1. Policy Document Terms & Conditions

The insurance cover provided under this Policy to the Insured Person up to the Sum Insured and is and shall be subject to (a) the terms and conditions of this Policy and (b) the receipt of premium, and (c) the information disclosed to Us (including by way of the proposal form) by You or on Your behalf and on behalf of all persons to be insured. Please inform Us immediately of any change in the address, Primary Insured, state of health, or of any other changes affecting You and/or any Insured Person.

2. Basic Benefits

The following Basic Benefits shall be available only if specified to be applicable in the Schedule of Insurance Certificate, subject to the terms, conditions and limitations of the Basic Benefit under the Policy.

This Policy provides benefits up to the Sum Insured subject to any specific limits specified in the Product Benefits Table, the terms, conditions, limitations and specific and general exclusions mentioned in the Policy and as shown in the Schedule of Insurance Certificate and eligibility for the insurance plan opted for as specified in the Product Benefit Table.

2.1. Group Indemnity Cover

We will pay for the Group Indemnity Cover specified in the Product Benefits Table up to the Sum Insured of Group Indemnity Cover as specified in Schedule of Insurance Certificate.

2.1.1 Inpatient Care

We will cover Medical Expenses for:

(a) Surgical operations including pre and post operative care

(b) Nursing care, drugs and surgical dressings

(c) Medical Practitioner’s fee

(d) Operation theatre charges

(e) Diagnostic procedures and therapies

(f) The cost of prosthetics and other devices or equipment if implanted internally during a surgical operation

2.1.2 Hospital Accommodation

2.1.2.1 We will cover Reasonable and Customary Charges for Room Rent for accommodation in Hospital room as shown in the Schedule of Insurance Certificate

2.1.2.2 We will cover per day Intensive Care Unit (ICU) charges for accommodation in ICU as shown in the Schedule of Insurance Certificate

2.1.3 Pre-hospitalisation Medical Expenses and Post-hospitalisation Medical Expenses

We will cover Medical Expenses incurred due to Illness immediately before the Insured Person's admission and after the Insured Person's discharge from a Hospital, for a period as shown in the Schedule of Insurance Certificate, for the same Illness as long as We have accepted an Inpatient Care Hospitalisation claim under Clause 2.1.1 above. Pre and Post-hospitalisation Medical Expenses can be claimed as reimbursement only.

2.1.4 Day-Care Treatment

We will cover Medical Expenses for Day-Care Treatment where such treatments are undertaken by an Insured Person in a Hospital for a continuous period of less than 24 hours. Any OPD Treatment undertaken in a Hospital will not be covered.

We will also cover the Medical Expenses up to the Sum Insured for Chemotherapy, Radiotherapy, Hemodialysis or any other procedure which requires a period of specialized observation or care after completion of the procedure where such procedure is undertaken by an Insured Person in a Hospital for a continuous period of less than 24 hours.

2.1.5 Organ Transplant

We will cover Medical Expenses for an organ donor's treatment for the harvesting of the organ donated provided that:

(a) The donation conforms to the Transplantation of Human Organs Act 1994 and the organ is for the use of the Insured Person;

(b) The Insured Person has been medically advised to undergo an organ transplant;

We shall not cover:

(a) Pre-hospitalisation or Post-hospitalisation Medical Expenses or screening expenses of the donor or any other Medical Expenses as a result of the harvesting from the donor

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

(c) Treatment for an Insured Person unless, these expenses for the Insured Person are covered under Clause 2.1.1

2.1.6 Emergency Ground Ambulance

We will cover Reasonable and Customary Charges for ambulance expenses as specified in the Schedule of Insurance Certificate to transfer the Insured Person by surface transport following an Emergency to the nearest Hospital with adequate facilities provided that ;

(a) The ambulance service is offered by a healthcare or ambulance service provider; and

(b) We have accepted an Inpatient Care Hospitalisation claim under the provisions of Clause 2.1.1 above;

2.2. Group Hospital Cash Benefit

If an Insured Person is Hospitalised then We will pay the daily allowance specified in the Schedule of Insurance Certificate for each continuous and completed period of 24 hours of Hospitalisation provided that:

(a) The Insured Person is Hospitalised for a minimum period of atleast 2 days with continuous and completed period of at least 24 hours following which it will be payable from the first day of Hospitalisation;

(b) In any Policy Period, We shall not be liable to make payment of the Daily Allowance under this benefit for more than the number of days as specified in the Schedule of Insurance Certificate, including all days of admission to the Intensive Care Unit

2.3. Group Critical Illness Cover

If an Insured Person suffers a Critical Illness, We will pay the Critical Illness Sum Insured specified in the Schedule of Insurance Certificate provided that:

(a) The Critical Illness occurs or first manifests itself during the Policy Period; and

(b) The Insured Person survives for a minimum period of at least 30 days from the date of diagnosis of such Critical Illness for the claim to be admissible under Clause 2.3

(c) If We have admitted a claim under this cover for an Insured Person in any Policy Period, this cover shall not be renewed in respect of that Insured Person for any subsequent Policy Period

(d) Our total and cumulative liability for a Insured Person under this benefit will be limited to the Critical Illness Sum Insured

2.4. Group OPD Treatment Cover

If an Insured Person undergoes OPD Treatment, then We will reimburse the balanced proportionate percentage of the admitted claim amount specified in the Schedule of Insurance Certificate for the Medical Expenses incurred on:

(a) Medical Practitioners' consultation including treatment for dental treatment;
(b) Pharmacy Expenses;
(c) Diagnostic Procedures.

The percentage amount specified in the Schedule of Insurance Certificate will be contributed by the Insured Person.

Clause 4(e)(iv), Clause 4(e)(ix), Clause 4(e)(x) and Clause 4(e)(xxi) stand deleted if this benefit is in force.

2.5. Group Health Checkup Cover

We will reimburse the balanced proportionate percentage of admitted claim amount specified in Schedule of Insurance Certificate, for any cost of health checkup as mentioned in Annexure II, taken by an Insured Person up to the limit of Sum Insured as shown under the Schedule of Insurance Certificate. The percentage amount specified in the Schedule of Insurance Certificate will be contributed by the Insured Person.

2.6. Group Named Illness Cover

If an Insured Person suffers a specific Named Illness as shown in Schedule of Insurance Certificate, We will pay the Named Illness Sum Insured provided that:

(a) The Named Illness occurs or first manifests itself during the Policy Period; and

(b) The signs or symptoms of the Named Illness commence after the specified initial waiting period from the date of commencement of coverage of the Insured Person under the Policy as specified in the Schedule of Insurance Certificate

(c) Our total and cumulative liability for the Insured Person under this benefit will be limited to the Named Illness Sum Insured.

3. Optional Benefits

This Policy may also provide optional benefits if these are specified to be applicable in the Schedule of Insurance Certificate subject to the terms, conditions and limitations of the optional benefits.

4. Exclusions

We shall not be liable under this Policy for any claim in connection with or in respect of the following.

a. Pre-Existing Diseases

Benefits will not be available for Pre-Existing Diseases until 48 months of continuous coverage have elapsed from the date of commencement of coverage for the Insured Person.

Pre-existing Diseases exclude the list of conditions mentioned under ‘Specific Waiting Period’ under Clause 4(c).

b. 30 Days Waiting Period

We will not cover any treatment taken during the first 30 days since the date of commencement of coverage for the Insured Person, unless the treatment needed is the

result of an Accident or Cardio or Neurological Emergency. This waiting period does not apply for any subsequent and continuous Renewals of Your Policy.

c. Specific Waiting Periods

For all Insured Persons the conditions listed below will be subject to a waiting period of 24 months from the date of commencement of coverage for the Insured Person:

1. Stones in the urinary system
2. Stones in billiary system
3. Surgery on tonsils / adenoids
4. Uterine Polyps
5. Any type of breast lumps
6. Any type of treatment of Spondylosis /Spondylitis -
7. Inter Vertebral Disc Prolapse (IVDP) or such other degenerative disorders
8. Cataract
9. BPH – Benign prostatic hypertrophy
10. Hysterectomy / Myomectomy done due to Menorrhagia / fibroids
11. Fistula in ano
12. Fissure in ano
13. Piles
14. Hernia
15. Hydrocele
16. Sinusitis
17. Knee / hip joint replacement
18. Chronic Renal Failure(CRF) or end stage renal failure
19. Any type of Carcinoma / sarcoma / blood cancer
20. Osteo Arthritis of any joint
21. Gastric and duodenal Ulcers
22. Varicocele
23. Spermatocele
24. Dilatation and Curettage (D&C)

25. Diabetic Nephropathy and Retinopathy
26. Mastoidectomy (operation to remove piece of bone behind the ear)
27. Tympanoplasty (Surgery to repair tympanic membrane i.e. eardrum)
28. Gout
29. Rheumatism
30. Varicose veins, Varicose ulcers
31. Internal Congenital Anomaly

d. Permanent Exclusions

We shall not be liable under any circumstances, for any claim in connection with or with regard to any of the following permanent exclusions

i. Addictive conditions and disorders

Treatment related to Rehabilitation from addictive conditions and disorders, or from any kind of substance abuse or misuse.

ii. Ageing and puberty

Treatment to relieve symptoms caused by ageing, puberty, or other natural physiological cause, such as menopause and hearing loss caused by maturing or ageing.

iii. Artificial life maintenance

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

1. Deep coma and unresponsiveness to all forms of stimulation;
2. Absent pupillary light reaction;
3. Absent oculovestibular and corneal reflexes; or
4. Complete apnea.

iv. Ayurvedic and Homeopathic treatment.

Ayurvedic and Homeopathic streams of treatment.

v. Circumcision

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

vi. Conflict and disaster

Treatment for any Illness or Injury resulting from nuclear or chemical contamination, war, riot, revolution, or any similar event (other than natural disaster or calamity), if one or more of the following conditions apply:

1. The Insured Person put himself in danger by entering a known area of conflict where active fighting or insurrections are taking place

2. The Insured Person was an active participant in the above mentioned acts or events of a similar nature.

3. The Insured Person displayed a blatant disregard for personal safety

vii. Convalescence and Rehabilitation

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

1. Convalescence, Rehabilitation, supervision or any other purpose other than for receiving eligible treatment of a type that normally requires a stay in Hospital.

2. Receiving general nursing care or any other services that do not require the Insured Person to be in Hospital and could be provided in another establishment that is not a Hospital

3. Receiving services from a therapist or complementary Medical Practitioner or a practitioner of Alternative Treatments.

viii. Cosmetic Surgery

Treatment undergone purely for cosmetic or psychological reasons to improve appearance, unless such treatment is Medically Necessary as a part of treatment for cancer or Injury resulting from Accidents or burns and is required to restore functionality.

ix. Dental/Oral treatment

Treatment for any dental or oral condition, which includes Surgical Procedure for the treatment of bone disease when related to gum disease or damage, or treatment for, or treatment arising from, disorders of the tempromandibular joint.

EXCEPTION: We will pay for a Surgical Procedure for which the Insured Person is Hospitalised for a continuous minimum period of 24 hours and which is taken for Inpatient Care in a Hospital and carried out by a Medical Practitioner.

x. Drugs and dressings for OPD Treatment or take-home use

Any drugs or surgical dressings that are provided or prescribed in the case of OPD Treatment , or for an Insured Person to take home on leaving Hospital, for any condition, except as included in Post-hospitalisation Medical Expenses under Clause 2.1.3 above.

xi. External Congenital Anomaly

Treatment for any External Congenital Anomaly.

xii. Eyesight

Treatment to correct refractive errors of the eye, unless required as the result of an Accident or if the correction required is in excess of +/- 7.5 diopters. We will not pay for routine eye examinations, contact lenses, spectacles or laser eye sight correction.

xiii. Unproven / Experimental treatment

Unproven/Experimental treatment.

xiv. Unani, Yoga and Siddha treatment

Unani, Yoga and Siddha streams of treatment

xv. Health hydros, nature cure, wellness clinics etc.

Treatment or services received in health hydros, nature cure clinics or any establishment that is not a Hospital.

xvi. HIV and AIDS

Any treatment for or treatment arising from, Human Immunodeficiency Virus (HIV) or Acquired Immuno Deficiency Syndrome (AIDS), including any condition that is related to HIV or AIDS.

xvii. Hereditary conditions

Treatment of abnormalities, deformities, Illnesses present only because they have been passed down through the generations of the family.

xviii. Items of personal comfort and convenience, including but not limited to:

1. Telephone, television, diet charges, (unless the foregoing are included in Room Rent) personal attendant or barber or beauty services, baby food, cosmetics, napkins, toiletry items, guest services and similar incidental expenses or services.
2. Private nursing/attendant's charges incurred during Pre-Hospitalisation or Post-Hospitalisation.
3. Drugs or treatment not supported by prescription.

4. Issue of medical certificate and examinations as to suitability for employment or travel or any other such purpose.
5. Any charges incurred to procure any treatment/Illness related documents pertaining to any period of Hospitalisation/Illness.
6. External and or durable Medical/Non medical equipment of any kind used for diagnosis and/or treatment including CPAP, CAPD, Infusion pump etc.
7. Ambulatory devices such as walkers, crutches, belts, collars, caps, splints, slings, braces, stockings of any kind, diabetic foot wear, glucometer/thermometer and similar items and also any medical equipment which is subsequently used at home.
8. Qualified Nurses hired in addition to the Hospital's own staff.

xix. Psychiatric and Psychosomatic Conditions

Treatment of any mental Illness or sickness or disease including a psychiatric condition, disorganisation of personality or mind, or emotions or behaviour, Parkinsons or Alzheimer's disease even if caused or aggravated by or related to an Accident or Illness or general debility or exhaustion ("run-down condition");

xx. Obesity

Treatment for obesity.

xxi. OPD Treatment

OPD Treatment is not covered, except to the extent specified in Clause 2.4.

xxii. Reproductive medicine - Birth control & Assisted reproduction

1. Any type of contraception, sterilization, termination of pregnancy (except as provided for under Optional Benefit) or family planning.

2. Treatment to assist reproduction, including IVF treatment.

xxiii. Self-inflicted injuries

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

xxiv. Sexual disorder and gender issues

Treatment of any sexual disorder including impotence (irrespective of the cause) and sex changes or gender reassignments or erectile dysfunction.

xxv. Sexually transmitted diseases

Treatment for any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.

xxvi. Sleep disorders

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

xxvii. Speech disorders

Treatment for speech disorders, including stammering

xxviii. Treatment for developmental problems

Treatment for, or related to developmental problems, including:

1. learning difficulties, such as dyslexia;

2. behavioral problems, including attention deficit hyperactivity disorder (ADHD);

xxix. Treatment received outside India

Any treatment received outside India

xxx. Unrecognized physician or Hospital:

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

2. Treatment in any Hospital or by any Medical Practitioner or any other provider of services that We have blacklisted as listed on Our website.

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

xxxi. Unlawful Activity

Any condition as a result of Insured Person committing or attempting to commit a breach of law with criminal intent.

xxxii. Genetic disorders

Any genetic disorders resulting from a defect in the genes.

xxxiii. Any expenses as mentioned under the List of Expenses Generally Excluded as mentioned in Annexure IV except for all claims made under the Critical Illness Benefit.

5. Standard Terms and Conditions

a. Reasonable Care

The Insured Person shall take all reasonable steps to safeguard against any Accident or Illness that may give rise to any claim under this Policy.

b. Observance of terms and conditions

The due observance and fulfillment of the terms, conditions and endorsement of this Policy in so far as they relate to anything to be done or complied with by the Insured Person, shall be a condition precedent to any liability to make payment under this Policy.

c. Subrogation

The Insured Person shall do and concur in doing and permit to be done all such acts and things as may be necessary or required by Us, before or after indemnification, in enforcing or endorsing any rights or remedies, or of obtaining relief or indemnity, to which We are or would become entitled or subrogated. Neither You nor any Insured Person shall do any acts or things that prejudice these subrogation rights in any manner. Any recovery made by Us pursuant to this clause shall first be applied to the amounts paid or payable by Us under this Policy and the costs and expenses incurred by Us in effecting the recovery, where after We shall pay the balance amount to You. This clause would not be applicable for fixed benefit sections of Policy.

d. Contribution

It is agreed and understood that if in addition to this Policy, there is any other insurance policy in force under which a claim for reimbursement of Medical Expenses in respect of the Insured Person could be made, then You may choose the insurance policy under which You wish the claim to be settled. If, in such cases, the amount claimed (after considering the applicable deductibles and Co-Payment) exceeds the sum insured under a single policy You may choose the insurance policies under which the claim is to be settled and if this Policy is chosen then We will settle the claim for by applying the Contribution provisions. This clause would not be applicable for fixed benefit sections of Policy.

e. Fraudulent claims

If a claim is in any way found to be fraudulent, or if any false statement, or declaration is made or used in support of such a claim, or if any fraudulent means or devices are

used by the Insured Person or anyone acting on behalf of the Insured Person to obtain any benefit under this Policy, then the said claim under this Policy shall be void and such claims being processed shall be forfeited for any/all Insured Persons under that claim and all sums paid shall be repaid to Us by all Insured Persons who shall be jointly liable for such repayment.

f. Notification of Changes

It is a condition precedent to Our liability to make any payment under this Policy that You shall give Us written notice immediately of any change in the address, nature of job through the format (Annexure A), state of health and any other changes affecting You or any Insured Person.

We shall allow the enhancement in Sum Insured or scope of cover only at the time of Renewal. However, if You require enhancement in Sum Insured and/or change in scope of cover for any Insured Persons in the event of their change in grade or salary, You shall intimate Us the same immediately in the format attached as Annexure B. The decision of acceptance of enhancement of the Sum Insured or the scope of cover for such Insured Persons will be based on Our underwriting policy and shall be subject to payment of applicable premium for such enhanced cover.

g. Free Look Period

You will have a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of this Policy. If You have any objections to any of the terms and conditions, You may cancel the Policy stating the reasons for cancellation and provided that no claims have been made under the Policy, We will refund the premium paid by You after deducting the amounts spent on stamp duty charges and proportionate risk premium for the period on cover. All rights and benefits under this Policy shall immediately stand extinguished on the free look cancellation of the Policy. The free look provision is not applicable and available at the time of Renewal of the Policy.

h. Cancellation/ Termination

1. Cancellation by Policyholder:

You may terminate this Policy by giving 7 days' prior written notice to Us. We shall cancel the Policy and refund the premium (for all lives which have not registered a claim with Us) for the period as mentioned herein below till the termination date of the Policy. Further, We shall not be liable for any claim, if reported after the termination date of the Policy:

Length of time Policy in force	**Refund of premium**
up to 1/12 of Policy Period	75%

up to 1/4 of Policy Period	50%
up to 1/2 of Policy Period	25%
exceeding 1/2 of Policy Period	0%

2. Cancellation by Us:

We may terminate this Policy by sending 30 days prior written notice to Your address shown in the Schedule of Insurance Certificate without refund of premium if in Our opinion:

You or any Insured Person or any person acting on behalf of either has acted in a dishonest or fraudulent manner, provided false or incorrect information, or suppressed any important information, under or in relation to this Policy.

i. Territorial Jurisdiction

All benefits and optional benefits are available in India only and all claims shall be payable in India in Indian Rupees only.

j. Policy Disputes

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

k. Renewal of Policy

The Renewal premium is payable on or before the due date in the amount shown in the Schedule of Insurance Certificate or at such altered rate as may be reviewed and notified by Us before completion of the Policy Period. We are under no obligation to notify You of the Renewal date of Your Policy. We will allow a Grace Period of 30 days from the due date of the Renewal premium for payment to Us.

If the Policy is not renewed within the Grace Period then We may agree to issue a fresh Policy subject to Our underwriting criteria and no continuing benefits shall be available from the expired Policy.

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

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l. Notices

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

i. You and/or the Insured Person at the address specified in the Schedule of Insurance Certificate or at the changed address of which We must receive written notice.

ii. Us at the following address.

Customer Service Department
Max Bupa Health Insurance Company Limited
B-1/I-2, Mohan Cooperative Industrial Estate,
Mathura Road,
New Delhi - 110044
Customer Helpline No.: 1860-500-8888
Fax No.: 011-30902010

In addition, We may send You other information through electronic and telecommunications means with respect to Your Policy from time to time.

m. Claims Procedure

All claims under this Policy will be adjudicated within 30 days after the occurrence of the event and further submission of claims form with specified documents. The benefits will be paid in line with the coverage in the insurance plan opted by You.

i. We reserve the right to call for:

a) Any other necessary documentation or information that We believe may be required; and

b) A medical examination by Our Medical Practitioner or for an investigation as often as We believe this to be necessary. Any expenses related to such examination or investigation shall be borne by Us.

ii. In the event of the Insured Person's death during Hospitalisation, written notice accompanied by a copy of the post mortem report (if any) shall be given to Us within 14 days regardless of whether any other notice has been given to Us. We reserve the right to require an autopsy.

iii. In respect of any claim under Section I of Product Benefit Table or Rider:

(a) Cashless Hospitalisation Facility for Network Provider Hospitals:

i. The health card We provide will enable an Insured Person to access treatment on a cashless basis only at any Network Hospital on the production of the card to the Hospital prior to admission, provided that:

(1) The Insured Person has notified Us in writing at least 72 Hours before a planned Hospitalisation. In a situation where an

Emergency Care is required, the Insured Person (or person on behalf of the Insured Person) should notify Us in writing within 48 hours of Hospitalisation; and

(2) We have pre-authorized the Inpatient Care or Day Care Treatment.

ii. Cashless settlement will not be available if the Insured Person takes treatment in an Non-Network Hospital.

iii. For cashless Hospitalisation We will make the payment of the amounts assessed to be due directly to the Network Provider Hospital. The treatment must take place within 15 days of the pre-authorization date and pre-authorization is only valid if all the details of the authorized treatment, including dates, Hospital and locations, match with the details of the actual treatment received. In case the Insured Person is covered under the Co-Payment clause of the Optional Benefits, We will pay the final bill as assessed and approved by Us, to the Network Provider Hospital, net of the applicable Co-Payment applied to the approved amount. The balance amount and other inadmissible costs will be borne by the Insured Person and paid directly by the Insured Person to the Network Provider Hospital.

iv. If pre-authorisation is not obtained then the Cashless facility will not be available and the claims procedure shall be as per (b) (ii) below.

(b) Non-Network Hospitals & All Other Claims for Reimbursement:

(i) In all Hospitalisations which have not been pre-authorized, We must be notified in writing within 48 hours of the Insured Person's admission to the Hospital or before the Insured Person's discharge from the Hospital, whichever is earlier. The notification should be provided by the Insured Person. In the event the Insured Person is unable to provide the notification due to ill health, then the notification should be provided by an immediate adult member of the Insured Person's family.

(ii) For any Illness or Accident or medical condition that requires Hospitalisation, the Insured Person shall deliver to Us the documents listed below, at his own expense, within 15 days of the Insured Person's discharge from Hospital (when the claim is only in respect of post-Hospitalisation, within 30 days of the completion of the post-Hospitalisation):

(1) Duly filled claim form.

(2) Original bills, receipts and discharge certificate/card from the Hospital/ Medical Practitioner. (Self attested copies of bills,

receipts and Hospital discharge summary can be provided for Critical Illness or Hospital Cash claim)

(3) Original bills from chemists supported by proper prescription.

(4) Original consultation notes and/or investigation test reports and payment receipts supported by prescription. (Self attested copies of bills, receipts and Hospital discharge summary can be provided for Critical Illness or Hospital Cash claim)

(5) Medical Practitioner's referral letter advising Hospitalisation in non-accident cases.

(6) Details of any other insurance policy that may respond to the claim.

(7) First Information Report (FIR)/Panchnama/Medico Legal Certificate for medico-legal cases.

(iii) For any medical treatment taken from an Non-Network Hospital We will only pay only Reasonable and Customary Charges. Delayed payments shall attract interest as per applicable regulations.

(c) In respect of any claim under Section II to Section V of Product Benefit Table:

All claims under this Policy will be settled, including its rejection, within 30 days from filing of the claim or receipt of last necessary document whichever is later. The benefits will be paid in line with the coverage in the insurance plan opted by You.

(d) It is hereby agreed and understood that in providing pre-authorisation or accepting a claim for reimbursement under this Policy or making a payment under this Policy, We make no representation and/or give no guarantee and/or assume no responsibility for the appropriateness, quality or effectiveness of the treatment sought or provided.

(e) An updated list of Network Provider Hospitals is available on Our website www.maxbupa.com or may be obtained on request from Our nearest branch office.

n. Notification of Claim:

a) In all Hospitalisations which have not been pre-authorized, We must be notified in writing within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier. The Notification of Claim should be ideally provided by the Policyholder/Insured Person. In the event Policyholder and Insured Person is unwell, then the Notification of Claim should be provided by

any immediate adult member of the family. The notification should be sent to Us via one of the following:

(i) By calling Us at 1860-500-8888

(ii) By registered post sent to:

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

(iii) By writing an email to customercare@maxbupa.com.

All claims to be notified to Us within timelines as mentioned in 5 (n) (a). If any delay in intimation is genuine and for reasons beyond the control of the Insured Person or Nominee specified in the Schedule of Insurance Certificate, We may condone such delay and process the claim. We reserve the right to decline such requests for claim processing where there is no merit for the delay in reporting the claim

b) If You hold an indemnity policy with Us, a single notification for claim will apply to both the indemnity plan as well as any other Policy.

c) Upon acceptance of a claim, the payment of the amount due shall be made within 7 days from the date of acceptance of the claim. In the case of delay in payment, We shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.

o. Alteration to the Policy

This Policy, the Schedule of Insurance Certificate, the Proposal Form, any forms, Benefits, endorsements, and any Memorandum (if any) shall be read together as one contract and any words or expressions to which specific meanings attached shall bear such specific meanings wherever they shall appear. No change or alteration in this Policy shall be valid until approved and endorsed by Our authorized officer in writing.

p. Withdrawal of Product

This product may be withdrawn at Our option subject to prior approval of Insurance Regulatory and Development Authority (IRDA) or due to a change in regulations. In such a case We shall provide an option to migrate to Our other suitable retail products as available with Us.

q. Revision or Modification

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

r. Nomination & Assignment

The Primary Insured should at the inception make a nomination for the purpose of payment of claims. Any change of nomination shall be communicated to Us in writing and such change shall be effective only when an endorsement on the Policy is made by Us.

For any Insured Person other than the Primary Insured, for the purpose of payment of claims in the event of the death of that Insured Person, the default nominee shall be the Primary Insured

In absence of nominee details for the Primary Insured the default nominee shall be the legal heirs of that Primary Insured.

No assignment of this Policy or the benefits thereunder shall be permitted.

s. Obligations in case of a minor

If an Insured Person is less than 18 years of age, the Primary Insured shall be completely responsible for ensuring compliance with all the terms and conditions of this Policy on behalf of that Insured Person.

t. Obligations of the Policyholder

You shall inform Us about any addition or deletion of the Insured Person in the Policy. All the additions and deletions for previous month should be shared with Us by the 15^{th} day of the current month. Any person may be added as an Insured Person during the Policy Period if his application for insurance cover has been accepted by Us, additional proportionate premium is paid and We have issued an endorsement confirming the addition of this person as an Insured Person.

Any Insured Person may be deleted from coverage during the Policy Period. We will refund the premium received in respect of that Insured Person on a pro- rata basis provided that no claim has been registered in respect of that Insured Person on or before the date of deletion.
You shall inform to the members of the group about the ‘Disclosures on Continuity’.

u. Disclosures on Continuity

If a Primary Insured ceases to be a member of Your group during the Policy Period, then cover under the Policy for that Primary Insured and his Dependants (who are named as Insured Persons in the Schedule) will immediately and automatically cease. Upon being informed, the Primary Insured can give Us a written request prior

to or within 5 days of the date of cessation of group membership, to issue a new retail health insurance policy to himself and his Dependents (who were named as Insured Persons in the Schedule) for cover up to his Sum Insured under the Policy, on payment of premium in full for the new policy. This shall be subject to the following:

1. the issue of the new retail policy shall be subject to Our underwriting requirements, as prevailing at the time of issuance of the retail policy, and We may seek additional information before issuing a new policy;

2. We are not bound to continue all terms and conditions of the present cover under the Policy of the Primary Insured and his Dependents under the new policy, however for calculation of waiting periods including for Pre-Existing Diseases under the new policy the time spent by Primary Insured and his Dependants under this Policy may be taken into account, provided new policy is taken without any break from this Policy. Coverage under the new policy shall be available only for the period for which the premium has been received by Us;

Children whose age exceeds the maximum entry age would also be given an option to migrate to our suitable retail health insurance offering as available with Us at the time of Renewal.

v. Customer Service and Grievances Reddressal:

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

Customer Services Department
Max Bupa Health Insurance Company Limited
B1/I-2, Mohan Cooperative Industrial Estate,
Mathura Road,
New Delhi - 110044
Customer Helpline No.: 1860-500-8888
Fax No.: 011-30902010

Email ID: customercare@maxbupa.com

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

Head – Customer Services
Max Bupa Health Insurance Company Limited

B-1/I-2, Mohan Cooperative Industrial Estate,
Mathura Road,
New Delhi - 110044
Customer Helpline No.: 1860-500-8888

Fax No.: 011-30902010

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

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

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

1. only if the grievance has been rejected by the Grievance Redressal Machinery of the Insurer;
2. within a period of one year from the date of rejection by the insurer;
3. if it is not simultaneously under any litigation.

6. Interpretations & Definitions

In this Policy the following words or phrases shall have the meanings attributed to them wherever they appear in this Policy and for this purpose the singular will be deemed to include the plural, the male gender includes the female where the context permits:

Def. 1. **Accident** or **Accidental** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

Def. 2. **Alternative Treatments** are forms of treatments other than "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context

Def. 3. **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 approved.

Def. 4. **Contribution** is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any benefit offered on fixed benefit basis.

Def. 5. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

- **5a) Internal Congenital Anomaly** – Congenital anomaly which is not in the visible and accessible parts of the body
- **5b) External Congenital Anomaly** – Congenital anomaly which is in the visible and accessible parts of the body

Def. 6. **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.

Def. 7. **Critical Illness** means the following illnesses:

1. Cancer Of Specified Severity

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

The following are excluded:

- Tumours showing the malignant changes of carcinoma in situ and tumours which are histologically described as premalignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.

- Any skin cancer other than invasive malignant melanoma.
- 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.
- Papillary micro - carcinoma of the thyroid less than 1 cm in diameter.
- Chronic lymphocyctic leukaemia less than RAI stage 3.
- Microcarcinoma of the bladder.
- All tumours in the presence of HIV infection.

2. First Heart Attack – Of Specified Severity

The first 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 shall be evidenced by all of the following criteria:

a) history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain); and
b) new characteristic electrocardiogram changes; and
c) elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following 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

3. Open Chest CABG

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.

Excluded are:

a) Angioplasty and/or any other intra-arterial procedures
b) Any key-hole or laser Surgery.

4. Open Heart Replacement Or Repair Of Heart Valves

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.

Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

5. Coma Of Specified Severity

A state of unconsciousness with no reaction or response to external stimuli or internal needs.
This diagnosis must be supported by evidence of all of the following:

a) no response to external stimuli continuously for at least 96 hours;
b) life support measures are necessary to sustain life; and
c) permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

6. Kidney Failure Requiring Regular Dialysis

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

7. Stroke Resulting In Permanent Symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source.
Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain.

Evidence of permanent neurological deficit lasting for atleast 3 months has to be produced.

The following are excluded from Stroke:

i. Transient ischemic attacks (TIA)
ii. Traumatic Injury of the brain
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions

8. Major Organ / Bone Marrow Transplant

The actual undergoing of a transplant of:

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

The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

The following are excluded:

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

9. Permanent Paralysis Of Limbs

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

10. Motor Neuron Disease With Permanent Symptoms

Motor neurone disease diagnosed by a specialist Medical Practitioner as Spinal Muscular Atrophy, Progressive Bulbar Palsy, Amyotrophic Lateral Sclerosis or Primary Lateral Sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. **Multiple Sclerosis With Persisting Symptoms**

The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

- investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be Multiple Sclerosis; and
- there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and
- well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast one month apart.

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

Def. 8. **Day care centre** means any institution established for Day Care Treatment of illness and / or injuries or a medical set up within a Hospital and which has been registered 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:-

- has qualified nursing staff under its employment
- has qualified Medical Practitioner (s) in charge
- has a fully equipped operation theatre of its own where Surgical Procedures are carried out
- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

Def. 9. **Day Care Treatment** means a 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 hrs because of technological advancement, and
b) which would have otherwise required a Hospitalisation of more than 24 hours.

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

Def. 10. **Dental Treatment** is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

Def. 11. **Diagnostic Procedures** means Investigations, such as X-Ray or blood tests, to find the cause of your symptoms and medical condition.

Def. 12. **Disclosure to information norm** means the Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Def. 13. **Dependents** means the Primary Insured's family members listed below:

i) Legally married spouse as long as he or she continues to be married to the Primary Insured;
ii) Dependent Child

Def. 14. **Dependent Child** means a child or children (natural or legally adopted) aged less than 21 years at the time inception and at every Renewal of the Policy with Us, who is financially dependent on the primary insured or proposer and does not have his / her independent sources of income.

Def. 15. **Emergency Care** means management for a severe Illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the insured person's health.

Def. 16. **Emergency** means a severe Illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Doctor to prevent death or serious long term impairment of the Insured Person's.

Def. 17. **Family Floater Cover** means a cover in terms of which the Primary Insured and the Primary Insured's Dependents named in the Schedule are covered under the Policy as Insured Persons under the same Sum Insured.

Def. 18. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre existing diseases. Coverage is not available for the period for which no premium is received.

Def. 19. **Hospital** means any institution established for in-patient care and Day Care Treatment of illness and / or injuries and which has been registered as a Hospital with the local authorities under 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 at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
(b) Has qualified nursing staff under its employment round the clock;
(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 will make these accessible to the Insurance company's authorized personnel.

Def. 20. **Hospitalisation or Hospitalised** means admission in a Hospital for a minimum period of 24 Inpatient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24consecutive hours.

Def. 21. **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.

Def. 22. **Intensive Care Unit** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

Def. 23. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

- **23a) Acute Condition** is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his/her state of health immediately before suffering the disease/illness/injury which leads to full recovery.
- **23b) Chronic Condition** is defined as a disease, illness or injury that has one or more of the following characteristics: - it needs ongoing or long term monitoring through consultations, examinations, checkups and/or tests – it needs ongoing or long term control or relief of symptoms – it requires rehabilitation or for you to be specially trained to cope with it – it continues indefinitely – it comes back or is likely to come back.

Def. 24. **Inpatient Care** means treatment for which the insured person has to stay in a Hospital for more than 24 hours for a covered event.

Def. 25. **Insured Person** means the Primary Insured and those of his Dependents named as insured in the Schedule of Insurance Certificate.

Def. 26. **Medical Advise** means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

Def. 27. **Medical Practitioner** is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy setup 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.

Def. 28. **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.

Def. 29. **Medically Necessary** treatment 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;
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.

Def. 30. **Named Illness** means the diseases named below :

1. Typhoid
    a. Diagnosis must be confirmed by a positive Widal Test
2. Malaria
    a. Diagnosis must be confirmed by a positive blood test for Malarial Parasite
3. Dengue
    a. Diagnosis must be confirmed by a positive Dengue Serology
4. Tuberculosis
    a. Diagnosis must be confirmed by
        i. a AFB positive sputum or
        ii. Treatment with anti tubercular drugs
5. Impacted Wisdom Tooth
    a. Diagnosis must be confirmed by X- Ray reports
6. Maternity Complications - Gestational Diabetes
    a. Diagnosis must be confirmed by laboratory and clinical confirmation of pregnancy induced diabetes
7. Maternity Complications - Ectopic Pregnancy
    a. Diagnosis must be confirmed by Ultrasound / CT Scan
8. Kidney Stones
    a. Diagnosis must be confirmed by Ultrasound / CT Scan
9. Tetanus
    a. Diagnosis must be confirmed clinically

10. Meningitis
    a. Diagnosis must be confirmed by Lumbar puncture

Def. 31. **Network Provider** means Hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a Cashless facility..

Def. 32. **Non-Network** means any Hospital, Day care centre or other provider that is not part of the network.

Def. 33. **Notification of Claim** means the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.

Def. 34. **OPD Treatment** means the treatment in which the Insured visits a clinic / Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

Def. 35. **Policy** means these terms and conditions, any annexure thereto and the Schedule of Insurance Certificate (as amended from time to time), the information statements in the proposal form or the Information Summary Sheet and the policy wording (including endorsements, if any).

Def. 36. **Policy Period** means the period between the date of commencement and the expiry date specified in the Schedule of Insurance Certificate.

Def. 37. **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.

Def. 38. **Post-hospitalisation Medical Expenses** means Medical Expenses incurred immediately after the Insured Person is discharged from the hospital, provided that:

a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
b) The Inpatient Care Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

Def. 39. **Pre-Existing Disease** means any condition, ailment or Injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months to prior to the first policy issued by the insurer.

Def. 40. **Pre-hospitalisation Medical Expenses** means Medical Expenses incurred immediately before the Insured Person is Hospitalised, provided that:

c) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

d) The Inpatient Care Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

Def. 41. **Primary Insured** means Your group member who is named as the Primary Insured and as an Insured Person in the Schedule of Insurance Certificate.

Def. 42. **Product Benefits Table means** the Product Benefits Table issued by Us and accompanying this Policy and annexures thereto.

Def. 43. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

Def. 44. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved.

Def. 45. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of Grace Period for treating the Renewal continuous for the purpose of all waiting periods.

Def. 46. **Rehabilitation** means a treatment aimed at restoring health or mobility, or to allow a person to live an independent life, such as after a stroke.

Def. 47. **Rider** means a rider, if any, issued by Us, attached to and forming part of this Policy.

Def. 48. **Room Rent shall** means the amount charged by a Hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

Def. 49. **Schedule of Insurance Certificate** means the Schedule of Insurance issued by Us, and, if more than one, then the latest in time.

Def. 50. **Specified Network Provider** means a subset of Max Bupa Network Provider as specified in Schedule of Insurance Certificate

Def. 51. **Subrogation** 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.

Def. 52. **Sum Insured** means the amount specified in the Schedule of Insurance Certificate for an Insured Person which represents Our maximum total and cumulative liability for any and all claims made by that Insured Person under the Policy. For a Family Floater Cover only Sum Insured means the amount specified in the Schedule of Insurance Certificate for a Primary Insured which represents Our maximum liability for any and all claims made under the Policy by that Insured Person and all his Dependants who are covered under the Policy as Insured Persons.

Def. 53. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or Day care centre by a Medical Practitioner

Def. 54. **Unproven or Experimental treatment** means a treatment including drug experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

Def. 55. **We/Our/Us/Insurer** means Max Bupa Health Insurance Company Limited

Def. 56. **You/Your/Policyholder** means the person named in the Schedule of Insurance Certificate who has concluded this Policy with Us**.**

Any reference to any statute shall be deemed to refer to any replacement or amendment to that statute.

Annexure I – List of Insurance Ombudsmen

Office of the Ombudsman	Name of the Ombudsman	Contact Details	Areas of Jurisdiction
AHMEDABAD		Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@gbic.co.in	Gujarat , Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Shri. M. Parshad	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@gbic.co.in	Karnataka
BHOPAL	Shri Raj Kumar Srivastava	Insurance Ombudsman, Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, M alviya Nagar, Opp. Airtel, Near New Market, BHOPAL-462 023. Tel.:- 0755-2769201/2769202 Fax : 0755-2769203 Email: bimalokpal.bhopal@gbic.co.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Shri. B. N. Mishra	Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest park Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.co.in	Orissa
CHANDIGARH		Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@gbic.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir , Chandigarh
CHENNAI	Shri Virender Kumar	Insurance Ombudsman, Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@gbic.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)

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

Office of the Ombudsman	Name of the Ombudsman	Contact Details	Areas of Jurisdiction
LUCKNOW	Shri. N. P. Bhagat	Insurance Ombudsman, Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@gbic.co.in	Districts of Uttar Pradesh: Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, 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	Shri A.K.Dasgupta	Insurance Ombudsman, Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@gbic.co.in	Goa, Mumbai metropolitan region excluding Navi Mumbai & Thane
NOIDA	Shri Ajesh Kumar	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15 Distt: Gautam Budh Nagar, UP – 201301 Tel: 0120-2514250/2514251/2514253 Email: bimalokpal.noida@gbic.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA	Shri Sadasiv Mishra	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800006 Tel: 0612-2680952 Email: bimalokpal.patna@gbic.co.in	Bihar, Jharkhand.
PUNE	Shri. A. K. Sahoo	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 32341320 Email: bimalokpal.pune@gbic.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

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

Tel.: 022 - 26106889 / 671 / 980 **Fax:** 022 - 26106949
Email: inscoun@gbic.co.in
Smt. Ramma Bhasin, Secretary General
Shri. Y.R. Raigar, Secretary

Annexure II

Health Checkup

1 Complete Blood Count and Erythrocyte Sedimentation Rate (ESR) Test
2 Urine Routine and Microscopic
3 Fasting Blood Sugar Test and Post Prandial (lunch)
4 Lipid Profile
5 ECG
6 Chest X ray
7 Blood Test for average plasma sugar concentration in past 90 days (Hba1c)
8 Ultrasound whole abdomen
9 Liver Function Test (LFT)
10 Kidney Function Test (KFT)
11 Hepatitis B surface antigen (HbsAg or Australia Antigen Test)
12 Tread Mill Test (TMT) or Stress Test
13 Thyroid Function Test (TFT)
14 Prostrate Exam (males only)
15 Mammography (females only)
16 HIV
17 Blood grouping and Rh factor
18 Uric Acid
19 Pap Smear for Cervix (females)
20 Pulmonary Function Test (PFT)

Annexure III

Sr	Illness/Condition	Sub-limit (in Rs)		
		Option A	**Option B**	**Option C**
1	Appendicitis	30,000	25,000	20,000
2	Cataract (per eye)	20,000	15,000	10,000
3	Gall bladder stones	30,000	25,000	20,000
4	Hernia (per side)	30,000	25,000	20,000
5	Hydrocoele	20,000	15,000	10,000
6	Hysterectomy	50,000	30,000	20,000
7	Joint Replacement	120,000	100,000	80,000
8	Piles	25,000	20,000	15,000
9	Kidney Stones including DJ stent removal	40,000	30,000	15,000
10	Ailments or procedures related to ischemic heart disease	150,000	125,000	100,000

Annexure IV

List of Generally excluded in Hospitalisation Policy		
SNO	**List of Expenses Generally Excluded ("Non-Medical")in Hospital Indemnity Policy -**	**SUGGESTIONS**
TOILETRIES/COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS		
1	HAIR REMOVAL CREAM	Not Payable
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BRUSH	Not Payable
8	COSY TOWEL	Not Payable
9	HAND WASH	Not Payable
10	M01STUR1SER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable
15	BELTS/ BRACES	Essential and may be paid specifically for cases who have undergone surgery of thorcic or lumbar spine.
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable
18	CAPS	Not Payable
19	COLD PACK/HOT PACK	Not Payable
20	CARRY BAGS	Not Payable
21	CRADLE CHARGES	Not Payable
22	COMB	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25	EYE PAD	Not Payable
26	EYE SHEILD	Not Payable
27	EMAIL / INTERNET CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	Not Payable

29	FOOT COVER	Not Payable
30	GOWN	Not Payable
31	LEGGINGS	Essential in bariatric and varicose vein surgery and should be considered for these conditions where surgery itself is payable.
32	LAUNDRY CHARGES	Not Payable
33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SANITARY PAD	Not Payable
36	SLIPPERS	Not Payable
37	TELEPHONE CHARGES	Not Payable
38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Not Payable
40	TOOTH BRUSH	Not Payable
41	GUEST SERVICES	Not Payable
42	BED PAN	Not Payable
43	BED UNDER PAD CHARGES	Not Payable
44	CAMERA COVER	Not Payable
45	CLINIPLAST	Not Payable
46	CREPE BANDAGE	Not Payable/ Payable by the patient
47	CURAPORE	Not Payable
48	DIAPER OF ANY TYPE	Not Payable
49	DVD, CD CHARGES	Not Payable (However if CD is specifically sought by Insurer/T PA then payable)
50	EYELET COLLAR	Not Payable
51	FACE MASK	Not Payable
52	FLEXI MASK	Not Payable
53	GAUSE SOFT	Not Payable
54	GAUZE	Not Payable
55	HAND HOLDER	Not Payable
56	HANSAPLAST/ADHESIVE BANDAGES	Not Payable
57	INFANT FOOD	Not Payable
58	SLINGS	Reasonable costs for one sling in case of upper arm fractures should be considered
ITEMS SPECIFIC ALL Y EXCLUDED IN THE POLICIES		
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Exclusion in policy unless otherwise specified
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Exclusion in policy unless otherwise specified
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Exclusion in policy unless otherwise specified
62	HORMONE REPLACEMENT THERAPY	Exclusion in policy unless otherwise specified
63	HOME VISIT CHARGES	Exclusion in policy unless otherwise specified

64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Exclusion in policy unless otherwise specified
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	Exclusion in policy unless otherwise specified
66	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	Exclusion in policy unless otherwise specified
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Exclusion in policy unless otherwise specified
68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Exclusion in policy unless otherwise specified
69	DONOR SCREENING CHARGES	Exclusion in policy unless otherwise specified
70	ADMISSION/REGISTRATION CHARGES	Exclusion in policy unless otherwise specified
71	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Exclusion in policy unless otherwise specified
72	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not payable - Exclusion in policy unless otherwise specified
73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Not payable as per HIV/AIDS exclusion
74	STEM CELL IMPLANTATION/ SURGERY and storage	Not Payable except Bone Marrow Transplantation where covered by policy
ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS		
75	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not payable separately
76	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of Instruments not payable.
77	MICROSCOPE COVER	Payable under OT Charges, not payable separately
78	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT Charges, not payable separately
79	SURGICAL DRILL	Payable under OT Charges, not payable separately
80	EYE KIT	Payable under OT Charges, not payable separately
81	EYE DRAPE	Payable under OT Charges, not payable separately
82	X-RAY FILM	Payable under Radiology Charge s, not as consumable

83	SPUTUM CUP	Payable under Investigation Charges, not as consumable
84	BOYLES APPARATUS CHARGES	Part of OT Charges, not separately
85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
86	Antiseptic or disinfectant lotions	Not Payable -Part of Dressing Charges
87	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES,SYRINGES	Not Payable -Part of Dressing Charges
88	COTTON	Not Payable -Part of Dressing Charges
89	COTTON BANDAGE	Not Payable -Part of Dressing Charges
90	MICROPORE/ SURGICAL TAPE	Not Payable-Payable by the patient when prescribed , otherwise included as Dressing Charges
91	BLADE	Not Payable
92	APRON	Not Payable -Part of Hospital Services/Disposable linen to be part of OT/ICU charges
93	TORNIQUET	Not Payable (service is charged by hospitals, consumables cannot be separately charged)
94	ORTHOBUNDLE, GYNAEC BUNDLE	Part of Dressing Charges
95	URINE CONTAINER	Not Payable
ELEMENTS OF ROOM CHARGE		
96	LUXURY TAX	Actual tax levied by government is payable .Part of room charge for sublimits
97	HVAC	Part of room charge not payable separately
98	HOUSE KEEPING CHARGES	Part of room charge not payable separately
99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
100	TELEVISION & AIR CONDITIONER CHARGES	Payable under room charges not if separately levied
101	SURCHARGES	Part of room charge not payable separately
102	ATTENDANT CHARGES	Not Payable - P art of Room Charges
103	IM IV INJECTION CHARGES	Part of nursing charges, not payable
104	CLEAN SHEET ^	Part of Laundry/Housekeeping not payable separately
105	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
106	BLANKET/WARMER BLANKET ADMINISTRATIVE OR NON-MEDICAL CHARGES	Not Payable- part of room charges
107	ADMISSION KIT	Not Payable
108	BIRTH CERTIFICATE	Not Payable

109	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
110	CERTIFICATE CHARGES	Not Payable
111	COURIER CHARGES	Not Payable
112	CONVENYANCE CHARGES	Not Payable
113	DIABETIC CHART CHARGES	Not Payable
114	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
115	DISCHARGE PROCEDURE CHARGES	Not Payable
116	DAILY CHART CHARGES	Not Payable
117	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
118	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
119	FILE OPENING CHARGES	Not Payable
120	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
121	MEDICAL CERTIFICATE	Not Payable
122	MAINTENANCE CHARGES	Not Payable
123	MEDICAL RECORDS	Not Payable
124	PREPARATION CHARGES	Not Payable
125	PHOTOCOPIES CHARGES	Not Payable
126	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
127	WASHING CHARGES	Not Payable
128	MEDICINE BOX	Not Payable
129	MORTUARY CHARGES	Payable upto 24 hrs, shifting charges not payable
130	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
EXTERNAL DURABLE DEVICES		
131	WALKING AIDS CHARGES	Not Payable
132	BIPAP MACHINE	Not Payable
133	COMMODE	Not Payable
134	CPAP/ CAPD EQUIPMENTS Device	Not Payable
135	INFUSION PUMP - COST Device	Not Payable
136	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
137	PULSEOXYMETER CHARGES Device	Not Payable
138	SPACER	Not Payable
139	SPIROMETRE Device	Not Payable
140	SP0 2PROB E	Not Payable
141	NEBULIZER KIT	Not Payable

142	STEAM INHALER	Not Payable
143	ARMSLING	Not Payable
144	THERMOMETER	Not Payable (paid by patient)
145	CERVICAL COLLAR	Not Payable
146	SPLINT	Not Payable
147	DIABETIC FOOT WEAR	Not Payable
148	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
149	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
150	LUMBOSACRAL BELT	Essential and should be paid specifically for cases who have undergone surgery of lumbar spine.
151	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia /quadriplegia for any reason and at reasonable cost of approximately Rs 200/ day
152	AMBULANCE COLLAR	Not Payable
153	AMBULANCE EQUIPMENT	Not Payable
154	MICROSHEILD	Not Payable
155	ABDOMINAL BINDER	Essential and should be paid in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction , liver transplant etc.
ITEMS PA YABLE IF SUPPORTED BY A PRESCRIPTION		
156	BETADINE \ HYDROGEN PEROXIDE\SPIRIT\DISINFECTANTS ETC	May be payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital
157	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Post hospitalisation nursing charges not Payable
158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGESDIET CHARGES	Patient Diet provided by hospital is payable
159	SUGAR FREE Tablets	Payable -Sugar free variants of admissible medicines are not excluded
160	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	Payable when prescribed
161	Digestion gels	Payable when prescribed
162	ECG ELECTRODES	Upto 5 electrodes are required for every case visiting OT o r ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable.
163	GLOVES Sterilized Gloves	payable /unsterilized gloves not payable

164	HIV KIT	Payable - payable Preoperative screening
165	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
166	LOZENGES	Payable when prescribed
167	MOUTH PAINT	Payable when prescribed
168	NEBULISATION KIT	If used during hospitalisation is payable reasonably
169	NOVARAPID	Payable when prescribed
170	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
171	ZYTEE GEL	Payable when prescribed
172	VACCINATION CHARGES	Routine Vaccination not Payable / Post Bite Vaccination Payable
PART OF HOSPITAL'S OWN COSTS AND NOT PA YA BLE		
173	AHD	Not Payable - Part of Hospital's internal Cost
174	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
175	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost
OTHERS		
176	VACCINE CHARGES FOR BABY	Payable as per plan
177	AESTHETIC TREATMENT / SURGERY	Not Payable
178	TPA CHARGES	Not Payable
179	VISCO BELT CHARGES	Not Payable
180	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT,ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
181	EXAMINATION GLOVES	Not Payable
182	KIDNEY TRAY	Not Payable
183	MASK	Not Payable
184	OUNCE GLASS	Not Payable
185	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable, except for telemedicine consultations w here covered by policy
186	186 OXYGEN MASK	Not Payable
187	PAPER GLOVES	Not Payable
188	PELVIC TRACTION BELT	Should be payable in case of PIVI) requiring traction as this is generally not reused
189	REFERAL DOCTOR'S FEES	Not Payable
190	ACCU CHECK (Glucometery/ Strips)	Not payable pre hospitilasation o r post hospitalisation / Reports and Charts required / Device not payable
191	PAN CAN	Not Payable
192	SOFNET	Not Payable
193	TROLLY COVER	Not Payable
194	UROMETER, URINE JUG	Not Payable

195	AMBULANCE	Payable-Ambulance from home to hospital or inter hospital shifts is payable/ RTA as specific requirement is payable
196	TEGADERM / VASOFIX SAFETY	Payable - maximum o f 3 in 48 hrs an d then 1 in 24 hrs
197	URINE BAG P	Payable where medically necessary till a reasonable cost - maximum 1 per 24 hrs
198	SOFTOVAC	Not Payable
199	STOCKINGS	Essential for case like CABG etc. where it should be paid.