

Heartbeat – Prospectus cum Sales Literature

'Heartbeat' - Start a healthy relationship

'Heartbeat' provides health insurance coverage for you and your family. It not only gives you the flexibility to choose the right cover for your needs, but also gives you the option to choose from a varied list of benefits and rewards as per your requirements. Apart from offering you this health insurance cover, we are also committed to provide you with quality services when you need it the most.

Why Niva Bupa is the healthier Health Insurance for you and your family:

- You talk to us directly, not through any third parties. We will be there for you when you need us. Because you should concentrate on getting healthier, not chasing your claims.
- We are with you at every step of the way in your life. For a happy occasion like the delivery of your baby, to your child's vaccinations, or at other times when there is an illness in the family- we have it covered. New born babies are automatically covered till the end of the policy year.
- You can access our cashless facility at the hospitals of your city which are part of our partner network.
- To build a relationship that lasts a lifetime, we make all efforts to understand your health profile during enrollment, so that when you need us, we can provide speedy and efficient support.
- We cover families across life stages – from newborns to senior citizens of any age, covering up to 19 relationships in one policy.
- We assure you renewability of your policy for lifetime, if you pay renewal premium within the grace period of 30 days of expiry of your previous policy. You should renew on or before the renewal date of the policy to ensure you have continued medical insurance cover even during the grace period.
- As with all health insurance policies, you may save tax under Section 80D of the Income Tax Act when you buy a Niva Bupa health insurance policy. (Tax benefits are subject to changes in the tax laws, so please consult your tax advisor for more details)

1. Policy Design

- 'Heartbeat' product can be issued to an individual customer or to a family with up to 4 children (referred to as a 'family floater' policy) or extended family (referred to as a 'family first' policy).
- The family floater policy is available in any of the following combinations:
 - 1 Adult + 1 Child
 - 1 Adult + 2 Children
 - 1 Adult + 3 Children
 - 1 Adult + 4 Children
 - 2 Adults
 - 2 Adults + 1 Child
 - 2 Adults + 2 Children
 - 2 Adults + 3 Children
 - 2 Adults + 4 Children

- The family includes spouse and dependent children and can comprise up to a unit of 6 insured persons of which up to 4 can be children.
- The premium for family floater policies depends on the age of the eldest insured person.
- The range of entry ages for Adults under the policy is from 18 years (last birthday) to 65 years (last birthday). The range of entry ages for dependent children is from 91 days to 21 years under a family floater policy.
Please note if any Insured Person who is a child and has completed 22 years at the time of Renewal, then such Insured Person will have to take a separate policy based on Our underwriting guidelines, as he/she will no longer be eligible to be covered under a Family Floater Policy as a dependent child. In such cases, the credit of the Waiting Periods served under the Policy will be passed on to the separate policy taken by such Insured Person.
- The Family First may be available in any of the below relationships with the Proposer
 - a. Legally married spouse as long as he or she continues to be married to You; b. Son; c. Daughter-in-law as long as Your son continues to be married to Your Daughter-in-law; d. Daughter; e. Son-in-Law as long as Your daughter continues to be married to Your Son-in-law; f. Father; g. Mother; h. Father-in-law as long as Your spouse continues to be married to You; i. Mother-in-law as long as Your spouse continues to be married to You.; j. Grandfather; k. Grandmother; l. Grandson; m. Granddaughter; n. Brother; o. Sister; p. Sister-in-law; q. Brother-in-law; r. Nephew; s. Niece.
- The premium for Family First policies depends on the individual age of each insured customer in the Extended Family.
- **Term discount:** The default policy term for all plans is one year. Two year policy term option is also available under the product. The level of discount is as below:
 - **2 year term:** 12.5% on the premium for second policy year
- **Favourable Claim Experience Discount:**
 - You will get a discount on your policy of up to 42% on the renewal premium basis the value of the claims paid in a policy year.
 - A Trend and Level Score will be allotted to you each year.
 - **Trend Score:** A score for the policy basis the claim amount paid in the policy year.
 - **Level Score:** A calculated score at policy level which will determine the discount on the renewal premium.

Note: For Renewal policies, for the first time only, the claim experience of up to last 5 years will be considered to offer the discount.

Level Grid

Level	-3	-2	-1	0	1	2	3	4	5	6	7	8	9	10
Discount	42%	36%	33%	30%	27%	24%	21%	18%	15%	12%	9%	6%	3%	0%

Level 0: When customer takes out a policy with Niva Bupa, they start at level 0 with 30% Discount

Level -3 is the highest level a customer can be at with 42% discount. And Level 10 can be the lowest level a customer can reach, with 0% discount.

The movement between levels will depend on following Trend Grid:

Customer Claim Scenario	Moement During Renewal
0 or No Claim	Moves up the grid by 1 level
Claim up to INR 40,000	Stays in the same level
More than INR 40,000- and up to INR 75,000	Moves down the grid 1 level
More than INR 75,000- and up to INR 1,50,000	Moves down the grid by 2 levels
More than INR 1,50,000	Moves down the gird by 3 levels

You can also choose an optional aggregate annual deductible (top-up cover) along with Silver plan for Individual and Family Floater variants.

- Additional optional co-payment of 10% or 20% is allowed in the product. Insured can avail discount equivalent to the co-payment chosen.
- Silver Individual and Family Floater plan is available for renewal policyholder's only.
- The premium rates for the plans offered are annexed hereto with the prospectus as annexure VI.

2. Coverage Options

- **In case of Individual or Family Floater** - range from Rs. 2 lacs (for renewal policy) / Rs. 5 lacs (for new policy) to Rs. 1 Crore depending on the plan you choose. The details of the plans are available in the product benefits table.

- **In case of Family First:**

Flexible Base Sum Insured per person (one amount chosen for all family members) as well as a floater Sum Insured that can be utilized once the Base Sum Insured per person is consumed. This provides flexibility for families to decide their optimal cover:

Choose individual cover from options given below:

- Base Sum Insured Options for Silver are - Rs 1L, 2L, Rs 3L, Rs 4L, and Rs 5L
- Base Sum Insured Options for Gold - Rs 1L, Rs 2L, Rs 3L, Rs 4L, Rs 5L, Rs10L and Rs 15L
- Base Sum Insured Options for Platinum- Rs5L, 10L and Rs 15L

Choose family floater cover from options given below:

Family Floater Sum Insured

- For Silver – Rs. 3L, Rs. 4L, Rs. 5L, Rs. 10L and Rs. 15L
- For Gold – Rs. 3L, Rs. 4L, Rs. 5L, Rs. 10L, Rs. 15L, Rs.20L, Rs.30L and Rs.50L
- For Platinum- Rs. 15L, Rs 20L, Rs. 30L and Rs. 50L

In case of Individual Policy, Sum Insured means the total of the Base Sum Insured, Loyalty Additions and re-fill amount, which is Our maximum, total and cumulative liability for any and all claims during the Policy Year in respect of the Insured Person.

In case of Family Floater Policy, Sum Insured means the total of the Base Sum Insured, Loyalty Additions and re-fill amount, which is Our maximum, total and cumulative liability for any and all claims during the Policy Year in respect of all Insured Persons.

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

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

Illustration for Family First Policy:

Family Members	Age	Base Sum Insured (in lacs)
Father	66	2
Mother	65	2
Son	40	2
Daughter-in law	39	2
Base Sum Insured for all Insured Persons taken together		8 lacs

<i>Family Floater Sum Insured</i>	<i>5 lacs</i>
Sum Insured	13 lacs

The details of the plans are available in the product benefits table for Family First Policy.

3. Product Features and Benefits – Key Highlights

The benefits available under this Policy are described below.

- a. The Policy covers Reasonable and Customary Charges incurred towards medical treatment taken by the Insured Person during the Policy Period for an Illness, Injury or condition as described in the sections below and contracted or sustained during the Policy Period. The benefits listed in the sections below will be payable subject to the terms, conditions and exclusions of this Policy and the availability of the Sum Insured and any sub-limits for the benefit as maybe specified in the Policy Schedule.
- b. All the benefits (including optional benefits) which are available under the Policy along with the respective limits / amounts applicable based on the Sum Insured have been summarized in the Product Benefit Table in Annexure II.
- c. The expenses that are not covered or subsumed into room charges / procedure charges / costs of treatment are mentioned in Annexure VI.
- d. All claims under the Policy must be made in accordance with the process defined under Section 8 (Claim Process & Requirements).
- e. All claims paid under any benefit except for those admitted under Section 3.11 (Health Check-up), Section 3.13 (Pharmacy and diagnostic services), Section 3.16 (Emergency Assistance Services except Medical Evacuation), Section 3.18 (Second Medical Opinion), Section 4.1 (Personal Accident Cover), Section 4.2 (Critical Illness Cover), Section 4.3 (e-Consultation), Section 4.4 (Premium Waiver) and Section 4.5 (Hospital Cash) shall reduce the Sum Insured for the Policy Year in which the Insured Event in relation to which the claim is made has been occurred, unless otherwise specified in the respective section. Thereafter only the balance Sum Insured after payment of claim amounts admitted shall be available for future claims arising in that Policy Year.

3.1. Inpatient Care

What is covered:

We will indemnify the Medical Expenses incurred for one or more of the following due to the Insured Person’s Hospitalization during the Policy Period following an Illness or Injury:

- a. Room Rent: Room boarding and nursing charges during Hospitalization as charged by the Hospital where the Insured Person availed medical treatment;
- b. Medical Practitioners’ fees, excluding any charges or fees for Standby Services;
- c. Investigative tests or diagnostic procedures directly related to the Insured Event which led to the current Hospitalization;
- d. Medicines, drugs as prescribed by the treating Medical Practitioner related to the Insured Event that led to the current Hospitalization;
- e. Intravenous fluids, blood transfusion, injection administration charges allowable consumables, and/or enteral feedings.
- f. Operation theatre charges;
- g. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery;
- h. Intensive Care Unit Charges.

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

- a. The Hospitalization is for Medically Necessary Treatment and advised in writing by a Medical Practitioner.
- b. If the Insured Person is admitted in a Hospital room where the room category opted or Room Rent incurred is higher than the eligibility as specified in the Policy Schedule, then We shall be liable to pay only a pro-rated portion of the total Associated Medical Expenses (including surcharge or taxes thereon) as per the following formula:
(Eligible Room Rent limit / Room Rent actually incurred) * total Associated Medical Expenses

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

- c. We will pay the visiting fees or consultation charges for any Medical Practitioner visiting the Insured Person only if:
 - i. The Medical Practitioner’s treatment or advice has been specifically sought by the Hospital; and
 - ii. The visiting fees or consultation charges are included in the Hospital’s bill

3.2. Pre-hospitalization Medical Expenses

What is covered:

We will indemnify on Reimbursement basis only, the Insured Person's Pre-hospitalization Medical Expenses incurred in respect of an Illness or Injury.

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

- a. We have accepted a claim under Section 3.1 (Inpatient Care) or Section 3.4 (Day Care Treatment) or Section 3.5 (Domiciliary Hospitalization) or Section 3.6 (Alternative Treatments), or Section 3.24 (Modern Treatments).
- b. Pre-hospitalization Medical Expenses are incurred for the same condition for which We have accepted the Inpatient Care or Day Care Treatment or Domiciliary Hospitalization or Alternative Treatments or Modern Treatments claim.
- c. The expenses are incurred after the inception of the First Policy with Us. If any portion of these expenses is incurred before the inception of the First Policy with Us, then We shall be liable only for those expenses incurred after the commencement date of the First Policy, irrespective of the initial waiting period.
- d. Pre-hospitalization Medical Expenses incurred on physiotherapy will also be payable provided that such physiotherapy is prescribed in writing by the treating Medical Practitioner as Medically Necessary Treatment and is directly related to the same condition that led to Hospitalization.
- e. Any claim admitted under this Section 3.2 shall reduce the Sum Insured for the Policy Year in which In-patient Care or Day Care Treatment or Domiciliary Hospitalization or Alternative Treatments or Modern Treatments claim has been incurred.

Sub-limit:

- a. We will pay above mentioned Pre-hospitalization Medical Expenses only for period up to 60 days immediately preceding the Insured Person's admission for Inpatient Care or Day Care Treatment or Domiciliary Hospitalization or Alternative Treatments or Modern Treatments.

3.3. Post-hospitalization Medical Expenses

What is covered:

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

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

- a. We have accepted a claim under Section 3.1 (Inpatient Care) or Section 3.4 (Day Care Treatment) or Section 3.5 (Domiciliary Hospitalization) or Section 3.6 (Alternative Treatments) or Section 3.24 (Modern Treatments).
- b. Post-hospitalization Medical Expenses are incurred for the same condition for which We have accepted the Inpatient Care or Day Care Treatment or Domiciliary Hospitalization or Alternative Treatments or Modern Treatments claim.
- c. The expenses incurred shall be as advised in writing by the treating Medical Practitioner.
- d. Post-hospitalization Medical Expenses incurred on physiotherapy will also be payable provided that such physiotherapy is prescribed in writing by the treating Medical Practitioner as Medically Necessary Treatment and is directly related to the same condition that led to Hospitalization.
- e. Any claim admitted under this Section 3.3 shall reduce the Sum Insured for the Policy Year in which In-patient Care or Day Care Treatment or Domiciliary Hospitalization or Alternative Treatments or Modern Treatments claim has been incurred.

Sub-limit:

- a. We will pay Post-hospitalization Medical Expenses only for up to 90 days immediately following the Insured Person's discharge from Hospital or Day Care Treatment or Domiciliary Hospitalization or Alternative Treatments or Modern Treatments.

3.4. Day Care Treatment

What is covered:

We will indemnify the Medical Expenses incurred on the Insured Person's Day Care Treatment during the Policy Period following an Illness or Injury. List of Day Care Treatments which are covered under the Policy are provided in Annexure III.

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

- a. The Day Care Treatment is advised in writing by a Medical Practitioner as Medically Necessary Treatment.

- b. Only those Day Care Treatments are covered that are mentioned under list of Day Care Treatments under Annexure III.
- c. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with Sections 3.2 and 3.3 above.

What is not covered:

OPD Treatment and Diagnostic Services costs are not covered under this benefit.

3.5. Domiciliary Hospitalization

What is covered:

We will indemnify on Reimbursement basis only, the Medical Expenses incurred for the Insured Person's Domiciliary Hospitalization during the Policy Period following an Illness or Injury.

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

- a. The Domiciliary Hospitalization continues for at least 3 consecutive days in which case We will make payment under this benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalization;
- b. The treating Medical Practitioner confirms in writing that the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital OR the Insured Person satisfies Us that a Hospital bed was unavailable.
- c. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with Sections 3.2 and 3.3 above.

3.6. Alternative Treatments

What is covered:

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

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

- a. The treatment should be taken in AYUSH Hospital.
- b. Pre-hospitalization Medical Expenses incurred for up to 60 days immediately preceding the Insured Person's admission and Post-hospitalization Medical Expenses incurred for up to 90 days immediately following the Insured Person's discharge will also be indemnified under this benefit in accordance with Sections 3.2 and 3.3 above, provided that these Medical Expenses relate only to Alternative Treatments and not Allopathy.
- c. Section 7.27 of the Permanent Exclusions (other than for Yoga) shall not apply to the extent this benefit is applicable.

3.7. Living Organ Donor Transplant

What is covered:

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

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

- a. The donation conforms to the Transplantation of Human Organs Act 1994 and any amendments thereafter and the organ is for the use of the Insured Person.
- b. The organ transplant is certified in writing by a Medical Practitioner as Medically Necessary Treatment for the Insured Person.
- c. We have accepted the recipient Insured Person's claim under Section 3.1 (Inpatient Care).

What is not covered:

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

- f. Any other medical treatment or complication in respect of the donor, which is directly or indirectly consequence to harvesting.

3.8. Emergency Ambulance

What is covered:

We will indemnify the costs incurred, on transportation of the Insured Person by road Ambulance to a Hospital for treatment in an Emergency following an Illness or Injury.

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

- a. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is injured or is ill to a Hospital where appropriate medical treatment can be obtained or;
- b. The medical condition of the Insured Person requires immediate ambulance services from the existing Hospital to another Hospital with advanced facilities as advised by the treating Medical Practitioner for management of the current Hospitalization.
- c. This benefit is available for only one transfer per Hospitalization.
- d. The ambulance service shall be offered by a healthcare or ambulance Service Provider.
- e. We have accepted a claim under Section 3.1 (Inpatient Care) above.
- f. We will cover expenses up to the amount specified in Your Policy Schedule.

What is not covered:

The Insured Person's transfer to any Hospital or diagnostic centre for evaluation purposes only.

3.9. Maternity Benefit

What is covered:

We will indemnify the Maternity Expenses incurred during the Policy Period.

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

- a. This benefit is available only if:
 - i. The female Insured Person of Age 18 years or above is covered under a Family First Policy; or
 - ii. Both the Insured Person and his / her legally married spouse are covered under a Family Floater Policy.
- b. This Benefit cannot be availed under an Individual Policy.
- c. The female Insured Person in respect of whom a claim for Maternity Benefits is made must have been covered as an Insured Person for a period of 24 months of continuous coverage since the inception of the First Policy, with maternity as a benefit, with Us.
- d. For the purposes of this benefit, We shall consider any eligibility period for maternity benefits served by the Insured Person under any previous policy with Us.
- e. The Maternity Expenses incurred are Reasonable and Customary Charges.
- f. The Maternity Benefit may be claimed under the Policy in respect of eligible Insured Person(s) only twice during the lifetime of the Policy including any Renewal thereafter for the delivery of a child or Medically Necessary and lawful termination of pregnancy up to maximum 2 pregnancies or terminations.
- g. Any treatment related to the complication of pregnancy or termination will be treated within the maternity sub limits.
- h. On Renewal or incase of internal Portability, if an enhanced sub-limit is applicable under this benefit, 24 months of continuous coverage (as per Section 3.9.c) would apply afresh to the extent of the increased benefit amount.
- i. Clause 7.14, 7.15 under Permanent Exclusions is superseded to the extent covered under this Benefit.

What is not covered:

- a. Expenses incurred in respect of the harvesting and storage of stem cells for any purposes whatsoever;
- b. Medical Expenses for ectopic pregnancy will be covered under the Section 3.1 (Inpatient Care) and shall not fall under the Maternity Benefit.
- c. Sections 3.2 (Pre-hospitalization Medical Expenses) and Section 3.3 (Post- hospitalization Medical Expenses) are not payable under this benefit.
- d. Any expenses to manage complications arising from or relating to pregnancy or termination of pregnancy within 24 months from the inception of the First Policy with Us.
- e. Pre-natal and post-natal Medical Expenses.

3.10. New Born Baby

What is covered:

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

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

- a. All the terms and conditions mentioned in Section 3.9 (Maternity Benefit) shall apply to this benefit as well.
- b. The New Born Baby should be added as an endorsement within 90 days from date of delivery
- c. We will indemnify the Reasonable and Customary Charges for Medical Expenses incurred for the below vaccination of the New Born Baby till the New Born Baby completes one year from his/her birth.

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

- d. If the Policy expires before the New Born Baby has completed one year, then Medical Expenses for balance vaccination shall not be covered and will be covered only if the Policy is Renewed with the New Born Baby as an Insured Person and not otherwise.
- e. On the expiry of the Policy Year We will cover the baby as an Insured Person under the Policy on request of the Proposer, subject to Our underwriting policy and payment of the applicable additional premium.

3.11. Health Check-up

What is covered:

The Insured Person may avail a health check-up, only for Diagnostic Tests, up to a sub-limit as per the Plan applicable to the Insured Person as specified in the Product Benefits Table.

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

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

- a. Health check-up will be available on Cashless Facility basis only and will be arranged at Our empanelled Service Providers.

What is not covered:

Any unutilized test or amount cannot be carried forward to the next Policy Year.

3.12. Re-fill Benefit

What is covered:

If the Base Sum Insured and increased Sum Insured under Loyalty Additions (Section 3.14) (if any) has been partially or completely exhausted due to claims paid or accepted as payable for any Illness / Injury during the Policy Year under Section 3.1 or Section 3.4 or Section 3.5 or Section 3.6 or Section 3.7 or Section 3.24, then We will provide an additional re-fill amount of maximum up to 100% of the Base Sum Insured.

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

- a. The re-fill amount shall be utilized only for subsequent claims under Section 3.1 (In-patient Care) or Section 3.4 (Day Care Treatment) or Section 3.5 (Domiciliary Hospitalization) or Section 3.6 (Alternative Treatments) or Section 3.7 (Living Organ Donor Transplant) or Section 3.24 (Modern Treatments) arising in that Policy Year for any or all Insured Person(s).
- b. We will provide a re-fill amount only once in a Policy Year.
- c. For Family Floater Policies, the re-fill amount will be available on a floater basis to all Insured Persons in that Policy Year.

What is not covered:

- a. If the re-fill amount is not utilized in whole or in part in a Policy Year, it cannot be carried forward to any extent in any subsequent Policy Year.
- b. This benefit is not available under Family First Policy.

3.13. Pharmacy and Diagnostic Services

What is covered:

You may purchase medicines or avail diagnostic services from Our Service Provider through Our website or mobile application.

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

- a. The cost for the purchase of the medicines or for availing diagnostic services shall be borne by You.
- b. Further it is made clear that purchase of medicines from Our Service Provider is Your absolute discretion and choice.

3.14. Loyalty Additions

What is covered:

- a. For an Individual Policy or Family Floater Policy, if the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year Policy Period respectively (if applicable), We will provide a Cumulative Bonus by increasing the Sum Insured applicable under the Policy by 10% of the Base Sum Insured of the immediately preceding Policy Year subject to a maximum of a percentage as specified in the Policy Schedule. There will be no change in the sub-limits applicable to various benefits due to increase in Sum Insured under this benefit.
- b. For a Family First Policy, if the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year Policy Period respectively (if applicable), We will provide a Cumulative Bonus by increasing the Sum Insured applicable under the Policy by 10% of the Base Sum Insured of the immediately preceding Policy Year of each individual Insured Person only subject to a maximum of a percentage as specified in the Policy Schedule. The increase shall not apply to the Floater Sum Insured stated in the Policy Schedule as applicable under the Policy. There will be no change in the sub-limits applicable to any benefit due to increase in Sum Insured under this benefit.

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

- a. If the Insured Person in the expiring Policy is covered under an Individual Policy and has an accumulated Cumulative Bonus in the expiring Policy under this benefit, and such expiring Policy is Renewed with Us on a Family Floater Policy, then We will provide the credit for the accumulated Cumulative Bonus to the Family Floater Policy.
- b. If the Insured Person in the expiring Policy is covered under an Individual Policy and has an accumulated Cumulative Bonus in the expiring Policy under this benefit, and such expiring Policy is Renewed with Us on a Family First Policy, then the accumulated Cumulative Bonus to be carried forward for credit in the Renewing Policy would be the accumulated Cumulative Bonus for that Insured Person only.
- c. If the Insured Persons in the expiring Policy are covered under a Family First Policy and have an accumulated Cumulative Bonus for each Insured Person in the expiring Policy under this benefit, and such expiring Policy is Renewed with Us on a Family Floater Policy with same or higher Base Sum Insured, then the accumulated Cumulative Bonus to be carried forward for credit in the Renewing Policy would be the least of the accumulated Cumulative Bonus amongst all the Insured Persons.
- d. If the Insured Persons in the expiring Policy are covered under a Family First Policy and have an accumulated Cumulative Bonus for each Insured Person in the expiring Policy under this benefit, and such expiring Policy is Renewed with Us on an

- Individual Policy with same or higher Base Sum Insured, then the accumulated Cumulative Bonus to be carried forward for credit in the Renewing Policy would be the accumulated Cumulative Bonus for that Insured Person.
- e. If the Insured Persons in the expiring Policy are covered on a Family Floater Policy and such Insured Persons Renew their expiring Policy with Us by splitting the Floater Sum Insured stated in the Policy Schedule in to two or more floater / individual / Family First Policy, then We will provide the credit of the accumulated Cumulative Bonus to the split Policy reduced proportionately.
 - f. If the Insured Persons covered on a Family Floater Policy are reduced at the time of Renewal, the applicable accumulated Cumulative Bonus shall also be reduced proportionately.
 - g. In case the Base Sum Insured under the Policy is reduced at the time of Renewal, the applicable accumulated Cumulative Bonus shall also be reduced in proportion to the Base Sum Insured. The maximum reduction in the accumulated Cumulative Bonus shall be limited to 50% of the accumulated Cumulative Bonus. Post reduction in the Base Sum Insured and the accumulated Cumulative Bonus, if the accumulated Cumulative Bonus is equal to or more than 100% of the revised Base Sum Insured, then there will be no further increase in the accumulated Cumulative Bonus upon Renewal of such Policy.
 - h. In case the Base Sum Insured under the Policy is increased at the time of Renewal, the applicable accumulated Cumulative Bonus shall also be increased in proportion to the Base Sum Insured. The maximum increase in the accumulated Cumulative Bonus shall be limited to 50% of the accumulated Cumulative Bonus. Post increase in the Base Sum Insured and the accumulated Cumulative Bonus, if the accumulated Cumulative Bonus is equal to or more than 100% of the revised Base Sum Insured, then there will be no further increase in the accumulated Cumulative Bonus upon Renewal of such Policy.
 - i. This benefit is not applicable for Health Check-up, Pharmacy & diagnostic services, Emergency assistance services, Second Medical Opinion, Child care benefits, and any of the optional benefits (if opted for). Enhancement of Sum Insured due to Loyalty Additions benefit cannot be utilized for the aforementioned benefits.

3.15. HIV / AIDS

What is covered:

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

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

- a. The Hospitalization or Day Care Treatment is Medically Necessary and the Illness is the outcome of HIV / AIDS. This needs to be prescribed in writing by a registered Medical Practitioner.
- b. The coverage under this benefit is provided for opportunistic infections which are caused due to low immunity status in HIV / AIDS resulting in acute infections which may be bacterial, viral, fungal or parasitic.
- c. The patient should be a declared HIV positive.
- d. This benefit is provided subject to a Waiting Period of 36 months from inception of the cover with Us, with HIV / AIDS covered as a benefit, for the respective Insured Person.
- e. Pre-hospitalization Medical Expenses incurred for up to 60 days, if falling within the Policy Period, immediately preceding the Insured Person's admission and Post-hospitalization Medical Expenses incurred for up to 90 days, if falling within the Policy Period, immediately following the Insured Person's discharge will also be indemnified under this benefit.

What is not covered:

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

Sub-limit:

- a. This benefit is covered up to a limit of Rs. 50,000.
- b. Pre-hospitalization and Post-hospitalization Medical Expenses are also covered within the overall benefit sub-limit as specified above in point (a).

3.16. Emergency Assistance Services

What is covered:

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

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

Conditions - Any coverage under this section 3.16 is subject to fulfilment of following conditions:

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

What is not covered:

- a. No claims for Reimbursement of expenses incurred for services arranged by Insured/Insured Person(s) will be entertained as the coverage under this section 3.16 are on Cashless Facility basis only.
- b. Emergency assistance service will not be provided in the following instances:
 - i. Travel undertaken specifically for securing medical treatment
 - ii. Services sought outside India.
 - iii. If Emergency is a result of injuries resulting from participation in acts of war or insurrection
 - iv. Commission of unlawful act(s).
 - v. Attempt at suicide /self-inflicted injuries.
 - vi. Incidents involving the use of drugs, unless prescribed by a physician
 - vii. Transfer of the insured person from one medical facility to another medical facility of similar capabilities and providing a similar level of care
- c. We / Our Service Provider will not evacuate or repatriate an insured person in the following instances:
 - i. Without medical authorization from attending physician
 - ii. With mild lesions, simple injuries such as sprains, simple fractures, or mild sickness or similar such conditions which can be treated by local doctors and do not prevent Insured Person(s) from continuing your trip or returning home as determined by Us / Our Service Provider's consulting physician and the Insured Person's attending physician

- iii. If the Insured Person is pregnant and beyond the end of the 28th week and with respect to the child born from the pregnancy, We / Our Service Provider shall not evacuate or repatriate the Insured Person and the child who was born while the Insured Person was traveling beyond the 28th week
 - iv. With mental or nervous disorders unless hospitalized
- d. Specific exclusions:
- i. Trips exceeding 90(ninety) days from declared residence.

While assistance services are available all over India, transportation response time is directly related to the location / jurisdiction where an event occurs. We / Our Service Provider is not responsible for failing to provide services or for delays in the delivery of services caused by reasons beyond Our reasonable control, including without any limitation, strike, road traffic, the weather conditions, availability and accessibility of airports, flight conditions, availability of hyperbaric chambers, pandemics and endemics, communications systems, absence of proper travel documents or where rendering of service is limited or prohibited by local law, edict or regulation. Our / Our Service Provider's performance of any obligation here in this section 3.16 shall be waived / excused if such failure to perform is caused by an event, contingency, or circumstance beyond its reasonable control that prevents, hinders or makes impractical the performance of services. Legal actions arising hereunder shall be barred unless written notice thereof is received by Us / Our Service Provider within one (1) year from the date of event giving rise to such legal action. All consulting physicians and Our Service Provider are independent contractors and not under the control of the Company. We / Our Service Provider are not responsible or liable for any service rendered herein through professionals to You.

3.17. Mental Disorders Treatment

What is covered:

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

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

- a. Mental Disorders Treatment is only covered where patient is diagnosed by a qualified psychiatrist or a professional registered with the concerned State Authority or a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post-graduate degree (Siddha) in Sirappu Maruthuvam.
- b. The Hospitalization is for Medically Necessary Treatment.
- c. The treatment should be taken in Mental Health Establishment Hospitals, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person, where persons with mental illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person; but does not include a family residential place where a person with mental illness resides with his relatives or friend.
- d. The Insured Person in respect of whom a claim for any expenses or complications arising from Mental Illness is made must have been covered as an Insured Person for a period of 36 months of continuous coverage since the inception of the First Policy, with Mental Illness as a benefit, with Us.
- e. Pre-hospitalization Medical Expenses incurred for up to 60 days, if falling within the Policy Period, immediately preceding the Insured Person's admission and Post-hospitalization Medical Expenses incurred for up to 90 days, if falling within the Policy Period, immediately following the Insured Person's discharge will also be indemnified under this benefit.

What is not covered:

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

Prospectus Cum Sales Literature

Sub-limit:

- a. The following disorders / conditions shall be covered only up to the limit specified in the Policy Schedule. This sub-limit shall apply for all the following disorders / conditions on cumulative basis.

Disorder / Condition	Description
Severe Depression	Severe depression is characterized by a persistent feeling of sadness or a lack of interest in outside stimuli. It affects the way one feels, thinks and behaves.
Schizophrenia	Schizophrenia is mental disorder, that distorts the way a person thinks, acts, expresses emotions, perceives reality, and relates to others. Schizophrenia result in combination of hallucinations, delusions, and extremely disordered thinking and behavior that impairs daily functioning,
Bipolar Disorder	Bipolar disorder is a mental illness that brings severe high and low moods and changes in sleep, energy, thinking, and behavior. It includes periods of extreme mood swings with emotional highs and lows.
Post traumatic stress disorder	Post-traumatic stress disorder is an anxiety disorder caused by very stressful, frightening or distressing events. It includes flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event.
Eating disorder	Eating disorder is a mental condition where people experience severe disturbances in their eating behaviors and related thoughts and emotions.
Generalized anxiety disorder	Generalized Anxiety Disorder is a mental health disorder characterized by a perpetual state of worry, fear, apprehension, inability to relax.
Obsessive compulsive disorders	Obsessive-compulsive disorder is an anxiety disorder in which people have recurring, unwanted thoughts, ideas or sensations (obsessions) that make them feel driven to do something repetitively (compulsions).
Panic disorders	Panic disorder is an anxiety disorder characterized by reoccurring unexpected panic attacks with sudden periods of intense fear. It may include palpitations, sweating, shaking, shortness of breath, numbness, or a feeling that something terrible is going to happen.
Personality disorders	Personality disorder is a type of mental disorder in which people have a rigid and unhealthy pattern of thinking, functioning and behaving. It includes trouble in perceiving and relating to situations and people.
Conversion disorders	Conversion disorder is a type of mental disorder where mental or emotional distress causes physical symptoms without the existence of an actual physical condition.
Dissociative disorders	Dissociative disorders are mental disorders that involve experiencing a disconnection and lack of continuity between thoughts, memories, surroundings, actions and identity.

ICD codes for the above disorders / conditions are provided in Annexure V.

- b. Pre-hospitalization and Post-hospitalization Medical Expenses are also covered within the overall benefit sub-limit as specified above in point (a).

3.18. Second Medical Opinion

What is covered:

If the Insured Person is diagnosed with a Specified Illness as defined under Section 12.72 or is planning to undergo a planned Surgery or a Surgical Procedure for any Illness or Injury, the Insured Person can, at the Insured Person's choice, obtain a Second Medical Opinion during the Policy Period.

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

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

What is not covered:

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

3.19. Child care Benefits

What is covered:

- a. We will indemnify the Reasonable and Customary Charges, once during a Policy Period, incurred for the vaccination of the Insured Persons less than 12 years of Age.
- b. We will also cover expenses towards one consultation for nutrition and growth provided to the child during a visit for vaccination.

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

- a. The following vaccinations will be covered under this benefit:

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

3.20. Specified Illness Cover (outside the geographical boundaries of India)

What is covered:

If an Insured Person suffers a Specified Illness as defined under Section 2.73 of the policy wordings during the Policy Period, We will indemnify the Reasonable and Customary Charges for Medical Expenses of the Insured Person incurred towards treatment of that Specified Illness that would otherwise have been payable under Section 3.1 (Inpatient Care), on Cashless Facility basis only.

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

- a. The symptoms of the Specified Illness first occur or manifest itself during the Policy Period and after completion of the 90 day from the inception of the First Policy with Us.
- b. The Specified Illness is diagnosed by a Medical Practitioner within India during the Policy Period and after completion of the 90 day from the inception of the First Policy with Us.
- c. Medical treatment for the Specified Illness is taken outside India within the Policy Period but only within those regions specified in the Policy Schedule.
- d. Clause 7.24 under Permanent Exclusions is superseded to the extent covered under this Benefit.

What is not covered:

- a. Any claims for Reimbursement of the costs incurred in relation to the treatment of the Specified Illness or any claims which are not pre-authorized by Us.
- b. Any costs or expenses incurred in relation to any persons accompanying the Insured Person during any period of treatment, even if such persons are also Insured Persons.
- c. Any costs or expenses incurred on things that are not in direct relation to the Medical Expenses for treatment under this benefit like travel expenses, etc shall not be covered.
- d. Any costs or expenses incurred in relation to personal stay or transportation in the overseas location where treatment is being taken.
- e. Sections 3.2 (Pre-hospitalization Medical Expenses) and Section 3.3 (Post- hospitalization Medical Expenses) are not payable under this benefit.
- f. Any costs or expenses incurred by any organ donor in relation to harvesting of organs.
- g. Any OPD Treatment taken outside India.

3.21. OPD Treatment and Diagnostic Services

What is covered:

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

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

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

3.22. Emergency Medical Evacuation (outside the geographical boundaries of India)

What is covered:

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

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

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

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

What is not covered:

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

3.23. Emergency Hospitalization (outside the geographical boundaries of India)

What is covered:

If the Insured Person is required to be admitted in a Hospital in an Emergency condition, We will indemnify the Medical Expenses incurred on Hospitalization of that Insured Person until the Insured Person reaches a Medically Stable Condition during the Policy Period on Cashless Facility basis only.

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

- a. The treating Medical Practitioner has advised that Hospitalization is Medically Necessary.
- b. The Insured Person is required to be admitted in a Hospital in an Emergency when the Insured Person is outside India, but within those regions specified in the Policy Schedule.
- c. The Medical Expenses incurred are for one or more of the following:
 - i. Room Rent: Room boarding and nursing charges during Hospitalization as charged by the Hospital where the Insured Person availed medical treatment;
 - ii. Medical Practitioners' fees, excluding any charges or fees for Standby Services;
 - iii. Investigative tests or diagnostic procedures directly related to the Insured Event which led to the current Hospitalization;
 - iv. Medicines, drugs as prescribed by the treating Medical Practitioner related to the Insured Event that led to the current Hospitalization;
 - v. Intravenous fluids, blood transfusion, injection administration charges and /or allowable consumables;
 - vi. Operation theatre charges;
 - vii. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery;
 - viii. Intensive Care Unit Charges.

3.24. Modern Treatments

What is covered:

- a. The following procedures / treatments will be covered either as Inpatient Care or as part of Day Care Treatment as per Section 3.1 and Section 3.4 respectively, in a Hospital :
 - i. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
 - ii. Balloon Sinuplasty
 - iii. Deep Brain stimulation
 - iv. Oral chemotherapy
 - v. Immunotherapy- Monoclonal Antibody to be given as injection
 - vi. Intra vitreal injections

- vii. Robotic surgeries
 - viii. Stereotactic radio surgeries
 - ix. BronchialThermoplasty
 - x. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
 - xi. IONM - (Intra Operative Neuro Monitoring)
 - xii. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.
- b. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with Sections 3.2 and 3.3 within the overall benefit sub-limit.

4. Optional Benefits

The following optional benefits shall apply under the Policy only if it is specified in the Policy Schedule. Optional benefits can be selected by You only at the time of issuance of the First Policy or at Renewal on payment of the corresponding additional premium. The optional benefits 'Personal Accident Cover', 'Critical Illness Cover' and 'Hospital Cash' will be payable (only on Reimbursement basis) if the conditions mentioned in the below sections are contracted or sustained by the Insured Person covered under these optional benefits during the Policy Period.

The applicable optional benefits will be payable subject to the terms, conditions and exclusions of this Policy and subject always to any sub-limits for the optional benefit as specified in the Policy Schedule.

All claims for any applicable optional benefits under the Policy must be made in accordance with the process defined under Section 8 (Claim Process & Requirements).

4.1. Personal Accident Cover

What is covered:

If the Insured Person covered under this optional benefit dies or sustains any Injury resulting solely and directly from an Accident occurring during the Policy Period at any location worldwide, and while the Policy is in force, We will provide the benefits described below.

a. Accident Death (AD)

What is covered:

If the Injury due to Accident solely and directly results in the Insured Person's death within 365 days from the occurrence of the Accident, We will make payment of Personal Accident Cover Sum Insured specified in the Policy Schedule. If a claim is made under this optional benefit, the coverage for that Insured Person under the Policy shall immediately and automatically cease. Any claim incurred before death of such Insured person shall be admissible subject to terms and conditions under this Policy.

b. Accident Permanent Total Disability (APTD)

What is covered:

If the Injury due to Accident solely and directly results in the Permanent Total Disability of the Insured Person which means that the Injury results in one or more of the following conditions within 365 days from the occurrence of an Accident, We will make payment of 125% of the Personal Accident Cover Sum Insured as specified in the Policy Schedule.

1. Loss of use of limbs or sight

The Insured Person suffers from total and irrecoverable loss of:

- a. The use of two limbs (including paraplegia and hemiplegia) OR
- b. The sight in both eyes OR
- c. The use of one limb and the sight in one eye

2. Loss of independent living

The Insured Person is permanently unable to perform independently three or more of the following six activities of daily living.

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

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

- i. The Permanent Total Disability is proved through a disability certificate issued by a Medical Board duly constituted by the Central and/or the State Government; and
- ii. We will admit a claim under this optional benefit only if the Permanent Total Disability continues for a period of at least 6 continuous calendar months from the commencement of the Permanent Total Disability unless it is irreversible, such as in case of amputation/loss of limbs etc; and
- iii. If the Insured Person dies before a claim has been admitted under this optional benefit, no amount will be payable under this optional benefit, however We will consider the claim under Section 4.1.a (Accident Death) subject to terms and conditions mentioned therein; and
- iv. We will not make payment under Accident Permanent Total Disability more than once in the Insured Person’s lifetime for any and all Policy Periods.
- v. If a claim under this optional benefit is admitted, then coverage for the Insured Person will immediately and automatically cease under Section 4.1(Personal Accident Cover) and this optional benefit shall not be applied in respect of that Insured Person on any Renewal thereafter. However, other applicable benefits can be Renewed in respect of the Insured Person.

c. Accident Permanent Partial Disability (APPD)

What is covered:

If the Injury due to Accident solely and directly results in the Permanent Partial Disability of the Insured Person which is of the nature specified in the table below within 365 days from the occurrence of such Accident, We will make payment under this optional benefit in accordance with the table below:

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

- 1. The Permanent Partial Disability is proved through a disability certificate issued by a Medical Board duly constituted by the Central and/or the State Government; and
- 2. We will admit a claim under this optional benefit only if the Permanent Partial Disability continues for a period of at least 6 continuous calendar months from the commencement of the Permanent Partial Disability, unless it is irreversible; and
- 3. If the Insured Person dies before a claim has been admitted under this optional benefit, no amount will be payable under this optional benefit, however We will consider the claim under Section 4.1.a (Accident Death) subject to the terms and conditions mentioned therein.
- 4. If a claim under this optional benefit has been admitted, then no further claim in respect of the same condition will be admitted under this optional benefit.
- 5. If a claim under this optional benefit is paid and the entire Personal Accident Sum Insured specified in the Policy Schedule does not get utilized, then the balance Personal Accident Cover Sum Insured shall be available for further claims under Section 4.1 (Personal Accident Cover) until the entire Personal Accident Cover Sum Insured is consumed. The Personal Accident Cover Sum Insured specified in the first Policy Schedule shall be a lifetime limit for the Insured Person and once this limit is exhausted, coverage for the Insured Person will immediately and automatically cease under Section 4.1 (Personal Accident Cover) and this optional benefit shall not be applied in respect of that Insured Person on any Renewal thereafter. However, other applicable benefits can be Renewed in respect of the Insured Person

Permanent Partial Disability Grid		
S. No.	Nature of Disability	% of Personal Accident Cover Sum Insured payable
1	Loss or total and permanent loss of use of both the hands from the wrist joint	100%
2	Loss or total and permanent loss of use of both feet from the ankle joint	100%
3	Loss or total and permanent loss of use of one hand from the wrist joint and of one foot from the ankle joint	100%
4	Loss or total and permanent loss of use of one hand from the wrist joint and total and permanent loss of sight in one eye	100%
5	Loss or total and permanent loss of use of one foot from the ankle joint and total and permanent loss of sight in one eye	100%
6	Total and permanent loss of speech and hearing in both ears	100%
7	Total and permanent loss of hearing in both ears	50%
8	Loss or total and permanent loss of use of one hand from wrist joint	50%
9	Loss or total and permanent loss of use of one foot from ankle joint	50%
10	Total and permanent loss of sight in one eye	50%
11	Total and permanent loss of speech	50%
12	Permanent total loss of use of four fingers and thumb of either hand	40%

13	Permanent total loss of use of four fingers of either hand	35%
14	Uniplegia	25%
15	Permanent total loss of use of one thumb of either hand	
	a. Both joints	25%
	b. One joint	10%
16	Permanent total loss of use of fingers of either hand	
	a. Three joints	10%
	b. Two joints	8%
	c. One joint	5%
17	Permanent total loss of use of toes of either foot	
	a. All toes- one foot	20%
	b. Great toe- both joints	5%
	c. Great toe- one joint	2%
	d. Other than great toe, one toe	1%

4.2. Critical Illness Cover

What is covered:

If the Insured Person covered under this optional benefit is diagnosed for the first time with any of the following listed Critical Illnesses or if any of the following Critical Illnesses occurs or manifests itself in the Insured Person during the Policy Period for the first time, We will pay the Critical Illness Sum Insured specified in the Policy Schedule provided that the Insured Person survives the Survival Period of 30 days from the diagnosis of the Critical Illness during the Policy Period.

a. Cancer of Specified Severity

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

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

b. Myocardial Infarction

(First Heart Attack of specific severity)

- I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
 - i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

 - ii. New characteristic electrocardiogram changes

 - iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

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

- c. **Open Chest CABG**
 - I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
 - II. The following are excluded:
 - i. Angioplasty and/or any other intra-arterial procedures

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

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

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

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

- h. **Major Organ /Bone Marrow Transplant**
 - I. The actual undergoing of a transplant of:
 - i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

- ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.
- II. The following are excluded:
 - i. Other stem-cell transplants
 - ii. Where only islets of langerhans are transplanted
- i. **Permanent Paralysis of Limbs**
 - I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.
- j. **Motor Neuron Disease with Permanent Symptoms**
 - I. Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.
- k. **Multiple Sclerosis with Persisting Symptoms**
 - I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
 - i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
 - ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.
 - II. Neurological damage due to SLE is excluded
- l. **Deafness**
 - I. Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means “the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing” in both ears.
- m. **End Stage Lung Failure**
 - I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
 - i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
 - ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
 - iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO₂ < 55mmHg); and
 - iv. Dyspnea at rest.
- n. **End Stage Liver Failure**
 - I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
 - i. Permanent jaundice; and
 - ii. Ascites; and
 - iii. Hepatic encephalopathy.
 - II. Liver failure secondary to drug or alcohol abuse is excluded.
- o. **Loss of Speech**
 - I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.
- p. **Third Degree Burns**

- I. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.
- q. Fulminant Viral Hepatitis**
- I. A sub-massive to massive necrosis of the liver by any virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:
- i. rapid decreasing of liver size; and
 - ii. necrosis involving entire lobules, leaving only a collapsed reticular framework; and
 - iii. rapid deterioration of liver function tests; and
 - iv. deepening jaundice; and
 - v. hepatic encephalopathy.
- Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria
- r. Aplastic Anemia**
- I. Aplastic Anemia is chronic persistent bone marrow failure. A certified hematologist must make the diagnosis of severe irreversible aplastic anemia. There must be permanent bone marrow failure resulting in bone marrow cellularity of less than 25% and there must be two of the following:
- i. Absolute neutrophil count of less than 500/mm³
 - ii. Platelets count less than 20,000/mm³
 - iii. Reticulocyte count of less than 20,000/mm³
- The Insured Person must be receiving treatment for more than 3 consecutive months with frequent blood product transfusions, bone marrow stimulating agents, or immunosuppressive agents or the Insured Person has received a bone marrow or cord blood stem cell transplant. Temporary or reversible Aplastic Anemia is excluded and not covered under this Policy
- s. Muscular Dystrophy**
- I. Muscular Dystrophy is a disease of the muscle causing progressive and permanent weakening of certain muscle groups. The diagnosis of Muscular Dystrophy must be made by a consultant neurologist, and confirmed with the appropriate laboratory, biochemical, histological, and electromyography evidence. The disease must result in the permanent inability of the Insured Person to perform (whether aided or unaided) at least three (3) of the six (6) "Activities of Daily Living".
- Activities of Daily Living are defined as:
- a. Washing : the ability to maintain an adequate level of cleanliness and personal hygiene
 - b. Dressing : the ability to put on and take off all necessary garments, artificial limbs or other surgical appliances that are Medically Necessary
 - c. Feeding : the ability to transfer food from a plate or bowl to the mouth once food has been prepared and made available
 - d. Toileting : the ability to manage bowel and bladder function, maintaining an adequate and socially acceptable level of hygiene
 - e. Mobility : the ability to move indoors from room to room on level surfaces at the normal place of residence
 - f. Transferring: the ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa
- t. Bacterial Meningitis**
- I. Bacterial meningitis is a bacterial infection of the meninges of the brain causing brain dysfunction. There must be an unequivocal diagnosis by a consultant physician of bacterial meningitis that must be proven on analysis and culture of the cerebrospinal fluid. There must also be permanent objective neurological deficit that is present on physical examination at least 3 months after the diagnosis of the meningitis infection.

Conditions applicable to 'Critical Illness cover':

- a. We will not make payment under Section 4.2 (Critical Illness Cover) more than once in the Insured Person's lifetime for any and all Policy Periods
- b. The diagnosis of a Critical Illness must be verified in writing by a Medical Practitioner.
- c. The Waiting Periods specified below shall be applicable to the Insured Person and claims shall be assessed accordingly. On Renewal, if the Critical Illness Cover Sum Insured specified in the Policy Schedule is enhanced, the Waiting Periods would apply afresh to the extent of the increase in benefit amount limit, subject to Underwriting Guidelines and in accordance with the existing guidelines of the IRDAI.

We shall not be liable to make any payment under this Policy for covered listed Critical Illnesses directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

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

- a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first Policy.
- b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Insurance Products) Regulations 2024, then waiting period for the same would be reduced to the extent of prior coverage.
- d. Coverage under the Policy after the expiry of 36 months for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

ii. 90 day Waiting Period

- a. Expenses related to the treatment of any Illness within 90 days from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
- b. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months
- c. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.
- d. If the Insured Person is diagnosed / undergoes a Surgical Procedure or any medical condition occurs falling under the definition of Critical Illness as specified above that may result in a claim, then We shall be given written notice immediately and in any event within 7 days of the aforesaid Illness/ condition/ Surgical Procedure.
- e. We shall not be liable to make any payment under this optional benefit if the Insured Person does not survive the Survival Period.
- f. If diagnosis of the Critical Illness takes place on or before the Policy expiry date specified in the Policy Schedule, but the Survival Period expires after the Policy expiry date, such claims would be admissible if the Insured Person survives the Survival Period.
- g. In the event of death of the Insured Person post the Survival Period, the immediate family member/relative of the Insured Person claiming on Insured Person's behalf must inform Us in writing immediately and send a copy of all the required documents to prove the cause of death within 30 days of the death. We upon acceptance of the admission of claim under the Policy shall make payment to the Nominee/legal heirs of the Insured Person.
- h. If We have admitted a claim under this optional benefit for an Insured Person in any Policy Year, this optional benefit shall not be renewed in respect of that Insured Person for any subsequent Policy Year, but the cover for this optional benefit will be renewable for other Insured Persons.

4.3. e-Consultation

What is covered:

If the Insured Person is diagnosed with an Illness or is planning to undergo a planned Surgery or a Surgical Procedure, the Insured Person can, at the Insured Person's sole direction, obtain an e-Consultation during the Policy Period.

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

- a. e-Consultation shall be requested through Our call centre or website chat.
- b. e-Consultation will be arranged by Us (without any liabilities) and will be based solely on the information provided by the Insured Person.
- c. e-Consultation must not be considered a substitute to medical opinion or advice nor shall be same pursued over a medical advice or opinion given by treating physician or doctor

- d. By seeking e-Consultation under this benefit, the Insured Person is not prohibited or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.
- e. The Insured Person is free to choose whether or not to obtain the e-Consultation, and if obtained then whether or not to act on it in whole or in part.
- f. e-Consultation under this benefit shall not be valid for any medico-legal purposes.
- g. We do not represent correctness of e-Consultation and shall not assume or deem to assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

4.4. Premium Waiver

What is covered:

If the Policyholder (who should also be an Insured Person) dies or is diagnosed or undergoes treatment for the first time, with any of the Specified Illness as mentioned under Section 2.73 of the policy wordings during the Policy Period, the cover under the Policy shall be automatically extended for a tenure of 1 Policy Year starting from the end of that Policy Period.

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

- a. This optional benefit is provided once in the lifetime in the Policy regardless of the number of years the Policy has served with Us.
- b. The symptoms of the Specified Illness first occur or manifest itself during the Policy Period and after completion of the 90 day from the inception of the First Policy with Us.
- c. The Specified Illness is diagnosed by a Medical Practitioner during the Policy Period and after completion of the 90 day from the inception of the First Policy with Us.
- d. If We have admitted a claim under this optional benefit during the Policy Period, this optional benefit shall not be renewed for any subsequent Policy Period.

What is not covered:

- a. This benefit is not available under Individual Policy.

4.5. Hospital Cash

What is covered:

If We have accepted an Inpatient Care Hospitalization claim under Section 3.1 (Inpatient Care), We will pay the Hospital Cash amount specified in the Policy Schedule up to a maximum 30 days of Hospitalization during the Policy Year for the Insured Person for each continuous period of 24 hours of Hospitalization from the first day of Hospitalization.

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

- a. The Insured Person has been admitted in a Hospital for a minimum period of 48 hours continuously.

4.6. Enhanced Geographical Scope for International Coverage

What is covered:

This optional benefit shall be subject to all guidelines and conditions mentioned under Section 3.20 (Specified Illness cover), Section 3.22 (Emergency Medical Evacuation – outside the geographical boundaries of India) and Section 3.23 (Emergency Hospitalization – outside the geographical boundaries of India), without limitation to the geographical coverage in USA & Canada unlike specified under Section 3.20, Section 3.22 and Section 3.23.

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

- a. Waiting Periods as specified under Section 6 shall apply afresh to the geographical coverage in USA & Canada when this Optional Cover is opted.

5. Claim Cost Sharing Option / Conditions

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

5.1. Co-payment

The Insured Person will bear a predetermined percentage of the admissible claim amounts subject to the Co-payment option chosen by You in the Proposal Form and / or Information Summary Sheet irrespective of the Age of the Insured Person and the number of claims made.

Co-payment will not apply to any claim under Section 3.11 (Health Check-up), Section 3.13 (Pharmacy and diagnostic services), Section 3.16 (Emergency Assistance Services), Section 3.18 (Second Medical Opinion), Section 3.20 (Specified Illness cover), Section 3.21 (OPD Treatment and Diagnostic Services), Section 4.1 (Personal Accident Cover), Section 4.2 (Critical Illness Cover), Section 4.3 (e-Consultation), Section 4.4 (Premium Waiver) and Section 4.5 (Hospital Cash).

5.2. Annual Aggregate Deductible

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

It is further agreed that:

- a. The provisions in Section 5.1 on Co-payment (if opted) will apply to any amounts payable by Us in respect of a claim made by the Insured Person after the Deductible has been exhausted.
- b. Deductible will not apply to any claim under Section 3.11 (Health Checkup), Section 3.13 (Pharmacy and diagnostic services), Section 3.18 (Second Medical Opinion), Section 4.1 (Personal Accident Cover), Section 4.2 (Critical Illness Cover), Section 4.3 (e-Consultation), Section 4.4 (Premium Waiver) and Section 4.5 (Hospital Cash).

6. Waiting Periods

All the Waiting Periods shall be applicable individually for each Insured Person and claims shall be assessed accordingly. On Renewal, if the Sum Insured or the benefit amount is enhanced, the Waiting Periods would apply afresh to the extent of the increased amount only. The Waiting Periods set out below shall not apply to Section 3.11 (Health Check-up), Section 3.13 (Pharmacy and diagnostic services), Section 4.1 (Personal Accident Cover), Section 4.2 (Critical Illness Cover), Section 4.3 (e-Consultation) and Section 4.4 (Premium Waiver). The Waiting Periods for Critical Illness Cover have already been specified under Section 4.2 respectively.

We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

6.1. Pre-existing Diseases (Code-Excl01):

- a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months (under gold & platinum Plans)/ 36 months (under Silver Plans) of continuous coverage after the date of inception of the first Policy .
- b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Insurance Products) Regulations 2024, then waiting period for the same would be reduced to the extent of prior coverage.
- d. Coverage under the Policy after the expiry of 24 months (under gold & platinum Plans)/ 36 months (under Silver Plans) for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

6.2. 30 day waiting period (Code-Excl03):

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

6.3. Specified disease/procedure waiting period (Code-Excl02)

For all Insured Persons who are above 45 years of Age as on the date of inception of the First Policy with Us, the following specifies disease/procedure waiting period will be applicable

- a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident (covered from day 1 or Cancer (covered after 30-day waiting period).
- b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
- d. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
- e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI then waiting period for the same would be reduced to the extent of prior coverage.
- f. List of specific diseases/procedures:
 - I. Pancreatitis and Stones in Biliary and Urinary System,
 - II. Cataract, Glaucoma and Retinal detachment,
 - III. Hyperplasia of Prostate, Hydrocele and spermatocele,
 - IV. Prolapse uterus or cervix, endometriosis, Fibroids, Polycystic ovarian disease (PCOD), hysterectomy (unless necessitated by Malignancy)
 - V. Hemorrhoids, Fissure or Fistula or Abscess of anal and rectal region,
 - VI. Hernia of any site or type,
 - VII. Osteoarthritis, joint replacement, osteoporosis, systemic connective tissue disorders, inflammatory polyarthropathies, Rheumatoid Arthritis, gout, intervertebral disc disorders, arthroscopic surgeries for ligament repair
 - VIII. Varicose veins of lower extremities
 - IX. All internal or external benign neoplasms/ tumours, cyst, sinus, polyps, nodules, mass or lump
 - X. Ulcer, erosion or varices of gastro intestinal tract
 - XI. Surgical treatment for diseases of middle ear and mastoid (including otitis media, cholesteatoma, perforation of tympanic membrane), Tonsils and adenoids, nasal septum and nasal sinuses

6.4. Personal Waiting Periods:

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

7. Permanent Exclusions

We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following unless specifically mentioned elsewhere in the Policy. Sections 7.1 to 7.27 are not applicable to Section 4.1 (Personal Accident Cover) and Section 4.2 (Critical Illness Cover).

The permanent exclusions applicable to Section 4.1 (Personal Accident Cover) and Section 4.2 (Critical Illness Cover) have been specified separately under Section 7.28 and Section 7.29 respectively.

7.1. Investigation & Evaluation (Code-Excl04)

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

7.2. Rest Cure, rehabilitation and respite care (Code-Excl05)

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

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

7.3. Obesity/ Weight Control (Code-Excl06)

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

- a. Surgery to be conducted is upon the advice of the Doctor.

- b. The surgery/Procedure conducted should be supported by clinical protocols.
 - c. The member has to be 18 years of age or older and;
 - d. Body Mass Index (BMI);
 - i. greater than or equal to 40 or
 - ii. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - 1. Obesity-related cardiomyopathy
 - 2. Coronary heart disease
 - 3. Severe Sleep Apnea
 - 4. Uncontrolled Type2 Diabetes
- 7.4. **Change-of-Gender treatments (Code-Excl07)**
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
- 7.5. **Cosmetic or plastic Surgery (Code-Excl08)**
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
- 7.6. **Hazardous or Adventure sports (Code-Excl09)**
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
- 7.7. **Breach of law (Code-Excl10)**
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
- 7.8. **Excluded Providers (Code-Excl11)**
Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our website / notified to the Policyholders are not admissible. However, in case of life threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.

The complete list of excluded providers can be referred to on our website.
- 7.9. Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code-Excl12)**
- 7.10. Treatments received in health spas, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code-Excl13)**
- 7.11. Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or Day Care procedure **(Code-Excl14)**
- 7.12. **Refractive Error (Code-Excl15)**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.

7.13. Unproven Treatments (Code-Excl16)

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

7.14. Sterility and Infertility (Code-Excl17)

Expenses related to sterility and infertility. This includes:

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

7.15. Maternity(Code-Excl18)

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

7.16. Ancillary Hospital Charges

Charges related to a Hospital stay not expressly mentioned as being covered. This will include charges for admission, discharge, administration, RMO charges, night charges, registration, documentation and filing, surcharges and service charges levied by the Hospital.

7.17. Circumcision:

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

7.18. Conflict & Disaster:

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

7.19. External Congenital Anomaly:

Screening, counseling or treatment related to external Congenital Anomaly.

7.20. Dental/oral treatment:

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

7.21. Hormone Replacement Therapy:

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

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

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

7.23. Sleep disorders:

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

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

7.25. Unrecognized Physician or Hospital:

- a. Treatment or Medical Advice provided by a Medical Practitioner not recognized by the Medical Council of India or by Central Council of Indian Medicine or by Central council of Homeopathy.
- b. Treatment provided by anyone with the same residence as an Insured Person or who is a member of the Insured Person's immediate family or relatives.
- c. Treatment provided by Hospital or health facility that is not recognized by the relevant authorities in India.

7.26. Artificial life maintenance for the Insured Person who has been declared brain dead or in vegetative state as demonstrated by:

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

7.27. AYUSH Treatment

Any form of AYUSH Treatments, except as mentioned under Section 3.6

7.28. Permanent Exclusions for Personal Accident Cover

We shall not be liable to make any payment under any benefits under Section 4.1 (Personal Accident Cover) if the claim is attributable to, or based on, or arises out of, or is directly or indirectly connected to any of the following:

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

7.29. Permanent Exclusions for Critical Illness Cover

We shall not be liable to make any payment under Section 4.2 (Critical Illness Cover) directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following unless specifically mentioned elsewhere in the Policy.

1. **AYUSH Treatment:**
Any covered Critical Illnesses diagnosed and/or treated by a Medical Practitioner who practices AYUSH Treatment.
2. **Conflict & Disaster:**
Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism.
3. **External Congenital Anomaly:**
Screening, counseling or treatment related to External Congenital Anomaly.

4. **Cosmetic or plastic Surgery (Code-Excl08)**

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

5. **Unproven Treatments (Code-Excl16)**

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

6. **Hazardous or Adventure sports (Code-Excl09)**

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

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

Expenses related to sterility and infertility. This includes:

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

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

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

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

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

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

11. **Breach of law (Code-Excl10)**

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

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

13. **Unrecognized Physician or Hospital:**

- a. Treatment or Medical Advice provided by a Medical Practitioner not recognized by the Medical Council of India or by Central Council of Indian Medicine or by Central council of Homeopathy.
- b. Treatment provided by anyone with the same residence as an Insured Person or who is a member of the Insured Person's immediate family or relatives.
- c. Treatment provided by Hospital or health facility that is not recognized by the relevant authorities in India.

8. **Claim Process & Requirements**

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

8.1. **Claims Administration:**

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

- a. We advise You to submit all claims related document, including documents for claims within the Deductible amount, once the Deductible limit has been exhausted.
- b. The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed.
- c. We/Our Service Provider must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.
- d. We and Our Service Provider must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.
- e. It is hereby agreed and understood that no change in the Medical Record provided under the Medical Advice information, by the Hospital or the Insured Person to Us or Our Service Provider during the period of Hospitalization or after discharge by any means of request will be accepted by Us. Any decision on request for acceptance of such change will be considered on merits where the change has been proven to be for reasons beyond the claimant's control.

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

- a. **For Availing Cashless Facility:** Cashless Facility can be availed only at Our Network Providers or Service Providers (as applicable). The complete list of Network Providers is available on Our website and at Our branches and can also be obtained by contacting Us over the telephone. In order to avail Cashless Facility, the following process must be followed:
 - i. Process for Obtaining Pre-Authorization
 - A. For Planned Treatment:

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

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

Once the final authorization request is received for discharge, the same will be processed within three hours from the final documents received. In case of delay from our end, any additional amount charged by the hospital will be borne by us. This amount will be paid over and above the policy limits.

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

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

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

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

In case of preauthorization request where chronicity of condition is not established as per clinical evidence based information, We may reject the request for preauthorization and ask the claimant to claim as Reimbursement. Claim document submission for Reimbursement shall not be deemed as an admission of Our liability.

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

We reserve the right to modify, add or restrict any Network Provider or Service Provider for Cashless Facility at Our sole discretion.

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

b. For Reimbursement Claims:

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

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

8.3. Claims Documentation:

For medical claims – Reimbursement Facility:

We shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense within 30 days of the Insured Event giving rise to a claim or within 30 days from the date of occurrence of an Insured Event or completion of Survival Period (in case of Critical Illness Cover).

For medical claims – Cashless Facility:

We will be provided these documents by the Network Provider immediately following the Insured Person's discharge from Hospital.

Necessary information and documentation for medical claims

- a. Claim form duly completed and signed by the claimant.
- b. Details of past medical history record, first and subsequent consultation.
- c. Age / Identity proof document of Insured Person in case of claim approved under Cashless Facility (not required if submitted at the time of pre-authorization request) and Policyholder in case of Reimbursement claim.

- i. Self attested copy of valid age proof (passport / driving license / PAN card / class X certificate / birth certificate);
- ii. Self attested copy of identity proof (passport / driving license / PAN card / voter identity card);
- iii. Recent passport size photograph
- d. Cancelled cheque/ bank statement / copy of passbook mentioning account holder's name, IFSC code and account number printed on it of Policyholder / nominee (in case of death of Policyholder).
- e. Original discharge summary.
- f. Bar code sticker and invoice for implants and prosthesis (if used and only in case of Surgery/Surgical Procedure).
- g. Original final bill from Hospital with detailed break-up and paid receipt.
- h. Room tariff of the entitled room category (in case of a Non-Network provider and if room tariff is not a part of Hospital bill): duly signed and stamped by the Hospital in which treatment is taken.
(In case You are unable to submit such document, then We shall consider the Reasonable and Customary Charges of the Insured Person's eligible room category of Our Network Provider within the same geographical area for identical or similar services.)
- i. Original bills of pharmacy/medicines purchased, or of any other investigation done outside Hospital with reports and requisite prescriptions.
- j. For Medico-legal cases (MLC) or in case of Accident
 - i. MLC/ Panchnama / First Information Report (FIR) copy attested by the concerned Hospital / police station (if applicable);
 - ii. Original self-narration of incident in absence of MLC / FIR.
- k. Original laboratory investigation, diagnostic, radiological & pathological reports with supporting prescriptions.

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

For Personal Accident claims

Additional claim documentation for Personal Accident Cover under Section 4.1:

- a. *Accident Death*
 - i. Copy of death certificate (issued by the office of Registrar of Births and Deaths or any other authorized legal institution)
 - ii. Copy of post mortem report wherever applicable
- b. *Accident Permanent Total Disability or Accident Permanent Partial Disability*
 - i. Certificate of disability issued by a Medical Board duly constituted by the Central and/or the State Government.

For Critical Illness claims

Additional claim documentation for Critical Illness Cover under Section 4.2:

- a. Treating Medical Practitioner's certification for insured person's survival post survival period.

For claims outside India

Additional claim documentation for claims incurring outside India:

- a. Passport copy with entry and exit stamps
- b. Additional documents as specified under each benefit

8.4. Claims Assessment & Repudiation:

- a. At Our discretion, We may investigate claims to determine the validity of a claim. All costs of investigation will be borne by Us and all investigations will be carried out by those individuals/entities that are authorized by Us in writing.
- b. Payment for Reimbursement claims will be made to You. In the unfortunate event of Your death, We will pay the Nominee named in the Policy Schedule or Your legal heirs or legal representatives holding a valid succession certificate.

- c. We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person had taken reasonable care, or that is brought about or contributed to by the Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.
 - d. If a claim is made which extends in to two Policy Periods, then such claim shall be paid taking into consideration the available Sum Insured in these Policy Periods. Such eligible claim amount will be paid to the Policyholder/Insured Person after deducting the extent of premium to be received for the Renewal/due date of premium of the Policy, if not received earlier.
 - e. All admissible claims under this Policy shall be assessed by Us in the following progressive order:-
 - i. If a room has been opted in a Hospital for which the room category is higher than the eligible limit as applicable for that Insured Person as specified in the Policy Schedule, then the Associated Medical Expenses payable shall be pro-rated as per the applicable limits in accordance with Section 3.1.
 - ii. The Deductible (if applicable) shall be applied to claims that are either paid or payable under this Policy. Our liability to make payment shall commence only once the amount of eligible claims as per policy terms and conditions exceeds the Deductible limit within the same Policy Year.
 - iii. Co-payment (if applicable) as specified in the Policy Schedule shall be applicable on the amount payable by Us.
 - f. The claim amount assessed in Section 8.4 e above would be deducted from the amount mentioned against each benefit and Sum Insured as specified in the Policy Schedule.
- 8.5. Delay in Claim Intimation or Claim Documentation:**
If the claim is not notified to Us or claim documents are not submitted within the stipulated time as mentioned in the above sections, then We shall be provided the reasons for the delay, in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.
- 8.6. Claims process for Section 4.3 (e-Consultation):**
After validation of Insured Person and Policy details, We will evaluate the information of the Insured Person from the perspective to check eligibility of cover only and if the request is approved, We will facilitate arrangement as per the conditions specified under respective benefits admissible to the Insured Person.
- 8.7. Claim process for Section 3.11 (Health Checkup)**
 - a. The Insured Person shall seek appointment by contacting Our Service Provider.
 - b. Our Service Provider will facilitate Your appointment.
 - c. Reports of the medical tests can be collected directly from the Service Provider.
- 8.8. Claims process for Section 3.16.b and Section 3.22 (Emergency Medical Evacuation)**
 - a. In the event of an Emergency, Our Service Provider shall be contacted immediately on the helpline number specified in the Insured Person's health card.
 - b. Our Service Provider will evaluate the necessity for evacuation of the Insured Person and if the request for Medical Evacuation is approved by Us, the Service Provider shall pre-authorise the type of travel that can be utilized to transport the Insured Person and provide information on the Hospital that may be approached for medical treatment of the Insured Person.
 - c. If the Service Provider pre-authorises the Medical Evacuation of the Insured Person by means of Air Transportation through an air ambulance or commercial flight whichever is best suited, the Service Provider shall also arrange for the same to be provided to the Insured Person unless there are any logistical constraints or the medical condition of the Insured Person prevents Emergency Medical Evacuation.
 - d. It is agreed and understood that We shall not cover any claims for Reimbursement of the costs incurred in the evacuation or transportation of the Insured Person or which are not pre-authorized by Our Service Provider.
- 8.9. Claim process for Section 3.18 (Second Medical Opinion)**
 - a. In the event of submission of request for Second Medical Opinion, Our Service Provider shall be contacted immediately on the helpline number specified in the Insured Person's health card.
 - b. Our Service Provider will evaluate the information of the Insured Person and if the request for Second Medical Opinion is approved, the Service Provider will facilitate arrangement as per conditions specified in the Section 3.18
- 8.10. Claim process for Section 3.20 (Specified Illness Cover)**
 - a. In the event of the diagnosis of a Specified Illness, the Insured Person should call Us immediately and in any event before the commencement of the travel for treatment overseas on the helpline number specified on in the Insured Person's health card, requesting for a pre-authorization for the treatment.
 - b. We will evaluate the request and the eligibility of the Insured Person's Policy and call for more information or details, if required.
 - c. We will communicate directly to the Service Provider and the Insured Person whether the request for pre-authorization has been approved or denied.

- d. If the pre-authorization request is approved, Our Service Provider will directly settle the claim with the Hospital. Any additional costs or expenses incurred by or on behalf of the Insured Person beyond the limits pre-authorized by the Service Provider or at any Non-Network Hospital shall be borne by the Insured Person.
- e. This benefit is available only as Cashless Facility through pre-authorization by Us.

8.11. Claims process for Section 3.23 (Emergency Hospitalization – outside the geographical boundaries of India)

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

9. Portability

A Policyholder has the choice to port his/ her policies from one Insurer to another. Irrespective of individual or group policy subject to the Board approved underwriting policy of the insurers.

The policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc from the Existing Insurer to the Acquiring Insurer in the previous policy.

10. Migration

In case of migration of one policy to another with the same Insurer, the policyholder (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy.

The insurer may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months.

11. General Terms and Conditions

11.1. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals.

The insured person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy.

In the event the policyholder disagrees to any of the policy terms or conditions, or otherwise and has not made any claim, he/she shall have the option to return the policy to the insurer for cancellation, stating the reasons for the same.

Irrespective of the reasons mentioned, the policyholder shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges.

11.2. Cancellation

The policy holder may cancel his/her policy at any time during the term, by giving 7 days' notice in writing. The insurer shall:

- a. Refund proportionate premium for unexpired policy period, if the term of the policy upto one year and there is no claim(s) made during the policy period.
- b. Refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years are not commenced.

c. Automatic Cancellation

Individual Policy:

The Policy shall automatically terminate in the event of death of the Insured Person.

For Family Floater Policies:

The Policy shall automatically terminate in the event of the death of all the Insured Persons.

Refund:

A refund in accordance with the table in Section 11.2.a shall be payable if there is an automatic cancellation of the Policy provided that no claim has been made and e-consultation, Health Check-up, Emergency Assistance Services or Second Medical Opinion have not been availed under the Policy by or on behalf of any Insured Person. We will pay

the refund of premium to the Nominee named in the Policy Schedule or Your legal heirs or legal representatives holding a valid succession certificate.

11.3. Pre-Insurance Medical Check-up

We may consider various attributes like age, sum insured, sum insured type, channel, location, insuring self vs insuring self + family etc to deploy different pre-policy medical check-ups and underwriting approaches (tele underwriting, tests etc).

If we issue you the policy, the costs of pre-policy medical check-up (if any) will be borne by Us.

11.4. Loading on Premium

- a. Based upon the disclosure of the health status of the persons proposed for insurance and declarations made in the Proposal or Insurance Summary Sheet, We may apply a risk loading on the premium payable (excluding statutory levies and taxes) under the Policy. The maximum risk loading applicable shall not exceed more than 250% of the premium.
- b. These loadings will be applied from inception date of the First Policy and subsequent Renewal(s) with Us.
- c. If a loading applies to the premium for the main Policy, such loading will also apply to the premium for the optional benefits selected except under Section 4.1 (Personal Accident Cover) and Section 4.3 (e-consultation).

11.5. Renewal of Policy

A health insurance policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured.

An insurer shall not deny the renewal of a health insurance policy on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy.

- a. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- b. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days (annual instalment) to maintain continuity of benefits without break in policy.
- c. Coverage is available during the grace period.
- d. No loading shall apply on renewals based on individual claims experience. However, discount in premium may be provided by insurers to individual policyholders for good claims experience.
- e. Insurer shall not resort to fresh underwriting by calling for medical examination, fresh proposal form etc at renewal stage where there is no change in sum insured offered. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured

11.6. Other Renewal Conditions:

a. Continuity of benefits on Timely Renewal:

- i.
- ii. The Renewal premium is payable on or before the due date and in any circumstances before the expiry of Grace Period
- iii. Renewal premium rates for this Policy may be further altered by Us including in the following circumstances:
 - A. You proposed to add an Insured Person to the Policy
 - B. You change any coverage provision
- iv. Renewal premium will alter based on individual Age. The reference of Age for calculating the premium for Family Floater Policies shall be the Age of the eldest Insured Person, and for Family First Policies it shall be the individual Age of each Insured Person of the family.

b. Reinstatement:

- i. The Policy shall lapse after the expiration of the Grace Period. If the Policy is not Renewed within the Grace Period then We may agree to issue a fresh Policy subject to Our underwriting criteria, as per Our Board approved underwriting policy and no continuing benefits shall be available from the expired Policy.

- ii. We will not pay for any Medical Expenses which are incurred between the date the Policy expires and the date immediately before the reinstatement date of Your Policy.
- iii. If there is any change in the Insured Person's medical or physical condition, We may add exclusions or charge an extra premium from the reinstatement date.

c. Disclosures on Renewal:

You shall make a full disclosure to Us in writing of any material change in the health condition or geographical location of any Insured Person at the time of seeking Renewal of this Policy, irrespective of any claim arising or made. The terms and condition of the existing Policy will not be altered.

d. Renewal for Insured Persons who have achieved Age 22:

If any Insured Person who is a child and has completed Age 22 years at the time of Renewal, then such Insured Person will have to take a separate policy based on Our underwriting guidelines, as per Our Board approved underwriting policy as he/she will no longer be eligible to be covered under a Family Floater Policy. In such cases, the credit of the Waiting Periods served under the Policy will be passed on to the separate policy taken by such Insured Person.

e. Addition of Insured Persons on Renewal:

Where an individual is added to this Policy, either by way of endorsement or at the time of Renewal, the Pre-existing Disease clause, exclusions, loading (if any) and Waiting Periods will be applicable considering such Policy Year as the first year of the Policy with Us for that Insured Person.

f. Changes to Sum Insured on Renewal:

You may opt for enhancement of Sum Insured at the time of Renewal, subject to underwriting. All Waiting Periods as defined in the Policy under Section 6 shall apply afresh for this enhanced limit from the effective date of such enhancement.

11.7. Change of Policyholder

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

11.8. Nomination

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

11.9. Obligations in case of a minor

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

11.10. Authorization to obtain all pertinent records or information:

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

11.11. Fraud

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

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy: a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true; b) the active concealment of a fact by the insured person having knowledge or belief of the fact; c) any other act fitted to deceive; and d) any such act or omission as the law specially declares to be fraudulent

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

11.12. Policy Disputes

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

11.13. Territorial Jurisdiction

All benefits are available in India only and all claims shall be payable in India in Indian Rupees only except for benefits and claims under Section 3.20 (Specified Illness cover) , Section 3.22 (Emergency Medical Evacuation – outside the geographical boundaries of India) and Section 3.23 (Emergency Hospitalization – outside the geographical boundaries of India).

11.14. Notices

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

- a. You/the Insured Person at the address specified in the Policy Schedule or at the changed address of which We must receive written notice.
- b. Us at the following address:
Niva Bupa Health Insurance Company Limited
D-5, 2nd Floor, Logix Infotech Park (opp. Metro Station),
Sector 59, Noida, Uttar Pradesh, 201301
Fax No.: 011-4174-3397
- c. No insurance agents, brokers or other person/entity is authorized to receive any notice on Our behalf.
- d. In addition, We may send You/the Insured Person other information through electronic and telecommunications means with respect to Your Policy from time to time.

11.15. Alteration to the Policy

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

11.16. Zonal pricing

For the purpose of calculating premium for silver and gold plan, following zones are available:

- Zone 1: All India coverage
- Zone 2: All India coverage (Co-payment applicable for Mumbai (including Navi Mumbai & Thane), Delhi NCR, Kolkata & Gujarat State)

If You select Zone 2, then 20% Co-payment will apply for treatment in Mumbai (including Navi Mumbai & Thane), Delhi NCR, Kolkata & Gujarat State. This Zone-wise Co-payment shall not be applicable to any claim under

Section 3.11 (Health Check-up), Section 3.13 (Pharmacy and diagnostic services), Section 3.16 (Emergency Assistance Services), Section 3.18 (Second Medical Opinion), Section 3.20 (Specified Illness cover), Section 3.21 (OPD Treatment and Diagnostic Services), Section 4.1 (Personal Accident Cover), Section 4.2 (Critical Illness Cover), Section 4.3 (e-Consultation), Section 4.4 (Premium Waiver) and Section 4.5 (Hospital Cash).

Note: Post choosing this option, zones can be changed only at the time of renewal on submission of proof of change in address or any other valid reason.

For the purpose of calculating premium for platinum plan, the country has been divided into the following 3 zones based on the address provided by You:

- Zone 1: Delhi (NCR), Surat, Kolkata, Mumbai (including Navi Mumbai & Thane)
- Zone 2: Pune, Ludhiana, Jaipur
- Zone 3: Rest of India
- Note: Zone based Co-payment is not applicable for platinum plan.

11.17. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

11.18. Withdrawal of Policy

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

11.19. Redressal of Grievances:

In case of any grievance the insured person may contact the company through

Website: www.nivabupa.com

Toll free: 1860-500-8888

E-mail: Email us through our service platform <https://rules.nivabupa.com/customer-service>

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

Fax : 011-4174-3397

Courier: Customer Services Department

Niva Bupa Health Insurance Company Limited

D-5, 2nd Floor, Logix Infotech Park (opp. Metro Station),

Sector 59, Noida, Uttar Pradesh, 201301

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at

Head – Customer Services

Niva Bupa Health Insurance Company Limited

D-5, 2nd Floor, Logix Infotech Park (opp. Metro Station),

Sector 59, Noida, Uttar Pradesh, 201301

Customer Helpline No: 1860-500-8888

Fax No.: 011-4174-3397

Email ID: Email our Grievance officer through our Grievance Redressal platform <https://transactions.nivabupa.com/pages/grievance-redressal.aspx> For updated details of grievance officer, kindly refer the link <https://www.nivabupa.com/customer-care/health-services/grievance-redressal.aspx>

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

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017 (at the addresses given in Annexure I).

Grievance may also be lodged at IRDAI Integrated Grievance Management System (Bima Bharosa portal) – www.bimabharosa.irdai.gov.in

11.20. Assignment

The Policy can be assigned subject to applicable laws.

11.21. Claim settlement (Provision for Penal interest)

- I. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- II. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- III. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- IV. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

11.22. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on the grounds of non-disclosure, misrepresentation, except on grounds of established fraud. The period of sixty continuous months is called as moratorium period. The moratorium will be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the Policy contract.

Note: the accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium Period.

11.23. Multiple Policies

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

11.24. Disclosure of Information

The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact by the policyholder

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

11.25. Condition Precedent to Admission of Liability

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

Disclaimer: This is only a summary of the product features and is for reference purpose only. The details of benefits available shall be as described in the policy document, and will be subject to the policy terms, conditions and exclusions. Please call our customer service if you require any further information or clarification.

Statutory Warning: Prohibition of rebates (under section 41 of Insurance Act 1938); (1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.

(2) Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Annexure I - List of Insurance Ombudsmen

Office Details	Jurisdiction of Office Union Territory, District)
<p>AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in</p>	<p>Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu.</p>
<p>BENGALURU - Smt. Neerja Shah Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase,</p>	<p>Karnataka.</p>

<p>Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in</p>	
<p>BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in</p>	<p>Madhya Pradesh Chhattisgarh.</p>
<p>BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 / 2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in</p>	<p>Orissa.</p>
<p>CHANDIGARH - Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in</p>	<p>Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh.</p>
<p>CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in</p>	<p>Tamil Nadu, UT- Pondicherry Town and Karaikal (which are part of UT of Pondicherry).</p>
<p>DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in</p>	<p>Delhi.</p>
<p>GUWAHATI - Shri Kiriti .B. Saha Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM).</p>	<p>Assam, Meghalaya, Manipur, Mizoram,</p>

Prospectus Cum Sales Literature

<p>Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in</p>	<p>Arunachal Pradesh, Nagaland and Tripura.</p>
<p>HYDERABAD - Shri I. Suresh Babu Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in</p>	<p>Andhra Pradesh, Telangana, UT of Yanam and part of UT of Pondicherry.</p>
<p>JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in</p>	<p>Rajasthan.</p>
<p>ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyards, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in</p>	<p>Kerala, UT of (a)Lakshadweep,(b) Mahe-a part of UT of Pondicherry.</p>
<p>KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in</p>	<p>West Bengal, Sikkim, UT of Andaman & Nicobar Islands.</p>
<p>LUCKNOW -Shri Justice Anil Kumar Srivastava 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@ecoi.co.in</p>	<p>Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.</p>
<p>MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W),</p>	<p>Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.</p>

<p>Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in</p>	
<p>NOIDA - Shri Chandra Shekhar Prasad 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@ecoi.co.in</p>	<p>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.</p>
<p>PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in</p>	<p>Bihar, Jharkhand.</p>
<p>PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in</p>	<p>Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.</p>

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

Tel.: 022 - 26106889 / 671 / 980
Fax: 022 - 26106949
Email: inscoun@ecoi.co.in
Shri. M.M.L. Verma, Secretary General
Smt. Moushumi Mukherji, Secretary

Ombudsmen details are subject to change. Please refer this link for the updated details: [CIO \(cioins.co.in\)](http://CIO(cioins.co.in))”

ANNEXURE II – Product Benefit Table (all limits in INR unless defined as percentage)

Individual and Family Floater - Silver Plan (Renewal only)		
Base Sum Insured (in Rs)	2 lacs	3 lacs
Benefits		
Inpatient care	Covered up to Sum Insured	
Room rent	Shared Room or 1% of the Base Sum Insured per day	
Pre-Hospitalization Medical Expenses (60 days)	Covered up to Sum Insured	
Post-Hospitalization Medical Expenses (90 days)	Covered up to Sum Insured	
Alternative Treatment	Covered up to Sum Insured	
Day Care Treatment	Covered up to Sum Insured	
Domiciliary Hospitalization	Covered up to Sum Insured	
Maternity Benefit (covered for up to 2 pregnancies or terminations) ⁽¹⁾	Covered up to Rs 20,000	Covered up to Rs 30,000
New Born Baby (covered uptill the end of Policy Year) ⁽¹⁾	Covered up to Sum Insured	
Vaccination of the new born baby	Covered until new born baby completes one year, vaccinations as per annexure	
Living Organ Donor Transplant	Covered up to Sum Insured	
Emergency Ambulance	Network Hospital: Covered up to Sum Insured Non-network Hospital: Covered up to Rs. 2,000 per event	
Re-fill benefit	Reinstate up to base Sum Insured. Applicable for same & different illness as well	
Pharmacy and diagnostic services	Available through our empanelled service provider	

Prospectus Cum Sales Literature

HIV / AIDS (waiting period of 4 years)	covered up to Rs 50,000
Emergency assistance services	covered up to Sum Insured
Mental disorder treatment (waiting period of 3 years)	Covered up to Sum Insured (sub-limit of Rs 50,000 applicable on few conditions)
Loyalty Additions	Increase of 10% of expiring Base Sum Insured in a Policy Year; maximum up to 50% of Base Sum Insured
Health Check-up ⁽²⁾	Once in two years, tests as per annexure
Modern Treatments	Covered up to Sum Insured.
Optional Benefits	
Hospital Cash ⁽³⁾	Rs 1,500/day
Personal Accident cover (for insured aged 18 years & above on individual basis)	Personal Accident cover will up to 5 times of base Sum Insured. Max INR 1 Cr.
Critical illness cover (for insured 18 years & above on individual basis)	Critical illness cover will be equal to base Sum Insured
e-consultation	Unlimited tele / online consultations
Premium Waiver	One time premium waiver if the Policyholder dies or suffers from specified illness
Claim cost sharing options	
Co-payment	Options of 10% and 20% co-payment
Annual aggregate Deductible	INR 10,000/ INR 20,000/ INR 30,000/ INR 50,000/ INR 1 lac/ INR 2 lacs / INR 3 lacs

(1) subject to a continuous coverage of 24 months of that Insured Person since the inception of the first Policy which offers Maternity benefit with Us.

(2) If the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year Policy Period (if applicable)

(3) **Hospital Cash** - Minimum 48 hrs of continuous hospitalization required. Maximum coverage offered for 30 days/policy year/insured person. Payment made from day one subject to hospitalization claim being admissible.

Individual and Family Floater - Gold Plan							
Base Sum Insured (in Rs)	5 lacs	7.5 lacs	10 lacs	15 lacs	20 lacs	30 lacs	50 lacs
Benefits							
Inpatient care	Covered up to Sum Insured						
Room rent	Covered up to Sum Insured (except for Suite or above room category)						
Pre-Hospitalization Medical Expenses (60 days)	Covered up to Sum Insured						
Post-Hospitalization Medical Expenses (90 days)	Covered up to Sum Insured						
Alternative Treatment	Covered up to Sum Insured						
Day Care Treatment	Covered up to Sum Insured						
Domiciliary Hospitalization	Covered up to Sum Insured						
Maternity Benefit (covered for up to 2 pregnancies or terminations) ⁽¹⁾	Covered up to Rs 40,000	Covered up to Rs 60,000	Covered up to Rs 70,000	Covered up to Rs 75,000	Covered up to Rs 80,000	Covered up to Rs 1,00,000	Covered up to Rs 1,00,000
New Born Baby (covered uptill the end of Policy Year) ⁽¹⁾	Covered up to Sum Insured						
Vaccination of the new born baby	Covered until new born baby completes one year, vaccinations as per annexure						
Living Organ Donor Transplant	Covered up to Sum Insured						
Emergency Ambulance	Network Hospital: Covered up to Sum Insured Non-network Hospital: Covered up to Rs. 2,000 per event						
Re-fill benefit	Reinstate up to base Sum Insured. Applicable for same & different illness as well						

Prospectus Cum Sales Literature

Pharmacy and diagnostic services	Available through our empanelled service provider							
HIV / AIDS (waiting period of 4 years)	covered up to Rs 50,000							
Emergency assistance services	covered up to Sum Insured							
Mental disorder treatment (waiting period of 3 years)	Covered up to Sum Insured (sub-limit of Rs 50,000 applicable on few conditions)							
Loyalty Additions	Increase of 10% of expiring Base Sum Insured in a Policy Year; maximum up to 100% of Base Sum Insured							
Health Check-up ⁽²⁾	Annual, Tests covered up to worth Rs 1,250 per Insured Person	Annual, Tests covered up to worth Rs 1,875 per Insured Person	Annual, Tests covered up to worth Rs 2,500 per Insured Person	Annual, Tests covered up to worth Rs 2,500 per Insured Person	Annual, Tests covered up to worth Rs 2,500 per Insured Person	Annual, Tests covered up to worth Rs 2,500 per Insured Person	Annual, Tests covered up to worth Rs 2,500 per Insured Person	Annual, Tests covered up to worth Rs 2,500 per Insured Person
Modern Treatments	Covered up to Sum Insured.							
Optional Benefits								
Hospital Cash ⁽³⁾	Rs 3,000/day							
Personal Accident cover (for insured aged 18 years & above on individual basis)	Personal Accident cover will be up to 5 times of base Sum Insured. Max INR 1 Cr							
Critical illness cover (for insured 18 years & above on individual basis)	Critical illness cover will be equal to base Sum Insured; subject to maximum of 10 lacs							
e-consultation	Unlimited tele / online consultations							

Premium Waiver	One time premium waiver if the Policyholder dies or suffers from specified illness
Claim cost sharing options	
Co-payment	Options of 10% and 20% co-payment
Annual Aggregate Deductible	INR 10,000/ INR 20,000/ INR 30,000/ INR 50,000/ INR 1 lac/ INR 2 lacs / INR 3 lacs/ INR 4 lacs/ INR 5Lacs/ 10 Lacs

(1) subject to a continuous coverage of 24 months of that Insured Person since the inception of the first Policy which offers Maternity benefit with Us.

(2) If the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year Policy Period (if applicable)

(3) Hospital Cash - Minimum 48 hrs of continuous hospitalization required. Maximum coverage offered for 30 days/policy year/insured person. Payment made from day one subject to hospitalization claim being admissible.

Individual and Family Floater - Platinum Plan				
Base Sum Insured (in Rs)	15 lacs	20 lacs	50 lacs	1 Cr
Benefits				
Inpatient care	Covered up to Sum Insured			
Room rent	Covered up to Sum Insured			
Pre-Hospitalization Medical Expenses (60 days)	Covered up to Sum Insured			
Post-Hospitalization Medical Expenses (90 days)	Covered up to Sum Insured			
Alternative Treatment	Covered up to Sum Insured			
Day Care Treatment	Covered up to Sum Insured			
Domiciliary Hospitalization	Covered up to Sum Insured			
Maternity Benefit (covered for up to 2 pregnancies or terminations) ⁽¹⁾	Covered up to Rs 120,000	Covered up to Rs 160,000	Covered up to Rs 200,000	Covered up to Rs 200,000
New Born Baby (covered uptill the end of Policy Year) ⁽¹⁾	Covered up to Sum Insured			
Vaccination of the new born baby	Covered until new born baby completes one year, vaccinations as per annexure			
Living Organ Donor Transplant	Covered up to Sum Insured			
Emergency Ambulance	Network Hospital: Covered up to Sum Insured Non-network Hospital: Covered up to Rs. 2,000 per event			
Re-fill benefit	Reinstate up to base Sum Insured. Applicable for same & different illness as well			
Pharmacy and diagnostic services	Available through our empanelled service provider			
HIV / AIDS (waiting period of 4 years)	covered up to Rs 50,000			
Emergency assistance services	covered up to Sum Insured			

Prospectus Cum Sales Literature

Mental disorder treatment (waiting period of 3 years)	Covered up to Sum Insured (sub-limit of Rs 50,000 applicable on few conditions)			
OPD Treatment and Diagnostic Services	Covered up to Rs 15,000	Covered up to Rs 20,000	Covered up to Rs 35,000	Covered up to Rs 50,000
Child Care Benefits (Vaccinations for children up to 12 years including one consultation for nutrition and growth during the visit for vaccination)	Covered up to Sum Insured (As per annexure)			
Emergency Medical Evacuation (outside the geographical boundaries of India)	Covered up to Sum Insured (for worldwide excluding USA & Canada)			
Emergency Hospitalization (outside the geographical boundaries of India)	Covered up to Sum Insured (for worldwide excluding USA & Canada)			
Specified Illness Cover (outside the geographical boundaries of India) ⁽²⁾	Covered up to Sum Insured (for worldwide excluding USA & Canada)			
Second Medical Opinion	Covered, One opinion per Insured Person per Specified Illness / planned Surgery / Surgical Procedure			
Loyalty Additions	Increase of 10% of expiring Base Sum Insured in a Policy Year; maximum up to 100% of Base Sum Insured			
Health Check-up ⁽³⁾	Annual, tests covered up to worth Rs 3750 per Insured Person	Annual, tests covered up to worth Rs 5000 per Insured Person	Annual, tests covered up to worth Rs 5000 per Insured Person	Annual, tests covered up to worth Rs 5000 per Insured Person
Modern Treatments	Covered up to Sum Insured.			
Optional Benefits				
Hospital Cash ⁽⁴⁾	Rs 6,000/day			
Enhanced Geographical Scope for International coverage	USA & Canada included for 'Emergency Medical Evacuation', 'Emergency Hospitalization' & 'Specified illness cover'			
Personal Accident cover (for insured aged 18 years & above on individual basis)	Personal Accident cover will be up to 5 times of base sum Insured. Max upto INR 1 Cr			

Critical illness cover (for insured 18 years & above on individual basis)	Critical illness cover will be equal to 10 lacs
e-consultation	Unlimited tele / online consultations
Premium Waiver	One time premium waiver if the Policyholder dies or suffers from specified illness
Claim cost sharing options	
Co-payment	Options of 10% and 20% co-payment
Annual Aggregate Deductible	INR 10,000/ INR 20,000/ INR 30,000/ INR 50,000/ INR 1 lac/ INR 2 lacs / INR 3 lacs/ INR 4 lacs/ INR 5Lacs/ 10 Lacs

(1) subject to a continuous coverage of 24 months of that Insured Person since the inception of the first Policy which offers Maternity benefit with Us.

(2) The symptoms of the Specified Illness first occur or manifest itself during the Policy Period and after completion of the 90 day from the inception of 1st Policy with Us.

(3) If the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year Policy Period (if applicable)

(4) Hospital Cash - Minimum 48 hrs of continuous hospitalization required. Maximum coverage offered for 30 days/policy year/insured person. Payment made from day one subject to hospitalization claim being admissible.

Family First - Silver Plan	
	Base Sum Insured: 1Lacs, 2Lacs, 3Lacs, 4Lacs & 5Lacs per Insured Person
	Floater Sum Insured – (available on a floating basis over Base Sum Insured): 3Lacs, 4Lacs, 5Lacs, 10Lacs & 15Lacs.
Benefits	
Inpatient care	Covered up to Sum Insured
Room rent	Rs 3,000 per day or Shared Room
Pre-Hospitalization Medical Expenses (60 days)	Covered up to Sum Insured
Post-Hospitalization Medical Expenses (90 days)	Covered up to Sum Insured
Alternative Treatment	Covered up to Sum Insured
Day Care Treatment	Covered up to Sum Insured
Domiciliary Hospitalization	Covered up to Sum Insured
Maternity Benefit (covered for up to 2 pregnancies or terminations) ⁽¹⁾	Covered up to Rs 35,000 per Policy Year
New Born Baby (covered uptill the end of Policy Year) ⁽¹⁾	Covered up to Sum Insured
Vaccination of the new born baby	Covered until new born baby completes one year, vaccinations as per annexure
Living Organ Donor Transplant	Covered up to Sum Insured
Emergency Ambulance	Network Hospital: Covered up to Sum Insured Non-network Hospital: Covered up to Rs. 2,000 per event
Pharmacy and diagnostic services	Available through our empanelled service provider
HIV / AIDS (waiting period of 4 years)	covered up to Rs 50,000
Emergency assistance services	covered up to Sum Insured

Prospectus Cum Sales Literature

Mental disorder treatment (waiting period of 3 years)	Covered up to Sum Insured (sub-limit of Rs 50,000 applicable on few conditions)
Loyalty Additions	Increase of 10% of expiring Base Sum Insured in a Policy Year; maximum up to 50% of Base Sum Insured
Health Check-up ⁽²⁾	Once in two years, tests as per annexure
Modern Treatments	Covered up to Sum Insured.
Optional Benefits	
Hospital Cash ⁽³⁾	Rs 1,500/day
Personal Accident cover (for insured aged 18 years & above on individual basis)	Personal Accident cover will be equal to 5 times of base Sum Insured; subject to maximum of INR 1 Cr
Critical illness cover (for insured 18 years & above on individual basis)	Critical illness cover will be equal to base Sum Insured
e-consultation	Unlimited tele / online consultations
Premium Waiver	One time premium waiver if the Policyholder dies or suffers from specified illness
Claim cost sharing options	
Co-payment	Options of 10% and 20% co-payment

(1) subject to a continuous coverage of 24 months of that Insured Person since the inception of the first Policy which offers Maternity benefit with Us.

(2) If the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year Policy Period (if applicable)

(3) Hospital Cash - Minimum 48 hrs of continuous hospitalization required. Maximum coverage offered for 30 days/policy year/insured person. Payment made from day one subject to hospitalization claim being admissible.

Family First - Gold Plan	
Base Sum Insured: 1Lacs, 2Lacs, 3Lacs, 4Lacs, 5Lacs, 10Lacs & 15Lacs per Insured Person	

	Floater Sum Insured – (available on a floating basis over Base Sum Insured): 3Lacs, 4Lacs, 5Lacs, 10Lacs, 15Lacs, 20Lacs, 30Lacs & 50Lacs
Benefits	
Inpatient care	Covered up to Sum Insured
Room rent	Covered up to Sum Insured (except for Suite or above room category)
Pre-Hospitalization Medical Expenses (60 days)	Covered up to Sum Insured
Post-Hospitalization Medical Expenses (90 days)	Covered up to Sum Insured
Alternative Treatment	Covered up to Sum Insured
Day Care Treatment	Covered up to Sum Insured
Domiciliary Hospitalization	Covered up to Sum Insured
Maternity Benefit (covered for up to 2 pregnancies or terminations) ⁽¹⁾	Covered up to Rs 50,000 per Policy Year
New Born Baby (covered uptill the end of Policy Year) ⁽¹⁾	Covered up to Sum Insured
Vaccination of the new born baby	Covered until new born baby completes one year, vaccinations as per annexure
Living Organ Donor Transplant	Covered up to Sum Insured
Emergency Ambulance	Network Hospital: Covered up to Sum Insured Non-network Hospital: Covered up to Rs. 2,000 per event
Pharmacy and diagnostic services	Available through our empanelled service provider
HIV / AIDS (waiting period of 4 years)	covered up to Rs 50,000
Emergency assistance services	covered up to Sum Insured
Mental disorder treatment (waiting period of 3 years)	Covered up to Sum Insured (sub-limit of Rs 50,000 applicable on few conditions)

Loyalty Additions	Increase of 10% of expiring Base Sum Insured in a Policy Year; maximum up to 100% of Base Sum Insured
Health Check-up ⁽²⁾	Annual, Tests covered up to worth Rs 2,500 per Insured Person
Modern Treatments	Covered up to Sum Insured.
Optional Benefits	
Hospital Cash ⁽³⁾	Rs 3,000/day
Personal Accident cover (for insured aged 18 years & above on individual basis)	Personal Accident cover will be equal to 5 times of base Sum Insured; subject to maximum of INR 1 Cr
Critical illness cover (for insured 18 years & above on individual basis)	Critical illness cover will be equal to base Sum Insured; subject to maximum of 10 lacs
e-consultation	Unlimited tele / online consultations
Premium Waiver	One time premium waiver if the Policyholder dies or suffers from specified illness
Claim cost sharing options	
Co-payment	Options of 10% and 20% co-payment

(1) subject to a continuous coverage of 24 months of that Insured Person since the inception of the first Policy which offers Maternity benefit with Us.

(2) If the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year Policy Period (if applicable)

(3) Hospital Cash - Minimum 48 hrs of continuous hospitalization required. Maximum coverage offered for 30 days/policy year/insured person. Payment made from day one subject to hospitalization claim being admissible.

Family First - Platinum Plan

	Base Sum Insured: 5Lacs, 10 Lacs & 15 Lacs per Insured Person
	Floater Sum Insured: (available on a floating basis over Base Sum Insured): 15Lacs, 20 Lacs, 30 Lacs & 50 Lacs.
Benefits	
Inpatient care	Covered up to Sum Insured
Room rent	Covered up to Sum Insured
Pre-Hospitalization Medical Expenses (60 days)	Covered up to Sum Insured
Post-Hospitalization Medical Expenses (90 days)	Covered up to Sum Insured
Alternative Treatment	Covered up to Sum Insured
Day Care Treatment	Covered up to Sum Insured
Domiciliary Hospitalization	Covered up to Sum Insured
Maternity Benefit (covered for up to 2 pregnancies or terminations) ⁽¹⁾	Covered up to Rs 100,000
New Born Baby (covered uptill the end of Policy Year) ⁽¹⁾	Covered up to Sum Insured
Vaccination of the new born baby	Covered until new born baby completes one year, vaccinations as per annexure
Living Organ Donor Transplant	Covered up to Sum Insured
Emergency Ambulance	Network Hospital: Covered up to Sum Insured Non-network Hospital: Covered up to Rs. 2,000 per event
Pharmacy and diagnostic services	Available through our empanelled service provider
HIV / AIDS (waiting period of 4 years)	covered up to Rs 50,000
Emergency assistance services	covered up to Sum Insured
Mental disorder treatment (waiting period of 3 years)	Covered up to Sum Insured (sub-limit of Rs 50,000 applicable on few conditions)

OPD Treatment and Diagnostic Services	Covered up to Rs 35,000
Child Care Benefits (Vaccinations for children up to 12 years including one consultation for nutrition and growth during the visit for vaccination)	Covered up to Sum Insured (As per annexure)
Emergency Medical Evacuation (outside the geographical boundaries of India)	Covered up to Sum Insured (for worldwide excluding USA & Canada)
Emergency Hospitalization (outside the geographical boundaries of India)	Covered up to Sum Insured (for worldwide excluding USA & Canada)
Specified Illness Cover (outside the geographical boundaries of India) ⁽²⁾	Covered up to Sum Insured (for worldwide excluding USA & Canada)
Second Medical Opinion	Covered, One opinion per Insured Person per Specified Illness / planned Surgery / Surgical Procedure
Loyalty Additions	Increase of 10% of expiring Base Sum Insured in a Policy Year; maximum up to 100% of Base Sum Insured
Health Check-up ⁽³⁾	Annual, tests covered up to worth Rs 5000 per Insured Person
Modern Treatments	Covered up to Sum Insured.
Optional Benefits	
Hospital Cash ⁽⁴⁾	Rs 6,000/day
Enhanced Geographical Scope for International coverage	USA & Canada included for 'Emergency Medical Evacuation', 'Emergency Hospitalization' & 'Specified illness cover'
Personal Accident cover (for insured aged 18 years & above on individual basis)	Personal Accident cover will be equal to 5 times of base Sum Insured; subject to maximum of INR 1 Cr
Critical illness cover (for insured 18 years & above on individual basis)	Critical illness cover will be equal to base Sum Insured; subject to maximum of 10 lacs
e-consultation	Unlimited tele / online consultations

Premium Waiver	One time premium waiver if the Policyholder dies or suffers from specified illness
Claim cost sharing options	
Co-payment	Options of 10% and 20% co-payment

- (1) subject to a continuous coverage of 24 months of that Insured Person since the inception of the first Policy which offers Maternity benefit with Us.
- (2) The symptoms of the Specified Illness first occur or manifest itself during the Policy Period and after completion of the 90 day from the inception of 1st Policy with Us.
- (3) If the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year Policy Period (if applicable)
- (4) Hospital Cash - Minimum 48 hrs of continuous hospitalization required. Maximum coverage offered for 30 days/policy year/insured person. Payment made from day one subject to hospitalization claim being admissible.

Annexure III - Day Care Treatments

Sr. No	Header	Procedure Name
I	Cardiology Related:	
1		CORONARY ANGIOGRAPHY
II	Critical Care Related:	
2		INSERT NON- TUNNEL CV CATH
3		INSERT PICC CATH (PERIPHERALLY INSERTED CENTRAL CATHETER)
4		REPLACE PICC CATH (PERIPHERALLY INSERTED CENTRAL CATHETER)
5		INSERTION CATHETER, INTRA ANTERIOR
6		INSERTION OF PORTACATH
III	Dental Related:	
7		SPLINTING OF AVULSED TEETH
8		SUTURING LACERATED LIP
9		SUTURING ORAL MUCOSA
10		ORAL BIOPSY IN CASE OF ABNORMAL TISSUE PRESENTATION
11		FNAC
12		SMEAR FROM ORAL CAVITY
IV	ENT Related:	
13		MYRINGOTOMY WITH GROMMET INSERTION
14		TYMpanoplasty (CLOSURE OF AN EAR DRUM 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 EAR DRUM 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 (POSTAURA/ENDAURAL APPROACH AS WELL AS SIMPLE TYPE -I TYMpanoplasty)
24		FENESTRATION OF THE INNER EAR
25		REVISION OF A FENESTRATION OF THE INNER EAR
26		PALATOPLASTY
27		TRANSORAL INCISION AND DRAINAGE OF A PHARYNGEAL ABSCESS
28		TONSILLECTOMY WITHOUT ADENOIDECTOMY
29		TONSILLECTOMY WITH ADENOIDECTOMY
30		EXCISION AND DESTRUCTION OF A LINGUAL TONSIL
31		REVISION OF A TYMpanoplasty
32		OTHER MICROSURGICAL OPERATIONS ON THE MIDDLE EAR
33		INCISION OF THE MASTOID PROCESS AND MIDDLE EAR
34		MASTOIDECTOMY
35		RECONSTRUCTION OF THE MIDDLE EAR
36		OTHER EXCISIONS OF THE MIDDLE AND INNER EAR
37		INCISION (OPENING) AND DESTRUCTION (ELIMINATION) OF THE INNER EAR

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

	81	COLONOSCOPY ,LESION REMOVAL
	82	ERCP
	83	COLONOSCOPY STENTING OF STRICTURE
	84	PERCUTANEOUS ENDOSCOPIC GASTROSTOMY
	85	EUS AND PANCREATIC PSEUDO CYST DRAINAGE
	86	ERCP AND CHOLEDOCHOSCOPY
	87	PROCTOSIGMOIDOSCOPY VOLVULUS DETORSION
	88	ERCP AND SPHINCTEROTOMY
	89	ESOPHAGEAL STENT PLACEMENT
	90	ERCP + PLACEMENT OF BILIARY STENTS
	91	SIGMOIDOSCOPY W / STENT
	92	EUS + COELIAC NODE BIOPSY
	93	UGI SCOPY AND INJECTION OF ADRENALINE, SCLEROSANTS BLEEDING ULCERS
VI	General Surgery Related:	
	94	INCISION OF A PILONIDAL SINUS / ABSCESS
	95	FISSURE IN ANO SPHINCTEROTOMY
	96	SURGICAL TREATMENT OF A VARICOCELE AND A HYDROCELE OF THE SPERMATIC CORD
	97	ORCHIDOPEXY
	98	ABDOMINAL EXPLORATION IN CRYPTORCHIDISM
	99	SURGICAL TREATMENT OF ANAL FISTULAS
	100	DIVISION OF THE ANAL SPHINCTER (SPHINCTEROTOMY)
	101	EPIDIDYMECTOMY
	102	INCISION OF THE BREAST ABSCESS
	103	OPERATIONS ON THE NIPPLE
	104	EXCISION OF SINGLE BREAST LUMP
	105	INCISION AND EXCISION OF TISSUE IN THE PERIANAL REGION
	106	SURGICAL TREATMENT OF HEMORRHOIDS
	107	OTHER OPERATIONS ON THE ANUS
	108	ULTRASOUND GUIDED ASPIRATIONS
	109	SCLEROTHERAPY,
	110	THERAPEUTIC LAPAROSCOPY WITH LASER
	111	INFECTED KELOID EXCISION
	112	AXILLARY LYMPHADENECTOMY
	113	WOUND DEBRIDEMENT AND COVER
	114	ABSCESS-DECOMPRESSION
	115	CERVICAL LYMPHADENECTOMY
	116	INFECTED SEBACEOUS CYST
	117	INGUINAL LYMPHADENECTOMY
	118	INCISION AND DRAINAGE OF ABSCESS
	119	SUTURING OF LACERATIONS
	120	SCALP SUTURING
	121	INFECTED LIPOMA EXCISION
	122	MAXIMAL ANAL DILATATION
	123	PILES
	124	A)INJECTION SCLEROTHERAPY

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

	170	PHOTODYNAMIC THERAPY OR ESOPHAGEAL TUMOUR AND LUNG TUMOUR
	171	EXCISION OF CERVICAL RIB
	172	LAPAROSCOPIC REDUCTION OF INTUSSUSCEPTION
	173	MICRODOCHECTOMY BREAST
	174	SURGERY FOR FRACTURE PENIS
	175	SENTINEL NODE BIOPSY
	176	PARASTOMAL HERNIA
	177	REVISION COLOSTOMY
	178	PROLAPSED COLOSTOMY- CORRECTION
	179	TESTICULAR BIOPSY
	180	LAPAROSCOPIC CARDIOMYOTOMY(HELLERS)
	181	SENTINEL NODE BIOPSY MALIGNANT MELANOMA
	182	LAPAROSCOPIC PYLOROMYOTOMY(RAMSTEDT)
	183	EXCISION OF FISTULA-IN-ANO
	184	EXCISION JUVENILE POLYPS RECTUM
	185	VAGINOPLASTY
	186	DILATATION OF ACCIDENTAL CAUSTIC STRICTURE OESOPHAGEAL
	187	PRESACRAL TERATOMAS EXCISION
	188	REMOVAL OF VESICAL STONE
	189	EXCISION SIGMOID POLYP
	190	STERNOMASTOID TENOTOMY
	191	INFANTILE HYPERTROPHIC PYLORIC STENOSIS PYLOROMYOTOMY
	192	EXCISION OF SOFT TISSUE RHABDOMYOSARCOMA
	193	MEDIASTINAL LYMPH NODE BIOPSY
	194	HIGH ORCHIDECTOMY FOR TESTIS TUMOURS
	195	EXCISION OF CERVICAL TERATOMA
	196	RECTAL-MYOMECTOMY
	197	RECTAL PROLAPSE (DELORME'S PROCEDURE)
	198	DETORSION OF TORSION TESTIS
	199	EUA + BIOPSY MULTIPLE FISTULA IN ANO
	200	CYSTIC HYGROMA - INJECTION TREATMENT
VII	Gynecology Related:	
	201	OPERATIONS ON BARTHOLIN'S GLANDS (CYST)
	202	INCISION OF THE OVARY
	203	INSUFFLATIONS OF THE FALLOPIAN TUBES
	204	OTHER OPERATIONS ON THE FALLOPIAN TUBE
	205	DILATATION OF THE CERVICAL CANAL
	206	CONISATION OF THE UTERINE CERVIX
	207	THERAPEUTIC CURETTAGE WITH COLPOSCOPY/BIOPSY/DIATHERMY/CRY OSURGERY/
	208	LASER THERAPY OF CERVIX FOR VARIOUS LESIONS OF UTERUS
	209	OTHER OPERATIONS ON THE UTERINE CERVIX
	210	LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE VAGINA AND THE POUCH OF DOUGLAS
	211	INCISION OF VAGINA
	212	INCISION OF VULVA
	213	CULDOTOMY

	214	SALPINGO-OOPHORECTOMY VIA LAPAROTOMY
	215	ENDOSCOPIC POLYPECTOMY
	216	HYSTEROSCOPIC REMOVAL OF MYOMA
	217	D&C
	218	HYSTEROSCOPIC RESECTION OF SEPTUM
	219	THERMAL CAUTERISATION OF CERVIX
	220	MIRENA INSERTION
	221	HYSTEROSCOPIC ADHESIOLYSIS
	222	LEEP (LOOP ELECTROSURGICAL EXCISION PROCEDURE)
	223	CRYOCAUTERISATION OF CERVIX
	224	POLYPECTOMY ENDOMETRIUM
	225	HYSTEROSCOPIC RESECTION OF FIBROID
	226	LLETZ (LARGE LOOP EXCISION OF TRANSFORMATION ZONE)
	227	CONIZATION
	228	POLYPECTOMY CERVIX
	229	HYSTEROSCOPIC RESECTION OF ENDOMETRIAL POLYP
	230	VULVAL WART EXCISION
	231	LAPAROSCOPIC PARAOVARIAN CYST EXCISION
	232	UTERINE ARTERY EMBOLIZATION
	233	LAPAROSCOPIC CYSTECTOMY
	234	HYMENECTOMY(IMPERFORATE HYMEN)
	235	ENDOMETRIAL ABLATION
	236	VAGINAL WALL CYST EXCISION
	237	VULVAL CYST EXCISION
	238	LAPAROSCOPIC PARATUBAL CYST EXCISION
	239	REPAIR OF VAGINA (VAGINAL ATRESIA)
	240	HYSTEROSCOPY, REMOVAL OF MYOMA
	241	TURBT
	242	URETEROCOELE REPAIR - CONGENITAL INTERNAL
	243	VAGINAL MESH FOR POP
	244	LAPAROSCOPIC MYOMECTOMY
	245	SURGERY FOR SUI
	246	REPAIR RECTO- VAGINA FISTULA
	247	PELVIC FLOOR REPAIR(EXCLUDING FISTULA REPAIR)
	248	URS + LL
	249	LAPAROSCOPIC OOPHORECTOMY
	250	NORMAL VAGINAL DELIVERY AND VARIANTS
VIII	Neurology Related:	
	251	FACIAL NERVE PHYSIOTHERAPY
	252	NERVE BIOPSY
	253	MUSCLE BIOPSY
	254	EPIDURAL STEROID INJECTION
	255	GLYCEROL RHIZOTOMY
	256	SPINAL CORD STIMULATION
	257	MOTOR CORTEX STIMULATION

	258	STEREOTACTIC RADIOSURGERY
	259	PERCUTANEOUS CORDOTOMY
	260	INTRATHECAL BACLOFEN THERAPY
	261	ENTRAPMENT NEUROPATHY RELEASE
	262	DIAGNOSTIC CEREBRAL ANGIOGRAPHY
	263	VP SHUNT
	264	VENTRICULOATRIAL SHUNT
IX	Oncology Related:	
	265	RADIOTHERAPY FOR CANCER
	266	CANCER CHEMOTHERAPY
	267	IV PUSH CHEMOTHERAPY
	268	HBI-HEMIBODY RADIOTHERAPY
	269	INFUSIONAL TARGETED THERAPY
	270	SRT-STEREOTACTIC ARC THERAPY
	271	SC ADMINISTRATION OF GROWTH FACTORS
	272	CONTINUOUS INFUSIONAL CHEMOTHERAPY
	273	INFUSIONAL CHEMOTHERAPY
	274	CCRT-CONCURRENT CHEMO + RT
	275	2D RADIOTHERAPY
	276	3D CONFORMAL RADIOTHERAPY
	277	IGRT- IMAGE GUIDED RADIOTHERAPY
	278	IMRT- STEP & SHOOT
	279	INFUSIONAL BISPHOSPHONATES
	280	IMRT- DMLC
	281	ROTATIONAL ARC THERAPY
	282	TELE GAMMA THERAPY
	283	FSRT-FRACTIONATED SRT
	284	VMAT-VOLUMETRIC MODULATED ARC THERAPY
	285	SBRT-STEREOTACTIC BODY RADIOTHERAPY
	286	HELICAL TOMOTHERAPY
	287	SRS-STEREOTACTIC RADIOSURGERY
	288	X-KNIFE SRS
	289	GAMMAKNIFE SRS
	290	TBI- TOTAL BODY RADIOTHERAPY
	291	INTRALUMINAL BRACHYTHERAPY
	292	ELECTRON THERAPY
	293	TSET-TOTAL ELECTRON SKIN THERAPY
	294	EXTRACORPOREAL IRRADIATION OF BLOOD PRODUCTS
	295	TELECOBALT THERAPY
	296	TELECESIUM THERAPY
	297	EXTERNAL MOULD BRACHYTHERAPY
	298	INTERSTITIAL BRACHYTHERAPY
	299	INTRACAVITY BRACHYTHERAPY
	300	3D BRACHYTHERAPY
	301	IMPLANT BRACHYTHERAPY

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

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

385	ARTHROSCOPIC REPAIR OF PCL TEAR KNEE
386	TENDON SHORTENING
387	ARTHROSCOPIC MENISCECTOMY - KNEE
388	TREATMENT OF CLAVICLE DISLOCATION
389	HAEMARTHROSIS KNEE- LAVAGE
390	ABSCESS KNEE JOINT DRAINAGE
391	CARPAL TUNNEL RELEASE
392	CLOSED REDUCTION OF MINOR DISLOCATION
393	REPAIR OF KNEE CAP TENDON
394	ORIF WITH K WIRE FIXATION- SMALL BONES
395	RELEASE OF MIDFOOT JOINT
396	ORIF WITH PLATING- SMALL LONG BONES
397	IMPLANT REMOVAL MINOR
398	K WIRE REMOVAL
399	POP APPLICATION
400	CLOSED REDUCTION AND EXTERNAL FIXATION
401	ARTHROTOMY HIP JOINT
402	SYME'S AMPUTATION
403	ARTHROPLASTY
404	PARTIAL REMOVAL OF RIB
405	TREATMENT OF SESAMOID BONE FRACTURE
406	SHOULDER ARTHROSCOPY / SURGERY
407	ELBOW ARTHROSCOPY
408	AMPUTATION OF METACARPAL BONE
409	RELEASE OF THUMB CONTRACTURE
410	INCISION OF FOOT FASCIA
411	CALCANEUM SPUR HYDROCORT INJECTION
412	GANGLION WRIST HYALASE INJECTION
413	PARTIAL REMOVAL OF METATARSAL
414	REPAIR / GRAFT OF FOOT TENDON
415	REVISION/REMOVAL OF KNEE CAP
416	AMPUTATION FOLLOW-UP SURGERY
417	EXPLORATION OF ANKLE JOINT
418	REMOVE/GRAFT LEG BONE LESION
419	REPAIR/GRAFT ACHILLES TENDON
420	REMOVE OF TISSUE EXPANDER
421	BIOPSY ELBOW JOINT LINING
422	REMOVAL OF WRIST PROSTHESIS
423	BIOPSY FINGER JOINT LINING
424	TENDON LENGTHENING
425	TREATMENT OF SHOULDER DISLOCATION
426	LENGTHENING OF HAND TENDON
427	REMOVAL OF ELBOW BURSA
428	FIXATION OF KNEE JOINT
429	TREATMENT OF FOOT DISLOCATION

	430	SURGERY OF BUNION
	431	INTRA ARTICULAR STEROID INJECTION
	432	TENDON TRANSFER PROCEDURE
	433	REMOVAL OF KNEE CAP BURSA
	434	TREATMENT OF FRACTURE OF ULNA
	435	TREATMENT OF SCAPULA FRACTURE
	436	REMOVAL OF TUMOR OF ARM/ ELBOW UNDER RA/GA
	437	REPAIR OF RUPTURED TENDON
	438	DECOMPRESS FOREARM SPACE
	439	REVISION OF NECK MUSCLE (TORTICOLLIS RELEASE)
	440	LENGTHENING OF THIGH TENDONS
	441	TREATMENT FRACTURE OF RADIUS & ULNA
	442	REPAIR OF KNEE JOINT
XV	Other operations on the mouth & face:	
	443	EXTERNAL INCISION AND DRAINAGE IN THE REGION OF THE MOUTH, JAW AND FACE
	444	INCISION OF THE HARD AND SOFT PALATE
	445	EXCISION AND DESTRUCTION OF DISEASED HARD AND SOFT PALATE
	446	INCISION, EXCISION AND DESTRUCTION IN THE MOUTH
	447	OTHER OPERATIONS IN THE MOUTH
XVI	Plastic Surgery Related:	
	448	CONSTRUCTION SKIN PEDICLE FLAP
	449	GLUTEAL PRESSURE ULCER-EXCISION
	450	MUSCLE-SKIN GRAFT, LEG
	451	REMOVAL OF BONE FOR GRAFT
	452	MUSCLE-SKIN GRAFT DUCT FISTULA
	453	REMOVAL CARTILAGE GRAFT
	454	MYOCUTANEOUS FLAP
	455	FIBRO MYOCUTANEOUS FLAP
	456	BREAST RECONSTRUCTION SURGERY AFTER MASTECTOMY
	457	SLING OPERATION FOR FACIAL PALSY
	458	SPLIT SKIN GRAFTING UNDER RA
	459	WOLFE SKIN GRAFT
	460	PLASTIC SURGERY TO THE FLOOR OF THE MOUTH UNDER GA
XVII	Thoracic surgery Related:	
	461	THORACOSCOPY AND LUNG BIOPSY
	462	EXCISION OF CERVICAL SYMPATHETIC CHAIN THORACOSCOPIC
	463	LASER ABLATION OF BARRETT'S OESOPHAGUS
	464	PLEURODESIS
	465	THORACOSCOPY AND PLEURAL BIOPSY
	466	EBUS + BIOPSY
	467	THORACOSCOPY LIGATION THORACIC DUCT
	468	THORACOSCOPY ASSISTED EMPYEMA DRAINAGE
XVIII	Urology Related:	
	469	HAEMODIALYSIS
	470	LITHOTRIPSY/NEPHROLITHOTOMY FOR RENAL CALCULUS

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

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

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

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

ANNEXURE V - ICD codes for the specified disorders / conditions

Disorder / Condition	ICD Codes
Severe Depression	F33.0, F33.1, F33.2, F33.4, F33.5, F33.6, F33.7, F33.8, F33.9, O90.6, F34.1, F32.81, F32.0, F32.1, F32.2, F32.4, F32.5, F32.6, F32.7, 32.8, F32.9, F33.9, F30.0, F30.1, F30.2, F30.4, F30.5, F30.6, F30.7, F30.8, F30.9, F32.3, F33.3, F43.21, F32.8, F33.40, F32.9
Schizophrenia	F20.0, F20.1, F20.2, F20.3, F20.5, F21, F22, F23, F24, F20.8, F25.0, F25.1, F25.8, F25.9
Bipolar Disorder	F31.0, F31.1, F31.2, F31.4, F31.5, F31.6, F31.7, F31.8, F31.9
Post traumatic stress disorder	F43.0, F43.1, F43.2, F43.8, F43.9
Eating disorder	F50.0, F50.2, F50.8, F98.3, F98.21, F50.8
Generalized anxiety disorder	F40.1, F41.0, F40.2, F40.8, F40.9, F41.1, F41.3, F41.8
Obsessive compulsive disorders	F42
Panic disorders	F41.1, F40.1, F60.7, F93.0, F94.0
Personality disorders	F60.0, F60.1, F60.2, F60.3, F60.4, F60.8, F60.6, F60.7, F60.5
Conversion disorders	F44.4, F44.5, F44.6, F44.7
Dissociative disorders	F44.5, F44.8, F48.1, F44.1, F44.2

ANNEXURE VI

The expenses that are not covered or subsumed into room charges / procedure charges / costs of treatment

List I – Expenses not covered

Sl. No.	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES

24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES

53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

Sl. No.	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN

10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

Sl. No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

Sl. No.	Item
---------	------

1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP- COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION\STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

Benefit Illustration

Benefit Illustration (5 Lac Sum Insured, Policy Term 1 year)										
Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount, if any	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or Consolidated premium for all members of family (Rs.)	Float or discount, if any	Premium after discount (Rs.)	Sum Insured (Rs.)
			Illustration 1							
18	20,24 0.74	500,000	NA	NA	NA	NA	20,240 .74	28,75 0.07	73,15 2.04	500,000
21	20,30 7.18	500,000	NA	NA	NA	NA	20,307 .18			
39	27,12 0.11	500,000	NA	NA	NA	NA	27,120 .11			
45	34,23 4.08	500,000	NA	NA	NA	NA	34,234 .08			
Total premium for all members of the family is Rs.1,01,902.12, when each member is covered separately. Sum Insured			Total premium for all members of the family is NA, when they are covered under a single policy. Sum Insured available for each family member is NA.				Total premium when the policy is opted on floater basis is Rs.73,152.04. Sum Insured of Rs.500,000 is available for the entire family.			

available for each individual is Rs.500,000.										
			Illustration 2							
55	61,99 8.20	500, 000	NA	NA	NA	NA	61,998 .20	20,52 0.94	138,8 11.01	500, 000
63	97,33 3.75	500, 000	NA	NA	NA	NA	97,333 .75			
Total premium for all members of the family is Rs.1,59,331.95, when each member is covered separately. Sum Insured available for each individual is Rs.500,000.			Total premium for all members of the family is NA, when they are covered under a single policy. Sum Insured available for each family member is NA.				Total premium when the policy is opted on floater basis is Rs.1,38,811.01. Sum Insured of Rs.500,000 is available for the entire family.			
			Illustration 3							
65	105,4 90.29	500, 000	NA	NA	NA	NA	105,49 0.29	57,00 4.65	185,0 50.97	500, 000
70	136,5 65.33	500, 000	NA	NA	NA	NA	136,56 5.33			
Total premium for all members of the family is Rs.2,42,055.62, when each member is covered separately. Sum Insured available for each individual is Rs.500,000.			Total premium for all members of the family is NA, when they are covered under a single policy. Sum Insured available for each family member is NA.				Total premium when the policy is opted on floater basis is Rs.1,85,050.97. Sum Insured of Rs.500,000 is available for the entire family.			

Note: Premium rates specified in the above illustration are standard premium rates without considering any loading. Also, the premium rates are exclusive of taxes applicable.

Zone 1 base premium (Level 10) is considered for Gold Variant

