

Smart Health



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Smart Health

1 Preamble

This is a contract of insurance between You and Us which is subject to the receipt of the full premium in advance and the terms, conditions and exclusions of this Policy. This Policy has been issued on the basis of the Disclosure to information norm, including the information provided by You in respect of the Insured Person/s in the Proposal form and accompanying documentation.

Note:

- *You/ Insured Person shall on Your/his/her own expense, inform Us immediately of any change in the address, nature of job, state of health, or of any other changes affecting You or any Insured Person.*
- *The terms listed in Section 5 (Definitions & Interpretation) and used elsewhere in the Policy Document with Initial Capitals shall have the meaning set out against them in Section 5 wherever they appear in the Policy Document. For the remaining terms and words used, the usual meaning as described in standard English language dictionaries shall apply. The words and expressions defined in the Insurance Act 1938, IRDAI Act 1999, regulations notified by the IRDAI and circulars and guidelines issued by the IRDAI shall carry the meanings given therein.*
- *Where the context permits, the singular will be deemed to include the plural, one gender shall be deemed to include the other genders and references to any statute shall be deemed to refer to any replacement or amendment of that statute.*

2 Scope of Cover: Benefits

The terms, conditions and exclusions governing the Benefits under this Policy are described below. The Policy Schedule/Certificate of Insurance will specify which Benefits are in force and available for the Insured Person. Benefits are effective only during the Operative Time as shown in the Policy Schedule/Certificate of Insurance.

- a. The Benefits listed in the sections below will be payable subject to the terms, conditions and exclusions of this Policy, the availability of the Benefit Sum Insured and any limits/sub-limits specified in the Policy Schedule/Certificate of Insurance as applicable at Group policy level or at individual/family level and may vary as per geography under the Benefits in force for the Insured Person.
- b. All claims for any Benefits under the Policy must be made in accordance with the claim process defined under the respective section in which the Benefit is being claimed.

2.1 Hospitalization Cover:

We will indemnify the Medical Expenses incurred in respect of an Insured Person in accordance with the terms and conditions of the benefits below in relation to any Illness (if the list of Illness is restricted it is as mentioned in the Policy Schedule/Certificate of Insurance) suffered or Injury sustained during the Policy Period provided that the treatment undertaken is Medically Necessary Treatment and is carried out on the written advice of a Medical Practitioner.

Smart Health

The expenses that are not covered or subsumed into room charges / procedure charges / costs of treatment are mentioned in Annexure II.

2.1.1 Coverage Options:

2.1.1.1. Inpatient Care

What is covered:

We will indemnify the Medical Expenses incurred on the Insured Person's Hospitalization following an Illness or Injury that occurs during the Policy Period.

Conditions:

- a. The Hospitalization is for Medically Necessary Treatment, is carried out on the written advice of a Medical Practitioner and follows Evidence Based Clinical Practices and standard treatment guidelines.
- b. The Medical Expenses incurred are Reasonable and Customary Charges for one or more of the following:
 - i. Room Rent;
 - ii. Nursing charges for Hospitalization as an Inpatient excluding private nursing charges;
 - iii. Medical Practitioners' fees, excluding any charges or fees for Standby Services;
 - iv. Physiotherapy, investigation and diagnostics procedures directly related to the current admission;
 - v. Medicines and drugs as prescribed by the treating Medical Practitioner;
 - vi. Intravenous fluids, blood transfusion, injection administration charges, allowable consumables and / or enteral feedings.
 - vii. Operation theatre charges;
 - viii. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery;
 - ix. ICU Charges.
 - x. If the Insured Person is admitted in a Hospital room where the room category opted or Room Rent incurred is higher than the eligibility as specified in the Policy Schedule, then We shall be liable to pay only a pro-rated portion of the total Associated Medical Expenses (including surcharge or taxes thereon) as per the following formula:

$(\text{Eligible Room Rent limit} / \text{Room Rent actually incurred}) * \text{total Associated Medical Expenses}$

Associated Medical Expenses shall include Room Rent, nursing charges, Medical Practitioners' fees and operation theatre charges.

Proportionate deductions will not be applied If the claim is of a 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.

What is not covered:

- a. We shall not be liable to pay the visiting fees or consultation charges for any Medical Practitioner visiting the Insured Person unless:

Smart Health

- i. The Medical Practitioner's treatment or advice has been sought by the Hospital; and
- ii. The visiting fees or consultation charges are included in the Hospital's bill; and
- iii. The visiting fees or consultation charges are not more than the treating or referral Medical Practitioner's consultation charges.

2.1.1.2. Pre-hospitalization Medical Expenses

What is covered:

We will indemnify the Insured Person's Pre-hospitalization Medical Expenses incurred following an Illness or Injury.

Conditions:

- a. We have accepted a claim under Section 2.1.1.1 (Inpatient Care) or Section 2.1.1.4 (Day Care Treatments) or 2.1.1.5 (Alternative Treatments) or Section 2.1.1.30 (Critical Illness Multiplier Indemnity Cover) in respect of that Insured Person.
- b. We shall not be liable to pay any Pre-hospitalization Medical Expenses for more than the number of days specified in the Policy Schedule/Certificate of Insurance immediately preceding the Insured Person's admission to Hospital for Inpatient Care or such expenses incurred prior to inception of the First Policy with Us.
- c. Pre-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.
- d. Pre-hospitalization Medical Expenses incurred on physiotherapy will also be payable provided that such physiotherapy is Medically Necessary Treatment and advised in writing by the treating Medical Practitioner.
- e. Any claim admitted under this Section 2.1.1.2 shall reduce the Sum Insured for the Policy Year in which claim under Section 2.1.1.1 (Inpatient Care) or Section 2.1.1.4 (Day Care Treatment) or Section 2.1.1.5 (Alternative Treatments) or Section 2.1.1.30 (Critical Illness Multiplier Indemnity Cover) has been incurred.

2.1.1.3. Post-hospitalization Medical Expenses

What is covered:

We will indemnify the Insured Person's Post-hospitalization Medical Expenses incurred following an Illness or Injury.

Conditions:

- a. We have accepted a claim under Section 2.1.1.1 (Inpatient Care) or Section 2.1.1.4 (Day Care Treatments) or 2.1.1.5 (Alternative Treatments) or Section 2.1.1.30 (Critical Illness Multiplier Indemnity Cover) in respect of that Insured Person.
- b. We shall not be liable to pay any Post-hospitalization Medical Expenses for more than the number of days specified in the Policy Schedule/Certificate of Insurance immediately following the Insured Person's discharge from Hospital.
- c. Post-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

Smart Health

- d. Post-hospitalization Medical Expenses incurred on physiotherapy will also be payable provided that such physiotherapy is Medically Necessary Treatment and advised in writing by the treating Medical Practitioner.
- e. Any claim admitted under this Section 2.1.1.3 shall reduce the Sum Insured for the Policy Year in which claim under Section 2.1.1.1 (Inpatient Care) or Section 2.1.1.4 (Day Care Treatment) or Section 2.1.1.5 (Alternative Treatments) or Section 2.1.1.30 (Critical Illness Multiplier Indemnity Cover) has been incurred.

2.1.1.4. Day Care Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Day Care Treatment following an Illness or Injury that occurs during the Policy Period.

Conditions:

- a. The Day Care Treatment is for Medically Necessary Treatment and is carried out on the written advice of a Medical Practitioner.
- b. The Medical Expenses incurred are Reasonable and Customary Charges for any procedure where an Insured Person as Day Care Treatment undertakes such procedure.
- c. The list of admissible Day Care Treatment would be as per the list in Annexure III unless list shared in Policy Schedule/Certificate of Insurance is different OR
- d. The Day Care Treatment would be covered if the Insured Person is admitted for more than 2 hours and less than 24 hours and would also cover treatment taken for Angiography, Dialysis, Radiotherapy or Chemotherapy for cancer
- e. Either Point c will be applicable or Point d will be applicable and is as mentioned in the Policy Schedule/Certificate of Insurance.
- f. We shall not cover any OPD Treatment and Diagnostic Services under this Benefit.

2.1.1.5. Alternative Treatments

What is covered:

We will indemnify the Medical Expenses incurred on the Insured Person's Hospitalization for Inpatient Care during the Policy Period on treatment taken under Ayurveda, Unani, Siddha and Homeopathy.

Conditions:

- a. The treatment should be taken in AYUSH Hospital. An AYUSH Hospital is a healthcare facility wherein medical / surgical / para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
 - a. Central or state government AYUSH Hospital; or
 - b. Teaching Hospital attached to AYUSH college recognized by the Central Government / Central Council of Indian Medicine / Central Council of Homeopathy; or
 - c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
 - i. Having at least five in-patient beds;

Smart Health

- 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.
- b. AYUSH Hospitals referred above shall also obtain either pre-entry level certificate (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or State Level Certificate (or higher level of certificate) under National Quality Assurance Standards (NQAS), issued by National Health Systems Resources Centre (NHSRC)
 - c. Any non-allopathic treatment taken by the Insured Person shall only be covered under Section 2.1.1.5 as per the applicable terms and conditions.
 - d. Medical Expenses incurred on treatment taken under Yoga and/or Naturopathy or any other alternative treatments shall not be covered unless specifically mentioned in Policy Schedule/Certificate of Insurance..

2.1.1.6. Domiciliary Hospitalization

What is covered:

We will indemnify the Medical Expenses incurred for the Insured Person's Domiciliary Hospitalization following an Illness or Injury that occurs during the Policy Period.

Conditions:

- a. The Domiciliary Hospitalization is for Medically Necessary Treatment and is carried out on the written advice of a Medical Practitioner.
- b. The Medical Expenses incurred are Reasonable and Customary Charges.
- c. Medical Expenses can be claimed under this Section on a Reimbursement basis only.
- d. The Domiciliary Hospitalization continues for at least 3 consecutive days unless waiver of deductible days or different number of days are specifically mentioned in Policy Schedule/Certificate of Insurance, in which case We will make payment under this Benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalization.

2.1.1.7. Organ Transplant

What is covered:

We will indemnify the Medical Expenses incurred for a living organ donor's Inpatient treatment for the harvesting of the organ donated during the Policy Period.

Conditions:

- a. The donation conforms to The Transplantation of Human Organs Act 1994 and amendments thereafter and the organ is for the use of the Insured Person.
- b. The recipient Insured Person has been Medically Advised in writing to undergo an organ transplant.
- c. We have accepted the recipient Insured Person's claim under Section 2.1.1.1 (Inpatient Care).

Smart Health

- d. The Medical Expenses incurred are Reasonable and Customary Charges.

What is not covered:

We shall not be liable to make any payment in respect of:

- a. Stem cell donation whether or not it is Medically Necessary Treatment except for Bone Marrow Transplant.
- b. Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.
- c. Screening or any other Medical Expenses related to the organ donor, which are not incurred during the duration of Insured Person's Hospitalization for organ transplant.
- d. Transplant of any organ/tissue where the transplant is Unproven / experimental treatment or investigational in nature.
- e. Expenses related to organ transportation or preservation.
- f. Any other medical treatment or complication in respect of the donor, which is directly or indirectly consequence to harvesting.

2.1.1.8. Maternity Expenses

What is covered:

We will indemnify the Medical Expenses incurred towards Medically Necessary Treatment of the Insured Person in case of normal delivery, routine or elective Caesarean or Complicated Pregnancy during the Policy Period.

Conditions:

- a. This Benefit is available only if
 - i. the female Insured Person is Age 18 years or above
 - ii. Either both the Insured Person and his / her partner are covered under a Family Floater Policy. OR this benefit can be availed under an Individual Cover if the female is insured under the policy.
- b. The female Insured Person in respect of whom a claim for Maternity Expenses is made must have been covered as an Insured Person for at least the period specified in the Policy Schedule/ Certificate of Insurance of continuous coverage since the inception of the First Policy with Us, with maternity as a Benefit.
- c. The Maternity Expenses incurred are Reasonable and Customary Charges.
- d. The Maternity Benefit may be claimed under the Policy in respect of eligible Insured Person(s) only twice during the lifetime of the Policy including any Renewal thereafter for the delivery of a child or Medically Necessary Treatment and lawful termination of pregnancy up to maximum of 2 pregnancies and 2 terminations.
- e. Any treatment related to the complication of pregnancy or termination will be treated within the maternity limits unless specifically mentioned as over and above the maternity limits up to the limits specified in the Policy Schedule/Certificate of Insurance
- f. On Renewal, if an enhanced Maternity Sum Insured is proposed, the specified period of continuous coverage (as per Section 2.1.1.8.c) would apply afresh to the extent of the increased Benefit amount.
- g. Re-Fill Sum Insured Benefit will not be available for any claims made under this Section unless specifically mentioned in the Policy Schedule/Certificate of Insurance.
- h. Section 2.1.2.B.XV (**Code-Excl18**) of the Specific Exclusions shall not apply only to the extent that this Benefit is applicable.

Smart Health

- i. If multiplier for multiple birth is opted as a benefit condition then the same will be specifically mentioned in the Policy Schedule/Certificate of Insurance.

For the purpose of this Section, "Complicated Pregnancy" means a medical condition arising during the antenatal stages of pregnancy or a medical condition arising during childbirth that requires a recognized obstetric procedure and post natal check-ups as a result of the complication of pregnancy for a period up to six weeks.

What is not covered:

We shall not be liable to make any payment in respect of the following:

- a. Expenses incurred in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future illnesses;
- b. Medical Expenses for ectopic pregnancy will be covered under Section 2.1.1.1 (Inpatient Care) and shall not fall under this Benefit unless specifically mentioned in the Policy Schedule/Certificate of Insurance.

2.1.1.9. New Born Baby Cover

What is covered:

We will indemnify the Medical Expenses incurred during the Policy Period, towards the Medically Necessary Treatment of the New Born Baby up to the limit specified in the Policy Schedule/Certificate of Insurance for the Opted period from the date of delivery as specifically mentioned in the Policy Schedule/Certificate of Insurance.

Conditions:

- a. The mother is an Insured Person under the Policy.
- b. A New Born Baby older than the eligible number of days of coverage as mentioned in the Policy Schedule/Certificate of Insurance can be covered under the Policy as an Insured Person only by way of an endorsement or at the next Renewal, whichever is earlier, on payment of the additional premium.

2.1.1.10. New Born Vaccination Cover

What is covered:

We will indemnify the expenses incurred during the Policy Period on vaccination of the New Born Baby till he/she completes 1 year of Age (List is in Annexure IV (Product Benefit Table) unless specifically mentioned in the Policy Schedule/Certificate of Insurance).

Conditions:

- a. Coverage of the New Born Baby on birth shall be subject to the addition of the New Born Baby as an Insured Person under the Policy by way of an endorsement or at the next Renewal whichever is earlier on payment of the requisite premium.

Smart Health

- b. The expenses incurred are Reasonable and Customary Charges.
- c. Expenses can be claimed under this Section on a Reimbursement basis only.

2.1.1.11. Pre and Post Natal Expenses

What is covered:

We will indemnify the Medical Expenses incurred during the Policy Year, in respect of pre- natal check-ups since confirmation of pregnancy, postnatal check-ups for a period up to eight weeks from delivery as specifically mentioned in the Policy Schedule/Certificate of Insurance, prescribed prenatal medicines and diagnostic tests up to the limit specified in the Policy Schedule/ Certificate of Insurance.

Conditions:

- a. The Medical Expenses incurred are Reasonable and Customary Charges.
- b. We have accepted a claim under Section 2.1.1.8 (Maternity Expenses) above in respect of the same delivery
- c. Expenses can be claimed under this Section on a Reimbursement basis only.

What is not covered:

We will not be liable to make any payment in respect of any Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses under Section 2.1.1.2 or Section 2.1.1.3 in relation to any claims made under this Benefit.

2.1.1.12. Cord Blood Banking Cost Cover

What is covered:

We will indemnify the Medical Expenses incurred during the Policy Period, in respect of the collection and storage of the umbilical cord blood as a one-time benefit for one episode of pregnancy only post delivery in a lifetime.

Conditions:

- a. We have accepted a claim under Section 2.1.1.8 (Maternity Expenses) above in respect of the same delivery
- b. Our maximum, total and cumulative liability under this Benefit shall be lower of the actual expenses incurred and the limit specified in the Policy Schedule/ Certificate of Insurance.
- c. Exclusion 'a' specified under Section 2.1.1.8 (Maternity Benefit) shall not apply only to the extent that this Benefit is applicable.

For the purpose of this Benefit, prophylactic collection and storage of umbilical cord blood is considered investigational and not medically necessary when proposed for an unspecified future use for an autologous stem cell transplant in the original donor or for an unspecified future use as an allogeneic stem cell transplant in a related or unrelated donor and this Benefit does not provide assurance further about use of umbilical cord blood/stem cell apart from one time storage.

Smart Health

2.1.1.13. Emergency Ground Ambulance

What is covered:

We will indemnify the expenses incurred on an ambulance during the Policy Period to transfer the Insured Person by surface transport following an Emergency.

Conditions:

- a. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is Injured or is ill to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital with advanced facilities as advised by the treating Medical Practitioner in writing for management of the current Hospitalization.
- b. The expenses incurred are Reasonable and Customary Charges.
- c. This Benefit is available for only one transfer per period of Hospitalization.
- d. The ambulance service is offered by a healthcare or ambulance Service Provider.
- e. We have accepted a claim under Section 2.1.1.1 (Inpatient Care) above in respect of the same period of Hospitalization or Section 2.1.1.4 (Day Care Treatments) or Section 2.1.1.5 (Alternative Treatments) or Section 2.1.1.30 (Critical Illness Multiplier Indemnity Cover).
- f. If a Non-Network Provider provides the ambulance, We will cover expenses incurred only up to the amount specified in the Policy Schedule/Certificate of Insurance.

What is not covered:

We will not make any payment under this Benefit if the Insured Person is transferred to any Hospital or diagnostic centre for evaluation purposes only.

2.1.1.14. Air Ambulance Cover

What is covered:

We will indemnify the expenses incurred on an air ambulance during the Policy Period to transport the Insured Person to the nearest Hospital following an Emergency within India

Conditions:

- a. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is Injured or is ill to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital with advanced facilities as advised by the treating Medical Practitioner in writing for management of the current Hospitalization.
- b. The expenses incurred are Reasonable and Customary Charges.
- c. This Benefit is available for only one transfer per period of Hospitalization.
- d. The ambulance service is offered by a healthcare or ambulance Service Provider.
- e. We have accepted a claim under Section 2.1.1.1 (Inpatient Care) above in respect of the same period of Hospitalization.

Smart Health

- f. The transportation should be provided by medically equipped aircraft which can provide medical care in flight and should have medical equipment vital to monitoring and treating the Insured Person suffering from an Illness/Injury such as but not limited to ventilators, ECGs, monitoring units, CPR equipment and stretchers.

2.1.1.15. Prosthetics Cover

What is covered:

If an Insured Person suffers an Injury or an Illness during the Policy Period that solely and directly results in physical loss of limb(s) within three hundred and sixty five (365) days from the date of the occurrence of such Accident or Illness, We will indemnify the cost of buying the Prosthetic as specified in Policy Schedule/Certificate of Insurance (List is in Annexure IV (Product Benefit Table) unless specifically mentioned in the Policy Schedule/Certificate of Insurance).

Conditions:

- a. We have accepted a claim under Section 2.1.1.1 (Inpatient Care) or Section 2.1.1.4 (Day Care Treatments) above.
- b. Our maximum, total and cumulative liability under this Benefit shall be lower of the actual expenses incurred and the limit as per the option specified in the Policy Schedule/Certificate of Insurance.
- c. Medical Expenses can be claimed under this Section on a Reimbursement basis only.
- d. This Benefit shall be payable for only one limb once in the Insured Person's lifetime irrespective of single or multiple limb loss unless specifically mentioned in the Policy Schedule/Certificate of Insurance.
- e. The permanence of total and irreversible loss of limb shall be proved with a disability certificate issued by a Medical Board duly constituted by the Central or the State Government being presented to Us.

For the purpose of this Benefit, Prosthetics means the articles or equipment that replaces all or a part of a limb where limb is defined as the arm / the leg of a person.

What is not covered:

- a. Any repairs or replacement of the Prosthetic.
- b. Durable Medical Equipment, which means equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of an Illness or Injury, and is appropriate for use in the home.
- c. Orthotics, which means devices that are designed to support a weakened body part and where these appliances are manufactured or custom-fitted to an individual member.

2.1.1.16. Compassionate Visit

What is covered:

If an Insured Person suffers an Injury or an Illness during the Policy Period that solely and directly results in the Insured Person's Hospitalization for more than seven (7) consecutive days We will indemnify the

Smart Health

expenses incurred in respect of travel of one Immediate Family member of the Insured Person to the place of Hospitalization of the Insured Person.

Conditions:

- a. No adult member of the Insured Person's Immediate Family is present within a distance of at least 150 kilometers from the place of Hospitalization of the Insured Person.
- b. The treating Medical Practitioner certifies in writing and Our panel Medical Practitioner confirms that the medical condition of the Insured Person is such that repatriation of the Insured Person is not possible and there is a need for a companion to be present while the Insured Person remains Hospitalized.
- c. Expenses can be claimed under this Section on a Reimbursement basis only.
- d. We will reimburse two-way airfare in a licensed common carrier or two-way railway tickets for the travel of the companion to the place of Hospitalization of the Insured Person.
- e. We have accepted a claim under Section 2.1.1.1 (Inpatient Care) or Section 2.1.1.30 (Critical Illness Multiplier Indemnity Cover) above.

For the purpose of this Benefit Immediate Family means any one of the relationships with the Insured Person: spouse, father, mother, father-in-law, mother-in-law, brother, sister-in-law, sister, brother-in-law, son or daughter.

2.1.1.17. Accompanying Person Accommodation Cover

What is covered:

If an Insured Person suffers an Injury or an Illness during the Policy Period that solely and directly results in the Insured Person's Hospitalization We will pay the amount specified in the Policy Schedule/Certificate of Insurance for each continuous and completed 24 hours of Hospitalization in respect of one Immediate Family member of the Insured Person to accompany the Insured Person in Hospital.

Conditions:

- a. No adult member of the Insured Person's Immediate Family is present within a distance of at least 150 kilometers from the place of Hospitalization of the Insured Person.
- b. Our panel Medical Practitioner confirms that the medical condition of the Insured Person is such there is a need for a companion to be present while the Insured Person remains Hospitalized.
- c. We have accepted a claim under Section 2.1.1.1 (Inpatient Care) or Section 2.1.1.30 (Critical Illness Multiplier Indemnity Cover) above.
- d. Our liability under this Benefit shall be in excess of the Deductible for each period of Hospitalization.
- e. Our maximum liability under this Benefit shall be the lower of 10 days or duration of Hospitalization.

For the purpose of this Benefit Immediate Family means any one of the relationships with the Insured Person: spouse, father, mother, father-in-law, mother-in-law, brother, sister-in-law, sister, brother-in-law, son or daughter.

2.1.1.18. Health Check-up

Smart Health

What is covered:

The Insured Person may avail a health check-up during the Policy Period as per the list specified in Annexure IV (Product Benefit Table) unless another list as specifically mentioned in the Policy Schedule/Certificate of Insurance).

- a. The eligibility of the Insured Person under this Benefit and the frequency of health check-ups will be as specified in the Policy Schedule/Certificate of Insurance.
- b. Any unutilized test or amount in one Policy Year cannot be carry forwarded to the next Policy Year.

2.1.1.19. Home Health Care Services

What is covered:

We will indemnify the Medical Expenses incurred on health care services taken by the Insured Person at home during the Policy Period through Our empanelled Service Provider. List of Home Health Care Services is in Annexure IV (Product Benefit Table) unless another list as specifically mentioned in the Policy Schedule/Certificate of Insurance).

Conditions:

- a. We have accepted a claim under Section 2.1.1.1 (Inpatient Care) or Section 2.1.1.30 (Critical Illness Multiplier Indemnity Cover) above and services under this Benefit are availed immediately following that Hospitalization.
- b. This Benefit can be availed on a Cashless Facility basis only.
- c. The medical condition of the Insured Person must be such that the treating Medical Practitioner expects the condition to improve in a reasonable and generally predictable period of time.
- d. Treatment under this Benefit will be provided under the supervision of a Medical Practitioner to safely and effectively administer the treatment plan for the condition of the Insured Person.
- e. The amount, frequency and time period of the services under this Benefit shall be reasonable, and in agreement between treating Medical Practitioner and the Insured Person availing the service.
- f. Services under this Benefit are available only through Our empanelled Service Providers in selected cities. Please contact Us for the updated list of cities where Home Health Care Services are available.

2.1.1.20. Sub-limit on Specified Illness/Conditions

What is covered:

If an Insured Person is Hospitalized during the Policy Period for any of the Specified Illnesses or Conditions specified in Policy Schedule/Certificate of Insurance then it is agreed that Our liability in respect of any claim made under the Policy for the entire policy period will be limited to the amount specified in Policy Schedule/Certificate of Insurance unless specifically mentioned that sub-limits will operate on Per Policy Basis.

2.1.1.21. Loyalty Credits: Sum Insured Enhancement

Smart Health

What is covered:

If the Insured Person's cover under the Policy is renewed with Us without a break We will increase the Base Sum Insured applicable under the Policy by the percentage as opted and specified in the Policy Schedule/Certificate of Insurance, for each successive renewal. The Sum Insured increase will be calculated as a percentage of the Base Sum Insured subject to the maximum of 200% of Base Sum Insured as specified in the Policy Schedule/Certificate of Insurance. The sub-limits applicable to various Benefits will remain the same and shall not increase proportionately with the Sum Insured.

Conditions:

- a. The Sum Insured shall be increased by a flat percentage for each successive Renewal without a break.
- b. At Renewal You/ Insured Person shall have an option to reinstate/ revise the Sum Insured by sending in writing the request for such Sum Insured revision. Any revision to Sum Insured shall always be subject to due underwriting by Us and acceptance of risk by Us in writing.
- c. If the Insured Person in the expiring cover under the Policy is covered under an Individual Cover and has an enhanced Sum Insured in the expiring cover under the Policy under this Benefit, and such expiring cover under the Policy is Renewed with Us as a Family Floater Cover, then We shall provide credit for Sum Insured enhancement to the Insured Person only and not to the other members of Family Floater Cover.
- d. If the Insured Persons in the expiring cover under the Policy are covered under a Family Floater Cover and have an accumulated Loyalty Credit for each Insured Person in the expiring cover under the Policy under this Benefit, and such expiring cover under the Policy is Renewed with Us as an Individual Cover with same or higher Base Sum Insured, then the accumulated Loyalty Cover to be carried forward for credit in the Renewing cover under the Policy would be the accumulated Loyalty Credit for that Insured Person.
- e. In case the Sum Insured of Section 2.1.1.1 (In-patient Care) is reduced at the time of Renewal, the applicable accumulated Loyalty Credit shall also be reduced in proportion to the Sum Insured of Section 2.1.1.1
- f. In case the Sum Insured of Section 2.1.1.1 (In-patient Care) under the Policy is increased at the time of Renewal, the applicable accumulated Loyalty Credit shall be carried forward.

2.1.1.22. No Claim Bonus

What is covered:

We will add a Cumulative Bonus in the form of a No Claim Bonus as a percentage specified in the Policy Schedule/Certificate of Insurance of the Sum Insured of Section 2.1.1.1 (In-patient Care) at the end of every Policy Year.

Conditions:

- i. No claim has been made under Section 2.1.1.1 (Inpatient Care), 2.1.1.2 & 2.1.1.3 (Pre & Post Hospitalization Expenses), 2.1.1.4 (Day Care Treatment), 2.1.1.6 (Domiciliary treatment), 2.1.1.7

Smart Health

- (Organ Transplant), 2.1.1.5 (Alternate treatment) 2.1.1.8 (Maternity Expenses) and 2.1.1.30 (Critical Illness Multiplier Indemnity Cover) in the immediately preceding Policy Year.
- ii. The No Claim Bonus will be added if the Policy is Renewed with Us by the end of the Grace Period or at the end of each Policy Year if the Policy continues to be in force.
 - iii. The No Claim Bonus will not be accumulated in excess of 200% of the Base Sum Insured under the current Policy with Us under any circumstances.
 - iv. Any No Claim Bonus that has accrued will be available for any claims made in the subsequent Policy Year.
 - v. Merging of Covers under the Policy: If the Insured Persons in the expiring Policy are covered under multiple Individual Covers and such expiring Policy has been Renewed with Us on a Family Floater Cover basis then the No Claim Bonus to be carried forward for credit in such Renewed Policy shall be the lowest percentage of No Claim Bonus of the last Policy Year amongst all the expiring Individual Covers being merged.
 - vi. Splitting of Covers under the Policy: If the Insured Persons in the expiring cover under the Policy are covered on a Family Floater Cover basis and such Insured Persons Renew their expiring cover with Us by splitting the Sum Insured in to two or more Family Floater/Individual Covers then the No Claim Bonus shall not be carried forward to the split covers.
 - vii. Reduction in Sum Insured: If the Sum Insured has been reduced at the time of Renewal, the applicable No Claim Bonus shall be calculated on the revised Sum Insured on a pro-rata basis.
 - viii. Increase in Sum Insured: If the Sum Insured has been increased at the time of Renewal the No Claim Bonus shall be calculated on the Sum Insured of the last completed Policy Year.

2.1.1.23. ReAssure

What is covered:

Once the Base Sum Insured, Loyalty Credit (if applicable), No Claim Bonus (if applicable) has been partially or completely exhausted due to claims paid or accepted as payable for any Illness / Injury during the Policy Year under Section 2.1.1.1 (Inpatient Care) or Section 2.1.1.4 (Day Care Treatments) or 2.1.1.5 (Alternative Treatments) or Section 2.1.1.30 (Critical Illness Multiplier Indemnity Cover), then We will provide an unlimited amount of coverage under this benefit.

Conditions - The above coverage is subject to fulfillment of following conditions:

- Amount provided under this benefit may be used for subsequent claims in respect of the Insured Person and the maximum liability under a single claim under this benefit shall be up to 200% of Base Sum Insured or as specified in the Policy Schedule/Certificate of Insurance.
- For Family Floater Policies, the amount under this benefit will be available on a floater basis to all Insured Persons in that Policy Year.

2.1.1.24. Co-payment

What is covered:

Smart Health

The Insured Person will pay the pre-determined percentage as specified in the Policy Schedule/ Certificate of Insurance as Co-Payment and We will pay the remaining part of the amount that We assess as the admissible amount in respect of any claim under this Section or selected sections as mentioned in the Policy Schedule/ Certificate of Insurance made by an Insured Person.

Conditions:

The Co-Payment percentage will be applicable on all claims under Hospitalization Cover Section except 2.1.1.8 (Maternity Expenses), 2.1.1.9 (New Born Baby Cover), 2.1.1.10 (New Born Vaccination), 2.1.1.11 (Pre & Post Natal), 2.1.1.12 (Cord Blood Banking), 2.1.1.13 (Emergency Ground Ambulance), 2.1.1.14 (Air Ambulance Cover), 2.1.1.15 (Prosthetic cover), 2.1.1.16 (Compassionate Visit), 2.1.1.17 (Accompanying person accommodation cover), 2.1.1.18 (Health Checkup), 2.1.1.20 (Sum-limits for Specified Illness/conditions), unless specifically mentioned in the Policy schedule/Certificate of Insurance.

2.1.1.25. Annual Aggregate Deductible

What is covered:

The Insured Person shall bear on his/her own account an amount equal to the Annual Aggregate Deductible specified in the Policy Schedule/ Certificate of Insurance for any and all admissible claim amounts We assess to be admissible in respect of all claims made by that Insured Person under Section 2.1.1(Hospitalization Cover) for In-patient Hospitalization claims under indemnity based options on the admissible claim amount during a Policy Year.

Conditions:

- Our liability to make payment under the Policy in respect of any claim made in that Policy Year will only commence once the Annual Aggregate Deductible has been exhausted.
- The provisions in Section 2.1.1.24 on Co-payment (if applicable) will apply to any amounts payable by Us in respect of a claim made by the Insured Person after the Annual Aggregate Deductible has been exhausted.
- Deductible under the Section 2.1.1.25 (Annual Aggregate Deductible) shall not apply to any claim under 2.1.1.8 (Maternity Expenses), 2.1.1.9 (New Born Baby Cover), 2.1.1.10 (New Born Vaccination), 2.1.1.11 (Pre & Post Natal), 2.1.1.12 (Cord Blood Banking), 2.1.1.13 (Emergency Ground Ambulance), 2.1.1.14 (Air Ambulance Cover), 2.1.1.15 (Prosthetic cover), 2.1.1.16 (Compassionate Visit), 2.1.1.17 (Accompanying person accommodation cover), 2.1.1.18 (Health Checkup), 2.1.1.20 (Sub-limits for Specified Illness/conditions)

2.1.1.26. Catastrophic Claim Deductible

What is covered:

The Insured Person shall bear on his/her own account an amount equal to the Annual Catastrophic Claim Deductible specified in the Policy Schedule/ Certificate of Insurance for any admissible claim amounts We assess to be admissible in respect of all claims made by that Insured Person under Section

Smart Health

2.1.1(Hospitalization Cover) for In-patient Hospitalization claims under indemnity based options on the admissible claim amount during Policy Year.

Conditions:

- Our liability to make payment under the Policy in respect of any claim made in that Policy Year will only commence once the Annual Catastrophic Claim Deductible has been exhausted.
- The provisions in Section 2.1.1.24 on Co-payment (if applicable) will apply to any amounts payable by Us in respect of a claim made by the Insured Person after the Annual Catastrophic Claim Deductible has been exhausted.
- Deductible under the Section 2.1.2.6 (Annual Catastrophic Claim Deductible) shall not apply to any claim under 2.1.1.8 (Maternity Expenses), 2.1.1.9 (New Born Baby Cover), 2.1.1.10 (New Born Vaccination), 2.1.1.11 (Pre & Post Natal), 2.1.1.12 (Cord Blood Banking), 2.1.1.13 (Emergency Ground Ambulance), 2.1.1.14 (Air Ambulance Cover), 2.1.1.15 (Prosthetic cover), 2.1.1.16 (Compassionate Visit), 2.1.1.17 (Accompanying person accommodation cover). 2.1.1.18 (Health Checkup), 2.1.1.20 (Sub-limits for Specified Illness/conditions).

2.1.1.27. Modern Treatments

What is covered:

These will be the procedures/treatments that will be covered either as Inpatient Care or as part of Day Care Treatment as per Section 2.1.1.1 and Section 2.1.1.4 respectively, in a Hospital. The list is in Annexure IV (Product Benefit Table) unless another list as specifically mentioned in the Policy Schedule/Certificate of Insurance with sub-limits, if any).

Conditions:

- a. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with Sections 2.1.1.2 and 2.1.1.3 within the overall benefit sub-limit.
- b. The following procedures / treatments as mentioned in Policy Schedule/Certificate of Insurance shall be covered only up to the sub-limit as specified in the Policy Schedule/Certificate of Insurance.
- c. If above section is applicable as per policy Schedule/Certificate of Insurance then this will supersede any of the pertaining exclusion.

2.1.1.28. Corporate Floater

We will provide a Corporate Floater for "items/diseases/conditions/procedures/treatments/syndromes" as specified in the Policy Schedule/Certificate of Insurance during the Policy Year, provided that:

- i. This Benefit will be restricted to Individual/ family to the amount specified in the Policy Schedule/Certificate of Insurance in respect of each and every Insured Person/ family, as opted.
- ii. If the cover under the Policy is issued on a Family Floater Cover basis, the enhanced Sum Insured on account of the Corporate Floater applicable will also be available on a Family Floater Cover basis.
- iii. Any Benefit accrued under this cover cannot be carried forward to the subsequent Policy Year.
- iv. The Benefit payable will be over and above the Base Sum Insured.

Smart Health

- v. All other terms, exclusions and conditions contained in the Policy or endorsed thereon remain unchanged.

2.1.1.29. Corporate Floater for any of 65 listed Critical Illnesses*

We will provide a Corporate Floater as specified in the Policy Schedule/ Certificate of Insurance during the Policy Year only for medical treatment for Critical Illnesses listed below provided that:

- i. This Benefit will be available for those Insured Persons who have already exhausted their Sum Insured limit subject to per Insured Person/ family limit as mentioned in the Policy Schedule/Certificate of Insurance.
- ii. This Benefit will be restricted to Individual/ family to the amount specified in the Policy Schedule/Certificate of Insurance in respect of each and every Insured Person/ family, as opted.
- iii. If the cover under the Policy is issued on a Family Floater Cover basis, the enhanced Sum Insured on account of the Corporate Floater applicable will also be available on a Family Floater Cover basis.
- iv. Any Benefit accrued under this cover cannot be carried forward to the subsequent Policy Year.
- v. The Benefit payable will be over and above the Base Sum Insured.
- vi. All other terms, exclusions and conditions contained in the Policy or endorsed thereon remain unchanged.

***List of 65 Critical Illnesses mentioned under Section 2.6**

2.1.1.30. Critical Illness Multiplier Indemnity Cover:

What is covered:

If the insured member is diagnosed and hospitalized for any of the selected combination of critical illness as mentioned in the Policy Schedule/Certificate of Insurance) and claim is admissible under the base policy then the Sum Insured for such critical Illness would be increased by a multiplier as mentioned in the Policy Schedule/Certificate of Insurance.

Conditions:

- a. Such increase in Sum Insured would be triggered only for treatment of the listed conditions; no other claim would be covered under the enhanced limit.
- b. The enhanced limit of Indemnity cannot be utilized for other members.
- c. In case of claim under listed Critical Illness first the enhanced Sum Insured (after the multiplier is triggered) will be exhausted on Indemnity basis then the base Sum Insured will be triggered, either in same claim or for a new claim
- d. The enhancement of limit will happen only once in policy year even if multiple listed Critical Illness is diagnosed.
- e. The enhanced Limit cannot be carried forward to next renewal

List and Definition of Critical Illnesses under Section 2.1.1.30

S.No.	Covered Condition	Definition
1.	Cancer - All conditions covered cancer variant	<p>I. A Malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be evidenced by histological evidence of malignancy and confirmed by a pathologist</p> <p>II. The term cancer includes:</p> <ol style="list-style-type: none"> Leukemia, lymphoma, and sarcoma Tumors showing the malignant changes of carcinoma in situ and tumors which are histologically described as pre-malignant or non-invasive including but not limited to : carcinoma in situ of breasts, cervical dysplasia CIN-1,CIN-2 and CIN-3 <p>III. The following are excluded:</p> <ol style="list-style-type: none"> Benign Lesions All tumors of prostate unless histologically classified as having a Gleason score of greater than 6 or having progressed to at least the clinical TNM classification of T2N0M0 Papillary micro-carcinoma of the thyroid less than 1cm in diameter Micro carcinoma of the bladder All tumors in presence of HIV
2.	Kidney failure	<p>I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function documented with raised level of S. Creatinine and S Urea, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a Nephrologist.</p>
3	Multiple sclerosis with persisting symptoms	<p>I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following, and confirmed by specialist medical examiner.</p> <p>II. Investigations including typical MRI and CSF findings which unequivocally confirm the diagnosis to be multiple sclerosis and there must be current clinical impairment of motor or sensory function</p> <p>III. Other causes of neurological damage such as SLE and HIV are excluded.</p>
4	Benign brain tumor	<p>I. A benign tumor in the brain where following conditions are met and its presence must be confirmed by a neurologist or neurosurgeon:</p> <ol style="list-style-type: none"> Has potential to cause permanent damage to the brain; If it has undergone surgical removal or if inoperable ,has caused a permanent neurological deficit such as but not restricted to characteristic symptoms of increased intracranial pressure such as papilloedema, mental symptoms, seizures, and sensory impairment; and Diagnosis is supported by findings on Magnetic Resonance Imaging , Computerized Tomography ,or other reliable imaging techniques The treatment is advised and justified medically by a certified neurologist <p>II. The following conditions are excluded:</p> <ol style="list-style-type: none"> Cysts, Granulomas, vascular malformations in the arteries or veins of the brain, hematomas, calcification.
5	Parkinson's Disease	<p>I. Hospitalization for treatment directly related of progressive degenerative primary idiopathic Parkinson's disease made by a consultant neurologist.</p> <p>II. Following will be excluded:</p> <ol style="list-style-type: none"> Parkinson's disease secondary to drug and/or alcohol abuse Psychiatric treatment directly or indirectly related to Parkinson's Disease
6	Alzheimer's Disease	<p>I. Progressive degenerative disease of the brain characterized by diffuse atrophy throughout the cerebral cortex with distinctive histopathology</p>

		<p>changes.</p> <p>II. Deterioration or loss of intellectual capacity as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning requiring the continuous supervision of the Insured Person. This diagnosis must be supported by the clinical confirmation of an appropriate consultant neurologist and supported by Company's appointed doctor.</p> <p>III. The following are excluded:</p> <ol style="list-style-type: none"> Any other type of irreversible organic disorder/dementia Non-organic disease such as neurosis and psychiatric illnesses; and Alcohol-related brain damage. Psychiatric treatment directly or indirectly related to Alzheimer's Disease
7	End stage liver failure	<p>I. End stage Liver Failure resulting in cirrhosis and irreversible failure of liver function that is evidenced by the following criteria and certified by Gastroenterologist:</p> <ol style="list-style-type: none"> Permanent jaundice Uncontrollable Ascites Hepatic encephalopathy Oesophageal or Gastric Varices and portal hypertension <p>II. Liver failure secondary to drug or alcohol abuse is excluded.</p>
8	Motor neuron disease	<p>I. Motor neuron disease diagnosed by a specialist Medical Practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of cortico-spinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction with a clear causation relation to MND.</p>
9	End stage lung failure	<p>I. End stage Respiratory failure including Chronic Interstitial Lung disease. Following criteria must be met:</p> <ol style="list-style-type: none"> Requiring permanent oxygen therapy as a result of a consistent FEV1 test value of less than one litre (Forced Expiratory Volume during the first second of forced exhalation) Arterial Blood Gas analysis with partial oxygen pressures of 55mmHg or less This diagnosis must be confirmed by the chest/ Respiratory physician.
10	Bacterial Meningitis	<p>I. Bacterial infection resulting in inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. This diagnosis must be confirmed by:</p> <ol style="list-style-type: none"> The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and A consultant neurologist. <p>II. Bacterial Meningitis in the presence of HIV infection is excluded.</p>
11	Aplastic Anaemia	<p>I. Aplastic Anaemia is chronic persistent bone marrow failure which results Anemia, Neutropenia and Thrombocytopenia requiring treatment with at least one of the following:</p> <ol style="list-style-type: none"> blood product transfusions, bone marrow stimulating agents, or immunosuppressive agents or bone marrow or cord blood stem cell transplant. <p>II. A certified hematologist must make the diagnosis of severe irreversible aplastic anaemia. There must be at least two of the following:</p> <ol style="list-style-type: none"> Absolute neutrophil count of less than 500/mm³ Platelets count less than 20,000/mm³ Reticulocyte count of less than 20,000/mm³

12	Pulmonary Thromboembolism	I. The blockage of an artery in the lung by a clot or other tissue from another part of the body. The pulmonary embolus must be unequivocally diagnosed by a specialist on either a V/Q scan (the isotope investigation which shows the ventilation and perfusion of lungs), angiography or electrocardiography, with evidence of right ventricular dysfunction and confirmation with D Dimer assay findings, and requiring medical or surgical treatment on an in-patient basis.
13	Primary (idiopathic) pulmonary hypertension	I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Catheterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment. II. The NYHA Classification of Cardiac Impairment are as follows: Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest. III. Pulmonary hypertension associated with occupational and environmental factors, Substance abuse (like tobacco etc), Lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.
14	Infective Endocarditis	I. Inflammation of the inner lining of the heart caused by infectious organisms, where all of the following criteria are met: a. Positive result of the blood culture proving presence of the infectious organism(s) b. Presence of at least moderate heart valve incompetence (meaning regurgitate fraction of 20% or more) or moderate heart valve stenosis (resulting in heart valve area of 30% or less of normal value) directly attributable to infective endocarditis and the severity of valvular disease/ risk factors and II. The diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a consultant cardiologist
15	Major organ /bone marrow transplant	I. The actual undergoing of a transplant of: a. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or b. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner. II. The following are excluded: a. Other stem-cell transplants b. Where only islets of langerhans are transplanted
16	Replacement / 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). II. 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. III. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty
17	Aortic Dissection	I. The actual undergoing of surgery for aortic dissection, needing excision and surgical replacement of the diseased part of the aorta with a graft. a. The term "aorta" means the thoracic and abdominal aorta but not its branches. b. A cardiologist must confirm the diagnosis and realization of surgery.

		c. Surgery performed using only minimally invasive or intra-arterial techniques are also covered
18	Cardiomyopathy	<p>I. An impaired function of heart muscle, unequivocally diagnosed as Cardiomyopathy by a consultant cardiologist who has been treating the patient, and which results in permanent physical impairment to the Degree of New York Heart Association classification Class IV, or its equivalent, based on the following classification criteria- Class IV: Inability to carry out any activity without discomfort.</p> <p>II. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced. The Diagnosis of Cardiomyopathy has to be supported by echo-graphic findings of compromised ventricular performance.</p> <p>III. Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.</p>
19	Surgery for Cardiac Arrhythmia	<p>I. Ablative procedure is defined as catheter ablation procedures using radiofrequency or cryothermal energy for treatment of a recurrent or persistent symptomatic arrhythmia refractory to antiarrhythmic drug therapy. Ablation procedures should immediately follow the diagnostic electrophysiology study. The ablative procedure must be certified to be absolutely necessary by a consultant cardiologist (electrophysiologist).</p> <p>II. Pre-procedural evaluation prior to ablation procedures as below should be completely documented:</p> <p>a. Strips from ambulatory Holter monitoring in documenting the arrhythmia</p> <p>b. Electrocardiographic and electrophysiologic recording cardiac mapping and localization of the arrhythmia during the ablative procedure.</p>
20	Angioplasty	<p>I. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).</p> <p>II. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.</p> <p>III. Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.</p>
21	Balloon Valvotomy/ Valvuloplasty	<p>I. The actual undergoing of Valvotomy and Valvuloplasty necessitated by the damage of the heart valve as confirmed by a specialist in the relevant field where the procedure is performed totally via intravascular catheter based techniques.</p> <p>II. The diagnosis of heart valve abnormality must be supported by cardiac catheterization or electrocardiogram and the procedure must be considered medically necessary by a consultant cardiologist.</p>
22	Carotid Artery surgery	<p>I. The actual undergoing of the surgery to the Carotid Artery to treat Carotid artery stenosis of 50% and above, as proven by angiographic evidence, of one (1) or more carotid arteries.</p> <p>II. Both of the following criteria must be met:</p> <p>a. Either:</p> <p>i. Actual undergoing of endarterectomy to alleviate the symptoms or,</p> <p>ii. Actual undergoing of an endovascular intervention such as angioplasty and/or stenting or atherectomy to alleviate the symptoms and</p> <p>b. The diagnosis and medical necessity of the treatment must be confirmed by a cardio-thoracic surgeon.</p>
23	Open Chest Coronary Artery Bypass Grafting(CABG)	<p>I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by CABG. The diagnosis must be supported</p>

		<p>by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.</p> <p>II. The following are excluded: Any key hole or Laser surgery</p>
24	Pericardectomy	<p>I. The undergoing of the pericardectomy performed by open heart surgery or key hole techniques as a result of pericardial disease. The surgical procedures must be certified to be medically necessary by a consulting cardiologist. Other procedures on the pericardium including pericardial biopsies and pericardial drainage procedures by needle aspiration are excluded.</p> <p>II. The actual undergoing of pericardectomy secondary to chronic constructive pericarditis.</p> <p>III. The following are specifically excluded:</p> <ol style="list-style-type: none"> Chronic constructive pericarditis related to alcohol or drug abuse or HIV Acute pericarditis due to any reason
25	Surgery to Place Ventricular Assist devices or Total Artificial Hearts	<p>I. This is an open chest procedure for implantation of Left ventricular Assist Device / Ventricular Assist Device as bridges to cardiac transplantation or destination therapy for long term use of the Refractory Heart Failure with reduced ejection fraction as defined below: NYHA class IV symptoms who failed to respond to optimal medical management for >=45 for the past 60 days, or have been intra-aortic balloon pump dependent for 7 days or IV inotrope dependent for 14 days.</p> <p>II. The following are excluded:</p> <ol style="list-style-type: none"> Ventricular dysfunction or Heart failure directly related to alcohol or drug abuse.
26	Myocardial Infarction	<p>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:</p> <ol style="list-style-type: none"> A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain) New characteristic electrocardiogram changes Elevation of infarction specific enzymes, Troponins or other specific biochemical markers. <p>II. The following are excluded:</p> <ol style="list-style-type: none"> Non- ST- segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T; Any type of angina pectoris Other acute Coronary Syndromes
27	Implantation of Pacemaker of Heart	<p>I. Actual undergoing of Insertion of a permanent cardiac pacemaker to correct serious cardiac arrhythmia which cannot be treated via other means. The insertion of the cardiac pacemaker must be certified to be medically necessary by a specialist in the relevant field.</p> <p>II. Following will be excluded:</p> <ol style="list-style-type: none"> Cardiac arrest secondary to alcohol, substance abuse or drug abuse.
28	Implantable Cardioverter Defibrillator	<p>I. Actual undergoing of insertion of an implantable cardiac defibrillator to correct serious cardiac arrhythmia which cannot be treated via other methods or the insertion of permanent cardiac defibrillator to correct sudden loss of heart function with cessation of blood circulation around the body resulting in unconsciousness. Insertion of Cardiac Defibrillator means surgical implantation of either Implantable Cardioverter- Defibrillator (ICD), or Cardiac Resynchronization Therapy with Defibrillator (CRT-D)</p> <p>II. The insertion of permanent Cardioverter- Defibrillator (ICD) must be certified to be absolutely necessary by a specialist in the relevant field.</p> <p>III. Following will be excluded:</p>

29	Stroke	<p>a. Cardiac arrest secondary to alcohol, substance or drug abuse.</p> <p>I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit has to be produced.</p> <p>II. The following are excluded:</p> <ul style="list-style-type: none"> a. Transient ischemic attacks (TIA) b. Traumatic injury of the brain c. Vascular disease affecting only the eye or optic nerve or vestibular functions.
30	Permanent paralysis of limbs	<p>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. Reconstruction surgeries required to attain best possible mobility will be included.</p> <p>II. Rehabilitative treatment , prosthesis and supporting aids like crutches/ vehicle/ home modification will be excluded.</p>
31	Burns	<p>I. Third degree (full thickness of the skin) burns covering at least 20% of the surface of the Insured Person's body. The condition should be confirmed by a consultant physician.</p> <p>II. Burns arising due to self- infliction are excluded.</p>
32	Blindness	<p>I. The Blindness is evidenced by: (Either of the below condition is mandatory and to be treatment advised by certified specialist)</p> <ul style="list-style-type: none"> a. corrected visual acuity being 3/60 or less in both eyes or ; b. the field of vision being less than 10 degrees in better eye with the best possible correction. <p>II. Treatments required for correction of blindness or improvement in visual acuity will be covered</p> <p>III. Exclusion:</p> <ul style="list-style-type: none"> a. Low vision condition b. Cost of enucleation related to tumors or other eye defects c. Cosmetic correction and related prosthesis cost d. Implantable or external visual implants e. Cases of blindness with low vision before the inception of the policy
33	Abdominal Aortic Aneurysm	<p>I. The actual undergoing of surgery for abdominal aortic aneurysm, needing excision and surgical replacement of the diseased part of the aorta with a graft.</p> <ul style="list-style-type: none"> a. The term "aorta" means the thoracic and abdominal aorta but not its branches. b. A cardiologist must confirm the diagnosis and realization of surgery c. Surgery performed using only minimally invasive or intra-arterial techniques are excluded.
34	Fulminant Viral Hepatitis	<p>I. A sub-massive to massive necrosis of the liver by any virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:</p> <ul style="list-style-type: none"> a. rapid decreasing of liver size as confirmed by abdominal ultrasound; and b. necrosis involving entire lobules, leaving only a collapsed reticular framework (histological evidence is required) ; and c. rapid deterioration of liver function tests; and d. deepening jaundice; and e. hepatic encephalopathy.

		<p>II. This excludes:</p> <p>a. Hepatitis infection or carrier status alone does not meet the diagnostic criteria.</p> <p>b. Fulminant Viral Hepatitis caused by alcohol, toxic substance or drug.</p>
35	Severe Rheumatoid Arthritis	<p>The unequivocal diagnosis of Severe Rheumatoid Arthritis with all of the following factors:</p> <p>I. Is in accordance with the criteria on Rheumatoid Arthritis of the American College of Rheumatology and has been diagnosed by the Rheumatologist.</p> <p>II. At least 3 joints are damaged or deformed such as finger joint, wrist, elbow, knee joint, hip joint, ankles, cervical spine or feet toe joint as confirmed by clinical and radiological evidence and cannot perform at least 3 types of daily routines permanently for at least 180 days.</p>
36	Systematic Lupus Erythematosus	<p>I. Multi-system, auto immuno disorder characterized by the development of auto-antibodies, directed against various self-antigens. For purposes of the definition of "Critical Illness", SLE is restricted to only those forms of systemic lupus erythematosus, which involve the kidneys and are characterized as Class III, Class IV, Class V or Class VI lupus nephritis under the Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS) classification of lupus nephritis (2003) below based on renal biopsy. There must be positive antinuclear antibody test.</p> <p>II. Other forms such as discoid lupus, and those forms with only hematological and joint involvement are specifically excluded.</p> <p>III. Abbreviated ISN/RPS classification of lupus nephritis (2003):</p> <p>a. Class I - Minimal mesangial lupus nephritis</p> <p>b. Class II - Mesangial proliferative lupus nephritis</p> <p>c. Class III - Focal lupus nephritis</p> <p>d. Class IV - Diffuse segmental (IV-S) or global (IV-G) lupus nephritis</p> <p>e. Class V - Membranous lupus nephritis</p> <p>f. Class VI - Advanced sclerosis lupus nephritis the final diagnosis must be confirmed by a certified doctor specializing in Rheumatology and Immunology</p>
37	Nephrotic syndrome	<p>I. Nephrotic syndrome is the onset of heavy proteinuria (>3.0 g/24 h), hypertension, hypercholesterolemia, hypoalbuminemia, edema/anasarca, and microscopic hematuria.</p> <p>II. A confirmed diagnosis of glomerulonephritis with nephrotic syndrome must be made by an appropriate Medical Practitioner along with relevant reports and should confirm a treatment regimen appropriate to the clinical presentation has been followed throughout the period to which syndrome relates.</p> <p>III. The syndrome must have continued for a period of at least 6 months from the date of confirmed diagnosis with or without intervening periods of remission.</p>

2.1.1.31. WELL MOTHER CARE EXPENSES

We will indemnify the Medical Expenses incurred during the Policy Period, in respect of the Room Rent coverage for mother who is required to feed the baby post birth if the new born baby (upto age of 2 years) is hospitalized.

Conditions:

- a. We have accepted a claim under Section 2.1.1.8 (Maternity Expenses) above in respect of the same delivery

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- b. Our maximum, total and cumulative liability under this Benefit shall be lower of the actual expenses incurred and the limit specified in the Policy Schedule/ Certificate of Insurance.

2.1.1.32. WELL BABY CARE EXPENSES

We will indemnify the Medical Expenses incurred during the Policy Period, in respect of the Coverage for necessary expenses related to the newborns wellbeing after birth and before discharge. These expenses include doctor check-up and any other check-up / tests performed to ensure that the baby is well at birth.

Conditions:

- a. We have accepted a claim under Section 2.1.1.8 (Maternity Expenses) above in respect of the same delivery
- b. Our maximum, total and cumulative liability under this Benefit shall be lower of the actual expenses incurred and the limit specified in the Policy Schedule/ Certificate of Insurance.

2.1.1.33. HIV/AIDS Cover

What is covered:

We will indemnify the expenses incurred by the Insured Person for Hospitalization (including Day Care Treatment) due to condition caused by or associated with HIV / AIDS up to the limit specified in Policy Schedule/Certificate of Insurance.

Conditions:

- a. The Hospitalization or Day Care Treatment is Medically Necessary and the Illness is the outcome of HIV / AIDS. This needs to be prescribed in writing by a registered Medical Practitioner.
- b. The coverage under this benefit is provided for opportunistic infections which are caused due to low immunity status in HIV / AIDS resulting in acute infections which may be bacterial, viral, fungal or parasitic.
- c. The patient should be a declared HIV positive.
- d. Pre-hospitalization and Post-hospitalization Medical Expenses incurred will be indemnified up to the opted limit and for opted number of days of coverage as mentioned in the Policy Schedule/Certificate of Insurance as per section 2.1.1.2 and section 2.1.1.3.

What is not covered:

- a. Chronic health conditions including ischemic heart disease, chronic liver disease, chronic kidney disease, cerebro-vascular disease/ stroke, bronchial asthma and neoplasm, which are not directly related to the patient's immunity status, would not be covered under this benefit.
- b. Lifestyle diseases like diabetes, hypertension, heart diseases and dyslipidemia, which are not related to HIV / AIDS, would not be covered under this benefit.

2.1.1.34. Mental Illness Cover

What is covered:

We will indemnify the expenses incurred by the Insured Person for Inpatient treatment for Mental Illness up to the limit as specified in the Policy Schedule/Certificate of Insurance.

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Conditions:

- a. Mental Disorders Treatment is only covered where patient is diagnosed by a qualified psychiatrist or a professional registered with the concerned State Authority or a professional having a post-graduate degree (Ayurveda) in Mano VigyanAvumManasRoga or a post-graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post-graduate degree (Siddha) in SirappuMaruthuvam.
- b. The Hospitalization is for Medically Necessary Treatment.
- c. The treatment should be taken in Mental Health Establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person, where persons with mental illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person; but does not include a family residential place where a person with mental illness resides with his relatives or friend.
- d. Pre-hospitalization and Post-hospitalization Medical Expenses incurred will be indemnified up to the opted limit and for opted number of days of coverage as mentioned in the Policy Schedule/Certificate of Insurance as per section 2.1.1.2 and section 2.1.1.3.

What is not covered:

- a. The condition which is not clinically significant or is related to anxiety, bereavement, relationship or academic problems, acculturation difficulties or work pressure.
- b. Treatment related to intentional self inflicted Injury or attempted suicide by any means.
- c. Mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence

2.1.1.35. Nursing Allowance

We will reimburse the expenses for the services of a registered nurse attending to the Insured Person at the Insured Person's home immediately following his discharge from Hospital, provided that:

- a) the Medical Practitioner treating the Insured Person recommends the provision of such care for medical reasons as a part of medical prescription, and
- b) We have accepted an inpatient care claim under Section 2.1.1.1, and subject to the limit/day and for specified number of days with optional Deductible/Franchise as specified in Policy Schedule/Certificate of Insurance.

2.1.1.36. Animal and Serpent Attack

We will cover Medical Expenses for Inpatient Care and/or OPD treatments (as per the option chosen) including inoculation and immunization in case of any animal/serpent attack up to the limit specified in Policy Schedule/Certificate of Insurance.

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Animal means any four (4) limbed animal that is not an insect or reptile.

Serpent or Snake means a legless reptile of the sub-order serpentes with a long, thin body.

2.1.1.37. **Emergency assistance services (only within India)**

This Policy provides a host of value added Emergency Medical Assistance and Emergency personal services as described below, on Cashless Facility basis.

- a. Medical referral: Insured Person will have tele-access to an operations center of Our Service Provider, who with their multilingual staff on duty 24 hours a day, 365 days a year will provide reference of doctors in the vicinity where the Insured Person is located for medical consultations. This medical consultation is only facilitated by Us / Our Service Provider and is independent judgment of medical consultant. We do not assume any liability and shall not be deemed to assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the professional giving medical consultant.
- b. Emergency medical evacuation: When an adequate medical facility is not available proximate to the Insured Person, as determined by the Insured Person's attending physician and agreed by Us / Our Service Provider, We/Our Service Provider will arrange and pay for ambulance services under appropriate medical supervision, by an appropriate mode of transport as decided by Us / Our Service Provider's consulting physician and patient's attending physician to the nearest medical facility capable of providing the required care.
- c. Medical repatriation: We / Our Service Provider will arrange and pay for transportation under medical supervision to the Insured Person's residence or to a medical or rehabilitation facility near the Insured Person's residence (as mentioned in the Policy Schedule/ Certificate of Insurance) when the Insured Person's attending physician determines that transportation is medically necessary and is agreed by Us / Our Service Provider, at such time as the Insured Person is medically cleared for travel by Us / Our Service Provider's consulting physician and Insured Person's attending physician.
- d. Compassionate visit: When an Insured Person will be hospitalized for more than 7 consecutive days and has travelled without a companion or doesn't have a companion by his / her side, We / Our Service Provider will arrange and pay for travel of a family member or personal friend to visit such Insured Person by providing an appropriate means of transportation via economy carrier transportation as determined by Us / Our Service Provider. The family member or the personal friend is responsible to meet all travel document requirements, as may be applicable.
- e. Care and/or transportation of minor children: One-way economy common carrier transportation, with attendants if required, will be provided to the place of residence of minor child(ren) when they are left unattended as a result of medical emergency or death of an Insured person.

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- f. Return of mortal remains: In the event of death of Insured Person, We/Our Service Provider will arrange and pay for the return of mortal remains to an authorized funeral home proximate to the Insured Person's legal residence.

Conditions–

Any coverage under this section is subject to fulfillment of following conditions:

- a. The services are provided when Insured Person(s) is/are traveling within India to a place which is at a minimum distance of 150(one hundred and fifty) kilometers or more away from the residential address as mentioned in the Policy Schedule/Certificate of Insurance, and the travel is for less than 90(ninety) days period.

What is not covered:

No claims for Reimbursement of expenses incurred for services arranged by Insured/Insured Person(s) will be entertained as the coverage under this section are on Cashless Facility basis only.

- a. Emergency assistance service will not be provided in the following instances:
- I. Travel undertaken specifically for securing medical treatment
 - II. Services sought outside India.
 - III. If Emergency is a result of injuries resulting from participation in acts of war or insurrection
 - IV. Commission of unlawful act(s).
 - V. Attempt at suicide /self-inflicted injuries.
 - VI. Incidents involving the use of drugs, unless prescribed by a physician
 - VII. Transfer of the insured person from one medical facility to another medical facility of similar capabilities and providing a similar level of care
- b. We / Our Service Provider will not evacuate or repatriate an insured person in the following instances:
- I. Without medical authorization from attending physician
 - II. With mild lesions, simple injuries such as sprains, simple fractures, or mild sickness or similar such conditions which can be treated by local doctors and do not prevent Insured Person(s) from continuing your trip or returning home as determined by Us / Our Service Provider's consulting physician and the Insured Person's attending physician
 - III. If the Insured Person is pregnant and beyond the end of the 28th week and with respect to the child born from the pregnancy, We / Our Service Provider shall not evacuate or repatriate the Insured Person and the child who was born while the Insured Person was traveling beyond the 28th week
 - IV. With mental or nervous disorders unless hospitalized

Specific exclusions:

- a. Trips exceeding 90(ninety) days from declared residence.

While assistance services are available all over India, transportation response time is directly related to the location / jurisdiction where an event occurs. We / Our Service Provider is not responsible for failing to provide services or for delays in the delivery of services caused reasons beyond Our reasonable control, including without any limitation, strike, road traffic, the weather conditions, availability and accessibility

Smart Health

of airports, flight conditions, availability of hyperbaric chambers, pandemics and endemics, communications systems, absence of proper travel documents or where rendering of service is limited or prohibited by local law, edict or regulation. Our / Our Service Provider's performance of any obligation here in this section shall be waived / excused if such failure to perform is caused by an event, contingency, or circumstance beyond its reasonable control that prevents, hinders or makes impractical the performance of services. Legal actions arising hereunder shall be barred unless written notice thereof is received by Us / Our Service Provider within one year from the date of event giving rise to such legal action. All consulting physicians and Our Service Provider are independent contractors and not under the control of the Company. We / Our Service Provider are not responsible or liable for any service rendered herein through professionals to You.

2.1.1.38. Empathy Benefit

In case of death during Hospitalization then the payout will be as per the options opted and as mentioned in the Policy schedule/ Certificate of Insurance.

As mentioned for the Insured in the Policy Schedule/Certificate of Insurance, this option will be available as:

Option 1 - Full payment of claim up to sum insured without any deductions for non-payable items, if death happens while hospitalization

Conditions:

If We have accepted a claim under section 2.1.1.1 (Inpatient care), then the items which are not payable as per List I – 'Expenses not covered' under Annexure II related to that particular claim will become payable.

Option 2 -Full payment of claim up to sum insured without any deduction if death happens within 24 hours of hospitalization

Conditions:

If We would have accepted a claim under section 2.1.1.1 (Inpatient care),if the insured would have survived for 24 hours or more, then the items which are not payable as per List I – 'Expenses not covered' under Annexure II related to that particular claim will become payable.

Option 3 - Lump sum payout up to the amount specified in the policy Schedule/Certificate of Insurance, if death happens while hospitalization

Conditions:

If We have accepted a claim under section 2.1.1.1 (Inpatient care) or would have accepted a claim under section 2.1.1.1 (Inpatient care) if the insured would have survived for 24 hours or more, then a lump-sum payout of amount mentioned in the Policy Schedule/Certificate of Insurance will be given to the Nominee.

Above Options can be combined in any reasonable fashion as specified in the Policy Schedule/Certificate of Insurance.

Smart Health

2.1.1.39. Weekly Benefit

What is covered:

If the Insured Person suffers from any illness (as mentioned in the Policy Schedule/ Certificate of Insurance) or injury which occurs during the Policy Period and which solely and directly results in the Insured Person's temporary inability to go to work, We will pay the amount as specified in the Policy Schedule/Certificate of Insurance.

Conditions:

- I. We have accepted a claim under Section 2.1.1.1 (Inpatient Care) above
- II. We will make payment under Section 2.1.1.39 for only a part of the week if the Insured Person has suffered Temporary inability for that part of the week.
- III. We shall not be liable to make any payment under Section 2.1.1.39 in respect of more than 100 continuous weeks, subject always to the Opted Sum Insured.
- IV. The amount payable under Section 2.5.1.39 is calculated on a per day basis and shall be payable after applicable continuous days of temporary inability as mentioned in Policy Schedule/Certificate of Insurance.
- V. We will make payment of the amount due under Section 2.5.1.39 on a weekly basis unless the Temporary inability continues for a continuous period of more than up to the number of days specified in the Policy Schedule/ Certificate of Insurance in which case We will make payment of the amount due under Section 2.5.1.39 at the end of every calendar month until the Temporary inability ceases.
- VI. This amount will be payable only for the days of temporary inability after the discharge from hospitalization
- VII. A certified Medical Practitioner must declare the insured temporarily unfit to travel and work with specified period of recovery.
- VIII. In the event of a dispute arising as to when Temporary enablement ceased, a Physician commissioned by the Company shall finally determine the date.
- IX. The benefit shall not in any event exceed the Total Sum Insured or the Maximum Number of Weeks as stated in the Policy Schedule/Certificate of Insurance.

2.1.1.40. Physiotherapy and Rehabilitation cover

We will indemnify the Medical Expenses incurred during the Policy Period up to limit as specified in the Policy Schedule/ Certificate of Insurance incurred on physiotherapy and rehabilitation for the Insured Person

Conditions:

- I. This Benefit shall be payable only if we have accepted a claim under Section 2.1.1.1 (In-patient care)
- II. The physiotherapy and Rehabilitation is Medically Necessary Treatment.

Smart Health

2.1.1.41. Claim Settlement in Network Provider only (Cashless)

The provisions of this Section shall be applicable if there is only Cashless Facility claim settlement option available under Section 2.1 (Hospitalization Cover)

- (a) If an Insured Person is Hospitalized in a Hospital as specified by Us and attached to the Policy Schedule/Certificate of Insurance as specific endorsement then it is agreed that We will pay 100% of any amount We assess for payment.
- (b) Any treatment taken at a Non-Network Provider shall not be covered under this Policy.

2.1.1.42. Claim Settlement on Reimbursement Only

The provisions of this Section shall be applicable if there is only Reimbursement Claim settlement option under Section 2.1 (Hospitalization Cover)

- (a) If an Insured Person is Hospitalized then it is agreed that We will pay the amount that We assess in respect of any claim under the Policy on reimbursement basis only.

2.1.2 Section Specific Conditions

All the Waiting Periods as specified in Policy Schedule/ Certificate of Insurance shall be applicable individually for each Insured Person and claims shall be assessed accordingly. On Renewal, if an enhanced Sum Insured is applied for, the Waiting Periods would apply afresh to the extent of the increase in Sum Insured only.

We shall not be liable to make any payment under this Policy directly or indirectly for, caused by, based on, arising out of or howsoever attributable to any of the following, except if any Insured Person suffers an Accident;

A. Waiting Periods

- (i) **Pre-existing Diseases (Code-Excl01):**
 - a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of the number of months (as mentioned in Policy Schedule/Certificate of Insurance) 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 number of months (as mentioned in Policy Schedule/Certificate of Insurance) for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.
- (ii) **Specified disease/procedure waiting period (Code- Excl02)**
 - a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of number of months (as mentioned in Policy Schedule/Certificate of Insurance) of continuous coverage after the date of inception of

the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident (covered from day 1).

- b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
- d. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
- e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI then waiting period for the same would be reduced to the extent of prior coverage.
- f. List of specific diseases/procedures unless specifically mentioned in Policy Schedule/Certificate of Insurance:
 - a. Pancreatitis and stones in billiard and urinary system
 - b. Cataract, glaucoma and other disorders of lens, disorders of retina
 - c. Hyperplasia of prostate, Hydrocele and spermatocoele
 - d. Abnormal utero-vaginal bleeding, female genital prolapse, endometriosis/adenomyosis, fibroids, PCOD, or any condition requiring dilation and curettage or hysterectomy
 - e. Hemorrhoids, fissure or fistula or abscess of anal and rectal region
 - f. Hernia of all sites,
 - g. Osteoarthritis, systemic connective tissue disorders, dorsopathies, spondylopathies, inflammatory polyarthropathies, arthrosis such as RA, gout, intervertebral disc disorders, arthroscopic surgeries for ligament repair
 - h. Chronic kidney disease and failure
 - i. Varicose veins of lower extremities
 - j. All internal or external benign or in situ neoplasms/tumours, cyst, sinus, polyp, nodules, swelling, mass or lump
 - k. Ulcer, erosion and varices of gastro intestinal tract
 - l. Surgical treatment for diseases of middle ear and mastoid (including otitis media, cholesteatoma, perforation of tympanic membrane), Tonsils and adenoids, nasal septum and nasal sinuses
 - m. Internal Congenital Anomaly
 - n. Surgery of Genito-urinary system unless necessitated by malignancy
 - o. Spinal disorders

(iii) 30 days waiting period (Code- Excl03):

- a. Expenses related to the treatment of any illness within 30 days from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
- b. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months
- c. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

If these diseases are Pre-Existing Diseases at the time of the Proposal or subsequently found to be Pre-Existing Diseases, the Pre-Existing Disease Waiting Periods as mentioned in the Policy Schedule/ Certificate of Insurance shall apply in respect of that Insured Person.

B. Permanent Exclusions:

A permanent exclusion will be applied on any medical or physical condition or treatment of an Insured Person, if specifically mentioned in the Policy Schedule and has been accepted by You. This option as per company's underwriting policy, will be used for such condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person.

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

I. 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.

II. 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:

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

III. Obesity/ Weight Control (Code-Excl06)

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

- a. Surgery to be conducted is upon the advice of the Doctor.
- b. The surgery/Procedure conducted should be supported by clinical protocols.
- c. The member has to be 18 years of age or older and;
- d. Body Mass Index (BMI);
 - I. greater than or equal to 40 or
 - II. 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

IV. Change-of-Gender treatments (Code-Excl07)

Smart Health

- Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
- V. **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.
- VI. **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.
- VII. **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.
- VIII. **Excluded Providers (Code-Excl11)**
Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our 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. The complete list of excluded providers can be referred to on our website.
- IX. Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code-Excl12)**
- X. Treatments received in health 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)**
- XI. 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)**
- XII. **Refractive Error (Code-Excl15)**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.
- XIII. **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.
- XIV. **Sterility and Infertility (Code-Excl17)**
Expenses related to sterility and infertility. This includes:
 - a. Any type of contraception, sterilization
 - b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

Smart Health

- c. Gestational Surrogacy
 - d. Reversal of sterilization
- XV. **Maternity (Code-Excl18)**
- a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
 - b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
- XVI. Charges related to a Hospital stay not expressly mentioned as being covered. This will include charges for RMO charges, surcharges and service charges levied by the Hospital.
- XVII. **Circumcision**
Circumcision unless necessary for the treatment of a disease or necessitated by an Accident.
- XVIII. **Conflict & Disaster:**
Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism.
- XIX. **External Congenital Anomaly:**
Screening, counseling or treatment related to external Congenital Anomaly.
- XX. **Dental/oral treatment:**
Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident.
- XXI. **Hormone Replacement Therapy:**
Treatment for any condition / illness which requires hormone replacement therapy.
- XXII. Multifocal Lens and ambulatory devices such as walkers, crutches, splints, stockings of any kind and also any medical equipment which is subsequently used at home.
- XXIII. **Sexually transmitted Infections & diseases (other than HIV / AIDS):**
Screening, prevention and treatment for sexually related infection or disease (other than HIV / AIDS).
- XXIV. **Sleep disorders:**
Treatment for any conditions related to disturbance of normal sleep patterns or behaviors.
- XXV. Any treatment or medical services received outside the geographical limits of India unless specifically opted for Option 2 or 3 of In-patient Care and mentioned in the Policy Schedule/Certificate of Insurance.
- XXVI. Any expenses incurred on OPD treatment (unless specifically mentioned in any benefit and/or specified in Policy Schedule/Certificate of Insurance).

2.1.3 Claims Process & Requirements:

The fulfillment of the terms and conditions of this Policy (including payment of full premium in advance by the due dates mentioned in the Policy Schedule/Certificate of Insurance) in so far as

Smart Health

they relate to anything to be done or complied with by any Insured Person, including complying with the following in relation to claims, shall be Condition Precedent to admission of Our liability under this Policy.

2.1.3.1. Claims Administration:

On the occurrence or discovery of any Illness or Injury that may give rise to a claim under this Section, the Claims Procedure set out below shall be followed:

- a. The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed. We shall not be obliged to make any payment that arises out of willful failure to comply with such directions, advice or guidance.
- b. We or Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.
- c. We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.

It is hereby agreed and understood that no change in the Medical Record provided under the Medical Advice information, by the Hospital or the Insured Person to Us or Our Service Provider during the period of Hospitalization or after discharge by any means of request will be accepted by Us. Any decision on request for acceptance of change will be at Our discretion.

2.1.3.2. Claims Procedure:

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:

A. For Availing Cashless Facility: Cashless Facility can be availed only at Our Network Providers or Service 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. In order to avail Cashless Facility, the following process must be followed:

- a. Process for Obtaining Pre-Authorization
 - i. For Planned Treatment:

We must be contacted to pre-authorize Cashless Facility for planned treatment at least 72 hours prior to the proposed treatment. Once the request for pre-authorization has been granted, the treatment must take place within 15 days of the pre-authorization date at a Network Provider.
 - ii. In Emergencies

If the Insured Person has been Hospitalized in an Emergency, We must be contacted to pre-authorize Cashless Facility within 48 hours of the Insured Person's Hospitalization or before discharge from the Hospital, whichever is earlier.
 - iii. Pre-authorization through digital platform:

Pre-authorization in respect to Health Checkup, Second Medical Opinion, OPD Consultation (on Cashless Facility) can also be requested through Our mobile application or website.

Smart Health

All final authorization requests, if required, shall be sent at least six hours prior to the Insured Person's discharge from the Hospital.

Each request for pre-authorization except for Health Checkup and e-Consultation must be accompanied with completely filled and duly signed pre-authorization form including all of the following details:

- I. The health card (if applicable) We have issued to the Insured Person at the time of inception of the cover under the Policy (if available) supported with KYC document;
- II. The Policy Number;
- III. Name of the Policyholder;
- IV. Name and address of Insured Person in respect of whom the request is being made;
- V. Nature of the Illness/Injury and the treatment/Surgery required;
- VI. Name and address of the attending Medical Practitioner;
- VII. Hospital where treatment/Surgery is proposed to be taken;
- VIII. Date of admission;
- IX. First and any subsequent consultation paper/Medical Record since beginning of diagnosis of that treatment/Surgery;
- X. Admission note;
- XI. Treating Medical Practitioner certificate for disease/event history with justification of Hospitalization.

If these details are not provided in full or are insufficient for Us to consider the request, We will request additional information or documentation in respect of that request.

When We have obtained sufficient details to assess the request, We will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim, applicable Deductibles/Co-payment and non-payable items, if applicable, or reject the request for pre-authorization specifying reasons for the rejection.

In case of pre-authorization request where chronicity of condition is not established as per clinical evidence based information, We may reject the request for pre-authorization and ask the claimant to claim as Reimbursement. Claim documents submission for Reimbursement should not be considered as an admission of liability.

Once the request for pre-authorization has been granted, the treatment must take place within 15 days of the pre-authorization date and pre-authorization shall be valid only if all the details of the authorized treatment, including dates, Hospital, locations, indications and disease details, match with the details of the actual treatment received. For Cashless Facility Hospitalization, We will make the payment of the amount assessed to be due, directly to the Network Provider.

We reserve the right to modify, add or restrict any Network Provider or Service Provider for Cashless Facility in Our sole discretion. Before availing Cashless Facility, please check the applicable updated list of providers.

Smart Health

B. Re-Authorization:

Cashless Facility will be provided subject to re-authorization if requested for either change in the line of treatment or in the diagnosis or for any procedure carried out on the incidental diagnosis/finding prior to the discharge from the Hospital.

C. For Reimbursement Claims:

For all claims for which Cashless Facility have not been pre-authorized or for which treatment has not been taken at a Network Provider, We shall be informed of the claim along with the following details within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier:

- i. The Policy Number;
- ii. Name of the Policyholder;
- iii. Name and address of the Insured Person in respect of whom the request is being made;
- iv. Nature of Illness or Injury and the treatment/Surgery taken;
- v. Name and address of the attending Medical Practitioner;
- vi. Hospital where treatment/Surgery was taken;
- vii. Date of admission and date of discharge;
- viii. Any other information that may be relevant to the Illness/ Injury/ Hospitalization.

2.1.3.3. Claims Documentation:

We shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense within 30 days of the Insured Person's discharge from Hospital (in the case of Pre-hospitalization Medical Expenses and Hospitalization Medical Expenses) or within 30 days of the completion of the Post-hospitalization Medical Expenses period (in the case of Post-hospitalization Medical Expenses).

For claims for which the use of Cashless Facility has been authorised, We will be provided these documents by the Network Provider immediately following the Insured Person's discharge from Hospital:

- a. Claim form duly completed and signed by the claimant.
Please provide mandatorily following information, if applicable
 - i. Current diagnosis and date of diagnosis;
 - ii. Past history and first consultation details;
 - iii. Previous admission/Surgery if any.
- b. Age/identity proof document of the Insured Person in case of Cashless Facility claim (not required if submitted at the time of pre-authorization request) and in Reimbursement claim.
 - i. Self-attested copy of valid Age proof (passport/driving license/PAN card/class X certificate/ birth certificate);
 - ii. Self-attested copy of identity proof (passport/driving license/PAN card/voter identity card);
 - iii. Recent passport size photograph.
- c. Cancelled cheque/bank statement/copy of passbook mentioning account holder's name, IFSC code and account number printed on it of the Insured Person/Nominee (in case of death of the Insured Person).
- d. Original Hospital discharge summary.
- e. Additional documents required in case of Surgery/Surgical Procedure.
- f. Bar code sticker and invoice for implants and prosthesis (if used);
- g. Original final bill from Hospital with detailed break-up and paid receipt.

Smart Health

- h. Room tariff of the entitled room category (in case of a Non-Network Provider and if room tariff is not a part of Hospital bill): duly signed and stamped by the Hospital in which treatment is taken. (In case the Insured Person/claimant are unable to submit such document, then We shall consider the Reasonable and Customary Charges of the Insured Person's eligible room category of the Our Network Provider within the same geographical area for identical or similar services.)
- i. Original bills of pharmacy/medicines purchased, or of any other investigation done outside Hospital with reports and requisite prescriptions.
- j. Copy of death certificate (in case of demise of the Insured Person).
- k. For Medico-legal cases (MLC) or in case of Accident
- l. MLC/First Information Report (FIR) copy attested by the concerned Hospital/police station (if applicable);
- m. Original self-narration of incident in absence of MLC/FIR.
- n. Original laboratory investigation, diagnostic and pathological reports with supporting prescriptions.
- o. Original X-Ray/MRI/ultrasound films and other radiological investigations.
- p. Certificate of disability issued by a Medical Board duly constituted by the Central and/or the State Government, if available (only in case of prosthetic cover)
- q. The retail invoice of the prosthetic with the packaging (only in case of prosthetic cover)

2.1.3.4. Claims Assessment:

- a. All admissible claims under this Section shall be assessed by Us in the following progressive order:-

If the Insured Person is admitted in a Hospital room where the room category opted or Room Rent incurred is higher than the eligibility as specified in the Policy Schedule, then We shall be liable to pay only a pro-rated portion of the total Associated Medical Expenses (including surcharge or taxes thereon) as per the following formula:

$(\text{Eligible Room Rent limit} / \text{Room Rent actually incurred}) * \text{total Associated Medical Expenses}$

Proportionate deductions will not be applied If the claim is of a 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.

- i. The Deductible (if applicable) shall be applied to the aggregate of all claims that are either paid or payable under this Section. Our liability to make payment shall commence only once the aggregate amount of all eligible claims as per Policy terms and conditions exceeds the Deductible limit within the same Policy Year.
- ii. Co-payment (if applicable) as specified in the Policy Schedule/Certificate of Insurance shall be applicable on the amount payable by Us.
- b. The claim amount assessed as mentioned above would be deducted from the amount mentioned against each Benefit and Sum Insured as specified in the Policy Schedule/Certificate of Insurance. The re-fill amount will be applied only once the Base Sum Insured is exhausted in the Policy Year.

Smart Health

2.2 Fixed Benefit Coverage for Named Illnesses

If an Insured Person suffers a Named Illness specified in Policy Schedule/Certificate of Insurance during the Policy Period, We will pay the Named Illness Sum Insured specified in the Policy Schedule/Certificate of Insurance.

Conditions:

- a. The Named Illness occurs or first manifests itself during the Policy Period; and
- b. The signs or symptoms of the Named Illness commence after the completion of the specified Pre-existing Disease and initial waiting period from the date of commencement of coverage of the Insured Person under the Policy as specified in the Policy Schedule/Certificate of Insurance.
- c. Our maximum, total and cumulative liability in respect of the Insured Person under this Benefit shall be limited to the Named Illness Sum Insured.
- d. We will pay the Benefit under this Section only once per Insured Person for each Named Illness during Policy Year.
- e. Claim for a Surgical Procedure would be paid only once per Insured Person in his lifetime.

2.2.1. Section Specific Condition

All the Waiting Periods as specified in Policy Schedule/ Certificate of Insurance shall be applicable individually for each Insured Person and claims shall be assessed accordingly. On Renewal, if an enhanced Sum Insured is applied for, the Waiting Periods would apply afresh to the extent of the increase in Sum Insured only.

We shall not be liable to make any payment under this Policy directly or indirectly for, caused by, based on, arising out of or howsoever attributable to any of the following, except if any Insured Person suffers an Accident;

A. Waiting Periods

- (i) **Pre-existing Diseases (Code–Excl01):**
 - a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of the number of months (as mentioned in Policy Schedule/Certificate of Insurance) 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 number of months (as mentioned in Policy Schedule/Certificate of Insurance) for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.
- (ii) **Specified disease/procedure waiting period (Code- Excl02)**
 - a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of number of months (as mentioned in Policy

Schedule/Certificate of Insurance) of continuous coverage after the date of inception of the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident (covered from day 1).

- b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
- d. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
- e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI then waiting period for the same would be reduced to the extent of prior coverage.
- f. List of specific diseases/procedures (Below mentioned diseases/procedures can be modified and in that case the list will be mentioned in Policy Schedule/Certificate of Insurance):
 - I. Pancreatitis and stones in billiard and urinary system
 - II. Cataract, glaucoma and other disorders of lens, disorders of retina
 - III. Hyperplasia of prostate, Hydrocele and spermatocele
 - IV. Abnormal utero-vaginal bleeding, female genital prolapse, endometriosis/adenomyosis, fibroids, PCOD, or any condition requiring dilation and curettage or hysterectomy
 - V. Hemorrhoids, fissure or fistula or abscess of anal and rectal region
 - VI. Hernia of all sites,
 - VII. Osteoarthritis, systemic connective tissue disorders, dorsopathies, spondylopathies, inflammatory polyarthropathies, arthrosis such as RA, gout, intervertebral disc disorders, arthroscopic surgeries for ligament repair
 - VIII. Chronic kidney disease and failure
 - IX. Varicose veins of lower extremities
 - X. All internal or external benign or in situ neoplasms/tumours, cyst, sinus, polyp, nodules, swelling, mass or lump
 - XI. Ulcer, erosion and varices of gastro intestinal tract
 - XII. Surgical treatment for diseases of middle ear and mastoid (including otitis media, cholesteatoma, perforation of tympanic membrane), Tonsils and adenoids, nasal septum and nasal sinuses
 - XIII. Internal Congenital Anomaly
 - XIV. Surgery of Genito-urinary system unless necessitated by malignancy
 - XV. Spinal disorders

(iii) **Initial waiting period:**

- a. A Waiting Period since beginning of cover under the First Policy, specified in the Policy Schedule/ Certificate of Insurance shall apply to any Illness contracted and/or Medical Expenses incurred in respect of any Illness by the Insured Person other than Hospitalization due to Accident.

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- b. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months
- c. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

If these diseases are Pre-Existing Diseases at the time of the Proposal or subsequently found to be Pre-Existing Diseases, the Pre-Existing Disease Waiting Periods as mentioned in the Policy Schedule/ Certificate of Insurance shall apply in respect of that Insured Person.

B. Permanent Exclusions:

A permanent exclusion will be applied on any medical or physical condition or treatment of an Insured Person, if specifically mentioned in the Policy Schedule and has been accepted by You. This option as per company's underwriting policy, will be used for such condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person.

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

I. 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.

II. 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:

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

III. Obesity/ Weight Control (Code-Excl06)

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

- a. Surgery to be conducted is upon the advice of the Doctor.
- b. The surgery/Procedure conducted should be supported by clinical protocols.
- c. The member has to be 18 years of age or older and;
- d. Body Mass Index (BMI);
 - I. greater than or equal to 40 or
 - II. 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:
 - v. Obesity-related cardiomyopathy
 - vi. Coronary heart disease
 - vii. Severe Sleep Apnea
 - viii. Uncontrolled Type2 Diabetes

IV. Change-of-Gender treatments (Code-Excl07)

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- Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
- V. **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.
- VI. **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.
- VII. **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.
- VIII. **Excluded Providers (Code-Excl11)**
Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our 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. The complete list of excluded providers can be referred to on our website.
- IX. Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code-Excl12)**
- X. Treatments received in health 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)**
- XI. 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)**
- XII. **Refractive Error (Code-Excl15)**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.
- XIII. **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.
- XIV. **Sterility and Infertility (Code-Excl17)**
Expenses related to sterility and infertility. This includes:
 - a. Any type of contraception, sterilization
 - b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

Smart Health

- c. Gestational Surrogacy
 - d. Reversal of sterilization

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

- XVI. Charges related to a Hospital stay not expressly mentioned as being covered. This will include charges for RMO charges, surcharges and service charges levied by the Hospital.

- XVII. **Circumcision**
Circumcision unless necessary for the treatment of a disease or necessitated by an Accident.

- XVIII. **Conflict & Disaster:**
Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism.

- XIX. **External Congenital Anomaly:**
Screening, counseling or treatment related to external Congenital Anomaly.

- XX. **Dental/oral treatment:**
Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident.

- XXI. **Hormone Replacement Therapy:**
Treatment for any condition / illness which requires hormone replacement therapy.

- XXII. Multifocal Lens and ambulatory devices such as walkers, crutches, splints, stockings of any kind and also any medical equipment which is subsequently used at home.

- XXIII. **Sexually transmitted Infections & diseases (other than HIV / AIDS):**
Screening, prevention and treatment for sexually related infection or disease (other than HIV / AIDS).

- XXIV. **Sleep disorders:**
Treatment for any conditions related to disturbance of normal sleep patterns or behaviors.

- XXV. Any treatment or medical services received outside the geographical limits of India.

- XXVI. Any expenses incurred on OPD treatment (unless specifically mentioned in any benefit and/or specified in Policy Schedule/Certificate of Insurance).

- 2.2.2. Claims Process & Requirements:**
The fulfillment of the terms and conditions of this Policy (including payment of full premium in advance by the due dates mentioned in the Policy Schedule/Certificate of Insurance) in so far as they relate to anything to be done or complied with by any Insured Person, including complying

with the following in relation to claims, shall be Condition Precedent to admission of Our liability under this Policy.

2.2.2.1. Claims Administration:

On the occurrence or discovery of any Illness or Injury that may give rise to a claim under this Section, the Claims Procedure set out below shall be followed:

- a. The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed. We shall not be obliged to make any payment that arises out of willful failure to comply with such directions, advice or guidance.
- b. We or Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.
- c. We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.

It is hereby agreed and understood that no change in the Medical Record provided under the Medical Advice information, by the Hospital or the Insured Person to Us or Our Service Provider during the period of Hospitalization or after discharge by any means of request will be accepted by Us. Any decision on request for acceptance of change will be at Our discretion.

2.2.2.2. Claims Procedure:

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:

We shall be informed of the claim along with the following details within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier:

- i. The Policy Number;
- ii. Name of the Policyholder;
- iii. Name and address of the Insured Person in respect of whom the request is being made;
- iv. Nature of Illness or Injury and the treatment/Surgery taken;
- v. Name and address of the attending Medical Practitioner;
- vi. Hospital where treatment/Surgery was taken;
- vii. Date of admission and date of discharge;

Any other information that may be relevant to the Illness/ Injury/ Hospitalization.

2.2.2.3. Claims Documentation

We shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense within 30 days of the Insured Person's discharge from Hospital.

- a. Claim form duly completed and signed by the claimant.
Please provide mandatorily following information, if applicable
 - i. Current diagnosis and date of diagnosis;
 - ii. Past history and first consultation details;
 - iii. Previous admission/Surgery if any.

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- b. Age/identity proof document of the Insured Person.
 - i. Self-attested copy of valid Age proof (passport/driving license/PAN card/class X certificate/ birth certificate);
 - ii. Self-attested copy of identity proof (passport/driving license/PAN card/voter identity card);
 - iii. Recent passport size photograph.
- c. Cancelled cheque/bank statement/copy of passbook mentioning account holder's name, IFSC code and account number printed on it of the Insured Person/Nominee (in case of death of the Insured Person).
- d. Original Hospital discharge summary.
- e. Additional documents required in case of Surgery/Surgical Procedure.
 - i. Bar code sticker and invoice for implants and prosthesis (if used);
- f. Original final bill from Hospital with detailed break-up and paid receipt.
- g. Original bills of pharmacy/medicines purchased, or of any other investigation done outside Hospital with reports and requisite prescriptions.
- h. Copy of death certificate (in case of demise of the Insured Person).
- i. For Medico-legal cases (MLC) or in case of Accident
 - i. MLC/First Information Report (FIR) copy attested by the concerned Hospital/police station (if applicable);
 - ii. Original self-narration of incident in absence of MLC/FIR.
- j. Original laboratory investigation, diagnostic and pathological reports with supporting prescriptions.
- k. Original X-Ray/MRI/ultrasound films and other radiological investigations.

2.2.2.4. Claims Assessment

The claim would be assessed and the payout would be made as per the Sum Insured specified in the Policy Schedule/Certificate of Insurance.

2.3 Hospital Cash Benefit:

2.3.1 Coverage Options

2.3.1.1. Daily Cash Benefit

What is covered:

If an Insured Person suffers an Illness or sustains an Injury that solely and directly leads to the Insured Person's Hospitalization during the Policy Period, then We will pay the daily cash amount specified in the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization.

Conditions:

- a. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Intensive Care Unit.

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- b. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization or Maternity Expenses or New Born Baby coverage unless specifically mentioned in the Policy schedule/Certificate of Insurance.

2.3.1. 2. ICU Cash Benefit

What is covered:

If an Insured Person is required to be admitted to the Intensive Care Unit of a Hospital solely and directly due to an injury arising from an Accident or due to an Illness, then We will pay twice the Daily Cash specified in the Certificate of Insurance for each continuous and completed period of 24 hours of admission in the Intensive Care Unit.

Conditions:

- a. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Hospital room.
- b. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization or Maternity Expenses or New Born Baby coverage unless specifically mentioned in the Policy schedule/Certificate of Insurance.

2.3.1. 3. Daily Cash Benefit with Franchise

What is covered:

If an Insured Person suffers an Illness or sustains an Injury that solely and directly leads to the Insured Person's Hospitalization during the Policy Period, then We will pay the daily allowance amount specified in the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization

Conditions:

- a. The Insured Person is Hospitalized for at least the minimum period specified in the Policy Schedule/Certificate of Insurance following which the Benefit amount will be payable from the first completed day of Hospitalization.
- b. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Intensive Care Unit.
- c. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization or Maternity Expenses or New Born Baby coverage unless specifically mentioned in the Policy schedule/Certificate of Insurance.

2.3.1. 4. ICU Cash Benefit with Franchise

What is covered:

Smart Health

If an Insured Person is required to be admitted to the Intensive Care Unit of a Hospital solely and directly due to an injury arising from an Accident or due to an Illness, then We will pay twice the Daily Cash specified in the Certificate of Insurance for each continuous and completed period of 24 hours of admission in the Intensive Care Unit.

Conditions:

- a. The Insured Person is Hospitalized for at least the minimum period specified in the Policy Schedule/Certificate of Insurance following which the Benefit amount will be payable from the first completed day of Hospitalization.
- b. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Hospital room.
- c. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization or Maternity Expenses or New Born Baby coverage unless specifically mentioned in the Policy schedule/Certificate of Insurance.

2.3.1. 5. Daily Hospital Cash with Deductible

What is covered:

If an Insured Person suffers an Illness or sustains an Injury that solely and directly leads to the Insured Person's Hospitalization during the Policy Period, then We will pay the daily allowance amount specified in the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization.

Conditions:

- a. The Insured Person is Hospitalized for at least the minimum period specified in the Policy Schedule/Certificate of Insurance following which the Benefit amount will be payable for completed days of Hospitalization following the completion of the Deductible.
- b. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Intensive Care Unit.
- c. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization or Maternity Expenses or New Born Baby coverage unless specifically mentioned in the Policy schedule/Certificate of Insurance..

2.3.1. 6. Accidental Hospital Cash Benefit

What is covered:

If an Insured Person sustains an Injury that solely and directly leads to the Insured Person's Hospitalization during the Policy Period, then We will pay the Accidental Hospital Cash amount specified in the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization.

Smart Health

Conditions:

- a. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Intensive Care Unit.
- b. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization

2.3.1. 7. Accidental Hospital ICU Cash Benefit

What is covered:

If an Insured Person is required to be admitted to the Intensive Care Unit of a Hospital solely and directly due to an injury arising from an Accident, then We will pay twice the Accidental Hospital Cash specified in the Certificate of Insurance for each continuous and completed period of 24 hours of admission in the Intensive Care Unit.

Conditions:

- a. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Hospital room.
- b. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization

2.3.1. 8. Accidental Hospital Cash Benefit with Franchise

What is covered:

If an Insured Person suffers an Injury that solely and directly leads to the Insured Person's Hospitalization during the Policy Period, then We will pay the daily Accidental Hospital Cash amount specified in the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization

Conditions:

- a. The Insured Person is Hospitalized for at least the minimum period specified in the Policy Schedule/Certificate of Insurance following which the Benefit amount will be payable from the first completed day of Hospitalization.
- b. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Intensive Care Unit.
- c. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization

2.3.1. 9. Accidental Hospital ICU Cash Benefit with Franchise

What is covered:

Smart Health

If an Insured Person is required to be admitted to the Intensive Care Unit of a Hospital solely and directly due to an injury arising from an Accident, then We will pay twice the Accidental Hospital Cash Benefit specified in the Certificate of Insurance for each continuous and completed period of 24 hours of admission in the Intensive Care Unit.

Conditions:

- a. The Insured Person is Hospitalized for at least the minimum period specified in the Policy Schedule/Certificate of Insurance following which the Benefit amount will be payable from the first completed day of Hospitalization.
- b. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Hospital room.
- c. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization

2.3.1. 10. Accidental Hospital Cash Benefit with Deductible

What is covered:

If an Insured Person suffers an Injury that solely and directly leads to the Insured Person's Hospitalization during the Policy Period, then We will pay the Accidental Hospital Cash amount specified in the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization.

Conditions:

- a. The Insured Person is Hospitalized for at least the minimum period specified in the Policy Schedule/Certificate of Insurance following which the Benefit amount will be payable for completed days of Hospitalization following the completion of the Deductible.
- b. We shall not be liable to make any payment under this Benefit in excess of the maximum number of days specified in the Policy Schedule/Certificate of Insurance, including all days of admission of the Insured Person in the Intensive Care Unit.
- c. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization

2.3.2 Section Specific Conditions:

All the Waiting Periods as specified in Policy Schedule/ Certificate of Insurance shall be applicable individually for each Insured Person and claims shall be assessed accordingly. On Renewal, if an enhanced Sum Insured is applied for, the Waiting Periods would apply afresh to the extent of the increase in Sum Insured only.

We shall not be liable to make any payment under this Policy directly or indirectly for, caused by, based on, arising out of or howsoever attributable to any of the following, except if any Insured Person suffers an Accident;

C. Waiting Periods

- (i) **Pre-existing Diseases (Code-Excl01):**

- a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of the number of months (as mentioned in Policy Schedule/Certificate of Insurance) 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 number of months (as mentioned in Policy Schedule/Certificate of Insurance) for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.
- (ii) **Specified disease/procedure waiting period (Code- Excl02)**
- a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of number of months (as mentioned in Policy Schedule/Certificate of Insurance) of continuous coverage after the date of inception of the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident (covered from day 1).
 - b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
 - c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
 - d. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
 - e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI then waiting period for the same would be reduced to the extent of prior coverage.
 - f. List of specific diseases/procedures (Below mentioned diseases/procedures can be modified and in that case the list will be mentioned in Policy Schedule/Certificate of Insurance) :
 - I. Pancreatitis and stones in billiard and urinary system
 - II. Cataract, glaucoma and other disorders of lens, disorders of retina
 - III. Hyperplasia of prostate, Hydrocele and spermatocoele
 - IV. Abnormal utero-vaginal bleeding, female genital prolapse, endometriosis/adenomyosis, fibroids, PCOD, or any condition requiring dilation and curettage or hysterectomy
 - V. Hemorrhoids, fissure or fistula or abscess of anal and rectal region
 - VI. Hernia of all sites,
 - VII. Osteoarthritis, systemic connective tissue disorders, dorsopathies, spondylopathies, inflammatory polyarthropathies, arthrosis such as RA, gout, intervertebral disc disorders, arthroscopic surgeries for ligament repair
 - VIII. Chronic kidney disease and failure
 - IX. Varicose veins of lower extremities

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- X. All internal or external benign or in situ neoplasms/tumours, cyst, sinus, polyp, nodules, swelling, mass or lump
- XI. Ulcer, erosion and varices of gastro intestinal tract
- XII. Surgical treatment for diseases of middle ear and mastoid (including otitis media, cholesteatoma, perforation of tympanic membrane), Tonsils and adenoids, nasal septum and nasal sinuses
- XIII. Internal Congenital Anomaly
- XIV. Surgery of Genito-urinary system unless necessitated by malignancy
- XV. Spinal disorders

(iii) Initial waiting period:

- a. A Waiting Period since beginning of cover under the First Policy, specified in the Policy Schedule/ Certificate of Insurance shall apply to any Illness contracted and/or Medical Expenses incurred in respect of any Illness by the Insured Person other than Hospitalization due to Accident.
- b. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months
- c. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

If these diseases are Pre-Existing Diseases at the time of the Proposal or subsequently found to be Pre-Existing Diseases, the Pre-Existing Disease Waiting Periods as mentioned in the Policy Schedule/ Certificate of Insurance shall apply in respect of that Insured Person.

D. Permanent Exclusions:

A permanent exclusion will be applied on any medical or physical condition or treatment of an Insured Person, if specifically mentioned in the Policy Schedule and has been accepted by You. This option as per company's underwriting policy, will be used for such condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person.

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

I. 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.

II. 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:

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

III. **Obesity/ Weight Control (Code-Excl06)**

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

- a. Surgery to be conducted is upon the advice of the Doctor.
- b. The surgery/Procedure conducted should be supported by clinical protocols.
- c. The member has to be 18 years of age or older and;
- d. Body Mass Index (BMI);
 - I. greater than or equal to 40 or
 - II. 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

IV. **Change-of-Gender treatments (Code-Excl07)**

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

V. **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.

VI. **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.

VII. **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.

VIII. **Excluded Providers (Code-Excl11)**

Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our 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. The complete list of excluded providers can be referred to on our website.

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

Smart Health

- X. Treatments received in health 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)**
- XI. 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)**
- XII. **Refractive Error (Code-Excl15)**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.
- XIII. **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.
- XIV. **Sterility and Infertility (Code-Excl17)**
Expenses related to sterility and infertility. This includes:
 - a. Any type of contraception, sterilization
 - b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
 - c. Gestational Surrogacy
 - d. Reversal of sterilization
- XV. **Maternity (Code-Excl18)**
 - a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
 - b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
- XVI. Charges related to a Hospital stay not expressly mentioned as being covered. This will include charges for RMO charges, surcharges and service charges levied by the Hospital.
- XVII. **Circumcision**
Circumcision unless necessary for the treatment of a disease or necessitated by an Accident.
- XVIII. **Conflict & Disaster:**
Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism.
- XIX. **External Congenital Anomaly:**
Screening, counseling or treatment related to external Congenital Anomaly.
- XX. **Dental/oral treatment:**
Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident.
- XXI. **Hormone Replacement Therapy:**

Smart Health

- Treatment for any condition / illness which requires hormone replacement therapy.
- XXII. Multifocal Lens and ambulatory devices such as walkers, crutches, splints, stockings of any kind and also any medical equipment which is subsequently used at home.
- XXIII. **Sexually transmitted Infections & diseases (other than HIV / AIDS):**
Screening, prevention and treatment for sexually related infection or disease (other than HIV / AIDS).
- XXIV. **Sleep disorders:**
Treatment for any conditions related to disturbance of normal sleep patterns or behaviors.
- XXV. Any treatment or medical services received outside the geographical limits of India.
- XXVI. Any expenses incurred on OPD treatment (unless specifically mentioned in any benefit and/or specified in Policy Schedule/Certificate of Insurance).

2.3.3 Claims Process & Requirement:

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

2.3.4 Notification of Claim:

If the treatment requires Hospitalization, We must be informed immediately and in any event not later than 7 days of the date of admission.

2.3.5 Claims documentation:

We shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense within 30 days of the Insured Person's discharge from Hospital.

- Claim form duly completed and signed by the claimant.
- All reports, including all medical reports, case histories, investigation reports, treatment papers, discharge summaries. We will accept copies of the documents, verified and attested by the Hospital.
- A precise diagnosis of the treatment for which a claim is made.

2.3.6 Claims Assessment:

All admissible claims under this Policy shall be assessed by Us in the following progressive order:-

- i. The Deductible/Franchise (if applicable) shall be applied to the aggregate of all claims that are either paid or payable under this Policy. Our liability to make payment shall commence only once the aggregate amount of all eligible claims as per Policy terms and conditions exceeds the Deductible/Franchise limit within the same Policy Year.

2.4 OPD Treatment and Services:

Smart Health

We will indemnify the Reasonable and Customary Charges incurred during the Policy Period for the following OPD Treatments as specified to be applicable in the Policy Schedule/Certificate of Insurance.

2.4.1 Coverage Options

2.4.1.1. Video Consultations

We will cover Video Consultations with certified General Practitioners for the Insured. A video consultation is an out-patient consultation, which is conducted over a video call between the Insured and the General Practitioner. The insured can take the number of consultations or as per a pre-defined limit within network or outside of the network, as specified in the Policy Schedule/Certificate of Insurance.

These consultations can be booked digitally via our website, Mobile application, and/or through our call centers.

Any unutilized amount or number of consultations in one Policy Year cannot be carry forwarded to the next Policy Year.

2.4.1.2. Tele Consultations

We will cover Tele Consultations with certified General Practitioners for the Insured. A Tele consultation is an out-patient consultation, which is conducted over an audio call between the Insured and the General Practitioner. The insured can take the number of consultations or as per a pre-defined limit within network or outside of the network, as specified in the Policy Schedule/Certificate of Insurance.

These consultations can be booked digitally via our website, Mobile application, and/or through our call centers.

Any unutilized amount or number of consultations in one Policy Year cannot be carry forwarded to the next Policy Year.

2.4.1.3. Physical Consultations

We will cover Physical Consultations with certified General Practitioners for the Insured. A Physical Consultation is an out-patient consultation, which is conducted over a face-to face meeting between the Insured and the General Practitioner. The insured can take the number of consultations or as per a pre-defined limit within network or outside of the network, as specified in the Policy Schedule/Certificate of Insurance.

These consultations can be booked via our website, Mobile application, through our call centers, or/and at the doctor's clinic/hospital.

Any unutilized amount or number of consultations in one Policy Year cannot be carry forwarded to the next Policy Year.

2.4.1.4. Video Consultations with specialists

We will cover Video Consultations with Specialists for the Insured. A video consultation is an out-patient consultation, which is conducted over a video call between the Insured and the Specialist. The insured can take the number of consultations or as per a pre-defined limit within network or outside of

Smart Health

the network, with the specified specialists as mentioned in the Policy Schedule/Certificate of Insurance.

These consultations can be booked digitally via our website, Mobile application, and/or through our call centers. The type of specialists covered will be as per Annexure IV (Product Benefit Table) unless another list as specifically mentioned in the Policy Schedule/Certificate of Insurance with sub-limits, if any).

Any unutilized amount or number of consultations in one Policy Year cannot be carry forwarded to the next Policy Year.

2.4.1.5. Tele Consultations with specialists

We will cover Tele Consultations with Specialists for the Insured. A Tele consultation is an out-patient consultation, which is conducted over an audio call between the Insured and the Specialist. The insured can take the number of consultations or as per a pre-defined limit within network or outside of the network, with the specified specialists as mentioned in the Policy Schedule/Certificate of Insurance.

These consultations can be booked digitally via our website, Mobile application, and/or through our call centers. Any unutilized amount or no. of consultations in one Policy Year cannot be carry forwarded to the next Policy Year.

2.4.1.6. Physical Consultations with specialists

We will cover Physical Consultations with Specialists for the Insured. A Physical Consultation is an out-patient consultation, which is conducted over a face-to face meeting between the Insured and the Doctor. The insured can take the number of consultations or as per a pre-defined limit within network or outside of the network, with the specified specialists as mentioned in the Policy Schedule/Certificate of Insurance.

These consultations can be booked via our website, Mobile application, through our call centers, or/and at the doctor's clinic/hospital.

Any unutilized amount or number of consultations in one Policy Year cannot be carry forwarded to the next Policy Year.

2.4.1.7. Diagnostic Services

- a. The Insured Person may avail specified diagnostic tests as mentioned in the Policy Schedule/Certificate of Insurance, from Our empanelled Service Provider through its mobile application or website. The cost of diagnostic tests shall be borne by the Insured Person. However, We shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further the diagnostic tests taken from Our empanelled Service Provider is the Insured Person's absolute discretion and choice.

OR

- b. Up to a pre-set limit or/and set of specified diagnostic tests can be utilized by the Insured as mentioned by us in the Policy Schedule/Certificate of Insurance.

Smart Health

Expenses can be claimed under this Section on a Reimbursement basis or on Cashless basis as mentioned in the policy schedule/ certificate of Insurance.

Conditions:

- a. Diagnostic Tests are performed on an outpatient basis with or without local anesthetics for topical, infiltration, nerve block anesthesia –with or without any requirement of Hospitalization for less than 24 hours.

2.4.1.8. Pharmacy

The Insured Person may purchase prescription or/and over the counter pharmacies as mentioned in the Policy Schedule/Certificate of Insurance, from our empanelled Service Provider through its mobile application or website. The cost for the purchase of the medicines shall be borne by the Insured Person. However, we shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further purchase of medicines from Our empanelled Service Provider is the Insured Person's absolute discretion and choice.

OR

Up to a pre-set limit can be utilized for prescription or/and over the counter pharmacies as mentioned by us in the Policy Schedule/Certificate of Insurance. Limits for prescription based and non-prescription based utilization can be different.

2.4.1.9. OPD Procedures

The Insured Person may undergo specified OPD procedures as mentioned in the Policy Schedule/Certificate of Insurance, from Our empanelled Service Provider through its mobile application or website. The cost of diagnostic tests shall be borne by the Insured Person. However, We shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further the procedures undergone from Our empanelled Service Provider is the Insured Person's absolute discretion and choice.

OR

Up to a pre-set limit or/and set of specified procedures can be utilized by the Insured as mentioned by us in the Policy Schedule/Certificate of Insurance.

Expenses can be claimed under this Section on a Reimbursement basis or on Cashless basis as mentioned in the policy schedule/ certificate of Insurance

Conditions:

- a. OPD procedures are performed on an outpatient basis with or without local anesthetics for topical, infiltration, nerve block anesthesia –with or without any requirement of Hospitalization for less than 24 hours.

2.4.1.10. Home Health Care Services

Smart Health

The Insured person may purchase home health care services as per Annexure IV – Product Benefit Table and as mentioned in the Policy Schedule/Certificate of Insurance, from our empanelled Service Provider through its mobile application or website. The cost for the purchase of these services shall be borne by the Insured Person. However, we shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further purchase of Home Health Care Services from Our empanelled Service Provider is the Insured Person's absolute discretion and choice.

OR

We will cover up to the limit as specified by us in the Policy Schedule/Certificate of Insurance for specified health care services as per Annexure IV (Product Benefit Table) unless another list as specifically mentioned in the Policy Schedule/Certificate of Insurance with sub-limits, if any.

Conditions:

- a. The medical condition of the Insured Person must be such that the treating Medical Practitioner expects the condition to improve in a reasonable and generally predictable period of time.
- b. Treatment under this Benefit will be provided under the supervision of a Medical Practitioner to safely and effectively administer the treatment plan for the condition of the Insured Person.
- c. The amount, frequency and time period of the services under this Benefit shall be reasonable, and in agreement between treating Medical Practitioner and the Insured Person availing the service.
- d. Expenses can be claimed under this Section on a Reimbursement basis or on Cashless basis as mentioned in the policy schedule/ certificate of Insurance.

2.4.1.11. Second Medical Opinion

If the Insured Person is planning to undergo a planned Surgery or a Surgical Procedure for any Illness or Injury, the Insured Person can, at the Insured Person's choice, obtain a Second Medical Opinion during the Policy Period.

As mentioned for the Insured in the Policy Schedule/Certificate of Insurance, this option will be available as

- Within Network Only **OR**
- Combination of both within & outside Network

Conditions –

The above coverage is subject to fulfillment of following conditions:

- a) Our Service Provider is contacted seeking the Second Medical Opinion.
- b) The Second Medical Opinion will be arranged by Our Service Provider and will be based only on the information and documentation provided by the Insured Person that will be shared with the Medical Practitioner.
- c) This benefit can be availed only once by an Insured Person during a Policy Year for the same Specified Illness or planned Surgery.

Smart Health

- d) By seeking the Second Medical Opinion under this Benefit the Insured Person is not prohibited or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.
- e) The Insured Person is free to choose whether or not to obtain the Second Medical Opinion, and if obtained then whether or not to act on it in whole or in part.
- f) The Second Medical Opinion under this Benefit shall be limited to defined criteria and not be valid for any medico legal purposes.

What is not covered:

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

2.4.1.12. Vaccination Cover

The Insured person may purchase specified Vaccinations as mentioned in the Policy Schedule/Certificate of Insurance, from our empanelled Service Provider through its mobile application or website. The cost for the purchase of these services shall be borne by the Insured Person. However, we shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further purchase of Vaccination Services from Our empanelled Service Provider is the Insured Person's absolute discretion and choice.

OR

We will cover up to a pre-set limit as mentioned in the Policy Schedule/Certificate of Insurance for specified vaccinations.

Conditions:

- a. The expenses incurred are Reasonable and Customary Charges.
- b. Expenses can be claimed under this Section on a Reimbursement basis or on Cashless basis as mentioned in the policy schedule/ certificate of Insurance.

2.4.1.13. From Section 2.4.1.1 to Section 2.4.1.10 and Section 2.4.1.12 – Can either have a combined OPD limit wallet and/or can have individual limits and the same will be mentioned in the Policy Schedule/Certificate of Insurance.

2.4.1.14. What is not covered under OPD Treatments (Section 2.4.1.1 to 2.4.1.6)

- a. We will only cover the cost of consultation and all other costs or charges will not be covered.
- b. Replacing any dental appliance which is lost or stolen unless specifically mentioned in the Policy Schedule/Certificate of Insurance.
- c. Plastic surgery or cosmetic surgery unless necessary as a part of Medically Necessary Treatment and certified in writing by the attending Medical Practitioner.
- d. Cost of frames for the prescribed lenses unless specifically mentioned in the Policy Schedule/Certificate of Insurance.

Smart Health

- e. Sunglasses, unless medically prescribed by the treating Medical Practitioner.
- f. Any lenses including contact lenses unless specifically mentioned in the Policy Schedule/Certificate of Insurance.

2.4.2 Claims Process & Requirements:

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

2.4.3 Claims Documentation:

- a. Claim form duly completed and signed by the claimant.
- b. Original Bills with detailed breakup of charges (including but not limited to pharmacy, purchase bill, consultation bill, and diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become our property.
- c. Original payment receipts
- d. All reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries, OPD treatment card, consultation notes.

2.4.4 Claims Assessment & Repudiation:

All admissible claims under this Policy shall be assessed by Us post considering Co-Payment (if applicable) as specified in the Policy Schedule/ Certificate of Insurance shall be applicable on the amount payable by Us.

2.5 Accidental Cover

The Benefits offered under this Section shall be available to the Insured Person up to the Accidental Cover Sum Insured subject to any specific limits stated in the Policy Schedule/Certificate of Insurance as per the eligibility under the opted Benefits. In case of Loan Linked scenario if Outstanding Loan Cover - Accident only is opted then the Outstanding loan (only principle) shall be covered up to proportionate percentage of Opted Loan Protector Sum Insured or outstanding loan(only principle) whichever is lower.

2.5.1 Coverage Options:

2.5.1.1. Accidental Death (AD)

What is covered:

If an Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period and which solely and directly results in the Insured Person's death within three hundred and sixty five (365) days from the date of occurrence of such Accident, We will pay the Accidental Cover Sum Insured specified in the Policy Schedule/ Certificate of Insurance.

Conditions:

Smart Health

- a. We will deduct any amounts already paid under Section 2.5.1.2 (Accidental Permanent Total Disability), 2.5.1.3 (Accidental Permanent Partial Disability) and 2.5.1.4 (Temporary Total Disability) from the amount payable under this Benefit.
- b. We shall not be liable to make any payment under Section 2.5.1.1 (Accidental Death) if We have already paid or accepted any claims under Section 2.5.1.2 (Accidental Permanent Total Disability) or 2.5.1.3 (Accidental Permanent Partial Disability) or 2.5.1.4 (Temporary Total Disability) in respect of that Insured Person and the total amount paid or payable under those claims is cumulatively greater than or equal to the Sum Insured.

2.5.1.2. Accidental Permanent Total Disability (PTD)

What is covered:

If an Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period and which solely and directly results in the Insured Person's Permanent Total Disability of the nature specified in the grid below, within three hundred and sixty five (365) days from the date of occurrence of such Accident, We will make payment in accordance with the grid below.

Conditions:

- a. The Permanent Total Disability is proved with a disability certificate issued by a Medical Board duly constituted by the Central or the State Government being presented to Us;
- b. We will admit a claim under Section 2.5.1.2 only if the Permanent Total Disability continues for a continuous period of at least six (6) calendar months from the commencement of the disability and such disability is permanent at the end of this period;
- c. If the Insured Person dies before a claim has been admitted under Section 2.5.1.2, We shall not be liable to make any payment under Section 2.5.1.2;
- d. We shall not be liable to make payment under Section 2.5.1.2 in respect of an Insured Person for any and all Policy Periods more than once in the Insured Person's lifetime;
- e. We will deduct any amounts already paid under Section 2.5.1.3 (Accidental Permanent Partial Disability) or 2.5.1.4 (Temporary Total Disability) from the amount payable under this Benefit.
- f. We shall not be liable to make any payment under Section 2.5.1.2 if We have already paid or accepted any claims under Section 2.5.1.3 or 2.5.1.4 in respect of that Insured Person and the total amount paid or payable under those claims is cumulatively greater than or equal to the Sum Insured.

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Nature of Permanent Total Disability (Indicative List)	% of the Accidental Cover Sum Insured Payable
Actual loss by physical separation or total and permanent loss of use of both hands	Up to 200%
Actual loss by physical separation or total and permanent loss of use of both feet	Up to 200%
Loss of sight in both eyes	Up to 200%
Actual loss by physical separation or total and permanent loss of use of one hand and one foot	Up to 200%
Actual loss by physical separation or total and permanent loss of use of one hand and sight in one eye	Up to 200%
Actual loss by physical separation or total and permanent loss of use of one foot and sight in one eye	Up to 200%
Loss of speech and loss of hearing in both ears	Up to 200%
Permanent and incurable paralysis of all limbs	Up to 200%
Permanent total loss of mastication	Up to 200%
The Insured Person suffers Injuries which do not fall within any of the categories specified above but are such that the Insured Person is unlikely to ever be able to physically engage in any occupation or employment or business for remuneration or profit.	Up to 200%

2.5.1.3. Accidental Permanent Partial Disability(PPD)

What is covered:

If an Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period and which solely and directly results in the Insured Person's Permanent Partial Disability which is of the nature specified in the grid below, within three hundred and sixty five (365) days from the date of occurrence of such Accident, We will make payment in accordance with the grid below.

Conditions:

- The Permanent Partial Disability is proved with a disability certificate issued by a Medical Board duly constituted by the Central or the State Government being presented to Us;
- We will admit a claim under Section 2.5.1.3 only if the Permanent Partial Disability continues for a period of at least six (6) continuous calendar months from the date of commencement of the disability and such disability is continuous and permanent at the end of this period;
- If the Insured Person dies before a claim has been admitted under Section 2.5.1.3, We shall not be liable to make any payment under Section 2.5.1.3;
- If We have admitted a claim under Section 2.5.1.2, then We shall not admit any claim under Section 2.5.1.3 in respect of the Insured Person;
- We will deduct any amounts already paid under Section 2.5.1.3 (Accidental Permanent Partial Disability) and 2.5.1.4 (Accidental Temporary Total Disability) from the amount payable under this Benefit.
- We shall not be liable to make any payment under Section 2.5.1.3 (Accidental Permanent Partial Disability) if We have already paid or accepted any claims under Section 2.5.1.1 (Accidental Death) or 2.5.1.2 (Accidental Permanent Total Disability) or 2.5.1.4 (Accidental Temporary Total Disability) in respect of that Insured Person and the total amount paid or payable under those claims is cumulatively greater than or equal to the Sum Insured.

Nature of Permanent Partial Disability (Indicative List)	% of Accidental Cover Sum Insured payable
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Total and irreversible loss of hearing in both ears	50%
Total and irreversible loss of speech	50%
Actual loss by physical separation or total and permanent loss of use of one hand	50%
Actual loss by physical separation or total and permanent loss of use of one foot	50%
Total and irreversible loss of sight in one eye	50%
Actual loss by physical separation or total and permanent loss of use of four fingers and thumb of one hand	40%
Actual loss by physical separation or total and permanent loss of use of four fingers	30%
Total and irreversible loss of hearing in one ear	30%
Actual loss by physical separation or total and permanent loss of use of thumb and index finger of the same hand	25%
Actual loss by physical separation of all toes	20%
Actual loss by physical separation or total and permanent loss of use of thumb	15%
Actual loss by physical separation or total and permanent loss of use of index finger	10%
Non union of fractured leg or kneecap	10%
Shortening of leg by at least 5 cm	7.5%
Actual loss by physical separation or total and permanent loss of use of middle finger	6%
Actual loss by physical separation or total and permanent loss of use of ring finger	5%
Actual loss by physical separation or total and permanent loss of use of little finger	4%
Actual loss by physical separation of great toe (both phalanges)	5%
Actual loss by physical separation of great toe (one phalanx)	2%
Actual loss by physical separation of any toes other than the great toe, provided that more than one toe is lost	1% each
Loss of metacarpals - first or second (additional) or third, fourth or fifth (additional)	3%

2.5.1.4. Temporary Total Disability (TTD)

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period and which solely and directly results in the Insured Person's Temporary Total Disability, We will pay the lower of the Insured Person's weekly earning per week and weekly limit opted for each week that the Temporary Total Disability continues, or the amount as specified in the Policy Schedule/Certificate of Insurance.

Conditions:

- For the purpose of Section 2.5.1.4, "weekly earning" shall not include any overtime, bonuses, tips, commissions, allowances or special compensations or any components of variable pay that the Insured Person may have otherwise been eligible to receive.
- We will make payment under Section 2.5.1.4 for only a part of the week if the Insured Person has suffered Temporary Total Disability for that part of the week.

Smart Health

- c. We shall not be liable to make any payment under Section 2.5.1.4 in respect of more than 100 continuous weeks, subject always to the Accidental Cover Sum Insured.
- d. The amount payable under Section 2.5.1.4 is calculated on a per day basis and shall be payable after up to 7 continuous days of temporary disability or as mentioned in the Policy Schedule/Certificate of Insurance
- e. We will make payment of the amount due under Section 2.5.1.4 on a weekly basis unless the Temporary Total Disability continues for a continuous period of more than 30 days in which case We will make payment of the amount due under Section 2.5.1.4 at the end of every calendar month until the Temporary Total Disability ceases.
- f. We will deduct any amounts already paid under Section 2.5.1.3 (Accidental Permanent Partial Disability) from the amount payable under this Benefit.

2.5.1.5. Air Accident Death

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident occurring whilst travelling by air as a fare paying passenger on an aircraft registered to an airline company for the transport of paying passengers on regular and published scheduled routes, during the Policy Period which solely and directly results in the Insured Person's death within three hundred and sixty five (365) days from the date of occurrence of such Accident, We will make a one time payment of the amount specified in the Policy Schedule/Certificate of Insurance.

Conditions:

We will deduct any amounts already paid under Section 2.5.1.2 (Accidental Permanent Total Disability), 2.5.1.3 (Accidental Permanent Partial Disability) and 2.5.1.4 (Accidental Temporary Total Disability) from the amount payable under this Benefit.

2.5.1.6. Accidental Medical Reimbursement

Option A

What is covered:

If the Insured Person is Hospitalized solely and directly due to an Injury sustained during the Policy Period, We will indemnify the Medical Expenses incurred on Hospitalization during the Policy Period as a result of the Injury.

Conditions:

- a. We shall not be liable to make any payment under this Benefit unless a claim has been admitted under Section 2.5.1.1 (Accidental Death) or Section 2.5.1.2 (Accidental Permanent Total Disability) or Section 2.6.1.3 (Accidental Permanent Partial Disability) or 2.5.1.4 (Accidental Temporary Total Disability)

Option B-

If the Insured Person is Hospitalized solely and directly due to an Injury sustained during the Policy Period, We will indemnify the following:

- a. The Medical Expenses incurred on Hospitalization during the Policy Period as a result of the Injury;

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- b. The Medical Expenses incurred on OPD Treatment during the Policy Period as a result of the Injury.

Conditions:

- a. We shall not be liable to make any payment under this Benefit unless a claim has been admitted under Section 2.5.1.1 (Accidental Death) or Section 2.5.1.2 (Accidental Permanent Total Disability) or Section 2.5.1.3 (Accidental Permanent Partial Disability) or 2.5.1.4 (Accidental Temporary Total Disability)
- b. Our maximum, total and cumulative liability to indemnify Medical Expenses incurred on OPD Treatment under this Benefit shall be limited to 20% of the Sum Insured for this Benefit.

Option C-

What is covered:

If the Insured Person is Hospitalized solely and directly due to an Injury sustained during the Policy Period, We will indemnify the following:

- a. The Medical Expenses incurred on Hospitalization during the Policy Period as a result of the Injury;
- b. The Medical Expenses incurred on OPD Treatment during the Policy Period as a result of the Injury.

Conditions:

- a. Our maximum, total and cumulative liability to indemnify Medical Expenses incurred on OPD Treatment under this Benefit shall be limited to 20% of the Sum Insured for this Benefit.

2.5.1.7. Education Allowance for Children

What is covered:

In the event of the Insured Person's Accidental death or Permanent Total Disability during the Policy Period, We will make a onetime payment of the amount specified in the Policy Schedule/Certificate of Insurance for the education of the Insured Person's Dependent Children.

Conditions:

This Benefit shall be payable only if We have accepted a claim under Section 2.5.1.1 (Accidental Death) or 2.5.1.2 (Accidental Permanent Total Disability (PTD)).

2.5.1.8. Residential or Vehicle Modification Allowance

What is covered:

In the event of the Insured Person's Permanent Total Disability, We will reimburse, the expenses incurred up to the amount specified in the Policy Schedule/ Certificate of Insurance towards the modification of residential accommodation and the vehicle of the Insured Person to adapt to the altered lifestyle of the Insured Person necessitated by the Permanent Total Disability condition.

Conditions:

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This Benefit shall be payable only if We have accepted a claim under Section 2.5.1.2 (Accidental Permanent Total Disability (PTD)).

2.5.1.9. Family Transportation Allowance

What is covered:

If an Insured Person suffers an Injury due to an Accident which occurs during the Policy Period that solely and directly results in the Insured Person's Accidental Death or Permanent Total Disability We will indemnify the expenses incurred in respect of travel of one Immediate Family member of the Insured Person to the place where the Insured Person is located.

Conditions:

- a. No adult member of the Insured Person's Immediate Family is present within a distance of at least 150 kilometers from the place the Insured Person is located.
- b. Our panel confirms that a companion is required.
- c. Expenses can be claimed under this Section on a Reimbursement basis only.
- d. We will reimburse two-way airfare in a licensed common carrier or two-way railway tickets for the travel of the companion to the place of Hospitalization of the Insured Person.
- e. We have accepted a claim under Section 2.5.1.1 (Accidental Death) or 2.5.1.2 (Accidental Permanent Total Disability (PTD)).

For the purpose of this Benefit Immediate Family means any one of the relationships with the Insured Person: spouse, father, mother, father-in-law, mother-in-law, brother, sister-in-law, sister, brother-in-law, son or daughter.

2.5.1.10. Last rites Expenses

What is covered:

In the event of the Accidental death of the Insured Person during the Policy Period, We will make a onetime payment to the Nominee/legal heir of the Insured Person of amount specified in the Policy Schedule/Certificate of Insurance towards the funeral expenses of that Insured Person.

Conditions:

This Benefit shall be payable only if We have accepted a claim under Section 2.5.1.1 (Accidental Death).

2.5.1.11. Broken Bones

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident which solely and directly results in a fracture of the Insured Person's bones within thirty (30) days from the date of occurrence of such Accident, We will make payment in accordance with the grid below.

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Conditions:

- a. We shall not be liable to make any payment under Section 2.5.1.11 unless the fracture is medically recognized and a physician has certified in writing the extent and nature of the fracture.
- b. If an Injury results in more than one fracture specified in the grid in Policy Schedule/Certificate of Insurance, We will be liable to pay the amount payable for each such fracture, subject to availability of the Broken Bones Sum Insured specified in the Policy Schedule/Certificate of Insurance.

Nature of Fracture(Indicative List)	% of Broken Bones Sum Insured payable	
	If treated with surgery under anesthesia	It treated without surgery
Fracture of skull, vertebral column (excluding coccyx)	100%	50%
Fracture of pelvis, thigh or knee cap	50%	25%
Fracture of lower leg (excluding small bones of hand and foot, fingers and toes), ankle, arm or forearm, elbow, facial bones	30%	15%
Fractures of rib or ribs, nose, collar bone, lower jaw, shoulder bone, small bones of hand and foot (excluding fingers and toes)	10%	5%
Fractures of fingers or toes, coccyx	6%	3%

2.5.1.12. Child Wedding

What is covered:

In the event of the Insured Person's Accidental Death or Accidental Permanent Total Disability during the Policy Period, We will make a onetime payment of the amount specified in the Policy Schedule/Certificate of Insurance for the wedding expenses of the Insured Person's Dependent Children.

Conditions:

This Benefit shall be payable only if We have accepted a claim under Section 2.5.1.1 (Accidental Death) or 2.5.1.2 (Accidental Permanent Total Disability (PTD)).

2.5.1.13. Burns

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident which solely and directly results in second or third degree burns, We will make payment in accordance with the grid below.

Conditions:

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- a. If the Injury results in more than one of the descriptions in the grid below, then We shall be liable to make payment in respect of the largest description only.
- b. If an Insured Person dies or is permanently, disabled as the result of the Injury, then any amount claimed and paid to an Insured Person under this Section will be deducted from any payment made under Section 2.5.1.1 (Accidental Death) or Section 2.5.1.2 (Accidental Permanent Total Disability (PTD)).

Indicative Table of Benefits:

	Description	%of Burns Sum Insured payable
Head	a) Third degree burns of 8% or more of the total head surface area	100%
	b) Second degree burns of 8% or more of the total head surface area	50%
	c) Third degree burns of 5% or more, but less than 8% of the total head surface area	80%
	d) Second degree burns of 5% or more, but less than 8% of the total head surface area	40%
	e) Third degree burns of 2% or more, but less than 5% of the total head surface area	60%
	f) Second degree burns of 2% or more, but less than 5% of the total head surface area	30%
Rest of Body	a) Third degree burns of 20% or more of the total body surface area	100%
	b) Second degree burns of 20% or more of the total body surface area	50%
	c) Third degree burns of 15% or more, but less than 20% of the total body surface area	80%
	d) Second degree burns of 15% or more, but less than 20% of the total body surface area	40%
	e) Third degree burns of 10% or more, but less than 15% of the total body surface area	60%
	f) Second degree burns of 10% or more, but less than 15% of the total body surface area	30%
	g) Third degree burns of 5% or more, but less than 10% of the total body surface area	20%
	h) Second degree burns of 5% or more, but less than 10% of the total body surface area	10%

2.5.1.14. Medical Insurance Premium Indemnity

What is covered:

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In the event of the Insured Person's Accidental Death during the Policy Period, We will pay in lump sum the cost of the medical insurance premiums for the Insured Person's surviving spouse and Dependent Children up to the amount stated in the Policy Schedule/Certificate of Insurance per year for up to the number of years stated in the Policy Schedule/ Certificate of Insurance.

Conditions:

This Benefit shall be payable only if We have accepted a claim under Section 2.5.1.1 (Accidental Death).

2.5.1.15. Physiotherapy charges following Accidental Injury

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident during the Policy Period, We will pay the Reasonable and Customary Charges up to limit as specified in the Policy Schedule/ Certificate of Insurance incurred on physiotherapy for the Insured Person's Injury

Conditions:

- a. This Benefit shall be payable only if We have accepted a claim under Section 2.5.1.2 (Accidental Permanent Total Disability (PTD)), 2.5.1.3 (Permanent Partial Disablement (PPD)) or 2.5.1.4 (Total Temporary Disablement (TTD)) in respect of the same Injury.
- b. The physiotherapy is Medically Necessary Treatment.

2.5.1.16. Chauffeur Benefit

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident during the Policy Period, We will indemnify the expenses incurred up to the limit specified in the Policy Schedule/Certificate of Insurance as a monthly allowance for the hire of a taxi or chauffeur driven car or other necessarily incurred extra costs to maintain the Insured Person's mobility to meet his/her business commitments.

Conditions:

- a. This Benefit shall be payable only if We have accepted a claim under Section 2.5.1.2 (Accidental Permanent Total Disability (PTD)), 2.5.1.3 (Permanent Partial Disablement (PPD)) or 2.5.1.4 (Total Temporary Disablement (TTD)) in respect of the same Injury.
- b. We shall not be liable to make any payment under this Benefit in excess of the period specified in the Policy Schedule/Certificate of Insurance.

2.5.1.17. Reconstructive Surgery

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period and which requires Reconstructive Surgery within six (6) months of the date of the

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Accident, then We will pay the actual costs of such Reconstructive Surgery up to the limit specified in the Policy Schedule/ Certificate of Insurance.

Conditions:

- For the purpose of this Benefit the Reconstructive Surgery means surgery to reconstruct cutaneous or underlying tissue, prescribed as necessary by a Medical Practitioner.
- The Benefit under this option shall be payable only if the Claim under Section 2.5.1.2 (Accidental Permanent Total Disability (PTD)) or 2.5.1.3 (Permanent Partial Disablement (PPD)) is admitted by Us.

What is not covered:

We shall not be liable to make any payment in respect of any Insured Person for:

- Any Reconstructive Surgery not performed by a fully registered and licensed cosmetic surgeon.
- Any Reconstructive Surgery an Insured Person elects to have and is not medically necessary.

2.5.1.18. Air Ambulance for Accidental Injuries

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period We will, on a Reimbursement basis, pay the Reasonable and Customary Charges incurred towards transportation of the Insured Person to the nearest Hospital by an air ambulance or to move the Insured Person to and from healthcare facilities during an Emergency within India only up to the limit specified in the Policy Schedule/Certificate of Insurance.

Conditions:

- i. We have accepted any claims under Sections 2.5.1.1 (Accidental Death) or 2.5.1.2 (Accidental Permanent Total Disability) in respect of that Insured Person.
- ii. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is injured to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital with advanced facilities as advised by the treating Medical Practitioner for management of the current Hospitalization.
- iii. This Benefit is available for one transfer per Accident.
- iv. The ambulance service is offered by a healthcare or ambulance Service Provider
- v. The transportation should be provided by medically equipped aircraft which can provide medical care in flight and should have medical equipment's vital to monitoring and treating the Insured Person suffering from an Illness/Injury such as but not limited to ventilators, ECG's, monitoring units, CPR equipment and stretchers.

2.5.1.19. Comatose Benefit

What is covered:

Smart Health

If the Insured Person suffers an Injury solely and directly due to an Accident which directly and independently of all other causes results in the Insured Person being in a Hospital in a Comatose State, within thirty (30) days of the Accident, then We will pay the amount specified in the Policy Schedule/Certificate of Insurance.

Conditions:

- 1) The Insured Person must be in the Hospital Intensive Care Unit for the duration of the Comatose State for any benefits to be payable.
- 2) The comatose state must continue for up to 90 days (as specified in the Policy Schedule/Certificate of Insurance) or more for this Benefit to be payable.
- 3) Our liability to make payment will be in excess of number of days as mentioned in Policy Schedule. In case of successive Comatose State with less than ten (10) days between each one for a same cause, the Deductible will only apply once, as the Comatose State will be deemed as one.
- 4) The maximum payout of this Benefit will be up to 52 weeks from the Accident in case of option 2 (as per the PBT).

For the purpose of this Benefit, Comatose State means a state of profound unconsciousness, characterized by the absence of spontaneous eye openings, response to painful stimuli, and vocalization.

2.5.1.20. Common Accident

What is covered:

If the Insured Person and his or her spouse sustain Injury in the same Accident during the Policy Period which, directly and independently of all other causes, results in the death of both (the Insured Person and the spouse) within three sixty five (365) days of the date of the Accident, then We will pay two (2) times the Accidental Death Sum Insured applicable to the Insured Person.

Conditions:

1. The Benefit under this option shall be payable only if a claim under Section 2.5.1.1 (Accidental Death) is admitted by Us.

2.5.1.21. Repatriation of Mortal Remains

What is covered:

We will cover the costs associated with the transportation of mortal remains of the Insured Person during the Policy Period from the place of death to the home country. In addition, assistance will be provided by Us (up to the defined limit specified in the Policy Schedule/Certificate of Insurance) or Our Service Provider for organizing or obtaining the necessary clearances for the repatriation of mortal remains.

Conditions:

- Claim is admissible under Section 2.5.1.1(Accidental Death)

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2.5.1.22. Rehabilitation cover

We will indemnify the Medical Expenses incurred during the Policy Period up to limit as specified in the Policy Schedule/ Certificate of Insurance incurred on rehabilitation for the Insured Person

Conditions:

- a. This Benefit shall be payable only if We have accepted a claim under Section 2.5.1.2 (Accidental Permanent Total Disability (PTD)), 2.5.1.3 (Permanent Partial Disablement (PPD)) or 2.5.1.4 (Total Temporary Disablement (TTD)) in respect of the same Injury.
- b. The Rehabilitation is Medically Necessary Treatment
- c. It can be availed on both OPD and IPD basis or as mentioned in the Policy Schedule/Certificate

Specific Definitions

Rehabilitation means:

- a. treatment by a therapist licensed, registered, or certified to provide such treatment; or
- b. treatment in an institution which is licensed to provide such treatment, when the treatment is intended to prepare the Insured Person for work in any gainful occupation, including the Insured Person's regular occupation

2.5.1.23. Ambulance Charges

If during the Period of Insurance, an Insured Person sustains Bodily Injury then the Company agrees to pay the actual ground ambulance costs incurred by the Insured Person up to the Limit stated in the Policy Schedule/Certificate of Insurance, for transportation to the nearest Hospital where adequate care can be provided

2.5.1.24. Evacuation Benefit

If during the Period of Insurance an Insured Person is Evacuating from the building that is the Primary Insured Person's place of employment and sustains Bodily Injury in the Evacuation which directly and independently of all other causes results in death or disablement within twelve (12) months of the Evacuation, then the Company agrees to pay the Compensation stated in the Policy Schedule/Certificate of Insurance.

Specific Definitions

Evacuating/ Evacuation means an emergency exit due to a fire, a fire alarm, a bomb scare (whether there is a bomb or not), or an armed attack on the building or the people in the building.

2.5.1.25. Animal Attack

If during the Period of Insurance, an Insured Person sustains Bodily Injury as the result of an attack by an Animal and is hospitalized for seventy-two (72) continuous hours, then the Company agrees to pay to the Insured Person the Total Sum Insured stated in the Schedule.

Specific Definition

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Animal means any four (4) limbed animal that is not an insect or reptile.

2.5.1.26. Parental Care Benefit

If during the Period of Insurance an Insured Person sustains Bodily Injury which directly and independently of all other causes results in Death within twelve (12) months of the Date of Loss, then the Company agrees to pay the Compensation shown in the Policy Schedule/Certificate of Insurance in equal shares to each Dependent Parent of the Insured Person.

Specific Definitions

Dependent Parent means the parents of the Insured Person or the Insured Person's Spouse. A Dependent Parent is eligible for this benefit if he or she, at the time of the Bodily Injury, is receiving support and care provided by the Insured Person or Spouse.

2.5.1.27. Family Counseling

If during the Period of Insurance an Insured Person sustains Bodily Injury which directly and independently of all other causes results in Death within twelve (12) months of the Date of Loss, then the Company agrees to pay the actual costs for professional counseling for the Insured Person's Spouse and Dependent Child up to the Compensation stated in the Policy Schedule/Certificate of Insurance

Specific Extensions

1. Disappearance: In the event of the disappearance of the Insured Person, following a forced landing, stranding, sinking or wrecking of a conveyance in which such Insured Person was known to have been travelling as an occupant, it shall be deemed after twelve (12) months, subject to all other terms and conditions of this Policy, that such Insured Person shall have died as the result of an Accident. If at any time, after the payment of a benefit under this Section, it is discovered that the Insured Person is still alive, then all payments shall be reimbursed in full to the Company.

2. Exposure: Death as a direct result of exposure to the elements shall be deemed to be Bodily Injury.

Specific Conditions

1. The total Sum Insured is the total amount payable for the Spouse and Dependent Child combined, not per person.

2.5.1.28. Home Tutor Expenses – Weekly

If during the Period of Insurance an insured Dependent Child sustains Bodily Injury (starting during the Period of Insurance) which directly and independently of all other causes results in Temporary Total Disablement, then the Company agrees to pay Home Tuition Fees per Day up to the amount stated in the Policy Schedule/Certificate of Insurance, for up to the maximum number of weeks stated in the Policy Schedule/Certificate of Insurance.

Specific Conditions

1. In the event of a dispute arising as to when Temporary Total Disablement ceased, the date shall be finally determined by a Physician commissioned by the Company who certifies:

- a. the date upon which the Insured Person recovered; or
- b. the date upon which the Insured Person recovered as far as he/she ever will; or
- c. the date from which the Insured Person is declared to have suffered Permanent Total Disablement;

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2. The benefit shall not in any event exceed the Total Sum Insured or the Maximum Number of Weeks as stated in the Schedule.

3. If an Insured Person has other insurance against a loss covered by this Section, then the Company shall not be liable for a greater proportion of the loss than the applicable benefit under this Section bears to the total applicable benefit under all such insurance.

Specific Definitions

1. Temporary Total Disablement means disablement which temporarily and entirely prevents an Insured Person from attending full time education at an accredited tertiary educational institution.

2. Home Tuition Fees means the costs for a fully registered and licensed teacher to continue the education of the Insured Person at home during Temporary Total Disablement.

2.5.1.29. Assault

If during the Period of Insurance an Insured Person sustains Bodily Injury that results in death or permanent disablement, as a result of or arising from Assault, then the Company agrees to pay to the Insured Person or the Insured Person's Beneficiary or legal representatives the increased amount of the Accidental death or permanent disablement Total Sum Insured stated under this Section in the Policy Schedule/Certificate of Insurance..

Specific Conditions

All Specific Extensions, Specific Provisions, Specific Conditions, Specific Definitions, Specific Claims Provisions and Specific Exclusions shall also apply to this Section for each benefit to which it attaches.

Specific Definitions

Assault means any willful or unlawful use of force inflicted upon an Insured Person that is a criminal offence in the jurisdiction in which it occurs and which results in Bodily Injury to an Insured Person.

Specific Exclusions

The Company shall not be liable to pay any benefit in respect of any Insured Person for an act of Assault by an Immediate Family Member.

2.5.1.30. EMI Cover

If during the Period of Insurance an Insured Person sustains Bodily Injury that results in Permanent Total Disability or Permanent Partial Disability as per Section 2.5.1.2 and Section 2.5.1.3 respectively. The EMI for maximum up to 12 months will be considered as pay out. The Actual EMI amount on the said Loan will be considered or the specified limit in the Policy Schedule/Certificate of Insurance, whichever is lower at the time of payment of the benefit. The EMI has to be in the name of the Insured Proposer.

2.5.1.31. Loss of Job

If during the Period of Insurance an Insured Person sustains Bodily Injury which directly and independently of all other causes results in death or disablement within twelve (12) months of the Date of Loss, then the Company agrees to pay to the Insured the amount specified in the Policy Schedule/Certificate of Insurance up to a maximum of 12 months.

2.5.2 Section specific Exclusions:

We shall not be liable to make any payment under any benefits under Section Personal Accident Cover if the claim is attributable to, or based on, or arises out of, or is directly or indirectly connected to any of the following:

- a. Suicide or self inflicted Injury, whether the Insured Person is medically sane or insane.
- b. Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism.
- c. Any change of profession after inception of the Policy or any Renewal which results in the enhancement of Our risk, if not accepted and endorsed by Us on the Policy Schedule.
- d. Committing an assault, a criminal offence or any breach of law with criminal intent.
- e. Taking or absorbing, accidentally or otherwise, any intoxicating liquor, drug, narcotic, medicine, sedative or poison, except as prescribed by a Medical Practitioner other than the Policyholder or an Insured Person.
- f. Participation in aviation/marine activities (including crew) other than as a passenger in an aircraft/water craft that is authorized by the relevant regulations to carry such passengers between established airports or ports.
- g. Engaging in or taking part in professional/adventure sports or any hazardous pursuits, speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving, polo, snow and ice sports, hunting.
- h. Body or mental infirmity or any Illness except where such condition arises directly as a result of an Accident during the Policy Period. However this exclusion is not applicable to claims made under Section of Permanent Partial Disability.

2.5.3 Claims Process and Requirements:

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.

2.5.4 Claims Procedure:

- a. Written notice of any occurrence which may give rise to a claim under this Policy must be given to Us as soon as practicable and in any case within thirty (30) Days after such occurrence. Written notice of claim must be given to Us immediately in the case of death, or within thirty (30) Days after the Date of Loss in all other cases.
- b. All certificates, information and evidence required by Us shall be furnished at no expense to Us and shall be in such form and of such nature as We may prescribe. When required by Us, at its own expense, You/Insured Person shall submit to medical examination in respect of any alleged claim that may give rise to a Benefit being paid.

2.5.5 Claims Documentation:

Complete, written proof of loss must be given to Us within sixty (60) Days after the Date of Loss, or as soon as reasonably possible.

- a. **Accidental Death**
 - i. Duly filled and signed claim form and Age / identity proof documents

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- ii. Copy of Death Certificate (issued by the office of Registrar of Births and Deaths or any other authorized legal institution)
 - iii. Copy of First Information Report (FIR) /Panchnama, if applicable
 - iv. Copy of Medico Legal Certificate duly attested by the concerned Hospital, if applicable.
 - v. Copy of Hospital record, if applicable
 - vi. Copy of post mortem report wherever applicable
- b. Accident Permanent Total Disability**
- i. Duly filled and signed claim form and Age / identity proof documents
 - ii. Hospital discharge summary (in original) / self attested copies if the originals are submitted with another insurer.
 - iii. Final Hospital bill (in original) / self attested copies if the originals are submitted with another insurer.
 - iv. Medical consultations and investigations done from outside the Hospital.
 - v. Certificate of Disability issued by a Medical Board duly constituted by the Central and/or the State Government.
 - vi. Copy of First Information Report (FIR) / Panchnama if applicable
 - vii. Copy of Medico Legal Certificate duly attested by the concerned Hospital, if applicable.
- c. Accident Permanent Partial Disability**
- i. Duly filled and signed claim form and Age / identity proof documents
 - ii. Hospital discharge summary (in original) / self attested copies if the originals are submitted with another insurer.
 - iii. Final Hospital bill (in original) / self attested copies if the originals are submitted with another insurer.
 - iv. Medical consultations and investigations done from outside the Hospital.
 - v. Certificate of Disability issued by a Medical Board duly constituted by the Central and/or the State Government.
 - vi. Copy of First Information Report (FIR) /Panchnama if applicable
 - vii. Copy of Medico Legal Certificate duly attested by the concerned Hospital, if applicable.
- d. Accidental Temporary Total Disability**
- i. Duly filled and signed claim form
 - ii. Hospital discharge summary (in original) / self attested copies if the originals are submitted with another insurer.
 - iii. Copy of First Information Report (FIR) /Panchnama / Inquest report duly attested by the concerned police station
 - iv. Copy of Medico Legal Certificate duly attested by the concerned hospital.
 - v. Attendance record of employer / Certificate of employer confirming period of absence
 - vi. Latest salary certificate with grade and designation
 - vii. Newspaper cuttings / news articles covering the Accident(if available)
- e. Accidental Medical Expenses**
1. In addition to the documents required for the Accidental Death, Accidental Permanent Total Disability, Accidental Permanent Partial Disability or Temporary Total Disability Benefits

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2. Final Hospital bill with receipt /copies attested by other insurer if the originals are submitted with them.
3. Original bills with supporting prescriptions and reports for investigations done outside the Hospital/ copies attested by other insurer if the originals are submitted with them.
4. Original bills with supporting prescriptions for medicines purchased from outside the Hospital / copies attested by other insurer if the originals are submitted with them.

f. Residential Accommodation and Vehicle Modification Allowance

1. Duly filled and signed claim form
2. Documents required for Accidental Permanent Total Disability (if not already submitted)
3. Bills for residential accommodation or vehicle modification.
4. Narration from architect / civil engineer / affidavit from the customer detailing the modifications done to the house.
5. Narration from vehicle workshop detailing the modifications done.

g. Family Transportation

1. Duly filled and signed claim form
2. Documents required for Accidental Death or Accidental Permanent Total Disability Benefits (if not already submitted)
3. Copy of ticket and invoice
4. Copy of boarding pass (if journey performed by air)

h. Last Rites

1. Duly filled and signed claim form
2. Documents required for Accidental Death Benefit (if not already submitted)

i. Broken bones cover

1. Duly filled and signed claim form
2. Hospital discharge summary (in original) / self attested copies if the originals are submitted with another insurer / consultation notes (if hospitalization has not occurred)
3. X-Ray and MRI films along with reports
4. Copy of First Information Report (FIR) /Panchnama / Inquest report duly attested by the concerned police station
5. Copy of Medico Legal Certificate (MLC) duly attested by the concerned hospital.
6. Narration of events of Accident if no FIR / MLC available
7. Newspaper cuttings / news articles covering the Accident (if available)

j. Education Allowance for Children/ Child Wedding:

1. Duly filled and signed claim form
2. Documents required for Accidental Death or Accidental Permanent Total Disability Benefits (if not already submitted)
3. Letter from employer or group administrator confirming the number of children of Insured Person.

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Any benefit that has been linked to Accidental Death, Disabilities, please share the relevant section documents along with additional documents required, if any.

2.5.6 Claims Assessment & Repudiation:

The claim amount assessed as mentioned above would be deducted from the amount mentioned against each Benefit and Sum Insured as specified in the Policy Schedule/Certificate of Insurance.

2.6 Critical illness Cover:

What is covered:

We will pay the amount specified in the Policy Schedule/Certificate of Insurance if the Insured Person is diagnosed with Critical Illness which is part of the selected option (as mentioned in Policy Schedule/Certificate of Insurance) during the Policy/Coverage Period or the Critical Illness first manifests itself in the Insured Person during the Policy Period. In case of Loan Linked scenario if Outstanding Loan Cover – Critical Illness only is opted then the Outstanding loan (only principle) shall be covered up to proportionate percentage of Opted Loan Protector Sum Insured or outstanding loan (only principle) whichever is lower.

Conditions:

- a. We shall not be liable to make any payment under this Benefit if the Insured Person does not survive the Survival Period specified in the Policy Schedule/Certificate of Insurance.
- b. We will not make payment under this Policy in respect of an Insured Person and for any and all Policy Period more than once in the Insured Person's lifetime. In any Policy Period a claim can be triggered for one life only except in co-applicants/ spouse option wherein the claim can be triggered for both the lives in the same Policy Period.
- c. The diagnosis of a Critical illness must be verified by a Medical Practitioner.
- d. The list of applicable Critical Illnesses for the Insured Person is provided in the Policy Schedule/Certificate of Insurance.

2.6.1 For the purpose of Section 2.6, 'Critical Illness' means the following illnesses:

1. Cancer of Specified Severity

- I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
- II. The following are excluded –
 - i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown 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;

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- 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

- 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).
- I. 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.
 - II. This excludes:
 - Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

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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

- I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.
- II. The following are excluded:
 - i. Transient ischemic attacks (TIA)
 - ii. Traumatic injury of the brain
 - iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

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 Neuron Disease with Permanent Symptoms

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

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.

12. Benign Brain Tumor

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

13. Blindness

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

14. Deafness

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

15. End Stage Lung Failure

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

16. End Stage Liver Failure

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

17. Loss of Speech

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

18. Loss of Limbs

- I. The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

19. Major Head Trauma

- I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The Accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.
- II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.
- III. The Activities of Daily Living are:
 - i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

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- ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
 - iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
 - iv. Mobility: the ability to move indoors from room to room on level surfaces;
 - v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
 - vi. Feeding: the ability to feed oneself once food has been prepared and made available.
- IV. The following are excluded:
- i. Spinal cord injury;

20. Primary (Idiopathic) Pulmonary Hypertension

- I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Catheterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.
- II. The NYHA Classification of Cardiac Impairment are as follows:
 - i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
 - ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.
- III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

21. Third Degree Burns

- I. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

22. Fulminant Viral Hepatitis

- I. A sub-massive to massive necrosis of the liver by any virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:
 - i. rapid decreasing of liver size as confirmed by abdominal ultrasound ; and
 - ii. necrosis involving entire lobules, leaving only a collapsed reticular framework (histological evidence is required) ; and
 - iii. rapid deterioration of liver function tests; and
 - iv. deepening jaundice; and
 - v. hepatic encephalopathy.
- II. This excludes:
 - i. Hepatitis infection or carrier status alone does not meet the diagnostic criteria.
 - ii. Fulminant Viral Hepatitis caused by alcohol, toxic substance or drug.

23. Aplastic Anaemia

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- I. Aplastic Anaemia is chronic persistent bone marrow failure. A certified hematologist must make the diagnosis of severe irreversible aplastic anaemia. There must be permanent bone marrow failure resulting in bone marrow cellularity of less than 25% and there must be two of the following:
 - i. Absolute neutrophil count of less than 500/mm³
 - ii. Platelets count less than 20,000/mm³
 - iii. Reticulocyte count of less than 20,000/mm³

The Insured Person must be receiving treatment for more than 3 consecutive months with frequent blood product transfusions, bone marrow stimulating agents, or immunosuppressive agents or the Insured Person has received a bone marrow or cord blood stem cell transplant. Temporary or reversible Aplastic Anaemia is excluded and not covered under this Policy

24. Muscular Dystrophy

- I. A group of hereditary degenerative diseases of muscle characterised by weakness and atrophy of muscle based on three (3) out of four (4) of the following conditions:
 1. Family history of other affected individuals;
 2. Clinical presentation including absence of sensory disturbance, normal cerebro-spinal fluid and mild tendon reflex reduction;
 3. Characteristic electromyogram; or
 4. Clinical suspicion confirmed by muscle biopsy.
- II. The diagnosis of muscular dystrophy must be unequivocal and made by a consultant neurologist.
- III. The condition must result in the inability of the Life Insured to perform (whether aided or unaided) at least 3 of the following 6 "Activities of Daily Living" for a continuous period of at least 6 months.

Activities of Daily Living are defined as:

- a. Washing : the ability to maintain an adequate level of cleanliness and personal hygiene
- b. Dressing : the ability to put on and take off all necessary garments, artificial limbs or other surgical appliances that are Medically Necessary
- c. Feeding : the ability to transfer food from a plate or bowl to the mouth once food has been prepared and made available
- d. Toileting : the ability to manage bowel and bladder function, maintaining an adequate and socially acceptable level of hygiene
- e. Mobility : the ability to move indoors from room to room on level surfaces at the normal place of residence
- f. Transferring: the ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa

25. Bacterial Meningitis

Bacterial infection resulting in inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit.

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- I. The neurological deficit must persist for at least 3 months.
- II. This diagnosis must be confirmed by:
- III. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
- IV. A consultant neurologist.
- V. This excludes:
Bacterial Meningitis in the presence of HIV infection is excluded.

26. Abdominal Aortic Aneurysm

The actual undergoing of surgery for abdominal aortic aneurysm, needing excision and surgical replacement of the diseased part of the aorta with a graft.

- i. The term "aorta" means the thoracic and abdominal aorta but not its branches.
- ii. A cardiologist must confirm the diagnosis and realization of surgery
- iii. Surgery performed using only minimally invasive or intra-arterial techniques are excluded.

27. Pneumonectomy

The undergoing of surgery on the advice of a consultant medical specialist to remove an entire lung due to any physical injury or disease.

- I. The following conditions are excluded:
 - i. Removal of a lobe of the lungs (lobectomy)
 - ii. Lung resection or incision

28. Apallic Syndrome

Universal necrosis of the brain cortex with the brainstem remaining intact.

- I. The Diagnosis must be definitely confirmed by a Registered Medical Practitioner, who is also a Neurologist holding such an appointment at an approved hospital.
- II. This condition must be documented for at least 30 days with no hope of recovery.

29. Aortic Dissection

The actual undergoing of surgery for aortic dissection, needing excision and surgical replacement of the diseased part of the aorta with a graft.

- I. The term "aorta" means the thoracic and abdominal aorta but not its branches.
- II. A cardiologist must confirm the diagnosis and realization of surgery.
- III. This excludes:
 - i. Surgery performed using only minimally invasive or intra-arterial techniques are excluded

30. Severe Rheumatoid Arthritis

The unequivocal diagnosis of Severe Rheumatoid Arthritis with all of the following factors:

- I. Is in accordance with the criteria on Rheumatoid Arthritis of the American College of Rheumatology and has been diagnosed by the Rheumatologist.
- II. At least 3 joints are damaged or deformed such as finger joint, wrist, elbow, knee joint, hip joint, ankles, cervical spine or feet toe joint as confirmed by clinical and radiological evidence and cannot perform at least 3 types of daily routines permanently for at least 180 days.

31. Progressive Scleroderma

A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs.

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- I. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.
- II. The following conditions are excluded: Localized scleroderma (linear scleroderma or morphea); Eosinophilic fasciitis; and CREST syndrome.

32. Loss of Independent Existence

Loss of Independent Existence Confirmation by a Consultant Physician of the loss of independent existence due to illness or trauma, lasting for a minimum period of 6 months and resulting in a permanent inability to perform at least three (3) of the following Activities of Daily Living activities either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent", shall mean beyond the scope of recovery with current medical knowledge and technology.

Activities of Daily Living :

1. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
2. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Mobility: the ability to move indoors from room to room on level surfaces;
5. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
6. Feeding: the ability to feed oneself once food has been prepared and made available.

33. Systematic Lupus Erythematosus with Renal Involvement

- I. Multi-system, auto immuno disorder characterized by the development of auto-antibodies, directed against various self-antigens. For purposes of the definition of "Critical Illness", SLE is restricted to only those forms of systemic lupus erythematosus, which involve the kidneys and are characterized as Class III, Class IV, Class V or Class VI lupus nephritis under the Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS) classification of lupus nephritis (2003) below based on **renal biopsy**. There must be positive antinuclear antibody test.
- II. Other forms such as discoid lupus, and those forms with only hematological and joint involvement are specifically excluded.

Abbreviated ISN/RPS classification of lupus nephritis (2003):

- Class I - Minimal mesangial lupus nephritis
- Class II - Mesangial proliferative lupus nephritis
- Class III - Focal lupus nephritis
- Class IV - Diffuse segmental (IV-S) or global (IV-G) lupus nephritis
- Class V - Membranous lupus nephritis
- Class VI - Advanced sclerosis lupus nephritis the final diagnosis must be confirmed by a certified doctor specializing in Rheumatology and Immunology

34. Parkinson's Disease

- I. The unequivocal diagnosis of progressive degenerative primary idiopathic Parkinson's disease (all other forms of Parkinsonism are excluded) made by a consultant neurologist.
- II. This diagnosis must be supported by all of the following conditions:
 - The disease cannot be controlled with medication; **and**

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- Objective signs of progressive impairment; **and**
- There is an inability of the Life assured to perform (whether aided or unaided) at least 3 of the following 6 “Activities of Daily Living” for a continuous period of at least 6 months.

The Activities of Daily Living are:

1. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
2. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Mobility: the ability to move indoors from room to room on level surfaces;
5. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
6. Feeding: the ability to feed oneself once food has been prepared and made available

Section i(c) of 2.7.4 of Specific Exclusions shall not apply to the extent this condition is applicable

- III. The following is excluded :
 - a. Drug-induced or toxic causes of Parkinsonism are excluded.

35. Alzheimer's Disease

- I. Progressive and permanent deterioration of memory and intellectual capacity as evidenced by accepted standardised questionnaires and cerebral imaging.
- II. The diagnosis of Alzheimer’s disease must be confirmed by an appropriate consultant and supported by the Company’s appointed doctor.
- III. There must be significant reduction in mental and social functioning requiring the continuous supervision of the life assured.
- IV. There must also be an inability of the Life Assured to perform (whether aided or unaided) at least 3 of the following 6 “Activities of Daily Living” for a continuous period of at least 3 months:

Activities of Daily Living are defined as:

1. Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
2. Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring – the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Toileting – the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
5. Feeding – the ability to feed oneself once food has been prepared and made available.
6. Mobility - the ability to move from room to room without requiring any physical assistance.

- V. The following are excluded:
 - a. Any other type of irreversible organic disorder/dementia
 - b. Non-organic disease such as neurosis and psychiatric illnesses; and
 - c. Alcohol-related brain damage.

Section i(c) of 2.7.4 of Specific Exclusions shall not apply to the extent this condition is applicable

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36. Uterine Rupture

A (spontaneous) full-thickness disruption of the uterine wall that also involves the overlying visceral peritoneum which results in clinically significant uterine bleeding and expulsion of uterine content into abdominal cavity, (also in pregnant women associated fetal distress) and requires a prompt cesarean delivery or uterine repair or hysterectomy.

- I. A waiting period of 10 months is applicable for this Illness.
- II. This excludes uterine scar rupture caused due to a preexisting scarred Uterus due to previous LSCS or any other uterine surgery that is before the inception of the Policy.

Section vii (e) of the Section 2.7.4 of Specific Exclusions shall not apply to the extent this benefit is applicable

37. Uterine inversion

The actual surgery for the treatment of uterine inversion in which the corpus (body of uterus) turns inside out and protrudes into the vagina or beyond the introitus, as a result of cause of excessive pressure on the fundus during delivery of the placenta, a flaccid uterus, or placenta accreta (abnormally adherent placenta).

- i. The diagnosis and requirement of surgery must be confirmed medically necessary clinically by a registered obstetrician
- ii. This benefit shall be available only as onetime benefit
- iii. A waiting period of 10 months is applicable for this Illness.

Section vii (e) of the Section 2.7.4 of Specific Exclusions shall not apply to the extent this benefit is applicable.

38. Medullary Cystic Kidney Disease

Medullary Cystic Kidney Disease where the following criteria are met:

- I. the presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;
- II. clinical manifestations of anaemia, polyuria, renal loss of sodium progressing to deterioration in kidney function; and
- III. the Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.
- IV. This excludes:
 - i. Isolated or benign kidney cysts.

39. Pituitary apoplexy in pregnancy

Pituitary apoplexy in pregnancy is abrupt destruction of pituitary tissue resulting from infarction or hemorrhage into the pituitary in women without any pre-existing pituitary lesion but where the pituitary is physiologically enlarged as a result of pregnancy.

The realization of the diagnosis must be established by a registered neurosurgeon or neurologist with investigations including but not limited to MRI scan of the brain.

- I. This include treatment surgical and/or medical treatment under registered medical practitioner and neurosurgeon
- II. A waiting period of 10 months is applicable for this Illness

Section vii (e) of the Section 2.7.4 of Specific Exclusions shall not apply to the extent this Benefit is applicable

40. Cardiomyopathy including Peripartum and postpartum Cardiomyopathy

- I. An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a Registered Medical Practitioner who is a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association classification Class IV or its equivalent, for at least six (6) months based on the following classification criteria:

Class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced.

- II. The Diagnosis of Cardiomyopathy has to be supported by echographic findings of compromised ventricular performance.
- III. A waiting period of 10 months is applicable for this Illness if it is related to Maternity
- IV. The following is excluded:
 - I. Cardiomyopathy directly related to alcohol or drug abuse is excluded.

Section vii (e) of the Section 2.7.4 of Specific Exclusions shall not apply to the extent this Benefit is applicable

41. Nephrotic Syndrome

- I. Nephrotic syndrome is the onset of heavy proteinuria (>3.0 g/24 h), hypertension, hypercholesterolemia, hypoalbuminemia, edema/anasarca, and microscopic hematuria.
- II. A confirmed diagnosis of glomerulonephritis with nephrotic syndrome must be made by an appropriate Medical Practitioner along with relevant reports and should confirm a treatment regimen appropriate to the clinical presentation has been followed throughout the period to which syndrome relates.
- III. The syndrome must have continued for a period of at least 6 months from the date of confirmed diagnosis with or without intervening periods of remission.

42. Cirrhosis of the Liver

- I. Cirrhosis is a late stage of scarring (fibrosis) of the liver caused by many forms of liver diseases and conditions, such as hepatitis.
- II. Characterized by at least three of the following conditions:
 - i. Jaundice
 - ii. Ascites
 - iii. Bleeding from esophageal varices
- III. Should be certified by a hepatologist and supported by a MRI and Ultrasound and elevated Bilirubin levels.
- IV. Drug or alcohol abuse leading to liver cirrhosis is excluded.

43. Nephrectomy/removal of one kidney

- I. The actual undergoing of a complete nephrectomy due to illness, disease or Accident. Nephrectomy for the purpose of organ donation is specifically excluded. The requirement of surgery has to be confirmed by a specialist medical practitioner.

44. Chronic Glomerulonephritis

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- I. The condition is characterized by irreversible and progressive glomerular and tubulointerstitial fibrosis, ultimately leading to a reduction in the glomerular filtration rate (GFR) and retention of uremic toxins. Should be evidenced by below:
 - i. Evidence of kidney damage based on abnormal urinalysis results (eg, proteinuria or hematuria) or structural abnormalities observed on ultrasound images and
 - ii. A GFR of less than 60 mL/min for 3 or more months.
- II. The diagnosis has to be confirmed by a qualified nephrologist.

45. Severe COPD

- I. Chronic obstructive pulmonary disease (COPD) is characterised by airflow obstruction that is not fully reversible. COPD is now the preferred term for patients with airflow obstruction who were previously diagnosed as having chronic bronchitis or emphysema and should be characterised by at least two of the following:
 - i. A consistent forced expiratory volume (FEV1) test value of less than one (1) liter (during the first second of a forced exhalation);
 - ii. Baseline arterial blood gas analysis showing arterial partial oxygen pressure at a level of fifty-five (55) mmHg or less; and
 - iii. Dyspnea at rest.
- II. The diagnosis must be confirmed by a Chest physician.

46. Surgery to Place Ventricular Assist Device or Total Artificial Hearts

- I. The actual undergoing of open heart surgery to place a Ventricular Assist Device or Total Artificial Heart medically necessitated by severe ventricular dysfunction or severe heart failure, with cardiac echocardiographic evidence of reduced left ventricular ejection fraction of less than 30%.
- II. The following are excluded:
 - i. Ventricular dysfunction or Heart failure directly related to alcohol or drug abuse is excluded.

47. Minimally Invasive Surgery to Aorta

- I. The actual undergoing of minimally invasive surgical repair (i.e. via percutaneous intra-arterial route) of a diseased portion of an aorta to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

48. Percutaneous Heart Valve Surgery

- I. The actual undergoing of surgery to replace existing heart valve by the deployment of a new replacement valve by percutaneous intravascular techniques not involving a thoracotomy. Percutaneous or transcatheter based repair procedures not involving replacement with a new valve are excluded.

49. Major Surgery to Aorta

- I. The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen.

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For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches (including aortofemoral or aortoiliac bypass grafts).

- II. The surgery must be determined to be medically necessary by a Consultant Cardiologist / Surgeon and supported by imaging findings.
- III. The following is excluded:
 - i. Surgery performed using only minimally invasive or intra-arterial techniques.

50. Heart Transplant

- I. The actual undergoing of a transplant of human heart that resulted from irreversible end stage heart failure. The undergoing of a heart transplant has to be confirmed by a specialist medical practitioner.

51. Aorta Graft Surgery

- I. The actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches.
- II. The Insured Person understands and agrees that we shall not cover:
 - i. Surgery performed using only minimally invasive or intra-arterial techniques.
 - ii. Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.
- III. The aorta is the main artery carrying blood from the heart. Aortic graft surgery benefit covers Surgery to the aorta wherein part of it is removed and replaced with a graft.

52. Hemiplegia

- I. The total and permanent loss of the use of one side of the body through paralysis caused by Illness or Injury, except when such Injury is self inflicted.

53. Tuberculosis Meningitis

- I. Meningitis caused by tubercle bacilli. Such a diagnosis must be supported by 1) and 2) and 3):
 - i. Findings in the cerebrospinal fluid (csf) report
 - ii. Presence of acid fast bacilli in the cerebrospinal fluid or growth of M. Tuberculosis demonstrated in the culture report or Nucleic acid amplification tests like PCR
- II. Certification by a registered doctor who is a specialist in neurology, or a physician with a degree of MD

54. Ovarian tumor of borderline malignancy/low malignant potential – with surgical removal of an ovary

- I. An ovarian tumor of borderline malignancy / low malignant potential that has been positively diagnosed with histological confirmation and has resulted in surgical removal of an ovary.
- II. For this definition the following are not covered:
 - i. Removal of an ovary due to a cyst.

Smart Health

55. Carcinoma in-situ of the cervix uteri – requiring treatment with hysterectomy

- I. Carcinoma in-situ of the cervix uteri (cervix) that requires treatment with hysterectomy.
- II. The hysterectomy must have been performed on the advice of a specialist to treat carcinoma in-situ of the cervix.
- III. The following are excluded:
 - i. All grades of dysplasia
 - ii. Cervical squamous epithelial lesion (SIL) and Cervical intra-epithelial neoplasia (CIN), unless carcinoma in-situ is present
 - iii. Carcinoma in-situ of any other gynaecological organ (for example the ovary, or the fallopian tube)
 - iv. Any other disease or disorder of the cervix or other gynaecological organs that is treated with hysterectomy.

56. Carcinoma in-situ of the urinary bladder

- I. Carcinoma in-situ of the urinary bladder that has been histologically confirmed on a pathology report.
- II. The following conditions are not covered:
 - i. Non-invasive papillary carcinoma
 - ii. Stage Ta bladder carcinoma
 - iii. All other forms of non-invasive carcinoma

57. Ductal or Lobular carcinoma in-situ of the breast – with specified treatment

- I. Diagnosis of ductal or lobular carcinoma in-situ of the breast, that is histologically confirmed, and results in undergoing surgical removal on the advice of the Medical Practitioner.

58. Testicular carcinoma in situ – requiring surgery to remove at least one testicle

- I. Diagnosis of, and having specified treatment of carcinoma in-situ of the testicle (also known as intratubular germ cell neoplasia unclassified or ITGCNU), histologically confirmed by biopsy, and as a result treated with orchidectomy (complete surgical removal of the testicle).

59. Small Bowel Transplant

The receipt of a transplant of small bowel with its own blood supply via a laparotomy resulting from small intestinal failure (serious malfunctioning bowel), and has developed complications from total parenteral nutrition or are unable to tolerate this form of feeding. Indication for undergoing surgery is certified by a registered medical practitioner who is a gastroenterologist. Drug or alcohol abuse leading to intestinal failure is excluded.

60. Severe ulcerative colitis – with operation to remove the entire large bowel

Acute fulminant ulcerative colitis with life threatening electrolyte disturbances.

All of the following criteria must be met:

- the entire colon is affected, with severe bloody diarrhoea; and
- the necessary treatment is total colectomy and ileostomy; and

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- the diagnosis must be based on histopathological features and confirmed by a registered Medical Practitioner who is a specialist in gastroenterology

61. Progressive Supranuclear Palsy – resulting in permanent symptoms

Confirmed by a registered doctor who is a specialist in neurology of a definite diagnosis of progressive supranuclear palsy. There must be permanent clinical impairment of motor function, eye movement disorder and postural instability for a minimum period of 30 days

62. Pheochromocytoma

Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines requiring the actual undergoing of surgery to remove the tumour.

The Diagnosis of Pheochromocytoma must be supported by plasma metanephrine levels and / or urine catecholamines and metanephrines and confirmed by a registered doctor who is an endocrinologist.

63. Myelofibrosis

A disorder which can cause fibrous tissue to replace the normal bone marrow and results in anaemia, low levels of white blood cells and platelets and enlargement of the spleen. The condition must have progressed to the point that it is permanent and the severity is such that the Insured Person requires a blood transfusion at least monthly. The diagnosis of myelofibrosis must be supported by bone marrow biopsy and confirmed by a registered Medical Practitioner who is a specialist.

64. Eisenmenger's Syndrome

Development of severe pulmonary hypertension and shunt reversal resulting from heart condition. The diagnosis must be made by a registered Medical Practitioner who is a specialist with echocardiography and cardiac catheterisation and supported by the following criteria:

- Mean pulmonary artery pressure > 40 mm Hg;
- Pulmonary vascular resistance > 3mm/L/min (Wood units); and
- Normal pulmonary wedge pressure < 15 mm Hg

65. Creutzfeldt-Jakob disease

Creutzfeldt-Jacob disease is an incurable brain infection that causes rapidly progressive deterioration of mental function and movement. A registered doctor who is a neurologist must make a definite diagnosis of Creutzfeldt-Jacob disease based on clinical assessment, EEG and imaging. There must be objective neurological abnormalities on exam along with severe progressive dementia.

2.6.2 Benefits Options under Section 2.6:

2.6.2.1. Sum Insured Enhancement

What is covered:

In consideration of additional premium received from You/Insured Person, it is hereby understood and agreed that, the Critical illness Sum Insured mentioned in the Policy Schedule/ Certificate of Insurance shall be increased automatically per annum by the percentage chosen, by the Insured Person and accepted by Us and mentioned in the Policy

Schedule/Certificate of Insurance. It is hereby clarified that the increase every time would be computed on the Critical illness Sum Insured at which the cover under the Policy had been issued the first time and not the increased Sum Insured in years succeeding the first year of cover under the Policy.

Conditions:

- a. The Sum Insured shall be increased by a flat percentage for every completed Policy Year.
- b. At Renewal the Insured Person shall have an option to revise the Sum Insured by sending in writing the request for such Sum Insured revision. Any revision to Sum Insured shall always be subject to due underwriting by Us and acceptance of risk by Us in writing.

2.6.2.2. Income Protector

What is covered:

Subject to Us accepting Our liability for a claim in respect of the Insured Person under Section 2.6.1 of this Policy and in consideration of additional premium received from You/Insured Person at the time of issuance of the Policy, it is hereby understood and agreed that in the event of Insured Person losing his job due to Critical Illness covered under this Section We shall, in addition to the Critical illness Sum Insured also pay the amount as prescribed in the Policy Schedule/ Certificate of Insurance up to the specified number of months as specified in Policy Schedule/ Certificate of Insurance as income to the Insured Person.

Conditions:

- For eligibility under this cover the job of the Insured Person must be permanent and not temporary or casual or seasonal or contractual or off roll and the Insured Person must be employed in that permanent job at the time of inception of the cover under the Policy and 90 days immediately following thereafter within the Policy/Coverage Period including the day of inception of the Policy.
- You/Insured Person has to provide all the documentary evidence of such loss of job
- We shall, in case it deems fit to do so, shall have the discretion to even pay all the specified monthly income benefits as mentioned in the Policy Schedule/ Certificate of Insurance in lump sum instead of monthly.

What is not covered:

- We shall not be liable to make any payment under this Section in event the Insured Person unemployment is a consequence of his termination, dismissal, suspension because of his involvement in any act of dishonesty and/or fraud and/or poor performance on the part of the Insured Person and/or his willful violation of any rules of the employer and/or laws for the time being in force and/or any disciplinary action against him by the employer.
- We shall not be liable to make any payment under this Section:
 - If the Insured Person is a self employed person during the entire Policy Period;

Smart Health

- During the entire Policy Period/ Coverage Period in case of any claim relating to unemployment from such job which is casual, temporary, seasonal or contractual in nature or any claim relating to an employee not on the direct rolls of the employer;
- In case of voluntary unemployment due to resignation during the entire Policy Period;
- In case of unemployment at the time of inception of the Policy/Coverage Period or unemployment arising within the first 90 days of inception of the Policy Period/ Coverage Period for any reason whatsoever including without limitation even if the Insured Person suffers Critical Illness.
- In case of unemployment during the entire Policy Period/ Coverage Period from a job under which no salary or any remuneration is provided to the Insured Person
- In case of suspension from employment on account of any pending enquiry being conducted by the employer/ public authority.
- In case of unemployment during the entire Policy Period/ Coverage Period due to retirement whether voluntary or otherwise.

In case of any unemployment during the entire Policy Period/ Coverage Period due to non-confirmation of employment after or during such period under which the Insured Person was under probation.

2.6.2.3. Staggered Payout

What is covered:

Subject to Us accepting Our liability against the claim under section 2.6.1 of this Policy and in consideration of additional premium received from You/Insured Person, notwithstanding anything contrary contained in the Policy, it is hereby understood and agreed that, in the event of claim We, in addition to Sum Insured for the Insured Person as mentioned in the Policy Schedule/ Certificate of Insurance shall also pay equal to 10% of the Sum Insured per annum for next 5 years. This is the staggered payout which shall be calculated on the Insured Person's Critical illness Sum Insured or on the increased sum insured if the Sum Insured Enhancement option is opted for.

Conditions:

Claim under this cover will be payable only when the claim under Section 2.6.1 under this Policy is payable.

2.6.2.4. Death Benefit

What is covered:

In the event of the Insured Person dies within the Survival period specified in the Policy Schedule/ Certificate of Insurance due to Critical Illness covered under Section 2.6.1 of this Policy, We shall pay in lump sum the amount as prescribed in the Policy Schedule/ Certificate

Smart Health

of Insurance to the nominee/ legal heir/s of the Insured Person as Death Benefit. In this case Our total liability under Section 2.6.1 shall be limited only to the limit specified in the Policy Schedule/ Certificate of Insurance as Death Benefit.

2.6.2.5. Second Medical Opinion for Critical Illness

What is covered:

If the Insured Person is diagnosed with a Critical Illness as defined under Section 2.6.1 or is planning to undergo a planned Surgery or a Surgical Procedure for that Critical Illness, the Insured Person can, at the Insured Person's choice, obtain a Second Medical Opinion from a Medical Practitioner arranged by Us:

- a. We/ Our Service Provider are contacted seeking the Second Medical Opinion.
- b. The Second Medical Opinion will be arranged by Us or Our Service Provider and will be based only on the information and documentation provided by the Insured Person that will be shared with the Medical Practitioner.
- c. This Benefit can be availed only once by an Insured Person during a Policy Year/ Coverage Period for the same Critical Illness or planned Surgery.
- d. By seeking the Second Medical Opinion under this Benefit the Insured Person is not prohibited or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.
- e. The Insured Person is free to choose whether or not to obtain the Second Medical Opinion, and if obtained then whether or not to act on it in whole or in part.
- f. The Second Medical Opinion under this Benefit shall be limited to defined criteria and not be valid for any medico legal purposes.

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

2.6.2.6. EMI Cover

Subject to Us accepting Our liability against the claim under section 2.6.1 of this Policy and in consideration of additional premium received from You/Insured Person, notwithstanding anything contrary contained in the Policy, it is hereby understood and agreed that, in the event of claim We, in addition to Sum Insured for the Insured Person as mentioned in the Policy Schedule/ Certificate of Insurance shall also pay the EMI for maximum up to 12 months. The Actual EMI amount on the said Loan will be considered or the specified limit in the Policy Schedule/Certificate of Insurance, whichever is lower at the time of payment of the benefit. The EMI has to be in the name of the Insured Proposer.

Additional Documents required at the time of claim intimation:

- 1- Loan Outstanding with bifurcation of principle amount and interest amount and any other charges, if any on the letter head of the respective Master policy holder and should be duly signed by the authorized signatory.

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- 2- Loan Account statement of last 10 transactions at least

Conditions:

Claim under this cover will be payable only when the claim under Section 2.6.1 under this Policy is payable.

2.6.2.7. Loss of Job

Subject to Us accepting Our liability against the claim under section 2.6.1 of this Policy and in consideration of additional premium received from You/Insured Person, notwithstanding anything contrary contained in the Policy, it is hereby understood and agreed that, in the event of claim We, in addition to Sum Insured for the Insured Person as mentioned in the Policy Schedule/ Certificate of Insurance shall also pay to the amount specified in the Policy Schedule/Certificate of Insurance up to a maximum of 12 months.

Additional Documents required at the time of claim intimation:

- 1- Bank statement showing last 3 Salary Credits
- 2- Last 3 months salary slips after which the salary credit has stopped along with Full and Final Settlement letter from the employer, stamped and signed by the authorized signatory.
- 3- In case of businessman, proof of Income loss to be submitted

2.6.3 Waiting Period Options under Section 2.6:

All the Waiting Periods as specified in Policy Schedule/ Certificate of Insurance shall be applicable individually for each Insured Person and claims shall be assessed accordingly. On Renewal, if an enhanced Sum Insured is applied for, the Waiting Periods would apply afresh to the extent of the increase in Sum Insured only.

We shall not be liable to make any payment under this Policy directly or indirectly for, caused by, based on, arising out of or howsoever attributable to any of the following, except if any Insured Person suffers an Accident;

Waiting Periods

- (i) **Pre-existing Diseases (Code-Excl01):**
 - a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of the number of months (as mentioned in Policy Schedule/Certificate of Insurance) 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 number of months (as mentioned in Policy Schedule/Certificate of Insurance) for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

(ii) **Specified disease/procedure waiting period (Code- Excl02)**

- a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of number of months (as mentioned in Policy Schedule/Certificate of Insurance) of continuous coverage after the date of inception of the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident (covered from day 1).
- b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
- d. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
- e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI then waiting period for the same would be reduced to the extent of prior coverage.
- f. List of specific diseases/procedures (Below mentioned diseases/procedures can be modified and in that case the list will be mentioned in Policy Schedule/Certificate of Insurance) :
- I. Pancreatitis and stones in billiard and urinary system
 - II. Cataract, glaucoma and other disorders of lens, disorders of retina
 - III. Hyperplasia of prostate, Hydrocele and spermatocoele
 - IV. Abnormal utero-vaginal bleeding, female genital prolapse, endometriosis/adenomyosis, fibroids, PCOD, or any condition requiring dilation and curettage or hysterectomy
 - V. Hemorrhoids, fissure or fistula or abscess of anal and rectal region
 - VI. Hernia of all sites,
 - VII. Osteoarthritis, systemic connective tissue disorders, dorsopathies, spondylopathies, inflammatory polyarthropathies, arthrosis such as RA, gout, intervertebral disc disorders, arthroscopic surgeries for ligament repair
 - VIII. Chronic kidney disease and failure
 - IX. Varicose veins of lower extremities
 - X. All internal or external benign or in situ neoplasms/tumours, cyst, sinus, polyp, nodules, swelling, mass or lump
 - XI. Ulcer, erosion and varices of gastro intestinal tract
 - XII. Surgical treatment for diseases of middle ear and mastoid (including otitis media, cholesteatoma, perforation of tympanic membrane), Tonsils and adenoids, nasal septum and nasal sinuses
 - XIII. Internal Congenital Anomaly
 - XIV. Surgery of Genito-urinary system unless necessitated by malignancy
 - XV. Spinal disorders

(iii) **Initial waiting period:**

- a. A Waiting Period since beginning of cover under the First Policy, specified in the Policy Schedule/ Certificate of Insurance shall apply to any Illness contracted and/or Medical Expenses incurred in respect of any Illness by the Insured Person other than Hospitalization due to Accident.
- b. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months
- c. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

If these diseases are Pre-Existing Diseases at the time of the Proposal or subsequently found to be Pre-Existing Diseases, the Pre-Existing Disease Waiting Periods as mentioned in the Policy Schedule/ Certificate of Insurance shall apply in respect of that Insured Person.

Permanent Exclusions:

A permanent exclusion will be applied on any medical or physical condition or treatment of an Insured Person, if specifically mentioned in the Policy Schedule and has been accepted by You. This option as per company's underwriting policy, will be used for such condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person.

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

I. 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.

II. 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:

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

III. Obesity/ Weight Control (Code-Excl06)

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

- a. Surgery to be conducted is upon the advice of the Doctor.
- b. The surgery/Procedure conducted should be supported by clinical protocols.
- c. The member has to be 18 years of age or older and;
- d. Body Mass Index (BMI);

Smart Health

- I. greater than or equal to 40 or
- II. 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
- IV. **Change-of-Gender treatments (Code-Excl07)**
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
- V. **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.
- VI. **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.
- VII. **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.
- VIII. **Excluded Providers (Code-Excl11)**
Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our 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. The complete list of excluded providers can be referred to on our website.
- IX. Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code-Excl12)**
- X. Treatments received in health 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)**
- XI. 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)**
- XII. **Refractive Error (Code-Excl15)**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.
- XIII. **Unproven Treatments (Code-Excl16)**

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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.

XIV. **Sterility and Infertility (Code-Excl17)**

Expenses related to sterility and infertility. This includes:

- a. Any type of contraception, sterilization
- b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- c. Gestational Surrogacy
- d. Reversal of sterilization

XV. **Maternity (Code-Excl18)**

- a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
- b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

XVI. Charges related to a Hospital stay not expressly mentioned as being covered. This will include charges for RMO charges, surcharges and service charges levied by the Hospital.

XVII. **Circumcision**

Circumcision unless necessary for the treatment of a disease or necessitated by an Accident.

XVIII. **Conflict & Disaster:**

Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism.

XIX. **External Congenital Anomaly:**

Screening, counseling or treatment related to external Congenital Anomaly.

XX. **Dental/oral treatment:**

Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident.

XXI. **Hormone Replacement Therapy:**

Treatment for any condition / illness which requires hormone replacement therapy.

XXII. Multifocal Lens and ambulatory devices such as walkers, crutches, splints, stockings of any kind and also any medical equipment which is subsequently used at home.

XXIII. **Sexually transmitted Infections & diseases (other than HIV / AIDS):**

Screening, prevention and treatment for sexually related infection or disease (other than HIV / AIDS).

XXIV. **Sleep disorders:**

Treatment for any conditions related to disturbance of normal sleep patterns or behaviors.

XXV. Any treatment or medical services received outside the geographical limits of India.

Smart Health

- XXVI. Any expenses incurred on OPD treatment (unless specifically mentioned in any benefit and/or specified in Policy Schedule/Certificate of Insurance).

2.6.4 Claims Process & Requirements:

The fulfillment of the terms and conditions of this Policy (including payment of full premium in advance by the due dates mentioned in the Certificate of Insurance) in so far as they relate to anything to be done or complied with by the Insured Person, including complying with the following in relation to claims, shall be Condition Precedent to admission of Our liability under this Policy.

2.6.5 Claims Administration:

On the occurrence or discovery of any Illness or Injury that may give rise to a claim under this Section, the Claims Procedure set out below shall be followed:

- a. The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed. We shall not be obliged to make any payment that arises out of willful failure to comply with such directions, advice or guidance.
- b. We and Our representatives must be permitted to inspect the Medical Records and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.
- c. We and Our representatives must be given all reasonable co-operations in investigating the claim in order to assess its liability and quantum in respect of the claim.

It is hereby agreed and understood that no change in the Medical Record provided under the Medical Advice, by the Hospital or the Insured Person to Us or Our Service Provider during the period of Hospitalization or after discharge by any means of request will be accepted by Us. Any decision on request for acceptance of change will be at Our discretion.

2.6.6 Claims Procedure

- a. If the Insured Person is diagnosed / underwent a Surgical Procedure or any medical condition falling under purview of the definition of Critical Illness as mentioned in the Policy that may result in a claim, then the Insured Person must provide intimation to Us immediately and in any event within 7 days of the aforesaid Illness/ condition/ surgical event or completion of Survival Period and which can be received from You/Insured Person through various modes like email / telephone/ fax/ in person or may be via letter or any other suitable mode. Upon receipt of information We will register the claim under a unique claim number.
- b. The following details are to be provided at the time of intimation of claim:
 - i. The Policy Number/Certificate Number,
 - ii. Name of the Policyholder;
 - iii. Employee No./ Member ID
 - iv. Name and address of the Insured Person in respect of whom the request is being made;
 - v. Nature of Illness or Injury and the treatment/Surgery taken;
 - vi. Name and address of the attending Medical Practitioner ;
 - vii. Hospital where treatment/Surgery was taken;

Smart Health

- viii. Date of Occurrence of Insured Event or/and date of admission ;
- ix. Any other information that may be relevant to the Illness/ Injury/ Hospitalization.

2.6.7 Claims Documentation

A. We shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense within 30 days of the date of occurrence of an Insured Event or completion of Survival Period, at own expense to avail the Claim.

- a. Claim form duly completed and signed by the Insured Person.
Please provide mandatorily following information if applicable
 - i. Current diagnosis and date of diagnosis;
 - ii. Past history and first consultation details;
 - iii. Previous admission/Surgery if any.
- b. Age/identity proof document of the Proposer.
 - i. Self attested copy of valid Age proof (passport / driving license / PAN card / class X certificate / birth certificate);
 - ii. Self attested copy of identity proof (passport / driving license / PAN card / voter identity card);
 - iii. Recent passport size photograph.
- c. Cancelled cheque/ bank statement / copy of passbook mentioning account holder's name, IFSC code and account number printed on it of Insured Person / nominee (in case of death of Insured Person)
- d. Hospital discharge summary(if applicable)
- e. Additional documents required in case of Surgery/Surgical Procedure (If applicable)
 - i. Bar code sticker and invoice for implants and prosthesis (if used)
- f. Original final bill from Hospital with detailed break-up and paid receipt (If applicable)
- g. Copy of death certificate (in case of demise of the Insured Person)
- h. For Medico-legal cases (MLC) or in case of Accident as may be applicable
 - i. MLC and First Information Report (FIR) copy duly attested by the concerned Hospital and police station respectively. (if applicable);
 - ii. Original self-narration of incident in absence of MLC/ FIR.
- i. Original laboratory investigation, diagnostic & pathological reports with supporting prescriptions.
- j. Original X-Ray/ MRI / ultrasound films and other radiological investigations.

B. Claims Documents applicable to Section 2.6.2.3 (Income Protector):

In the event of a claim arising out of an Insured Event covered under Section 2.6.2.3 above, You/Insured Person shall within thirty (30) days from the date of such severance from the employment, shall arrange for submission of the following documents to Us:

1. Duly completed claim form;
2. Certificate from the employer of the Insured Person confirming the severance from employment the date of and the reasons for the same.

If these details are not provided in full or are insufficient for Us to consider the request, We will request additional information or documentation in respect of that request.

i. Claims Assessment & Repudiation

Smart Health

We shall be under no obligation to make any payment under this Policy unless it has been provided with the documentation and information which We have requested to establish the circumstances of the claim, its quantum or liability for it, and unless the Insured Person has complied with his obligations under this Policy.

- a. We shall not be liable to make any payment under this Section in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means whether by the Insured Person or by any other person acting on his behalf.
- b. If We, for any reasons to be recorded in writing and communicated to the Insured Person, decide to reject a claim under the Policy, it shall do so within a period of up to the number of days specified in the Policy Schedule/ Certificate of Insurance from the receipt of last necessary information and documentation set out above.
- c. In the unfortunate event of the Insured Person death, We will pay the Nominee named in the Certificate of Insurance or the Insured Person's legal heirs or legal representatives holding a valid succession certificate.
- d. Our total liability in aggregate of all claims under the Policy for a specific Insured Person shall not exceed the respective Sum Insured as specified in the Certificate of Insurance of that Insured Person

2.7 Wellness Benefits:

This Section is available to either the Insured Person only or along with his/her spouse as specified in the Policy Schedule/Certificate of Insurance. Subject to the Policy terms and conditions and to encourage good health and well being, We shall provide the following wellness related services to You/Insured Person(s) covered under this Benefit through Our empanelled Service Providers.

2.7.1 Personalized health coaching:

This Benefit is available either to the Insured Person or the Insured Person along with his/her spouse. Subject to Policy terms and conditions and to encourage good health and well being, We shall provide the following wellness related services to the Insured Person(s) covered under this Benefit and We shall be assisted in administering these services through Our Service Provider:

- a. Personalized health coaching – The Insured Person will have the facility to connect with a personal coach through a mobile application to guide and motivate the Insured Person to achieve his/her personal health goals. The health coach facility assists in identifying factors relating to the Insured Person's lifestyle and habits and also suggests ways to shift these habits to improve activity and wellness and to encourage overall well-being.

The health coaching facility is unlimited and can be availed any number of times during the Policy Period. In order to obtain access to the health coach facility, the Insured Person would be required to download the mobile application and register his/her specified details through the mobile application. When registration is complete, the Insured Person's health coach will notify him/her through the mobile application to set up the Insured Person's introductory call where Insured Person will discuss with the health coach to establish his/her short and long term goals. Once these goals are recorded, the health coach will provide on-going daily support, motivation and interpretation of the Insured Person's tracking data to help the Insured Person stay on track to reach his/her goals. The Insured Person and the health coach will also be able to connect frequently to review the progress and revise the existing goals or set new goals.

The mobile application shall also keep track of Insured Person's steps taken, daily food logs etc., which can be accessed by the Insured Person, personal health coach and Our empanelled Medical Practitioners under this Benefit.

b. Calculation of health score - Health Score shall be calculated as per the table below:

Health Score Model		
Task Based	Tasks to be Completed	Complete & win (Points/task)
One time	Sign up & Activation	500
	Selecting your own goals	500
	Taking your first Health assessment	750
	Completing your first tele-consultation with Our empanelled Medical Practitioner	500
	Uploading your first health record	750
Weekly	Coach engagement (>3 interactions / week)	250
	Walking - Steps count (5000 steps /day --- 5 times /week)	300
	Daily food logs (minimum 10 logs/ week)	250
Monthly	Habit tracking (minimum 15 check in)	500
	Monthly Coach review – Call	500
Quarterly	Health Assessment	500
Half Yearly	Tele-consultation with Our empanelled Medical Practitioner	1200
	Sharing your test reports / records	1500

Performance Based	Parameters for performance review	Score - based on your performance (Max points / review)
One time	Health Assessment at the time of on boarding	2000
Monthly	Monthly performance - Quality score by personal health coach	2000
Quarterly	On completion of goal set by personal health coach	500
	Based on health assessment results	2000
Annual Health score	(Task based points + Performance based points)	Earn up to 1 lac points in a year

One time Task Based points in second and subsequent Policy Year will get replaced with Renewal points awarded on Renewal of the Policy along with Health Coach Benefit. For Health Score calculation, monthly scores will be calculated and accumulated to arrive at the annual Health Score.

c. Discount in renewal premium basis Health Score:

We will provide a discount in Renewal Base Premium based on the Insured Person's Health Score under this Benefit as per following table:

Health Score	Discount in Renewal Base Premium
0-9999	0%
10000-69999	5%
70000-79999	10%
80000-89999	15%
90000-100000	20%

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The Health Score of the Insured Person (average health score if both the Insured Person and spouse are covered under this Benefit) shall be considered for calculating the discount in Renewal Base Premium applicable to the Insured Person.

For the first Renewal, the Health Score at the end of nine Policy months shall be considered and pro-rated to arrive at the twelve months score for calculating the discount in Renewal Base Premium for the Insured Person. For subsequent Renewals, Health Score for the next twelve Policy months from the date of last annual Health Score calculation, shall be considered for calculating the discount in Renewal Base Premium for the Insured Person.

The above Benefits will be subject to following conditions:

- i. For services that are availed over phone or through online/ digital mode, the Insured Person will be required to provide the details as sought by Our Service Provider in order to establish authenticity and validity prior to availing such services.
- ii. It is entirely for the Insured Person(s) to decide whether to obtain these services, the extent to which he/she wishes to avail these services and further to decide whether to use any of these services and if so to which extent.
- iii. The services are intended to provide support information to the Insured Person to improve well-being and habits through working towards personalized health goals. These services are not medical advice and are not meant to substitute the Insured Person's visit/ consultation to an independent Medical Practitioner.
- iv. The information services provided under this Benefit, including information provided through personalized health coaching services, does not constitute medical advice of any kind and it is not intended to be, and should not be, used to diagnose or identify treatment for a medical or mental health condition. The information services provided under this Benefit, including information provided through personalized health coaching services, does not substitute for any medical advice as well.
- v. The Insured Person shall be free to consider or not consider the suggestions of the health coach and make any lifestyle changes based on information provided through these services. For any change the Insured Person makes to his lifestyle whether or not on the advice of the health coach, We or Our Service Provider shall in no manner be liable for any harm or injury, whether bodily or otherwise that may occur as a result of such lifestyle changes. The Insured Person must seek immediate medical advice if there is any adverse effect or discomfort on making any lifestyle changes.
- vi. We or Our Service Provider do not warrant the validity, accuracy, completeness, safety, quality, or applicability of the content or anything said or written by any personal health coach or any suggestions provided. We or Our Service Provider will not be liable for any damages sustained due to reliance by the Insured Person on such information or suggestions provided by any personal health coach.

Health Coaching through a personal health coach and calculation of the Health Score are being provided through Our Service Provider. For details on terms and conditions for use of health coaching services, please visit www.maxbupa.com/HealthCoach.

2.7.2 OPD Services

The Insured Person may avail OPD services from Our empanelled Service Provider through its mobile application or website. The cost for the OPD treatment shall be borne by the Insured Person. However, We shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further for OPD treatment taken from Our empanelled Service Provider is the Insured Person's absolute discretion and choice.

Smart Health

2.7.3 Pharmacy Services

The Insured Person may purchase medicines from Our empanelled Service Provider through its mobile application or website. The cost for the purchase of the medicines shall be borne by the Insured Person. However, We shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further purchase of medicines from Our empanelled Service Provider is the Insured Person's absolute discretion and choice.

2.7.4 Diagnostic Services

The Insured Person may avail various diagnostic tests from Our empanelled Service Provider through its mobile application or website. The cost of diagnostic tests shall be borne by the Insured Person. However, We shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further the diagnostic tests taken from Our empanelled Service Provider is the Insured Person's absolute discretion and choice.

2.7.5 Other Health Care Services

The Insured Person may avail various healthcare services as mentioned in the Policy Schedule/Certificate of Insurance from Our empanelled Service Provider through its mobile application or website. The cost of diagnostic tests shall be borne by the Insured Person. However, We shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further the services availed from Our empanelled Service Provider is the Insured Person's absolute discretion and choice.

2.8 Other Benefit

Any benefit in expiring Employer Employee policies that have premium implication of less than or equal to 5% can be offered.

3 General Exclusions (applicable to all Sections under the Policy unless specified otherwise):

We shall not be liable to make any payment under this Policy directly or indirectly for, caused by, based on, arising out of or howsoever attributable to any of the following unless specifically mentioned elsewhere in the Policy or in Policy Schedule/Certificate of Insurance.

- i. Conflict & Disaster: Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader).
- ii. Caused by or contributed to by or arising from ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel. For the purpose of this exclusion, combustion shall include any self-sustaining process of nuclear fission.
- iii. Breach of Law: Code: Excl 10: Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
- iv. Any injury as a result of Intentional self inflicted Injury, suicide or attempted suicide by any means.
- v. Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences thereof Code Excl 12

Smart Health

- vi. Intentional Inhaling any gas or fumes, except in the course of duty
- vii. Participation in aviation other than as a fare-paying passenger in an aircraft that is authorized by the relevant regulations to carry such passengers between established aerodromes.
- viii. Any disability arising out of Pre-Existing Disease if not accepted and endorsed by Us on the Policy Schedule or Certificate of Insurance.
- ix. Hazardous or Adventure Sports: Code Excl 09: Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
- x. 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.
- xi. Loss/damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any action taken in controlling, preventing, suppressing or in any way relating to any act of terrorism.
- xii. Any Injury/ Illness caused due to animal bite/ attack unless opted for the specific cover and same to be mentioned in the Policy Schedule/Certificate of Insurance.
- xiii. Any exclusion mentioned in the Policy Schedule/Certificate of Insurance or the breach of any specific condition mentioned in the Policy Schedule/Certificate of Insurance.

4 General Terms and Conditions

4.1 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

4.2 Free Look Period

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

The insured person shall be allowed free look period of fifteen days (thirty days for policies with a term of 3 years, if sold through distance marketing) 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

Smart Health

4.3 Cancellation

- I. 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 prorate or short period Grid 1/2 option opted by the Policyholder

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.

Short Period Grid 1

Timing of Cancellation	Refund %								
	Policy Term								
	1	1.5	2	2.5	3	3.5	4	4.5	5
Up to 30 days	75.0%	80.0%	85.0%	87.5%	90.0%	92.5%	92.5%	95.0%	95.0%
31 to 90 days	50.0%	65.0%	70.0%	75.0%	80.0%	85.0%	87.5%	87.5%	87.5%
3 to 6 months	25.0%	50.0%	60.0%	65.0%	67.5%	70.0%	75.0%	75.0%	75.0%
6 to 12 months	0.0%	25.0%	40.0%	45.0%	50.0%	55.0%	60.0%	65.0%	65.0%
12 to 18 months		0.0%	15.0%	30.0%	37.5%	45.0%	47.5%	50.0%	55.0%
18 to 24 months			0.0%	15.0%	25.0%	32.5%	37.5%	42.5%	47.5%
24 to 30 months				0.0%	12.5%	20.0%	25.0%	35.0%	40.0%
30 to 36 months					0.0%	10.0%	17.5%	25.0%	32.5%
36 to 42 months						0.0%	10.0%	17.5%	27.5%
42 to 48 months							0.0%	12.5%	20.0%
48 to 54 months								0.0%	10.0%
54 to 60 months									0.0%

Smart Health

is earlier. The Insured Person shall inform Us of such closure of the loan immediately in order to cancel the cover under the Policy. For loan linked policy, claim will be admissible only for active loans..

4.8 Premium Payment in Installments:

If the Insured Person has opted for payment of premium on an installment basis, i.e. Half yearly, Quarterly, or monthly, as mentioned in the Policy Schedule/Certificate of Insurance, the following conditions shall apply (notwithstanding any terms contrary elsewhere in the policy);

- a. Grace Period of 30 days in case of single premium policies, and a period of 15 days in case of other than single premium policies, would be given to pay the installment premium due for the policy.
- b. During such grace period, coverage will not be available from the due date of installment premium till the date of receipt of premium by Company.
- c. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
- d. No interest will be charged if the installment premium is not paid on due date
- e. In case of installment premium due not received within the grace period, the policy will get cancelled.
- f. In the event of a claim, all subsequent premium installments shall immediately become due and payable.
- g. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

4.9 Renewal of Policy

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

- I. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- II. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- III. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- IV. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
- V. No loading shall apply on renewals based on individual claims experience.

4.10 Other Renewal Conditions

a. Continuity of Benefits on Timely Renewal:

- i. The Renewal premium is payable on or before the due date and in any circumstances before the expiry of Grace Period, at such rate as may be reviewed and notified by Us before completion of the Policy Period provided that all such changes are approved by IRDAI and in accordance with the IRDAI's rules and regulations as applicable from time to time.
- ii. Renewal premium rates for this Policy may be further altered by Us including in the following circumstances:
 - A. You/Insured Person proposed to add an Insured Person to the Policy

Smart Health

- B. You/Insured Person change any coverage provision
- iii. Renewal premium will alter based on individual Age. The reference of Age for calculating the premium for Family Floater Policies shall be the Age of the eldest Insured Person.
- b. Reinstatement:**
- i. The Policy shall lapse after the expiration of the Grace Period. If the Policy is not renewed within the Grace Period then We may agree to issue a fresh Policy subject to Our underwriting criteria, as per Our Board approved underwriting Policy and no continuing benefits shall be available from the expired Policy.
- ii. We will not pay for any Medical Expenses which are incurred between the date the Policy expires and the date immediately before the reinstatement date of Your/Insured Person's Policy.
- iii. If there is any change in the Insured Person's medical or physical condition, We may add exclusions or charge an extra premium from the reinstatement date.
- c. Disclosures on Renewal:**
- You/Insured Person shall make a full disclosure to Us in writing of any material change in the health condition or geographical location of any Insured Person at the time of seeking Renewal of this Policy, irrespective of any claim arising or made. The terms and condition of the existing Policy will not be altered.
- d. Addition of Insured Persons on Renewal:**
- Where an individual is added to this Policy either by way of endorsement or at the time of Renewal, the Pre-Existing Disease clause, exclusions and Waiting Periods will be applicable considering such Policy Year as the first year of the Policy for that newly added individual with Us.
- e. Changes to Sum Insured on Renewal:**
- You/Insured Person may opt for enhancement of Sum Insured at the time of Renewal, subject to underwriting. Any enhanced Sum Insured applied on Renewal will not be available for an Illness or Injury already contracted under the preceding Policy Periods. All Waiting Periods as defined in the Policy shall apply afresh for this enhanced limit from the effective date of such enhancement.

4.11 Nomination

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

4.12 Obligations in case of a minor

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

Smart Health

4.13 Assignment

The Benefits under this Policy are assignable subject to applicable Laws.

4.14 Records to be maintained:

As a Condition Precedent, You/Insured Person shall keep an accurate record containing all relevant medical records and shall allow Us or Our representative(s) to inspect such records. You/Insured Person shall furnish such information as We may require under this Policy at any time during the Policy Period/Coverage Period.

4.15 Authorization to obtain all pertinent records or information:

As a Condition Precedent to the payment of Benefits, We and/or Our Service Provider shall have the authority to obtain all pertinent records or information from any Medical Practitioner, Hospital, clinic, insurer, individual or institution to assess the validity of a claim submitted by or on behalf of any Insured Person.

4.16 Fraud

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

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

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

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

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

4.17 Notification of Claim and Delay in Intimation:

The notification of all claims should be sent to Us via one of the following:
By calling Us at 1800-3010-3333

Smart Health

By registered post sent to:

Customer Services Department
Max Bupa Health Insurance Company Limited
B-1/1-2, Mohan Cooperative Industrial Estate
Mathura Road, New Delhi-110044
Fax No.: 1800-3070-3333

By writing an email to customercare@maxbupa.com.

If the claim is not notified to Us or claim documents are not submitted within the stipulated time as mentioned in the above sections, then We shall be provided the reasons for the delay, in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

If You/Insured Person holds multiple sections (Indemnity & Benefit) under this Policy with Us, a single notification for claim will apply to all the sections of the Policy.

4.18 Claims Settlement (Provision for Penal Interest)

- I. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- II. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 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)

4.19 Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein shall be governed by Indian law and shall be subject to the jurisdiction of the Indian Courts.

4.20 Territorial Jurisdiction

All Benefits are available in India only, and all claims shall be payable in India in Indian Rupees only.

4.21 Role of Group Administrator

The role of Group Policyholder as an administrator will only be to facilitate the insurance cover to its members. Any subsequent Policy servicing or claims related assistance shall directly be done by Us.

Smart Health

4.22 Notices

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

- a. The Insured Person at the address specified in the Policy Schedule/Certificate of Insurance or at the changed address of which We must receive written notice.
- b. Us at the following address:

Max Bupa Health Insurance Company Limited
B-1/I-2, Mohan Cooperative Industrial Estate
Mathura Road, New Delhi-110044
Fax No.: 011-3090-2010

- c. No insurance agents, brokers or other person/entity is authorized to receive any notice on Our behalf.
- d. In addition, We may send You/Insured Person other information through electronic and telecommunications means with respect to the Policy from time to time.

4.23 Alteration to the Policy

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by Us, which approval shall be evidenced by a written Endorsement signed and stamped by Us.

4.24 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 affected.

4.25 Withdrawal of Policy

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

4.26 Redressal of Grievance:

- a. In case of any grievance the insured person may contact the company through:

Website: www.maxbupa.com

Courier: Customer Services Department

Max Bupa Health Insurance Company Limited
B-1/I-2, Mohan Cooperative Industrial Estate
Mathura Road, New Delhi-110044

Customer Helpline No: 1860-500-8888

Fax No.: 011-3090-2010

Email ID: customercare@maxbupa.com

Senior citizens may write to us at: seniorcitizensupport@maxbupa.com

Smart Health

- b. 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

Head – Customer Services

Max Bupa Health Insurance Company Limited

B-1/I-2, Mohan Cooperative Industrial Estate

Mathura Road, New Delhi-110044

Customer Helpline No: 1860-500-8888

Fax No.: 011-3090-2010

Email ID: customercare@maxbupa.com

For updated details of grievance officer, kindly refer the link <https://www.maxbupa.com/customer-care/health-services/grievance-redressal.aspx>

If the Insured person is not satisfied with the above, they can escalate to GRO@maxbupa.com.

- c. If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017 (at the addresses given in Annexure 1).
- d. Grievance may also be lodged at IRDAI integrated Grievance Management System - <https://igms.irda.gov.in/>

4.27 Moratorium Period

After completion of eight continuous years under the policy, no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the Sums Insured of the first Policy and subsequently completion of 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 health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the Policy contract. The Policies would however be subject to all limits, sub limits, co-payments, deductibles as per the Policy contract.

4.28 Multiple Policies

- I. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
- II. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
- III. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

Smart Health

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

4.29 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)

4.30 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.

4.31 Complete Discharge

Any payment to the policy holder, insured person or his/her nominees or his/her legal representatives 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.

5 Definitions & Interpretation

The terms listed below in Section 5 and used elsewhere in the Policy in Initial Capitals shall have the meaning set out against them in Section 5 unless mentioned is any of the sections above separately..

- 5.1 Accident or Accidental** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
- 5.2 Anyone illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
- 5.3 Age** means age of the Insured person on last birthday as on date of commencement of the Policy.
- 5.4 AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.
- 5.5 AYUSH Hospital:** An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH **Medical Practitioner(s)** comprising of any of the following:
- a. Central or State Government AYUSH Hospital; or
 - b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
 - c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH **Medical Practitioner** and must comply with all the following criterion:
 - i. Having at least 5 in-patient beds;

Smart Health

- 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.

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

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

5.7 Associated Medical Expenses shall include Room Rent, nursing charges, Medical Practitioners' and operation theatre charges

5.8 Base Sum Insured means the amount stated in the Policy Schedule.

5.9 Bone Marrow Transplant is the actual undergoing of a transplant of human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner. The following will be excluded:

- i. Other stem-cell transplants
- ii. Where only islets of langerhans are transplanted

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

5.11 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.

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

5.13 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.

5.14 Co-payment means a cost-sharing requirement under a health insurance policy that provides that the Policyholder/insured will bear a specified percentage of the admissible claim's amount. A Co-payment does not reduce the Sum Insured.

5.15 Critical Illness, an Illness, medical event or Surgical Procedure specifically defined in Section 2.6.1

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

5.17 Date of Loss:

Smart Health

- a. for Accident means the date of the Accident.
 - b. for all other benefits means the date the event happened that leads to an alleged claim.
 - c. for Sickness means the first date of diagnosis or the date the Insured Person first became aware of the Sickness.
- 5.18 Day Care Centre** means any institution established for Day Care Treatment of Illness and/or Injuries or a medical set-up with a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criterion as under:
- a. has Qualified Nursing staff under its employment;
 - b. has qualified Medical Practitioner(s) in charge;
 - c. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
 - d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
- 5.19 Day Care Treatment** refers to medical treatment, and/or Surgical Procedure which is:
- a. undertaken under General or Local Anaesthesia in a Hospital/Day Care Center in less than 24 hrs because of technological advancement, and
 - b. which would have otherwise required a Hospitalization of more than 24 hours.
- Treatment normally taken on an outpatient basis is not included in the scope of this definition.
- 5.20 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.
- 5.21 Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and Surgery.
- 5.22 Diagnostic Services** means those diagnostic tests and exploratory or therapeutic procedures required for the detection, identification and treatment of a medical condition.
- 5.23 Disclosure to Information Norm** means 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.
- 5.24 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:
- a. the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
 - b. the patient takes treatment at home on account of non-availability of room in a Hospital.
- 5.25 Emergency** means a medical condition or symptom resulting from Illness or Injury which arises suddenly and unexpectedly and requires immediate care and treatment by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.
- 5.26 Evidence Based Clinical Practice** means process of making clinical decisions for Inpatient Care using current best evidence in conjugation with clinical expertise.
- 5.27 e-Consultation** means opinion from a Medical Practitioner who holds a valid registration from the medical council of any state or medical council of India or council for Indian medicine or for homeopathy set up by the Government of India or a state government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.
- 5.28 Family Floater Policy** means a Policy described as such in the Policy Schedule where the family members (two or more) named in the Policy Schedule are Insured Persons under this Policy. Only the following family members can be covered under a Family Floater Policy:

Smart Health

- a. Primary Insured Person; and/or
 - b. Primary Insured Person's legally married spouse (for as long as she/he continues to be married to the Primary Insured Person); and/or
 - c. Primary Insured Person's children who are less than 25 years of Age on the commencement of the Policy Period (a maximum 4 children can be covered under the Policy as Insured Persons).
- 5.29 First Policy** means for the purposes of this Policy the Policy Schedule issued to the Policyholder at the time of inception of the first Policy mentioned in the Policy Schedule with Us.
- 5.30 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.
- 5.31 Hospital** means any institution established for Inpatient Care and Day Care Treatment of Illness and / or Injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
- a. has Qualified Nursing staff under its employment round the clock;
 - b. has at least 10 Inpatient beds in towns having a population of less than 10,00,000 and at least 15 Inpatient beds in all other places;
 - c. has qualified Medical Practitioner(s) in charge round the clock;
 - d. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
 - e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.
- 5.32 Hospitalization or Hospitalized** means the admission in a Hospital for a minimum period of 24 consecutive Inpatient Care hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.
- 5.33 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 intensivists charges.
- 5.34 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:
- i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
 - ii. it needs ongoing or long-term control or relief of symptoms
 - iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
 - iv. it continues indefinitely
 - v. it recurs or is likely to recur
- 5.35 Injury** means accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.
- 5.36 Information Summary Sheet** means the information and details provided to Us or Our representatives over the telephone for the purposes of applying for this Policy which has been recorded by Us and confirmed by You.
- 5.37 Intensive Care Unit** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous

Smart Health

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.

- 5.38 Individual Policy** means a Policy described as such in the Policy Schedule where the individual named in the Policy Schedule is the Insured Person under this Policy.
- 5.39 Inpatient** means admission for treatment in a Hospital for more than 24 hours for an Insured Event.
- 5.40 Inpatient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.
- 5.41 Insured Event** means any event specifically mentioned as covered under this Policy.
- 5.42 Insured Person** means person(s) named as insured persons in the Policy Schedule.
- 5.43 IRDAI** means the Insurance Regulatory and Development Authority of India.
- 5.44 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
- 5.45 Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
- 5.46 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.
- 5.47 Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his licence.
- 5.48 Medical Record** means the collection of information as submitted in claim documentation concerning a Insured Person's Illness or Injury that is created and maintained in the regular course of management, made by Medical Practitioners who have knowledge of the acts, events, opinions or diagnoses relating to the Insured Person's Illness or Injury, and made at or around the time indicated in the documentation.
- 5.49 Medically Necessary Treatment** means any treatment, tests, medication, or stay in Hospital or stay in Hospital or part of a stay in hospital which:
- a. is required for the medical management of the Illness or Injury suffered by the insured;
 - b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
 - c. must have been prescribed by a Medical Practitioner;
 - d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
- 5.50 Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence.

Smart Health

- 5.51 Migration** means the right accorded to individual health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.
- 5.52 Network Provider** means Hospital or health care providers enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a Cashless Facility.
- 5.53 New Born Baby:** Newborn baby means baby born during the Policy Period and is aged up to 90 days
- 5.54 Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
- 5.55 Non-Network Provider** means any Hospital, Day Care Center or other provider that is not part of the network.
- 5.56 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.
- 5.57 Policy** means these terms and conditions, the Policy Schedule (as amended from time to time), Your statements in the Proposal and the Information Summary Sheet and any endorsements attached by Us to the Policy from time to time.
- 5.58 Policy Period** is the period between the inception date and the expiry date of the Policy as specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier.
- 5.59 Policy Year** means the period of one year commencing on the date of commencement specified in the Policy Schedule or any anniversary thereof.
- 5.60 Pre-existing Disease** means any condition, ailment, injury or disease
- 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
 - 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.
- 5.61 Pre-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:
- Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
 - The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
- 5.62 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:
- Such Medical Expenses are for the same condition for which the Insured Person's Hospitalization was required, and
 - The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
- 5.63 Policy Schedule** means a certificate issued by Us, and, if more than one, then the latest in time. The Policy Schedule contains details of the Policyholder, Insured Persons, the Sum Insured and other relevant details related to the coverage.
- 5.64 Portability** means the right accorded to an individual health insurance policyholders (including all members under **the family cover**), **to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.**
- 5.65 Primary Insured Person** means the Policyholder if he/she is covered under the Policy as an Insured Person. In case Policyholder is not an Insured Person, then Primary Insured Person will be the eldest Insured Person covered under the Policy.

Smart Health

- 5.66 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.
- 5.67 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.
- 5.68 Reimbursement** means settlement of claims paid directly by Us to the Policyholder/Insured Person.
- 5.69 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.
- 5.70 Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the Associated Medical Expenses.
- 5.71 Service Provider** means any person, organization, institution that has been empanelled with Us to provide services specified under the benefits to the Insured Person.
- 5.72 Single Private Room** means an air conditioned room in a Hospital where a single patient is accommodated and which has an attached toilet (lavatory and bath). Such room type shall be the most basic and the most economical of all accommodations available as a single room in that Hospital.
- 5.73 Standby Services** are services of another Medical Practitioner requested by treating Medical Practitioner and involving prolonged attendance without direct (face-to-face) patient contact or involvement.
- 5.74 Sum Insured** means the total of the Base Sum Insured which is Our maximum, total and cumulative liability for any and all claims during the Policy Year in respect of all Insured Person(s) which is specified in the Policy Schedule.
- 5.75 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 or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.
- 5.76 Survival Period** means the period, if any, specified under the Policy after the occurrence of an Insured Event that the Insured Person has to survive before a claim becomes admissible under the Policy.
- 5.77 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
- 5.78 Waiting Period** means a time-bound exclusion period related to condition(s) specified in the Policy Schedule or the Policy which shall be served before a claim related to such condition(s) becomes admissible.
- 5.79 We/Our/Us** means Max Bupa Health Insurance Company Limited.
- 5.80 You/Your/Policyholder** means the person named in the Policy Schedule who has concluded this Policy with Us.

Annexure I - List of Insurance Ombudsmen

Office of the Ombudsman	Name of the Ombudsman	Contact Details	Areas of Jurisdiction
AHMEDABAD	Shri. Kuldip Singh	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Smt. Neerja Shah	Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka
BHOPAL	Shri Guru Saran Shrivastava	Office of the Insurance Ombudsman, JanakVihar Complex, 2 nd 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	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Shri Suresh Chandra Panda	Office of the Insurance Ombudsman, 62, Forest park Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa
CHANDIGARH	Dr. Dinesh Kumar Verma	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:	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir , UT of Chandigarh

		bimalokpal.chandigarh@ecoi.co.in	
CHENNAI	Shri M. Vasantha Krishna	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	Tamil Nadu, UT- Pondicherry Town and Karaikal (which are part of UT of Pondicherry)
DELHI	Shri Sudhir Krishna	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481 / 23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi
GUWAHATI	Shri Kiriti .B. Saha	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Shri I. Suresh Babu	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, UT of Yanam and part of territory of UT of Pondicherry
JAIPUR	Smt. Sandhya Baliga	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@ecoi.co.in	Rajasthan
ERNAKULAM	Ms.PoonamBodra	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.	Kerala , UT of (a)Lakshadweep , (b) Mahe – a part of UT of Pondicherry

		<p>Tel.: 0484 - 2358759 / 2359338 Fax: 0484 – 2359336 <u>Email:</u> bimalokpal.ernakulam@ecoi.co.in</p>	
KOLKATA	Shri. P.K.Rath	<p>Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 – 22124341 <u>Email: bimalokpal.kolkata@ecoi.co.in</u></p>	West Bengal , UT of Andaman & Nicobar Islands , Sikkim
LUCKNOW	Shri Justice Anil Kumar Srivastava	<p>Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 – 2231310 <u>Email: bimalokpal.lucknow@ecoi.co.in</u></p>	Districts of Uttar Pradesh Laitpur, Jhansi, Mahoba Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur Lucknow, Unnao, Sitapur Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajganj Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI	Shri Milind A. Kharat	<p>Office of the Insurance Ombudsman, 3rd Floor, Jeevan SevaAnnexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 – 26106052</p>	Goa, Mumbai metropolitan region excluding Navi Mumbai Thane

		Email: bimalokpal.mumbai@ecoi.co.in	
NOIDA	Shri Chandra Shekhar Prasad	Office of the Insurance Ombudsman, BhagwanSahai Palace 4 th Floor, Main Road, Naya Bans, Sector 15 Distt: GautamBudh Nagar, UP – 201301 Tel: 0120-2514250/2514252/2514253 Email: bimalokpal.noida@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.
PATNA	Shri N.K.Singh	Office of the Insurance Ombudsman, 1 st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800006 Tel: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE	Shri. Vinay Shah	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Smart Health



EXECUTIVE COUNCIL OF INSURERS,
3rd Floor, Jeevan SevaAnnexe,
S. V. Road, Santacruz (W),
Mumbai - 400 054.

Tel.: 022 - 26106889 / 671 / 980

Fax: 022 - 26106949

Email: inscoun@ecoi.co.in

Shri. M.M.L. Verma, Secretary General
Smt. MoushumiMukherji, Secretary

ANNEXURE II

EXPENSES NOT COVERED OR SUBSUMED INTO ROOM CHARGES / PROCEDURE CHARGES / COSTS OF TREATMENT

List I – Expenses not covered

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

Smart Health

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

Smart Health

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	PULSEOXYMER 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
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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

DAY CARE TREATMENTS

Either one of the below two options will be chosen at the time of designing the policy

Option 1:

Any procedure/treatment that takes more than 2 hours and less than 24 hours of hospitalization will be covered under Day Care Procedures.

Option 2: List of Day Care Treatments or as specified in the Policy Schedule/Certificate of Insurance

Sr. No	Header	Procedure Name
I	Cardiology Related:	
	1	CORONARY ANGIOGRAPHY
II	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
III	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
IV	ENT Related:	
	13	MYRINGOTOMY WITH GROMMET INSERTION
	14	TYMpanoplasty
	15	REMOVAL OF A TYMPANIC DRAIN
	16	KERATOSIS REMOVAL UNDER GA
	17	OPERATIONS ON THE TURBINATES (NASAL CONCHA)
	18	TYMpanoplasty WITH 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 (POSTAURA/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
V	Gastroenterology Related:	
	71	CHOLECYSTECTOMY AND CHOLEDOCHO-JEJUNOSTOMY/ DUODENOSTOMY/GASTROSTOMY/EXPL ORATION 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 PAPILOTOMY
	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	COLONOSCOPY 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
VI	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,
	110	THERAPEUTIC LAPAROSCOPY WITH LASER
	111	INFECTED KELOID EXCISION
	112	AXILLARY LYMPHADENECTOMY
	113	WOUND DEBRIDEMENT AND COVER
	114	ABSCESS-DECOMPRESSION
	115	CERVICAL LYMPHADENECTOMY
	116	INFECTED SEBACEOUS CYST
	117	INGUINAL LYMPHADENECTOMY
	118	INCISION AND DRAINAGE OF ABSCESS
	119	SUTURING OF LACERATIONS
	120	SCALP SUTURING
	121	INFECTED LIPOMA EXCISION
	122	MAXIMAL ANAL DILATATION
	123	PILES
	124	A)INJECTION SCLEROTHERAPY
	125	B)PILES BANDING
	126	LIVER ABSCESS- CATHETER DRAINAGE
	127	FISSURE IN ANO- FISSURECTOMY
	128	FIBROADENOMA BREAST EXCISION

129	OESOPHAGEAL VARICES SCLEROTHERAPY
130	ERCP - PANCREATIC DUCT STONE REMOVAL
131	PERIANAL ABSCESS I&D
132	PERIANAL HEMATOMA EVACUATION
133	UGI SCOPY AND POLYPECTOMY OESOPHAGUS
134	BREAST ABSCESS I& D
135	FEEDING GASTROSTOMY
136	OESOPHAGOSCOPY AND BIOPSY OF GROWTH OESOPHAGUS
137	ERCP - BILE DUCT STONE REMOVAL
138	ILEOSTOMY CLOSURE
139	COLONOSCOPY
140	POLYPECTOMY COLON
141	SPLENIC ABSCESES LAPAROSCOPIC DRAINAGE
142	UGI SCOPY AND POLYPECTOMY STOMACH
143	RIGID OESOPHAGOSCOPY FOR FB REMOVAL
144	FEEDING JEJUNOSTOMY
145	COLOSTOMY
146	ILEOSTOMY
147	COLOSTOMY CLOSURE
148	SUBMANDIBULAR SALIVARY DUCT STONE REMOVAL
149	PNEUMATIC REDUCTION OF INTUSSUSCEPTION
150	VARICOSE VEINS LEGS - INJECTION SCLEROTHERAPY
151	RIGID OESOPHAGOSCOPY FOR PLUMMER VINSON SYNDROME
152	PANCREATIC PSEUDOCYSTS ENDOSCOPIC DRAINAGE
153	ZADEK'S NAIL BED EXCISION
154	SUBCUTANEOUS MASTECTOMY
155	EXCISION OF RANULA UNDER GA
156	RIGID OESOPHAGOSCOPY FOR DILATION OF BENIGN STRICTURES
157	EVERSION OF SAC UNILATERAL/BILATERAL
158	LORD'S PPLICATION
159	JABOULAY'S PROCEDURE
160	SCROTOPLASTY
161	CIRCUMCISION FOR TRAUMA
162	MEATOPLASTY
163	INTERSPHINCTERIC ABSCESS INCISION AND DRAINAGE
164	PSOAS ABSCESS INCISION AND DRAINAGE
165	THYROID ABSCESS INCISION AND DRAINAGE

	166	TIPS PROCEDURE FOR PORTAL HYPERTENSION
	167	ESOPHAGEAL GROWTH STENT
	168	PAIR PROCEDURE OF HYDATID CYST LIVER
	169	TRU CUT LIVER BIOPSY
	170	PHOTODYNAMIC THERAPY OR ESOPHAGEAL TUMOUR AND LUNG TUMOUR
	171	EXCISION OF CERVICAL RIB
	172	LAPAROSCOPIC REDUCTION OF INTUSSUSCEPTION
	173	MICRODOCHETOMY BREAST
	174	SURGERY FOR FRACTURE PENIS
	175	SENTINEL NODE BIOPSY
	176	PARASTOMAL HERNIA
	177	REVISION COLOSTOMY
	178	PROLAPSED COLOSTOMY- CORRECTION
	179	TESTICULAR BIOPSY
	180	LAPAROSCOPIC CARDIOMYOTOMY(HELLERS)
	181	SENTINEL NODE BIOPSY MALIGNANT MELANOMA
	182	LAPAROSCOPIC PYLOROMYOTOMY(RAMSTEDT)
	183	EXCISION OF FISTULA-IN-ANO
	184	EXCISION JUVENILE POLYPS RECTUM
	185	VAGINOPLASTY
	186	DILATATION OF ACCIDENTAL CAUSTIC STRICTURE OESOPHAGEAL
	187	PRESACRAL TERATOMAS EXCISION
	188	REMOVAL OF VESICAL STONE
	189	EXCISION SIGMOID POLYP
	190	STERNOMASTOID TENOTOMY
	191	INFANTILE HYPERTROPHIC PYLORIC STENOSIS PYLOROMYOTOMY
	192	EXCISION OF SOFT TISSUE RHABDOMYOSARCOMA
	193	MEDIASTINAL LYMPH NODE BIOPSY
	194	HIGH ORCHIDECTOMY FOR TESTIS TUMOURS
	195	EXCISION OF CERVICAL TERATOMA
	196	RECTAL-MYOMECTIONY
	197	RECTAL PROLAPSE (DELORME'S PROCEDURE)
	198	DETORSION OF TORSION TESTIS
	199	EUA + BIOPSY MULTIPLE FISTULA IN ANO
	200	CYSTIC HYGROMA - INJECTION TREATMENT
VII	Gynecology Related:	
	201	OPERATIONS ON BARTHOLIN'S GLANDS (CYST)

202	INCISION OF THE OVARY
203	INSUFFLATIONS OF THE FALLOPIAN TUBES
204	OTHER OPERATIONS ON THE FALLOPIAN TUBE
205	DILATATION OF THE CERVICAL CANAL
206	CONISATION OF THE UTERINE CERVIX
207	THERAPEUTIC CURETTAGE WITH COLPOSCOPY/BIOPSY/DIATHERMY/CRY OSURGERY/
208	LASER THERAPY OF CERVIX FOR VARIOUS LESIONS OF UTERUS
209	OTHER OPERATIONS ON THE UTERINE CERVIX
210	LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE VAGINA AND THE POUCH OF DOUGLAS
211	INCISION OF VAGINA
212	INCISION OF VULVA
213	CULDOTOMY
214	SALPINGO-OOPHORECTOMY VIA LAPAROTOMY
215	ENDOSCOPIC POLYPECTOMY
216	HYSTEROSCOPIC REMOVAL OF MYOMA
217	D&C
218	HYSTEROSCOPIC RESECTION OF SEPTUM
219	THERMAL CAUTERISATION OF CERVIX
220	MIRENA INSERTION
221	HYSTEROSCOPIC ADHESIOLYSIS
222	LEEP (LOOP ELECTROSURGICAL EXCISION PROCEDURE)
223	CRYOCAUTERISATION OF CERVIX
224	POLYPECTOMY ENDOMETRIUM
225	HYSTEROSCOPIC RESECTION OF FIBROID
226	LLETZ (LARGE LOOP EXCISION OF TRANSFORMATION ZONE)
227	CONIZATION
228	POLYPECTOMY CERVIX
229	HYSTEROSCOPIC RESECTION OF ENDOMETRIAL POLYP
230	VULVAL WART EXCISION
231	LAPAROSCOPIC PARAOVARIAN CYST EXCISION
232	UTERINE ARTERY EMBOLIZATION
233	LAPAROSCOPIC CYSTECTOMY
234	HYMENECTOMY(IMPERFORATE HYMEN)
235	ENDOMETRIAL ABLATION
236	VAGINAL WALL CYST EXCISION
237	VULVAL CYST EXCISION

	238	LAPAROSCOPIC PARATUBAL CYST EXCISION
	239	REPAIR OF VAGINA (VAGINAL ATRESIA)
	240	HYSTEROSCOPY, REMOVAL OF MYOMA
	241	TURBT
	242	URETEROCOELE REPAIR - CONGENITAL INTERNAL
	243	VAGINAL MESH FOR POP
	244	LAPAROSCOPIC MYOMECTOMY
	245	SURGERY FOR SUI
	246	REPAIR RECTO- VAGINA FISTULA
	247	PELVIC FLOOR REPAIR(EXCLUDING FISTULA REPAIR)
	248	URS + LL
	249	LAPAROSCOPIC OOPHORECTOMY
	250	NORMAL VAGINAL DELIVERY AND VARIANTS
VIII	Neurology Related:	
	251	FACIAL NERVE PHYSIOTHERAPY
	252	NERVE BIOPSY
	253	MUSCLE BIOPSY
	254	EPIDURAL STEROID INJECTION
	255	GLYCEROL RHIZOTOMY
	256	SPINAL CORD STIMULATION
	257	MOTOR CORTEX STIMULATION
	258	STEREOTACTIC RADIOSURGERY
	259	PERCUTANEOUS CORDOTOMY
	260	INTRATHECAL BACLOFEN THERAPY
	261	ENTRAPMENT NEUROPATHY RELEASE
	262	DIAGNOSTIC CEREBRAL ANGIOGRAPHY
	263	VP SHUNT
	264	VENTRICULOATRIAL SHUNT
IX	Oncology Related:	
	265	RADIOTHERAPY FOR CANCER
	266	CANCER CHEMOTHERAPY
	267	IV PUSH CHEMOTHERAPY
	268	HBI-HEMIBODY RADIOTHERAPY
	269	INFUSIONAL TARGETED THERAPY
	270	SRT-STEREOTACTIC ARC THERAPY
	271	SC ADMINISTRATION OF GROWTH FACTORS
	272	CONTINUOUS INFUSIONAL CHEMOTHERAPY

273	INFUSIONAL CHEMOTHERAPY
274	CCRT-CONCURRENT CHEMO + RT
275	2D RADIOTHERAPY
276	3D CONFORMAL RADIOTHERAPY
277	IGRT- IMAGE GUIDED RADIOTHERAPY
278	IMRT- STEP & SHOOT
279	INFUSIONAL BISPHOSPHONATES
280	IMRT- DMLC
281	ROTATIONAL ARC THERAPY
282	TELE GAMMA THERAPY
283	FSRT-FRACTIONATED SRT
284	VMAT-VOLUMETRIC MODULATED ARC THERAPY
285	SBRT-STEREOTACTIC BODY RADIOTHERAPY
286	HELICAL TOMOTHERAPY
287	SRS-STEREOTACTIC RADIOSURGERY
288	X-KNIFE SRS
289	GAMMAKNIFE SRS
290	TBI- TOTAL BODY RADIOTHERAPY
291	INTRALUMINAL BRACHYTHERAPY
292	ELECTRON THERAPY
293	TSET-TOTAL ELECTRON SKIN THERAPY
294	EXTRACORPOREAL IRRADIATION OF BLOOD PRODUCTS
295	TELECOBALT THERAPY
296	TELECESIUM THERAPY
297	EXTERNAL MOULD BRACHYTHERAPY
298	INTERSTITIAL BRACHYTHERAPY
299	INTRACAVITY BRACHYTHERAPY
300	3D BRACHYTHERAPY
301	IMPLANT BRACHYTHERAPY
302	INTRAVESICAL BRACHYTHERAPY
303	ADJUVANT RADIOTHERAPY
304	AFTERLOADING CATHETER BRACHYTHERAPY
305	CONDITIONING RADIOTHEAPRY FOR BMT
306	EXTRACORPOREAL IRRADIATION TO THE HOMOLOGOUS BONE GRAFTS
307	RADICAL CHEMOTHERAPY
308	NEOADJUVANT RADIOTHERAPY
309	LDR BRACHYTHERAPY

	310	PALLIATIVE RADIOTHERAPY
	311	RADICAL RADIOTHERAPY
	312	PALLIATIVE CHEMOTHERAPY
	313	TEMPLATE BRACHYTHERAPY
	314	NEOADJUVANT CHEMOTHERAPY
	315	ADJUVANT CHEMOTHERAPY
	316	INDUCTION CHEMOTHERAPY
	317	CONSOLIDATION CHEMOTHERAPY
	318	MAINTENANCE CHEMOTHERAPY
	319	HDR BRACHYTHERAPY
X	Operations on the salivary glands & salivary ducts:	
	320	INCISION AND LANCING OF A SALIVARY GLAND AND A SALIVARY DUCT
	321	EXCISION OF DISEASED TISSUE OF A SALIVARY GLAND AND A SALIVARY DUCT
	322	RESECTION OF A SALIVARY GLAND
	323	RECONSTRUCTION OF A SALIVARY GLAND AND A SALIVARY DUCT
	324	OTHER OPERATIONS ON THE SALIVARY GLANDS AND SALIVARY DUCTS
XI	Operations on the skin & subcutaneous tissues:	
	325	OTHER INCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
	326	SURGICAL WOUND TOILET (WOUND DEBRIDEMENT) AND REMOVAL OF DISEASED TISSUE OF THE SKIN AND SUBCUTANEOUS TISSUES
	327	LOCAL EXCISION OF DISEASED TISSUE OF THE SKIN AND SUBCUTANEOUS TISSUES
	328	OTHER EXCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
	329	SIMPLE RESTORATION OF SURFACE CONTINUITY OF THE SKIN AND SUBCUTANEOUS TISSUES
	330	FREE SKIN TRANSPLANTATION, DONOR SITE
	331	FREE SKIN TRANSPLANTATION, RECIPIENT SITE
	332	REVISION OF SKIN PLASTY
	333	OTHER RESTORATION AND RECONSTRUCTION OF THE SKIN AND SUBCUTANEOUS TISS
	334	CHEMOSURGERY TO THE SKIN
	335	DESTRUCTION OF DISEASED TISSUE IN THE SKIN AND SUBCUTANEOUS TISSUES
	336	RECONSTRUCTION OF DEFORMITY/DEFECT IN NAIL BED
	337	EXCISION OF BURSIRTIS
	338	TENNIS ELBOW RELEASE
XII	Operations on the Tongue:	
	339	INCISION, EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE TONGUE
	340	PARTIAL GLOSSECTOMY
	341	GLOSSECTOMY
	342	RECONSTRUCTION OF THE TONGUE

	343	SMALL RECONSTRUCTION OF THE TONGUE
XIII	Ophthalmology Related:	
	344	SURGERY FOR CATARACT
	345	INCISION OF TEAR GLANDS
	346	OTHER OPERATIONS ON THE TEAR DUCTS
	347	INCISION OF DISEASED EYELIDS
	348	EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE EYELID
	349	OPERATIONS ON THE CANTHUS AND EPICANTHUS
	350	CORRECTIVE SURGERY FOR ENTROPION AND ECTROPION
	351	CORRECTIVE SURGERY FOR BLEPHAROPTOSIS
	352	REMOVAL OF A FOREIGN BODY FROM THE CONJUNCTIVA
	353	REMOVAL OF A FOREIGN BODY FROM THE CORNEA
	354	INCISION OF THE CORNEA
	355	OPERATIONS FOR PTERYGIUM
	356	OTHER OPERATIONS ON THE CORNEA
	357	REMOVAL OF A FOREIGN BODY FROM THE LENS OF THE EYE
	358	REMOVAL OF A FOREIGN BODY FROM THE POSTERIOR CHAMBER OF THE EYE
	359	REMOVAL OF A FOREIGN BODY FROM THE ORBIT AND EYEBALL
	360	CORRECTION OF EYELID PTOSIS BY LEVATOR PALPEBRAE SUPERIORIS RESECTION (BILATERAL)
	361	CORRECTION OF EYELID PTOSIS BY FASCIA LATA GRAFT (BILATERAL)
	362	DIATHERMY/CRYOTHERAPY TO TREAT RETINAL TEAR
	363	ANTERIOR CHAMBER PARACENTESIS/ CYCLODIATHERMY/CYCLOCRYOTHERAP Y/ GONIOTOMY/TRABECULOTOMY AND FILTERING AND ALLIED OPERATIONS TO TREAT GLAUCOMA
	364	ENUCLEATION OF EYE WITHOUT IMPLANT
	365	DACRYOCYSTORHINOSTOMY FOR VARIOUS LESIONS OF LACRIMAL GLAND
	366	LASER PHOTOCOAGULATION TO TREAT RETINAL TEAR
	367	BIOPSY OF TEAR GLAND
	368	TREATMENT OF RETINAL LESION
XIV	Orthopedics Related:	
	369	SURGERY FOR MENISCUS TEAR
	370	INCISION ON BONE, SEPTIC AND ASEPTIC
	371	CLOSED REDUCTION ON FRACTURE, LUXATION OR EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
	372	SUTURE AND OTHER OPERATIONS ON TENDONS AND TENDON SHEATH
	373	REDUCTION OF DISLOCATION UNDER GA
	374	ARTHROSCOPIC KNEE ASPIRATION
	375	SURGERY FOR LIGAMENT TEAR

376	SURGERY FOR HEMOARTHROSIS/PYOARTHROSIS
377	REMOVAL OF FRACTURE PINS/NAILS
378	REMOVAL OF METAL WIRE
379	CLOSED REDUCTION ON FRACTURE, LUXATION
380	REDUCTION OF DISLOCATION UNDER LA
381	EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
382	EXCISION OF VARIOUS LESIONS IN COCCYX
383	ARTHROSCOPIC REPAIR OF ACL TEAR KNEE
384	CLOSED REDUCTION OF MINOR FRACTURES
385	ARTHROSCOPIC REPAIR OF PCL TEAR KNEE
386	TENDON SHORTENING
387	ARTHROSCOPIC MENISCECTOMY - KNEE
388	TREATMENT OF CLAVICLE DISLOCATION
389	HAEMARTHROSIS KNEE- LAVAGE
390	ABSCESS KNEE JOINT DRAINAGE
391	CARPAL TUNNEL RELEASE
392	CLOSED REDUCTION OF MINOR DISLOCATION
393	REPAIR OF KNEE CAP TENDON
394	ORIF WITH K WIRE FIXATION- SMALL BONES
395	RELEASE OF MIDFOOT JOINT
396	ORIF WITH PLATING- SMALL LONG BONES
397	IMPLANT REMOVAL MINOR
398	K WIRE REMOVAL
399	POP APPLICATION
400	CLOSED REDUCTION AND EXTERNAL FIXATION
401	ARTHROTOMY HIP JOINT
402	SYME'S AMPUTATION
403	ARTHROPLASTY
404	PARTIAL REMOVAL OF RIB
405	TREATMENT OF SESAMOID BONE FRACTURE
406	SHOULDER ARTHROSCOPY / SURGERY
407	ELBOW ARTHROSCOPY
408	AMPUTATION OF METACARPAL BONE
409	RELEASE OF THUMB CONTRACTURE
410	INCISION OF FOOT FASCIA
411	CALCANEUM SPUR HYDROCORT INJECTION
412	GANGLION WRIST HYALASE INJECTION

	413	PARTIAL REMOVAL OF METATARSAL
	414	REPAIR / GRAFT OF FOOT TENDON
	415	REVISION/REMOVAL OF KNEE CAP
	416	AMPUTATION FOLLOW-UP SURGERY
	417	EXPLORATION OF ANKLE JOINT
	418	REMOVE/GRAFT LEG BONE LESION
	419	REPAIR/GRAFT ACHILLES TENDON
	420	REMOVE OF TISSUE EXPANDER
	421	BIOPSY ELBOW JOINT LINING
	422	REMOVAL OF WRIST PROSTHESIS
	423	BIOPSY FINGER JOINT LINING
	424	TENDON LENGTHENING
	425	TREATMENT OF SHOULDER DISLOCATION
	426	LENGTHENING OF HAND TENDON
	427	REMOVAL OF ELBOW BURSA
	428	FIXATION OF KNEE JOINT
	429	TREATMENT OF FOOT DISLOCATION
	430	SURGERY OF BUNION
	431	INTRA ARTICULAR STEROID INJECTION
	432	TENDON TRANSFER PROCEDURE
	433	REMOVAL OF KNEE CAP BURSA
	434	TREATMENT OF FRACTURE OF ULNA
	435	TREATMENT OF SCAPULA FRACTURE
	436	REMOVAL OF TUMOR OF ARM/ ELBOW UNDER RA/GA
	437	REPAIR OF RUPTURED TENDON
	438	DECOMPRESS FOREARM SPACE
	439	REVISION OF NECK MUSCLE (TORTICOLLIS RELEASE)
	440	LENGTHENING OF THIGH TENDONS
	441	TREATMENT FRACTURE OF RADIUS & ULNA
	442	REPAIR OF KNEE JOINT
XV	Other operations on the mouth & face:	
	443	EXTERNAL INCISION AND DRAINAGE IN THE REGION OF THE MOUTH, JAW AND FACE
	444	INCISION OF THE HARD AND SOFT PALATE
	445	EXCISION AND DESTRUCTION OF DISEASED HARD AND SOFT PALATE
	446	INCISION, EXCISION AND DESTRUCTION IN THE MOUTH
	447	OTHER OPERATIONS IN THE MOUTH
XVI	Plastic Surgery Related:	

	448	CONSTRUCTION SKIN PEDICLE FLAP
	449	GLUTEAL PRESSURE ULCER-EXCISION
	450	MUSCLE-SKIN GRAFT, LEG
	451	REMOVAL OF BONE FOR GRAFT
	452	MUSCLE-SKIN GRAFT DUCT FISTULA
	453	REMOVAL CARTILAGE GRAFT
	454	MYOCUTANEOUS FLAP
	455	FIBRO MYOCUTANEOUS FLAP
	456	BREAST RECONSTRUCTION SURGERY AFTER MASTECTOMY
	457	SLING OPERATION FOR FACIAL PALSY
	458	SPLIT SKIN GRAFTING UNDER RA
	459	WOLFE SKIN GRAFT
	460	PLASTIC SURGERY TO THE FLOOR OF THE MOUTH UNDER GA
XVII	Thoracic surgery Related:	
	461	THORACOSCOPY AND LUNG BIOPSY
	462	EXCISION OF CERVICAL SYMPATHETIC CHAIN THORACOSCOPIC
	463	LASER ABLATION OF BARRETT'S OESOPHAGUS
	464	PLEURODESIS
	465	THORACOSCOPY AND PLEURAL BIOPSY
	466	EBUS + BIOPSY
	467	THORACOSCOPY LIGATION THORACIC DUCT
	468	THORACOSCOPY ASSISTED EMPYAEMA DRAINAGE
XVIII	Urology Related:	
	469	HAEMODIALYSIS
	470	LITHOTRIPSY/NEPHROLITHOTOMY FOR RENAL CALCULUS
	471	EXCISION OF RENAL CYST
	472	DRAINAGE OF PYONEPHROSIS/PERINEPHRIC ABSCESS
	473	INCISION OF THE PROSTATE
	474	TRANSURETHRAL EXCISION AND DESTRUCTION OF PROSTATE TISSUE
	475	TRANSURETHRAL AND PERCUTANEOUS DESTRUCTION OF PROSTATE TISSUE
	476	OPEN SURGICAL EXCISION AND DESTRUCTION OF PROSTATE TISSUE
	477	RADICAL PROSTATOVESICULECTOMY
	478	OTHER EXCISION AND DESTRUCTION OF PROSTATE TISSUE
	479	OPERATIONS ON THE SEMINAL VESICLES
	480	INCISION AND EXCISION OF PERIPROSTATIC TISSUE
	481	OTHER OPERATIONS ON THE PROSTATE
	482	INCISION OF THE SCROTUM AND TUNICA VAGINALIS TESTIS

483	OPERATION ON A TESTICULAR HYDROCELE
484	EXCISION AND DESTRUCTION OF DISEASED SCROTAL TISSUE
485	OTHER OPERATIONS ON THE SCROTUM AND TUNICA VAGINALIS TESTIS
486	INCISION OF THE TESTES
487	EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE TESTES
488	UNILATERAL ORCHIDECTOMY
489	BILATERAL ORCHIDECTOMY
490	SURGICAL REPOSITIONING OF AN ABDOMINAL TESTIS
491	RECONSTRUCTION OF THE TESTIS
492	IMPLANTATION, EXCHANGE AND REMOVAL OF A TESTICULAR PROSTHESIS
493	OTHER OPERATIONS ON THE TESTIS
494	EXCISION IN THE AREA OF THE EPIDIDYMIS
495	OPERATIONS ON THE FORESKIN
496	LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE PENIS
497	AMPUTATION OF THE PENIS
498	OTHER OPERATIONS ON THE PENIS
499	CYSTOSCOPICAL REMOVAL OF STONES
500	CATHETERISATION OF BLADDER
501	LITHOTRIPSY
502	BIOPSY OF TEMPORAL ARTERY FOR VARIOUS LESIONS
503	EXTERNAL ARTERIO-VEINOUS SHUNT
504	AV FISTULA - WRIST
505	URSL WITH STENTING
506	URSL WITH LITHOTRIPSY
507	CYSTOSCOPIC LITHOLAPAXY
508	ESWL
509	BLADDER NECK INCISION
510	CYSTOSCOPY & BIOPSY
511	CYSTOSCOPY AND REMOVAL OF POLYP
512	SUPRAPUBIC CYSTOSTOMY
513	PERCUTANEOUS NEPHROSTOMY
514	CYSTOSCOPY AND "SLING" PROCED
515	TUNA- PROSTATE
516	EXCISION OF URETHRAL DIVERTICULUM
517	REMOVAL OF URETHRAL STONE
518	EXCISION OF URETHRAL PROLAPSE
519	MEGA-URETER RECONSTRUCTION

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	520	KIDNEY RENOSCOPY AND BIOPSY
	521	URETER ENDOSCOPY AND TREATMENT
	522	VESICO URETERIC REFLUX CORRECTION
	523	SURGERY FOR PELVI URETERIC JUNCTION OBSTRUCTION
	524	ANDERSON HYNES OPERATION (OPEN PYELOPALSTY)
	525	KIDNEY ENDOSCOPY AND BIOPSY
	526	PARAPHIMOSIS SURGERY
	527	INJURY PREPUCE- CIRCUMCISION
	528	FRENULAR TEAR REPAIR
	529	MEATOTOMY FOR MEATAL STENOSIS
	530	SURGERY FOR FOURNIER'S GANGRENE SCROTUM
	531	SURGERY FILARIAL SCROTUM
	532	SURGERY FOR WATERING CAN PERINEUM
	533	REPAIR OF PENILE TORSION
	534	DRAINAGE OF PROSTATE ABSCESS
	535	ORCHIECTOMY
	536	CYSTOSCOPY AND REMOVAL OF FB

ANNEXURE IV

Product Benefit Table



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