Smart Health
Policy Wordings

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.

Note:

- *You/ Insured Person shall on Your/his/her own expense, inform Us immediately of any change in the address, nature of job, state of health, or of any other changes affecting You or any Insured Person*.

- *The terms listed in Section 2 (Definitions & Interpretation) and used elsewhere in the Policy Document with Initial Capitals shall have the meaning set out against them in Section 5 wherever they appear in the Policy Document. For the remaining terms and words used, the usual meaning as described in standard English language dictionaries shall apply. The words and expressions defined in the Insurance Act 1938, IRDAI Act 1999, regulations notified by the IRDAI and circulars and guidelines issued by the IRDAI shall carry the meanings given therein.*

- *Where the context permits, the singular will be deemed to include the plural, one gender shall be deemed to include the other genders and references to any statute shall be deemed to refer to any replacement or amendment of that statute.*

2. Definitions and Interpretations

The terms listed below in Section 2 and used elsewhere in the Policy in Initial Capitals shall have the meaning set out against them in Section 5unless mentioned is any of the sections above separately.

Standard Definitions:

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

2.2 **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.

2.3 **AYUSH Hospital:** An 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 for 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 5 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.

2.4 **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 wheresurgical procedures are to be carried out;

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

2.5 **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.

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

2.7 **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.

2.8 **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.

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

2.10 **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.

2.11 **Day Care Treatment** refers to medical treatment, and/or Surgical Procedure which is:

a. undertaken under General or Local Anaesthesia in a Hospital/Day Care Center in less than 24 hrs because of technological advancement, and
b. Which would have otherwise required a Hospitalization of more than 24 hours. Treatment normally taken on an outpatient basis is not included in the scope of this definition.

2.12 **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.

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

2.14 **Disclosure to Information Norm** means 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.

2.15 **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.

2.16 **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.

2.17 **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as Waiting Periods and coverage of Pre-existing Diseases. Coverage is not available for the period for which no premium is received.

2.18 **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.

2.19 **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.

2.20 **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.

2.21 **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

2.22 **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.

2.23 **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.

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

2.25 **Maternity expenses:** Maternity expenses means;

a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sectionsincurred during hospitalization);
b. expenses towards lawful medical termination of pregnancy during the policy period

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

2.27 **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.

2.28 **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.

2.29 **Medically Necessary Treatment** means any treatment, tests, medication, or stay in Hospital or stay in Hospital or part of a stay in hospital which:

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

2.30 **Migration** means the right accorded to individual health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre- existing conditions and time bound exclusions, with the same insurer.

2.31 **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.

2.32 **New Born Baby:** Newborn baby means baby born during the Policy Period and is aged up to 90 days

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

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

2.35 **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.

2.36 **Pre-existing Disease** means any condition, ailment, injury or disease

a. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

2.37 **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.

2.38 **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.

2.39 **Portability** means the right accorded to an individual health insurance policyholders (including all members under the family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

2.40 **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.

2.41 **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.

2.42 **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.

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

2.44 **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 Centre by a Medical Practitioner.

2.45 **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

Specific Definitions:

2.46 **Age** means age of the Insured person on last birthday as on date of commencement of the Policy.

2.47 **AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.

2.48 **Base Sum Insured** means the amount stated in the Policy Schedule.

2.49 **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

2.50 **Break in Policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

2.51 **Associated Medical Expenses** shall include Room Rent, nursing charges, Medical Practitioners' and operation theatre charges

2.52 **Critical Illness**, an Illness, medical event or Surgical Procedure specifically defined in Section 3.7.1

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

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

2.55 **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.

2.56 **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).

2.57 **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.

2.58 **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.

2.59 **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.

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

2.61 **Insured Event** means any event specifically mentioned as covered under this Policy.

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

2.63 **IRDAI** means the Insurance Regulatory and Development Authority of India.

2.64 **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.

2.65 **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 oflife, 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.

2.66 **Off-label drug or treatment** means use of pharmaceutical drug for an unapproved indication or in an unapproved age group, dosage or route of administration.

2.67 **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.

2.68 **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.

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

2.70 **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.

2.71 **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.

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

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

2.74 **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.

2.75 **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.

2.76 **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.

2.77 **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.

2.78 **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.

2.79 **We/Our/Us** means Niva Bupa Health Insurance Company Limited.
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 at Group policy level or at individual/family level and may vary as per geography 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.

- Here is a quick review of the benefits:

Benefit	**Section Reference**
I. Hospitalization Cover	**Section 3.1**
In-patient Hospitalization	3.1.1.1
Pre-hospitalization expenses	3.1.1.2
Pre and Post Hospitalization	3.1.1.3
Day Care Treatment	3.1.1.4
Alternative Treatments	3.1.1.5
Domiciliary Hospitalization	3.1.1.6
Organ Transplant	3.1.1.7
Maternity Expenses	3.1.1.8
Emergency Ground Ambulance	3.1.1.9
Air Ambulance Cover	3.1.1.10
Health Check-up	3.1.1.11
Loyalty Credits: Sum Insured Enhancement	3.1.1.12
No Claim Bonus	3.1.1.13
Reassure	3.1.1.14
Co-payment	3.1.1.15
Annual Aggregate Deductible	3.1.1.16
Modern Treatments	3.1.1.17
Critical Illness Multiplier Indemnity Cover	3.1.1.18
II.Hospital Cash Benefit	**Section 3.2**
Daily Hospital Cash	3.2.1.1
ICU Cash Benefit	3.2.1.2
Daily Cash Benefit with Franchise	3.2.1.3
ICU Cash Benefit with Franchise	3.2.1.4

Daily Hospital Cash with Deductible	3.2.1.5
Accidental Hospital Cash Benefit	3.2.1.6
Accidental Hospital ICU Cash Benefit	3.2.1.7
Accidental Hospital Cash Benefit with Franchise	3.2.1.8
Accidental Hospital ICU Cash Benefit with Franchise	3.2.1.9
Accidental Hospital Cash Benefit with Deductible	3.2.1.10
III. OPD Treatment and Services	**Section 3.3**
Video Consultations	3.3.1.1
Tele Consultations	3.3.1.2
Physical Consultations	3.3.1.3
Video Consultations with specialists	3.3.1.4
Tele Consultations with specialists	3.3.1.5
Physical Consultations with specialists	3.3.1.6
Diagnostic Services	3.3.1.7
Pharmacy	3.3.1.8
Home Health Care Services	3.3.1.9
Second Medical Opinion	3.3.1.10
IV. Accidental Cover	**Section 3.5**
Accidental Death (AD)	3.4.1.1
Accidental Permanent Total Disability (PTD)	3.4.1.2
Accidental Permanent Partial Disability(PPD)	3.4.1.3
Temporary Total Disability (TTD)	3.4.1.4
Accidental Medical Reimbursement	3.4.1.5
Education Allowance for Children	3.4.1.6
Broken Bones	3.4.1.7
Child Wedding.	3.4.1.8
Burns	3.4.1.9
Air Ambulance for Accidental Injuries	3.4.1.10
Common Accident	3.4.1.11
Ambulance Charges	3.4.1.12
V. Critical Illness Cover	**Section 3.6**
Income Protector	3.5.2.1
Second Medical Opinion for Critical Illness	3.5.2.2
EMI Cover	3.5.2.3

3.1 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 (if the list of Illness is restricted it is as mentioned in the Policy Schedule/Certificate of Insurance) 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.

The expenses that are not covered or subsumed into room charges / procedure charges / costs of treatment are mentioned in Annexure II.

3.1.1 Coverage Options:

3.1.1.1. Inpatient Care

What is covered:
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, allowable consumables and / or enteral feedings.
   vii. Operation theatre charges;
   viii. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery;
   ix. ICU Charges.
   x. If the Insured Person is admitted in a Hospital room where the room category opted or Room Rent incurred is higher than the eligibility as specified in the Policy Schedule, then We shall be liable to pay only a pro-rated portion of the total Associated Medical Expenses (including surcharge or taxes thereon) as per the following formula:

(Eligible Room Rent limit / Room Rent actually incurred) * total Associated Medical Expenses

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

Proportionate deductions will not be applied If the claim is of a hospitals which do 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.

3.1.1.2. Pre-hospitalization Medical Expenses

What is covered:

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 3.1.1.1 (Inpatient Care) or Section 3.1.1.4 (Day Care Treatments) or 3.1.1.5 (Alternative Treatments) or Section 3.1.1.18 (Critical Illness Multiplier Indemnity Cover) in respect of that Insured Person.
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 a Reimbursement basis only.
d. 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.
e. Any claim admitted under this Section 3.1.1.2 shall reduce the Sum Insured for the Policy Year in which claim under Section 3.1.1.1 (Inpatient Care) or Section 3.1.1.4 (Day Care Treatment) or Section 3.1.1.5 (Alternative Treatments) or Section 3.1.1.18 (Critical Illness Multiplier Indemnity Cover)has been incurred.

3.1.1.3. Post-hospitalization Medical Expenses

What is covered:

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 3.1.1.1 (Inpatient Care) or Section 3.1.1.4 (Day Care Treatments) or 3.1.1.5 (Alternative Treatments) or Section 3.1.1.18 (Critical Illness Multiplier Indemnity Cover)in respect of that Insured Person.
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 a Reimbursement basis only.
d. 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.
e. Any claim admitted under this Section 3.1.1.3 shall reduce the Sum Insured for the Policy Year in which claim under Section 3.1.1.1 (Inpatient Care) or Section 3.1.1.4 (Day Care Treatment) or Section 3.1.1.5 (Alternative Treatments) or Section 3.1.1.18 (Critical Illness Multiplier Indemnity Cover) has been incurred.

3.1.1.4. Day Care Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Day Care Treatment following an Illness orInjury 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 an Insured Person as Day Care Treatment undertakes such procedure.
c. The list of admissible Day Care Treatment would be as per the list in Annexure III unless list shared in Policy Schedule/Certificate of Insurance is different OR
d. The Day Care Treatment would be covered if the Insured Person is admitted for more than 2 hours and less than 24 hours and would also cover treatment taken for Angiography, Dialysis, Radiotherapy or Chemotherapyfor cancer
e. Either Point c will be applicable or Point d will be applicable and is as mentioned in the Policy Schedule/Certificate of Insurance.
f. We shall not cover any OPD Treatment and Diagnostic Services under this Benefit.

3.1.1.5. Alternative Treatments

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

Conditions:

a. The treatment should be taken in AYUSH Hospital. An 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.

b. AYUSH Hospitals referred above shall also obtain either pre-entry level certificate (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or StateLevel Certificate (or higher level of certificate) under National Quality Assurance Standards (NQAS), issued by National Health Systems Resources Centre (NHSRC)

c. Any non-allopathic treatment taken by the Insured Person shall only be covered under Section 3.1.1.5 as per the applicable terms and conditions.

d. Medical Expenses incurred on treatment taken under Yoga and/or Naturopathy or any other alternative treatments shall not be covered unless specifically mentioned in Policy Schedule/Certificate of Insurance..

3.1.1.6. Domiciliary Hospitalization

What is covered:

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 a Reimbursement basis only.

d. The Domiciliary Hospitalization continues for at least 3 consecutive days unless waiver of deductible days or different number of days are specifically mentioned in Policy Schedule/Certificate of Insurance, in which case

We will make payment under this Benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalization.

3.1.1.7. Organ Transplant

What is covered:

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 3.1.1.1 (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. Stem cell donation whether or not it is Medically Necessary Treatment except for Bone Marrow Transplant.
b. Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.
c. Screening or any other Medical Expenses related to the organ donor, which are not incurred during the duration of Insured Person's Hospitalization for organ transplant.
d. Transplant of any organ/tissue where the transplant is Unproven / experimental treatment or investigational in nature.
e. Expenses related to organ transportation or preservation.
f. Any other medical treatment or complication in respect of the donor, which is directly or indirectly consequence to harvesting.

3.1.1.8. Maternity Expenses

What is covered:

We will indemnify the Medical Expenses incurred towards Medically Necessary Treatment of the Insured Person in case of normal delivery, routine or elective Caesarean or Complicated Pregnancy during the Policy Period.

Conditions:

a. This Benefit is available only if
   i. female Insured Person is Age 18 years or above
   ii. the Either both the Insured Person and his / her partner are covered under a Family Floater Policy. OR this benefitcan be availed under an Individual Cover if the female is insured under the policy.

b. The female Insured Person in respect of whom a claim for Maternity Expenses is made must have been covered as an Insured Person for at least the period specified in the Policy Schedule/ Certificate of Insuranceof continuous coverage since the inception of the First Policy with Us, with maternity as a Benefit.
c. The Maternity Expenses incurred are Reasonable and Customary Charges.
d. The Maternity Benefit may be claimed under the Policy in respect of eligible Insured Person(s) only twice during the lifetime of the Policy including any Renewal thereafter for the delivery of a child or Medically Necessary Treatment and lawful termination of pregnancy up to maximum of 2 pregnancies and2 terminations.
e. Any treatment related to the complication of pregnancy or termination will be treated within the maternity limits unless specifically mentioned as over and above the maternity limits up to the limits specified in the Policy Schedule/Certificate of Insurance
f. On Renewal, if an enhanced Maternity Sum Insured is proposed, the specified period of continuous coverage (as per Section 3.1.1.8.c) would apply afresh to the extent of the increased Benefit amount.
g. Re-Fill Sum Insured Benefit will not be available for any claims made under this Section unless specifically mentioned in the Policy Schedule/Certificate of Insurance.
h. Section 3.1.2.B.XV (**Code-Excl18)** of the Specific Exclusions shall not apply only to the extent that this Benefit is applicable.
i. If multiplier for multiple birth is opted as a benefit condition then the same will be specifically mentioned in the Policy Schedule/Certificate of Insurance.

For the purpose of this Section, “Complicated Pregnancy” means a medical condition arising during the antenatal stages of pregnancy or a medical condition arising during childbirth that requires a recognized obstetric procedure and post natal check-ups as a result of the complication of pregnancy for a period up to six weeks.

What is not covered:

We shall not be liable to make any payment in respect of the following:
a. Expenses incurred in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future Illnesses;
b. Medical Expenses for ectopic pregnancy will be covered under Section 3.1.1.1 (Inpatient Care) and shall not fall under this Benefit unless specifically mentioned in the Policy Schedule/Certificate of Insurance.

3.1.1.9. Emergency Ground Ambulance

What is covered:

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 3.1.1.1 (Inpatient Care) above in respect of the same period of Hospitalization or Section 3.1.1.4 (Day Care Treatments) or Section 3.1.1.5 (Alternative Treatments) or Section 3.1.1.18 (Critical Illness Multiplier Indemnity Cover).
f. If a Non-Network Provider provides the ambulance, 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 centre for evaluation purposes only.

3.1.1.10. Air Ambulance Cover

What is covered:

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 3.1.1.1 (Inpatient Care) above in respect of the same period of Hospitalization.

f. 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.

3.1.1.11. Health Check-up

What is covered:

The Insured Person may avail a health check-up during the Policy Period as per the list specified in Annexure IV (Product Benefit Table) unless another list as specifically mentioned in the Policy Schedule/Certificate of Insurance).

a. The eligibility of the Insured Person under this Benefit and the frequency of heath check-ups will be as specified in the Policy Schedule/Certificate of Insurance.
b. Any unutilized test or amount in one Policy Year cannot be carry forwarded to the next Policy Year.

3.1.1.12. Loyalty Credits: Sum Insured Enhancement

What is covered:

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 200% 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 3.1.1.1 (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 3.1.1.1

f. In case the Sum Insured of Section 3.1.1.1 (In-patient Care) under the Policy is increased at the time of Renewal, the applicable accumulated Loyalty Credit shall be carried forward.

3.1.1.13. No Claim Bonus

What is covered:

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 3.1.1.1 (In-patient Care) at the end of every Policy Year.

Conditions:

i. No claim has been made under Section 3.1.1.1 (Inpatient Care), 3.1.1.2 & 3.1.1.3 (Pre & Post Hospitalization Expenses), 3.1.1.4 (Day Care Treatment), 3.1.1.6 (Domiciliary treatment), 3.1.1.7 (Organ Transplant), 3.1.1.5 (Alternate treatment) 3.1.1.8 (Maternity Expenses)and 3.1.1.30 (Critical Illness Multiplier Indemnity Cover) 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 200% 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.

3.1.1.14. ReAssure

What is covered:

Once the Base Sum Insured, Loyalty Credit (if applicable), No Claim Bonus (if applicable) has been partially or completely exhausted due to claims paid or accepted as payable for any Illness / Injury during the Policy Year under Section 3.1.1.1 (Inpatient Care) or Section 3.1.1.4 (Day Care Treatments) or 3.1.1.5 (Alternative Treatments) or Section 3.1.1.18 (Critical Illness Multiplier Indemnity Cover), then We will provide an unlimited amount of coverage under this benefit.

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

- Amount provided under this benefit may be used for subsequent claims in respect of the Insured Person and the maximum liability under a single claim under this benefit shall be up to 200% of Base Sum Insured or as specified in the Policy Schedule/Certificate of Insurance.
- For Family Floater Policies, the amount under this benefit will be available on a floater basis to all Insured Persons in that Policy Year.

3.1.1.15. Co-payment

What is covered:

The Insured Person will pay the pre-determined percentage as specified in the Policy Schedule/ Certificate of Insurance as Co-Payment and We will pay the remaining part of the amount that We assess as the admissible amount in respect of any claim under this Section or selected sections as mentioned in the Policy Schedule/ Certificate of Insurance made by an Insured Person.

Conditions:

The Co-Payment percentage will be applicable on all claims under Hospitalization Cover Section except 3.1.1.8 (Maternity Expenses, 3.1.1.13 (Emergency Ground Ambulance), 3.1.1.9 (Air Ambulance Cover), 3.1.1.11 (Health Checkup), unless specifically mentioned in the Policy schedule/Certificate of Insurance.

3.1.1.16. Annual Aggregate Deductible

What is covered:

The Insured Person shall bear on his/her own account an amount equal to the Annual Aggregate Deductible specified in the Policy Schedule/ Certificate of Insurance for any and all admissible claim amounts We assess to be admissible in respect of all claims made by that Insured Person under Section 3.1.1(Hospitalization Cover)

for In-patient Hospitalization claims under indemnity based options on the admissible claim amount during a Policy Year.

Conditions:

- Our liability to make payment under the Policy in respect of any claim made in that Policy Year will only commence once the Annual Aggregate Deductible has been exhausted.
- The provisions in Section 3.1.1.15 on Co-payment (if applicable) will apply to any amounts payable by Us in respect of a claim made by the Insured Person after the Annual Aggregate Deductible has been exhausted.
- Deductible under the Section 3.1.1.26 (Annual Aggregate Deductible) shall not apply to any claim under 3.1.1.8 (Maternity Expenses), 3.1.1.9 (Emergency Ground Ambulance), 3.1.1.10 (Air Ambulance Cover), 3.1.1.11 (Health Checkup)

3.1.1.17. Modern Treatments

What is covered:

These will be the procedures/treatments that will be covered either as Inpatient Care or as part of Day Care Treatment as per Section 3.1.1.1 and Section 3.1.1.4 respectively, in a Hospital. The list is in Annexure IV (Product Benefit Table) unless another list as specifically mentioned in the Policy Schedule/Certificate of Insurance with sub-limits, if any).

Conditions:

a. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with Sections 3.1.1.2 and 3.1.1.3 within the overall benefit sub-limit.
b. The following procedures / treatments as mentioned in Policy Schedule/Certificate of Insurance shall be covered only up to the sub-limit as specified in the Policy Schedule/Certificate of Insurance.
c. If above section is applicable as per policy Schedule/Certificate of Insurance then this will supersede any of the pertaining exclusion.

3.1.1.18. Critical Illness Multiplier Indemnity Cover:

What is covered:

If the insured member is diagnosed and hospitalized for any of the selected combination of critical illness as mentioned in the Policy Schedule/Certificate of Insurance) and claim is admissible under the base policy then the Sum Insured for such critical Illness would be increased by a multiplier as mentioned in the Policy Schedule/Certificate of Insurance.

Conditions:

a. Such increase in Sum Insured would be triggered only for treatment of the listed conditions; no other claim would be covered under the enhanced limit.
b. The enhanced limit of Indemnity cannot be utilized for other members.
c. In case of claim under listed Critical Illness first the enhanced Sum Insured (after the multiplier is triggered) will be exhausted on Indemnity basis then the base Sum Insured will be triggered, either in same claim or for a new claim
d. The enhancement of limit will happen only once in policy year even if multiple listed Critical Illness is diagnosed.
e. The enhanced Limit cannot be carried forward to next renewal

List and Definition of Critical Illnesses under Section 3.1.1.18

Sr	List of Critical Illness *(Definitions of these Critical Illnesses are given below this table)*	Basic	Intermediate	Advanced
1	Abdominal Aortic Aneurysm	x	X	✓
2	Alzheimer's Disease	x	X	✓
3	Aortic Dissection	x	X	✓
4	Apallic Syndrome	x	X	✓
5	Aplastic Anaemia	x	✓	✓
6	Bacterial Meningitis	x	✓	✓
7	Benign brain tumor	x	✓	✓
8	Blindness	x	✓	✓
9	Cancer of specified severity	✓	✓	✓
10	Cardiomyopathy including Peripartum and postpartum Cardiomyopathy	X	X	✓
11	Coma of specified severity	✓	✓	✓
12	Deafness	x	✓	✓
13	End stage liver failure	x	✓	✓
14	End stage lung failure	x	✓	✓
15	Fulminant Viral Hepatitis	x	✓	✓
16	Kidney failure requiring regular dialysis	✓	✓	✓
17	Loss of independent existence	x	X	✓
18	Loss of limbs	x	✓	✓
19	Loss of speech	x	✓	✓
20	Major head trauma	x	✓	✓
21	Major organ /bone marrow transplant	✓	✓	✓
22	Medullary Cystic Kidney Disease	X	X	✓

23	Motor neuron disease with permanent symptoms	✓	✓	✓
24	Multiple sclerosis with persisting symptoms	✓	✓	✓
25	Muscular Dystrophy	x	✓	✓
26	Myocardial infarction	✓	✓	✓
27	Nephrotic syndrome	x	x	✓
28	Open chest CABG	✓	✓	✓
29	Open heart replacement or repair of heart valves	✓	✓	✓
30	Parkinson's Disease	x	x	✓
31	Permanent paralysis of limbs	✓	✓	✓
32	Pituitary apoplexy in pregnancy	x	x	✓
33	Pneumonectomy	x	x	✓
34	Primary (idiopathic) pulmonary hypertension	x	x	✓
35	Progressive Scleroderma	x	x	✓
36	Severe Rheumatoid Arthritis	x	x	✓
37	Stroke resulting in permanent symptoms	✓	✓	✓
38	Systematic Lupus Erythematous with Renal Involvement	x	x	✓
39	Third degree burns	x	✓	✓
40	Uterine inversion	x	x	✓
41	Uterine Rupture	x	x	✓

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. Neurological damage due to SLE is 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 suchas 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 (PaO2 < 55mmHg); 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.

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 Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

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 diseasedpart 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 medicalknowledge 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, autoimmuno 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
ClassVI - 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 6months.

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

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 theCompany's appointed doctor.
III. There must be significant reduction in mental and social functioning requiring the continuous supervision ofthe 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.

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.

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.

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

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.

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.

3.1.1.19. Claim Settlement in Network Provider only (Cashless)

The provisions of this Section shall be applicable if there is only Cashless Facility claim settlement option available under Section 3.1 (Hospitalization Cover)

(a) If an Insured Person is Hospitalized in a Hospital as specified by Us and attached to the Policy Schedule/Certificate of Insurance as specific endorsement then it is agreed that We will pay 100% of any amount We assess for payment.

(b) Any treatment taken at a Non-Network Provider shall not be covered under this Policy.

3.1.1.20. Claim Settlement on Reimbursement Only

The provisions of this Section shall be applicable if there is only Reimbursement Claim settlement option under Section 3.1 (Hospitalization Cover)

(a) If an Insured Person is Hospitalized then it is agreed that We will pay the amount that We assess in respect of any claim under the Policy on reimbursement basis only.

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3.1.2 **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 Policy Schedule/Certificate of Insurance) in so far as they relate to anything to be doneor 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.

3.1.3.1. 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 OurService 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 Ourdiscretion.

3.1.3.2. Claims Procedure:

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

A. **For Availing Cashless Facility:** Cashless Facility can be availed only at Our Network Providers or Service Providers. 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:

a. 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 CashlessFacility 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)canalso be requested through Our mobile application or website.

All final authorization requests, if required, shall be sent at least six hours prior to the Insured Person's discharge from the Hospital.

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

I. 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;
II. The Policy Number;
III. Name of the Policyholder;
IV. Name and address of Insured Person in respect of whom the request is being made;
V. Nature of the Illness/Injury and the treatment/Surgery required;
VI. Name and address of the attending Medical Practitioner;
VII. Hospital where treatment/Surgery is proposed to be taken;

VIII. Date of admission;

IX. First and any subsequent consultation paper/Medical Record since beginning of diagnosis of that treatment/Surgery;

X. Admission note;

XI. Treating Medical Practitioner certificate for 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.

B. Re-Authorization:

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

C. **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.

3.1.3.3. Claims Documentation:

We shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense within 30 days of the Insured Person's discharge from Hospital (in the case of Pre-hospitalization Medical Expenses and Hospitalization Medical Expenses) or within 30 days of the completion of the Post-hospitalization Medical Expenses period (in the case of Post-hospitalization Medical Expenses).
For 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.
f. Bar code sticker and invoice for implants and prosthesis (if used);
g. Original final bill from Hospital with detailed break-up and paid receipt.
h. Room tariff of the entitled room category (in case of a Non-Network Provider and if room tariff is not a part of Hospital bill): duly signed and stamped by the Hospital in which treatment is taken.
(In case the Insured Person/claimant are unable to submit such document, then Weshall 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.)

i. Original bills of pharmacy/medicines purchased, or of any other investigation done outside Hospital with reports and requisite prescriptions.
j. Copy of death certificate (in case of demise of the Insured Person).
k. For Medico-legal cases (MLC) or in case of Accident
l. MLC/First Information Report (FIR) copy attested by the concerned Hospital/police station (if applicable);
m. Original self-narration of incident in absence of MLC/FIR.
n. Original laboratory investigation, diagnostic and pathological reports with supporting prescriptions.
o. Original X-Ray/MRI/ultrasound films and other radiological investigations.
p. 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)
q. The retail invoice of the prosthetic with the packaging (only in case of prosthetic cover)

3.1.3.4. Claims Assessment:

a. All admissible claims under this Section shall be assessed by Us in the following progressive order:-
If the Insured Person is admitted in a Hospital room where the room category opted or Room Rent incurred is higherthan the eligibility as specified in the Policy Schedule, then We shall be liable to pay only a pro-rated portion ofthe total Associated Medical Expenses (including surcharge or taxes thereon) as per the following formula:
(Eligible Room Rent limit / Room Rent actually incurred) * total Associated Medical Expenses

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

i. 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.
ii. 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.

3.2. Hospital Cash Benefit:

3.2.1. Coverage Options

3.2.1.1. Daily Cash Benefit

What is covered:

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 daily cash amount specified in the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization.

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 unless specifically mentioned in the Policy schedule/Certificate of Insurance.

3.2.1.2. ICU Cash Benefit

What is covered:

If an Insured Person is required to be admitted to the Intensive Care Unit of a Hospital solely and directly due to an injury arising from an Accident or due to an Illness, then 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 Hospital room.
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 unless specifically mentioned in the Policy schedule/Certificate of Insurance.

3.2.1.3. Daily Cash Benefit with Franchise

What is covered:

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 daily allowance amount specified in the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization

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 unless specifically mentioned in the Policy schedule/Certificate of Insurance.

3.2.1.4. ICU Cash Benefit with Franchise

What is covered:

If an Insured Person is required to be admitted to the Intensive Care Unit of a Hospital solely and directly due to an injury arising from an Accident or due to an Illness, then 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 Hospital room.
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 unless specifically mentioned in the Policy schedule/Certificate of Insurance.

3.2.1.5. Daily Hospital Cash with Deductible

What is covered:

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 daily allowance amount specified in the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization.

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 unless specifically mentioned in the Policy schedule/Certificate of Insurance..

3.2.1.6. Accidental Hospital Cash Benefit

What is covered:

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

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

3.2.1.7. Accidental Hospital ICU Cash Benefit

What is covered:

If an Insured Person is required to be admitted to the Intensive Care Unit of a Hospital solely and directly due to an injury arising from an Accident, then We will pay twice the Accidental Hospital Cash specified in the Certificateof 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 Hospital room.
b. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization

3.2.1.8. Accidental Hospital Cash Benefit with Franchise

What is covered:

If an Insured Person suffers an I**n**jury that solely and directly leads to the Insured Person's Hospitalization during the Policy Period, then We will pay the daily Accidental Hospital Cash amount specified in the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization

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

3.2.1.9. Accidental Hospital ICU Cash Benefit with Franchise

What is covered:

If an Insured Person is required to be admitted to the Intensive Care Unit of a Hospital solely and directly due to an injury arising from an Accident, then We will pay twice the Accidental Hospital Cash Benefit 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 Hospital room.
c. We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization

3.2.1.10. Accidental Hospital Cash Benefit with Deductible

What is covered:

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

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

3.2.2. Claims Process & Requirement:

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

3.2.2.1. Notification of Claim:

If the treatment requires Hospitalization, We must be informed immediately and in any event not later than 7 days of the date of admission.

3.2.2.2. Claims documentation:

We shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense within 30 days of the Insured Person's discharge from Hospital.

- Claim form duly completed and signed by the claimant.
- All reports, including all medical reports, case histories, investigation reports, treatment papers, discharge summaries. We will accept copies of the documents, verified and attested by the Hospital.
- A precise diagnosis of the treatment for which a claim is made.

3.2.2.3. Claims Assessment:

All admissible claims under this Policy shall be assessed by Us in the following progressive order:-

i. The Deductible/Franchise (if applicable) shall be applied to the aggregate of all claims that are either paid or payable under this Policy. Our liability to make payment shall commence only once the aggregate amount of

all eligible claims as per Policy terms and conditions exceeds the Deductible/Franchise limit within the same Policy Year.

3.3. OPD Treatment and Services:

We will indemnify the Reasonable and Customary Charges incurred during the Policy Period for the following OPD Treatments as specified to be applicable in the Policy Schedule/Certificate of Insurance.

3.3.1. Coverage Options

3.3.1.1. 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.

3.3.1.2. 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.

3.3.1.3. 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.

3.3.1.4. 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 IV (Product Benefit Table) unless another list as specifically mentioned in the Policy Schedule/Certificate of Insurance with sub-limits, if any).

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

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

3.3.1.6. 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.

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

3.3.1.7. Diagnostic Services

The Insured Person may avail specified diagnostic tests 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.
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 any requirement of Hospitalization for less than 24 hours.

3.3.1.8. Pharmacy

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.

3.3.1.9. Home Health Care Services

The Insured person may purchase home health care services as per Annexure IV – Product Benefit Table and as mentioned in the Policy Schedule/Certificate of Insurance, from our empanelled Service Provider through itsmobile 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 healthcare services as per Annexure IV (Product Benefit Table) unless another list as specifically mentioned in thePolicy Schedule/Certificate of Insurance with sub-limits, if any.

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.

3.3.1.10. Second Medical Opinion

If the Insured Person 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 fulfillment of following conditions:

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

What is not covered:

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.

What is not covered under OPD Treatments (Section 3.3.1.1 to 3.3.1.6)

A. We will only cover the cost of consultation and all other costs or charges will not be covered.

B. Replacing any dental appliance which is lost or stolen unless specifically mentioned in the Policy Schedule/Certificate of Insurance.

C. Plastic surgery or cosmetic surgery unless necessary as a part of Medically Necessary Treatment and certified in writing by the attending Medical Practitioner.

D. Cost of frames for the prescribed lenses unless specifically mentioned in the Policy Schedule/Certificate of Insurance.

E. Sunglasses, unless medically prescribed by the treating Medical Practitioner.

F. Any lenses including contact lenses unless specifically mentioned in the Policy Schedule/Certificate of Insurance.

3.3.2 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 asa Condition Precedent to Our liability under this Section the following procedure shall be complied with:

3.3.2.1 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.

3.3.2.2. 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.

3.4. Accidental 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. In case of Loan Linked scenario if Outstanding Loan Cover - Accident only is opted then the Outstanding loan (only principle) shall be covered up to proportionate percentage of Opted Loan Protector Sum Insured or outstanding loan(only principle) whichever is lower.

3.4.1 Coverage Options:

3.4.1.1 Accidental Death (AD)

What is covered:

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 death within three hundred and sixty five (365) days from the date of occurrence of such Accident, We will pay the Accidental Cover Sum Insured specifiedin the Policy Schedule/ Certificate of Insurance.

Conditions:

a. We will deduct any amounts already paid under Section 3.5.1.2 (Accidental Permanent Total Disability), 3.5.1.3 (Accidental Permanent Partial Disability) and 3.5.1.4 (Temporary Total Disability) from the amount payable under this Benefit.
b. We shall not be liable to make any payment under Section 3.5.1.1 (Accidental Death) if We have already paid or accepted any claims under Section 3.5.1.2 (Accidental Permanent Total Disability) or 3.5.1.3 (Accidental Permanent Partial Disability) or 3.5.1.4 (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.

3.4.1.2 Accidental Permanent Total Disability (PTD)

What is covered:

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 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 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 3.4.1.2 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 3.4.1.2, We shall not be liable to make any payment under Section 3.4.1.2;
d. We shall not be liable to make payment under Section3.4.1.2 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 Section3.4.1.3 (Accidental Permanent Partial Disability) or 3.4.1.4 (Temporary Total Disability) from the amount payable under this Benefit.
f. We shall not be liable to make any payment under Section 3.4.1.2 if We have already paid or accepted any claims under Section 3.4.1.3 or 3.4.1.4 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 (Indicative List)	% of the Accidental Cover Sum Insured Payable
Actual loss by physical separation or total and permanent loss of use of both hands	Up to 200%
Actual loss by physical separation or total and permanent loss of use of both feet	Up to 200%
Loss of sight in both eyes	Up to 200%
Actual loss by physical separation or total and permanent loss of use of one hand and one foot	Up to 200%
Actual loss by physical separation or total and permanent loss of use of one hand and sight in one eye	Up to 200%
Actual loss by physical separation or total and permanent loss of use of one foot and sight in one eye	Up to 200%
Loss of speech and loss of hearing in both ears	Up to 200%
Permanent and incurable paralysis of all limbs	Up to 200%
Permanent total loss of mastication	Up to 200%
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.	Up to 200%

3.4.1.3 Accidental Permanent Partial Disability(PPD)

What is covered:

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 Section3.4.1.3 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 Section3.5.1.3, We shall not be liable to make any payment under Section3.4.1.3;
d. If We have admitted a claim under Section3.4.1.2, then We shall not admit any claim under Section3.4.1.3 in respect of the Insured Person;
e. We will deduct any amounts already paid under Section 3.4.1.3 (Accidental Permanent Partial Disability) and **3.4.1.4** (Accidental Temporary Total Disability) from the amount payable under this Benefit.
f. We shall not be liable to make any payment under Section3.4.1.3(Accidental Permanent Partial Disability) if We have already paid or accepted any claims under Section 3.4.1.1 (Accidental Death) or 3.4.1.2 (Accidental Permanent Total Disability) or 3.4.1.4(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(Indicative List)	% 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%

3.4.1.4 Temporary Total Disability (TTD)

What is covered:

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:

a. For the purpose of Section 3.4.1.4, "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.
b. We will make payment under Section3.4.1.4 for only a part of the week if the Insured Person has suffered Temporary Total Disability for that part of the week.
c. We shall not be liable to make any payment under Section 3.4.1.4 in respect of more than 100 continuous weeks, subject always to the Accidental Cover Sum Insured.
d. The amount payable under Section 3.4.1.4 is calculated on a per day basis and shall be payable after up to7 continuous days of temporary disability or as mentioned in the Policy Schedule/Certificate of Insurance
e. We will make payment of the amount due under Section3.4.1.4on a weekly basis unless the Temporary Total Disability continues for a continuous period of more than 30 days in which case Wewill make payment of the amount due under Section 34.1.4 at the end of every calendar month until the Temporary Total Disability ceases.

f. We will deduct any amounts already paid under Section 3.4.1.3 (Accidental Permanent Partial Disability)3.5.1.4from the amount payable under this Benefit.

3.4.1.5 Accidental Medical Reimbursement

Option A

What is covered:

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.

Conditions:

a. We shall not be liable to make any payment under this Benefit unless a claim has been admitted under Section 3.4.1.1 (Accidental Death) or Section 3.4.1.2 (Accidental Permanent Total Disability) or Section 3.4.1.3 (Accidental Permanent Partial Disability) or 3.4.1.4 (Accidental Temporary Total Disability)

Option B-

If the Insured Person is Hospitalized solely and directly due to an Injury sustained during the Policy Period, We will indemnify the following:

a. The Medical Expenses incurred on Hospitalization during the Policy Period as a result of the Injury;
b. The Medical Expenses incurred on OPD Treatment during the Policy Period as a result of the Injury.

Conditions:

a. We shall not be liable to make any payment under this Benefit unless a claim has been admitted under Section 3.4.1.1 (Accidental Death) or Section 3.4.1.2 (Accidental Permanent Total Disability) or Section 3.4.1.3 (Accidental Permanent Partial Disability) or 3.4.1.4 (Accidental Temporary Total Disability)

Option C-

What is covered:

If the Insured Person is Hospitalized solely and directly due to an Injury sustained during the Policy Period, We will indemnify the following:

a. The Medical Expenses incurred on Hospitalization during the Policy Period as a result of the Injury;
b. The Medical Expenses incurred on OPD Treatment during the Policy Period as a result of the Injury.

3.4.1.6 Education Allowance for Children

What is covered:

In the event of the Insured Person's Accidental death or Permanent Total Disability during the Policy Period, We will make a onetime payment of the amount specified in the Policy Schedule/Certificate of Insurance for the education of the Insured Person's Dependent Children.

Conditions:

This Benefit shall be payable only if We have accepted a claim under Section 3.4.1.1 (Accidental Death) or 3.4.1.2 (Accidental Permanent Total Disability (PTD).

3.4.1.7 Broken Bones

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident which solely and directly results in a fracture of the Insured Person's bones within thirty (30) days from the date of occurrence of such Accident, We will make payment in accordance with the grid below.

Conditions:

a. We shall not be liable to make any payment under Section 3.4.1.11unless the fracture is medically recognized and a physician has certified in writing the extent and nature of the fracture.

b. If an Injury results in more than one fracture specified in the grid in Policy Schedule/Certificate of Insurance, We will be liable to pay the amount payable for each such fracture, subject to availability of the Broken Bones Sum Insured specified in the Policy Schedule/Certificate of Insurance.

Nature of Fracture(Indicative List)	**% of Broken Bones Sum Insured payable**	
	If treated with surgery under anesthesia	**It treated without surgery**
Fracture of skull, vertebral column (excluding coccyx)	100%	50%
Fracture of pelvis, thigh or knee cap	50%	25%
Fracture of lower leg (excluding small bones of hand and foot, fingers and toes), ankle, arm or forearm, elbow,facial bones	30%	15%
Fractures of rib or ribs, nose, collar bone, lower jaw, shoulder bone, small bones of hand and foot (excluding fingers and toes)	10%	5%
Fractures of fingers or toes, coccyx	6%	3%

3.4.1.8 Child Wedding

What is covered:

In the event of the Insured Person's Accidental Death or Accidental Permanent Total Disability during the Policy Period, We will make a onetime payment of the amount specified in the Policy Schedule/Certificate of Insurance for the wedding expenses of the Insured Person's Dependent Children.

Conditions:

This Benefit shall be payable only if We have accepted a claim under Section 3.4.1.1 (Accidental Death) or 3.4.1.2 (Accidental Permanent Total Disability (PTD)).

3.4.1.9 Burns

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident which solely and directly results in second or third degree burns, Wewill make payment in accordance with the grid below.

Conditions:

a. If the Injury results in more than one of the descriptions in the grid below, then We shall be liable to make payment in respect of the largest description only.

b. If an Insured Person dies or is permanently, disabled as the result of the Injury, then any amount claimed and paid to an Insured Person under this Section will be deducted from any payment made under Section 3.5.1.1 (Accidental Death) or Section 3.5.1.2 (Accidental Permanent Total Disability (PTD)).

Indicative Table of Benefits:

	Description	**%of Burns Sum Insured payable**
Head	a) Third degree burns of 8% or more of the total head surface area	100%
	b) Second degree burns of 8% or more of the total head surface area	50%
	c) Third degree burns of 5% or more, but less than 8% of the total head surface area	80%
	d) Second degree burns of 5% or more, but less than 8% of the total head surface area	40%
	e) Third degree burns of 2% or more, but less than 5% of the total head surface area	60%

	f) Second degree burns of 2% or more, but less than 5% of the total head surface area	30%
Rest of Body	a) Third degree burns of 20% or more of the total body surface area	100%
	b) Second degree burns of 20% or more of the total body surface area	50%
	c) Third degree burns of 15% or more, but less than 20% of the total body surface area	80%
	d) Second degree burns of 15% or more, but less than 20% of the total body surface area	40%
	e) Third degree burns of 10% or more, but less than 15% of the total body surface area	60%
	f) Second degree burns of 10% or more, but less than 15% of the total body surface area	30%
	g) Third degree burns of 5% or more, but less than 10% of the total body surface area	20%
	h) Second degree burns of 5% or more, but less than 10% of the total body surface area	10%

3.4.1.10 Air Ambulance for Accidental Injuries

What is covered:

If the Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy PeriodWe will, on a Reimbursement basis, pay the Reasonable and Customary Charges incurred towards transportation of the Insured Person to the nearest Hospital by an air ambulance or to move the Insured Person to and from healthcare facilities during an Emergency within India only up to the limit specified in the Policy Schedule/Certificate of Insurance.

Conditions:

i. We have accepted any claims under Sections 3.4.1.1 (Accidental Death) or 3.4.1.2 (Accidental Permanent Total Disability) in respect of that Insured Person.

ii. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is injured to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital with advanced facilities as advised by the treating Medical Practitioner for management of the current Hospitalization.

iii. This Benefit is available for one transfer per Accident.

iv. The ambulance service is offered by a healthcare or ambulance Service Provider

v. The transportation should be provided by medically equipped aircraft which can provide medical care in flight and should have medical equipment's vital to monitoring and treating the Insured Person suffering from an Illness/Injury such as but not limited to ventilators, ECG's, monitoring units, CPR equipment and stretchers.

3.4.1.11 Common Accident

What is covered:

If the Insured Person and his or her spouse sustain Injury in the same Accident during the Policy Period which, directly and independently of all other causes, results in the death of both (the Insured Person and the spouse) within three sixty five (365) days of the date of the Accident, then We will pay two (2) times the Accidental Death Sum Insured applicable to the Insured Person.

Conditions:

1. The Benefit under this option shall be payable only if a claim under Section 3.4.1.1 (Accidental Death) is admitted by Us.

3.4.1.12 Ambulance Charges

If during the Period of Insurance, an Insured Person sustains Bodily Injury then the Company agrees to pay the actual ground ambulance costs incurred by the Insured Person up to the Limit stated in the Policy Schedule/Certificate of Insurance, for transportation to the nearest Hospital where adequate care can be provided

3.4.2 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.

3.4.3 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 and in any case within thirty (30) Days after such occurrence. Written notice of claim must be given to Us immediately in the case of death, or within thirty (30) Days after the Date of Loss in all other cases.

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.

3.4.4 Claims Documentation:

Complete, written proof of loss must be given to Us within sixty (60) Days after the Date of Loss, or as soon as reasonably possible.

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

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. 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.

d. 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)

e. Accidental Medical Expenses

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.

f. Broken bones cover

1. Duly filled and signed claim form
2. Hospital discharge summary (in original) / self attested copies if the originals are submitted with another insurer / consultation notes (if hospitalization has not occurred)
3. X-Ray and MRI films along with reports
4. Copy of First Information Report (FIR) /Panchnama / Inquest report duly attested by the concerned police station
5. Copy of Medico Legal Certificate (MLC) duly attested by the concerned hospital.
6. Narration of events of Accident if no FIR / MLC available
7. Newspaper cuttings / news articles covering the Accident (if available)

g. Education Allowance for Children/ Child Wedding:

1. Duly filled and signed claim form
2. Documents required for Accidental Death or Accidental Permanent Total Disability Benefits (if not already submitted)
3. Letter from employer or group administrator confirming the number of children of Insured Person.

Any benefit that has been linked to Accidental Death, Disabilities, please share the relevant section documentsalong with additional documents required, if any.

3.4.5 Claims Assessment & Repudiation:

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.

3.5. Critical illness Cover:

What is covered:

We will pay the amount specified in the Policy Schedule/Certificate of Insurance if the Insured Person is diagnosed with Critical Illness which is part of the selected option (as mentioned in Policy Schedule/Certificate of Insurance) during the Policy/Coverage Period or the Critical Illness first manifests itself in the Insured Person during the Policy Period. In case of Loan Linked scenario if Outstanding Loan Cover – Critical Illness only is opted then the Outstanding loan (only principle) shall be covered up to proportionate percentage of Opted Loan Protector Sum Insured or outstanding loan (only principle) whichever is lower.

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. We will not make payment under this Policy in respect of an Insured Person and for any and all Policy Period more than once in the Insured Person's lifetime. In any Policy Period a claim can be triggered for one life only except in co-applicants/ spouse option wherein the claim can be triggered for both the lives in the samePolicy Period.
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 is provided in the Policy Schedule/ Certificate of Insurance.

3.5.1 For the purpose of Section 3.5, 'Critical Illness' means the following Illnesses:

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

1. Cancer of Specified Severity

III. 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.

IV. The following are excluded –

x. 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.

xi. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

xii. Malignant melanoma that has not caused invasion beyond the epidermis;

xiii. 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

xiv. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

xv. Chronic lymphocytic leukaemia less than RAI stage 3

xvi. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

xvii. 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)

III. 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.

IV. 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

III. 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.

IV. 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).

III. 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.

IV. This excludes:

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

5. Coma of Specified Severity

III. 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:

iv. no response to external stimuli continuously for at least 96 hours;

v. life support measures are necessary to sustain life; and

vi. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

IV. 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

II. 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

III. 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.

IV. The following are excluded:

iv. Transient ischemic attacks (TIA)

v. Traumatic injury of the brain

vi. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. Major Organ /Bone Marrow Transplant

III. 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.

IV. The following are excluded:

iii. Other stem-cell transplants

iv. Where only islets of langerhans are transplanted

9. Permanent Paralysis of Limbs

II. 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

II. 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

III. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

iii. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

iv. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

IV. Neurological damage due to SLE is excluded.

12. Benign Brain Tumor

IV. 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 suchas CT scan or MRI.

V. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

iii. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or

iv. Undergone surgical resection or radiation therapy to treat the brain tumor.

VI. 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

IV. Total, permanent and irreversible loss of all vision in both eyes as a result of Illness or Accident.

V. The Blindness is evidenced by:

iii. corrected visual acuity being 3/60 or less in both eyes or ;

iv. the field of vision being less than 10 degrees in both eyes.

VI. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure

14. Deafness

II. 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

II. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

v. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and

vi. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and

vii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and

viii. Dyspnea at rest.

16. End Stage Liver Failure

III. Permanent and irreversible failure of liver function that has resulted in all three of the following:

iv. Permanent jaundice; and

v. Ascites; and

vi. Hepatic encephalopathy.

IV. Liver failure secondary to drug or alcohol abuse is excluded.

17. Loss of Speech

III. 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.

18. Loss of Limbs

II. 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

V. 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.

VI. 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.

VII. The Activities of Daily Living are:

vii. 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;

viii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

ix. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

x. Mobility: the ability to move indoors from room to room on level surfaces;

xi. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

xii. Feeding: the ability to feed oneself once food has been prepared and made available.

VIII. The following are excluded:

ii. Spinal cord injury;

20. Primary (Idiopathic) Pulmonary Hypertension

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

V. The NYHA Classification of Cardiac Impairment are as follows:

iii. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

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

VI. 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

II. 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

III. 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:

vi. rapid decreasing of liver size as confirmed by abdominal ultrasound ; and

vii. necrosis involving entire lobules, leaving only a collapsed reticular framework (histological evidence is required) ; and

viii. rapid deterioration of liver function tests; and

ix. deepening jaundice; and

x. hepatic encephalopathy.

IV. This excludes:

iii. Hepatitis infection or carrier status alone does not meet the diagnostic criteria.

iv. Fulminant Viral Hepatitis caused by alcohol, toxic substance or drug.

23. Aplastic Anaemia

II. 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:

iv. Absolute neutrophil count of less than 500/mm³

v. Platelets count less than 20,000/mm³

vi. 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

IV. 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.

V. The diagnosis of muscular dystrophy must be unequivocal and made by a consultant neurologist.

VI. 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:

g. Washing : the ability to maintain an adequate level of cleanliness and personal hygiene

h. Dressing : the ability to put on and take off all necessary garments, artificial limbs or other surgical appliances that are Medically Necessary

i. Feeding : the ability to transfer food from a plate or bowl to the mouth once food has been prepared and made available

j. Toileting : the ability to manage bowel and bladder function, maintaining an adequate and socially acceptable level of hygiene

k. Mobility : the ability to move indoors from room to room on level surfaces at the normal place of residence

l. 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.

VI. The neurological deficit must persist for at least 3 months.

VII. This diagnosis must be confirmed by:

VIII. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and

IX. A consultant neurologist.

X. 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.

iv. The term “aorta” means the thoracic and abdominal aorta but not its branches.

v. A cardiologist must confirm the diagnosis and realization of surgery

vi. 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.

II. 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.

III. The Diagnosis must be definitely confirmed by a Registered Medical Practitioner, who is also a Neurologist holding such an appointment at an approved hospital.

IV. 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 diseasedpart of the aorta with a graft.

IV. The term “aorta” means the thoracic and abdominal aorta but not its branches.

V. A cardiologist must confirm the diagnosis and realization of surgery.

VI. This excludes:

ii. 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:

III. Is in accordance with the criteria on Rheumatoid Arthritis of the American College of Rheumatology and has been diagnosed by the Rheumatologist.

IV. 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.

III. 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.

IV. 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 medicalknowledge and technology.

Activities of Daily Living :

7. 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;
8. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
9. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
10. Mobility: the ability to move indoors from room to room on level surfaces;
11. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
12. Feeding: the ability to feed oneself once food has been prepared and made available.

33. Systematic Lupus Erythematosus with Renal Involvement

III. 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.

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

34. Parkinson's Disease

IV. The unequivocal diagnosis of progressive degenerative primary idiopathic Parkinson's disease (all other forms of Parkinsonism are excluded) made by a consultant neurologist.

V. 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 6months.

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

VI. The following is excluded :

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

35. Alzheimer's Disease

VI. Progressive and permanent deterioration of memory and intellectual capacity as evidenced by accepted standardised questionnaires and cerebral imaging.

VII. The diagnosis of Alzheimer's disease must be confirmed by an appropriate consultant and supported by the Company's appointed doctor.

VIII. There must be significant reduction in mental and social functioning requiring the continuous supervision of the life assured.

IX. 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:

7. 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;
8. Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
9. Transferring – the ability to move from a bed to an upright chair or wheelchair and vice versa;
10. Toileting – the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
11. Feeding – the ability to feed oneself once food has been prepared and made available.
12. Mobility - the ability to move from room to room without requiring any physical assistance.

X. 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.

III. A waiting period of 10 months is applicable for this Illness.

IV. 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) .

iv. The diagnosis and requirement of surgery must be confirmed medically necessary clinically by a registered obstetrician
v. This benefit shall be available only as onetime benefit
vi. 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:

V. the presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;
VI. clinical manifestations of anaemia, polyuria, renal loss of sodium progressing to deterioration in kidney function; and
VII. the Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.
VIII. This excludes:
ii. 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.

III. This include treatment surgical and/or medical treatment under registered medical practitioner and neurosurgeon
IV. 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

V. 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.

VI. The Diagnosis of Cardiomyopathy has to be supported by echographic findings of compromised ventricular performance.
VII. A waiting period of 10 months is applicable for this Illness if it is related to Maternity
VIII. The following is excluded:
4 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

IV. Nephrotic syndrome is the onset of heavy proteinuria (>3.0 g/24 h), hypertension, hypercholesterolemia, hypoalbuminemia, edema/anasarca, and microscopic hematuria.

V. 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.

VI. 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).

3.5.2 Benefits Options under Section 3.5:

3.5.2.1 Income Protector

What is covered:

Subject to Us accepting Our liability for a claim in respect of the Insured Person under Section 3.6.1 of this Policy and in consideration of additional premium received from You/Insured Person at the time of issuance of the Policy, it is hereby understood and agreed that in the event of Insured Person losing his job due to Critical Illness covered under this Section We shall, in addition to the Critical illness Sum Insured also pay in lump- sum the amount as prescribed in the Policy Schedule/ Certificate of Insurance up to the specified number of months as specified in Policy Schedule/ Certificate of Insurance as income to the Insured Person.

Conditions:

- For eligibility under this cover the job of the Insured Person must be permanent and not temporary or casual or seasonal or contractual or off roll and the Insured Person must be employed in that permanent job at the time of inception of the cover under the Policy and 90 days immediately following thereafter within the Policy/Coverage Period including the day of inception of the Policy.
- You/Insured Person has to provide all the documentary evidence of such loss of job

What is not covered:

- We shall not be liable to make any payment under this Section in event the Insured Person unemployment is a consequence of his termination, dismissal, suspension because of his involvement in any act of dishonesty and/or fraud and/or poor performance on the part of the Insured Person and/or his willful violation of any

rules of the employer and/or laws for the time being in force and/or any disciplinary action against him by the employer.

- We shall not be liable to make any payment under this Section:
  - If the Insured Person is a self employed person during the entire Policy Period;
  - During the entire Policy Period/ Coverage Period in case of any claim relating to unemployment from such job which is casual, temporary, seasonal or contractual in nature or any claim relating to an employee not onthe direct rolls of the employer;
  - In case of voluntary unemployment due to resignation during the entire Policy Period;
  - In case of unemployment at the time of inception of the Policy/Coverage Period or unemployment arising within the first 90 days of inception of the Policy Period/ Coverage Period for any reason whatsoever including without limitation even if the Insured Person suffers Critical Illness.
  - In case of unemployment during the entire Policy Period/ Coverage Period from a job under which no salary or any remuneration is provided to the Insured Person
  - In case of suspension from employment on account of any pending enquiry being conducted by the employer/ public authority.
  - In case of unemployment during the entire Policy Period/ Coverage Period due to retirement whether voluntary or otherwise.

In case of any unemployment during the entire Policy Period/ Coverage Period due to non-confirmation of employment after or during such period under which the Insured Person was under probation.

3.5.2.2 Second Medical Opinion for Critical Illness

What is covered:

If the Insured Person is diagnosed with a Critical Illness as defined under Section 3.5.1 or is planning to undergo a planned Surgery or a Surgical Procedure for that Critical Illness, the Insured Person can, at the Insured Person's choice, obtain a Second Medical Opinion from a Medical Practitioner arranged by Us:

a. We/ Our Service Provider are contacted seeking the Second Medical Opinion.
b. The Second Medical Opinion will be arranged by Us or Our Service Provider and will be based only on the information and documentation provided by the Insured Person that will be shared with the Medical Practitioner.
c. This Benefit can be availed only once by an Insured Person during a Policy Year/ Coverage Period for the same Critical Illness or planned Surgery.
d. By seeking the Second Medical Opinion under this Benefit the Insured Person is not prohibited or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.

e. The Insured Person is free to choose whether or not to obtain the Second Medical Opinion, and if obtained then whether or not to act on it in whole or in part.

f. The Second Medical Opinion under this Benefit shall be limited to defined criteria and not be valid for any medico legal purposes.

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.

3.5.2.3 EMI Cover

Subject to Us accepting Our liability against the claim under section 3.5.1 of this Policy and in consideration of additional premium received from You/Insured Person, not withstanding anything contrary contained in the Policy, it is hereby understood and agreed that, in the event of claim We, in addition to Sum Insured for the Insured Person as mentioned in the Policy Schedule/ Certificate of Insurance shall also pay the EMI for maximum up to 12 months in lump-sum. The Actual EMI amount on the said Loan will be considered or the specified limit in the Policy Schedule/Certificate of Insurance, whichever is lower at the time of payment of the benefit. The EMI has to be in the name of the Insured Proposer.

Additional Documents required at the time of claim intimation:

1- Loan Outstanding with bifurcation of principle amount and interest amount and any other charges, if any on the letter head of the respective Master policy holder and should be duly signed by the authorized signatory.

2- Loan Account statement of last 10 transactions at least

Conditions:

Claim under this cover will be payable only when the claim under Section 356.1 under this Policy is payable.

3.5.3 Claims Process & Requirements:

The fulfillment of the terms and conditions of this Policy (including payment of full premium in advance by the duedates 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.

3.5.4 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, adviceor 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 changewill be at Our discretion.

3.5.5 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.

3.5.6 Claims Documentation

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

a. Claim form duly completed and signed by the Insured Person.
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 Proposer.

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. 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.

B. **Claims Documents applicable to Section 3.6.2.3 (Income Protector)**:

In the event of a claim arising out of an Insured Event covered under Section 3.6.2.3 above, You/Insured Person shall within thirty (30) days from the date of such severance from the employment, shall arrange for submission of the following documents to Us:

1. Duly completed claim form;
2. Certificate from the employer of the Insured Person confirming the severance from employment the date of and the reasons for the same.

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

i. 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 up to the number of days specified in the Policy Schedule/ Certificate of Insurance 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

3.6 Wellness Benefits:

This Section is available to either the Insured Person only or along with his/her spouse as specified in the Policy Schedule/Certificate of Insurance. Subject to the Policy terms and conditions and to encourage good health and well being, We shall provide the following wellness related services to You/Insured Person(s) covered under this Benefit through Our empanelled Service Providers.

3.6.1. OPD Services

The Insured Person may avail OPD services from Our empanelled Service Provider through its mobile application or website. The cost for the OPD treatment 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 for OPD treatment taken from Our empanelled Service Provider is the Insured Person's absolute discretion and choice.

3.6.2 Pharmacy Services

The Insured Person may purchase medicines 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.

3.6.3 Diagnostic Services

The Insured Person may avail various diagnostic tests 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.

3.6.4 Other Health Care Services

The Insured Person may avail various healthcare services 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 services availed from Our empanelled Service Provider is the Insured Person's absolute discretion and choice.

4. Exclusions

A. Waiting Periods

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 with Us.

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 (Health Insurance) regulations, 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.

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 with us. 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 (Below mentioned diseases/procedures can be modified and in that case the list will be mentioned in Policy Schedule/Certificate of Insurance) :

I. Pancreatitis and stones in billiard 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

Initial waiting period:

a. A Waiting Period since beginning of cover under the First Policy, specified in the Policy Schedule/ Certificate of Insurance shall apply to any Illness contracted and/or Medical Expenses incurred in respect of any Illness by the Insured Person other than Hospitalization due to Accident.

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.

If these diseases are Pre-Existing Diseases at the time of the Proposal or subsequently found to be Pre-Existing Diseases, the Pre-Existing Disease Waiting Periods as mentioned in the Policy Schedule/ Certificate of Insurance shall apply in respect of that Insured Person.

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.

Standard Exclusions:

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

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 dioptres.

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.

Specific Exclusions

XVI. 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.

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

XVIII. 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.

XIX. External Congenital Anomaly:
Screening, counseling or treatment related to external Congenital Anomaly.

XX. 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.

XXI. Hormone Replacement Therapy:
Treatment for any condition / illness which requires hormone replacement therapy.

XXII. 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.

XXIII. Sexually transmitted Infections & diseases (other than HIV / AIDS):
Screening, prevention and treatment for sexually related infection or disease (other than HIV / AIDS).

XXIV. Sleep disorders:
Treatment for any conditions related to disturbance of normal sleep patterns or behaviors.

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

XXVI. Any expenses incurred on OPD treatment (unless specifically mentioned in any benefit and/or specified in Policy Schedule/Certificate of Insurance.

XXVII. 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).

XXVIII. Caused by or contributed to by or arising from ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel. For the purpose of this exclusion, combustion shall include any self-sustaining process of nuclear fission.

XXIX. Any injury as a result of Intentional self inflicted Injury, suicide or attempted suicide by any means.

XXX. Intentional Inhaling any gas or fumes, except in the course of duty

XXXI. 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.

XXXII. Any disability arising out of Pre-Existing Disease if not accepted and endorsed by Us on the Policy Schedule or Certificate of Insurance.

XXXIII. Hazardous or Adventure Sports: Code Excl 09: 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.

XXXIV. Loss/damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any action taken in controlling, preventing, suppressing or in any way relating to any act of terrorism.

XXXV. Any Injury/ Illness caused due to animal bite/ attack unless opted for the specific cover and same to be mentioned in the Policy Schedule/Certificate of Insurance.

XXXVI. Any exclusion mentioned in the Policy Schedule/Certificate of Insurance or the breach of any specificcondition mentioned in the Policy Schedule/Certificate of Insurance.

5. General Terms and Conditions

5.1. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policyatleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link
https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

5.2. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at thetime of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days(thirty days for policies with a term of 3 years,if sold through distance marketing) from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

I. If the insured has not made any claim during the Free Look Period, the insured shall be entitled to a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges

5.3. Cancellation

I. The policyholder may cancel this policy by giving 15 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as prorate or short period Grid 1/2 option opted bythe Policyholder

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

Short Period Grid

	Refund %								
	Policy Term								
Timing of Cancellation	**1**	**1.5**	**2**	**2.5**	**3**	**3.5**	**4**	**4.5**	**5**
Up to 30 days	75.0%	80.0%	85.0%	87.5%	90.0%	92.5%	92.5%	95.0%	95.0%
31 to 90 days	50.0%	65.0%	70.0%	75.0%	80.0%	85.0%	87.5%	87.5%	87.5%
3 to 6 months	25.0%	50.0%	60.0%	65.0%	67.5%	70.0%	75.0%	75.0%	75.0%
6 to 12 months	0.0%	25.0%	40.0%	45.0%	50.0%	55.0%	60.0%	65.0%	65.0%
12 to 18 months		0.0%	15.0%	30.0%	37.5%	45.0%	47.5%	50.0%	55.0%
18 to 24 months			0.0%	15.0%	25.0%	32.5%	37.5%	42.5%	47.5%
24 to 30 months				0.0%	12.5%	20.0%	25.0%	35.0%	40.0%

30 to 36 months					0.0 %	10.0%	17.5%	25.0%	32.5%
36 to 42 months						0.0%	10.0%	17.5%	27.5%
42 to 48 months							0.0%	12.5%	20.0%
48 to 54 months								0.0%	10.0%
54 to 60 months									0.0%

II. 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.

In case of death of an Insured, pro-rate refund of the premium for the deceased insured will be refunded, provided there is no history of claim.

5.4. Premium Payment in Installments:

If the Insured Person has opted for payment of premium on an installment basis, i.e. Half yearly, Quarterly, or monthly, as mentioned in the Policy Schedule/Certificate of Insurance, the following conditions shall apply (notwithstanding any terms contrary elsewhere in the policy);

a. Grace Period of 30 days in case of single premium policies, and a period of 15 days in case of other than single premium policies, would be given to pay the installment premium due for the policy.
b. During such grace period, coverage will not be available from the due date of installment premium till the date of receipt of premium by Company.
c. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
d. No interest will be charged If the installment premium is not paid on due date
e. In case of installment premium due not received within the grace period, the policy will get cancelled.
f. In the event of a claim, all subsequent premium installments shall immediately become due and payable.
g. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

5.5. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

I. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
II. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
III. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
IV. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

V. No loading shall apply on renewals based on individual claims experience.

5.6. 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.

5.7. Fraud

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

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent

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

5.8. Claims Settlement (Provision for Penal Interest)

I. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

II. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

III. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

IV. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

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

5.9. 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 affected.

5.10. 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 theCompany at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver ofwaiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

5.11. Redressal of Grievance:

a. In case of any grievance the Insured Person may contact the company through:

Website: www.nivabupa.com
Toll free: 1860-500-8888
E-mail: Email us through our service platform https://rules.nivabupa.com/customer-service/ (Senior citizens may write to us at: seniorcitizensupport@nivabupa.com)
Fax: 011-4174-3397
Courier: Customer Services Department
D-5, 2nd Floor, Logix Infotech Park
opp. Metro Station, Sector 59, Noida,
Uttar Pradesh, 201301

b. 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
D-5, 2nd Floor, Logix Infotech Park
opp. Metro Station, Sector 59, Noida,
Uttar Pradesh, 201301

Contact No: 1860-500-8888
Fax No: 011-4174-3397
Email ID: Email our Grievance officer through our Grievance Redressal platform https:// transactions.nivabupa.com/pages/grievance-redressal.aspx

For updated details of grievance officer, kindly refer the link https://www.nivabupa.com/customer-care/health-services/grievance-redressal.aspx

If the Insured Person is not satisfied with the above, they can escalate to our Grievance Redressal officer through our platform https://transactions.nivabupa.com/pages/grievance-redressal.aspx.

c. 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 (Refer below Annexure).

d. Grievance may also be lodged at IRDAI Integrated Grievance Management System –bimabharosa.irdai.gov.in

5.12. Moratorium Period

After completion of eight continuous years under the policy, no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the Sums Insured of the first Policy and subsequently completion of eight continuous years would be applicable from date of enhancement of Sums Insured only on the enhanced limits. After the expiry of moratorium period, no healthinsurance claim shall be contestable except for proven fraud and permanent exclusions specified in the Policy contract. The Policies would however be subject to all limits, sub limits, co-payments, deductibles as per the Policy contract.

5.13. Multiple Policies

I. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

II. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

III. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

IV. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy

5.14. Disclosure of Information

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

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

5.15. 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.

5.16. Complete Discharge

Any payment to the policy holder, insured person or his/her nominees or his/her legal representatives or assignee or to the hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the company to the extent of that amount for the particular claim.

5.17. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. lf such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an lndian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periodsas per IRDAI guidelines on portability

For Detailed Guidelines on portability, kindly refer the link
https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

Specific Terms and Conditions:

5.18. 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 InsuredPersons under the Family Floater Cover.

5.19. Cancellation by Us:

We may terminate the Policy/ Certificate of Insurance during the Policy Period /Coverage Period by sending 15 days prior written notice to You/ Insured Person at the address shown in the Policy Schedule/Certificate of Insurance without refund of premium (for cases other than non cooperation) if :

i. Insured Person or any person acting on behalf of either has acted in a dishonest or fraudulent manner under or in relation to this Policy; and/or

ii. Insured Person has not disclosed the Material Facts or misrepresented in relation to the Policy; and/or

For avoidance of doubt, it is clarified that no claims shall be admitted and/or paid by Us during the notice period incase of cancellation by Us.

5.20. For installment premium, We will refund premium on pro rata basis after deducting Our expenses

5.21. 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. For loan linked policy, claim will admissible only for active loans..

5.22. 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 by way of endorsement or 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 Policyshall apply afresh for this enhanced limit from the effective date of such enhancement.

5.23. 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.

5.24. Assignment

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

5.25. 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.

5.26. 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.

5.27. Notification of Claim and Delay in Intimation:

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

By calling Us at 1860-500-8888

By registered post sent to:

Customer Services Department
Niva Bupa Health Insurance Company Limited
2nd Floor, Plot No D-5, Logix infotech Park,
Opp Metro station, Sector 59,
Noida, Uttar Pradesh- 201301
Fax No.: +91 11 41743397
Email us through our service platform https://rules.nivabupa.com/customer-service/
(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.

5.28. 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.

5.29. Territorial Jurisdiction

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

5.30. 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.

5.31. 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 2nd Floor, Plot No D-5,
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.

5.32. 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.

Annexure I - List of Insurance Ombudsmen

Office Details	**Jurisdiction of Office Union Territory, District)**
AHMEDABAD Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Mr Vipin Anand Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL Shri R. M. Singh Insurance Ombudsman Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chhattisgarh.

BHUBANESHWAR Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH Mr Atul Jerath Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana(excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI Shri Segar Sampathkumar Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Tamil Nadu PuducherryTown and Karaikal (which are part of Puducherry).
DELHI Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
	Assam, Meghalaya, Manipur,

GUWAHATI Shri Somnath Ghosh Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Shri N. Sankaran Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR Shri Rajiv Dutt Sharma Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
ERNAKULAM Shri G. Radhakrishnan Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341	West Bengal, Sikkim, Andaman & Nicobar Islands.

Email: bimalokpal.kolkata@cioins.co.in	
LUCKNOW Shri Justice Anil Kumar SrivastavaOffice of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952	Bihar, Jharkhand.

Email: bimalokpal.patna@cioins.co.in	
PUNE Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

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

Tel.: 022 - 69038801/03/04/05/06/07/08/09

Email: inscoun@cioins.co.in Shri B.

C. Patnaik, Secretary General
Smt Poornima Gaitonde, Secretary

ANNEXURE II

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 III

DAY CARE TREATMENTS

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 coveredunder Day Care Procedures.

Option 2: List of Day Care Treatments or as specified in the Policy Schedule/Certificate of Insurance

Sr. No	Header	Procedure Name
I	**Cardiology Related:**	
	1	CORONARY ANGIOGRAPHY
II	**Critical Care Related:**	
	2	INSERT NON- TUNNEL CV CATH
	3	INSERT PICC CATH (PERIPHERALLY INSERTED CENTRAL CATHETER)
	4	REPLACE PICC CATH (PERIPHERALLY INSERTED CENTRAL CATHETER)
	5	INSERTION CATHETER, INTRA ANTERIOR
	6	INSERTION OF PORTACATH
III	**Dental Related:**	
	7	SPLINTING OF AVULSED TEETH
	8	SUTURING LACERATED LIP
	9	SUTURING ORAL MUCOSA
	10	ORAL BIOPSY IN CASE OF ABNORMAL TISSUE PRESENTATION
	11	FNAC
	12	SMEAR FROM ORAL CAVITY
IV	**ENT Related:**	
	13	MYRINGOTOMY WITH GROMMET INSERTION
	14	TYMPANOPLASTY
	15	REMOVAL OF A TYMPANIC DRAIN
	16	KERATOSIS REMOVAL UNDER GA
	17	OPERATIONS ON THE TURBINATES (NASAL CONCHA)
	18	TYMPANOPLASTY WITH 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 PAPILLOTOMY
	76	ESOPHAGOSCOPE AND SCLEROSANT INJECTION
	77	EUS + SUBMUCOSAL RESECTION
	78	CONSTRUCTION OF GASTROSTOMY TUBE
	79	EUS + ASPIRATION PANCREATIC CYST
	80	SMALL BOWEL ENDOSCOPY (THERAPEUTIC)
	81	COLONOSCOPY ,LESION REMOVAL
	82	ERCP
	83	COLONSCOPY STENTING OF STRICTURE
	84	PERCUTANEOUS ENDOSCOPIC GASTROSTOMY
	85	EUS AND PANCREATIC PSEUDO CYST DRAINAGE
	86	ERCP AND CHOLEDOCHOSCOPY
	87	PROCTOSIGMOIDOSCOPY VOLVULUS DETORSION
	88	ERCP AND SPHINCTEROTOMY
	89	ESOPHAGEAL STENT PLACEMENT
	90	ERCP + PLACEMENT OF BILIARY STENTS
	91	SIGMOIDOSCOPY W / STENT
	92	EUS + COELIAC NODE BIOPSY

	93	UGI SCOPY AND INJECTION OF ADRENALINE, SCLEROSANTS BLEEDING ULCERS
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 ABSCESSES 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 RADIOTHEARPY 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 SKIN
	335	DESTRUCTION OF DISEASED TISSUE IN THE SKIN AND SUBCUTANEOUS TISSUES
	336	RECONSTRUCTION OF DEFORMITY/DEFECT IN NAIL BED
	337	EXCISION OF BURSIRTIS
	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/CYCLOCRYOTHERAP Y/ 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 LA
	381	EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
	382	EXCISION OF VARIOUS LESIONS IN COCCYX
	383	ARTHROSCOPIC REPAIR OF ACL TEAR KNEE
	384	CLOSED REDUCTION OF MINOR FRACTURES
	385	ARTHROSCOPIC REPAIR OF PCL TEAR KNEE
	386	TENDON SHORTENING
	387	ARTHROSCOPIC MENISCECTOMY - KNEE
	388	TREATMENT OF CLAVICLE DISLOCATION
	389	HAEMARTHROSIS KNEE- LAVAGE
	390	ABSCESS KNEE JOINT DRAINAGE
	391	CARPAL TUNNEL RELEASE
	392	CLOSED REDUCTION OF MINOR DISLOCATION
	393	REPAIR OF KNEE CAP TENDON
	394	ORIF WITH K WIRE FIXATION- SMALL BONES
	395	RELEASE OF MIDFOOT JOINT
	396	ORIF WITH PLATING- SMALL LONG BONES
	397	IMPLANT REMOVAL MINOR
	398	K WIRE REMOVAL
	399	POP APPLICATION
	400	CLOSED REDUCTION AND EXTERNAL FIXATION
	401	ARTHROTOMY HIP JOINT
	402	SYME'S AMPUTATION
	403	ARTHROPLASTY
	404	PARTIAL REMOVAL OF RIB
	405	TREATMENT OF SESAMOID BONE FRACTURE
	406	SHOULDER ARTHROSCOPY / SURGERY
	407	ELBOW ARTHROSCOPY
	408	AMPUTATION OF METACARPAL BONE
	409	RELEASE OF THUMB CONTRACTURE
	410	INCISION OF FOOT FASCIA
	411	CALCANEUM SPUR HYDROCORT INJECTION
	412	GANGLION WRIST HYALASE INJECTION

	413	PARTIAL REMOVAL OF METATARSAL
	414	REPAIR / GRAFT OF FOOT TENDON
	415	REVISION/REMOVAL OF KNEE CAP
	416	AMPUTATION FOLLOW-UP SURGERY
	417	EXPLORATION OF ANKLE JOINT
	418	REMOVE/GRAFT LEG BONE LESION
	419	REPAIR/GRAFT ACHILLES TENDON
	420	REMOVE OF TISSUE EXPANDER
	421	BIOPSY ELBOW JOINT LINING
	422	REMOVAL OF WRIST PROSTHESIS
	423	BIOPSY FINGER JOINT LINING
	424	TENDON LENGTHENING
	425	TREATMENT OF SHOULDER DISLOCATION
	426	LENGTHENING OF HAND TENDON
	427	REMOVAL OF ELBOW BURSA
	428	FIXATION OF KNEE JOINT
	429	TREATMENT OF FOOT DISLOCATION
	430	SURGERY OF BUNION
	431	INTRA ARTICULAR STEROID INJECTION
	432	TENDON TRANSFER PROCEDURE
	433	REMOVAL OF KNEE CAP BURSA
	434	TREATMENT OF FRACTURE OF ULNA
	435	TREATMENT OF SCAPULA FRACTURE
	436	REMOVAL OF TUMOR OF ARM/ ELBOW UNDER RA/GA
	437	REPAIR OF RUPTURED TENDON
	438	DECOMPRESS FOREARM SPACE
	439	REVISION OF NECK MUSCLE (TORTICOLLIS RELEASE)
	440	LENGTHENING OF THIGH TENDONS
	441	TREATMENT FRACTURE OF RADIUS & ULNA
	442	REPAIR OF KNEE JOINT
XV	**Other operations on the mouth & face:**	
	443	EXTERNAL INCISION AND DRAINAGE IN THE REGION OF THE MOUTH, JAW AND FACE
	444	INCISION OF THE HARD AND SOFT PALATE
	445	EXCISION AND DESTRUCTION OF DISEASED HARD AND SOFT PALATE
	446	INCISION, EXCISION AND DESTRUCTION IN THE MOUTH
	447	OTHER OPERATIONS IN THE MOUTH
XVI	**Plastic Surgery Related:**	

	448	CONSTRUCTION SKIN PEDICLE FLAP
	449	GLUTEAL PRESSURE ULCER-EXCISION
	450	MUSCLE-SKIN GRAFT, LEG
	451	REMOVAL OF BONE FOR GRAFT
	452	MUSCLE-SKIN GRAFT DUCT FISTULA
	453	REMOVAL CARTILAGE GRAFT
	454	MYOCUTANEOUS FLAP
	455	FIBRO MYOCUTANEOUS FLAP
	456	BREAST RECONSTRUCTION SURGERY AFTER MASTECTOMY
	457	SLING OPERATION FOR FACIAL PALSY
	458	SPLIT SKIN GRAFTING UNDER RA
	459	WOLFE SKIN GRAFT
	460	PLASTIC SURGERY TO THE FLOOR OF THE MOUTH UNDER GA
XVII	**Thoracic surgery Related:**	
	461	THORACOSCOPY AND LUNG BIOPSY
	462	EXCISION OF CERVICAL SYMPATHETIC CHAIN THORACOSCOPIC
	463	LASER ABLATION OF BARRETT'S OESOPHAGUS
	464	PLEURODESIS
	465	THORACOSCOPY AND PLEURAL BIOPSY
	466	EBUS + BIOPSY
	467	THORACOSCOPY LIGATION THORACIC DUCT
	468	THORACOSCOPY ASSISTED EMPYAEMA 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 OFTEMPORAL 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

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