

<Date>
<Name of the Policyholder>
<Address>
<City> - <Pin Code><State>
G. O. Name: <G O Name>

Telephone: <Telephone number>
Email id: <Email address>

Welcome Dear <Name of the Policyholder>,

Axis Max Life Insurance Limited (“AMLI”) & Niva Bupa Health Insurance Company Limited (“Niva Bupa”) have come together to offer you Axis Max Life Insurance & Niva Bupa Health Insurance Smart Life-N-Health Loansure Plan, a Non-Linked Non-Participating Group Combi Insurance Plan with UIN <<104Y134V01>>.

This product is a Life and Health Combi of Axis Max Life Group Credit Life Secure Plan (UIN: 104N072V04) and Niva Bupa’s Xpress Health (UIN : NBHHLGP22208V022122).

We request you to go through the enclosed Policy contract with Policy number <Policy Number>.

**What to do
in case of
errors**

On examination of the Policy (enclosed herewith), if You notice any mistake or error, proceed as follows:

1. Contact our customer helpdesk or your Agent immediately at the details mentioned below.
2. We will rectify the mistake/error and send an updated Policy to You.

**Free Look
Cancellation**

You and/or the Member, except for the Policy / Certificate of Insurance with tenure of less than a year, have the option to cancel the Policy/Certificate of Issuance if You/Member disagree with any of the Policy terms and conditions or otherwise by sending a written request to Us, stating the reason for objection. This request must be sent to Us within the FreeLook period of 30 (thirty) days beginning from the date of receiving the Policy/Certificate of Insurance to review the terms and conditions of the Policy/Certificate of Insurance.

Where free look cancellation is exercised by You, the Policy shall terminate immediately and all rights, benefits and interests under the Policy shall cease immediately. However, the cover in respect of existing Members will continue as per the terms of Certificate of Insurance. No new Members will be enrolled under the Policy.

Where free look cancellation is exercised by Member, Upon receipt of request, if no claim has been made under the Certificate of Insurance, the Certificate of Insurance shall terminate immediately and all rights, benefits and interests shall cease immediately. The Member will be entitled to refund of the Premiums paid less proportionate risk Premium for the period of cover, the expenses, if any incurred on medical examination of the Member(s) and stamp duty paid, if any.

We will be delighted to offer You any assistance or clarification You may inquire about the Policy/ COI or claim-related services at the respective contact details mentioned in the Policy Contract/ COI.

We value your association with Us and assure You the best of Our service, always.



Yours Sincerely,
Axis Max Life Insurance Ltd. (Lead Insurer)

<<Name>>

<<Designation>>

Axis Max Life Insurance Limited

Regd Office: Plot No. 90C, Urban Estate, Udyog Vihar, Sector 18, Gurugram, 122015, Haryana, India

Phone: 4219090 Fax: 4159397 (From Delhi and Other cities: 0124) Customer Helpline: 1860 120 5577

Visit Us at: <https://www.axismaxlife.com> E-mail: Groupcombihelpdesk@axismaxlife.com

IRDAI Registration No: 104 Corporate Identity Number: U74899HR2000PLC143012

Niva Bupa Health Insurance:

IRDAI Registration No. 145; Registered Office: C-98, First Floor, Lajpat Nagar, Part 1, New Delhi – 110024; CIN: L66000DL2008PLC182918. Visit us at: www.nivabupa.com



POLICY PREAMBLE

AXIS MAX LIFE INSURANCE LIMITED

Regd. Office: Plot No. 90C, Urban Estate, Udyog Vihar, Sector 18, Gurugram, 122015, Haryana, India

and

NIVA BUPA HEALTH INSURANCE COMPANY LIMITED

Regd. Office: C-98 Lajpat Nagar 1, New Delhi-110024

Axis Max Life Insurance & Niva Bupa Health Insurance Smart Life-N-Health LoanSure Plan

UIN- 104Y134V01

Axis Max Life Insurance Limited (“AMLI”) and Niva Bupa Health Insurance Company Limited (“Niva Bupa”) has entered this contract of Combi insurance with the Master Policyholder on the lives of the persons referred to in the Schedule to the Policy. This Policy has been effected on the lives of the Members based on the Proposal Form, declarations, enrollment form and Premium deposit made by the Master Policyholder.

AMLI agrees to pay the Life Insurance cover benefit and Niva Bupa agrees to pay the Health Insurance cover benefit under this Policy on the happening of the Insured Event, while this Policy is in force, subject to the terms and conditions stated herein.

On examination of this Policy, if the Master Policyholder notices any mistake or error, this Policy should be returned to Us for rectifying the same.

Axis Max Life Insurance Limited (Lead Insurer)

Place of Issuance: Gurugram, Haryana

POLICY SCHEDULE

I. DETAILS OF POLICY

BASE POLICY – Axis Max Life Insurance & Niva Bupa Health Insurance Smart Life-N-Health LoanSure Plan

TYPE OF POLICY – A Non-Linked Non-Participating Group Combi Insurance Plan

OFFICE –

POLICY NO:

PROPOSAL NO:

DATE OF PROPOSAL:

DATE OF COMMENCEMENT OF RISK (Effective Date of Coverage):

MASTER POLICYHOLDER:

Details of Insured as at the Effective Date of Coverage: As per Register of Members provided by Master Policyholder

ADDRESS (For all communication purposes):

TEL. NO.:

MOBILE NO.:

EMAIL:

Maturity Date: N/A

Date on which Survival Benefit is payable: N/A

NAME OF THE INSURANCE AGENT/ INSURANCE Intermediary:

INSURANCE AGENT/ INSURANCE Intermediary LICENSE NO.:

INSURANCE AGENT/ INSURANCE Intermediary CODE:

ADDRESS:

TEL. NO.:

MOBILE NO.:

EMAIL:

Details of Sales Personnel (for direct sales only):

II. ELIGIBILITY CRITERIA

Eligibility criteria for admission to the group and other special terms and conditions [The eligibility criteria are to be mentioned on a case specific basis – below is only an indicative list]

- i. There must be a clear relationship between individual Members and the Master Policyholder.
- ii. The Master Policyholder would be the authorized person to act on behalf of all Members of group for the purpose of this Policy.
- iii. The group should not be formed for the sole purpose of taking the insurance coverage under this Policy.
- iv. The minimum group size should be 50 (Fifty) Members for obtaining insurance coverage under this Policy.

III. DETAILS OF POLICY COVERAGE

Section 1: Combi Details

Combi Variants:

Total Premium:

Total applicable Taxes, cesses and levies:

Premium Mode: Single Premium

Date of Commencement of Risk /Effective Date of Coverage:

For existing Members:

Section 2: Life Cover Benefit Details

Number of Members Admitted at the Date of Commencement of Risk /Effective Date of Coverage:

Total Sum Assured on Death:

Death Benefit Option Chosen:

- i) Option A - Decreasing Cover:

Whether moratorium option chosen:

- ii) Option B - Level Cover:

Riders:

Free Cover Limit (if any):

Policy Term: The Policy continues, until terminated by either of the parties in accordance with Section 4 of Part D.

Section 3: Health Cover

S.No.	Name of the Benefit ⁽¹⁾	Particulars
1	Video Consultations	<<Amount/Number/NA>>
2	Tele Consultations	<<Amount/Number/NA>>
3	Physical Consultations	<<Amount/Number/NA>>
4	Video Consultations with Specialists	<<Amount/Number/NA>>
5	Tele Consultations with Specialists	<<Amount/Number/NA>>
6	Physical Consultations with Specialists	<<Amount/Number/NA>>
7	Diagnostic Services	<<Yes/Amount/NA>>
8	Pharmacy Services	<<Yes/Amount/NA>>
9	Home Health Care Services	<<Yes/Amount/NA>>
10	Vaccination Cover	<<Yes/Amount/NA>>
11	Annual Health Check-up	<<Yes/Amount/Number/NA>>
12	Daily Cash Benefit	<<INR >> per day. Maximum <<No.>> days
13	ICU Cash Benefit	<<INR >> per day. Maximum <<No.>> days
14	Emergency Assistance Service	<<Yes/No>>
15	Second Medical Opinion	<<Yes/No>>
16	Hospitalization Cover	
A	Base Sum Insured	<<Max Limit/NA>>
B	Hospital accommodation- Room Rent/day	<<Max Limit/NA>>
C	Hospital accommodation- ICU/day	<<Max Limit/NA>>
D	Day Care Treatment	<<Yes/No>>
E	Pre/Post Hospitalization- Days of Coverage	<<No. of days>>
F	Domiciliary Hospitalization	<<Max Limit/NA>>
G	AYUSH Benefit	<<Max Limit/NA>>
H	Organ Transplant	<<Yes/No>>
I	Emergency Road Ambulance	<<Max Limit/NA>>
J	Air Ambulance	<<Max Limit/NA>>
K	Modern Treatments	<<Max Limit/NA>>
L	Loyalty Credits	<<Yes/No>>
M	No Claim Bonus	<<Yes/No>>
17	Critical Illness Cover	<<Max Limit/NA>>
18	Personal Accident Cover	<<Max Limit/NA>>
19	Serious Illness Cover	<<Min Max Hospitalization and payout grid/NA>>

¹The details of the benefits will change depending upon the Plan opted. All the benefits are as per Policy Period basis, if otherwise not mentioned. The details which are not applicable under the Policy will not be shown

Waiting Periods

<u>Waiting Periods</u>
1. Initial Waiting Period – <<up to 30 days>>
2. Specific Disease Waiting Period– << up to 24 months>>
3. Pre-Existing Disease (PED) Waiting Period- <<up to 30 months>>
4. Survival Period (For Critical Illness Benefit) Waiting Period- <<up to 120 days>>
5. Free Look Provision – 15 days

Note:

- The terms and conditions applicable to the Life Insurance cover are set out in Part B to Part G of this Policy (Segment A) and the terms and conditions applicable to the Health Insurance Cover are set out in Part H of this Policy (Segment B).
- You are advised to read the relevant Parts carefully to understand the benefits, exclusions, limitations, and other applicable provisions relating to each cover.

SEGMENT A: LIFE COVER

PART B

1. DEFINITIONS AND INTERPRETATION

1.1. Definitions

The words and phrases listed below shall have the meanings attributed to them wherever they appear in this Policy unless the context otherwise requires:

- i. **“Age”** means age of the Member as at last birthday on the Entry Date or the previous Policy Anniversary, as the case may be;
- ii. **“Beneficiary”** means a person who has been nominated by the Member as a beneficiary and whose name, age and relationship with Member has been recorded by the Policyholder in the Register of Members, along with name of guardian in case of minor person in accordance with Section 6 of Part F and registered by Us or any person as specified in Section 2 of Part D who is eligible to receive the Death Benefit payable under this Policy;
- iii. **“Borrower”** or **“Co-borrower”** means a natural person who has been extended a loan facility or advance in any form by the Master Policyholder;
- iv. **“Certificate of Insurance”** means a certificate issued by Us on the basis of the details mentioned in the Member’s enrollment form, to each Member evidencing the acceptance of risk on the life of the Member under this Policy;
- v. **“Company”**, **“We”**, **“Us”**, **“Our”** means Axis Max Life Insurance Limited;
- vi. **“Death Benefit”** means the benefit which is payable on death of Member, as stated in the Policy/ Certificate of Insurance;
- vii. **“Death Benefit Option”** means the option chosen by the Master Policyholder, at the time of the Proposal Form and as specified in the Schedule;
- viii. **“Date of Commencement of Risk /Effective Date of Coverage”** means the date as specified in the Schedule, on which the Insurance on the lives of the Members under this Policy commences which will be later of:
 - i) the date of realization of the Premium by Us; or
 - ii) the date of underwriting decision by Us;
- ix. **“Entry Date”** means:
 - a. in relation to the existing Eligible Members, as at the date of commencement of this Policy who are admitted to the Insurance, the Date of Commencement of Risk /Effective Date of Coverage; and
 - b. in relation to Eligible Member(s) admitted to the Insurance under this Policy after the Date of Commencement of Risk /Effective Date of Coverage (**“New Members”**), the date on which they become eligible and their names are entered in the Register of Members, provided:
 - (i) the loan is sanctioned by the Master Policyholder and the same has been intimated to Us in writing by the Master Policyholder;
 - (ii) We have received the single Premium from the Master Policyholder/ the Member, as the case may be; and
 - (iii) We have agreed to add the New Member under this Policy based on Our underwriting decision.
- x. **“Eligible Member”** means the Borrower or Co-Borrower, who has met the eligibility requirements as specified in Section 1 of Part F of this Policy and the Schedule, to participate in the Insurance under this Policy;
- xi. **“Expiry Date”** means the date as specified in the Schedule and the Certificate of Insurance and recorded in the Register of Members, on which the Insurance effected on the life of the Member under this Policy expires;

- xii. **“Free Cover Limit”** means the Sum Assured on Death amount as specified in the Schedule, up to which Insurance cover can be allowed based on simple insurability conditions without requiring any evidence of health;
- xiii. **“Insurance”** means the insurance cover effected on the lives of the Members under this Policy;
- xiv. **“Insurance Act”** means the Insurance Act, 1938;
- xv. **“IRDA”** means the Insurance Regulatory and Development Authority constituted under the Insurance Regulatory and Development Authority Act, 1999;
- xvi. **“Insured Event”** means the death of a Member while the Insurance is in force;
- xvii. **“Master Policyholder”** or **“You”** means an institution or entity to whom this Policy is issued by Us, as specified in the Schedule;
- xxviii. **“Member”** means the Eligible Member on whose life the Insurance has been effected in accordance with the provisions of this Policy and who has been issued a Certificate of Insurance by Us;
- xix. **“Nominee”** means the person specified by the Member whose name is registered and recorded by the Master Policyholder in the Register of Members in accordance with Section 6 of Part F of this Policy, who is authorized to receive the Death Benefit secured under this Policy from Us, upon the death of the Member;
- xx. **“Period of Coverage”** means the period specified in the Certificate of Insurance, during which the Insurance on the life of a Member continues under this Policy;
- xxi. **“Policy”** means **“Group Credit Life Secure Plan”**, a non-participating single premium group term insurance plan, the operation, regulation and management of which is governed by the documents comprising the Policy documentation which is made up of the Proposal Form and any additional information that the Master Policyholder provides in respect of the Master Policyholder’s proposal, these terms and conditions, the Schedule, the Register of Members, declarations and other particulars, if any received from the Members subject to Our acceptance of the same;
- xxii. **“Policy Anniversary”** means the annual anniversary of the Date of Commencement of Risk /Effective Date of Coverage;
- xxiii. **“Policy Term”** means the term of the Policy as selected by the Master Policyholder and as specified in the Schedule;
- xxiv. **“Premium”** means the amount payable by the Master Policyholder under this Policy, as specified in the Schedule, in respect of each Member on or before his Entry Date, in order to secure the Death Benefit under this Policy;
- xxv. **“Proposal Form”** means the Master Policyholder’s statements in the proposal for this Policy submitted by or on behalf of the Members along with any other information or documentation provided to Us prior to inception of this Policy;
- xxvi. **“Register of Members”** means the register of Members maintained by the Master Policyholder in accordance with Section 6 of Part F of this Policy , which register shall stand updated from time to time only after intimating Us, which is deemed to be incorporated in and forms part of this Policy;
- xxvii. **“Rider”** means the insurance cover(s) added to a Policy/ Certificate of Insurance for additional Premium or charge;
- xxviii. **“Rider Benefits”** means an amount of benefit payable on occurrence of a specified event covered under the Rider, and is an additional benefit under the Policy/ Certificate of Insurance, and may include waiver of premium benefit on other applicable Rider(s);
- xxix. **“Schedule”** means the schedule and any endorsements attached to and forming part of this Policy and if an updated Schedule is issued, then, the Schedule which is latest in time;
- xxx. **“Sum Assured on Death”** means the absolute amount of benefit, as specified in the Register of Members or the Certificate of Insurance, as the case may be, which is guaranteed to become payable on the death of a Member during the Period of Coverage in accordance with the terms and conditions of the Policy
- xxxi. **“Surrender”** means complete withdrawal or termination of the Certificate of Insurance;

xxxii. “**Surrender Value**” means the amount, if any, that becomes payable on the Surrender of the Certificate of Insurance during its term, in accordance with Part D of this Policy.

1.2. **Interpretations**

- i. References to the masculine or the singular will include references to the feminine and the plural, and vice versa.
- ii. References to any statute or statutory enactment shall include re-enactment or amendment to the same.
- iii. Section headings are for ease of reference only and have no interpretive value.
- iv. Reference to days, unless context otherwise requires, means calendar days only.

PART C

1. BENEFIT

1.1 Death Benefit

Subject to Section 2 and 4 of Part D and Section 2 of Part F and of this Policy, if this Policy and Insurance are in force, then, upon death of the Member during the Period of Coverage, We shall pay one of the Death Benefit specified below, depending upon the Death Benefit Option chosen by the Master Policyholder to the Beneficiary:

1.1.1. Option A - Decreasing Cover

If the Master Policyholder has chosen option – A as the Death Benefit Option under this Policy, the Sum Assured on Death payable by Us shall be the Sum Assured on Death outstanding as per the schedule of Sum Assured on Death indicated in the Certificate of Insurance, irrespective of the actual loan outstanding on the date of death of such Member.

1.1.2. Option B - Level Cover

If the Master Policyholder has chosen option – B as the Death Benefit Option under this Policy, We shall pay the Sum Assured on Death as chosen by the Master Policyholder or the Member and specified in the Certificate of Insurance.

1.2 Moratorium Option

1.2.1 Under this Policy, the moratorium period option is available with option A – decreasing cover as the Death Benefit Option, as set out in Section 1.1.1 above. The moratorium period can be chosen in multiples of 1 (One) months and the minimum moratorium period permitted is 1 (One) months.

1.2.2 If the moratorium option is chosen by the Member, the Sum Assured on Death for a Member shall remain unchanged throughout the moratorium period. Upon the expiry of the moratorium period, the Sum Assured on Death will decrease during the remainder of the Period of Coverage. Upon death of such a Member during the moratorium period and on approval of the claim by Us, We shall pay the Sum Assured on Death as specified in the Certificate of Insurance, irrespective of the actual loan outstanding.

1.3 Maturity Benefit & Survival Benefit

No maturity or survival benefits are payable under the Policy.

2. PREMIUM

2.1 A single Premium is payable by the Master Policyholder/ the Member, as the case may be, in respect of each Member on or before his Entry Date, either at the Master Policyholder's office or at Our office, based on the Premium as determined by Us and specified in the Certificate of Insurance.

2.2 In addition to the single Premium, We reserve the right to charge an extra Premium or deny coverage in respect of Eligible Member(s) who in Our opinion pose a higher risk to Us, as determined by Our underwriters, based on evidence of health and/or other information received by Us during the underwriting process.

2.3 The single Premium is subject to applicable taxes levies and cesses, which shall be entirely borne by the Master Policyholder/ the Member, as the case may be.

PART D

1. SURRENDER BENEFIT

- 1.1 During the Period of Coverage, a Member may at any time, request for the surrender of his Insurance by making a written request through the Master Policyholder or directly to Us. Upon receipt of such written request and provided We have not received a claim request for Death Benefit under Section 1 of Part C of this Policy for such Member, We shall pay the Surrender Value to the Member, based on the formula given below:

$$\text{Surrender Value} = 70\% \text{ of Premium paid} * (\text{Unexpired Period of Coverage in months on the date of Surrender}^{\wedge} / \text{Total Period of Coverage in months}) * (\text{Sum Assured on Death applicable on the date of Surrender}^{\wedge\wedge} / \text{Sum Assured on Death on the Date of Commencement of Risk / Effective Date of Coverage})$$

$\wedge$ Ignoring fraction of a month

$\wedge\wedge$ As per the schedule mentioned in the Certificate of Insurance

- 1.2 Upon receipt of a valid surrender request from the Member, the Insurance in respect of such Member shall cease and on payment of the Surrender Value as per Section 1.1 above, all benefits and rights under this Policy and/or Certificate of Insurance in respect of such Member shall automatically cease.
- 1.3 Payment of the Surrender Value under this Policy paid to a Member shall constitute a valid discharge of Our liability in respect to such Member, under this Policy.

2. PAYMENT OF DEATH BENEFIT

- 2.1 Subject to Sections 1 of Part C, 4 of Part D and 2 of Part F of this Policy, the Death Benefit is payable under this Policy only on submission of satisfactory proof of the Member's death to Us by the Master Policyholder, subject to the Policy and Insurance remaining in force. The Death Benefit under this Policy shall be payable to:
- i. Nominee(s), where a valid nomination has been recorded and registered with the Master Policyholder in the Register of Members in accordance with Section 10 of Part F of this Policy; or
 - ii. proving executors, administrators or other legal representatives who have obtained representation to the Member's estate from a competent court, if the Nominee is not living at that time; or
 - iii. such person or persons as directed by a court of competent jurisdiction in India, limited at all times to the monies payable under this Policy.
- 2.2 No Death Benefit under this Policy is payable, if the date of death of the Member precedes the Entry Date of that Member.
- 2.3 Any Death Benefit/ claim payments under this Policy shall be made in Indian rupees by Us or in any other currency in accordance with the applicable guidelines issued by the Reserve Bank of India from time to time.
- 2.4 Once the Death Benefit under this Policy is paid to the Beneficiary, the same shall constitute a valid discharge in respect of such Member of Our liability under this Policy.

3. TERMINATION OF INSURANCE

The Insurance on the life of a Member shall automatically cease on the earliest of the following dates:

- i) on the Expiry Date; or
- ii) on the date on which the death claim of the Member is admitted by Us; or
- iii) on the date of receipt of a valid request for surrender of Insurance from the Member by Us.

4. TERMINATION OF POLICY

- i) This Policy may be terminated by either the Master Policyholder or the Company by giving 90 (Ninety) days prior written notice to the other party. In the event of such termination, each Member's coverage under the Insurance shall continue as an individual policy until the date of the expiration of the Period of Coverage.

- ii) Upon termination of this Policy, no new enrollment forms for Eligible Members will be accepted by Us from the date of such termination, but all obligations in respect of the Members enrolled under this Policy shall continue until the expiry of the Period of Coverage of each Member or surrender of the Certificate of Insurance, whichever is earlier.

5. FREE LOOK PERIOD

The Master Policyholder and/or the Member have a period of 30 (Thirty) days beginning from the date of receipt of this Policy and/or the Certificate of Insurance, as the case may be, to review the terms and conditions of this Policy and/or the Certificate of Insurance. The Master Policyholder or the Member, as the case may be, except for the Policy / Certificate of Insurance with tenure of less than a year, has an option to cancel the Policy/ Certificate of Insurance if You/Member as the case may be, disagree with any of the Policy terms and conditions or otherwise by sending a written request to Us, stating the objections. Upon receipt of Your/Member(s) request, as the case may be, this Policy or Certificate of Insurance, as the case may be, shall terminate immediately and all rights, benefits and interests under this Policy shall cease immediately. The Member will be entitled to refund of the Premiums paid, after deducting the proportionate risk Premium for the period of cover, stamp duty paid and the expenses incurred on medical examination of the Members, if any, irrespective of the reasons mentioned.

For the sake of clarity, it is clarified that:

Where free look cancellation is exercised by You, the Policy shall terminate immediately and all rights, benefits and interests under the Policy shall cease immediately. However, the cover in respect of existing Members will continue as per the terms of Certificate of Insurance. No new Members will be enrolled under the Policy.

Where free look cancellation is exercised by Member, Upon receipt of request, if no claim has been made under the Certificate of Insurance, the Certificate of Insurance shall terminate immediately and all rights, benefits and interests shall cease immediately. The Member will be entitled to refund of the Premiums paid less proportionate risk Premium for the period of cover, the expenses, if any incurred on medical examination of the Member(s) and stamp duty paid, if any.



PART E

POLICY CHARGES

APPLICABLE FEES/ CHARGES UNDER THE POLICY

This Policy is a non-linked non-participating group pure risk life insurance plan and therefore, Part E is not applicable to this Policy.

PART F

GENERAL TERMS AND CONDITIONS

1. ELIGIBILITY, PARTICIPATION AND TERMINATION

1.1 Eligibility

1.1.1. A person shall be eligible to be a Member, if such person fulfills all the conditions specified below in addition to those specified in the Schedule:

- i. is a natural person;
- ii. is between 15 (Fifteen) years and 75 (Seventy Five) years (both inclusive) of Age on the Date of Commencement of Risk /Effective Date of Coverage or the Entry Date and will not be more than 77 (Seventy Seven) years of Age on the date the Insurance expires; and
- iii. the proposed Period of Coverage on the Date of Commencement of Risk /Effective Date of Coverage or the Entry Date is not less than 1 (one) month.

1.1.2 If the loan is jointly availed, then, the Co-Borrowers must individually satisfy the eligibility conditions mentioned in this Section to become a Member. If any one Borrower does not satisfy the eligibility criteria mentioned in this Section, We will only admit such Borrower, who satisfies the eligibility criteria mentioned in this Section, to this Policy and provide the Insurance to such person.

1.2 Participation

1.2.1 An Eligible Member may apply to Us through the Master Policyholder by completing the following procedure:

- i. by submitting an enrollment form for membership and satisfactory evidence of insurability through the Master Policyholder to Us; and
- ii. submission of reports based on the medical examination, as determined by Us, shall be required for all Eligible Members whose total proposed Sum Assured on Death, combined with amounts already insured or proposed to be insured under other policies issued by Us, exceeds the Free Cover Limit, as determined by Us and as specified in the Schedule.

1.2.2 The Free Cover Limit will only be applicable where Insurance coverage is compulsory for all Members.

1.2.3 We reserve the right to refuse grant of Insurance without assigning any reason in respect of Eligible Members that represent a sub-standard risk as determined by Us based on evidence of health and other information received by Us during the participation process.

2. CLAIM

2.1 Subject to Section 4 of Part D and Section 9 of Part F of this Policy and other terms and conditions of this Policy and Insurance remaining in force, the Master Policyholder with respect to any Member must notify Us in writing of the happening of the Insured Event, within 30 (Thirty) days from the date of happening of such an Insured Event. The claim should be registered with Us at the address mentioned below or any other office of the Company:

Claims Department,
Axis Max Life Insurance Limited,
Operations Centre, Claims Unit,
Plot 90C, Sector 18, Udyog Vihar, Gurugram 122002,
Haryana, India.

2.2 Upon receipt of satisfactory proof of the happening of the Insured Event and its cause, We shall process the claim request under this Policy. For processing a claim request under this Policy, We will require all of the following documents:

2.2.1 Documents for death claims

- i. Claimant's statement in the prescribed form;
- ii. original Certificate of Insurance;

- iii. original/ attested copy of death certificate issued by the local/municipal authority;
- iv. identity proof of the Member and the Nominee(s) bearing their photographs and signatures
- v. copy of bank passbook / cancelled cheque of the Claimant with name and account number printed
- vi. any other documents or information required by Us for assessing and approving the claim request.

2.2.2 Additional documents in case of death due to medical reason:-

- i. attending physician's statement and hospital treatment certificate (if any);
- ii. discharge summary / indoor case papers in case death happened due to medical reasons in a hospital;

2.2.3 Additional documents in case of Accidental Death/Murder/Suicide cases and any unnatural death:-

- i. a copy of police complaint/ first information report
- ii. a copy of duly certified post mortem report- autopsy/viscera report and a copy of the final police investigation report /charge sheet

2.2.4 Additional documents in case of death in foreign country:-

- i. body transfer certificate / embassy documents / post-mortem report whichever applicable
- ii. Copy of passport

2.3 We reserve the right to scrutinize the documents submitted by the claimant and/or investigate the cause of death of the Member and repudiate the claim partially or completely on the basis of Our scrutiny of the documents or investigation, as the case may be. We shall only pay the appropriate Death Benefit under this Policy subject to Our satisfaction:

- i. that the Death Benefit has become payable as per the terms and conditions of this Policy; and
- ii. of the bonafides and credentials of the person(s) claiming the Death Benefit under this Policy.

2.4 Any person claiming the Death Benefit under this Policy can download the claim request documents from Our website <https://www.axismaxlife.com> or can obtain the same from Our branches or offices.

2.5 In case of lender-borrower groups i.e. (i) Reserve Bank of India (RBI) regulated Scheduled Banks (including Co-operative Banks), (ii) Non-Banking Financial Companies (NBFCs) having Certificate of Registration from RBI, (iii) National Housing Board (NHB) regulated Housing Finance Companies, (iv) National Minority Development Finance Corporation (NMDFC) and its State Channelizing Agencies, (v) Small Finance Banks regulated by RBI, (vi) Mutually Aided Cooperative Societies formed and registered under the applicable State Act concerning such Society, (vii) Microfinance Companies registered under Section 8 of the Companies Act, 2013, or (viii) any other entity as may be approved by the IRDAI, the following conditions shall apply to claims payments under the Policy:

2.5.1 We may make the payment of outstanding loan balance amount to You by deducting from the claim proceeds payable under the Policy, in accordance with the IRDAI guidelines as amended from time to time provided the Members provide authorisation to do so. The Members may provide the said authorisation either on the Entry Date or at a later date. The balance of the claim proceeds (if any) will be made to the Claimant;

2.5.2 You shall provide us details of the credit account statement with respect to the Members as per the guidelines issued by IRDAI from time to time.

2.5.3 We reserve the right to:

2.5.3.1 audit or cause an audit into the accuracy of the credit account statements of the Members in respect of which claims will be settled, on completion of every financial year and shall audit or cause an audit into the accuracy of the credit account statement of the deceased Members furnished by You or conduct a surprise inspection of Your books and records at least once a year to ensure total compliance with applicable IRDAI group circular/guidelines; or

2.5.3.2 You shall provide a certification from Your internal statutory auditors regarding the compliance to the applicable IRDAI group circular/guidelines that the outstanding loan

balance being shown in the credit account statement/claim discharge form is correct as per the conditions governing the credit account/loan account.

- 2.6 Subject to Our discretion and satisfaction, in exceptional circumstances such as on happening of a Force Majeure Event, We may decide to waive all or any of the requirements mentioned in this Policy.
- 2.7 The Claimant is required to intimate Us along with necessary documents as mentioned above, regarding a claim under the Policy, at the earliest possible time either in person or through online mode or Our distribution channel or authorized call centre. For any support or guidance in relation to claims, please contact us at Helpline No. – 1860 120 5577, Email: Groupcombihelpdesk@axismaxlife.com.

3. PREMIUM RATES

- 3.1 We reserve the right to revise the Premium rate from time to time during the Policy Term by giving a written notice of not less than 30 (Thirty) days to the Master Policyholder.
- 3.2 The revised Premium rates will only be applicable to Eligible Members who will be covered under this Policy, after the effective date of revision of the Premium rates by Us.

4. TAXES

- 4.1. All Premiums received, benefits payable, and/or funds accumulated under the Policy or as may be maintained by Us for Policyholders/Members are subject to applicable taxes, cesses, and levies, including but not limited to Goods and Services Tax (GST) and Income Tax, as applicable, which shall be entirely borne by You/Member and will always be paid by You/Member at the time of Premium payment, receipt of benefits and/or fund payout, as applicable.
- 4.2. Notwithstanding anything contained in this Policy or otherwise, We hereby reserve the right to claim, deduct, reduce and/or set-off a sum equivalent to any tax, interest, penalty, and/or other payments, as maybe imposed by any legislation, regulation, order, judgment, or otherwise, from any benefits payable to You/Member, Nominee, or assignee or from the funds accumulated under the Policy or funds maintained by Us.
- 4.3. Tax benefits may be available as per prevailing tax laws. Tax laws, their interpretation and/or application, including benefits arising thereunder are subject to change. You/Member are advised to consult tax advisor regarding the tax benefits and liabilities applicable to you.

5 CERTIFICATE OF INSURANCE

- 5.1 We shall issue in the name of each Member, an individual Certificate of Insurance certifying that the person named therein has become a Member under this Policy.
- 5.2 In the event of any inconsistency or contradiction between the terms and conditions of this Policy and the Certificate of Insurance, the terms and conditions contained in this Policy will prevail.

6 REGISTER OF MEMBERS

- 6.1 Under this Policy, the Master Policyholder shall always keep a record of all material information with respect to each Member including the Member's name, gender, Age, date of birth, address Date of Commencement of Risk /Effective Date of Coverage or Entry Date, Certificate of Insurance number, Death Benefit Option, original loan repayment schedule, moratorium option, moratorium period, Expiry Date, the Death Benefit payable, Period of Coverage, Nominee, Nominee's relationship with the Member, Nominee's address, appointee (in case of minor Nominee) details, appointee's relationship with the Nominee, appointee's address and other pertinent information, as may be necessary to carry out the terms and operation of this Policy, in the Register of Members.
- 6.2 In the event the Register of Members is amended, such an amendment shall become effective only after Our approval of the same. Any amendment to the terms and conditions of this Policy on account of any amendment to the Register of Members shall be given effect to by issuance of appropriate endorsements to the Policy issued by Us and signed by Our authorized officer.
- 6.3 The Master Policyholder shall furnish to Us all information, documentation and evidence which We may require with regard to any matter pertaining to this Policy. All documents furnished to the Master Policyholder by any Member in connection with the Insurance and other records which may have a bearing

on the Insurance under this Policy, shall be informed to Us and shall be open for Our inspection at all reasonable times.

7 SUICIDE EXCLUSION

- 7.1 Notwithstanding anything stated herein, if a Member commits suicide, within 12 (twelve) months from the Date of Commencement of Risk /Effective Date of Coverage or Entry Date, as the case may be, such Member's Insurance shall cease immediately and no Death Benefit is payable under this Policy in relation to such Member. In such an event, We will only refund the Premium received by Us (inclusive of extra premiums and excluding taxes, if any) in respect of such Member, without interest and after deducting any expenses incurred by Us for the grant of Insurance. However, the nominee or beneficiary of the Member (s) will be entitled to at least 80% (Eighty Percent) of the Premium paid to Us till the date of death of the Member(s) or the Surrender Value available as on the date of death, whichever is higher, provided the Policy is in force.
- 7.2 For the sake of clarity, if a Borrower commits suicide, within 12 (twelve) months from the Date of Commencement of Risk /Effective Date of Coverage or Entry Date, as the case may be, such Borrower's Insurance shall cease immediately and no Death Benefit is payable under this Policy in relation to such Borrower. In such an event, We will only refund the Premium received by Us (inclusive of extra premiums and excluding taxes, if any) in respect of such Borrower, without interest and after deducting any expenses incurred by Us for the grant of Insurance. However, the nominee or beneficiary of the Member (s) will be entitled to at least 80% (Eighty Percent) of the Premiums paid to Us till the date of death of the Borrower or the Surrender Value available as on the date of death, whichever is higher, provided the Policy is in force. If Co-Borrower survives the Borrower, then, the Insurance for such Co-Borrower shall continue in accordance with the terms and conditions of this Policy.

8 DECLARATION OF CORRECT AGE

Declaration of the correct Age of the Member(s) is important for Our underwriting process, before issuance of this Policy and/or Certificate of Insurance(s). The Premiums are calculated on the basis of the Age of the Member(s). If the Age declared in the Proposal Form and/or Member enrolment application form is found to be incorrect anytime during the Policy Term and/or Period of Coverage at the time of claim, then subject to Section 9 of Part F of this Policy, We may at Our discretion:

- i. cancel the Policy and/or the Certificate of Insurance and pay the Surrender Value; or
- ii. adjust the Premium payable by the Master Policyholder/ the Member or Death Benefit payable to the Beneficiary, based on the true Age and/or gender of the Member.

9. FRAUD, MIS-STATEMENT AND FORFEITURE

Fraud, mis-statement and forfeiture would be dealt with in accordance with provisions of Section 45 of the Insurance Act, 1938 as amended from time to time. *[A leaflet containing the simplified version of the provisions of the above section is enclosed in Annexure – (1) for reference].*

10 NOMINATION

Nomination is allowed as per Section 39 of the Insurance Act, 1938 as amended from time to time. *[A leaflet containing the simplified version of the provisions of the above section is enclosed in Annexure – (2) for reference].* Member may request for a cancellation or change of nomination(s) for a Certificate of Insurance along with necessary details of substituted nominee. Additional charges, not exceeding Rs. 100/- on each occasion may be applicable for cancellation or change of nominee.

11 ASSIGNMENT

Assignment shall be applicable in accordance with provisions of Section 38 of the Insurance Act, as amended from time to time. *[A leaflet containing the simplified version of the provisions of the above section is enclosed in Annexure – (3) for reference].*

12 ADMINISTRATIVE AND JUDICIAL INTERVENTION

If any administrative or judicial body imposes any condition on this Policy for any reason, We are bound to follow the same which may include suspension of the Death Benefit payable and obligations under this Policy.

13 TRAVEL AND OCCUPATION

There are no restrictions on travel or occupation under this Policy.

14 ELECTRONIC TRANSACTIONS

The Master Policyholder will adhere to and comply with all such terms and conditions as prescribed by Us from time to time, and all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or any combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by Us or on Our behalf, for and in respect of this Policy, or in relation to any of Our products and services, shall constitute legally binding and valid transactions when executed in adherence to and in compliance with the terms and conditions for such facilities, as may be prescribed by Us from time to time.

15 AMENDMENT

No amendments to this Policy will be effective, unless such amendments are expressly approved in writing by Us.

16 FORCE MAJEURE

If Our performance or any of Our obligations are in any way prevented or hindered as a consequence of any act of God or State, strike, lock out, legislation or restriction by any government or any other authority or any other circumstances beyond Our anticipation or control, the performance of this Policy shall be wholly or partially suspended during the continuance of such force majeure.

17. COMMUNICATION & NOTICES

- 17.1 Our contact details are mentioned in the Schedule. For any updates, please visit Our website <https://www.axismaxlife.com>. The Master Policyholder and/or the Member should mention the correct Policy number for all communication(s) made to Us and for all Premium remittances made by the Master Policyholder.
- 17.2 All notices meant for Us must be in writing and delivered to Our address as mentioned in Part G of this Policy, or such other address as We may notify from time to time.
- 17.3 All notices meant for the Master Policyholder/Member will be in writing and will be sent by Us to the Master Policyholder's/Member's address as shown in the Schedule/ Certificate of Insurance by posting the same through e-mail/electronic mode or hand delivery. If the Master Policyholder/ Member/ Nominee change their address, the Master Policyholder/Member/Nominee must notify Us immediately and should ensure that the updated information has reached Us. Failure in timely notification of change of address could result in a delay in processing of benefits payable under the Policy.

18. GOVERNING LAW AND JURISDICTION:

- 18.1 Indian law shall govern this Policy and the relationship between the Master Policyholder and Us.
- 18.2 This Policy, and all rights, obligations and liabilities arising hereunder, shall be enforced in accordance with the laws of India.
- 18.3 The competent courts in India shall have exclusive jurisdiction in all matters and causes arising out of this Policy.

19. ISSUANCE OF DUPLICATE POLICY

- 19.1 The Master Policyholder may request for a duplicate copy of the Policy to Us along with relevant documents. Additional charges not exceeding Rs.250/- may be applicable for issuance of the duplicate Policy.

20 TRANSLATION

- 20.1 In the event of any conflict or discrepancy between any translated version and the English language version of this Policy contract, the English language version of this Policy contract shall prevail.

PART G

GRIEVANCE REDRESSAL MECHANISM AND OMBUDSMAN DETAILS

DISPUTE REDRESSAL PROCESS UNDER THE POLICY

1. All consumer grievances and/or queries may be first addressed to Our customer helpdesk as mentioned below or the office as mentioned in the Schedule:
 - a. Group Business Operation, Axis Max Life Insurance Limited, Plot 90C, Urban Estate, Udyog Vihar, Sector 18, Gurugram, 122015, Haryana, India, Helpline No: 1860 120 5577, Email: Groupcombihelpdesk@axismaxlife.com, or
 - b. To any office of Axis Max Life Insurance Limited.
2. In case the the Complainant is not satisfied with the decision or has not received any response within 14 (Fourteen) days:
 - 2.1 the complainant may file a written complaint with full details of the complaint and the complainant's contact information to the following official for resolution:

Grievance Redressal Officer,
Axis Max Life Insurance Limited
Plot No. 90C, Urban Estate, Udyog Vihar,
Sector 18, Gurugram, 122015, Haryana, India.
Helpline No. – 1860 120 5577 or (0124) 4219090
Email: manager.services@axismaxlife.com
 - 2.2 The complainant or his legal heirs may approach the Grievance Cell of the IRDAI on the following contact details:

IRDAI Grievance Call Centre (Bima Bharosa Shikayat Nivaran Kendra)
Toll Free No:155255 or 1800 4254 732
Email ID: complaints@irdai.gov.in
Website - bimabharosa.irdai.gov.in
 - 2.3 The complainant can also register the complaint online at <https://www.bimabharosa.irdai.gov.in/>
 - 2.4 The complainant can also register the complaint through fax/paper by submitting their complaint to:

Policyholder Protection & Grievance Redressal Department (PPGR) Insurance Regulatory and Development Authority of India
Sy No. 115/1, Financial District,
Nanakramguda,Gachibowli,
Hyderabad – 500 032
Ph: (040) 20204000
3. In case the complainant is not satisfied with Our redressal, or have not received any reply from Us within a period of 1 (One) month, or rejection of complaint by Us, the complainant may approach the Insurance Ombudsman at the address mentioned in Annexure A or at the IRDAI website <https://www.irdai.gov.in> or on Council of Insurance Ombudsmen website at <https://www.cioins.co.in>, if the grievance pertains to:
 - i. delay in settlement of a claim beyond the time specified by Us;
 - ii. any partial or total repudiation of a claim by Us;
 - iii. dispute over Premium paid or payable in terms of the Policy; or
 - iv. misrepresentation of Policy terms and conditions at any time in the Policy document or Policy contract;
 - v. dispute on the legal construction of the Policy in so far as such dispute relate to a claim;
 - vi. Policy servicing by Us, Our agents or intermediaries;
 - vii. issuance of insurance policy, which is not in conformity with the proposal form submitted by You;
 - viii. non issuance of any insurance document after receipt of the Premium.
 - ix. any other matter resulting from non-observance of or non-adherence to the provisions of any regulations made by the IRDAI with regard to protection of policyholders' interests or otherwise, or of any circulars, Guidelines or instructions issued by the IRDAI or of the terms and conditions of the policy

contract, in so far as they relate to issues mentioned in this para 3 above.

4. As per Rule 14 of the Insurance Ombudsman Rules, 2017, a complaint to the Insurance Ombudsman can be made only within a period of 1 (One) year after receipt of Our rejection of the representation or after receipt of Our decision which is not to Your satisfaction or if We fail to furnish reply after expiry of a period of one month from the date of receipt of the written representation of the complainant, provided the complaint is not on the same matter, for which any proceedings before any court, or consumer forum or arbitrator is pending.

Annexure 1

Section 45 – Policy shall not be called in question on the ground of mis-statement after three years

Provisions regarding policy not being called into question in terms of Section 45 of the Insurance Act, 1938, as amended from time to time are as follows:

1. No Policy of Life Insurance shall be called in question on any ground whatsoever after expiry of 3 years from
 - a. the date of issuance of policy or
 - b. the date of commencement of risk or
 - c. the date of revival of policy or
 - d. the date of rider to the policywhichever is later.
2. On the ground of fraud, a policy of Life Insurance may be called in question within 3 years from
 - a. the date of issuance of policy or
 - b. the date of commencement of risk or
 - c. the date of revival of policy or
 - d. the date of rider to the policywhichever is later.

For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which such decision is based.

3. Fraud means any of the following acts committed by insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a life insurance policy:
 - a. The suggestion, as a fact of that which is not true and which the insured does not believe to be true;
 - b. The active concealment of a fact by the insured having knowledge or belief of the fact;
 - c. Any other act fitted to deceive; and
 - d. Any such act or omission as the law specifically declares to be fraudulent.
4. Mere silence is not fraud unless, depending on circumstances of the case, it is the duty of the insured or his agent keeping silence to speak or silence is in itself equivalent to speak.
5. No Insurer shall repudiate a life insurance policy on the ground of fraud, if the insured / 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 mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.
6. Life insurance Policy can be called in question within 3 years on the ground that any statement of or suppression of a fact material to expectancy of life of the insured was incorrectly made in the proposal or other document basis which policy was issued or revived or rider issued. For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which decision to repudiate the policy of life insurance is based.
7. In case repudiation is on ground of mis-statement and not on fraud, the premium collected on policy till the date of repudiation shall be paid to the insured or legal representative or nominee or assignees of insured, within a period of 90 days from the date of repudiation.
8. Fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer. The onus is on insurer to show that if the insurer had been aware of the said fact, no life insurance policy would have been issued to the insured.
9. The insurer can call for proof of age at any time if he is entitled to do so and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof of age of life insured. So, this Section will not be applicable for questioning age or adjustment based on proof of age submitted subsequently.

[Disclaimer: This is only a simplified version prepared for general information. You are advised to refer to the Insurance Act 1938 as amended from time to time for complete and accurate details.]

Annexure 2

Section 39 - Nomination by Policyholder

Nomination of a life insurance policy is as below in accordance with Section 39 of the Insurance Act, 1938 as amended from time to time. The extant provisions in this regard are as follows:

1. The policyholder of a life insurance policy on his own life may nominate a person or persons to whom money secured by the policy shall be paid in the event of his death.
2. Where the nominee is a minor, the policyholder may appoint any person to receive the money secured by the policy in the event of policyholder's death during the minority of the nominee. The manner of appointment is to be laid down by the insurer.
3. Nomination can be made at any time before the maturity of the policy.
4. Nomination may be incorporated in the text of the policy itself or may be endorsed on the policy communicated to the insurer and can be registered by the insurer in the records relating to the policy.
5. Nomination can be cancelled or changed at any time before policy matures, by an endorsement or a further endorsement or a will as the case may be.
6. A notice in writing of change or cancellation of nomination must be delivered to the insurer for the insurer to be liable to such nominee. Otherwise, insurer will not be liable if a bonafide payment is made to the person named in the text of the policy or in the registered records of the insurer.
7. Fee to be paid to the insurer for registering change or cancellation of a nomination can be specified by the Authority through Regulations.
8. On receipt of notice with fee, the insurer should grant a written acknowledgement to the policyholder of having registered a nomination or cancellation or change thereof.
9. A transfer or assignment made in accordance with Section 38 shall automatically cancel the nomination except in case of assignment to the insurer or other transferee or assignee for purpose of loan or against security or its reassignment after repayment. In such case, the nomination will get affected to the extent of insurer's or transferee's or assignee's interest in the policy. The nomination will get revived on repayment of the loan.
10. The right of any creditor to be paid out of the proceeds of any policy of life insurance shall not be affected by the nomination.
11. In case of nomination by policyholder whose life is insured, if the nominees die before the policyholder, the proceeds are payable to policyholder or his heirs or legal representatives or holder of succession certificate.
12. In case nominee(s) survive the person whose life is insured, the amount secured by the policy shall be paid to such survivor(s).
13. Where the policyholder whose life is insured nominates his
 - a. parents or
 - b. spouse or
 - c. children or
 - d. spouse and children
 - e. or any of themthe nominees are beneficially entitled to the amount payable by the insurer to the policyholder unless it is proved that policyholder could not have conferred such beneficial title on the nominee having regard to the nature of his title.
14. If nominee(s) die after the policyholder but before his share of the amount secured under the policy is paid, the share of the expired nominee(s) shall be payable to the heirs or legal representative of the nominee or holder of succession certificate of such nominee(s).
15. The provisions of sub-section 7 and 8 (13 and 14 above) shall apply to all life insurance policies maturing for payment after the commencement of Insurance Laws (Amendment) Act, 2015.

16. If policyholder dies after maturity but the proceeds and benefit of the policy has not been paid to him because of his death, his nominee(s) shall be entitled to the proceeds and benefit of the policy.
17. The provisions of Section 39 are not applicable to any life insurance policy to which Section 6 of Married Women's Property Act, 1874 applies or has at any time applied except where before or after Insurance Act, 1938 as amended from time to time, a nomination is made in favour of spouse or children or spouse and children whether or not on the face of the policy it is mentioned that it is made under Section 39. Where nomination is intended to be made to spouse or children or spouse and children under Section 6 of MWP Act, it should be specifically mentioned on the policy. In such a case only, the provisions of Section 39 will not apply.

[Disclaimer: This is only a simplified version prepared for general information. You are advised to refer to the Insurance Act 1938 as amended from time to time for complete and accurate details.]

Annexure 3

Section 38 - Assignment and Transfer of Insurance Policies

Assignment or transfer of a policy should be in accordance with Section 38 of the Insurance Act, 1938 as amended from time to time. The extant provisions in this regard are as follows:

1. This policy may be transferred/assigned, wholly or in part, with or without consideration.
2. An Assignment may be effected in a policy by an endorsement upon the policy itself or by a separate instrument under notice to the Insurer.
3. The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made.
4. The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.
5. The transfer or assignment shall not be operative as against an insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy thereof certified to be correct by both transferor and transferee or their duly authorised agents have been delivered to the insurer.
6. Fee to be paid for assignment or transfer can be specified by the Authority through Regulations.
7. On receipt of notice with fee, the insurer should Grant a written acknowledgement of receipt of notice. Such notice shall be conclusive evidence against the insurer of duly receiving the notice.
8. If the insurer maintains one or more places of business, such notices shall be delivered only at the place where the policy is being serviced.
9. The insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is a. not bonafide; b. not in the interest of the policyholder; c. not in public interest; or d. is for the purpose of trading of the insurance policy.
10. Before refusing to act upon endorsement, the insurer should record the reasons in writing and communicate the same in writing to policyholder within 30 days from the date of policyholder giving a notice of transfer or assignment.
11. In case of refusal to act upon the endorsement by the insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the insurer.
12. The priority of claims of persons interested in an insurance policy would depend on the date on which the notices of assignment or transfer is delivered to the insurer; where there are more than one instruments of transfer or assignment, the priority will depend on dates of delivery of such notices. Any dispute in this regard as to priority should be referred to the Authority.
13. Every assignment or transfer shall be deemed to be absolute assignment or transfer and the assignee or transferee shall be deemed to be absolute assignee or transferee, except a. where assignment or transfer is subject to terms and conditions of transfer or assignment OR b. where the transfer or assignment is made upon condition that i. the proceeds under the policy shall become payable to policyholder or nominee(s) in the event of assignee or transferee dying before the insured; or ii. the insured surviving the term of the policy. Such conditional assignee will not be entitled to obtain a loan on policy or surrender the policy. This provision will prevail notwithstanding any law or custom having force of law which is contrary to the above position.
14. In other cases, the insurer shall, subject to terms and conditions of assignment, recognize the transferee or assignee named in the notice as the absolute transferee or assignee and such persona shall be subject to all liabilities and equities to which the transferor or assignor was subject to at the date of transfer or assignment; b. may institute any proceedings in relation to the policy; and c. obtain loan under the policy or surrender the policy without obtaining the consent of the transferor or assignor or making him a party to the proceedings.
15. Any rights and remedies of an assignee or transferee of a life insurance policy under an assignment or transfer effected before commencement of the Insurance Laws (Amendment) Act, 2015 shall not be affected by this section.



[Disclaimer: This is only a simplified version prepared for general information. You are advised to refer to the Insurance Act, 1938 as amended from time to time for complete and accurate details.]

SEGMENT A: HEALTH COVER

PART H: Health Cover

1. Preamble

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

All treatments in this policy will be considered if they are conducted in India.

2. Definitions

2.1. Standard Definitions:

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

Def.2. AYUSH Hospital is a healthcare facility wherein medical / surgical / para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

- a. Central or state government AYUSH Hospital; or
- b. Teaching Hospital attached to AYUSH college recognized by the Central Government / Central Council of Indian Medicine / Central Council of Homeopathy; or
- c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
 - i. Having at least five in-patient beds;
 - ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
 - iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Def.3. Cashless Facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

Def.4. Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

Def.5. Day Care Treatment refers to medical treatment, and/or Surgical Procedure which is:

- a. undertaken under General or Local Anaesthesia in a Hospital/Day Care Centre in less than 24 hrs because of technological advancement, and
- b. which would have otherwise required a Hospitalization of more than 24 hours.

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

Def.6. Day Care Centre means any institution established for Day Care Treatment of Illness and/or Injuries or a medical set-up with a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criterion as under:

- a. has Qualified Nursing staff under its employment;
- b. has qualified Medical Practitioner(s) in charge;
- c. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
- d. Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Def.7. Deductible means a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Def.8. Disclosure to information norm: The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Def.9. Domiciliary Hospitalization means medical treatment for an Illness/disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

- a. the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
- b. the patient takes treatment at home on account of non availability of room in a Hospital.

Def.10. Emergency care means management for an Illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

Def.11. Grace Period means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

Def.12. Hospital means any institution established for Inpatient Care and Day Care Treatment of Illness and/or Injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

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

Def.13. Hospitalization or Hospitalized means the admission in a Hospital for a minimum period of 24 consecutive Inpatient Care hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

Def.14. ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

Def.15. Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

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

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

- i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
- ii. it needs ongoing or long-term control or relief of symptoms
- iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it

- iv. it continues indefinitely
- v. it recurs or is likely to recur

Def.16. Injury means accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

Def.17. Inpatient means admission for treatment in a Hospital for more than 24 hours for an Insured Event.

Def.18. Inpatient Care means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

Def.19. Intensive Care Unit means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

Def.20. Medical Advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

Def.21. Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.

Def.22. Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his licence.

Def.23. Medically Necessary Treatment means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

- i. is required for the medical management of the Illness or Injury suffered by the insured;
- ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- iii. must have been prescribed by a Medical Practitioner;
- iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Def.24. Migration means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credit gained for pre-existing conditions and specific waiting periods from one health insurance policy to another with the same insurer.

Def.25. Network Provider means Hospital or health care providers enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a Cashless Facility.

Def.26. Notification of Claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

Def.27. Non-Network Provider means any Hospital, Day Care Center or other provider that is not part of the network.

Def.28. OPD Treatment means the one in which the Insured visits a clinic / Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or In-patient.

Def.29. Pre-existing Disease means any condition, ailment, injury or disease

- a. That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer, or
- b. For which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

Def.30. Pre-hospitalization Medical Expenses means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:

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

Def.31. Post-hospitalization Medical Expenses means medical expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the Hospital, provided that:

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

Def.32. Portability means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing disease and specific waiting periods from one insurer to another.

Def.33. Reasonable and Customary Charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved.

Def.34. Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of Grace Period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time bound exclusions and for all Waiting Periods.

Def.35. Specific Waiting period means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break

Def.36. Unproven/Experimental treatment:

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

2.2. Specific Definitions:

Def.36. Any one illness means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

Def.36. Age means age of the Insured person on last birthday as on date of commencement of the Policy.

Def.37. AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

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

Def.38. Associated Medical Expenses shall include Room Rent, nursing charges, Medical Practitioners' fees and operation theatre charges.

Def.39. Base Sum Insured means the amount stated in the Policy Schedule.

Def.40. Bone Marrow Transplant is the actual undergoing of a transplant of human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner. The following will be excluded:

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

Def.41. Break in Policy means the period of gap that occurs at the end of the existing policy term/instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.

Def.42. Congenital Anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

a. Internal Congenital Anomaly: Congenital Anomaly which is not in the visible and accessible parts of the body.

b. External Congenital Anomaly: Congenital Anomaly which is in the visible and accessible parts of the body.

Def.43. Co-payment means a cost-sharing requirement under a health insurance policy that provides that the Policyholder/insured will bear a specified percentage of the admissible claim's amount. A Co-payment does not reduce the Sum Insured.

Def.44. Dental Treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and Surgery.

Def.45. Diagnostic Services means those diagnostic tests and exploratory or therapeutic procedures required for the detection, identification and treatment of a medical condition.

Def.45. Emergency means a medical condition or symptom resulting from Illness or Injury which arises suddenly and unexpectedly and requires immediate care and treatment by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

Def.46. Evidence Based Clinical Practice means process of making clinical decisions for Inpatient Care using current best evidence in conjugation with clinical expertise.

Def.47. e-Consultation means opinion from a Medical Practitioner who holds a valid registration from the medical council of any state or medical council of India or council for Indian medicine or for homeopathy set up by the Government of India or a state government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.

Def.48. Family Floater Policy means a Policy described as such in the Policy Schedule where the family members (two or more) named in the Policy Schedule are Insured Persons under this Policy. Only the following family members can be covered under a Family Floater Policy:

a. Primary Insured Person; and/or

b. Primary Insured Person's legally married spouse (for as long as she/he continues to be married to the Primary Insured Person); and/or

c. Primary Insured Person's children who are less than 25 years of Age on the commencement of the Policy Period (a maximum 4 children can be covered under the Policy as Insured Persons).

Def.49. First Policy means for the purposes of this Policy the Policy Schedule issued to the Policyholder at the time of inception of the first Policy mentioned in the Policy Schedule with Us.

Def.50. Information Summary Sheet means the information and details provided to Us or Our representatives over the telephone for the purposes of applying for this Policy which has been recorded by Us and confirmed by You.

Def.51. Individual Policy means a Policy described as such in the Policy Schedule where the individual named in the Policy Schedule is the Insured Person under this Policy.

Def.52. Insured Event means any event specifically mentioned as covered under this Policy.

Def.53. Insured Person means person(s) named as insured persons in the Policy Schedule.

Def.54. IRDAI means the Insurance Regulatory and Development Authority of India.

Def.55. Maternity expenses: Maternity expenses means;

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

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

Def.56. Medical Record means the collection of information as submitted in claim documentation concerning a Insured Person's Illness or Injury that is created and maintained in the regular course of

management, made by Medical Practitioners who have knowledge of the acts, events, opinions or diagnoses relating to the Insured Person's Illness or Injury, and made at or around the time indicated in the documentation.

Def.57. Mental Illness means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence.

Def.58. New Born Baby: Newborn baby means baby born during the Policy Period and is aged upto 90 days

Def.59. Policy means these terms and conditions, the Policy Schedule (as amended from time to time), Your statements in the Proposal and the Information Summary Sheet and any endorsements attached by Us to the Policy from time to time.

Def.60. Policy Period is the period between the inception date and the expiry date of the Policy as specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier.

Def.61. Policy Year means the period of one year commencing on the date of commencement specified in the Policy Schedule or any anniversary thereof.

Def.61. Policy Schedule means a certificate issued by Us, and, if more than one, then the latest in time. The Policy Schedule contains details of the Policyholder, Insured Persons, the Sum Insured and other relevant details related to the coverage.

Def.62. Primary Insured Person means the Policyholder if he/she is covered under the Policy as an Insured Person. In case Policyholder is not an Insured Person, then Primary Insured Person will be the eldest Insured Person covered under the Policy.

Def.63. Qualified Nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

Def.64. Reimbursement means settlement of claims paid directly by Us to the Policyholder/Insured Person.

Def.65. Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the Associated Medical Expenses.

Def.66. Service Provider means any person, organization, institution that has been empanelled with Us to provide services specified under the benefits to the Insured Person.

Def.67. Single Private Room means an air conditioned room in a Hospital where a single patient is accommodated and which has an attached toilet (lavatory and bath). Such room type shall be the most basic and the most economical of all accommodations available as a single room in that Hospital.

Def.68. Standby Services are services of another Medical Practitioner requested by treating Medical Practitioner and involving prolonged attendance without direct (face-to-face) patient contact or involvement.

Def.69. Sum Insured means the total of the Base Sum Insured which is Our maximum, total and cumulative liability for any and all claims during the Policy Year in respect of all Insured Person(s) which is specified in the Policy Schedule.

Def.70. Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering or prolongation of life, performed in a Hospital or Day Care Center by a Medical Practitioner.

Def.71. Survival Period means the period, if any, specified under the Policy after the occurrence of an Insured Event that the Insured Person has to survive before a claim becomes admissible under the Policy.

Def.72. Waiting Period means a time-bound exclusion period related to condition(s) specified in the Policy Schedule or the Policy which shall be served before a claim related to such condition(s) becomes admissible.

Def.73. We/Our/Us means Niva bupa Health Insurance Company Limited.

Def.74. You/Your/Policyholder means the person named in the Policy Schedule who has concluded this Policy with Us.

3. Scope of Cover: Benefits

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

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

3.1 OPD Consultations

3.1.1 Video Consultations

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

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

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

3.1.2 Tele Consultations

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

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

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

3.1.3 Physical Consultations

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

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

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

3.1.4 Video Consultations with specialists

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

These consultations can be booked digitally via our website, Mobile application, and/or through our call centers. The type of specialists covered will be as per Annexure 3.

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

3.1.5 Tele Consultations with specialists

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

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

The type of specialists covered will be as per Annexure 3.

Any unutilized amount or no. of consultations in one Policy Year cannot be carry forwarded to the next Policy Year.

3.1.6 Physical Consultations with specialists

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

These consultations can be booked via our website, Mobile application, through our call centers, or/and at the doctor's clinic/hospital. The type of specialists covered will be as per Annexure 3.

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

3.1.7 What is not covered under OPD Treatments

1. We will only cover the cost of consultation in Sections 3.1.1, 3.1.2, 3.1.3, 3.1.4, 3.1.5, 3.1.6, and all other costs or charges will not be covered.
2. Replacing any dental appliance which is lost or stolen.
3. Plastic surgery or cosmetic surgery unless necessary as a part of Medically Necessary Treatment and certified in writing by the attending Medical Practitioner.
4. Cost of frames for the prescribed lenses.
5. Sunglasses, unless medically prescribed by the treating Medical Practitioner.
6. Any lenses including contact lenses.

3.1.8 Claims Process & Requirements:

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

3.1.8.1 Claims Documentation:

- a. Claim form duly completed and signed by the claimant.
- b. Original Bills with detailed breakup of charges (including but not limited to pharmacy, purchase bill, consultation bill, and diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.
- c. Original payment receipts

- d. All reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries, OPD treatment card, consultation notes.

3.1.8.2 Claims Assessment & Repudiation:

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

3.2 Diagnostic Services

The Insured Person may avail specified diagnostic tests as per Annexure 4 and as mentioned in the Policy Schedule/Certificate of Insurance, from Our empanelled Service Provider through its mobile application or website. The cost of diagnostic tests shall be borne by the Insured Person. However, We shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further the diagnostic tests taken from Our empanelled Service Provider is the Insured Person's absolute discretion and choice.

OR

Up to a pre-set limit or/and set of specified diagnostic tests can be utilized by the Insured as mentioned by us in the Policy Schedule/Certificate of Insurance. The list of tests will be as per Annexure 4.

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

Conditions:

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

3.3 Pharmacy Services

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

OR

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

3.4 Home Health Care Services

The Insured person may purchase home health care services as per Annexure 5 and as mentioned in the Policy Schedule/Certificate of Insurance, from our empanelled Service Provider through its mobile application or website. The cost for the purchase of these services shall be borne by the Insured Person. However, we shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further purchase of Home Health Care Services from Our empanelled Service Provider is the Insured Person's absolute discretion and choice.

OR

We will cover up to the limit as specified by us in the Policy Schedule/Certificate of Insurance for specified health care services as per Annexure 5.

Conditions:

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

3.5 Vaccination Cover

The Insured person may purchase specified Vaccinations as per Annexure 6 and as mentioned in the Policy Schedule/Certificate of Insurance, from our empanelled Service Provider through its mobile application or website. The cost for the purchase of these services shall be borne by the Insured Person. However, we shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further purchase of Vaccination Services from Our empanelled Service Provider is the Insured Person's absolute discretion and choice.

OR

We will cover up to a pre-set limit as mentioned in the Policy Schedule/Certificate of Insurance for specified vaccinations as per Annexure 6.

Conditions:

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

3.6 Annual Health Check-up

The Insured Person may avail a health check-up during the Policy Period as per the list specified in Annexure 7 or up to the limit specified in the Policy Schedule/Certificate of Insurance. These tests can be booked via our website, Mobile application, through our call centers, or/and at the doctor's clinic/hospital.

- a. The eligibility of the Insured Person under this Benefit and the frequency of health check-ups will be as specified in the Policy Schedule/Certificate of Insurance.
- b. Expenses can be claimed under this Section on a Reimbursement basis or on Cashless basis as mentioned in the policy schedule/ certificate of Insurance.
- c. Any unutilized test or amount in one Policy Year cannot be carry forwarded to the next Policy Year.

3.7 Daily Cash Benefit

If an Insured Person due to illness or injury is hospitalized, then we will pay the amount as specified in the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization.

In case of hospitalization in Intensive Care Unit (Optional Benefit) – This is an optional benefit, can be opted if Daily Cash Benefit is opted. We will pay twice the Daily Cash specified in the Certificate of Insurance for each continuous and completed period of 24 hours of admission in the Intensive Care Unit.

Conditions:

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

3.7.1 Daily Cash Benefit with Franchise

If an Insured Person due to illness or injury is hospitalized, then We will pay the amount specified in the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization.

In case of hospitalization in Intensive Care Unit (Optional Benefit) - This is an optional benefit, can be opted if Daily Cash Benefit with Franchise is opted. We will pay twice the Daily Cash specified in the Certificate of Insurance for each continuous and completed period of 24 hours of admission in the Intensive Care Unit.

Conditions:

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

3.7.2 Daily Cash Benefit with Deductible

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

In case of hospitalization in Intensive Care Unit (Optional Benefit) - This is an optional benefit, can be opted if Daily Cash Benefit with Deductible is opted - We will pay twice the Daily Cash specified in the Certificate of Insurance for each continuous and completed period of 24 hours of admission in the Intensive Care Unit.

Conditions:

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

3.8 Emergency Assistance Services

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

- 3.8.1 **Medical referral:** Insured Person will have tele-access to an operations center of Our Service Provider, who with their multilingual staff on duty 24 hours a day, 365 days a year will provide reference of doctors in the vicinity where the Insured Person is located for medical consultations. This medical consultation is only facilitated by Us / Our Service Provider and is independent judgment of medical consultant. We do not assume any liability and shall not be deemed to assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the professional giving medical consultant.
- 3.8.2 **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.
- 3.8.3 **Medical repatriation:** We / Our Service Provider will arrange and pay for transportation under medical supervision to the Insured Person's residence or to a medical or rehabilitation facility near the Insured Person's residence (as mentioned in the Policy Schedule/ Certificate of Insurance) when the Insured Person's attending physician determines that transportation is medically necessary and is agreed by Us / Our Service Provider, at such time as the Insured Person is medically cleared for travel by Us / Our Service Provider's consulting physician and Insured Person's attending physician.
- 3.8.4 **Compassionate visit:** When an Insured Person will be hospitalized for more than 7 consecutive days and has travelled without a companion or doesn't have a companion by his / her side, We / Our Service Provider will arrange and pay for travel of a family member or personal friend to visit such Insured Person by providing an appropriate means of transportation via economy carrier transportation as determined by Us / Our Service Provider. The family member or the personal friend is responsible to meet all travel document requirements, as may be applicable.
- 3.8.5 **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.
- 3.8.6 **Return of mortal remains:** In the event of death of Insured Person, We/Our Service Provider will arrange and pay for the return of mortal remains to an authorized funeral home proximate to the Insured Person's legal residence.

Conditions:

Any coverage under this section is subject to 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/Certificate of Insurance, and the travel is for less than 90(ninety) days period.

What is not covered:

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

- a) Emergency assistance service will not be provided in the following instances:
- Travel undertaken specifically for securing medical treatment
 - Services sought outside India.
 - If Emergency is a result of injuries resulting from participation in acts of war or insurrection
 - Commission of unlawful act(s).
 - Attempt at suicide /self-inflicted injuries.
 - Incidents involving the use of drugs, unless prescribed by a physician
 - Transfer of the insured person from one medical facility to another medical facility of similar capabilities and providing a similar level of care
- b) We / Our Service Provider will not evacuate or repatriate an insured person in the following instances:
- Without medical authorization from attending physician
 - 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
 - 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
 - With mental or nervous disorders unless hospitalized

3.9 Second Medical Opinion

If the Insured Person is diagnosed with a Specified Illness as defined in Annexure 10 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.

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

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

Conditions:

The above coverage is subject to fulfilment of following conditions:

- Our Service Provider is contacted seeking the Second Medical Opinion.
- 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.
- This benefit can be availed only once by an Insured Person during a Policy Year for the same Specified Illness or planned Surgery.
- By seeking the Second Medical Opinion under this Benefit the Insured Person is not prohibited or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.

- e) The Insured Person is free to choose whether or not to obtain the Second Medical Opinion, and if obtained then whether or not to act on it in whole or in part.
- f) The Second Medical Opinion under this Benefit shall be limited to defined criteria and not be valid for any medico legal purposes.

What is not covered:

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

3.10 Hospitalization Cover:

We will indemnify the Medical Expenses incurred in respect of an Insured Person in accordance with the terms and conditions of the Benefits below in relation to any Illness suffered or Injury sustained during the Policy Period provided that the treatment undertaken is Medically Necessary Treatment and is carried out on the written advice of a Medical Practitioner.

Coverage Options:

3.10.1 Inpatient Care

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

Conditions:

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

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

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

Proportionate deductions will not be applied if the claim is of a hospital which does not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

What is not covered:

- a. We shall not be liable to pay the visiting fees or consultation charges for any Medical Practitioner visiting the Insured Person unless:
 - i. The Medical Practitioner's treatment or advice has been sought by the Hospital; and
 - ii. The visiting fees or consultation charges are included in the Hospital's bill; and
 - iii. The visiting fees or consultation charges are not more than the treating or referral Medical Practitioner's consultation charges.

3.10.2 Pre-hospitalization Medical Expenses

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

Conditions:

- a. We have accepted a claim under Section 3.10.1 (Inpatient Care), 3.10.4 (Day Care Treatment) or 3.10.5 (AYUSH Benefit) above in respect of that Insured Person for the same period of Hospitalization.
- b. We shall not be liable to pay any Pre-hospitalization Medical Expenses for more than the number of days specified in the Policy Schedule/Certificate of Insurance immediately preceding the Insured Person's admission to Hospital for Inpatient Care or such expenses incurred prior to inception of the First Policy with Us.
- c. Pre-hospitalization Medical Expenses can be claimed under this Section on Reimbursement basis or up to the specified limit as mentioned in the Policy Schedule/Certificate of Insurance.
- d. This Benefit is not applicable for any expenses incurred outside India.
- e. Pre-hospitalization Medical Expenses incurred on physiotherapy will also be payable provided that such physiotherapy is Medically Necessary Treatment and advised in writing by the treating Medical Practitioner.

3.10.3 Post-hospitalization Medical Expenses

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

Conditions:

- a. We have accepted a claim under Section 3.10.1 (Inpatient Care), 3.10.4 (Day Care Treatment) or 3.10.5 (AYUSH Benefit).
- b. We shall not be liable to pay any Post-hospitalization Medical Expenses for more than the number of days specified in the Policy Schedule/Certificate of Insurance immediately following the Insured Person's discharge from Hospital.
- c. Post-hospitalization Medical Expenses can be claimed under this Section on Reimbursement basis or up to the specified limit as mentioned in the Policy Schedule/Certificate of Insurance.
- d. This Benefit is not applicable for expenses incurred outside India.
- e. Post-hospitalization Medical Expenses incurred on physiotherapy will also be payable provided that such physiotherapy is Medically Necessary Treatment and advised in writing by the treating Medical Practitioner.

3.10.4 Day Care Treatment

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

Conditions:

- a. The Day Care Treatment is for Medically Necessary Treatment and is carried out on the written advice of a Medical Practitioner.
- b. The Medical Expenses incurred are Reasonable and Customary Charges for any procedure where such procedure is undertaken by an Insured Person as Day Care Treatment.
- c. The list of admissible Day Care Treatment would be as per Annexure 8.
- d. We shall not cover any OPD Treatment and Diagnostic Services under this Benefit.

3.10.5 AYUSH Benefit

We will indemnify the Medical Expenses incurred on the Insured Person's Hospitalization during the Policy Period for treatment under Ayurveda, Unani, Siddha or Homeopathy systems in a government Hospital or in any institute recognized by government and/or accredited by Quality Council of India/ National Accreditation Board on Health.

Conditions:

- a. The Hospitalization is for Medically Necessary Treatment and is carried out on the written advice of a Medical Practitioner.
- b. The Medical Expenses incurred are Reasonable and Customary Charges.
- c. Our maximum, total and cumulative liability under this Benefit shall be limited to the amount specified in the Policy Schedule/Certificate of Insurance.
- d. Pre-hospitalization Medical Expenses incurred for up to the number of days specified in the Policy Schedule/Certificate of Insurance prior to the Alternative Treatment being commenced and Post-hospitalization Medical Expenses incurred for up to the number of days specified in the Policy Schedule/Certificate of Insurance following the Alternative Treatment being concluded will also be indemnified under this Benefit provided that these Medical Expenses relate to the Alternative Treatment only and not to any allopathic treatment.

3.10.6 Domiciliary Hospitalization

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

Conditions:

- a. The Domiciliary Hospitalization is for Medically Necessary Treatment and is carried out on the written advice of a Medical Practitioner.
- b. The Medical Expenses incurred are Reasonable and Customary Charges.
- c. Medical Expenses can be claimed under this Section on Reimbursement basis or up to the specified limit as mentioned in the Policy Schedule/Certificate of Insurance.
- d. 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.

3.10.7 Organ Transplant

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

Conditions:

- a. The donation conforms to The Transplantation of Human Organs Act 1994 and amendments thereafter and the organ is for the use of the Insured Person.
- b. The recipient Insured Person has been Medically Advised in writing to undergo an organ transplant.

- c. We have accepted the recipient Insured Person's claim under Section 3.10.1 (Inpatient Care).
- d. The Medical Expenses incurred are Reasonable and Customary Charges.

What is not covered:

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

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

3.10.8 Emergency Road Ambulance- Within India

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

Conditions:

- a. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is Injured or is ill to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital with advanced facilities as advised by the treating Medical Practitioner in writing for management of the current Hospitalization.
- b. The expenses incurred are Reasonable and Customary Charges.
- c. This Benefit is available for only one transfer per period of Hospitalization.
- d. The ambulance service is offered by a healthcare or ambulance Service Provider.
- e. We have accepted a claim under Section 3.10.1 (Inpatient Care) above in respect of the same period of Hospitalization.
- f. We will cover expenses incurred only up to the amount specified in the Policy Schedule/Certificate of Insurance.

What is not covered:

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

3.10.9 Air Ambulance Cover

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

Conditions:

- a. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is injured or is ill to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital with advanced facilities as advised by the treating Medical Practitioner in writing for management of the current Hospitalization.
- b. The expenses incurred are Reasonable and Customary Charges.
- c. This Benefit is available for only one transfer per period of Hospitalization.
- d. The ambulance service is offered by a healthcare or ambulance Service Provider.

- e. We have accepted a claim under Section 3.10.1 (Inpatient Care) above in respect of the same period of Hospitalization.
- f. We will cover expenses incurred only up to the amount specified in the Policy Schedule/Certificate of Insurance.
- g. The transportation should be provided by medically equipped aircraft which can provide medical care in flight and should have medical equipment vital to monitoring and treating the Insured Person suffering from an Illness/Injury such as but not limited to ventilators, ECGs, monitoring units, CPR equipment and stretchers.
- h. We will not make any payment under this Benefit if the Insured Person is transferred to any Hospital or diagnostic center for evaluation purposes only.

3.10.10 Loyalty Credits: Sum Insured Enhancement

If the Insured Person's cover under the Policy is renewed with Us without a break We will increase the Base Sum Insured applicable under the Policy by the percentage as opted and specified in the Policy Schedule/Certificate of Insurance, for each successive renewal. The Sum Insured increase will be calculated as a percentage of the Base Sum Insured subject to the maximum of 100% of Base Sum Insured as specified in the Policy Schedule/Certificate of Insurance. The sub-limits applicable to various Benefits will remain the same and shall not increase proportionately with the Sum Insured.

Conditions:

- a. The Sum Insured shall be increased by a flat percentage for each successive Renewal without a break.
- b. At Renewal You/ Insured Person shall have an option to reinstate/ revise the Sum Insured by sending in writing the request for such Sum Insured revision. Any revision to Sum Insured shall always be subject to due underwriting by Us and acceptance of risk by Us in writing.
- c. If the Insured Person in the expiring cover under the Policy is covered under an Individual Cover and has an enhanced Sum Insured in the expiring cover under the Policy under this Benefit, and such expiring cover under the Policy is Renewed with Us as a Family Floater Cover, then We shall provide credit for Sum Insured enhancement to the Insured Person only and not to the other members of Family Floater Cover.
- d. If the Insured Persons in the expiring cover under the Policy are covered under a Family Floater Cover and have an accumulated Loyalty Credit for each Insured Person in the expiring cover under the Policy under this Benefit, and such expiring cover under the Policy is Renewed with Us as an Individual Cover with same or higher Base Sum Insured, then the accumulated Loyalty Cover to be carried forward for credit in the Renewing cover under the Policy would be the accumulated Loyalty Credit for that Insured Person.
- e. In case the Sum Insured of Section 3.10.1 (In-patient Care) is reduced at the time of Renewal, the applicable accumulated Loyalty Credit shall also be reduced in proportion to the Sum Insured of Section 3.10.1
- f. In case the Sum Insured of Section 3.10.1 (In-patient Care) under the Policy is increased at the time of Renewal, the applicable accumulated Loyalty Credit shall be carried forward.

3.10.11 No Claim Bonus

We will add a Cumulative Bonus in the form of a No Claim Bonus as a percentage specified in the Policy Schedule/Certificate of Insurance of the Sum Insured of Section 3.10.1 (In-patient Care) at the end of every Policy Year.

Conditions:

- i. No claim has been made under Section 3.10.1 (Inpatient Care), 3.10.2 & 3.10.3 (Pre & Post Hospitalization Expenses), 3.10.4 (Day Care Treatment), 3.10.6 (Domiciliary treatment), 3.10.7 (Organ Transplant), 3.10.5 (AYUSH benefit) in the immediately preceding Policy Year.
- ii. The No Claim Bonus will be added if the Policy is Renewed with Us by the end of the Grace Period or at the end of each Policy Year if the Policy continues to be in force.
- iii. The No Claim Bonus will not be accumulated in excess of 100% of the Base Sum Insured under the current Policy with Us under any circumstances.
- iv. Any No Claim Bonus that has accrued will be available for any claims made in the subsequent Policy Year.
- v. Merging of Covers under the Policy: If the Insured Persons in the expiring Policy are covered under multiple Individual Covers and such expiring Policy has been Renewed with Us on a Family Floater Cover basis then the No Claim Bonus to be carried forward for credit in such Renewed Policy shall be the lowest percentage of No Claim Bonus of the last Policy Year amongst all the expiring Individual Covers being merged.
- vi. Splitting of Covers under the Policy: If the Insured Persons in the expiring cover under the Policy are covered on a Family Floater Cover basis and such Insured Persons Renew their expiring cover with Us by splitting the Sum Insured in to two or more Family Floater/Individual Covers then the No Claim Bonus shall not be carried forward to the split covers.
- vii. Reduction in Sum Insured: If the Sum Insured has been reduced at the time of Renewal, the applicable No Claim Bonus shall be calculated on the revised Sum Insured on a pro-rata basis.
- viii. Increase in Sum Insured: If the Sum Insured has been increased at the time of Renewal the No Claim Bonus shall be calculated on the Sum Insured of the last completed Policy Year.
- ix. The No Claim Bonus is provisional and is subject to decrease by the same percentage as specified in the Policy Schedule/ Certificate of Insurance if a claim is made in the expiring Policy Year.

3.10.12 Modern Treatments

The following procedures / treatments will be covered either as Section 3.10.1 (Inpatient Care) or 3.10.4 as part of (Day Care) in a hospital up to the limit as specified in the Policy Schedule/Certificate of Insurance.

- a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
- b. Balloon Sinuplasty
- c. Deep Brain stimulation
- d. Oral chemotherapy
- e. Immunotherapy- Monoclonal Antibody to be given as injection
- f. Intra vitreal injections
- g. Robotic surgeries
- h. Stereotactic radio surgeries
- i. Bronchical Thermoplasty
- j. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
- k. IONM - (Intra Operative Neuro Monitoring)
- l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

Sub-limit:

- a. The following procedures / treatments shall be covered only up to the sub-limit as specified for each procedure / treatment in the below table:

Procedure / Treatment	Sub-limit* (Rs.)
Deep Brain Stimulation	5 Lac
Immunotherapy- Monoclonal Antibody to be given as injection	5 Lac
Intra vitreal injections	5 Lac
Robotic surgeries	2.5 Lac

Stereotactic radio surgeries	3.5 Lac
Bronchical Thermoplasty	2 Lac
Vaporisation of the prostate (Green laser treatment or holmium laser treatment)	2 Lac

*Maximum payout will be the sub-limit specified or Base Sum Insured, whichever is lower.

- b. Pre-hospitalization and Post-hospitalization Medical Expenses are also covered within the overall benefit sub-limit as specified above in point (a).
- c. The expenses that are not covered or subsumed into room charges / procedure charges / costs of treatment are placed as Annexure 2

3.10.13 Section Specific Conditions

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

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

A. Waiting Periods

3.10.13.1 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 the number of months (as mentioned in Policy Schedule/Certificate of Insurance) 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 number of months (as mentioned in Policy Schedule/Certificate of Insurance) for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

3.10.13.2 Specified disease/procedure waiting period (Code- Excl02)

- a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of number of months (as mentioned in Policy Schedule/Certificate of Insurance) of continuous coverage after the date of inception of the first Policy. This exclusion shall not be applicable for claims arising due to an Accident (covered from day 1).
- b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
- d. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.

- e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI then waiting period for the same would be reduced to the extent of prior coverage.
- f. List of specific diseases/procedures:
 - I. Pancreatitis and stones in biliary and urinary system
 - II. Cataract, glaucoma and other disorders of lens, disorders of retina
 - III. Hyperplasia of prostate, hydrocele and spermatocele
 - IV. Abnormal utero-vaginal bleeding, female genital prolapse, endometriosis/adenomyosis, fibroids, PCOD, or any condition requiring dilation and curettage or hysterectomy
 - V. Hemorrhoids, fissure or fistula or abscess of anal and rectal region
 - VI. Hernia of all sites,
 - VII. Osteoarthritis, systemic connective tissue disorders, dorsopathies, spondylopathies, inflammatory polyarthropathies, arthrosis such as RA, gout, intervertebral disc disorders, arthroscopic surgeries for ligament repair
 - VIII. Chronic kidney disease and failure
 - IX. Varicose veins of lower extremities
 - X. All internal or external benign or in situ neoplasms/tumours, cyst, sinus, polyp, nodules, swelling, mass or lump
 - XI. Ulcer, erosion and varices of gastro intestinal tract
 - XII. Surgical treatment for diseases of middle ear and mastoid (including otitis media, cholesteatoma, perforation of tympanic membrane), Tonsils and adenoids, nasal septum and nasal sinuses
 - XIII. Internal Congenital Anomaly
 - XIV. Surgery of Genito-urinary system unless necessitated by malignancy
 - XV. Spinal disorders

3.10.13.3 30-day waiting period (Code- Excl03):

- a. Expenses related to the treatment of any Illness upto 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.

B. Permanent Exclusions:

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

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

a. Standard Exclusion:

I. Investigation & Evaluation (Code-Excl04)

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

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

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

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

III. Obesity/ Weight Control (Code-Excl06)

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

- a. Surgery to be conducted is upon the advice of the Doctor.
- b. The surgery/Procedure conducted should be supported by clinical protocols.
- c. The member has to be 18 years of age or older and;
- d. Body Mass Index (BMI);
 - I. greater than or equal to 40 or
 - II. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - i. Obesity-related cardiomyopathy
 - ii. Coronary heart disease
 - iii. Severe Sleep Apnea
 - iv. Uncontrolled Type2 Diabetes

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

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

V. Cosmetic or plastic Surgery (Code-Excl08)

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

VI. Hazardous or Adventure sports (Code-Excl09)

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

VII. Breach of law (Code-Excl10)

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

VIII. Excluded Providers (Code-Excl11)

Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our website / notified to the Policyholders are not admissible. However, in case of life threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim. The complete list of excluded providers can be referred to on our website.

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

X. Treatments received in health 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)**

XI. Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or Day Care procedure **(Code-Excl14)**

XII. Refractive Error (Code-Excl15)

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.

XIII. Unproven Treatments (Code-Excl16)

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

XIV. Sterility and Infertility (Code-Excl17)

Expenses related to sterility and infertility. This includes:

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

XV. Maternity (Code-Excl18)

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

b. Specific Exclusion:

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

II. Circumcision

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

III. 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.

IV. External Congenital Anomaly:

Screening, counseling or treatment related to external Congenital Anomaly.

V. 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.

VI. Hormone Replacement Therapy:

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

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

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

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

IX. **Sleep disorders:**

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

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

XI. Any expenses incurred on OPD treatment

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 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 shall be waived / excused if such failure to perform is caused by an event, contingency, or circumstance beyond its reasonable control that prevents, hinders or makes impractical the performance of services. Legal actions arising hereunder shall be barred unless written notice thereof is received by Us / Our Service Provider within one year from the date of event giving rise to such legal action. All consulting physicians and Our Service Provider are independent contractors and not under the control of the Company. We / Our Service Provider are not responsible or liable for any service rendered herein through professionals to You.

3.10.14 Claims Process & Requirements:

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

A. Claims Administration

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

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

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

B. 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:

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

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

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

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

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

- a. The health card (if applicable) We have issued to the Insured Person at the time of inception of the cover under the Policy (if available) supported with KYC document;
- b. The Policy Number;
- c. Name of the Policyholder;
- d. Name and address of Insured Person in respect of whom the request is being made;
- e. Nature of the Illness/Injury and the treatment/Surgery required;
- f. Name and address of the attending Medical Practitioner;
- g. Hospital where treatment/Surgery is proposed to be taken;
- h. Date of admission;
- i. First and any subsequent consultation paper/Medical Record since beginning of diagnosis of that treatment/Surgery;
- j. Admission note;
- k. Treating Medical Practitioner certificate for disease/event history with justification of Hospitalization.

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

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

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

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

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

IV. Re-Authorization

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

Note: We offer Cashless Everywhere, even in hospitals which are not part of our network. For More details and process please visit our website: <https://transactions.nivabupa.com/cashlessclaims/pages/intimation-claim.aspx>

V. For Reimbursement Claims:

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

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

C. Claims Documentation:

We shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense at the earliest possible time. For claims for which the use of Cashless

Facility has been authorised, We will be provided these documents by the Network Provider immediately following the Insured Person's discharge from Hospital:

- a. **Claim form duly completed and signed by the claimant.** Please provide mandatorily following information, if applicable
 - i. Current diagnosis and date of diagnosis;
 - ii. Past history and first consultation details;
 - iii. Previous admission/Surgery if any.
- b. **Age/identity proof document** of the Insured Person in case of Cashless Facility claim (not required if submitted at the time of pre-authorization request) and in Reimbursement claim.
 - i. Self-attested copy of valid Age proof (passport/driving license/PAN card/class X certificate/ birth certificate);
 - ii. Self-attested copy of identity proof (passport/driving license/PAN card/voter identity card);
 - iii. Recent passport size photograph.
- c. Cancelled cheque/bank statement/copy of passbook mentioning account holder's name, IFSC code and account number printed on it of the Insured Person/Nominee (in case of death of the Insured Person).
- d. Original Hospital discharge summary.
- e. Additional documents required in case of Surgery/Surgical Procedure.
 - i. Bar code sticker and invoice for implants and prosthesis (if used);
- f. Original final bill from Hospital with detailed break-up and paid receipt.
- g. Room tariff of the entitled room category (in case of a Non-Network Provider and if room tariff is not a part of Hospital bill): duly signed and stamped by the Hospital in which treatment is taken.
(In case the Insured Person/claimant are unable to submit such document, then We shall consider the Reasonable and Customary Charges of the Insured Person's eligible room category of the Our Network Provider within the same geographical area for identical or similar services.)
- h. Original bills of pharmacy/medicines purchased, or of any other investigation done outside Hospital with reports and requisite prescriptions.
 - i. Copy of death certificate (in case of demise of the Insured Person).
- j. For Medico-legal cases (MLC) or in case of Accident
 - i. MLC/First Information Report (FIR) copy attested by the concerned Hospital/police station (if applicable);
 - ii. Original self-narration of incident in absence of MLC/FIR.
- k. Original laboratory investigation, diagnostic and pathological reports with supporting prescriptions.
 - l. Original X-Ray/MRI/ultrasound films and other radiological investigations.
- m. Certificate of disability issued by a Medical Board duly constituted by the Central and/or the State Government, if available (only in case of prosthetic cover)
- n. The retail invoice of the prosthetic with the packaging (only in case of prosthetic cover)

D. Claims Assessment:

- a. All admissible claims under this Section 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/Certificate of Insurance, then the Associated Medical Expenses payable shall be pro-rated as per the applicable limits specified in the Policy Schedule/Certificate of Insurance.
 - ii. The Deductible (if applicable) shall be applied to the aggregate of all claims that are either paid or payable under this Section. Our liability to make payment shall commence only once the aggregate amount of all eligible claims as per Policy terms and conditions exceeds the Deductible limit within the same Policy Year.

- iii. Co-payment (if applicable) as specified in the Policy Schedule/Certificate of Insurance shall be applicable on the amount payable by Us.
- b. The claim amount assessed as mentioned above would be deducted from the amount mentioned against each Benefit and Sum Insured as specified in the Policy Schedule/Certificate of Insurance. The re-fill amount will be applied only once the Base Sum Insured is exhausted in the Policy Year.

3.11 Critical illness Cover:

We will pay the amount specified in the Policy Schedule/Certificate of Insurance if the Insured Person is diagnosed with any Critical Illness as mentioned in the Policy Schedule/Certificate of Insurance.

Conditions:

- a. We shall not be liable to make any payment under this Benefit if the Insured Person does not survive the Survival Period specified in the Policy Schedule/Certificate of Insurance.
- b. Payment under this policy will be made as mentioned in the Policy Schedule/ Certificate of Insurance.
- c. The diagnosis of a Critical illness must be verified by a Medical Practitioner.
- d. The list of applicable Critical Illnesses for the Insured Person will be as per Annexure 9.
- e. If the benefit amount in your policy is linked to any of the below options (as mentioned in the Policy Schedule/Certificate of Insurance) then the insured will be asked for documents as proof at the time of issuance of the policy or/and claims for the specified category.
 - I. Based on Weekly, Monthly, Quarterly Salary: The take home Salary of the Insured will be considered as the declared Salary at the time of buying the policy. We will not consider bonus and other payouts as part of the Salary. Salary has to be in the name of the Insured Proposer.
 - II. Based on Fixed Deposit (FD) Amount: The amount deposited as FD by the Insured at the time of buying the policy will be considered. The FD has to be in the name of the Insured Proposer. The Interest earned on the fixed deposit will not be considered at the time of payment of benefit.
 - III. Based on Balance of the Savings Account: The Average quarterly balance maintained as confirmed by the bank or the balance on the day of issuance of policy (for new accounts), in the said Savings Account in the name of the Insured will be considered. The Savings Account has to be in the name of the Insured Proposer.
 - IV. Based on Credit Card Limit: The set Credit Card limit on the said card (as declared by the insured) in the name of the Insured, on the day of buying the policy will be considered. Change in the limits of the Card post policy issuance will not be considered.
 - V. Based on Loan Amount: The principal outstanding amount on the said loan (the loan basis which the policy was issued) on the day of the event giving rise to the claim. We will not consider any top ups and/or upgrades post policy issuance as part of the said loan. The loan has to be in the name of the Insured Proposer.
 - VI. Based on EMIs on Loan Amount: The EMI amount for up to 24 months will be considered as pay out. The Actual EMI amount on the said Loan (the loan basis which the policy was issued) will be considered at the time of payment of the benefit. . We will not consider any top ups and/or upgrades post policy issuance as part of the said loan. The EMI has to be in the name of the Insured Proposer.
 - VII. Based on payment of Utility Bills: The amount paid towards utility bills- up to past 180 days, or/and up to last 24 bills paid- will be considered as the base amount for payout. Utility bills will include all or any of the following bills: telephone bills, mobile recharge and top ups, electricity bill, gas bill, water bill, broadband/internet bill or any other category of bill as defined by us at the time of Policy issuance. The utility bills paid should be in the name of the Insured Proposer.

- f. The maximum payout will be as per the Maximum Sum Insured mentioned in the Product Benefit Table (Annexure 12). This maximum cap will be applicable even when the amount is linked to any category as mentioned in point (e) above.

3.11.1 Section Specific Conditions

All Waiting Periods will be applicable individually for each Insured person as specified in the Policy Schedule/ Certificate of Insurance. On Renewal, if an increased Sum Insured is applied, the Waiting Periods would apply afresh to the extent of the increase in Sum Insured only, 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 directly or indirectly for, caused by, based on, arising out of or howsoever attributable to any of the following, except if any Insured Person suffers an Accident;

A. Waiting Period

3.11.1.1 Pre-existing Diseases (Code–Excl01):

- Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of the number of months (as mentioned in Policy Schedule/Certificate of Insurance) of continuous coverage after the date of inception of the first Policy.
- In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- 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.
- Coverage under the Policy after the expiry of number of months (as mentioned in Policy Schedule/Certificate of Insurance) for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

3.11.1.2 30-day waiting period (Code- Excl03):

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

3.11.1.3 Survival Period:

- The payment of the Benefit shall be subject to survival of the Insured Person for the duration specified in Policy Schedule/ Certificate of Insurance post the first diagnosis of the Critical Illness
- The Critical Illness cover is not applicable in the event of Death of Insured Person during the Survival Period as specified in Policy Schedule/ Certificate of Insurance following diagnosis of Critical Illness

- If diagnosis takes place on or before the Policy/ Coverage expiry date, but the Survival Period expires after the Policy/ Coverage end date, We will pay a claim provided that the Insured Person survives duration as specified in Policy Schedule/ Certificate of Insurance from the date of diagnosis.

B. Permanent Exclusions:

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

i. 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.

ii. 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.

iii. 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.

iv. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- Excl12**v. Sterility and Infertility: Code- Excl17**

Expenses related to sterility and infertility. This includes:

- I. Any type of contraception, sterilization
- II. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- III. Gestational Surrogacy
- IV. Reversal of sterilization

vi. Maternity: Code Excl18

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

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

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

viii. 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

ix. Alternative Treatments:

Any covered Critical Illnesses diagnosed and/or treated by Medical Practitioner who practices Alternative Medicine.

x. External Congenital Anomaly:

Screening, counseling or treatment related to External Congenital Anomaly.

3.11.2 Claims Process & Requirements:

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

A. Claims Administration:

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

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

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

B. Claims Procedure

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

- v. Nature of Illness or Injury and the treatment/Surgery taken;
- vi. Name and address of the attending Medical Practitioner ;
- vii. Hospital where treatment/Surgery was taken;
- viii. Date of Occurrence of Insured Event or/and date of admission ;
- ix. Any other information that may be relevant to the Illness/ Injury/ Hospitalization.

C. Claims Documentation

We shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense at the earliest possible time.

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

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.

D. Claims Assessment & Repudiation

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

- a. We shall not be liable to make any payment under this Section in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means whether by the Insured Person or by any other person acting on his behalf.
- b. If We, for any reasons to be recorded in writing and communicated to the Insured Person, decide to reject a claim under the Policy, it shall do so within a period of 30 days from the receipt of last necessary information and documentation set out above.
- c. In the unfortunate event of the Insured Person death, We will pay the Nominee named in the Certificate of Insurance or the Insured Person's legal heirs or legal representatives holding a valid succession certificate.
- d. Our total liability in aggregate of all claims under the Policy for a specific Insured Person shall not exceed the respective Sum Insured as specified in the Certificate of Insurance of that Insured Person

3.12 Accident Cover

The Benefits offered under this Section shall be available to the Insured Person up to the Accidental Cover Sum Insured subject to any specific limits stated in the Policy Schedule/Certificate of Insurance as per the eligibility under the opted Benefits.

Cover duration options range from 24 hours to up to 1 year

Coverage Options:

3.12.1 Accidental Death (AD)

If the death of an insured person is solely and directly due to an Accident within 365 days from the date of occurrence of such Accident, We will pay the Accidental Cover Sum Insured specified in the Policy Schedule/Certificate of Insurance.

Conditions:

- a. If your policy schedule mentions any or all of the following benefits, We will deduct any amounts already paid under Section 3.12.2 (Accidental Permanent Total Disability), 3.12.3 (Accidental Permanent Partial Disability) and 3.12.4 (Temporary Total Disability) from the amount payable under this Benefit.
- b. We shall not be liable to make any payment under Section 3.12.1 (Accidental Death) if We have already paid or accepted any claims under Section 3.12.2 (Accidental Permanent Total Disability), 3.12.3 (Accidental Permanent Partial Disability) and 3.12.4 (Temporary Total Disability) in respect of that Insured Person and the total amount paid or payable under those claims is cumulatively greater than or equal to the Sum Insured.

3.12.2 Accidental Permanent Total Disability (PTD)

If an Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period and which solely and directly results in the Insured Person's Permanent Total Disability of the nature

specified in the grid below, within 365 days from the date of occurrence of such Accident, We will make payment in accordance with the grid below.

Conditions:

- a. The Permanent Total Disability is proved with a disability certificate issued by a Medical Board duly constituted by the Central or the State Government being presented to Us;
- b. We will admit a claim under Section 3.12.2 only if the Permanent Total Disability continues for a continuous period of at least six (6) calendar months from the commencement of the disability and such disability is permanent at the end of this period;
- c. If the Insured Person dies before a claim has been admitted under Section 3.12.2, We shall not be liable to make any payment under Section 3.12.2
- d. We shall not be liable to make payment under Section 3.12.2 in respect of an Insured Person for any and all Policy Periods more than once in the Insured Person's lifetime;
- e. We will deduct any amounts already paid under Section 3.12.3 (Accidental Permanent Partial Disability) or 3.12.4 (Temporary Total Disability) from the amount payable under this Benefit.
- f. We shall not be liable to make any payment under Section 3.12.2, if We have already paid or accepted any claims under Section 3.12.3 (Accidental Permanent Partial Disability) or 3.12.4 (Temporary Total Disability) in respect of that Insured Person and the total amount paid or payable under those claims is cumulatively greater than or equal to the Sum Insured.

Nature of Permanent Total Disability	% of the Accidental Cover Sum Insured Payable
Actual loss by physical separation or total and permanent loss of use of both hands	100%
Actual loss by physical separation or total and permanent loss of use of both feet	100%
Loss of sight in both eyes	100%
Actual loss by physical separation or total and permanent loss of use of one hand and one foot	100%
Actual loss by physical separation or total and permanent loss of use of one hand and sight in one eye	100%
Actual loss by physical separation or total and permanent loss of use of one foot and sight in one eye	100%
Loss of speech and loss of hearing in both ears	100%
Permanent and incurable paralysis of all limbs	100%
Permanent total loss of mastication	100%
The Insured Person suffers Injuries which do not fall within any of the categories specified above but are such that the Insured Person is unlikely to ever be able to physically engage in any occupation or employment or business for remuneration or profit.	100%

3.12.3 Accidental Permanent Partial Disability(PPD)

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

Conditions:

- a. The Permanent Partial Disability is proved with a disability certificate issued by a Medical Board duly constituted by the Central or the State Government being presented to Us;
- b. We will admit a claim under Section 3.12.3 only if the Permanent Partial Disability continues for a period of at least six (6) continuous calendar months from the date of commencement of the disability and such disability is continuous and permanent at the end of this period;
- c. If the Insured Person dies before a claim has been admitted under Section 3.12.3, We shall not be liable to make any payment under Section 3.12.3;
- d. If We have admitted a claim under Section 3.12.2 (Accidental Permanent Total Disability), then We shall not admit any claim under Section 3.12.3 (Accidental Permanent Partial Disability) in respect of the Insured Person;
- e. We shall not be liable to make any payment under Section 3.12.3 (Accidental Permanent Partial Disability) if We have already paid or accepted any claims under Section 3.12.1 (Accidental Death) or 3.12.2 (Accidental Permanent Total Disability) or 3.12.4 (Accidental Temporary Total Disability) in respect of that Insured Person and the total amount paid or payable under those claims is cumulatively greater than or equal to the Sum Insured.

Nature of Permanent Partial Disability	% of Accidental Cover Sum Insured payable
Total and irreversible loss of hearing in both ears	50%
Total and irreversible loss of speech	50%
Actual loss by physical separation or total and permanent loss of use of one hand	50%
Actual loss by physical separation or total and permanent loss of use of one foot	50%
Total and irreversible loss of sight in one eye	50%
Actual loss by physical separation or total and permanent loss of use of four fingers and thumb of one hand	40%
Actual loss by physical separation or total and permanent loss of use of four fingers	30%
Total and irreversible loss of hearing in one ear	30%
Actual loss by physical separation or total and permanent loss of use of thumb and index finger of the same hand	25%
Actual loss by physical separation of all toes	20%
Actual loss by physical separation or total and permanent loss of use of thumb	15%
Actual loss by physical separation or total and permanent loss of use of index finger	10%
Non union of fractured leg or kneecap	10%
Shortening of leg by at least 5 cm	7.5%
Actual loss by physical separation or total and permanent loss of use of middle finger	6%
Actual loss by physical separation or total and permanent loss of use of ring finger	5%
Actual loss by physical separation or total and permanent loss of use of little finger	4%

Actual loss by physical separation of great toe (both phalanges)	5%
Actual loss by physical separation of great toe (one phalanx)	2%
Actual loss by physical separation of any toes other than the great toe, provided that more than one toe is lost	1% each
Loss of metacarpals - first or second (additional) or third, fourth or fifth (additional)	3%

3.12.4 Temporary Total Disability (TTD)

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

Conditions:

- For the purpose of Section 3.12.4 "weekly earning" shall not include any overtime, bonuses, tips, commissions, allowances or special compensations or any components of variable pay that the Insured Person may have otherwise been eligible to receive.
- We will make payment under Section 3.12.4 for only a part of the week if the Insured Person has suffered Temporary Total Disability for that part of the week.
- We shall not be liable to make any payment under Section 3.12.4 in respect of more than 100 continuous weeks, subject always to the Accidental Cover Sum Insured.
- The amount payable under Section 3.12.4 is calculated on a per day basis and shall be payable after 3 continuous days of temporary disability.
- We will make payment of the amount due under Section 3.12.4 on a weekly basis unless the Temporary Total Disability continues for a continuous period of more than 30 days in which case We will make payment of the amount due under Section 3.12.4 at the end of every calendar month until the Temporary Total Disability ceases.
- We will deduct any amounts already paid under Section 3.12.3 (Accidental Permanent Partial Disability) and 3.12.4 (Accidental Temporary Total Disability) from the amount payable under this Benefit.

3.12.5 Accidental Medical Reimbursement

If the Insured Person is Hospitalized solely and directly due to an Injury sustained during the Policy Period, We will indemnify the Medical Expenses incurred on Hospitalization during the Policy Period as a result of the Injury. The payment will be made as specified in the policy schedule/ certificate of Insurance.

Conditions:

- We shall not be liable to make any payment under this Benefit unless a claim has been admitted under Section 3.12.1 (Accidental Death) or Section 3.12.2 (Accidental Permanent Total Disability) or Section 3.12.3 (Accidental Permanent Partial Disability) or Section 3.12.4 (Accidental Temporary Total Disability)

OR

If the Insured Person is hospitalized solely and directly due to an Injury sustained during the Policy Period, We will indemnify the Medical Expenses incurred on Hospitalization during the Policy Period as a result of the Injury. The payment will be made as specified in the policy schedule/ certificate of Insurance.

Conditions:

- a. Payment under this benefit will be made even if there is no claim admitted Section 3.12.1 (Accidental Death) or Section 3.12.2 (Accidental Permanent Total Disability) or Section 3.12.3 (Accidental Permanent Partial Disability) or Section 3.12.4 (Accidental Temporary Total Disability)

3.12.6 Benefit amount

If for Section 3.12.1 (Accidental Death) or Section 3.12.2 (Accidental Permanent Total Disability) or Section 3.12.3 (Accidental Permanent Partial Disability) or Section 3.12.4 (Accidental Temporary Total Disability) or Section 3.12.5 (Accidental Medical Reimbursement) the benefit amount in the policy is linked to any of the following (as mentioned in the Policy Schedule/Certificate of Insurance). The insured will be asked for documents as proof for the specified benefit amount category at the time of issuance of the policy or/and claims.

- a. Based on Weekly, Monthly, Quarterly Salary: The take home Salary of the Insured will be considered as the declared Salary at the time of buying the policy. We will not consider bonus and other payouts as part of the Salary. Salary has to be in the name of the Insured Proposer.
- b. Based on Fixed Deposit (FD) Amount: The amount deposited as FD by the Insured at the time of buying the policy will be considered. The FD has to be in the name of the Insured Proposer. The Interest earned on the fixed deposit will not be considered at the time of payment of benefit.
- c. Based on Balance of the Savings Account: The Average quarterly balance maintained as confirmed by the bank or the balance on the day of issuance of policy (for new accounts), in the said Savings Account in the name of the Insured will be considered. The Savings Account has to be in the name of the Insured Proposer.
- d. Based on Credit Card Limit: The set Credit Card limit on the said card (as declared by the insured) in the name of the Insured, on the day of buying the policy will be considered. Change in the limits of the Card post policy issuance will not be considered.
- e. Based on Loan Amount: The principal outstanding amount on the said loan (the loan basis which the policy was issued) on the day of the event giving rise to the claim. We will not consider any top ups and/or upgrades post policy issuance as part of the said loan. The loan has to be in the name of the Insured Proposer.
- f. Based on EMIs on Loan Amount: The EMI amount for up to 24 months will be considered as pay out. The Actual EMI amount on the said Loan (the loan basis which the policy was issued) will be considered at the time of payment of the benefit. . We will not consider any top ups and/or upgrades post policy issuance as part of the said loan. The EMI has to be in the name of the Insured Proposer.
- g. Based on payment of Utility Bills: The amount paid towards utility bills- up to past 180 days, or/and up to last 24 bills paid- will be considered as the base amount for payout. Utility bills will include all or any of the following bills: telephone bills, mobile recharge and top ups, electricity bill, gas bill, water bill, broadband/internet bill or any other category of bill as defined by us at the time of Policy issuance. The utility bills paid should be in the name of the Insured Proposer.
- h. The maximum payout will be as per the Maximum Sum Insured mentioned in the Product Benefit Table (Annexure 12). This maximum cap will be applicable even when the amount is linked to any category as mentioned in points 'a' to 'g' above.

3.12.7 Section specific Exclusions:

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

- I. Death or any disablement resulting from, caused by, contributed to or aggravated or prolonged by child birth or from pregnancy.
- II. Participation in aviation other than as a fare-paying passenger in an aircraft that is authorized by the relevant regulations to carry such passengers between established aerodromes.
- III. Any disability arising out of Pre-Existing Disease if not accepted and endorsed by Us on the Policy Schedule/Certificate of Insurance.
- IV. Body or mental infirmity or any disease except where such condition arises directly due to an Accident occurring during the Policy Period.
- V. Death or disability due to mental disorders or disturbances of consciousness, strokes, fits or convulsions which affect the entire body and pathological disturbances caused by the mental reaction to the same.

3.12.8 Claims Process and Requirements:

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

A. Claims Procedure:

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

B. Claims Documentation:

We shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense at the earliest possible time.

a. Accidental Death

- i. Duly filled and signed claim form and Age / identity proof documents
- ii. Copy of Death Certificate (issued by the office of Registrar of Births and Deaths or any other authorized legal institution)
- iii. Copy of First Information Report (FIR) /Panchnama, if applicable
- iv. Copy of Medico Legal Certificate duly attested by the concerned Hospital, if applicable.
- v. Copy of Hospital record, if applicable
- vi. Copy of post mortem report wherever applicable

b. Accident Permanent Total Disability and Accident Permanent Partial Disability

- i. Duly filled and signed claim form and Age / identity proof documents
- ii. Hospital discharge summary (in original) / self-attested copies if the originals are submitted with another insurer.
- iii. Final Hospital bill (in original) / self-attested copies if the originals are submitted with another insurer.
- iv. Medical consultations and investigations done from outside the Hospital.
- v. Certificate of Disability issued by a Medical Board duly constituted by the Central and/or the State Government.
- vi. Copy of First Information Report (FIR) / Panchnama if applicable

vii. Copy of Medico Legal Certificate duly attested by the concerned Hospital, if applicable.

c. Accidental Temporary Total Disability

- i. Duly filled and signed claim form
- ii. Hospital discharge summary (in original) / self-attested copies if the originals are submitted with another insurer.
- iii. Copy of First Information Report (FIR) /Panchnama / Inquest report duly attested by the concerned police station
- iv. Copy of Medico Legal Certificate duly attested by the concerned hospital.
- v. Attendance record of employer / Certificate of employer confirming period of absence
- vi. Latest salary certificate with grade and designation
- vii. Newspaper cuttings / news articles covering the Accident(if available)

d. Accidental Medical Reimbursement

1. In addition to the documents required for the Accidental Death, Accidental Permanent Total Disability, Accidental Permanent Partial Disability or Temporary Total Disability Benefits
2. Final Hospital bill with receipt /copies attested by other insurer if the originals are submitted with them.
3. Original bills with supporting prescriptions and reports for investigations done outside the Hospital/ copies attested by other insurer if the originals are submitted with them.
4. Original bills with supporting prescriptions for medicines purchased from outside the Hospital / copies attested by other insurer if the originals are submitted with them.

C. Claims Assessment & Repudiation:

All admissible claims under this Section shall be assessed by Us in the following progressive order:-
The claim amount assessed as mentioned above would be deducted from the amount mentioned against each Benefit and Sum Insured as specified in the Policy Schedule/Certificate of Insurance.

3.13 Serious Illness

For any Illness, accident or/and surgery that requires the Insured to be admitted in the Hospital for the number of days as mentioned in the Policy Schedule/ Certificate in Insurance, then We will pay the benefit amount (as per the policy schedule/ certificate of insurance) for the policy.

A Minimum of 1 day of hospitalization will be required.

NOTE: One day will be considered as completion of 24 hours in admission

Conditions:

- a. The Hospitalization is for Medically Necessary Treatment, is carried out on the written advice of a Medical Practitioner and follows Evidence Based Clinical Practices and standard treatment guidelines.
- b. If the benefit amount in your policy is linked to any of the below options (as mentioned in the Policy Schedule/Certificate of Insurance) then the insured will be asked for documents as proof at the time of issuance of the policy or/and claims for the specified category.
 - I. Basis a fixed payout amount as per limits mentioned in the policy schedule.
 - II. Based on Weekly, Monthly, Quarterly Salary: The take home Salary of the Insured will be considered as the declared Salary at the time of buying the policy. We will not consider bonus and other payouts as part of the Salary. Salary has to be in the name of the Insured Proposer.
 - III. Based on Fixed Deposit (FD) Amount: The amount deposited as FD by the Insured at the time of buying the policy will be considered. The FD has to be in the name of the Insured Proposer. The Interest earned on the fixed deposit will not be considered at the time of payment of benefit.
 - IV. Based on Balance of the Savings Account: The Average quarterly balance maintained as confirmed by the bank or the balance on the day of issuance of policy (for new accounts), in the said Savings Account in the name of the Insured will be considered. The Savings Account has to be in the name of the Insured Proposer.
 - V. Based on Credit Card Limit: The set Credit Card limit on the said card (as declared by the insured) in the name of the Insured, on the day of buying the policy will be considered. Change in the limits of the Card post policy issuance will not be considered.
 - VI. Based on Loan Amount: The principal outstanding amount on the said loan (the loan basis which the policy was issued) or a percentage of the principal outstanding loan amount or a percentage of the loan amount on the day of the event giving rise to the claim. We will not consider any top ups and/or upgrades post policy issuance as part of the said loan. The loan has to be in the name of the Insured Proposer.
 - VII. Based on EMIs on Loan Amount: The EMI amount will be considered as pay out. The Actual EMI amount on the said Loan (the loan basis which the policy was issued) will be considered at the time of payment of the benefit. . We will not consider any top ups and/or upgrades post policy issuance as part of the said loan. The EMI has to be in the name of the Insured Proposer.
 - VIII. Based on payment of Utility Bills: The amount paid towards utility bills- up to past 180 days, or/and up to last 24 bills paid- will be considered as the base amount for payout. Utility bills will include all or any of the following bills: telephone bills, mobile recharge and top ups, electricity bill, gas bill, water bill, broadband/internet bill or any other category of bill as defined by us at the time of Policy issuance. The utility bills paid should be in the name of the Insured Proposer.
- c. The maximum payout will be as per the Maximum Sum Insured mentioned in the Product Benefit Table (Annexure 12). This maximum cap will be applicable even when the amount is linked to any category as mentioned in point (c) above.

3.13.1 Section Specific Conditions

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

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

A. Waiting Periods

a. Pre-existing Diseases (Code–Excl01):

- i. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of the number of months (as mentioned in Policy Schedule/Certificate of Insurance) of continuous coverage after the date of inception of the first Policy.
- ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- iii. 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.
- iv. Coverage under the Policy after the expiry of number of months (as mentioned in Policy Schedule/Certificate of Insurance) for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

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

- i. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of number of months (as mentioned in Policy Schedule/Certificate of Insurance) of continuous coverage after the date of inception of the first Policy. This exclusion shall not be applicable for claims arising due to an Accident (covered from day 1).
- ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- iii. 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.
- iv. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
- v. 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.
- vi. List of specific diseases/procedures:
 1. Pancreatitis and stones in biliary and urinary system
 2. Cataract, glaucoma and other disorders of lens, disorders of retina
 3. Hyperplasia of prostate, hydrocele and spermatocele
 4. Abnormal utero-vaginal bleeding, female genital prolapse, endometriosis/adenomyosis, fibroids, PCOD, or any condition requiring dilation and curettage or hysterectomy
 5. Hemorrhoids, fissure or fistula or abscess of anal and rectal region
 6. Hernia of all sites,

7. Osteoarthritis, systemic connective tissue disorders, dorsopathies, spondylopathies, inflammatory polyarthropathies, arthrosis such as RA, gout, intervertebral disc disorders, arthroscopic surgeries for ligament repair
8. Chronic kidney disease and failure
9. Varicose veins of lower extremities
10. All internal or external benign or in situ neoplasms/tumours, cyst, sinus, polyp, nodules, swelling, mass or lump
11. Ulcer, erosion and varices of gastro intestinal tract
12. 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
13. Internal Congenital Anomaly
14. Surgery of Genito-urinary system unless necessitated by malignancy
15. Spinal disorders

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

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

B. Permanent Exclusions:

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

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

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.

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.

3. 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.

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. 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.

6. 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. 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.

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

9. 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)

10. 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.

11. 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

12. 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.

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

14. 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.

15. External Congenital Anomaly:

Screening, counseling or treatment related to external Congenital Anomaly.

16. 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.

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

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

3.13.2 Claims Process & Requirements:

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

A. Claims Administration:

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

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

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

B. Claims Procedure

- a. If the Insured Person is Hospitalized / underwent a Surgical Procedure or any medical condition falling under purview of the definition of Serious Illness as mentioned in the Policy that may result in a claim, then the Insured Person must provide intimation to Us immediately of the aforesaid Illness/ condition/ surgical event and which can be received from You/Insured Person through various modes like email / telephone/ fax/ in person or may be via letter or any other suitable mode. Upon receipt of information We will register the claim under a unique claim number.
- b. The following details are to be provided at the time of intimation of claim:
 - a. The Policy Number/Certificate Number,

- b. Name of the Policyholder;
- c. Employee No./ Member ID
- d. Name and address of the Insured Person in respect of whom the request is being made;
- e. Nature of Illness or Injury and the treatment/Surgery taken;
- f. Name and address of the attending Medical Practitioner ;
- g. Hospital where treatment/Surgery was taken;
- h. Date of Occurrence of Insured Event or/and date of admission ;
- i. Any other information that may be relevant to the Illness/ Injury/ Hospitalization.

C. Claims Documentation

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

- i. Claim form duly completed and signed by the Insured Person. Please provide mandatorily following information if applicable
- ii. Date of Hospitalization and date of discharge
- iii. Past history and first consultation details;
- iv. Previous admission/Surgery if any.
- v. Age/identity proof document of the Proposer.
- vi. Self-attested copy of valid Age proof (passport / driving license / PAN card / class X certificate / birth certificate);
- vii. Self-attested copy of identity proof (passport / driving license / PAN card / voter identity card);
- viii. Recent passport size photograph.
- ix. Cancelled cheque/ bank statement / copy of passbook mentioning account holder's name, IFSC code and account number printed on it of Insured Person / nominee (in case of death of Insured Person)
- x. Hospital discharge summary(if applicable)
- xi. Original final bill from Hospital with detailed break-up and paid receipt (If applicable)
- xii. Copy of death certificate (in case of demise of the Insured Person)
- xiii. For Medico-legal cases (MLC) or in case of Accident as may be applicable
- xiv. MLC and First Information Report (FIR) copy duly attested by the concerned Hospital and police station respectively. (if applicable);
- xv. Original self-narration of incident in absence of MLC/ FIR.

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.

D. Claims Assessment & Repudiation

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

- a. We shall not be liable to make any payment under this Section in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means whether by the Insured Person or by any other person acting on his behalf.
- b. If We, for any reasons to be recorded in writing and communicated to the Insured Person, decide to reject a claim under the Policy, it shall do so within a period of 30 days from the receipt of last necessary information and documentation set out above.

- c. In the unfortunate event of the Insured Person death, We will pay the Nominee named in the Certificate of Insurance or the Insured Person's legal heirs or legal representatives holding a valid succession certificate.
- d. Our total liability in aggregate of all claims under the Policy for a specific Insured Person shall not exceed the respective Sum Insured as specified in the Certificate of Insurance of that Insured Person

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

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

- i. Conflict & Disaster: Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader).
- ii. **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.
- iii. 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, para-military or air force operation during peace time.
- iv. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- **Excl12**
- v. Inhaling any gas or fumes, accidentally or otherwise, except in the course of duty.
- vi. Participation in aviation other than as a fare-paying passenger in an aircraft that is authorized by the relevant regulations to carry such passengers between established aerodromes.
- vii. **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.
- viii. **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.
- ix. **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.
- x. Any exclusion mentioned in the Policy Schedule/Certificate of Insurance or the breach of any specific condition mentioned in the Policy Schedule/Certificate of Insurance.
- xi. Any disability arising out of Pre-Existing Disease if not accepted and endorsed by Us on the Policy Schedule or Certificate of Insurance.

5. General Terms and Conditions

5.1 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.

5.2 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.

5.3 Free Look Period

The Free Look Period shall be applicable on 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.

5.4 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.

The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

5.5 Automatic Cancellation:

i. Individual Cover:

The Certificate of Insurance coverage shall automatically terminate in the event of death of the Insured Person.

ii. For Family Floater Cover

The cover under the Policy coverage shall automatically terminate in the event of the death of all the Insured Persons under the Family Floater Cover.

5.6 Cancellation in case of Credit Linked Cases:

In cases the Policy is linked to the credit/ loan tenure, the coverage will continue till the end of loan tenure subject to maximum tenure of 5 years, closure of the loan or Policy Period/ Coverage Period Term whichever

is earlier. The Insured Person shall inform Us of such closure of the loan immediately in order to cancel the cover under the Policy.

5.7 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 installment) 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

5.8 Other Renewal Conditions

a. Continuity of Benefits on Timely Renewal:

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

b. Reinstatement:

- i. The Policy shall lapse after the expiration of the Grace Period. If the Policy is not renewed within the Grace Period then We may agree to issue a fresh Policy subject to Our underwriting criteria, as per Our Board approved underwriting Policy and no continuing benefits shall be available from the expired Policy.
- ii. We will not pay for any Medical Expenses which are incurred between the date the Policy expires and the date immediately before the reinstatement date of Your/Insured Person's Policy.
- iii. If there is any change in the Insured Person's medical or physical condition, We may add exclusions or charge an extra premium from the reinstatement date.

c. Disclosures on Renewal:

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

d. Addition of Insured Persons on Renewal:

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

e. Changes to Sum Insured on Renewal:

You/Insured Person may opt for enhancement of Sum Insured at the time of Renewal, subject to underwriting. Any enhanced Sum Insured applied on Renewal will not be available for an Illness or Injury already contracted under the preceding Policy Periods. All Waiting Periods as defined in the Policy shall apply afresh for this enhanced limit from the effective date of such enhancement.

5.9 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.

5.10 Obligations in case of a minor

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

5.11 Assignment

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

5.12 Records to be maintained:

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

5.13 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.

5.14 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 pa(y 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.

5.15 Notification of Claim and Delay in Intimation:

The notification of all claims should be sent to Us via one of the following:

Customer Care no: 1860-500-8888

By registered post sent to:

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

Fax No.: +91 11 41743397

Email ID: B2Bclaimbcp@nivabupa.com / Senior citizens may write to us at: seniorcitizensupport@nivabupa.com

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

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

5.16 Claims Settlement (Provision for Penal Interest)

- I. The Company shall settle or reject a claim, as the case may be, within 15 days from the claim submission date.
- II. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of claim intimation until the date of payment of claim at a rate of 2% above the bank rate.

(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)

5.17 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.

5.18 Territorial Jurisdiction

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

5.19 Role of Group Administrator

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

5.20 Notices

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

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

Niva Bupa Health Insurance Company Limited
D-5, 2nd Floor, Logix Infotech Park
opp. Metro Station, Sector 59, Noida, Uttar Pradesh, 201301
Fax No.: +91 11 41743397

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

5.21 Alteration to the Policy

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

5.22 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.

5.23 Withdrawal of Policy

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

5.24 Redressal of Grievance:

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

Website: www.nivabupa.com

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

Fax No.: +91 11 41743397

Customer Care no: 1860-500-8888

Email ID: B2Bclaimbcp@nivabupa.com

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

- a. 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

Fax No.: +91 11 41743397

Customer Care no: 1860-500-8888

Email ID: B2Bclaimbcp@nivabupa.com

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 A).

Grievance may also be lodged at IRDAI integrated Grievance Management System – www.bimabharosa.irdai.gov.in

5.25 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.

5.26 Multiple Policies:

A. Indemnity Based Policies:

- a. 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 Policyholder shall be considered

as the Primary Insurer and will 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.

- b. If the amount to be claimed exceeds the available coverage of the said policy, then the primary insurer shall seek the details of other available policies of the policyholder and shall coordinate with other insurers to ensure settlement of the balance amount as per the policy conditions, without causing any hassles to the policy holder.

B. Benefit Based Policies:

- a. On occurrence of the insured event, the policy holder can claim from all Insurers under all policies.

5.27 Disclosure to Information

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

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

5.28 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.

Annexure 1
NA

Annexure 2

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

List I – Expenses not covered

Sl. No.	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE

18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
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

Annexure 3
LIST OF SPECIALISTS

This is an indicative List. Any or all can be opted from this list

S.No	List
1	Dietician
2	Gynaecologist
3	Psychologist
4	Psychiatrist
5	Health Coach/ Health Doctor
6	Paediatrician
7	ENT
8	Ophthalmologist

Annexure 4

LIST OF DIAGNOSTIC TESTS

This is an indicative list of services. Any or all can be opted for from this list

S.No	Tests
1	CBC- (Haemoglobin, PCV, TLC, RBC Count, MCV, MCH, MCHC, Platelet Count, Automated DLC, Absolute Differential Counts, RDW
2	Urine- Routine & Microscopic
3	Random Blood Sugar
4	Blood Sugar- Fasting and Post Prandial
5	Serum Cholestrol
6	Lipid Profile
7	Serum Cretinine and Urea
8	Serum LDL
9	Serum LDL & HDL
10	HBA1C
11	Renal Function Test
12	Liver Function Test
13	Thyroid Function Test
14	X-ray, Ultra sound
15	PAP Smear (For Female), PSA-Male
16	ECG
17	Serum Electrolytes
18	Uric Acid
19	Calcium
20	Vitamin B-12
21	Vitamin D3
22	Bone Densitometry Test
23	2D ECHO
24	Treadmill Test (TMT)
25	Mammography & Female hormones (for Female)
26	Erythrocyte Sedimentation Rate (ESR)
27	Dental Consultation
28	Physician Consultation
29	Blood Group

Annexure 5

LIST OF HOME HEALTH CARE SERVICES

This is an indicative list of services. Any or all can be opted for from this list

S.No	Service
1	Doctor at home
2	Nurse at home
3	Physiotherapist at home
4	Attendant at home
5	Diagnostic Tests at Home

Annexure 6

LIST OF VACCINATIONS

This is an indicative list of services. Any or all can be opted for from this list

S.No	List
1	Influenza
2	Pneumonia
3	Cervical Cancer
4	Hepatitis B
5	Typhoid
6	BCG
7	OPV + IPV 1
8	OPV + IPV 1
9	DPT
10	Haemophilus influenzae type B
11	Tetanus
12	Rota
13	MMR
14	Hepatitis A

Annexure 7

LIST OF TESTS UNDER ANNUAL HEALTH CHECK-UP

This is an indicative list. Any or all can be opted for from this list

S.No	Tests
1	CBC- (Haemoglobin, PCV, TLC, RBC Count, MCV, MCH, MCHC, Platelet Count, Automated DLC, Absolute Differential Counts, RDW
2	Urine- Routine & Microscopic
3	Random Blood Sugar
4	Blood Sugar- Fasting and Post Prandial
5	Serum Cholestrol
6	Lipid Profile
7	Serum Cretinine and Urea
8	Serum LDL
9	Serum LDL & HDL
10	HBA1C
11	Renal Function Test
12	Liver Function Test
13	Thyroid Function Test
14	X-ray, Ultra sound
15	PAP Smear (For Female), PSA-Male
16	ECG
17	Serum Electrolytes
18	Uric Acid
19	Calcium
20	Vitamin B-12
21	Vitamin D3
22	Bone Densitometry Test
23	2D ECHO
24	Treadmill Test (TMT)
25	Mammography & Female hormones (for Female)
26	Erythrocyte Sedimentation Rate (ESR)
27	Dental Consultation
28	Physician Consultation
29	Blood Group

Annexure 8
DAY CARE TREATMENTS

For Section 3.10.4, either one of the below two options will be chosen at the time of designing the policy

Option 1:

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

Option 2: List of Day Care Treatments

S.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 EARDRUM PERFORATION/RECONSTRUCTION OF THE AUDITORY OSSICLES)
	15	REMOVAL OF A TYMPANIC DRAIN
	16	KERATOSIS REMOVAL UNDER GA
	17	OPERATIONS ON THE TURBINATES (NASAL CONCHA)
	18	TYMpanoplasty (CLOSURE OF AN EARDRUM PERFORATION/RECONSTRUCTION OF THE AUDITORY OSSICLES)
	19	REMOVAL OF KERATOSIS OBTURANS
	20	STAPEDOTOMY TO TREAT VARIOUS LESIONS IN MIDDLE EAR
	21	REVISION OF A STAPEDECTOMY
	22	OTHER OPERATIONS ON THE AUDITORY OSSICLES
	23	MYRINGOPLASTY (POSTAURA/ENDAURAL APPROACH AS WELL AS SIMPLE TYPE -I TYMpanoplasty)

	24	FENESTRATION OF THE INNER EAR
	25	REVISION OF A FENESTRATION OF THE INNER EAR
	26	PALATOPLASTY
	27	TRANSORAL INCISION AND DRAINAGE OF A PHARYNGEAL ABSCESS
	28	TONSILLECTOMY WITHOUT ADENOIDECTOMY
	29	TONSILLECTOMY WITH ADENOIDECTOMY
	30	EXCISION AND DESTRUCTION OF A LINGUAL TONSIL
	31	REVISION OF A TYMPANOPLASTY
	32	OTHER MICROSURGICAL OPERATIONS ON THE MIDDLE EAR
	33	INCISION OF THE MASTOID PROCESS AND MIDDLE EAR
	34	MASTOIDECTOMY
	35	RECONSTRUCTION OF THE MIDDLE EAR
	36	OTHER EXCISIONS OF THE MIDDLE AND INNER EAR
	37	INCISION (OPENING) AND DESTRUCTION (ELIMINATION) OF THE INNER EAR
	38	OTHER OPERATIONS ON THE MIDDLE AND INNER EAR
	39	EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE NOSE
	40	OTHER OPERATIONS ON THE NOSE
	41	NASAL SINUS ASPIRATION
	42	FOREIGN BODY REMOVAL FROM NOSE
	43	OTHER OPERATIONS ON THE TONSILS AND ADENOIDS
	44	ADENOIDECTOMY
	45	LABYRINTHECTOMY FOR SEVERE VERTIGO
	46	STAPEDECTOMY UNDER GA
	47	STAPEDECTOMY UNDER LA
	48	TYMPANOPLASTY (TYPE IV)
	49	ENDOLYMPHATIC SAC SURGERY FOR MENIERE'S DISEASE
	50	TURBINECTOMY
	51	ENDOSCOPIC STAPEDECTOMY
	52	INCISION AND DRAINAGE OF PERICHONDritis
	53	SEPTOPLASTY
	54	VESTIBULAR NERVE SECTION
	55	THYROPLASTY TYPE I
	56	PSEUDOCYST OF THE PINNA - EXCISION
	57	INCISION AND DRAINAGE - HAEMATOMA AURICLE
	58	TYMPANOPLASTY (TYPE II)
	59	REDUCTION OF FRACTURE OF NASAL BONE
	60	THYROPLASTY TYPE II
	61	TRACHEOSTOMY
	62	EXCISION OF ANGIOMA SEPTUM
	63	TURBINOPLASTY
	64	INCISION & DRAINAGE OF RETRO PHARYNGEAL ABSCESS

	65	UVULO PALATO PHARYNGO PLASTY
	66	ADENOIDECTOMY WITH GROMMET INSERTION
	67	ADENOIDECTOMY WITHOUT GROMMET INSERTION
	68	VOCAL CORD LATERALISATION PROCEDURE
	69	INCISION & DRAINAGE OF PARA PHARYNGEAL ABSCESS
	70	TRACHEOPLASTY
V	Gastroenterology Related:	
	71	CHOLECYSTECTOMY AND CHOLEDOCHO-JEJUNOSTOMY/ DUODENOSTOMY/GASTROSTOMY/EXPL ORATION COMMON BILE DUCT
	72	ESOPHAGOSCOPY, GASTROSCOPY, DUODENOSCOPY WITH POLYPECTOMY/ REMOVAL OF FOREIGN BODY/DIATHERMY OF BLEEDING LESIONS
	73	PANCREATIC PSEUDOCYST EUS & DRAINAGE
	74	RF ABLATION FOR BARRETT'S OESOPHAGUS
	75	ERCP AND PAPILOTOMY
	76	ESOPHAGOSCOPE AND SCLEROSANT INJECTION
	77	EUS + SUBMUCOSAL RESECTION
	78	CONSTRUCTION OF GASTROSTOMY TUBE
	79	EUS + ASPIRATION PANCREATIC CYST
	80	SMALL BOWEL ENDOSCOPY (THERAPEUTIC)
	81	COLONOSCOPY ,LESION REMOVAL
	82	ERCP
	83	COLONOSCOPY STENTING OF STRICTURE
	84	PERCUTANEOUS ENDOSCOPIC GASTROSTOMY
	85	EUS AND PANCREATIC PSEUDO CYST DRAINAGE
	86	ERCP AND CHOLEDOCHOSCOPY
	87	PROCTOSIGMOIDOSCOPY VOLVULUS DETORSION
	88	ERCP AND SPHINCTEROTOMY
	89	ESOPHAGEAL STENT PLACEMENT
	90	ERCP + PLACEMENT OF BILIARY STENTS
	91	SIGMOIDOSCOPY W / STENT
	92	EUS + COELIAC NODE BIOPSY
	93	UGI SCOPY AND INJECTION OF ADRENALINE, SCLEROSANTS BLEEDING ULCERS
VI	General Surgery Related:	
	94	INCISION OF A PILONIDAL SINUS / ABSCESS
	95	FISSURE IN ANO SPHINCTEROTOMY
	96	SURGICAL TREATMENT OF A VARICOCELE AND A HYDROCELE OF THE SPERMATIC CORD
	97	ORCHIDOPEXY
	98	ABDOMINAL EXPLORATION IN CRYPTORCHIDISM
	99	SURGICAL TREATMENT OF ANAL FISTULAS
	100	DIVISION OF THE ANAL SPHINCTER (SPHINCTEROTOMY)

	101	EPIDIDYMECTOMY
	102	INCISION OF THE BREAST ABSCESS
	103	OPERATIONS ON THE NIPPLE
	104	EXCISION OF SINGLE BREAST LUMP
	105	INCISION AND EXCISION OF TISSUE IN THE PERIANAL REGION
	106	SURGICAL TREATMENT OF HEMORRHOIDS
	107	OTHER OPERATIONS ON THE ANUS
	108	ULTRASOUND GUIDED ASPIRATIONS
	109	SCLEROTHERAPY,
	110	THERAPEUTIC LAPAROSCOPY WITH LASER
	111	INFECTED KELOID EXCISION
	112	AXILLARY LYMPHADENECTOMY
	113	WOUND DEBRIDEMENT AND COVER
	114	ABSCESS-DECOMPRESSION
	115	CERVICAL LYMPHADENECTOMY
	116	INFECTED SEBACEOUS CYST
	117	INGUINAL LYMPHADENECTOMY
	118	INCISION AND DRAINAGE OF ABSCESS
	119	SUTURING OF LACERATIONS
	120	SCALP SUTURING
	121	INFECTED LIPOMA EXCISION
	122	MAXIMAL ANAL DILATATION
	123	PILES
	124	A)INJECTION SCLEROTHERAPY
	125	B)PILES BANDING
	126	LIVER ABSCESS- CATHETER DRAINAGE
	127	FISSURE IN ANO- FISSURECTOMY
	128	FIBROADENOMA BREAST EXCISION
	129	OESOPHAGEAL VARICES SCLEROTHERAPY
	130	ERCP - PANCREATIC DUCT STONE REMOVAL
	131	PERIANAL ABSCESS I&D
	132	PERIANAL HEMATOMA EVACUATION
	133	UGI SCOPY AND POLYPECTOMY OESOPHAGUS
	134	BREAST ABSCESS I& D
	135	FEEDING GASTROSTOMY
	136	OESOPHAGOSCOPY AND BIOPSY OF GROWTH OESOPHAGUS
	137	ERCP - BILE DUCT STONE REMOVAL
	138	ILEOSTOMY CLOSURE
	139	COLONOSCOPY
	140	POLYPECTOMY COLON
	141	SPLENIC ABSCESES LAPAROSCOPIC DRAINAGE

	142	UGI SCOPY AND POLYPECTOMY STOMACH
	143	RIGID OESOPHAGOSCOPY FOR FB REMOVAL
	144	FEEDING JEJUNOSTOMY
	145	COLOSTOMY
	146	ILEOSTOMY
	147	COLOSTOMY CLOSURE
	148	SUBMANDIBULAR SALIVARY DUCT STONE REMOVAL
	149	PNEUMATIC REDUCTION OF INTUSSUSCEPTION
	150	VARICOSE VEINS LEGS - INJECTION SCLEROTHERAPY
	151	RIGID OESOPHAGOSCOPY FOR PLUMMER VINSON SYNDROME
	152	PANCREATIC PSEUDOCYSTS ENDOSCOPIC DRAINAGE
	153	ZADEK'S NAIL BED EXCISION
	154	SUBCUTANEOUS MASTECTOMY
	155	EXCISION OF RANULA UNDER GA
	156	RIGID OESOPHAGOSCOPY FOR DILATION OF BENIGN STRICTURES
	157	EVERSION OF SAC UNILATERAL/BILATERAL
	158	LORD'S 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 RETINAL TEAR
	367	BIOPSY OF TEAR GLAND
	368	TREATMENT OF RETINAL LESION
XIV	Orthopedics Related:	
	369	SURGERY FOR MENISCUS TEAR
	370	INCISION ON BONE, SEPTIC AND ASEPTIC

	371	CLOSED REDUCTION ON FRACTURE, LUXATION OR EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
	372	SUTURE AND OTHER OPERATIONS ON TENDONS AND TENDON SHEATH
	373	REDUCTION OF DISLOCATION UNDER GA
	374	ARTHROSCOPIC KNEE ASPIRATION
	375	SURGERY FOR LIGAMENT TEAR
	376	SURGERY FOR HEMOARTHROSIS/PYOARTHROSIS
	377	REMOVAL OF FRACTURE PINS/NAILS
	378	REMOVAL OF METAL WIRE
	379	CLOSED REDUCTION ON FRACTURE, LUXATION
	380	REDUCTION OF DISLOCATION UNDER 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	ABSCCESS 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-VENOUS 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 9

LIST OF CRITICAL ILLNESSES

This is an indicative list, all or any can be opted from this list:

For the purpose of Section 3.11, 'Critical Illness' means the following Illnesses:

1. Cancer of Specified Severity

- I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
- II. The following are excluded –
 - i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
 - ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
 - iii. Malignant melanoma that has not caused invasion beyond the epidermis;
 - 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 be low and with mitotic count of less than or equal to 5/50 HPFs;

2. Myocardial Infarction - (First Heart Attack of specific severity)

- I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
 - i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
 - ii. New characteristic electrocardiogram changes
 - iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.
- II. The following are excluded:
 - i. Other acute Coronary Syndromes
 - ii. Any type of angina pectoris
- III. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. Open Chest CABG

- I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone)

or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

- II. The following are excluded:
 - i. Angioplasty and/or any other intra-arterial procedures

4. Open Heart Replacement or Repair of Heart Valves

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s).

- I. The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist Medical Practitioner.
- II. This excludes:
Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

5. Coma of Specified Severity

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

6. Kidney Failure requiring Regular Dialysis

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

7. Stroke resulting in Permanent Symptoms

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

8. Major Organ /Bone Marrow Transplant

- I. The actual undergoing of a transplant of:
 - i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
 - ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.
- II. The following are excluded:

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

9. Permanent Paralysis of Limbs

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

10. Motor Neuron Disease with Permanent Symptoms

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

11. Multiple Sclerosis with Persisting Symptoms

- I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
 - i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
 - ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.
- II. Other causes of neurological damage such as SLE and HIV are excluded.

12. Benign Brain Tumor

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

13. Blindness

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

14. Deafness

- I. Total and irreversible loss of hearing in both ears as a result of Illness or Accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT)

specialist. Total means “the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing” in both ears.

15. End Stage Lung Failure

- 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 ($\text{PaO}_2 < 55\text{mmHg}$); and
 - iv. Dyspnea at rest.

16. End Stage Liver Failure

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

17. Loss of Speech

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

18. Loss of Limbs

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

19. Major Head Trauma

- I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The Accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.
- II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word “permanent” shall mean beyond the scope of recovery with current medical knowledge and technology.
- III. The Activities of Daily Living are:
 - i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
 - ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
 - iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

- iv. Mobility: the ability to move indoors from room to room on level surfaces;
 - v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
 - vi. Feeding: the ability to feed oneself once food has been prepared and made available.
- IV. The following are excluded:
- i. Spinal cord injury;

20. Primary (Idiopathic) Pulmonary Hypertension

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

21. Third Degree Burns

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

22. Fulminant Viral Hepatitis

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

23. Aplastic Anaemia

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

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

24. Muscular Dystrophy

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

Activities of Daily Living are defined as:

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

25. Bacterial Meningitis

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

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

26. Abdominal Aortic Aneurysm

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

- i. The term “aorta” means the thoracic and abdominal aorta but not its branches.
- ii. A cardiologist must confirm the diagnosis and realization of surgery

- iii. Surgery performed using only minimally invasive or intra-arterial techniques are excluded.

27. Pneumonectomy

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

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

28. Apallic Syndrome

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

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

29. Aortic Dissection

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

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

30. Severe Rheumatoid Arthritis

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

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

31. Progressive Scleroderma

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

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

32. Loss of Independent Existence

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

Activities of Daily Living :

- 1. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
- 2. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

3. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Mobility: the ability to move indoors from room to room on level surfaces;
5. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
6. Feeding: the ability to feed oneself once food has been prepared and made available.

33. Systematic Lupus Erythematosus with Renal Involvement

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

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

Class I - Minimal mesangial lupus nephritis

Class II - Mesangial proliferative lupus nephritis

Class III - Focal lupus nephritis

Class IV - Diffuse segmental (IV-S) or global (IV-G) lupus nephritis

Class V - Membranous lupus nephritis

Class VI - Advanced sclerosis lupus nephritis the final diagnosis must be confirmed by a certified doctor specializing in Rheumatology and Immunology

34. Parkinson's Disease

- I. The unequivocal diagnosis of progressive degenerative primary idiopathic Parkinson's disease (all other forms of Parkinsonism are excluded) made by a consultant neurologist.
- II. This diagnosis must be supported by all of the following conditions:
 - The disease cannot be controlled with medication; **and**
 - Objective signs of progressive impairment; **and**
 - There is an inability of the Life assured to perform (whether aided or unaided) at least 3 of the following 6 “Activities of Daily Living” for a continuous period of at least 6 months.

The Activities of Daily Living are:

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

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

III. The following is excluded :

- a. Drug-induced or toxic causes of Parkinsonism are excluded.

35. Alzheimer's Disease

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

Activities of Daily Living are defined as:

1. Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
 2. Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
 3. Transferring – the ability to move from a bed to an upright chair or wheelchair and vice versa;
 4. Toileting – the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
 5. Feeding – the ability to feed oneself once food has been prepared and made available.
 6. Mobility - the ability to move from room to room without requiring any physical assistance.
- V. The following are excluded:
 - a. Any other type of irreversible organic disorder/dementia
 - b. Non-organic disease such as neurosis and psychiatric illnesses; and
 - c. Alcohol-related brain damage.

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

36. Uterine Rupture

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

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

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

37. Uterine inversion

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

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

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

38. Medullary Cystic Kidney Disease

Medullary Cystic Kidney Disease where the following criteria are met:

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

39. Pituitary apoplexy in pregnancy

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

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

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

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

40. Cardiomyopathy including Peripartum and postpartum Cardiomyopathy

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

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

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

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

41. Nephrotic Syndrome

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

42. Cirrhosis of the Liver

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

43. Nephrectomy/removal of one kidney

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

44. Chronic Glomerulonephritis

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

45. Severe COPD

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

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

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

47. Minimally Invasive Surgery to Aorta

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

48. Percutaneous Heart Valve Surgery

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

49. Major Surgery to Aorta

- I. The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches (including aortofemoral or aortoiliac bypass grafts).
- II. The surgery must be determined to be medically necessary by a Consultant Cardiologist / Surgeon and supported by imaging findings.
- III. The following is excluded:
 - i. Surgery performed using only minimally invasive or intra-arterial techniques.

50. Heart Transplant

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

51. Aorta Graft Surgery

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

52. Hemiplegia

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

53. Tuberculosis Meningitis

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

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

- I. An ovarian tumor of borderline malignancy / low malignant potential that has been positively diagnosed with histological confirmation and has resulted in surgical removal of an ovary.

- II. For this definition the following are not covered:
 - i. Removal of an ovary due to a cyst.

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

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

56. Carcinoma in-situ of the urinary bladder

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

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

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

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

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

Annexure 10

LIST OF SPECIFIED ILLNESSES OR PROCEDURES**a. Cancer:**

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

What is not Covered: All tumors in the presence of HIV infection are excluded.

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. 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:

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

e. Stroke Resulting in Permanent Symptoms:

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source.

Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain.

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

The following are excluded:

- v. Transient ischemic attacks (TIA)

- vi. Traumatic Injury of the brain
- vii. Vascular disease affecting only the eye or optic nerve or vestibular functions

f. Surgery of Aorta:

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

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

g. Angioplasty:

- I. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).
- II. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.
- III. Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

h. Primary (Idiopathic) Pulmonary Hypertension:

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

i. Brain Surgery:

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

Specific Exclusion: Surgery for treating Neurocysticercosis.

Annexure 11

NA

Annexure 12

PRODUCT BENEFIT TABLE

Policy Tenure	Non- loan linked - 1 year; Loan linked- up to 5 years		
Entry Age	Adult- 18yrs to 80 Yrs. Child- 0 day to 30 Yrs.		
Plans	Individual Or Floater Or Combination of the two which includes following relationships- Self, Legally married spouse , up to 4 children (Son/Daughter), Daughter-in-law, Father, Mother, Father-in-law , Mother-in-law , Grandfather, Grandmother, Grandson, Granddaughter, Son-in-law, Brother, Sister, Sister-in-law, Brother-in-law, Nephew, Niece Borrower, Co-borrower		
Waiting Periods	Initial Waiting Period	Range between 0 to 30 days	
	PED	Range between 0 to 48 months	
	Specific Illness	Range between 0 to 24 months	
	Survival Period (For CI)	Range between 0 to 120 days	
S.No	Main Benefit	Details	Options within the benefit
1	Video Consultations >> Video Consultations with General Practitioner		Option 1: Unlimited Consultations Option 2: Fixed no. of consultations ranging between 1 to 50 per policy Option 3: Costs up to INR 1 Lac Option 4: Actuals up to INR 5000 per Visit Option 5: Any possible reasonable combination of above

			Available on Only Network, Only Non Network & Combination of both
2	Tele Consultations >> Tele Consultations with General Practitioner		Option 1: Unlimited Consultations Option 2: Fixed no. of consultations ranging between 1 to 50 Option 3: Costs up to INR 1 Lac Option 4: Actuals up to INR 5000 per Visit Option 5: Any possible reasonable combination of above Available on Only Network, Only Non Network & Combination of both
3	Physical Consultations >> Physical face to face consultations with General Practitioner		Option 1: Unlimited Consultations Option 2: Fixed no. of consultations ranging between 1 to 50 Option 3: Costs up to INR 1L Option 4: Actuals up to INR 5000 per Visit Option 5: Co-payment up to 50% Option 6: Any possible reasonable combination of above Available on Only Network, Only Non Network & Combination of both
4	Video Consultations with Specialists>> Video Consultations with Specialists(Annexure 3 for List of Specialists)		Option 1: Unlimited Consultations Option 2: Fixed no. of consultations ranging between 1 to 50 Option 3: Costs up to INR 1L Option 4: Actuals up to INR 5000 per Visit Option 5: Any possible reasonable combination of

			aboveAvailable on Only Network, Only Non Network & Combination of both
5	Tele Consultations with Specialists >> Tele Consultations with Specialists (Annexure 3 for List of Specialists)		Option 1: Unlimited Consultations Option 2: Fixed no. of consultations ranging between 1 to 50 Option 3: Costs up to INR 1L Option 4: Actuals up to INR 5000 per Visit Option 5: Any possible reasonable combination of above Available on Only Network, Only Non Network & Combination of both
6	Physical Consultations with Specialists >> Physical face to face consultations with Specialists (Annexure 3 for List of Specialists)		Option 1: Unlimited Consultations Option 2: Fixed no. of consultations ranging between 1 to 50 Option 3: Costs up to INR 1L Option 4: Actuals up to INR 5000 per Visit Option 5: Co-payment up to 50% Option 6: Any possible reasonable combination of above Available on Only Network, Only Non Network & Combination of both

7	Diagnostic Services (Annexure 4 for list of Diagnostic Services)		Option 1: Services through Company's empanelled Provider Option 2: up to 10 tests per Insured basis indicative list Option 3: Basis select combination of tests Option 4: Costs up to INR 1L Option 5: Unlimited Diagnostic tests and Investigations Option 6: Any possible reasonable combination of above
8	Pharmacy Services		Prescription Based, Over the counter based pharmacies or Both Option 1: Services through Company's empanelled Provider Option 2: Costs up to INR 1L
9	Home Health Care Service (Annexure 5 for list of Home Health Care Services)		Option 1: Services through Company's empanelled Provider Option 2: Basis select combination of Services Option 3: Costs up to INR 1L Option 4: Services up to INR 10,000 per service. Option 5: Fixed number of services ranging between 1 to 1000 Option 6: Any Combination of Above
10	Vaccinations Cover (Annexure 6 for List of Vaccinations)		Option 1: Services through Company's empanelled Provider Option 2: up to 10 vaccinations per Insured basis indicative list Option 3: Basis select combination of Vaccines Option 4: Costs up to INR 1L Option 5: Any possible reasonable combination of above

11	Annual Health Check-up (Annexure 7 for List of Annual Health Check-up)		Option 1: up to 10 tests per Insured basis indicative list Option 2: Basis select combination of tests Option 3: Costs up to INR 1L Option 4: Any possible reasonable combination of above It can be provided to Option 1: Per Insured Adult Option 2: Per Insured Adult+ One non Insured related Adult
12	Daily Cash Benefit		Option 1: up to INR 10,000 per day Option 2: up to INR 10,000 per day with Franchise of 1/2/3/4/5/6/7 days Option 3: up to INR 10,000 per day with deductible of 1/2/3/4/5/6/7 days Option 4: Any possible reasonable combination of above Maximum Coverage of up to 90 days
13	ICU Cash Benefit		Twice of Daily Cash Benefit >> 'ICU Cash Benefit' can be opted only when Hospital Daily Cash Benefit is opted >> Total Maximum Coverage of 90 days (including Hospitalization Daily Cash)
14	Emergency Assistance Service		Emergency assistance services (only within India) 1) Medical referral 2) Emergency medical evacuation (Air Ambulance) 3) Medical repatriation 4) Compassionate visit 5) Care and/or transportation of minor children - Return of mortal remains up to Base Sum Insured

15	Second Medical Opinion(Annexure 10 List of Illnesses covered in Second Medical Opinion)		Option 1: Covered worldwide, One opinion per Insured Person per Specified Illness / planned Surgery (Network + Non-Network)Option 2: Covered worldwide, One opinion per Insured Person per Specified Illness / planned Surgery (Network only)
16	Inpatient Benefit	Sum Insured Options (	up to 50L
		Deductible	up to 10L
		Co-Payment	up to 50%
		• Nursing charges excluding private nursing charges • Medical Practitioners' fees, excluding any charges or fees for Standby Services • Medicines, drugs and consumables • Physiotherapy, investigation and diagnostics procedures directly related to admission • Intravenous fluids, blood transfusion, injection administration charges and /or consumables • Operation theatre charges • The cost of prosthetics and other devices or equipment if implanted	Sum Insured Options of up to INR 50 Lakhs

		internally during Surgery	
		Day Care Treatment (Annexure 8 for Options & list of Day Care Treatments)	
		Domiciliary Treatment	
		Organ Transplant Modern Treatments (with sub-limits on specific treatments. Mentioned in the Policy Document)	
		Hospital accommodation- Room Rent/day	Option 1: up to 100% SI Option 2: Room category wise restriction as given below: Option a: General Ward Option b: Air Conditioned Twin Sharing room Option c: Air Conditioned Single Private Room Option d: Air Conditioned Single Private Deluxe Room Option e: Private Suite (above Deluxe room) Option 3: Any possible reasonable combination of above
		Hospital accommodation- ICU/day	Option 1: up to 100% of SI Option 2: Double of Room rent/day subject to maximum of up to SI.
		Pre Hospitalization Medical Expenses	(Option 1: From 30 days to 180 days

		Post Hospitalization Medical Expenses	(Option 1: From 30 days to 180 days
		AYUSH Benefit	Option 1: 100% of SI
		Emergency Road Ambulance- Within India	(Option 1: Lump sum amount up to 10,000 in multiple of 1000 Available on Only Network, Only Non Network & A Combination of Both
		Air Ambulance Cover	Covered up to 100% of Sum Insured or up to 2L whichever is minimum. Available on Only Network, Only Non Network & A Combination of Both
		Loyalty Credits : Sum Insured Enhancement	Sum insured will be enhanced per annum by selected % up to 100% Base Sum Insured (Options for enhancement- 5%/ 10%/ 15%/ 20% of Base Sum Insured
		No Claim Bonus - Sum Insured to increase by selected % for every claim free year - Sum Insured to decrease by same % in case of claim	Options- 5%/10%/15%/20%/25% per annum up to 100% of Base Sum Insured Benefit cannot be opted if 'Loyalty Credit' is opted

17	Critical Illness cover >> Basis a defined list of Critical Illnesses Benefit to be offered on Diagnosis of Illness (Annexure 9 for List of Critical Illnesses)		Option 1: Lump sum benefit up to INR 5Cr. Option 2: Benefit up to 100X of the amount linked to the salary (monthly, quarterly or annually), income, bank account, credit card limit, credit card bill, Utility bills of the consumer, loan. Maximum up to 5Cr. Option 3: Benefit up to 150% of the amount linked to the salary (monthly, quarterly or annually), income, bank account, credit card limit, credit card bill, Utility bills of the consumer, loan. Maximum up to 5Cr. Option 4: Benefit paid for up to 2 different illnesses in a policy year. Option 5: Any possible reasonable combination of above options.
18	3 Personal Accident Cover >> Benefits under Personal Accident 1. Accidental Death (AD) 2. Accidental Permanent Total Disability (PTD) 3. Accidental Permanent Partial Disability (PPD) 4. Temporary Total Disability (TTD) 5. Accidental Medical Reimbursement(	1. Accidental Death (AD)	Option 1: Lump sum benefit up to INR 10Cr. Option 2: Benefit up to 100X of the amount linked to the salary (monthly, quarterly or annually), income, bank account, credit card limit, credit card bill, Utility bills of the consumer, loan. Option 3: Benefit up to 150% of the amount linked to the salary (monthly, quarterly or annually), income, bank account, credit card limit, credit card bill, Utility bills of the consumer, loan. Option 4: Any possible reasonable combination of above options.

		2.Accidental Permanent Total Disability (PTD)	Option 1: Lump sum benefit up to INR 1 0Cr.Option 2: Benefit up to 100X of the amount linked to the salary (monthly, quarterly or annually), income, bank account, credit card limit, credit card bill, Utility bills of the consumer, loan. Option 3: Benefit up to 150% of the amount linked to the salary (monthly, quarterly or annually), income, bank account, credit card limit, credit card bill, Utility bills of the consumer, loanOption 4: Any possible reasonable combination of above options.
		3.Accidental Permanent Partial Disability (PPD)	Option 1: Lump sum benefit up to INR 1 0Cr.Option 2: Benefit up to 100X of the amount linked to the salary (monthly, quarterly or annually), income, bank account, credit card limit, credit card bill, Utility bills of the consumer, loan. Option 3: Benefit up to 150% of the amount linked to the salary (monthly, quarterly or annually), income, bank account, credit card limit, credit card bill, Utility bills of the consumer, loanOption 4: Any possible reasonable combination of above options.

		4.. Temporary Total Disability (TTD)	Option 1: Lump sum benefit up to INR 1 0Cr.Option 2: Benefit up to 100X of the amount linked to the salary (monthly, quarterly or annually), income, bank account, credit card limit, credit card bill, Utility bills of the consumer, loan. Option 3: Benefit up to 150% of the amount linked to the salary (monthly, quarterly or annually), income, bank account, credit card limit, credit card bill, Utility bills of the consumer, loanOption 4: Any possible reasonable combination of above options (Maximum of up to 100 continuous weeks)
		5.Accidental Medical Reimbursement (Can or cannot be linked to 1 ,2,3 above)	Option 1: Lump sum benefit up to INR 1 0Cr.Option 2: Benefit up to 100X of the amount linked to the salary (monthly, quarterly or annually), income, bank account, credit card limit, credit card bill, Utility bills of the consumer, loan. Option 3: Benefit up to 150% of the amount linked to the salary (monthly, quarterly or annually), income, bank account, credit card limit, credit card bill, Utility bills of the consumer, loanOption 4: Any possible reasonable combination of above options. Only Accidental hospitalization up to Rs. 50,000

19	Serious Illness Any hospitalization which is 1 day or more Payouts will be made according to the minimum and maximum hospitalization days. Payouts in a year: Option 1: Unlimited Option 2: Up to 30 in a policy year		Option 1: Overall Sum Insured up to INR 1 Crore Option 2: Payout Options Option a: Staggered- weekly, monthly, quarterly, annually Option b: Lump sum Option 3: Benefit up to 100X of the amount linked to the salary (monthly, quarterly or annually), income, bank account, credit card limit, credit card bill, Utility bills of the consumer, loan. Option 4: Benefit up to 150% of the amount linked to the salary (monthly, quarterly or annually), income, bank account, credit card limit, credit card bill, Utility bills of the consumer, loan Option 5: Any possible reasonable combination of above options.
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Annexure A: List of Insurance Ombudsman

AHMEDABAD - Office of the Insurance Ombudsman, 6th Floor, Jeevan Prakash Building, Tilak Marg, Relief Road, Ahmedabad- 380 001. Tel:- 079-25501201/02 Email: oio.ahmedabad@cioins.co.in (State of Gujarat and Union Territories of Dadra & Nagar Haveli and Daman and Diu.)

BENGALURU - Office of the Insurance Ombudsman, Jeevan Soudha Bldg., PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560078. Tel.: 080-26652048/26652049 Email: oio.bengaluru@cioins.co.in (State of Karnataka)

BHOPAL- Office of the Insurance Ombudsman, 1st Floor, Jeevan Shikha, 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills, Bhopal-462 011. Tel:- 0755-2769201/2769202/2769203 Email: oio.bhopal@cioins.co.in (States of Madhya Pradesh and Chhattisgarh.)

BHUBANESHWAR - Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneswar - 751009. Tel:- 0674-2596461/2596455/2596429/2596003. Email: oio.bhubaneswar@cioins.co.in (State of Odisha.)

CHANDIGARH - Office of the Insurance Ombudsman, S.C.O. No. 20-27, Ground Floor, Jeevan Deep Building, Sector 17-A, Chandigarh-160017. Tel:- 0172 - 2706468 Email: oio.chandigarh@cioins.co.in [States of Punjab, Haryana (excluding 4 districts viz, Gurugram, Faridabad, Sonapat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh and Chandigarh]

CHENNAI- Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai-600 018. Tel:- 044-24333668 / 24333678 Email: oio.chennai@cioins.co.in [State of Tamil Nadu and Union Territories - Puducherry Town and Karaikal (which are part of Union Territory of Puducherry).]

DELHI- Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi-110002. Tel:- 011– 46013992/ 23213504/ 23232481 Email: oio.delhi@cioins.co.in (State of Delhi, 4 districts of Haryana viz, Gurugram, Faridabad, Sonapat and Bahadurgarh)

KOCHI- Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G. Road, Kochi 682011. Tel : 0484-2358759 Email: oio.ernakulam@cioins.co.in (State of Kerala and Union Territory of (a) Lakshadweep (b) Mahe - a part of Union Territory of Puducherry.)

GUWAHATI - Office of the Insurance Ombudsman, “Jeevan Nivesh”, 5th Floor, Near Pan Bazar, S.S. Road, Guwahati- 781001 (ASSAM) Tel:- 0361-2632204/ 2602205/ 2631307 Email: oio.guwahati@cioins.co.in (States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.)

HYDERABAD - Office of the Insurance Ombudsman, 6-2-46, 1st Floor, “Moin Court”, Lane Opp. Hyundai Showroom, A.C. Guards, Lakdi-Ka-Pool, Hyderabad-500 004. Tel : 040-23312122/ 23376991 / 23376599 / 23328709 / 23325325 Email: oio.hyderabad@cioins.co.in (State of Andhra Pradesh, Telangana and Yanam and part of the Union Territory of Puducherry.)

JAIPUR- Office of the Insurance Ombudsman, Ground Floor, Jeevan Nidhi II Bldg, Bhawani Singh Marg, Jaipur – 302005 Tel : 0141-2740363 Email: oio.jaipur@cioins.co.in (State of Rajasthan)

KOLKATA - Office of the Insurance Ombudsman, Hindustan Building, Annexe, 7th Floor, 4, C.R. Avenue, Kolkata - 700 072. Tel : 033-22124339/22124341 Email: oio.kolkata@cioins.co.in (States of West Bengal, Sikkim, and Union Territories of Andaman and Nicobar Islands.)

LUCKNOW- Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-2, Nawal Kishore Road, Hazratganj, Lucknow- 226001. Tel.: 0522 - 4002082 / 3500613 Email: oio.lucknow@cioins.co.in (Following Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.)

MUMBAI - Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), Mumbai 400054. Tel : 022- 69038800/27/29/31/32/33 Email: oio.mumbai@cioins.co.in ([List of wards](#) under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.)

NOIDA - Office of the Insurance Ombudsman, 4th Floor, Bhagwan Sahai Palace, Main Road, Naya Bans, Sector-15, Distt: Gautam Buddh Nagar, U.P. - 201301. Tel: 0120-2514252/2514253 Email: oio.noida@cioins.co.in (State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.)

PATNA - Office of the Insurance Ombudsman, 2nd floor, Lalit Bhawan, Bailey Road, Patna - 800001 Tel No: 0612-2547068, Email id : oio.patna@cioins.co.in (State of Bihar, Jharkhand.)

PUNE - Office of the Insurance Ombudsman, 3rd Floor, Jeevan Darshan Bldg, C.T.S. Nos. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411030. Tel.: 020-24471175 Email: oio.pune@cioins.co.in (State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region.)

THANE - Office of the Insurance Ombudsman, 2nd Floor, Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West), Thane – 400604 Email id: oio.thane@cioins.co.in (Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T".)