

1. Preamble

This is a contract of insurance between **You** and **Us** which is subject to the realisation of the full premium in advance and the terms, conditions and exclusions to this **Policy**. This **Policy** has been issued on the basis of the **Disclosure to Information Norm**, including the information provided by **You** in respect of the **Insured Persons** in the Proposal and the **Information Summary Sheet**.

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

Note: *The terms listed in Section 12 (Definitions & Interpretation) and used elsewhere in the Policy in Initial Capitals and Bold shall have the meaning set out against them in Section 12 wherever they appear in the Policy.*

2. Benefits available under the Policy

- a. The Benefits available under this **Policy** are described below.
- b. The **Policy** covers **Reasonable and Customary Charges** incurred towards medical treatment taken by the **Insured Person** during the **Policy Period** for an **Illness, Injury** or conditions described in the sections below, if it is contracted or sustained by an **Insured Person** during the **Policy Period**. The Benefits listed in the sections below will be payable subject to the terms, conditions and exclusions of this **Policy** and the availability of the **Sum Insured** and subject always to any sub-limits in respect of that Benefit as specified in the **Product Benefits Table** and any limits specified in the **Product Benefits Table** as applicable under the Plan in force for the **Insured Person** as specified in the **Schedule of Insurance Certificate**.
- c. All claims for any benefits under the **Policy** must be made in accordance with the process defined under Section 9 (Claim process & Requirements).
- d. All claims paid under any benefit except for Section 3.6 (**Second Medical Opinion**), Section 4.2 (Health Checkup) and Section 5.1 (Hospital Cash) shall reduce the **Sum Insured** for that **Policy Year** and only the balance **Sum Insured** after payment of claim amounts admitted shall be available for all future claims arising in that **Policy Year**.

2.1 Inpatient Care

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

- a. The **Hospitalization** is **Medically Necessary** and advised 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, drugs as prescribed by the treating **Medical Practitioner**;
 - vi. Intravenous fluids, blood transfusion, injection administration charges and /or consumables;
 - vii. Operation theatre charges;
 - viii. The cost of prosthetics and other devices or equipment, if implanted internally during **Surgery**;
 - ix. **Intensive Care Unit** charges.
- c. If the **Insured Person** is admitted in the **Hospital** in a room category/**Room Rent** higher than the eligibility as specified in the **Product Benefits Table**, then **We** shall be liable to pay only a pro-rated proportion of the total **Associated Medical Expenses** (including surcharge or taxes thereon) in the proportion of the difference between the **Room Rent** actually incurred and the entitled room category/eligible **Room Rent** to the **Room Rent** actually incurred.
- d. **We** shall not be liable to pay the visiting fees or consultation charges for any **Medical Practitioner** visiting the **Insured Person** unless such:
 - i. **Medical Practitioner's** treatment or advice has been sought by the **Hospital**; and
 - ii. Visiting fees or consultation charges are included in the **Hospital's** bill; and
 - iii. Visiting fees or consultation charges are not more than the treating or referral **Medical Practitioner's** consultation charges.

2.2 Pre-hospitalization Medical Expenses

We will indemnify the **Insured Person's Pre-hospitalization Medical Expenses** incurred following an **Illness** or **Injury** that occurs during the **Policy Period** provided that:

- a. We have accepted a claim for **Inpatient Care** under Section 2.1 (**Inpatient Care**) above.
- b. We will not be liable to pay **Pre-hospitalization Medical Expenses** for more than 60 days 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 the **Policy** on a **Reimbursement** basis only.
- d. This benefit is not applicable for expenses incurred outside India as defined under Section 3.3.1 (**Emergency Medical Evacuation** – outside the geographical boundaries of India), Section 3.4 (**Emergency Hospitalization** – outside the geographical boundaries of India) and Section 3.5 (**Specified Illness** cover – outside the geographical boundaries of India).
- e. **Pre-hospitalization Medical Expenses** incurred on Physiotherapy will also be payable provided that such Physiotherapy is **Medically Necessary** and advised by the treating **Medical Practitioner** and has been availed under as **Complementary & Alternative Medicine** only.

2.3 Post-hospitalization Medical Expenses

We will indemnify the **Insured Person's Post-hospitalization Medical Expenses** incurred following an **Illness** or **Injury** that occurs during the **Policy Period** as advised by the treating **Medical Practitioner** provided that:

- a. We have accepted a claim for **Inpatient Care** under Section 2.1 (**Inpatient Care**) above.
- b. We will not be liable to pay **Post-hospitalization Medical Expenses** for more than 90 days immediately following the **Insured Person's** discharge from **Hospital**.
- c. **Post-hospitalization Medical Expenses** can be claimed under the **Policy** on a **Reimbursement** basis only.
- d. This benefit is not applicable for expenses incurred outside India as defined under Section 3.3.1 (**Emergency Medical Evacuation** – outside the geographical boundaries of India), Section 3.4 (**Emergency Hospitalization** – outside the geographical boundaries of India) and Section 3.5 (**Specified Illness** cover for treatment outside the geographical boundaries of India).
- e. **Post-hospitalization Medical Expenses** incurred on Physiotherapy will also be payable provided that such Physiotherapy is **Medically Necessary** and advised by the treating **Medical Practitioner** and has been availed under as **Complementary & Alternative Medicine** only.

2.4 Alternative Treatments

We will indemnify the **Reasonable and Customary Charges** for **Medical Expenses** incurred on the **Insured Person's Medically Necessary** and **Medically Advised Inpatient Hospitalization** during the **Policy Period** on treatment taken under Ayurveda, Unani, Sidha and Homeopathy (AYUSH) in a government **Hospital** or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health.

Pre-hospitalization Medical Expenses incurred for upto 60 days prior to the **Alternative Treatments** being commenced and **Post-hospitalization Medical Expenses** incurred for up to 90 days following the **Alternative Treatment** being concluded will also be indemnified under this Benefit provided that these **Medical Expenses** relate only to **Alternative Treatments** only and not Allopathy.

Section 8.7 of the Permanent Exclusions shall not apply to the extent this Benefit is applicable.

2.5 Day Care Treatment

We will indemnify the **Medical Expenses** incurred on the **Insured Person's Hospitalization** for any **Day Care Treatment** during the **Policy Period** following an **Illness** or **Injury** that occurs during the **Policy Period** provided that:

- a. The **Day Care Treatment** is **Medically Necessary** and follows the written advice of a **Medical Practitioner**.
- b. The **Medical Expenses** incurred are **Reasonable and Customary Charges** for any procedure where such procedure is undertaken by an **Insured Person** as **Day Care Treatment**.
- c. The following procedures will be covered as **Day Care Treatment** under this benefit as they each require a period of specialized observation or care after completion of the procedure :
 - i. Stereotactic radiotherapy, radiotherapy, chemotherapy and immunotherapy for cancer (approved immunosuppressant drugs will be payable only if administered as a part of these procedures)
 - ii. Renal dialysis(Erythropoietin for chronic renal failure will be payable only if administered as a part of this procedure)
- d. We will not cover any **OPD Treatment** and **Diagnostic Services** under this Benefit.

2.6 Domiciliary Hospitalization

We will indemnify on a **Reimbursement** basis the **Medical Expenses** incurred for **Domiciliary Hospitalization** during the **Policy Period** following an **Illness** or **Injury** that occurs during the **Policy Period** provided that:

- a. The **Domiciliary Hospitalization** continues for at least 3 consecutive days in which case **We** will make payment under this Benefit in respect of **Medical Expenses** incurred from the first day of **Domiciliary Hospitalization**;
- b. The treating **Medical Practitioner** confirms in writing that the **Insured Person's** condition was such that the **Insured Person** could not be transferred to a **Hospital** OR the **Insured Person** satisfies **Us** that a **Hospital** bed was unavailable.

2.7 Maternity Benefit

We will indemnify the **Maternity Expenses** incurred during the **Policy Period** provided that:

- a. This benefit is available only if:
 - i. The female **Insured Person** of **Age** 18 years or above is covered under a **Family First Policy**; or
 - ii. Both the **Insured Person** and his / her legally married spouse are covered under a **Family Floater Policy**.
- b. This Benefit cannot be availed under an **Individual Policy**.
- c. The female **Insured Person** in respect of whom a claim for Maternity Benefits is made must have been covered as an **Insured Person** for a period of 24 months of continuous coverage since the inception of the **First Policy**, with maternity as a benefit, with **Us**.
- d. For the purposes of this benefit, **We** shall consider any eligibility period for maternity benefits served by the **Insured Person** under any previous policy with **Us**.
- e. The **Maternity Expenses** incurred are **Reasonable and Customary Charges**.
- f. 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** and lawful termination of pregnancy up to maximum 2 pregnancies or terminations.
- g. Any treatment related to the complication of pregnancy or termination will be treated within the maternity sub limits.
- h. On **Renewal**, if an enhanced **Sum Insured** is applied, 24 months of continuous coverage (as per Section 2.7 c.) would apply afresh to the extent of the increased benefit amount.

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 the Section 2.1 (**Inpatient Care**) and shall not fall under the Maternity Benefit.
- c. Sections 2.2 (**Pre-hospitalization Medical Expenses**) and Section 2.3 (**Post- hospitalization Medical Expenses**) are not payable under this benefit.
- d. Any **Maternity Expenses** or complications arising from or relating to pregnancy, complication of pregnancy or termination of pregnancy within 24 months from the inception of the **First Policy** with **Us**.
- e. Pre-natal and post-natal **Medical Expenses** are not payable under this benefit.

2.8 New Born Baby

We will cover the **Medical Expenses** incurred towards the medical treatment of the **Insured Person's New Born Baby** from the date of delivery until the expiry of the **Policy Year**, subject to continuous coverage of 24 months of that **Insured Person** since the inception of the **First Policy** which offers Maternity Benefit with **Us**, without the requirement of payment of any additional premium provided that;

- a. All the terms and conditions mentioned in Section 2.7 (Maternity Benefit) shall apply to this benefit as well.
- b. **We** have accepted the addition of the **New Born Baby** as an endorsement within 90 days from date of delivery
- c. **We** will indemnify the **Reasonable and Customary Charges** for **Medical Expenses** incurred for the vaccination of the **New Born Baby** shown in Annexure II to this **Policy** until the **New Born Baby** completes one year.
- d. If the **Policy** expires before the **New Born Baby** has completed one year, then **Medical Expenses** for vaccination will be covered only if the **Policy** is **Renewed** with the **New Born Baby** as an **Insured Person**.
- e. On the expiry of the **Policy Year** **We** will cover the baby as an **Insured Person** under the **Policy** on request of the Proposer, subject to **Our** Board approved underwriting policy and payment of the applicable additional premium.

2.9 Living Organ Donor Transplant

We will indemnify the **Medical Expenses** incurred for a living organ donor's **Inpatient** treatment for the harvesting of the organ donated provided that:

- 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** to undergo an organ transplant.
- c. **We** have accepted the recipient **Insured Person's** claim under Section 2.1 (**Inpatient Care**).
- d. **Medical Expenses** incurred are **Reasonable and Customary Charges**.

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

- a. The living organ donor's stay in a **Hospital** that is needed for them to donate their organ.
- b. Stem cell donation except for **Bone Marrow Transplant**.
- c. **Pre-hospitalization Medical Expenses** or **Post-hospitalization Medical Expenses** of the organ donor.
- d. Screening or any other **Medical Expenses** of the organ donor.
- e. Costs directly or indirectly associated with the acquisition of the donor's organ.
- f. Transplant of any organ/tissue where the transplant is experimental or investigational.
- g. Expenses related to organ transportation or preservation.
- h. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

2.10 Emergency Ambulance

We will indemnify the **Reasonable and Customary Charges** for ambulance expenses incurred to transfer the **Insured Person** by surface transport following an **Emergency** provided that:

- 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** for management of the current **Hospitalization**.
- b. This benefit is available for one transfer per **Hospitalization**.
- c. The ambulance service is offered by a healthcare or ambulance **Service Provider**.
- d. **We** have accepted a claim under Section 2.1 (**Inpatient Care**) above.
- e. If the ambulance is provided by a **Non-Network** provider, **We** will cover expenses up to the amount specified in the **Product Benefits Table**.
- f. **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.

3. Additional Benefits (for Platinum Policyholders only)

Note: The following benefits shall be available within the Policy Period only if the Insured Person is eligible to receive the benefits as per the Insured Person's Plan in the Product Benefits Table and as specified in the Schedule of Insurance Certificate.

The Additional Benefits cover **Reasonable and Customary Charges** incurred towards the medical treatment taken by the **Insured Person** during the **Policy Period** for an **Illness, Injury** or conditions described in the sections below, if it is contracted or sustained by an **Insured Person** during the **Policy Period**.

Additional Benefits will be payable subject to the terms, conditions and exclusions of this **Policy** and the availability of the **Sum Insured** and subject always to any sub-limits in respect of that Additional Benefit as specified in the **Product Benefits Table** and any limits specified in the **Product Benefits Table** as applicable under the Plan in force for the **Insured Person** as specified in the **Schedule of Insurance Certificate**.

All **Waiting Periods** under Section 7 and Permanent Exclusions under Section 8 shall apply to this section, unless specified otherwise in the **Policy**.

All claims for any benefits under the **Policy** must be made in accordance with the process defined under Section 9 (Claim process & Requirements).

3.1 OPD Treatment and Diagnostic Services

We will indemnify the **Reasonable and Customary Charges** incurred for **OPD Treatment** and/or **Diagnostic Services** and/or prescribed medicines for the **OPD Treatment** taken during the **Policy Period** provided that:

- a. Expenses under this benefit are covered for ayurvedic or homeopathic or unani or sidha or allopathic services only and not in conjugation with each other.
- b. For treatment taken under ayurveda, homeopathy, unani or sidha (AYUSH), expenses are covered only if taken in a government **Hospital** or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health.
- c. The **OPD Treatment** and/or **Diagnostic Services** are **Medically Necessary** and follow the written advice of a **Medical Practitioner**.
- d. **Diagnostic Services** are performed on an outpatient basis with or without local anesthetics for topical, infiltration, nerve block anesthesia and require **Hospitalization** for less than 24 hours.
- e. If the **Policy** is **Renewed** with **Us** without any break and there is a unutilized amount (not used by the **Insured Person**) under the applicable sub-limit (as specified in the **Product Benefits Table**) in a **Policy Year**, then **We** will carry forward 80% of this unutilized amount to the immediately succeeding **Policy Year**, provided that the total amount (including the unutilized amount available under this Additional Benefit) shall at no time exceed 2.5 times the amount of the entitlement in respect of this Additional Benefit under the Plan applicable to the **Insured Person**.
- f. Section 8.7 of the Permanent Exclusions shall not apply to this benefit.

3.2 Child Care Benefits

We will indemnify the **Reasonable and Customary Charges**, once during a **Policy Period**, incurred for the vaccination of the **Insured Persons** less than 12 years of **Age** for the vaccinations shown in Annexure III to this **Policy**.

We will also cover expenses towards one consultation for nutrition and growth provided to the child during a visit for vaccination.

3.3 Emergency Medical Evacuation

We will indemnify the **Reasonable and Customary Charges** for the **Insured Person's Medical Evacuation** in an **Emergency** and for which medical facilities are not available locally, but within the regions specified in the **Schedule of Insurance Certificate** during the **Policy Period** on **Cashless Facility** basis only provided that:

3.3.1 Outside the geographical boundaries of India

- a. **We** will provide this benefit from the place of **Insured Person's Hospitalization** (required for stabilization) to a **Hospital** where adequate treatment is available, if necessary treatment is not available locally or **Medical Evacuation** is **Medically Necessary** for saving the life of the **Insured Person**.

- b. **Medical Evacuation** is **Medically Necessary** and advised in the opinion of the treating **Medical Practitioner**.
- c. **We** or **Our Service Provider** has approved the request for **Medical Evacuation**.
- d. **We** or **Our Service Provider**, will arrange for the evacuation utilizing the means best suited to do so, based on the medical severity of **Insured Person(s)** condition.
- e. **We** will also cover the costs of transportation of an attending **Medical Practitioner** if this is **Medically Necessary** and advised.
- f. Under this benefit **We** will cover expenses for services provided and/or arranged by **Us** for the transportation of the **Insured Person** and shall include medical services and cost for medical supplies necessarily incurred as a result of the **Emergency Medical Evacuation**.
- g. **We** shall not be liable if necessary medical treatment can be provided at the **Hospital** where the **Insured Person** is situated at the time of **Emergency**.

3.3.2 **Within the geographical boundaries of India**

- a. **We** will provide this benefit from the place of **Insured Person's Hospitalization** (required for stabilization) to a **Hospital** where adequate treatment is available.
- b. **Medical Evacuation** by means of **Air Transportation** through air ambulance or commercial flight is **Medically Necessary** and advised in the opinion of treating **Medical Practitioner**.
- c. **We** or **Our Service Provider** has approved the request for **Medical Evacuation** and has certified that **Insured Person** to be evacuated is medically fit to be evacuated by **Air Transportation** through air ambulance/commercial flight.
- d. **We** or **Our Service Provider**, will arrange for the evacuation by means of **Air Transportation** through air ambulance or commercial flight utilizing the means best suited to do so, based on the medical severity of **Insured Person(s)** condition.
- e. **We** will also cover the costs of transportation of an attending **Medical Practitioner** if this is **Medically Necessary** and is advised by **Our Service Provider**.
- f. Under this benefit, **We** will cover expenses for services provided and/or arranged by **Us** for the transportation of the **Insured Person** and shall include medical services and cost for medical supplies necessarily incurred as a result of the **Emergency Medical Evacuation**.
- g. **We** shall not be liable to make any payment under this Benefit if necessary medical treatment can be provided at the **Hospital** where the **Insured Person** is situated at the time of **Emergency**.

For **Emergency Medical Evacuation**, **We** will not pay for:

- a. Any costs or expenses incurred in relation to any persons accompanying the **Insured Person** to be evacuated, even if such persons are also **Insured Person(s)**.
- b. Any expenses already included in the cost of a scheduled trip, including but not limited to the unutilized portion of the return air ticket for the scheduled trip.
- c. Any expenses for a service not approved and arranged by **Us** or **Our** authorized representative.

3.4 **Emergency Hospitalization (outside the geographical boundaries of India)**

If the **Insured Person** is required to be admitted in a **Hospital** immediately after the **Emergency Medical Evacuation** for the same diagnosis, **We** will indemnify the **Medical Expenses** incurred on **Hospitalization** of that **Insured Person** until the **Insured Person** reaches a **Medically Stable Condition** during the **Policy Period** on **Cashless Facility** basis only provided that:

- a. The **Hospitalization** is **Medically Necessary** and follows the written advice of the treating **Medical Practitioner**.
- b. The **Insured Person** is required to be admitted in a **Hospital** in an **Emergency** when the **Insured Person** is outside India, but within those regions specified in the **Schedule of Insurance Certificate**.
- c. 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**;
 - iii. **Medical Practitioners'** fees, excluding any charges or fees for **Standby Services**;
 - iv. Physiotherapy, investigation and diagnostics procedures directly related to the current admission;
 - v. Medicines, drugs as prescribed by the treating **Medical Practitioner**;
 - vi. Intravenous fluids, blood transfusion, injection administration charges and /or consumables;
 - vii. Operation theatre charges;
 - viii. The cost of prosthetics and other devices or equipment if implanted internally during a **Surgical Procedure**;
 - ix. **Intensive Care Unit** charges.

3.5 Specified Illness Cover (outside the geographical boundaries of India)

If an **Insured Person** suffers a **Specified Illness** as defined under Section 12.76 during the **Policy Period**, **We** will indemnify the **Reasonable and Customary Charges for Medical Expenses** of the **Insured Person** incurred towards treatment of that **Specified Illness** that would otherwise have been payable under Section 2.1 (**Inpatient Care**), on **Cashless Facility** basis only, provided that:

- a. The symptoms of the **Specified Illness** first occur or manifest itself during the **Policy Period** and after completion of the 90 day from the inception of the **First Policy** with **Us**.
- b. The **Specified Illness** is diagnosed by a **Medical Practitioner** within India during the **Policy Period** and after completion of the 90 day from the inception of the **First Policy** with **Us**.
- c. Medical treatment for the **Specified Illness** is taken outside India within the **Policy Period** but only within those regions specified in the **Schedule of Insurance Certificate**.
- d. It is agreed and understood that **We** shall not cover:
 - i. Any claims for **Reimbursement** of the costs incurred in relation to the treatment of the **Specified Illness** or any claims which are not pre-authorized by **Us**.
 - ii. Any costs or expenses incurred in relation to any persons accompanying the **Insured Person** during any period of treatment, even if such persons are also **Insured Persons**.
 - iii. Any costs or expenses incurred in relation to the travel to or from the overseas location where treatment is being taken.
 - iv. Any costs or expenses incurred in relation to personal stay or transportation in the overseas location where treatment is being taken.
 - v. Any pre-hospitalization or post-hospitalization costs or expenses incurred by or on behalf of the **Insured Person**.
 - vi. Any costs or expenses incurred in relation to transportation of repatriation of the mortal remains of the **Insured Person**.
 - vii. Any costs or expenses incurred by any organ donor in relation to harvesting of organs.
 - viii. Any **OPD Treatment** taken outside India.

3.6 Second Medical Opinion

If the **Insured Person** is diagnosed with a **Specified Illness** as defined under Section 12.76 or 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** provided that:

- 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**.
- 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.
- g. **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**.

4. Policy Value Added Benefits

Note: The following benefits shall be available only if the **Insured Person** is eligible to receive the benefits as per the **Insured Person's Plan** in the **Product Benefits Table** and as specified in the **Schedule of Insurance Certificate** in the **Policy Year** preceding the current **Policy**.

All claims for any benefits under the **Policy** must be made in accordance with the process defined under Section 9 (Claim process & Requirements).

4.1 Loyalty Additions

- a. For an **Individual Policy** or **Family Floater Policy**, if the **Policy** is **Renewed** with **Us** without a break or if the **Policy** continues to be in force for the 2nd **Policy Year** in the 2 year **Policy Period** (if applicable), each **Policy Year We** will increase the **Sum Insured** applicable under the **Policy** by 10% of the **Base Sum Insured** of the immediately preceding **Policy Year** subject to the percentage limit specified in the **Schedule of Insurance Certificate**. The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the **Sum Insured**.
- b. For a **Family First Policy**, if the **Policy** is **Renewed** with **Us** without a break or if the **Policy** continues to be in force for the 2nd **Policy Year** in the 2 year **Policy Period** (if applicable), each **Policy Year We** will increase the **Sum Insured** applicable under the **Policy** by 10% of the **Base Sum Insured** of each individual **Insured Person** only and the increase shall not apply to the Floater **Sum Insured** stated in the **Schedule of Insurance Certificate** as applicable under the **Policy**. The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the **Sum Insured**.
- c. If the **Insured Person** in the expiring **Policy** is covered under an **Individual Policy** and has an accumulated Loyalty Addition in the expiring **Policy** under this benefit, and such expiring **Policy** is **Renewed** with **Us** on a **Family Floater Policy**, then **We** shall not provide any credit for the accumulated Loyalty Addition to the **Family Floater Policy**.
- d. If the **Insured Person** in the expiring **Policy** is covered under an **Individual Policy** and has an accumulated Loyalty Addition in the expiring **Policy** under this benefit, and such expiring **Policy** is **Renewed** with **Us** on a **Family First Policy**, then the accumulated Loyalty Addition to be carried forward for credit in the **Renewing Policy** would be the accumulated Loyalty Addition for that **Insured Person** only.
- e. If the **Insured Persons** in the expiring **Policy** are covered under a **Family First Policy** and have an accumulated Loyalty Addition for each **Insured Person** in the expiring **Policy** under this benefit, and such expiring **Policy** is **Renewed** with **Us** on a **Family Floater Policy** with same or higher **Base Sum Insured**, then the accumulated Loyalty Addition to be carried forward for credit in the **Renewing Policy** would be the least of the accumulated Loyalty Addition amongst all the **Insured Persons**.
- f. If the **Insured Persons** in the expiring **Policy** are covered under a **Family First Policy** and have an accumulated Loyalty Addition for each **Insured Person** in the expiring **Policy** under this benefit, and such expiring **Policy** is **Renewed** with **Us** on an **Individual Policy** with same or higher **Base Sum Insured**, then the accumulated Loyalty Addition to be carried forward for credit in the **Renewing Policy** would be the accumulated Loyalty Addition for that **Insured Person**.
- g. If the **Insured Persons** in the expiring **Policy** are covered on a **Family Floater Policy** and such **Insured Persons Renew** their expiring **Policy** with **Us** by splitting the Floater Sum Insured stated in the **Schedule of Insurance Certificate** in to two or more floater / individual / **Family First Policy**, then **We** shall not provide any credit of the accumulated Loyalty Addition to the split **Policy**.
- h. In case the **Base Sum Insured** under the **Policy** is reduced at the time of **Renewal**, the applicable accumulated Loyalty Addition shall also be reduced in proportion to the **Base Sum Insured**.
- i. In case the **Base Sum Insured** under the **Policy** is increased at the time of **Renewal**, the applicable accumulated Loyalty Addition shall be carried forward.

Note: For expiring policies where the option to receive vouchers has already been selected and availed, the vouchers shall continue to be valid until their period of expiry. However, **Renewal** of such **Policy** shall be eligible for an increase in the **Sum Insured** only.

4.2 Health Checkup

If the **Policy** is **Renewed** with **Us** without a break or if the **Policy** continues to be in force for the 2nd **Policy Year** in the 2 year **Policy Period** (if applicable), then the **Insured Person** may avail a health check-up, only for **Diagnostic Tests**, up to a sub-limit as per the Plan applicable to the **Insured Person** as specified in the **Product Benefits Table** on **Cashless Facility** basis provided that:

- a. Health check-up will be arranged only at **Our** empanelled **Service Providers**.
- b. The **Insured Person** will not be eligible to avail a health check-up in the first **Policy Year** in which he/she is covered as an **Insured Person** under the **Policy**.
- c. Any unutilized test or amount cannot be carry forwarded to the next **Policy Year**.

Note – In case of silver plan, a pre-defined set of tests can be availed by the **Insured Person**. A list of eligible tests is attached in Annexure – V.

5. Optional Benefits

The following optional benefits shall apply under the **Policy** as per the plan in the **Product Benefits Table** and as specified in the **Schedule of Insurance Certificate** and shall apply to all **Insured Persons** only if such optional benefits are selected by **You**. These optional benefits can be selected only at the time of issuance of the **First Policy** or at **Renewal** by **You**. 'Hospital Cash' and 'Enhanced Geographical Scope for International coverage' benefits can be added to the **Policy** on payment of the corresponding additional premium. If a loading applies to the premium for the main **Policy**, such loading will also apply to the premium for any optional benefits selected.

The Optional Benefits cover **Reasonable and Customary Charges** incurred towards the medical treatment taken by the **Insured Person** during the **Policy Period** for an **Illness, Injury** or conditions described in the sections below, if it is contracted or sustained by an **Insured Person** during the **Policy Period**.

All claims for any benefits under the **Policy** must be made in accordance with the process defined under Section 9 (Claim process & Requirements).

5.1 Hospital Cash

If **We** have accepted an **Inpatient Care Hospitalization** claim under Section 2.1 (**Inpatient Care**), **We** will pay the Hospital Cash amount specified in the **Product Benefits Table** up to a maximum 30 days of **Hospitalization** during the **Policy Year** for the **Insured Person** for each continuous period of 24 hours of **Hospitalization** from the first day of **Hospitalization** provided that:

- a. The **Insured Person** has been admitted in a **Hospital** for a minimum period of 48 hours continuously.
- b. **We** will not make any payment under this option for Section 2.6 (**Domiciliary Hospitalization**), Section 2.7 (Maternity Benefit) and Section 2.8 (**New Born Baby**).

5.2 Enhanced Geographical Scope for International Coverage

Notwithstanding anything contrary to the terms and conditions specified therein, geographic coverage for the benefits set out in Section 3.3.1 (**Emergency Medical Evacuation** – outside the geographical boundaries of India), Section 3.4 (**Emergency Hospitalization** – outside the geographical boundaries of India) and Section 3.5 (**Specified Illness** cover – outside the geographical boundaries of India) is extended to include USA & Canada.

6. Claim Cost Sharing Options

The following claim cost sharing options shall apply under the **Policy** as per the plan in the **Product Benefits Table** and as specified in the **Schedule of Insurance Certificate** and shall apply to all **Insured Persons** only if such options are selected by **You**. These claim cost sharing options can be selected only at the time of issuance of the **First Policy** or at **Renewal** by **You**.

6.1 Co-payment

The **Insured Person** will bear a predetermined percentage of the admissible claim amounts subject to the **Co-payment** option chosen by **You** irrespective of the **Age** of the **Insured Person** and the number of claims made. **Co-payment** will not apply to any claim under section 3.6 (**Second Medical Opinion**), Section 4.2 (Health Checkup) and Section 5.1 (Hospital Cash).

6.2 Annual Aggregate Deductible

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

It is further agreed that:

- a. The provisions in Section 6.1 on **Co-payment** (if opted) will apply to any amounts payable by **Us** in respect of a claim made by the **Insured Person** after the **Deductible** has been exhausted.
- b. **Deductible** will not apply to any claim under Section 3.6 (**Second Medical Opinion**), Section 4.2 (Health Checkup) and Section 5.1 (Hospital Cash).

7. Waiting Periods

All the **Waiting Periods** shall be applicable individually for each **Insured Person** and claims shall be assessed accordingly. On **Renewal**, if an enhanced **Sum Insured** is applied, 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 caused by, based on, arising out of or howsoever attributable to any of the following:

7.1 Pre-existing Diseases:

All **Pre-existing Diseases** shall not be covered until 24 months of continuous coverage have elapsed since the inception of the **First Policy** with **Us** for **Insured Persons** to whom the Gold and Platinum Plans are applicable and until 48 months of continuous coverage have elapsed since the inception of the **First Policy** with **Us** for **Insured Persons** to whom the Silver Plan is applicable.

No benefits shall be paid for any **Pre-existing Disease** unless such **Pre-existing Disease** is stated in the Proposal and specifically accepted by **Us** and endorsed thereon.

7.2 Initial Waiting Period (30 days):

All the benefits under the **Policy** and any treatment taken unless the treatment needed is the result of an **Accident** that occurs during the **Policy Period** will be subject to a **Waiting Period** of 30 days since the inception of the **First Policy** with **Us**.

7.3 Specific Waiting Periods:

For all **Insured Persons** who are above 45 years of **Age** as on the date of inception of the **First Policy** with **Us**, the medical conditions and/or surgical treatment listed below will be subject to a **Waiting Period** of 24 months unless the condition is directly caused by cancer (as defined in Section 12.76.a) or an **Accident** and will be covered in the third **Policy Year** as long as the **Insured Person** has been insured continuously under the **Policy** without any break:

- a. Pancreatitis and Stones in Biliary and Urinary System,
- b. Cataract, Glaucoma and other disorders of lens, disorders of Retina,
- c. Hyperplasia of Prostate, Hydrocele and spermatocele,
- 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,
- h. Chronic kidney disease and failure,
- i. Diabetes and its related complications,
- j. Varicose veins of lower extremities,
- k. Disease of middle ear and mastoid including Otitis Media, Cholesteatoma, Perforation of Tympanic Membrane,
- l. All internal or external benign or In Situ Neoplasms/Tumours, Cyst, Sinus, Polyp, Nodules, Swelling, Mass or Lump,
- m. Ulcer, Erosion and Varices of Upper Gastro Intestinal Tract,
- n. Tonsils and Adenoids, Nasal Septum and Nasal Sinuses,
- o. Internal Congenital Anomaly.

If the **Insured Person** is suffering from the above **Illness/condition** as a **Pre-existing Diseases** or a condition under Personal **Waiting Periods** at the time of inception of the **First Policy** with **Us**, any claim in respect of that **Illness/condition** shall not be covered until 48 months of continuous coverage have elapsed since the inception of the **First Policy** with **Us** for **Insured Persons** to whom the Silver Plan is applicable.

*Note: For all **Renewing Insured Persons** for whom the **First Policy** document states that this **Specific Waiting Period** applies only above 60 years of **Age**, the terms of the **Specific Waiting Period** as set out in the **First Policy** document (including the list of relevant medical conditions and surgical conditions as set out below) shall continue to apply until any **Waiting Period** has expired. The medical conditions and/or surgical treatments applicable to **First Policies** issued earlier are as follows:*

- a. Stones in the urinary system (eg kidney/bladder)
- b. Stones in billiary system (eg gall stones)
- c. Cataract
- d. BPH - Benign prostatic hypertrophy
- e. Menorrhagia, Fibromyoma, Uterine prolapse including any condition requiring Hysterectomy.
- f. Piles (Haemorrhoids)
- g. Hernia (Inguinal/umbilical and gastric)
- h. Degenerative disorders of knee/hip
- i. Chronic renal failure or end stage renal failure
- j. Retinopathy
- k. Diabetes and related treatments

7.4 Personal Waiting Periods:

Conditions specified for an **Insured Person** under Personal **Waiting Period** in the **Schedule of Insurance Certificate** will be subject to a **Waiting Period** of 24 months from the inception of the **First Policy** with **Us** and will be covered from the commencement of the third **Policy Year** as long as the **Insured Person** has been insured continuously under the **Policy** without any break.

8. 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 **Schedule of Insurance Certificate** and has been accepted by **You**. This option 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**.

8.1 Ancillary Hospital Charges

Charges related to a **Hospital** stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, RMO charges, night charges, registration, documentation and filing, surcharges. Service charges levied by the **Hospital** shall not be covered.

8.2 Hazardous Activities

Any claim relating to **Hazardous Activities**.

8.3 Artificial life maintenance:

Artificial life maintenance, including life support machine used to sustain a person, who has been declared brain dead, as demonstrated by:

- a. Deep coma and unresponsiveness to all forms of stimulation; or
- b. Absent pupillary light reaction; or
- c. Absent oculovestibular and corneal reflexes; or
- d. Complete apnea.

8.4 Autoimmune Disorders

Screening, counseling, treatment or complications related to autoimmune diseases.

8.5 Behavioral, Neurodevelopmental and Neurodegenerative Disorders:

Medical services for behavioral, neurodevelopmental delays and disorders such as:

- a. Disorders of adult personality including gender related problems, gender change;
- b. Disorders of speech and language including stammering, dyslexia;
- c. All Neurodegenerative disorders including Dementia, Alzheimer's disease and Parkinson's disease.

8.6 Circumcision:

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

8.7 Complementary & Alternative Medicine:

Any form of **Complementary & Alternative Medicine**.

8.8 Conflict & Disaster:

Treatment for any **Illness** or **Injury** resulting directly or indirectly from nuclear or chemical contamination, war or act of war, riot, revolution, chemical or biological disaster, radiation of any kind, acts of terrorism or any similar event (other than natural disaster or calamity), if one or more of the following conditions apply:

- a. The **Insured Person** puts himself in danger by entering a known area of conflict where active fighting or insurrections are taking place;
- b. The **Insured Person** was an active participant in the above mentioned acts or events of a similar nature;
- c. The **Insured Person** displayed a blatant disregard for personal safety.

8.9 External Congenital Anomaly, Hereditary or Genetic Disorders:

Screening, counseling or treatment related to external **Congenital Anomaly, Hereditary or Genetic Disorders**.

8.10 Convalescence & Rehabilitation:

Hospital accommodation when it is used solely or primarily for any of the following purposes:

- a. Any services related to **Complementary & Alternative Medicine** provided for the purpose of **Convalescence, Rehabilitation and Respite Care** other than for receiving eligible treatment of a type that normally requires a stay in **Hospital**.
- b. 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.

- c. Hospice care - Any services for people who are terminally ill to address medical, physical, social, emotional and spiritual need.

8.11 Cosmetic and Reconstructive Surgery:

- a. Any treatment undergone purely for cosmetic or psychological reasons to improve appearance, unless such treatment is **Medically Necessary** as a part of reconstructive procedure related to cancer or treatment for **Injury** resulting from **Accidents** or burns, and is required to restore functionality.
- b. Gynaecomastia, Abdominoplasty, blepharoplasty, mammoplasty, Chemical Peel, Rhinoplasty, Otoplasty, Liposuction and Lipectomy will not be payable even in case of **Accident** or burn or cancer.

8.12 Dental/oral treatment:

Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and Gingiva except for **Inpatient Hospitalization** due to an **Accident**.

8.13 Eyesight & Optical Services:

Any treatment to correct refractive errors of the eye, unless required as the result of an **Accident**. **We** will not pay for routine eye examinations, contact lenses, spectacles or laser eye sight correction.

8.14 Experimental/Investigational or Unproven Treatment:

- a. Services including device, treatment, procedure or pharmacological regimens which are considered as experimental, investigational or unproven.
- b. **Medical Devices**, Vascular or Coronary Stents: Biodegradable (bioresorbable, bioabsorbable) polymer drug eluting stents will be considered as experimental and investigational for all purpose.
- c. Stem Cell Transplant: Any stem cell transplant other than for **Bone Marrow Transplant**.

8.15 HIV, AIDS, and related complex:

Any condition directly or indirectly caused by or associated with Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), including any condition that is related to HIV or AIDS.

8.16 Hospitalization not justified:

Admission solely for the purpose of Physiotherapy, evaluation, investigations, diagnosis or observation services or not consistent with standard treatment guidelines (as defined by Clinical Establishments (Registration and Regulation) Act 2010 and amendments thereafter) or **Evidence Based Clinical Practices**.

8.17 Inconsistent, Irrelevant or Incidental Diagnostic procedures:

Charges incurred primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the current diagnosis and treatment even if the same requires confinement at a **Hospital**.

8.18 Mental and Psychiatric Conditions:

Treatment related to symptoms, complications and consequences of mental **Illness**, mood disorders, psychotic and non-psychotic disorders such as:

- a. Intentional self inflicted **Injury** or attempted suicide by any means.
- b. Depression, anxiety, dissociative or stress-related disorders.

8.19 Non-Medical Expenses:

- a. Items of personal comfort and convenience.
 - i. Personal attendant or beauty services, cosmetics, toiletry items, guest services and similar incidental expenses or services.
 - ii. Issue of medical certificate and examinations as to suitability for employment or travel or any other such purpose.
 - iii. Any charges incurred to procure any treatment/**Illness** related documents pertaining to any period of **Hospitalization/Illness**.
 - iv. Intra Ocular Lens: Any of the following classes of intraocular lens implants for any indication, including aphakia such as Multifocal IOL, Presbyopia or Astigmatism Correcting IOL, Phakic IOL, Pseudoaccommodating IOL.
- b. External or Ambulatory Devices
 - i. External and or durable medical/non-medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD or infusion pump.
 - ii. Ambulatory devices such as walkers, crutches, belts, collars, caps, splints, slings, braces, stockings of any kind, diabetic foot wear, glucometer /thermometer and similar items and also any medical equipment which is subsequently used at home.

- c. Visiting Charges:
Any travelling charge for visiting consultant.

8.20 Obesity and Weight Control Programs:

Services including medical treatment and **Surgical Procedures** and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

8.21 Off- label drug or treatment:

Use of pharmaceutical drugs for an unapproved indication or in an unapproved age group, dosage, or route of administration as regulated and approved by Central Drugs Standard Control Organization (CDSCO).

8.22 Puberty and Menopause related Disorders:

Treatment for any symptoms, **Illness**, complications arising due to physiological conditions associated with Puberty, Menopause such as menopausal bleeding or flushing.

8.23 Reproductive medicine & other Maternity Expenses: Any assessment or treatment method for:

- a. Birth Control
Any type of contraception, sterilization, abortions, voluntary termination of pregnancy (except under **Maternity Expenses** for Medical Termination of Pregnancy (MTP) as governed by MTP Act 1971 under Section 2.7 above) or family planning;
- b. Assisted Reproduction
Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI, Gestational Surrogacy;
- c. Sexual disorder and Erectile Dysfunction.
Treatment of any sexual disorder including impotence (irrespective of the cause) and sex changes or gender reassignments or erectile dysfunction;
- d. Any costs or expenses related to pregnancy, complications arising from pregnancy or medical termination of pregnancy except to the extent covered under Section 2.7 (Maternity Benefit) if applicable.

8.24 Robotic Assisted Surgery, Light Amplification by Stimulated Emission of Radiation (LASER) & Light based Treatment:

Any invasive or non invasive procedures in which a robotic surgical system or light based measure is used either in conjugation with base procedure or alone and liability will be based on the agreed tariff rate or Reasonable and Customary Charges for the base procedure including but not limited to Cyberknife, Da Vinci, Laser Ablation, Femto second laser.

8.25 Sexually transmitted Infections & diseases:

Screening, prevention and treatment for sexually related infection or disease including but not limited to Genital Warts, Syphilis, Gonorrhea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.

8.26 Sleep disorders:

Treatment for any conditions related to disturbance of normal sleep patterns or behaviors such as Sleep apnea, snoring, etc.

8.27 Substance related and Addictive Disorders:

Treatment and complications related to disorders of intoxication, dependence, abuse, and withdrawal caused by drugs and other substances such as alcohol, opioids or nicotine.

8.28 Traffic Offences & Unlawful Activity:

Any condition occurring either as a result of breach of law with criminal intent or/and violation of traffic rules.

8.29 Treatment received outside India:

Any treatment or medical services received outside India except for treatment undertaken under Section 3.3.1 (**Emergency Medical Evacuation** – outside the geographical boundaries of India), Section 3.4 (**Emergency Hospitalization** – outside the geographical boundaries of India) and Section 3.5 (**Specified Illness** cover – outside the geographical boundaries of India).

8.30 Unrecognized Physician or Hospital:

- a. Treatment or **Medical Advice** provided by a **Medical Practitioner** not recognized by the Medical Council of India or by Central Council of Indian Medicine or by Central council of Homeopathy or by relevant authorities in the area or country where the treatment is taken.
- b. Treatment or **Medical Advice** related to one system of medicine provided by a **Medical Practitioner** of another system of medicine.
- c. Treatment provided by anyone with the same residence as an **Insured Person** or who is a member of the **Insured Person's** immediate family or relatives.
- d. Treatment provided by **Hospital** or health facility that is not recognized by the relevant authorities in India or any other country where treatment takes place, or is an unrecognized **Hospital** listed by **Us** on **Our** website or **Policy** document
- e. Treatment or services received in health hydros, nature cure clinics or any establishment that is not a recognized **Hospital** or healthcare facility.

8.31 Generally Excluded Expenses

Any costs or expenses specified in the list of expenses generally excluded at Annexure IV.

9. Claims Process & Requirements

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

9.1 Claims Administration:

On the occurrence or discovery of any **Illness** or **Injury** that may give rise to a claim under this **Policy**, 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 payments that are brought about or contributed to as a consequence of or failure to follow such directions, advice or guidance.
- b. If requested by **Us** and at **Our** cost, the **Insured Person** must submit himself or herself to medical examination by **Our Medical Practitioner** as often as **We** consider reasonable and necessary.
- c. **We/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.
- d. **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.
- e. 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.

9.2 **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**. 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:

i. Process for Obtaining Pre-Authorization

A. 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**.

B. 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.

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 must be accompanied with completely filled and duly signed pre-authorization form including all of the following details:

- I. The health card **We** have issued to the **Insured Person** at the time of inception of the **Policy** 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**.

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.

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** and pre-authorization shall be valid only if all the details of the authorized treatment, including dates, **Hospital** and locations, match with the details of the actual treatment received. For cashless **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** for **Cashless Facility** in **Our** sole discretion. Before availing **Cashless Facility**, please check the applicable updated list of **Network Providers**.

ii. Reauthorization

Cashless Facility will not be provided where re-authorization is not requested for either change in the line of treatment or in the diagnosis or for any procedure carried out on the incidental diagnosis/finding.

b. 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**.

9.3 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 those 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. KYC Document: Of **Insured Person** in case of cashless claim and Proposer in case of **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 **Policyholder** / nominee (in case of death of **Policyholder**).
- d. Original discharge summary.
- e. Additional documents required in case of **Surgery/Surgical Procedure**.
 - i. Original surgical notes;
 - ii. Pre Anesthesia check up report (PAC);

- iii. Bar code sticker and invoice for implants and prosthesis (if used);
- iv. Indoor case paper/OT notes (if required).
- f. Original final bill from **Hospital** with detailed break-up and paid receipt.
- g. Room tariff of the entitled room category (in case of a **Non-Network** provider): duly signed and stamped by the **Hospital** in which treatment is taken.
(In case **You** are unable to submit such document, then **We** shall consider the **Reasonable and Customary Charges** of the **Insured Person's** eligible room category of **Our Network Provider** within the same geographical area for identical or similar services.)
- h. Original bills of pharmacy/medicines purchased, or of any other investigation done outside **Hospital** with reports and requisite prescriptions.
- i. Copy of death certificate (in case of demise of the **Insured Person**).
- j. 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.
- k. Original first consultation paper (in case **Illness** is diagnosed for the first time).
- l. Original laboratory investigation, diagnostic & pathological reports with supporting prescriptions.
- m. Original X-Ray/ MRI / ultrasound films and other radiological investigations.

*In the event of the **Insured Person's** death during **Hospitalization**, written notice accompanied by a copy of the post mortem report (if any) shall be given to **Us** regardless of whether any other notice has been given to **Us**.*

9.4 **Claims Assessment & Repudiation:**

- a. At **Our** discretion, **We** may investigate claims to determine the validity of a claim. All costs of investigation will be borne by **Us** and all investigations will be carried out by those individuals/entities that are authorized by **Us** in writing.
- b. **We** shall settle or repudiate a claim within 30 days of the receipt of the last necessary information and documentation set out above. In case of any suspected fraud, the last "necessary" document shall include the receipt of the investigation report from **Our** investigator/representatives. In case of delay in payment, **We** shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by **Us**.
- c. Payment for **Reimbursement** claims will be made to **You**. In the unfortunate event of **Your** death, **We** will pay the Nominee named in the **Schedule of Insurance Certificate** or **Your** legal heirs or legal representatives holding a valid succession certificate.
- d. If a claim is made which extends in to two **Policy Periods**, then such claim shall be paid taking into consideration the available **Sum Insured** in these **Policy Periods** including the **Deductible** for each **Policy Period**. Such eligible claim amount will be paid to the **Policyholder/Insured Person** after deducting the extent of premium to be received for the **Renewal**/due date of premium of the **Policy**, if not received earlier.
- e. All admissible claims under this **Policy** shall be assessed by **Us** in the following progressive order:-
 - i. If a room has been opted in a **Hospital** for which the **Room Rent** or room category is higher than the eligible limit as applicable for that **Insured Person** as specified in the **Schedule of Insurance Certificate**, then the **Associated Medical Expenses** payable shall be pro-rated as per the applicable limits in accordance with Section 2.1c.
 - ii. The **Deductible** (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 claims payable or paid exceeds the **Deductible**.
 - iii. **Co-payment** (if applicable) shall be applicable on the amount payable by **Us** as specified in the **Schedule of Insurance Certificate**.
- f. The claim amount assessed in Section 9.4 e above would be deducted from the amount mentioned against each benefit and **Sum Insured** as specified in the **Schedule of Insurance Certificate**.

9.5 Delay in Claim Intimation:

If the claim is not notified to **Us** 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.

9.6 Claims process for Sections 3 & 4

9.6.1 For Section 3.3 (Emergency Medical Evacuation)

- a. In the event of an **Emergency**, **Our Service Provider** shall be contacted immediately on the helpline number specified in the **Insured Person's** health card.
- b. **Our Service Provider** will evaluate the necessity for evacuation of the **Insured Person** and if the request for **Medical Evacuation** is approved, the **Service Provider** shall pre-authorise the type of travel that can be utilized to transport the **Insured Person** and provide information on the **Hospital** that may be approached for medical treatment of the **Insured Person**.
- c. If the **Service Provider** pre-authorises the **Medical Evacuation** of the **Insured Person** by means of **Air Transportation** through an air ambulance or commercial flight whichever is best suited, the **Service Provider** shall also arrange for the same to be provided to the **Insured Person** unless there are any logistical constraints or the medical condition of the **Insured Person** prevents **Emergency Medical Evacuation**.
- d. It is agreed and understood that **We** shall not cover any claims for **Reimbursement** of the costs incurred in the evacuation or transportation of the **Insured Person** or which are not pre-authorized by **Our Service Provider**.

9.6.2 For Section 3.4 (Emergency Hospitalization - outside the geographical boundaries of India)

- a. The health card **We** provide will enable the **Insured Person** to access medical treatment at any **Network Provider** outside India, but within those regions specified in the **Schedule of Insurance Certificate**, on a cashless basis only by the production of the card to the **Network Provider** prior to admission, subject to the following:
 - i. In the event of an **Emergency**, the **Insured Person** or **Network Provider** shall call **Our Service Provider** immediately, on the helpline number specified in the **Insured Person's** health card, requesting for a pre-authorization for the medical treatment required.
 - ii. **Our Service Provider** will evaluate the request and the eligibility of the **Insured Person** under the **Policy** and call for more information or details, if required. **Our Service Provider** will communicate directly to the **Hospital** whether the request for pre-authorization has been approved or denied.
 - iii. If the pre-authorization request is approved, **Our Service Provider** will directly settle the claim with the **Hospital**. Any additional costs or expenses incurred by or on behalf of the **Insured Person** beyond the limits pre-authorized by the **Service Provider** shall be borne by the **Insured Person**.
 - iv. It is agreed and understood that **We** shall not cover any claims for **Reimbursement** of the costs incurred in relation to the **Hospitalization** of the **Insured Person** while inside or outside India or any claims which are not pre-authorized by **Our Service Provider**.

9.6.3 For Section 3.5 (Specified Illness Cover – outside the geographical boundaries of India)

- a. In the event of the diagnosis of a **Specified Illness**, the **Insured Person** should call **Us** immediately and in any event before the commencement of the travel for treatment overseas on the helpline number specified on in the **Insured Person's** health card, requesting for a pre-authorization for the treatment.
- b. **We** will evaluate the request and the eligibility of the **Insured Person's Policy** and call for more information or details, if required.
- c. **We** will communicate directly to the **Service Provider** and the **Insured Person** whether the request for pre-authorization has been approved or denied.
- d. If the pre-authorization request is approved, **Our Service Provider** will directly settle the claim with the **Hospital**. Any additional costs or expenses incurred by or on behalf of the **Insured Person** beyond the limits pre-authorized by the **Service Provider** or at any **Non-Network Hospital** shall be borne by the **Insured Person**.
- e. This benefit is available only as **Cashless Facility** through pre-authorization by **Us**.

9.6.4 **For Section 3.6 (Second Medical Opinion)**

- a. In the event of submission of request for **Second Medical Opinion**, **Our Service Provider** shall be contacted immediately on the helpline number specified in the **Insured Person's** health card.
- b. **Our Service Provider** will evaluate the information of the **Insured Person** and if the request for **Second Medical Opinion** is approved, the **Service Provider** will facilitate arrangement as per conditions specified in the Section 3.6

9.6.5 **For Section 4.2 (Health Checkup)**

- a. The **Insured Person** shall seek appointment by contacting **Our Service Provider**.
- b. **Our Service Provider** will facilitate **Your** appointment.
- c. Reports of the medical tests can be collected directly from the **Service Provider**.

10. Portability Option

If **You/the Insured Person** has exercised the **Portability** Option at the time of **Renewal** of **Your** previous health insurance policy by submitting **Your** application and the completed **Portability** form with complete documentation at least 45 days before the expiry of **Your** previous **Policy Period**, then the **Insured Person** will be provided with credit gained for **Pre-existing Diseases** in terms of **Waiting Periods** and time bound exclusions up to the existing **Sum Insured** and cover in accordance with the existing guidelines of the **IRDAI** provided that:

- a. The ported **Insured Person** was insured continuously and without a break under another Indian retail health insurance policy with any other Indian general insurance company or stand-alone health insurance company or any group/retail indemnity health insurance policy from **Us**.
- b. The **Waiting Period** with respect to change in **Sum Insured** or plan shall be taken into account as follows:
 - i. If the ported **Sum Insured** is higher than the **Sum Insured** under the expiring policy, **Waiting Periods** would be applied on the amount of proposed increase in **Sum Insured** only, in accordance with the existing guidelines of the **IRDAI**.
 - ii. If the ported **Sum Insured** is lower than the **Sum Insured** under previous policy then the applicable **Waiting Periods** would be reduced by the number of months of continuous coverage under the previous policy.
 - iii. If the proposed Plan is to be changed and not the **Sum Insured** then the applicable **Waiting Periods** would be applied as per the proposed plan.
- c. In case of different policies and plan in previous years, the **Portability** Option would be provided for the expiring policy or Plan which is to be ported to **Us**.
- d. The **Waiting Period** for maternity benefits is not reduced on account of the previous period of insurance coverage even if the previous insurance policy incorporated a **Waiting Period** for maternity benefits.
- e. The **Portability** Option has been accepted by **Us** within 15 days of receiving **Your** Proposal and **Portability** Form subject to the following:
 - i. **You** shall have given **Us** all additional documentation and/or information that **We** requested for;
 - ii. **You** shall have paid **Us** the applicable premium in full;
 - iii. **We** might have, subject to **Our** medical underwriting as per **Our** Board approved underwriting policy, restricted the terms upon which **We** have offered cover, the decision as to which shall be in **Our** sole and absolute discretion;
 - iv. There was no obligation on **Us** to insure all **Insured Persons** or to insure all **Insured Persons** on the proposed terms, even if **You** have given **Us** all documentation;
 - v. **We** have received necessary details of medical history and claim history from the previous insurance company for the **Insured Person's** previous health insurance policy through the **IRDAI's** web portal.
 - vi. No additional loading or charges have been applied by **Us** exclusively for porting the **Policy**.
- f. In case **You** have opted to switch to any other insurer under **Portability** provisions (Porting Out) and the outcome of acceptance of the **Portability** request is awaited from the new insurer on the date of **Renewal**,
 - i. **We** may upon **Your** request extend this **Policy** for a period of not less than one month at an additional premium to be paid on a pro rata basis.
 - ii. If during this extension period a claim has been reported, **You** shall be required to first pay the balance of the full annual **Policy** premium. **Our** liability for the payment of such claim shall commence only once such premium is received. Alternately **We** may deduct the premium for the balance period and pay the balance claim amount if any and issue the **Policy** for the remaining period.
 - iii. **We** reserve the right to modify or amend the terms and the applicability of the **Portability** option in accordance with the provisions of the regulations and guidance issued by the **IRDAI** as amended from time to time.

11. General Terms and Conditions

11.1 Free Look Provision

- a. The free look period shall be applicable at the inception of the **Policy** and is not applicable and available at the time of **Renewal** of the **Policy** or in cases of **Portability**.
- b. **You** have a period of 15 days from the date of receipt of the **Policy** document to review the terms and conditions of this **Policy**.
- c. If **You** have any objections to any of the terms and conditions, **You** may cancel the **Policy** stating the reasons for cancellation and provided that no claims have been made and the **Second Medical Opinion** has not been availed under the **Policy**.
- d. **We** will refund the premium paid by **You** after deducting the amounts spent on pre-insurance medical check-up (if any), stamp duty charges and proportionate risk premium for the period of cover.
- e. **Your** rights under this **Policy** will immediately stand extinguished on the free look cancellation of the **Policy**

11.2 Cancellation/Termination (other than Free Look cancellation)

- a. **Cancellation by You: You** may terminate this **Policy** by giving 30 days prior written notice to **Us**. **We** shall cancel the **Policy** for the balance of the **Policy Period** and refund the premium (exclusive of service tax) for the unexpired term as mentioned herein below, provided that no claim has been made and the **Second Medical Opinion** or health check-up have not been availed under the **Policy** by or on behalf of any **Insured Person**:

Policy in-force up to	Policy Period 1 year	Policy Period 2 years
	Refund Premium (%)	Refund Premium (%)
Up to 30 days	75%	87.5%
31 to 90 days	50%	75%
91 to 180 days	25%	62.5%
181 to 365 days	0%	50%
366 to 455 days	<i>Not applicable</i>	25%
456 to 545 days	<i>Not applicable</i>	12%
Exceeding 545 days	<i>Not applicable</i>	0%

b. Automatic Cancellation:

- i. **Individual Policy:**
The **Policy** shall automatically terminate in the event of death of the **Insured Person**.
- ii. For **Family Floater Policies** and **Family First Policies**:
The **Policy** shall automatically terminate in the event of the death of all the **Insured Persons**.
- iii. Refund:
A refund in accordance with the table in Section 11.2 (a) shall be payable if there is an automatic cancellation of the **Policy** provided that no claim has been made and the **Second Medical Opinion** or health check-up have not been availed under the **Policy** by or on behalf of any **Insured Person**.

- c. **Cancellation by Us: We** may terminate this **Policy** during the **Policy Period** by sending 30 days prior written notice to **Your** address shown in the **Schedule of Insurance Certificate** without refund of premium (for cases other than non cooperation) if:
 - i. **You** or any **Insured Person** or any person acting on behalf of either has acted in a dishonest or fraudulent manner under or in relation to this **Policy**; and/or
 - ii. **You** or any **Insured Person** has not disclosed the material facts or misrepresented in relation to the **Policy**; and/or
 - iii. **You** or any **Insured Person** has not co-operated with **Us**. In such cases, premium will be refunded on pro-rata basis provided that no claim has been filed under the **Policy** by or on behalf of any **Insured Person**; and/or
 - iv. **You** fail or refuse to pay or refund any amount **You** owe **Us**.

For avoidance of doubt, it is clarified that no claims shall be admitted and/or paid by **Us** and the **Second Medical Opinion** and health check-up cannot be availed during the notice period.

11.3 Loading on Premium

- a. Based on **Our** discretion, upon the disclosure of the health status of the persons proposed for insurance and declarations made in the Proposal or Insurance Summary Sheet, **We** may apply a risk loading on the premium payable (excluding statutory levies and taxes) or Special Conditions on the **Policy**. The maximum risk loading applicable shall not exceed more than 350% of the premium.
- b. These loadings will be applied from inception date of the **First Policy** including subsequent **Renewal(s)** with **Us**.
- c. **We** may apply a specific personal **Waiting Period** on a medical condition/ailment depending on the past history or additional **Waiting Periods** on **Pre-existing Diseases** as part of the special conditions on the **Policy**.

11.4 Renewal of Policy

This **Policy** is **Renewable** for life however this **Policy** will automatically terminate at the end of the **Policy Period** or **Grace Period** and **We** are under no obligation to give intimation in this regard.

a. Continuity of Benefits on Timely Renewal:

- i. The Benefits under the **Policy** can be availed continuously after completion of the **Policy Period** if the **Renewal** request is made along with the applicable premium on a timely basis.
- ii. 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.
- iii. **Renewal** premium rates for this **Policy** may be further altered by **Us** including in the following circumstances:
 - A. **You** proposed to add an **Insured Person** to the **Policy**
 - B. **You** change any coverage provision
 - C. **You** change **Your** residence to different zip code
- iv. **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**, and for **Family First Policies** it shall be the individual **Age** of each **Insured Person** of the family.
- v. **Renewal** premium will not alter based on individual claims experience. **Renewal** premium rates may be changed by **Us** provided that such changes are approved by **IRDAI** and in accordance with the **IRDAI's** rules and regulations as applicable from time to time.

b. Grace Period:

- i. If **You** do not **Renew** the **Policy** by the due dates specified in the **Schedule of Insurance Certificate**, **You** or any other eligible adult **Insured Person** may apply to **Renew** the **Policy** within the **Grace Period** of 30 days of the end of the **Policy Period** subjected to receipt of application and payment of premium from such **Insured Person** and evidence satisfactory to **Us** of the agreement of all other **Insured Persons** and **You** (except in case of death). If **We** accept such application and the premium for the **Renewed Policy** is paid on time, then the **Policy** shall be treated as having been **Renewed** without a break in cover.
- ii. Any claim made during **Grace Period** will not be payable under this **Policy**.

c. 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 happen between the date the **Policy** expires and the date immediately before the reinstatement date of **Your 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.

d. Disclosures on Renewal:

You 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.

e. Renewal for Insured Persons who have achieved Age 21:

If any **Insured Person** who is a child and has completed **Age 21** years at the time of **Renewal**, then such **Insured Person** will have to take a separate policy based on **Our** underwriting guidelines, as per **Our** Board approved underwriting policy as he/she will no longer be eligible to be covered under a **Family Floater Policy**. In such cases, the credit of the **Waiting Periods** served under the **Policy** will be passed on to the separate policy taken by such **Insured Person**.

f. Addition of Insured Persons on Renewal:

Where an individual is added to this **Policy** (including for **New Born Babies** added to the **Policy** under section 2.8), either by way of endorsement or at the time of **Renewal**, the **Pre existing Disease** clause, exclusions and **Waiting Periods** will be applicable considering such **Policy Year** as the first year of the **Policy** with **Us**.

g. Changes to Sum Insured on Renewal:

- i. Wherever the **Sum Insured** is reduced on any **Policy Renewals**, the **Waiting Periods** as defined under Section 7 shall be waived only up to the lowest **Sum Insured** of the last 48/24 consecutive months as applicable to the relevant **Waiting Periods** of the Plan opted.
- ii. 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** under Section 7 shall apply afresh for this enhanced limit from the effective date of such enhancement.

h. Renewal Promise:

Renewal of the **Policy** will not ordinarily be denied other than on grounds of moral hazard, misrepresentation or fraud or non-cooperation by **You**.

If on the death of some of the **Insured Persons** during the **Policy Period** which results in the remaining **Insured Persons** being ineligible to avail a **Family Floater Policy** or **Family First Policy**, on **Renewal**, **We** will issue eligible insurance cover to the remaining **Insured Persons** subject to **Our** Board-approved underwriting policy.

11.5 Change of Policyholder

- a. The **Policyholder** may be changed only at the time of **Renewal**. The new **Policyholder** must be a member of the **Insured Person's** immediate family. Such change would be solely subject to **Our** discretion and payment of premium by **You**. The **Renewed Policy** shall be treated as having been **Renewed** without break. The **Policyholder** may be changed upon request in case of **Your** death, **Your** emigration from India or in case of **Your** divorce during the **Policy Period**.
- b. Any alteration in the plan due to unavoidable circumstances as in case of the **Policyholder's** death, emigration or divorce during the **Policy Period** should be reported to **Us** immediately. Coverage of Benefits in such scenario will be limited to current **Policy Year**.
- c. **Renewal** of such **Policies** will be according to terms and conditions of existing **Policy**.

11.6 Nomination

- a. **You** are mandatorily 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 **Your** death.
- b. Any change of nomination shall be communicated to **Us** in writing and such change shall be effective only when an endorsement on the **Policy** is made by **Us**.
- c. In case of any **Insured Person** other than **You** under the **Policy**, for the purpose of payment of claims in the event of death, the default nominee would be **You**.

11.7 Obligations in case of a minor

If an **Insured Person** is less than 18 years of **Age**, **You** or another adult **Insured Person** or legal guardian (in case of **Your** 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**.

11.8 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**.

In the event of the **Insured Person's** death, **We** and/or **Our Service Provider** may request an examination of the **Insured Person's** body, for identification purposes, subject to any law of the applicable jurisdiction relating to such examinations.

11.9 Fraudulent claims

If a claim is in any way found to be fraudulent, or if any false statement, or declaration is made or used in support of such a claim, or if any fraudulent means or devices are used by the **Insured Person** or anyone acting on behalf of the **Insured Person** or any false or incorrect **Disclosure to Information Norms** to obtain any benefit under this **Policy**, then **We** may reserve the right to re-underwrite or cancel the **Policy** and all claims being processed shall be forfeited for all **Insured Persons** and all sums paid under this **Policy** shall be repaid to **Us** by **You** who shall be jointly liable for such repayment.

11.10 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.

11.11 Territorial Jurisdiction

All benefits are available in India only, and all claims shall be payable in India in Indian Rupees only except for benefits and claims under Section 3.3.1 (**Emergency Medical Evacuation** – outside the geographical boundaries of India), Section 3.4 (**Emergency Hospitalization** – outside the geographical boundaries of India) and Section 3.5 (**Specified Illness** cover – outside the geographical boundaries of India).

11.12 Notices

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

- a. **You/the Insured Person** at the address specified in the **Schedule of Insurance Certificate** 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.: 1800-3070-3333
- 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/the Insured Person** other information through electronic and telecommunications means with respect to **Your Policy** from time to time.

11.13 Alteration to the Policy

This **Policy** constitutes the complete contract of insurance. Any change in the **Policy** will only be evidenced by a written endorsement signed and stamped by **Us**. No one except **Us** can within the permission of the **IRDAI** change or vary this **Policy**.

11.14 Revision or Modification

This product/plan may be revised or modified subject to prior approval of the **IRDAI**. In such case **We** shall notify **You** of any such change at least 3 months prior to the date from which such revision or modification shall come into effect, provided it is not otherwise provided by the **IRDAI**.

11.15 Withdrawal of Product

This product or any variant/plan under the product may be withdrawn at **Our** option subject to prior approval of **IRDAI** or due to a change in regulations. In such a case **We** shall provide an option to migrate to **Our** other suitable retail products as available with **Us** and **We** shall also notify **You** of any such change at least 3 months prior to the date from which such withdrawal shall come into effect.

11.16 Customer Service and Grievances Redressal:

a. In case of any query or complaint/grievance, **You/the Insured Person** may approach **Our** office at the following address:

Customer Services Department
Max Bupa Health Insurance Company Limited
B-1/I-2, Mohan Cooperative Industrial Estate
Mathura Road, New Delhi-110044
Contact No: 1800-3010-3333
Fax No.: 1800-3070-3333
Email ID: customercare@maxbupa.com

b. In case **You/the Insured Person** are not satisfied with the decision of the above office, or have not received any response within 10 days, **You** may contact the following official for resolution:

Head – Customer Services
Max Bupa Health Insurance Company Limited
B-1/I-2, Mohan Cooperative Industrial Estate
Mathura Road, New Delhi-110044
Contact No: 1800-3010-3333
Fax No.: 1800-3070-3333
Email ID: customercare@maxbupa.com

c. In case **You/the Insured Person** are not satisfied with **Our** decision/resolution, **You** may approach the Insurance Ombudsman at the addresses given in Annexure I.

d. The complaint should be made in writing duly signed by the complainant or by his/her legal heirs with full details of the complaint and the contact information of the complainant.

e. As per provision 13(3) of the Redressal of Public Grievances Rules 1998, the complaint to the Ombudsman can be made only if the grievance

- i. Has been rejected by the Grievance Redressal Machinery of the Insurer;
- ii. Within a period of one year from the date of rejection by the insurer;
- iii. If it is not simultaneously under any litigation.

12. Definitions & Interpretation

For the purposes of interpretation and understanding of this **Policy**, **We** have defined, herein below some of the important words used in the **Policy** and for the remaining language and the words; they shall have the usual meaning as described in standard English language dictionaries. The words and expressions defined in the Insurance Act 1938, IRDA Act 1999, regulations notified by the **IRDAI** and circulars and guidelines issued by the **IRDAI** shall carry the meanings explained therein.

Note: *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.*

- 12.1 **Accident** or **Accidental** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
- 12.2 **Age** means age last birthday.
- 12.3 **Air Transportation** means air conveyance required to transport the **Insured Person** during a **Medical Evacuation**.
- 12.4 **Alternative Treatments** are forms of treatments other than allopathic treatment or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.
- 12.5 **Associated Medical Expenses** shall include **Room Rent**, nursing charges for **Hospitalization** as an **Inpatient** excluding private nursing charges, **Medical Practitioners'** fees excluding any charges or fees for **Standby Services**, investigation and diagnostics procedures directly related to the current admission, operation theatre charges and **Intensive Care Unit** charges.
- 12.6 **Base Sum Insured** means the amount stated in the **Schedule of Insurance Certificate**.
- 12.7 **Bone Marrow Transplant** is a condition where the **Insured Person** needs necessary medical treatment to replace malignant or defective bone marrow with normal bone marrow from healthy donors to stimulate the production of formed blood cells.
- 12.8 **Cashless Facility** means a facility extended by the insurer to the **Insured Person** where the payments, of the costs of treatment undergone by the **Insured Person** in accordance with the **Policy** terms and conditions, are directly made to the **Network Provider** by the insurer to the extent pre-authorization approved.
- 12.9 **Complementary & Alternative Medicine** means **Alternative Treatments** done alone or along with conventional/modern medicine.
- 12.10 **Condition Precedent** shall mean a **Policy** term or condition upon which the Insurer's liability under the **Policy** is conditional upon.
- 12.11 **Congenital Anomaly** refers to 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.
- 12.12 **Convalescence, Rehabilitation and Respite Care** means any care arrangement in a residential setting or in a **Hospital** or any other healthcare facility like health hydros, nature cure clinics, wellness centre, palliative centre for services related to help the physically or cognitively impaired to achieve or regain their maximum functional potential for mobility, self-care and independent living, although not necessarily complete independence.
- 12.13 **Co-payment** is a cost-sharing requirement under a health insurance policy that provides that the **Policyholder/insured** will bear a specified percentage of the admissible claim amount. A **Co-payment** does not reduce the **Sum Insured**.
- 12.14 **Day Care Center** means any institution established for **Day Care Treatment of Illness** and/or **Injuries** or a medical set-up within a **Hospital** and which has been registered within the local authorities, wherever applicable, and is under the supervision of a registered and qualified **Medical Practitioner** AND must comply with all the following minimum criteria:
- 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.
- 12.15 **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 OPD basis is not included in the scope of this definition.
- 12.16 **Deductible** is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the **Sum Insured**.
- 12.17 **Dental Treatment** is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and **Surgery** excluding any form of cosmetic **Surgery/implants**.
- 12.18 **Diagnostic Tests** means investigations, such as X-Ray or blood tests, to determine the cause of symptoms and/or medical conditions.
- 12.19 **Diagnostic Services** means a broad range of **Diagnostic Tests** and exploratory or therapeutic procedures essential for detection, identification and treatment of medical condition.
- 12.20 **Disclosure to Information Norm** means the **Policy** shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
- 12.21 **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**.
- 12.22 **Emergency** means a serious 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.
- 12.23 **Evidence Based Clinical Practice** means process of making clinical decisions for **Inpatient Care** using current best evidence in conjugation with clinical expertise.
- 12.24 **Family Floater Policy** means a **Policy** described as such in the **Schedule of Insurance Certificate** where the family members (two or more) named in the **Schedule of Insurance Certificate** are insured under this **Policy**. Only the following family members can be covered under a **Family Floater Policy**:
- a. **Insured Person**; and/or
 - b. **Insured Person's** legally married spouse (for as long as they continue to be married); and/or
 - c. **Insured Person's** children who are less than 21 years of **Age** on the commencement of the **Policy Period** (maximum 4 children can be covered).
- 12.25 **Family First Policy** means a **Policy** described as such in the **Schedule of Insurance Certificate** where **You** and **Your** family members named in the **Schedule of Insurance Certificate** are insured under this **Policy**. Only the following family members can be covered under a **Family First Policy**:
- a. **Your** legally married spouse for as long as **Your** spouse continues to be married to **You**;
 - b. Son;
 - c. Daughter-in-law as long as **Your** son continues to be married to **Your** Daughter-in-law;
 - d. Daughter;
 - e. Son-in-law as long as **Your** daughter continues to be married to **Your** Son-in-law;
 - f. Father;
 - g. Mother;
 - h. Father-in-law as long as **Your** spouse continues to be married to **You**;
 - i. Mother-in-law as long as **Your** spouse continues to be married to **You**;
 - j. Grandfather;
 - k. Grandmother;
 - l. Grandson;
 - m. Granddaughter;
 - n. Brother;
 - o. Sister;
 - p. Sister-in-law;
 - q. Brother-in-law;
 - r. Nephew;
 - s. Niece.
- 12.26 **First Policy** means the **Schedule of Insurance Certificate** issued to the **Policyholder** at the time of inception of the **Policy** mentioned in the **Schedule of Insurance Certificate** with **Us**.
- 12.27 **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to **Renew** or continue a policy in force without loss of continuity benefits such as

Waiting Periods and coverage of **Pre-existing Diseases**. Coverage is not available for the period for which no premium is received.

- 12.28 **Hazardous Activities** means any sport or activity, which is potentially dangerous to the **Insured Person** whether he is trained or not. Such sport/activity includes but is not limited to **Insured Persons** whilst engaging in speed racing of any kind (other than on foot), professional or competitive sport, bungee jumping, parasailing, ballooning, parachuting, base jumping, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving, snow and ice sports or involving a naval military or air force operation. **Insured Person** whilst flying or taking part in aerial activities (including cabin crew) except as a fare-paying passenger in a regular scheduled airline or air charter company.
- 12.29 **Hereditary or Genetic Disorder** means any **Illness** or disorder presented at birth or later in life caused by inheritance of abnormal gene or chromosome by the **Insured Person**.
- 12.30 **Hospital (within India)** 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 the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
- 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;
 - has **Qualified Nursing** staff under its employment round the clock;
 - has qualified **Medical Practitioner (s)** in charge round the clock;
 - has a fully equipped operation theatre of its own where **Surgical Procedures** are carried out;
 - maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.
- 12.31 **Hospital (outside India)** means an institution (including nursing homes) established outside India for **Inpatient** medical care and treatment of sickness and injuries which has been registered and licensed as such with the appropriate local or other authorities in the relevant area, wherever applicable, and is under the constant supervision of a **Medical Practitioner**. The term **Hospital** shall not include a clinic, rest home, or convalescent home for the addicted, detoxification centre, sanatorium, old age home.
- 12.32 **Hospitalization or Hospitalized** means the admission in a **Hospital** for a minimum period of 24 **Inpatient Care** consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.
- 12.33 **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**.
- 12.34 **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**.
- 12.35 **Intensive Care Unit** means an identified section, ward or wing of a **Hospital** which is under the constant supervision of a dedicated **Medical Practitioner(s)**, and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
- 12.36 **Illness** means sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the **Policy Period** and requires medical treatment.
- 12.37 **Individual Policy** means a **Policy** described as such in the **Schedule of Insurance Certificate** where the individual named in the **Schedule of Insurance Certificate** is insured under this **Policy**.
- 12.38 **Inpatient** means the **Insured Person's** admission for treatment in a **Hospital** for more than 24 hours for a covered event.
- 12.39 **Inpatient Care** means treatment for which the **Insured Person** has to stay in a **Hospital** for more than 24 hours for a covered event.
- 12.40 **Insured Person** means person named as insured in the **Schedule of Insurance Certificate**.
- 12.41 **IRDAI** means the Insurance Regulatory and Development Authority of India.
- 12.42 **LASER & Light based Treatment** means a procedure that uses focused light emission or amplification for treatment of medical conditions.
- 12.43 **Maternity Expense** shall include:
- Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during **Hospitalization**);
 - Expenses towards lawful medical termination of pregnancy during the **Policy Period**.
- 12.44 **Medical Advice** means any consultation or advice from a **Medical Practitioner** including the issue of any prescription or repeat prescription.

- 12.45 **Medical Devices** are devices intended for internal or external use in the diagnosis, treatment, mitigation or prevention of disease or disorder.
- 12.46 **Medical Evacuation** means the transportation of the **Insured Person** in an **Emergency** from the place of **Insured Person's Hospitalization** (required for stabilization) to the **Hospital** where adequate treatment is available, provided that treatment is not available locally.
- 12.47 **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.
- 12.48 **Medical Practitioner** is 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.
Only for the purposes of any claim or treatment permitted to be made or taken outside India in accordance with section 3.3.1 (**Emergency Medical Evacuation** – outside the geographical boundaries of India), section 3.4 (**Emergency Hospitalization** – outside the geographical boundaries of India) and Section 3.5 (**Specified Illness** cover – outside the geographical boundaries of India), **Medical Practitioner** shall mean a general practitioner, surgeon, anaesthetist or physician who:
- holds a degree of a recognized institute; and
 - is registered with a Medical Council or equivalent body of the country where the treatment has taken place; and
 - is legally qualified to practice medicine or **Surgery** in the jurisdiction where he practices.
- 12.49 **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 a **Medical Practitioner** who has 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.
- 12.50 **Medically Necessary** treatment is defined as any treatment, tests, medication, or stay in **Hospital** or part of a stay in **Hospital** which:
- is required for the medical management of the **Illness** or **Injury** suffered by the insured;
 - must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
 - must have been prescribed by a **Medical Practitioner**;
 - must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
- 12.51 **Medically Stable Condition** means the condition of the **Insured Person** as certified by the treating **Medical Practitioner** when the **Injuries** or **Illness** suffered by the **Insured Person** have been brought under control or have become resistant to deterioration.
- 12.52 **Network Provider** means **Hospitals** or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a **Cashless Facility**.
Only for the purposes of any claim or treatment permitted to be made or taken outside India in accordance with section 3.3.1 (**Emergency Medical Evacuation** – outside the geographical boundaries of India), section 3.4 (**Emergency Hospitalization** – outside the geographical boundaries of India) & section 3.5 (**Specified Illness** cover – outside the geographical boundaries of India), **Network Provider** shall mean the **Hospitals** that are a part of the **Service Provider's** network, a list of which is available with the **Service Provider**.
- 12.53 **New Born Baby** means baby born during the **Policy Period** and is aged between 1 day and 90 days, both days inclusive.
- 12.54 **Notification of Claim** is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.
- 12.55 **Non-Network** means any **Hospital**, **Day Care Center** or other provider that is not part of the network.
- 12.56 **Off-label drug or treatment** means use of pharmaceutical drug for an unapproved indication or in an unapproved age group, dosage or route of administration.
- 12.57 **OPD Treatment** is one in which the **Insured Person** 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 Person** is not admitted as a day care patient or **Inpatient**.
- 12.58 **Policy** means these terms and conditions, the **Schedule of Insurance Certificate** (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.
- 12.59 **Policy Period** is the period between the inception date and the expiry date of the **Policy** as specified in the **Schedule of Insurance Certificate** or the date of cancellation of this **Policy**, whichever is earlier.

- 12.60 **Policy Year** means the period of one year commencing on the date of commencement specified in the **Schedule of Insurance Certificate** or any anniversary thereof.
- 12.61 **Pre-existing Disease** means any condition, ailment or **Injury** or related condition(s) for which the **Insured Person** had signs or symptoms, and / or were diagnosed, and / or received **Medical Advice/** treatment within 48 months, prior to the first **Policy** issued by **Us**.
- 12.62 **Pre-hospitalization Medical Expenses: Medical Expenses** incurred immediately before the **Insured Person** is **Hospitalised**, 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.
- 12.63 **Post-hospitalization Medical Expenses: Medical Expenses** incurred immediately after the **Insured Person** is discharged from the **Hospital**, 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.
- 12.64 **Portability** means transfer by an individual health insurance policyholder (including family cover) of the credit gained for Pre-existing conditions and time bound exclusions if he/she chooses to switch from one insurer to another.
- 12.65 **Product Benefits Table** means the **Product Benefits Table** issued by **Us** and accompanying this **Policy** which specifies the Plan applicable, the Benefits available to the **Insured Persons** and any sub-limits applicable to each Benefit.
- 12.66 **Qualified Nurse** is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
- 12.67 **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.
- 12.68 **Reimbursement** means settlement of claims paid directly by **Us** directly to the **Policyholder/Insured Person**.
- 12.69 **Renewal** defines 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 all **Waiting Periods**.
- 12.70 **Robotic Assisted Surgery** refers to a technology used to assist the surgeon in controlling operative field via a terminal and manipulates robotic surgical instruments via a control panel. The use of computers and robotics is intended to enhance dexterity to facilitate microscale operations
- 12.71 **Room Rent** means the amount charged by a **Hospital** for the occupancy of a bed on per day (24 hours) basis and shall include **Associated Medical Expenses**.
- 12.72 **Schedule of Insurance Certificate** means a certificate issued by **Us**, and, if more than one, then the latest in time. The **Schedule of Insurance Certificate** contains details of the **Policyholder, Insured Persons** and the Benefits applicable under the **Policy**.
- 12.73 **Second Medical Opinion** means an alternate evaluation of diagnosis or treatment modalities arranged by **Us** from a **Medical Practitioner** related to **Specified Illnesses** or planned **Surgery** or **Surgical Procedure** which the **Insured Person** has been diagnosed or advised to undergo during the **Policy Year**. The **Second Medical Opinion** will be arranged by **Us** solely on the **Insured Person's** request.
- 12.74 **Service Provider** means any person, organization, institution that has been empanelled with **Us** to provide services specified under the benefits to the **Insured Person**.
- 12.75 **Shared Room** means a **Hospital** room with two or more patient beds with or without attached shared bathroom.
- 12.76 **Specified Illness** means the following **Illnesses** or procedures:
- Cancer:
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.
Specific Exclusion: All tumors in the presence of HIV infection are excluded.
 - Myocardial Infarction (Heart Attack):
The death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area.
 - Coronary Artery Bypass Graft (CABG):
The actual undergoing of open / keyhole chest **Surgery** for the correction of one or more coronary arteries, which is/are narrowed or blocked. The diagnosis must be supported by relevant **Diagnostic Tests** and confirmed by a cardiologist.
 - Major Organ Transplant:

The actual undergoing of a transplant of one or more of the following human organs: heart, lung, liver, kidney, pancreas as a result of irreversible end-stage failure of the relevant organ, or human bone marrow using haematopoietic stem cells.

Specific Exclusions: The following are excluded:

- i. Other stem-cell transplants
- ii. Transplant of islets of Langerhans only

e. **Stroke:**

Any cerebrovascular incident including infarction of brain tissue, thrombosis in an intracranial vessel, hemorrhage and embolisation from an extra cranial source, which results in neurological sequelae. Transient Ischemic Attacks (TIA) are excluded. Treatment of the neurological sequelae is excluded from the cover if the primary condition is not covered.

f. **Surgery of Aorta:**

Surgery of aorta including graft, insertion of stents or endovascular repair.

Specific Exclusion: **Surgery** for correction of an underlying **Congenital Anomaly**.

g. **Coronary Angioplasty:**

Procedures done for widening a narrowed or obstructed blood vessel of the heart in which a stent may or may not be inserted into the blood vessel. The same is payable only if the procedure is done subsequent to Myocardial infarction or Anginal attack.

h. **Primary Pulmonary Arterial Hypertension:**

An abnormal elevation in pulmonary artery pressure with or without any known cause. The disease must be confirmed by cardiac catheterisation.

i. **Brain Surgery:**

Any brain (intracranial) **Surgery** required to treat traumatic or non-traumatic conditions.

Specific Exclusion: **Surgery** for treating Neurocysticercosis.

12.77 **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.

12.78 **Suite Room** means

- a. a space available for boarding in a **Hospital** which contains two or more rooms; Or
- b. a space available for boarding in a **Hospital** which contains an extended living/dining/kitchen area

12.79 **Sum Insured:**

In case of **Individual Policy**, **Sum Insured** means the total of the **Base Sum Insured** and Loyalty Additions as per Section 4.1 which is **Our** maximum, total and cumulative liability for any and all claims during the **Policy Year** in respect of the **Insured Person**.

In case of **Family Floater Policy**, **Sum Insured** means the total of the **Base Sum Insured** and Loyalty Additions as per Section 4.1 which is **Our** maximum, total and cumulative liability for any and all claims during the **Policy Year** in respect of all **Insured Persons**.

In case of **Family First Policy**, **Sum Insured** means the total of the **Base Sum Insured** for each **Insured Person**, the Loyalty Additions as per Section 4.1 for each **Insured Person** and the Floater Sum Insured specified in the **Schedule of Insurance Certificate** which is **Our** maximum, total and cumulative liability for any and all claims during the **Policy Year** in respect of each **Insured Person**. For aforesaid purposes:

- a. The **Base Sum Insured** stated in the **Schedule of Insurance Certificate** for each **Insured Person** is available for claims in respect of that **Insured Person** only, during the **Policy Year**.
- b. If the **Base Sum Insured** for an **Insured Person** is exhausted due to payment of claims, then that **Insured Person** may utilise the Floater Sum Insured stated in the **Schedule of Insurance Certificate** for any claims arising in that **Policy Year**. In the event of a claim being admitted from the Floater Sum Insured, the Floater Sum Insured shall stand correspondingly reduced by the amount of claim paid (including 'taxes') or admitted and only the remaining amount of the Floater Sum Insured shall be available for claims arising in that **Policy Year** in respect of the **Insured Persons** who have exhausted their **Base Sum Insured** during that **Policy Year**.
- c. The total of the **Base Sum Insured** for all **Insured Persons**, the Loyalty Additions as per Section 4.1 for all **Insured Persons** and the Floater Sum Insured specified in the **Schedule of Insurance Certificate** is **Our** maximum, total and cumulative liability for all claims during a **Policy Year** in respect of all **Insured Persons**.

If the **Policy Period** is 2 years, then the **Sum Insured** shall be applied separately for each **Policy Year** in the **Policy Period**.

- 12.80 **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an **Illness** or **Injury**, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a **Hospital** or **Day Care Center** by a **Medical Practitioner**.
- 12.81 **Unproven/Experimental treatment** means treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
- 12.82 **Waiting Period** means a time-bound exclusion period related to condition(s) specified in the **Schedule of Insurance Certificate** or the **Policy** which shall be served before a claim related to such condition(s) becomes admissible.
- 12.83 **We/Our/Us** means Max Bupa Health Insurance Company Limited.
- 12.84 **You/Your/Policyholder** means the person named in the **Schedule of Insurance Certificate** 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		Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@gbic.co.in	Gujarat , Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Shri. M. Parshad	Insurance Ombudsman, 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@gbic.co.in	Karnataka
BHOPAL	Shri Raj Kumar Srivastava	Insurance Ombudsman, Office of the Insurance Ombudsman, Janak Vihar Complex, 2 nd Floor, 6, M alviya Nagar, Opp. Airtel, Near New Market, <u>BHOPAL-462 023.</u> Tel.:- 0755-2769201/2769202 Fax : 0755-2769203 Email: bimalokpal.bhopal@gbic.co.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Shri. B. N. Mishra	Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest park Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.co.in	Orissa
CHANDIGARH		Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@gbic.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir , Chandigarh
CHENNAI	Shri Virender Kumar	Insurance Ombudsman, 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@gbic.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)

Office of the Ombudsman	Name of the Ombudsman	Contact Details	Areas of Jurisdiction
DELHI	Smt. Sandhya Baliga	Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.co.in	Delhi
GUWAHATI		Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@gbic.co.in	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Shri G.Rajeswara Rao	Insurance Ombudsman, Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@gbic.co.in	Andhra Pradesh, Telangana and Yanam – a part of territory of Pondicherry
JAIPUR	Shri. Ashok K. Jain	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@gbic.co.in	Rajasthan
ERNAKULAM	Shri. P. K. Vijayakumar	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@gbic.co.in	Kerala , Lakshadweep , Mahe – a part of Pondicherry
KOLKATA	Shri. K. B. Saha	Insurance Ombudsman, Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@gbic.co.in	West Bengal , Andaman & Nicobar Islands , Sikkim

Office of the Ombudsman	Name of the Ombudsman	Contact Details	Areas of Jurisdiction
LUCKNOW	Shri. N. P. Bhagat	Insurance Ombudsman, Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@gbic.co.in	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, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI	Shri A.K.Dasgupta	Insurance Ombudsman, Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@gbic.co.in	Goa, Mumbai metropolitan region excluding Navi Mumbai & Thane
NOIDA	Shri Ajesh Kumar	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4 th Floor, Main Road, Naya Bans, Sector 15 Distt: Gautam Budh Nagar, UP – 201301 Tel: 0120-2514250/2514251/2514253 Email: bimalokpal.noida@gbic.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 Sadasiv Mishra	Office of the Insurance Ombudsman, 1 st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800006 Tel: 0612-2680952 Email: bimalokpal.patna@gbic.co.in	Bihar, Jharkhand.
PUNE	Shri. A. K. Sahoo	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 32341320 Email: bimalokpal.pune@gbic.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

GOVERNING BODY OF INSURANCE COUNCIL,
3rd Floor, Jeevan Seva Annexe,
S. V. Road, Santacruz (W),
Mumbai - 400 054.

Tel.: 022 - 26106889 / 671 / 980

Fax: 022 - 26106949

Email: inscoun@gbic.co.in

Smt. Ramma Bhasin, Secretary General

Shri. Y.R. Raigar, Secretary

Annexure II – List of covered vaccinations

Time interval	Vaccination to be done (Age)	Frequency
0-3 months	BCG (From birth to 1 weeks)	1
	OPV (1 week) + IPV1 (6 week,10 weeks)	3
	DPT (6& 10 week)	2
	Hepatitis-B (0 & 6 week,)	2
	Haemophilus influenzae type B (Hib) (6 & 10 Week)	2
	Rota (6 & 10 Week)	2
3-6 months	OPV (6 month) + IPV (14 week)	2
	DPT (14 week)	1
	Hepatitis-B (6 month)	1
	Haemophilus influenzae type B (Hib) (14 week)	1
	Rota (14 week)	1
9 months	MMR (9 Months)	1
	OPV (9 Months)	1
12 months	Typhoid(12 Months)	1
	Hepatitis A (12 Months)	1

Annexure III – List of covered vaccinations

Time interval	Vaccination to be done (Age)	Frequency
1-2 years	OPV (15 &18 months)	2
	DPT (15-18 months)	1
	Haemophilus influenzae type B (Hib) (15-18 months)	1
	Meningococcal vaccine (24 months)	1
After 10 years	Tetanus Toxoide	1

ANNEXURE IV- LIST OF GENERALLY EXCLUDED ITEMS IN HOSPITALIZATION POLICY

Standard list of expenses generally excluded ("non-medical expenses") in Hospitalization indemnity policies		
S.No.	Items	Recommendations
A	Toiletries/ cosmetics/ personal comfort or convenience items	Payable/Non Payable
1	Hair removing cream charges	Not payable
2	Baby charges	(unless specified/indicated) Not payable
3	Baby food	Not payable
4	Baby utilities charges	Not payable
5	Baby set	Not payable
6	Baby bottles	Not payable
7	Bottle	Not payable
8	Brush	Not payable
9	Cosy towel	Not payable
10	Hand wash	Not payable
11	Moisturiser paste brush	Not payable
12	Powder	Not payable
13	Razor	Not payable
14	Towel	Not payable
15	Shoe cover	Not payable
16	Beauty services	Not payable
17	Belts/ braces	Essential and should be paid at least specifically for cases who have undergone surgery of thoracic or lumbar spine.
18	Buds	Not payable
19	Barber charges	Not payable
20	Caps	Not payable
21	Cold pack/hot pack	Not payable
22	Carry bags	Not payable
23	Cradle charges	Not payable
24	Comb	Not payable
25	Disposable razor charges (for site for preparation)	Not payable
26	Eau-de-cologne / room fresheners	Not payable
27	Eye pad	Not payable
28	Eye shield	Not payable
29	Email / internet charges	Not payable
30	Food charges (other than patient's diet provided by hospital)	Not payable
31	Foot cover	Not payable
32	Gown	Not payable
33	Leggings	Essential in bariatric and varicose vein surgery and may be considered for at least these conditions where surgery itself is payable.
34	Laundry charges	Not payable

35	Mineral water	Not payable
36	Oil charges	Not payable
37	Sanitary pad	Not payable
38	Slippers	Not payable
39	Telephone charges	Not payable
40	Tissue paper	Not payable
41	Tooth paste	Not payable
42	Tooth brush	Not payable
43	Guest services	Not payable
44	Bed pan	Not payable
45	Bed under pad charges	Not payable
46	Camera cover	Not payable
47	Care free	Not payable
48	Cliniplast	Not payable
49	Crepe bandage	Payable only treatment warrant usage
50	Curapore	Not payable
51	Diaper of any type	Not payable
52	Dvd, cd charges	Not payable (However If CD is specifically sought by Insurer/TPA then payable)
53	Eyelet collar	Not payable
54	Face mask	Not payable
55	Flexi mask	Not payable
56	Gause soft	Not payable
57	Gauze	Not payable
58	Hand holder	Not payable
59	Hansaplast/ adhesive bandages	Not payable
60	Lactogen/ infant food	Not payable
61	Slings	Reasonable costs for one sling in case of upper arm fractures may be considered

S. No.	Items	Recommendations
B	Items Specifically Excluded in Policies	Payable/Non Payable
1	Weight control programs/ supplies/ services	Exclusion in policy unless otherwise specified
2	Cost of spectacles/ contact lenses/ hearing aids etc.,	Exclusion in policy unless otherwise specified
3	Dental treatment expenses that do not require hospitalization	Exclusion in policy unless otherwise specified
4	Hormone replacement therapy	Exclusion in policy unless otherwise specified
5	Home visit charges	Exclusion in policy unless otherwise specified
6	Infertility/ sub-fertility/ assisted conception procedure	Exclusion in policy unless otherwise specified
7	Obesity (including morbid obesity) treatment	Exclusion in policy unless otherwise specified
8	Psychiatric & psychosomatic disorders	Exclusion in policy unless otherwise specified
9	Corrective surgery for refractive error	Exclusion in policy unless otherwise specified
10	Treatment of sexually transmitted diseases	Exclusion in policy unless otherwise specified
11	Donor screening charges	Exclusion in policy unless otherwise specified
12	Admission/registration charges	Exclusion in policy unless otherwise specified

13	Hospitalization for evaluation/ diagnostic purpose	Exclusion in policy unless otherwise specified
14	Expenses for investigation/ treatment irrelevant to the disease for which admitted or diagnosed	Exclusion in policy not payable unless otherwise specified
15	Any expenses when the patient is diagnosed with retro virus + or suffering from /HIV/ aids etc is detected/directly or indirectly	Not payable as per HIV / aids exclusion
16	Stem cell implantation/ surgery & storage	Not payable except bone marrow transplantation where covered by policy

S. No.	Items	Recommendations
C	Items which form part of Hospital services where separate consumables are not payable but the service is	Payable/non payable
1	Ward and theatre booking charges	Payable under OT charges, not payable separately
2	Arthroscopy & endoscopy instruments	Rental charged by the hospital payable. Purchase of instruments not payable.
3	Microscope cover	Payable under OT charges, not payable separately
4	Surgical blades,harmonic scalpel,shaver	Payable under OT charges, not payable separately
5	Surgical drill	Payable under OT charges, not payable separately
6	Eye kit	Payable under OT charges, not payable separately
7	Eye drape	Payable under OT charges, not payable separately
8	X-ray film	Payable under radiology charges, not as consumable
9	Sputum cup	Payable under investigation charges, not as consumable
10	Boyles apparatus charges	Part of OT charges, not separately
11	Blood grouping and cross matching of donors samples	Part of cost of blood, not payable
12	Antiseptic or disinfectant lotions	Not payable-part of dressing charges
13	Band aids, bandages, sterile injections, needles, syringes	Not payable - part of dressing charges
14	Cotton	Not payable-part of dressing charges
15	Cotton bandage	Not payable-part of dressing charges
16	Micropore/ surgical tape	Not payable-payable by the patient when prescribed, otherwise included as dressing charges
17	Blade	Not payable
18	Apron	Not payable -part of hospital services/disposable linen to be part of OT/ ICU charges
19	Torniquet	Not payable (service is charged by hospitals, consumables cannot be separately charged)
20	Orthobundle, gynaec bundle	Part of dressing charges
21	Urine container	Not payable

S. No.	Items	Recommendations
D	Elements Of Room Charge	Payable/Non Payable

1	Luxury tax	Policy exclusion - not payable. If there is no policy exclusion, then actual tax levied by government is payable - part of room charge for sub limits
2	Hvac	Part of room charge not payable separately
3	House keeping charges	Part of room charge not payable separately
4	Service charges where nursing charge also charged	Part of room charge not payable separately
5	Television & air conditioner charges	Payable under room charges not if separately levied
6	Surcharges	Part of room charge not payable separately. Paid in case of trust hospital if nursing and service charges are to be charged
7	Attendant charges	Not payable - part of room charges
8	IM/ IV injection charges	Part of nursing charges, not payable
9	Clean sheet	Part of laundry/housekeeping not payable separately
10	Extra diet of patient (other than that which forms not payable if it is policy exclusion. Otherwise patient diet provided by part of bed charge)	Hospital is payable
11	Blanket/warmer blanket	Not payable- part of room charges

S. No.	Items	Recommendations
E	Administrative or Non-medical Charges	Payable/Non Payable
1	Admission kit	Not payable
2	Birth certificate	Not payable
3	Blood reservation charges and ante natal booking charges	Not payable
4	Certificate charges	Not payable
5	Courier charges	Not payable
6	Conveyance charges	Not payable
7	Diabetic chart charges	Not payable
8	Documentation charges / administrative	Expenses not payable
9	Discharge procedure charges	Not payable
10	Daily chart charges	Not payable
11	Entrance pass / visitors pass charges	Not payable
12	Expenses related to prescription on discharge	To be claimed by patient under post -hosp where admissible
13	File opening charges	Not payable
14	Incidental expenses / misc. Charges (not explained)	Not payable
15	Medical certificate	Not payable
16	Maintenance charges	Not payable
17	Medical records	Not payable
18	Preparation charges	Not payable
19	Photocopies charges	Not payable
20	Patient identification band / name tag	Not payable
21	Washing charges	Not payable

22	Medicine box	Not payable
23	Mortuary charges	Payable upto 24 hrs, shifting charges not payable
24	Medico legal case charges (MLC charges)	Not payable

S. No.	Items	Recommendations
F	External Durable Devices	Payable/Non Payable
1	Walking aids charges	Not payable
2	Bipap machine	Not payable
3	Commode not payable	Not payable
4	CPAP/ CPAD equipments device	Not payable
5	Infusion pump - cost device	Not payable
6	Oxygen cylinder (for usage outside the hospital)	Not payable (in case of post-hospitalization expenses, cost of oxygen prescribed payable, but not the cost of the cylinder)
7	Pulse oxymeter charges device	Not payable
8	Spacer	Not payable
9	Spirometre device	Not payable
10	Spo2 probe	Not payable
11	Nebulizer kit	Not payable
12	Steam inhaler	Not payable
13	Arm sling pouch	Not payable
14	Thermometer	Not payable (paid by patient)
15	Cervical collar	Not payable
16	Splint	Not payable
17	Diabetic foot wear	Not payable
18	Knee braces (long/ short/ hinged)	Not payable
19	Knee immobilizer/shoulder immobilizer	Not payable
20	Lumbo sacral belt	Essential and should be paid at least specifically for cases who have undergone surgery of lumbar spine
21	Nimbus bed or water or air bed charges	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/ quadriplegia for any reason and at reasonable cost of approximately Rs 200/day
22	Ambulance collar	Not payable
23	Ambulance equipment	Not payable
24	Microsheild	Not payable
25	Abdominal binder	Essential and should be paid at least in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.

S. No.	Items	Recommendations
G	Items Payable If Supported By A Prescription	Payable/Non Payable
1	Betadine \ hydrogen peroxide\spirit\detol \savlon\ disinfectants etc	May be payable when prescribed for patient, not payable for hospital use in ot or ward or for dressings ward or for dressings

2	Private nurses charges- special nursing charges	Not payable if policy excludes; post hospitalization nursing charges not payable
3	Nutrition planning charges - dietician charges- diet charges	If policy excludes diet charges - not payable; patient diet provided by hospital is payable
4	Sugar free tablets	Payable -sugar free variants of admissible medicines are not excluded
5	Cream powder lotion (toiletries are not payable, only prescribed medical pharmaceuticals payable)	Payable when prescribed
6	Digestive gel/ antacid gel	Payable when prescribed
7	Ecg electrodes	Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable
8	Gloves sterilized gloves	Payable / unsterilized gloves not payable
9	Hiv kit	Payable - pre-operative screening
10	Listerine/ antiseptic mouthwash	Payable when prescribed
11	Lozenges	Payable when prescribed
12	Mouth paint	Payable when prescribed
13	Nebulisation kit	If used during hospitalization is payable reasonably
14	Neosprin	Payable when prescribed
15	Novarapid	Payable when prescribed
16	Volini gel/ analgesic gel	Payable when prescribed
17	Zytee gel	Payable when prescribed
18	Vaccination charges	Routine vaccination not payable / post bite vaccination payable

S. No.	Items	Recommendations
H	Part of Hospital's own costs and not payable	Payable/Non Payable
1	AHD	Not payable - part of hospital's internal cost
2	Alcohol swabes	Not payable - part of hospital's internal cost
3	Scrub solution/sterillium	Not payable - part of hospital's internal cost
4	Vaccine charges for baby	Not payable
5	Aesthetic treatment / surgery	Not payable
6	Tpa charges	Not payable
7	Visco belt charges	Not payable
8	Any kit with no details mentioned [delivery kit, not payable orthokit, recovery kit, etc]	Not payable
9	Examination gloves	Not payable
10	Kidney tray	Not payable
11	Mask	Not payable
12	Ounce glass	Not payable
13	Outstation consultant's/ surgeon's fees	Not payable, except for telemedicine consultations where covered by policy
14	Oxygen mask	Not payable
15	Paper gloves	Not payable

16	Pelvic traction belt	Should be payable in case of PIVD requiring traction as this is generally not reused
17	Referral doctor's fees	Not payable
18	Accu check (glucometry/ strips)	Not payable. Pre-hospitalization or post-hospitalization / reports and charts required/ device not payable
19	Pan can	Not payable
20	Sofnet	Not payable
21	Trolley cover	Not payable
22	Urometer, urine jug	Not payable
23	Ambulance	Payable as per the terms of the policy
24	Tegaderm / vasofix safety	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs
25	Urine bag	Payable where medically necessary till a reasonable cost maximum 1 per 24 hrs
26	Softovac	Not payable
27	Stockings	Essential for case like CABG etc. Where it should be paid.
28	Additional room charges/bed charges for attendant	Not payable
29	Attender bed charges	Not payable
30	Investigation charges not related to the diagnosis	Not payable
31	Iv fluid infusion charges	As nursing charges included in the room charges
32	Multiple consultation charges not related to diagnosed ailments	Not payable
33	RMO charges not payable if visit charges are applied.	Not payable
34	Psychiatric consultation charges	Not payable
35	Anti-d/rho clone etc-immunisation for rh negative mother carrying rh positive baby	Payable only in first pregnancy provided gravida status is I-0, if it is I-1 not payable.
36	Maternity related consultations	Not payable
37	Maternity related expenses	Not payable
38	Ac charges	Not payable
39	Attendant/ayah/ward boy charges	Not payable
40	Body wash	Not payable
41	Electricity charges (levied by hospital)	Not payable
42	Establishment charges	Not payable
43	File charges	Not payable
44	Gate pass charges	Not payable
45	Home nursing charges	Not payable
46	Insurance processing charges	Not payable
47	Registration charges/fee	Not payable
48	Water charges (levied by hospital)	Not payable
49	Naturopathy treatment charges	Not payable
50	Non-allopathic treatment charges.	Not payable
51	Yoga charges	Not payable
52	Surgery for correction of eye sight like myopia/hypermotropia/amblyopia/	Payable only under policies where ped is covered by way of deletion of the exclusion or by way of

	presbiopia/atigmatism/strabismus, etc	entitlement after lapse of specified period of claim free duration
53	Room fresheners	Not payable
54	Loban	Not payable
55	Nebulization mask	Not payable
56	One touch sure strip	Not payable
57	Under pads	Not payable
58	Alpha bed/water bed etc.	Not payable
59	Ambulatory devices like walker/crutches/wheel chair etc.	Not payable
60	Instrument charges where no details of procedure/instrument used is given.	Not payable
61	Bili blanket	Not payable
62	Bills not in proper format/not serially numbered and printed bill.	Not payable
63	Charges paid to organ donors	Not payable
64	Credit bills-no cash paid receipt.	Not payable
65	Duplicate bills.	Not payable
66	Health drinks-horlicks, viva, bournvita and protein powder including lactogen	Admissible only to the extent prescribed
67	No bills for claimed amount	Not payable
68	Ultroid system	Not payable
69	RMO charges	RMO charges not payable if visit charges are applied.
70	Service charges	Not payable if nursing charges are paid
71	IV administration charge	Not payable if nursing charges are paid
72	IV fluid administration charge	Not payable if nursing charges are paid
73	Injection charges	Not payable if nursing charges are paid
74	Administrative charge	Not payable if nursing charges are paid

ANNEXURE V – List of tests covered under health check-up for Heartbeat Silver

Age Band <= 35 years	Age Band 36 - 50 years	Age Band > 50 years
Complete Blood Count	Complete Blood Count	Complete Blood Count
Urine Routine Analysis	Urine Routine Analysis	Urine Routine Analysis
Random Blood Sugar	HBA1C	ESR
Serum Cholesterol	Serum Cholesterol	HBA1C
Serum LDL	Serum LDL	Serum Cholesterol
	Serum Creatinine	Serum HDL
	Urea	Serum LDL
		Kidney Function Test
		Urea