GROUP HEALTH INSURANCE POLICY

Policy Wordings

1. PREAMBLE

This Policy is a contract of insurance issued by [Raheja QBE General Insurance Company Limited] (hereinafter called the „Company") to the Proposer mentioned in the Schedule (hereinafter called the "Insured") to cover the person(s) named in the schedule (hereinafter called the "Insured Persons"). The Policy is based on the statements and declaration provided in the Proposal Form by the Proposer and is subject to receipt of the requisite premium.

2. OPERATIVE CLAUSE

If during the Policy Period an Insured Person is required to be hospitalized for treatment of an Illness or Injury at a Hospital/ Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify Medically necessary, expenses towards the Coverage mentioned in the Policy Schedule.

Provided further that,

a. Any amount payable under the policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions contained herein.
b. The maximum liability of the Company under all such Claims for the entire policy period, shall be the Sum Insured opted and mentioned in the Policy Schedule.
c. Maximum liability of the Company under all such Claims for the entire policy period, shall be the Sum Insured opted and mentioned in the Policy Schedule

3. Definitions

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

1) **Accident or Accidental -** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2) **Age –** means completed years on Your last birthday as per the English Calendar regardless of the actual time of birth, at the time of commencement of Policy Period.
3) **Aggregate Deductible –** Aggregate deductible is a cost-sharing requirement under this Policy that provides that the Company will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the Company. A deductible does not reduce the sum insured. The deductible is applicable in aggregate towards hospitalization expenses covered and admissible as per terms and conditions of this Policy and incurred during the Policy period by insured (individual Policy) or insured family (in case of floater Policy).

4) **Ambulance –** means a motor vehicle operated by a licensed/authorized service provider and equipped for taking sick or injured people requiring medical attention to and from Hospital in emergencies.

5) **Anyone 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.

6) **Authority -** means the Insurance Regulatory and Development Authority of India established under the provisions of section 3 of the Insurance Regulatory and development Authority Act, 1999 (41 of 1999).

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

8) **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:

   d) Having at least 5 in-patient beds

   e) Having qualified AYUSH Medical Practitioner in charge round the clock

   f) Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out

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

9) **AYUSH Day Care Centre** Means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health center 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:

   a) Having qualified registered AYUSH Medical Practitioner(s) in charge;

   b) Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

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

   (Explanation: Medical Practitioner referred in the definition of "AYUSH Hospital" and "AYUSH Day Care Centre" shall carry the same meaning as defined in the definition of

"Medical Practitioner" under Chapter I of Guidelines)

10) **Bank Rate** - means "Bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due".
11) **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.
12) **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.
13) **Commencement Date** means the commencement date of this Policy as specified in the Policy Schedule.
14) **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 claims amount. A co-payment does not reduce the Sum Insured
15) **Condition Precedent** - means a policy term or condition upon which the Insurer`s liability under the Policy is conditional upon.
16) **Congenital Anomaly** - means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
17) **Internal Congenital Anomaly** – congenital anomaly which is not in the visible and accessible parts of the body.
18) **External Congenital Anomaly** - congenital anomaly which is in the visible and accessible parts of the body.
19) **Day Care Centre** - means any institution established for Day Care Treatment of Illness and / or injuries or a medical setup with a Hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criterion as under: has qualified nursing staff under its employment; has qualified Medical Practitioner (s) in charge; has a fully equipped operation theatre of its own where surgical procedures are carried out;

    maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.
20) **Day Care treatment** - means medical treatment, and/or Surgical Procedure which is:

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

    Note: Treatment normally taken on an Out-patient basis is not included in the scope of this definition.
21) **Deductible/Excess** - 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.

22) **Dependents** - means the persons named in the Policy Schedule who are Your:

Spouse – The Primary Insured's legally married spouse as long as he/she continues to be married to the Primary Insured.

Children – The Primary Insured's children with age group of 91 days or above, as long as they are financially dependent on him/her with no source of independent income and have not established their own independent households.

Parents – The Primary Insured's natural parents or parents that have legally adopted him.

Parents-in-law - The Primary Insured's parents-in-law.

Siblings – The Primary insured`s siblings as long as they are unmarried and financially dependent on him/her with no source of independent income and have not established their own independent households.

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

24) **Diagnosis** - means conclusion drawn by a registered Medical Practitioner, supported by acceptable clinical, radiological, histological, histo-pathological, and laboratory evidence wherever applicable.

25) **Disease Sublimit** – means a cost sharing requirement under a health insurance Policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit.

26) **Disclosure of information norm** - means the Policy shall be void and all premiums paid thereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any Material Fact by the Policy Holder.

(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)

27) **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:

the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or

the patient takes treatment at home on account of non-availability of room in a Hospital.

28) **Emergency** - means a severe Illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a Medical Practitioner to prevent death or serious long- term impairment of the Insured Person's health.

29) **Emergency Care** - means management for an Illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a Medical Practitioner to prevent death or serious long-term impairment of the Insured Person's health.

30) **Family Floater** - means a Policy described as such in the Policy Schedule where You and

Your Dependents named in the Policy Schedule are covered under this Policy as at the Commencement Date. The Sum Insured for a Family Floater is the amount shown in the Policy Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during each Policy Year.

31) **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 the Policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

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

32) **Harvesting** – means a surgical procedure to remove organs or tissues from a donor (Cadaveric or live), for the purpose of organ transplantation.

33) **Home Care Treatment** means treatment availed by the Insured Person at home for an illness or injury, which in normal course would require care and treatment at a hospital but is actually taken at home provided that:

    The Medical practitioner advices the Insured person to undergo treatment at home.

    There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment.

    Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.

34) **Hospital** - means any institution established for In-Patient Care and Day Care Treatment of Illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishment (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:

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

35) **Hospitalization or Hospitalized** - means admission in a hospital for a minimum of 24 consecutive "In - Patient Care" hours except for specified procedures / treatments, where such admission could be for a period of less than 24 consecutive hours.

36) **Illness** - means a sickness or a disease or pathological condition leading to the impairment

of normal physiological function and requires medical treatment.

37) **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.

38) **Chronic Condition** is defined as a disease, Illness, or Injury that has one or more of the following characteristics:

a) it needs ongoing or long-term monitoring through consultations, examinations, check- ups, and / or tests.

b) it needs ongoing or long-term control or relief of symptoms.

c) It requires rehabilitation for the patient or for the patient to be specially trained to cope with it.

d) it continues indefinitely

e) it recurs or is likely to recur.

39) **Immediate Family Member** - includes the Insured Person's legal spouse, children, parents, parents- in- law, or any other relation specifically mentioned in the Policy Schedule.

40) **Injury** - means Accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

41) **In-patient Care** -means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

42) **Insured Person** - means persons named in the Policy Schedule.

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

44) **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.

45) **IRDAI** – means the Insurance Regulatory and Development Authority of India.

46) **Maternity Expenses** - means:

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

expenses towards lawful medical termination of pregnancy during the Policy Period.

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

48) **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.

49) **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 its scope and jurisdiction of license.

Medical Practitioner should not be the Insured Person or his/her Immediate Family Member or anyone who is living in the same household as the Insured Person.

50) **Medically Necessary Treatment** - means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

is required for the medical management of the Illness or Injury suffered by the Insured.

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

must have been prescribed by a Medical Practitioner.

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

51) **Migration** – means the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. from one health insurance policy to another with the same insurer.

52) **Material facts** shall mean all relevant information as sought by the company in the proposal form and all other connected documents which form basis on which the policy is issued to enable the Company to take informed decision in the context of underwriting and the risk parameters.

53) **Material Duties** shall mean the essential tasks, functions and operations, and the skills, abilities, knowledge, training & experience, generally required by the Employers from the full-time confirmed employees engaged in a particular occupation and cannot be reasonably modified or omitted.

54) **Material Change** - The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and /or premium, if necessary, accordingly.

55) **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.

56) **Non-Network Provider** - means any hospital, day care center or other provider that is not part of the network.

57) **New Born Baby** - means baby born during the Policy Period and is aged up to 90 days.

58) **Notification of Claim** - means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

59) **Outpatient (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.

60) **Policy** - means Your proposal, the Schedule, annexures, insuring clauses that are appearing in each applicable coverage, definitions, exclusions, conditions and other terms contained herein and any endorsement attaching to or forming part hereof, either at inception or during the Policy Period.

61) **Policyholder** - means the person or entity named in the Policy Schedule as the Policyholder.

62) **Policy Period** - means the period commencing from Policy start date and time as specified in the Policy Schedule and terminating at midnight on the Policy end date as specified in the Policy Schedule.

63) **Policy Year** – means a period of 12 consecutive months commencing from the Policy Period start date and such12 consecutive months thereafter but not beyond the Policy Period.

64) **Policy Schedule** – means schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the Policy Period and the limits and conditions, to which the benefits under the Policy are subject to, including any annexures and/or endorsements.

65) **Portability** – means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc., from the Existing Insurer to the Acquiring Insurer in the previous policy.

66) **Pre-existing Disease** means any condition, ailment, injury or disease:

   a. That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer OR

   b. For which medical advice or treatment was recommended by, or received from, a physician not more than 36 months prior to the date of commencement of the policy.

67) **Primary Insured** - means the person who has been first enrolled by group policyholder as a member under this Policy and who in turn has included his/her family members.

68) **Proposal Form** - means a form to be filled in by the prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the Insurer in respect of a risk, in order to enable the Insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.

69) **Pre-Hospitalization Medical Expenses** - means Medical Expenses incurred during pre-defined number of days preceding the Hospitalization of the Insured Person, provided that:
Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

70) **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:
Such Medical Expenses are for the same condition for which the Insured Person's Hospitalization was required, and
The inpatient Hospitalization claim for such Hospitalization is admissible by the insurance company.

71) **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.

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

73) **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.

74) **Room Rent** - means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated Medical Expenses.

75) **Specific Waiting Periods**- means a period up to 36 months from the commencement of a Health Insurance Policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

76) **Sum Insured** - means the specified amount mentioned in the Policy Schedule/Certificate of Insurance which represents Our maximum liability for each Insured Person or family, in case of Family Floater plan for any and all benefits claimed for during the Policy Year.

77) **Sub-limit** means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit.

78) **Subrogation** shall mean the right of the Insurer to assume the rights of the Insured person to recover expenses paid out under the Policy that may be recovered from any other source.

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

80) **"Third Party Administrators or TPA"** means any person who is registered under the IRDAI (Third Party Administrators - Health Services) Regulations, 2016 notified by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of

providing health services as defined in those Regulations.

81) **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.

82) **Waiting Period** – means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the waiting period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

83) **We/Our/Us / Insurer** - means Raheja QBE General Insurance Limited.

84) **You/Your** - means the Policyholder or Primary Insured named in the Policy Schedule.

4. Coverages

Your coverage(s) are mentioned in the Policy Schedule / Certificate of Insurance. We will provide the coverage as detailed below for an event that occurs during the Policy Year. Each coverage is subject to the terms, conditions and exclusions of this Policy. We will pay as specified under each of the coverage in the Policy Schedule / Certificate of Insurance.

4.1 Hospitalization Cover

A. In-Patient Hospitalization Accident & illness cover

If Insured has opted for this Cover, We will cover the Medical Expenses for one or more of the following arising out of an Insured Person's Hospitalization following an Illness or Injury that occurs during the Policy Period of insurance subject to terms and conditions as listed below.

Reasonable and Customary Charges for Room Rent for accommodation in Hospital room and other boarding charges up to the limits as specified in the Policy Schedule/Certificate of Insurance of this Policy.

1. ICU Charges
2. Medical Practitioner's fees, including fees of surgeon, consultants, physicians, specialists and anesthetist's treating the Insured Person.
3. Qualified Nurses charges.
4. Operation theatre expenses, Anesthesia, blood, oxygen and blood transfusion charges, Cost of Pacemaker, Diagnostic materials and X rays, Dialysis, Chemotherapy, radiotherapy.
5. Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner.
6. Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized.
7. Surgical appliances and allowable prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

Special condition:

1. Hospitalization is medically necessary and follows the written advice of a Medical Practitioner
2. If the Insured Person is admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule/Certificate of Insurance of this Policy, then the Insured Person shall bear a ratable proportion of the total Associated Medical Expenses in the proportion of the difference between the Room Rent of the entitled room category to the Room Rent actually incurred.
   i. Associated Medical Expenses shall include - Room Rent, nursing charges, operation theatre charges, Practitioner including surgeon / anesthetist / specialist within the same Hospital where the Insured Person has been admitted. “Associated Medical
   ii. Expenses” does not include cost of pharmacy and consumables, cost of implants and medical devices and cost of diagnostics.
   ii. Proportionate deductions are not applied in respect of the 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.

A.1. Day Care Treatment

We will also cover the medical expenses incurred for Day Care Treatment on the written medical advice of a Medical Practitioner following an illness or injury which occurs during the Policy Period, up to the limits specified in the Policy schedule/certificate of insurance.

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

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

A.2 Domiciliary Hospitalization

We will pay the Medial Expenses incurred by Insured for any illness or Injury requiring medical treatment taken at home, which would otherwise have required Hospitalization, provided that:

The condition of the patient is such that she/he is not in a condition to be moved to a hospital or

The patient takes treatment at home on account of non-availability of room in a hospital, and

The condition for which the medical treatment is required continues for at least 3 days, in which case We will pay the reasonable charge of any necessary medical treatment for the entire period

No Payment will be made if the condition for which You require medical treatment is due to:

- Asthma,
- Bronchitis,
- Tonsillitis,

- Upper Respiratory Tract Infection including Laryngitis and Pharyngitis,
- Cough and Cold,
- Influenza,
- Arthritis,
- Gout and Rheumatism,
- Chronic Nephritis and Nephritic Syndrome,
- Diarrhea and all types of Dysenteries including Gastroenteritis,
- Diabetes Mellitus and Insipidus,
- Epilepsy,
- Hypertension,
- Pyrexia of unknown Origin.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

A.3. Pre-Hospitalization Expenses

We will pay for consultations, investigations and the cost of medicines incurred for a period mentioned in the Policy schedule/Certificate of Insurance prior to the date of admission in a hospital, provided that:

Such Expenses recommended by the Hospital/Medical Practitioner were in fact incurred for the same condition for which the Subsequent Hospitalization was required.

We have accepted an Inpatient Hospitalization Claim under Section A, or

A.1 or A.2 Cover of this Policy.

A.4 Post hospitalization Expenses

We will pay for consultations, investigations and the cost of medicines incurred for a period mentioned in the Policy schedule/certificate of insurance from the date of Discharge from the hospital, provided that:

The expenses are recommended by the Hospital/Medical Practitioner and are for the same condition for which Insured was hospitalized.

We have accepted an Inpatient Hospitalization Claim under Section A or A.1 or A.2 of this Policy.

B. In-Patient Hospitalization Accident cover

If Insured has opted for this Cover, we will cover the Medical Expenses for one or more of the following arising out of an Insured Person's Hospitalization during the Policy Period following an accidental Injury that occurs during the Policy Period:

Reasonable and Customary Charges for Room Rent for accommodation in Hospital room and other boarding charges up to the limits as specified in the Policy Schedule / Product Benefit

Table of this Policy;

1. ICU Charges
2. Medical Practitioner's fees, including fees of surgeon, consultants, physicians, specialists and anesthetist's treating the Insured Person.
3. Qualified Nurses charges;
4. Operation theatre expenses, Anesthesia, blood, oxygen and blood transfusion charges, Cost of Pacemaker, Diagnostic materials and X rays, Dialysis, Chemotherapy, radiotherapy.
5. Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner.
6. Investigative tests or diagnostic procedures directly related to the Injury for which the Insured Person is Hospitalized.
7. Surgical appliances and allowable prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

Special Condition:

Hospitalization is medically necessary and follows the written advice of a Medical Practitioner.

If the Insured Person is admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule / Product Benefit Table of this Policy, then the Insured Person shall bear a ratable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled room category to the Room Rent actually incurred.

Associated Medical Expenses shall include - Room Rent, nursing charges, operation theatre charges, Practitioner including surgeon/ anesthetist/ specialist within the same Hospital where the Insured Person has been admitted. "Associated Medical Expenses" does not include cost of pharmacy and consumables, cost of implants and medical devices and cost of diagnostics.

Proportionate deductions are not applied in respect of the 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.

B.1 Day Care Treatment

We will also cover the medical expenses incurred for Day Care Treatment on the written medical advice of a Medical Practitioner following an accidental injury which occurs during the Policy Period, up to the limits specified in the Policy schedule/certificate of insurance.

Treatment undertaken under General or Local Anesthesia in a Hospital / Day Care Centre in less than 24 hrs. because of technological advancement, and

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

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

B.2 Domiciliary Hospitalization

We will pay the Medial Expenses incurred by Insured for any accidental Injury requiring medical treatment taken at home, which would otherwise have required Hospitalization, provided that:

The condition of the patient is such that she/he is not in a condition to be moved to a Hospital or

The patient takes treatment at home on account of non-availability of room in a Hospital, and

The condition for which the medical treatment is required continues for at least 3 days, in which case We will pay the reasonable charge of any necessary medical treatment for the entire period

No Payment will be made if the condition for which You require medical treatment is due to:

- Asthma,
- Bronchitis,
- Tonsillitis,
- Upper Respiratory Tract Infection including Laryngitis and Pharyngitis,
- Cough and Cold,
- Influenza,
- Arthritis,
- Gout and Rheumatism,
- Chronic Nephritis and Nephritic Syndrome,
- Diarrhea and all types of Dysenteries including Gastroenteritis,
- Diabetes Mellitus and Insipidus,
- Epilepsy,
- Hypertension,
- Pyrexia of unknown Origin.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

B.3 Pre-Hospitalization Expenses

We will pay for consultations, investigations and the cost of medicines incurred for a period mentioned in the Policy schedule/Certificate of Insurance prior to the date of admission in a hospital, provided that:

Such Expenses recommended by the Hospital/Medical Practitioner were in fact incurred for the same condition for which the Subsequent Hospitalization was required.

We have accepted an Inpatient Hospitalization Claim under Section B or B.1 or B.2. of this Policy.

B.4 Post hospitalization Expenses

We will pay for consultations, investigations and the cost of medicines incurred for a period mentioned in the Policy schedule/certificate of insurance from the date of Discharge from the

hospital, provided that:

The expenses are recommended by the Hospital/Medical Practitioner and are for the same condition for which Insured was hospitalized.

We have accepted an Inpatient Hospitalization Claim under Section B or B.1. or B.2. of this Policy.

4.2 Advance Treatment

We will pay the cost of the treatment listed below or part of the treatments (wherever medically indicated) either as in-patient or as part of domiciliary hospitalization or as day care treatment in a hospital as specified in the Policy schedule.

- Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
- Balloon Sinuplasty
- Deep Brain stimulation
- Oral chemotherapy
- Immunotherapy- Monoclonal Antibody to be given as injection
- Intravitreal injections
- Robotic surgeries
- Stereotactic radio surgeries
- Bronchial Thermoplasty
- Vaporization of the prostrate (Green laser treatment or holmium laser treatment)
- IONM - (Intra Operative Neuro Monitoring)
- Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

4.3 AYUSH Benefit

We will pay the Medical Expenses for Insured's In-patient Treatment, taken under Ayurveda, Yoga and naturopathy, Unani, Siddha or Homeopathy. This is up to the Sum Insured mentioned in the Policy Schedule

4.3.1 A government hospital or in any institute recognized by government and/or accredited by Quality Council of India or National Accreditation Board on Health.

4.3.2 Teaching hospitals of AYUSH colleges recognized by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH)

4.3.3 AYUSH hospitals having registration with Government authority under appropriate Act in the State/UT and complies with the following as minimum criteria:

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.

We won't pay for: a) Outpatient Medical Expenses. b) All Preventive and Rejuvenation Treatments (non-curative in nature) including, without limitation, treatments that are not Medically Necessary. This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy. The payment under this benefit is within the Base Cover.

5. Add-on coverages

5.1 Home care treatment expenses

If Insured has opted for this Cover, Home Care Treatment means Treatment availed by the Insured Person at home for illness or accident, which in normal course would require care and treatment at a hospital but is actually taken at home maximum up to 14 days per incident provided that:

The Medical practitioner advices the Insured person to undergo treatment at home.

There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment.

Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.

The insured shall be permitted to avail the services as prescribed by the medical practitioner. Cashless or reimbursement facility shall be offered under homecare expenses subject to claim settlement policy disclosed in the website.

In case the insured intends to avail the services of non-network provider claim shall be subject to reimbursement, a prior approval from the Insurer needs to be taken before availing such services.

The payment under this benefit is within the Base Cover, subject to limits specified, if any.

5.2 Organ Donor Cover

If Insured has opted for this Cover, we will pay the Expenses incurred towards in- patient Hospitalization of an organ donor for Insured Person's organ transplant Surgery during the Policy period provided that:

- the organ donor conforms to the provisions of The Transplantation of Human Organs Act, 1994 and other applicable laws.
- the organ donated is for the use of the Insured Person provided
- that the Insured Person has undergone an organ transplantation on the basis of Medical Advice.

- A claim has been admitted by Us under Base Cover Inpatient Care,

We will not cover:

- Any Pre-hospitalization Medical Expenses, Post-hospitalization Medical Expenses, or screening expenses of the organ donor, or any other Medical Expenses as a result of the harvesting from the organ donor;
- Costs directly or indirectly associated with the acquisition of the donor's organ.
- Any other medical treatment or complication in respect of the donor consequent to organ donation.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy. The payment under this benefit is within the Base Cover, subject to limits specified, if any.

5.3 Health Check up

If Insured has opted for this Cover, the Insured Person/s covered under the policy may avail the set of health check-ups as specified in the Policy Schedule with Our Network Provider. Health Check Ups will be arranged by Us and conducted at Our Network Providers, provided that:

- The Insured Person is an Adult (Aged 18 Years and above)
- It is available only once a year.
- The payment under this benefit is over and above the Base Cover, subject to limits specified, if any.

5.4 Maternity

If Insured has opted for this Cover, we will pay the Maternity Expenses incurred towards the delivery of a baby and/or treatment related to any complication of pregnancy or medically necessary termination. This is up to the Sum Insured opted by Insured and as mentioned in the Policy Schedule against this Section, during the Policy Period provided that:

a) Medical Expenses are covered for the delivery of first two living children of the Insured person and/or any surgical procedures required to be carried out on the Insured Person as a direct result of the delivery.

b) A waiting period as mentioned in the Policy schedule shall apply to the Primary Insured and his/her spouse from the date both are covered under the Policy.

c) A waiting period shall not apply to the Primary Insured and his/her spouse if waiver of waiting period is opted and mentioned in the Policy schedule.

d) Medical Expenses incurred in connection with the lawful medical termination of pregnancy. The payment under this benefit is within the Base Cover, subject to limits specified, if any.

5.5 Baby Day One Cover

If Insured has opted for this cover, We shall cover new born baby from birth upto the sum insured, otherwise the minimum age for an Insured person has to be 91 days.

5.6 Pre and Post Natal Expenses

If Insured has opted for this Cover, we will pay for pre and post-natal medical expenses as an outpatient/inpatient treatment, including but not limited to expenses for antenatal checkups, doctor's consultations, arising therefrom up to maternity sum insured specified in the Policy schedule.

Note:

Pre-Natal means the period between conception and birth.

Post-Natal means the period beginning immediately after the birth of a child and extending for 60 days.

The payment under this benefit is within the Maternity sum insured, subject to limits specified, if any.

5.7 Reinstatement of Sum insured

If Insured has opted for this cover, the insured can reinstate his sum insured upto 100%, in case the original sum insured is all used up in treatment.

This reinstated sum insured cannot be used for the same illness/injury that the Insured person was treated for during the Policy Period.

The reinstatement sum insured can be used for Inpatient Hospitalization, pre and post hospitalization, Day care treatment, Domiciliary treatment and Ayush Treatment.

Reinstatement benefit can't be used for the first claim the Insured makes.

If the reinstatement benefit isn't used, it can't be carried forward to the next year.

For Individual Policies, the reinstated sum insured will be available on Individual basis, whereas in case of a Family floater Policy, it will be available on a floater basis.

For any single claim during the Policy Period, the maximum Insured can claim for is Sum Insured

In a Policy period, the amount of all the claims put together should not be more than the total of: the sum insured, the reinstated sum insured.

In case of Portability, the credit for continuity in sum insured would be available only to the extent of sum insured of the expiring Policy, including reinstatement.

5.8 Recharge of Sum Insured

If Insured has opted for this cover, the insured can recharge his sum insured upto 100%, in case the original sum is all used up in treatment. This recharged sum insured can be used for the same illness/injury that the Insured person was treated for during the Policy Period.

The recharged sum insured can be used for Inpatient Hospitalization, pre and post hospitalization, Day care treatment, Domiciliary treatment and Ayush Treatment.

Recharged benefit can be used for the same treatment on which the original sum insured was spent.

If the recharged benefit isn't used, it can't be carried forward to the next year.

For Individual Policies, the recharged sum insured will be available on an Individual basis, whereas in case of a Family floater Policy, it will be available on a floater basis.

For any single claim during the Policy Period, the maximum Insured can claim for is Sum Insured

In case of Portability, the credit for continuity in sum insured would be available only to the extent of sum insured of the expiring Policy, including recharged sum insured.

If the Insured Person has the reinstatement benefit as well he/she does not need to use this up first for the recharged benefit to kick in. If the sum insured is used up, we will not take into account the reinstatement sum Insured.

5.9 Co-payment

If Insured has opted for this benefit, then insured will be liable to bear the percentage of the claimed amount opted for, if the claim is payable as per terms and condition.

5.10 Emergency Ambulance

If Insured has opted for this Cover, we will pay for the expenses incurred towards transportation of Insured to the nearby Hospital or health care center incase of an medical emergency on the medical practitioners recommendation, provided that:

We have accepted a claim under Inpatient Hospitalization

The amount payable will not exceed the maximum specified in the Policy schedule.

The Coverage also Includes the cost of Transportation from a Hospital to another nearest Hospital which is prepared to admit insured and provide the necessary medical services, if such medical services cannot satisfactorily be provided at a Hospital where Insured is situated. Such road Transportation has to be prescribed by a Medical Practitioner and/or should be Medically Necessary.

The payment under this benefit is within the Base Cover, subject to limits specified, if any.

5.11 Air Ambulance

If Insured has opted for this cover, we will pay for the expenses incurred towards Insured's transportation in an airplane or helicopter certified to be used as an ambulance to the nearest Hospital with adequate facilities in an Emergency following an Illness or Injury which occurs during the Policy Period provided that:

Such transportation of Insured Person cannot be provided by a road ambulance.

Claim for Inpatient Hospitalization in the Hospital Insured Person is transported to is admissible under Base Cover of this Policy;

Treatment is not available at the location where Insured Person is situated at the time of the Emergency.

Such medical evacuation is prescribed by a Medical Practitioner and is medically necessary;

Insured Person is situated in India and the treatment is required in India only and not overseas in any condition whatsoever.

The air ambulance provider is registered in India.

Expenses incurred towards return transportation by air ambulance is excluded under this Benefit.

Expenses incurred for such Air Ambulance services in the event of any catastrophe or natural calamity will not be covered.

The payment under this benefit is within the Base Cover, subject to limits specified, if any.

5.12 Corporate Buffer

If Insured has opted for this cover, an additional sum insured as mentioned in the Policy schedule will be available to the Insured which is in addition to the basic Sum Insured reflected in the Policy Schedule Individual/floater.

Corporate buffer as stated in the Policy schedule will be available to the insured for additional payment to the Insured person during the Policy period subject to the limits and conditions specified in the Policy schedule.

5.13 Outpatient cover

If Insured has opted for this cover, we will cover the reasonable and customary charges incurred towards medical illness or injury of the insured person in an outpatient setup as specified in the Policy schedule provided that:

- the medical consultation fees are necessary as per the medical practitioner.
- the diagnostic test are recommended by the medical practitioner for illness/injury.
- the medicine purchased by insured are prescribed by medical practitioner.

The benefits payable under outpatient cover shall be upto the limit specified in the Policy schedule and the copay and deductible shall be applicable as specified in the Policy schedule. The payment under this benefit is over and above the Base Cover, subject to limits specified, if any.

5.14 Well child cover

If Insured has opted for this cover, we will provide cover for expenses incurred towards regular preventive care, diagnostic tests and vaccines upto the first 2 years of childbirth and upto the limit specified in the Policy schedule.

The payment under this benefit is within the Base Cover, subject to limits specified, if any.

This cover shall not be applicable if insured has opted clause 5.24 i.e. Vaccination coverage benefit under the policy.

5.15 Well women cover

If Insured has opted for this cover, we will provide cover for expenses incurred towards preventive care like screening, lab tests and counselling for women upto the limit specified in the Policy schedule.

The payment under this benefit is within the Base Cover, subject to limits specified, if any.

5.16 Wellness Benefit

If Insured has opted for this cover, we will provide the benefits listed below to insured as mentioned in the Policy schedule, We intend to incentivize the Insured Person(s) for taking care of his/her health/fitness and maintaining healthy lifestyle through such preventative and wellness services.

There are a total of 12 services under Wellness Benefit Program. Services applicable for Your Policy are as shown in Your Policy Schedule. only services mentioned in your Policy Schedule/Certificate of Insurance are available for You.

5.16.1 Doctor on Call

Upon Your request, we will facilitate an appointment, through Our empaneled Service Provider, with a Medical Practitioner who can help You by providing round-the-clock medical helpline services through an online portal as a chat service, a call back service or a voice call service.

5.16.2 Wellness Coach

In order to educate, empower and engage You to become more aware of Your health and proactively manage it, We will, through periodic communications like e-mailers, blogs and online platform provide You information on wellness coaching in areas such as: a) Weight Management b) Activity and Fitness c) Nutrition d) Tobacco Cessation e) Alcohol Abuse de-addiction Program f) Information on various diseases g) Dietary Plans

5.16.3 Lab Services (Home Collection)

Upon Your request, we will facilitate, through Our empaneled Service Provider, Collection of test samples such as blood, urine, stool etc. from Your home address for further testing and analysis. The cost of these tests and reports will have to be borne by You.

5.16.4 Pharmacy (Home Delivery)

Upon Your request, we will facilitate, through Our Empaneled Service Provider, home delivery of the Medications Prescribed by a Registered Medical Practitioner from the nearby Network Pharmacy, subject to copy of prescription being shared (where ever required) and availability of the medication with the Pharmacy. The cost of the medication will have to be borne by You.

5.16.5 Vital/Physical Activity Monitoring Services

Upon Your request, we will facilitate, through Our Empaneled Service Provider, the integration of Your Health Device(s) such as Blood-Pressure Monitors, Glucometers, Wireless Pedometers,

Smart Watches etc. to an online database that will track and asses Your vitals as reported by the device. It can provide periodic updates and reports of your health status. The cost of the device will have to be borne by You.

5.16.6 Reminder Notifications

Upon Your request, We will facilitate, through Our Empaneled Service Provider, routine notification messages via mail or a messaging portal or a follow-up call to You as a reminder to schedule Your medical appointments and/or take daily dosage of Your medicine as per the information shared by You.

5.16.7 Medical Wallet

Upon Your request, we will arrange, through Our Empaneled Service Provider, for a medical wallet. This will be a digital cloud service which will allow You to store all Your medical reports online. It will provide easy access of medical history and reports to the treating Medical Practitioners and to any other person with whom You may share the login and access codes, easing Your need to physically carry documents with You.

5.16.8 Report Aggregation

Upon Your request, we will facilitate, through Our empaneled Service Provider, for regular analysis of Your health status as per the medical records/reports shared by You. It will highlight your wellbeing or any areas of concern or deterioration in Your health, allowing You to take necessary calls about your health.

5.16.9 Home Care Services

Upon Your request, we will facilitate, through Our empaneled Service Provider, Home Care Services for You in case You are in need of any of the following: a. Home Care Nursing b. Patient Assistant c. Physiotherapy d. Yoga Trainer e. Psychologist f. Palliative Care g. Renting Medical equipment. For Example - Wheelchair, Patient Bed, Oxygen Cylinder etc.

The cost of the Services/Equipment will have to be borne by You.

5.16.10 Ambulance Arrangement Services

Upon request, we will facilitate, through Our empaneled Service Provider, ambulance services for Your transportation subject to availability of ambulance in the area where such service needs to be arranged. The cost of the transportation will have to be borne by You.

5.16.11 Pick-up and Drop Services for Consultation

Upon Your request, We will facilitate, through Our empaneled Service Provider, Pick-up and Drop Service, for Your transportation to the Health Care Facility for treatment/Diagnostics subject to availability of vehicle/taxi in the area where such service needs to be arranged. The cost of the transportation will have to be borne by You.

5.16.12 Prioritizing Appointments

Upon Your request, we will facilitate, through Our empaneled Service Provider, prioritization of Your appointment, based on the urgency, with the Network Providers offering the necessary treatment/diagnostics subject to availability of the service(s). The cost of the Consultancy/Diagnostic will have to be borne by You.

Terms and Conditions applicable to Wellness Benefit Program:

- Any Information provided by You shall be kept confidential.
- For services which are provided through Our empaneled Service Provider/Medical Experts/Centers, we are acting only as a facilitator, hence We would not be liable for any incremental costs or the services.
- All medical services are being provided by empaneled Service Provider/Medical Experts/Centers who are empaneled after full due diligence. An insured Person may however consult their Personal/Family Doctor before availing the medical services. The decisions to utilize the services will solely be at the discretion of the Insured Person.
- We/Company/Us or its Group Entities, affiliates, officers, employees, agents, are not responsible for or liable for any actions, claims, demands, losses, damages, costs, charges, and expenses which an Insured Person/You may claim to have suffered or sustained or incurred by way of or on account of utilization of any benefits specified herein.
- This shall not be deemed to substitute the Insured Person's visit or consultation to an Independent Medical Practitioner. The Insured Person is free to choose whether or not to undergo the same and if done whether or not to act on it.
- We do not 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.

5.17 Disease wise Sublimit

If Insured has opted for this Cover, sub limits shall be applicable for disease specified in the Policy schedule/Certificate of insurance.

The payment under this benefit is within the Base Cover, subject to limits specified, if any.

5.18 Accidental Death

If an Insured has opted for this cover and If an Insured Person suffers an Injury due to an Accident during the Policy Period which is the sole and direct cause of his death within (365) days from the date of the Accident, then We will pay the Sum Insured as specified in the Policy Schedule/ Certificate of Insurance.

We will pay, the sum insured less any other amount paid or payable under: Permanent Total Disability and Permanent Partial Disability section of this Policy, if these coverages are offered under this Policy, as the result of the same Accident

Disappearance

If Insured's body has not been found within three hundred and sixty-five (365) days after the forced landing, stranding, sinking or wrecking of a conveyance in which You were travelling as a passenger or as a result of any Acts of God peril, it shall be presumed that You have suffered death resulting from the Accident covered by this Policy.

If at any time, after the payment of the Accidental death benefit, it is discovered that Insured is still alive, all payments made under this benefit to the Nominee shall be reimbursed in full to Us.

Note - Once a claim has been accepted and paid under this Benefit then this Policy shall immediately and automatically cease with immediate effect in respect of that Insured Person

The payment under this benefit is over and above the base cover, subject to limits specified, if any.

5.19 PERMANENT TOTAL DISABLEMENT

If an Insured has opted for this cover and If an Insured Person suffers an Injury due to an Accident during the Policy Period, which is the sole and direct cause of "Permanent Total Disablement" within 365 days from the Date of accident, then We will pay the sum insured as specified in the table of losses.

Sr. no	Type of loss	Percentage of sum insured payable
1	Total and irrecoverable loss of sight of both eyes	100%
2	Loss by physical separation or total and permanent loss of use of both hands or both feet	100%
3	Loss by physical separation or total and permanent loss of use of one hand and one foot	100%
4	Total and irrecoverable loss of sight of one eye and loss of a Limb	100%
5	Total and irrecoverable loss of hearing of both ears and loss of one Limb/loss of sight of one eye	100%
6	Total and irrecoverable loss of hearing of both ears and loss of speech	100%
7	Total and irrecoverable loss of speech and loss of one Limb/loss of sight of one eye	100%

We will pay, provided such disability has continued for a period of 365 days and is total, continuous and Permanent at the end of this period.

For the purpose of this Benefit:

Limb means a hand at or above the wrist or a foot above the ankle

Physical separation of one hand or foot means separation at or above wrist and/or at or above ankle, respectively.

Specific Conditions:

- If the Insured Person suffers Accidental Injuries resulting in more than one of the Permanent Total Disablement, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured opted by Insured and mentioned against this Section.
- Once a claim has been accepted under this Section, this Policy will immediately and automatically cease in respect of that Insured Person.
- The payment under this benefit is over and above the Base cover, subject to limits specified, if any.

5.20 PERMANENT PARTIAL DISABLEMENT

If an Insured has opted for this cover and If an Insured Person suffers an Injury due to an Accident during the Policy Period which results into Permanent Partial Disability within (365) days from the date of the Accident, then We will pay the Sum Insured as stated in the below table of losses.

We will pay, provided such disability has continued for a period of (365) days and is total, continuous and Permanent at the end of this period.

Sr. no	Type of loss	Percentage of sum insured payable
1	Loss of sight of one eye	50%
2	Loss of One hand	50%
3	Loss of One leg	50%
4	Loss of speech	50%
5	Loss of Hearing - Both Ears	75%
6	Loss of Hearing - One Ear	30%
7	Loss of all toes of one foot	20%
8	Loss of toes great - both phalanges	5%
9	Loss of toes great - one phalanx	2%
10	Loss of toes other than great - each toe	2%
11	Loss of four fingers and thumb of one hand	50%
12	Loss of four fingers of one hand	40%
13	Loss of thumb - both phalanges	25%
14	Loss of thumb - one phalanx	10%
15	Loss of index finger - three phalanges	15%

16	Loss of index finger - two phalanges	10%
17	Loss of index finger - one phalanx	5%
18	Loss of middle finger or ring finger or little finger - three phalanges	10%
19	Loss of middle finger or ring finger or little finger - two phalanges	7%
20	Loss of middle finger or ring finger or little finger - one phalanx	3%

Note:

For the purpose of this Cover, Loss means:

The physical separation of a body part, or

The total loss of functional use of body part or organ provided which has continued for at least 365 days from the date of accident, provided that We must be satisfied at the expiry of the 365 days that there is no reasonable medical hope for improvement.

When more than one form of disability results from one Accident, we will add the percentages of each disability together. However, we will not pay more than 100% of the Sum Insured stated in the Policy Schedule/ Certificate of Insurance.

If a claim is payable for loss or loss of use of a whole member of the body, a claim for parts of that member cannot also be made*. * Illustration – Member means one entire hand and part means fingers/thumb of that hand. So, if a claim is admitted for loss by physical separation of one entire hand, then loss for fingers/thumb of that hand will not be admitted.

If the Insured suffers from a Permanent Partial Disablement not listed in the above table, then an external medical advisor will determine the disablement percentage.

The payment under this benefit is over and above the Base cover, subject to limits specified, if any.

5.21 Convalescence Benefit

If you have opted for this cover, we will pay Insured the Sum Insured as mentioned in the Policy Schedule for this benefit if the Insured Person is admitted in a Hospital for a minimum period as specified in the Policy schedule of Insurance provided that:

We have accepted a claim for the base cover under the Policy in respect of the same Hospitalization.

We shall be liable to make payment under this cover in respect of an Insured Person only once during the Policy year.

This benefit is applicable only once in a Policy period, irrespective of type of Policy (Individual/Floater)

The payment under this benefit is over and above the base cover, subject to limits specified, if any.

Deductible is not applicable for this cover.

5.22 Critical Illness Indemnity cover

If You have opted for this Cover, we will pay Insured reasonable and Customary charges that are medically necessary and incurred by Insured in respect of an admissible hospitalization claim, upto the Sum Insured as mentioned in the Policy Schedule against this Section, the additional sum under this extension will be available only once the original sum insured has been exhausted, in case Insured is diagnosed as suffering from any of the Critical Illnesses or undergoing covered Surgical Procedures as specified below Provided that,

- The Insured Person suffers a critical illness specifically listed and defined in this Policy
- This Critical illness or covered surgical procedure has happened to Insured for the first time in his life.
- We will not make any payment if Insured is diagnosed as suffering from Critical Illness within the number of days (i.e. Initial Waiting Period) mentioned in the Policy Schedule/Certificate of Insurance from the date of inception of first policy with us.
- The Critical Illness or the Surgical Procedure Claim is not a consequence of or arising out of any pre-existing condition/disease
- Reasonable and Customary Charges for Room Rent for accommodation in Hospital room and other boarding charges up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy.
- ICU Charges
- Medical Practitioner's fees, including fees of surgeon, consultants, physicians, specialists and anesthetists treating the Insured Person.
- Qualified Nurses charges.
- Operation theatre expenses, Anesthesia, blood, oxygen and blood transfusion charges, Cost of Pacemaker, Diagnostic materials and X rays, Dialysis, Chemotherapy, radiotherapy
- Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner.
- Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized.
- Surgical appliances and allowable prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

Special Condition-

Hospitalization is medically necessary and follows the written advice of a Medical Practitioner.

If the Insured Person is admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule / Product Benefit Table of this Policy, then the Insured Person shall bear a ratable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled room category to the Room Rent actually incurred.

Associated Medical Expenses shall include - Room Rent, nursing charges, operation theatre

charges, Practitioner including surgeon/ anesthetist/ specialist within the same Hospital where the Insured Person has been admitted. “Associated Medical Expenses” does not include cost of pharmacy and consumables, cost of implants and medical devices and cost of diagnostics.

Proportionate deductions are not applicable for ICU charges.

Proportionate deductions are not applied in respect of the 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.

The payment under this benefit is over and above the Base cover, subject to limits specified, if any.

5.23 Critical Illness Benefit cover

If You have opted for this Cover, We will pay Insured the Sum Insured as mentioned in the Policy Schedule against this Section, in case Insured is diagnosed as suffering from any of the Critical Illnesses or undergoing covered Surgical Procedures as specified below Provided that,

- This Critical illness or covered surgical procedure has happened to Insured for the first time in his life.
- We will not make any payment if Insured is diagnosed as suffering from Critical Illness within the number of days (i.e. Initial Waiting Period) mentioned in the Policy Schedule/Certificate of Insurance from the date of inception of first policy with us.
- Insured survive for a minimum period specified in the Policy schedule or certificate of Insurance from the date of diagnosis of such Critical Illness, unless this condition is specifically waived by Us
- The Critical Illness or the Surgical Procedure Claim is not a consequence of or arising out of any preexisting condition/disease
- Once a claim has been Paid under Critical Illness and / or Surgical Procedure, Cover under this Section shall cease, and no further payment will be made for any consequent disease or any dependent disease.
- Critical Illness means the following major disease, which Insured have been diagnosed during the Policy Period to have suffered from and which requires Hospitalization and are specifically defined as below:
- The payment under this benefit is over and above the Base cover, subject to limits specified, if any.
- Critical Illness means the major disease mentioned in the Policy schedule, which Insured have been diagnosed during the Policy Period to have suffered from and which requires Hospitalization and are specifically defined as below:

Cancer of Specified Severity

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.

The following are excluded –

- All tumors which are histologically described as carcinoma in situ, benign, premalignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
- Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond.
- Malignant melanoma that has not caused invasion beyond the epidermis.
- 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
- All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below.
- Chronic lymphocytic leukemia less than RAI stage 3
- Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
- All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
- All tumors in the presence of HIV infection.

Myocardial infarction (first heart attack of specific severity)

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:

- A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
- New characteristic electrocardiogram changes
- Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

- Other acute Coronary Syndromes
- Any type of angina pectoris
- A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

Open chest CABG

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 breastbone) 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.

The following are excluded:

i. Angioplasty and/or any other intra-arterial procedures

Heart Valve replacement

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

Aorta Graft Surgery

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.

Primary Pulmonary Arterial Hypertension

An unequivocal diagnosis of Primary Pulmonary Arterial 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.

The NYHA Classification of Cardiac Impairment are as follows:

- Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
- Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

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.

Coronary Artery Disease

The narrowing of the lumen of at least one coronary artery by a minimum of 75% and of two others by a minimum of 60%, as proven by coronary arteriography, regardless of whether or not any form of coronary artery Surgery has been performed. Coronary arteries herein refer to left main stem, left anterior descending circumflex and right coronary artery.

Stroke resulting in permanent symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, hemorrhage and embolization 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.

The following are excluded:

- Transient ischemic attacks (TIA)

- Traumatic injury of the brain
- Vascular disease affecting only the eye or optic nerve or vestibular functions

Permanent paralysis of Limbs

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

Motor Neuron Disease with permanent symptoms

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.

Coma of specified severity

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

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

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

Benign Brain Tumor

- Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.
- 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.
- 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.

Multiple sclerosis with persisting symptoms

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

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

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

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

Parkinson's Disease

The occurrence of Parkinson's Disease where there is an associated Neurological

Deficit that results in Permanent Inability to perform independently atleast three of the activities of daily living as defined below.

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

Parkinson's disease secondary to drug and/or alcohol abuse is excluded

Alzheimer's Disease

Clinically established diagnosis of Alzheimer's Disease (presenile dementia) resulting in a permanent inability to perform independently three or more activities of daily living – bathing, dressing/undressing, getting to and using the toilet, transferring from bed to chair or chair to bed, continence, eating/drinking and taking medication – or resulting in need of supervision and permanent presence of care staff due to the disease. These conditions have to be medically documented for at least 3 months

Apallic Syndrome

Universal necrosis of the brain cortex, with the brain stem intact. Diagnosis must be definitely confirmed by a Registered Medical practitioner who is also a neurologist holding such an appointment at an approved hospital. This condition must be documented for at least one (1) month.

Creutzfeldt Jakob Disease

A Diagnosis of Creutzfeldt-Jakob disease must be made by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical loss of the ability in mental and social functioning for a minimum period of 30 days to the extent that permanent supervision or assistance by a third party is required. Social functioning is defined as the ability of the individual to interact in the normal or usual way in society. Mental functioning would mean functions /processes such as perception, introspection, belief, imagination reasoning which we can do with our minds.

Kidney failure requiring regular dialysis

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

End stage liver failure

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

- Permanent jaundice; and
- Ascites;
- Hepatic encephalopathy.

Liver failure secondary to drug or alcohol abuse is excluded.

Aplastic anemia

Irreversible persistent bone marrow failure which results in anemia, neutropenia and thrombocytopenia requiring treatment with at least two (2) of the following:

- Blood product transfusion.
- Marrow stimulating agents.
- Immunosuppressive agents; or
- Bone marrow transplantation.

The diagnosis of aplastic anemia must be confirmed by a bone marrow biopsy. Two out of the following three values should be present: - Absolute Neutrophil count of 500 per cubic millimeter or less; - Absolute Reticulocyte count of 20,000 per cubic millimeter or less; and - Platelet count of 20,000 per cubic millimeter or less.

Subject to terms, conditions, limitations and exclusions mentioned in the Policy.

Fulminant Hepatitis

A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:

- Rapid decreasing of liver size;
- Necrosis involving entire lobules, leaving only a collapsed reticular framework;
- Rapid deterioration of liver function tests;
- Deepening jaundice; and
- Hepatic encephalopathy. Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria.

Good Pasture's syndrome

- Good Pasture's syndrome is an autoimmune disease in which antibodies attack the lungs and kidneys, leading to permanent lung and kidney damage. The permanent damage should be for a continuous period of at least thirty (30) days.

- The Diagnosis must be proven by Kidney biopsy and confirmed by a Specialist Medical Practitioner (Rheumatologist).

Progressive Scleroderma

A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. 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. The following conditions are excluded:

- Localized scleroderma (linear scleroderma or morphea);
- Eosinophilic fasciitis; and
- CREST syndrome.

Loss of Limbs

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.

Blindness

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

The Blindness is evidenced by:

- corrected visual acuity being 3/60 or less in both eyes or
- the field of vision being less than 10 degrees in both eyes.
- The diagnosis of blindness must be confirmed and must not be correctable by aids or Surgical Procedure.

Deafness

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 ninety (90) decibels across all frequencies of hearing” in both ears.

Loss of speech

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 twelve (12) months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

All psychiatric related causes are excluded

Third degree burns

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

Major Head trauma

Accidental head Injury resulting in permanent Neurological deficit to be assessed no sooner than three (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.

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.

The Activities of Daily Living are:

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

Muscular dystrophy

Muscular Dystrophy is a disease of the muscle causing progressive and permanent weakening and atrophy of certain muscle groups based on three (3) out of four (4) of the following conditions: • Family history of the other affected individuals • Clinical presentation including absence of sensory disturbances, normal cerebrospinal fluid and mild tendon reflex reduction; • Characteristic electromyogram; or • Clinical suspicion confirmed by muscle biopsy II. The diagnosis of Muscular Dystrophy must be confirmed by a Neurologist, and confirmed with the appropriate laboratory, biochemical, histological, and electromyographic evidence. III. The disease must result in the permanent inability of the Insured Person to perform (whether aided or unaided) at least three (3) of the six IF (6)"Activities of Daily Living" for a continuous period of six (6) months.

5.24 Vaccination

If Insured has opted for this Cover, we will pay vaccination expenses of the child up to the age of 18 yrs including inoculation and immunization upto the sum insured specified in the Policy schedule.

The payment under this benefit is over and above the Base cover, subject to limits specified, if any.

This cover shall not be applicable if insured has opted clause 5.14 i.e. Well child cover benefit under the policy.

5.25 Family Transportation

If Insured has opted for this Cover, if an insured is Hospitalized for five consecutive days or more and if Hospitalization is as per the scope of in-patient hospitalization of this Policy, for any illness as specified in Policy Schedule/Certificate of Insurance, then We will reimburse the amount up to the limit specified against this family transportation in the Policy Schedule/Certificate of Insurance, incurred in respect of a maximum of two of Insured Person's Immediate Family Members for two way airfare or two way first class railway ticket in a licensed common carrier to the place where Insured Person is Hospitalized provided that:

- Insured Person is Hospitalized in a Hospital which is situated at a distance of at least 100 kilometers from Your actual place of residence.
- The attending Medical Practitioner recommends the personal attendance of an Immediate Family Member.
- Travel by the Immediate Family Member to the place of Hospitalization is commenced during the period of Your Hospitalization
- This Benefit will be provided only once per Insured Person per Policy year.

"Immediate Family Member" would mean spouse, children and dependent parents of the Insured Person.

Additional claim documents for this Extension Cover:

Tickets and boarding passes, if applicable

The payment under this benefit is within the Base cover, subject to limits specified, if any.

5.26 Daily Hospital cash benefit

If Insured has opted for this Cover, we will pay daily cash if the Insured person is admitted in hospital due to sickness/injury and such hospitalization is medically necessary & recommended by the Medical Practitioner, then

- We will pay the Daily Benefit amount for the number of days Insured Person is Hospitalized.
- Our maximum liability will be limited to the Daily Benefit amount, number of hospitalization days and applicable deductible Day/s specified in the Policy Schedule / Certificate of insurance.

The payment under this benefit is over and above the Base cover, subject to limits specified, if any.

5.27 Lasik Cover

If Insured has opted for this cover, we will pay in case of compound myopic astigmatism, to the level of refractive errors specified. As per request by customer/proposer, we will specify below conditions in Policy documents provided to customer, to confirm the liability under the Policy.

Level of refractive errors. Beyond +/- 7.5 Dioptre

The payment under this benefit is within the Base cover, subject to limits specified, if any.

5.28 Infertility Treatment

If Insured has opted for this cover, we will pay for Invitro fertilization (IVF), Gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures, and any related prescription medication treatment. This extension would also cover embryo transport, donor ovum and

semen and related costs, including collection and preparation, required towards treatment related to infertility and sterilization, up to the amount mentioned in the Policy Schedule. The Insured Person should be between 18 and 50 years old.

Exclusion - List of Expenses Generally Excluded ("Non-medical") in Hospital Indemnity Policy.

The payment under this benefit is within the Base cover, subject to limits specified, if any.

5.29 Super Top Up cover

If Insured has opted for this cover, We will pay Insured if he/she suffers an Illness or Accident during the Policy Year requiring Hospitalization on an inpatient basis or treatment defined as a Day Care Procedure, and cumulative Hospitalization Expenses during the Policy Year exceeds the aggregate Deductible specified in the Policy Schedule, We will reimburse the portion of the Medical Expenses for such Hospitalization or any subsequent Hospitalization which exceeds the aggregate Deductible. Claim shall be payable only if the treatment claimed is within the scope of the Policy subject to terms, conditions, exclusions and limitations. We shall in no case be liable to pay more than the Sum Insured specified in the Policy Schedule/ certificate of insurance.

5.30 Tele consultation

If Insured has opted for this cover, We will provide services to insured upto the limit specified in the Policy schedule to take consultation from a Doctor through virtual medium, such as audio, video, online portal, chat or mobile application for a routine health query or for first and second opinions. This will also include consulting a professional expert through a hotline number for any social, mental, emotional, and environmental or other issue faced by the Insured Person which affects his / her wellbeing. This facility is meant to give him / her access to consultations and is not a substitute for meeting a doctor.

Consultation with doctors will be available when needed, through our network providers" helpline. Based on the information given by the Insured Person, medicines, including over-the-

counter medicines or other suggestions, may be given. We will not be responsible for any inaccuracy in the advice or information given.

5.31 Assistance Services

If Insured has opted for this cover, We will provide services to insured if he/she is more than 150 Kilometers away from home (the address last known), is within Indian territory, and has not been away from that address for more than 90 days.

The Services would be given by us through our panel service provider, with prior intimation and acceptance by the Insurance Company. No claims for reimbursement are accepted. All the exclusions mentioned in the Policy are applicable.

This benefit may be extended to mid term joiners and their dependents, on payment of additional premium.

1. **Medical referrals** – The Insured can call our operations center staff 24 hrs a day, every day of the year, and rely on help in multiple languages.
2. **Emergency Medical Evacuation** – Our service provider will arrange transport under due medical supervision, to the nearest medical facility which can give the needed care within India.
3. **Medical Repatriation** – Our Service provider will arrange for the Insured person to be taken back home in India or medical facility near home, under medical supervision, when our service provider's doctor and the Insured Person's doctor says such travel is medically necessary and the Insured Person is medically cleared for travel.
4. **Medical Monitoring**- Our doctor will check the Insured Person's condition and will a) stay in regular touch with the attending doctor and/or hospital and b) pass on the necessary information to family members.
5. **Compassionate visit** - When an Insured Person is hospitalized for more than seven continuous days and is traveling in India without a companion, our Service Provider will arrange for a family member or friend to travel economy class to visit the Insured Person. The family member or friend has to arrange for all the travel documents needed.
6. **Repatriation of remains** – In case of Insured's death away from home but
7. within India, our service provider will arrange and pay for the return of mortal remains to an authorized funeral home close to the Insured Person's home in India.

5.32 Second Opinion

If Insured has opted for this cover, If the Insured Person is diagnosed with any specified critical Illness or has to undergo any Surgery or Surgical Procedure during the Policy Year then at the Insured Person's request, We will arrange the second opinion from a Medical Practitioner selected by the Insured Person from Our Service Provider's panel. This coverage is subject to :

a. The Second Medical Opinion will be based only on the information and documentation provided by the Insured Person that will be shared with the Medical Practitioner.

b. This benefit can be availed only once by an Insured Person during a Policy Year for the same Illness.
c. Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained then whether or not to act on it.
d. Under this Benefit, We are only providing the Insured Person with access to an E-opinion and We shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.
e. The opinion provided under this Benefit shall be limited to the covered Illnesses and not be valid for any medico legal purposes
f. We do not 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.

Service Provider - means any person, clinic, organization or institution that has been empaneled with Us to provide Second Opinion.

5.33 Excess/Deductible

If Insured has opted for this cover, all admissible claims under this Policy is subject to the excess/deductible amount as specified in the Policy schedule for all Insured Persons covered under the Policy.

Deductible shall not apply to following coverages if opted:

- Hospital Daily Cash
- Corporate Floater (Including Critical Illness Floater)
- Critical Illness Benefit
- Convalescence Benefit
- Second Opinion
- Super Top Up Cover
- Family Transportation Benefit
- Emergency Ambulance / Air Ambulance

6. Exclusions

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

Exclusions* (which can be waived off on payment of additional premium)

6.1 Waiting period

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

6.1 A. Pre-Existing Diseases: (Code- Excl01)

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct

complications shall be excluded until the expiry of 36/24/12 months of continuous coverage after the date of inception of the first policy with insurer.

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 36/24/12 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

6.1.B. Specific Illness Waiting Period: (Code- Excl02)

a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first policy with the Insurer. This exclusion shall not be applicable for claims arising due to an accident.
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.

List of applicable disease for 12 months waiting period are:

i. Benign ENT disorders
ii. Tonsillectomy
iii. Adenoidectomy
iv. Mastoidectomy
v. Tympanoplasty
vi. Hysterectomy
vii. All internal or external benign tumors, cyst, sinus, polyps of any kind including benign breast lump
viii. Benign prostate hypertrophy
ix. Cataract and Senile Cataract
x. Gastric and Duodenal Ulcer

xi. Gout and Rheumatism
xii. Hernia of all types
xiii. Hydrocele
xiv. Non-Infective Arthritis
xv. Piles, Fissures and Fistula in anus
xvi. Pilonidal sinus, Sinusitis and related disorders
xvii. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
xviii. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
xix. Varicose Veins and Varicose Ulcers

6.1.C. 30-day waiting period: (Code- Excl03)

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

6.2 Obesity/ Weight Control (Code- Excl06)

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

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
    a. greater than or equal to 40 or
    b. 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

6.3 Hazardous or Adventure sports: (Code- Excl09)

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing,

mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

6.4 Refractive Error: (Code- Excl15)

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

6.5 Sterility and Infertility: (Code- Excl17)

Expenses related to Birth Control, sterility and infertility. This includes:

i. Any type of contraception, sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

6.6 Maternity Expenses (Code: Excl 18):

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

6.7 Any expenses incurred on Outpatient treatment (OPD treatment).

6.8 Any expenses related to cochlear implants, Gamma knife/cyber knife, sleep apnea, injection of Remicade/Avastin.

6.9 Any medical expenses incurred on new-born /children below age of 91 days will not be covered under the Policy.

6.10 External Congenital Anomaly: Any expenses incurred towards screening, counselling and treatment related to external congenital anomalies.

Exclusions (which cannot be waived)

6.11 Investigation & Evaluation (Code- Excl04)

Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

6.12 Exclusion Name: 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:

- 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.
- Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

6.13 Change-of-Gender treatments: (Code- Excl07)

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

6.14 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.

6.15 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.

6.16 Excluded Providers: (Code – Excl11)

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its 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.

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

6.18 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)

6.19 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)

6.20 Unproven Treatments:(Code- Excl16)

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

6.21 War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

6.22 Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing any illness, incapacitating disablement or death.
b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

6.23 Any treatment and/or diagnostic reports taken or any other medical expenses incurred outside the geographical limits of India.

7. General Terms and Conditions

Conditions applicable when the claim arises

7.1 Cashless Facility:

(i) Treatment may be taken in a network provider and is subject to pre authorization by the Company or its authorized TPA.

(ii) Cashless request form available with the network provider and TPA shall be completed and

sent to the Company/TPA for authorization. (iii) The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification. (iv) At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses. (v) The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details. (vi)In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company / TPA for reimbursement.

7.2 Reimbursement:

Notice of claim with particulars relating to Policy numbers, name of the Insured Person in respect of whom claim is made, nature of illness/ injury and name and address of the attending Medical Practitioner/ Hospital/ Nursing Home should be given to Us immediately on hospitalization/ injury/ death, failing which admission of claim would be based on the merits of the case at our discretion. The Insured Person/s shall after intimation as aforesaid, further submit at his/her own expense to the TPA as specified below.

Sr No	Type of Claim	Prescribed Time Limit
1.	Reimbursement of hospitalization, day care and pre-hospitalization expenses	Within 30 days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within 15 days from completion of post hospitalization treatment.

7.3 Notification of claim:

Notice with full particulars shall be sent to the company/TPA (if applicable) as under:

Within 24 hours from the date of emergency hospitalization required or before the Insured person's discharge from Hospital, whichever is earlier.

At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

7.4 Documents

7.4.1 List of documents to be submitted as per following table:

Sr. no.	List of Documents / information	Inpatient Hospitalization claim	Outpatient OPD claim	Critical Illness (Benefit)	Hospital Daily cash	AD/PTD/PPD
1	Claim form duly completed in all respects	√	√	√	√	√
2	Medical Case History / Summary	√	X	√	√	√
3	Medical Records (Optional Documents may be asked on need basis: Indoor case papers, OT notes, PAC notes etc.)	√	X	√	√	√
4	Original Hospital Main Bill	√	X	x	x	x
5	Original Hospital Bill Break Up	√	X	x	x	x
6	Original Pharmacy Bills	√	√	x	x	x
7	Prescriptions for the Medicines purchased (except hospital supply) and investigations done outside the Hospital	√	√	x	x	x
8	Consultation Papers	√	√	√	x	√
9	Investigation Reports	√	√	√	x	√
10	Digital Images/CDs of the Investigation Procedures (if required)	√	√	x	x	√
11	MLC/FIR Report (If applicable)	√	X	√	x	√
12	Inquest Panchanama report issued by the Police	√	X	√	x	√
13	Original Invoice/Sticker (If applicable)	√	X	x	x	x
14	Post Mortem Report (If applicable)	√	X	x	x	√
15	Disability Certificate (If applicable)	√	X	√	x	√
16	Attending Physician Certificate (If applicable)	√	X	√	x	√
17	Ante-natal Record (If applicable)	√	X	x	x	x

18	Birth discharge Summary (If applicable)	√	X	x	x	x
19	Death Certificate (If applicable)	√	X	√	x	√
20	*KYC (Photo ID card) (If applicable)	√	√	√	√	√
21	Bank Details with Cancelled Cheque	√	√	√	√	√

The Company may call for additional documents / information and / or carry out verification on a case to case basis to ascertain the facts collect additional information/documents of the case to determine the extent of loss. Verification carried out will be done by professional Investigators or a member of the Service Provider and costs for such investigations shall be borne by the Company.

7.4.2 The Company may accept claims where documents have been provided after a delayed interval in case such delay is proved to be for reasons beyond the control of the Insured/ Insured Person/s. The Insured shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder.

7.5 Payment of Claims

1. We shall be under no obligation to make any payment under this Policy unless We have received all the premium payments in full and all payments have been realized and We have been provided with the documentation and information. We have requested to establish the circumstances of the claim, its quantum or Our liability for it.
2. We will only make payment to You under this Policy. In the event of Your death, We will make payment to the Nominee (as named in the Policy Schedule)/ legal heir as the case may be.
3. Payments under this Policy shall only be made in Indian Rupees.
4. Our liability to make payment under this policy will only begin when the Aggregate Deductible as mentioned in Schedule is exceeded.
5. All admissible claims shall be assessed basis following order:

   a. Basis of claim payment shall be aggregate of Medical expenses incurred for all hospitalization (s) incepting during each policy year payable under this Policy and which exceeds the Aggregate Deductible applicable per policy year basis as mentioned in the Policy Schedule.

   b. Any claim under this Policy shall be payable by Us only if the sum of the amount of covered Medical Expenses in respect to Hospitalization(s) of Insured Person (on Individual basis in case of Individual Policy and on Family Floater basis in case of Family Floater Policy) exceeds the Aggregate Deductible applicable on per year.

Note

In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents listed under condition and claim settlement advice, duly certified by the other insurer. .

7.6 Time limit for submission of claim documents to the Company/ TPA

i. Documents supporting the pre-hospitalization and hospitalization claim must be submitted within 30 days from the date of discharge from the Hospital.

ii. Documents supporting the post hospitalization claim must be submitted within 30 days from completion of post hospitalization treatment.

iii. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person.

iv. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer or reimbursement provider, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer or reimbursement provider.

7.7 Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as may be the case, 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 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 the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days the Insurer shall be liable to pay interest 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 lndia (RBI) at the beginning of the financial year in which claim has fallen due)

Reference link:

List of Blacklisted hospitals - https://www.rahejaqbe.com/hospital-locator

List of TPA - https://www.rahejaqbe.com/claims/health-claims

7.8 Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of the claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

7.9 Services Offered by TPA

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include

- Claim settlement and claim rejection;
- Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

7.10 Complete Discharge

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital/Nursing Home, as the case may be, for any benefit under the policy shall in all cases be a full, valid and effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

7.11 Disclaimer

If the Company shall disclaim liability to the insured person for any claim hereunder and if the insured person shall not within twelve calendar months from the date of receipt of the notice of such disclaimer notify the Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

7.12 Payment of Claim

All claims under the policy shall be payable in Indian currency and through NEFT/ RTGS/Cheque or DD only.

Conditions Precedent to the contract

7.13 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.

(Note: “Material facts” for the purpose of this policy shall mean all important, essential and relevant information sought by the company in the proposal form and other connected documents to enable him to take informed decision in the context of underwriting the risk)

7.14 **Condition Precedent to Admission of Liability**

The due observance and fulfilment of the terms and conditions of the Policy, by the insured person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the Policy.

7.15 No Constructive Notice

Any knowledge or information of any circumstances or condition in relation to the Insured Person which is in the possession of the Company other than that expressly disclosed in the Proposal Form or otherwise in writing to, shall not be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

7.16 Electronic Transactions

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

Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Insured. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated/ confirmed by the Insured.

Conditions applicable during Contract

7.17 Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and /or premium, if necessary, accordingly.

7.18 Notice & Communication

- Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
- Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
- The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

7.19 Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

7.20 Application of Aggregate Deductible

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed to pay and/or reimburse actual expenses incurred in excess of the Aggregate Deductible as specified in the Policy Schedule.

The company will pay for the Medical Expenses, in excess of aggregate deductible stated in the Policy Schedule on the aggregate of covered medical expenses exceeds the aggregate deductible applicable on policy per year basis depending upon the plan opted.

However, Our total liability under this Policy for payment of any and all Claims in aggregate during each Policy Year of the Policy Period shall not exceed the Sum Insured and Restored Sum Insured if any available to the Insured and stated in the Policy Schedule.

7.21 Multiple Policies

In case of multiple policies taken by an insured person during

i. 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 insurers 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.

7.22 Fraud

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

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

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

- the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
- the active concealment of a fact by the insured person having knowledge or belief of the fact;
- any other act fitted to deceive; and
- 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.

7.23 Grace Period

A Grace Period of 30 days is available for Renewal of the Policy. Any Illness, disease or condition contracted during Grace Period will not be covered and will be treated as Pre-existing diseases.

The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

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

Policies for which Premium is received after the Grace Period shall be considered as a fresh policy.

7.24 Premium Payment Options:

If the Insured Person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly, as mentioned in the Policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

- Grace Period of as per the following Days would be given to Pay the instalment premium due for the Policy.
- The Benefits provided under – “Waiting Periods”, “Specific Waiting Periods” Sections shall continue in the event of payment of Premium within the stipulated grace Period.
- No interest will be charged If the installment premium is not paid on due date.
- In case of installment premium due not received within the grace period, the Policy will get cancelled.

Options	**Instalment Premium Option**	**Grace Period Applicable**
Option 1	Yearly	30 Days
Option 2	Half Yearly	30 Days
Option 3	Quarterly	30 Days
Option 4	Monthly	15 Days

In case of failure of transaction in ECS mode of payment and/or instalment premium due not received within the grace period, the policy will get cancelled and fresh policy would be issued with fresh waiting periods after obtaining consent from the customer.

In case of change in terms and conditions of the policy contract or in premium rate, the ECS authorization shall be obtained afresh ensuring an informed choice to the policy holder.

The insurer can withdraw ECS mode of payment by giving 15 days" notice prior to the due date of premium payable.

All terms and conditions for this product is as per the Insurance Regulatory and Development Authority of India (Insurance Products) Regulations, 2024 read with Master Circular on IRDAI (Insurance Products) Regulations 2024 - Health Insurance or any amendment thereof from time to time in respect of break in policy.

7.25 Cancellation

a) The policyholder may cancel this policy by giving 7 days written notice.

b) In case the Policyholder requests cancellation of the Policy, where no claims are made under the Policy, the Company shall refund proportionate premium for the unexpired policy period on prorate basis.

c) In case the Policyholder requests for cancellation of the Policy, where there are claims made under the Policy, then there shall be no refund of premium for the unexpired policy period.

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

7.26 Group Administrator

The Group Administrator i.e. Policyholder shall take all reasonable steps to cover their members or employees of the company and ensure timely payment of premium in respect of the persons covered. The Group administrator will collect premium from members wherever applicable as mentioned in the Group/Master policy issued to the Group administrator. The Group administrator will neither charge more premium nor alter the scope of coverage offered under the Group/Master policy.

Group/Master policy will be issued to the group administrator and all members wherever required will be provided with the certificate of insurance by Us. We reserve the right to inspect the record at any time to ensure that terms and conditions of group policy and provisions of IRDAI group guidelines contained in circular ref: Master Circular on Operations and Allied Matters of Insurers 2024 - Health Insurance & Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024 and any amendments thereto are being adhered. We may also require submission of certificate of compliance from Your Group Administrator auditors.

The Group administrator will provide all possible help to its member and facilitate any service required under the Policy including claims. Notwithstanding this a member of the group covered under the Policy shall be free to contact Us directly for filing the claim or any assistance required under the Policy.

7.27 Automatic change in Coverage under the policy

The coverage for the Insured Person shall automatically terminate: In the case of his/ her (Insured Person) demise.

However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other Insured Persons may also apply to renew the Policy. In case, the Insured Person is minor, the Policy shall be renewed only through any one of his/her natural guardian or guardian appointed by Court. All relevant particulars in respect of such person (including his/her relationship with the Insured person) must be submitted to the Company along with the application. Provided no Claim has been made, and termination takes place on account of death of the Insured Person, pro-rata refund of premium of the deceased Insured Person for the balance period of the Policy will be effective. Upon exhaustion of sum insured and cumulative bonus, for the Policy year. However, the Policy is subject to renewal on the due date as per the applicable terms and conditions.

7.28 Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

7.29 Portability

The Insured Person will have the option to port the Policy to other insurers as per extant Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

The waiting periods specified in section 6 shall be reduced by the number

of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.

Portability benefit will be offered to the extant of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on portability, kindly refer the link
http://www.rahejaqbe.com/frontend/images/health- basic-guideline/pdf/download/Portability_Migration_Guideline.pdf

7.30 Renewal of Policy

The Policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person provided that the policy is not withdrawn and also subject to conditions stated under clause 7.32. The renewal premium shall be paid to the Company on or before the date of expiry of the Policy or of the subsequent renewal thereof.

i. The Company shall endeavor to give notice for renewal. However, the Company is not bound to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured 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 to maintain continuity of benefits without Breakin Policy. Coverage is not available during the grace period.
v. If not renewed within Grace Period after due renewal date, the Policy shall terminate.

7.31 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 before the changes are affected.

7.32 Withdrawal of Policy

The product will be withdrawn only after due approval from the Authority. We will inform the Policyholder in the event We may decide to withdraw the product.

In such cases, where Policy is falling due for Renewal within 90 days from the date of withdrawal, we will provide the Policyholder one time option to renew the existing Policy with us or migrate to modified or new suitable health insurance policy with Us. Any Policy falling due for Renewal after 90 days from the date of withdrawal will have to migrate to a modified or new suitable health insurance policy with Us.

Individual members will also have an option to opt for suitable health insurance Policy with Us subject to applicable Portability norms in vogue.

7.33 Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever the Sum Insured is enhanced, the completion of sixty continuous months would be applicable from date of enhancement of sums insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the Policy contract.

7.34 Free look period

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting the policy.

The insured shall be allowed a period of thirty days from date of receipt of the Policy, whether received electronically or otherwise, to review the terms and conditions of the Policy. If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. 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; or

ii. where the risk has already commenced and the option of return of the Policy is exercised by the insured, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period

7.35 Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved, evidenced by a written endorsement signed and stamped by the Company.

7.36 Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal, subject to underwriting by the Company. For any increase in Sum Insured, the waiting period shall start afresh for the incremental portion of the sum insured.

7.37 Terms and condition of the Policy

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document.

7.38 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 policy at least 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 below link.

Link: http://www.rahejaqbe.com/frontend/images/health-basic-guideline/pdf/download/Portability_Migration_Guideline.pdf

7.39 Nomination:

The policy holder 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 policy holder. 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. For claims settlement under reimbursement, the Company will pay the policy holder. In the event of death of policy holder, the company will pay the nominee (as named in the policy schedule/Policy Certificate/Endorsement if any)) and incase there is no subsisting nominee, to the legal heirs or legal representatives of the policy holder whose discharge shall be treated as full and final of its liability under the policy.

8. REDRESSAL OF GRIEVANCE

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

Website: www.rahejaqbe.com
Toll free: 1800-102- 7723 (9 am to 8 pm, Monday to Saturday)
E-mail: customercare@rahejaqbe.com
Telephone: 022 – 69155050

For Senior Citizen: 1800-102- 7723 (9 am to 8 pm, Monday to Saturday)
E-mail: seniorcitizencare@rahejaqbe.com

Courier: Any branch office or the correspondence address, during normal business hours

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:

RAHEJA QBE GENERAL INSURANCE COMPANY LIMITED
Fulcrum, 501 & 502, A Wing, 5th Floor, IA Project Road, Sahar
Andheri East, Mumbai 400059, India
Tel: 022 - 69155050

Website: www.rahejaqbe.com
Email: complaintsofficer@rahejaqbe.com

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://bimabharosa.irdai.gov.in/

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.

The contact details of Ombudsman offices are mentioned below:

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat, UT of Dadra and Nagar Haveli, Damanand Diu	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02 Email: oio.ahmedabad@cioins.co.in
Karnataka	Office of the Insurance Ombudsman, Jeevansoudha Building, PID No.57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru- 560078.Tel:080-26652048/26652049, Email: oio.bengaluru@cioins.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, 1st floor, Jeevan Shikha, 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462011. Tel.: 0755 - 2769201 / 2769202 / 2769203 Email: oio.bhopal@cioins.co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneswar - 750009. Tel.: 0674 - 2596461 /2596455/2596429/2596003 Email: oio.bhubaneswar@cioins.co.in

Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.	Office of the Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: oio.chandigarh@cioins.co.in
Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai 600018. Tel. 044 – 24333668/ 24333678. Email: oio.chennai@cioins.co.in
Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel: 011 - 46013992/ 23213504/23232481 Email: oio.delhi@cioins.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Near Pan Bazar, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 / 2631307 Email: oio.guwahati@cioins.co.in
Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Hyundai Showroom, A.C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325 Email: oio.hyderabad@cioins.co.in
Rajasthan	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363 Email: oio.jaipur@cioins.co.in
Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.	Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G. Road, Kochi - 682 011. Tel: 0484 – 2358759 Email: oio.ernakulam@cioins.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands.	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: oio.kolkata@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,	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: oio.lucknow@cioins.co.in

Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	
List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: oio.mumbai@cioins.co.in
State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	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: oio.noida@cioins.co.in
Bihar, Jharkhand	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: oio.patna@cioins.co.in
State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region	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.: 020-24471175 Email: oio.pune@cioins.co.in
Area of Navi Mumbai, Thane District, Raigad District, Palghar District and **wards of Mumbai**, M/East, M/West, N, S and T."	Office of the Insurance Ombudsman, 2nd Floor, Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West)- 400604 Tel. :022-20812868/69 Email: oio.thane@cioins.co.in

The details of Insurance Ombudsman are available on website:
https://www.cioins.co.in/Ombudsman
On the website of General Insurance Council: www.gicouncil.in and our website www.rahejaqbe.com or from any of the Our offices.

Annexure-I
Items for which optional cover may be offered by Insurers List I - Non Payable Items

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	HOSPITALIZATION 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