insured per day.
Proportionate Deduction:
In case of admission to a room at rates exceeding the aforesaid limits, the reimbursement or payment of all associated Medical Expenses incurred at the Hospital, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent.

(2) For Secure plan (all Sum Insured):

Reimbursement or payment of Room Rent and other boarding charges, and Qualified Nurses' charges incurred at the Hospital shall be as per "Single private room category. In case of admission to Intensive Care Unit or Intensive Cardiac Care Unit (ICCU), reimbursement or payment of such Medical Expenses shall be as per actual expenses.
Proportionate Deduction:
In case of admission to a room category higher than the basic Single room category (Deluxe, Super deluxe, Suite room and likewise) of the Hospital, the reimbursement or payment of all associated Medical Expenses incurred at the Hospital, shall be effected in the same proportion as the Single private room category rate per day bears to the actual rate per day of the room category utilized. Such proportionate deductions shall not be 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.

(3) For Support Plus plan, Shield and Premium plans, there will not be any cap on the Room Rent and We will reimburse reasonable and necessary Room Rent, other boarding charges and Qualified Nurses' charges incurred at the Hospital for treatment of an Illness or Injury which is admissible and payable under the Policy.

Associated expenses refer to the medical expenses which vary as per room category opted in the Hospital. These shall not include Cost of pharmacy and consumables; cost of implants and medical devices; cost of diagnostics.

For Cataract, following sublimits shall apply:

a) Support Plan- up to Rs. 25,000 per eye per Policy Year
b) Secure and Support Plus plan – up to Rs. 35,000 per eye per Policy Year
c) Shield plan– up to Rs. 50,000 per eye per Policy Year
d) Premium plan– up to Rs. 1,00,000 per eye per Policy Year

2.2 Pre-Hospitalisation Expenses

We shall, on a reimbursement basis, cover Your Pre-hospitalization Medical Expenses incurred in respect of an Injury or Illness that occurs during the Policy Period, immediately prior to Your date of Hospitalization and up to the limits specified in the Policy Schedule/Product Benefits Table, provided that a claim has been admitted by Us under Inpatient Care under Section 2.1 above and is related to the same Illness/Injury/condition.

2.3 Post-Hospitalisationl Expenses

We shall, on a reimbursement basis, cover Your Post-hospitalization Medical Expenses incurred due to an Injury or Illness that occurs during the Policy Period, immediately after Your discharge from the Hospital and up to the limits specified in the Policy Schedule/Product Benefits Table, provided that a claim has been admitted by Us under Inpatient Care under Section 2.1 above and is related to the same Illness/Injury/condition.

2.4 Day Care Treatment

We will cover the Medical Expenses incurred on Your Day Care Treatment on the recommendation of a Medical Practitioner following an Illness or Injury which occurs during the Policy Period provided that the Medical Expenses incurred are for Medically Necessary Treatment and up to the limits specified in the Policy Schedule/Product Benefits Table. Any OPD treatment undertaken in a Hospital/Day Care Centre will not be covered under this Benefit. Pre-hospitalization Medical Expenses and Post- hospitalization Medical Expenses are not payable under this Benefit. Please refer to Annexure III for list of Day Care Treatments.

2.5 Ambulance Cover

We will cover the Reasonable and Customary Charges up to the limit specified in the Policy Schedule/Product Benefits Table that are incurred towards Your transportation by road ambulance to the nearest Hospital with adequate facilities in an Emergency following an

Illness or Injury which occurs during the Policy Period provided that the ambulance service is offered by a registered healthcare or ambulance service provider and a claim has been admitted by Us under Inpatient Care under Section 2.1 above.

2.6 Organ Donor Expenses

We will cover the Medical Expenses incurred towards in- patient Hospitalization of an organ donor for Your organ transplant Surgery during the Policy Year provided that:

a) the organ donor conforms to the provisions of The Transplantation of Human Organs Act, 1994 and other applicable laws.
b) the organ donated is for the use of the Insured Person provided that the Insured Person has undergone an organ transplantation on the basis of Medical Advice;

c) A claim has been admitted by Us under Inpatient Care under Section 2.1 above.

Subject to the above, We will not cover:

a) Any Pre-hospitalization Medical Expenses, Post-hospitalization Medical Expenses, or screening expenses of the organ donor, or any other Medical Expenses as a result of the harvesting from the organ donor;

b) Costs directly or indirectly associated with the acquisition of the donor's organ;

c) Any other medical treatment or complication in respect of the donor consequent to organ donation.

2.7 Domiciliary Hospitalisation

We will on reimbursement basis, cover the Medical Expenses incurred for Your Domiciliary Hospitalization during the Policy Period following an Illness or Injury that occurs during the Policy Period provided that the Domiciliary Hospitalization continues for an uninterrupted period of at least 3 days and the condition for which treatment is taken would otherwise have necessitated Hospitalization as long as either

a) the attending Medical Practitioner confirms in writing that You cannot be transferred to a Hospital or
b) You satisfy Us that a Hospital bed was unavailable.

If a claim has been admitted by Us under this Benefit, then claims for Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses shall also be payable.

2.8 AYUSH Treatment

We will, on a reimbursement basis, cover Your Medical Expenses incurred for Inpatient Care during the Policy Period on treatment taken under AYUSH Treatment in:

- a government Hospital or in any institute recognized by the government and/or accredited by the Quality Council of India/National Accreditation Board on Health
- Teaching Hospitals of AYUSH colleges recognised by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH)
- AYUSH Hospitals having registration with a Government Authority under appropriate Act in the State/UT and complies with the following as minimum criteria:
    - Has at least fifteen in-patient beds;
    - Has minimum five qualified and registered AYUSH doctors;
    - has qualified paramedical staff under its employment round the clock;
    - has dedicated AYUSH therapy sections;
    - maintains daily records of patients and make these accessible to the insurance company's authorized personnel

Our maximum liability will be limited up to the amount provided in the Policy Schedule/Product Benefits Table.
Exclusion 3.2.3 does not apply to this Benefit.

2.9 IVF Treatment Cover

We shall cover the Medical Expenses incurred by the Insured Person during the Policy Period for her IVF (in-vitro fertilization) treatment undertaken at a clinic duly registered in accordance with applicable law and on the written Medical Advice of a specialist Medical Practitioner, maximum up to the limit as mentioned in the Policy Schedule/Product Benefits Table, provided that the Insured Person undergoes the treatment before 40 years of Age.
A waiting period of 3 years from the Policy Inception Date shall be applicable for this Benefit.
Following shall not be covered under this Benefit:

a) Any expenses with respect to the Insured Person's use of third party surrogate or gestational carrier in pregnancy
b) Any expenses for consultation, diagnostic tests or procedure or any such other expenses for diagnosis of infertility

2.10 Bariatric Surgery Cover

We shall cover the Medical Expenses incurred by the Insured Person during the Policy Period for undergoing medically necessary Bariatric Surgery prescribed by a specialist Medical Practitioner, maximum up to the limit as mentioned in the Policy Schedule/Product Benefits Table, provided that

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

A waiting period of 3 years from the Policy Inception Date shall be applicable for this Benefit.

2.11 Psychiatric treatment Cover

We shall cover Medical Expenses for in-patient treatment of the Insured Person during the Policy Period maximum up to the limit as mentioned in the Policy Schedule/Product Benefits Table, provided the Hospitalization is for Medically Necessary Treatment and prescribed in writing by a registered mental health specialist or psychiatrist
We shall also cover pre & post hospitalization expenses related to such in-patient psychiatric Hospitalization up to the no. of days as covered as per section 2.2 and 2.3 respectively.
For following mental disorders / conditions, shall be covered after a waiting period of 36 months from Policy inception date and a sub-limit of Rs. 50,000 shall be applicable on cumulative basis. This sub-limit includes pre and post hospitalization expenses for these specified disorders.

Name of condition/disorder	ICD codes
Severe Depression	F30, F32, F33
Schizophrenia and Psychosis	F20, F21, F22, F23, F24, F25, F28, F29
Bipolar disorder	F31, F34
Post traumatic stress Disorder	F43
Obsessive compulsive disorders	F42
Panic disorders including anxiety	F40, F41, F93, F94
Personality and related disorders	F60, F44, F48

2.12 Lasik Surgery Cover

We shall cover the Medical Expenses incurred by the Insured Person during the Policy Period for undergoing LASIK Surgery for correction of refractive error, maximum up to the limit as mentioned in the Policy Schedule/Product Benefits Table, provided that:

a) the Insured Person has a refractive index of plus/minus 7.5 or more; and
b) the procedure is prescribed as medically necessary by a Medical Practitioner who is an ophthalmologist.

A waiting period of 3 years from the Policy Inception Date shall be applicable for this Benefit.

2.13 HIV/ AIDS Cover

We will cover the in-patient Hospitalization, Day care treatment and Pre-post Hospitalization expenses incurred by Insured Person during the Policy Period as per the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 and amendments thereafter due to condition caused by or associated with HIV / AIDS, provided that such treatment is availed as per written prescription by a registered Medical Practitioner.

Pre Hospitalization and Post hospitalization days limit will be as applicable under section 2.2 and 2.3 of this Policy.

2.14 Modern treatment Procedures:

The following procedures will be covered (wherever medically indicated) either as in patient (Section 2.1) or as part of day care treatment in a hospital (Section 2.4) up to the Sum Insured, specified in the policy schedule, during the policy period:

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

Additional Benefits:

This Policy offers the following additional benefits which shall be applicable to all Insured Persons as per the Plan opted and mentioned in Policy Schedule. Benefits under this Section are subject to the terms, conditions and exclusions of this Policy. Claims under this Section shall not impact the Sum Insured.

2.15 Cumulative Bonus

In a Policy Year, if there are no claims paid or outstanding under Section 2.1 to 2.14 and under Section 2.26 & 2.31, then at the time of Renewal of the Policy, We shall apply a Cumulative Bonus on the Sum Insured for each such claim free Policy Year provided the Policy has been Renewed with Us without a break. The percentage of the Sum Insured and maximum Cumulative Bonus that can be accrued shall be as per the following:

a) Support plan: 10% of Sum Insured per claim free Policy Year up to a maximum of 50% of Sum Insured
b) Secure plan: 10% of Sum Insured per claim free Policy Year up to a maximum of 50% of Sum Insured
c) Support Plus plan: 10% of Sum Insured per claim free Policy Year up to a maximum of 100% of Sum Insured
d) Shield plan: 20% of Sum Insured per claim free Policy Year up to a maximum of 100% of Sum Insured
e) Premium plan: 33.33% of Sum Insured per claim free Policy Year up to a maximum of 100% of Sum Insured

The following conditions shall be applicable:

a) The sub-limits applicable to various Benefits will remain the same and shall not increase proportionately with accrual of Cumulative Bonus

b) Cumulative Bonus which is accrued during a claim free Policy Year shall be available to those Insured Persons who were insured in such claim free Policy Year and continue to be insured in the subsequent Policy Year;

c) If the Sum Insured is increased or decreased, Cumulative Bonus shall be calculated on the basis of the Sum Insured of the last completed Policy Year and shall be capped to the maximum amount of Cumulative Bonus on the Sum Insured as permitted under the plan;

d) Recharge Sum Insured shall not be considered for calculating Cumulative Bonus;

e) If a Cumulative Bonus has been applied and a claim is made in any Policy Year, then in the subsequent Policy Year We shall not decrease the accrued Cumulative Bonus except if, and to the extent, it is utilized as claim payout.

f) Cumulative Bonus shall be applicable on an annual basis subject to the Renewal of the Policy;

g) The entire Cumulative Bonus shall be forfeited if the Policy is not continued/Renewed before expiry of the Grace Period.

h) The Cumulative Bonus shall be available for any claims under sections 2.1 to 2.14 only, subject always to any sub-limits mentioned therein.

2.16 E-Opinion for Critical Illness

If You are diagnosed with a Critical Illness during the Policy Period, then You may at Your sole discretion choose to avail of a second e-opinion from Our panel of Medical Practitioners for the Critical Illness and We shall arrange for and cover the e-opinion, provided that:

a) We have received a request from You to exercise this option;

b) The e-opinion will be based only on the information and documentation provided by You to Us, which shall be shared with the Medical Practitioner;

c) This Benefit can be availed only once during a Policy Year and only once during the lifetime of an Insured Person for the same Critical Illness;

d) This Benefit shall be available to only those Insured Persons that are Aged 18 years or above on the Policy Start Date and such Insured Persons are not covered under the Policy as the Policyholder's child;

e) This Benefit is only a value added service provided by Us and does not deem to substitute Your visit or consultation to an independent Medical Practitioner;

f) You are free to choose whether or not to obtain the e-opinion, and if obtained then whether or not to act on it;

g) We shall not, in any event, be responsible for any actual or alleged errors or representations made by any Medical Practitioner (including in any e- opinion) or for any consequence of actions taken or not taken in reliance thereon;

h) The e-opinion under this Policy shall be limited to the covered Critical Illnesses set out below and not be valid for any medical legal purposes;

i) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, Medical Advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner;

j) For the purpose of this Benefit, covered Critical Illness means:

i. Cancer of Specified Severity
ii. Myocardial Infarction (First Heart Attack of specific severity)
iii. Open Chest CABG
iv. Open Heart Replacement or Repair of Heart Valves
v. Coma of Specified Severity
vi. Kidney Failure requiring Regular Dialysis
vii. Stroke resulting in Permanent Symptoms
viii. Major Organ/Bone Marrow Transplant
ix. Permanent paralysis of Limbs
x. Motor Neurone Disease with Permanent Symptoms
xi. Multiple Sclerosis with Persisting Symptoms

2.17 Annual Health Check-up

We will arrange for a health check-up in accordance with the plan specified in the Policy Schedule/Product Benefits Table, if requested by You. We will cover health check-ups arranged by Us through Our empanelled Network Providers, provided that:

a) This Benefit shall be available once per Policy Year per Insured Person who is Aged 26 and above.

b) This Benefit will be provided irrespective of any claim being made in the Policy Year.

This Benefit is over and above the Sum Insured and cannot be carried forward if the Benefit is not availed during the period as specified above.

Health check-up test list is as below:

Support Plan	Secure Plan	Support Plus plan	Shield Plan	Premium Plan	Any Plan with Optional covers Aggregate Deductible and/or Voluntary Co-payment opted
(If optional Covers Aggregate Deductible and/or Voluntary Co-payment are **not** opted)					
CBC	CBC	CBC	CBC	CBC	CBC
ESR	ESR	ESR	ESR	ESR	ESR
Urine Routine	Urine Routine	Urine Routine	Urine Routine	Urine Routine	Urine Routine
MER	MER	MER	MER	MER	MER
Total Cholesterol	Total Cholesterol	Total Cholesterol	Total Cholesterol	Total Cholesterol	Total Cholesterol
FBS	FBS	HbA1c	HbA1c	HbA1c	FBS
		Lipid Profile	Lipid Profile	Lipid Profile	
			ECG	ECG	
			PSA (for males)/ PAP smear (for females)	PSA (for males)/ PAP smear (for females)	
				Liver Profile	
				Kidney Profile	

				Cardiac Risk Profile	

Reference:
CBC- Complete Blood count
ESR- Erythrocyte Sedimentation rate
MER- Medical Examination Report
FBS- Fasting Blood Sugar
HbA1c- Glycated Haemoglobin test
ECG- Electrocardiogram
PSA- Prostate Specific Antigen

2.18 Fitness Rewards and Wellness Services

1. Fitness Rewards

You can earn Fitness Rewards points in the manner set out below.
For Policies with Policy Period of one year, percentages as mentioned in the table below shall apply. For Policies with Policy Period of 2 and 3 years, in order to calculate the Fitness Rewards points, the Policy premium shall be divided by 2 and 3 respectively. Further, for Individual Policies, percentages as mentioned in the tables below would apply and for Family Floater Policies, percentages as mentioned in the tables below divided by the number of Insured Persons who are covered other than as dependent children under the Policy shall be applicable for the purpose of calculating the Fitness Rewards points.

a) Through Medical Check up: If You avail of our Health Check- up Benefit and undergo the medical tests at Our Network Providers and thereafter submit the medical test reports to Us, then if all the test results are within the normal range for the respective tests, We shall award You with Fitness Rewards points equivalent to the percentage of the premium paid as per the table below.

b) Through Fitness Activities: You can also earn Fitness Rewards points by engaging in physical activities to keep Yourself active and healthy. If You do any of the following activities during the Policy Year, We shall award you with Fitness Rewards points equivalent to the percentage of premium paid as per the table below. You can take one or more activities amongst these any number of times in a Policy Year and Fitness Rewards points shall be awarded to You subject to the maximum Fitness Reward points as mentioned in the table below.
* Participation and completion of marathon run (at least 10 Km)
* Gym/Yoga /Zumba/ Dancing or any other fitness centres' membership for atleast one year
* Participation and completion of any other professional sport event

c) You can also earn Fitness Rewards points by participating in health programs or any health initiatives sponsored by Us. Fitness Rewards points for an activity can be earned only once per Insured Person (who is covered other than as dependent children under this Policy) in a Policy Year, under this section.

Activity	**Points to be earned as a percentage of existing Policy premium**
By availing our Health Check- up Benefit	1%
Participation and completion of marathon run (at least 10 Km)	1.5%
Gym/Yoga/Zumba/Dancing or any other fitness centres' membership for atleast one year	2%
Participation and completion of any other Professional sport event	2.5%

Participation in any Health Program sponsored by Us	5%
Maximum Fitness Rewards Points per Policy Year	**10%**

In case We do not sponsor any event during the policy year, We shall consider multiple claims for reward points for other fitness activities as specified above, and provide the points as specified against that activity, subject always to the condition that maximum 10% of points can be earned per Policy Year.

Redemption of Fitness Reward Points:

You can redeem the earned Fitness Reward points as discount on premium at the time of Renewal of the Policy.

If You wish to know the present value of Fitness Rewards points earned, then You may contact Us at our toll free number or through Our website. In any event, We shall send You an updated statement of the value of the Fitness Rewards points earned on an annual basis on any of the contact details as provided by You.

2. Wellness Services:

a) Doctor on call: You can consult with a Medical Practitioner from Our panel of Network Providers to discuss any health related query. You can avail this service maximum 3 times per Policy Year.

b) Specialist's e-opinion: You can avail a specialist Medical Practitioner's opinion on Your health queries that require such specialist Medical Practitioner's consideration. We have a panel of specialist Medical Practitioner in the field of pediatrics, gynaecology, cardiology, oncology and other major branches of medical science. You can avail this service maximum 3 times per Policy Year.

c) Nutritional e-counselling: On Your request, We will provide You with a Dietician and nutritional e-counselling. You can avail this service maximum 3 times per Policy Year.

For availing above services, You can call our customer care number 1800 266 3202 or write to Us on customercare@magma-hdi.co.in. Our executive will help You for availing these services.

d) We may provide information on offers related to healthcare services like consultation, diagnostics, medical equipments and pharmacy. Please visit our website www.magma-hdi.co.in to know about such offers.

Terms and conditions under Fitness Rewards and Wellness Services

* All relevant documents, reports, receipts etc for earning Fitness Rewards points must be submitted to Us within 60 days of undertaking such activity.

* Wellness services are provided through empanelled service providers as applicable and We are only acting as a facilitator. Therefore, We shall not be liable for any incremental costs incurred or the services availed.

* The decision to utilize these advices/services is solely and absolutely at Your discretion. You should consult Your Medical Practitioner before availing/taking the Medical Advices/ services. We shall not be liable towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations suggested under this Benefit

* There shall not be any cash redemption against the wellness points.

* We, Our group entities, or affiliates, their respective directors, officers, employees, agents, vendors, shall not be responsible for or liable for, any actions, claims, demands, losses, damages, costs, charges and expenses which any Insured Person claims to have suffered, sustained or incurred, by way of and / or on account of this Benefit.

Any wellness services offered hereunder are subject to the guidelines issued by the IRDAI from time to time.

We shall send You any notifications/communication required to be sent hereunder on your registered email ID or on Your registered contact number or through any other mode as decided by Us.

2.19 Early Joining Benefit

We shall provide You a one- time amount of Rs.2500 in 6th Policy Year if Policy is claim-free for 5 years from Policy Inception Date and an additional one-time amount of Rs.5000 in 11th Policy Year if Policy is claim-free for 10 years from Policy Inception Date provided that:
a) The age of senior most member covered in the policy at the time of first purchase should be below 40 years, and the policy is renewed continuously with Us;
b) the Policy is claim-free since the Policy Inception Date;

c) the amount provided under this Benefit can be reimbursed for any out-patient Medical Expenses including pharmacy . No direct cash benefit shall be offered under this Cover; and

d) the unutilized amount can be carried forwarded to the subsequent Policy Years.

e) The benefit amount shall lapse if the Policy is not renewed with Us.

2.20 Green Channel Benefit

If You opt to avail of in-patient treatment on cashless basis in a PPN (preferred provider network) as specified by Us, We shall, in addition to the amount payable under Section 2.1 (Inpatient Care), provide a one- time amount for each such Hospitalization as reimbursement against:

a) expenses for any non-payable items with respect to that particular hospitalization, Or
b) expenses for any health wearable device purchased by the insured after claim for such hospitalization is accepted

Maximum amount provided under this benefit for each such hospitalization in PPN network is:

- Rs. 1,000, if payable Inpatient Care claim amount is up to Rs. 50,000
- Rs. 2,000, if payable Inpatient Care claim amount is above Rs. 50,000

List of PPN is available on Our website www.magma-hdi.co.in

2.21 Recharge of Sum Insured

We will provide 100% Recharge of the Sum Insured up to 5 times in a Policy Year, provided that:

a) The Sum Insured and Cumulative Bonus (if any) is insufficient for a claim as a result of previous claims in that Policy Year;

b) The Recharge of Sum Insured shall not be available for claims towards an Illness or Injury (including complications) for which a claim has been paid or accepted as payable in the current Policy Year for the same Insured Person under Inpatient Care under Section 2.1. This condition shall be applicable each time Recharge of Sum Insured is triggered. For any subsequent Recharge of Sum Insured, the illness or Injury (including any complications) must be unrelated to illness or injury for which claim has been paid earlier in the same policy year under In-patient Section or under Recharge of Sum Insured Section ;

c) The Recharge of Sum Insured shall be available only in respect of Your future claims that become payable under Section 2 Base Covers of the Policy and shall not be applicable to the first claim in the Policy Year;

d) For any one claim, Recharge of Sum Insured will be done maximum once.

e) If the Policy issued is a Family Floater Policy, then the Recharge of Sum Insured shall also be available on a floater basis;

f) If the Recharge of Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

For any single claim during a Policy Year the maximum claim amount payable shall be the sum of:

i. The Sum Insured
ii. Cumulative Bonus

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. Cumulative Bonus
iii. Recharge of Sum Insured up to 500% of Sum Insured

2.22 Hospital Cash

If You are Hospitalized during the Policy Period and if We have accepted an Inpatient Care claim under Section 2.1, then We shall, in addition, pay the daily cash amount specified in the Policy Schedule /Product Benefits Table for each continuous and completed period of 24 hours of Hospitalization provided that:

a. You should have been Hospitalized for a minimum period of 48 hours continuously;
b. We shall not make any payment under this Benefit to You for more than 30 days of Hospitalisation in total under any Policy Year.

c. We shall not make any payment under this Benefit for any diagnosis or treatment arising from or related to pregnancy (whether uterine or extra uterine), childbirth including caesarean section, medical termination of pregnancy and/or any treatment related to pre and post-natal care of the New Born Baby.

2.23 Compassionate Visit in case of CI

If We have accepted Your claim for Hospitalization in case of Critical Illness as per Section 2.1, then We shall reimburse the amount up to the limit specified against this Benefit in the Policy Schedule/Product Benefits Table, incurred in respect of a maximum of two of Your Immediate Family Members for two way airfare or two way first class railway ticket in a licensed common carrier to the place where You are Hospitalized provided that:

a) You are Hospitalized in a Hospital which is situated at a distance of at least 100 kilometres from Your actual place of residence;
b) The attending Medical Practitioner recommends the personal attendance of an Immediate Family Member;
c) Travel by the Immediate Family Member to the place of Hospitalization is commenced during the period of Your Hospitalization
d) This Benefit shall be provided only once per Policy Year.

“Immediate Family Member” would mean spouse, children and dependant parents of the Insured Person.

2.24 Loss of income benefit

If We have accepted a claim for an Illness or Injury that results in Permanent Total Disablement, then We shall pay the amount (as lump sum) as specified against this Benefit in the Policy Schedule/Product Benefits Table.

Permanent total disablement for the purpose of this Benefit is defined as any injury or illness due to which the Insured Person is disabled from engaging in his/her primary occupation and loses his/her source of income generation as a consequence thereof. Such state of permanent total disablement must be certified by Medical Practitioner.

1. In case of an Individual Policy :

a. In case of salaried Insured Persons: Monthly amount equal to 1/12th of the Sum Insured or the Insured Person’s per month salary based on the average of last 3 months salary slip, whichever is lower shall be paid for a maximum of 6 months. Net monthly income (post tax), that is, monthly in hand salary excluding overtime, bonuses, tips, commissions or any other special compensation shall be considered for the purpose of payout under this benefit;

b. In case of self-employed Insured Persons: Monthly amount equal to 1/12th of the Sum Insured or monthly income based on the last income tax returns filed with the income tax department, whichever is lower; shall be paid for a maximum of 6 months. This payout shall consider income from primary occupation only and shall not include income from any other sources.

2. In case of a Family Floater Policy :

   a. In case of salaried Insured Persons: Monthly amount equal to 1/12th of the Sum Insured, or per month salary of the Insured Person based on the average of last 3 months salary slip of the Insured Person, or per month salary of the Policyholder based on the average of last 3 months salary slip of the Policyholder whichever is lower, shall be paid for a maximum of 6 months. Net monthly income (post tax), that is, monthly in hand salary excluding overtime, bonuses, tips, commissions or any other special compensation shall be considered for the purpose of payout under this benefit;

   b. In case of self-employed Insured Persons: Monthly amount equal to $1/12^{th}$ of the Sum Insured, or per month income of the Insured Person based on the last income tax return filed with the income tax department, or monthly income of the Policyholder based on the last income tax returns filed with the income tax department; whichever is lower shall be paid for a maximum of 6 months. This payout shall consider income from primary occupation only and will not include income from any other sources.

3. In case Policyholder and Insured person are not Income Tax Assessee: Monthly income will be assessed basis the income proof provided on self-declaration basis along with bank statements / any other income statements as proof for the past 12 months. However, for such cases income will be considered as lower of self- declared amount or the income slab up to which individual is not an Income Tax Assessee (as per prevalent Income Tax act). We will pay up to a maximum of 6 monthly benefits where each monthly benefit will be equal to $1/12^{th}$ of the Sum Insured or monthly income as declared by you or $1/12^{th}$ of the income as defined in the income tax slab for which an individual is not an Income Tax Assessee.

This Benefit shall be paid, subject to a valid admissible claim, only once during the lifetime of the Insured Person.

2.25 Enhanced Daily Cash Benefit

A daily cash amount will be payable per day if You are Hospitalised in a shared accommodation at a Network Provider for each continuous and completed period of 24 hours if the Hospitalisation exceeds 48 hours, provided that

a) Our maximum liability shall be restricted to the amount mentioned in the Policy Schedule/Product Benefits Table, and
b) Complete duration of Hospitalization is in a shared accommodation
c) This Benefit shall not be applicable to the time spent by You in an Intensive Care Unit, and
d) A claim has been admitted by Us under Inpatient Care under Section 2.1 above.

This allowance shall be paid in addition to the amount paid under Hospital Cash benefit (Section 2.22).

2.26 Home Treatment Additional Daily Cash Benefit

In case You opt for home care treatment by a service provider authorised by Us for an Illness or Injury which otherwise would have required Hospitalization as an in-patient, then in addition to coverage for such home hospitalization treatment expenses and Pre & post home hospitalization expenses up to the Sum Insured, We shall pay You a lump sum amount as Daily Cash Benefit for each completed day of such treatment as specified in the Product Benefits Table/ Policy Schedule. Such home care treatment shall be authorized and provided by Our authorized service providers on the basis of Cashless facility. All other conditions and limits in terms of number of days for Pre & post hospitalization as specified in section 2.2 and 2.3 shall be applicable.

The Daily Cash Benefit shall not be available for treatment taken at home for following procedures

- Chemotherapy

- Dialysis

2.27 Companion Benefit

We will pay the amount specified in the Policy Schedule/Product Benefits Table for each continuous and completed period of 24 hours of Hospitalization towards the expenses incurred by the person accompanying the Insured Person at the Hospital during such Insured Person's treatment for an Illness or Injury provided that:

a. Such Insured Person who is Hospitalized is Aged 12 years or below.
b. The Insured Person should have been Hospitalized for a minimum period of 48 hours continuously;
c. Such Hospitalization claim is payable as per Section 2.1 In-patient care.

d. We will not make any payment under this Benefit for more than 15 days of Hospitalisation in total under any Policy Year.
Such accompanying person may or may not be an Insured person under this Policy.

2.28 Maternity Benefits

This Benefit is available for You or Your spouse provided both are legally married and are covered under the same Family Floater Policy. If You are a widow, then this Benefit can be availed only in respect of a pregnancy conceived by You when You and Your spouse were both covered as Insured Persons during the Policy Period or under the immediately preceding Policy with Us.
A waiting period of 48 months from the Policy Inception Date shall be applicable for this Benefit.
The following covers are available under this Benefit:

1) Maternity Cover

a) We shall cover Maternity expenses up to the limit specified in the Product Benefits Table/ Policy Schedule for Hospitalization for the delivery of Your child or for lawful medically necessary termination of pregnancy (including abortion and miscarriage required or arising due accidental injuries) maximum up to 2 deliveries or termination of pregnancy during Your lifetime.

b) The following Medical Expenses are not covered under this Benefit:

i) Medical Expenses in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future Illnesses;

ii) Medical Expenses for ectopic pregnancy which are covered under Inpatient Care Benefit.

iii) Pre-hospitalization Medical Expenses and Post- hospitalization Medical Expenses shall not be covered under this Benefit.

2) New Born Baby Cover

If Hospitalization of a New Born Baby is required and if We have accepted a claim under Maternity Cover as mentioned above, then We will cover the Medical Expenses incurred towards the Medically Necessary Treatment of Your New Born Baby up to 90 days from birth. Our maximum liability under this Benefit will be subject to the limit specified in the Policy Schedule/Product Benefits Table.

You can add Your New Born Baby to this Policy after 91 days from the date of birth of the New Born Baby, subject to acceptance thereof as per Our underwriting guidelines and realization of applicable premium for the remaining Policy Period.

3) Vaccination for New Born Baby

We will cover Reasonable and Customary Charges for vaccination expenses of the New Born Baby for the vaccinations as mentioned below until the New Born Baby completes one year irrespective of the end of the Policy Period. Our maximum liability under this Benefit is up to the limit as defined in the Product Benefits Table/ Policy Schedule. This limit forms a part of the limit of Benefit defined for Section 2.28- 2) (New Born Baby Cover) above.

Time Interval	Vaccine	Age
	BCG	Birth to 2 weeks

0- 3 months	OPV Or OPV+	0,6,10 weeks 6,10 weeks
	DPT	6,10 weeks
	Hepatitis B	Birth, 6 weeks
	Haemophilus influenzae type B vaccine(Hib)	6,10 weeks
3- 6 months	OPV or OPV+ IPV2	14 weeks
	DPT	14 weeks
	Hepatitis B	14 weeks
	Haemophilus influenzae type B vaccine(Hib)	14 weeks
9 months	Measels	9 months
12 months	Chicken pox	12 months

2.29 Outpatient Cover

We will cover the Reasonable and Customary Charges incurred for medically necessary consultations with a Medical Practitioner on an out-patient basis to assess Your health condition for any Illness. We will also cover the Reasonable and Customary Charges incurred for undergoing any Diagnostic Tests prescribed by the Medical Practitioner and medicines purchased under and supported with a Medical Practitioner's prescription. The amount payable under this Benefit shall be up to the sub-limit shown in the Policy Schedule/Product Benefits Table.

We will also cover the Reasonable and Customary Charges for Dental Treatment, cost of spectacles, contact lenses and hearing aids, once in 2 Policy Years with a sublimit of 30% of the annual limit for OPD Treatment shown in the Policy Schedule/Product Benefits Table, that is, all the bills for these expenses within the policy periods can be accumulated and claimed at once.
Initial waiting period of 30 days, pre-existing disease waiting period and specific disease waiting period shall be applicable as specified in section 3 of the policy.

2.30 Convalescence Benefit

We will pay a lump sum amount of Rs.20000/- towards convalescence only once per Policy Year provided that a claim has been admitted by Us under Inpatient Care under Section 2.1 above for Hospitalization beyond 15 consecutive and completed days.

2.31 Worldwide Emergency Hospitalization Cover

We will cover the Medical Expenses incurred outside India in relation to You , up to the limits specified in the Policy Schedule/Product Benefits Table, provided that:

a) Such Medical Expenses are incurred with respect to Medically Necessary Treatment, where such treatment has been certified as an Emergency by a Medical Practitioner and cannot be postponed until You have returned to India and is payable as per Section 2.1 of the Policy;

b) The Medical Expenses payable shall be limited to Inpatient Care only;

c) Any payment under this Benefit shall be on a cashless basis or reimbursed only in Indian rupees;

d) The payment of any claim under this Benefit shall be based on the rate of exchange as on the date of payment to the Hospital published by the Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian rupees for payment of claim. Where, on the date of discharge, if RBI rates are not published, the exchange rate next published by the RBI shall be considered for conversion;

e) Each admissible claim shall be subject to a Deductible of as specified in Product Benefit Table/ Policy Schedule;

f) Our overall liability will be limited to 50% of the Sum Insured up to a maximum of Rs.20 lacs;

g) This Benefit is available on a worldwide basis;

h) Recharge of Sum Insured shall not be available for this Benefit;

i) This Benefit is available as Cashless facility through pre-authorization by Our service provider as well as on a re-imbursement basis through Us. Process for Cashless facility through pre-authorization by Our service provider is as mentioned below:

   i) In the event of an Emergency, You shall call Our service provider immediately, maximum within 24 hours of such hospitalization, on the helpline number specified in the Policy Schedule, requesting for a pre-authorization for the medical treatment required;
   ii) Our service provider will evaluate the request and Your eligibility under the Policy and call for more information or details, if required;

   iii) Our service provider will communicate within 24 hours of receiving the complete information, directly to the Hospital as to whether the request for pre-authorization has been approved or denied;

   iv) If the pre-authorization request is approved, Our service provider will directly settle the claim with the Hospital. Any additional costs or expenses incurred by You beyond the limits pre-authorized by the service provider shall be borne by You;

   v) We shall not cover any costs or expenses incurred in relation to any persons accompanying You during the period of Hospitalization, even if such persons are also Insured Persons.

Exclusion 3.2.26 & 3.2.27 do not apply to this Benefit.

2.32 Air Ambulance Cover

We shall cover the expenses up to the limit specified in the Policy Schedule/Product Benefits Table that are incurred towards Your transportation in an airplane or helicopter certified to be used as an ambulance to the nearest Hospital with adequate facilities in an Emergency following an Illness or Injury which occurs during the Policy Period provided that:

a. Such transportation of You cannot be provided by a road ambulance;
b. Your claim for Hospitalization in the Hospital You are transported to is admissible under Section 2.1 of this Policy;
c. Medically Necessary Treatment is not available at the location where You are situated at the time of the Emergency;

d. Your medical evacuation is prescribed by a Medical Practitioner and is medically necessary;

e. You are situated in India and the treatment is required in India only and not overseas in any condition whatsoever;

f. The air ambulance provider is registered in India;

g. Expenses incurred towards Your return transportation by air ambulance is excluded under this Benefit.

Optional Covers

All Optional Covers issued under this Policy shall be subject to the terms, conditions and exclusions of this Policy. All other Policy terms, conditions and exclusions shall remain unchanged.

Critical Illness Cover and Personal Accident Cover shall be applicable for the Insured Person(s) with respect to whom these covers are opted by paying additional premium and upon acceptance by Us and are specified in the Policy Schedule. The limits for these Optional Covers are applicable for each Insured Person.

Optional Covers Aggregate Deductible and Voluntary Co-pay, if opted shall be applicable to all the Insured Persons under the Policy.

Other Optional Covers, if opted shall also be applicable to all the Insured Persons under the Policy and claims under any of these optional covers shall impact the Cumulative Bonus in this Policy.

1. Critical Illness Cover

We shall pay the amount as specified in the Policy Schedule/Product Benefits Table against this Benefit as a lump sum in addition to payment made by Us under Section 2.1, if any, provided that:

i. The Insured Person is first diagnosed as suffering from a Critical Illness during the Policy Period, and
ii. The Insured Person survives for at least 30 days following such diagnosis.

We will not make any payment under this Benefit if the Insured Person is first diagnosed as suffering from a Critical Illness within 90 days of the Policy Start Date from which this Optional Cover was opted with respect to that Insured Person. This Benefit can be availed by the Insured Person only once during his/her lifetime. No claim under this Benefit will be admissible in case any of the Critical Illnesses is a consequence of or arises out of any Pre-Existing Disease within 48 months of first policy Start date. Such Pre-Existing Illness declared by You and accepted by Us at the time of first Policy issuance.

For the purpose of this Benefit, covered Critical Illness means:

i. Cancer of Specified Severity
ii. Myocardial Infarction (First Heart Attack of specific severity)
iii. Open Chest CABG
iv. Open Heart Replacement or Repair of Heart Valves
v. Coma of Specified Severity
vi. Kidney Failure requiring Regular Dialysis
vii. Stroke resulting in Permanent Symptoms
viii. Major Organ/Bone Marrow Transplant
ix. Permanent paralysis of Limbs
x. Motor Neurone Disease with Permanent Symptoms
xi. Multiple Sclerosis with Persisting Symptoms

If a claim becomes admissible under this Benefit, this Optional Cover shall not be available for that Insured Person at the time of Renewal.

Any Mandatory Co-Payment, Voluntary Co-Payment, Aggregate Deductible or Zone based Co-Payment shall not be applicable for claim payment under this Benefit.

2. Personal Accident Cover

If at any time during the Policy Period, the Insured Person sustains an Injury resulting solely and directly due to an Accident anywhere in the world, and causes any of the following events, then We shall pay the Insured Person or his/her nominee as the case may be, the amount(s) hereinafter set forth.

Events covered:

a) Accidental Death
If such Injury results in the death of the Insured Person within twelve calendar months from the date of the Accident, then We will pay the Sum Insured stated in the Policy Schedule/Product Benefits Table.

b) Permanent Total Disablement

1. If such Injury, within twelve calendar months from the date of the Accident, results in any of the following, then as per the table below, We shall pay a lump sum amount equal to the percentage of limit as mentioned for Personal Accident Benefit in the Product Benefits Table /Policy Schedule,

Nature of Disablement	Percentage of Limit for Personal Accident Cover payable
Total and irrecoverable loss of sight of both eyes	100%
Actual loss by physical separation of two entire hands	100%
Actual loss by physical separation of two entire feet	100%
Actual loss by physical separation of one entire hand and one entire foot	100%
Total & irrecoverable loss of sight of one eye	50%
Actual loss by physical separation of one entire hand or of one entire foot	50%
Total and irrecoverable loss of use of a hand or a foot without physical separation	50%
If such Injury shall, as a direct consequence thereof, immediately, permanently, totally and absolutely, disable the Insured Person from engaging in any employment or occupation of any description	100%

For the purpose of Clause 1.above, physical separation of a hand means separation at or above the wrist and of the foot means separation at or above the ankle.

If a claim becomes admissible under this Benefit where the claim paid is 100% of the limit under this Optional cover, then this Optional Cover shall not be available for that Insured Person at the time of Renewal.

Any Mandatory Co-Payment, Voluntary Co-Payment, Aggregate Deductible or Zone based Co-Payment shall not be applicable for claim payment under this Benefit.

3. Aggregate Deductible

If this cover is opted, the Policy becomes a Top-up policy wherein claim in a Policy Year becomes payable by Us only after deductible limit is crossed. A deductible does not reduce Sum Insured.

The Insured Person shall bear on his/her own account an amount equal to the Deductible specified in the Policy Schedule for any and all claim amounts We assess to be payable by Us in respect of all claims made by the Insured Person under the Policy for a Policy Year. Our liability to make payment under the Policy in respect of any claim made in that Policy Year will only commence once the Deductible has been exhausted during the Policy Year.

The Deductible shall apply on individual basis in case of individual policy and on floater basis in case of floater policy.

Only the expenses incurred by You under the following Sections of this Policy, subject to any sublimit therein and Zone based Co-Payment as per Section 5.5, which otherwise would have been payable under Your Plan, shall be considered for Deductible- Base Covers (i.e. Section 2.1 to Section 2.14), Section 2.28, , Section 2.31 and Section 2.32.

It is further agreed that Mandatory Co-Payment and Voluntary Co-Payment, if opted under this Policy shall be applicable after the Deductible has been exhausted.

All claim documents must be submitted even for the claims which are within the Deductible limit.

If We have admitted a claim under the Policy to which the provisions of Section 4.1.5 are applicable, then:

a) the provisions in Section 4.1.5 will apply only to any amounts payable by Us in respect of a claim made by the Insured Person after the Deductible has been exhausted; and

4. Voluntary Co-Payment

For each and every claim You shall bear the percentage of admissible claim amount as opted by You under this Optional Cover and mentioned on Your Policy Schedule irrespective of the Your Age.

Such Voluntary Co-Payment shall not be applicable to any claim amount payable under following Sections of this Policy: Section 2.16 to Section 2.20, Section 2.22 to Section 2.25 and Section 2.27.

Co-payment applicable as per this Cover shall be in addition to any other Co-payment (Mandatory Co-Payment, Co-payment for treatment in higher zone) applicable under this Policy.

5. Hospital Cash Optional Cover

If You are Hospitalized during the Policy Period and if We have accepted an Inpatient Care claim under Section 2.1, then We shall, in addition, pay the daily cash amount specified in the Policy Schedule /Product Benefits Table for each continuous and completed period of 24 hours of Hospitalization provided that:

a. You should have been Hospitalized for a minimum period of 48 hours continuously;
b. We shall not make any payment under this Benefit to You for more than 10 days of Hospitalisation in total under any Policy Year.

Any payment under this optional cover will be in addition to benefit under section 2.22 (Hospital Cash), if applicable.

6. Bonus Booster:

If this optional cover is in force, the percentage of the Sum Insured and maximum Cumulative Bonus that can be accrued as defined in Section 2.15 “Cumulative Bonus” of this Policy, shall be modified as 20% of Sum Insured per claim free Policy Year up to a maximum of 100% of Sum Insured, for Support, Secure and Support Plus plans:

All other terms and conditions as defined in Section 2.15 “Cumulative Bonus” of this Policy, remain unchanged.

7. Maternity Benefits Optional Cover:

This Benefit is available for You or Your spouse provided both are legally married and are covered under the same Family Floater Policy. If You are a widow, then this Benefit can be availed only in respect of a pregnancy conceived by You when You and Your spouse were both covered as Insured Persons during the Policy Period or under the immediately preceding Policy with Us.

If any room rent limit or room type limit is applicable to your plan as per section 2.1 (Inpatient Care), then such limits shall also be applicable for any claims under this optional cover as well.

A waiting period of 48 months from the Policy Start date of the Policy with which this optional cover was opted and renewed continuously thereafter, shall be applicable for this Benefit.

The following covers are available under this Benefit:

i) Maternity Cover

a) We shall cover Maternity expenses up to the limit specified in the Product Benefits Table/ Policy Schedule for Hospitalization for the delivery of Your child or for lawful medically necessary termination of pregnancy (including abortion and miscarriage required or arising due accidental injuries) maximum up to 2 deliveries or termination of pregnancy during Your lifetime.

b) The following Medical Expenses are not covered under this Benefit:

i) Medical Expenses in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future Illnesses;

ii) Medical Expenses for ectopic pregnancy which are covered under Inpatient Care Benefit.

iii) Pre-hospitalization Medical Expenses and Post- hospitalization Medical Expenses shall not be covered under this Benefit.

Our maximum liability under this Benefit will be subject to the limit specified in the Policy Schedule/Product Benefits Table.

ii) New Born Baby Cover

If Hospitalization of a New Born Baby is required and if We have accepted a claim under Maternity Cover as mentioned above, then We will cover the Medical Expenses incurred towards the Medically Necessary Treatment of Your New Born Baby up to 90 days from birth. Our maximum liability under this Benefit will be subject to the limit specified in the Policy Schedule/Product Benefits Table.

iii) Vaccination for New Born Baby

We will cover Reasonable and Customary Charges for vaccination expenses of the New Born Baby for the vaccinations as mentioned below until the New Born Baby completes one year irrespective of the end of the Policy Period. Our maximum liability under this Benefit is up to the limit as defined in the Product Benefits Table/ Policy Schedule. This limit forms a part of the limit of Benefit defined for New Born Baby Cover under this optional cover as stated above.

Time Interval	**Vaccine**	**Age**
1- 3 months	BCG	Birth to 2 weeks
	OPV Or OPV+	0,6,10 weeks 6,10 weeks
	DPT	6,10 weeks
	Hepatitis B	Birth, 6 weeks
	Haemophilus influenzae type B vaccine**(**Hib)	6,10 weeks
3- 6 months	OPV or OPV+ IPV2	14 weeks
	DPT	14 weeks
	Hepatitis B	14 weeks

	Haemophilus influenzae type B vaccine(Hib)	14 weeks
9 months	Measels	9 months
12 months	Chicken pox	12 months

8. Home treatment Additional Daily Cash Optional Cover

In case You opt for home care treatment by a service provider authorised by Us for an Illness or Injury which otherwise would have required Hospitalization as an in-patient, then in addition to coverage for such home hospitalization treatment expenses and Pre & post home hospitalization expenses up to the Sum Insured, We shall pay You a lump sum amount as Daily Cash Benefit for each completed day of such treatment as specified in the Product Benefits Table/ Policy Schedule. Such home care treatment shall be authorized and provided by Our authorized service providers on the basis of Cashless facility. All other conditions and limits in terms of number of days for Pre & post hospitalization as specified in section 2.2 and 2.3 shall be applicable.

The Daily Cash Benefit shall not be available for treatment taken at home for following procedures

- Chemotherapy
- Dialysis

9. Enhanced Pre & Post hospitalization Cover

If this optional cover is in force, the limit of coverage in terms of number of days immediately prior to Your date of Hospitalization and , the limit of coverage in terms of number of days immediately after Your discharge from the Hospital as per Section 2.2 and 2.3 of this Policy will be 60 days and 90 days respectively.

All other terms and conditions as defined in Section 2.2 and 2.3 i.e. “Pre- Hospitalisation Expenses” and “Post- Hospitalisationl Expenses” of this Policy, remain unchanged.

10. Worldwide Emergency Hospitalization Optional Cover

We will cover the Medical Expenses incurred outside India in relation to You , up to the limits specified in the Policy Schedule/Product Benefits Table, provided that:

j) Such Medical Expenses are incurred with respect to Medically Necessary Treatment, where such treatment has been certified as an Emergency by a Medical Practitioner and cannot be postponed until You have returned to India and is payable as per Section 2.1 of the Policy;

k) The Medical Expenses payable shall be limited to Inpatient Care only;

l) Any payment under this Benefit shall be on a cashless basis or reimbursed only in Indian rupees;

m) The payment of any claim under this Benefit shall be based on the rate of exchange as on the date of payment to the Hospital published by the Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian rupees for payment of claim. Where, on the date of discharge, if RBI rates are not published, the exchange rate next published by the RBI shall be considered for conversion;

n) Each admissible claim shall be subject to a Deductible of Rs. 2 Lakh

o) Our overall liability will be limited to 50% of the Sum Insured up to a maximum of Rs.10 lakh;

p) This Benefit is available on a worldwide basis;

q) Recharge of Sum Insured shall not be available for this Benefit;

r) This Benefit is available as Cashless facility through pre-authorization by Our service provider as well as on a re-imbursement basis through Us. Process for Cashless facility through pre-authorization by Our service provider is as mentioned below:

i) In the event of an Emergency, You shall call Our service provider immediately, maximum within 24 hours of such hospitalization, on the helpline number specified in the Policy Schedule, requesting for a pre-authorization for the medical treatment required;
ii) Our service provider will evaluate the request and Your eligibility under the Policy and call for more information or details, if required;

iii) Our service provider will communicate within 24 hours of receiving the complete information, directly to the Hospital as to whether the request for pre-authorization has been approved or denied;

iv) If the pre-authorization request is approved, Our service provider will directly settle the claim with the Hospital. Any additional costs or expenses incurred by You beyond the limits pre-authorized by the service provider shall be borne by You;

v) We shall not cover any costs or expenses incurred in relation to any persons accompanying You during the period of Hospitalization, even if such persons are also Insured Persons.

Exclusion 3.2.26 & 3.2.27 do not apply to this Benefit.

11. OPD & Home Care for Covid-19:

This optional cover shall be applicable for the Insured Person(s) with respect to whom it is opted by paying additional premium and upon acceptance by Us and up to the limit as specified in the Policy Schedule.

A waiting period of 15 days shall be applicable.

We will reimburse Home Care Treatment expenses, if treatment is availed by the Insured person on being diagnosed as Covid-19 positive, where he is advised quarantine or isolation at home or a Covid isolation facility for a maximum of 14 days per incident maximum up to the sum insured as specified in the policy schedule provided that the Medical Practitioner advices the Insured person to undergo treatment at home/isolation facility.

In this benefit, the following shall be covered if prescribed by the treating medical practitioner and is related to treatment of COVID:

a. Diagnostic tests undergone at home or at diagnostic centre. Eg. Blood profiling, RT-PCR, RAT, HRCT etc.
b. Medicine prescribed in writing
c. Consultation charges of the medical practitioner including Tele Medicine charges
d. Nursing charges related to medical staff
e. Cost of Pulse oximeter (maximum up to Rs 1,000)
f. Oxygen cylinder and Nebulizer
g. Pulmonary Rehabilitation consultations for next 14 days after the initial 14 days of home isolation.
h. Expenses like PPE kits, sanitation charges etc. either by attending doctor/nurse or attendant while providing the treatment

Exclusion 3.1.3, 3.2.20 & 3.2.21 will not be applicable for this Cover.

12. Non-payable expense Cover:

If this optional cover is in forced, as specified in your Policy Schedule, We shall also cover the expenses as listed under "List I – Item for which coverage in not available in the policy" of Annexure II of this Policy under Section 2.1 (Inpatient Care) and Section 2.4 (Day Care treatment).

13. Recharge Benefit for same illnesses:

If this optional cover is in force, Benefit mentioned under section 2.21, (Recharge of Sum Insured) is extended to include provision of recharge benefit for same or related illness as well, as long as the subsequent Hospitalization claim is arising due to relapse or complication of the disease that caused precedent claim. Recharge will not trigger if such subsequent hospitalization/day care is for treatment which was considered to be required as part of overall treatment plan at the time of diagnosis of disease or at the time of precedent hospitalization claim; for e.g. Chemotherapy sessions for cancer, periodic Dialysis for renal failure. Further, subject to above condition, where the claim is due to same or related illness to which a claim has already been paid, a waiting period of 45 days from the date of discharge from hospital for precedent claim of that illness or injury shall be applicable.

Such Recharge for same illness shall be available only once during a Policy Year. All other terms and conditions of section 2.21, (Recharge of Sum Insured) shall be applicable except point (b).
Illustration for this optional cover:

	Example 1	Example 2	Example 3	Example 4
Policy SI	5 lakh	5 lakh	5 Lakh	5 Lakh
No claim Bonus (NCB)+ Bonus Booster (BB)	1 lakh	50,000	0	0
1st Claim reason	Heart Attack	Renal failure	Covid19	Covid19
1st claim amount	8 Lakh	5 Lakh	5 Lakh	5 Lakh
1st claim paid amount	6 Lakh	5 Lakh	4 Lakh	4 Lakh
Balance SI+NCB+BB	0	50,000	1 lakh	1 lakh
2nd claim reason	Stroke	Dialysis	Covid Reinfection (after 30 days from previous hospitalization)	Covid Reinfection (after 3 months from previous hospitalization)
2nd claim amount	10 lakh	1 lakh	5 lakh	5 lakh
Will recharge trigger	Yes	No	No	Yes
2nd claim paid amount	5 lakh	50,000 (from balance SI)	1 lakh (from balance SI)	5 lakh

14. Zone wise Co-pay Waiver:

We shall waive off the co-pay as applicable per section 5.5 of this policy, in case treatment is taken in a zone higher than the applicable zone as mentioned in Policy Schedule. If this optional cover is opted at the time of renewal, a waiting period of 1 year from the date this optional cover is opted in the renewal policy shall be applicable. During this 1 year waiting period, zone based co-pay as specified under section 5.5 will continue to apply. Such waiting period shall not be applicable if this optional cover is opted at the time of first purchase of this policy with us as new customer or as a port policy from other insurer.

However, We reserve the right to dis-allow re-opting this optional cover, at our discretion, once it is discontinued by Policyholder. Whenever allowed, the 1 year waiting period shall start afresh on re-opting this optional cover post discontinuation.

15) Waiver of Deductible:

This optional cover is available only if Aggregate Deductible Optional Cover (Optional Cover 3) is opted.

In consideration to additional premium paid towards this optional cover with a Super Top up policy (i.e. OneHealth policy with Aggregate deductible), we give you an option to waive the deductible and convert it into a base policy after 4 policy years. We will give you the continuity benefit on the complete Sum Insured and no fresh waiting periods will be applicable. Following conditions will apply:

1. Maximum Sum Insured available shall be one step higher than the nearest SI option to the sum of Sum insured and deductible amount at the time of inception of your first Super Top Up policy with Us.

Example: For policy with Sum Insured 5 lakh and deductible 3 lakh,

Sum of SI & Deductible= 5+3= 8 lakh

Nearest SI option to above sum: 7.5 Lakh

Maximum SI option at the time of conversion to base policy: One step higher than 7.5 lakh, that is, 10 Lakh.

2. In case any of the insured person develops any health condition during the coverage tenure under super top up policy, an additional loading maximum up to 50% on total premium may be applied. Any loading once applied will be applicable on total premium and on all subsequent renewals.

3. You have to provide a declaration regarding health conditions status at the time of switch. We reserve the right to deny claim and cancel your policy anytime if this declaration is found to be untrue anytime thereafter.

Section 3. Exclusions

3.1 Standard Exclusions

3.1.1) Pre-Existing Diseases (Code- Excl01):

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months (for Support Plan) ; 36 months (for Secure, Support Plus and Shield Plan) ; 24 months (for Premium Plan); of continuous coverage after the date of inception of the first policy with us.
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 above defined months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

3.1.2) Specific Diseases Waiting Period (Code- Excl02):

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage, as may be the case after the date of inception of the first policy with the Insurer. 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.

List of these diseases is:

1. Cataract
2. Stones in biliary and urinary systems
3. Hernia / Hydrocele
4. Hysterectomy for any benign disorder
5. Lumps / cysts / nodules / polyps / internal tumours
6. Gastric and Duodenal Ulcers
7. Surgery on tonsils / adenoids
8. Osteoarthrosis / Arthritis / Gout / Rheumatism / Spondylosis / Spondylitis / Intervertebral Disc Prolapse
9. Fissure / Fistula / Haemorrhoid
10. Sinusitis / Deviated Nasal Septum / Tympanoplasty / Chronic Suppurative Otitis Media
11. Benign Prostatic Hypertrophy
12. Knee/Hip Joint replacement and any ligament, tendon or muscle tear
13. Dilatation and Curettage
14. Varicose veins
15. Dysfunctional Uterine Bleeding / Fibroids / Prolapse Uterus / Endometriosis
16. Chronic Renal Failure or end stage Renal Failure
17. Internal congenital anomalies/diseases/defects

3.1.3) First Thirty Days Waiting Period (Code- Excl03)

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

3.1.4) Investigation & Evaluation (Code Excl04):

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

3.1.5) Rest Cure, Rehabilitation and respite Care (Code Excl05)

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

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

3.1.6) Change of Gender treatment (Code Excl07)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

3.1.7) Cosmetic or Plastic Surgery (Code Excl08)

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

3.1.8) Hazardous or Adventure sports: (Code- Excl09)

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

3.1.9) Breach of law (Code Excl10)

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

3.1.10) 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.

List of these have been provided on Our website.

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

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

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

3.1.14) Refractive Error (Code Excl15)

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

3.1.15) Unproven treatments (Code Excl16)

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

3.1.16) 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

Note: This exclusion shall not apply for IVF treatment (as per Section 2.9 IVF Treatment Cover).

3.1.17) Maternity expenses (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.

Note: This exclusion does not apply to Maternity Benefits (Section 2.28)

3.2) Specific Exclusions:

3.2.1) 90 days Initial Waiting Period for Optional Cover-Critical Illness Cover

The lump sum benefit shall not be payable for any Critical Illness claims arising in the first 90 days from the Policy Start Date from which the Critical Illness optional cover was opted and Renewed continuously thereafter.

3.2.2) A special waiting period, not exceeding 48 months, may be applied to individual Insured Persons depending upon the declarations made in the proposal form and existing health conditions. Such waiting periods shall be specifically stated in the Policy Schedule and will be applied only after receiving the Insured Person's specific consent. Any special waiting period in respect of Pre- Existing diseases shall not exceed 48 months.

3.2.3) Any Alternative Treatment except for the Benefits under Section 2.8 (AYUSH Treatment)

3.2.4) Charges related to a Hospital stay not expressly mentioned as being covered. Service charges levied by the Hospital under whatever head. Complete list of these excluded expenses are mentioned in Annexure II of this Policy The list is available on our website www.magma hdi.com. This exclusion does not apply for Section 2.20 (Green Channel Benefit)

3.2.5) Expenses for Artificial life maintenance, including life support machine used to sustain a person, incurred after confirmation by the treating doctor that the patient is in vegetative state

3.2.6) Any charges incurred to procure any medical certificate, medical records, treatment or Illness/Injury related documents pertaining to any period of Hospitalization/Day Care Treatment undertaken for any Illness or Injury.

3.2.7) Circumcision unless necessary for the treatment of an Illness or disease or necessitated by an Accident.

3.2.8) Treatment for any Illness or Injury resulting from nuclear or chemical contamination, war, riot, revolution or acts of terrorism (other than natural disaster or calamity).

3.2.9) Treatment for any External Congenital Anomaly.

3.2.10) Dental Treatment including Surgical Procedures for the treatment of bone disease when related to gum disease or damage, or treatment for, or treatment arising from, disorders of the temporomandibular joint. This exclusion does not apply for Outpatient Cover (Section2.29)

EXCEPTION: We will pay for a Surgical Procedure wherein the Insured Person Hospitalized as a result of an Accident and which is undertaken for Inpatient Care in a Hospital and carried out by a Medical Practitioner.

3.2.11) Any drugs or Surgical dressings that are provided or prescribed in the case of OPD treatment, or for the Insured Person to take home on leaving the Hospital, for any condition, except as included in Post-hospitalization Medical Expenses under Section 2.3 above. This exclusion does not apply to Outpatient Cover (Section 2.29)

3.2.12) We will not pay for routine eye examinations, contact lenses spectacles, hearing aids, dentures and artificial teeth. This exclusion does not apply for Outpatient Cover (Section 2.29)

3.2.13) Any treatment arising from and/or taken for Crohn's Disease ,Ulcerative colitis, Cystic kidneys, Neurofibromatosis, Factor V Leiden Thrombophilia, Familial Hypercholesterolemia, Haemophilia, Hereditary Fructose Intolerance, Hereditary Hemochromatosis, Hereditary Spherocytosis.

3.2.14) Private nursing/attendant's charges incurred during pre-hospitalization or post-hospitalization.

3.2.15) Drugs or treatment not supported by prescription.

3.2.16) Issue of fitness certificate and fitness examinations.

3.2.17) Any charges incurred to procure any treatment/Illness related documents pertaining to any period of Hospitalization/Illness.

3.2.18) External and/ or durable medical/non-medical equipment used for diagnosis and/ or treatment

3.2.19) Ambulatory devices, walkers, crutches, belts, collars, caps, splints, slings, braces, stockings of any kind, diabetic foot wear, glucometer/thermometer and also any medical equipment which is subsequently used at home.

3.2.20) OPD treatment is not covered.
However this exclusion does not apply for:
Outpatient Cover (Section 2.29)
Vaccination for New Born Baby (Section 2.28 (3))

3.2.21) All preventive care, vaccination including inoculation and immunisations except in case of Vaccination for New Born Baby (Section 2.28 (3))

3.2.22) Treatment for, or arising from, an Injury that is intentionally self-inflicted, including attempted suicide.

3.2.23) Treatment for sleep apnea, snoring, or any other sleep-related breathing problem.

3.2.24) Any treatment received outside India. This exclusion does not apply for Section 2.31 (Worldwide Emergency Hospitalization Cover).

3.2.25) Treatment provided by a Medical Practitioner who is not recognized by the Medical Council of India.

3.2.26) Treatment provided by anyone with the same residence as the Insured Person or who is a member of the Insured Person's immediate family.

3.2.27) X-Ray or laboratory examinations or other diagnostic studies, not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury, whether or not requiring Hospitalization.

Section 4. General Terms and Clauses

4.1) Standard General Term and Clauses

4.1.1) Disclosure to Information

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

4.1.2) Condition Precedent to admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

4.1.3) Claim Settlement (Provision for penal interest)

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

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

(iii) However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

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

(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.

4.1.4) Complete Discharge

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

4.1.5) Multiple Policies

1. 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.

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

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

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

4.1.6) 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 mis-statement of or suppression of material fact are within the knowledge of the insurer.

4.1.7) Cancellation/ Termination (other than Free Look cancellation)

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

We shall cancel the Policy and refund the premium for the balance of the Policy Period in accordance with the table below, after deducting the amount spent on pre-policy medical check up by Us, provided that no claim has been made under the Policy by or on behalf of any Insured Person.

Cancellation date up to (x months) from the Policy Start Date	Refund of Premium (basis Policy Period)		
	1 Year	2 Year	3 Year
Up to 1 month	75.00%	87.50%	91.50%
1 month to 3 months	50.00%	75.00%	88.50%
3 months to 6 months	25.00%	62.50%	75.00%
6 months to 12 months	0.00%	50.00%	66.50%
12 months to 15 months	NA	25.00%	50.00%
15 months to 18 months	NA	12.50%	41.50%
18 months to 24 months	NA	0.00%	33.00%
24 months to 30 months	NA	NA	8.00%
Beyond 30 months	NA	NA	0.00%

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any Benefit has been availed by the Insured person under the Policy.

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

4.1.8) Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the Policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

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

4.1.9) 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/whatsNew_Layout.aspx?page=PageNo3987&flag=1

4.1.10) Renewal of Policy

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

a) The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
b) Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years
c) Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
d) At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits with Break in Policy. Coverage is not available during the grace period.
e) No loading shall apply on renewals based on individual claim experience.

4.1.11) Withdrawal of the 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.

4.1.12) Moratorium Period:

After completion of eight continuous years under the policy no look back would 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 eight continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy 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, deductible as per the policy contract.

4.1.13) Premium Payment in Instalments (Wherever applicable)

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 benefits 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.

4.1.14) Possibility of Revision of Terms of the Policy including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

4.1.15) Free Look Provision

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 shall be allowed a free look provision 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;

4.1.16) Redressal of Grievance

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

Website: www.magma-hdi.co.in
Toll free: 1800 266 3202
E –mail: Gro@magma-hdi.co.in
Fax: 91 033 4401 7471
Courier: Any of Our branch offices or corporate office during business hours

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured Person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at:

Magma HDI General Insurance Co. Ltd.,
Office no. 516 and 517, 5th Floor,
Neelkanth Corporate Park,
Plot No. 240, 2401/1-8,
Kirol Road, Vidyavihar West
Mumbai – Maharashtra 400 086

For updated details of grievance officer, kindly refer the link https://www.magmahdi.com/grievance-redressal.

If Insured Person is not satisfied with the redressal of grievance through above methods, insured person may may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules, 2017. The contact details of the Insurance Ombudsman offices have been provided as Annexure-I

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

4.1.17) Nomination

The Policyholder is required at the Policy Inception Date 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 Policy Schedule/Policy certificate/Endorsement, (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

4.2) Specific Terms and Clauses

4.2.1) Alteration to the Policy

This Policy constitutes the complete contract of insurance. Subject to the provisions of applicable law, no change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement signed and stamped by Us. No one except Us can change or vary this Policy.

4.2.2) Change of Policyholder

The Policyholder may be changed only at the time of Renewal of the Policy. The new Policyholder must be a member of the original Policyholder's immediate family. The Renewed Policy shall be treated as having been Renewed without break.

The Policyholder may be changed upon request in situations like Policyholder's demise, moving out of India or in case of divorce

4.2.3) No Constructive Notice

Any knowledge or information of any circumstances or condition in relation to the Policyholder/Insured Person which is in Our possession and not specifically informed by the Policyholder/ Insured Person shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

4.2.4) Limitation of Liability

If a claim is rejected or partially settled and is not the subject of any pending suit or other proceeding or arbitration, as the case may be, within twelve months from the date of such rejection or settlement the claim shall be deemed to have been abandoned and Our liability shall be extinguished and shall not be recoverable thereafter.

4.2.5) Records to be maintained

The Policyholder or the Insured Person, as the case may be shall keep an accurate record containing all relevant and accurate medical records like in-patient records, Discharge summary , medical certificates, medical prescriptions, diagnostic reports and reports confirming the need for treatment (if any) and shall allow Us or our representative(s) to inspect such records. The Policyholder or the Insured Person as the case may be, shall furnish such information as may be required by Us under this Policy at any time during the Policy Period or until final adjustment (if any) and resolution of all claims under this Policy.

4.2.6) Geographical Scope

The geographical scope of this Policy applies to events within India other than for Worldwide
Emergency Hospitalization Cover and for Personal Accident Optional Covers. However, all admitted or payable claims shall be settled in India in Indian rupees other than for Worldwide Emergency Hospitalization.

4.2.7) Policy Disputes

Any and all disputes or differences under or in relation to this Policy herein shall be determined by Indian law and shall be subject to the jurisdiction of the Indian Courts.

4.2.8) Material Change

It is a Condition Precedent to the Our liability under the Policy that the Policyholder shall immediately notify Us in writing of any material change in the risk on account of change in the nature of occupation or business at his/her own expense. We may, in Our discretion, adjust the scope of cover and/or the premium payable, accordingly. The Policyholder/You must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, endorsement or reinstatement of the Policy. The Policy terms and conditions shall not be altered.

4.2.9) Communications & Notices

Any communication or notice or instruction under this Policy shall be in writing and will be sent to:

a) To Us, at the address as specified in Policy Schedule

b) The Policyholder's, at the address as specified in Policy Schedule

c) No insurance agents, brokers, other person or entity is authorized to receive any notice on behalf of Us unless explicitly stated in writing by Us

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

Section 5) Other Terms and Conditions:

5.1) Loading

We shall apply a risk loading on the premium payable as per Our board approved underwriting policy (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance), which shall be mentioned specifically in the Policy Schedule. The maximum risk loading applicable shall not exceed 100% per diagnosis / medical condition and an overall risk loading of 200%. These loadings are applied from the Policy Inception Date including subsequent Renewal(s) with Us or on the receipt of a request for increase in Sum Insured (for which the loading shall be applied on the increased Sum Insured).
We will inform the Policyholder about the applicable risk loading through post/courier/email/phone. The Policyholder shall revert to Us with his/her written consent and additional premium (if any), within 15 days of the issuance of such counter offer. In case, the Policyholder neither accepts the counter offer nor reverts to Us within 15 days, We shall cancel his/her application and refund the premium paid within the next 15 days.
No loading shall be applied at the time of Renewal on the basis of individual claim experience.

5.2) Mandatory Co –Payment

A 20% Co-Payment on admissible claim amount shall be applicable for each claim if the Insured Person is Aged 61 years or more at the Policy Inception Date.
This Mandatory Co-Payment shall apply in addition to any other Co-Payment, if applicable as per the Optional Cover "Voluntary Co-Payment" chosen by the Insured under this Policy.

5.3) Endorsements

We may allow the following endorsements. You/the Policyholder should request for any endorsement in writing. Any endorsement that is accepted by Us shall be effective from the date of the request as received from You/the Policyholder, or the date of receipt of premium, whichever is later.

(i) Non-Financial Endorsements – which do not affect the premium.
   (1) Minor rectification/correction in name of the Policyholder/ Insured Person)
   (2) Rectification in gender
   (3) Rectification in relationship of the Insured Person with the Policyholder
   (4) Rectification of date of birth of the Insured Person (if this does not impact the premium)
   (5) Change in the address of the Policyholder
   (6) Change/Updation in the contact details
   (7) Change in Nominee Details

(ii) Financial Endorsements – which result in alteration in premium
   (1) Addition of Insured Person (New Born Baby or newly wedded spouse)
   (2) Addition of any Insured Person
   (3) Deletion of Insured Person
   (4) Change in Age/Date of Birth (if this impacts the premium)
   (5) Change in address (if this impacts zone and hence premium)
   (6) Change in plan and/or Sum Insured
   (7) Addition/removal of Optional Cover(s)

Financial endorsements (1), as mentioned above, can be allowed during the term of Policy, all other financial endorsements are allowed at the time of renewal only.

We reserve the rights to do underwriting in case of any such endorsement requests.
Fresh waiting period shall be applicable with respect to the Insured person added after Policy Inception Date. Where the Policy is Renewed for enhanced Sum Insured, all waiting periods would start and apply afresh for the amount of increase in Sum Insured.

5.4) Special Conditions Applicable for Policies Issued With Premium Payment on Instalment Basis

Notwithstanding the provision of Grace period as stated in the clause " Premium Payment in Instalments" above, we shall provide, Relaxation period instead of Grace period as below:

a) A relaxation period of maximum 15 days from the due date of the instalment payable shall be provided. Coverage will be available during such Relaxation period.
b) In case of any claim during the relaxation period, an amount equivalent to the balance of the instalment premiums payable in the Policy Period shall be recoverable from the admissible claim amount payable.
c) If the instalment premium due is not received within the above relaxation period, the Policy will be cancelled. We may issue a fresh Policy with all waiting periods applicable subject to Our underwriting guidelines.
d) If the claim amount is lesser than the balance premium payable, then no claims would be payable till the applicable premium is recovered.

We may also allow premium instalment payment through ECS mode.

You must ensure that there are sufficient funds in Your bank account, through which You have opted ECS facility for payment of premium for this Policy. In case of failure of transactions in ECS mode and non-payment of premium instalment maximum within Relaxation period, the Policy will be terminated. We reserve the rights to do fresh underwriting for issuance of new Policy, in such cases.

In case there is change either in the terms and conditions of the policy contract or in the premium rate, the ECS authorization shall be obtained afresh. You may withdraw from the ECS mode by giving Us a notice at least fifteen days prior to the due date of instalment premium payable as per Your ECS mandate form.

You should carefully take note of the procedures and timelines to be adhered to in connection with the ECS mandate as specified in the ECS mandate form duly filled by You at the time of opting this mode of payment.

5.5) Zone Classification, Premium and Zone based Co-pay

For the purpose of Policy issuance, the premium will be computed basis the zone of residence of the Policyholder. The premium would be applicable zone wise and the cities defined in each zone are as under:

a. **Zone 1** means Delhi including National Capital Region, Mumbai including Thane, Navi Mumbai, Vasai-Virar, Bangalore and Gujarat,
b. **Zone 2** means Coimbatore, Pune, Hyderabad, Chandigarh, Chennai, Kolkata and Kerala
c. **Zone 3** means Rest of India excluding areas falling under Zone 1 and Zone 2

Zone classification can be changed by Us after informing the Policyholder at least 3 months in advance, subject to approval from the IRDAI.

In case You opt to take treatment in a zone higher than the applicable zone as mentioned in Policy Schedule, You shall bear a Co-Payment on admissible claim amount as mentioned below:

a. Zone 2 to Zone 1: 25% for every claim made
b. Zone 3 to Zone 2: 20% for every claim made
c. Zone 3 to Zone 1: 35% for every claim made

Such co-pay shall not be applicable for Emergency Hospitalization and Emergency treatment required due to Accident that happens whilst the Insured Person was outside the zone as applicable in the Policy Schedule.

In case You opt to take treatment in a zone lower than the applicable zone as mentioned in Policy Schedule, no Co-Payment shall be applicable. Such Co-Payment shall be in addition to the Mandatory Co-payment and Voluntary Co-Payment, as applicable under the Policy. Zone shall be based on city of residence of the Policyholder. We also provide the Policyholder an option to choose a zone higher or lower than this zone based on residence of the Insured Person(s).

5.6) Claim Procedure

Provided that due adherence/observance and fulfilment of the terms and conditions of this Policy (conditions and all endorsements hereon are to be read as part of this Policy) shall so far as they relate to anything to be done or not to be done by You and / or any Insured Person be a Condition Precedent to admission of Our liability under this Policy.

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

1. **a) For Availing Cashless Facility (Procedure for Domestic Claims)**

   Cashless facility can be availed only at Our Network Providers. The complete list of Network Providers is available on Our website and at Our branches and can also be obtained by contacting Us over the telephone. The updated list of TPA containing complete details is available on Our website www.magma-hdi.co.in and is also attached as [Annexure IV].

   Cashless facility will be availed through the TPA. The TPA will be contacted on its helpline and must be provided with the membership number, Policy Number and the name of the Insured Person at least 72 hours before admission to the Hospital for planned Hospitalization and within 24 hours of admission to the Hospital in case of Emergency Hospitalization. The TPA will also, by fax or e-mail, be provided with details of Hospitalization like diagnosis, name of the Hospital, duration of stay in the Hospital, estimated expenses of Hospitalization etc. in the prescribed form available with the insurance help desk at the Hospital. Any additional information as may be required by the medical panel of the TPA must also be furnished. After establishing the admissibility of the claim under the Policy, the TPA shall provide a pre-authorisation to the Hospital guaranteeing payment of the Hospitalization expenses subject to the Sum Insured, terms conditions and limitations of the Policy. The authorization shall be issued to the Network Provider within 24 hours of receiving the complete information.

   For availing Home treatment, You can contact Our Authorized Home care provider. The updated list of Our authorized Home care provider is available on Our website www.magma-hdi.co.in. You can also call at our customer care number 1800 3002 3202 for information and assistance. The Home care provider shall evaluate Your eligibility and, if Home care is assessed to be advisable for Your health condition, will contact Our TPA. The TPA shall provide a pre-authorisation to Home care provider within 24 hours of receiving the complete information.

   In case as per Our authorized Home care provider, Home care is not found to be advisable for Your health condition, You can avail the treatment at a Hospital as an in-patient and the claim for the same on Cashless or reimbursement process.

b) For Availing cashless facility (Procedure for Worldwide Emergency Cover)

Please follow the procedure as mentioned in Section 2.31 (i) to avail Cashless facility in case of Hospitalization outside India.

2. **For admission in Non-Network Provider or into Network Provider if Cashless facility is not availed (Re-imbursement Claims) (For Domestic Claims as well as Worldwide Emergency Hospitalization)**

   a. **Intimation of claim:** Preliminary intimation of claim with particulars relating to Policy Number, name of the Insured Person in respect of whom claim is made, nature of Illness/Injury and name and address of the attending Hospital, must be provided to Us at least 72 hours before admission to the Hospital in case of planned Hospitalization, and within 24 hours of admission in the Hospital, in case of Emergency Hospitalization.

3. **Submission of claim:** The claim form along with the attending Medical Practitioner's certificate duly filled and signed in all respects with the following claim documents will be submitted to Us not later than 30 days from the date of discharge from the Hospital.

   Mandatory documents

a. Duly completed claim form

b. Test reports and prescriptions relating to first / previous consultations for the same or related illness.

c. Case history / admission-discharge summary describing the nature of the complaints and its duration, treatment given, advice on discharge etc. issued by the Hospital.

d. Death summary in case of death of the Insured Person at the Hospital.

e. Post Mortem Report, if applicable & if conducted

f. Hospital receipts / bills / cash memos in original (including advance and final Hospital settlement receipts).

g. All test reports for X-rays, ECG, Scan, MRI, Pathology etc., including the Medical Practitioner's prescription advising such tests/investigations (CDs of angiogram, surgery etc. need not be sent unless specifically sought).

h. Medical Practitioner's prescriptions with cash bills for medicines purchased from outside the Hospital.

i. F.I.R/MLC. in the case of Accidental Injury and English translation of the same, if in any other language.

j. Legal heir certificate in the absence of nomination under the Policy, in case of death of the Insured Person. In the absence of legal heir certificate, evidence establishing legal heirship may be provided as required by Us.

k. For a) maternity claims, discharge summary mentioning LMP, EDD & Gravida b) Cataract claims - IOL sticker c) PTCA claims - Stent sticker.

l. Copies of health insurance policies held with any other insurer covering the Insured Person(s).

m. If a claim is partially settled by any other insurer, a certificate from the other insurer confirming the final claim amount settled by them and that original claim documents are retained at their end.

n. For Domiciliary Hospitalization claims, a certificate from the attending Medical Practitioner confirming that the condition of the Insured Person is such that he/she is not in a condition to be removed to a Hospital.

o. Additional documents for Air Ambulance Cover:

    i. Certification by the treating Medical Practitioner of such life threatening Emergency condition and confirming that current Hospital does not have suitable medical equipment and technology for the life threatening condition.

    ii. Bills/receipts of transportation agency/ambulance company/air ambulance receipts.

p. Additional documents for Worldwide Emergency Hospitalization– the Insured Person's passport, visa, tickets and boarding passes.

q. Additional documents for Compassionate visit–tickets and boarding passes, if applicable

Documents to be submitted if specifically sought:

a. Copy of indoor case records (including Qualified Nurse's notes, OT notes and anaesthetists' notes, vitals chart).

b. Copy of extract of inpatient register.

c. Attendance records of employer/educational institution.

d. Complete medical records (including indoor case records and OP records) of past Hospitalization/treatment, if any.

e. Attending Medical Practitioner's certificate clarifying.

i. reason for Hospitalization and duration of Hospitalization
ii. history of any self-inflicted Injury
iii. history of alcoholism, smoking
iv. history of associated medical conditions, if any

f. Previous master health check-up records/pre-employment medical records, if any.

g. Any other document necessary in support of the claim on case to case basis.

The claim documents should be sent to the address mentioned in Claim form.

4. Payment of Claim

a) No liability under the Policy will be admitted, if the claim is fraudulent or supported by fraudulent means.

b) The Insured Person or any person acting on behalf of the Insured Person, as the case may be, must provide at his/her expense, all the information asked by Us in relation to the claim and he/she must provide all reasonable cooperation and assistance to Us as may be required.

c) If required, the Insured Person or any person acting on behalf of the Insured Person, as the case may be, must give consent to obtain medical reports from the Medical Practitioner at Our expense.

d) If requested by Us, the Insured Person must agree to be examined by a Medical Practitioner of Our choice and at Our expense.

e) All claims under this Policy shall be payable in Indian Currency. All medical treatments for the purpose of this Policy will be required to be taken in India only except for Worldwide Emergency Hospitalization.

f) Claims under this Policy shall be settled or rejected, as the case may be, within 30 days of the receipt of the last necessary document.

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Annexure I

The contact details of the **Insurance Ombudsman** offices are as below-

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat , UT of Dadra and Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka	Office of the Insurance Ombudsman, JeevanSoudhaBuilding,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab , Haryana, Himachal Pradesh, Jammu and Kashmir, UT of 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@gbic.co.in
Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.

	Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in
Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, JeevanNivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh, Telangana and UT of Yanam – a part of the UT of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Rajasthan	Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
Kerala , UT of (a) Lakshadweep, (b) Mahe – a part of UT of Pondicherry	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in
West Bengal, UT of Andaman and Nicobar Islands, Sikkim	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, JeevanSevaAnnexe, S. V. Road, Santacruz (W),

	Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in
State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514251 / 2514253 Email: bimalokpal.noida@ecoi.co.in
Bihar, Jharkhand.	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Email: bimalokpal.patna@ecoi.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	Office of the Insurance Ombudsman, JeevanDarshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 32341320 Email: bimalokpal.pune@ecoi.co.in

Annexure II

List I – Item for which coverage in not available in the policy

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES

16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN

65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

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

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

Sl No.	Item

1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

Sl No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer& Strips
18	URINE BAG

Annexure III

List of Day Care Surgeries

CARDIOLOGY RELATED	
1	CORONARY ANGIOGRAPHY
	CRITICAL CARE RELATED
2	INSERT NON- TUNNEL CV CATH
3	INSERT PICC CATH (PERIPHERALLY INSERTED CENTRAL CATHETER)
4	REPLACE PICC CATH (PERIPHERALLY INSERTED CENTRAL CATHETER)
5	INSERTION CATHETER, INTRA ANTERIOR
6	INSERTION OF PORTACATH
	DENTAL RELATED
7	SPLINTING OF AVULSED TEETH
8	SUTURING LACERATED LIP
9	SUTURING ORAL MUCOSA
10	ORAL BIOPSY IN CASE OF ABNORMAL TISSUE PRESENTATION
11	FNAC
12	SMEAR FROM ORAL CAVITY
13	MYRINGOTOMY WITH GROMMET INSERTION
14	T Y M PA N O P L A S T Y (C L O S U R E O F A N E A R D R U M PERFORATION/RECONSTRUCTION OF THE AUDITORY OSSICLES)
15	REMOVAL OF A TYMPANIC DRAIN
16	KERATOSIS REMOVAL UNDER GA
17	OPERATIONS ON THE TURBINATES (NASAL CONCHA)
18	T Y M PA N O P L A S T Y (C L O S U R E O F A N E A R D R U M PERFORATION/RECONSTRUCTION OF THE AUDITORY OSSICLES)
19	REMOVAL OF KERATOSIS OBTURANS
20	STAPEDOTOMY TO TREAT VARIOUS LESIONS IN MIDDLE EAR
21	REVISION OF A STAPEDECTOMY
22	OTHER OPERATIONS ON THE AUDITORY OSSICLES
23	MYRINGOPLASTY (POST-AURA/ENDAURAL APPROACH AS WELL AS SIMPLE TYPE -I TYMPANOPLASTY)
24	FENESTRATION OF THE INNER EAR
25	REVISION OF A FENESTRATION OF THE INNER EAR
26	PALATOPLASTY
27	TRANSORAL INCISION AND DRAINAGE OF A PHARYNGEAL ABSCESS
28	TONSILLECTOMY WITHOUT ADENOIDECTOMY
29	TONSILLECTOMY WITH ADENOIDECTOMY
30	EXCISION AND DESTRUCTION OF A LINGUAL TONSIL
31	REVISION OF A TYMPANOPLASTY
32	OTHER MICROSURGICAL OPERATIONS ON THE MIDDLE EAR
33	INCISION OF THE MASTOID PROCESS AND MIDDLE EAR
34	MASTOIDECTOMY
35	RECONSTRUCTION OF THE MIDDLE EAR
36	OTHER EXCISIONS OF THE MIDDLE AND INNER EAR

37	INCISION (OPENING) AND DESTRUCTION (ELIMINATION) OF THE INNER EAR
38	OTHER OPERATIONS ON THE MIDDLE AND INNER EAR
39	EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE NOSE
40	OTHER OPERATIONS ON THE NOSE
41	NASAL SINUS ASPIRATION
42	FOREIGN BODY REMOVAL FROM NOSE
43	OTHER OPERATIONS ON THE TONSILS AND ADENOIDS
44	ADENOIDECTOMY
45	LABYRINTHECTOMY FOR SEVERE VERTIGO
46	STAPEDECTOMY UNDER GA
47	STAPEDECTOMY UNDER LA
48	TYMPANOPLASTY (TYPE IV)
49	ENDOLYMPHATIC SAC SURGERY FOR MENIERE'S DISEASE
50	TURBINECTOMY
51	ENDOSCOPIC STAPEDECTOMY
52	INCISION AND DRAINAGE OF PERICHONDRITIS
53	SEPTOPLASTY
54	VESTIBULAR NERVE SECTION
55	THYROPLASTY TYPE I
56	PSEUDOCYST OF THE PINNA - EXCISION
57	INCISION AND DRAINAGE - HAEMATOMA AURICLE
58	TYMPANOPLASTY (TYPE II)
59	REDUCTION OF FRACTURE OF NASAL BONE
60	THYROPLASTY TYPE II
61	TRACHEOSTOMY
62	EXCISION OF ANGIOMA SEPTUM
63	TURBINOPLASTY
64	INCISION & DRAINAGE OF RETRO PHARYNGEAL ABSCESS
65	UVULO PALATO PHARYNGO PLASTY
66	ADENOIDECTOMY WITH GROMMET INSERTION
67	ADENOIDECTOMY WITHOUT GROMMET INSERTION
68	VOCAL CORD LATERALISATION PROCEDURE
69	INCISION & DRAINAGE OF PARA PHARYNGEAL ABSCESS
70	TRACHEOPLASTY
GASTROENTEROLOGY RELATED	
71	CHOLECYSTECTOMY AND CHOLEDOCHO-JEJUNOSTOMY/ DUODENOSTOMY/GASTROSTOMY/EXPLORATION COMMON BILE DUCT
72	ESOPHAGOSCOPY, GASTROSCOPY, DUODENOSCOPY WITH POLYPECTOMY/ REMOVAL OF FOREIGN BODY/DIATHERMY OF BLEEDING LESIONS
73	PANCREATIC PSEUDOCYST EUS & DRAINAGE
74	RF ABLATION FOR BARRETT'S OESOPHAGUS
75	ERCP AND PAPILLOTOMY
76	ESOPHAGOSCOPE AND SCLEROSANT INJECTION
77	EUS + SUBMUCOSAL RESECTION
78	CONSTRUCTION OF GASTROSTOMY TUBE

79	EUS + ASPIRATION PANCREATIC CYST
80	SMALL BOWEL ENDOSCOPY (THERAPEUTIC)
81	COLONOSCOPY ,LESION REMOVAL
82	ERCP
83	COLONSCOPY STENTING OF STRICTURE
84	PERCUTANEOUS ENDOSCOPIC GASTROSTOMY
85	EUS AND PANCREATIC PSEUDO CYST DRAINAGE
86	ERCP AND CHOLEDOCHOSCOPY
87	PROCTOSIGMOIDOSCOPY VOLVULUS DETORSION
88	ERCP AND SPHINCTEROTOMY
89	ESOPHAGEAL STENT PLACEMENT
90	ERCP + PLACEMENT OF BILIARY STENTS
91	SIGMOIDOSCOPY W / STENT
92	EUS + COELIAC NODE BIOPSY
93	UGI SCOPY AND INJECTION OF ADRENALINE, SCLEROSANTS BLEEDING ULCERS
	GENERAL SURGERY RELATED
94	INCISION OF A PILONIDAL SINUS / ABSCESS
95	FISSURE IN ANO SPHINCTEROTOMY
96	SURGICAL TREATMENT OF A VARICOCELE AND A HYDROCELE OF THE SPERMATIC CORD
97	ORCHIDOPEXY
98	ABDOMINAL EXPLORATION IN CRYPTORCHIDISM
99	SURGICAL TREATMENT OF ANAL FISTULAS
100	DIVISION OF THE ANAL SPHINCTER (SPHINCTEROTOMY)
101	EPIDIDYMECTOMY
102	INCISION OF THE BREAST ABSCESS
103	OPERATIONS ON THE NIPPLE
104	EXCISION OF SINGLE BREAST LUMP
105	INCISION AND EXCISION OF TISSUE IN THE PERIANAL REGION
106	SURGICAL TREATMENT OF HEMORRHOIDS
107	OTHER OPERATIONS ON THE ANUS
108	ULTRASOUND GUIDED ASPIRATIONS
109	SCLEROTHERAPY, ETC.
110	L A PA R OTO M Y F O R G R A D I N G LY M P H O M A W I T H SPLENECTOMY/LIVER/LYMPH NODE BIOPSY
111	THERAPEUTIC LAPAROSCOPY WITH LASER
112	APPENDICECTOMY WITH/WITHOUT DRAINAGE
113	INFECTED KELOID EXCISION
114	AXILLARY LYMPHADENECTOMY
115	WOUND DEBRIDEMENT AND COVER
116	ABSCESS-DECOMPRESSION
117	CERVICAL LYMPHADENECTOMY
118	INFECTED SEBACEOUS CYST
119	INGUINAL LYMPHADENECTOMY
120	INCISION AND DRAINAGE OF ABSCESS
121	SUTURING OF LACERATIONS
122	SCALP SUTURING

123	INFECTED LIPOMA EXCISION
124	MAXIMAL ANAL DILATATION
125	PILES
126	A)INJECTION SCLEROTHERAPY
127	B)PILES BANDING
128	LIVER ABSCESS- CATHETER DRAINAGE
129	FISSURE IN ANO- FISSURECTOMY
130	FIBROADENOMA BREAST EXCISION
131	OESOPHAGEAL VARICES SCLEROTHERAPY
132	ERCP - PANCREATIC DUCT STONE REMOVAL
133	PERIANAL ABSCESS I&D
134	PERIANAL HEMATOMA EVACUATION
135	UGI SCOPY AND POLYPECTOMY OESOPHAGUS
136	BREAST ABSCESS I& D
137	FEEDING GASTROSTOMY
138	OESOPHAGOSCOPY AND BIOPSY OF GROWTH OESOPHAGUS
139	ERCP - BILE DUCT STONE REMOVAL
140	ILEOSTOMY CLOSURE
141	COLONOSCOPY
142	POLYPECTOMY COLON
143	SPLENIC ABSCESSES LAPAROSCOPIC DRAINAGE
144	UGI SCOPY AND POLYPECTOMY STOMACH
145	RIGID OESOPHAGOSCOPY FOR FB REMOVAL
146	FEEDING JEJUNOSTOMY
147	COLOSTOMY
148	ILEOSTOMY
149	COLOSTOMY CLOSURE
150	SUBMANDIBULAR SALIVARY DUCT STONE REMOVAL
151	PNEUMATIC REDUCTION OF INTUSSUSCEPTION
152	VARICOSE VEINS LEGS - INJECTION SCLEROTHERAPY
153	RIGID OESOPHAGOSCOPY FOR PLUMMER VINSON SYNDROME
154	PANCREATIC PSEUDOCYSTS ENDOSCOPIC DRAINAGE
155	ZADEK'S NAIL BED EXCISION
156	SUBCUTANEOUS MASTECTOMY
157	EXCISION OF RANULA UNDER GA
158	RIGID OESOPHAGOSCOPY FOR DILATION OF BENIGN STRICTURES
159	EVERSION OF SAC
160	UNILATERAL
161	ILATERAL
162	LORD'S PLICATION
163	JABOULAY'S PROCEDURE
164	SCROTOPLASTY
165	CIRCUMCISION FOR TRAUMA
166	MEATOPLASTY
167	INTERSPHINCTERIC ABSCESS INCISION AND DRAINAGE

168	PSOAS ABSCESS INCISION AND DRAINAGE
169	THYROID ABSCESS INCISION AND DRAINAGE
170	TIPS PROCEDURE FOR PORTAL HYPERTENSION
171	ESOPHAGEAL GROWTH STENT
172	PAIR PROCEDURE OF HYDATID CYST LIVER
173	TRU CUT LIVER BIOPSY
174	PHOTODYNAMIC THERAPY OR ESOPHAGEAL TUMOUR AND LUNG TUMOUR
175	EXCISION OF CERVICAL RIB
176	LAPAROSCOPIC REDUCTION OF INTUSSUSCEPTION
177	MICRODOCHECTOMY BREAST
178	SURGERY FOR FRACTURE PENIS
179	SENTINEL NODE BIOPSY
180	PARASTOMAL HERNIA
181	REVISION COLOSTOMY
182	PROLAPSED COLOSTOMY- CORRECTION
183	TESTICULAR BIOPSY
184	LAPAROSCOPIC CARDIOMYOTOMY(HELLERS)
185	SENTINEL NODE BIOPSY MALIGNANT MELANOMA
186	LAPAROSCOPIC PYLOROMYOTOMY(RAMSTEDT)
GYNAECOLOGY RELATED	
187	OPERATIONS ON BARTHOLIN'S GLANDS (CYST)
188	INCISION OF THE OVARY
189	INSUFFLATIONS OF THE FALLOPIAN TUBES
190	OTHER OPERATIONS ON THE FALLOPIAN TUBE
191	DILATATION OF THE CERVICAL CANAL
192	CONISATION OF THE UTERINE CERVIX
193	THERAPEUTIC CURETTAGE WITH COLPOSCOPY / BIOPSY / DIATHERMY / CRYOSURGERY
194	LASER THERAPY OF CERVIX FOR VARIOUS LESIONS OF UTERUS
195	OTHER OPERATIONS ON THE UTERINE CERVIX
196	INCISION OF THE UTERUS (HYSTERECTOMY)
197	LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE VAGINA AND THE POUCH OF DOUGLAS
198	INCISION OF VAGINA
199	INCISION OF VULVA
200	CULDOTOMY
201	SALPINGO-OOPHORECTOMY VIA LAPAROTOMY
202	ENDOSCOPIC POLYPECTOMY
203	HYSTEROSCOPIC REMOVAL OF MYOMA
204	D&C
205	HYSTEROSCOPIC RESECTION OF SEPTUM
206	THERMAL CAUTERISATION OF CERVIX
207	MIRENA INSERTION
208	HYSTEROSCOPIC ADHESIOLYSIS
209	LEEP
210	CRYOCAUTERISATION OF CERVIX
211	POLYPECTOMY ENDOMETRIUM

212	HYSTEROSCOPIC RESECTION OF FIBROID
213	LLETZ
214	CONIZATION
215	POLYPECTOMY CERVIX
216	HYSTEROSCOPIC RESECTION OF ENDOMETRIAL POLYP
217	VULVAL WART EXCISION
218	LAPAROSCOPIC PARAOVARIAN CYST EXCISION
219	UTERINE ARTERY EMBOLIZATION
220	LAPAROSCOPIC CYSTECTOMY
221	HYMENECTOMY(IMPERFORATE HYMEN)
222	ENDOMETRIAL ABLATION
223	VAGINAL WALL CYST EXCISION
224	VULVAL CYST EXCISION
225	LAPAROSCOPIC PARATUBAL CYST EXCISION
226	REPAIR OF VAGINA (VAGINAL ATRESIA)
227	HYSTEROSCOPY, REMOVAL OF MYOMA
228	TURBT
229	URETEROCOELE REPAIR - CONGENITAL INTERNAL
230	VAGINAL MESH FOR POP
231	LAPAROSCOPIC MYOMECTOMY
232	SURGERY FOR SUI
233	REPAIR RECTO- VAGINA FISTULA
234	PELVIC FLOOR REPAIR(EXCLUDING FISTULA REPAIR)
235	URS + LL
236	LAPAROSCOPIC OOPHORECTOMY
237	NORMAL VAGINAL DELIVERY AND VARIANTS
NEUROLOGY RELATED	
238	FACIAL NERVE PHYSIOTHERAPY
239	NERVE BIOPSY
240	MUSCLE BIOPSY
241	EPIDURAL STEROID INJECTION
242	GLYCEROL RHIZOTOMY
243	SPINAL CORD STIMULATION
244	MOTOR CORTEX STIMULATION
245	STEREOTACTIC RADIOSURGERY
246	PERCUTANEOUS CORDOTOMY
247	INTRATHECAL BACLOFEN THERAPY
248	ENTRAPMENT NEUROPATHY RELEASE
249	DIAGNOSTIC CEREBRAL ANGIOGRAPHY
250	VP SHUNT
251	VENTRICULOATRIAL SHUNT
252	RADIOTHERAPY FOR CANCER
253	CANCER CHEMOTHERAPY
254	IV PUSH CHEMOTHERAPY
255	HBI-HEMIBODY RADIOTHERAPY

256	INFUSIONAL TARGETED THERAPY
257	SRT-STEREOTACTIC ARC THERAPY
258	SC ADMINISTRATION OF GROWTH FACTORS
259	CONTINUOUS INFUSIONAL CHEMOTHERAPY
260	INFUSIONAL CHEMOTHERAPY
261	CCRT-CONCURRENT CHEMO + RT
262	2D RADIOTHERAPY
263	3D CONFORMAL RADIOTHERAPY
264	IGRT- IMAGE GUIDED RADIOTHERAPY
265	IMRT- STEP & SHOOT
266	INFUSIONAL BISPHOSPHONATES
267	IMRT- DMLC
268	ROTATIONAL ARC THERAPY
269	TELE GAMMA THERAPY
270	FSRT-FRACTIONATED SRT
271	VMAT-VOLUMETRIC MODULATED ARC THERAPY
272	SBRT-STEREOTACTIC BODY RADIOTHERAPY
273	HELICAL TOMOTHERAPY
274	SRS-STEREOTACTIC RADIOSURGERY
275	X-KNIFE SRS
276	GAMMAKNIFE SRS
277	TBI- TOTAL BODY RADIOTHERAPY
278	INTRALUMINAL BRACHYTHERAPY
279	ELECTRON THERAPY
280	TSET-TOTAL ELECTRON SKIN THERAPY
281	EXTRACORPOREAL IRRADIATION OF BLOOD PRODUCTS
282	TELECOBALT THERAPY
283	TELECESIUM THERAPY
284	EXTERNAL MOULD BRACHYTHERAPY
285	INTERSTITIAL BRACHYTHERAPY
286	INTRACAVITY BRACHYTHERAPY
287	3D BRACHYTHERAPY
288	IMPLANT BRACHYTHERAPY
289	INTRAVESICAL BRACHYTHERAPY
290	ADJUVANT RADIOTHERAPY
291	AFTERLOADING CATHETER BRACHYTHERAPY
292	CONDITIONING RADIOTHEARPY FOR BMT
293	EXTRACORPOREAL IRRADIATION TO THE HOMOLOGOUS BONE GRAFTS
294	RADICAL CHEMOTHERAPY
295	NEOADJUVANT RADIOTHERAPY
296	LDR BRACHYTHERAPY
297	PALLIATIVE RADIOTHERAPY
298	RADICAL RADIOTHERAPY
299	PALLIATIVE CHEMOTHERAPY
300	TEMPLATE BRACHYTHERAPY

301	NEOADJUVANT CHEMOTHERAPY
302	ADJUVANT CHEMOTHERAPY
303	INDUCTION CHEMOTHERAPY
304	CONSOLIDATION CHEMOTHERAPY
305	MAINTENANCE CHEMOTHERAPY
306	HDR BRACHYTHERAPY
OPERATIONS ON THE SALIVARY GLANDS AND SALIVARY DUCTS	
307	INCISION AND LANCING OF A SALIVARY GLAND AND A SALIVARY DUCT
308	EXCISION OF DISEASED TISSUE OF A SALIVARY GLAND AND A SALIVARY DUCT
309	RESECTION OF A SALIVARY GLAND
310	RECONSTRUCTION OF A SALIVARY GLAND AND A SALIVARY DUCT
311	OTHER OPERATIONS ON THE SALIVARY GLANDS AND SALIVARY DUCTS
OPERATIONS ON THE SKIN & SUBCUTANEOUS TISSUE	
312	OTHER INCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
313	SURGICAL WOUND TOILET (WOUND DEBRIDEMENT) AND REMOVAL OF DISEASED TISSUE OF THE SKIN AND SUBCUTANEOUS TISSUES
314	LOCAL EXCISION OF DISEASED TISSUE OF THE SKIN AND SUBCUTANEOUS TISSUES
315	OTHER EXCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
316	SIMPLE RESTORATION OF SURFACE CONTINUITY OF THE SKIN AND SUBCUTANEOUS TISSUES
317	FREE SKIN TRANSPLANTATION, DONOR SITE
318	FREE SKIN TRANSPLANTATION, RECIPIENT SITE
319	REVISION OF SKIN PLASTY
320	OTHER RESTORATION AND RECONSTRUCTION OF THE SKIN AND SUBCUTANEOUS TISSUES.
321	CHEMOSURGERY TO THE SKIN.
322	DESTRUCTION OF DISEASED TISSUE IN THE SKIN AND SUBCUTANEOUS TISSUES
323	RECONSTRUCTION OF DEFORMITY/DEFECT IN NAIL BED
324	EXCISION OF BURSIRTIS
325	TENNIS ELBOW RELEASE
OPERATIONS ON THE TONGUE	
326	INCISION, EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE TONGUE
327	PARTIAL GLOSSECTOMY
328	GLOSSECTOMY
329	RECONSTRUCTION OF THE TONGUE
330	OTHER OPERATIONS ON THE TONGUE
OPTHALMOLOGY RELATED	
331	SURGERY FOR CATARACT
332	INCISION OF TEAR GLANDS
333	OTHER OPERATIONS ON THE TEAR DUCTS
334	INCISION OF DISEASED EYELIDS
335	EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE EYELID
336	OPERATIONS ON THE CANTHUS AND EPICANTHUS
337	CORRECTIVE SURGERY FOR ENTROPION AND ECTROPION
338	CORRECTIVE SURGERY FOR BLEPHAROPTOSIS
339	REMOVAL OF A FOREIGN BODY FROM THE CONJUNCTIVA
340	REMOVAL OF A FOREIGN BODY FROM THE CORNEA

341	INCISION OF THE CORNEA
342	OPERATIONS FOR PTERYGIUM
343	OTHER OPERATIONS ON THE CORNEA
344	REMOVAL OF A FOREIGN BODY FROM THE LENS OF THE EYE
345	REMOVAL OF A FOREIGN BODY FROM THE POSTERIOR CHAMBER OF THE EYE
346	REMOVAL OF A FOREIGN BODY FROM THE ORBIT AND EYEBALL
347	CORRECTION OF EYELID PTOSIS BY LEVATOR PALPEBRAE SUPERIORIS RESECTION (BILATERAL)
348	CORRECTION OF EYELID PTOSIS BY FASCIA LATA GRAFT (BILATERAL)
349	DIATHERMY/CRYOTHERAPY TO TREAT RETINAL TEAR
350	ANTERIOR CHAMBER PARACENTESIS / CYCLODIATHERMY / CYCLOCRYOTHERAPY / GONIOTOMY / TRABECULOTOMY AND FILTERING AND ALLIED OPERATIONS TO TREAT GLAUCOMA
351	ENUCLEATION OF EYE WITHOUT IMPLANT
352	DACRYOCYSTORHINOSTOMY FOR VARIOUS LESIONS OF LACRIMAL GLAND
353	LASER PHOTOCOAGULATION TO TREAT RATINAL TEAR
354	BIOPSY OF TEAR GLAND
355	TREATMENT OF RETINAL LESION
ORTHOPAEDICS RELATED	
356	SURGERY FOR MENISCUS TEAR
357	INCISION ON BONE, SEPTIC AND ASEPTIC
358	CLOSED REDUCTION ON FRACTURE, LUXATION OR EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
359	SUTURE AND OTHER OPERATIONS ON TENDONS AND TENDON SHEATH
360	REDUCTION OF DISLOCATION UNDER GA
361	ARTHROSCOPIC KNEE ASPIRATION
362	SURGERY FOR LIGAMENT TEAR
363	SURGERY FOR HEMOARTHROSIS/PYOARTHROSIS
364	REMOVAL OF FRACTURE PINS/NAILS
365	REMOVAL OF METAL WIRE
366	CLOSED REDUCTION ON FRACTURE, LUXATION
367	REDUCTION OF DISLOCATION UNDER GA
368	EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
369	EXCISION OF VARIOUS LESIONS IN COCCYX
370	ARTHROSCOPIC REPAIR OF ACL TEAR KNEE
371	CLOSED REDUCTION OF MINOR FRACTURES
372	ARTHROSCOPIC REPAIR OF PCL TEAR KNEE
373	TENDON SHORTENING
374	ARTHROSCOPIC MENISCECTOMY - KNEE
375	TREATMENT OF CLAVICLE DISLOCATION
376	HAEMARTHROSIS KNEE- LAVAGE
377	ABSCESS KNEE JOINT DRAINAGE
378	CARPAL TUNNEL RELEASE
379	CLOSED REDUCTION OF MINOR DISLOCATION
380	REPAIR OF KNEE CAP TENDON
381	ORIF WITH K WIRE FIXATION- SMALL BONES
382	RELEASE OF MIDFOOT JOINT
383	ORIF WITH PLATING- SMALL LONG BONES

384	IMPLANT REMOVAL MINOR
385	K WIRE REMOVAL
386	POP APPLICATION
387	CLOSED REDUCTION AND EXTERNAL FIXATION
388	ARTHROTOMY HIP JOINT
389	SYME'S AMPUTATION
390	ARTHROPLASTY
391	PARTIAL REMOVAL OF RIB
392	TREATMENT OF SESAMOID BONE FRACTURE
393	SHOULDER ARTHROSCOPY / SURGERY
394	ELBOW ARTHROSCOPY
395	AMPUTATION OF METACARPAL BONE
396	RELEASE OF THUMB CONTRACTURE
397	INCISION OF FOOT FASCIA
398	CALCANEUM SPUR HYDROCORT INJECTION
399	GANGLION WRIST HYALASE INJECTION
400	PARTIAL REMOVAL OF METATARSAL
401	REPAIR / GRAFT OF FOOT TENDON
402	REVISION/REMOVAL OF KNEE CAP
403	AMPUTATION FOLLOW-UP SURGERY
404	EXPLORATION OF ANKLE JOINT
405	REMOVE/GRAFT LEG BONE LESION
406	REPAIR/GRAFT ACHILLES TENDON
407	REMOVE OF TISSUE EXPANDER
408	BIOPSY ELBOW JOINT LINING
409	REMOVAL OF WRIST PROSTHESIS
410	BIOPSY FINGER JOINT LINING
411	TENDON LENGTHENING
412	TREATMENT OF SHOULDER DISLOCATION
413	LENGTHENING OF HAND TENDON
414	REMOVAL OF ELBOW BURSA
415	FIXATION OF KNEE JOINT
416	TREATMENT OF FOOT DISLOCATION
417	SURGERY OF BUNION
418	INTRA ARTICULAR STEROID INJECTION
419	TENDON TRANSFER PROCEDURE
420	REMOVAL OF KNEE CAP BURSA
421	TREATMENT OF FRACTURE OF ULNA
422	TREATMENT OF SCAPULA FRACTURE
423	REMOVAL OF TUMOR OF ARM/ ELBOW UNDER RA/GA
424	REPAIR OF RUPTURED TENDON
425	DECOMPRESS FOREARM SPACE
426	REVISION OF NECK MUSCLE (TORTICOLLIS RELEASE)
427	LENGTHENING OF THIGH TENDONS
428	TREATMENT FRACTURE OF RADIUS & ULNA

429	REPAIR OF KNEE JOINT
OTHER OPERATIONS ON THE MOUTH & FACE	
430	EXTERNAL INCISION AND DRAINAGE IN THE REGION OF THE MOUTH, JAW AND FACE
431	INCISION OF THE HARD AND SOFT PALATE
432	EXCISION AND DESTRUCTION OF DISEASED HARD AND SOFT PALATE
433	INCISION, EXCISION AND DESTRUCTION IN THE MOUTH
434	OTHER OPERATIONS IN THE MOUTH
PAEDIATRIC SURGERY RELATED	
435	EXCISION OF FISTULA-IN-ANO
436	EXCISION JUVENILE POLYPS RECTUM
437	VAGINOPLASTY
438	DILATATION OF ACCIDENTAL C AUSTIC STRICTURE OESOPHAGEAL
439	PRESACRAL TERATOMAS EXCISION
440	REMOVAL OF VESICAL STONE
441	EXCISION SIGMOID POLYP
442	STERNOMASTOID TENOTOMY
443	I N F A N T I L E H Y P E RT R O P H I C P Y L O R I C S T E N O S I S PYLOROMYOTOMY
444	EXCISION OF SOFT TISSUE RHABDOMYOSARCOMA
445	MEDIASTINAL LYMPH NODE BIOPSY
446	HIGH ORCHIDECTOMY FOR TESTIS TUMOURS
447	EXCISION OF CERVICAL TERATOMA
448	RECTAL-MYOMECTOMY
449	RECTAL PROLAPSE (DELORME'S PROCEDURE)
450	DETORSION OF TORSION TESTIS
451	EUA + BIOPSY MULTIPLE FISTULA IN ANO
452	CYSTIC HYGROMA - INJECTION TREATMENT
PLASTIC SURGERY RELATED	
453	CONSTRUCTION SKIN PEDICLE FLAP
454	GLUTEAL PRESSURE ULCER-EXCISION
455	MUSCLE-SKIN GRAFT, LEG
456	REMOVAL OF BONE FOR GRAFT
457	MUSCLE-SKIN GRAFT DUCT FISTULA
458	REMOVAL CARTILAGE GRAFT
459	MYOCUTANEOUS FLAP
460	FIBRO MYOCUTANEOUS FLAP
461	BREAST RECONSTRUCTION SURGERY AFTER MASTECTOMY
462	SLING OPERATION FOR FACIAL PALSY
463	SPLIT SKIN GRAFTING UNDER RA
464	WOLFE SKIN GRAFT
465	PLASTIC SURGERY TO THE FLOOR OF THE MOUTH UNDER GA
THORACIC SURGERY RELATED	
466	THORACOSCOPY AND LUNG BIOPSY
467	EXCISION OF CERVICAL SYMPATHETIC CHAIN THORACOSCOPIC
468	LASER ABLATION OF BARRETT'S OESOPHAGUS
469	PLEURODESIS

470	THORACOSCOPY AND PLEURAL BIOPSY
471	EBUS + BIOPSY
472	THORACOSCOPY LIGATION THORACIC DUCT
473	THORACOSCOPY ASSISTED EMPYAEMA DRAINAGE
UROLOGY RELATED	
474	HAEMODIALYSIS
475	LITHOTRIPSY/NEPHROLITHOTOMY FOR RENAL CALCULUS
476	EXCISION OF RENAL CYST
477	DRAINAGE OF PYONEPHROSIS/PERINEPHRIC ABSCESS
478	INCISION OF THE PROSTATE
479	TRANSURETHRAL EXCISION AND DESTRUCTION OF PROSTATE TISSUE
480	TRANSURETHRAL AND PERCUTANEOUS DESTRUCTION OF PROSTATE TISSUE
481	OPEN SURGICAL EXCISION AND DESTRUCTION OF PROSTATE TISSUE
482	RADICAL PROSTATOVESICULECTOMY
483	OTHER EXCISION AND DESTRUCTION OF PROSTATE TISSUE
484	OPERATIONS ON THE SEMINAL VESICLES
485	INCISION AND EXCISION OF PERIPROSTATIC TISSUE
486	OTHER OPERATIONS ON THE PROSTATE
487	INCISION OF THE SCROTUM AND TUNICA VAGINALIS TESTIS
488	OPERATION ON A TESTICULAR HYDROCELE
489	EXCISION AND DESTRUCTION OF DISEASED SCROTAL TISSUE
490	OTHER OPERATIONS ON THE SCROTUM AND TUNICA VAGINALIS TESTIS
491	INCISION OF THE TESTES
492	EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE TESTES
493	UNILATERAL ORCHIDECTOMY
494	BILATERAL ORCHIDECTOMY
495	SURGICAL REPOSITIONING OF AN ABDOMINAL TESTIS
496	RECONSTRUCTION OF THE TESTIS
497	IMPLANTATION, EXCHANGE AND REMOVAL OF A TESTICULAR PROSTHESIS
498	OTHER OPERATIONS ON THE TESTIS
499	EXCISION IN THE AREA OF THE EPIDIDYMIS
500	OPERATIONS ON THE FORESKIN
501	LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE PENIS
502	AMPUTATION OF THE PENIS
503	OTHER OPERATIONS ON THE PENIS
504	CYSTOSCOPICAL REMOVAL OF STONES
505	CATHETERISATION OF BLADDER
506	LITHOTRIPSY
507	BIOPSY OFTEMPORAL ARTERY FOR VARIOUS LESIONS
508	EXTERNAL ARTERIO-VENOUS SHUNT
509	AV FISTULA - WRIST
510	URSL WITH STENTING
511	URSL WITH LITHOTRIPSY
512	CYSTOSCOPIC LITHOLAPAXY
513	ESWL

514	BLADDER NECK INCISION
515	CYSTOSCOPY & BIOPSY
516	CYSTOSCOPY AND REMOVAL OF POLYP
517	SUPRAPUBIC CYSTOSTOMY
518	PERCUTANEOUS NEPHROSTOMY
519	CYSTOSCOPY AND "SLING" PROCEDURE.
520	TUNA- PROSTATE
521	EXCISION OF URETHRAL DIVERTICULUM
522	REMOVAL OF URETHRAL STONE
523	EXCISION OF URETHRAL PROLAPSE
524	MEGA-URETER RECONSTRUCTION
525	KIDNEY RENOSCOPY AND BIOPSY
526	URETER ENDOSCOPY AND TREATMENT
527	VESICO URETERIC REFLUX CORRECTION
528	SURGERY FOR PELVI URETERIC JUNCTION OBSTRUCTION
529	ANDERSON HYNES OPERATION
530	KIDNEY ENDOSCOPY AND BIOPSY
531	PARAPHIMOSIS SURGERY
532	INJURY PREPUCE- CIRCUMCISION
533	FRENULAR TEAR REPAIR
534	MEATOTOMY FOR MEATAL STENOSIS
535	SURGERY FOR FOURNIER'S GANGRENE SCROTUM
536	SURGERY FILARIAL SCROTUM
537	SURGERY FOR WATERING CAN PERINEUM
538	REPAIR OF PENILE TORSION
539	DRAINAGE OF PROSTATE ABSCESS
540	ORCHIECTOMY
541	CYSTOSCOPY AND REMOVAL OF FB