Heartbeat
Policy Terms & Conditions

1. Preamble

This 'Heartbeat' policy is a contract of insurance between You and Us which is subject to payment of full premium in advance and the terms, conditions and exclusions of this Policy. This Policy has been issued on the basis of the Disclosure to Information Norm, including the information provided by You in the Proposal Form and / or the Information Summary Sheet.

Please inform Us immediately of any change in the address or any other changes affecting You or any Insured Person which would impact the benefits, terms and conditions under this Policy.

In addition, please note the list of exclusions is set out in Section 7 of this Policy.

2. Definitions & Interpretation

For the purposes of interpretation and understanding of this Policy, We have defined, in Section 12, some of the important words used in the Policy which will have the special meaning accorded to these terms for the purposes of this Policy. For the remaining language and words used, the usual meaning as described in standard English language dictionaries shall apply. The words and expressions defined in the Insurance Act 1938, IRDA Act 1999, regulations notified by the IRDAI and circulars and guidelines issued by the IRDAI, together with their amendment shall carry the meanings given therein.

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

3. Benefits available under the Policy

The benefits available under this Policy are described below.

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

3.1 Inpatient Care

What is covered:

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

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

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

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

Associated Medical Expenses shall include Room Rent, nursing charges, Medical Practitioners' fees and operation theatre charges
c. We will pay the visiting fees or consultation charges for any Medical Practitioner visiting the Insured Person only if:
   i. The Medical Practitioner's treatment or advice has been specifically sought by the Hospital; and
   ii. The visiting fees or consultation charges are included in the Hospital's bill

3.2 Pre-hospitalization Medical Expenses

What is covered:

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

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

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

Sub-limit:

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

3.3 Post-hospitalization Medical Expenses

What is covered:

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

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

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

Sub-limit:

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

3.4 Day Care Treatment

What is covered:

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

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

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

What is not covered:

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

3.5 Domiciliary Hospitalization

What is covered:

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

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

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

3.6 Alternative Treatments

What is covered:

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

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

The treatment should be taken in AYUSH Hospital.

a. Pre-hospitalization Medical Expenses incurred for up to 60 days immediately preceding the Insured Person's admission and

Post-hospitalization Medical Expenses incurred for up to 90 days immediately following the Insured Person's discharge will also be indemnified under this benefit in accordance with Sections 3.2 and 3.3 above, provided that these Medical Expenses relate only to Alternative Treatments and not Allopathy.

b. Section 7.27 of the Permanent Exclusions (other than for Yoga) shall not apply to the extent this benefit is applicable.

3.7 Living Organ Donor Transplant

What is covered:

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

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

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

What is not covered:

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

3.8 Emergency Ambulance

What is covered:

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

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

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

What is not covered:

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

3.9 Maternity Benefit

What is covered:

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

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

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

What is not covered:

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

3.10 New Born Baby

What is covered:

We will cover the Medical Expenses incurred towards the medical treatment of the Insured Person's New Born Baby from the date of delivery until the expiry of the Policy Year, subject to continuous coverage of 24 months of that Insured Person since the inception of

the First Policy which offers Maternity Benefit with Us, without the requirement of payment of any additional premium

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

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

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

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

3.11 Health Check-up

What is covered:

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

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

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

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

What is not covered:

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

3.12 Re-fill Benefit

What is covered:

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

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

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

What is not covered:

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

3.13 Pharmacy and Diagnostic Services

What is covered:

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

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

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

3.14 Loyalty Additions

What is covered:

a. For an Individual Policy or Family Floater Policy, if the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year Policy Period respectively (if applicable), We will provide Loyalty Additions in the form of Cumulative Bonus by increasing the Sum Insured applicable under the Policy by 10% of the Base Sum Insured of the immediately preceding Policy Year subject to a maximum of a percentage as specified in the Policy Schedule. There will be no change in the sub-limits applicable to various benefits due to increase in Sum Insured under this benefit.
b. For a Family First Policy, if the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year Policy Period respectively (if applicable), We will provide Loyalty Additions in the form of Cumulative Bonus by

increasing the Sum Insured applicable under the Policy by 10% of the Base Sum Insured of the immediately preceding Policy Year of each individual Insured Person only subject to a maximum of a percentage as specified in the Policy Schedule. The increase shall not apply to the Floater Sum Insured stated in the Policy Schedule as applicable under the Policy. There will be no change in the sub-limits applicable to any benefit due to increase in Sum Insured under this benefit.

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

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

3.15 HIV / AIDS

What is covered:

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

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

a. The Hospitalization or Day Care Treatment is Medically Necessary and the Illness is the outcome of HIV / AIDS. This needs to be prescribed in writing by a registered Medical Practitioner.
b. The coverage under this benefit is provided for opportunistic infections which are caused due to low immunity status in HIV / AIDS resulting in acute infections which may be bacterial, viral, fungal or parasitic.
c. The patient should be a declared HIV positive.
d. This benefit is provided subject to a Waiting Period of 48 months from inception of the cover with Us, with HIV / AIDS covered as a benefit, for the respective Insured Person.
e. Pre-hospitalization Medical Expenses incurred for up to 60 days, if falling within the Policy Period, immediately preceding the Insured Person's admission and Post-hospitalization Medical Expenses incurred for up to 90 days, if falling within the Policy Period, immediately following the Insured Person's discharge will also be indemnified under this benefit as per Section 3.2 & Section 3.3 respectively.

What is not covered:

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

Sub-limit:

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

3.16 Emergency Assistance Services

What is covered:

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

a. **Medical referral:** Insured Person(s) will have tele-access to an operations center of Our Service Provider, who with their multilingual staff on duty 24(twenty-four) hours a day, 365(three hundred and sixty-five) days a year will provide reference of doctors in the vicinity where the Insured Person is located for medical consultations. This medical consultation is only facilitated by Us / Our Service Provider and is independent judgment of medical consultant. We do not assume any liability and shall not be deemed to assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the professional giving medical consultant.

b. **Emergency medical evacuation:** When an adequate medical facility is not available proximate to the Insured Person, as determined by the Insured Person's attending physician and agreed by Us / Our Service Provider, We/Our Service Provider will arrange and pay for ambulance services under appropriate medical supervision, by an appropriate mode of transport as decided by Us / Our Service Provider's consulting physician and patient's attending physician to the nearest medical facility capable of providing the required care.

c. **Medical repatriation:** We / Our Service Provider will arrange and pay for transportation under medical supervision to the Insured Person's residence or to a medical or rehabilitation facility near the Insured Person's residence (as mentioned in the Policy Schedule) when the Insured Person's attending physician determines that transportation is medically necessary and is agreed by Us / Our Service Provider, at such time as the Insured Person is medically cleared for travel by Us / Our Service Provider's consulting physician and Insured Person's attending physician.

d. **Compassionate visit:** When an Insured Person will be hospitalized for more than seven (7) consecutive days and has travelled without a companion or doesn't have a companion by his / her side, We / Our Service Provider will arrange and pay for travel of a family member or personal friend to visit such Insured Person by providing an appropriate means of transportation via economy carrier transportation as determined by Us / Our Service Provider. The family member or the personal friend is responsible to meet all travel document requirements, as may be applicable.

e. **Care and/or transportation of minor children:** One-way economy common carrier transportation, with attendants if required, will be provided to the place of residence of minor child(ren) when they are left unattended as a result of medical emergency or death of an Insured person.

f. **Return of mortal remains:** In the event of death of Insured Person, We/Our Service Provider will arrange and pay for the return of mortal remains to an authorized funeral home proximate to the Insured Person's legal residence.

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

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

What is not covered:

a. No claims for Reimbursement of expenses incurred for services arranged by Insured/Insured Person(s) will be entertained as the coverage under this section 3.16 are on Cashless Facility basis only.

b. Emergency assistance service will not be provided in the following instances:
   i. Travel undertaken specifically for securing medical treatment
   ii. Services sought outside India.
   iii. If Emergency is a result of injuries resulting from participation in acts of war or insurrection
   iv. Commission of unlawful act(s).
   v. Attempt at suicide /self-inflicted injuries.
   vi. Incidents involving the use of drugs, unless prescribed by a physician
   vii. Transfer of the insured person from one medical facility to another medical facility of similar capabilities and providing a similar level of care

c. We / Our Service Provider will not evacuate or repatriate an insured person in the following instances:
   i. Without medical authorization from attending physician
   ii. With mild lesions, simple injuries such as sprains, simple fractures, or mild sickness or similar such conditions which can be treated by local doctors and do not prevent Insured Person(s) from continuing your trip or returning home as determined by Us / Our Service Provider's consulting physician and the Insured Person's attending physician
   iii. If the Insured Person is pregnant and beyond the end of the 28th week and with respect to the child born from the pregnancy, We / Our Service Provider shall not evacuate or repatriate the Insured Person and the child who was born while the Insured Person was traveling beyond the 28th week
   iv. With mental or nervous disorders unless hospitalized

d. Specific exclusions:
   i. Trips exceeding 90(ninety) days from declared residence.

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

3.17 Mental Disorders Treatment

What is covered:

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

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

a. Mental Disorders Treatment is only covered where patient is diagnosed by a qualified psychiatrist or a professional registered with the concerned State Authority or a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post-graduate degree (Siddha) in Sirappu Maruthuvam.
b. The Hospitalization is for Medically Necessary Treatment.
c. The treatment should be taken in Mental Health Establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person, where persons with mental illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person; but does not include a family residential place where a person with mental illness resides with his relatives or friend.
d. The Insured Person in respect of whom a claim for any expenses or complications arising from Mental Illness is made must have been covered as an Insured Person for a period of 36 months of continuous coverage since the inception of the First Policy, with Mental Illness as a benefit, with Us.
e. Pre-hospitalization Medical Expenses incurred for up to 60 days, if falling within the Policy Period, immediately preceding the Insured Person's admission and Post-hospitalization Medical Expenses incurred for up to 90 days, if falling within the Policy Period, immediately following the Insured Person's discharge will also be indemnified under this benefit as per Section 3.2 & Section 3.3 respectively.

What is not covered:

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

Sub-limit:

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

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

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

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

3.18 Second Medical Opinion

What is covered:

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

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

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

What is not covered:

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

3.19 Child care Benefits

What is covered:

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

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

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

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

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

What is covered:

If an Insured Person suffers a Specified Illness as defined under Section 12.72 during the Policy Period, We will indemnify the Reasonable and Customary Charges for Medical Expenses of the Insured Person incurred towards treatment of that Specified Illness that would otherwise have been payable under Section 3.1 (Inpatient Care), on Cashless Facility basis only.

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

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

What is not covered:

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

3.21 OPD Treatment and Diagnostic Services

What is covered:

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

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

a. Expenses under this benefit are covered for ayurvedic or homeopathic or unani or sidha or allopathic services only.
b. For treatment taken under ayurveda, homeopathy, unani or sidha (AYUSH), expenses are covered only if taken in a government Hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health.
c. The OPD Treatment and/or Diagnostic Services are Medically Necessary and follow the written advice of a Medical Practitioner.

d. Diagnostic Services are performed on an outpatient basis with or without local anesthetics for topical, infiltration, nerve block anesthesia and require Hospitalization for less than 24 hours.
e. If the Policy is Renewed with Us without any break and there is a unutilized amount (not used by the Insured Person) under the applicable sub-limit (as specified in the Product Benefits Table) in a Policy Year, then We will carry forward 80% of this unutilized amount to the immediately succeeding Policy Year, provided that the total amount (including the unutilized amount available under this Benefit) shall at no time exceed 2.5 times the amount of the entitlement in respect of this Benefit under the Plan applicable to the Insured Person.

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

What is covered:

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

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

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

What is not covered:

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

3.23 Emergency Hospitalization (outside the geographical boundaries of India)

What is covered:

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

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

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

3.24 Modern Treatments

What is covered:

a. The following procedures / treatments will be covered either as Inpatient Care or as part of Day Care Treatment as per Section 3.1 and Section 3.4 respectively, in a Hospital :
   i. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
   ii. Balloon Sinuplasty
   iii. Deep Brain stimulation
   iv. Oral chemotherapy
   v. Immunotherapy- Monoclonal Antibody to be given as injection
   vi. Intra vitreal injections
   vii. Robotic surgeries
   viii. Stereotactic radio surgeries
   ix. BronchicalThermoplasty
   x. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
   xi. IONM - (Intra Operative Neuro Monitoring)
   xii. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.
b. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with Sections 3.2 and 3.3 within the overall benefit sub-limit.

Special condition applicable for robotic surgeries:
A limit of maximum INR 1 Lac will apply to all robotic surgeries, except the following:

i. Robotic total radical prostatectomy
ii. Robotic cardiac surgeries
iii. Robotic partial nephrectomy
iv. Robotic surgeries for malignancies

4. Optional Benefits

The following optional benefits shall apply under the Policy only if it is specified in the Policy Schedule. Optional benefits can be selected by You only at the time of issuance of the First Policy or at Renewal on payment of the corresponding additional premium.

The optional benefits 'Personal Accident Cover', 'Critical Illness Cover' and 'Hospital Cash' will be payable (only on Reimbursement basis) if the conditions mentioned in the below sections are contracted or sustained by the Insured Person covered under these optional benefits during the Policy Period.

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

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

4.1 Personal Accident Cover

What is covered:

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

a. Accident Death (AD)

What is covered:

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

b. Accident Permanent Total Disability (APTD)

What is covered:

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

i. Loss of use of limbs or sight
The Insured Person suffers from total and irrecoverable loss of:
   1. The use of two limbs (including paraplegia and hemiplegia) OR
   2. The sight in both eyes OR
   3. The use of one limb and the sight in one eye

ii. Loss of independent living
The Insured Person is permanently unable to perform independently three or more of the following six activities of daily living.
   1. Washing: the ability to maintain an adequate level of cleanliness and personal hygiene.
   2. Dressing: the ability to put on and take off all necessary garments, artificial limbs or other surgical appliances that are medically necessary.
   3. Feeding: the ability to transfer food from a plate or bowl to the mouth once food has been prepared and made available.
   4. Toileting: the ability to manage bowel and bladder function, maintaining an adequate and socially acceptable level of hygiene.
   5. Mobility: the ability to move indoors from room to room on level surfaces at the normal place of residence.
   6. Transferring: the ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa.

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

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

c. Accident Permanent Partial Disability (APPD)

What is covered:

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

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

i. The Permanent Partial Disability is proved through a disability certificate issued by a Medical Board duly constituted by the Central and/or the State Government; and
ii. We will admit a claim under this optional benefit only if the Permanent Partial Disability continues for a period of at least

6 continuous calendar months from the commencement of the Permanent Partial Disability, unless it is irreversible; and

iii. If the Insured Person dies before a claim has been admitted under this optional benefit, no amount will be payable under this optional benefit, however We will consider the claim under Section 4.1.a (Accident Death) subject to the terms and conditions mentioned therein.

iv. If a claim under this optional benefit has been admitted, then no further claim in respect of the same condition will be admitted under this optional benefit.

v. If a claim under this optional benefit is paid and the entire Personal Accident Sum Insured specified in the Policy Schedule does not get utilized, then the balance Personal Accident Cover Sum Insured shall be available for further claims under Section 4.1 (Personal Accident Cover) until the entire Personal Accident Cover Sum Insured is consumed. The Personal Accident Cover Sum Insured specified in the first Policy Schedule shall be a lifetime limit for the Insured Person and once this limit is exhausted, coverage for the Insured Person will immediately and automatically cease under Section 4.1 (Personal Accident Cover) and this optional benefit shall not be applied in respect of that Insured Person on any Renewal thereafter. However, other applicable benefits can be Renewed in respect of the Insured Person

Permanent Partial Disability Grid

S. No.	Nature of Disability	% of Personal Accident Cover Sum Insured payable
1	Loss or total and permanent loss of use of both the hands from the wrist joint	100%
2	Loss or total and permanent loss of use of both feet from the ankle joint	100%
3	Loss or total and permanent loss of use of one hand from the wrist joint and of one foot from the ankle joint	100%
4	Loss or total and permanent loss of use of one hand from the wrist joint and total and permanent loss of sight in one eye	100%
5	Loss or total and permanent loss of use of one foot from the ankle joint and total and permanent loss of sight in one eye	100%
6	Total and permanent loss of speech and hearing in both ears	100%
7	Total and permanent loss of hearing in both ears	50%
8	Loss or total and permanent loss of use of one hand from wrist joint	50%
9	Loss or total and permanent loss of use of one foot from ankle joint	50%
10	Total and permanent loss of sight in one eye	50%
11	Total and permanent loss of speech	50%
12	Permanent total loss of use of four fingers and thumb of either hand	40%
13	Permanent total loss of use of four fingers of either hand	35%
14	Uniplegia	25%
15	Permanent total loss of use of one thumb of either hand	
	a. Both joints	25%
	b. One joint	10%
16	Permanent total loss of use of fingers of either hand	
	a. Three joints	10%
	b. Two joints	8%
	c. One joint	5%
17	Permanent total loss of use of toes of either foot	
	a. All toes- one foot	20%
	b. Great toe- both joints	5%
	c. Great toe- one joint	2%
	d. Other than great toe, one toe	1%

4.2 Critical Illness Cover

What is covered:

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

a. Cancer of Specified Severity

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

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

b. Myocardial Infarction

(First Heart Attack of specific severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
   i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
   ii. New characteristic electrocardiogram changes
   iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

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

c. Open Chest CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

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

d. Open Heart Replacement or Repair of Heart Valves

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

e. Coma of Specified Severity

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
   i. no response to external stimuli continuously for at least 96 hours;
   ii. life support measures are necessary to sustain life; and
   iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

f. Kidney Failure requiring Regular Dialysis

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

g. Stroke resulting in Permanent Symptoms

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:
   i. Transient ischemic attacks (TIA)
   ii. Traumatic injury of the brain
   iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

h. Major Organ /Bone Marrow Transplant

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

II. The following are excluded:
    i. Other stem-cell transplants
    ii. Where only islets of langerhans are transplanted

i. Permanent Paralysis of Limbs

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

j. Motor Neuron Disease with Permanent Symptoms

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

k. Multiple Sclerosis with Persisting Symptoms

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

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

l. Deafness

I. Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing" in both ears.

m. End Stage Lung Failure

I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
    i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
    ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
    iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
    iv. Dyspnea at rest.

n. End Stage Liver Failure

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
    i. Permanent jaundice; and
    ii. Ascites; and
    iii. Hepatic encephalopathy.

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

o. Loss of Speech

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

II. All psychiatric related causes are excluded

p. Third Degree Burns

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

q. Fulminant Viral Hepatitis

I. A sub-massive to massive necrosis of the liver by any virus, leading precipitously to liver failure.
This diagnosis must be supported by all of the following:
    i. rapid decreasing of liver size; and
    ii. necrosis involving entire lobules, leaving only a collapsed reticular framework; and
    iii. rapid deterioration of liver function tests; and
    iv. deepening jaundice; and
    v. hepatic encephalopathy.
    Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria

r. Aplastic Anemia

I. Aplastic Anemia is chronic persistent bone marrow failure. A certified hematologist must make the diagnosis of severe irreversible aplastic anemia. There must be permanent bone marrow failure resulting in bone marrow cellularity of less than 25% and there must be two of the following:
    i. Absolute neutrophil count of less than 500/mm^3
    ii. Platelets count less than 20,000/mm^3
    iii. Reticulocyte count of less than 20,000/mm^3
    The Insured Person must be receiving treatment for more than 3 consecutive months with frequent blood product transfusions, bone marrow stimulating agents, or immunosuppressive agents or the Insured Person has received a bone marrow or cord blood stem cell transplant. Temporary or reversible Aplastic Anemia is excluded and not covered under this Policy

s. Muscular Dystrophy

I. Muscular Dystrophy is a disease of the muscle causing progressive and permanent weakening of certain muscle groups. The diagnosis of Muscular Dystrophy must be made by a consultant neurologist, and confirmed with the appropriate laboratory, biochemical, histological, and electromyography evidence. The disease must result in the permanent inability of the Insured Person to perform (whether aided or unaided) at least three (3) of the six (6)"Activities of Daily Living".
Activities of Daily Living are defined as:
    a. Washing : the ability to maintain an adequate level of cleanliness and personal hygiene
    b. Dressing : the ability to put on and take off all necessary garments, artificial limbs or other surgical appliances that are Medically Necessary

c. Feeding : the ability to transfer food from a plate or bowl to the mouth once food has been prepared and made available
d. Toileting : the ability to manage bowel and bladder function, maintaining an adequate and socially acceptable level of hygiene
e. Mobility : the ability to move indoors from room to room on level surfaces at the normal place of residence
f. Transferring: the ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa

t. Bacterial Meningitis

I. Bacterial meningitis is a bacterial infection of the meninges of the brain causing brain dysfunction. There must be an unequivocal diagnosis by a consultant physician of bacterial meningitis that must be proven on analysis and culture of the cerebrospinal fluid. There must also be permanent objective neurological deficit that is present on physical examination at least 3 months after the diagnosis of the meningitis infection.

Conditions applicable to 'Critical Illness cover':

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

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

a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first Policy with Us.
b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under the Policy after the expiry of 48 months for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

ii. 90 day Initial Waiting Period

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

4.3 e-Consultation

What is covered:

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

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

a. e-Consultation shall be requested through Our call centre or website chat.
b. e-Consultation will be arranged by Us (without any liabilities) and will be based solely on the information provided by the Insured Person.
c. e-Consultation must not be considered a substitute to medical opinion or advise nor shall be same pursued over a medical advice or opinion given by treating physician or doctor
d. By seeking e-Consultation under this benefit, the Insured Person is not prohibited or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.
e. The Insured Person is free to choose whether or not to obtain the e-Consultation, and if obtained then whether or not to act on it in whole or in part.

f. e-Consultation under this benefit shall not be valid for any medico-legal purposes.
g. We do not represent correctness of e-Consultation and shall not assume or deem to assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

4.4 Premium Waiver

What is covered:

If the Policyholder (who should also be an Insured Person) dies or is diagnosed or undergoes treatment for the first time, with any of the Specified Illness as mentioned under Section 12.72 during the Policy Period, the cover under the Policy shall be automatically extended for a tenure of 1 Policy Year starting from the end of that Policy Period.

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

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

What is not covered:

a. This benefit is not available under Individual Policy.

4.5 Hospital Cash

What is covered:

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

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

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

4.6 Enhanced Geographical Scope for International Coverage

What is covered:

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

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

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

5. Claim Cost Sharing Option / Conditions

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

5.1 Co-payment

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

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

5.2 Annual Aggregate Deductible

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

It is further agreed that:

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

6. Waiting Periods

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

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

6.1 Pre-existing Diseases (Code-Excl01):

a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months (under gold & platinum Plans)/ 48 months (under Silver Plans) of continuous coverage after the date of inception of the first Policy with Us.
b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under the Policy after the expiry of 24 months (under gold & platinum Plans)/ 48 months (under Silver Plans) for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

6.2 30-day Waiting Period (Code-Excl03)

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

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

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

a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident (covered from day 1 or Cancer (covered after 30-day waiting period).
b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI then waiting period for the same would be reduced to the extent of prior coverage.
f. List of specific diseases/procedures:
    a. Pancreatitis and Stones in Biliary and Urinary System,
    b. Cataract, Glaucoma and other disorders of lens, disorders of Retina,
    c. Hyperplasia of Prostate, Hydrocele and spermatocele,
    d. Abnormal Utero-vaginal bleeding, female genital Prolapse, Endometriosis/Adenomyosis, Fibroids, PCOD, or any condition requiring dilation and curettage or Hysterectomy,
    e. Hemorrhoids, Fissure or Fistula or Abscess of anal and rectal region,
    f. Hernia of all sites,
    g. Osteoarthritis, Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, inflammatory Polyarthropathies, Arthrosis such as RA, Gout, Intervertebral Disc disorders,
    h. Chronic kidney disease and failure,
    i. Varicose veins of lower extremities,
    j. Disease of middle ear and mastoid including Otitis Media, Cholesteatoma, Perforation of Tympanic Membrane,
    k. All internal or external benign or In Situ Neoplasms/Tumours, Cyst, Sinus, Polyp, Nodules, Swelling, Mass or Lump,
    l. Ulcer, Erosion and Varices of Upper Gastro Intestinal Tract,
    m. Tonsils and Adenoids, Nasal Septum and Nasal Sinuses,
    n. Internal Congenital Anomaly.

6.4 Personal Waiting Periods:

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

7. Permanent Exclusions

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

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

7.1 Investigation & Evaluation (Code-Excl04)

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

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

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

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

7.3 Obesity/ Weight Control (Code-Excl06)

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

a. Surgery to be conducted is upon the advice of the Doctor.
b. The surgery/Procedure conducted should be supported by clinical protocols.
c. The member has to be 18 years of age or older and;
d. Body Mass Index (BMI);
    i. greater than or equal to 40 or
    ii. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

1. Obesity-related cardiomyopathy
2. Coronary heart disease
3. Severe Sleep Apnea
4. Uncontrolled Type2 Diabetes

7.4 Change-of-Gender treatments (Code-Excl07)
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

7.5 Cosmetic or plastic Surgery (Code-Excl08)
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

7.6 Hazardous or Adventure sports (Code-Excl09)
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

7.7 Breach of law (Code-Excl10)
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

7.8 Excluded Providers (Code-Excl11)
Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our website / notified to the Policyholders are not admissible. However, in case of life threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.

The complete list of excluded providers can be referred to on our website.

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

7.10 Treatments received in 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)**

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

7.12 Refractive Error (Code-Excl15)
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

7.13 Unproven Treatments (Code-Excl16)
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

7.14 Sterility and Infertility (Code-Excl17)
Expenses related to sterility and infertility. This includes:
a. Any type of contraception, sterilization
b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c. Gestational Surrogacy
d. Reversal of sterilization

7.15 Maternity (Code-Excl18)
a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization) except ectopic pregnancy;
b. Expenses towards miscarriage (unless due to an Accident) and lawful medical termination of pregnancy during the Policy Period.

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

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

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

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

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

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

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

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

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

7.25 Unrecognized Physician or Hospital:

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

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

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

7.27 AYUSH Treatment

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

7.28 Permanent Exclusions for Personal Accident Cover

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

a. Suicide or self inflicted Injury, whether the Insured Person is medically sane or insane.
b. Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism.
c. Service in the armed forces, or any police organization, of any country at war or at peace or service in any force of an international body or participation in any of the naval, military or air force operation during peace time.
d. Any change of profession after inception of the Policy or any Renewal which results in the enhancement of Our risk, if not accepted and endorsed by Us on the Policy Schedule.
e. Committing an assault, a criminal offence or any breach of law with criminal intent.
f. Taking or absorbing, accidentally or otherwise, any intoxicating liquor, drug, narcotic, medicine, sedative or poison, except as prescribed by a Medical Practitioner other than the Policyholder or an Insured Person.
g. Participation in aviation/marine activities (including crew) other than as a passenger in an aircraft/water craft that is authorized by the relevant regulations to carry such passengers between established airports or ports.
h. Engaging in or taking part in professional/adventure sports or any hazardous pursuits, speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving, polo, snow and ice sports, hunting.
i. Body or mental infirmity or any Illness except where such condition arises directly as a result of an Accident during the Policy Period. However this exclusion is not applicable to claims made under Section 4.1.c (Permanent Partial Disability).

7.29 Permanent Exclusions for Critical Illness Cover

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

1. AYUSH Treatment:

Any covered Critical Illnesses diagnosed and/or treated by a Medical Practitioner who practices AYUSH Treatment.

2. Conflict & Disaster:

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

3. External Congenital Anomaly:

Screening, counseling or treatment related to External Congenital Anomaly.

4. Cosmetic or plastic Surgery (Code-Excl08)

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

5. Unproven Treatments (Code-Excl16)

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

6. Hazardous or Adventure sports (Code-Excl09)

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

7. Sterility and Infertility (Code-Excl17)

Expenses related to sterility and infertility. This includes:

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

8. Maternity (Code-Excl18)

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

9. Sexually transmitted Infections & Diseases:
Screening, prevention and treatment for sexually related infection or disease.

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

11. Breach of law (Code-Excl10)
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

12. Treatments received in 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)**

13. Unrecognized Physician or Hospital:

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

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

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

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

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

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

i. Process for Obtaining Pre-Authorization

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

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

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

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

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

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

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

In case of preauthorization request where chronicity of condition is not established as per clinical evidence based information, We may

reject the request for preauthorization and ask the claimant to claim as Reimbursement. Claim document submission for Reimbursement shall not be deemed as an admission of Our liability.

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

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

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

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

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

8.3 Claims Documentation:

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

For medical claims – Cashless Facility:
We will be provided these documents by the Network Provider immediately following the Insured Person's discharge from Hospital.

Necessary information and documentation for medical claims

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

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

For Personal Accident claims
Additional claim documentation for Personal Accident Cover under Section 4.1:

a. Accident Death
    i. Copy of death certificate (issued by the office of Registrar of Births and Deaths or any other authorized legal institution)
    ii. Copy of post mortem report wherever applicable

b. Accident Permanent Total Disability or Accident Permanent Partial Disability
    i. Certificate of disability issued by a Medical Board duly constituted by the Central and/or the State Government.

For Critical Illness claims
Additional claim documentation for Critical Illness Cover under Section 4.2:

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

For claims outside India
Additional claim documentation for claims incurring outside India:

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

8.4 Claims Assessment & Repudiation:

a. At Our discretion, We may investigate claims to determine the validity of a claim. All costs of investigation will be borne by Us and all investigations will be carried out by those individuals/ entities that are authorized by Us in writing.
b. Payment for Reimbursement claims will be made to You. In the unfortunate event of Your death, We will pay the Nominee named in the Policy Schedule or Your legal heirs or legal representatives holding a valid succession certificate.
c. We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person had taken reasonable care, or that is brought about or contributed to by the Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.
d. If a claim is made which extends in to two Policy Periods, then such claim shall be paid taking into consideration the available Sum Insured in these Policy Periods. Such eligible claim amount will be paid to the Policyholder/Insured Person after deducting the extent of premium to be received for the Renewal/due date of premium of the Policy, if not received earlier.
e. All admissible claims under this Policy shall be assessed by Us in the following progressive order:-
    i. If a room has been opted in a Hospital for which the room category is higher than the eligible limit as applicable for that Insured Person as specified in the Policy Schedule, then the Associated Medical Expenses payable shall be pro-rated as per the applicable limits in accordance with Section 3.1.
    ii. The Deductible (if applicable) shall be applied to claims that are either paid or payable under this Policy. Our liability to make payment shall commence only once the amount of eligible claims as per policy terms and conditions exceeds the Deductible limit within the same Policy Year.
    iii. Co-payment (if applicable) as specified in the Policy Schedule shall be applicable on the amount payable by Us.
f. The claim amount assessed in Section 8.4 f above would be deducted from the amount mentioned against each benefit and Sum Insured as specified in the Policy Schedule.

8.5 Delay in Claim Intimation or Claim Documentation:

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

8.6 Claims process for Section 4.3 (e-Consultation):

After validation of Insured Person and Policy details, We will evaluate the information of the Insured Person from the perspective to check eligibility of cover only and if the request is approved, We will facilitate arrangement as per the conditions specified under respective benefits admissible to the Insured Person.

8.7 Claim process for Section 3.11 (Health Checkup)

a. The Insured Person shall seek appointment by contacting Our Service Provider.
b. Our Service Provider will facilitate Your appointment.
c. Reports of the medical tests can be collected directly from the Service Provider.

8.8 Claims process for Section 3.16.b and Section 3.22 (Emergency Medical Evacuation)

a. In the event of an Emergency, Our Service Provider shall be contacted immediately on the helpline number specified in the Insured Person's health card.
b. Our Service Provider will evaluate the necessity for evacuation of the Insured Person and if the request for Medical Evacuation is approved by Us, the Service Provider shall pre-authorise the type of travel that can be utilized to transport the Insured Person and provide information on the Hospital that may be approached for medical treatment of the Insured Person.
c. If the Service Provider pre-authorises the Medical Evacuation of the Insured Person by means of Air Transportation through an air ambulance or commercial flight whichever is best suited, the Service Provider shall also arrange for the same to be provided to the Insured Person unless there are any logistical constraints or the medical condition of the Insured Person prevents Emergency Medical Evacuation.
d. It is agreed and understood that We shall not cover any claims for Reimbursement of the costs incurred in the evacuation or transportation of the Insured Person or which are not pre-authorized by Our Service Provider.

8.9 Claim process for Section 3.18 (Second Medical Opinion)

a. In the event of submission of request for Second Medical Opinion, Our Service Provider shall be contacted immediately on the helpline number specified in the Insured Person's health card.
b. Our Service Provider will evaluate the information of the Insured Person and if the request for Second Medical Opinion is approved, the Service Provider will facilitate arrangement as per conditions specified in the Section 3.18

8.10 Claim process for Section 3.20 (Specified Illness Cover)

a. In the event of the diagnosis of a Specified Illness, the Insured Person should call Us immediately and in any event before the commencement of the travel for treatment overseas on the helpline number specified on in the Insured Person's health card, requesting for a pre-authorization for the treatment.
b. We will evaluate the request and the eligibility of the Insured Person's Policy and call for more information or details, if required.
c. We will communicate directly to the Service Provider and the Insured Person whether the request for pre-authorization has been approved or denied.
d. If the pre-authorization request is approved, Our Service Provider will directly settle the claim with the Hospital. Any additional costs or expenses incurred by or on behalf of the Insured Person beyond the limits pre-authorized by the Service Provider or at any Non-Network Hospital shall be borne by the Insured Person.
e. This benefit is available only as Cashless Facility through pre-authorization by Us.

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

a. The health card We provide will enable the Insured Person to access medical treatment at any Network Provider outside India, but within those regions specified in the Policy Schedule, on a cashless basis only by the production of the card to the Network

Provider prior to admission, subject to the following:

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

9. Portability

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

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

10. 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 atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

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

11. General Terms and Conditions

11.1 Free Look Period

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

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

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

a. 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
b. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
c. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period

11.2 Cancellation

I. The policyholder may cancel this policy by giving 30 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

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

1 year		2 years	
Policy in-force up to	**Refund Premium (%)**	**Policy in-force up to**	**Refund Premium (%)**
Up to 30 days	75%	Up to 30 days	87.5%
31 to 90 days	50%	31 to 90 days	75%
91 to 180 days	25%	91 to 180 days	62.5%
exceeding 180 days	0%	181 to 365 days	50%
		366 to 455 days	25%
		456 to 545 days	12%
		Exceeding 545 days	0%

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

11.3 Automatic Cancellation

Individual Policy:

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

For Family Floater Policies:

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

Refund:

A refund in accordance with the table in Section 11.2 (I) shall be payable if there is an automatic cancellation of the Policy provided that no claim has been made and e-consultation, Health Check-up, Emergency Assistance Services or Second Medical Opinion have not been availed under the Policy by or on behalf of any Insured Person. We will pay the refund of premium to the Nominee named in the Policy Schedule or Your legal heirs or legal representatives holding a valid succession certificate.

11.4 Loading on Premium

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

11.5 Renewal of Policy

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

I. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
II. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
III. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
IV. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
V. No loading shall apply on renewals based on individual claims experience.

11.6 Other Renewal Conditions:

a. Continuity of benefits on Timely Renewal:

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

b. Reinstatement:

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

c. Disclosures on Renewal:

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

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

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

e. Addition of Insured Persons on Renewal:

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

f. Changes to Sum Insured on Renewal:

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

11.7 Change of Policyholder

a. The Policyholder may be changed only at the time of Renewal. The new Policyholder must be a member of the Insured Person's immediate family. Such change would be solely subject to Our discretion and payment of premium by You. The Renewed Policy shall be treated as having been Renewed without break. The Policyholder may be changed upon request in case of Your death, Your emigration from India or in case of Your divorce during the Policy Period.

b. Any alteration in the Policy due to unavoidable circumstances as in case of the Policyholder's death, emigration or divorce during the Policy Period should be reported to Us immediately.
c. Renewal of such Policies will be according to terms and conditions of existing Policy.

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

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

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

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

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

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

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

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

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

11.14 Notices
Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to:
a. You/the Insured Person at the address specified in the Policy Schedule or at the changed address of which We must receive written notice.
b. Us at the following address:
Max Bupa Health Insurance Company Limited
C-98, Lajpat Nagar 1, Delhi-110024
Fax No.: 011-3090-2010
c. No insurance agents, brokers or other person/entity is authorized to receive any notice on Our behalf.
d. In addition, We may send You/the Insured Person other information through electronic and telecommunications means with respect to Your Policy from time to time.

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

11.16 Zonal pricing
For the purpose of calculating premium for silver and gold plan, following zones are available:
- Zone 1: All India coverage
- Zone 2: All India coverage (Co-payment applicable for Mumbai (including Navi Mumbai & Thane), Delhi NCR, Kolkata & Gujarat State).

If You select Zone 2, then 20% Co-payment will apply for treatment in Mumbai (including Navi Mumbai & Thane), Delhi NCR, Kolkata & Gujarat State. This Zone-wise Co-payment shall not be applicable to any claim under Section 3.11 (Health Check-up), Section 3.13 (Pharmacy and diagnostic services), Section 3.16 (Emergency Assistance Services), Section 3.18 (Second Medical Opinion), Section 3.20 (Specified Illness cover), Section 3.21 (OPD Treatment and Diagnostic Services), Section 4.1 (Personal Accident Cover), Section 4.2 (Critical Illness Cover), Section 4.3 (e-Consultation), Section 4.4 (Premium Waiver) and Section 4.5 (Hospital Cash).

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

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

- Zone 1: Delhi (NCR), Surat, Kolkata, Mumbai (including Navi Mumbai & Thane)
- Zone 2: Pune, Ludhiana, Jaipur
- Zone 3: Rest of India

Note: Zone based Co-payment is not applicable for platinum plan.

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

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

11.18 Withdrawal of Policy

I. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

II. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

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11.19 Redressal of Grievances:

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

Website: www.maxbupa.com

Customer Helpline No: 1860-500-8888

E-mail: customercare@maxbupa.com (Senior citizens may write to us at: seniorcitizensupport@maxbupa.com)

Fax : 011-3090-2010

Courier: Customer Services Department
Max Bupa Health Insurance Company Limited
C-98, Lajpat Nagar 1, Delhi-110024

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

Head – Customer Services
Max Bupa Health Insurance Company Limited
C-98, Lajpat Nagar 1, Delhi-110024
Customer Helpline No: 1860-500-8888
Fax No.: 011-3090-2010
Email ID: customercare@maxbupa.com

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

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

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

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

11.20 Assignment

The Policy can be assigned subject to applicable laws.

11.21 Claim settlement (Provision for Penal interest)

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

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

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

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

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

11.22 Moratorium Period

After completion of eight continuous years under the Policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first Policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the Policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the Policy contract.

11.23 Multiple Policies

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

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

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

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

11.24 Disclosure of Information

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

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

11.25 Condition Precedent to Admission of Liability

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

12. Defined Terms

The terms listed below in Section 12 and used elsewhere in the Policy in Initial Capitals shall have the meaning set out against them in Section 12.

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

12.2 Age means age as on last birthday.

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

12.4 AYUSH Hospital:

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

a. Central or State Government AYUSH Hospital; or
b. Teaching Hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council of Homeopathy; or
c. AYUSH Hospital, standalone or co-located with In-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
   i. Having at least 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

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

12.6 Base Sum Insured means the amount stated in the Policy Schedule.

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

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

12.8 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.

12.9 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.

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

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

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

12.12 Critical Illness, an Illness, medical event or Surgical Procedure specifically defined in Section 4.2.

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

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

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

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

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

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

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

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

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

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

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

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

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

12.21 Emergency Assistance Service Provider means the licensed entity which will provide identified emergency medical assistance and personal services to people travelling more than 150(one hundred and fifty) kilometers from their declared place of residence in India.

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

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

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

a. Insured Person; and/or
b. Insured Person's legally married spouse (for as long as she/he continues to be married to the Insured Person); and/or
c. Insured Person's children who are less than 21 years of Age on the commencement of the Policy Period (a maximum 4 children can be covered under the Policy as Insured Persons).

12.25 Family First Policy means a Policy described as such in the Policy Schedule where You and Your family members named in the Policy Schedule are insured under this Policy. Only the following family members can be covered under a Family First Policy:

a. Your legally married spouse for as long as Your spouse continues to be married to You;
b. Son;
c. Daughter-in-law as long as Your son continues to be married to Your Daughter-in-law;
d. Daughter;
e. Son-in-law as long as Your daughter continues to be married to Your Son-in-law;
f. Father;
g. Mother;
h. Father-in-law as long as Your spouse continues to be married to You;
i. Mother-in-law as long as Your spouse continues to be married to You;
j. Grandfather;
k. Grandmother;
l. Grandson;
m. Granddaughter;
n. Brother;
o. Sister;
p. Sister-in-law;
q. Brother-in-law;
r. Nephew;
s. Niece.

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

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

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

a. has Qualified Nursing staff under its employment round the clock;
b. has at least 10 Inpatient beds in towns having a population of less than 10,00,000 and at least 15 Inpatient beds in all other places;
c. has qualified Medical Practitioner(s) in charge round the clock;

d. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

12.29 Hospital (outside India) means an institution (including nursing homes) established outside India for Inpatient medical care and treatment of sickness and injuries which has been registered and licensed as such with the appropriate local or other authorities in the relevant area, wherever applicable, and is under the constant supervision of a Medical Practitioner. The term Hospital shall not include a clinic, rest home, or convalescent home for the addicted, detoxification centre, sanatorium, old age home.

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

12.31 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.

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

(a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
(b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
   i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
   ii. it needs ongoing or long-term control or relief of symptoms
   iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
   iv. it continues indefinitely
   v. it recurs or is likely to recure

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

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

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

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

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

12.38 IRDAI means the Insurance Regulatory and Development Authority of India.

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

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

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

12.42 Maternity Expense shall include:

a. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization);
b. Expenses towards lawful medical termination of pregnancy during the Policy Period.

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

12.44 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.

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

Only for the purposes of any claim or treatment permitted to be made or taken outside India, Medical Practitioner shall mean a general practitioner, surgeon, anaesthetist or physician who:

a. holds a degree of a recognized institute; and
b. is registered with a Medical Council or equivalent body of the country where the treatment has taken place; and
c. is legally qualified to practice medicine or Surgery in the jurisdiction where he practices.

12.46 Medical Record means the collection of information as submitted in claim documentation concerning a Insured Person's Illness or Injury that is created and maintained in the regular course of management, made by Medical Practitioners who have knowledge of the acts, events, opinions or diagnoses relating to the Insured Person's Illness or Injury, and made at or around the time indicated in the documentation.

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

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

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

12.49 Migration: "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 for pre-existing conditions and time bound exclusions, with the same insurer.

12.50 Network Provider means Hospital enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a Cashless Facility.
Only for the purposes of any claim or treatment permitted to be made or taken outside India, Network Provider shall mean the Hospitals that are a part of the Service Provider's network, a list of which is available with the Service Provider.

12.51 New Born Baby means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

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

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

12.54 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12.66 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.

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

12.68 Second Medical Opinion means an alternate evaluation of diagnosis or treatment modalities arranged by Us from a Medical Practitioner related to Specified Illnesses or planned Surgery or Surgical Procedure which the Insured Person has been diagnosed or advised to undergo during the Policy Year. The Second Medical Opinion will be arranged by Us solely on the Insured Person's request.

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

12.70 Shared accommodation means a Hospital room with two or more patient beds.

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

12.72 Specified Illness means the following Illnesses or procedures:

a. Cancer:
A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
Specific Exclusion: All tumors in the presence of HIV infection are excluded.

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

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

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

II. The following are excluded:
i. Other stem-cell transplants
ii. Where only islets of langerhans are transplanted

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

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

Evidence of permanent neurological deficit lasting for atleast 3 months has to be produced.
The following are excluded:
i. Transient ischemic attacks (TIA)
ii. Traumatic Injury of the brain
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions

f. Surgery of Aorta:
Surgery of aorta including graft, insertion of stents or endovascular repair.
Specific Exclusion: Surgery for correction of an underlying Congenital Anomaly.

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

III. Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

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

i. Brain Surgery:
   Any brain (intracranial) Surgery required to treat traumatic or non-traumatic conditions.
   Specific Exclusion: Surgery for treating Neurocysticercosis.

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

12.74 Suite Room means
a. a space available for boarding in a Hospital which contains two or more rooms; Or
b. a space available for boarding in a Hospital which contains an extended living/dining/kitchen area

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

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

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

   If the Policy Period is 2 years, then the Sum Insured shall be applied separately for each Policy Year in the Policy Period.

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

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

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

12.79 We/Our/Us means Max Bupa Health Insurance Company Limited.

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

Annexure I

List of Insurance Ombudsmen

Office Details	Jurisdiction of Office Union Territory,District)
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Smt. Neerja Shah Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka.
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
CHANDIGARH - Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh.
CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	Tamil Nadu,UT- Pondicherry Town and Karaikal (which are part of UT of Pondicherry).

Office Details	Jurisdiction of Office Union Territory,District)
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi
GUWAHATI - Shri Kiriti .B. Saha Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Shri I. Suresh Babu Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, UT of Yanam and part of UT of Pondicherry.
JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, UT of (a)Lakshadweep,(b) Mahe-a part of UT of Pondicherry.
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, UT of Andaman & Nicobar Islands.
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.

Office Details	Jurisdiction of Office Union Territory,District)
MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

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

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

HEALTH INSURANCE

ANNEXURE II

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

Individual and Family Floater - Silver Plan (Renewal only)

Base Sum Insured (in Rs)	2 lacs	3 lacs
Benefits		
Inpatient care	Covered up to Sum Insured	
Room rent	Shared Room or 1% of the Base Sum Insured per day	
Pre-Hospitalization Medical Expenses (60 days)	Covered up to Sum Insured	
Post-Hospitalization Medical Expenses (90 days)	Covered up to Sum Insured	
Alternative Treatment	Covered up to Sum Insured	
Day Care Treatment	Covered up to Sum Insured	
Domiciliary Hospitalization	Covered up to Sum Insured	
Maternity Benefit (covered for up to 2 pregnancies or terminations) (1)	Covered up to Rs 20,000	Covered up to Rs 30,000
New Born Baby (covered uptill the end of Policy Year) (1)	Covered up to Sum Insured	
Vaccination of the new born baby	Covered until new born baby completes one year, vaccinations as per annexure	
Living Organ Donor Transplant	Covered up to Sum Insured	
Emergency Ambulance	Network Hospital: Covered up to Sum Insured Non-network Hospital: Covered up to Rs. 2,000 per event	
Re-fill benefit	Reinstate up to base Sum Insured. Applicable for same & different illness as well	
Pharmacy and diagnostic services	Available through our empanelled service provider	
HIV / AIDS (waiting period of 4 years)	Covered up to Rs 50,000	
Emergency assistance services	Covered up to Sum Insured	
Mental disorder treatment (waiting period of 3 years)	Covered up to Sum Insured (sub-limit of Rs 50,000 applicable on few conditions)	
Loyalty Additions	Increase of 10% of expiring Base Sum Insured in a Policy Year; maximum up to 50% of Base Sum Insured	
Health Check-up (2)	Once in two years, tests as per annexure	
Modern Treatments	Covered up to Sum Insured with sub-limit of Rs. 1Lac on few robotic surgeries	
Optional Benefits		
Hospital Cash (3)	Rs 1,500/day	
Personal Accident cover (for insured aged 18 years & above on individual basis)	Personal Accident cover will be equal to 5 times of base Sum Insured	
Critical illness cover (for insured 18 years & above on individual basis)	Critical illness cover will be equal to base Sum Insured	
e-consultation	Unlimited tele / online consultations	
Premium Waiver	One time premium waiver if the Policyholder dies or suffers from specified illness	
Claim cost sharing options		
Co-payment	Options of 10% and 20% co-payment	
Annual aggregate Deductible	1 lac/ 2 lacs / 3 lacs	

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

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

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

MAX Bupa HEALTH INSURANCE

Individual and Family Floater - Gold Plan

Base Sum Insured (in Rs)	5 lacs	7.5 lacs	10 lacs	15 lacs	20 lacs	30 lacs	50 lacs
Benefits							
Inpatient care	Covered up to Sum Insured						
Room rent	Covered up to Sum Insured (except for Suite or above room category)						
Pre-Hospitalization Medical Expenses (60 days)	Covered up to Sum Insured						
Post-Hospitalization Medical Expenses (90 days)	Covered up to Sum Insured						
Alternative Treatment	Covered up to Sum Insured						
Day Care Treatment	Covered up to Sum Insured						
Domiciliary Hospitalization	Covered up to Sum Insured						
Maternity Benefit (covered for up to 2 pregnancies or terminations) (1)	Covered up to Rs 40,000	Covered up to Rs 60,000	Covered up to Rs 70,000	Covered up to Rs 75,000	Covered up to Rs 80,000	Covered up to Rs 1,00,000	Covered up to Rs 1,00,000
New Born Baby (covered uptill the end of Policy Year) (1)	Covered up to Sum Insured						
Vaccination of the new born baby	Covered until new born baby completes one year, vaccinations as per annexure						
Living Organ Donor Transplant	Covered up to Sum Insured						
Emergency Ambulance	Network Hospital: Covered up to Sum Insured Non-network Hospital: Covered up to Rs. 2,000 per event						
Re-fill benefit	Reinstate up to base Sum Insured. Applicable for same & different illness as well						
Pharmacy and diagnostic services	Available through our empanelled service provider						
HIV / AIDS (waiting period of 4 years)	Covered up to Rs 50,000						
Emergency assistance services	Covered up to Sum Insured						
Mental disorder treatment (waiting period of 3 years)	Covered up to Sum Insured (sub-limit of Rs 50,000 applicable on few conditions)						
Loyalty Additions	Increase of 10% of expiring Base Sum Insured in a Policy Year; maximum up to 100% of Base Sum Insured						
Health Check-up (2)	Annual, Tests covered up to worth Rs 1,250 per Insured Person	Annual, Tests covered up to worth Rs 1,875 per Insured Person	Annual, Tests covered up to worth Rs 2,500 per Insured Person	Annual, Tests covered up to worth Rs 2,500 per Insured Person	Annual, Tests covered up to worth Rs 2,500 per Insured Person	Annual, Tests covered up to worth Rs 2,500 per Insured Person	Annual, Tests covered up to worth Rs 2,500 per Insured Person
Modern Treatments	Covered up to Sum Insured with sub-limit of Rs. 1Lac on few robotic surgeries						
Optional Benefits							
Hospital Cash (3)	Rs 3,000/day						
Personal Accident cover (for insured aged 18 years & above on individual basis)	Personal Accident cover will be equal to 5 times of base Sum Insured; subject to maximum of 50 lacs						
Critical illness cover (for insured 18 years & above on individual basis)	Critical illness cover will be equal to base Sum Insured; subject to maximum of 10 lacs						
e-consultation	Unlimited tele / online consultations						
Premium Waiver	One time premium waiver if the Policyholder dies or suffers from specified illness						
Claim cost sharing options							
Co-payment	Options of 10% and 20% co-payment						

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

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

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

MAX Bupa HEALTH INSURANCE

Individual and Family Floater - Platinum Plan

Base Sum Insured (in Rs)	15 lacs	20 lacs	50 lacs	1 Cr
Benefits				
Inpatient care	Covered up to Sum Insured			
Room rent	Covered up to Sum Insured			
Pre-Hospitalization Medical Expenses (60 days)	Covered up to Sum Insured			
Post-Hospitalization Medical Expenses (90 days)	Covered up to Sum Insured			
Alternative Treatment	Covered up to Sum Insured			
Day Care Treatment	Covered up to Sum Insured			
Domiciliary Hospitalization	Covered up to Sum Insured			
Maternity Benefit (covered for up to 2 pregnancies or terminations) [1]	Covered up to Rs 120,000	Covered up to Rs 160,000	Covered up to Rs 200,000	Covered up to Rs 200,000
New Born Baby (covered uptill the end of Policy Year) [1]	Covered up to Sum Insured			
Vaccination of the new born baby	Covered until new born baby completes one year, vaccinations as per annexure			
Living Organ Donor Transplant	Covered up to Sum Insured			
Emergency Ambulance	Network Hospital: Covered up to Sum Insured Non-network Hospital: Covered up to Rs. 2,000 per event			
Re-fill benefit	Reinstate up to base Sum Insured. Applicable for same & different illness as well			
Pharmacy and diagnostic services	Available through our empanelled service provider			
HIV / AIDS (waiting period of 4 years)	Covered up to Rs 50,000			
Emergency assistance services	Covered up to Sum Insured			
Mental disorder treatment (waiting period of 3 years)	Covered up to Sum Insured (sub-limit of Rs 50,000 applicable on few conditions)			
OPD Treatment and Diagnostic Services	Covered up to Rs 15,000	Covered up to Rs 20,000	Covered up to Rs 35,000	Covered up to Rs 50,000
Child Care Benefits (Vaccinations for children up to 12 years including one consultation for nutrition and growth during the visit for vaccination)	Covered up to Sum Insured (As per annexure)			
Emergency Medical Evacuation (outside the geographical boundaries of India)	Covered up to Sum Insured (for worldwide excluding USA & Canada)			
Emergency Hospitalization (outside the geographical boundaries of India)	Covered up to Sum Insured (for worldwide excluding USA & Canada)			
Specified Illness Cover (outside the geographical boundaries of India) [2]	Covered up to Sum Insured (for worldwide excluding USA & Canada)			
Second Medical Opinion	Covered, One opinion per Insured Person per Specified Illness / planned Surgery / Surgical Procedure			
Loyalty Additions	Increase of 10% of expiring Base Sum Insured in a Policy Year; maximum up to 100% of Base Sum Insured			
Health Check-up [3]	Annual, tests covered up to worth Rs 3750 per Insured Person	Annual, tests covered up to worth Rs 5000 per Insured Person	Annual, tests covered up to worth Rs 5000 per Insured Person	Annual, tests covered up to worth Rs 5000 per Insured Person
Modern Treatments	Covered up to Sum Insured with sub-limit of Rs. 1Lac on few robotic surgeries			
Optional Benefits				
Hospital Cash [4]	Rs 6,000/day			

Base Sum Insured (in Rs)	15 lacs	20 lacs	50 lacs	1 Cr
Enhanced Geographical Scope for International coverage	USA & Canada included for 'Emergency Medical Evacuation', 'Emergency Hospitalization' & 'Specified illness cover'			
Personal Accident cover (for insured aged 18 years & above on individual basis)	Personal Accident cover will be equal to 50 lacs			
Critical illness cover (for insured 18 years & above on individual basis)	Critical illness cover will be equal to 10 lacs			
e-consultation	Unlimited tele / online consultations			
Premium Waiver	One time premium waiver if the Policyholder dies or suffers from specified illness			
Claim cost sharing options				
Co-payment	Options of 10% and 20% co-payment			

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

Family First - Silver Plan

	Base Sum Insured: 1Lacs, 2Lacs, 3Lacs, 4Lacs & 5Lacs per Insured Person **Floater Sum Insured – (available on a floating basis over Base Sum Insured):** 3Lacs, 4Lacs, 5Lacs, 10Lacs &15Lacs.
Benefits	
Inpatient care	Covered up to Sum Insured
Room rent	Rs 3,000 per day or Shared Room
Pre-Hospitalization Medical Expenses (60 days)	Covered up to Sum Insured
Post-Hospitalization Medical Expenses (90 days)	Covered up to Sum Insured
Alternative Treatment	Covered up to Sum Insured
Day Care Treatment	Covered up to Sum Insured
Domiciliary Hospitalization	Covered up to Sum Insured
Maternity Benefit (covered for up to 2 pregnancies or terminations) (1)	Covered up to Rs 35,000 per Policy Year
New Born Baby (covered uptill the end of Policy Year) (1)	Covered up to Sum Insured
Vaccination of the new born baby	Covered until new born baby completes one year, vaccinations as per annexure
Living Organ Donor Transplant	Covered up to Sum Insured
Emergency Ambulance	Network Hospital: Covered up to Sum Insured Non-network Hospital: Covered up to Rs. 2,000 per event
Pharmacy and diagnostic services	Available through our empanelled service provider
HIV / AIDS (waiting period of 4 years)	Covered up to Rs 50,000
Emergency assistance services	Covered up to Sum Insured
Mental disorder treatment (waiting period of 3 years)	Covered up to Sum Insured (sub-limit of Rs 50,000 applicable on few conditions)
Loyalty Additions	Increase of 10% of expiring Base Sum Insured in a Policy Year; maximum up to 50% of Base Sum Insured
Health Check-up (2)	Once in two years, tests as per annexure
Modern Treatments	Covered up to Sum Insured with sub-limit of Rs. 1Lac on few robotic surgeries
Optional Benefits	
Hospital Cash (3)	Rs 1,500/day
Personal Accident cover (for insured aged 18 years & above on individual basis)	Personal Accident cover will be equal to 5 times of base Sum Insured
Critical illness cover (for insured 18 years & above on individual basis)	Critical illness cover will be equal to base Sum Insured
e-consultation	Unlimited tele / online consultations
Premium Waiver	One time premium waiver if the Policyholder dies or suffers from specified illness
Claim cost sharing options	
Co-payment	Options of 10% and 20% co-payment

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

Family First - Gold Plan

	Base Sum Insured: 1Lacs, 2Lacs, 3Lacs, 4Lacs, 5Lacs, 10Lacs & 15Lacs per Insured Person **Floater Sum Insured – (available on a floating basis over Base Sum Insured):** 3Lacs, 4Lacs, 5Lacs, 10Lacs, 15Lacs, 20Lacs, 30Lacs & 50Lacs
Benefits	
Inpatient care	Covered up to Sum Insured
Room rent	Covered up to Sum Insured (except for Suite or above room category)
Pre-Hospitalization Medical Expenses (60 days)	Covered up to Sum Insured
Post-Hospitalization Medical Expenses (90 days)	Covered up to Sum Insured
Alternative Treatment	Covered up to Sum Insured
Day Care Treatment	Covered up to Sum Insured
Domiciliary Hospitalization	Covered up to Sum Insured
Maternity Benefit (covered for up to 2 pregnancies or terminations) (1)	Covered up to Rs 50,000 per Policy Year
New Born Baby (covered uptill the end of Policy Year) (1)	Covered up to Sum Insured
Vaccination of the new born baby	Covered until new born baby completes one year, vaccinations as per annexure
Living Organ Donor Transplant	Covered up to Sum Insured
Emergency Ambulance	Network Hospital: Covered up to Sum Insured Non-network Hospital: Covered up to Rs. 2,000 per event
Pharmacy and diagnostic services	Available through our empanelled service provider
HIV / AIDS (waiting period of 4 years)	Covered up to Rs 50,000
Emergency assistance services	Covered up to Sum Insured
Mental disorder treatment (waiting period of 3 years)	Covered up to Sum Insured (sub-limit of Rs 50,000 applicable on few conditions)
Loyalty Additions	Increase of 10% of expiring Base Sum Insured in a Policy Year; maximum up to 100% of Base Sum Insured
Health Check-up (2)	Annual, Tests covered up to worth Rs 2,500 per Insured Person
Modern Treatments	Covered up to Sum Insured with sub-limit of Rs. 1Lac on few robotic surgeries
Optional Benefits	
Hospital Cash (3)	Rs 3,000/day
Personal Accident cover (for insured aged 18 years & above on individual basis)	Personal Accident cover will be equal to 5 times of base Sum Insured; subject to maximum of 50 lacs
Critical illness cover (for insured 18 years & above on individual basis)	Critical illness cover will be equal to base Sum Insured; subject to maximum of 10 lacs
e-consultation	Unlimited tele / online consultations
Premium Waiver	One time premium waiver if the Policyholder dies or suffers from specified illness
Claim cost sharing options	
Co-payment	Options of 10% and 20% co-payment

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

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

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

Family First - Platinum Plan

	Base Sum Insured: 5Lacs, 10 Lacs & 15 Lacs per Insured Person **Floater Sum Insured: (available on a floating basis over Base Sum Insured):** 15Lacs, 20 Lacs, 30 Lacs & 50 Lacs.
Benefits	
Inpatient care	Covered up to Sum Insured
Room rent	Covered up to Sum Insured
Pre-Hospitalization Medical Expenses (60 days)	Covered up to Sum Insured
Post-Hospitalization Medical Expenses (90 days)	Covered up to Sum Insured
Alternative Treatment	Covered up to Sum Insured
Day Care Treatment	Covered up to Sum Insured
Domiciliary Hospitalization	Covered up to Sum Insured
Maternity Benefit (covered for up to 2 pregnancies or terminations) (1)	Covered up to Rs 100,000
New Born Baby (covered uptill the end of Policy Year) (1)	Covered up to Sum Insured
Vaccination of the new born baby	Covered until new born baby completes one year, vaccinations as per annexure
Living Organ Donor Transplant	Covered up to Sum Insured
Emergency Ambulance	Network Hospital: Covered up to Sum Insured Non-network Hospital: Covered up to Rs. 2,000 per event
Pharmacy and diagnostic services	Available through our empanelled service provider
HIV / AIDS (waiting period of 4 years)	Covered up to Rs 50,000
Emergency assistance services	Covered up to Sum Insured
Mental disorder treatment (waiting period of 3 years)	Covered up to Sum Insured (sub-limit of Rs 50,000 applicable on few conditions)
OPD Treatment and Diagnostic Services	Covered up to Rs 35,000
Child Care Benefits (Vaccinations for children up to 12 years including one consultation for nutrition and growth during the visit for vaccination)	Covered up to Sum Insured (As per annexure)
Emergency Medical Evacuation (outside the geographical boundaries of India)	Covered up to Sum Insured (for worldwide excluding USA & Canada)
Emergency Hospitalization (outside the geographical boundaries of India)	Covered up to Sum Insured (for worldwide excluding USA & Canada)
Specified Illness Cover (outside the geographical boundaries of India) (2)	Covered up to Sum Insured (for worldwide excluding USA & Canada)
Second Medical Opinion	Covered, One opinion per Insured Person per Specified Illness / planned Surgery / Surgical Procedure
Loyalty Additions	Increase of 10% of expiring Base Sum Insured in a Policy Year; maximum up to 100% of Base Sum Insured
Health Check-up (3)	Annual, tests covered up to worth Rs 5000 per Insured Person
Modern Treatments	Covered up to Sum Insured with sub-limit of Rs. 1Lac on few robotic surgeries
Optional Benefits	
Hospital Cash (4)	Rs 6,000/day
Enhanced Geographical Scope for International cover-age	USA & Canada included for 'Emergency Medical Evacuation', 'Emergency Hospitalization' & 'Specified illness cover'
Personal Accident cover (for insured aged 18 years & above on individual basis)	Personal Accident cover will be equal to 5 times of base Sum Insured; subject to maximum of 50 lacs

	Base Sum Insured: 5Lacs, 10 Lacs & 15 Lacs per Insured Person **Floater Sum Insured: (available on a floating basis over Base Sum Insured):** 15Lacs, 20 Lacs, 30 Lacs & 50 Lacs.
Critical illness cover (for insured 18 years & above on individual basis)	Critical illness cover will be equal to base Sum Insured; subject to maximum of 10 lacs
e-consultation	Unlimited tele / online consultations
Premium Waiver	One time premium waiver if the Policyholder dies or suffers from specified illness
Claim cost sharing options	
Co-payment	Options of 10% and 20% co-payment

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

MAX Bupa HEALTH INSURANCE

Annexure III

Day Care Treatments

Sr. No	Procedure Name
I. Cardiology Related:	
1	CORONARY ANGIOGRAPHY
II. Critical Care Related:	
2	INSERT NON- TUNNEL CV CATH
3	INSERT PICC CATH (PERIPHERALLY INSERTED CENTRAL CATHETER)
4	REPLACE PICC CATH (PERIPHERALLY INSERTED CENTRAL CATHETER)
5	INSERTION CATHETER, INTRA ANTERIOR
6	INSERTION OF PORTACATH
III. Dental Related:	
7	SPLINTING OF AVULSED TEETH
8	SUTURING LACERATED LIP
9	SUTURING ORAL MUCOSA
10	ORAL BIOPSY IN CASE OF ABNORMAL TISSUE PRESENTATION
11	FNAC
12	SMEAR FROM ORAL CAVITY
IV. ENT Related:	
13	MYRINGOTOMY WITH GROMMET INSERTION
14	TYMPANOPLASTY (CLOSURE OF AN EARDRUM PERFORATION/ RECONSTRUCTION OF THE AUDITORY OSSICLES)
15	REMOVAL OF A TYMPANIC DRAIN
16	KERATOSIS REMOVAL UNDER GA
17	OPERATIONS ON THE TURBINATES (NASAL CONCHA)
18	TYMPANOPLASTY (CLOSURE OF AN EARDRUM PERFORATION/ RECONSTRUCTION OF THE AUDITORY OSSICLES)
19	REMOVAL OF KERATOSIS OBTURANS
20	STAPEDOTOMY TO TREAT VARIOUS LESIONS IN MIDDLE EAR
21	REVISION OF A STAPEDECTOMY

Sr. No	Procedure Name
22	OTHER OPERATIONS ON THE AUDITORY OSSICLES
23	MYRINGOPLASTY (POSTAURA/ ENDAURAL APPROACH AS WELL AS SIMPLE TYPE -I TYMPANOPLASTY)
24	FENESTRATION OF THE INNER EAR
25	REVISION OF A FENESTRATION OF THE INNER EAR
26	PALATOPLASTY
27	TRANSORAL INCISION AND DRAINAGE OF A PHARYNGEAL ABSCESS
28	TONSILLECTOMY WITHOUT ADENOIDECTOMY
29	TONSILLECTOMY WITH ADENOIDECTOMY
30	EXCISION AND DESTRUCTION OF A LINGUAL TONSIL
31	REVISION OF A TYMPANOPLASTY
32	OTHER MICROSURGICAL OPERATIONS ON THE MIDDLE EAR
33	INCISION OF THE MASTOID PROCESS AND MIDDLE EAR
34	MASTOIDECTOMY
35	RECONSTRUCTION OF THE MIDDLE EAR
36	OTHER EXCISIONS OF THE MIDDLE AND INNER EAR
37	INCISION (OPENING) AND DESTRUCTION (ELIMINATION) OF THE INNER EAR
38	OTHER OPERATIONS ON THE MIDDLE AND INNER EAR
39	EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE NOSE
40	OTHER OPERATIONS ON THE NOSE
41	NASAL SINUS ASPIRATION
42	FOREIGN BODY REMOVAL FROM NOSE
43	OTHER OPERATIONS ON THE TONSILS AND ADENOIDS

Sr. No	Procedure Name
44	ADENOIDECTOMY
45	LABYRINTHECTOMY FOR SEVERE VERTIGO
46	STAPEDECTOMY UNDER GA
47	STAPEDECTOMY UNDER LA
48	TYMPANOPLASTY (TYPE IV)
49	ENDOLYMPHATIC SAC SURGERY FOR MENIERE'S DISEASE
50	TURBINECTOMY
51	ENDOSCOPIC STAPEDECTOMY
52	INCISION AND DRAINAGE OF PERICHONDRITIS
53	SEPTOPLASTY
54	VESTIBULAR NERVE SECTION
55	THYROPLASTY TYPE I
56	PSEUDOCYST OF THE PINNA - EXCISION
57	INCISION AND DRAINAGE - HAEMATOMA AURICLE
58	TYMPANOPLASTY (TYPE II)
59	REDUCTION OF FRACTURE OF NASAL BONE
60	THYROPLASTY TYPE II
61	TRACHEOSTOMY
62	EXCISION OF ANGIOMA SEPTUM
63	TURBINOPLASTY
64	INCISION & DRAINAGE OF RETRO PHARYNGEAL ABSCESS
65	UVULO PALATO PHARYNGO PLASTY
66	ADENOIDECTOMY WITH GROMMET INSERTION
67	ADENOIDECTOMY WITHOUT GROMMET INSERTION
68	VOCAL CORD LATERALISATION PROCEDURE
69	INCISION & DRAINAGE OF PARA PHARYNGEAL ABSCESS
70	TRACHEOPLASTY

Sr. No	Procedure Name
V. Gastroenterology Related:	
71	CHOLECYSTECTOMY AND CHOLEDOCHO-JEJUNOSTOMY/ DUODENOSTO-MY/ GASTROSTOMY/EXPL ORATION COMMON BILE DUCT
72	ESOPHAGOSCOPY, GASTROSCOPY, DUODENOSCOPY WITH POLYPECTOMY/ REMOV-AL OF FOREIGN BODY/DIATHERMY OF BLEEDING LESIONS
73	PANCREATIC PSEUDOCYST EUS & DRAINAGE
74	RF ABLATION FOR BARRETT'S OESOPHAGUS
75	ERCP AND PAPILLOTOMY
76	ESOPHAGOSCOPE AND SCLEROSANT INJECTION
77	EUS + SUBMUCOSAL RESECTION
78	CONSTRUCTION OF GASTROSTOMY TUBE
79	EUS + ASPIRATION PANCREATIC CYST
80	SMALL BOWEL ENDOSCOPY (THERAPEUTIC)
81	COLONOSCOPY ,LESION REMOVAL
82	ERCP
83	COLONSCOPY STENTING OF STRICTURE
84	PERCUTANEOUS ENDOSCOPIC GASTROSTOMY
85	EUS AND PANCREATIC PSEUDO CYST DRAINAGE
86	ERCP AND CHOLEDOCHOSCOPY
87	PROCTOSIGMOIDOSCOPY VOLVULUS DETORSION
88	ERCP AND SPHINCTEROTOMY
89	ESOPHAGEAL STENT PLACEMENT
90	ERCP + PLACEMENT OF BILIARY STENTS
91	SIGMOIDOSCOPY W / STENT
92	EUS + COELIAC NODE BIOPSY
93	UGI SCOPY AND INJECTION OF ADRENALINE, SCLEROSANTS BLEEDING ULCERS

Sr. No	Procedure Name
VI. General Surgery Related:	
94	INCISION OF A PILONIDAL SINUS / ABSCESS
95	FISSURE IN ANO SPHINCTEROTOMY
96	SURGICAL TREATMENT OF A VARICOCELE AND A HYDROCELE OF THE SPERMATIC CORD
97	ORCHIDOPEXY
98	ABDOMINAL EXPLORATION IN CRYPTORCHIDISM
99	SURGICAL TREATMENT OF ANAL FISTULAS
100	DIVISION OF THE ANAL SPHINCTER (SPHINCTEROTOMY)
101	EPIDIDYMECTOMY
102	INCISION OF THE BREAST ABSCESS
103	OPERATIONS ON THE NIPPLE
104	EXCISION OF SINGLE BREAST LUMP
105	INCISION AND EXCISION OF TISSUE IN THE PERIANAL REGION
106	SURGICAL TREATMENT OF HEMORRHOIDS
107	OTHER OPERATIONS ON THE ANUS
108	ULTRASOUND GUIDED ASPIRATIONS
109	SCLEROTHERAPY,
110	THERAPEUTIC LAPAROSCOPY WITH LASER
111	INFECTED KELOID EXCISION
112	AXILLARY LYMPHADENECTOMY
113	WOUND DEBRIDEMENT AND COVER
114	ABSCESS-DECOMPRESSION
115	CERVICAL LYMPHADENECTOMY
116	INFECTED SEBACEOUS CYST
117	INGUINAL LYMPHADENECTOMY
118	INCISION AND DRAINAGE OF ABSCESS
119	SUTURING OF LACERATIONS
120	SCALP SUTURING

Sr. No	Procedure Name
121	INFECTED LIPOMA EXCISION
122	MAXIMAL ANAL DILATATION
123	PILES
124	A)INJECTION SCLEROTHERAPY
125	B)PILES BANDING
126	LIVER ABSCESS- CATHETER DRAINAGE
127	FISSURE IN ANO- FISSURECTOMY
128	FIBROADENOMA BREAST EXCISION
129	OESOPHAGEAL VARICES SCLEROTHERAPY
130	ERCP - PANCREATIC DUCT STONE REMOVAL
131	PERIANAL ABSCESS I&D
132	PERIANAL HEMATOMA EVACUATION
133	UGI SCOPY AND POLYPECTOMY OESOPHAGUS
134	BREAST ABSCESS I& D
135	FEEDING GASTROSTOMY
136	OESOPHAGOSCOPY AND BIOPSY OF GROWTH OESOPHAGUS
137	ERCP - BILE DUCT STONE REMOVAL
138	ILEOSTOMY CLOSURE
139	COLONOSCOPY
140	POLYPECTOMY COLON
141	SPLENIC ABSCESSES LAPAROSCOPIC DRAINAGE
142	UGI SCOPY AND POLYPECTOMY STOMACH
143	RIGID OESOPHAGOSCOPY FOR FB REMOVAL
144	FEEDING JEJUNOSTOMY
145	COLOSTOMY
146	ILEOSTOMY
147	COLOSTOMY CLOSURE
148	SUBMANDIBULAR SALIVARY DUCT STONE REMOVAL
149	PNEUMATIC REDUCTION OF INTUSSUSCEPTION

Sr. No	Procedure Name
150	VARICOSE VEINS LEGS - INJECTION SCLEROTHERAPY
151	RIGID OESOPHAGOSCOPY FOR PLUMMER VINSON SYNDROME
152	PANCREATIC PSEUDOCYSTS ENDOSCOPIC DRAINAGE
153	ZADEK'S NAIL BED EXCISION
154	SUBCUTANEOUS MASTECTOMY
155	EXCISION OF RANULA UNDER GA
156	RIGID OESOPHAGOSCOPY FOR DILATION OF BENIGN STRICTURES
157	EVERSION OF SAC UNILATERAL/ BILATERAL
158	LORD'S PLICATION
159	JABOULAY'S PROCEDURE
160	SCROTOPLASTY
161	CIRCUMCISION FOR TRAUMA
162	MEATOPLASTY
163	INTERSPHINCTERIC ABSCESS INCISION AND DRAINAGE
164	PSOAS ABSCESS INCISION AND DRAINAGE
165	THYROID ABSCESS INCISION AND DRAINAGE
166	TIPS PROCEDURE FOR PORTAL HYPERTENSION
167	ESOPHAGEAL GROWTH STENT
168	PAIR PROCEDURE OF HYDATID CYST LIVER
169	TRU CUT LIVER BIOPSY
170	PHOTODYNAMIC THERAPY OR ESOPHAGEAL TUMOUR AND LUNG TUMOUR
171	EXCISION OF CERVICAL RIB
172	LAPAROSCOPIC REDUCTION OF INTUSSUSCEPTION
173	MICRODOCHECTOMY BREAST
174	SURGERY FOR FRACTURE PENIS
175	SENTINEL NODE BIOPSY
176	PARASTOMAL HERNIA
177	REVISION COLOSTOMY

Sr. No	Procedure Name
178	PROLAPSED COLOSTOMY-CORRECTION
179	TESTICULAR BIOPSY
180	LAPAROSCOPIC CARDIOMYOTOMY(HELLERS)
181	SENTINEL NODE BIOPSY MALIGNANT MELANOMA
182	LAPAROSCOPIC PYLOROMYOTOMY(RAMSTEDT)
183	EXCISION OF FISTULA-IN-ANO
184	EXCISION JUVENILE POLYPS RECTUM
185	VAGINOPLASTY
186	DILATATION OF ACCIDENTAL CAUSTIC STRICTURE OESOPHAGEAL
187	PRESACRAL TERATOMAS EXCISION
188	REMOVAL OF VESICAL STONE
189	EXCISION SIGMOID POLYP
190	STERNOMASTOID TENOTOMY
191	INFANTILE HYPERTROPHIC PYLORIC STENOSIS PYLOROMYOTOMY
192	EXCISION OF SOFT TISSUE RHABDOMYOSARCOMA
193	MEDIASTINAL LYMPH NODE BIOPSY
194	HIGH ORCHIDECTOMY FOR TESTIS TUMOURS
195	EXCISION OF CERVICAL TERATOMA
196	RECTAL-MYOMECTOMY
197	RECTAL PROLAPSE (DELORME'S PROCEDURE)
198	DETORSION OF TORSION TESTIS
199	EUA + BIOPSY MULTIPLE FISTULA IN ANO
200	CYSTIC HYGROMA - INJECTION TREATMENT
VII. Gynecology Related:	
201	OPERATIONS ON BARTHOLIN'S GLANDS (CYST)
202	INCISION OF THE OVARY

Sr. No	Procedure Name
203	INSUFFLATIONS OF THE FALLOPIAN TUBES
204	OTHER OPERATIONS ON THE FALLOPIAN TUBE
205	DILATATION OF THE CERVICAL CANAL
206	CONISATION OF THE UTERINE CERVIX
207	THERAPEUTIC CURETTAGE WITH COLPOSCOPY/BIOPSY/ DIATHERMY/CRY OSURGERY/
208	LASER THERAPY OF CERVIX FOR VARIOUS LESIONS OF UTERUS
209	OTHER OPERATIONS ON THE UTERINE CERVIX
210	LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE VAGINA AND THE POUCH OF DOUGLAS
211	INCISION OF VAGINA
212	INCISION OF VULVA
213	CULDOTOMY
214	SALPINGO-OOPHORECTOMY VIA LAPAROTOMY
215	ENDOSCOPIC POLYPECTOMY
216	HYSTEROSCOPIC REMOVAL OF MYOMA
217	D&C
218	HYSTEROSCOPIC RESECTION OF SEPTUM
219	THERMAL CAUTERISATION OF CERVIX
220	MIRENA INSERTION
221	HYSTEROSCOPIC ADHESIOLYSIS
222	LEEP (LOOP ELECTROSURGICAL EXCISION PROCEDURE)
223	CRYOCAUTERISATION OF CERVIX
224	POLYPECTOMY ENDOMETRIUM
225	HYSTEROSCOPIC RESECTION OF FIBROID
226	LLETZ (LARGE LOOP EXCISION OF TRANSFORMATION ZONE)
227	CONIZATION
228	POLYPECTOMY CERVIX

Sr. No	Procedure Name
229	HYSTEROSCOPIC RESECTION OF ENDOMETRIAL POLYP
230	VULVAL WART EXCISION
231	LAPAROSCOPIC PARAOVARIAN CYST EXCISION
232	UTERINE ARTERY EMBOLIZATION
233	LAPAROSCOPIC CYSTECTOMY
234	HYMENECTOMY(IMPERFORATE HYMEN)
235	ENDOMETRIAL ABLATION
236	VAGINAL WALL CYST EXCISION
237	VULVAL CYST EXCISION
238	LAPAROSCOPIC PARATUBAL CYST EXCISION
239	REPAIR OF VAGINA (VAGINAL ATRESIA)
240	HYSTEROSCOPY, REMOVAL OF MYOMA
241	TURBT
242	URETEROCOELE REPAIR - CONGENITAL INTERNAL
243	VAGINAL MESH FOR POP
244	LAPAROSCOPIC MYOMECTOMY
245	SURGERY FOR SUI
246	REPAIR RECTO- VAGINA FISTULA
247	PELVIC FLOOR REPAIR(EXCLUDING FISTULA REPAIR)
248	URS + LL
249	LAPAROSCOPIC OOPHORECTOMY
250	NORMAL VAGINAL DELIVERY AND VARIANTS
VIII. Neurology Related:	
251	FACIAL NERVE PHYSIOTHERAPY
252	NERVE BIOPSY
253	MUSCLE BIOPSY
254	EPIDURAL STEROID INJECTION
255	GLYCEROL RHIZOTOMY
256	SPINAL CORD STIMULATION
257	MOTOR CORTEX STIMULATION
258	STEREOTACTIC RADIOSURGERY
259	PERCUTANEOUS CORDOTOMY

Sr. No	Procedure Name
260	INTRATHECAL BACLOFEN THERAPY
261	ENTRAPMENT NEUROPATHY RELEASE
262	DIAGNOSTIC CEREBRAL ANGIOGRAPHY
263	VP SHUNT
264	VENTRICULOATRIAL SHUNT
IX. Oncology Related:	
265	RADIOTHERAPY FOR CANCER
266	CANCER CHEMOTHERAPY
267	IV PUSH CHEMOTHERAPY
268	HBI-HEMIBODY RADIOTHERAPY
269	INFUSIONAL TARGETED THERAPY
270	SRT-STEREOTACTIC ARC THERAPY
271	SC ADMINISTRATION OF GROWTH FACTORS
272	CONTINUOUS INFUSIONAL CHEMOTHERAPY
273	INFUSIONAL CHEMOTHERAPY
274	CCRT-CONCURRENT CHEMO + RT
275	2D RADIOTHERAPY
276	3D CONFORMAL RADIOTHERAPY
277	IGRT- IMAGE GUIDED RADIOTHERAPY
278	IMRT- STEP & SHOOT
279	INFUSIONAL BISPHOSPHONATES
280	IMRT- DMLC
281	ROTATIONAL ARC THERAPY
282	TELE GAMMA THERAPY
283	FSRT-FRACTIONATED SRT
284	VMAT-VOLUMETRIC MODULATED ARC THERAPY
285	SBRT-STEREOTACTIC BODY RADIOTHERAPY
286	HELICAL TOMOTHERAPY
287	SRS-STEREOTACTIC RADIOSURGERY
288	X-KNIFE SRS
289	GAMMAKNIFE SRS
290	TBI- TOTAL BODY RADIOTHERAPY

Sr. No	Procedure Name
291	INTRALUMINAL BRACHYTHERAPY
292	ELECTRON THERAPY
293	TSET-TOTAL ELECTRON SKIN THERAPY
294	EXTRACORPOREAL IRRADIATION OF BLOOD PRODUCTS
295	TELECOBALT THERAPY
296	TELECESIUM THERAPY
297	EXTERNAL MOULD BRACHYTHERAPY
298	INTERSTITIAL BRACHYTHERAPY
299	INTRACAVITY BRACHYTHERAPY
300	3D BRACHYTHERAPY
301	IMPLANT BRACHYTHERAPY
302	INTRAVESICAL BRACHYTHERAPY
303	ADJUVANT RADIOTHERAPY
304	AFTERLOADING CATHETER BRACHYTHERAPY
305	CONDITIONING RADIOTHEARPY FOR BMT
306	EXTRACORPOREAL IRRADIATION TO THE HOMOLOGOUS BONE GRAFTS
307	RADICAL CHEMOTHERAPY
308	NEOADJUVANT RADIOTHERAPY
309	LDR BRACHYTHERAPY
310	PALLIATIVE RADIOTHERAPY
311	RADICAL RADIOTHERAPY
312	PALLIATIVE CHEMOTHERAPY
313	TEMPLATE BRACHYTHERAPY
314	NEOADJUVANT CHEMOTHERAPY
315	ADJUVANT CHEMOTHERAPY
316	INDUCTION CHEMOTHERAPY
317	CONSOLIDATION CHEMOTHERAPY
318	MAINTENANCE CHEMOTHERAPY
319	HDR BRACHYTHERAPY
X. Operations on the salivary glands & salivary ducts:	
320	INCISION AND LANCING OF A SALIVARY GLAND AND A SALIVARY DUCT

Sr. No	Procedure Name
321	EXCISION OF DISEASED TISSUE OF A SALIVARY GLAND AND A SALIVARY DUCT
322	RESECTION OF A SALIVARY GLAND
323	RECONSTRUCTION OF A SALIVARY GLAND AND A SALIVARY DUCT
324	OTHER OPERATIONS ON THE SALIVARY GLANDS AND SALIVARY DUCTS
XI. Operations on the skin & subcutaneous tissues:	
325	OTHER INCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
326	SURGICAL WOUND TOILET (WOUND DEBRIDEMENT) AND REMOVAL OF DISEASED TIS-SUE OF THE SKIN AND SUBCUTANEOUS TISSUES
327	LOCAL EXCISION OF DISEASED TISSUE OF THE SKIN AND SUBCUTANEOUS TISSUES
328	OTHER EXCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
329	SIMPLE RESTORATION OF SURFACE CONTINUITY OF THE SKIN AND SUBCUTANEOUS TISSUES
330	FREE SKIN TRANSPLANTATION, DONOR SITE
331	FREE SKIN TRANSPLANTATION, RECIPIENT SITE
332	REVISION OF SKIN PLASTY
333	OTHER RESTORATION AND RECONSTRUCTION OF THE SKIN AND SUBCUTANEOUS TISS
334	CHEMOSURGERY TO THE S
335	DESTRUCTION OF DISEASED TISSUE IN THE SKIN AND SUBCUTANEOUS TISSUES
336	RECONSTRUCTION OF DEFORMITY/DEFECT IN NAIL BED
337	EXCISION OF BURSIRTIS
338	TENNIS ELBOW RELEASE
XII. Operations on the Tongue:	
339	INCISION, EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE TONGUE

Sr. No	Procedure Name
340	PARTIAL GLOSSECTOMY
341	GLOSSECTOMY
342	RECONSTRUCTION OF THE TONGUE
343	SMALL RECONSTRUCTION OF THE TONGUE
XIII. Ophthalmology Related:	
344	SURGERY FOR CATARACT
345	INCISION OF TEAR GLANDS
346	OTHER OPERATIONS ON THE TEAR DUCTS
347	INCISION OF DISEASED EYELIDS
348	EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE EYELID
349	OPERATIONS ON THE CANTHUS AND EPICANTHUS
350	CORRECTIVE SURGERY FOR ENTROPION AND ECTROPION
351	CORRECTIVE SURGERY FOR BLEPHAROPTOSIS
352	REMOVAL OF A FOREIGN BODY FROM THE CONJUNCTIVA
353	REMOVAL OF A FOREIGN BODY FROM THE CORNEA
354	INCISION OF THE CORNEA
355	OPERATIONS FOR PTERYGIUM
356	OTHER OPERATIONS ON THE CORNEA
357	REMOVAL OF A FOREIGN BODY FROM THE LENS OF THE EYE
358	REMOVAL OF A FOREIGN BODY FROM THE POSTERIOR CHAMBER OF THE EYE
359	REMOVAL OF A FOREIGN BODY FROM THE ORBIT AND EYEBALL
360	CORRECTION OF EYELID PTOSIS BY LEVATOR PALPEBRAE SUPERIORIS RESECTION (BILATERAL)
361	CORRECTION OF EYELID PTOSIS BY FASCIA LATA GRAFT (BILATERAL)
362	DIATHERMY/CRYOTHERAPY TO TREAT RETINAL TEAR

Sr. No	Procedure Name
363	ANTERIOR CHAMBER PARACENTESIS/ CYCLODIATHERMY/ CYCLOCRYOTHERAP Y/ GONIOTOMY/TRABECULOTOMY AND FILTERING AND ALLIED OPERATIONS TO TREAT GLAUCOMA
364	ENUCLEATION OF EYE WITHOUT IMPLANT
365	DACRYOCYSTORHINOSTOMY FOR VARIOUS LESIONS OF LACRIMAL GLAND
366	LASER PHOTOCOAGULATION TO TREAT RATINAL TEAR
367	BIOPSY OF TEAR GLAND
368	TREATMENT OF RETINAL LESION
XIV. Orthopedics Related:	
369	SURGERY FOR MENISCUS TEAR
370	INCISION ON BONE, SEPTIC AND ASEPTIC
371	CLOSED REDUCTION ON FRACTURE, LUXATION OR EPIPHYSEOLYSIS WITH OSTEO-SYNTHESIS
372	SUTURE AND OTHER OPERATIONS ON TENDONS AND TENDON SHEATH
373	REDUCTION OF DISLOCATION UNDER GA
374	ARTHROSCOPIC KNEE ASPIRATION
375	SURGERY FOR LIGAMENT TEAR
376	SURGERY FOR HEMOARTHROSIS/ PYOARTHROSIS
377	REMOVAL OF FRACTURE PINS/ NAILS
378	REMOVAL OF METAL WIRE
379	CLOSED REDUCTION ON FRACTURE, LUXATION
380	REDUCTION OF DISLOCATION UNDER GA
381	EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
382	EXCISION OF VARIOUS LESIONS IN COCCYX

Sr. No	Procedure Name
383	ARTHROSCOPIC REPAIR OF ACL TEAR KNEE
384	CLOSED REDUCTION OF MINOR FRACTURES
385	ARTHROSCOPIC REPAIR OF PCL TEAR KNEE
386	TENDON SHORTENING
387	ARTHROSCOPIC MENISCECTOMY - KNEE
388	TREATMENT OF CLAVICLE DISLOCATION
389	HAEMARTHROSIS KNEE- LAVAGE
390	ABSCESS KNEE JOINT DRAINAGE
391	CARPAL TUNNEL RELEASE
392	CLOSED REDUCTION OF MINOR DISLOCATION
393	REPAIR OF KNEE CAP TENDON
394	ORIF WITH K WIRE FIXATION-SMALL BONES
395	RELEASE OF MIDFOOT JOINT
396	ORIF WITH PLATING- SMALL LONG BONES
397	IMPLANT REMOVAL MINOR
398	K WIRE REMOVAL
399	POP APPLICATION
400	CLOSED REDUCTION AND EXTERNAL FIXATION
401	ARTHROTOMY HIP JOINT
402	SYME'S AMPUTATION
403	ARTHROPLASTY
404	PARTIAL REMOVAL OF RIB
405	TREATMENT OF SESAMOID BONE FRACTURE
406	SHOULDER ARTHROSCOPY / SURGERY
407	ELBOW ARTHROSCOPY
408	AMPUTATION OF METACARPAL BONE
409	RELEASE OF THUMB CONTRACTURE
410	INCISION OF FOOT FASCIA

Sr. No	Procedure Name
411	CALCANEUM SPUR HYDROCORT INJECTION
412	GANGLION WRIST HYALASE INJECTION
413	PARTIAL REMOVAL OF METATARSAL
414	REPAIR / GRAFT OF FOOT TENDON
415	REVISION/REMOVAL OF KNEE CAP
416	AMPUTATION FOLLOW-UP SURGERY
417	EXPLORATION OF ANKLE JOINT
418	REMOVE/GRAFT LEG BONE LESION
419	REPAIR/GRAFT ACHILLES TENDON
420	REMOVE OF TISSUE EXPANDER
421	BIOPSY ELBOW JOINT LINING
422	REMOVAL OF WRIST PROSTHESIS
423	BIOPSY FINGER JOINT LINING
424	TENDON LENGTHENING
425	TREATMENT OF SHOULDER DISLOCATION
426	LENGTHENING OF HAND TENDON
427	REMOVAL OF ELBOW BURSA
428	FIXATION OF KNEE JOINT
429	TREATMENT OF FOOT DISLOCATION
430	SURGERY OF BUNION
431	INTRA ARTICULAR STEROID INJECTION
432	TENDON TRANSFER PROCEDURE
433	REMOVAL OF KNEE CAP BURSA
434	TREATMENT OF FRACTURE OF ULNA
435	TREATMENT OF SCAPULA FRACTURE
436	REMOVAL OF TUMOR OF ARM/ ELBOW UNDER RA/GA
437	REPAIR OF RUPTURED TENDON
438	DECOMPRESS FOREARM SPACE
439	REVISION OF NECK MUSCLE (TORTICOLLIS RELEASE)

Sr. No	Procedure Name
440	LENGTHENING OF THIGH TENDONS
441	TREATMENT FRACTURE OF RADIUS & ULNA
442	REPAIR OF KNEE JOINT
XV. Other operations on the mouth & face:	
443	EXTERNAL INCISION AND DRAINAGE IN THE REGION OF THE MOUTH, JAW AND FACE
444	INCISION OF THE HARD AND SOFT PALATE
445	EXCISION AND DESTRUCTION OF DISEASED HARD AND SOFT PALATE
446	INCISION, EXCISION AND DESTRUCTION IN THE MOUTH
447	OTHER OPERATIONS IN THE MOUTH
XVI. Plastic Surgery Related:	
448	CONSTRUCTION SKIN PEDICLE FLAP
449	GLUTEAL PRESSURE ULCER-EXCISION
450	MUSCLE-SKIN GRAFT, LEG
451	REMOVAL OF BONE FOR GRAFT
452	MUSCLE-SKIN GRAFT DUCT FISTULA
453	REMOVAL CARTILAGE GRAFT
454	MYOCUTANEOUS FLAP
455	FIBRO MYOCUTANEOUS FLAP
456	BREAST RECONSTRUCTION SURGERY AFTER MASTECTOMY
457	SLING OPERATION FOR FACIAL PALSY
458	SPLIT SKIN GRAFTING UNDER RA
459	WOLFE SKIN GRAFT
460	PLASTIC SURGERY TO THE FLOOR OF THE MOUTH UNDER GA
XVII. Thoracic surgery Related:	
461	THORACOSCOPY AND LUNG BIOPSY

Sr. No	Procedure Name
462	EXCISION OF CERVICAL SYMPATHETIC CHAIN THORACOSCOPIC
463	LASER ABLATION OF BARRETT'S OESOPHAGUS
464	PLEURODESIS
465	THORACOSCOPY AND PLEURAL BIOPSY
466	EBUS + BIOPSY
467	THORACOSCOPY LIGATION THORACIC DUCT
468	THORACOSCOPY ASSISTED EMPYAEMA DRAINAGE
XVIII. Urology Related:	
469	HAEMODIALYSIS
470	LITHOTRIPSY/NEPHROLITHOTOMY FOR RENAL CALCULUS
471	EXCISION OF RENAL CYST
472	DRAINAGE OF PYONEPHROSIS/ PERINEPHRIC ABSCESS
473	INCISION OF THE PROSTATE
474	TRANSURETHRAL EXCISION AND DESTRUCTION OF PROSTATE TISSUE
475	TRANSURETHRAL AND PERCUTANEOUS DESTRUCTION OF PROSTATE TISSUE
476	OPEN SURGICAL EXCISION AND DESTRUCTION OF PROSTATE TISSUE
477	RADICAL PROSTATOVESICULECTOMY
478	OTHER EXCISION AND DESTRUCTION OF PROSTATE TISSUE
479	OPERATIONS ON THE SEMINAL VESICLES
480	INCISION AND EXCISION OF PERIPROSTATIC TISSUE
481	OTHER OPERATIONS ON THE PROSTATE
482	INCISION OF THE SCROTUM AND TUNICA VAGINALIS TESTIS
483	OPERATION ON A TESTICULAR HYDROCELE

Sr. No	Procedure Name
484	EXCISION AND DESTRUCTION OF DISEASED SCROTAL TISSUE
485	OTHER OPERATIONS ON THE SCROTUM AND TUNICA VAGINALIS TESTIS
486	INCISION OF THE TESTES
487	EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE TESTES
488	UNILATERAL ORCHIDECTOMY
489	BILATERAL ORCHIDECTOMY
490	SURGICAL REPOSITIONING OF AN ABDOMINAL TESTIS
491	RECONSTRUCTION OF THE TESTIS
492	IMPLANTATION, EXCHANGE AND REMOVAL OF A TESTICULAR PROSTHESIS
493	OTHER OPERATIONS ON THE TESTIS
494	EXCISION IN THE AREA OF THE EPIDIDYMIS
495	OPERATIONS ON THE FORESKIN
496	LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE PENIS
497	AMPUTATION OF THE PENIS
498	OTHER OPERATIONS ON THE PENIS
499	CYSTOSCOPICAL REMOVAL OF STONES
500	CATHETERISATION OF BLADDER
501	LITHOTRIPSY
502	BIOPSY OFTEMPORAL ARTERY FOR VARIOUS LESIONS
503	EXTERNAL ARTERIO-VENOUS SHUNT
504	AV FISTULA - WRIST
505	URSL WITH STENTING
506	URSL WITH LITHOTRIPSY
507	CYSTOSCOPIC LITHOLAPAXY
508	ESWL
509	BLADDER NECK INCISION
510	CYSTOSCOPY & BIOPSY

Sr. No	Procedure Name
511	CYSTOSCOPY AND REMOVAL OF POLYP
512	SUPRAPUBIC CYSTOSTOMY
513	PERCUTANEOUS NEPHROSTOMY
514	CYSTOSCOPY AND "SLING" PROCED
515	TUNA- PROSTATE
516	EXCISION OF URETHRAL DIVERTICULUM
517	REMOVAL OF URETHRAL STONE
518	EXCISION OF URETHRAL PROLAPSE
519	MEGA-URETER RECONSTRUCTION
520	KIDNEY RENOSCOPY AND BIOPSY
521	URETER ENDOSCOPY AND TREATMENT
522	VESICO URETERIC REFLUX CORRECTION
523	SURGERY FOR PELVI URETERIC JUNCTION OBSTRUCTION
524	ANDERSON HYNES OPERATION (OPEN PYELOPALSTY)
525	KIDNEY ENDOSCOPY AND BIOPSY
526	PARAPHIMOSIS SURGERY
527	INJURY PREPUCE- CIRCUMCISION
528	FRENULAR TEAR REPAIR
529	MEATOTOMY FOR MEATAL STENOSIS
530	SURGERY FOR FOURNIER'S GANGRENE SCROTUM
531	SURGERY FILARIAL SCROTUM
532	SURGERY FOR WATERING CAN PERINEUM
533	REPAIR OF PENILE TORSION
534	DRAINAGE OF PROSTATE ABSCESS
535	ORCHIECTOMY
536	CYSTOSCOPY AND REMOVAL OF FB

ANNEXURE IV

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

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

ANNEXURE V

ICD codes for the specified disorders / conditions

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

ANNEXURE VI

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

LIST I – EXPENSES NOT COVERED

Sl. No.	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES

Sl. No.	Item
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

Sl. No.	Item
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

Sl. No.	Item
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

LIST IV – ITEMS THAT ARE TO BE SUBSUMED INTO COSTS OF TREATMENT

Sl. No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT

Sl. No.	Item
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG