Preamble: The proposal and declaration given by the proposer and other documents if any shall form the basis of this Contract and is deemed to be incorporated herein. The two parties to this contract are the Policy Holder/Insured/Insured Persons (also referred as You) and Religare Health insurance Company Ltd. (also referred as Company/ We/Us),and all the Provisions of Indian Contract Act, 1872, shall hold good in this regard. The references to the singular include references to the plural; references to the male include the references to the female; and references to any statutory enactment include subsequent changes to the same and vice versa. The sentence construction and wordings in the Policy documents should be taken in its true sense and should not be taken in a way so as to take advantage of the Company by filing a claim which deviates from the purpose of Insurance.

In return for premium paid, the Company will pay the Insured in case a valid claim is made:

In consideration of the premium paid by the Policy Holder, subject to the terms & conditions contained herein, the Company agrees to pay/indemnify the Insured Person(s), the amount of such expenses that are reasonably and necessarily incurred up to the limits specified against respective Benefit in any Policy Year.

Policy Terms & Conditions

Please check whether the details given by you about the insured persons in the proposal form (a copy of which was provided at the time of issuance of cover for the first time) are incorporated correctly in the policy schedule. If you find any discrepancy, please inform us within 15 days from the date of receipt of the policy, falling which the details relating to the person/s covered would be taken as correct.

So also the coverage details may also be gone through and in the absence of any communication from you within 15 days from the date of receipt of the policy, it would be construed that the policy issued is correct and the claims if any arise under the policy will be dealt with based on proposal /policy details.

For the purposes of interpretation and understanding of the product the Company has defined, herein below some of the important words used in the product and for the remaining language and the words the Company believes to mean the normal meaning of the English language as explained in the standard language dictionaries. The words and expressions defined in the Insurance Act, IRDA Act, regulations notified by the Insurance Regulatory and Development Authority of India ("Authority") and circulars and guidelines issued by the Authority shall carry the meanings described therein. The terms and conditions, insurance coverage and exclusions, other Benefits, various procedures and conditions which have been built-in to the product are to be construed in accordance with the applicable provisions contained in the product.
The terms defined below have the meanings ascribed to them wherever they appear in this Policy and, where appropriate.

1. Definitions

1.1 **Accidental / Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

1.2 **Age** means the completed age of the Insured Person as on his last birthday.

1.3 **Alternative treatments** are forms of treatments other than treatment "Allopathy" or "modern medicine" and include Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

1.4 **Ambulance** means a vehicle operated by a licensed/ authorized service provider and equipped for the transport and paramedical treatment of persons requiring medical attention.

1.5 **Annexure** means the document attached and marked as Annexure to this Policy.

1.6 **Any One Illness (not applicable for Travel and Personal Accident Insurance)** means a continuous Period of Illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where the treatment was taken

1.7 **Assistance Service Provider** means the service provider specified in the Policy Certificate appointed by the Company from time to time.

1.8 **Cashless Facility** means a facility extended by the insurer to the Insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network Provider by the insurer to the extent pre-authorization is approved.

1.9 **City of Residence** means and includes any city, town or village in which the Insured Person is currently residing in India and as specified in the Insured Person's corresponding address in the Policy Certificate.

1.10 **Claim** means a demand made in accordance with the terms and conditions of the Policy for payment of the specified Benefits in respect of the Insured Person as covered under the Policy.

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

1.12 **Company (also referred as Insurer/We/Us)** means Religare Health Insurance Company Limited.

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

1.14 **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

1.15 **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.

1.16 **Cumulative Bonus** shall mean any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

1.17 **Covered Conditions:** means diseases / illnesses/Surgical Procedures limited to the below definitions and extent of coverage. These definitions should be read in conjunction with the Plan opted in the Policy Certificate(Please refer Annexure V to Policy Terms and Conditions). Coverage will only be as per the Plan opted

i. Cancer (Varies from IRDAI Standard Definitions 2016)

(I) A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy and confirmed by a pathologist.

(II) The term cancer includes

A. leukemia, lymphoma, and sarcoma.
B. Tumor's showing the malignant changes of carcinoma in situ and tumours which are histologically described as pre-malignant or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3

The following are excluded:

A. Benign lesions
B. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0;
C. Papillary micro - carcinoma of the thyroid less than 1 cm in diameter;
D. Microcarcinoma of the bladder;

E. All tumours in the presence of HIV infection.

Heart Related Conditions

ii. Pulmonary Thromboembolism

Acute Pulmonary Thromboembolism: means the blockage of an artery in the lung by a clot or other tissue from another part of the body. The Pulmonary Embolus must be unequivocally diagnosed by a specialist on either a V/Q scan (the isotope investigation which shows the ventilation and perfusion of the lungs), angiography or echocardiography, with evidence of right ventricular dysfunction and conformation with D Dimer assay findings, and requiring medical or surgical treatment on an inpatient basis.

iii. Primary(Idiopathic) Pulmonary Hypertension (Varies from IRDAI Standard Definitions 2016)

A. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.
B. The NYHA Classification of Cardiac Impairment are as follows:

Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

Following are excluded:

A. Pulmonary hypertension associated with occupational and environmental factors
B. Substance abuse (like tobacco etc.),
C. lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, any heart disease and all secondary causes

iv. Infective Endocarditis

Inflammation of the inner lining of the heart caused by infectious organisms, where all of the following criteria are met:

A. Positive result of the blood culture proving presence of the infectious organism(s)

B. Presence of at least moderate heart valve incompetence (meaning regurgitate fraction of twenty percent (20%) or above) or moderate heart valve stenosis (resulting in heart valve area of thirty percent (30%) or less of normal value) directly attributable to Infective Endocarditis; without any other valvular disease/risk factors and

C. The Diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a consultant cardiologist.

v. Heart Valve Replacement/repair (Varies from IRDAI Standard Definitions 2016)

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

vi. Surgery of Aorta

The actual undergoing of major surgery/minimally invasive surgical repair(i.e. via percutaneous intra-arterial route) to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen with a graft. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. The treatment will be including but not limited to Angioplasty.

vii. Cardiomyopathy

A. An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a consultant cardiologist who has been treating the patient, and which results in permanent physical impairment to the degree of New York Heart Association classification Class IV, or its equivalent, based on the following classification criteria: Class IV - Inability to carry out any activity without discomfort.
B. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced. The Diagnosis of Cardiomyopathy has to be supported by echographic findings of compromised ventricular performance.

Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.

viii. Surgery for cardiac arrhythmia

Ablative Procedure is defined as catheter ablation procedures using radiofrequency or cryothermal energy for treatment of a recurrent or persistent symptomatic arrhythmia refractory to antiarrhythmic drug therapy. Ablation procedures should immediately follow the diagnostic electorphysiology study. The ablative procedure must be certified to be absolutely necessary by a consultant cardiologist (electrophysiologist).

Pre-procedural evaluation prior to ablation procedures and ablation procedures as below should be completely documented:

A. Strips from ambulatory Holter monitoring in documenting the arrhythmia.
B. Electrocardiographic and electrophysiologic recording, cardiac mapping and localization of the arrhythmia during the ablative procedure.

ix. Angioplasty

Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

A. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

x. Balloon Valvotomy/Valvuloplasty

The actual undergoing of Valvotomy or Valvuloplasty necessitated by damage of the heart valve as confirmed by a specialist in the relevant field where the procedure is performed totally via intravascular catheter based techniques.

The diagnosis of heart valve abnormality must be supported by cardiac catheterization or Echocardiogram and the procedure must be considered medically necessary by a consultant cardiologist

xi. Carotid Artery Surgery

The actual undergoing of surgery to the Carotid Artery to treat carotid artery stenosis of fifty percent (50%) and above, as proven by angiographic evidence, of one (1) or more carotid arteries. Both criteria (a) and (b) below must be met:

A. Either:

i. Actual undergoing of endarte rectomy to alleviate the symptoms; or
ii. Actual undergoing of an endovascular intervention such as angioplasty and/or stenting or atherectomy to alleviate the symptoms; and

B. The Diagnosis and medical necessity of the treatment must be confirmed by a cardio-thoracic surgeon.

xii. Coronary Artery Bypass Graft (Varies from IRDAI Standard Definitions 2016)

The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is / are narrowed or blocked, by Coronary Artery Bypass Graft (CABG). The

diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist Medical Practitioner.

Exclusion: Any key-hole or laser surgery.

xiii. Pericardectomy

The undergoing of a pericardectomy performed by open heart surgery or keyhole techniques as a result of pericardial disease. The surgical procedures must be certified to be medically necessary by a consultant cardiologist. Other procedures on the pericardium including pericardial biopsies, and pericardial drainage procedures by needle aspiration are excluded.

The actual undergoing of pericardiectomy secondary to chronic constrictive pericarditis.

The following are specifically excluded:

A. Chronic constrictive pericarditis related to alcohol or drug abuse or HIV
B. Acute pericarditis due to any reason

xiv. Surgery to Place Ventricular Assist Devices or Total Artificial Hearts

This is an open chest procedure for implantation of Left Ventricular Assist Device/Ventricular Assist Device as bridges to cardiac transplantation or destination therapy for long term use for the Refractory Heart Failure with reduced ejection fraction as defined below:

NYHA Class IV symptoms who failed to respond to optimal medical management for >= 45 of the past 60 days, or have been intra-aortic balloon pump dependent for 7 days, or IV inotrope dependent for14 days.

The following are excluded:

A. Ventricular dysfunction or Heart failure directly related to alcohol or drug abuse

xv. Myocardial Infarction (Varies from IRDAI Standard Definitions 2016)

The occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by the following criteria:

A. A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain);
B. New characteristic electrocardiogram changes;
C. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following conditions are excluded:

A. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T;
B. Other acute Coronary Syndromes;
C. Any type of angina pectoris.

xvi. Implantation of Pacemaker of Heart:

Actual undergoing of Insertion of a permanent cardiac pacemaker to correct serious cardiac arrhythmia which cannot be treated via other means. The insertion of the cardiac pacemaker must be certified to be medically necessary by a specialist in the relevant field.

Following will be excluded:

A. Cardiac arrest secondary to alcohol, substance abuse or drug misuse

xvii. Implantable Cardioverter Defibrillator:

A. Actual undergoing of insertion of an implantable cardiac defibrillator to correct serious cardiac arrhythmia which cannot be treated via other methods or the insertion of permanent cardiac defibrillator to correct sudden loss of heart function with cessation of blood circulation around the body resulting in unconsciousness .
Insertion of Cardiac Defibrillator means surgical implantation of either Implantable Cardioverter-Defibrillator (ICD), or Cardiac Resynchronization Therapy with Defibrillator (CRT-D)

B. The insertion of a permanent Cardioverter-Defibrillator (ICD) must be certified to be absolutely necessary by a specialist in the relevant field.

Following will be excluded:

i. Cardiac arrest secondary to alcohol, substance abuse or drug misuse

Conditions other than Heart and Cancer

xviii. End Stage Renal Failure (Varies from IRDAI Standard Definitions 2016)

End stage renal disease presenting as chronic irreversible failure of both kidneys to function documented with raise level of S Creatinine and S Urea, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a Nephrologist.

xix. Multiple Sclerosis (Varies from IRDAI Standard Definitions 2016)

The definite occurrence of multiple sclerosis, the diagnosis of which must be supported by following, and certified by a Physician/Neurophysician:

A. Investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
B. There must be current clinical impairment of motor or sensory function

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

xx. Benign Brain Tumor (Varies from IRDAI Standard Definitions 2016)

A benign tumour in the brain where following conditions are met and Its presence must be confirmed by a neurologist or neurosurgeon:

A. Has potential to cause permanent damage to the brain;
B. If it has undergone surgical removal or, if inoperable, has caused a permanent neurological deficit such as but not restricted to characteristic symptoms of increased intracranial pressure such as papilloedema, mental symptoms, seizures and sensory impairment; and
C. Diagnosis is supported by findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques.
D. The treatment is advised and justified medically by a certified Neurologist

Following will be excluded:

A. Cysts;
B. Granulomas;
C. Vascular malformations;
D. Haematomas;
E. Calcification;

xxi. Parkinson's Disease

Hospitalization for treatment directly related to progressive degenerative idiopathic Parkinson's Disease, certified and diagnosed by a consultant neurologist.

Following will be excluded:

A. Parkinson's disease secondary to drug and/or alcohol abuse
B. Psychiatric treatment directly or indirectly related to Parkinson's disease

This Benefit shall supersede exclusion of Parkinson's disease specified under Clause 4.2(a)(14) of General Exclusions.

xxii. Alzheimer's Disease

A. Alzheimer's (presenile dementia) disease is a progressive degenerative disease of the brain characterized by diffuse atrophy throughout the cerebral cortex with distinctive histopathologic changes.
B. Deterioration or loss of intellectual capacity as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning requiring the continuous supervision of the Insured Person. This diagnosis must be supported by the clinical confirmation of an appropriate consultant neurologist and supported by the Company's appointed doctor.

Following will be excluded:

A. Non organic diseases such as neurosis and psychiatric illnesses;
B. Alcohol related brain damage;
C. Any other type of irreversible organic disorder/dementia;
D. Psychiatric treatment directly or indirectly related to Alzheimer's disease

This Benefit shall supersede exclusion of Parkinson's disease specified under Clause 4.2(a)(14) of General Exclusions.

xxiii. End Stage Liver Disease (Varies from IRDAI Standard Definitions 2016)

End stage liver disease resulting in cirrhosis and irreversible liver damage, evidenced by the following criteria and certified by a Gastroenterologist :

A. Permanent jaundice;
B. Uncontrollable ascites;
C. Hepatic encephalopathy;
D. Oesophageal or Gastric Varices and portal hypertension;

Liver disease arising out of or secondary to alcohol or drug misuse is excluded.

xxiv. Motor Neurone Disorder

Motor neurone disease diagnosed by a Neurophysician as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction with a clear causation relation to MND.

xxv. End Stage Lung Disease

End Stage Respiratory Failure including Chronic Interstitial Lung Disease. Following criteria must be met:

A. Requiring permanent oxygen therapy as a result of a consistent FEV1 test value of less than one litre. (Forced Expiratory Volume during the first second of a forced exhalation);
B. Arterial Blood Gas analysis with partial oxygen pressures of 55mmHg or less;
C. This diagnosis must be confirmed by a chest/Respiratory physician.

xxvi. Bacterial Meningitis

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. This diagnosis must be confirmed by:

A. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture;
B. A consultant neurologist.

Bacterial Meningitis in the presence of HIV infection is excluded.

xxvii. Aplastic Anaemia

Chronic persistent bone marrow failure which results in Anaemia, Neutropenia and Thrombocytopenia requiring treatment with at least one of the following:

A. Blood product transfusion;
B. Marrow stimulating agents;
C. Immunosuppressive agents; or
D. Bone marrow transplantation

The diagnosis must be confirmed by a hematologist using relevant laboratory investigations including Bone Marrow Biopsy. Two out of the following three values should be present:

A. Absolute Neutrophil count of 500 per cubic millimetre or less;
B. Absolute Reticulocyte count of 20,000 per cubic millimetre or less;
C. Platelet count of 20,000 per cubic millimetre or less.

xxviii. Major Organ Transplant

The actual undergoing of a transplant of:

A. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ; or
B. Human bone marrow using hematopoietic stem cells.

The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.
The following are excluded:

A. Other stem-cell transplants;
B. Where only islets of Langerhans are transplanted.

xxix. Stroke (Varies from IRDAI Standard Definitions 2016)

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

xxx. Paralysis (Varies from IRDAI Standard Definitions 2016)

A. Total and irreversible loss of use of two or more limbs as a result of Injury or disease of the brain or spinal cord. A specialist Medical Practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery. Reconstruction surgeries required to attain best possible mobility will be included

B. Rehabilitative treatment, prosthesis and supporting aids like crutches/wheel chair/vehicle/home modification will be excluded

xxxi. Major Burns (Varies from IRDAI Standard Definitions 2016)

Third degree (full thickness of the skin) burns covering at least 20% of the surface of the Insured Person's body. The condition should be confirmed by a consultant physician.

Burns arising due to self-infliction are excluded.

xxxii. Blindness (Varies from IRDAI Standard Definitions 2016)

A. 'Blindness' is defined as visual acuity of less than 3/60, or a corresponding visual field loss to less than 10°, in the better eye with the best possible correction.

B.Treatments required for correction of blindness or improvement in visual acuity will be covered

Following will be excluded:

(I) Treatment for Low vision: 'low vision' is defined as visual acuity of less than 6/18 but equal to or better than 3/60, or a corresponding visual field loss to less than 20°, in the better eye with the best possible correction.

(II) Cases of blindness with Low Vision before the inception of policy

(III) Cost of enucleation related to tumor's or other eye defects

(IV) Cost of prosthesis for cosmetic correction

(V) Visual aids implantable or external

xxxiii. Surgery/Surgical Procedure: means manual and/or operative procedure(s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering or prolongation of life, performed in a Hospital or a Day Care Centre by a Medical Practitioner.

1.18 Day Care Centre means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under—

a. has qualified nursing staff under its employment;

b. has qualified Medical Practitioner/s in-charge;

c. has a fully equipped operation theatre of its own, where Day Care Treatment is carried out.

d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

1.19 **Day Care Treatment** means medical treatment, and/ or Surgical Procedure which is:

a. undertaken under general or local anesthesia in a Hospital/ Day Care Centre in less than 24 consecutive hours because of technological advancement, and

b. which would have otherwise required a Hospitalization of more than 24 hours.

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

1.20 **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.

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

1.22 **Disclosure to Information Norm:** The Policy shall be void and all premium paid thereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

1.23 **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.

1.24 **Diagnosis** means pathological conclusion drawn by a registered medical practitioner, supported by acceptable Clinical, radiological, histological, histo-pathological and laboratory evidence wherever applicable.

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

1.26 **Empanelled Provider** means any qualified diagnostic center, Hospital and Medical Practitioner that has been empanelled with the Company to provide Services

1.27 **Grace Period** means the specified period of time immediately following the premium due date during which 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.

1.28 **Hazardous Activities** (or Adventure sports) means any sport or activity, which is potentially dangerous to the Insured whether he is trained or not. Such sport/activity includes (but not limited to) stunt activities of any kind, adventure racing, base jumping, biathlon, big game hunting, black water rafting, BMX stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/ pot holing, cave tubing, rock climbing/ trekking/ mountaineering, cycle racing, cyclo cross, drag racing, endurance testing, hand gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting,

judo, karate, kendo, lugging, risky manual labor, marathon running, martial arts, micro – lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/ parapenting, piloting aircraft, polo, power lifting, power boat racing, quad biking, river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting or wrestling of any type.

1.29 **Hospital** (not applicable for Overseas Travel Insurance) means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under 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:

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

1.30 **Hospitalization** (not applicable for Overseas Travel Insurance) means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

1.31 **ICU Charges** or (Intensive care Unit) Charges means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

1.32 **Indemnity/Indemnify** means compensating the Insured Person up to the extent of Expenses incurred, on occurrence of an event which results in a financial loss and is covered as the subject matter of the Insurance Cover.

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

(a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery

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

(a) It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests;
(b) It needs ongoing or long-term control or relief of symptoms;
(c) It requires rehabilitation for the patient or for the patient to be specially trained to cope with it;
(d) It continues indefinitely;
(e) It recurs or is likely to recur.

1.34 **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.

1.35 **In-patient Care** (not applicable for Overseas Travel Insurance) means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

1.36 **Insured Event** means an event that is covered under the Policy; and which is in accordance with the Policy Terms & Conditions.

1.37 **Insured Person (Insured)** means a person whose name specifically appears under Insured in the Policy Certificate and with respect to whom the premium has been received by the Company.

1.38 **Intensive Care Unit (ICU)** 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.

1.39 **Maternity expenses** shall include—

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).

b. expenses towards lawful medical termination of pregnancy during the policy period.

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

1.41 **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.

1.42 **Medical Practitioner** (not applicable for Overseas Travel Insurance) 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 license.

1.43 **Medically Necessary Treatment** (not applicable for Overseas Travel Insurance) means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

a. Is required for the medical management of the Illness or Injury suffered by the Insured Person;

b. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

c. Must have been prescribed by a Medical Practitioner;

d. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

1.44 **Network Provider** (not applicable for Overseas Travel Insurance) means the Hospitals enlisted by an Insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured by a Cashless Facility.

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

1.46 **Nominee** means the person named in the Policy Certificate or as declared with the Policyholder who is nominated to receive the benefits under this Policy in accordance with the terms of the Policy, if the Insured Person is deceased.

1.47 **Notification of Claim** means the process of intimating a Claim to the Insurer or TPA through any of the recognized modes of communication.

1.48 **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 is not admitted as a day care or In-patient.

1.49 **Policy** means these Policy terms and conditions and Annexures thereto, the Proposal Form, Policy Certificate and Optional Cover (if applicable) which form part of the Policy and shall be read together.

1.50 **Policy Certificate** is a certificate attached to and forming part of this Policy.

1.51 **Policy Year** means a period of one year commencing on the Policy Period Start Date or any anniversary thereof.

1.52 **Policyholder** (also referred as You) means the person named in the Policy Certificate as the Policyholder.

1.53 **Policy Period** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date of the Policy as specifically appearing in the Policy Certificate.

1.54 **Policy Period End Date** means the date on which the Policy expires, as specifically appearing in the Policy Certificate.

1.55 **Policy Period Start Date** means the date on which the Policy commences, as specifically appearing in the Policy Certificate.

1.56 **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.

1.57 **Post-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the Hospital provided that:

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

1.58 **Pre-existing Disease** (not applicable for Overseas Travel Insurance) means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.

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

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

1.60 **Qualified Nurse** (not applicable for Overseas Travel Insurance) is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

1.61 **Reasonable and Customary Charges** (not applicable for Overseas Travel Insurance) 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.

1.62 **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 gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

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

1.64 **Scheduled Airline** means any civilian aircraft operated by a civilian scheduled air carrier holding a certificate, license or similar authorization for civilian scheduled air carrier transport issued by the country of the aircraft's registry, and which in accordance therewith flies, maintains and publishes tariffs for regular passenger service between named cities at regular and specified times, on regular or chartered flights operated by such carrier.

1.65 **Senior Citizen** means any person who has completed sixty or more years of age as on the date of commencement or renewal of a health insurance policy.

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

1.67 **Subrogation** (Applicable to other than Health Policies and health sections of Travel and PA policies) means the right of the Insurer to assume the rights of the Insured Person to recover expenses paid out under the Policy that may be recovered from any other source.

1.68 **Sum Insured** means the amount specified in the Policy Certificate, for which premium is paid by the Policyholder

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

1.70 **Total Sum Insured** is the sum total of Sum Insured and the Sum Insured accrued as No Claims Bonus, Quick Recovery Counseling, OPD Expenses and /or Unlimited Automatic Recharge (Optional Cover), and /or Air Ambulance Cover (Optional Cover), and/or Additional Sum Insured for Accidental Hospitalization (Optional Cover). It represents the Company's maximum, total and cumulative liability for in respect of the Insured Person for any and all Claims incurred during the Policy Year. If the Policy Period is more than 12 months, then it is clarified that the Sum Insured shall be applied separately for each Policy Year in the Policy Period.

1.71 **Unproven/Experimental Treatment** means a treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

1.72 **Variable Medical Expenses** means those Medical Expenses as listed below which vary in accordance with the Room Rent or Room Category or ICU Charges applicable in a Hospital:

(a) Room, boarding, nursing and operation theatre expenses as charged by the Hospital where the Insured Person availed medical treatment;

(b) Intensive Care Unit charges;

(c) Fees charged by surgeon, anesthetist, Medical Practitioner;

(d) Investigation expenses incurred towards diagnosis of ailment requiring Hospitalization. Expenses related to the Hospitalization will be considered in proportion to the room rent stated in the Policy.

1.73 **Installment:** Means Payment of Premium through monthly/quarterly mode by the Policy Holder/Insured, applicable only for Policy Term of two or three years.

The following definitions are redefined which supersedes those respective definitions mentioned above, for Benefits and Optional Covers effective out of India:

1.74 **Medical Practitioner** means a person who holds a valid registration issued by the Medical Council/Statutory Regulatory Authority for Medical Education in that Country and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

1.75 **Qualified Nurse** means a person who holds a valid registration issued by the Nursing Council/Statutory Regulatory Authority for Medical Education in that Country and thereby entitled to render Nursing Care within the scope and jurisdiction of license.

1.76 **Unproven/Experimental Treatment** means a treatment including drug experimental therapy which is not based on established medical practice, is treatment experimental or unproven.

2. SCOPE OF COVER

GENERAL CONDITIONS APPLICABLE TO ALL THE BENEFITS AND OPTIONAL BENEFITS

1. The maximum, total and cumulative liability of the Company in respect of an Insured Person for any and all Claims arising under this Policy during the Policy Year shall not exceed the Total Sum Insured for that Insured Person.

   I. For any single Claim during a Policy Year, the maximum Claim amount payable shall be sum total of Sum Insured, No Claims Bonus, Quick Recovery Counseling, OPD Expenses, Unlimited Automatic Recharge, Additional Sum Insured for Accidental Hospitalization and Air Ambulance Cover.
   II. All Claims shall be payable subject to the terms, conditions, exclusions, sub-limits and wait periods of the Policy and subject to availability of the Total Sum Insured.
   III. The Company's liability shall be restricted to the payment of the balance amount subject to the available Total Sum Insured.

2. The Co-payment proportion (if applicable) shall be borne by the Insured Person on each Claim which will be applicable on Benefits namely Hospitalization Expenses, Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses, Chemotherapy and Radiotherapy Cover, Dialysis Cover, Ambulance Cover, Organ Donor Cover, Alternative Treatments, Quick Recovery Counseling ,Global Coverage, OPD Expenses, Room Rent Modification, Air Ambulance Cover and Additional Sum Insured for Accidental Hospitalization.
3. At the time of issue of the first Policy with the Company, if Age of Insured Person is 61 Years or above, such Insured Person shall bear a mandatory Co-payment of 20% per Claim (over & above any other co-payment, if any) and the Company's liability shall be restricted to the payment of the balance amount subject to the available Total Sum Insured. All the existing customers who have been issued a policy before attaining 61 years of age will have an option of Co-payment of 20% per claim (over & above any other co-payment, if any) .The Premium will be adjusted accordingly.
4. Deductible Option (if opted) is applicable on the Benefits namely Hospitalization Expenses, Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses, Chemotherapy and Radiotherapy Cover, Dialysis Cover, Ambulance Cover, Organ Donor Cover, Alternative Treatments,

Global Coverage, Room Rent Modification, Air Ambulance Cover and Additional Sum Insured for Accidental Hospitalization.

5. Any Claim paid for Benefits namely Hospitalization Expenses, Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses, Chemotherapy and Radiotherapy Cover, Dialysis Cover, Ambulance Cover, Organ Donor Cover, Alternative Treatments, Global coverage, Quick Recovery Counseling, OPD Expenses, Room Rent Modification(Optional Benefit),Air Ambulance(Optional Benefit), Additional Sum Insured for Accidental Hospitalization(Optional Benefit) shall reduce the Total Sum Insured for the Policy Year and only the balance shall be available for all the future claims for that Policy Year.
6. Admissibility of a Claim under Benefit "Hospitalization Expenses" is a pre-condition to the admission of a Claim under Pre Hospitalization Medical Expenses and Post Hospitalization Medical expenses, Chemotherapy and Radiotherapy Cover ,Dialysis Cover, Ambulance Cover, Organ Donor Cover, Alternative Treatments, Quick Recovery Counseling, Unlimited Automatic Recharge, OPD Expenses, Air Ambulance Cover, Additional Sum Insured for Accidental Hospitalization and the event giving rise to a Claim under Benefit "Hospitalization Expenses" shall be within the Policy Period for the Claim of such Benefit to be accepted.
7. If the Insured Person suffers a relapse within 45 days from the date of last discharge / consultation from the Hospital for which a Claim has been made, then such relapse shall be deemed to be part of the same Claim and all the limits of Per Claim Limit under this Policy shall be applied as if they were under a single Claim.
8. Option of Mid-term inclusion of a Person in the Policy will be only upon marriage or childbirth; Additional differential premium will be calculated on a pro rata basis.
9. Coverage amount limits for Benefits 'Quick Recovery Counseling ', 'OPD Expenses', 'Air Ambulance Cover' and Additional Sum Insured for Accidental Hospitalization are covered over and above the 'Sum Insured'.
10. Insured persons belonging to the same family are covered on an Individual basis, then every Insured person can opt for different Sum Insured and different Optional Covers.
11. Premium can be paid in Installments (Monthly and Quarterly) or single payment option. Installment option can only be opted during policy inception/Renewal and for policy tenure of 2/3 years.
12. Admissibility of a claim under the policy is subject to purview of coverage under the policy
13. There is no restriction on number of plans that can be opted by the Insured and the Benefits of each plan will be independently available to the Insured.
14. Coverage under this Policy is on Individual basis. Coverage for Child less than 5 years of age is provided only if 1 Adult aged 18 years or above is covered under the same Policy. Sum Insured/Optional Benefit coverage amount opted for Child less than 5 years of age should not be more than Sum Insured/ Optional Benefit coverage amount opted for the Adult under the same Policy.
15. Benefit Coverage opted for Child less than 5 years of age should be same as of that Adult covered under the Policy

2.1 Benefit 1 : Hospitalization Expenses

If an Insured Person is diagnosed with an illness or suffers an injury and which requires the Insured Person to be admitted in a Hospital in India which should be Medically Necessary during the Policy Period and while the Policy is in force for:

(i) In-patient Care: The Company will indemnify the Insured Person for Medical Expenses incurred towards Hospitalization due to Covered Conditions, through Cashless or Reimbursement Facility, maximum up to the Sum Insured ,as specified in the Policy Certificate, provided that the Hospitalization is for a minimum period of 24 consecutive hours and was prescribed in writing, by a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were Medically Necessary.

(ii) Day Care Treatment: The Company will indemnify the Insured Person for Medical Expenses incurred on Day Care Treatment due to Covered Conditions through Cashless or Reimbursement Facility, maximum up to the Sum Insured ,as specified in the Policy Certificate, provided that the Day Care Treatment is listed as per the Annexure-I to Policy Terms & Conditions and period of treatment of the Insured Person in the Hospital/Day Care Centre does not exceed 24 hours, which would otherwise require an in-patient admission and such Day Care Treatment was prescribed in written, by a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were Medically Necessary. The Day care List will Vary as per the Plan opted by the Policy Holder/Insured Person(Please refer Page 1 of Annexure -I to Policy Terms and Conditions)

(iii) Conditions applicable for Hospitalization Expenses (Benefit 1):

(a) <u>Room/Boarding and nursing expenses as charged by the Hospital where the Insured Person availed medical treatment (Room Rent / Room Category):</u>

If the Insured Person is admitted in a Hospital room where the Room Category opted or *Room Rent incurred is higher than the eligible Room Category/ Room Rent* as specified in the Policy Certificate, then,

I. The Insured Person shall bear the ratable proportion of the total Variable Medical Expenses (including applicable surcharge and taxes thereon) in the proportion of the difference between the Room Rent actually incurred and the Room Rent specified in the Policy Certificate or the Room Rent of the entitled Room Category to the Room Rent actually incurred.

The Policy Certificate will specify the eligibility of Room Rent or Room Category applicable for the Insured Person under the Policy. The Room Rent or Room Category available under this Policy is mentioned as follows:

1) **<u>Single Private Room</u>** If the Policy Certificate states '<u>Single Private Room</u>' as eligible Room Category, it means the maximum eligible Room Category in case of Hospitalization of the Insured Person payable by the Company is limited to stay in a Single Private Room.

2) If the Policy Certificate states 'up to 1% of the Sum Insured per day' as eligible Room Rent, it means the maximum eligible Room Rent of the Insured Person payable by the Company is limited to 1% of the Sum Insured per day of Hospitalization. Any amount accrued as No Claims Bonus under (Benefit 10) shall not form part of Sum Insured.

3) The nomenclature of Room categories may vary from one hospital to the other. Hence, the final consideration will be as per the definition of the Rooms mentioned in the Policy.

(b) Intensive Care Unit Charges (ICU Charges):

1) If the Insured Person is admitted in an ICU where the ICU charges incurred are higher than the ICU Charges specified in the Policy Certificate, then the Insured Person shall bear the ratable proportion of the Variable Medical Expenses (including applicable surcharge and taxes thereon) in the proportion of the difference between the ICU charges actually incurred and the ICU Charges specified in the Policy Certificate to the ICU charges actually incurred.

The Policy Certificate will specify the limit of ICU Charges applicable for the Insured Person under the Policy. The ICU Charges available under this Policy are as follows:

2) If the Policy Certificate states 'up to 2% of the Sum Insured per day' as eligible ICU Charges per day of Hospitalization, it means the maximum eligible ICU charges of the Insured Person payable by the Company is limited to 2% of the Sum Insured per day of Hospitalization. Any amount accrued as No Claims Bonus (Benefit 10) shall not form part of Sum Insured.

3) If the Policy Certificate states the eligibility of ICU Charges of the Insured Person as 'no sub-limit', it means that there is no separate restriction on ICU Charges incurred towards stay in ICU during Hospitalization.

2.2 Benefit 2 : Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses

The Company will *indemnify the Insured Person for Medical Expenses incurred which are Medically Necessary*, only through Reimbursement Facility, maximum up to the Sum Insured, as specified in the Policy Certificate, provided that the Medical Expenses so incurred are related to the same Covered Conditions for which the Company has accepted the Insured Person's Claim under Benefit 1 (Hospitalization Expenses) and subject to the conditions specified below:

(i) Under Pre-hospitalization Medical Expenses, *for a period of 30 days immediately prior to the Insured Person's date of admission to the Hospital*, provided that the Company shall not be liable to make payment for any Pre-hospitalization Medical Expenses that were incurred before the Policy Start Date; and

(ii) Under Post-hospitalization Medical Expenses, *for a period of 60 days immediately after the Insured Person's date of discharge from the Hospital*.

(iii) If the provisions of Clause 5.7(d)(Payment terms) is applicable to a Claim, then:

a) The date of admission to Hospital for the purpose of this Benefit shall be the date of the first admission to the Hospital for the Illness deemed or Injury sustained to be Any One Illness; and

b) The date of discharge from Hospital for the purpose of this Benefit shall be the last date of discharge from the Hospital in relation to the Illness deemed or Injury sustained to be Any One Illness.

2.3 Benefit 3:Chemotherapy and Radiotherapy Cover:

The Company will indemnify the Insured person up to Sum Insured as specified in the Policy Certificate for availing Chemotherapy and Radiotherapy treatment through Re-imbursement/Cashless facility provided that the Medical Expenses so incurred are related to the Covered Condition(Cancer) for which the Company has accepted the Insured Person's Claim under Benefit 1 (Hospitalization Expenses)

However a Claim under 'Oral Chemotherapy' will only be admissible if:

1. If a Claim is made under Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses

2. If a Claim is made under Benefit 13(OPD Expenses)

Clause 4.2 a (32) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

Note: We shall not be liable to make any payment in respect of Medical Expenses incurred on Chemotherapy and Radiotherapy which relate to Cancer which occurred and was diagnosed as a Chronic Condition prior to the Policy Start Date;

2.4 Benefit 4: Dialysis Cover

The Company will indemnify for the Medical Expenses incurred on dialysis up to the Sum Insured through Cashless/Reimbursement facility as specified in the Policy Certificate provided that the Medical Expenses so incurred are related to the Covered Conditions for which the Company has accepted the Insured Person's Claim under Benefit 1 (Hospitalization Expenses)

Note: We shall not be liable to make any payment in respect of Medical Expenses incurred on dialysis which relate to kidney disease which occurred and was diagnosed as a Chronic Condition prior to the Policy Start Date;

2.5 Benefit 5: Ambulance Cover

The Company will *indemnify the Insured Person*, through Cashless or Reimbursement Facility, up to the amount specified against this Benefit in the Policy Certificate, provided that the Medical Expenses so incurred are related to the Covered Conditions for which the Company has accepted the Insured Person's Claim under Benefit 1 (Hospitalization Expenses) and subject to conditions as specified below:

(i) Such ambulance transportation is offered by a Hospital or by an Ambulance service provider for the Insured Person's necessary transportation; and
(ii) Such ambulance transportation is certified by the treating Medical Practitioner; and
(iii) Such Transportation is from the place of occurrence of Medical Emergency of the Insured person, to the nearest Hospital; and/or
(iv) Such Transportation is from one Hospital to another Hospital for the purpose of providing better Medical aid to the Insured Person, following an Emergency.

2.6 Benefit 6:Organ Donor Cover

The Company will *indemnify the Insured Person*, through Cashless or Reimbursement Facility, up to the amount/limit specified against this Benefit in the Policy Certificate, for the Medical Expenses *incurred in respect of the donor, for organ transplant surgery* during the Policy Year, provided that the Medical Expenses so incurred are related to the Covered Conditions for which the Company has accepted the Insured Person's Claim under Benefit 1 (Hospitalization Expenses) and subject to conditions as specified below:

(i) The Organ donor is an eligible donor in accordance with The Transplantation of Human Organs Act, 1994 (amended) and other applicable laws and rules.
(ii) The Insured Person is the recipient of the Organ so donated by the Organ Donor.
(iii) The Company will not be liable to pay the Medical Expenses incurred by the Insured Person towards Pre-Hospitalization Medical Expenses and Post Hospitalization Medical Expenses (Benefit 2) or any other Medical Expenses in respect of the donor consequent to the harvesting.
(iv) Clause 4.2 (a) (19) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

2.7 Benefit 7:Alternative Treatments

The Company will indemnify the Insured Person, through Cashless or Reimbursement Facility, up to the amount/limit specified in the Policy Certificate, towards in-patient Medical Expenses incurred with respect to the Insured Person's Medical treatment undergone at any Government hospital or in any Institute recognized by Government and / or accredited by Quality Council of India / National Accreditation Board on Health or teaching hospitals of AYUSH colleges recognized by Central Council of Indian Medicine and Central Council of Homeopathy through

any of the alternative treatments namely Ayurveda, Sidha, Unani and Homeopathy, provided that the Medical Expenses so incurred are related to the Covered Conditions for which the Company has accepted the Insured Person's Claim under In-patient Care of Benefit 1 (Hospitalization Expenses) and subject to conditions as specified below:

(i) Medical Treatment should be rendered from a registered Medical Practitioner who holds a valid practicing license in respect of such Alternative Treatments; and
(ii) Such treatment taken is within the jurisdiction of India; and
(iii) Clause 4.2 a (20) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

2.8 Benefit 8:Second Opinion

In the event that the Insured Person is diagnosed with or has undergone/undergoing with any of the Covered Conditions as mentioned under Clause 1.17, then at the Policyholder's / Insured Person's request, the Company shall arrange for a Second Opinion from a Medical Practitioner within India.

(i) It is agreed and understood that the Second Opinion will be based only on the information and documentation provided to the Company which will be shared with the Medical Practitioner and is subject to the conditions specified below:

i) This Benefit is available only up to the purview of Coverage available under this Policy
ii) This Benefit can be availed only once by an Insured Person during the Policy Year
iii) The Insured Person is free to choose whether or not to obtain the Second Opinion and, if obtained under this Benefit, then whether or not to act on it.
iv) This Benefit is for additional information purposes only and does not and should not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.
v) The Company does not provide a Second Opinion or make any representation as to the adequacy or accuracy of the same, the Insured Person's or any other person's reliance on the same or the use to which the Second Opinion is put.
vi) The Company does not assume any liability for and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner or in any Second Opinion or for any consequences of actions taken or not taken in reliance thereon.
vii) The Policyholder or Insured Person shall hold the Company harmless for any loss or damage caused by or arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions or representations made by the Medical Practitioner or for any consequences of any action taken or not taken in reliance thereon.
viii) Any Second Opinion provided under this Benefit shall not be valid for any medico-legal purposes.
ix) The Second Opinion does not entitle the Insured Person to any consultation from or further opinions from that Medical Practitioner.

2.9 Benefit 9:Annual Health Check-up

(i) On the Policyholder's / Insured Person's request, through Cashless Facility, the Company will arrange for the Insured Person's Annual Health Check-up from second Policy Year on Continuous Coverage for the list of medical tests specified below at its Network Provider/Empanelled Provider in India, subject to the conditions specified below:

a) This Benefit shall be available only once during a Policy Year per Insured Person;
b) This Benefit does not reduce the Sum Insured and will not affect any Claim made under Benefit 10(No Claims Bonus)
c) Medical Tests covered in the Annual Health Check-up, applicable for Sum Insured up to 50 Lakh Rupees for Insured Persons who are of Age 18 years or above on the Policy Period Start Date, are as follows :-

Set No.	List of Medical Tests covered as a part of Annual Health Check-up	Sum Insured in Lakhs
1	Complete Blood Count with ESR, Urine Routine, Blood Group, Fasting Blood Sugar, Serum Cholesterol, SGPT, Serum Creatinine, ECG	1L/2L/3L/4L
2	Complete Blood Count with ESR, Urine Routine, Blood Group, Fasting Blood Sugar, Lipid Profile, Kidney Function Test, ECG	5L/7L/10L
3	Complete Blood Count with ESR, Urine Routine, Blood Group, Fasting Blood Sugar, Lipid Profile, TMT, Kidney Function Test	20L/25L/50L

d) Medical Tests covered in the Annual Health Check-up, applicable for SI=100L/200L/300L/600L, for Insured Persons who are of Age 18 years or above on the Policy Period Start Date, are as follows :-

Infection Markers Complete Blood Count(CBC) ESR ABO Group & Rh Type Urine Routine Stool Routine	Lipid Profile Cholesterol LDL HDL Triglycerides VLDL
Liver Function Test S Bilirubin (Total/Direct) SGPT SGOT GGT Alkaline Phosphatase Total Protein Albumin : Globulin	Kidney Function Test Creatinine Blood Urea Nitrogen Uric Acid
Lung Function Markers	Diabetes Markers

Lung Function Test	Hba1c
Cardiac Markers Treadmill Test ECG	Imaging Tests X-Ray – Chest Ultrasound Abdomen

e) Medical Tests covered in the Annual Health Check-up, applicable for Insured Persons who are of Age below 18 years on the Policy Period Start Date for all Plans are as follows :-

List of Medical Tests covered as a part of Annual Health Check-up
Physical Examination (Height, Weight and Body Mass Index (BMI)), Eye Examination, Dental Examination and Scoring, Growth Charting, Doctor Consultation, Urine Examination (Routine and Microscopic)

2.10 Benefit 10:No Claims Bonus:

At the end of 1st Claim free Policy Year, the Company will enhance the Sum Insured by 50%, at the end of 2ndClaim free Policy Year by 25% and at the end of 3rd Claim free Policy Year by 25%, on a cumulative basis, as a No Claims Bonus for each completed and continuous Policy Year/s, subject to the conditions specified below:

(i) In any Policy Year, the accrued No Claims Bonus shall not exceed 100% of the Sum Insured available in the renewed Policy.

(ii) The No Claims Bonus shall not enhance or be deemed to enhance any Conditions as prescribed under Clause 2.1(iii).

(iii) The No Claims Bonus which is accrued during the claim-free Policy Year will only be available to those Insured Persons who were insured in such claim-free Policy Year and continue to be insured in the subsequent Policy Year.

(iv) The entire No Claims Bonus will be forfeited if the Policy is not continued / renewed on or before Policy Period End Date or the expiry of the Grace Period whichever is later.

(v) The No Claims Bonus shall be applicable on an annual basis subject to continuation of the Policy.

(vi) If the Insured Persons in the expiring policy are covered on a Floater basis and such Insured Persons renew their expiring Policy with the Company by splitting the Floater Sum Insured in to 2 (two) or more Individual covers, then the No Claims Bonus of the expiring Policy shall be apportioned to such renewed Policy in the proportion of the Sum Insured of each of the renewed Policy.

(vii) This clause does not alter the Company's right to decline renewal or cancellation of the Policy for reasons as specified in Clause 6.1 (Disclosure to Information Norm).

(viii) In the event of a Claim occurring during any Policy Year, the accrued No Claims Bonus will be reduced by same rate at which it is accrued of the Sum Insured at the commencement of next Policy Year, but in no case shall the Total Sum Insured be reduced than the Sum Insured.

(ix) In case Sum Insured under the Policy is reduced at the time of renewal, the applicable No Claims Bonus shall also be reduced in proportion to the Sum Insured.

(x) In case Sum Insured under the Policy is increased at the time of renewal, the No Claims Bonus shall be calculated on the Sum Insured applicable on the last completed Policy Year.

(xi) The Recharge amount ('Unlimited Automatic Recharge') shall not be considered while calculating 'No Claims Bonus'.

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

2.11 Benefit 11:Health Services: If an Insured Person is diagnosed with or has undergone with any of the Covered Conditions as mentioned under Definition 1.17, then Company will provide

a. Quick Recovery Counseling: The Company will indemnify the Insured Person and /or his/her adult family member covered under the policy through Reimbursement/Cashless Facility, for seeking counseling of a psychologist through face to face consultation for dealing with post hospitalization trauma up to the amount per Session specified against this Benefit in the Policy Certificate, during the Policy Year, provided that the services availed are related to the Covered Conditions for which the Company has accepted the Insured Person's Claim under Benefit 1 (Hospitalization Expenses) and subject to conditions as specified below:

i. This service can be availed maximum up to 8 times in a policy year and twice in a month.

ii. All valid claims incurred by the Insured Person in a policy year will be payable by the Company. However, in case of reimbursement, claim can be filed with the Company, only twice during that Policy year, as and when that Insured Person may deem fit

Clause 4.2 (a) (14) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

b. Doctor on Call : The Insured Person may seek medical advice from a Medical Practitioner through the telephonic or online mode by contacting the Company on the helpline details specified on the Company's website

c. Health Portal: The Insured Person may access health related information and services such as health risk assessment, Doctor on chat, Special rates for OPD, Diagnostics and Pharmacy through Network Providers ,etc as available on the Company's website

2.12 Benefit 12:Global Coverage:

The Company shall indemnify the Insured Person, through Cashless or Reimbursement Facility, for Hospitalization Expenses incurred outside India up to the Sum Insured, subject to the conditions specified below:

(i) This Benefit is available only up to the purview of Coverage available under this Policy
(ii) A mandatory Co-Payment of 10% per Claim is applicable, which will be in addition to any other co-payment (if any) applicable in the Policy.

(iii) This Benefit is available only if the Policy holder/Insured person has chosen a Sum Insured of Rs 100 L or more.

(iv) The Benefit is available for 45 continuous days from the date of travel in a Single Trip and 90 days on a cumulative basis as a whole, in a Policy Year.

(v) The Medical expenses payable shall be limited to Inpatient Care & Day Care Treatment under Benefit 1 (Hospitalization Expenses) only;

(vi) The payment of any Claim under this Benefit will be based on the rate of exchange as on the Date of Loss published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian Rupees for payment of Claims. If on the Insured Person's Date of Loss, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.

(vii) Optional Benefit 5 (Room Rent Modification) is not applicable for any Claims made under Global Coverage

Note:

a) Clause 5.7(a) of Payment Terms under Claims Procedure and Management is superseded to the extent covered under this Benefit.

b) Exclusions applicable to this Benefit have been mentioned under Permanent Exclusions, Clause 4.2.

2.13 Benefit 13:OPD Expenses :

The Company will indemnify the Insured Person, through Reimbursement/Cashless Facility, for availing Out-Patient consultations, Diagnostic Examinations and Pharmacy expenses, up to the amount/limit specified against this Benefit in the Policy Certificate, during the Policy Year, Provided that the Medical Expenses so incurred are related to the Covered Conditions for which the Company has accepted the Insured Person's Claim under In-patient Care of Benefit 1 (Hospitalization Expenses) and subject to conditions as specified below :

(a) Coverage for the Benefit 'OPD Expenses' is provided for entire Policy Year.

(b) All the valid OPD claim expenses incurred by the Insured Person in a policy year will be payable by the Company. However, in case of reimbursement, claim can be filed with the Company, only twice during that Policy year, as and when that Insured Person may deem fit

3. OPTIONAL BENEFITS:

The Policy provides the following Optional Benefits which can be opted either at the inception of the policy or at the time of renewal. The Policy Certificate will specify the Optional Benefits that are in force for the Insured Persons.

3.1 Optional Benefit 1: Deductible Option:

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Benefit, The claim amount assessed by the Company for a particular claim shall be reduced by the Deductible as specified

in the Policy Certificate in accordance with Clause 5.6 (b) (iii) (Claims Assessment) and the Company shall be liable to make payment under the Policy for any Claim only when the Deductible on that Claim is exhausted.

(i) The Deductible shall be applicable on an aggregate basis for all Claims made by the Insured Person in a Policy Year.

(ii) Policyholder is entitled for a reduction on the Premium payable varying with the deductible amount chosen

(iii) Illustration for applicability of Deductible in the claim reported under same Policy Year:

Case	Sum Insured	Deductible	Claim 1	Claim 2	Claim 3	Payable 1	Payable 2	Payable 3
1	500,000	100,000	75,000	125,000	100,000	-	100,000	100,000
2	500,000	100,000	75,000	250,000	300,000	-	225,000	275,000
3	500,000	100,000	250,000	400,000	400,000	150,000	350,000	Claim not payable as SI is exhausted
4	500,000	100,000	7,00,000	0	0	500,000	0	0

3.2 Optional Benefit 2: Co-Payment Option:

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Benefit, the Insured Person will bear a Co-payment, as specified in the Policy Certificate, in accordance with Clause 5.6 (b) (iv) (Claims Assessment) and the Company's liability shall be restricted to the balance amount payable.

This Optional Benefit is not applicable in case the Insured Person age at entry is 61 years and above- please refer to Section 2 (3) of General conditions for details.

3.3 Optional Benefit 3: Unlimited Automatic Recharge:

If a Claim is payable under the Policy, then the Company agrees to automatically make the re-instatement of up to the Sum Insured unlimited times during the Policy Year and subject to conditions as specified below:

(i) The Recharge shall be utilized only after the Sum Insured, No Claims Bonus (Benefit – 10), and Additional Sum Insured for Accidental Hospitalization (Optional Cover – 6) has been completely exhausted in that Policy Year.

(ii) This Benefit is only available if the Policy Holder/Insured Person chooses a Sum Insured Of greater than 1 L and less than equal to 50 L.

(iii) The Recharge is applicable only for Benefit 1 (Hospitalization Expenses).

(iv) The Recharge shall be available only for all future Claims which are not in relation to any Illness or Injury for which a Claim has already been admitted for that Insured Person during that Policy Year.

(v) Benefit No Claims Bonus (Benefit – 10) shall not be considered while calculating 'Unlimited Automatic Recharge'.

(vi) Any unutilized Recharge cannot be carried forward to any subsequent Policy Year.

(vii) For any single Claim during a Policy Year the maximum Claim amount payable shall be sum total of:

a) Sum Insured
b) No Claims Bonus (Benefit – 10)
c) Additional Sum Insured for Accidental Hospitalization (Optional Cover – 6)

(viii) During a Policy Year, the aggregate Claim amount payable, subject to admissibility of the Claim, shall not exceed the sum total of:

a) Sum Insured
b) No Claims Bonus (Benefit – 10)
c) Additional Sum Insured for Accidental Hospitalization (Optional Cover – 6)
d) Unlimited Automatic Recharge (Optional Benefit-3)

3.4 Optional Benefit 4: International Second Opinion:

"International Second Opinion" is an extension to Benefit 8 (Second Opinion) and hence all the provisions stated under Clause 2.8, holds good for Clause 3.4 as well, except that the geographical scope of coverage through Optional Benefit 4 is applicable to worldwide excluding India only.

3.5 Optional Benefit 5:Room Rent Modification:

Notwithstanding anything to the contrary in the Policy, By Choosing this Optional Benefit the Insured Person will have no limit on Room Rent/Room Category and ICU Charges during Hospital Accommodation for In -patient Care for the Covered Conditions as specified in the Policy Certificate and Subject to the conditions as specified below:

(i) This Optional Benefit is only valid if the Policy Holder/Insured Person has chosen a Sum Insured of Rs 5 Lakhs or More.
(ii) Clause 3.5 is not valid for any Claim for In-patient Care under Benefit 12: Global Coverage

3.6 Optional Benefit 6:Additional Sum Insured for Accidental Hospitalization:

In case any Claim is made for Emergency Care of any Injury due to an Accident during the Policy Period, the Company shall automatically provide an additional Sum Insured equal to Sum Insured for In-patient Care for that Insured Person who is hospitalized, provided that:

(i) if at all there is any concurrency between the Coverage under the Policy and the claim made under Accidental Hospitalization The 'additional Sum Insured for Accidental Hospitalization' shall be utilized only after the Sum Insured and No Claims Bonus(if any) has been completely exhausted.

(ii) The 'additional Sum Insured Accidental Hospitalization' shall be available only for such Insured Person for whom Claim for Hospitalization following the Accident has been accepted under the Policy;

(iii) The 'additional Sum Insured Accidental Hospitalization' shall be applied only once during the Policy Year.

3.7 Optional Benefit 7:Air Ambulance Cover:

The Company will indemnify the Insured Person up to the amount specified against this Benefit in the Policy Certificate, for the Reasonable and Customary Charges necessarily *incurred on availing Air Ambulance services,* in India, offered by a Hospital or by an Ambulance service provider for the Insured Person's necessary transportation, provided that:

(i) The treating Medical Practitioner certifies in writing that the severity or the nature of the Insured Person's Illness or Injury warrants the Insured Person's requirement for Air Ambulance;

(ii) The transportation expenses under this Optional Benefit include transportation from the place of occurrence of Medical Emergency of the Insured person, to the nearest Hospital; and/or transportation from one Hospital to another Hospital for the purpose of providing better Medical aid to the Insured Person, following an Emergency;

(iii) This Benefit will be extended through Cashless Facility, if the costs are certified and authorized by the Company or the Assistance Service Provider in advance. In case the Insured Person has a Life Threatening Medical Condition and the Insured Person (or his representatives) arranges for the emergency Air Ambulance at their own expense, then the Company will reimburse such costs incurred in accordance with the terms of this Optional Benefit;

(iv) Payment under this Optional Benefit is subject to a Claim for the same Illness or Injury being admitted by the Company under Benefit 1(Hospitalization Expenses)

(v) For Additional Documents to be submitted for any Claim under this Benefit please refer Clause 5.5 b)

3.8 Optional Benefit 8: Reduction of PED Wait period

Choosing this Optional Benefit reduces the applicable wait period of 48 months for Claims related to Pre-existing diseases, to 24 months.

Hence all the provisions stated under Clause 4.1 (iii) and Definition 1.58 holds good for Clause 3.8 as well, except that the claims will be admissible for any Medical Expenses incurred for Hospitalization in respect of diagnosis/treatment of any Pre-existing Disease after just 24 months of continuous coverage has elapsed, since the inception of the first Policy with the Company.

NOTE: This Optional Benefit will be available only at the time of inception of the Policy and only for the Sum Insured chosen at that time

4. EXCLUSIONS

4.1. Wait Period

(i) Initial Waiting Period

a) Claim for any Medical Expenses incurred for treatment of any Illness during the first 90 days from the Policy Period Start Date shall not be admissible, except those Medical Expenses incurred as a result of an Injury within the Policy Period.

b) This exclusion shall not apply for subsequent Policy Years provided that there is no Break in Policy for that Insured Person and that the Policy has been renewed with the Company for that Insured Person within the Grace Period and for the same or lower Sum Insured.

(ii) Specific Waiting Period for Covered Conditions (applicable only for Operation Mediclaim)

Any Claim for or arising out of any of the following Illnesses or Surgical Procedures shall not be admissible during the first 24 (twenty four) consecutive months of coverage of the Insured Person by the Company from the first Policy Period Start Date:

1. Any treatment related to Arthritis (if non-infective), Osteoarthritis and Osteoporosis, Gout, Rheumatism, Spinal Disorders(unless caused by accident), Joint Replacement Surgery(unless caused by accident), Arthroscopic Knee Surgeries/ACL Reconstruction/Meniscal and Ligament Repair
2. Surgical treatments for Benign ear, nose and throat (ENT) disorders and surgeries for – Adenoidectomy, Mastoidectomy, Tonsillectomy and Tympanoplasty), Nasal Septum Deviation, Sinusitis and related disorders and surgeries related to disorders of internal ear, middle ear, external ear disorders, and Upper airway disease
3. Benign Prostatic Hypertrophy
4. Cataract
5. Dilatation and Curettage
6. Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, Gastric and Duodenal Ulcers
7. Surgery of Genito-urinary system unless necessitated by malignancy
8. All types of Hernia & Hydrocele
9. Hysterectomy for menorrhagia or Fibromyoma or prolapse of uterus unless necessitated by malignancy
10. Internal tumours, skin tumours, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant
11. Kidney Stone / Ureteric Stone / Lithotripsy / Gall Bladder Stone
12. Myomectomy for fibroids
13. Varicose veins and varicose ulcers

(iii) Wait Period for Pre-existing Diseases: Claims will not be admissible for any Medical Expenses incurred for Hospitalization in respect of diagnosis/treatment of any Pre-existing Disease until 48 months of continuous coverage has elapsed, since the inception of the first Policy with the Company.

(iv) If the Sum Insured is enhanced on any renewal of this Policy, the waiting periods as defined above in Clauses 4.1(i), 4.1(ii) and 4.1(iii) shall be applicable afresh to the incremental amount of the Sum Insured only.

(v) If the Sum Insured is reduced on any renewal of this Policy, the credit for waiting periods as defined above in Clauses 4.1(i), 4.1(ii) and 4.1(iii) shall be restricted to the lowest Sum Insured under the previous Policy.

(vi) The Waiting Periods as defined in Clauses 4.1(i), 4.1(ii) and 4.1(iii) shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

(vii) If Coverage for Benefits (in case of change in Product Plan) or Optional Benefits are added afresh at the time of renewal of this Policy, the Waiting Periods as defined above in Clauses 4.1 (i), 4.1(ii) and 4.1(iii) shall be applicable afresh to the newly added Benefits or Optional Benefits, from the time of such renewal.

4.2. Permanent Exclusions:

Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy terms and conditions.

a) The following list of permanent exclusions is applicable to all the Benefits including Optional Benefits

1. Any item or condition or treatment specified in List of Non-Medical Items (Annexure – II to Policy Terms & Conditions).

2. The Company shall not admit any Claim in respect of an Insured Person for which involves treatment/consultation in any of the hospitals as listed in Annexure – III to the Policy Terms & Conditions.
3. Treatments rendered by a Doctor who shares the same residence as an Insured Person or who is a member of an Insured Persons's family.
4. Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T-Cell Lymphotropic Virus Type III (HTLV–III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.
5. Any treatment arising from or traceable to pregnancy (including voluntary termination), miscarriage (unless due to an Accident), childbirth, maternity (including caesarian section), abortion or complications of any of these. This exclusion will not apply to ectopic pregnancy.
6. Any treatment arising from or traceable to any fertility, sterilization, birth control procedures, contraceptive supplies or services including complications arising due to supplying services or Assisted Reproductive Technology.

7. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.
8. Charges incurred (or Treatment undergone) in connection with routine eye examinations and ear examinations, dentures, artificial teeth and all other similar external appliances and / or devices whether for diagnosis or treatment.
9. Unproven/Experimental or investigational treatments which are not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness for which confinement is required at a Hospital. Any Illness or treatment which is a result or a consequence of undergoing such experimental or unproven treatment.
10. Expenses incurred (or Treatment undergone) on High Intensity Focused Ultra Sound, Balloon Sinuplasty, Enhanced External Counter Pulsation Therapy and related therapies. Deep Brain Simulation, Hyperbaric Oxygen Therapy, Robotic Surgery ((whether invasive or non-invasive), Holmium Laser Enucleation of Prostate, KTP Laser surgeries, cyber knife treatment, Femto laser surgeries, bioabsorbable stents.
11. Any expenses related to instruments used in treatment of sleep disorder or sleep apnea syndrome and oxygen concentrator for asthmatic condition, cost of cochlear implants and related surgery.
12. Any treatment related to general debility convalescence, cure, rest cure, health hydros, nature cure clinics, sanatorium treatment, Rehabilitation measures, private duty nursing, respite care, long-term nursing care, custodial care or any treatment in an establishment that is not a Hospital
13. Treatment of any external Congenital Anomaly or Illness or defects or anomalies or treatment relating to external birth defects.
14. Treatment of mental illness or psychological disorders or Parkinson's or Alzheimer's disease even if caused or aggravated by or related to an Accident or Illness.
15. Cosmetic surgery or plastic surgery or related treatment of any description, including any complication arising from these treatments, other than as may be necessitated due to an Injury, cancer or burns.
16. Any treatment / surgery for change of sex or gender reassignments including any complication arising from these treatments.
17. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident.
18. All preventive care (except eligible and entitled for Benefit 9: Annual Health Check-up), Vaccination, including Inoculation and Immunizations (except in case of post-bite treatment), vitamins and tonics.
19. All expenses (or Treatment undergone) related to donor treatment including surgery to remove organs from the donor, in case of transplant surgery.
20. Non-Allopathic Treatment or treatment related to any unrecognized systems of medicine.
21. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
22. Any Illness or Injury directly or indirectly resulting or arising from or occurring during commission of any breach of any law by the Insured Person with any criminal intent.

23. Act of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane or Illness or Injury attributable to consumption, use, misuse or abuse of intoxicating drugs, alcohol ,tobacco(smoking/non -smoking)or hallucinogens.
24. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
    a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
    b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
    c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.
25. Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants.
26. Alopecia wigs and/or toupee and all hair or hair fall treatment and products.
27. Any treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification center, sanatorium, home for the aged, mentally disturbed, remodeling clinic or similar institutions.
28. Stem cell implantation/surgery and storage except for allogeneic bone marrow transplantation
29. All the Hazardous Activities
30. Taking part or is supposed to participate in a naval, military, air force operation or aviation in a professional or semi-professional nature.
31. Remicade, Avastin or similar injectable treatment not requiring 24 hour hospitalization.
32. Oral Chemotherapy.
33. Treatment sought for any medical condition, not covered under the Benefit but arising during the Hospitalization for the condition covered under the Benefit.

b) Additional Exclusions applicable to any Claim under the Optional Benefit 6 'Additional Sum Insured due to Accidental Hospitalization'

Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible, unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

1. The Insured Person operating or learning to operate any aircraft or performing duties as a Person of a crew on any aircraft or Scheduled Airline or any airline personnel;
2. The Insured Person flying in an aircraft other than as a fare paying passenger in a Scheduled Airline;

3. Participation in actual or attempted felony, riots, civil commotion or criminal misdemeanor;
4. The Insured Person engaging in sporting activities in so far as they involve the training for or participation in competitions of professional sports;
5. The Insured Person working in or with mines, tunneling or explosives or involving electrical installation with high tension supply or conveyance testing or oil rigs work or ship crew services or as jockeys or circus personnel or aerial photography;
6. Persons whilst working with in activities like racing on wheels or horseback, winter sports, canoeing involving white water rapids, any bodily contact sport;
7. Resulting due to any disease or infection except where such condition arises directly as a consequence of an accident during the Policy Year;
8. Infections (except pyogenic infection which occurs through an Accidental cut or wound);
9. As a result of any curative treatments or interventions that the Insured Person has carried out or have carried out on the Insured Person's body.

c) Additional Exclusions applicable to any Claim for the Covered Condition related to Operation Mediclaim Plan:

1. All OPD based procedures not requiring day care/hospitalization
2. Any Surgery done for diagnostic/investigative purpose except in case of Pre and Post Hospitalization

Note to 'Permanent Exclusions': In addition to the foregoing, any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above Permanent Exclusions shall also be excluded.

5. Claims Procedure and Management

This section explains about procedures involved to file a valid Claim by the Insured Person and related processes involved to manage the Claim by the Company.

5.1 Pre-requisite for admissibility of a Claim:

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

(i) The Condition Precedent Clause has to be fulfilled.

(ii) The health damage caused, Medical Expenses incurred, subsequently the Claim being made, should be with respect to the Insured Person only. The Company will not be liable to indemnify the Insured Person for any loss other than the covered Benefits and any other person who is not accepted by the Company as an Insured Person.

(iii) The holding Insurance Policy should be in force at the event of the Claim. All the Policy Terms and Conditions, wait periods and exclusions are to be fulfilled including the realization of Premium by their respective due dates.

(iv) All the required and supportive Claim related documents are to be furnished within the stipulated timelines. The Company may call for additional documents wherever required.

5.2 Claim settlement - Facilities

(a) Cashless Facility

The Company extends Cashless Facility as a mode to indemnify the medical expenses incurred by the Insured Person at a Network Provider. For this purpose, the Insured Person will be issued a "Health card" at the time of Policy purchase, which has to be preserved and produced at any of the Network Providers in the event of Claim being made, to avail Cashless Facility. The following is the process for availing Cashless Facility:-

(i) **Submission of Pre-authorization Form:** A Pre-authorization form which is available on the Company's Website or with the Network Provider, has to be duly filled and signed by the Insured Person and the treating Medical Practitioner, as applicable, which has to be submitted electronically by the Network Provider to the Company for approval. Only upon due approval from the Company, Cashless Facility can be availed at any Network Hospital.

(ii) **Identification Documents:** The "Health card" provided by the Company under this Policy, along with one Valid Photo Identification Proof of the Insured Person are to be produced at the Network Provider, photocopies of which shall be forwarded to the Company for authentication purposes. Valid Photo Identification Proof documents which will be accepted by the Company are Voter ID card, Driving License, Passport, PAN Card, Aadhar Card or any other identification proof as stated by the Company.

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

(iv) **Company's Authorization:**

a) If the request for availing Cashless Facility is authorized by the Company, then payment for the Medical Expenses incurred in respect of the Insured Person shall not have to be made to the extent that such Medical Expenses are covered under this Policy and fall within the amount authorized in writing by the Company for availing Cashless Facility.

b) An Authorization letter will include details of Sanctioned Amount, any specific limitation on the Claim, and any other details specific to the Insured Person, if any, as applicable.

c) In the event that the cost of Hospitalization exceeds the authorized limit, the Network Provider shall request the Company for an enhancement of Authorization Limit stating details of specific circumstances which have led to the need for increase in the previously authorized limit. The Company will verify the eligibility and evaluate the request for enhancement on the availability of further limits.

(v) **Event of Discharge from Hospital:** All original bills and evidence of treatment for the Medical Expenses incurred in respect of the Hospitalization of the Insured Person and all other information and documentation specified under Clauses 5.4 and 5.5 shall be submitted by the Network Provider immediately and in any event before the Insured Person's discharge from Hospital.

(vi) **Company's Rejection:** If the Company does not authorize the Cashless Facility due to insufficient Sum Insured or insufficient information provided to the Company to determine the admissibility of the Claim, then payment for such treatment will have to be made by the Policyholder / Insured Person to the Network Provider, following which a Claim for reimbursement may be made to the Company which shall be considered subject to the Insured Person's Policy limits and relevant conditions. Please note that rejection of a Pre-authorization request is in no way construed as rejection of coverage or treatment. The Insured Person can proceed with the treatment, settle the hospital bills and submit the claim for a possible reimbursement.

(vii) **Network Provider related:** The Company may modify the list of Network Providers or modify or restrict the extent of Cashless Facilities that may be availed at any particular Network Provider. For an updated list of Network Providers and the extent of Cashless Facilities available at each Network Provider, the Insured Person may refer to the list of Network Providers available on the Company's website or at the call center.

(viii) **Claim Settlement:** For Claim settlement under Cashless Facility, the payment shall be made to the Network Provider whose discharge would be complete and final.

(ix) **Claims incurred outside India:** The Company's Assistance Service Provider should be intimated for availing Cashless Facility outside India under Optional Benefit 4(International Second Opinion) and Benefit 12(Global Coverage)

(b) **<u>Re-imbursement Facility</u>**

(i) It is agreed and understood that in all cases where intimation of a Claim has been provided under Reimbursement Facility and/or the Company specifically states that a particular Benefit is payable only under Reimbursement Facility, all the information and documentation specified in Clause 5.4 and Clause 5.5 shall be submitted to the Company at Policyholder's / Insured Person's own expense, immediately and in any event within 30 days of Insured Person's discharge from Hospital.

(ii) The Company shall give an acknowledgement of collected documents. However, in case of any delayed submission, the Company may examine and relax the time limits mentioned upon the merits of the case.

(iii) In case a reimbursement claim is received after a Pre-Authorization letter has been issued for the same case earlier, before processing such claim, a check will be made with the Network Provider whether the Pre-authorization has been utilized. Once such check and declaration is received from the Network Provider, the case will be processed.

(iv) For Claim settlement under reimbursement, the Company will pay the Policyholder. In the event of death of the Policyholder, the Company will pay the nominee (as named in the Policy Certificate) and in case of no nominee, to the legal heirs or legal representatives of the

Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

(v) 'Date of Loss' under Reimbursement Facility is the 'Date of Admission' to Hospital in case of Hospitalization & actual Date of Loss for non-Hospitalization related Benefits.

5.3 Duties of a Claimant/ Insured Person in the event of Claim

(a) It is agreed and understood that as a Condition Precedent for a Claim to be considered under this Policy:

(i) The Policyholder / Insured Person shall check the updated list of Network Provider before submission of a pre-authorization request for Cashless Facility.

(ii) All reasonable steps and measures must be taken to avoid or minimize the quantum of any Claim that may be made under this Policy.

(iii) Intimation of the Claim, notification of the Claim and submission or provision of all information and documentation shall be made promptly and in any event in accordance with the procedures and within the timeframes specified in Clause 5 (Claims Procedure and Management) of the Policy.

(iv) The Insured Person will, at the request of the Company, submit himself / herself for a medical examination by the Company's nominated Medical Practitioner as often as the Company considers reasonable and necessary. The cost of such examination will be borne by the Company.

(v) The Company's Medical Practitioner and representatives shall be given access and co-operation to inspect the Insured Person's medical and Hospitalization records and to investigate the facts and examine the Insured Person.

(vi) The Company shall be provided with complete necessary documentation and information which the Company has requested to establish its liability for the Claim, its circumstances and its quantum.

5.4 Claims Intimation

Upon the occurrence of any Illness or Injury that may result in a Claim under this Policy, then as a Condition Precedent to the Company's liability under the Policy, all of the following shall be undertaken:

(i) If any Illness is diagnosed or discovered or any Injury is suffered or any other contingency occurs which has resulted in a Claim or may result in a Claim under the Policy, the Company shall be notified with full particulars within 48 hours from the date of occurrence of event either at the Company's call center or in writing.

(ii) Claim must be filed within 30 days from the date of discharge from the hospital in case of hospitalization and actual date of loss in case of non-hospitalization Benefits.
Note: 5.4 (i) and 5.4 (ii) are precedent to admission of liability under the policy.

(iii) The following details are to be disclosed to the Company at the time of intimation of Claim:

1. Policy Number;
2. Name of the Policyholder;
3. Name of the Insured Person in respect of whom the Claim is being made;
4. Nature of Illness or Injury and Benefit under which the Claim is being made

5. Name and address of the attending Medical Practitioner and Hospital;
6. Date of admission to Hospital or proposed date of admission to Hospital for planned Hospitalization;
7. Any other necessary information, documentation or details requested by the Company.

(iv) In case of an Emergency Hospitalization, the Company shall be notified either at the Company's call center or in writing immediately and in any event within 48 hours of Hospitalization commencing or before the Insured Person's discharge from Hospital.

(v) In case of an Planned Hospitalization, the Company shall be notified either at the Company's call center or in writing at least 48 hours prior to planned date of admission to Hospital

5.5 Documents to be submitted for filing a valid Claim

a) The following information and documentation shall be submitted in accordance with the procedures and within the timeframes specified in Clause 5 in respect of all Claims:

1. Duly filled and signed Claim form by the Insured Person;
2. Copy of Photo ID of Insured Person;
3. Medical Practitioner's referral letter advising Hospitalization;
4. Medical Practitioner's prescription advising drugs or diagnostic tests or consultations;
5. Original bills, receipts and discharge summary from the Hospital/Medical Practitioner;
6. Original bills from pharmacy/chemists;
7. Original pathological/diagnostic test reports/radiology reports and payment receipts;
8. Operation Theatre Notes;
9. Indoor case papers;
10. Original investigation test reports and payment receipts supported by Doctor's reference slip;
11. Ambulance Receipt;
12. Any other document as required by the Company to assess the Claim, in case fraud is suspected.

b) Additional Documents to be submitted for any Claim under Optional Benefit 7(Air Ambulance Cover)

It is a condition precedent to the Company's liability under this Optional Benefit that the following information and documentation shall be submitted to the Company or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

I. Medical reports and transportation details issued by the air ambulance service provider, prescriptions and medical report by the attending Medical Practitioner furnishing the name of the Insured Person and details of treatment rendered along with the statement confirm the necessity of air ambulance services.

II. Documentary proof for expenses incurred towards availing Air Ambulance services.

Notes:

- The Company may give a waiver to one or few of the above mentioned documents depending upon the case.
- Additional documents as specified against any Benefit shall be submitted to the company.
- The Company will accept bills/invoices which are made in the Insured Person's name only.
- The company may seek any other document as required to assess the Claim.
- Only in the event that original bills, receipts, prescriptions, reports or other documents have already been given to any other insurance company, the company will accept properly verified photocopies of such documents attested by such other insurance company along with an original certificate of the extent of payment received from such insurance company.

However, claims filed even beyond the timelines mentioned above should be considered if there are valid reasons for any delay.

5.6 Claim Assessment

a. The Company shall scrutinize the Claim and supportive documents, once received. In case of any deficiency, the Company may call for any additional documents or information as required, based on the circumstances of the Claim.

b. All admissible Claims under this Policy shall be assessed by the Company in the following progressive order:

(i) If a Room/ICU accommodation has been opted for where the Room Rent or Room Category or ICU Charges is higher than the eligible limit as applicable for that Insured Person as specified in the Policy Certificate, then the Variable Medical Expenses payable shall be pro-rated as per the applicable limits in accordance with Clause 2.1(iii) (a) & (b).

(ii) If any sub-limits on Room Rent/Category for Medical Expenses are applicable as specified in the Policy Certificate, the Company's liability to make payment shall be limited to the extent of the applicable sub-limit for that Medical Expense.

(iii) The Deductible (if applicable) shall be applied to the aggregate of all Claims that are either paid or payable under this Policy. The Company's liability to make payment shall commence only once the aggregate amount of all Claims payable or paid exceed the Deductible .Similarly, if 'Deductible per claim' is applicable, the Company's liability to make payment shall commence only once the 'Deductible per claim' limit is exceeded.

(iv) Co-payment (if applicable) shall be applicable on the admissible claim amount payable by the Company

c. The Claim amount assessed in Clause 5.6 (b) above would be deducted from the following amounts in the following progressive order:

(i) Sum Insured;
(ii) No Claims Bonus (if applicable);
(iii) Additional Sum Insured for Accidental Hospitalization (if applicable);
(iv) Unlimited Automatic Recharge (if applicable).

d. All claims incurred in India are dealt by the Company directly.

5.7 Payment Terms

(a) This Policy covers only medical treatment taken entirely within India. All payments under this Policy shall be made in Indian Rupees and within India.

(b) The Company shall have no liability to make payment of a Claim under the Policy in respect of an Insured Person during the Policy Period, once the Total Sum Insured for that Insured Person is exhausted.

(c) **The Company shall settle or reject any Claim within 30 days** of receipt of all the necessary documents / information as required for settlement of such Claim and sought by the Company. The Company shall provide the Policyholder / Insured Person an offer of settlement of Claim and upon acceptance of such offer by the Policyholder / Insured Person the Company shall make payment within 7 days from the date of receipt of such acceptance. However, if a claim warrants an investigation in the opinion of the Company, then the Company shall settle the claim within 45 days from the date of receipt of last necessary document. In case there is delay in the payment beyond the stipulated timelines from the date of receipt of last necessary document to the date of payment of claim, the Company shall pay additional amount as 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 it. For the purpose of this clause, 'bank rate' shall mean the existing bank rate as notified by Reserve Bank of India, unless the extent regulation requires payment based on some other prescribed interest rate.

(d) **If the Policyholder / Insured Person suffers a relapse within 45 days** of the date of discharge from the Hospital for which a Claim has been made, then such relapse shall be deemed to be part of the same Claim and all the limits for Any One Illness under this Policy shall be applied as if they were under a single Claim.

(e) The Claim shall be paid only for the Policy Year in which the Insured event which gives rise to a Claim under this Policy occurs.

(f) The Premium for the policy will remain the same for the policy period mentioned in the Policy Certificate.

6. GENERAL TERMS AND CONDITIONS

6.1 Disclosure to Information Norm

If any untrue or incorrect statements are made or there has been a misrepresentation, mis-description or non-disclosure of any material particulars or any material information having been withheld, or if a Claim is fraudulently made or any fraudulent means or devices are used by the Policyholder, the Insured Person or any one acting on his or their behalf, the Company shall have no liability to make payment of any Claims and the premium paid shall be forfeited to the Company on cancellation of the Policy

6.2 Observance of Terms and Conditions

The due observance and fulfillment of the terms and conditions of this Policy (including the realization of premium by their respective due dates and compliance with the specified

procedure on all Claims) in so far as they relate to anything to be done or complied with by the Policyholder or any Insured Person, shall be Condition Precedent to the Company's liability under the Policy.

6.3 Material Change

It is a condition precedent to the Company's liability under the Policy that the Policyholder shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business at his own expense The Company may adjust the scope of cover and / or the premium paid or payable, accordingly.

6.4 Records to be maintained

The Policyholder or Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require under this Policy at any time during the Policy Period or Policy Year or until final adjustment (if any) and resolution of all Claims under this Policy.

6.5 No constructive Notice

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

6.6 Complete Discharge

Payment made by the Company to the Policyholder or Insured Person or the nominee of the Policyholder or the legal representative of the Policyholder or to the Hospital, as the case may be, of any Medical Expenses or compensation or Benefit under the Policy shall in all cases be complete and construe as an effectual discharge in favor of the Company.

6.7 Multiple Policies

a. In case any Policyholder/Insured Person is covered under more than one indemnity insurance policies, with the Company or with other insurers, the Policyholder/Insured Person shall have the right to settle the Claim with any of the Company, provided that the Claim amount payable is up to the Sum Insured of such Policy.
b. In case the Claim amount under a single policy exceeds the Sum Insured, then Policyholder/Insured Person shall have the right to choose the companies with whom the Claim is to be settled. Further, policyholder/Insured Person shall have the right to choose the companies from whom he/she wants to claim the balance amount. Insured shall only be indemnified the hospitalization costs in accordance with terms & conditions of chosen Policy.

c. This clause shall not apply to any Benefit offered on a fixed Benefit basis.

6.8 Free Look Period

a. The Policyholder may, within 15 days from the receipt of the Policy document, return the Policy stating reasons for his objection, if the Policyholder disagrees with any Policy terms and conditions.
b. If no Claim has been made under the Policy, the Company will refund the premium received after deducting proportionate risk premium for the period on cover, expenses for medical examination and stamp duty charges. If only part of the risk has commenced, such proportionate risk premium shall be calculated as commensurate with the risk covered during such period. All rights under the Policy will immediately stand extinguished on the free look cancellation of the Policy.
c. Provision for Free look period is not applicable and available at the time of renewal of the Policy.

6.9 Policy Disputes

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

6.10 Renewal Terms

(a) This Policy will automatically terminate on the Policy Period End Date. All renewal applications should reach the Company on or before the Policy Period End Date.
(b) The premium payable on renewal shall be paid to the Company on or before the Policy Period End Date and in any event before the expiry of the Grace Period.
(c) For the purpose of this provision, Grace Period means a period of 30 days immediately following the Policy Period End Date during which a payment can be made to renew this Policy without loss of continuity Benefits. Coverage is not available for the period for which premium is not received by the Company and the Company shall not be liable for any Claims incurred during such period.
(d) The Company will ordinarily not refuse to renew the Policy except on ground of fraud, moral hazard or misrepresentation or non-co-operation by the Insured.
(e) The Company may carry out underwriting in accordance with its Board approved underwriting policy in relation to any request for change in Sum Insured or Deductible at the time of renewal of the Policy.
(f) This product may be withdrawn / modified by the Company after due approval from the Authority (IRDAI). In case this product is withdrawn / modified by the Company, this Policy can be renewed under the then prevailing Health Insurance Product or its nearest substitute approved by the Authority (IRDAI). The Company shall duly intimate the Policyholder at least three months prior to the date of such modification / withdrawal of this product and the options available to the Policyholder at the time of Renewal of this Policy.
(g) The Company may revise the renewal premium payable under the Policy provided that revisions to the renewal premium are in accordance with the Authority's (IRDAI) rules and regulations as

applicable from time to time. Change in rates will be applicable only post approval by the Authority and be effective from the date of launch of the revised Product and shall be applied only prospectively thereafter for new policies and at the date of renewal for renewals.

(h) Renewal shall be offered lifelong. The Insured Person shall be given an option to port this Policy into any other health insurance product of the Company and credit shall be given for number of years of continuous coverage under this Policy for the standard waiting periods.

(i) No loading based on individual claim experience shall be applicable on renewal premium payable.

6.11 Cancellation / Termination

(a) The Company may at any time, cancel this Policy on grounds as specified in Clause 6.1 by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to the Policyholder at his last known address and the Company shall have no liability to make payment of any Claims and the premium paid shall be forfeited and no refund of premium shall be effected by the Company.

(b) The Policyholder may also give 15 days' notice in writing, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of the notice, cancel the Policy and refund the premium for the unexpired period of this Policy at the short period scales as mentioned below, provided no Claim has been made under the Policy.

Refund % to be applied on premium received

Cancellation date from Policy Period Start Date	**Policy Tenure – 1 Year**	**Policy Tenure – 2 Years**	**Policy Tenure – 3 Years**
Up to 1 month	75.00%	87.50%	91.50%
1 month to 3 months	50.00%	75.00%	88.50%
3 months to 6 months	25.00%	62.50%	75.00%
6 months to 12 months	0.00%	50.00%	66.50%
12 months to 15 months	N.A.	25.00%	50.00%
15 months to 18 months	N.A.	12.50%	41.50%
18 months to 24 months	N.A.	0.00%	33.00%
24 months to 30 months	N.A.	N.A.	8.00%
Beyond 30 months	N.A.	N.A.	0.0%

(c) In case of demise of the Policyholder,

(i) Where the Policy covers only the Policyholder, this Policy shall stand null and void from the date and time of demise of the Policyholder. The premium would be refunded for the unexpired period of this Policy at the short period scales.

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

I. Written notice in this regard is given to the Company before the Policy Period End Date; and
II. A person of Age 18 years or above, who satisfies the Company's criteria applies to become the Policyholder.

6.12 Limitation of liability

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

6.13 Communication

a. Any communication meant for the Company must be in writing and be delivered to its address shown in the Policy Certificate. Any communication meant for the Policyholder/ Insured Person will be sent by the Company to his last known address or the address as shown in the Policy Certificate.
b. All notifications and declarations for the Company must be in writing and sent to the address specified in the Policy Certificate.Agents are not authorized to receive notices and declarations on the Company's behalf.
c. Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

6.14 Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company. However, change or alteration with respect to increase/ decrease of the Sum Insured shall be permissible only at the time of renewal of the Policy.

6.15 Out of all the details of the various Benefits provided in the Policy Terms and Conditions, only the details pertaining to Benefits chosen by policyholder as per Policy Certificate shall be considered relevant

6.16 Electronic Transactions

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

with the Company's terms and conditions for such facilities, as may be prescribed from time to time. Any terms and conditions related to electronic transactions shall be within the approved Policy Terms and Conditions

6.17 Portability and Continuity Benefits

(i) Insured(s) have an option to migrate from their existing health insurance policy of any other Indian non-life insurer/standalone health insurer to any other similar policy with the company, at the time of renewal, provided the previous policy/policies has been maintained without any break and the policy holder shall apply to company at least 45 days before, but not earlier than 60 days from the policy renewal date of his or her existing policy in prescribed format.

(ii) The Waiting Periods as defined in Clauses 4.1(i), 4.1(ii) and 4.1(iii) of this Policy shall be reduced by the number of months of continuous coverage under such health insurance policy with the previous insurer to the extent of the sum insured and the deductible under the expiring health insurance policy.

(iii) The Waiting Periods under Clauses 4.1(i), 4.1(ii) and 4.1(iii) shall be applicable afresh to the amount by which the Sum Insured under this Policy exceeds the sum insured and the deductible under the terms of the expiring policy.

(iv) The Waiting Periods as defined in Clauses 4.1(i), 4.1(ii) and 4.1(iii) shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

(v) Credit for the sum insured of the expiring policy to be carried forward for credit in this Policy would be applied on an individual basis only.

(vi) In case the Policyholder has opted to switch to any other insurer under portability and the outcome of acceptance of the portability is awaited from the new insurer on the date of renewal:

a) The Company may at the request of the Policyholder, extend the Policy for a period not less than 1 month at an additional premium to be paid on a pro-rated basis.
b) In case any Claim is reported during the extended Policy Period, the Policyholder shall first pay the premium so as to make the extended Policy Period part of Policy, as applicable. In such cases, Policyholder shall be liable to pay the premium for the balance period and continue with the Company for that Policy year.

6.18 Special Terms and Conditions Applicable for Policies issued with Option of Premium Payment On Installment Basis

If the Policy Holder/Insured Person has opted for a Policy Period of more than one year and opted for payment of premium on an installment basis, as specified in the Policy Certificate, the following conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy):

1. In case of any Hospitalization claim (Cashless/Re-imbursement), an amount equivalent to the balance of the installment premiums payable in the Policy Year would be recoverable from the admissible claim amount payable in respect of the Insured Person.
2. Relaxation Period for the Policies with Installment Option would be as Under:

Installment Option	**Relaxation Period for Premium Payment under Installment Option**
Quarterly	15 days for each installment
Monthly	5 days for each installment

3. In case of installment premiums not received within the Relaxation Period for Premium payment the Policy will get cancelled

4. Tenure Discount will not be applicable if the Insured Person has opted for Premium Payment on Installment basis.

For the purpose of this provision, Relaxation Period means a period of 15/5 days depending on the Installment Option immediately following the Premium installment due Date during which a payment can be made to renew this Policy without loss of continuity Benefits. Coverage is not available for the period for which premium is not received by the Company and the Company shall not be liable for any Claims incurred during such period

6.19 Mid Term addition and Assignment

a) Special Terms and Conditions Applicable for Mid Term addition of some Optional Benefits

Notwithstanding anything to the contrary in the Policy, the Policyholder/Insured Person has an option to apply for the specified Optional Benefits within 90 days of the Policy Period Start date or Renewal date, subject to Conditions specified below:

1. This feature can only be availed for Optional Benefit 3: Unlimited Automatic Recharge, Optional Benefit 4 :International Second Opinion, Optional Benefit 6: Additional Sum Insured for Accidental Hospitalization and Optional Benefit 7:Air Ambulance Cover

2. Additional Premium for the Optional Benefit opted will be Calculated on a Pro-rated basis form the date of addition of the Benefit

3. All the Waiting Periods on the Optional Benefit/s opted will be applicable from the date of addition of the Optional Benefit, except those Medical Expenses incurred as a result of an Injury within the Policy Period.

b) Assignment of Policy

1. This policy may be transferred/assigned, wholly or in part, with or without consideration.

2. An Assignment may be effected in a policy by an endorsement upon the policy itself or by a separate instrument under notice to the Insurer.
3. The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made.
4. The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.
5. The transfer or assignment shall not be operative as against an Insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy there of certified to be correct by both transferor and transferee or their duly authorized agents have been delivered to the Insurer.
6. The Insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is (a) not bonafide or (b) not in the interest of the policyholder or (c) not in public interest or (d) is for the purpose of trading of the insurance policy.
7. In case of refusal to act upon the endorsement by the Insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the Insurer.

Note: *This is only a simplified version of (Assignment or Transfer) for general information purpose only. For full texts of this section please refer to Section 38 of Insurance Act , 1938 as amended by Insurance Laws(Amendment) Act,2015 .*

6.20 Grievances

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

(a) If the Policyholder / Insured Person has a grievance that the Policyholder / Insured Person wishes the Company to redress, the Policyholder / Insured Person may contact the Company with the details of the grievance through:

Website: www.religarehealthinsurance.com
Email: customerfirst@religarehealthinsurance.com
Contact No.:1800-200-4488
Fax: 1800-200-6677
Courier: Any of Our Branch Office or corporate office

The Policyholder/Insured Person may also approach the grievance cell at any of the Company's branches with the details of his/her grievance during the Company's working hours from Monday to Friday.

Exclusively for Senior Citizens, the Company has a separate extension on the Customer Service Toll Free Number. This separate customer service channel prioritizes and routes any kind of request / grievance raised by Senior Citizens through various fast track internal escalations leading to lesser Turn-Around-Time (TAT) for request / grievance addressal

(b) If the Policyholder / Insured Personis not satisfied with the Company's redressal of the Policyholder's / Insured Person's grievance through one of the above methods, the Policyholder / Insured Person's may contact the Company's Head of Customer Service at:

Head – Customer Services,
Religare Health Insurance Company Limited,
Vipul Tech Square, Tower C,
3rd Floor, Golf Course Road, Sector - 43,
Gurgaon, Haryana – 122009

(c) If the Policyholder / Insured Person is not satisfied with the Company's redressal of the Policyholder's / Insured Person's grievance through one of the above methods, the Policyholder / Insured Person may approach the nearest Insurance Ombudsman for resolution of the grievance. The contact details of Ombudsmen offices are mentioned below:

Office of the Ombudsman	Contact Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 E-mail : bimalokpal.ahmedabad@gbic.co.in	Gujarat , Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Office of the Insurance Ombudsman, Jeevan Soudha Building ,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@gbic.co.in	Karnataka
BHOPAL	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003.	Madhya Pradesh & Chhattisgarh

	Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@gbic.co.in	
BHUBANESHWAR	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	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	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)
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.co.in	Delhi
GUWAHATI	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	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	Office of the Insurance Ombudsman,	Rajasthan

	Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@gbic.co.in	
ERNAKULAM	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	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
LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@gbic.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@gbic.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane

PATNA	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@gbic.co.in	Bihar, Jharkhand
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 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
PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@gbic.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

The updated details of Insurance Ombudsman are available on website of IRDAI: www.irdai.gov.in, on the website of General Insurance Council: www.gicouncil.org.in, on the Company's website www.religarehealthinsurance.com or from any of the Company's offices. Address and contact number of Governing Body of Insurance Council –

Office of the 'Governing Body of Insurance Council'
Secretary General / Secretary,
3rd Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz(W),
Mumbai – 400 054.
Tel : 022-26106245/889/671
Fax : 022-26106949
Email- inscoun@gbic.co.in

Super Mediclaim– Annexure I to Policy Terms & Conditions:

		PLAN NAME			
Sr.No	**Related Procedures***	**Heart Mediclaim**	**Operation Mediclaim**	**Critical Mediclaim**	**Cancer Mediclaim**
1.	Cardiology	Yes	Yes	Yes	No
2.	Critical Care Related	Yes	Yes	Yes	No
3.	Dental Related(Except FNAC)	No	Yes	No	No
4.	FNAC	No	Yes	Yes	Yes
5.	ENT Related	No	Yes	Yes	Yes
6.	Gastroenterology	No	Yes	Yes	Yes
7.	General Surgery Related	No	Yes	Yes	Yes
8.	Gynecology	No	Yes	Yes	Yes
9.	Neurology	No	Yes	Yes	Yes
10.	Oncology	No	No	Yes	Yes
11.	Operations on the Salivary glands and Salivary ducts	No	Yes	Yes	Yes
12.	Operations on the skin & Subcutaneous tissues	No	Yes	Yes	Yes
13.	Operations on tongue	No	Yes	Yes	Yes
14.	Ophthalmology related except Cataract	No	Yes	Yes	Yes

15.	Cataract	No	Yes	No	No
16.	Orthopedic related	No	Yes	No	No
17.	Other operations of mouth and face	No	Yes	Yes	Yes
18.	Pediatric surgery related	No	Yes	Yes	Yes
19.	Plastic Surgery related	No	Yes	Yes	Yes
20.	Thoracic Surgery related	No	Yes	Yes	Yes
21.	Urology except Hemodialysis	No	Yes	Yes	Yes
22.	Hemodialysis	No	No	Yes	Yes

***** *Please refer below for details of Procedures Covered*

Annexure I - List of Day Care Surgeries

1. **Cardiology Related:**

    1. CORONARY ANGIOGRAPHY

2. **Critical Care Related:**

    2. INSERT NON- TUNNEL CV CATH
    3. INSERT PICC CATH (PERIPHERALLY INSERTED CENTRAL CATHETER)
    4. REPLACE PICC CATH (PERIPHERALLY INSERTED CENTRAL CATHETER)
    5. INSERTION CATHETER, INTRA ANTERIOR
    6. INSERTION OF PORTACATH

3. **Dental Related:**

    7. SPLINTING OF AVULSED TEETH
    8. SUTURING LACERATED LIP
    9. SUTURING ORAL MUCOSA
    10. ORAL BIOPSY IN CASE OF ABNORMAL TISSUE PRESENTATION
    11. FNAC
    12. SMEAR FROM ORAL CAVITY

4. **ENT Related:**

    13. MYRINGOTOMY WITH GROMMET INSERTION
    14. TYMPANOPLASTY (CLOSURE OF AN EARDRUM PERFORATION/RECONSTRUCTION OF THE AUDITORY OSSICLES)
    15. REMOVAL OF A TYMPANIC DRAIN
    16. KERATOSIS REMOVAL UNDER GA
    17. OPERATIONS ON THE TURBINATES (NASAL CONCHA)
    18. TYMPANOPLASTY (CLOSURE OF AN EARDRUM PERFORATION/RECONSTRUCTION OF THE AUDITORY OSSICLES)
    19. REMOVAL OF KERATOSIS OBTURANS
    20. STAPEDOTOMY TO TREAT VARIOUS LESIONS IN MIDDLE EAR
    21. REVISION OF A STAPEDECTOMY
    22. OTHER OPERATIONS ON THE AUDITORY OSSICLES
    23. MYRINGOPLASTY (POST-AURA/ENDAURAL APPROACH AS WELL AS SIMPLE TYPE -I TYMPANOPLASTY)
    24. FENESTRATION OF THE INNER EAR
    25. REVISION OF A FENESTRATION OF THE INNER EAR
    26. PALATOPLASTY
    27. TRANSORAL INCISION AND DRAINAGE OF A PHARYNGEAL ABSCESS
    28. TONSILLECTOMY WITHOUT ADENOIDECTOMY
    29. TONSILLECTOMY WITH ADENOIDECTOMY
    30. EXCISION AND DESTRUCTION OF A LINGUAL TONSIL
    31. REVISION OF A TYMPANOPLASTY
    32. OTHER MICROSURGICAL OPERATIONS ON THE MIDDLE EAR
    33. INCISION OF THE MASTOID PROCESS AND MIDDLE EAR

34. MASTOIDECTOMY
35. RECONSTRUCTION OF THE MIDDLE EAR
36. OTHER EXCISIONS OF THE MIDDLE AND INNER EAR
37. INCISION (OPENING) AND DESTRUCTION (ELIMINATION) OF THE INNER EAR
38. OTHER OPERATIONS ON THE MIDDLE AND INNER EAR
39. EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE NOSE
40. OTHER OPERATIONS ON THE NOSE
41. NASAL SINUS ASPIRATION
42. FOREIGN BODY REMOVAL FROM NOSE
43. OTHER OPERATIONS ON THE TONSILS AND ADENOIDS
44. ADENOIDECTOMY
45. LABYRINTHECTOMY FOR SEVERE VERTIGO
46. STAPEDECTOMY UNDER GA
47. STAPEDECTOMY UNDER LA
48. TYMPANOPLASTY (TYPE IV)
49. ENDOLYMPHATIC SAC SURGERY FOR MENIERE'S DISEASE
50. TURBINECTOMY
51. ENDOSCOPIC STAPEDECTOMY
52. INCISION AND DRAINAGE OF PERICHONDRITIS
53. SEPTOPLASTY
54. VESTIBULAR NERVE SECTION
55. THYROPLASTY TYPE I
56. PSEUDOCYST OF THE PINNA - EXCISION
57. INCISION AND DRAINAGE - HAEMATOMA AURICLE
58. TYMPANOPLASTY (TYPE II)
59. REDUCTION OF FRACTURE OF NASAL BONE
60. THYROPLASTY TYPE II
61. TRACHEOSTOMY
62. EXCISION OF ANGIOMA SEPTUM
63. TURBINOPLASTY
64. INCISION & DRAINAGE OF RETRO PHARYNGEAL ABSCESS
65. UVULO PALATO PHARYNGO PLASTY
66. ADENOIDECTOMY WITH GROMMET INSERTION
67. ADENOIDECTOMY WITHOUT GROMMET INSERTION
68. VOCAL CORD LATERALISATION PROCEDURE
69. INCISION & DRAINAGE OF PARA PHARYNGEAL ABSCESS
70. TRACHEOPLASTY

5. Gastroenterology Related:

71. CHOLECYSTECTOMY AND CHOLEDOCHO-JEJUNOSTOMY/ DUODENOSTOMY/GASTROSTOMY/EXPLORATION COMMON BILE DUCT
72. ESOPHAGOSCOPY, GASTROSCOPY, DUODENOSCOPY WITH POLYPECTOMY/ REMOVAL OF FOREIGN BODY/DIATHERMY OF BLEEDING LESIONS
73. PANCREATIC PSEUDOCYST EUS & DRAINAGE
74. RF ABLATION FOR BARRETT'S OESOPHAGUS
75. ERCP AND PAPILLOTOMY
76. ESOPHAGOSCOPE AND SCLEROSANT INJECTION
77. EUS + SUBMUCOSAL RESECTION

78. CONSTRUCTION OF GASTROSTOMY TUBE
79. EUS + ASPIRATION PANCREATIC CYST
80. SMALL BOWEL ENDOSCOPY (THERAPEUTIC)
81. COLONOSCOPY ,LESION REMOVAL
82. ERCP
83. COLONSCOPY STENTING OF STRICTURE
84. PERCUTANEOUS ENDOSCOPIC GASTROSTOMY
85. EUS AND PANCREATIC PSEUDO CYST DRAINAGE
86. ERCP AND CHOLEDOCHOSCOPY
87. PROCTOSIGMOIDOSCOPY VOLVULUS DETORSION
88. ERCP AND SPHINCTEROTOMY
89. ESOPHAGEAL STENT PLACEMENT
90. ERCP + PLACEMENT OF BILIARY STENTS
91. SIGMOIDOSCOPY W / STENT
92. EUS + COELIAC NODE BIOPSY
93. UGI SCOPY AND INJECTION OF ADRENALINE, SCLEROSANTS BLEEDING ULCERS

6. General Surgery Related:

94. INCISION OF A PILONIDAL SINUS / ABSCESS
95. FISSURE IN ANO SPHINCTEROTOMY
96. SURGICAL TREATMENT OF A VARICOCELE AND A HYDROCELE OF THE SPERMATIC CORD
97. ORCHIDOPEXY
98. ABDOMINAL EXPLORATION IN CRYPTORCHIDISM
99. SURGICAL TREATMENT OF ANAL FISTULAS
100. DIVISION OF THE ANAL SPHINCTER (SPHINCTEROTOMY)
101. EPIDIDYMECTOMY
102. INCISION OF THE BREAST ABSCESS
103. OPERATIONS ON THE NIPPLE
104. EXCISION OF SINGLE BREAST LUMP
105. INCISION AND EXCISION OF TISSUE IN THE PERIANAL REGION
106. SURGICAL TREATMENT OF HEMORRHOIDS
107. OTHER OPERATIONS ON THE ANUS
108. ULTRASOUND GUIDED ASPIRATIONS
109. SCLEROTHERAPY, ETC.
110. LAPAROTOMY FOR GRADING LYMPHOMA WITH SPLENECTOMY/LIVER/LYMPH NODE BIOPSY
111. THERAPEUTIC LAPAROSCOPY WITH LASER
112. APPENDICECTOMY WITH/WITHOUT DRAINAGE
113. INFECTED KELOID EXCISION
114. AXILLARY LYMPHADENECTOMY
115. WOUND DEBRIDEMENT AND COVER
116. ABSCESS-DECOMPRESSION
117. CERVICAL LYMPHADENECTOMY
118. INFECTED SEBACEOUS CYST
119. INGUINAL LYMPHADENECTOMY
120. INCISION AND DRAINAGE OF ABSCESS
121. SUTURING OF LACERATIONS
122. SCALP SUTURING
123. INFECTED LIPOMA EXCISION

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

173. TRU CUT LIVER BIOPSY
174. PHOTODYNAMIC THERAPY OR ESOPHAGEAL TUMOUR AND LUNG TUMOUR
175. EXCISION OF CERVICAL RIB
176. LAPAROSCOPIC REDUCTION OF INTUSSUSCEPTION
177. MICRODOCHECTOMY BREAST
178. SURGERY FOR FRACTURE PENIS
179. SENTINEL NODE BIOPSY
180. PARASTOMAL HERNIA
181. REVISION COLOSTOMY
182. PROLAPSED COLOSTOMY- CORRECTION
183. TESTICULAR BIOPSY
184. LAPAROSCOPIC CARDIOMYOTOMY(HELLERS)
185. SENTINEL NODE BIOPSY MALIGNANT MELANOMA
186. LAPAROSCOPIC PYLOROMYOTOMY(RAMSTEDT)

7. Gynecology Related:

187. OPERATIONS ON BARTHOLIN'S GLANDS (CYST)
188. INCISION OF THE OVARY
189. INSUFFLATIONS OF THE FALLOPIAN TUBES
190. OTHER OPERATIONS ON THE FALLOPIAN TUBE
191. DILATATION OF THE CERVICAL CANAL
192. CONISATION OF THE UTERINE CERVIX
193. THERAPEUTIC CURETTAGE WITH COLPOSCOPY/BIOPSY/DIATHERMY/CRYOSURGERY/
194. LASER THERAPY OF CERVIX FOR VARIOUS LESIONS OF UTERUS
195. OTHER OPERATIONS ON THE UTERINE CERVIX
196. INCISION OF THE UTERUS (HYSTERECTOMY)
197. LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE VAGINA AND THE POUCH OF DOUGLAS
198. INCISION OF VAGINA
199. INCISION OF VULVA
200. CULDOTOMY
201. SALPINGO-OOPHORECTOMY VIA LAPAROTOMY
202. ENDOSCOPIC POLYPECTOMY
203. HYSTEROSCOPIC REMOVAL OF MYOMA
204. D&C
205. HYSTEROSCOPIC RESECTION OF SEPTUM
206. THERMAL CAUTERISATION OF CERVIX
207. MIRENA INSERTION
208. HYSTEROSCOPIC ADHESIOLYSIS
209. LEEP
210. CRYOCAUTERISATION OF CERVIX
211. POLYPECTOMY ENDOMETRIUM
212. HYSTEROSCOPIC RESECTION OF FIBROID
213. LLETZ
214. CONIZATION
215. POLYPECTOMY CERVIX
216. HYSTEROSCOPIC RESECTION OF ENDOMETRIAL POLYP
217. VULVAL WART EXCISION

218. LAPAROSCOPIC PARAOVARIAN CYST EXCISION
219. UTERINE ARTERY EMBOLIZATION
220. LAPAROSCOPIC CYSTECTOMY
221. HYMENECTOMY(IMPERFORATE HYMEN)
222. ENDOMETRIAL ABLATION
223. VAGINAL WALL CYST EXCISION
224. VULVAL CYST EXCISION
225. LAPAROSCOPIC PARATUBAL CYST EXCISION
226. REPAIR OF VAGINA (VAGINAL ATRESIA)
227. HYSTEROSCOPY, REMOVAL OF MYOMA
228. TURBT
229. URETEROCOELE REPAIR - CONGENITAL INTERNAL
230. VAGINAL MESH FOR POP
231. LAPAROSCOPIC MYOMECTOMY
232. SURGERY FOR SUI
233. REPAIR RECTO- VAGINA FISTULA
234. PELVIC FLOOR REPAIR(EXCLUDING FISTULA REPAIR)
235. URS + LL
236. LAPAROSCOPIC OOPHORECTOMY
237. NORMAL VAGINAL DELIVERY AND VARIANTS

8. Neurology Related:

238. FACIAL NERVE PHYSIOTHERAPY
239. NERVE BIOPSY
240. MUSCLE BIOPSY
241. EPIDURAL STEROID INJECTION
242. GLYCEROL RHIZOTOMY
243. SPINAL CORD STIMULATION
244. MOTOR CORTEX STIMULATION
245. STEREOTACTIC RADIOSURGERY
246. PERCUTANEOUS CORDOTOMY
247. INTRATHECAL BACLOFEN THERAPY
248. ENTRAPMENT NEUROPATHY RELEASE
249. DIAGNOSTIC CEREBRAL ANGIOGRAPHY
250. VP SHUNT
251. VENTRICULOATRIAL SHUNT

9. Oncology Related:

252. RADIOTHERAPY FOR CANCER
253. CANCER CHEMOTHERAPY
254. IV PUSH CHEMOTHERAPY
255. HBI-HEMIBODY RADIOTHERAPY
256. INFUSIONAL TARGETED THERAPY
257. SRT-STEREOTACTIC ARC THERAPY
258. SC ADMINISTRATION OF GROWTH FACTORS
259. CONTINUOUS INFUSIONAL CHEMOTHERAPY
260. INFUSIONAL CHEMOTHERAPY

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

10. Operations on the salivary glands & salivary ducts:

307. INCISION AND LANCING OF A SALIVARY GLAND AND A SALIVARY DUCT
308. EXCISION OF DISEASED TISSUE OF A SALIVARY GLAND AND A SALIVARY DUCT
309. RESECTION OF A SALIVARY GLAND
310. RECONSTRUCTION OF A SALIVARY GLAND AND A SALIVARY DUCT
311. OTHER OPERATIONS ON THE SALIVARY GLANDS AND SALIVARY DUCTS

11. Operations on the skin & subcutaneous tissues:

312. OTHER INCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
313. SURGICAL WOUND TOILET (WOUND DEBRIDEMENT) AND REMOVAL OF DISEASED TISSUE OF THE SKIN AND SUBCUTANEOUS TISSUES
314. LOCAL EXCISION OF DISEASED TISSUE OF THE SKIN AND SUBCUTANEOUS TISSUES
315. OTHER EXCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
316. SIMPLE RESTORATION OF SURFACE CONTINUITY OF THE SKIN AND SUBCUTANEOUS TISSUES
317. FREE SKIN TRANSPLANTATION, DONOR SITE
318. FREE SKIN TRANSPLANTATION, RECIPIENT SITE
319. REVISION OF SKIN PLASTY
320. OTHER RESTORATION AND RECONSTRUCTION OF THE SKIN AND SUBCUTANEOUS TISSUES.
321. CHEMOSURGERY TO THE SKIN.
322. DESTRUCTION OF DISEASED TISSUE IN THE SKIN AND SUBCUTANEOUS TISSUES
323. RECONSTRUCTION OF DEFORMITY/DEFECT IN NAIL BED
324. EXCISION OF BURSIRTIS
325. TENNIS ELBOW RELEASE

12. Operations on the Tongue:

326. INCISION, EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE TONGUE
327. PARTIAL GLOSSECTOMY
328. GLOSSECTOMY
329. RECONSTRUCTION OF THE TONGUE
330. OTHER OPERATIONS ON THE TONGUE

13. Ophthalmology Related:

331. SURGERY FOR CATARACT
332. INCISION OF TEAR GLANDS
333. OTHER OPERATIONS ON THE TEAR DUCTS
334. INCISION OF DISEASED EYELIDS
335. EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE EYELID
336. OPERATIONS ON THE CANTHUS AND EPICANTHUS
337. CORRECTIVE SURGERY FOR ENTROPION AND ECTROPION
338. CORRECTIVE SURGERY FOR BLEPHAROPTOSIS
339. REMOVAL OF A FOREIGN BODY FROM THE CONJUNCTIVA
340. REMOVAL OF A FOREIGN BODY FROM THE CORNEA
341. INCISION OF THE CORNEA
342. OPERATIONS FOR PTERYGIUM
343. OTHER OPERATIONS ON THE CORNEA

344. REMOVAL OF A FOREIGN BODY FROM THE LENS OF THE EYE
345. REMOVAL OF A FOREIGN BODY FROM THE POSTERIOR CHAMBER OF THE EYE
346. REMOVAL OF A FOREIGN BODY FROM THE ORBIT AND EYEBALL
347. CORRECTION OF EYELID PTOSIS BY LEVATOR PALPEBRAE SUPERIORIS RESECTION (BILATERAL)
348. CORRECTION OF EYELID PTOSIS BY FASCIA LATA GRAFT (BILATERAL)
349. DIATHERMY/CRYOTHERAPY TO TREAT RETINAL TEAR
350. ANTERIOR CHAMBER PARACENTESIS/ CYCLODIATHERMY/CYCLOCRYOTHERAPY/ GONIOTOMY/TRABECULOTOMY AND FILTERING AND ALLIED OPERATIONS TO TREAT GLAUCOMA
351. ENUCLEATION OF EYE WITHOUT IMPLANT
352. DACRYOCYSTORHINOSTOMY FOR VARIOUS LESIONS OF LACRIMAL GLAND
353. LASER PHOTOCOAGULATION TO TREAT RATINAL TEAR
354. BIOPSY OF TEAR GLAND
355. TREATMENT OF RETINAL LESION

14. Orthopedics Related:

356. SURGERY FOR MENISCUS TEAR
357. INCISION ON BONE, SEPTIC AND ASEPTIC
358. CLOSED REDUCTION ON FRACTURE, LUXATION OR EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
359. SUTURE AND OTHER OPERATIONS ON TENDONS AND TENDON SHEATH
360. REDUCTION OF DISLOCATION UNDER GA
361. ARTHROSCOPIC KNEE ASPIRATION
362. SURGERY FOR LIGAMENT TEAR
363. SURGERY FOR HEMOARTHROSIS/PYOARTHROSIS
364. REMOVAL OF FRACTURE PINS/NAILS
365. REMOVAL OF METAL WIRE
366. CLOSED REDUCTION ON FRACTURE, LUXATION
367. REDUCTION OF DISLOCATION UNDER GA
368. EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
369. EXCISION OF VARIOUS LESIONS IN COCCYX
370. ARTHROSCOPIC REPAIR OF ACL TEAR KNEE
371. CLOSED REDUCTION OF MINOR FRACTURES
372. ARTHROSCOPIC REPAIR OF PCL TEAR KNEE
373. TENDON SHORTENING
374. ARTHROSCOPIC MENISCECTOMY - KNEE
375. TREATMENT OF CLAVICLE DISLOCATION
376. HAEMARTHROSIS KNEE- LAVAGE
377. ABSCESS KNEE JOINT DRAINAGE
378. CARPAL TUNNEL RELEASE
379. CLOSED REDUCTION OF MINOR DISLOCATION
380. REPAIR OF KNEE CAP TENDON
381. ORIF WITH K WIRE FIXATION- SMALL BONES
382. RELEASE OF MIDFOOT JOINT
383. ORIF WITH PLATING- SMALL LONG BONES
384. IMPLANT REMOVAL MINOR
385. K WIRE REMOVAL
386. POP APPLICATION

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

15. Other operations on the mouth & face:

430. EXTERNAL INCISION AND DRAINAGE IN THE REGION OF THE MOUTH, JAW AND FACE
431. INCISION OF THE HARD AND SOFT PALATE
432. EXCISION AND DESTRUCTION OF DISEASED HARD AND SOFT PALATE

433. INCISION, EXCISION AND DESTRUCTION IN THE MOUTH
434. OTHER OPERATIONS IN THE MOUTH

16. Pediatric surgery Related:

435. EXCISION OF FISTULA-IN-ANO
436. EXCISION JUVENILE POLYPS RECTUM
437. VAGINOPLASTY
438. DILATATION OF ACCIDENTAL CAUSTIC STRICTURE OESOPHAGEAL
439. PRESACRAL TERATOMAS EXCISION
440. REMOVAL OF VESICAL STONE
441. EXCISION SIGMOID POLYP
442. STERNOMASTOID TENOTOMY
443. INFANTILE HYPERTROPHIC PYLORIC STENOSIS PYLOROMYOTOMY
444. EXCISION OF SOFT TISSUE RHABDOMYOSARCOMA
445. MEDIASTINAL LYMPH NODE BIOPSY
446. HIGH ORCHIDECTOMY FOR TESTIS TUMOURS
447. EXCISION OF CERVICAL TERATOMA
448. RECTAL-MYOMECTOMY
449. RECTAL PROLAPSE (DELORME'S PROCEDURE)
450. DETORSION OF TORSION TESTIS
451. EUA + BIOPSY MULTIPLE FISTULA IN ANO
452. CYSTIC HYGROMA - INJECTION TREATMENT

17. Plastic Surgery Related:

453. CONSTRUCTION SKIN PEDICLE FLAP
454. GLUTEAL PRESSURE ULCER-EXCISION
455. MUSCLE-SKIN GRAFT, LEG
456. REMOVAL OF BONE FOR GRAFT
457. MUSCLE-SKIN GRAFT DUCT FISTULA
458. REMOVAL CARTILAGE GRAFT
459. MYOCUTANEOUS FLAP
460. FIBRO MYOCUTANEOUS FLAP
461. BREAST RECONSTRUCTION SURGERY AFTER MASTECTOMY
462. SLING OPERATION FOR FACIAL PALSY
463. SPLIT SKIN GRAFTING UNDER RA
464. WOLFE SKIN GRAFT
465. PLASTIC SURGERY TO THE FLOOR OF THE MOUTH UNDER GA

18. Thoracic surgery Related:

466. THORACOSCOPY AND LUNG BIOPSY
467. EXCISION OF CERVICAL SYMPATHETIC CHAIN THORACOSCOPIC
468. LASER ABLATION OF BARRETT'S OESOPHAGUS
469. PLEURODESIS
470. THORACOSCOPY AND PLEURAL BIOPSY
471. EBUS + BIOPSY
472. THORACOSCOPY LIGATION THORACIC DUCT

473. THORACOSCOPY ASSISTED EMPYAEMA DRAINAGE

19. Urology Related:

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

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

Sr. No.	Annexure – II List of Expenses Excluded ("Non-medical") in Hospital Indemnity Policy
	TOILETRIES/ COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS
1	HAIR REMOVAL CREAM
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
3	BABY FOOD
4	BABY UTILITES CHARGES
5	BABY SET
6	BABY BOTTLES
7	BRUSH
8	COSY TOWEL
9	HAND WASH
10	MOISTURISER PASTE BRUSH
11	POWDER
12	RAZOR
13	SHOE COVER
14	BEAUTY SERVICES
15	BELTS/ BRACES
16	BUDS
17	BARBER CHARGES
18	CAPS
19	COLD PACK/HOT PACK
20	CARRY BAGS
21	CRADLE CHARGES
22	COMB
23	DISPOSABLES RAZORS CHARGES (for site preparations)
24	EAU-DE-COLOGNE / ROOM FRESHNERS
25	EYE PAD
26	EYE SHEILD
27	EMAIL / INTERNET CHARGES
28	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
29	FOOT COVER
30	GOWN
31	LEGGINGS
32	LAUNDRY CHARGES
33	MINERAL WATER
34	OIL CHARGES
35	SANITARY PAD
36	SLIPPERS
37	TELEPHONE CHARGES
38	TISSUE PAPER
Sr. No.	**List of Expenses Excluded ("Non-medical")in Hospital Indemnity Policy**

39	TOOTH PASTE
40	TOOTH BRUSH
41	GUEST SERVICES
42	BED PAN
43	BED UNDER PAD CHARGES
44	CAMERA COVER
45	CLINIPLAST
46	CREPE BANDAGE
47	CURAPORE
48	DIAPER OF ANY TYPE
49	DVD, CD CHARGES
50	EYELET COLLAR
51	FACE MASK
52	FLEXI MASK
53	GAUSE SOFT
54	GAUZE
55	HAND HOLDER
56	HANSAPLAST/ ADHESIVE BANDAGES
57	LACTOGEN/ INFANT FOOD
58	SLINGS
ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES	
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS, ETC.,
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION
62	HORMONE REPLACEMENT THERAPY
63	HOME VISIT CHARGES
64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT
66	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR
68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES
69	DONOR SCREENING CHARGES
70	ADMISSION/REGISTRATION CHARGES
71	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
72	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED
73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY
74	STEM CELL IMPLANTATION/ SURGERY and storage

Sr. No.	List of Expenses Excluded ("Non-medical")in Hospital Indemnity Policy
ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS	
75	WARD AND THEATRE BOOKING CHARGES
76	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS
77	MICROSCOPE COVER
78	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER
79	SURGICAL DRILL
80	EYE KIT
81	EYE DRAPE
82	X-RAY FILM
83	SPUTUM CUP
84	BOYLES APPARATUS CHARGES
85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
86	SAVLON
87	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES
88	COTTON
89	COTTON BANDAGE
90	MICROPORE/ SURGICAL TAPE
91	BLADE
92	APRON
93	TORNIQUET
94	ORTHOBUNDLE, GYNAEC BUNDLE
95	URINE CONTAINER
ELEMENTS OF ROOM CHARGE	
96	LUXURY TAX
97	HVAC
98	HOUSE KEEPING CHARGES
99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
100	TELEVISION & AIR CONDITIONER CHARGES
101	SURCHARGES
102	ATTENDANT CHARGES
103	IM IV INJECTION CHARGES
104	CLEAN SHEET
105	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
106	BLANKET/WARMER BLANKET
ADMINISTRATIVE OR NON-MEDICAL CHARGES	
107	ADMISSION KIT
108	BIRTH CERTIFICATE
109	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
Sr. No.	**List of Expenses Excluded ("Non-medical")in Hospital Indemnity Policy**

110	CERTIFICATE CHARGES
111	COURIER CHARGES
112	CONVENYANCE CHARGES
113	DIABETIC CHART CHARGES
114	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
115	DISCHARGE PROCEDURE CHARGES
116	DAILY CHART CHARGES
117	ENTRANCE PASS / VISITORS PASS CHARGES
118	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
119	FILE OPENING CHARGES
120	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
121	MEDICAL CERTIFICATE
122	MAINTAINANCE CHARGES
123	MEDICAL RECORDS
124	PREPARATION CHARGES
125	PHOTOCOPIES CHARGES
126	PATIENT IDENTIFICATION BAND / NAME TAG
127	WASHING CHARGES
128	MEDICINE BOX
129	MORTUARY CHARGES
130	MEDICO LEGAL CASE CHARGES (MLC CHARGES)
EXTERNAL DURABLE DEVICES	
131	WALKING AIDS CHARGES
132	BIPAP MACHINE
133	COMMODE
134	CPAP/ CAPD EQUIPMENTS
135	INFUSION PUMP - COST
136	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
137	PULSEOXYMETER CHARGES
138	SPACER
139	SPIROMETRE
140	SPO2 PROBE
141	NEBULIZER KIT
142	STEAM INHALER
143	ARMSLING
144	THERMOMETER
145	CERVICAL COLLAR
146	SPLINT
147	DIABETIC FOOT WEAR
Sr. No.	**List of Expenses Excluded ("Non-medical")in Hospital Indemnity Policy**
148	KNEE BRACES (LONG/ SHORT/ HINGED)
149	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER

150	LUMBO SACRAL BELT
151	NIMBUS BED OR WATER OR AIR BED CHARGES
152	AMBULANCE COLLAR
153	AMBULANCE EQUIPMENT
154	MICROSHEILD
155	ABDOMINAL BINDER
ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION	
156	BETADINE \ HYDROGEN PEROXIDE\SPIRIT\DISINFECTANTS ETC
157	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES
159	SUGAR FREE Tablets
160	CREAMS POWDERS LOTIONS (Toileteries are not payable, only prescribed medical pharmaceuticals payable)
161	Digestion gels
162	ECG ELECTRODES
163	GLOVES
164	HIV KIT
165	LISTERINE/ ANTISEPTIC MOUTHWASH
166	LOZENGES
167	MOUTH PAINT
168	NEBULISATION KIT
169	NOVARAPID
170	VOLINI GEL/ ANALGESIC GEL
171	ZYTEE GEL
172	VACCINATION CHARGES
PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE	
173	AHD
174	ALCOHOL SWABES
175	SCRUB SOLUTION/STERILLIUM OTHERS
176	VACCINE CHARGES FOR BABY
177	AESTHETIC TREATMENT / SURGERY
178	TPA CHARGES
179	VISCO BELT CHARGES
180	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
181	EXAMINATION GLOVES
182	KIDNEY TRAY
183	MASK
Sr. No.	**List of Expenses Excluded ("Non-medical")in Hospital Indemnity Policy**
184	OUNCE GLASS
185	OUTSTATION CONSULTANT'S/ SURGEON'S FEES
186	OXYGEN MASK
187	PAPER GLOVES
188	PELVIC TRACTION BELT

189	REFERAL DOCTOR'S FEES
190	ACCU CHECK (Glucometery/ Strips)
191	PAN CAN
192	SOFNET
193	TROLLY COVER
194	UROMETER, URINE JUG
195	AMBULANCE
196	TEGADERM / VASOFIX SAFETY
197	URINE BAG
198	SOFTOVAC
199	STOCKINGS

Note: Items mentioned under sub heading “Items payable if supported by a Prescription” will be payable only if supported by Medical Practitioner’s prescription. All other items mentioned are excluded under this Policy.

Annexure V(Schedule of Benefits):

Plan Name	Critical Mediclaim	Cancer Mediclaim	Heart Mediclaim	Operation Mediclaim
Sum Insured (SI) – on annual basis (in Rs.)	1L,2L,3L,5L,7L,10L,20L,25L,50L,100L,200L,300L,600L	1L,2L,3L,5L,7L,10L,20L,25L,50L,100L,200L,300L,600L	1L,2L,3L,5L,7L,10L,20L,25L,50L,100L,200L,300L,600L	1L,2L,3L,5L,7L,10L,20L,25L,50L,100L,200L,300L,600L
Covered Conditions(Illnesses /Diseases/Surgeries)	32 Critical illnesses(Please refer Appendix-III)	Cancer	Heart related Critical illnesses(Please refer Appendix-III)	All Surgeries
Age of Proposer (Adult)	18 years or above	18 years or above	18 years or above	18 years or above
Entry Age – Minimum	Child: 91 days to 4 years with at least 1 member of age 18 years or above is covered or; 5 years on Individual basis Adult: 18 years and above	Child: 91 days to 4 years with at least 1 member of age 18 years or above is covered or; 5 years on Individual basis Adult: 18 years and above	Child: 91 days to 4 years with at least 1 member of age 18 years or above is covered or; 5 years on Individual basis Adult: 18 years and above	Child: 91 days to 4 years with at least 1 member of age 18 years or above is covered or; 5 years on Individual basis Adult: 18 years and above
Entry Age – Maximum	Lifelong	Lifelong	Lifelong	Lifelong
Exit Age	No exit age	No exit age	No exit age	No exit age
Cover Type (on individual basis)	Maximum up to 6 Persons	Maximum up to 6 Persons	Maximum up to 6 Persons	Maximum up to 6 Persons
Pre-policy Issuance Medical Check up	Yes, as per Appendix – I	No Medicals required	Yes, as per Appendix – I	Yes, as per Appendix –I
Tenure	1/2/3 Years	1/2/3 Years	1/2/3 Years	1/2/3 Years
Premium Payment Mode*	Single/Monthly/Quarterly	Single/Monthly/Quarterly	Single/Monthly/Quarterly	Single/Monthly/Quarterly

*Premium payment mode other than single payment is only available for Policy tenure of 2 /3 years

Plan Name	Critical Mediclaim	Cancer Mediclaim	Heart Mediclaim	Operation Mediclaim
Sum Insured (SI) – on annual basis (in Rs.)	1L,2L,3L,5L,7L,10L,20L,25L,50L,100L,200L,300L,600L	1L,2L,3L,5L,7L,10L,20L,25L,50L,100L,200L,300L,600L	1L,2L,3L,5L,7L,10L,20L,25L,50L,100L,200L,300L,600L	1L,2L,3L,5L,7L,10L,20L,25L,50L,100L,200L,300L,600L
Benefits				
Hospitalization Expenses				
- In-Patient Care	Up to SI	Up to SI	Up to SI	Up toSI
- Day Care Treatment	Up to SI	Up to SI	Up to SI	Up to SI
Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses	Pre-Hospitalization for 30 days & Post-Hospitalization for 60 days; Maximum up to SI	Pre-Hospitalization for 30 days & Post-Hospitalization for 60 days; Maximum up to SI	Pre-Hospitalization for 30 days & Post-Hospitalization for 60 days; Maximum up to SI	Pre-Hospitalization for 30 days & Post-Hospitalization for 60 days; Maximum up to SI
Chemotherapy and Radiotherapy Cover	Up to SI	Up to SI	Not Available	Not Available
Dialysis Cover	Up to SI	Not Available	Not Available	Not Available
Ambulance Cover	Up to Rs 3000 per hospitalization	Up to Rs 3000 per hospitalization	Up to Rs 3000 per hospitalization	Up to Rs 3000 per hospitalization
Organ Donor Cover	Up to SI or 15 L whichever is lower	Up to SI or 15 L whichever is lower	Up to SI or 15 L whichever is lower	Up to SI or 15 L whichever is lower
Alternative Treatments	Up to 25% of SI	Up to 25% of SI	Up to 25% of SI	Not Available
Second Opinion	Once per Covered Condition per policy year	Once per Covered Condition per policy year	Once per Covered Condition per policy year	Once per Covered Condition per policy year
Annual Health Check-up	Annual from 2nd Policy Year on Continuous Coverage	Annual from 2nd Policy Year on Continuous Coverage	Annual from 2nd Policy Year on Continuous Coverage	Annual from 2nd Policy Year on Continuous Coverage
Plan Name	**Critical Mediclaim**	**Cancer Mediclaim**	**Heart Mediclaim**	**Operation**

				Mediclaim
Sum Insured (SI) – on annual basis (in Rs.)	1L,2L,3L,5L,7L,10L,20L,25L,50L,100L,200L,300L,600L	1L,2L,3L,5L,7L,10L,20L,25L,50L,100L,200L,300L,600L	1L,2L,3L,5L,7L,10L,20L,25L,50L,100L,200L,300L,600L	1L,2L,3L,5L,7L,10L,20L,25L,50L,100L,200L,300L,600L
No Claims Bonus(NCB)	50%/25%/25%-Corresponding increase in SI for 1st, 2nd and 3rd continuous claim-free Policy Years respectively, Max up to 100% of SI(50%/25/25%-Corresponding decrease in SI per Policy Year in case a claim has been paid; Such decrease is only in SI accrued as NCB)	50%/25%/25%-Corresponding increase in SI for 1st, 2nd and 3rd continuous claim-free Policy Years respectively, Max up to 100% of SI(50%/25/25%-Corresponding decrease in SI per Policy Year in case a claim has been paid; Such decrease is only in SI accrued as NCB)	50%/25%/25%-Corresponding increase in SI for 1st, 2nd and 3rd continuous claim-free Policy Years respectively, Max up to 100% of SI(50%/25/25%-Corresponding decrease in SI per Policy Year in case a claim has been paid; Such decrease is only in SI accrued as NCB)	50%/25%/25%-Corresponding increase in SI for 1st, 2nd and 3rd continuous claim-free Policy Years respectively, Max up to 100% of SI(50%/25/25%-Corresponding decrease in SI per Policy Year in case a claim has been paid; Such decrease is only in SI accrued as NCB)
Health Services				
- Quick Recovery Counseling	Up to Rs 1000 Per Session, Maximum 8 Sessions Post Hospitalization in a Policy year(can be availed twice in a month)	Up to Rs 1000 Per Session, Maximum 8 Sessions Post Hospitalization in a Policy year(can be availed twice in a month)	Up to Rs 1000 Per Session, Maximum 8 Sessions Post Hospitalization in a Policy year(can be availed twice in a month)	Up to Rs 1000 Per Session, Maximum 8 Sessions Post Hospitalization in a Policy year(can be availed twice in a month)
-Doctor on Call	Yes(Telephonic/Online Mode)	Yes(Telephonic/Online Mode)	Yes(Telephonic/Online Mode)	Yes(Telephonic/Online Mode)
-Health Portal	Value added Services through Company's Website	Value added Services through Company's Website	Value added Services through Company's Website	Value added Services through Company's Website
Global Coverage: Coverage outside India - 45 continuous days	Up to SI; only for SI >=1Cr (Limited to In-Patient Care and	Up to SI; only for SI >=1Cr (Limited to In-Patient Care and	Up to SI; only for SI >=1Cr (Limited to In-Patient Care and	Up to SI; only for SI >=1Cr (Limited to In-Patient Care and

in a single trip; Max. 90 days on a cumulative basis, in a Policy Year.	Day-Care treatment) with a Co-payment of 10% per Claim	Day-Care treatment with a Co-payment of 10% per Claim	Day-Care treatment with a Co-payment of 10% per Claim	Day-Care treatment with a Co-payment of 10% per Claim
OPD Expenses (Diagnostics + Consultations + Pharmacy)	Up to 1% of SI ,Max up to Rs 25,000	Up to 1% of SI ,Max up to Rs 25,000	Up to 1% of SI ,Max up to Rs 25,000	Not Available
Optional Benefits				
Deductible Option– on an aggregate basis per Policy Year (in Rs.)	5K / 10K / 25K / 50K / 1L / 2L / 3L / 5L/7L/10L	5K / 10K / 25K / 50K / 1L / 2L / 3L / 5L/7L/10L	5K / 10K / 25K / 50K / 1L / 2L / 3L / 5L/7L/10L	5K / 10K / 25K / 50K / 1L / 2L / 3L / 5L/7L/10L

Plan Name	Critical Mediclaim	Cancer Mediclaim	Heart Mediclaim	Operation Mediclaim
Sum Insured (SI) – on annual basis (in Rs.)	1L,2L,3L,5L,7L,10L ,20L,25L,50L,100L ,200L,300L,600L	1L,2L,3L,5L,7L,10L,20L,25L,50L,100L,200L,300L,600L	1L,2L,3L,5L,7L,10L,20L,25L,50L,100L,200L,300L,600L	1L,2L,3L,5L,7L,10L,20L,25L,50L,100L,200L,300L,600L
Co-Payment Option	20 % per claim, for all customers whose entry age is 60 years and below(Mandatory for customers whose entry age is 61 years and above, please refer to point 5 of the notes for details)	20 % per claim, for all customers whose entry age is 60 years and below(Mandatory for customers whose entry age is 61 years and above, please refer to point 5 of the notes for details)	20 % per claim, for all customers whose entry age is 60 years and below(Mandatory for customers whose entry age is 61 years and above, please refer to point 5 of the notes for details)	20 % per claim, for all customers whose entry age is 60 years and below(Mandatory for customers whose entry age is 61 years and above, please refer to point 5 of the notes for details)
Unlimited Automatic Recharge	Up to SI available only for 2/3/5/7/10/20/25 /50 Lacs SI options	Up to SI available only for 2/3/5/7/10/20/25 /50 Lacs SI options	Up to SI available only for 2/3/5/7/10/20/25 /50 Lacs SI options	Up to SI available only for 2/3/5/7/10/20/25 /50 Lacs SI options
International Second Opinion	Once per Covered Condition per policy year	Once per Covered Condition per policy year	Once per Covered Condition per policy year	Once per Covered Condition per policy year

Room Rent Modification	No sub-limit on Room Rent/Room Category only if SI>=5 L and Claims Made in India	No sub-limit on Room Rent/Room Category only if SI>=5 L and Claims Made in India	No sub-limit on Room Rent/Room Category only if SI>=5 L and Claims Made in India	No sub-limit on Room Rent/Room Category only if SI>=5 L and Claims Made in India
Additional Sum Insured for Accidental Hospitalization	100% of SI, if an Insured is admitted under In-patient Care due to an accident	100% of SI, if an Insured is admitted under In-patient Care due to an accident(	100% of SI, if an Insured is admitted under In-patient Care due to an accident	100% of SI, if an Insured is admitted under In-patient Care due to an accident
Air Ambulance Cover	Up to Rs 5 Lakhs	Up to Rs 5 Lakhs	Up to Rs 5 Lakhs	Up to Rs 5 Lakhs
Reduction in PED Wait Period	Option to reduce the Wait Period from 48 to 24 Months	Option to reduce the Wait Period from 48 to 24 Months	Option to reduce the Wait Period from 48 to 24 Months	Option to reduce the Wait Period from 48 to 24 Months

Plan Name	**Critical Mediclaim**	**Cancer Mediclaim**	**Heart Mediclaim**	**Operation Mediclaim**
Sum Insured (SI) – on annual basis (in Rs.)	1L,2L,3L,5L,7L,10L ,20L,25L,50L,100L ,200L,300L,600L	1L,2L,3L,5L,7L,10L,2 0L,25L,50L,100L,20 0L,300L,600L	1L,2L,3L,5L,7L,10L,2 0L,25L,50L,100L,20 0L,300L,600L	1L,2L,3L,5L,7L,10L,2 0L,25L,50L,100L,20 0L,300L,600L
SUB-LIMITS:				
Room Rent/Room Category	Up to 1% of SI per day for SI less than 5 Lakhs; Single Private Room for SI greater than equal to 5 Lakhs	Up to 1% of SI per day for SI less than 5 Lakhs; Single Private Room for SI greater than equal to 5 Lakhs	Up to 1% of SI per day for SI less than 5 Lakhs; Single Private Room for SI greater than equal to 5 Lakhs	Up to 1% of SI per day for SI less than 5 Lakhs; Single Private Room for SI greater than equal to 5 Lakhs
ICU Charges	Up to 2% of SI per day for SI less than 5 Lakhs ;and No Sub-limit for SI greater than equal to 5 Lakhs	Up to 2% of SI per day for SI less than 5 Lakhs ;and No Sub-limit for SI greater than equal to 5 Lakhs	Up to 2% of SI per day for SI less than 5 Lakhs ;and No Sub-limit for SI greater than equal to 5 Lakhs	Up to 2% of SI per day for SI less than 5 Lakhs ;and No Sub-limit for SI greater than equal to 5 Lakhs

Wait Periods:				
Initial Waiting Period	90 Days	90 Days	90 Days	90 Days
Specific Waiting Period	Not Available	Not Available	Not Available	24 months
Pre-existing Disease	48 months	48 months	48 months	48 months

Appendix – I (Pre-policy Issuance Medical Check-up)

Age/ Sum Insured	Upto 10 Lakhs	10-25L	50 L-1 Cr	2Cr - 6 Cr	Critical Mediclaim
Upto 50 Yrs	-	Tele UW	Tele UW	MER+Tele UW	
51-55 years	PPC 4	PPC 6	PPC 6	PPC 7	
56 years and above	PPC 4	PPC 6	PPC 6	PPC 7	

Age/ Sum Insured	Upto 10 Lakhs	10-25L	50 L	1Cr - 6 Cr	Cancer Mediclaim
0 - 50 years	Tele UW	Tele UW	Tele UW	Tele UW	
56-60 years	Tele UW	Tele UW	Tele UW	Tele UW	
>60 Years	Tele UW	Tele UW	Tele UW	Tele UW	

Age/ Sum Insured	Upto 10 Lakhs	10-25L	50 L	1Cr - 6 Cr	Heart Mediclaim
Upto 50 years	-	-	Tele UW	Tele UW	
51 and 60 Years	PPC 1	PPC 1	PPC 1	PPC 5	
60 Years and above	PPC 2	PPC 2	PPC 3	PPC 5	

Age/ Sum Insured	Upto 10 Lakhs	10-25L	50 L-1 Cr	2Cr - 6 Cr	Operation Mediclaim
Upto 50 Yrs	-	Tele UW	Tele UW	MER+ Tele UW	
51-55 years	PPC 4	PPC 6	PPC 6	PPC 7	
56 years and above	PPC 4	PPC 6	PPC 6	PPC 7	

Note: The above mentioned grid may be modified/waived after due approval by Head underwriter.

Sets	Medical Tests
PPC 1	MER, CBC &ESR, HBA1C, T. Cholesterol, ECG, SGPT, S. Creatinine, RUA
PPC 2	MER, CBC & ESR, HBA1C, T. Cholesterol, TMT, SGPT, S. Creatinine, RUA
PPC 3	MER, CBC & ESR, HBA1C, Lipids, LFT with GGT, RUA, TMT, HBsAg, S. Creatinine
PPC 4	CBC, ESR , Urine Routine, GPE, CXR, HB1AC, S.Cholestrol, ECG, LFT, KFT
PPC 5	MER, CBC & ESR, HBA1C, Lipids, Chest - X Ray, TSH, 2D ECHO, TMT
PPC 6	CBC, ESR, Urine Routine, MER, CXR, HB1AC, Lipid Profile , TMT, LFT, KFT, TM (PSA – Male, PAP – Females)
PPC 7	MER, CBC & ESR, HBA1C, Lipids, LFT with GGT, RUA, HBsAg, RFT, USG abd/pelvis (M&F), CEA, PSA (M), PAP (F), Chest - X Ray, PFT, TSH, 2D ECHO, TMT

Appendix- II - Basis of treatment of Optional Covers

Optional Covers	Pay-out Basis	SUM INSURED AND IMPACT ON BASIC / MEDICAL SUM INUSRED
1. Deductible Option	Indemnity	Not Applicable
2.Co-payment Option	Indemnity	Not Applicable
3.Unlimited Automatic Recharge	Indemnity	SI as per the Original Basic / Medical SI is recharged Unlimited times
4.International Second Opinion	Benefit	Not Applicable
5. Room Rent Modification	Indemnity	No limit on Room Rent
6. Additional Sum Insured for Accidental Hospitalization	Indemnity	Additional SI as per the Original Basic / Medical SI; For Critical Illness/Surgery due to accidents, Basic/Medical SI to exhaust first
7. Air Ambulance Cover	Indemnity	Separate SI - claim doesn't impact

		the Basic / Medical SI
8.Reduction of PED Wait Period	Indemnity	Not applicable

Appendix -III – List of Critical Illness(s) and Surgeries

Sr. No	Critical Mediclaim	Cancer Mediclaim	Heart Mediclaim	Operation Mediclaim
1	Cancer	CANCER	Pulmonary Thromboembolism	ALL SURGERIES
2	End Stage Renal Failure		Primary(Idiopathic) Pulmonary	
3	Multiple Sclerosis		Infective Endocarditis	
4	Benign Brain Tumor		Heart Valve Replacement/repair	
5	Parkinson's Disease		Surgery of Aorta	
6	Alzheimer's Disease		Cardiomyopathy	
7	End Stage Liver Disease		Surgery for cardiac arrhythmia	
8	Motor Neuron Disorder		Angioplasty	
9	End Stage Lung Disease		Balloon Valvotomy/Valvuloplasty	
10	Bacterial Meningitis		Carotid Artery Surgery	
11	Aplastic Anaemia		Coronary Artery Bypass Graft	
12	Pulmonary Thromboembolism		Pericardectomy	
13	Primary(Idiopathic) Pulmonary		Surgery to Place Ventricular Assist Devices or Total Artificial Hearts	
14	Infective Endocarditis		Myocardial Infarction	
15	Major Organ Transplant		Implantation of Pacemaker of Heart	
16	Heart Valve Replacement/repair		Implantable Cardioverter Defibrillator	
18	Cardiomyopathy			
19	Surgery for cardiac arrhythmia			
20	Angioplasty			
21	Balloon Valvotomy/Valvuloplasty			
22	Carotid Artery Surgery			
23	Coronary Artery Bypass Graft			
24	Pericardectomy			
25	Surgery to Place Ventricular Assist Devices or Total Artificial Hearts			
26	Stroke			
27	Paralysis			
28	Myocardial Infarction			
29	Implantation of Pacemaker of Heart			
30	Implantable Cardioverter Defibrillator:			
31	Major Burns			
32	Blindness			